REPORT OF THE TASK FORCE ON QUALITY LONG TERM CARE
(Senate Concurrent Resolution 39)

TASK FORCE ON QUALITY LONG-TERM CARE

Research Memorandum No. 493

LEGISLATIVE RESEARCH COMMISSION
Frankfort, Kentucky
February 2002

LONG-TERM CARE IN KENTUCKY
(Senate Concurrent Resolution 39)

TASK FORCE ON QUALITY LONG-TERM CARE

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MEMORANDUM

TO: Senator David Williams
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Members of the Legislative Research Commission

FROM: Senator Richie Sanders, Co-Chair
Representative Harry Moberly, Co-Chair
Task Force on Quality Long-Term Care

SUBJECT: Task Force on Quality Long-Term Care Report

DATE: February 18, 2002

Senate Concurrent Resolution 39 of the 2000 Session directed the Task Force on Quality Long-Term Care to make recommendations concerning the institutional and community-based provision of long-term care in Kentucky. Beginning in April 2001, the Task Force met monthly to accomplish its charge, and this report is a product of that study. Pursuant to SCR 39, this Final Report of the findings and recommendations of the Task Force is being provided to the Legislative Research Commission.

Staff of the Legislative Research Commission prepared the report, and their assistance to the Task Force is gratefully acknowledged.

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CONTENTS

SUMMARY

The Task Force on Quality Long-Term Care met monthly from April, 2001, through October, 2001, as required by Senate Concurrent Resolution 39 from the 2000 General Assembly. Testimony was heard from national experts and advocates on long-term care, and the Task Force divided into two work groups to consider the issues. Following completion of the discussion, the Task Force made the following recommendations:

RECOMMENDATIONS

Subject to the availability of sufficient funding during the 2002-2004 biennium, the Task Force adopted the following recommendations from the Work Group for Issues 1-5:

1. **Upgrade the eleven part-time nursing home ombudsmen positions to full-time positions in the Pennyrile, Lake Cumberland, Lincoln Trail, Purchase, FIVCO, Buffalo Trace, Kentucky River, Gateway, Northern Kentucky, Green River, and Big Sandy Area Development Districts, and provide for a minimum of one full-time ombudsman position for every 2,000 nursing home residents.**
2. **The Long Term Care Coordinating Council, authorized under KRS 216.583 but not funded, should be reconstituted and fulfill its duties as mandated.**
3. **The Cabinet for Health Services should re-evaluate and study the Medicaid reimbursement system that uses the Minimum Data Set (MDS) and Resource Utilization Groups (RUGS), giving consideration to the funding needed for outlier costs experienced by hospital-based long term care facilities as well as free-standing facilities. Additional study should be given to the funding needed for the care of persons whose behavioral symptoms cannot be safely managed in the normal nursing home setting, with consideration given to the plausibility of providing more appropriate placement for affected persons, such as the establishment of special behavior units and the possibility of providing additional training and/or resources to long-term care facilities that commit extraordinary resources to care for these persons.**
4. **Kentucky should utilize the civil monetary penalties (CMPs), collected through the fine process for regulatory violations, to establish grants and expenditures for improvement of quality long-term care for nursing home residents. The state should provide initial funds for facilities that are interested in implementing programs such as the Eden Alternative, provide training to the volunteer**

ombudsman program, and provide additional staff training to poor-performing facilities, as determined by past survey histories of facilities.

5. **Kentucky should fully fund its price-based reimbursement system for Medicaid beneficiaries who receive nursing facility services. Full funding must include a system of accountability that assures that additional funds be used to increase front-line staff or for other expenditures necessary to meet the needs of residents.**

Subject to the availability of sufficient funding during the 2002-2004 biennium, the Task Force adopted the following recommendations from the Work Group for Issues 6-7:

1. **An overall goal of establishing a public policy for long-term care in Kentucky should be established, giving individuals a right to live in the community in the place of their choice, with a right to be educated about their rights and choices. Individuals have a right to a timely evaluation of their ability to live in or return to the community, have the right to appropriate, community-based services, the right to a high quality of care, and the right to funding mechanisms that support them whether they are at home or in the community.**
2. **The Cabinet for Health Services should conduct a comprehensive, statewide educational effort to inform the affected individuals and their families, elected officials, other policymakers, and the general public regarding the rights of individuals with disabilities and the frail elderly to live in the community, in the home, and in the least restrictive environment of their choice.**
3. **The Cabinet for Health Services should make available Community Living Assessment Teams to provide, upon request of individuals and their families, an appropriate and timely evaluation of an institutionalized person's ability to return to a home of choice in the community, or an appropriate and timely evaluation of a person currently living in the community who desires to delay, prevent, or divert his or her institutionalization, if appropriate services are available, funding is economically feasible, and the individual or his or her family asks for the community services.**
4. **The 2002 General Assembly should approve a community services ombudsman program providing a full-time paid ombudsman in each Area Agency on Aging.**
5. **The 2002 General Assembly should direct the Cabinet for Health Services and the Cabinet for Families and Children to develop and implement a pilot integrated care management system in two area development districts by January 1, 2003.**
6. **The 2002 General Assembly should support the development of the "Aging Client Care Management and Record System" in the Cabinet for Health Services that links health and social service providers. This system may be implemented first as a pilot project in two area development districts.**
7. **The 2002 General Assembly should authorize the transfer of Medicaid funds currently allocated for nursing home care to home and community based**

services and direct the Cabinet for Health Services to develop a pilot "person centered/directed funding program" to permit up to 500 persons with disabilities and the frail elderly currently residing in long-term care facilities to return, at their option, to the community and a home and least restrictive environment of their choice.

8. **The 2002 General Assembly should authorize a Family Caregiver Support Program in the Cabinet for Health Services for the benefit of caregivers of physically and mentally impaired adults in need of long-term care services.**
9. **The 2002 General Assembly should provide additional funds for expansion of the Personal Care Assistance Program, Cabinet for Health Services, to serve 500 more persons with disabilities during FY 02-04.**
10. **The 2002 General Assembly should provide additional funds for expansion of the Home Care Program, Cabinet for Health Services, to serve 2,800 additional older persons during FY 02-04.**

TASK FORCE CREATION AND PURPOSE

Authorized by Senate Concurrent Resolution 39 in the 2000 General Assembly, the Task Force on Quality Long-Term Care met monthly from April through October, 2001. The Task Force was charged with studying methods to promote and enhance the quality of care provided in Kentucky's long-term care facilities as well as in-home and community-based services, including but not limited to the following:

(1) Wage pass through programs to increase staff salaries;

(2) Financial incentives for facilities exceeding quality standards;

(3) Linkage of reimbursement to staffing levels;

(4) Provision of additional training for facility staff;

(5) Mandatory staff-to-patient ratios;

(6) Assisted living facilities and other nonmedical socially oriented living arrangements in the community; and

(7) Noninstitutional services delivered in the home of the client including, but not limited to, the provision of home health, meals, housekeeping, and assistance with personal care.

INTRODUCTION

To facilitate discussion of the broad nature of its jurisdiction, the Task Force divided into two work groups, the first to consider the medical and mostly institutional issues, and the second to consider the nonmedical and mostly home and community-based issues. The work groups met monthly and reported at each meeting of the full Task Force.

The full Task Force received testimony from nationally recognized experts about Kentucky’s changing demographics and about the efforts of other states to address the challenges of long-term care. A copy of the monthly agendas is attached as Appendix A. To assist the reader with a better understanding of the nature of the issues, a glossary of long-term care terms, which was distributed at the first Task Force meeting, is attached as Appendix B. A listing of the meeting handouts is attached as Appendix C.

PART 1: BACKGROUND[1]

Task Force Testimony

Demographics

The Director of the Kentucky State Data Center testified as to the significant growth in the next decade of the sixty-five and older population in Kentucky.[2] People are living longer, and most of the state's current growth has been in the forty-four to sixty-five age range. He indicated that, as more people live longer, there will be more relatives in their fifties and sixties caring for them who will need to work longer to sustain the necessary income. Living arrangements of the elderly may be influenced by their disability status and need for assistance. Women are living longer and more are living alone.

In the early 1900s, only one out of ten people lived beyond the age of sixty-five, while in 2000 the rate became eight out of ten. The State Data Center Director said that there will be fewer caregivers for the elderly in the future due to the aging of the workforce and the increasing numbers of the elderly. He indicated that between 2010 and 2030, *all* growth in Kentucky's population will be in the sixty-five and older group. The average household of the future likely will have more older parents with fewer children to take care of them.

A health policy consultant with the National Conference of State Legislatures testified that the long-term care industry is highly regulated, and there is much concern about the availability of competent health professionals who are trained to provide long-term care services.[3] The consultant said that there is a national shortage of front-line workers, and the shortage is expected to worsen. Front-line workers historically make low wages, lack benefits and training, and have little opportunity for career advancement. Thirty-six states have mandatory staff-to-patient ratios, and while there are federal standards for registered and licensed nurses, there are none for nurses aides. In Kentucky's nursing homes, staff spend approximately 3.59 hours of care per day per resident, which is relatively high when compared to other states in the southern United States.

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[1] Part I summarizes the testimony received by the Task Force. No attempt is made to expand on, comment on, or draw additional conclusions from the material presented. The presenter is identified at the beginning of each topical section. All following statements can be attributed to the testimony of that previously identified presenter unless specifically attributed to another source.

[2] Testimony of the Kentucky State Data Center before the Task Force on May 23, 2001.

[3] Testimony of the National Conference of State Legislatures before the Task Force on May 23, 2001.

Attitudes of Elderly Kentuckians

According to a study by the Kentucky Long Term Policy Research Center, forty-two percent of older people who become frail and unable to care for themselves will be taken care of by families and the government.[4] Citizens believe government support for medical care and long-term care is important, particularly for basic medical care, prescription drug coverage, nursing home care, transportation, housekeeping, cooking, and general assisted living. Despite the need for services, many people are not familiar with available in-home services, adult day care, Alzheimer's respite, long-term care ombudsmen, personal care attendants, senior community service employment, or senior health insurance counseling.

A survey of Kentuckians by the Long Term Policy Research Center found that 1) Kentuckians are retiring earlier than planned, often due to health problems; 2) financing medical care for older Kentuckians will be a significant challenge because many expect to rely heavily on Medicare; 3) most will find their standard of living about the same in retirement, but for those who rely on Social Security, retirement is likely to mark a change for the worse; 4) the future viability of Social Security and employer pension plans will have a significant effect on income security in Kentucky; 5) the health status of older Kentuckians is poorer than in most other states, so long-term care needs may be even more important here; 6) most older citizens believe government support is important for a range of programs and services for older citizens, including long-term care; 7) most older citizens believe that these services should be linked to financial need; and 8) most older citizens believe that both government and family should assume responsibility for frail elders.[5]

Availability of Services

The Interim Commissioner of the Kentucky Department for Medicaid Services testified that the bulk of long-term care is rendered through family caregiving.[6] One out of every four households is involved in family caregiving for an elderly and/or disabled relative. Many states have caregiver programs that provide information, referral services, and case management, and there has been an increase in respite care services. Some states provide tax credits or deductions for family caregivers and pay families to provide care for a family member.

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[4] Testimony of the Kentucky Long-Term Policy Research Center before the Task Force on June 27, 2001.

[5] Testimony of the Kentucky Long-Term Policy Research Center before the Task Force on June 27, 2001.

[6] Testimony of the Department for Medicaid Services before the Task Force on June 27, 2001.

Medicaid-covered services include medical care provided in a licensed nursing facility. The nursing facility may be a freestanding institution, a hospital-based institution, or a nursing facility that offers specialized services for ventilator-dependent patients, brain injury patients, or pediatric patients.

Medicaid also covers services for patients in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). Covered services include room and board, nursing services, medical and surgical supplies, laundry services, and personal items routinely provided by the facility.

The following services are also included if ordered by a physician: prescription drugs, x-rays, physical therapy, speech therapy, occupational therapy, laboratory services, oxygen, and related oxygen supplies. Physician-ordered services are reimbursed separately from the nursing facility on a per diem rate.

Nursing Practitioners in Long-Term Care Facilities

A consultant for the long-term care industry profession testified about her experience with long-term care around the country.[7] She believes that there has been an erosion of respect for professionals in long-term care. Most federal regulations are good but probably need to be updated.

She provided the following information and suggestions. Approximately 800,000 long-term care healthcare caregivers will be needed by 2008. Healthcare, not just long-term care, needs to address the nursing shortage. The nursing shortage today is supply-driven as compared to 1988 when it was demand-driven. The average age of a registered nurse is 46.5 years; younger people are not choosing nursing as a profession in sufficient numbers, in part due to burdensome regulation. The regulatory system for long-term care encourages burdensome oversight through a survey process in which investigators monitor nursing notes, convesations, and sevices during nearly annual inspections. Given that the average reimbursement rate from Medicaid is $9 less than cost, there is no financial reward for nurses to work in long-term care facilities.

Kentucky should design a system to evaluate the level of care and give consumers a true picture of what services and resources are available in nursing facilities. Technologies exist to use data-driven evaluation of nursing facilities to use accurate information that would give consumers and providers better information, and it should all be premised on the philosophy of quality improvement. Strategies should be developed to attract and retain healthcare workers. A coalition with universities should be established

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[7] Testimony of SunBridge Healthcare and the American Health Care Association before the Task Force on September 26, 2001.

to have Centers of Excellence for Long-Term Care. The price-based reimbursement system should be fully funded.

There should be an improvement in the working environment to make long-term care facilities more desirable work settings, but the consultant would not recommend mandatory staffing ratios because they have not been proven to accomplish the goal of improving quality. She recommended that every nursing facility be required to evaluate every resident and provide the level of care necessary, using the Minimum Data Set.

Nonmedical Practitioners In Long-Term Care Facilities

Information in this section was provided by representatives for nonmedical practitioners about the role of non-physician practitioners in the continuum of long-term care.[8] The vision is to provide essential practitioner primary care services to the long-term care continuum—its patients and families, its physicians and all members of the health care team devoted to attentive quality care in a facility or in the home. One company in Louisville provides services to approximately 16,000 nursing home residents in twelve states. Approximately 2,000 nursing home patients are served in Kentucky in Louisville, Lexington, Bowling Green, and Owensboro in community-based settings. Nurse practitioners and physician assistants are appropriate in the long-term care continuum in that they bring both a medical and nursing frame of reference to primary medical care, act as a bridge to the entire care support network such as Home Health Agencies, Hospice and Rehabilitation Centers, nursing homes, and community-based medical care, and provide an attentive approach to care. The autonomy given to nurse practitioners and physician assistants at point of service has been increased over the last several years in health care with proven outcomes.

For the Louisville company, non-physician practitioners helped reduce hospital re-admissions by approximately thirty percent. Reimbursement is made directly through Medicare Part B and Medicaid. By managing day-to-day chronic medical conditions, there has been a dramatic decrease in utilization of the emergency room and the need to return to institutional settings. Nurse practitioners and physician assistants are effective at reducing multiple medications and poly-pharmacy issues. Liability issues have decreased because the health professionals are intervening faster and are on-site to attend to the needs of patients.

Peer communication has reduced duplication. The families and patients are satisfied because of the extra attentiveness received, and national accreditation is used to address quality in long-term care facilities. Nurse aides and nursing staff often are the most overworked. A physician would have to see at least seven nursing home patients to

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[8] Testimony of HealthEssentials before the Task Force on September 26, 2001.

break even, and most physicians do not have seven patients at one facility, but non-physician caregivers can provide the care economically and efficiently.

On-site assessment is the most critical aspect of care, and non-physician practitioners play a big role in assessments. Access obstacles of in-home patients are transportation, acute systemic disease, incontinence, behavioral or psychiatric impairment, financial issues, social support, and the fact that many patients outlive their primary care physician. Non-physician practitioners can provide assessment help and manage the patients' health conditions before they become critical.

Nurse practitioners and physician assistants can write prescription orders, with the exclusion of scheduled drugs, without the co-signature of a physician, but the physician must sign off on what a nurse practitioner or physician assistant is allowed to do. Nurse practitioners and physician assistants can do regulatory visits with physicians, cannot certify patients for Medicare Part A hospice or home health, and can do care-plan oversight for hospice and home health.

Alternative Strategies

While long-term care involves nursing homes, hospitals, and community-based organizations, most long-term care is rendered in the home by family members.[9] Many states have caregiver programs that provide information, referral services, and case management, and there is an increase in respite care services. Some states are providing tax breaks for family caregivers and paying families to provide care for a family member.

Family caregivers are the backbone of the long-term care system, and the system is well-served by supporting those caregivers and educating them about appropriate care to assure that high quality care is given, thus minimizing the possible use of future institutional long-term care that might be paid for by Medicaid. California, Pennsylvania, Oregon, and Nebraska reportedly have good family caregiver programs. Another method of supporting family caregivers is to encourage adult day care programs that provide respite care by caring for elderly persons while their family caregivers leave to perform certain other personal tasks that would otherwise be neglected.

The Task Force learned that family support programs have not historically been paid for by Medicaid, which instead pays for *institutional* long-term care with little or no prior authorization. The requirement that community-based programs receive prior authorization and the failure to support family caregiver programs are reverse incentives built into the system.

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[9] Summary of information received by the Work Group for Issues 6-7, June and July, 2001.

The Task Force received testimony on another innovative alternative strategy from the chief executive officer of The Episcopal Church Home in Louisville, Kentucky.[10] There are nursing homes in all 120 counties, constituting an existing delivery system. One way to increase capacity to accommodate some of the anticipated growth expected among the elderly over the next ten years is to provide day care services within institutions that are appropriate for the people being served, which could probably be done at a much lower cost because many of the overhead costs associated with the building and commercial kitchen are already built into the nursing home. The benefit is that 1,500 to 1,600 more clients could be served per day. Kentucky could receive federal funds from the Administration on Aging through a demonstration grant.

The formula for determining the level of need that a community has for licensed long-term care beds should be improved and strengthened by recognizing 1) the existence of alternate or community-based long-term care services that play a key role in meeting the community's need; 2) the anticipated growth in the elderly population, based on statistically valid predictive indices already in use by the U.S. Census Bureau rather than reacting to demand after it outweighs supply; 3) the aggregate acuity of the residents currently served by licensed facilities in that area; and 4) occupancy of the currently licensed facilities in the community. The capital costs associated with converting already licensed Personal Care Home beds to Nursing Facility or Skilled Nursing Facility beds is significantly less than new constructions and should be given greater priority among competing Certificate of Need proposals for meeting the community's established "need."

The regulations that permit a Continuing Care Retirement Community to add nursing facility beds without a new Certificate of Need should be revised to require that the ratio of nursing facility/skilled nursing facility beds to non-nursing facility/skilled nursing facility beds be changed from 1:4 to 1:3. There is evidence to suggest that because people are entering retirement communities at more advanced ages than previously, their movement through the available continuum of care is more rapid. This places greater demand on the more intense levels of care in that continuum in order to meet the more rapidly changing needs of the residents. The number of Kentucky retirement communities is small enough for this adjustment to pose little threat to competition in any given area, or exceed the established long-term care facility need.

There should be flexibility in the Certificate of Need process to stimulate innovation while protecting the public's interest. The current reimbursement system for long-term care institutional-based services does not sufficiently recognize the value of training.

Finally, the chief executive officer for The Episcopal Church Home stated that there should be a Medicaid reimbursement model that capitalizes on the positive features of the acuity-based system now in place but that also 1) provides for adequate levels of direct care staff who are competitively paid; 2) recognizes the value of staff training and

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[10] Testimony of The Episcopal Church Home before the Task Force on July 25, 2001.

continuing education; and 3) more effectively reflects time-intensive needs of residents with altered behaviors.

Olmstead Decision

The Interim Secretary of the Cabinet for Health Services, and Task Force member, testified that the *"Olmstead"* decision rendered by the United States Supreme Court in June 1999 provides that it is a violation of the Americans with Disabilities Act (ADA) for states to discriminate against people with disabilities by not providing community-based services alternatives to qualified individuals.[11] The Center for Medicare and Medicaid Services (CMS) mandated compliance plans for all states, and approximately thirty-seven states currently are working on compliance plans. Texas, North Carolina, Ohio, and Missouri have completed a compliance plan, and Kentucky is working toward its own comprehensive working plan for placing all qualified persons with disabilities in less restrictive settings. Under *Olmstead*, any waiting list for community-based services must move at a reasonable pace. Approximately 795,000 individuals could be affected by this compliance plan, or 19.8 percent of Kentucky's population. The Community Placement Test requires treatment professionals to determine if community placement is appropriate, if the transfer from an institution is unopposed by the person, and if the placement can be reasonably accommodated. The Office of Civil Rights (OCR) will work with all states on compliance planning, and CMS will provide support and guidance to the states. Kentucky was the first state to receive OCR assistance with its compliance plan. States have the opportunity to apply for a System Change Grant to make system modifications.

The 2000-2002 Biennial Budget allocated funds that added an additional 500 slots in community supported services for individuals with mental retardation or developmental disabilities as a result of the enactment of House Bill 144 of the 2000 General Assembly. House Bill 843 of the 2000 General Assembly created the Commission on Services and Supports for Individuals with Mental Illness, Alcohol and Other Drug Abuse Disorders, and Dual Diagnosis that will sunset in four years. During the 2000 Regular Session, Senate Concurrent Resolution 39 created the Task Force on Quality Long-Term Care. Both the Commission and Task Force have allowed stakeholder involvement. The Cabinet is looking at Medicaid waivers with an emphasis on changing the current service delivery system by exploring new federal program opportunities, such as Ticket-to-Work. The Cabinet also is considering options to transition current long-term facility residents back into the community with ample supports.

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[11] Testimony of the Cabinet for Health Services before the Task Force on August 22, 2001, referring to *Olmstead v.* L. C., 527 U.S.581 (1999).

In July 2001, Kentucky applied for a Nursing Home Transition Grant and should have a decision by September 2001. The Cabinet also is applying for a Real C.H.O.I.C.E.S. Grant (Citizen monitoring, Housing Options and Investing in Creative Educational Solutions), which would assist in notifying people of their options to nursing homes prior to being admitted. This long-range implementation of the Olmstead plan will be an on-going strategic plan with many revisions to meet the goals and objectives of the planning initiatives and to maximize consumer involvement and participation. The Cabinet has made this a high priority and has designated staff from the Secretary's office, Office of Program Support, Department for Mental Health/Mental Retardation Services, Office of Aging Services, Department for Medicaid Services, and the Department for Public Health to collaborate with a wide array of stakeholders to build a collaborative document.

In November 2000, Kentucky was one of seven states to receive a Robert Wood Johnson Foundation planning grant that would allow Kentucky to have resources to conduct a comprehensive Olmstead plan. The Cabinet contracted with the UK-Interdisciplinary Human Development Institute (IHDI) to facilitate the planning initiatives and coordinate activities of all stakeholders, and it established a state Olmstead Planning Committee that developed mission and vision statements and guiding principles and represents a wide range of stakeholders. The committee established the following four work groups: 1) Employment Assistance; 2) Transportation; 3) Housing Options and Supports; and 4) Person-Centered Funding.

Compliance with the Olmstead decision allows states the flexibility to establish individualized plans and timeframes appropriate to the specific needs of the disabled population and service delivery system. This will be accomplished by building the infrastructure to create viable choices to institutionalization.

The Coordinator of the Olmstead State Plan Project said that the committee would (1) look to see if the formal assessment process that is completed when an individual enters a long-term care facility is a fair process, (2) develop a method to inform individuals of any alternatives to leave a facility and return to the community, and (3) investigate the feasibility of providing a grant to individuals who leave a facility but have to "spend-down" to meet Medicaid requirements.[12]

Long-Term Care and Mental Health

The Interim Secretary of the Cabinet for Health Services and one of the legislative co-chairs testified about the work of the Commission on Mental Health, Alcohol and Other Drug Abuse Disorders, and Dual Diagnoses, authorized by House Bill 843 from

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[12] Testimony of the Olmstead State Plan Project before the Task Force on August 22, 2001.

the 2000 Regular Session.[13] This legislation continued a national focus on issues of mental health and substance abuse summarized in the Report on Mental Health by the U.S. Surgeon General. HB 843 created a mechanism for long-range, coordinated planning for mental health, substance abuse disorders, and dual diagnoses. It mandated that the Regional Mental Health/Mental Retardation Boards institute regional planning councils to conduct assessment and strategic planning and required no less than two stakeholder representatives. The fourteen regional boards developed a template to assure consistency of regional assessments and the reliability of aggregate data and to prepare reports to be submitted to the Commission. As mandated by House Bill 843, the Commission submitted a report to the Governor and the General Assembly on June 21, 2001.

A representative of the Kentucky Association of Regional Mental Health/Mental Retardation Programs said that mental illness and substance abuse disorders cross all spectrums of age and socioeconomic classifications and the systems that provide care to Kentuckians.[14] At least one in every five Kentuckians has a mental illness or substance abuse disorder. Approximately sixty percent of incarcerated individuals, both juveniles and adults, have some mental illness or substance abuse disorder. If these incarcerated individuals do not receive treatment and are released or probated, they are likely to return to crime. The University of Kentucky conducted a study that estimated that each dollar invested in substance abuse treatment yields an eight dollar return. The mental health safety net system has been underfunded, and the stigma of mental illness and substance abuse prevents people from accessing treatment. Kentucky ranks 44th nationally in per capita spending on mental health and substance abuse services.

The Commission has prepared a ten-year plan that would increase funding for mental health and substance services through the Department of Mental Health/Mental Retardation Services. If community-based services are not provided to individuals early, the result may be costly treatment for long-term care in jails and hospitals. In 1994, Kentucky's budget bill established regional crisis stabilization service units, but only eighteen have been funded. The state may wish to develop transportation and suitable housing options and housing supports for individuals with mental health and/or substance abuse disorders. Kentucky is one of the few states in which Medicaid does not provide substance abuse treatment for Medicaid-eligible individuals but does provide mental illness treatment.

One-third of released parolees return because of the inability to receive drug and/or alcohol abuse therapy because they were not Medicaid eligible. The cost to return to the system is approximately $22 million per year.

The Commissioner of the Department for Mental Health/Mental Retardation Services said that there is a specialized geriatric unit at Central State Hospital that works

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[13] Testimony before the Task Force on July 25, 2001.

[14] Testimony of the Kentucky Association of Regional Mental Health/Mental Retardation Programs before the Task Force on July 25, 2001.

with elderly patients who have a history of severe and persistent mental illness.[15] This unit works with Alzheimer's patients who cannot be managed in other settings.

An unfunded Alzheimer's Council was created by the legislature in 1996. A paid position was created within the Office of Aging Services to help the Council address issues related to Alzheimer's care and other neurological disorders. One focus of the Council has been to serve as an information clearinghouse for statewide Alzheimer's chapters to make them aware of available resources for assistance and to identify grants to focus on some of these issues.

The Commissioner of the Department for Mental Health/Mental Retardation Services[16] and the Director of the Kentucky Developmental Disabilities Council[17] testified about the Commission on Services and Supports for Individuals with Mental Retardation and Developmental Disabilities, created by House Bill 144 of the 2000 General Assembly. The concept for House Bill 144 came from a group of individuals who went to Washington as part of the President's Commission on Mental Retardation. There was a consensus from this group that the three majors issues looming over the field of mental retardation and disabilities were the lack of program coordination, and funding, and quality of services. The Commission was mandated to develop a ten-year plan to address the issues outlined in House Bill 144 and provide oversight of the implementation of the plan. After several months of work, the Commission made approximately one hundred recommendations that were broken down into five broad areas with outcomes: (1) prevention and education; (2) choice; (3) quality; (4) access; and (5) financing.

Thirteen statewide forums were conducted with over 500 people participating, and the Commission reviewed all of the suggestions from the forums. The Department of Medicaid Services is reviewing approaches to make waivers more flexible and has hired a private consultant to look at other states' approaches. The Department for Mental Health/Mental Retardation Services recruited new providers for covered services. Funds have been allocated to individuals on the top of the waiting list, and many people are receiving services even though the plan has not been fully implemented.

Long-term care for this population begins when the individuals are children, and the need for supports varies throughout their lifetime. Kentucky is about average in per capita spending for facility-based services for people with mental retardation but is 50th in per capita spending on community-based services for the same population. These calculations were done before the Governor and the General Assembly added $50 million dollars to the budget for these services in the 2000-2002 Biennial Budget.

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[15] Testimony of the Department for Mental Health/Mental Retardation Services before the Task Force on July 25, 2001.

[16] Testimony of the Department for Mental Health/Mental Retardation Services before the Task Force on July 25, 2001.

[17] Testimony of the Kentucky Developmental Disabilities Council before the Task Force on July 25, 2001.

There are four different funding streams for mental health/mental retardation programs. During the last biennium, Medicaid spent approximately $92 million for 1,019 individuals in Intermediate Care Facilities for people with Mental Retardation (ICF-MR). During the last biennium, Medicaid spent approximately $75.5 million dollars on 1,541 individuals in the Supports for Community Living waiver. State regional councils receive approximately $5 million general fund dollars for 450 individuals in the Supported Living Program. The state general funds that go through the Department for Mental Health/Mental Retardation Services to Community Health Centers served approximately 7,100 at a cost of approximately $21.5 million.

The Commission studied how to make the Medicaid program work as effectively as the Supported Living Program. The problem is that Medicaid is a healthcare funding stream, and there is not as much flexibility with these medical funds as with state general funds. The Supported Living Program allows the individual to hire and fire an attendant, who does not have to be attached to a licensed agency. Community-based programs can work for a lot of people, and the money should follow the individual.

Testimony of Nursing Home Residents, Advocates, and Administrators

The Task Force heard from nursing home residents about their experiences living in the institutions.[18] Each of the residents testified that they all have had good experiences in nursing homes and that staff are very helpful. Living at the nursing home has given them independence and a sense of being at home.

One of the residents said she did not want to be an imposition on her children. Her own home would have needed special handicap accessibility to have allowed her to remain there, and she would have needed special staff assistance with activities of daily living. Having money for an apartment or assisted living facility would be helpful. A family member for one of the residents said there is a significant amount of guilt for placing a parent in a nursing home.

Representatives of a resident and family advocacy group, the Mayfair Manor Family Council, testified that (1) most nursing homes have a shortage of staff, (2) most staff are not properly trained, (3) there is a lack of communication between shifts, (4) there is a lack of communication between families and the administrator and staff, (5) salaries are inadequate for staff, (6) the staff to resident ratios should be changed, (7) there are too many regulations that interfere with care, (8) the food listed on the menu is not always what is served, and (9) there are problems with the privacy law in that necessary patient information may not be conspicuously posted.[19]

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[18] Testimony before the Task Force on August 22, 2001.

[19] Testimony before the Task Force on August 22, 2001.

The Chairman of the Board of the Kentucky Association of Health Care Facilities said that 99.9 percent of his facility's admissions arrive directly from hospitals.[20] The Maximum Data Set is used for an assessment of each person admitted. Annual audit figures are sent to the Cabinet for Health Services.

The Director of Nursing at Parkway Medical Center testified that there are many detailed regulations that are interpreted differently by staff.[21] Staff members must finish seventy-five hours in the classroom. Many aides do not have a GED or high school diploma. Criminal record checks are completed for each new staff member. Paperwork requirements take too much time away from patient care. Staffing ratios should be based on the acuity of care. Most nursing homes are understaffed. There should be consistency in administration and staff for long-term stability. There is a problem with employees not calling or showing up for work, which leaves a facility understaffed. Twelve hours are mandated throughout the year for continuing education.

Financing

The Task Force heard about the strained budgetary concerns facing Kentucky and the impact these may have on long-term care services over the next few years.[22] Concern focused both on the downturn in the economy as a whole and on the Medicaid shortfall.

Medicaid is the major public payor of long-term care services. Seventy-seven and one-half percent ($638 million) of these Medicaid funds are used for institutional care, while home and community based services use 22.5 percent ($186 million). Approximately twenty-five percent of the Medicaid budget covers between 22,000 to 24,000 people who receive long-term care services. The national trend recognizes continued heavy growth for home and community-based services.

In addition to services covered under traditional Medicaid, Kentucky has six waiver programs in its Medicaid program that focus on various aspects of long-term care: Home and Community-Based Waiver, Community Living Waiver (Mental Retardation/Developmental Disabilities), Model II Waiver (ventilator dependent), Brain Injury Waiver, Personal Care Assistance Waiver, and Home Care Waiver. No people are being served in the Personal Care Assistance or Home Care Waiver programs. Home and community-based services also are provided through state funds in the Personal Care Assistance, Home Care, and Supported Living programs.

There are 285 nursing facility Medicaid providers in Kentucky that serve 21,951 recipients. Total expenditures for State Fiscal Year 2001 are $506,565,346. There are ten

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[20] Testimony before the Task Force on August 22, 2001.

[21] Testimony before the Task Force on August 22, 2001.

[22] Testimony of the Department for Medicaid Services before the Task Force on June 27, 2001.

ICF/MR Medicaid providers who serve 1,208 participants. Total expenditures for State Fiscal Year 2001 are $83,378,852.

The Division of Long-Term Care administers programs that require a waiver from the Centers for Medicaid Services (CMS, formerly the Health Care Financing Administration). In all of the waiver programs, participants must meet nursing facility or ICF/MR level of care.

The Model Waiver II program is designed for Medicaid eligible recipients who are ventilator dependent and may, without these services, be required to be admitted to a hospital-based nursing facility. These services are available to individuals of any age and include private duty nursing and respiratory therapy. There are nineteen Medicaid providers who serve one hundred recipients. The total expenditures for State Fiscal Year 2001 are $4,545,069.

The Supports for Community Living (SCL) waiver program is designed for Medicaid eligible recipients as an alternative to institutional care for an individual diagnosed with mental retardation or a developmental disability. The SCL waiver provides an eligible individual with the opportunity to remain in or return to a community in the least restrictive setting. Covered services offered in the SCL waiver include support coordination, community habilitation, supported employment, prevocational services, residential supports, community living supports, behavior supports, psychological services, occupational therapy, physical therapy, speech therapy, respite, and specialized medical equipment and supplies. There are seventy-two active Medicaid providers who can serve up to 1,937 individuals, which includes 250 new recipients being added to the SCL waiver in State Fiscal Year 2002. The total expenditures for the SCL waiver in State Fiscal Year 2001 are $67,800,580.

The Home and Community-Based (HCB) waiver is designed for Medicaid eligible participants who are aged or disabled. Services under the HCB waiver include assessment/reassessment, care planning, case management, homemaker, personal care, attendant care, respite, adult day health care, and minor home adaptations. There are 102 HCB waiver providers who can serve up to 17,050 individuals. Total expenditures for in-home services under the HCB waiver for State Fiscal Year 2001 are $46,211,534, and total expenditures for the Adult Day Health Care portion of the HCB waiver for State Fiscal Year 2001 are $15,771,658. There are 114 Adult Day Health Care Medicaid providers.

The Acquired Brain Injury (ABI) waiver program is designed for Medicaid eligible recipients with an acquired brain injury who are receiving services in the community. Eligible recipients must be at least twenty-one years of age, but less than sixty-five years of age, with cognitive, behavioral, or physical impairments that necessitate supervised and supportive services. Excluding congenital injuries, there is no restriction with regard to the age of the individual at the time of the injury. Services included under the ABI waiver include case management, personal care services, respite, companion services, structured day program, prevocational services, supported employment, behavior programming, counseling and training, occupational therapy, speech, hearing and language services, specialized medical equipment and supplies, environmental services, and community residential services. There are fifty-four Medicaid providers who can serve up to 110 individuals. Total expenditures for State Fiscal Year 2001 are $561,802.

The Homecare and Personal Care Assistant waiver programs are two new waivers administered by the Office of Aging Services. Eligibility criteria for these waivers was developed by the Office of Aging Services in collaboration with the Department for Medicaid Services. These waivers are funded from General Fund money allocated to the Office of Aging Services and do not require services to be provided by licensed health care providers. Funds are being transferred to the Department for Medicaid Services for the purpose of matching state Medicaid requirements.

The Homecare waiver program is limited to eligible recipients sixty years of age or older. The services covered under the Homecare waiver include case management, homemaker, personal care, and environmental accessibility adaptations. There are thirty-seven providers who have received a Medicaid provider number who will be able to serve up to 990 individuals. There have not been any expenditures for State Fiscal Year 2001.

The Personal Care Assistant waiver program is designed for Medicaid eligible recipients eighteen years of age or older who have severe physical disabilities and permanent or temporary recurring functional loss of one or more limbs. The services covered under the Personal Care Assistant waiver include case management, personal care assistance (routine bodily functioning, dressing, housecleaning, laundry, preparation and consumption of food, moving in and out of bed, routine bathing, ambulating, and any other similar activity of daily living as performed by an attendant), and personal care coordination services. There are eleven Personal Care Assistant waiver Medicaid providers who can serve up to eighty-two recipients. There have not been any expenditures for State Fiscal Year 2001.

Work Group for Issues 1-5

This work group was assigned to discuss the first five issues specified in Senate Concurrent Resolution 39, as follows:

- Wage pass through programs to increase staff salaries;
- Financial incentives for facilities exceeding quality standards;
- Linkage of reimbursement to staffing levels;
- Provision of additional training for facility staff; and
- Mandatory staff-to-patient ratios.

Given the inherent overlap involved with discussion of these issues, the five topic areas were combined into three discussion areas: reimbursement, staffing, and quality.

Reimbursement. For reimbursement, it was noted that wage pass-through programs were revenue measures to be used for staff enhancement. Merely providing funds to a facility would not assure increased staff without a requirement for an accounting. On the other hand, macro managing a long-term care facility would not necessarily increase the ultimate goal of improving the quality of long-term care.

Medicaid is the state's largest payor of long-term care services. Medicaid personnel testified that a simplified wage pass-through program already exists, at least for minimum wage adjustments. With a total long-term care budget of $592 million less $68 million for cost-based facilities, there is $524 million remaining for price-based facilities. The Minimum Data Set (MDS) helps evaluate facilities for reimbursement purposes. Federal officials review twenty-five percent of the charts to determine if the MDS diagnosis is reflected.

Staffing. Some states use other categories of staffing to supplement certified nurse assistants and other nurses that provide much of the frontline staffing in long-term care facilities. Work group members disagreed as to whether the proper use of staffing should be left to the individual facility or whether further standards should be mandated by the state. Staffing ratios are the tool used by some states to quantify the standard, assuming that more numbers of caregivers equal enhanced quality of care. Certain minimum staffing requirements are mandated by the federal government, and indeed Kentucky has a higher per resident ratio of caregiver than other states in its southern geographic region, as reflected in Table 1 (demonstrating the resident to nurse ratios).

Table 1

# of Residents per RN		# of Residents per LPN	# of Residents per CAN	# of Residents per Total Nursing Staff
US	5.7 to 1	5.3 to 1	1.7 to 1	1.1 to 1
KY	8.2 to 1	6.7 to 1	2.1 to 1	1.3 to 1

Source: Wendy Fox-Grage, National Conference of State Legislatures, May 23, 2001.

Table 2 demonstrates the number of nursing hours per resident for each resident day.

Table 2

RN Hrs/Resident/Day		LPN Hrs/Resident/Day	CAN Hrs/Resident/Day	Total Nursing Hrs/Resident/Day
US	1	0.9	2.4	4.3
KY	1	1	2.7	4.7

Source: Wendy Fox-Grage, National Conference of State Legislatures, May 23, 2001.

More efficient management and leadership development may lead to better quality of care. The work group noted that proactive leaders increase morale and have a positive impact on care. Empowering and training facility directors of nursing and administrators are keys to improving the quality of care. Facilities with fewer staff may provide better care because of good management, high morale, and highly trained and dedicated staff.

The single task worker concept would allow facilities to hire staff to perform certain menial tasks related to resident care, such as feeding. As of the fall, 2001, the United States Congress is considering a proposal that would allow facilities to employ workers for their residents' nutrition and hydration needs. Currently, there are projects pending several states in which unlicensed and uncertified personnel can engage in these activities. Single task workers were employed in Kentucky in the early 1990s, but this practice was prohibited by federal law changes in the mid-1990s due to the mistaken belief, according to some work group members, that these workers required additional training and state supervision.

Quality. The work group found that it is difficult to link dollars to quality without first defining "quality." Consumers define quality through the ombudsman complaint data, and quality is judged through the regulatory enforcement process. This latter process, called surveying, identifies violations of federal and state regulations, but the penalties are viewed by administrators as too punitive, rather than educational.

The state and federal certification and regulatory processes are very similar. If a statement of deficiency is issued under a federal law survey, then the state will reference that deficiency in the state's licensing statement of deficiency. Differences lie in the enforcement process where, under a federal law finding of immediate jeopardy, termination of the provider agreement can be recommended in as few as two days and no more than twenty-three days later. Monetary penalties may be imposed from $3,000 to $10,000 *per day* that the immediate jeopardy finding is in effect. Under state law, the state has three days to issue a citation, and the maximum *one time* fine is $1,500.

Federal law requires a survey of each facility every fifteen months, although Kentucky attempts to survey every twelve months. Surveys are unannounced, and federal law requires that at least ten percent of the surveys be conducted at "off hours," defined as weekends, evening, or holidays. Kentucky's survey training program for its inspectors is nationally acclaimed.

Work Group for Issues 6-7

This work group was assigned to discuss the last two issues specified in Senate Concurrent Resolution 39, as follows:

- Assisted living facilities and other nonmedical socially oriented living arrangements in the community; and
- Noninstitutional services delivered in the home of the client including, but not limited to, the provision of home health, meals, housekeeping, and assistance with personal care.

The work group concentrated on broadening its understanding of the resources for the elderly and the efficiencies in the delivery of community-based services. Understanding that Medicaid reimburses for a significant percentage of community-based service care, members reviewed existing Medicaid programs and coverage affecting the frail elderly and long-term care in general.

The work group did not devote significant time to discussion of assisted-living facilities or communities. Assisted-living communities are certified by the Office of Aging Services within the Cabinet for Health Services but are not reimbursed by Medicaid. The Kentucky Assisted Living Facilities Association recommended to the work group that providers of senior and long-term care services give a resource sheet of available senior and long-term care services prior to move-in/admission and move-out/discharge, and that consumer-directed care management be made available for a fee to self-pay clients and government assistance clients. The latter would promote the goal of providing services in the most appropriate, least restrictive, and most cost-effective setting. Consideration of these recommendations was incorporated into broader discussions of single point of entry and consumer-directed choice.

Members presented their vision and goals, which involved general concepts of improved quality of life through empowerment to enabling programs directed at providing services based upon consumer choice rather than historical necessity. Many elderly today receive nursing home care due to the belief that there is no alternative. This belief to an extent may be founded in fact, but also may be due more to the convenience of simply contacting a nursing home facility about which the person is already familiar. Education of the person thus becomes a necessity in order to acquaint him or her of available choices.

Medicaid. One of the critical components of determining availability of services involves determining payment sources for the services. Merely because a service exists in a community does not mean that it will be provided without charge to someone without means. If the person qualifies for Medicaid and the provider accepts Medicaid reimbursement, then the service truly is available.

The work group discussed the same Medicaid waiver programs as were discussed by the full Task Force, and this discussion will not be duplicated here. As a summary, the work group reviewed the eligibility criteria for and services covered by the Home and Community-Based waiver, the Supports for Community Living waiver, the acquired brain injury waiver, the Model II waiver, the personal care attendant program waiver, and the home care waiver.

KenPAC Care Coordination services currently are available to certain SSI recipients who are medically fragile, with multiple physical and behavioral health needs. This program began on April 9, 2001, with the mission of coordinating care by acting as a liaison with providers, Medicaid, and recipients; obtaining referrals from providers; and acting as a liaison between the community and the department. Continuity of care is the goal.

Medicaid Estate Recovery. The work group reviewed Medicaid qualifying criteria and the Medicaid estate recovery process. Estate recovery is the process by which the state may seek recovery of the long-term care and medical expenses it has paid on behalf of a person after the person dies. A claim is filed with the person's estate, but certain exemptions exist. A representative of the Department for Medicaid Services testified that there is no estate recovery if the deceased is under age fifty-five, if there is a surviving spouse, if the estate is valued at less than $5,000, if there is a child under the age of twenty-one, if the property is used as an operating farm, or if the estate is bequeathed to a disabled adult child. An exemption must be specifically requested after a claim is filed.

Many families may view the estate recovery as an impediment to seeking long-term care out of fear that there will be no estate for their heirs. Others may fear applying for Medicaid coverage due to a lack of knowledge of exemptions. There was no available data on the number of people who may have sought advice on Medicaid estate recovery from the Office of Aging Services and who subsequently failed to seek available services due to the recovery process.

Noninstitutional Care. The work group discussed methods of coordinating the care that the elderly and disabled receive and the manner in which that coordination could be made available. Much of this discussion focused on the implementation aspects of recommendations that are included with the discussion of the work group's recommendations later in this report.

PART 2: RECOMMENDATIONS

Following the conclusion of their deliberations, the work groups presented their preliminary recommendations to the full Task Force. Noting its concern about funding over the next biennium yet wanting to establish policy direction, any recommendations requiring an appropriation were adopted *contingent upon the availability of funds* during the next budget period.

INSTITUTIONAL RECOMMENDATIONS

The Task Force adopted the following recommendations relevant to the jurisdiction of the Work Group for Issues 1-5:

1. **Upgrade the eleven part-time nursing home ombudsmen positions to full-time positions in the Pennyrile, Lake Cumberland, Lincoln Trail, Purchase, FIVCO, Buffalo Trace, Kentucky River, Gateway, Northern Kentucky, Green River, and Big Sandy Area Development Districts, and provide for a minimum of one full-time ombudsman position for every 2,000 nursing home residents.**

The nursing home ombudsman program works with nursing home facilities, residents, and their families to resolve complaints and problems. The program currently serves more than 34,000 residents in Kentucky's nursing home facilities and handles more than 7,000 complaints per year. The vast majority of these complaints are satisfactorily resolved. However, only four of Kentucky's fifteen Area Development Districts have a full time ombudsman, limiting the ability to visit facilities as often as needed. Additional ombudsmen should be funded in area development districts with large nursing home populations to permit a minimum of at least one ombudsman per 2,000 nursing home beds, but flexibility should be given to the Cabinet for Health Services and Office of Aging Services to determine within which of the area development districts the positions are most needed. This expansion would also be a cost-effective method to provide direct assistance to residents, as well as counseling to family members and help in relocating residents.

The Task Force estimated the cost of this recommendation to be approximately $450,000 per fiscal year.

2. **The Long Term Care Coordinating Council, authorized under KRS 216.583 but not funded, should be reconstituted and fulfill its duties as mandated.**

The 1982 Kentucky General Assembly established the Long-term Care Coordinating Council, which was directed to meet quarterly and at such times as the council deemed necessary and prepare an annual report to the General Assembly and to the Governor. This council received no funding in subsequent budgets and its duties were never fulfilled. The Task Force believes that an efficient way to continue discussion of important long-term care issues would be to reconvene the council, update its membership, and amend its responsibilities.

The Task Force recommended that the council's membership be comprised of the following members of the Cabinet for Health Services: the Commissioner of the Department of Public Health; the Inspector General; the Director of the Division of Long Term Care; the Executive Director of the Office of Aging Services; the Commissioner of the Department of Medicaid Services; the General Counsel of the Cabinet for Health Services; and the Long-term Care Ombudsman. The Task Force recommended the following members from outside the cabinet: a representative of the Kentucky Association of Health Care Facilities; a representative of the Kentucky Medical Directors Association; a representative from the Kentucky Association of Directors of Nursing Administrators; a representative of the Kentucky Association of Homes and Services for the Aging; and a consumer representative.

The duties of the council should include preparation of an annual report on long-term care to the General Assembly and Governor, the Chairs of the Health and Welfare Committee, the Director of the Legislative Research Commission, and the Chairs of the Medicaid Managed Care Oversight Advisory Committee containing the following: (a) the status of implementation of the state long-term care policy; (b) an appraisal of the problems of residents of long-term care facilities; (c) an overview of the activities of the council; and (d) recommendations for improving the quality and delivery of long-term care services in the Commonwealth; (e) the adequacy of reimbursement; (f) the effectiveness of the regulatory system; and (g) the identification and assessment of barriers to accessing long-term care services.

3. **The Cabinet for Health Services should re-evaluate and study the Medicaid reimbursement system that uses the Minimum Data Set (MDS) and Resource Utilization Groups (RUGS), giving consideration to the funding needed for outlier costs experienced by hospital-based long term care facilities as well as free-standing facilities. Additional study should also be given to the funding needed for the care of persons whose behavioral symptoms cannot be safely managed in the normal nursing home setting, with consideration given to the plausibility of providing more appropriate placement for affected persons, such as the establishment of special behavior units; and the possibility of providing additional training and/or resources to long-term care facilities that commit extraordinary resources to care for these persons.**

Following discussion of the institutional long-term care reimbursement system and the assurances of the Cabinet for Health Services that this system had been evaluated extensively, the Task Force considered whether to recommend a more detailed reimbursement policy. Because of the funding issues currently facing long-term care and the complexities of the MDS and RUGS, further study was recommended.

Concern over the inadequacy of the reimbursement focused on the additional cost of care necessary for persons with dementia-related behavioral symptoms that are common among long-term care residents. The number of persons affected by these conditions is expected to increase as the population ages. Many affected persons will rely on long term care facilities to care for them at some point during their illness.

According to CMS Nursing Home Compare, thirty-one percent of persons residing in Medicare/Medicaid-funded nursing facilities in Kentucky exhibit behavioral symptoms such as wandering, aggressive verbal or physical behavior, or inappropriate social actions that need special treatment and sensitive care. Behaviors that result from the loss of brain cells due to Alzheimer's disease or related disorders and the subsequent inability to interpret the environment do not respond to acute psychiatric treatment. The Department for Mental Health and Retardation does not provide or arrange for services to persons whose behavior results from Alzheimer's disease and organic disorders. Affected persons require care that falls within the scope of nursing facility services.

A small but significant number of these persons exhibit behavioral symptoms the management of which requires one-on-one attention by properly trained staff for significant portions of the day and individualized environmental adaptations. Testimony indicated that failure to provide these resources exposes others to potential harm. Residents of long-term care facilities suffer from disabling conditions that hamper their ability to protect themselves from harm.

Further testimony found that most nursing facilities do not have sufficient staff to provide one-to-one attention for even a small number of their patients. Most certified nursing assistants and other direct-care nursing facility staff have little understanding of Alzheimer's disease and how environmental factors can trigger behavior symptoms in patients. Kentucky's reimbursement system does not provide nursing facilities the financial incentive they need to commit the staff, training, environmental adaptations, and other resources needed to maintain such persons.

There are 140 Alzheimer's-specific nursing facility beds in Kentucky, with forty available to Medicaid-eligible residents. These facilities operate under the same reimbursement system as do other nursing facilities, providing no incentive to accept patients who have been rejected by other facilities because the patients' conditions require significantly greater resources.

For this reason, the Task Force recommends that further study be given to the issue of caring for persons whose behavioral symptoms cannot be safely managed in the normal nursing home setting, and that examination be made of possible solutions to include the plausibility of providing more appropriate placement for affected persons such as the establishment of special behavior units; and the possibility of providing additional training and/or resources to long-term care facilities who commit extraordinary resources to care for such persons.

4. **Kentucky should utilize the civil monetary penalties (CMPs), collected through the fine process for regulatory violations, to establish grants and expenditures for improvement of quality long-term care for nursing home residents. The state should provide initial funds for facilities that are interested in implementing programs such as the Eden Alternative, provide training to the volunteer ombudsman program, and provide additional staff training to poor-performing facilities, as determined by past survey histories of facilities.**

The Task Force was divided as to whether the system of regulatory enforcement of nursing home laws is overly burdensome or whether it fairly meets the needs of residents. One unifying thought on the issue was the civil monetary penalties should be used to improve the quality of care in the facilities. Currently, these funds, totaling $2.5 million, are not designated for use.

The Eden Alternative is a new philosophy of long-term care service that seeks to build coalitions of people and organizations that are committed to creating better social and physical environments for people. Eden seeks to help others create enlivening environments and with the goal of eliminating the plagues of loneliness, helplessness, and boredom.[23]

5. **Kentucky should fully fund its price-based reimbursement system for Medicaid beneficiaries who receive nursing facility services. Full funding must include a system of accountability that assures that additional funds be used to increase front-line staff or for other expenditures necessary to meet the needs of residents.**

Kentucky's new payment system, the price-based reimbursement system, went into effect in mid-1999 and is based on identifying and correlating service needs with reimbursement levels. It is a capitated, acuity-based payment system that was developed cooperatively by the state and provider community, and is considered significant in that its design is predicated upon accurately assessing patient care needs and providing individual nursing facilities with the fiscal resources necessary to meet these needs. It was estimated that the cost to fully fund these facilities would be approximately $34 million.

Labor (nursing) accounts for approximately fifty-five percent of "the price" paid to providers. As the primary cost input in the reimbursement calculation, these payments are

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[23] The Eden Alternative. http://www.edenalt.com. October 24, 2002. The core concept of The Eden Alternative teaches people to see the environments as habitats for human beings rather thatn facilities for the frail and elderly. It demonstrates how companion animals, the opportunity to give meaningful care to other living creaturs, and the variety and spontaneity that mark an enlivened environment can succeed where pills and therapies fail.

adjusted periodically (quarterly, based upon patient acuity and every four years taking into account all costs borne by the provider) by the state to reflect fluctuations in wages necessary to attract and retain adequate staff. Any additional fiscal resources made available should be used to periodically adjust ("rebase") payments to providers in order more adequately to reflect current costs of providing services.

Recognizing that its charge under SCR 39 was to consider staff-to-resident and wage pass-through issues, the Task Force directed that a system of accountability be instituted by the Cabinet for Health Services, Department for Medicaid Services, to assure that the funds would be used to increase front-line staff or to offset other expenditures necessary to meet the needs of residents.

NONMEDICAL/COMMUNITY-BASED RECOMMENDATIONS

The Task Force adopted the following recommendations relevant to the jurisdiction of the Work Group for Issues 6-7:

1. **The General Assembly should declare that the public policy for long-term care in Kentucky is to give individuals a right to live in the community in the place of their choice, and to educate individuals and their informal caregivers about their rights and choices. Individuals have a right to a timely evaluation of their ability to live in or return to the community, have the right to appropriate community-based services and a full range of choices to support an integrated and seamless continuum of care. There should be a right to high quality of care, regardless of setting, whether institutional, in the community, or in the home, and individuals should have the right to programs and funding mechanisms that support them to remain in their home and community of choice. This policy should be consistent throughout all branches and agencies of state government, including but not limited to the Cabinet for Health Services and Cabinet for Families and Children.**

Many people believe that Kentucky lacks a clear and consistent state policy on information about, access to, and organization of programs and services for persons with disabilities and the frail elderly. Current policies vary, depending on the specific program initiative, target population group, disabling condition, or funding source. Some people believe that the lack of a coherent and coordinated policy causes confusion among the disabled and frail elderly as well as the governmental employees who are assigned to implement the task at hand. The Task Force felt that consistent policy guidance is critical because many of these programs serve the same persons.

The Task Force recommends that all executive agencies, particularly the Cabinet for Health Services, Cabinet for Families and Children, Department of Insurance, Transportation Cabinet, Workforce Development Cabinet, and Kentucky Housing Corporation, be directed to examine, in conjunction with affected persons and consumer advocates, all regulations, plans, and policies to determine compliance with the content and spirit of this policy directive and report to the General Assembly by January 1, 2003, the status of compliance and, if deficient, present a plan and timeline for compliance.

The Task Force does not believe that this recommendation will require additional funding. Current appropriations for planning activities should be utilized for this assignment.

2. **The Cabinet for Health Services should conduct a comprehensive, statewide educational effort to inform the affected individuals and their families, elected officials, other policymakers, and the general public regarding the rights of individuals with disabilities and the frail elderly to live in the community, in the home, and in the least restrictive environment of their choice.**

Tens of thousands of Kentuckians with disabilities potentially are eligible for services by state programs, but many may not be aware of their eligibility for or the availability of these services. This is especially true regarding the elderly. A recent study found that less than four percent of Kentuckians knew about programs for older persons that were available through state and local agencies. Guidance for compliance with the U.S. Supreme Court's Olmstead decision notes that persons have a right to be informed about available services, their eligibility requirements, and how to access them. The state has a legal obligation to provide this information in an available, accessible, and comprehendible manner. This is especially true for persons living in institutions and those still living in the community but who are high-risk for institutionalization. The Work Group for Issues 6-7 believes that, in reality, Kentucky has more than a legal responsibility; it has a moral obligation to go beyond just informing and advising but to go so far as educating these vulnerable populations of their right to not only live in a home of their choice but to know the options available as they make their choice.

The Task Force indicated that affected persons and related consumer groups should be consulted and involved in designing and implementing the education programs. Informational materials must be clear and concise and consider the elderly and caregivers as the prime audience. Special efforts must be made to reach caregivers in their work place, in places of worship, and through various community organizations. The Task Force indicated that a nursing home ombudsman should visit every resident of a long-term care facility to deliver information to the resident, be available to meet with the resident's family, and provide more information or assistance upon request.

The Task Force supports the following: The Cabinet for Health Services should expand its website to provide a comprehensive profile of long-term care services and providers, by county. All licensed providers and contractors should be required to update the required information on a quarterly basis, with Area Agencies on Aging responsible for monitoring compliance and accuracy and assisting providers who have limited access to the website. Each licensed or approved provider of long-term care services should be required to provide each client, upon initial inquiry and any subsequent inquiry regarding services, a resource sheet that lists available services in the area and contacts, compiled from the Cabinet for Health Services' website.

The Task Force estimated the cost for this recommendation in FY 2002-2003 to be $100,000, and in FY 03-04 to be $250,000.

3. **The Cabinet for Health Services should make available Community Living Assessment Teams to provide, upon request of individuals and their families, an appropriate and timely evaluation of an institutionalized person's ability to return to a home of choice in the community, or an appropriate and timely evaluation of a person currently living in the community who desires to delay, prevent, or divert his or her institutionalization, if appropriate services are available, funding is economically feasible, and the individual or his or her family asks for the community services.**

The Task Force found that too often individuals are admitted to nursing homes or other institutions without the persons' or their families' understanding the potential for them to remain in the community in the home of their choice. All individuals residing in institutions are assessed upon admission and periodically thereafter by qualified professionals (usually employees of the institution) who certify the care needed, which, in most cases, validates the need for institutional care. This recommendation would incorporate a "second opinion" in the process for all individuals who request an assessment. The Community Living Assessment Team would be well-versed in the requirements for independent living for persons with disabilities. They would be knowledgeable of community resources, care options, and consumer-directed care. These teams would have a secondary goal of helping persons identify and access the most desired living arrangement as determined with the individuals and their families. While many persons may neither desire an assessment or agree with the findings and recommendations, many others may discover that they too can return to the living environment of their choice or never even have to leave home.

The Task Force indicated that the following procedures should be used. Affected persons, families, and consumer advocates should be involved in planning, designing, and assessing the evaluation process. Appropriate community agencies with proven expertise (e.g. Centers for Accessible Living) should be considered as key resources for developing the evaluation protocol and approach and possibly be utilized to conduct the evaluations. All individuals requesting an evaluation must be evaluated and advised of the findings, conclusions, and recommendations within sixty days of receipt of a request by the Cabinet for Health Services. The Cabinet for Health Services shall establish, no later than July 2002, a gatekeeper system to insure that no person supported by state or state/federal program funds is admitted, except for emergency situations, to any facility or institution before having an opportunity for a "second opinion" evaluation. The Cabinet for Health Services, no later than January, 2003, shall establish and implement a procedure to identify individuals defined as "high-risk for institutionalization" and develop and coordinate a plan to prevent, delay, or divert their institutionalization.

The Task Force estimated the cost for this recommendation in FY 2002-2003 to be $100,000 (500 persons at $200 each), and in FY 03-04 to be $200,000 (1,000 persons at $200 each).

4. **The 2002 General Assembly should approve a community services ombudsman program providing a full-time paid ombudsman in each Area Agency on Aging.**

The effectiveness of the Nursing Home Ombudsman program is well-known in Kentucky and other states. These programs have added a new dimension to the monitoring of quality and adequacy of care by giving nursing home residents and their families an unbridled means to express one of the best indicators of quality care — consumer satisfaction. Attempting to build on this success, several states have implemented ombudsman programs to advise and assist consumers served by home and community-based programs. Given Kentucky's increasing emphasis on serving older persons in their homes and the resurgence of public interest in assuring quality in long-term care, the Task Force believes that the implementation of a Community Services Ombudsman Program is an appropriate next step.

A new administrative structure is unnecessary since the services provided will be quite similar with only the service settings different. Service provision will need to be more proactive than reactive given that clients will usually be at individual locations throughout the community and absent from the locations where professionals would otherwise observe problems or issues affecting the clients' health and well-being. All providers should be required to advise clients periodically of the availability of the ombudsman for advice and assistance. The Community Services Ombudsman Program will require more detailed and more frequent training and greater access to information since home and community based clients present a wide range of needs not experienced by persons in facilities. The Task Force envisions community services ombudsmen to be advocates, facilitators, enablers, and dreamers who are willing to help individuals realize their dream of remaining in the appropriate home of their choice.

The Task Force estimated the cost for this recommendation in FY 2002-2003 to be $175,000 (7 persons at $25,000 each), and in FY 03-04 to be $375,000 (15 persons at $25,000 each).

5. **The 2002 General Assembly should direct the Cabinet for Health Services and the Cabinet for Families and Children to develop and implement a pilot integrated care management system in two area development districts by January 1, 2003.**

Numerous reports and studies produced by various commissions and task forces in state government over more than a decade have hailed the merits of “single point of entry,” i.e. integrated care management. Program managers have cited this as the solution to duplication of services and the only way to have a consumer-friendly delivery system. The Task Force found that, to date, no one in Kentucky has provided the leadership or taken the necessary actions to implement this solution. Kentucky should look to other states where such systems have been in place and working successfully for several years.

The key factor for integrated care management is the concept that the “benefits follow the person,” letting the individual in consultation with the care manager make the final decision about what services are needed, who will provide the service, and under what type of arrangements. This would give persons the maximum amount of choice, control, and flexibility in how their needed services are organized and delivered.

The Task Force believes that the most important consideration in moving to this concept of service delivery is that the current program structure must change and adapt rather than simply overlaying another duplicative, costly system. Existing program-oriented case managers must be retrained to a new concept of care management, with a person-centered focus matching available and more flexible funding, tailored to the individual’s needs rather than placing persons into predetermined program molds. Community transition and living must be the focus of the new care manager. The Task Force believes that a Global Funding Waiver under Medicaid should be requested for the pilot area to make available a broader range of service options (some of which are now provided and funded with one hundred percent state dollars) that are needed to enable the frail elderly to remain in the community.

Frail elderly who reside in the pilot area development districts and who are identified as high-risk for institutionalization should receive services under the “new” care manager and integrated-funding system by July 1, 2003.

The Task Force estimated the cost for this recommendation to be $250,000 for start-up expenses, which might be eligible for a Medicaid match. Individuals should be maintained in their home and community with the majority of funding coming from existing program resources in the care of the integrated care management system.

6. **The 2002 General Assembly should support the development of the “Aging Client Care Management and Record System” in the Cabinet for Health Services that links health and social service providers. This system may be implemented first as a pilot project in two area development districts.**

Approximately 175,000 elderly are served annually by over three hundred home and community based providers and a greater number by facility and institutional providers. Only the Medicaid program can track individuals among a wide variety of service providers, but information collected by Medicaid is used primarily for payment purpose. The wealth of information in the Medicaid system that could be utilized for managing and coordinating care of recipients remains virtually untouched. While each provider collects reams of diagnostic and treatment information on clients, the vast majority of the information never gets beyond the individual agency or program. Legitimate reasons for the lack of sharing of information may be cited (including confidentiality), although the primary cause is that the long-term care delivery system is disjointed and there is no record system that reaches across all providers with a primary goal of facilitating the delivery of coordinated care. This proposal will create an integrated client care management system that will link all providers and provide a data bank for early case finding and intervention, client intake, demographics, care planning, service scheduling, outcome monitoring, and routine data and fiscal reporting.

The Task Force believes that consumers should be involved in designing the system since confidentiality of information will be an important issue to both the provider and the consumer. The system must be capable of linking with the Medicaid management information system for a wide variety of applications, e.g. case management, early case finding, preventive services, etc. One of the major applications for Medicaid data could be the development of utilization profiles that produce indicators for persons becoming high-risk of institutionalization.

The system must also be capable of linking with the Cabinet for Health Services' website to match client needs with available resources. The system design must maintain consumer oriented-care management as its primary goal. The majority of costs of ongoing operation will be supported by participating agencies.

The Task Force estimated the cost for the development of an Aging Client Care Management and Record System to be $1,675,000, although this estimate was based upon a broader proposal for the entire state, rather than the more limited version adopted.

7. **The 2002 General Assembly should authorize the transfer of Medicaid funds currently allocated for nursing home care to home and community based services and direct the Cabinet for Health Services to develop a pilot "person centered/directed funding program" to permit up to 500 persons with disabilities and the frail elderly currently residing in long-term care facilities to return, at their option, to the community and a home and least restrictive environment of their choice.**

The Task Force was deeply divided on this recommendation. While there seemed to be general agreement with support of community-based services and the ability of people to make their own informed choices, there was great reluctance to support funding of this recommendation at the expense of institutional care. It was suggested that this recommendation conflicts with the recommendation for full-funding of the price-based reimbursement system.

As for this particular recommendation, the Task Force understood that people of all ages, and particularly the elderly, may prefer to receive long-term care services in their own home or a home of their choice in the community. Persons with disabilities may want the opportunity to make their own decisions about the long-term care services they receive, who delivers the services, under what circumstances, and on what schedule. The majority of people believe that this choice provides them with a greater degree of independence and control over their lives, that they receive an improved quality of care, and that they can buy more services than they could under traditional LTC services. These individuals feel they have the ability to measure the technical quality of the services provided, and they know they have the ability to measure their satisfaction with the services as well as the services' impact on their quality of life.

The Task Force believes that consumers must be involved in planning, implementation, and monitoring of the initiative to ensure that the primary goal– improving the quality of life– is not compromised. The pilot program should be available on a statewide basis to minimize the impact on nursing home occupancy in any particular area. Program participants must meet the same health and functional criteria required for nursing facility admission.

The Task Force recognized that the individual must have the choice to manage his or her own care, if found capable, or to pay a care manager, and the Task Force supports the following procedures for executing the recommendation. The individual must have the right to choose, purchase, and manage his or her own LTC services using eligible Medicaid funds. The person must have the right and authority to selected, employ, direct, and dismiss all caregivers. Family members, other than a spouse, must be eligible to be paid for providing care and assistance as set forth in the approved care plan. The state agency must designate an agency or organization to assist individuals in developing a care plan, including training of caregivers, and to approve and periodically monitor implementation, including paying expenses authorized in the care plan and approved by the individual. The state agency must ensure that at least one individual in each area development district is well-trained in the concept, spirit, and intent of person centered/directed funding and designated to provide assistance in developing and monitoring the plan and advising and helping the individuals selected for the program. The state agency must establish an appeal process for persons aggrieved by the decisions of the state agency relating to selection of participants, care planning, monitoring, and other aspects of the program's implementation. Participants shall be held harmless and able to return to the traditional long-term care services for which they are eligible upon thirty days written notice to the state agency.

The Task Force estimated the cost for this recommendation in FY 2002-2003 to be $5,250,000 (150 persons at $35,000 each), and in FY 03-04 to be $17,500,000 (500 persons at $35,000 each), with training and start-up costs in FY 2002-2004 of $100,000.

8. **The 2002 General Assembly should authorize a Family Caregiver Support Program in the Cabinet for Health Services for the benefit of caregivers of physically and mentally impaired adults in need of long-term care services.**

Family caregivers are Kentucky's greatest resource for long-term care services providing up to eight-five percent of the care for functionally dependent and cognitively impaired elderly relatives. An estimated one in three persons cares each year for one or more ill or disabled family members or friends of all ages, particularly the elderly. Half or more of the caregivers juggle work, family, and caregiving responsibilities, resulting in work disruptions and lost productivity. Business and industry report that after childcare, caregiving for older or disabled family members is the next most frequently mentioned reason for absenteeism. Worry over paying for care especially plagues the working poor and even some middle-income families who are not eligible for public benefits yet who cannot afford the out-of-pocket cost of care.

The Task Force supports the following procedures in implementing this recommendation. The family caregiver should be considered the client of the program, which must be consumer-directed and permit a wide variety of eligible services and options, including caregiver education, counseling, training and support, information and assistance regarding benefits, resources, etc., initial and ongoing assessment of needs and care planing, supplemental services, and respite care. Respite care should be flexible– adult day care, short stays in nursing home or assisted living facilities, care in private homes, foster care, or other arrangements acceptable to the individual and the family should be allowed in order to provide a temporary break for the caregiver. Family members should be eligible to receive payment for providing respite care and other necessary respite-related services. Medicaid matching funds would be desirable, although the program must also provide for services for certain non-Medicaid eligibles such as the working poor and, in certain circumstances, middle income caregivers. The program must be designed to enhance and complement the National Family Caregivers Program being implemented as a demonstration project.

The Task Force estimated the cost for this recommendation in FY 2002-2003 to be $2,000,000 and in FY 03-04 to be $4,000,000 (10 hours a week @ $7 an hour or roughly $3,600 each year per individual).

9. **The 2002 General Assembly should provide additional funds for expansion of the Personal Care Assistance Program, Cabinet for Health Services, to serve 500 more persons with disabilities during FY 02-04.**

The Personal Care Assistance Program assists adults eighteen years of age and older who have functional loss of two or more limbs to live independently in the home of their choice. These individuals direct their own care and select, hire, supervise, and dismiss their personal care attendant, who may be a family member. Clients can receive up to forty hours of attendant services per week. This program provides individuals a high level of involvement in their care and enables them to personalize the services to their particular schedule and needs. The flexibility of the program enables clients to meet a wide range of personal assistance needs so vital to delaying admission to an institution, and it may provide the services needed to enable a person to return to the community. The program typically has a waiting list of over 700 individuals and was expanded to add 100 clients during FY 2000-2002.

An administrative network is in place throughout the state for an expansion. The Task Force believes that family members should be eligible to serve and be paid as personal care assistants. An adequate wage should be permitted in order to attract and keep qualified attendants. Clients of this program should be a high priority for assistance from the community services ombudsman discussed above. The program should be expanded by 250 clients each year of the biennium.

The Task Force estimated the cost for this recommendation in FY 2002-2003 to be $3,250,000 (250 persons at $13,000 each), and in FY 03-04 to be $6,500,000 (500 persons at $13,000 each).

10. **The 2002 General Assembly should provide additional funds for expansion of the Home Care Program, Cabinet for Health Services, to serve 2,800 additional older persons during FY 02-04.**

The Home Care Program is an important component of Kentucky's home and community-based services system. It is designed to help older persons maintain independence and dignity and to remain in their own homes and communities. Home care clients have multiple functional disabilities and many are considered at risk for nursing home placement. Most live alone and have little in-home support, sixty-nine percent are over seventy-five years of age, and twenty-seven percent are over eighty-five. The majority of the clients are in poverty. The program is very flexible, which enables services to be tailored to the particular needs of the client. The history of the program reveals that with limited amounts of direct services (often a single, one-time service) and service coordination, older persons are able to overcome numerous physical and environmental problems and continue to live a relatively independent life and avoid nursing home placement. There is currently a waiting list of over 3,500 persons.

A statewide service delivery network exists. The Task Force supports the following procedures. Adequate hourly wages must be permitted in order to recruit and retain qualified workers. Family members, neighbors, and other individuals should be eligible to be employed to accomplish job tasks for which they are qualified. This should save a substantial amount on travel time and expense and related administrative expenses while greatly expanding the pool of workers. The wide range of services now provided should be continued, although administering agencies should be required to demonstrate that funding under this program was used as a resource of last resort.

The Task Force estimated the cost for this recommendation in FY 2002-2003 to be $2,100,000 (1,400 persons at $1,500 each), and in FY 03-04 to be $4,200,000 (2,800 persons at $1,500 each).

APPENDICES

APPENDIX A: Agendas

APPENDIX B: Glossary

APPENDIX C: Meeting Handouts

APPENDIX A

AGENDAS

TASK FORCE ON QUALITY LONG-TERM CARE

Meeting No. 1

TIME:	1:00 P.M.
DATE:	April 25, 2001
PLACE:	Room 131, Capitol Annex

I. Call to Order and Roll Call

II. Welcome and Announcements

Sen. Richie Sanders, Co-Chair

Rep. Harry Moberly, Co-Chair

III. Introductions of Task Force Members

Members are requested to provide a brief explanation of the organization or agency they represent and summarize their interest in the issues facing the Task Force.

IV. Overview of Office of Aging Services

Jerry Whitley, Executive Director
Office of Aging Services

V. Overview of Long-Term Care Issues from the Division of Long Term Care

Edward Wilson, Director
Division of Long Term Care

VI. Discussion of Next Meeting

VII. Adjournment

TASK FORCE ON QUALITY LONG-TERM CARE

Meeting No. 2

TIME:	1:00 P.M.
DATE:	May 23, 2001
PLACE:	Room 131, Capitol Annex

I. Call to Order and Roll Call

II. Welcome and Announcements

Sen. Richie Sanders, Co-Chair

Rep. Harry Moberly, Co-Chair

III. Approval of April 25, 2001 Minutes

IV. Overview of Aging Population Growth

Ron Crouch
Urban Studies Institute
College of Business & Public Administration
University of Louisville

V. States' Strategies Toward Long-Term Care

Wendy Fox-Grage, Health Policy Analyst
National Conference of State Legislatures
Washington, D.C.

VI. Discussion of Work Plan and Work Groups

VII. Adjournment

TASK FORCE ON QUALITY LONG-TERM CARE

Meeting No. 3

TIME:	1:00 P.M.
DATE:	June 27, 2001
PLACE:	Room 129, Capitol Annex

I. **Call to Order and Roll Call**

II. **Welcome and Announcements**

Sen. Richie Sanders, Co-Chair

Rep. Harry Moberly, Co-Chair

III. **Approval of May 23, 2001 Minutes**

IV. **Workgroup Reports and Discussion**

V. **Presentation: "Planning for the Future: 2000 Survey of Current and Coming Retirees in the Commonwealth"**

Michal Smith-Mello, Senior Policy Analyst
Amy L. Watts, Policy Analyst
Kentucky Long-Term Policy Research Center

VI. **Medicaid and Long-Term Care in Kentucky**

Ellen Hesen, Commissioner
Department for Medicaid Services

VII. **Adjournment**

TASK FORCE ON QUALITY LONG-TERM CARE

Meeting No. 4

TIME:	1:00 P.M.
DATE:	July 25, 2001
PLACE:	Room 129, Capitol Annex

I. **Call to Order and Roll Call**

II. **Welcome and Announcements**

Sen. Richie Sanders, Co-Chair

Rep. Harry Moberly, Co-Chair

III. **Approval of June 27, 2001 Minutes**

IV. **Work Group Reports and Discussion**

V. **Alternative Strategies for Providing Adult Day Services**

Keith Knapp, CEO
The Episcopal Church Home
Louisville, Kentucky

VI. **Update: Commission on Services and Supports for Individuals with Mental Illness, Alcohol and Other Drug Abuse Disorders, and Dual Diagnoses**

Marcia Morgan, Interim Secretary, Co-Chair
Cabinet for Health Services

Representative Mary Lou Marzian, Co-Chair

VII. **Update: Commission on Services and Supports for Individuals with Mental Retardation and Developmental Disabilities**

Pat Seybold, Developmental Disabilities Council

Margaret Pennington, Commissioner
Department for Mental Health/Mental Retardation Services

VIII. Next Meeting: August 22, 2001

IX. Adjournment

TASK FORCE ON QUALITY LONG-TERM CARE

Meeting No. 5

TIME:	1:00 P.M.
DATE:	August 22, 2001
PLACE:	Room 131, Capitol Annex

I. Call to Order and Roll Call

II. Welcome and Announcements

Sen. Richie Sanders, Co-Chair

Rep. Harry Moberly, Co-Chair

III. Approval of July 25, 2001 Minutes

IV. Nursing Home Resident Testimony

V. Nursing Home Administrator Testimony

VI. *Olmstead* State Plan Presentation

Jim Kimbrough, Coordinator
Olmstead State Plan Project
University of Kentucky Interdisciplinary
Human Development Institute

Marcia Morgan, Interim Secretary
Cabinet for Health Services

VII. Work Group Reports and Discussion of Preliminary Recommendations

Work Group for Issues 1-5
Work Group for Issues 6-7

VIII. Next Meeting: September 26, 2001

IX. Adjournment

TASK FORCE ON QUALITY LONG-TERM CARE

Meeting No. 6

TIME:	1:00 P.M.
DATE:	September 26, 2001
PLACE:	Room ***149***, Capitol Annex

I. Call to Order and Roll Call

II. Welcome and Announcements

Sen. Richie Sanders, Co-Chair

Rep. Harry Moberly, Co-Chair

III. Approval of August 22, 2001 Minutes

IV. Long-Term Care Delivery: National Perspective and Research Update

Rosalie Kane, Ph.D.
Director, Long Term Care Resource Center
University of Minnesota

V. Role of Non-Physician Practitioners in the Continuum of Long-Term Care

G. Scott Hansel, CEO
HealthEssentials, Inc.
Louisville, KY

VI. Long-Term Care and the Nursing Home Industry

Mary Ousley, R.N., Executive Vice President
SunBridge Healthcare
First Vice Chair, Board for the American Health Care Association

VII. Work Group Reports and Discussion of Recommendations

Work Group for Issues 1-5

Work Group for Issues 6-7

VIII. Next Meeting: October 24, 2001

IX. Adjournment

TASK FORCE ON QUALITY LONG-TERM CARE

Meeting No. 7

TIME:	1:00 P.M.
DATE:	October 24, 2001
PLACE:	Room ***131***, Capitol Annex

I. Call to Order and Roll Call

II. Welcome and Announcements

Sen. Richie Sanders, Co-Chair

Rep. Harry Moberly, Co-Chair

III. Approval of September 26, 2001 Minutes

IV. Work Group Reports and Discussion of Recommendations

Work Group for Issues 1-5
Work Group for Issues 6-7

V. Adjournment

APPENDIX B

GLOSSARY

GLOSSARY

(1) “Activities of daily living” means normal daily activities, including bathing, dressing, grooming, transferring, toileting, and eating. (As used in KRS 194A.700 to 194A.729.)

(2) “Administrative regulation” means a regulation adopted and promulgated pursuant to the procedures in KRS Chapter 13A.

(3) “Affected persons” means the applicant; any person residing within the geographic area served or to be served by the applicant; any person who regularly uses health facilities within that geographic area; health facilities located in the health service area in which the project is proposed to be located which provide services similar to the services of the facility under review; health facilities which, prior to receipt by the agency of the proposal being reviewed, have formally indicated an intention to provide similar services in the future; and the cabinet and third-party payors who reimburse health facilities for services in the health service area in which the project is proposed to be located. (As used in KRS Chapter 216B.)

(4) “Applicant” means any physician's office requesting a major medical equipment expenditure of one million five hundred thousand dollars ($1,500,000) or more after July 15, 1996, adjusted annually, or any person, health facility, or health service requesting a certificate of need or license. (As used in KRS Chapter 216B.)

(5) “Assistance with self-administration of medication” means:

(a) Reminding the client to take medications;

(b) Reading the medication's label;

(c) Confirming that medication is being taken by the client for whom it is prescribed;

(d) Opening the dosage packaging or medication container, but not removing or handling the actual medication;

(e) Storing the medication in a manner that is accessible to the client; and

(f) Making available the means of communicating with the client's physician and pharmacy for prescriptions by telephone, facsimile, or other electronic device. (As used in KRS 194A.700 to 194A.729.)

(6) “Assisted-living community” means a series of living units on the same site, operated as one (1) business entity, and certified under KRS 194A.707 to provide services for five (5) or more adult persons not related within the third degree of consanguinity to the owner or manager. (As used in KRS 194A.700 to 194A.729.)

(7) “Board” means the Kentucky Board of Licensure for Nursing Home Administrators. (As used in KRS Chapter 216A.)

(8) “Cabinet” means the Cabinet for Health Services. (As used in KRS 216.515 to 216.530, KRS 216.537 to 216.590, and KRS Chapter 216B.)

(9) “Capital expenditure” means an expenditure made by or on behalf of a health facility which:

(a) Under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance or is not for investment purposes only; or

(b) Is made to obtain by lease or comparable arrangement any facility or part thereof or any equipment for a facility or part thereof. (As used in KRS Chapter 216B.)

(10) "Capital expenditure minimum" means one million five hundred thousand dollars ($1,500,000) beginning with July 15, 1994, and as adjusted annually thereafter. In determining whether an expenditure exceeds the expenditure minimum, the cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the improvement, expansion, or replacement of any plant or any equipment with respect to which the expenditure is made shall be included. Donations of equipment or facilities to a health facility which if acquired directly by the facility would be subject to review under this chapter shall be considered a capital expenditure, and a transfer of the equipment or facilities for less than fair market value shall be considered a capital expenditure if a transfer of the equipment or facilities at fair market value would be subject to review. (As used in KRS Chapter 216B.)

(11) "Certificate of need" means an authorization by the cabinet to acquire, to establish, to offer, to substantially change the bed capacity, or to substantially change a health service as covered by this chapter. (As used in KRS Chapter 216B.)

(12) "Certified surgical assistant" means a certified surgical assistant or certified first assistant who is certified by the National Surgical Assistant Association on the Certification of Surgical Assistants, the Liaison Council on Certification of Surgical Technologists, or the American Board of Surgical Assistants. The certified surgical assistant is an unlicensed health-care provider who is directly accountable to a physician licensed under KRS Chapter 311 or, in the absence of a physician, to a registered nurse licensed under KRS Chapter 314. (As used in KRS Chapter 216B.)

(13) "Chiropractor" means a person authorized to practice chiropractic under KRS Chapter 312.

(14) "Client" means an adult person who has entered into a lease agreement with an assisted-living community. (As used in KRS 194A.700 to 194A.729.)

(15) “Continuing care retirement community” means a community that provides, on the same campus, a continuum of residential living options and support services to persons sixty (60) years of age or older under a written agreement. The residential living options shall include independent living units, nursing home beds, and either assisted living units or personal care beds. (As used in KRS Chapter 216B.)

(16) “Council” means the Advisory Council for Medical Assistance.

(17) “Crime” means a conviction of or a plea of guilty to a felony offense related to theft; abuse or sale of illegal drugs; abuse, neglect, or exploitation of an adult; or the commission of a sex crime. Conviction of or a plea of guilty to an offense committed outside the Commonwealth of Kentucky is a crime if the offense would have been a felony in Kentucky if committed in Kentucky.

(18) “Danger” means physical harm or threat of physical harm to one's self or others. (As used in KRS 194A.700 to 194A.729.)

(19) “Dentist” means a person authorized to practice dentistry under laws of the Commonwealth.

(20) “Direct service” means personal or group interaction between the employee and the nursing facility resident or the senior citizen. (As used in KRS 216.785 to 216.793.)

(21) “Formal review process” means the ninety (90) day certificate-of-need review conducted by the cabinet. (As used in KRS Chapter 216B.)

(22) “Health facility” means any institution, place, building, agency, or portion thereof, public or private, whether organized for profit or not, used, operated, or designed to provide medical diagnosis, treatment, nursing, rehabilitative, or preventive care and includes alcohol abuse, drug abuse, and mental health services. This shall include, but shall not be limited to, health facilities and health services commonly referred to as hospitals, psychiatric hospitals, physical rehabilitation hospitals, chemical dependency programs, tuberculosis hospitals, skilled nursing facilities, nursing facilities, nursing homes, personal care homes, intermediate care facilities, family

care homes, primary care centers, rural health clinics, outpatient clinics, ambulatory care facilities, ambulatory surgical centers, emergency care centers and services, ambulance providers, hospices, community mental health and mental retardation centers, home health agencies, kidney disease treatment centers and freestanding hemodialysis units, facilities and services owned and operated by health maintenance organizations directly providing health services subject to certificate of need, and others providing similarly organized services regardless of nomenclature. (As used in KRS Chapter 216B.)

(23) “Health professional” means a physician, physician assistant, nurse, doctor of chiropractic, mental health professional, optometrist, dentist, or allied health professional who is licensed in Kentucky.

(24) “Health services” means clinically related services provided within the Commonwealth to two (2) or more persons, including, but not limited to, diagnostic, treatment, or rehabilitative services, and includes alcohol, drug abuse, and mental health services. (As used in KRS Chapter 216B.)

(25) “Independent living” means the provision of living units and supportive services including, but not limited to, laundry, housekeeping, maintenance, activity direction, security, dining options, and transportation. (As used in KRS Chapter 216B.)

(26) “Instrumental activities of daily living” means activities to support independent living including, but not limited to, housekeeping, shopping, laundry, chores, transportation, and clerical assistance. (As used in KRS 194A.700 to 194A.729.)

(27) “Intraoperative surgical care” includes the practice of surgical assisting in which the certified surgical assistant is working under the direction of the operating physician as a first or second assist, and which may include the following procedures:

(a) Positioning the patient;

(b) Preparing and draping the patient for the operative procedure;

(c) Observing the operative site during the operative procedure;

(d) Providing the best possible exposure of the anatomy incident to the operative procedure;

(e) Assisting in closure of incisions and wound dressings; and

(f) Performing any task, within the role of an unlicensed assistive person, required by the operating physician incident to the particular procedure being performed. (As used in KRS Chapter 216B.)

(28) "Licensee" in the case of a licensee who is an individual means the individual, and in the case of a licensee who is a corporation, partnership, or association means the corporation, partnership, or association. (As used in KRS 216.537 to 216.590.)

(29) "Living unit" means a portion of an assisted-living community occupied as the living quarters of a client under a lease agreement. (As used in KRS 194A.700 to 194A.729.)

(30) "Long-term-care facilities" means those health-care facilities in the Commonwealth which are defined by the Cabinet for Health Services to be family-care homes, personal-care homes, intermediate-care facilities, skilled-nursing facilities, nursing facilities as defined in Pub. L. 100-203, nursing homes, and intermediate-care facilities for the mentally retarded and developmentally disabled. (As used in KRS 216.515 to 216.530 and KRS 216.537 to 216.590.)

(31) "Long-term care ombudsman" means the person responsible for the operation of a long-term care ombudsman program which investigates and resolves complaints made by or on behalf of residents of long-term care facilities. (As used in KRS 216.537 to 216.590.)

(32) "Major medical equipment" means equipment which is used for the provision of medical and other health services and which costs in excess of the medical

equipment expenditure minimum. For purposes of this subsection, “medical equipment expenditure minimum” means one million five hundred thousand dollars ($1,500,000) beginning with July 15, 1994, and as adjusted annually thereafter. In determining whether medical equipment has a value in excess of the medical equipment expenditure minimum, the value of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition of the equipment shall be included. (As used in KRS Chapter 216B.)

(33) “Medical care” as used in this chapter means essential medical, surgical, chiropractic, dental, optometric, podiatric, telehealth, and nursing services, in the home, office, clinic, or other suitable places, which are provided or prescribed by physicians, optometrists, podiatrists, or dentists licensed to render such services, including drugs and medical supplies, appliances, laboratory, diagnostic and therapeutic services, nursing-home and convalescent care, hospital care as defined in KRS 205.560(1)(a), and such other essential medical services and supplies as may be prescribed by such persons; but not including abortions, or induced miscarriages or premature births, unless in the opinion of a physician such procedures are necessary for the preservation of the life of the woman seeking such treatment or except in induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the mother or her unborn child. However, this section does not authorize optometrists to perform any services other than those authorized by KRS Chapter 320.

(34) “Mobile nonambulatory” means unable to walk without assistance, but able to move from place to place with the use of a device including, but not limited to, a walker, crutches, or wheelchair. (As used in KRS 194A.700 to 194A.729.)

(35) “Nonsubstantive review” means an expedited review conducted by the cabinet of an application for a certificate of need as authorized under KRS 216B.095. (As used in KRS Chapter 216B.)

(36) “Nonclinically-related expenditures” means expenditures for:

(a) Repairs, renovations, alterations, and improvements to the physical plant of a health facility which do not result in a substantial change in beds, a substantial change in a health service, or the addition of major medical equipment, and do not constitute the replacement or relocation of a health facility; or

(b) Projects which do not involve the provision of direct clinical patient care including, but not limited to, the following:

1. Parking facilities;
2. Telecommunications or telephone systems;
3. Management information systems;
4. Ventilation systems;
5. Heating or air conditioning, or both;
6. Energy conservation; or
7. Administrative offices. (As used in KRS Chapter 216B.)

(37) “Nurse” means a person authorized to practice professional nursing under the laws of the Commonwealth.

(38) “Nursing home” means a facility which provides routine medical care in which physicians regularly visit patients, which provide nursing services and procedures employed in caring for the sick which require training, judgment, technical knowledge, and skills beyond that which the untrained person possesses, and which maintains complete records on patient care, and which is licensed pursuant to the provisions of KRS 216B.015. In KRS Chapter 216A, the term “nursing home” means a place devoted primarily to the maintenance and operation of facilities for the treatment and care of persons who suffer from illness, disease, deformity or injury not requiring the intensive care normally provided in a hospital, but who do require care in excess of room, board and laundry and who need medical and nursing care.

(39) “Nursing home administrator” means any individual responsible for planning, organizing, directing, and controlling the operation of a nursing home, or who in fact performs such functions, whether or not such functions are shared by one or more other persons. (As used in KRS Chapter 216A.)

(40) “Nursing pool” means any person, firm, corporation, partnership, or association engaged for hire in the business of providing or procuring temporary employment in nursing facilities for medical personnel including, but not limited to, nurses, nursing assistants, nurses' aides, and orderlies. (As used in KRS 216.785 to 216.793.)

(41) “Office” means the Office of Aging Services. (As used in KRS 194A.700 to 194A.729.)

(42) “Optometrist” means a person authorized to practice optometry under the laws of the Commonwealth.

(43) “Other persons eligible for medical assistance” may include the categorically needy excluded from money payment status by state requirements and classifications of medically needy individuals as permitted by federal laws and regulations and as prescribed by administrative regulation of the secretary for health services or his designee.

(44) “Perioperative nursing” means a practice of nursing in which the nurse provides preoperative, intraoperative, and postoperative nursing care to surgical patients. (As used in KRS Chapter 216B.)

(45) “Pharmacist” means a person authorized to practice pharmacy under the laws of the Commonwealth.

(46) “Physician” means a person authorized to practice medicine or osteopathy under the laws of the Commonwealth.

(47) “Podiatrist” means a person authorized to practice podiatry under the laws of the Commonwealth.

(48) “Primary-care center” means a facility which provides comprehensive medical care with emphasis on the prevention of disease and the maintenance of the patients' health as opposed to the treatment of disease.

(49) “Public assistance recipient” means a person who has been certified by the Department for Community Based Services of the Cabinet for Families and Children as being eligible for, and a recipient of, public assistance under the provisions of this chapter.

(50) “Registered nurse first assistant” means one who:

(a) Holds a current active registered nurse licensure;

(b) Is certified in perioperative nursing; and

(c) Has successfully completed and holds a degree or certificate from a recognized program, which shall consist of:

1. The Association of Operating Room Nurses, Inc., Core Curriculum for the registered nurse first assistant; and

2. One (1) year of postbasic nursing study, which shall include at least forty-five (45) hours of didactic instruction and one hundred twenty (120) hours of clinical internship or its equivalent of two (2) college semesters.

A registered nurse who was certified prior to 1995 by the Certification Board of Perioperative Nursing shall not be required to fulfill the requirements of paragraph (c) of this subsection. (As used in KRS Chapter 216B.)

(51) “Resident” means any person who is admitted to a long-term-care facility as defined in KRS 216.515 to 216.530 for the purpose of receiving personal care and assistance. (As used in KRS 216.515 to 216.530.) “Resident” means any person admitted to a long-term care facility as defined by this section. (As used in KRS 216.537 to 216.590.)

(52) “Secretary” means the secretary of the Cabinet for Health Services. (As used in KRS 216.537 to 216.590 and KRS Chaper 216B.)

(53) “Senior citizen” means a person sixty (60) years of age or older.

(54) “State health plan” means the document prepared triennially, updated annually, and approved by the Governor. (As used in KRS Chapter 216B.)

(55) “Substantial change in a health service” means:

  (a) The addition of a health service for which there are review criteria and standards in the state health plan;

  (b) The addition of a health service subject to licensure under this chapter; or

  (c) The reduction or termination of a health service which had previously been provided in the health facility. (As used in KRS Chapter 216B.)

(56) “Telehealth consultation” means a medical or health consultation, for purposes of patient diagnosis or treatment, that requires the use of advanced telecommunications technology, including, but not limited to:

  (a) Compressed digital interactive video, audio, or data transmission;

  (b) Clinical data transmission via computer imaging for teleradiology or telepathology; and

  (c) Other technology that facilitates access to health care services or medical specialty expertise.

(57) “Third party” means an individual, institution, corporation, company, insurance company, personal representative, administrator, executor, trustee, or public or private agency, including, but not limited to, a reparation obligor and the assigned claims bureau under the Motor Vehicle Reparations Act, Subtitle 39 of KRS Chapter 304, who is or may be liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or recipient of medical assistance provided under Title XIX of the Social Security Act, 42 U.S.C. sec. 1396 et seq.

(58) “Vendor payment” means a payment for medical care which is paid by the Cabinet for Health Services directly to the authorized person or institution which rendered medical care to an eligible recipient.

(59) “Willful interference” means an intentional, knowing, or purposeful act or omission which hinders or impedes the lawful performance of the duties and responsibilities of the ombudsman as set forth in this chapter. (As used in KRS 216.537 to 216.590.)

APPENDIX C

MEETING HANDOUTS

MEETING HANDOUTS

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