Senior Care Task Force
Working Group B – Access to Services
Recommendation Characterization
April 15, 2022
9:00-10:30am

Meeting Notes

Meeting Materials:
Preliminary Recommendation List

Agenda:
9:00AM Welcome and Introductions
9:10AM Recommendation Characterization
10:25AM Administrative Updates and Next Steps
10:30AM Adjourn

Meeting Commitments:
- Come ready to discuss and compromise
- Keep remarks succinct and on topic
- Don't hesitate to ask clarifying questions
- Start and end on time

Attendees
Working group members:
Sarah Schlitter, JCDS; Jamie Gideon, Alzheimer's Association; Annette Graham, Central Plains Area Agency on Aging; Jan Kimbrell, Silver Haired Legislators; Staci Carson, JCDS; Heather Brown, JCDS

KHI Staff
Hina Shah, Emma Uridge

KLRD Staff
Sean Marshall, Connor Stangler

Welcome and Introductions
"What is one thing you want to keep top of mind when thinking about your recommendations today?"

- Jamie Gideon: I hope to make actionable recommendations.

- Jan Kimbrell: I hope whatever the group comes up with does not get sent to the backburner and the recommendations make it through to get passed by the legislature.

- Heather Brown: Focus on recommendations that can be obtainable, and group needs to be specific.

- Staci Carson: Take actionable steps to make differences.

- Annette Graham: How best can we improve access for older adults 60+ across Kansas?

Recommendation Discussion

Working group members reviewed and characterized recommendations under WGB's assigned areas of focus. The group discussed recommendations listed below, which reflect the changes and discussion in purple. The three areas of focus addressed in the meeting were the Provision of care for seniors in the state of Kansas who suffer from Alzheimer's disease, dementia, or other age-related mental health conditions, Rebalancing of Home and Community-Based Services, and Adult Daycare Resources

Topic: (P) Provision of care for seniors in the state of Kansas who suffer from Alzheimer's disease, dementia, or other age-related mental health conditions

Theme 1: Legislation and Policy

1.1 Have the Alzheimer's Disease Task Force present to the Legislature once each legislative session around changes from last report out, actionable items for this session.

- Member defined regularly as at least once each legislative session. Indicators to present on may include relevant changes, and any actionable items for each session, which changes yearly.

1.2 Use the Alzheimer's Association State Plan and Alzheimer's Disease Task Force to develop recommendations to prepare the service system by looking at trends and numbers to ensure facilities are prepared for capacity; staffing; funding to meet the increasing demands for services as the population ages.

- Working group member indicated that the Alzheimer's Disease Task Force submitted 40 recommendations in the Kansas Alzheimer's state plan for consideration. The recommendation was submitted to consider preparation for the numbers of seniors in need of services and looking at trends to make sure facilities are prepared for increased capacity with appropriate resources (e.g., staffing, beds, space).

- Working group member stated that preparing the service system will need an evaluation of current and future funding, and how the Senior Care Task Force will move forward to get that funding appropriated.

1.3 Reinstate the State Agency Advisory Council. If reinstituted, the State Aging Advisory Council strongly recommended to mirror the federal composition of the Area Agencies on Aging advisory council defined in the Older Americans Act, including: More than 50 percent are older persons, including minority individuals who are participants or who are eligible to participate in programs under this part; Representatives of older persons; Representatives of health care provider organizations, including providers of veterans' health care (if appropriate); Representatives of supportive services providers organizations; Persons with leadership experience in the private and voluntary sectors; Elected officials; and The general public; rep from Alzheimer's Disease Task Force. (Adapted from k4ad)

- Working group clarified that it is recommended for the AAAs mirror the Older Americans Act, stating recommendation is appropriate and will help Kansas achieve goal of the Senior Care Task Force.

- Other members agreed and changed “must” to “strongly recommend”, stating inclusion and keeping Kansans together is important.
- Working group agreed to add someone from Alzheimer’s Disease Task Force to be a member.

1.4 Establish a permanent, full-time Dementia and Alzheimer’s Disease Coordinator position at Kansas Department for Aging and Disability Services (KDADS) with the following roles and responsibilities.

- Member indicated that the Alzheimer’s Association listed this as a priority nationwide. Half of states already have a full-time or part-time position. Legislature would need to fully fund this position.

a. Serve as federal and state liaison and training administrator at KDADS.
b. Use Civil Monetary Penalty (CMP) funds to provide advanced dementia care training for all care staff.
c. Provide standardized training for Community Mental Health Centers (CMHC) or other designated locations e.g., senior centers, AAAs collaborate with those with expertise on geriatric mental health and administer dementia training targeted at caregivers.

- Working group member indicated CMHCs regional model is too far for seniors living in rural and frontier areas, so member offered to not limit P1.4c to just CMHCs. Members indicated a possible solution would be to hold training at senior centers or at a regional AAA office.

- Working group member thought a dementia specialist would not be appropriate for geriatric mental health training since Alzheimer’s and dementia are not considered mental health conditions by the Alzheimer’s Association. Geriatric mental health does not naturally fall under the expertise of a dementia coordinator. Chair indicated that this is a good point and changed to “coordinate or collaborate with” to provide someone with knowledge and expertise on geriatric mental health.

- Member noted that training can be administered at other locations, and not just senior centers.

d. Have Alzheimer’s Association, or AAAs, to focus on identifying family caregivers on the brink of burnout to keep the individual in the home, promote their resources, and do outreach to local agencies, LTCs, and Community Mental Health Centers (CMHCs).

- Member indicated that under the Older Americans Act (OAA), AAAs are already required to be a resource for caregivers and questioned if there could be more collaboration with the Alzheimer’s association to communicate that.
- Member stated that the Alzheimer’s Association also provides this service, and the group could create a new subset of recommendations regarding respite care services instead. Member noted that some groups are trying to create funding in Kansas for respite services, but not through legislature.

1.5 Utilize Area Agencies on Aging (AAA) to provide information and referral services and coordination of services for older adults aged 60 and older and caregivers.

a. Establish a referral service for family caregivers to help determine what services must be sought for care recipient in larger metro areas. Give them contact numbers and addresses to study for themselves.

- Working group member noted that under older Americans act, AAAs have title 3e which assigns roles and responsibilities for the National Caregiver Program. Title 3e requires AAAs to provide information for services, and this recommendation is duplicative of existing role of AAAs and will be tabled.

1.6 Director of Aging at KDADS will expand their scope to:

a. Educate local staff of private as well as public services to programs available to seniors to enable home-based care and services.
b. Educate landlords on section 8 to increase accessible and affordable housing options.
c. Market the Statewide Aging and Disability Resource Center (ADRC) phone number to access information on HCBS, PACE and other options for long-term care across the state.

- Working group members chose to expand the scope for the Director of Aging at KDADS who may already accomplish a, b, and c.

Theme 2: Increase Collaboration for Improved Care Coordination

2.1 Kansas should reenlist in the Money Follows the Person Program to assist with transitions for individuals wanting to move back to the community.

- Working group member indicated that the Money Follows the Person is a CMS program, and Kansas used to participate. CMS may allow more states to apply for this program. Member said it is better to state "ask Kansas if they want to participate" or "Kansas should reenlist".

2.2 PACE model training for transitioning individuals with dementia between homes assisted living to Nursing Home with Skilled Care to provide transition planning for seniors, their family, and caregivers in long-term care, home health, and for seniors in general that will include nurses and direct care staff to make the adjustment safer and less stressful for all with consideration for rural parts of state where PACE model doesn't exist.

- Working group member was not sure what model training is being mentioned, and that language needs to be more specific. KHI facilitator will follow-up with Shawn Sullivan from Midland Care Connection.
- Member elaborated that "between homes" most likely means a senior in assisted living is placed in a nursing home with skilled care, and rationale for the recommendation is those with dementia have transitioning trauma that can be prevented with proper transition planning.
- Member pointed out that model training may work well in urban areas, but not rural/frontier areas. Member added this consideration to the recommendation.

2.3 Change policy to allow shared resources, that may become available for home-based care and more isolated in long-term care.

If providers are collaborating to provide services to someone, both providers should be compensated.

- Group agreed to pause discussion on this recommendation to do more research. Recommendation may need to be put in appendix for future efforts.

Theme 3: Education and Training

3.1 Require education training credits for dementia training annually for all long-term care employees with a minimum of 4 initial hours each year within first 90 days of employment: minimum of 2 continuing education (CE) credits after that, and two hours of continuing education (CE) for physicians, social workers, and licensed mental health professionals through respective boards.

- Member indicated that dementia training for providers keep this population top of mind. Providers will be held accountable by requiring specific CE hours to maintain license through their various licensure boards. By adding "long-term care (LTC) employees", it would be easier lift to get this implemented. The original recommendation encompasses multiple boards and regulatory authorities which could be problematic.
- Another member disagreed, saying that using all LTC employees may be problematic, but it shouldn't be. Care may come from cooking or maintenance staff, who can provide time and understanding to patients while licensed and certified staff are doing direct-care duties.
- Others agreed, the Alzheimer's Association recommends that all LTC employees that encounter patients with these diseases should have training on Alzheimer's and dementia. Member pointed out that there is no requirement for dementia care CE for LTC direct care workers. Workers may get initial training, but training is not required by all Kansas Facilities. Recommendation needs to be worded to not just be continuing education, but a requirement for onboarding.
- Alzheimer's Association recommends minimum of 4 initial hours annually, and training to be administered within the first 90 days of employment, then 2 CE after initial year of employment.

3.2 Require education training credits for geriatric mental health training annually for all long-term care employees with a minimum of 3 initial hours each year, and 3 hours of continuing education (CE) for social workers, and licensed mental health professionals through respective boards.

- Working group member noted that there is no mention of training for mental health in P3.1 recommendation and that recommendation should include social workers, and LTC staff. P3.2 is a new recommendation created from P3.1 to address training requirements for geriatric mental health. Three hours is standard for this specific training.

Topic: (R) Rebalancing of Home and Community-Based Services

Theme 1. Increase Rates and Service Offerings for Medicaid Waivers

1.1 Modify the HCBS Waiver to include the following services:

a. Home delivered meals to the Frail Elderly (FE) and Home and Community Based Services (HCBS) waiver.

- Member noted that home delivered meals are available on the physical disability waiver.

b. Include access to technology and training on how to use technology as an MCO member benefit for those receiving HCBS services.

- Member noted technology literacy is an issue for seniors and training on technology is needed.

c. Add case management services to the HCBS, Frail Elderly (FE), Physical Disability (PD) and Brain Injury (BI) waiver for those 60+.

1.2 Create in statute a mechanism to increase provider rates for the Physical Disability (PD), and Frail Elderly (FE) waivers annually or every other year.

- KHI will reach out to subject matter expert on the process for provider rate increases for standards across the country.

1.3 Increase rates for personal care services and determine pay based on geographic location.

- Member says it is more expensive to bring workers to rural and frontier areas and want salaries to reflect that.

1.4 *Ensure services under the Frail Elderly (FE) waiver are structured to meet the needs of those 60+ with IDD.*

- Member stated that the FE, PD, and IDD waivers all have different authorizations for services and questioned if these services, specifically under the FE waiver, can be adapted for the IDD waiver?
- Another member noted that some services under FE waiver can be added to IDD waiver.

Theme 2: Regulatory Enforcement, Legislation, and Policy

2.1 Leverage the increase in protected income level to mitigate any costs associated with coming into compliance with the CMS final settings rule.

- Member speculated if Governor Kelly signed the latest budget recommendations for raising the protected income level to 300% federal SSI for those receiving waivers. Before it was less than 150% SSI.
- Working group reached consensus they were unsure about recommendation mitigating any costs.

2.2 Require providers to pass on % rate increase to workers to impact workforce availability.

- Related to rate increases, group needs to designate percent of income in this recommendation to dedicate funds to workforce. There are currently no stipulations on how to use reimbursement rate increases.
- Member was concerned that the proposed rate increase will be used for administration costs and workers may not see increase in salary or hourly pay. Member indicated that there are funds allocated that must go to retention and recruitment.
- Member wondered what happens if provider reimbursement rate is raised, but does not get passed to the staff, citing the workforce shortage is about pay.

- Entities that can weigh in on this include the AAAs networks where pay rates are outlined in service contracts.
- Working group still needs to determine the rate increase percentage.

2.3 Provide financial incentives to rural hospital outpatient services to be PACE provider in smaller communities.

- No discussion on this recommendation from working group.

2.4 Utilize the Client Assessment and Referral and Evaluation (CARE) score to create tiered level of services for HBCS clients in assisted living and Home Plus, instead of per unit fees that are difficult for providers to budget for.

- No discussion on this recommendation from working group.

Theme 4 Education and Training

4.1 Require continuing education requirements annually to health care professionals and providers about HCBS and other options, including wellness monitoring, for older adults so that the first option is not nursing home referral to increase its use as low-cost medical care.

- Working group decided recommendation will be kept as a separate HCBS-focused training recommendation rather than combine with the other training recommendations focused on Alzheimer's and dementia. Number of hours for continuing education still needs to be determined.
- Group needs to define and distinguish between Medicaid HCBS services and generic HCBS services not associated with Medicaid.
- Group member indicated that wellness monitoring may not fit in the recommendation. Others countered that it should be kept because it is a resource to provide nursing care to keep seniors out of nursing homes. Member offered to include implementing continuing education to providers that can include wellness monitoring.

Theme 5 Case Management Services

5.1 Add case management services through the Aging and Disability Resource Center (ADRC) to assist those needing assistance as they onboard or transition programs.

- Member noted that case management is not offered through the ADRC. ADRC has a call center and offers referral services, options counseling, and assessment. Group reached consensus to change "expand" to "add".
- Member referenced R1.1c that adds case management services for FE, PD, and BI waivers, and asked if group adds case management services to waivers, if there is a need to add to ADRC.
- Other member indicated that R1.1c discusses Medicaid vs non-Medicaid seniors. ADRC provides services to non-Medicaid populations, and this recommendation would be intended for those onboarding or transitioning to non-Medicaid programs.

Theme 6 Increase Access to Affordable Housing

6.1 Encourage collaboration to invest in housing options to increase the availability of accessible, affordable housing options for older adults.

- Members added "encourage collaboration" to recommendation. Member from JCDS offered up collaboration with a non-profit not currently affiliated with JCDS, but they seek to provide affordable and accessible housing. Member wondered if they could also seek housing options for those with IDD.
- Member wondered if there is current research on how the senior care task force can incentivize both sides of a collaborative effort. KHI facilitator offered that the group could recommend the legislature fund a study on this effort, and that group needs to determine who will be collaborating.

Topic: (A) Adult Daycare Resources

Theme 1: Funding, Legislation, and Policy

1.1 Increase funding/reimbursement rates to Adult Daycare Services and Day Service providers to increase staffing and more opportunities to serve people in their homes during the day vs. going to a facility.

- Group needs to explicitly define adult daycare versus day services. Member indicated that day service providers are for HCBS IDD services and is different than adult daycare services.
- Member wondered if rate increases will be for both services. Member stated the term "daycare" is terminology used outside the IDD waiver. Rate increase may apply to both services, not just adult daycare.
- Group would like to designate a % increase for reimbursement rates and may look at lessons learned from other states to determine.

1.2 The State of Kansas will provide grants for senior centers, housing providers, and assisted living providers to retrofit or establish space appropriate for adult day centers.

- Group reached consensus that additional funding from KDADS will be needed to execute this recommendation.
- Member asked about the opportunities for multiple agencies with similar goals to work together to provide funding.
- Sean Marshall will provide KLRD perspective on budgets that may allow for additional funding from state to accomplish the recommendation. KHI will follow up with KDADS and KDHE to see how funding and grant contract process works with an assigned entity to gauge feasibility for involving key collaborators from multiple agencies with funding housed in one place.
- Member indicated that with collaboration, funding would need oversight, which might be an issue depending on the collaboration.

Theme 2: Utilize Senior Centers to Administer Services

2.1 Expand the PACE Program across the state to serve as a hub to administer social models of adult day services that focus on person-centered care for the needs of older adults and increase eligibility criteria for the program area.

a. *Current Senior Centers will connect with community partners, who also provide day services and involve non-traditional stakeholders (community members & business leaders) to develop pilot programs for community members to discuss health, oral health, using technology, etc.*

- Member says PACE centers are not located in Western Kansas and expanding urban-centered PACE program may not serve all seniors living in Kansas.
- Another member says criteria for PACE program is 55+ in need of skilled nursing care, and individuals must reside in an area where PACE services are offered. Currently, only three areas of the state provide PACE services, and program is not able to serve all counties.

2.2 Expand reach of the PACE program for transportation among providers to bring services to those being served in-home to minimize costs and expand accessibility.

(Rationale: for those that may not be able to travel safely or may be disoriented by changing locations.)

- Member indicated that transportation may not fit under A2.1a for senior centers and offered recommendation subset to be its own recommendation.
- A lot of centers don't provide transportation to and from centers. Other member stated that senior centers in rural counties like Gerry County, include transportation.

2.3 KDADS will lead recruitment for providers to administer respite services; Providers will develop respite services; AAAs and reimbursement entities will market those services.

- Member said providers could develop respite services and market it with help from the AAAs Options Program and others who reimburse for those services and programs. Respite care services requires licensure so it would have to be the providers, with KDADS maybe taking lead in getting more providers.
- Member discussed challenge of inconsistent availability of respite services in some areas of the state. For example, respite services only were available when census was low at an assisted living facility.

Theme 4 Utilize Volunteers

4.1 AAAs and senior centers will partner with Kansas Alzheimer's Association and AARP to access resources, training, and technical assistance for adult day service training and volunteer engagement.

a. Volunteers may be younger from 4H, boy scouts, high school, or college; and AAAs and senior centers can partner with Retired and Senior Volunteer Program and Senior Companion programs (through AmeriCorps) to utilize the volunteers in adult day service programs.

- Member stated that KCDS provides a listing of services in the area and other resources seniors may be able to receive. Another member suggested AAAs and senior center site managers can use this information to get volunteers.
- Member noted that AAAs have existing relationships with senior centers because centers serve as a congregate nutrition service site, so there is a current connection with them on sharing information about services.

- Group decided to combine recommendations A4.1 - A4.3 into one recommendation.

Administrative Updates

Working group members were asked to provide additional insight on recommendations discussed during this meeting, or to submit proposed changes to the preliminary recommendation list before the next meeting, on April 29, 2022.