2024 Annual Report

Subcommittee on Alzheimer's Disease and Other Related Dementia

RSA 126-A:15-a (HB 1572, Chapter 67:1, Laws of 2014)

November 20th, 2024

Subcommittee Membership

Senator Kevin Avard (Chair)
Representative Erica Layon (Vice Chair)
Wendi Aultman - Department of Health and Human Services
Sunny Shea - Attorney General, Designee
Kathy Harvard - Caregiver
Meghan Wentworth - Assisted Living Industry
Kim Mohan - NHNPA
Keliane Totten - Home Care Association
Maureen Murtagh - NH Board of Nursing
Jennifer Horgan - Alzheimer's Association, MA/NH Chapter
Janessa Luke - A representative of the nursing facility industry.
Laura Rocha - A researcher with Alzheimer's-related expertise in basic transitional, clinical, or drug development science.
Maria Camerlengo - A representative of the adult day care services industry.

Adjunct Members

Jay Gupta, Pharmacist

Duties of the Subcommittee

The subcommittee shall:

A. Review other states' plans for Alzheimer's disease.
B. Survey individuals with Alzheimer's disease to more accurately estimate the number of persons in the state with the disease.
C. Study existing services and resources, including but not limited to:
    a. The type, cost, and availability of dementia services.
    b. Dementia-specific training requirements for long-term care staff.
    c. Quality care measures across all care settings.
    d. Capacity of public safety and law enforcement to respond to persons with Alzheimer's disease.
    e. Availability of home and community-based resources for persons with Alzheimer's disease and respite care to assist families and caregivers.
    f. Inventory of long-term care dementia care units and beds.
    g. Adequacy and appropriateness of geriatric-psychiatric units for persons with behavior disorders associated with Alzheimer's disease and related dementia.
    h. Assisted living residential options for persons with dementia.
    i. State support of Alzheimer's disease research through New Hampshire universities and other resources.

D. Determine state policies and responses that are necessary to provide clear and coordinated services and supports to persons, families, and caregivers living with Alzheimer's disease and develop strategies to address any identified gaps in service.
E. Establish a New Hampshire state plan for Alzheimer's disease and other related dementia as approved by the health and human services oversight committee.

Meeting Summaries
(PowerPoints presented to the Subcommittee are included in the attached minutes)

Note: The comments made by members of the Subcommittee represent their own views and not necessarily the views of their organization or agency.

January 31, 2024
Melissa Grenier, Regional Manager for the Alzheimer's Association's MA/NH Chapter delivered an "Alzheimer's and Dementia 101" presentation to the Subcommittee, providing a baseline of information regarding Alzheimer's and dementia to subcommittee members.

The Subcommittee received an update on the status of the public awareness campaign from the Department of Health and Human Services. Discussion ensued surrounding a review of compliance with the licensing and training requirements of healthcare providers in the state, and facilities' marketing of their qualifications to provide dementia care that can be misleading to families.

February 21, 2024
Dr. Dax Volle, Assistant Professor of Psychiatry and Associate Director of the Geriatric Psychiatry Fellowship Program at Dartmouth-Hitchcock Medical Center, and Corie E. Crane, DNP, Psychiatry Provider, presented a PowerPoint entitled "Dementia Care in New Hampshire", which covered epidemiology/demographics, neuropsychiatric symptoms of dementia, and services available in NH.

The subcommittee discussed the constraints facing individuals in need of inpatient services, the future availability of blood biomarker testing in the state, the strains of ServiceLink and caregivers across the state, and compliance with training requirements in healthcare facilities.

March 27, 2024
Sunny Mulligan Shea, Victim Witness Advocate at the NH Department of Justice, and Bryan J. Townsend, II, Senior Assistant Attorney General, Prosecutor, presented "Protecting New Hampshire's Older Adults Now and in the Future". They explained the work of the Elder Abuse & Financial Exploitation Unit, along with the risk factors older adults in the state are faced with and the current statutory landscape surrounding their work.

The Subcommittee discussed different types of abuse such as, hoarding (self-neglect), theft charges, including forgery and any form of identity fraud (criminal), and mandatory reporting requirements for various service providers, including Meals on Wheels volunteers. Ms. Shea provided information on signs of possible exploitation and what makes someone particularly vulnerable. She further explained that 1 in 10 older adults are victimized each year and explained

that the Unit receives roughly 35 referrals a week, all of which are reviewed by just two attorneys. The Subcommittee discussed the recently passed legislation that allows banks to freeze accounts for suspected exploitation and the implementation of this statute by financial institutions.

April 24, 2024
Laurie Duff, Director of Senior Services at Easterseals NH, VT & Farnum, presented to the Subcommittee on adult day programs in New Hampshire. NH has adult day centers in Conway, Hollis, Hooksett, Hudson, Jaffrey, Manchester, Merrimack, Nashua, Rochester, and Salem. There have been 9 closures of adult day centers in the last 10 years. Ms Duff explained that Medicaid reimbursement rates have led to financial struggle for these facilities, but recent changes to rates has eased some of that strain. She went on to say that adult day programs are a very under-utilized resource, resulting in low census rates, as there is still very low awareness about the programs among the general public. Adult day centers in New Hampshire are medical and require a referral from a doctor.

The Subcommittee discussed what services and supports are provided at adult day centers and the state of awareness surrounding this resource. Ms. Duff explained how the Program of All-Inclusive Care for the Elderly (PACE model) is used in other states for all-inclusive care of the elderly, but she noted that New Hampshire's rural nature would need to be considered in a model such as that. Ms. Aultman stated that DHHS has been working with a consultant focusing on feasibility study for PACE and a Dual Eligible Special Needs Plans (D-SNIP), which is all-inclusive supports to cover services for individuals who are dually qualified for Medicare and Medicaid. The Subcommittee discussed different opportunities to increase awareness including through the public awareness campaign and in doctors' offices.

May 29, 2024
Gina Balkus, CEO of Home Care, Hospice & Palliative Care Alliance of New Hampshire, presented "Understanding Home Health & Hospice Options" to the Subcommittee. Ms. Balkus explained that NH licenses all home health agencies, with two categories: medical and non-medical agencies. If an agency is non-medical, it is limited to providing personal care and homemaking services, and no medical care services are delivered.

Ms. Balkus walked the Subcommittee through the qualifications required for these services and explained the Choices for Independence Program (CFI), which is a Medicaid Program for individuals who qualify for nursing home care, but choose to receive services at home. She also explained the state of hospice care in New Hampshire and the role of advanced directives. Ms. Luke noted the importance of palliative care as a stepping stone in the care journey.

Recommendations

The Subcommittee has spent the last year gathering information regarding the landscape in New Hampshire surrounding Alzheimer's and dementia and has worked on developing a needs assessment. While the Subcommittee intends to gather more information from identified areas, in the coming year it will begin drafting an updated state plan, and provide legislative and regulatory recommendations for the 2026 Session.

Subcommittee on Alzheimer's and Related Dementia Minutes
Wednesday, January 31st at 3:00 p.m.
State House Room 103

Meeting called to order at 3:01 p.m.

Vice Chair Representative Layon presiding.

Present: Representative Layon, Wendi Aultman, Sunny Mulligan Shea, Jessica Eskeland, Dr. Dax Volle, Maria Camerlengo, Jay Gupta, Kathy Harvard, Janessa Luke, Gina Balkus

Absent: Senator Avard, Maureen Murtagh, Meghan Wentworth, Kim Mohan, Laura Rocha.

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Minutes from the 12/11/23 meeting unanimously approved.

Melissa Grenier, Regional Manager for the Alz Association's MA/NH Chapter appeared before the Subcommittee to present. Ms. Grenier has a background as a licensed social worker and has been working in the human services field for 19 years.

Ms. Grenier delivered an "Alzheimer's and dementia 101" presentation to the Subcommittee.

Alzheimer's and Dementia: Areas of Impact in NH

Feb. 12th, 2024

Melissa Grenier, LCSW, Regional Manager, NH
NH State Commission on Aging

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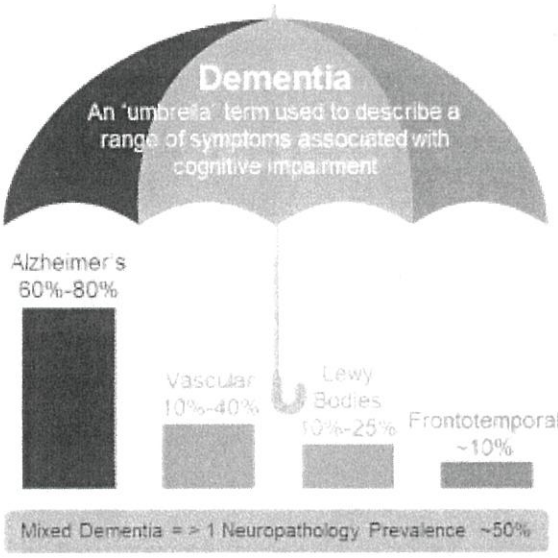
Objectives

- Overview of Alzheimer's Disease and dementia
- Recognize how Alzheimer's affects the brain and a person's functioning
- Learn about the prevalence of Alzheimer's and dementia in NH
- Learn how Alzheimer's and Dementia impacts NH's caregivers and healthcare system

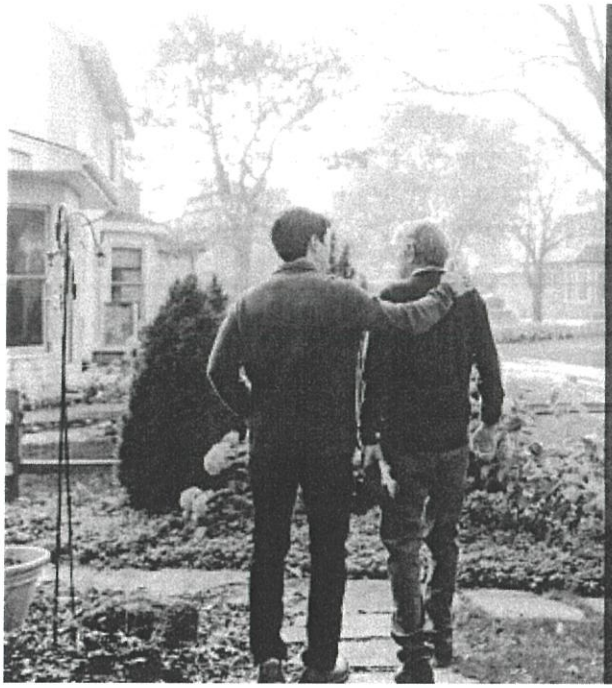
Dementia is a Syndrome

- Dementia is a collection of symptoms related to cognitive decline
- Can include cognitive, behavioral and psychological symptoms
- Due to biological changes in the brain
- Alzheimer's is most common cause
- Mixed dementia is very prevalent
- Some causes of cognitive decline are reversible and not truly dementia



Alzheimer's Disease

- In Alzheimer's, the neurons damaged first are those in parts of the brain responsible for memory, language and thinking.
- As a result, the first symptoms tend to be memory, language and thinking problems.
- Although these symptoms are new to the individual affected, the brain changes that cause them are thought to begin 20 years or more before symptoms start.



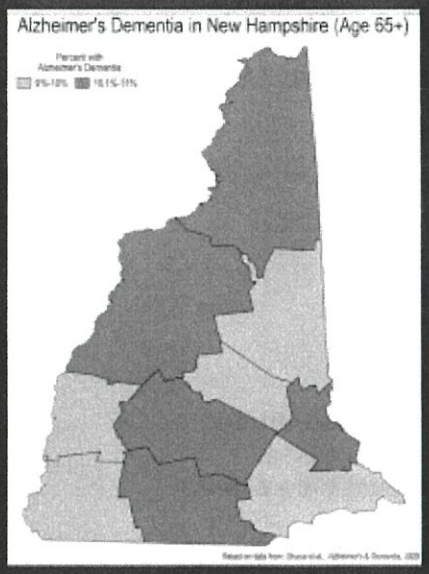
Approximately how many Granite Staters are currently living with Alzheimer's?

- 50,000
- 26,000
- 90,000
- 70,000

County Data, 2023

County	Alzheimer's Dementia Prevalence Est	
	Total Pop. Age 65+ (nearest 100)	AD Cases Age 65+ (nearest 100)
	263,100	26,500
Belknap	14,500	1,400
Carroll	14,600	1,400
Cheshire	16,300	1,600
Coos	7,800	800
Grafton	20,000	2,000
Hillsborough	69,900	7,300
Merrimack	29,500	3,000
Rockingham	59,600	5,900
Strafford	21,100	2,100
Sullivan	9,900	1,000

(https://aaic.alz.org/releases_2023/us-county-level-alzheimers-prevelance-estimates.asp; https://alz-journals.onlinelibrary.wiley.com/doi/10.1002/alz.13081)



ALZHEIMER'S ASSOCIATION

County Data (continued)

- Information was collected via cognitive data from the Chicago Health and Aging Project, a population-based study, and combined it with the National Center for Health Statistics 2020 bridged-race population estimates to determine the prevalence of AD in adults ≥65 years.
- Older average age and higher percentages of Black and Hispanic residents (ex: Merrimack and Hillsborough Counties) are specific demographics that may explain higher prevalence in some counties.
- This information, in addition to raising awareness of the Alzheimer's crisis in specific communities, may help public health programs better allocate funding, staffing and other resources for caring for people with Alzheimer's and all other dementia.

Gender, Racial and Ethnic Disparities in Alzheimer's Prevalence

Age is the greatest risk factor for developing Alzheimer's. 1 in 9 Americans over age 65 will develop Alzheimer's.



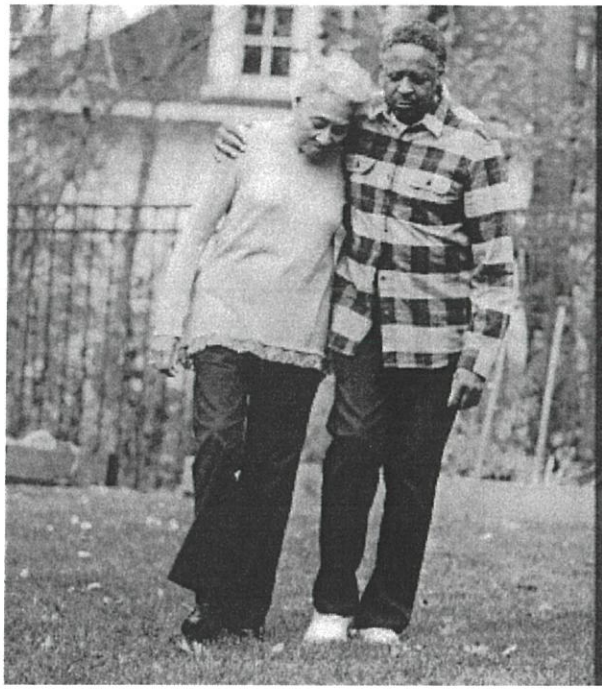
Almost **two-thirds** of Americans with Alzheimer's are **women.**



Older **Black** and **Hispanic** Americans are disproportionately more likely than older **Whites** to have Alzheimer's or other dementias.



Ethnoracial groups have been historically **underrepresented** in clinical studies, underscoring the need for more **diversity** in dementia research.



About how many Granite Staters provide unpaid care for people living with Alzheimer's or other dementias?

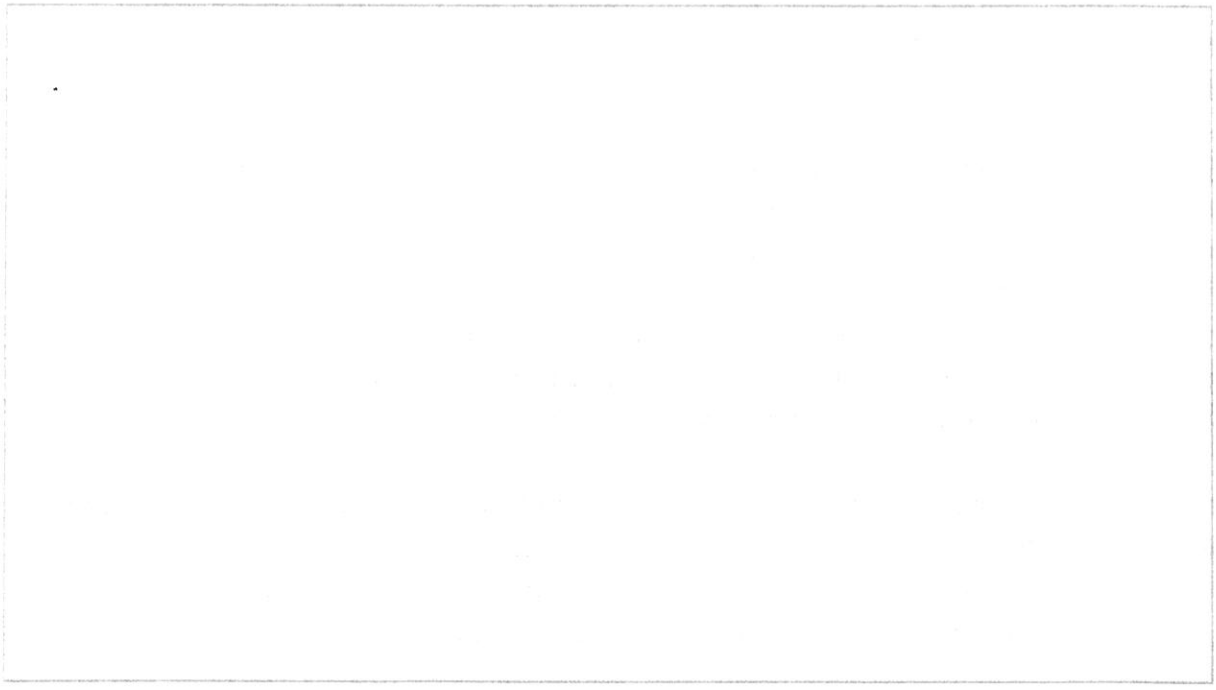
- 75,000
- 200,000
- 110,000
- 58,000

Impact on caregivers

- 83% of the help provided to older adults in the United States comes from family members, friends or unpaid caregivers.
- Caregiver tasks can include: help with activities of daily living; managing medications and other treatments; managing behavioral symptoms; arranging, hiring and supervising paid care; providing transportation; and more.
- Burden of caregiving is physical, emotional, mental, spiritual and financial.
- Dementia caregivers report higher levels of physical, emotional, and financial stress than caregivers for other older adults.
- On average, unpaid caregivers provide approximately 30 hours of care per week, or 1,565 hours of care per year.

Impact on Granite State Healthcare

- $254 Million: Medicaid costs of caring for people with Alzheimer's (2020); $335 Million: Medicaid costs of caring for people with Alzheimer's (projected for 2025)
- $28,086: per capita Medicare spending on people with dementia (2022)
- 33: Number of geriatricians in 2021 (118% increase needed to meet demand in 2050)
- 8,410: Number of home health and personal care aides in 2020 (30.4% increase needed to meet the demand in 2030)



There were no questions from the group at the conclusion of the presentation. Members should contact Ms. Eskeland or Ms. Grenier with any follow-up questions.

Rep. Layon indicated that the Subcommittee would be receiving more informational presentations moving forward, and noted that there seem to be some great opportunities to share with the group.

Rep. Layon referenced the subcommittee goals draft document previously provided to the members and whether there was any discussion on that.

Mr. Gupta thinks root causes are missing and would like to see options for reversal and treatment covered.

Rep. Layon noted that she feels the document is a good outlook for our work, and that we can discuss finalizing it further when we're all together as a group.

Ms. Aultman noted that she provided an update last Friday to the Health and Human Services Oversight Committee re: the public awareness campaign for brain health, Alzheimer's disease, and other related dementias, as passed in last year's budget.

The Department is currently in the procurement phase, so she is limited in terms of the information she can provide, but she provided the link to the contracting page which identifies what the procurement document is, the scope of work they're looking for, and questions and answers the Department has received from potential bidders. She expects it will be a competitive process, and the Department is currently reviewing proposals.

She expects, based on the work being done in the Contracting Unit, that they'll have a contractor hopefully by the end of May at the latest. They have two Governor & Council meetings in May and are hoping to be on the agenda for one of those meetings.

Rep. Layon noted that it will be really exciting to get that work underway, and noted the Subcommittee can plan for future agendas toward the summer working on this campaign and having the Subcommittee participating in that.

Ms. Harvard noted that she'd like to add to the list of Subcommittee goals the need for healthcare workforce resources; specifically, reviewing training requirements and healthcare workforce availability so we know what our pool is and whether it meets the demands of our population, and assess what resources exist right now with training programs.

Ms. Mulligan Shea wants to add looking at the availability and options for dementia care. She wants to explore what it means when a provider or facility says they're qualified to provide dementia care. What does that mean? Facilities claim to be memory care facilities and she doesn't find them to be particularly well-equipped to meet the needs of this population. What does that mean and what standards exist?

Rep. Layon added that then the question would be whether there should be more intensive licensing standards to equip facilities for people with more advanced dementia. We should look at the potential for carving out nuances between memory care and acute memory care.

Ms. Mulligan Shea noted that the idea that people call themselves something simply because it's lucrative isn't fair to patients or families.
Ms. Aultman noted that we can think about different ways we can incorporate levels of what people need for education and experience. We know that there are licensing requirements for minimum hours of training and what kind of training needs to be included, but she also thinks about other areas that may not currently be addressed but could make a facility more dementia-friendly.

Mr. Gupta noted that he saw these kinds of issues arise in the substance use disorder area, with lots of facilities opening up shops that weren't adequately equipped to serve that population.

Mr. Gupta asked about the potential for a remote participation option for these meetings.

Rep. Layon noted that meetings need to be in-person for the Legislature and noted that they provide for better collaboration.

Ms. Eskeland will work with Senator Avard to ensure these meetings are live-streamed.

Adjourned at 3:48 p.m.

Subcommittee on Alzheimer's and Related Dementia Minutes
Wednesday, February 21, 2024 at 3:00 p.m.
State House Room 103

Meeting called to order at 3:00 p.m.

Present: Representative Layon, Wendi Aultman, Maria Camerlengo, Jessica Eskeland, Meghan Wentworth, Kathy Harvard, Janessa Luke, Gina Balkus, Sunny Mulligan Shea, Dax Volle

Absent: Senator Avard, Maureen Murtagh, Kim Mohan, Laura Rocha, Jay Gupta

Note: The comments made by members of the Subcommittee represent their own views and not necessarily the views of their organization or agency.

Minutes

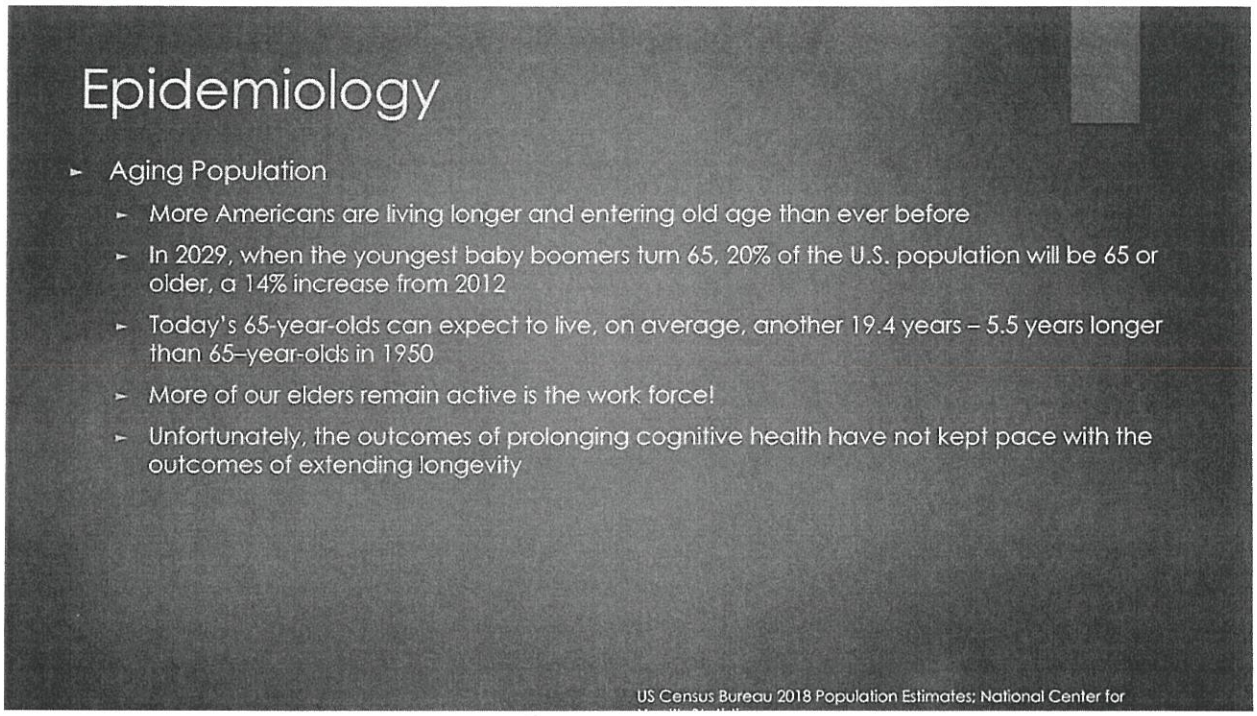
Dr. Dax Volle, Assistant Professor of Psychiatry and Associate Director of the Geriatric Psychiatry Fellowship Program at Dartmouth-Hitchcock Medical Center presented to the Subcommittee, accompanied by his colleague Corie E. Crane, DNP, Psychiatry Provider.

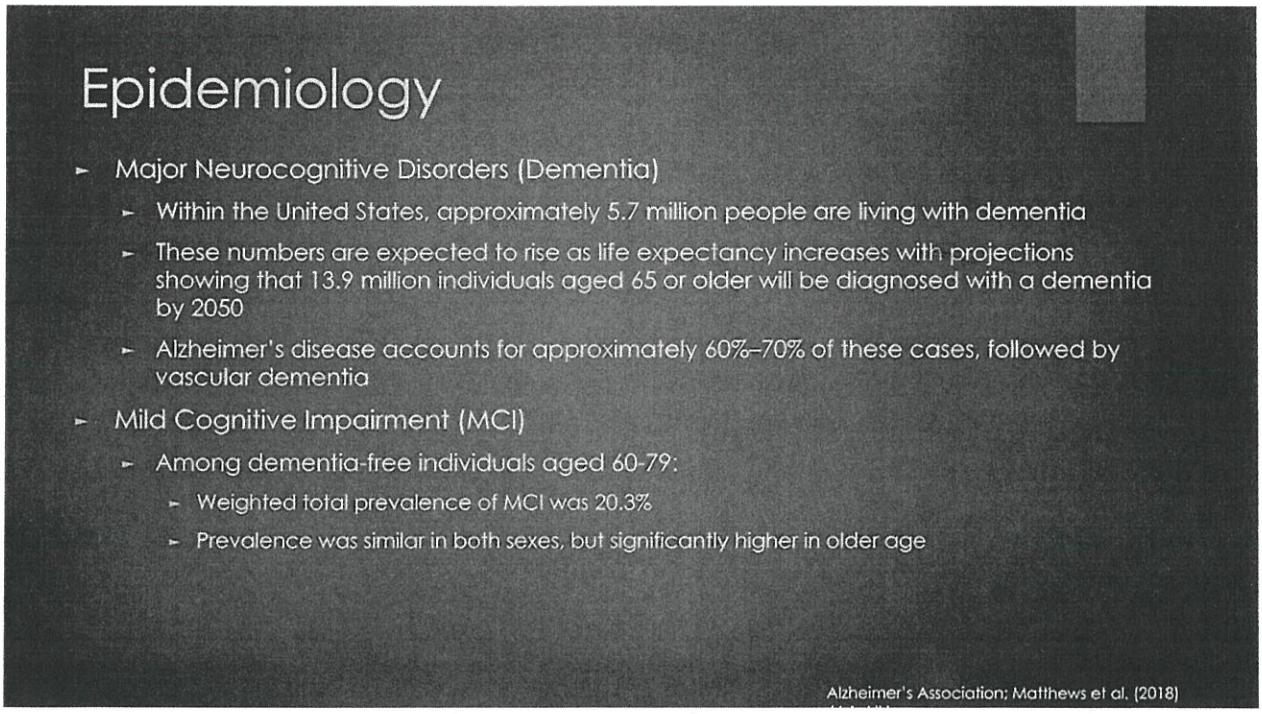
Dr. Volle directs clinical services, administration, and research at Dartmouth-Hitchcock.

Dr. Volle shared a PowerPoint presentation, which is available to accompany these minutes and appears below.

Outline

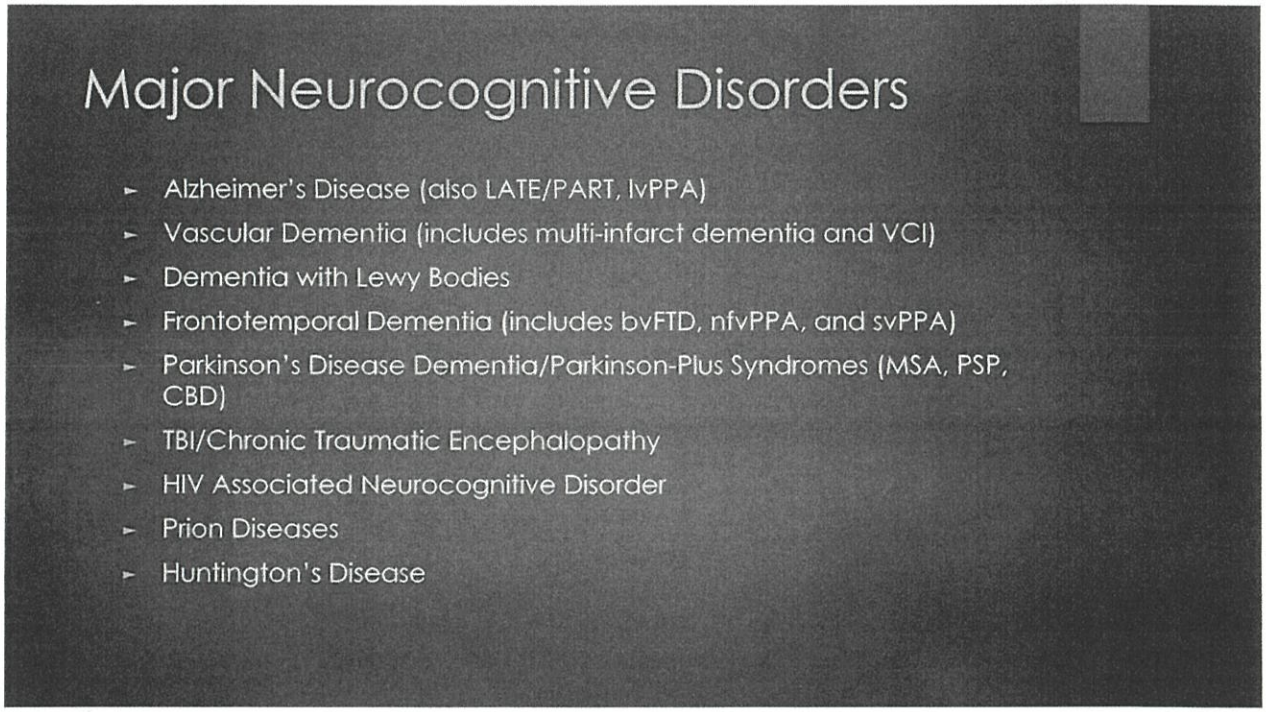
- Epidemiology/Demographics
- Neuropsychiatric Symptoms of Dementia
- Service Availability

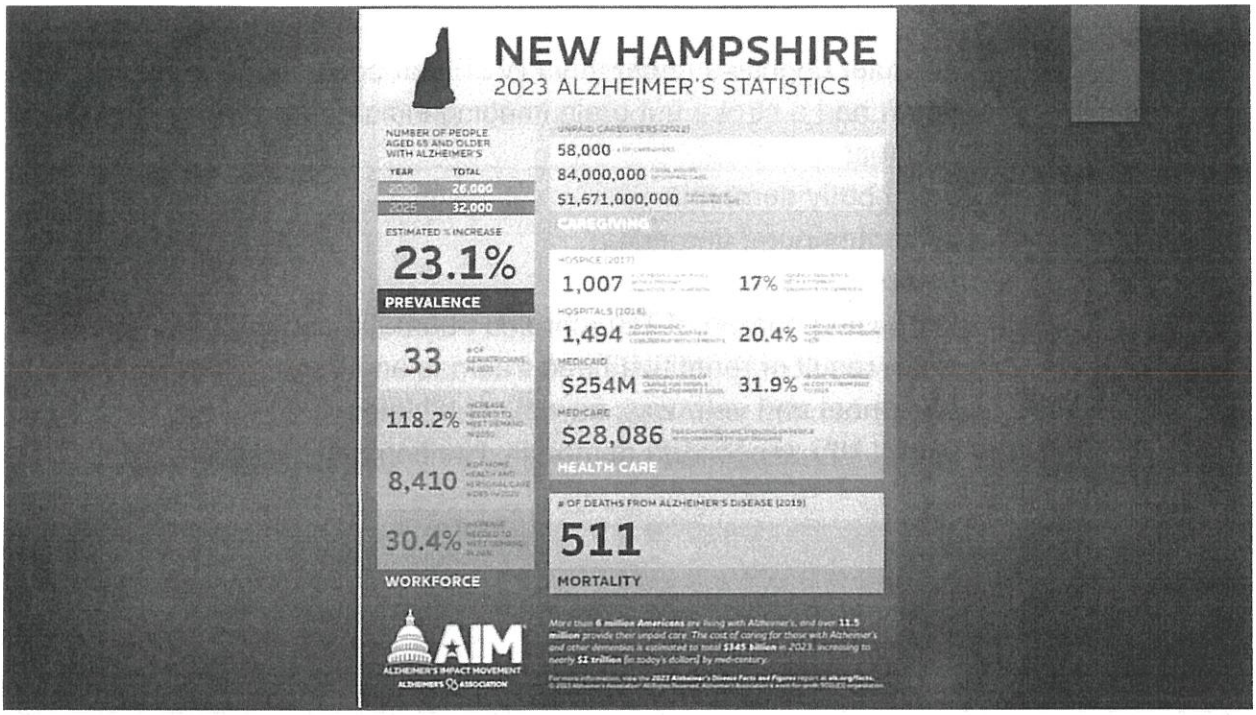




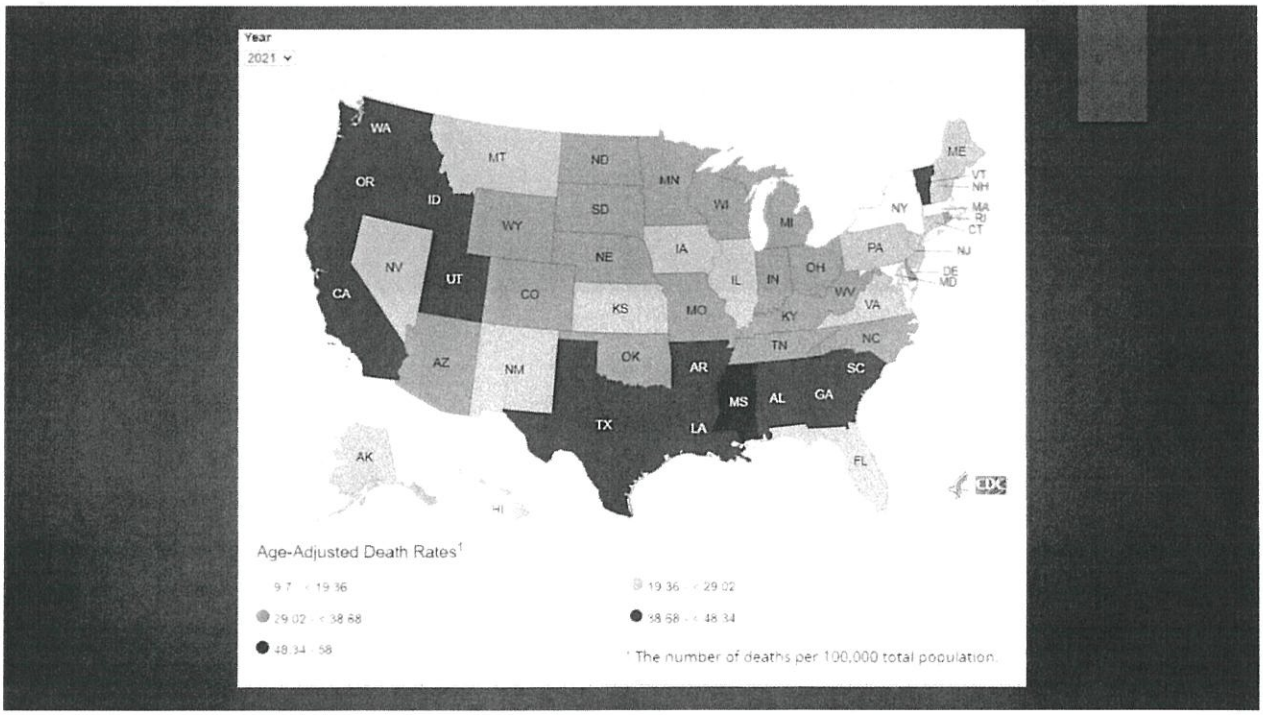
- With mild cognitive impairment (MCI) there isn't necessarily a full dementia diagnosis.
    - When we talk about dementia, it includes a broad variety of things:
        - Alzheimer's is most common type
            - There are also variants of Alzheimer's

- Vascular dementia (can be the result of multiple strokes) or vascular cognitive impairment (VCI) can occur when a patient has never had a stroke but brain imaging indicates evidence of wear and tear
- Lewy body dementia
- Frontotemporal dementia
- Parkison's disease
- Increasing burden of TBI (chronic traumatic encephalopathy) which is the result of repetitive head traumas and largely affects military personnel and veterans, as well as athletes
- Rarer: HIV associated dementia, Huntington's disease



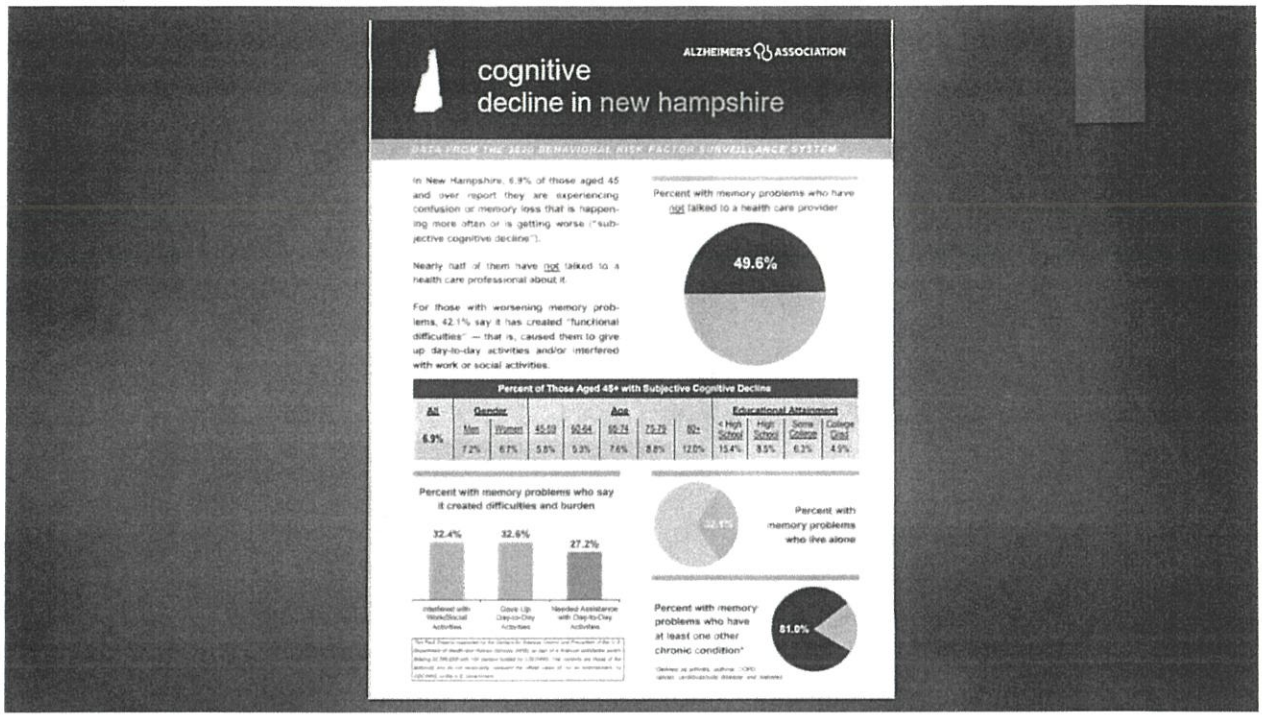


- These NH 2023 facts and figures were compiled by the Alzheimer's Association
  - Highlights our state's lack of geriatricians
  - Highlighted significant healthcare workforce needs and the demand for caregivers, as well as the struggle for unpaid caregivers

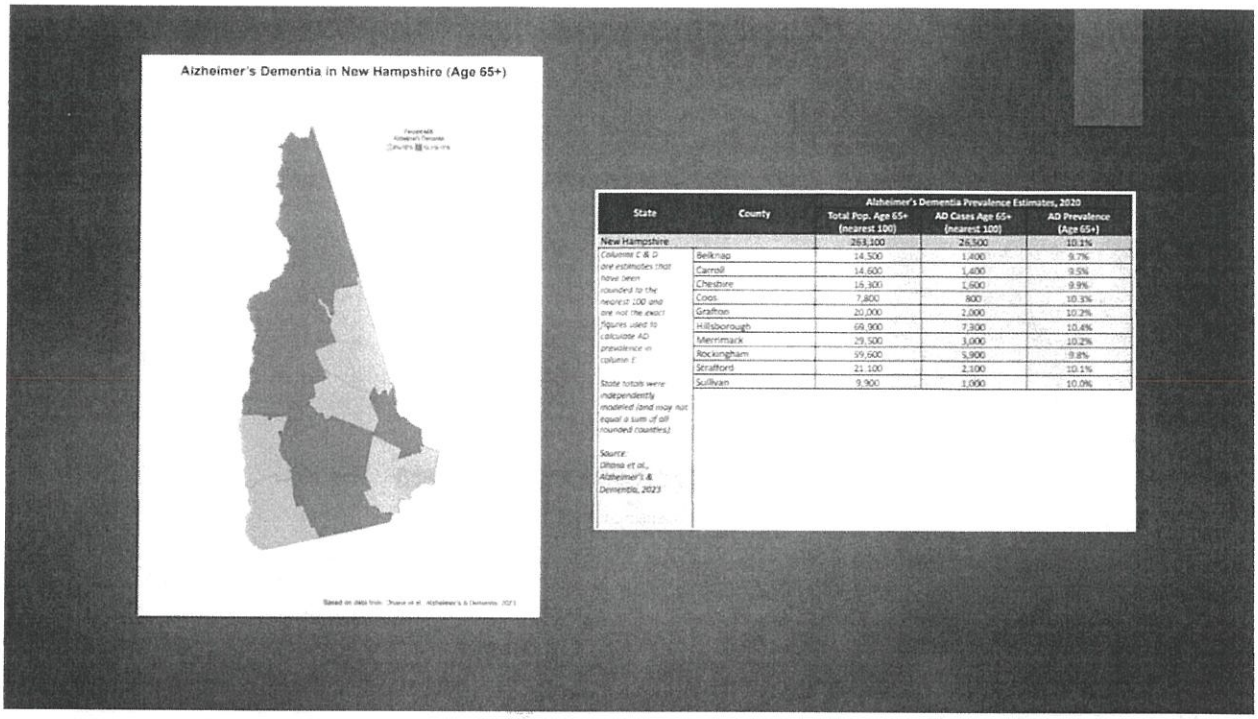


- In terms of per capita deaths from Alzheimer's specifically, New Hampshire is in the lower range right now

- That said, we're going to be contending with the silver tsunami very soon



- Cognitive decline in NH
  - About 7% of those older than 45 are experiencing some confusion (subjective decline) that's getting worse and most of them haven't talked to a healthcare provider about it
  - Assistance is coming primarily from spouses/unpaid caregivers

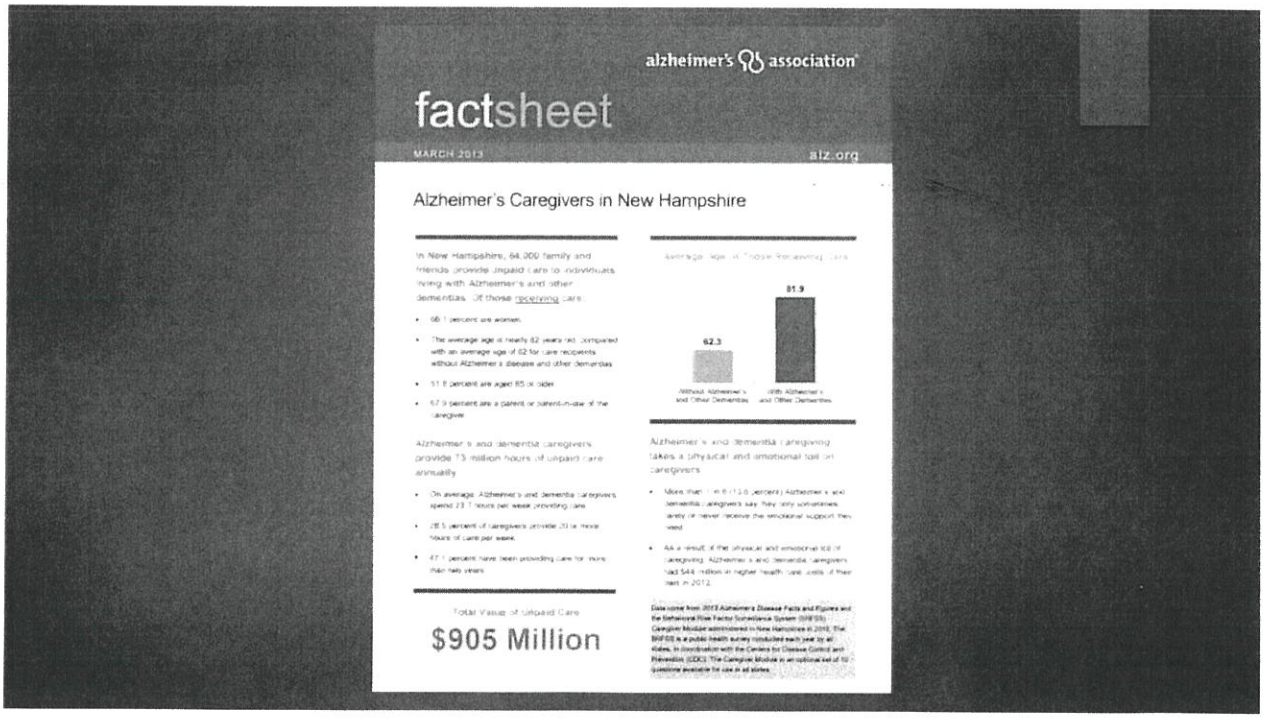


Alzheimer's Dementia Prevalence Estimates, 2020

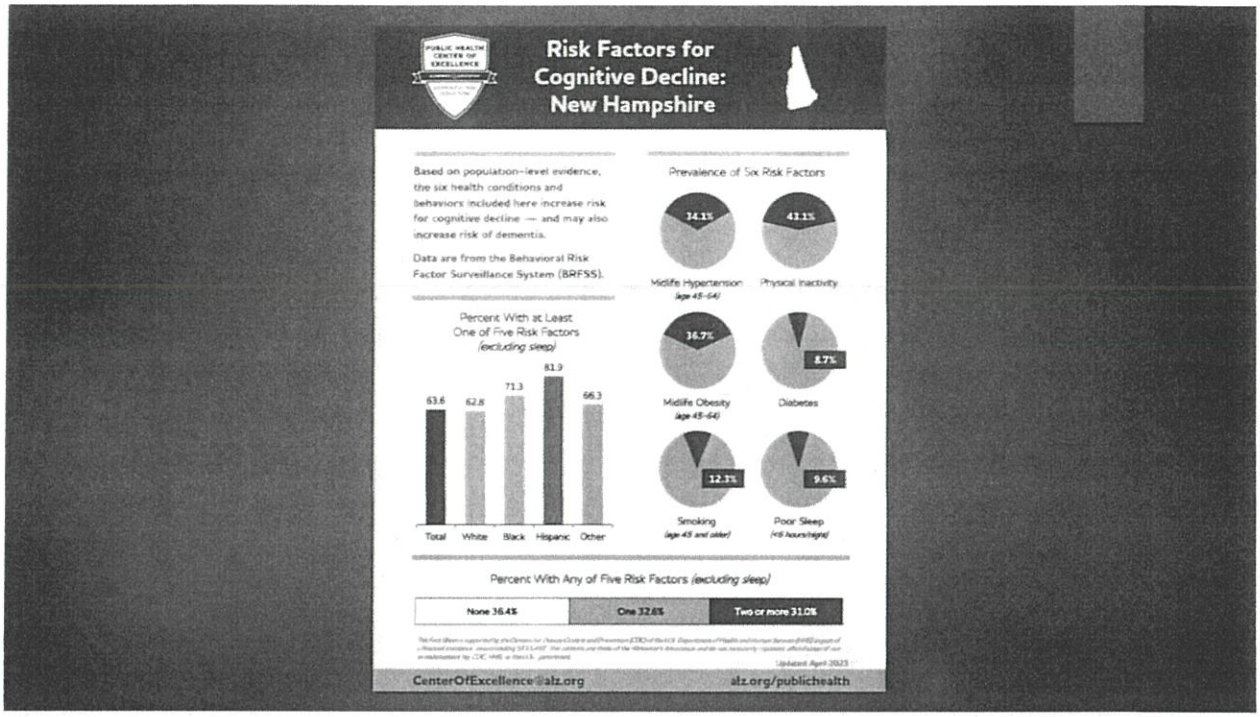
State	County	Total Pop. Age 65+ (nearest 100)	AD Cases Age 65+ (nearest 100)	AD Prevalence (Age 65+)
New Hampshire		263,100	26,500	10.1%
Columns C & D are estimates that have been rounded to the nearest 100 and are not the exact figures used to calculate AD prevalence in column E	Belknap	14,500	1,400	9.7%
	Carroll	14,600	1,400	9.5%
	Cheshire	16,300	1,600	9.9%
	Coos	7,800	800	10.3%
	Grafton	20,000	2,000	10.2%
	Hillsborough	69,900	7,300	10.4%
	Merrimack	29,500	3,000	10.2%
	Rockingham	59,600	5,900	9.8%
	Strafford	21,100	2,100	10.1%
State totals were independently modeled (and may not equal a sum of all rounded counties).	Sullivan	9,900	1,000	10.0%

Source: Dhana et al., Alzheimer's & Dementia, 2023

- Every county in NH, ages 65+ has significant prevalence of diagnosed Alzheimer's specifically - not MCI or SCI or other dementing illnesses.



- On average, unpaid caregivers spend about 24 hours/week providing care
- Chronic duration of unpaid caregiving is an issue

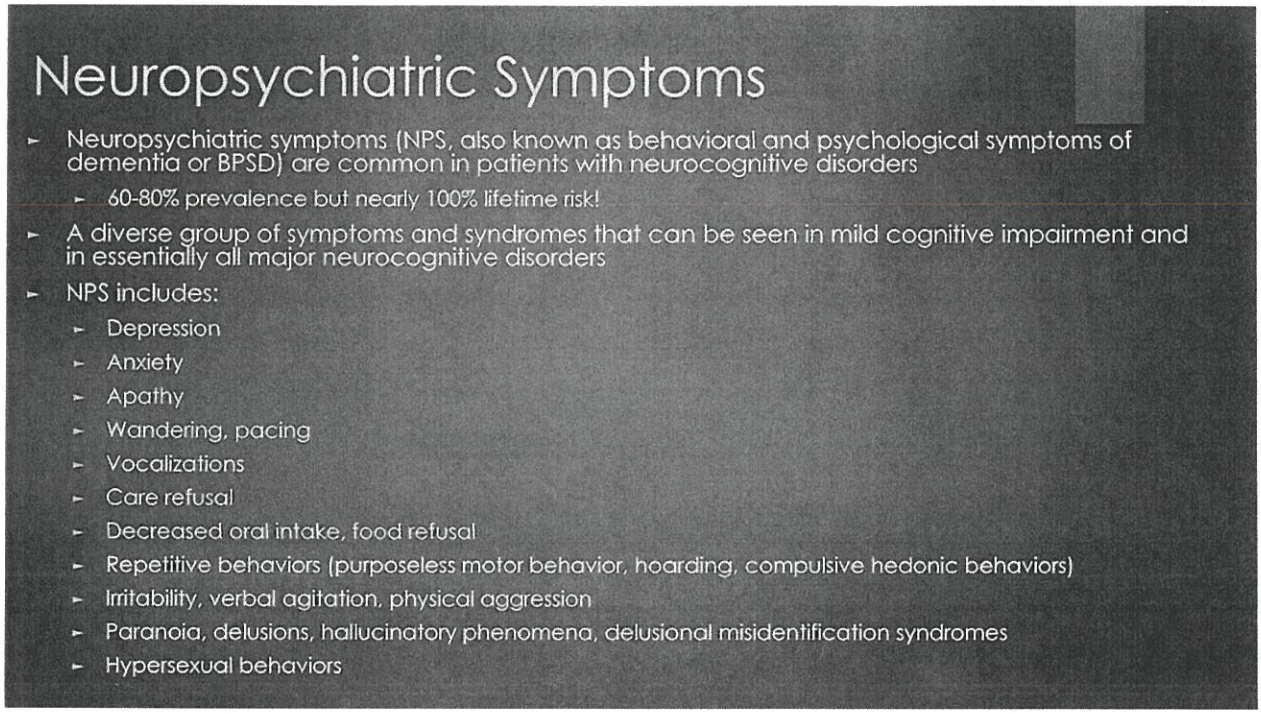


- Risk factors for cognitive decline in NH
  - Where can we spend time reducing prevalence/incidence of dementia in NH?
  - Hypertension, physical inactivity, obesity, smoking, and poor sleep are all risk factors for developing Alzheimer's or other dementia. If we were able to intervene earlier on, we could postpone the onset of these diseases.

Data for the other dementias?

- No state level data and epidemiologic data itself is pretty sparse and conflicting

- Challenges:
    - No state level data and epidemiological data exists for other dementias
    - As a result, we have a good sense of what's going on with Alzheimer's but not other dementias



    - Neuropsych symptoms
        - Above and beyond memory decline and caregiving requirements, these symptoms compound the difficulty of these diagnoses.
        - 60-80% of those with dementia will develop these but almost 100% lifetime risk of developing them over the illness
        - NPS associated with significant morbidity and it is challenging to get care
        - There are only 2 FDA approved treatments for NPS and there are no standardized guidelines for evaluation and management of NPS
        - Most of what's being done for treatment is off-label and cobbled together

Neuropsychiatric Symptoms

- NPS are associated with significant morbidity and an accelerated functional decline
  - Also increased with a much higher degree of caregiver fatigue/burnout, caregiver termination, early placement, and potential for abuse/neglect
- Despite this, there are only two FDA approved treatment for NPS and no standardized guidelines for the evaluation and management of NPS
  - Pimavanserin for psychosis due to Parkinson Disease
  - Brexpiprazole for agitation in Alzheimer's dementia
- NPS are a syndrome, not a disease!
  - This makes evaluation and management as well as studying these symptoms difficult

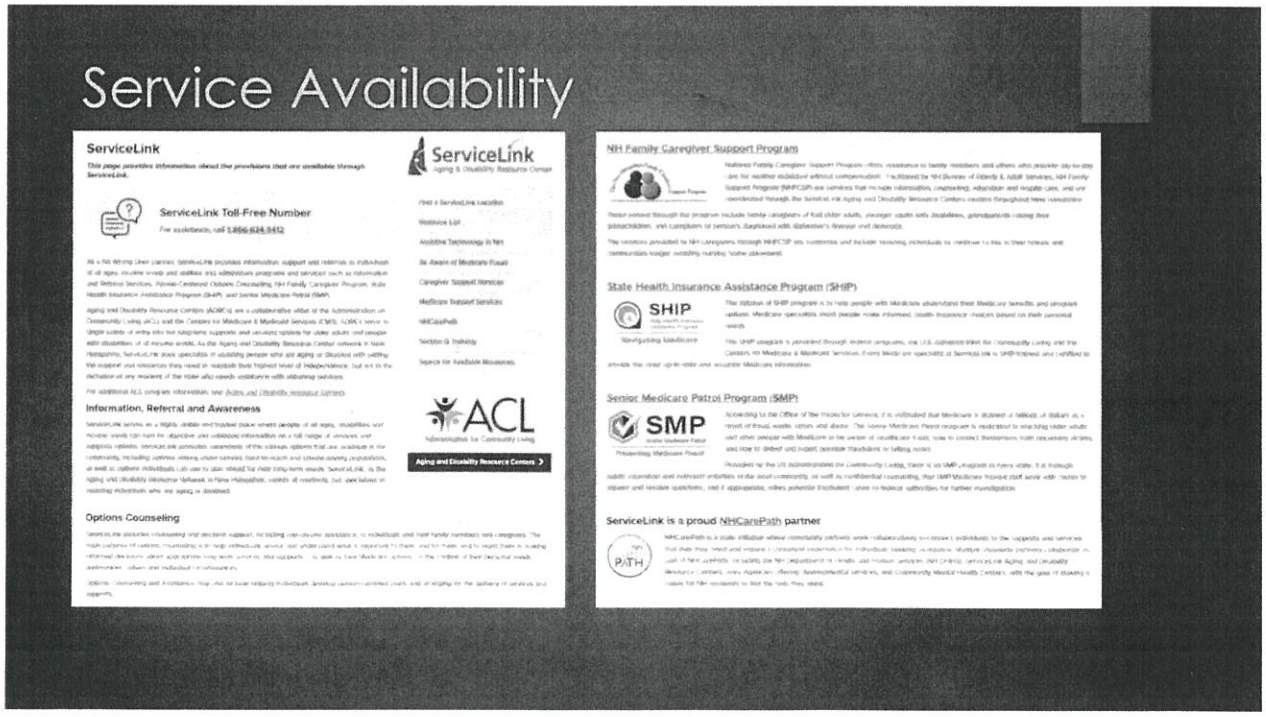
Lyketsos et al. (2000) AJP; Tractenberg et al. (2002) JNCN; Alexopolous et al. (2005) JCP

Service Availability

- Wide spectrum of service needs
  - Caregiver support
  - Direct caregiving
  - Day programs
  - Primary care/geriatrician practices
  - Independent living facilities
  - Assisted living facilities
  - Memory care units
  - Continuing care retirement communities
  - Specialist dementia care programs
  - Inpatient geriatric psychiatry units

- Service availability:
  - Caregivers need support
  - There is a huge need for direct caregiving
  - Day programs are vital as they allow family caregivers to stay in the workforce

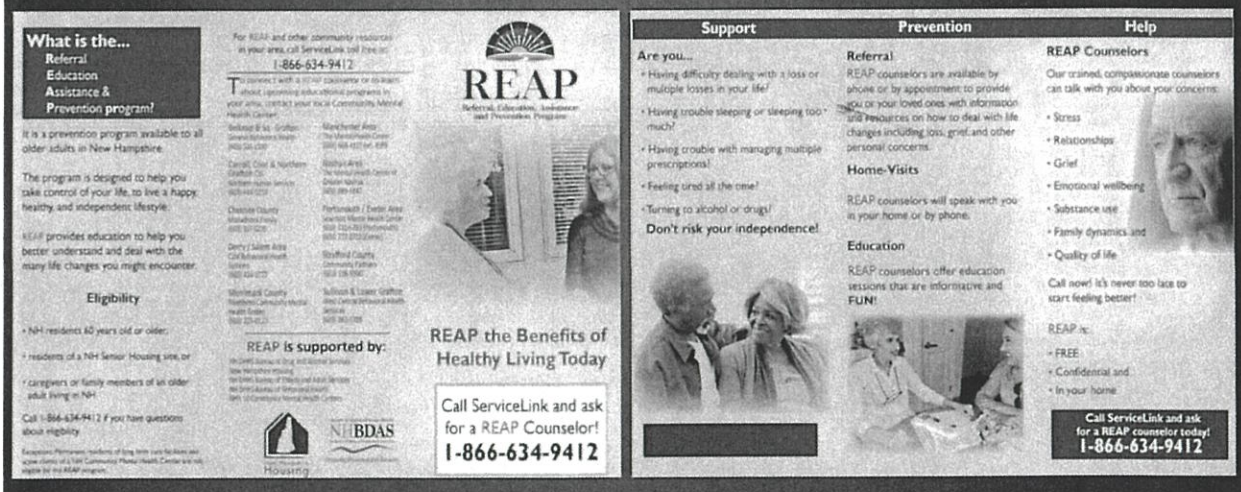
    - Availability of specialist dementia care programs and inpatient geriatric psych units are critical
- General service available to patients and families
    - ServiceLink: website is challenging to navigate. If you think of who's using this website, it's often contradictory, not curated, and it contains out of date information.
    - Dr. Volle and Dr. Crane were discussing how hard it is to find how many practices in NH have a geriatric psychiatric specialist. They want this to be thought about moving forward.
    - REAP is run through the State and is for adults 60+ that are residents who need some level of psychotherapy/service integration. In general it's administered very well. It is administered through the community mental health programs and depends on staff availability, which is inconsistent throughout the state.
- If you had someone who needed emergent hospitalization we'd ideally want to do it outside of the hospital, as this tends to be the less costly and disruptive option.
- There are only 4 places in the state with the expertise to do this.
- When patients need geriatric psychiatric services at in-patient level, they're treated in the ED to the extent hospital staff feel capable of doing so, or admitted to a medical unit, which ties up medical bed availability, and they may not receive the same level of staff expertise and attention they would at a specialty unit.



Service Availability

- ServiceLink website is challenging to navigate, often contradictory, not curated, and contains much out of date information

Service Availability



What is the...
Referral
Education
Assistance &
Prevention program?

It is a prevention program available to all older adults in New Hampshire.

The program is designed to help you take control of your life, to live a happy, healthy, and independent lifestyle.

REAP provides education to help you better understand and deal with the many life changes you might encounter.

Eligibility

- NH residents 60 years old or older;
- residents of a NH Senior Housing site, or
- caregivers or family members of an older adult living in NH.

Call 1-866-634-9412 if you have questions about eligibility.

For REAP and other community resources in your area, call ServiceLink toll free at:
1-866-634-9412

To connect with a REAP counselor or to learn about upcoming educational programs in your area, contact your local Community Mental Health Center:

Belknap & Lks. - Grafton: Genesis Behavioral Health (603) 524-3309
Manchester Area: The Mental Health Center (603) 668-4111 ext. 4189
Carroll, Coos & Northern Grafton Co.: Northern Human Services (603) 444-5711
Bristol Area: The Mental Health Center of Greater Nashua (603) 889-6141
Cheshire County: Monadnock Family Services (603) 357-5529
Portsmouth / Exeter Area: Seacoast Mental Health Center (603) 516-7830 (Portsmouth) (603) 772-5702 (Exeter)
Derry / Salem Area: Child Behavioral Health Systems (603) 434-0775
Strafford County: Community Partners (603) 516-5900
Merrimack County: Riverbend Community Mental Health Center (603) 225-8505
Sullivan & Lower Grafton Area: Central Behavioral Health Services (603) 542-7958

REAP is supported by:

NH Housing
NHBDAS

REAP
Referral, Education, Assistance and Prevention Program

REAP the Benefits of Healthy Living Today

Call ServiceLink and ask for a REAP Counselor!
1-866-634-9412

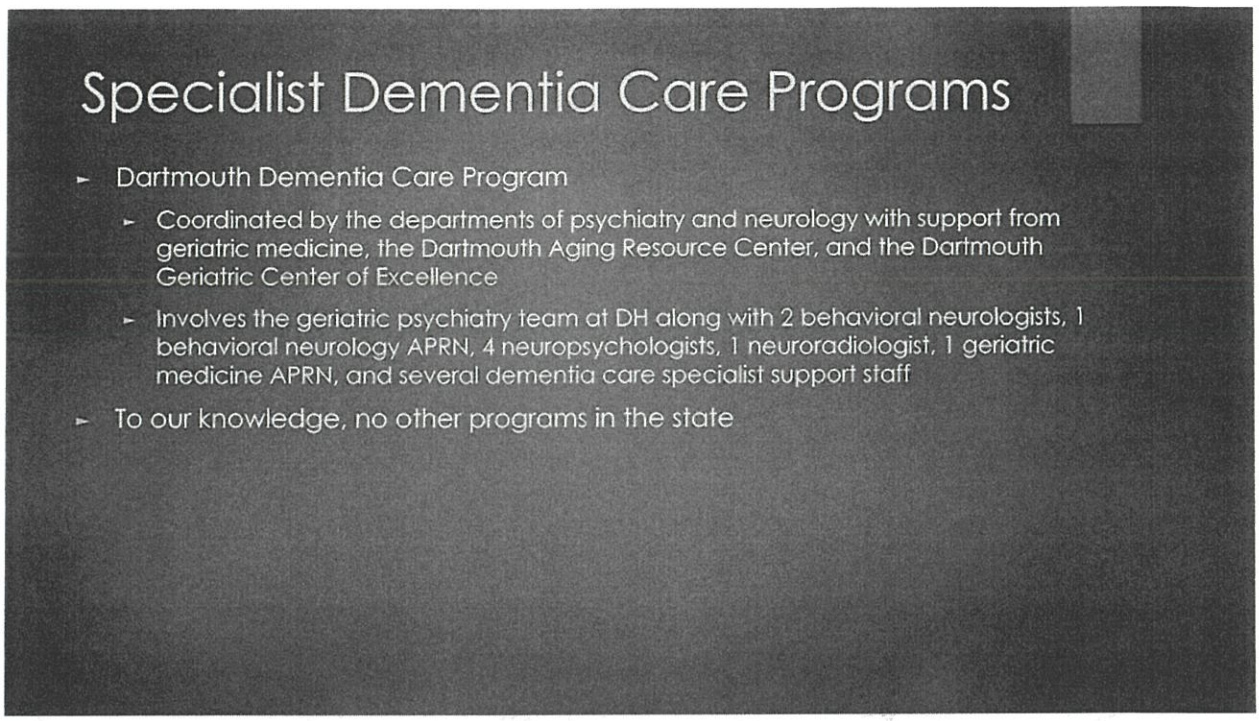
Support	Prevention	Help
Are you... • Having difficulty dealing with a loss or multiple losses in your life? • Having trouble sleeping or sleeping too much? • Having trouble with managing multiple prescriptions? • Feeling tired all the time? • Turning to alcohol or drugs? **Don't risk your independence!**	**Referral** REAP counselors are available by phone or by appointment to provide you or your loved ones with information and resources on how to deal with life changes including loss, grief, and other personal concerns. **Home Visits** REAP counselors will speak with you in your home or by phone. **Education** REAP counselors offer education sessions that are informative and **FUN!**	**REAP Counselors** Our trained, compassionate counselors can talk with you about your concerns: • Stress • Relationships • Grief • Emotional wellbeing • Substance use • Family dynamics and • Quality of life Call now! It's never too late to start feeling better! REAP is: • FREE • Confidential and • In your home **Call ServiceLink and ask for a REAP counselor today!** **1-866-634-9412**

Geriatric Psychiatry Inpatient Units

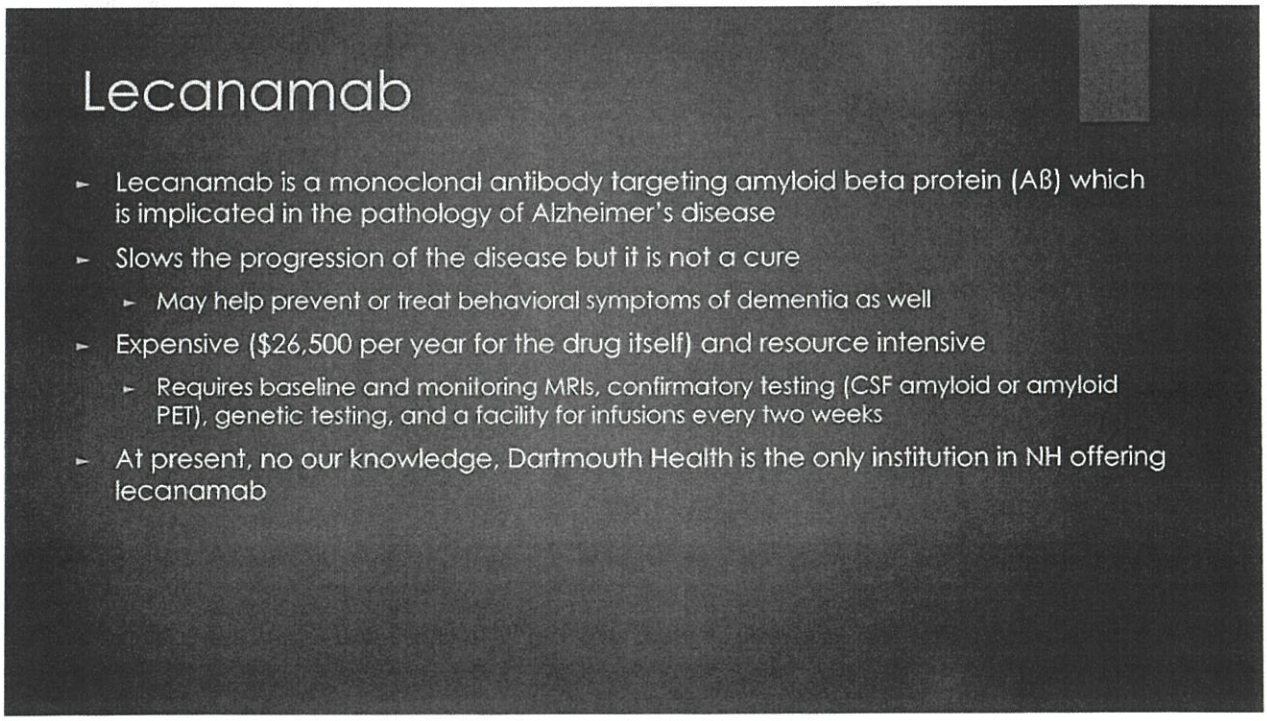
- Ray of Hope at Cottage Hospital (Woodsville, NH)
  - 10 bed voluntary unit
- Elliot Hospital Geriatric Psychiatry Unit (Manchester, NH)
  - 26 bed voluntary/involuntary unit
- St. Joseph Hospital Senior Behavioral Health Unit (Nashua, NH)
  - 24 bed voluntary unit
- Frisbie Memorial Hospital (Rochester, NH)
  - 9 bed voluntary unit

Geriatric Psychiatry Programs

- Dartmouth Health Geriatric Psychiatry (Lebanon, NH)
  - 3 geriatric psychiatrists and 1 APRN at DHMC, 4 neuropsychologists, staff psychologists available but not dedicated to geriatric psychiatry, planning to hire a social worker soon
  - Also 1 geriatric psychiatrist at the White River Junction VAMC, 2 geriatric psychiatrists at New Hampshire Hospital, 1 geriatric psychiatrist at Glencliff Home and West Central Behavioral Health
- Generations Geriatric Mental Health (Manchester, NH)
  - 4 geriatric psychiatrists, 3 APRNs, 4 PAs, 2 neuropsychologists, 3 social workers, 1 psychologist
- Silver Birch Geriatrics (Dover, NH)
  - 1 geriatric psychiatrist
- Life Management Center for Adults (Derry, NH)
  - 2 geriatric psychiatrists
- Seacoast Mental Health Center (Portsmouth/Exeter, NH)
  - 1 geriatric psychiatrist

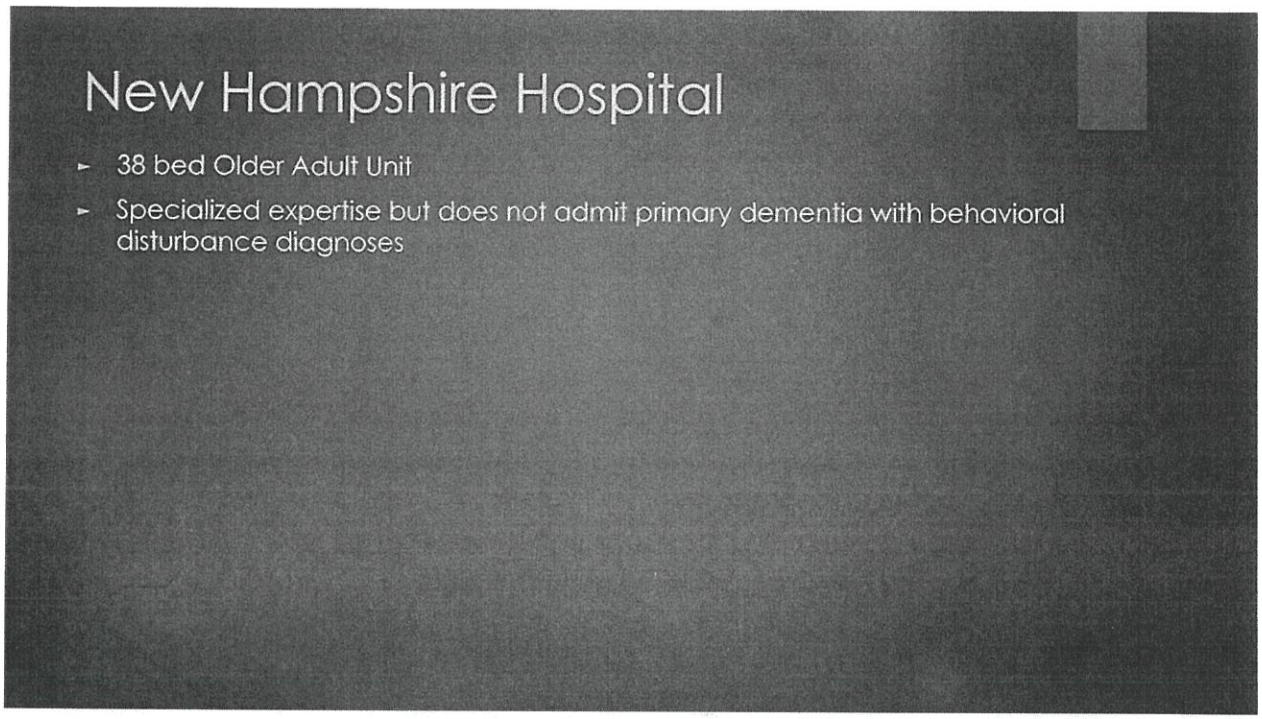


- Specialist dementia care programs:
  - Dartmouth Dementia Care Program - as far as they know there's no other specialty referral program like this in the state
  - Most challenging aspect is siloed nature of medical care

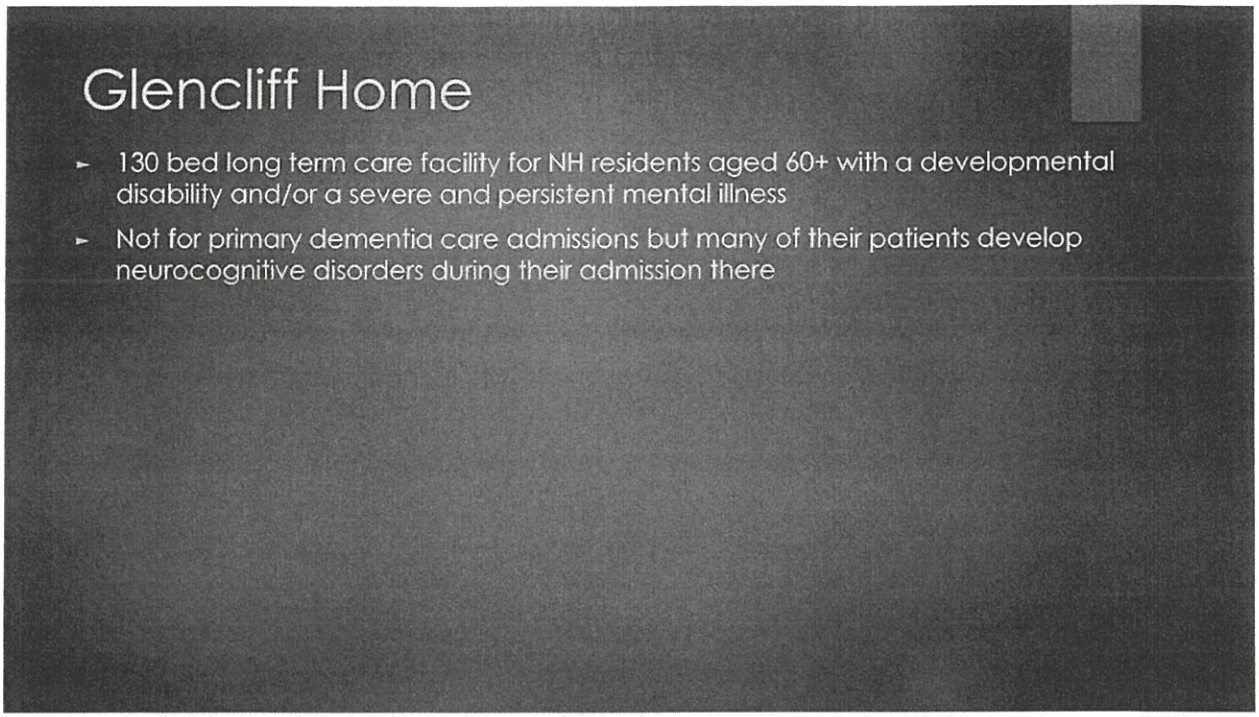


- Lecanamab

- Dr. Volle went over what it is and what it does and the challenges to access patients face
- As far as we know, Dartmouth Health is the only institution currently offering this in New Hampshire. Several patients are currently moving through the evaluation pipeline.



- NH Hospital - won't admit because of a civil statute issue

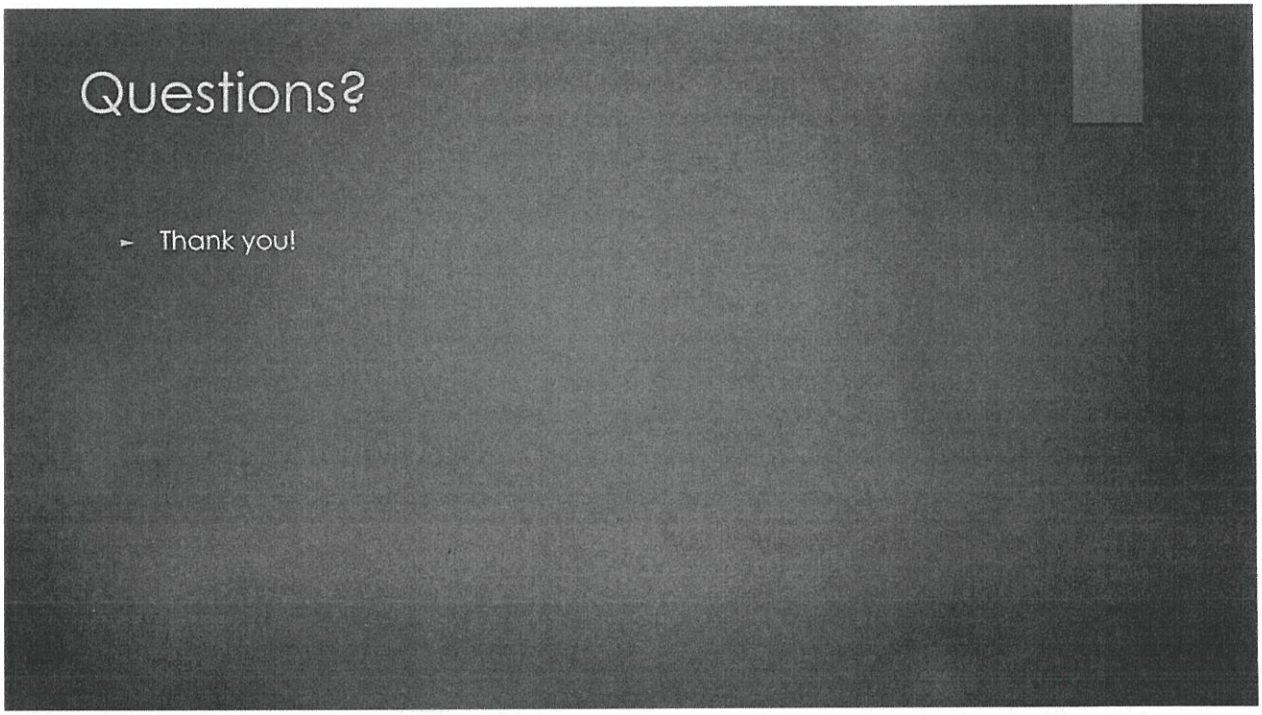


- Glencliff Home serves individuals age 60+ with developmental disability and/or severe and persistent mental illness



- What's needed:
    - Broader early screening programs for dementia and neuropsychiatric symptoms of dementia
    - More in-home caregiver support/availability

- More inpatient geriatric psychiatry unit capacity
- Broader availability of specialist dementia care program capacity
- Refinement of already available service curation platforms (like ServiceLink)
- Ongoing/increased support for all existing programs.



- Ms. Mulligan Shea asked about Dartmouth-Hitchcock's speciality program, and whether that will be a hospital unit?
- Dr. Volle noted that currently that program is all outpatient focused.
- Ms. Mulligan Shea asked where patients go if they need in-patient service.
- Dr. Volle responded that they'll usually stay in the emergency room. The occasionally try to send patients to Ray of Hope or other available units.
- Ms. Harvard asked a question about biomarkers, and asked what Dartmouth-Hitchcock is thinking about incorporating biomarker testing into the early diagnosis process.
- Dr. Volle noted that biomarker testing is available now. Dartmouth-Hitchcock can conduct lumbar punctures for patients now. They also have amyloid PET imaging available only for patients moving toward the pathway to lecanemab treatment.
- Dr. Volle further noted that blood-based testing is commercially available. It's being looked at by the pharmacy and therapeutics committee, but looks like something that would be game-changing down the line. For example, a blood-based test would be much more preferable to a spinal tap or brain scan.

- Ms. Aultman noted that she is aware of struggles around using ServiceLink and noted Dr. Volle's recommendations. She noted that some of these challenges are a recurring theme as the Department solicits feedback, and she acknowledged there is a growing need for these kinds of services, particularly for stressed caregivers. Ms. Aultman noted that information shared with this Subcommittee and the information Dr. Volle presented is helpful in terms of knowing about resources and tools that can inform how we can improve things. Ms. Aultman noted that more discussion around what we can do to make some improvements would be helpful, as she has some leverage to put some focus on where we can make improvements with the website and talking about REAP and caregiver support and respite programs offered by the Department. The Department is very interested in figuring out how to make progress and improvements over time. Jess her spiel
- Ms. Balkus asked what the average length of stay in a geriatric psychiatric unit is.
- Dr. Volle responded that it's typically 3-7 days for an adult; and the average geriatric psychiatric stay duration is usually around 14-21 days. When someone needs inpatient geriatric psychiatric admission, their circumstances have usually deteriorated to the point where the caregiving situation at home is hard to go back to. The sticking point is of course the availability of care provision.
- Ms. Balkus asked whether discharge at that point would usually be to a skilled nursing facility.
- Dr. Volle responded that it could be, or to a respite facility.
- Ms. Balkus noted that from a home health perspective: When a Medicare beneficiary has home a health benefit and a skilled nurse goes in, nurses or PTs have to do Oasis, which is a comprehensive assessment tool standardized for home care. Just recently, effective in '23, CMS did add in assessment questions regarding cognitive decline and dementia, and so when those are identified, treatment is supposed to be incorporated into the plan of care but generally Medicare home health is short-term skilled nursing or rehab care.
- Ms. Balkus noted that we've talked a lot about family caregivers and noted there are also professional caregivers in the CFI program. A lot of patients in the CFI program are patients living with dementia. The good news is that with the recent adoption of rate increases in the last state budget, she's hearing anecdotally from agencies that do CFI that they're finally able to recruit new staff and they're filling positions for the first time in years. This is good news from a professional caregiving perspective.
- Ms. Mulligan Shea asked Ms. Balkus whether there are qualified people available to address the cognitive issues that are identified as a result of this recently enhanced health evaluation.

- Ms. Balkus responded that the information would likely go back to the person's physician in terms of how that information should be incorporated into the patient's plan of care. These people are either referred by a physician or are receiving post-acute care services.
- Ms. Harvard asked Dr. Volle, regarding workforce readiness: In terms of nursing support staff, to what extent are nursing programs doing dementia training? Is it currently required or covered?
- Dr. Volle knows it's a core requirement of medical school curriculum. From there to the point of residency training after medical school, the requirement is less standardized depending on where you are.
- Dr. Crane highlighted that it is a requirement in nursing programs, but is not always consistent. She shared it was a small component of her nurse practitioner education.
- Ms. Harvard noted that she raised this point because we've addressed training in legislation but the need for more education is a recurring theme. In considering the situation of difficult behaviors that cause hospitalization, sometimes that's an assisted living facility that doesn't know how to manage difficult behaviors that are hallmark of Alzheimer's and other dementia. This also goes back to workforce training and readiness. Ms. Harvard wanted to flag that we need to look at the issue of dementia care training.
- Ms. Wentworth noted that in 2019 we passed legislation that caregivers have to have at least 8 hours of training on dementia.
- Ms. Eskeland once again raised the Subcommitee's interest, and potential request for, information regarding implementation of, and compliance with, this training requirement in healthcare facilities.
- Ms. Balkus noted that her Alliance offers trainings in 21 online modules and shared that in the first year it was available, over 14k people went through the program.
- Ms. Balkus noted that Health Facilities Licensing was not checking implementation and compliance in the beginning of the pandemic, but that health facilities administration surveyors typically look at this.
- Ms. Balkus further noted that for nursing homes and assisted living facilities, CMS offers a free dementia care program.
- Ms. Aultman noted that in thinking of unpaid caregivers who don't have access to Association trainings, online education options would be helpful for these folks.
- Ms. Aultman noted that BEAS has been thinking about some of the technology and things to put in place in the home to help with safety and some of the behaviors, etc. They've developed for Medicaid a waiver to pay for some of those things. She asked Dr. Volle what other things he might give referrals to to help people stay in their home longer?

- Dr. Volle noted that he uses the Aging Resource Center, which is part of Dartmouth-Hitchcock but separate from the hospital and has a staff nurse, a dementia care specialist, and someone able to help families get pointed in the right direction.
- Dr. Volle further noted that memory cafes for patients (which provide a social hour for patients) is helpful, as is having staff that help families navigate care decisions in an individualized way. He also noted that the Savvy Caregiver Program (which offers a standardized group of educational modules) is helpful for caregivers.
- At this point there were no further questions and the meeting concluded at 4:00 p.m.

Subcommittee on Alzheimer's and Related Dementia Minutes
Wednesday, March 27, 2024 at 1:00 p.m.
State House Room 103

Meeting called to order at 1:00 p.m.

Present: Senator Avard, Jay Gupta, Maureen Murtagh, Wendi Aultman, Jessica Eskeland, Gina Balkus, Sunny Mulligan Shea

Absent: Representative Layon, Dax Volle, Kathy Harvard, Janessa Luke, Meghan Wentworth, Maria Camerlengo, Kim Mohan, Laura Rocha

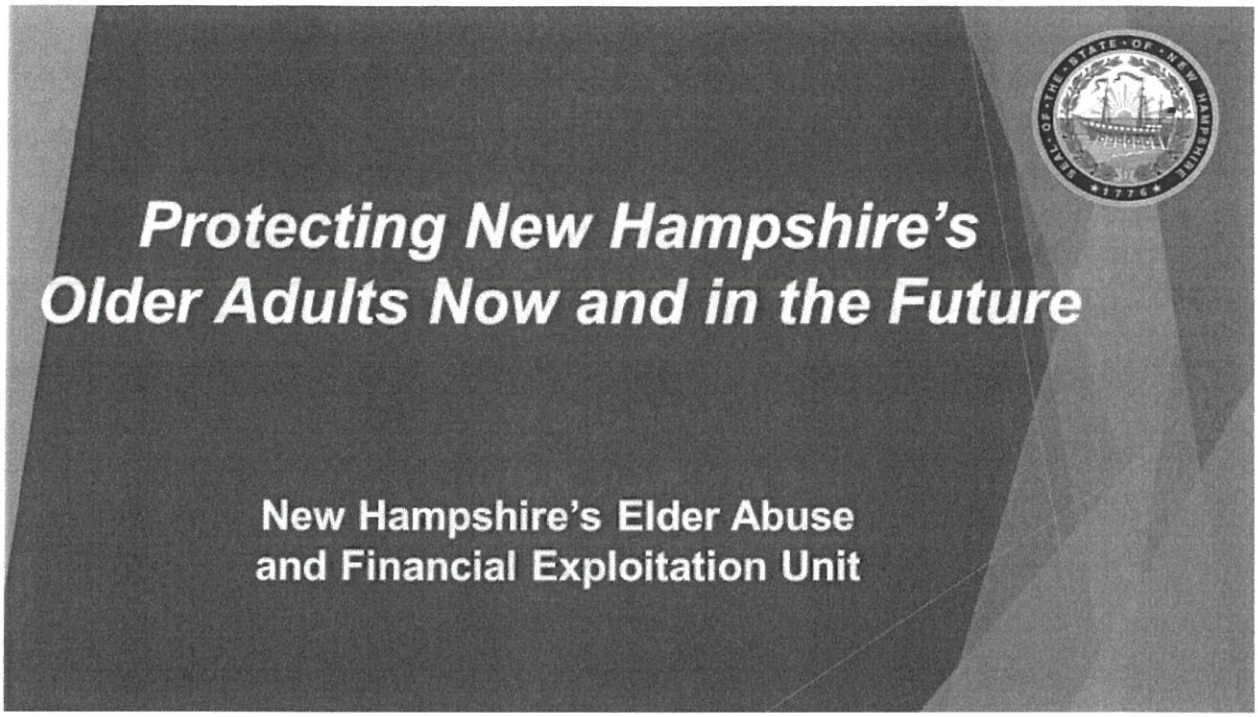
Note: The comments made by members of the Subcommittee represent their own views and not necessarily the views of their organization or agency.

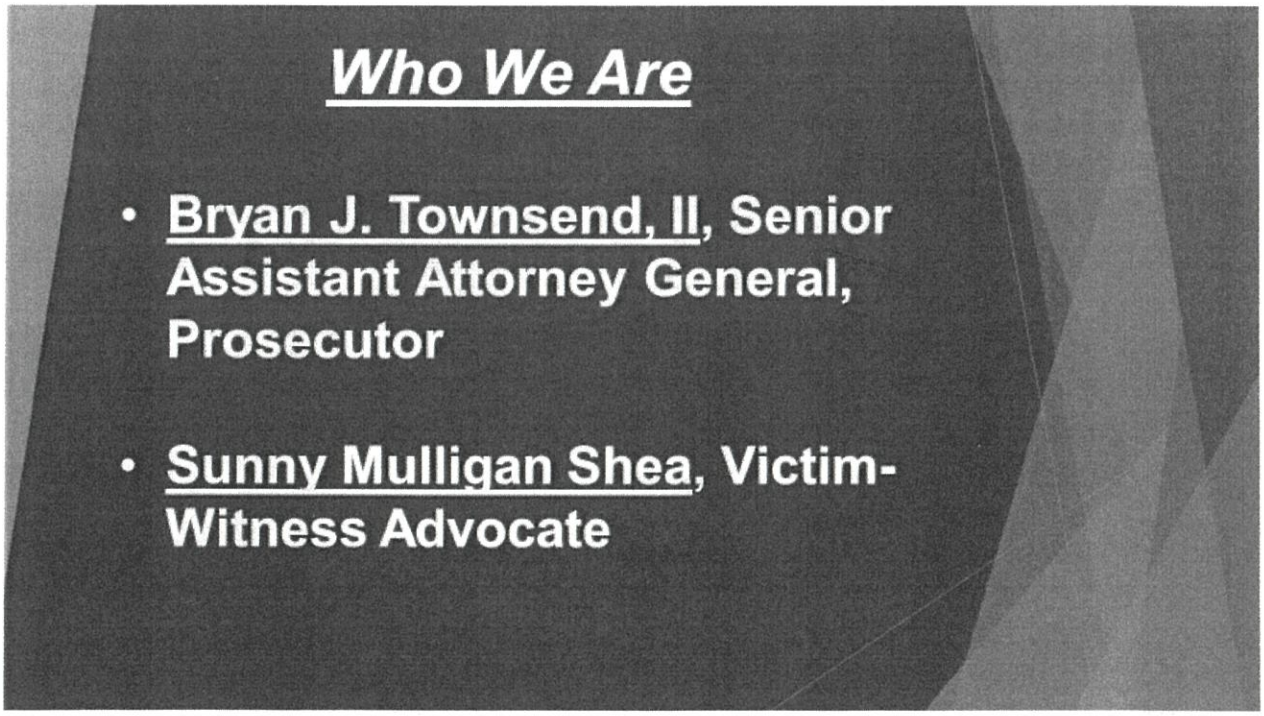
Minutes from the 2/21/24 meeting unanimously approved.

Minutes

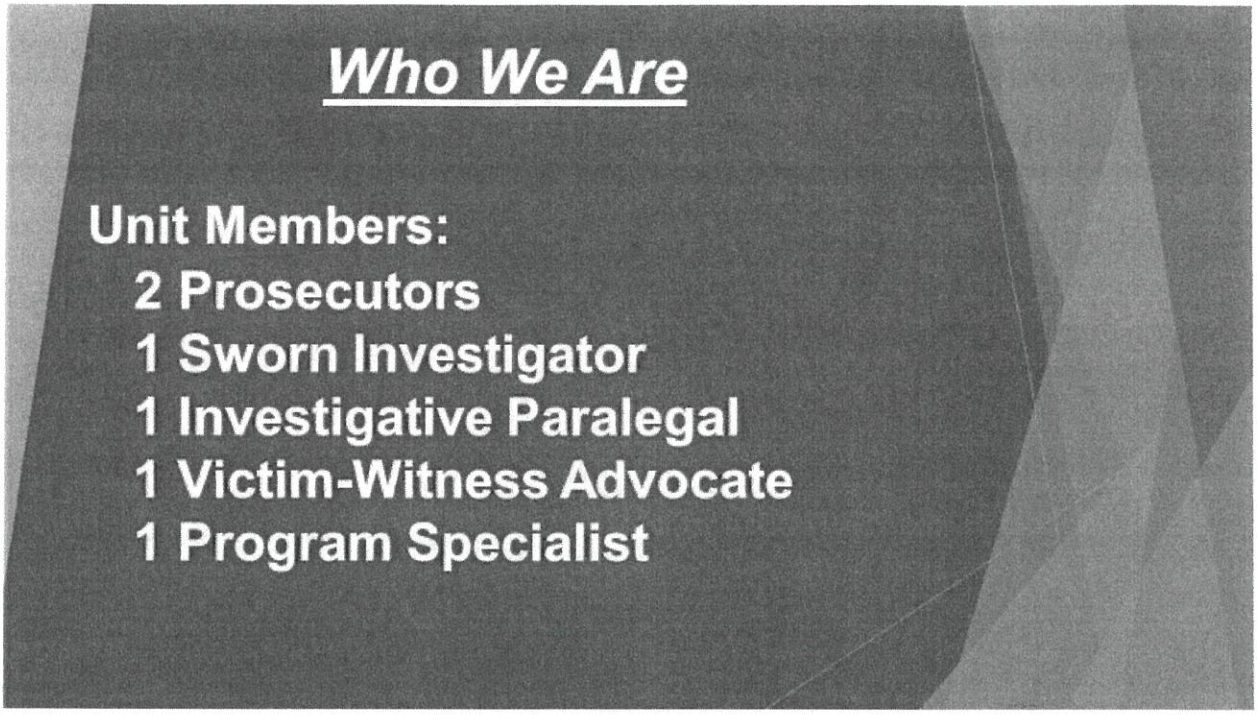
Sunny Mulligan Shea, Victim Witness Advocate at the NH Department of Justice, and Bryan J. Townsend, II, Senior Assistant Attorney General, Prosecutor, presented to the Subcommittee.

Ms. Shea and Mr. Townsend shared a PowerPoint presentation, which is available to accompany these minutes and appears below.

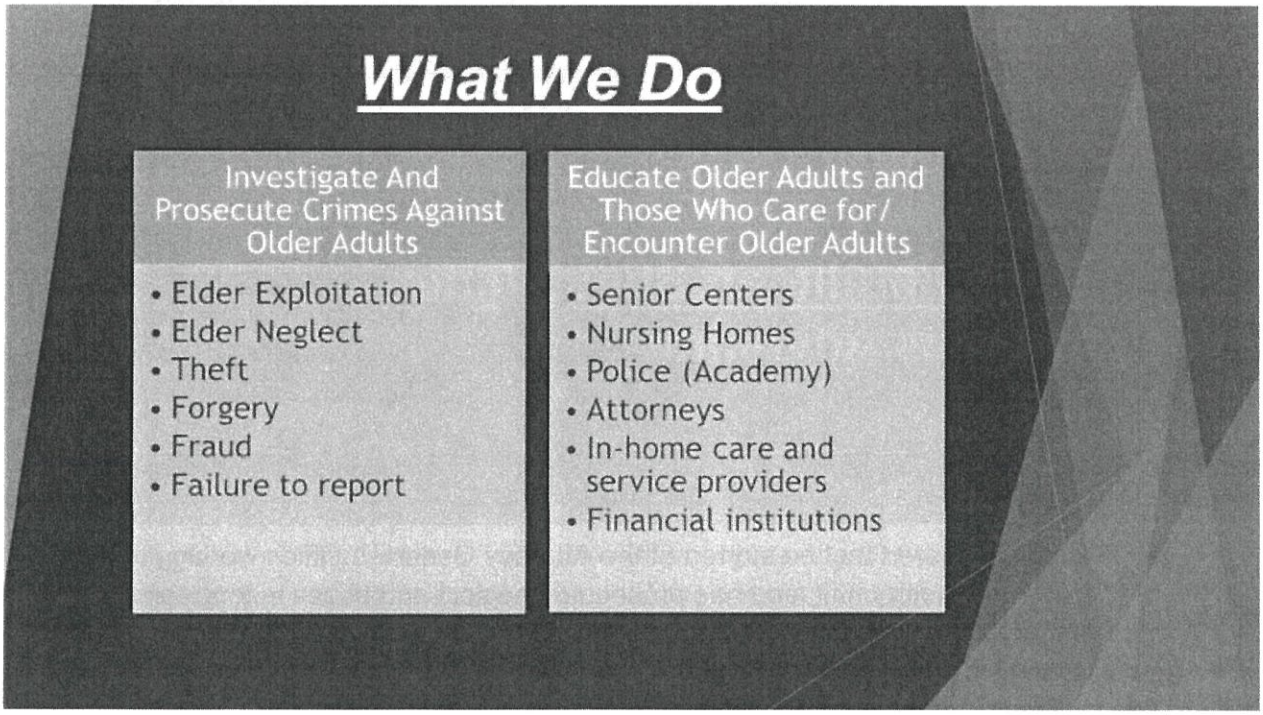




- Mr. Townsend shared that he started at the Attorney General's Office working in the Medicaid fraud control unit, and has prosecuted neglect and abuse in long-term care facilities that accept Medicaid. He has been with the Elder Abuse & Financial Exploitation Unit for 5 years.
- The Unit investigates and prosecutes crimes against older adults (60+), and prosecutes cases up through the point of trial and, if needed, up to the state's Supreme Court.



- The Unit had a staff of two until a year ago, when the Legislature granted their request for more funding, which has allowed them to expand. They now employ a sworn investigator, who is a former DEA agent.
- The Program Specialist role was made possible by a federal grant. This position helps in terms of outreach to communities and law enforcement and raising awareness of scams and mandatory reporting.



How We Do It

Reporter(s):

- Family
- Neighbors
- Caregivers
- Medical Staff
- Finance Inst.
- Police Dept.
- Attorneys

BEAS

Local Police Department

Elder Abuse Unit

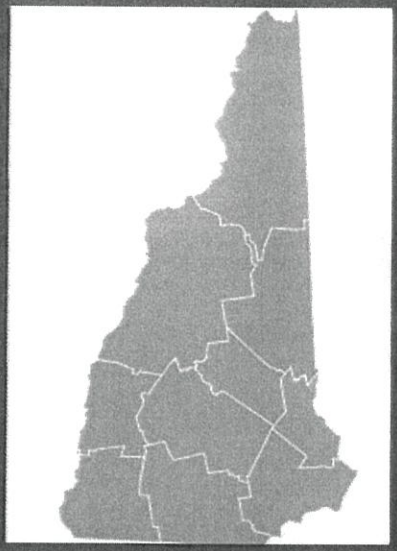
Why We're Here



1 in 10 older adults victimized each year

Only 1 in 24 reported

Why We're Here



1.4 Million People

370,000 Older Adults (Ages 60+)

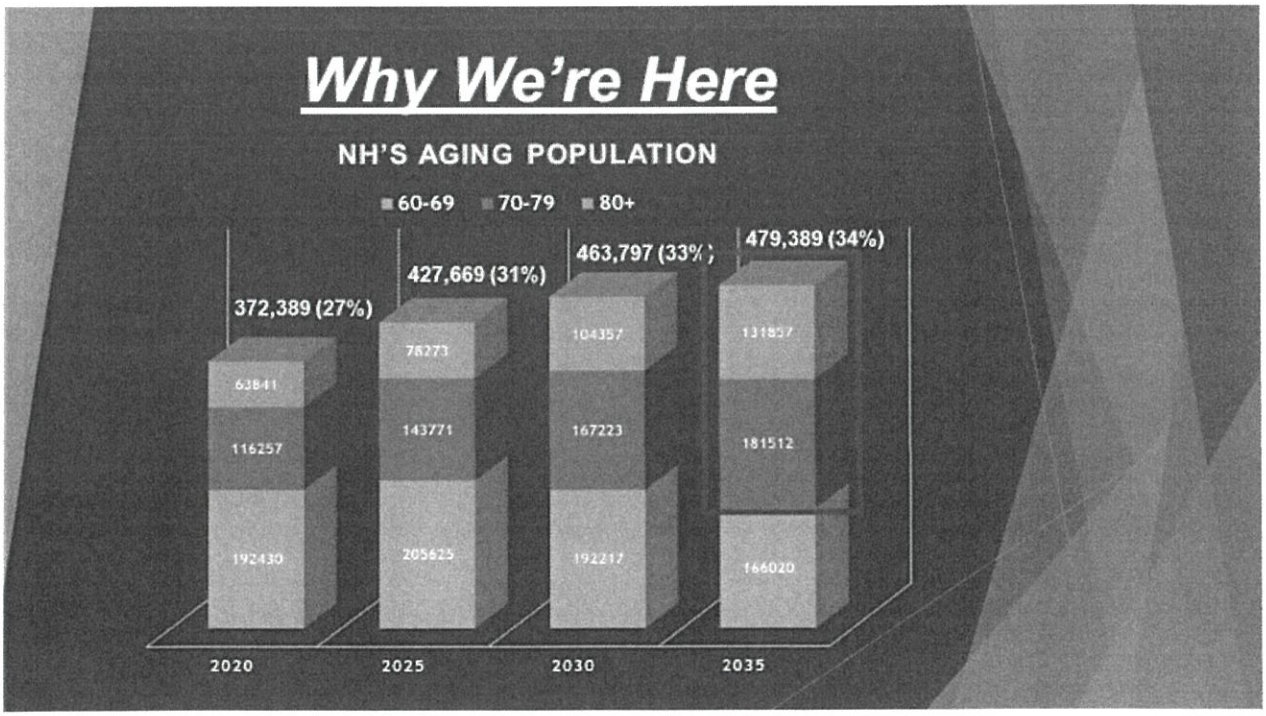
37,000 Victimized

1,500 Reporting

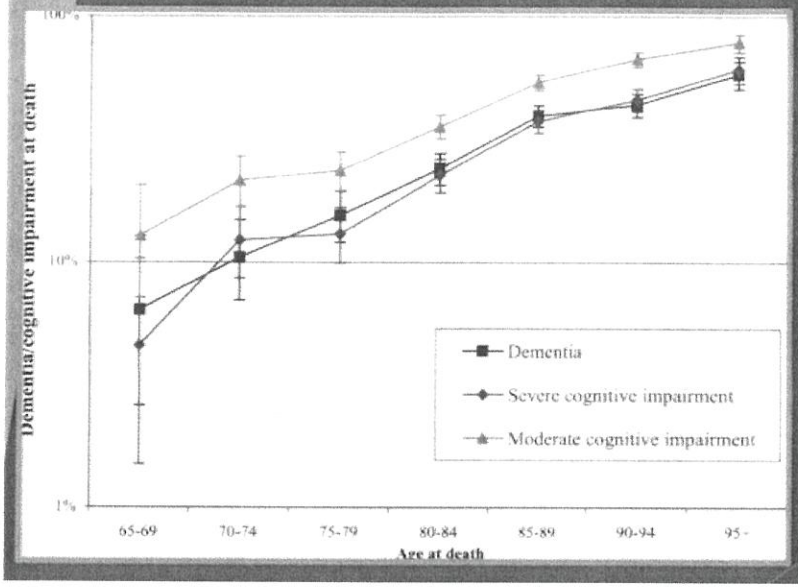
Why We're Here

***Abuse and Exploitation Risk Factors*:**

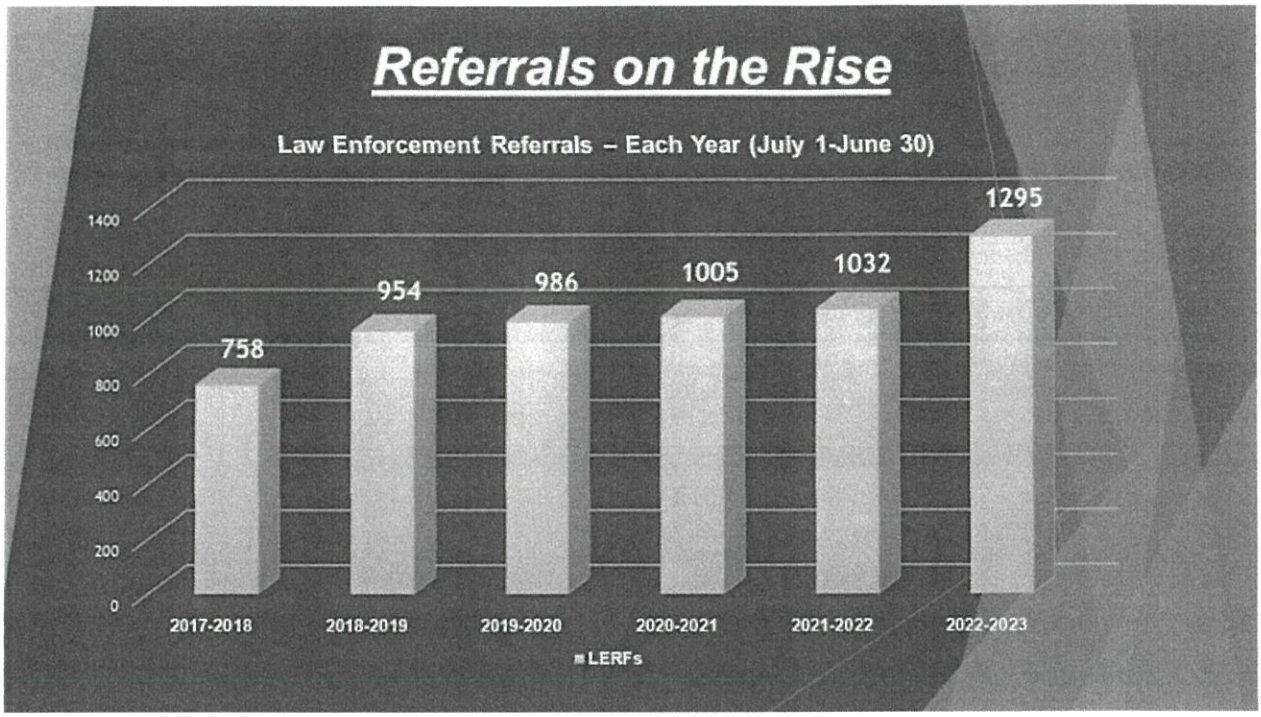
- Poor health, mental decline, physical illness or disability (e.g. dementia)
- Requiring assistance with daily living activities such as shopping, preparing meals, managing money, and fiscal affairs
- Lack of social support (e.g. losing friends)
- Steady stream of income (e.g. social security, pension, investment accounts)


Why We're Here
NH'S AGING POPULATION
60-69
70-79
80+
372,389 (27%)
427,669 (31%)
463,797 (33%)
479,389 (34%)
63841
116257
192430
78273
143771
205625
104357
167223
192217
131857
181512
166020
2020
2025
2030
2035

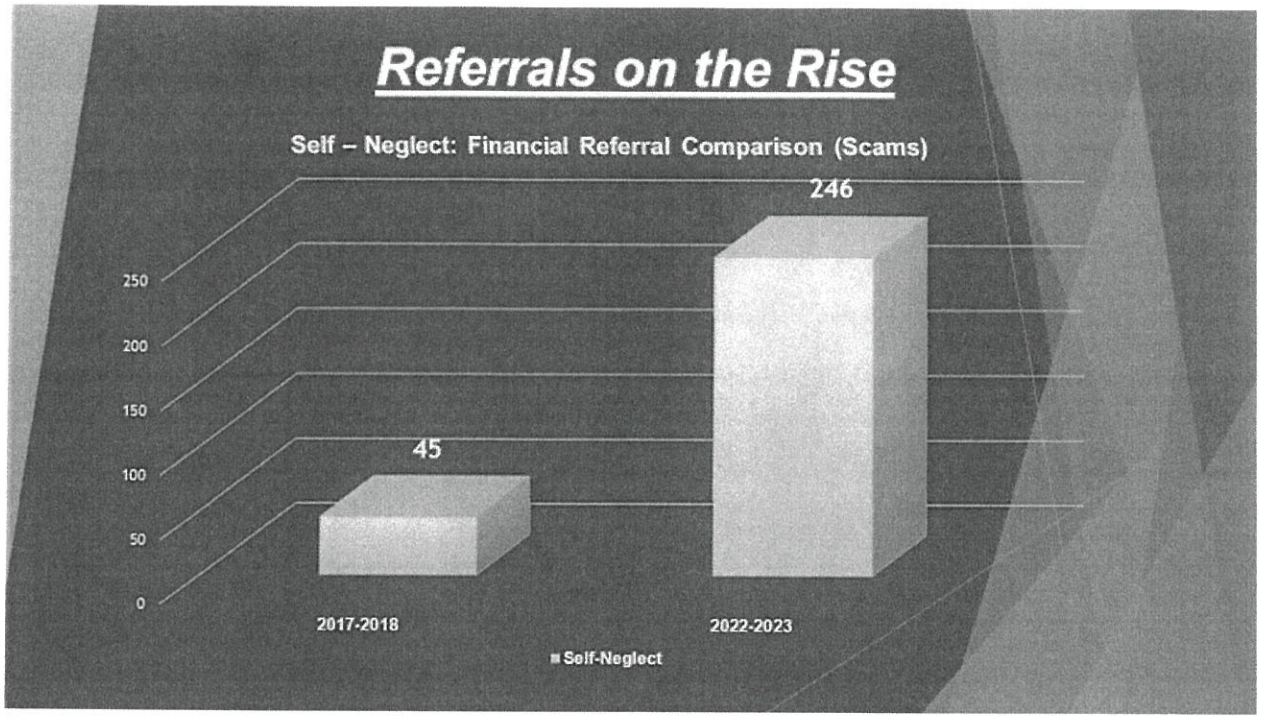
Why We're Here



5 x more likely to suffer abuse


Referrals on the Rise
Law Enforcement Referrals – Each Year (July 1-June 30)
1400
1200
1000
800
600
400
200
0
758
954
986
1005
1032
1295
2017-2018
2018-2019
2019-2020
2020-2021
2021-2022
2022-2023
LERFs

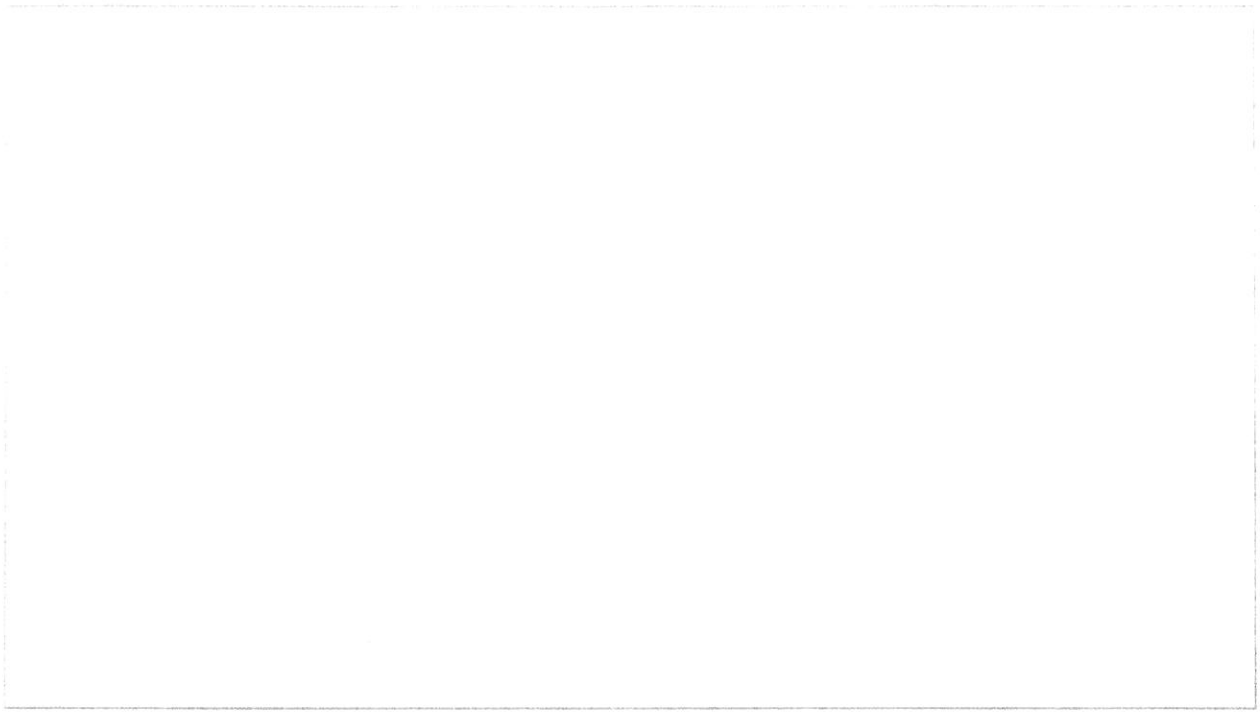
Referrals on the Rise

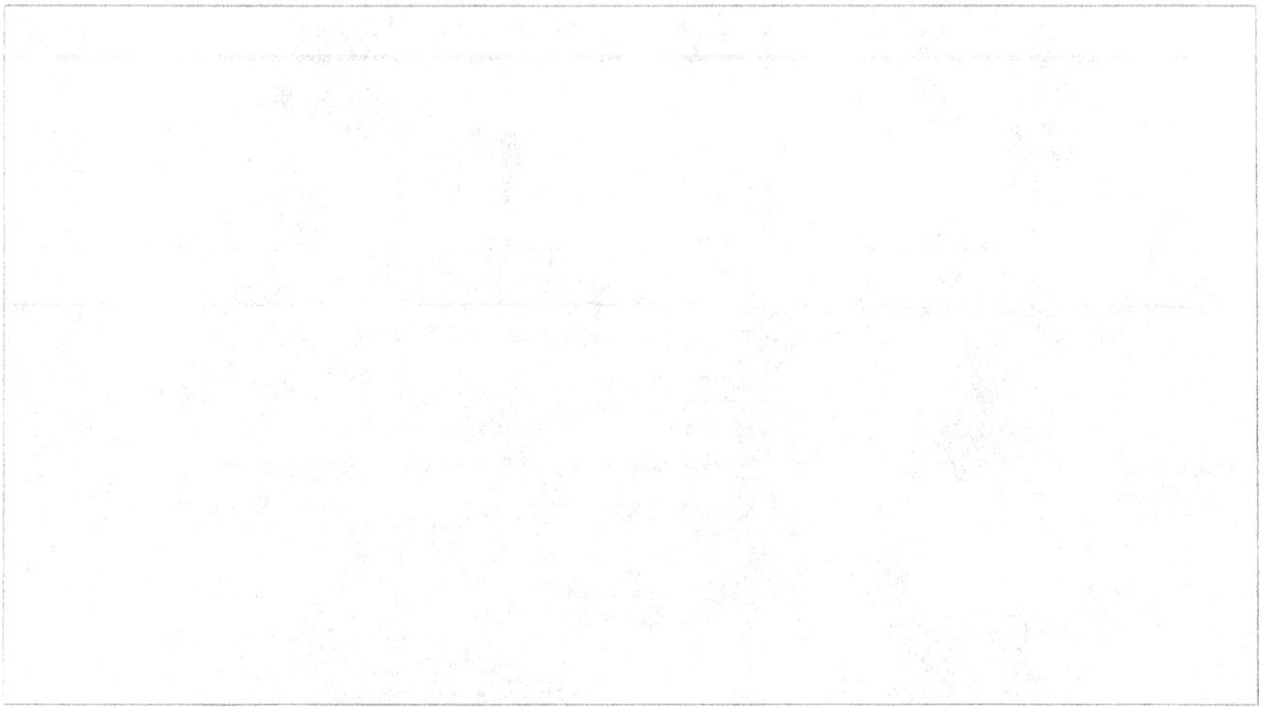


State v. Newton



- Son stole $325,000
- Lacked capacity at the time of trial (Dementia-Alzheimer's type)
- Defendant convicted after trial – Sentenced to 5-10 years in NHSP





- Mr. Townsend highlighted two laws particularly relevant to the Unit's work:
    - HB 1555, relative to the neglect of elderly, disabled, or impaired adults and relative to financial exploitation (passed in 2014).
    - This legislation targets individuals who are trusted persons who take advantage of elderly/vulnerable individuals, such as Powers of Attorneys, trustees, guardians, etc.

    - The law prohibits taking of property through use of undue influence, coercion, threats, or when you have a reasonable belief that a person lacks capacity (passed as an amendment to the law). They've successfully charged this a number of times.
    - The Unit also frequently pursues theft charges, including forgery and any form of identity fraud. They also bring charges of failure to report.
    - Mr. Townsend noted that New Hampshire is a mandatory reporting state for all abuse/neglect/financial exploitation against vulnerable individuals. It is a misdemeanor offense if you knowingly fail to report such activity.
- Ms Shea noted that a major objective of the Unit is education and raising awareness.
    - They want to make people aware of the laws, the mandatory reporting requirements, and what abuse and neglect is. It's akin to where we were with child abuse 20 years ago - people didn't want to acknowledge it. No one wants to believe this happens.
- Senator Avard asked whether hoarding counts as abuse and neglect.
- Ms. Shea responded that hoarding would be considered self-neglect, which can't be prosecuted and usually ends up with the Bureau of Elderly and Adult Services at DHHS.
- Senator Avard asked whether someone is required to report hoarding behavior.
- Mr. Townsend responded that yes; hoarding and any kind of self-neglect are subject to our mandatory reporting laws.
- Ms. Shea noted that there has been lots of good awareness raised about this issue. Hoarding cases usually wind up being referred to Adult Protective Services, which works with town health enforcement officers. Lots of times these people aren't necessarily vulnerable.
- Senator Avard asked who someone should call if they're aware of a bad caretaker.
- Ms. Aultman responded that they should call the Bureau of Elderly and Adult Services.
- Senator Avard asked whether people are aware of this.
- Mr. Townsend responded that educating and raising awareness is a large part of the Unit's work.
- Senator Avard noted he would like to do a PSA spot on his show about this, approximately 15 seconds in duration.
    - Ms. Eskeland will connect with Ms. Shea, Ms. Aultman, and the Senator on that.
- Ms. Murtagh asked whether the Unit finds that some elderly individuals who are hoarding have lost so much in their lives that they're just afraid to get rid of things?
- Ms. Aultman responded that she believes there are different circumstances. Every situation is different in terms of self-neglect. APS workers conduct outreach, use strategies, and partner with the individual and their support system to get to a place where they can be safe and still have access to the services they need. Sometimes they provide support with cleaning and removal.
- Ms. Aultman noted that oftentimes it takes a period of time to work with someone to get to a place where they are doing better. There's a spectrum of self-neglect and varying degrees of risk. Partnerships with public health officers help.
- Senator Avard asked whether Meals on Wheels workers are required to report?

- Ms. Aultman responded that they are. Ms. Shea added that sometimes Meals on Wheels volunteers have a protocol for reporting through an administrator.
- Mr. Townsend noted that the Unit has received a number of reports from Meals on Wheels volunteers, especially during the pandemic.
- Senator Avard asked how they determine when someone is taking advantage of an individual.
- Ms. Shea responded that they talk to in-home care providers. She added that sometimes the signs are subtle. She noted that her first financial exploitation case was in 2015 and they got a call from a woman who was friends with her ex-husband and she learned he didn't have any money in his bank account. It turned out that a woman in his building was "helping" him. She opened credit cards in his name and ruined him financially. She noted it's important to keep an eye out for new "best friends" or changes in habits. She noted that bankers are great allies in this work and recognizing exploitative activity.
- Ms. Balkus noted that she serves on a credit union's board of directors and sees monthly reports about how many scams they stop and how much fraud/abuse/scamming of seniors takes place. It's amazing how much banks are able to pick up. Tellers are trained to ask questions. Sometimes people don't believe they're being scammed. Credit unions do an amazing job educating their staff and reporting exploitation.
- Mr. Townsend noted that they prosecuted a grandparent scam case. This is when an elderly person gets a call from someone claiming to be their grandchild who claims to have been arrested. They put someone claiming to be law enforcement on the line who says, "Pay bail money or your grandchild won't be released."
- They prosecuted a case operating out of the Dominican Republic and Canada. They had couriers working in MA and NJ. There were 11 NH victims.
    - The one common denominator for those who didn't get scammed was the involvement of bank tellers. If tellers questioned the transaction, they typically stopped the scam. The banks did not ask questions of those individuals who ended up losing their money in the scam.
- Ms. Shea noted that most of the Unit's referrals come from APS through the mandatory reporting process. They come from families reporting on siblings, neighbors who notice suspicious changes, hospitals/medical staff from nurses, VNAs, mental health centers, financial institutions (advisors, banks, credit unions) and police departments. Also from attorneys who are helping a client with estate planning and notice something suspicious.
    - If APS thinks the behavior is criminal in nature they send a LERF (law enforcement referral form).
- Ms. Shea noted that they've seen a huge uptick in reporting this year.
- Senator Avard asked whether the Unit is understaffed.
- Mr. Townsend responded that they get about 35 referrals a week, all of which are reviewed by just two attorneys.
- Ms. Shea noted that they try to work around the capacity issue by working with counties when a case is really egregious, as they can prosecute it, too.
- Senator Avard asked whether fines are levied.
- Ms. Shea responded that they can ask for a restitution order, but fining is more a civil procedure.

- Mr. Townsend noted that the Unit doesn't do any civil work. They always ask for restitution if their prosecution is successful, and penalties can be assessed on felony offenses. Usually there's some level of incarceration involved, and if there's a finding by BEAS, the offending individual is put on a registry that prohibits them from serving in any fiduciary or caregiving capacity for one year. This registry isn't public.
- Ms. Balkus noted that all home care agencies have to do a BEAS check on anyone they hire, as do nursing homes.
- Mr. Townsend noted that 1 in 10 older adults are victimized each year (whether it be through financial exploitation, neglect, or abuse) but only 1 in 24 are ever reported.
    - NH has 1.4 million people and 370k age 60+ which means about 37k are victimized every year, and the Unit only receives 1,500 of those instances.
    - Mr. Townsend noted that there are many reasons individuals don't report abuse or neglect. They may be completely dependent on the abuser, scared, or fearful of going into a nursing home.
    - Ms. Shea noted that individuals at higher risk include those with mental decline, physical illness/disability, including dementia or Alzheimer's, because they may not have the ability to take care of themselves. This vulnerability represents an opportunity for an abuser. As cognition declines, exploitation at the hands of family members goes up. In fact, 60% of elder abuse and exploitation is perpetrated by family members. Lack of social support is also a risk factor. People are lonely.
    - Risk factors include lack of social supports, loneliness, and steady streams of income (retirement, Social Security).
    - Caregiver neglect is the most common form of neglect. Only 1 in 57 cases of caregiver neglect is reported. This is typically because the person is completely dependent on their abuser. This is not delineated professional vs. family caregivers. Anecdotally, it's probably 50/50.
    - Ms. Shea noted that paid caregivers are probably more quickly reported than family caregivers.
    - We know NH has a rapidly aging population, and we are facing a "silver tsunami". Individuals with a cognitive deficit are 5 times more likely to be neglected or abused as an elderly person.
- Mr. Townsend commented on reporting trends and noted that most self-neglect cases are folks who have fallen victim to a scam. These cases aren't easily prosecutable because perpetrators are elsewhere and victims are at risk of losing everything. Numbers have changed a little, largely sparked by COVID.
- Most common physical abuse is domestic violence situations between spouses. The Unit also sees physical abuse cases in facilities. This often involves inadequately trained caregivers getting frustrated with patients with cognitive deficits.
- The Unit has also prosecuted sexual abuse cases. One individual was an aid in a LTC facility and took advantage of a woman who was completely incapacitated. Sexual abuse cases are highly underreported because a perpetrator usually has to get caught, and many of these victims don't remember it happened.

- Senator Avard noted he would love to have Ms. Shea and Mr. Townsend on his show to give this presentation.
- Ms. Shea noted that the Unit is trying to squash law enforcement's view that if someone lacks mental capacity or dies that their perpetrator can't be prosecuted. They are also working to dispel the notion that if it's family it's civil law not criminal.
- Ms. Shea recounted several instances of family members exploiting and abusing elderly family members.
- Mr. Townsend noted that the people who commit these crimes aren't what you'd usually think of as criminals. Unit staff advise against giving people the benefit of the doubt if you see something that's suspicious or that makes you feel uncomfortable.
- Ms. Aultman noted that it helps when you do outreach because even if you don't know it, you're preventing someone from thinking they're getting away with it.
- Senator Avard asked whether there is legislation that would help.
- Ms. Aultman noted that there was a bill recently passed in cooperation with the bankers that allows financial institutions to freeze assets and partner with APS if they suspect exploitation.
- Ms. Shea responded that there may be a point when additional legislation is needed. APS is tracking how many banks are freezing accounts. Some banks are reluctant to do so, so the Unit is raising awareness with them. One thing they're finding is that sometimes the allowed 15-day doesn't allow enough time for an adequate investigation.
- Ms. Shea noted that one of their frustrations is more with serving subpoenas. The feds don't have to comply with subpoenas, which is really frustrating, especially when you're investigating social security fraud.
- Ms. Aultman noted that at DHHS, in addition to the work the Unit is doing to do outreach, APS does outreach and they've seen evidence of increases in reports and volume going up.
- Ms. Aultman continued that she believes the public awareness campaign for brain health, Alzheimer's disease and other dementias, as well as other outreach activities DHHS will be doing, will generate additional awareness and additional resorts, which means additional volume that they'll need capacity for.
- They are seeing that APS is hitting capacity in some areas of the state, and expertise around financial exploitation is very specialized, and not something they teach in social work in college. We have a wishlist of things that we've created as evidence of the work that's been happening.
- Meeting concluded at 3:15 p.m.

Subcommittee on Alzheimer's and Related Dementia Minutes
Wednesday, April 24, 2024 at 3:00 p.m.
Legislative Office Building Room 103

Meeting called to order at 3:00 p.m.

Present: Representative Layon, Wendi Aultman, Sunny Mulligan Shea, Jessica Eskeland, Dax Volle, Gina Balkus, Maureen Murtagh, Kathy Harvard

Absent: Senator Avard, Meghan Wentworth, Kim Mohan, Janessa Luke, Maria Camerlengo, Jay Gupta, Jeffrey Salloway

Note: The comments made by members of the Subcommittee represent their own views and not necessarily the views of their organization or agency.

Minutes

- Rep. Layon opened the meeting at 3:04 p.m.
- Gina Balkus and Dax Volle moved and seconded approval of the minutes. The minutes from the 2/21/24 meeting were unanimously approved.
- Laurie Duff, Director of Senior Services at Easterseals NH, VT & Farnum, presented to the Subcommittee on adult day programs in New Hampshire.
- Ms. Duff has been with Easter Seals for 27 years and has seen the history of adult day programs in this state.
- Adult day programs have been around for about 40 years.
- Definition:
    - Adult day services is a system of professionally delivered, integrated, home- and community-based, therapeutic, social, and health-related services provided to individuals to sustain living within the community.
- National landscape:
    - Adult day services represent a growing source of long term care (there are between 4,600 and 5,000 centers across the country).
    - They provide comprehensive healthcare services, including chronic disease management.
    - These programs are leaders in community-based care for persons living with dementia, and they are an essential source of support for family caregivers.
- New Hampshire adult day landscape:
    - There are adult day centers in Conway, Hollis, Hooksett, Hudson, Jaffrey, Manchester, Merrimack, Nashua, Rochester, and Salem.

- There are varying models of care throughout New Hampshire. Some programs are attached to social service agencies and some are for-profit and independently owned.
- Ms. Duff noted that there used to be more "mom and pop" programs in the past, but those have struggled to survive through the pandemic.
- There have been 9 closures in the last 10 years. Most of these closures came as a direct result of the Medicaid reimbursement rate being stuck at $52/day for each individual being served for many years.
- As of July of '22, the Medicaid CFI rate went up to $75/day.
- In January of '24, the adult day rate went up to $85/day. The legislature also took care of rate parity for Older American Act dollars, which had been stuck at a lower rate.
- Straight Medicaid (for managed care) has also come up to $85/day. For many years that rate was struck in the $50/day range
- Right now, adult day programs in NH are collectively licensed to serve 720 individuals. Adult day also counts staff as part of that number.
- Easter Seals is licensed for 140 individuals, and that includes staff, so based on that, they can determine what they want their program to look like.
- The licensing ratio is 1 to 8 for the more general part of their program, and it is 1 to 5 for their patients living with dementia.
- Most adult day programs are currently struggling with low census.
- All programs had to close for 6 months during the pandemic and struggled getting people back in for a whole host of reasons.
- Adult day programs are also a very under-utilized resource. There is still very low awareness and misinformation among the general public about these services.
- Ms. Duff noted that lots of people still call it "adult day care" and that's not how these programs refer to themselves.
- A cost analysis conducted by Genworth Life determined that adult day services are a cost effective option in long-term care. Based on using an adult day program for 40 hours a week, they generated the following annual cost analysis between industries:
    - Adult day programs: $24,180/year
    - Home health aide (working 44 hours/week): $91,524/year
    - Homemakers (working 44 hours/week): $68,640
    - Assisted living: $87,300/year
    - Nursing home: $144,180/year

- The most common diagnoses participants are living with include: cardiac, stroke, diabetes, mental health, and memory impairment. There tend to be lots of chronic health issues.
- In adult day programs, hospital readmissions and emergency department visits are reduced because participants have nursing eyes on them all day long. Program staff provide case management with physicians when someone is in their care.
- They do health monitoring, which is critical for the chronic disease population.
- Individuals come anywhere from 4-10 hours per day. 10 hours is a long time so they try to avoid that. The programs receive the same pay for however long participants stay.
- Ms. Duff noted that she sees a lot of longevity in the adult day world. These programs don't experience the workforce issues many healthcare facilities have.
- Benefits of adult day programs for persons with dementia:
    - Therapeutic and engaging activities all day long are good for brain health.
    - Individuals coming to these programs tend to be more engaged, sleep better at night, and be more alert because they're communicating and socializing throughout the day.
    - It's a structured day, which is something someone with dementia really needs.
    - These programs provide hygiene and personal care assistance. Sometimes it's hard for a family caregiver to provide that. Some programs provide showering assistance in day programs, as well.
    - Most adult day programs have a secure environment. Some programs have separate programs altogether specifically for folks living with dementia.
    - Adult day program staff are trained, and most are certified dementia practitioners.
- Benefits for families of those living with dementia:
    - These safe and reliable services help allow families and caregivers to continue to work and provide non-working caregivers respite so they can continue to be healthy.
    - Caregivers and families can have peace of mind knowing that their loved one is somewhere safe with trained professionals caring for them.

        - Adult day services provide extensive support and education throughout the day as well. They will work with families and provide tips to make things work better at home.
    - Elements of adult day health programs:
        - Probably 25% of their population is living alone at home, so these programs provide self-management education.
        - They provide cognitive/physical/emotional programming, most of which are evidence-based that show the validity of what we're doing.
        - These programs ensure participants are fed. Sometimes the meal they receive at an adult day program is the only one they have that day.
        - These programs also provide transportation assistance to the extent they are able to.
    - Programming can include:
        - Bowling, gardening, drumming, board games, painting, and jigsaw puzzles, just to name a few.
        - There is an emphasis put on providing purposeful programming.
        - They assess what individuals enjoy doing/used to enjoy doing. We find something that brings them joy while they're with us.
    - Impact:
        - Ms. Duff noted these programs don't want to just provide programming for the sake of it. They want to make an impact, hopefully related to social determinants of health.
        - When someone is enrolled in an adult day program, they are being assessed in four areas.
            - Reducing loneliness. For this, they use UCLA loneliness assessment scale. 86% of new participants, 90 days after enrollment, show significant decrease in their measured level of loneliness.
            - Decrease of fall risk. Programs assess a person's level of falls risk using the Johns Hopkins Falls Risk model. 78% of new participants have shown a decrease in falls risk levels.
            - Prevent depression. This is measured using the PHQ9 Questionnaire. 97% of participants report a significantly reduced level of depression after 90 days of programming..
            - Monitor cognitive changes. For this, programs use the Mini-Mental State Exam. This is trickier because between 50-70% of our enrollees have varying levels of cognitive impairment - it might be mild or mid stages.

        - They also have a quality of life tool they use for someone more advanced which is more of a visual assessment they use (and is evidence-based).
    - These outcomes are achieved by enhancing physical fitness and preventing depression.
- Call to action slide
    - Adult day programming is a valuable option within the LTC system.
    - It keeps caregivers in the workforce and helps address the problems associated with social isolation.
    - Ms. Duff wants the legislature and the subcommittee to support legislation for adult day funding, and would encourage us all to spread the word about these invaluable services.
- Rep. Layon asked what role adult day services play in changing the statistical outcome for someone who breaks their leg.
- Ms. Duff responded that if that person received adult day services, they'd receive PT/OT/speech or whatever therapy they need. They also provide physical fitness programming and encourage physical activity.
- Rep. Layon asked whether hygiene and toileting services are provided.
- Ms. Duff responded that they are, and that LNAs are available to help with these activities.
- Kathy Havard asked about the referral process. She wondered whether adult day programs were receiving more referrals through case management prior to the pandemic, and asked whether that has declined. She asked what are the constraints around people using these services?
- Ms. Duff responded that pre-pandemic, her program never had to market their services. For every 3 or 4 folks you bring in, 2 or 3 are discharged, so it's a constant turnover. Not because adult day can't continue to care for them, but typically because a person's circumstances change.
- If you asked every program who their best referral service is, they'd say word of mouth. We see a lot of generational clients. They still receive a fair amount from hospitals and care management companies, physicians, social workers in physician offices, and the VA, but by and large, their biggest referral source is families.
- Ms. Harvard asked whether there is another resource we should be talking about? If this is a resource available to some people that we'd want to make sure that's included for people to be aware of?
- Ms. Duff replied that yes, it is. We need to raise awareness.
- Gina Balkus asked whether all adult day programs are medical based or are some non-medical?

- Ms. Duff replied that in New Hampshire, they're just medical. There's an adult day program in Merrimack at a church, but they're all volunteers and don't charge and they're only open one day per week.
- Ms. Balkus noted that she's heard from home care agencies privately owned that they're looking into opening adult day programs, so that's a good thing. But once again, they're mom and pop agencies and may struggle to maintain viability.
- Ms. Duff replied that in January of last year another one opened in Manchester on the east side near the hospital and it was operated by a nurse practitioner, and she was open for just 3 months because she just didn't have the clientele.
- Rep Layon asked whether some centers are providing transportation or is it a matter of linking into things like CART?
- Ms. Duff replied that anyone who's a Medicare recipient can tap into managed care transportation routes. Some programs have their own buses but most plug into MCO transportation.
- Sunny Mulligan Shea asked whether, if centers provide transportation, do they bill Medicaid for that service?
- Ms. Duff replied that if they're set up to do so, yes.
- Ms. Mulligan Shea asked whether ServiceLink knows how to refer people to these programs.
- Ms. Duff replied that yes, they do.
- Ms. Mulligan Shea noted that we're licensed in this state for 720 program participants, and asked how many of those spots are filled?
- Ms. Duff will get that information to the Subcommittee.
- Wendi Aultman said it's trending at about half of what's licensed. There's no waiting list.
- Ms. Mulligan Shea asked whether an individual can still use these services if they don't have a medical need.
- Ms. Duff noted that her program's license is set up in such a way that they need to get orders from a PCP, so they would need that referral.
- Ms. Mulligan Shea noted that it seems like that should be changed because there are lots of other non-medical needs. Would that be a helpful change?
- Ms. Duff replied that that would mean going back to a medical/social model.
- Ms. Mulligan Shea noted that the DOJ sees lots of people exploited due to lack of social contact and loneliness.
- Ms. Mulligan Shea went on to note that it seems like such a change would be a huge reduction of strain on families.
- Ms. Duff noted that the PACE model is very popular in other states. It is a program for all-inclusive care for the elderly. Basically, the adult day program acts as the hub and participants are able to see their physician, psychiatrist, podiatrist, whoever, and get PT/OT/speech therapy all in one place.

- She went on to note that the challenge is we're a pretty rural state, and it's a Medicare-based program so some entity, generally an insurance company or a VNA, administers it.
- Ms. Mulligan Shea asked whether that is a model Ms. Duff would like to see here in New Hampshire.
- Ms. Duff noted that she'd love to see some sort of hybrid to that. Not sure what that looks like. She thinks the state would welcome different ideas and strategies to get to a different outcome, but we haven't been able to figure that one out.
- Ms. Aultman noted that DHHS has been working with a consultant for a couple weeks and they're focusing on feasibility study for PACE and a DSNIP which is all-inclusive supports to cover services for individuals who are dually qualified for Medicare and Medicaid.
- She noted that a DSNIP model would be managed through one of the state's 3 contracted MCOs and PACE could be managed through nationally organized companies who provide oversight.
- She noted that the purpose of the feasibility study is to learn more and level set everyone on what their understanding of those 2 models is and what it would take to implement. The Department will start likely in June engaging stakeholders and others in the work the feasibility group is doing.
- Ms. Balkus noted re: the PACE program that several years ago her organization brought in a speaker from PA who had started a PACE program, and noted that it requires an enormous amount of capital, over $5 million, to get it started and a certain threshold of participants. She noted it's almost like creating a little insurance company with a building.
- Ms. Balkus went on to say she thinks it would be great to have one in NH and noted that the entities probably most able to do it would be large social service agencies like Easter Seals or Harvard Health Care or a large hospital system, because then you have physicians and hospitals all together.
- Ms. Aultman noted that the feasibility study is in its first phase, then they'll need to see the report and results and go through a decision-making process in terms of saying whether it's feasible, so part of their contract would be to take the next step if we determine feasibility and help with planning what that would look like. They also have to take into consideration the cost and policies, etc.
- Rep. Layon noted that that's an area where we're looking at density and how small a state we are and if it's NH specific we may not have the density and geographic spread to make it work, but I hope it works because it's a challenge to get all of these services.
- Dr. Volle noted that the point about physician referrals is important because being within a large hospital system like Dartmouth Hitchcock, you're depending on the knowledge of a social worker/care manager/physician being aware these things

exist. Any way we can raise awareness would be great. It's such a cost-effective and efficacious model, why isn't this being considered more as a stopgap between being at home and being in residential care?

- Dr. Volle went on to say that education at a health system level could be great.
- Ms. Duff asked whether Dr. Volle had any suggestions to that end?
- Dr. Volle responded that perhaps this could be a component of some sort of care requirements, or bundled into a package of elder care.
- Dr. Volle further noted that within dementia care, trying to coordinate dementia care or geriatric psychiatry and having a statewide collective of these people would be great. The challenge is that they're all in disparate health systems, either in large hospital systems or in private practice. That would be a good place to start. Similarly with PCP offices. That's the place most people receive care.
- Ms. Duff noted that there is a physician in Manchester who is their second best referral source and he actually writes a prescription for social connection for patients with MCI, and this has been incredibly helpful.
- Ms. Aultman noted that at a future meeting DHHS can discuss the contract for the public awareness campaign. Part of the campaign will be thinking about those barriers in terms of information and access.
- Ms. Harvard noted that in the caregiver community, the absence of adult day programming is something you hear a lot about. There are 2 ways to work on this: creating a more informed referral source with PCPs, but the other is creating demand and awareness in the caregiving community to ask for it and know things are available. I think we have to create a bit of demand. Caregivers need to be encouraged to speak up.
- Rep. Layon noted she wondered if the lack of referrals was due to lack of knowledge, and noted that some people just don't go to PCPs. However, this might be different if you know you can access services and you can get referrals to things that will help your quality of life, that should be the goal and would help caregivers.
- Ms. Aultman noted that part of the Department's project, in addition to the feasibility study, is a contract with Rockingham county working with them on a pilot project for informing individuals and families about adult day services and making connections with them and collecting data around that. They just started having some planning meetings with them over the last 2-3 weeks. DHHS will keep us posted as that project progresses.
- Ms. Aultman further noted that the purpose is to make connections with other counties. She noted there are lots of people on waiting lists for residential care who could potentially benefit from these services. That will also help inform the work.

- Ms. Duff welcomed any member of the subcommittee to reach out to her if there's a facility we'd like to tour or learn more about.

Meeting concluded at 4:00 p.m.

Subcommittee on Alzheimer's and Related Dementia Minutes
Wednesday, May 29, 2024 at 1:00 p.m.
State House Room 103

Meeting called to order at 1:09 p.m.

Present: Representative Layon, Jessica Eskeland, Gina Balkus, Maureen Murtagh, Sunny Mulligan Shea, Janessa Luke, Kathy Harvard

Absent: Senator Avard, Wendi Aultman, Meghan Wentworth, Maria Camerlengo, Dax Volle, Kim Mohan, Laura Rocha

Note: The comments made by members of the Subcommittee represent their own views and not necessarily the views of their organization or agency.

Minutes from the 4/24/24 meeting unanimously approved.

Minutes

Gina Balkus, CEO of Home Care, Hospice & Palliative Care Alliance of New Hampshire, presented "Understanding Home Health & Hospice Options" to the Subcommittee.

- Ms. Balkus noted that as follow-up to the presentation the Subcommittee received about adult day centers, she felt it would be helpful to hear about options for home health for those living with Alzheimer's or other dementia.
- NH licenses all home health agencies, which is not the case in every state. There are two categories of home health agencies: medical and non-medical agencies. If an agency is non-medical, it is limited to providing personal care and homemaking services, and no medical care services are delivered. Most medical care home health services are provided by Medicare home health, followed by commercial insurance and Medicaid, and some CFI and the VA, as well as hospice. On the non-medical side, those services are usually covered by NH CFI, private pay, long-term care insurance, or the VA.
- Medicare and Medicaid home health services primarily consist of skilled nursing services. Provision of these services are considered to be short-term and intermittent; not long-term. Medicare generally covers services for a 30-day period of care with an option to renew for another 30 days, but can go no longer. Services might include a nurse visiting once or twice a week, or someone needing PT, OT, speech/language therapy, or social services.
- What does that mean for dementia or Alzheimer's? Generally, those patients would be getting care that's not hands-on. It might be someone on a new medication for Alzheimer's or dementia and they need to be managed in terms of how they're responding, or someone for whom the family caregiver is struggling with disruptive behavior and trying to better understand how to keep the patient less agitated. Lots of caregiver and patient education goes along with these services. Someone with

Alzheimer's or other dementia may require PT, and that's where Medicaid certified home care can come in.

- It is important to know there's certain criteria Medicare has for being eligible for home health services, which can sometimes be a barrier to care. In order to be eligible, a patient must be confined to their home (this is only a requirement for Medicare; not Medicaid or VA services). Medicare is for people over 65 who are disabled; Medicaid might come into play for someone under 65 who's low-income and needs home care or someone commercially insured under 65. Primarily, Medicare is the largest payor of all in home care.
- Further, in order to be eligible for Medicare home health services, a patient must have a documented need for skilled services and be under the care of a physician or NP, or authorized PA. In order for Medicare to cover these services, there must be very clear documentation about why the patient needs services at home.
- In addition, the patient must receive these services under a home health plan of care developed by a home care agency and signed off on by the patient's provider.
- The patient must have a face-to-face encounter with the provider within 30 days after the start of care or 90 days prior to care. These are rigid criteria and sometimes are barriers to care. The biggest barrier is probably the home-bound requirement criteria. Someone might be on Medicare and Medicaid and if they are not homebound, Medicare won't cover these services. (Medicaid might.)
- The home-bound criteria applies to someone who is homebound because of illness or injury or who is in need of supportive devices or reliant upon the assistance of another person to leave their place of residence. If someone can't leave home or drive without assistance, that would qualify. They would also be considered home-bound if they have a condition for which leaving home is contraindicated. This could apply to someone in advanced stages of dementia who shouldn't leave their home. These circumstances would have to be documented by a physician. Going to adult day doesn't apply; individuals can still go to those programs and be considered home-bound.

Ms. Mulligan Shea asked whether there is a cap for how long these services can be provided.

Ms. Balkus responded that there isn't really, but that episodic care usually lasts for 60 days. There might be two separate episodes of care, but generally not three.

Rep. Layon asked whether it would count as homebound if someone could not safely leave their home. Ms. Balkus responded that yes, if it would be unsafe to leave the home, that would count.

Rep. Layon asked whether this homebound qualification requires that the patient identify as being homebound, and noted that matters of pride could be an issue. Ms. Balkus responded that no, this status only requires documentation by a physician.

Ms. Balkus discussed the Choices for Independence Program.

- CFI is a Medicaid program NH has for low-income adults who also have a clinical need for skilled nursing care for long-term care. These are people who qualify for nursing homes but choose to receive services at home.
- Once someone is determined financially and clinically eligible, their case is turned over to a case manager who arranges an array of services that may include home care.
- Even though these services are long-term care and are considered skilled nursing services, it's a lower level of care than what would be provided through Medicare or Medicaid episodic care.
- Nurses providing services in the CFI program (either RNs or LPNs) might come in and do pill-planners. An RN might do a patient assessment every other week, or minor wound care, help manage medicine changes. If a patient's condition changes, an RN would come in.
- In order to bill under Medicare and Medicaid, and generally commercial insurance, the agency must be licensed by the state as a medical agency and also be Medicare certified. Agencies are generally surveyed by a federal team which is housed at DHHS. To provide CFI services, agencies don't need to be Medicare certified (this is an important distinction). But in order to provide skilled nursing or home aid services, an agency must be certified as a medical agency by the state.
- Not all CFI providers are licensed as medical agencies.
- Another type of care out there is non-medical care. Agencies licensed by the state to do personal care, homemaking, and provide companionship. For many patients with Alzheimer's or other dementia, this is what they need at the beginning of the disease trajectory.
- CFI does not pay for companionship care, but many non-medical agencies (like franchises) do this kind of care.
- CFI covers personal care and homemaking. Homemaking is the next level up from companionship. Personal care is next level up below home health aides. CFI does cover transportation, too.
- The challenge for many people is that if you're low-income and eligible for nursing care you can get your CFI services through the state. If you have a higher income, you might be able to afford private pay or you might have long-term care insurance.
- For people who don't have long-term care insurance or who lack the ability to pay and don't get CFI, it's a real challenge to afford private pay insurance, as right now it's probably up around $32/hour.

Ms. Harvard asked whether Ms. Balkus could break down in rough percentages of those populations. Ms. Balkus responded that she does not have this data.

Ms. Balkus noted that the VA does cover some personal care. Many home care agencies work with the VA and report that they are really difficult to work with. It takes a long time for agencies to get paid.

Ms. Balkus discussed hospice care.

- Medicare, Medicaid, and some commercial insurers cover hospice. Under Medicare, it's an elected benefit. When you elect the Medicare benefit for hospice you generally have to agree to no longer seek curative care. Someone still may seek palliative care.
- Hospice care must be provided by a Medicare certified agency.
- Hospice can be renewed, and even revoked if the patient gets better.
- CMS often has Medicare administrative contractors do medical reviews on hospice cases lasting over 180 days.
- In hospice there's an interdisciplinary team providing services to the patient and their family. This team includes a hospice medical director, nurses, LNAs, social workers, chaplains, and bereavement counselors and hospice volunteers.
- Dementia has surpassed cancer as one of the leading causes of admission to hospice.
- If someone is under 65, commercial insurance will often cover hospice care.

Ms. Harvard noted that hospice seems like a fuzzy area. Where does the idea of hospice come from, because it doesn't seem that there's much hospice awareness among families and caregivers. Does a hospice recommendation come from a patient's PCP? Or is this happening by word of mouth?

Ms. Balkus noted that the referral should come from the patient's PCP, but unfortunately they're often hesitant to bring it up. The referral could also come from a specialist.

Rep. Layon asked when, in the hospice setting, do conversations happen about how to treat other ailments that are starting to spread. She shared that in the case of her family member, there wasn't a conversation about how to support the person while not necessarily fighting the infection?

Ms. Balkus responded that ideally people would have filled out an advanced directive and made their wishes known, and noted that newer directives have some great questions. The Foundation for Healthy Communities has these documents.

Ms. Balkus went on to note that not everyone has an advanced directive, so it's imperative that families have a good understanding of what they think someone would have wanted. Generally, the hospice team will work through those issues with the family.

Ms. Luke noted that palliative care is an important stepping stone, particularly when it comes to symptom management. At-home palliative care must be done by a nurse practitioner or physician and billed through the home care benefit, which has criteria requirements.

Ms. Luke noted that there are hospice houses in New Hampshire, and some are considered units of hospitals. Patients can also elect to receive hospice services at home. Some nursing homes serve as general inpatient care facilities for the purposes of hospice care, and almost all of them allow hospice services to be provided in their facilities, but some refuse to do so.

Rep. Layon indicated that she may request assistance in introducing language in the future requiring these facilities to allow hospice services to be provided.

Ms. Eskeland shared that she is leaving the Alzheimer's Association and that someone will be named to replace her on the Subcommittee as soon as her position is filled.

Rep. Layon indicated that the Subcommittee would take a break from meeting for the summer months.

Ms. Eskeland indicated that Chelsea Gordon, Director of Policy and Advocacy at the Alzheimer's Association, and Tom Prasol of Demers & Prasol, would be in touch with Senator Avard about scheduling meetings in the fall.

Meeting closed at 2:10 p.m.