NCIOM North Carolina Institute of Medicine
shaping policy for a healthier state

TASK FORCE ON ALZHEIMER'S DISEASE AND RELATED DEMENTIA

NORTH CAROLINA INSTITUTE OF MEDICINE
630 DAVIS DRIVE, SUITE 100
MORRISVILLE, NC 27560

JUNE 26, 2015
10:00 am - 3:00 pm

Meeting Summary

INTRODUCTION AND WELCOME TO THE TASK FORCE

Co-chair Doug Dickerson called the meeting to order and welcomed everyone

Task Force members in attendance: Steve Freedman, Kalyan K. Ghosh, Sara Jane Melton, Lucille Bearon, Rep. Marilyn Avila, Kathleen Welsh-Bohmer, Nacy Washington, Renee Batts, Alicia Blater, Patricia Sprigg, Linda Darden, Sheila Davies, John K. Eller, James H. Johnson, Jr., Joe Stevenson, Pamela Sarsfield Fox, Margaret A. Noel, Len Lecci, Polly Welsh, Connie Bishop

Steering Committee members and co-chairs in attendance: Mary Bethel, Scott Herrick, Alice Watkins, Doug Dickerson, Lisa Gwyther, Goldie Byrd, Peggy Terhune

Speakers/guests in attendance: Philip D. Sloane, Nancy Smith Hunnicutt, Lorretta Matters, Kaycee Sink, Pamela Dillingham, Meka Sales, Deb Burcombe, Pamela Dickens, Peggy Best, Nique Williams, Thomas, Kathie Smith, Tamara Norris, Brian Spillman, Cathy Hebert, Janeli Smith

NCIOM Staff in attendance: Adam Zolotor, Michelle Ries, Rose Kerber

HEALTH PROFESSIONAL TRAINING

Renee Batts
Associate Director, Allied Health
North Carolina Community Colleges System

Ms. Batts gave an overview of the health sciences training programs at North Carolina's 58 community colleges. She highlighted the RIBN program as a successful effort to increase NC'S health workforce. Discussion points revolved around challenges to offering geriatric or dementia-specific certification.

Loretta Matters, RN, MSN
Associate Director
Center of Excellence in Geriatric Nursing Education
Duke University School of Nursing

Ms. Matters discussed the importance of effective communication between providers and

dementia patients. In addition, she reviewed the Center's ongoing collaborations. Discussion points included Geriatric Education Centers; delirium training; team-based training; and NICHE hospitals.

Philip D. Sloane, MD, MPH
Elizabeth and Oscar Goodwin Distinguished Professor of Family Medicine
Co-Director, Program on Aging, Disability and Long-Term Care
Cecil G. Sheps Center for Health Services Research
University of North Carolina at Chapel Hill

Dr. Sloane emphasized the importance of creating environments that can optimize the quality of life of dementia patients. In particular, he discussed the need for delivering specialized training to caregivers and paraprofessionals. Discussion points included evidence-based programs like Bathing Without a Battle; provider pocket cards with billing codes and referral resources; and challenges for training/retaining CNAs.

HEALTH SYSTEM CAPACITY AND ACCESS TO CARE

Linda Darden, MHA, CPA
President and CEO
Hospice and Palliative Care Center

Ms. Darden provided an overview of hospice and palliative care. Hospice is primarily covered by Medicare and requires a 6 month life expectancy. Palliative care can be provided without a 6 month prognosis, but it is offered in limited settings. Discussion points included Medicaid hospice provisions; Advanced Care Planning and Advanced Directives; the need for end of life training; and relaxing eligibility requirements for hospice care, including the 6 month prognosis.

Polly Welsh
Executive Vice President
North Carolina Health Care Facilities Association

Ms. Welsh reviewed the training program and registry system for Nurse Aides. She also highlighted efforts at improving dementia care in North Carolina facilities including reduction of anti-psychotic medication use, and adoption of Mouth Care Without a Battle. Discussion points included reimbursement issues; legal risks in nursing homes; respite care; culture change around respect of paraprofessionals; and the regulatory environment.

Nancy Smith Hunnicutt
Long Term Care Regional Ombudsman
Land of Sky Area Agency on Aging

Ms. Hunnicutt addressed challenges in treating dementia patients in a hospital setting, where there is no clear protocol for administering care correctly. Discussion points included distinguishing between dementia and delirium; providing screening tools to caregivers; educating nurses; establishing a pain protocol; keeping detailed medical histories; and using "slow medicine."

Kaycee Sink, MD, MAS
Associate Professor and Interim Chief
Section on Gerontology and Geriatric Medicine
Wake Forest University School of Medicine

Dr. Sink spoke about the need for better geriatric training for all physicians given the shortage of geriatric specialists. She emphasized the need for hospital units better suited to the needs of dementia and delirium patients to reduce functional decline associated with hospitalization. Discussion points included Acute Care for the Elderly (ACE) units; low pay for geriatricians; memory clinic waiting lists; and transitions between care settings.

Questions from Rep. Avila: Do certificate of need laws hamper accessibility? What is the impact of the shift from fee-for-service to Managed Care? Asked for a response at a later date.

ECONOMIC IMPACT OF ALZHEIMER'S DISEASE

James H. Johnson, Jr., PhD
Director, Urban Investment Strategies Center
Frank Hawkins Kenan Institute of Private Enterprise
William R. Kenan Jr. Distinguished Professor of Strategy and Entrepreneurship
Kenan-Flagler Business School, University of North Carolina at Chapel Hill

Dr. Johnson presented demographic information about the aging population of North Carolina. He emphasized the need for integrating the built environment with person-centered activities and assistive technologies, including wearable technologies and urban design for the aging population. Discussion points included population distribution in NC; dying rural counties; the Aging in Place Research Framework from the Elder Care Economy Innovations Hub; and the importance of education for developing the future tax base.

DISCUSSION OF POTENTIAL RECOMMENDATIONS: HEALTH PROFESSIONAL TRAINING, ACCESS TO CARE, HEALTH SYSTEM CAPACITY

Ms. Ries facilitated discussion around Training and Health System Capacity.
Training discussion and recommendations

- Need for outpatient care worker training including CNAs and Home Aides
    - There is proposed legislation that will require EMTs to have competency evaluation
- Need to incentivize direct care workers to help them get certification and additional training, not just more regulation of workers. Incentives might include compensation, benefits, higher reimbursement rates, loan forgiveness or others
- Care workers need more recognition and respect, their employers need a better understanding of who has had what training; what roles each plays
    - Should include care workers in discussions around training
    - Need to establish better support systems for care workers than national chains offer
- Create more opportunities for dementia certification at all possible levels, including community colleges
- Create a coordinated training entity for caregivers and providers
- Disseminate a pocket card about dementia (resource referral, billing codes, etc.) for

physicians and nurses throughout the state, especially in rural areas
- Health care worker registry may not be enough to regulate care workers, consider additional regulatory structures
- Expand behavioral management training to reduce pharmacological dependence
    - Expand collaborative programs that already do this
- Train providers in cultural competency
- Q: Do providers need more training in dementia care?
- A: Yes, many don't receive the right training, often feel that nothing can be done for these patients, don't understand how to communicate with them
- Need a system for referring people to resources
- Create a private-public scholarship program to encourage nurse and others to go into geriatrics, engage corporate sponsors
- Broaden diversity incentives in medical school admissions in order to attract and educate more people that might work in aging. Barriers to recruitment are largely financial, geriatrics offers flexibility which is attractive, but the debt-to-pay ratio is high
- Expand education models like RIBN and RN-BSN articulation agreement that can keep people in area
- Make training programs convenient, flexible and less formal, establish a core of content that everyone learns (nurses, physicians, caregivers, etc.)
- Create dementia modules for emergency workers
- Early diagnosis must be culturally competent and accessible
- Education of all health workforce – to be aware of special needs of older adults, with dementia – starting with point of entry, moving through until discharge (beyond?)
- Training must be where people are – draw on public health
- Family caregivers – increase access to information, re: chronic problems, not knowing where to go for resources and assistance. Physical care – how to do things? Where are these resources and how to help families have access to them?

Health System Capacity and Access discussion and recommendations:
- Remove reimbursement barriers
    - Clinics switch from physician-based to hospital-based billing under Medicaid which means that reimbursement models change
- Create incentives for NPs and PAs to go into geriatric care
- Establish protocol for behavioral management, should precede medication management
- Palliative care models should allow for earlier eligibility and stays over 6 months
- Need more dementia-related assessments and diagnostic tools
- Address waiting lists for services (adult day care, respite, HCBS waivers, awareness of available resources)
- Remote access screening tools and multidimensional screening tools
- Evaluate the economic impact of respite care- can it save Medicaid money?
    - Case managers are often unaware of waivers
    - Need ways of integrating reimbursement
- Create/expand dementia call systems
- Need safe environments for people with behavioral challenges other than ER
    - Create special units, geriatric inpatient or special care units
    - Keep Medicaid issues in mind