THE UNIVERSITY OF ARIZONA
JAMES E. ROGERS COLLEGE OF LAW
Health Law

Where Do We Go From Here? Long-Term Care After COVID-19

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Disclosures

- No relevant conflicts of interests.

- This is not legal advice.

Overview

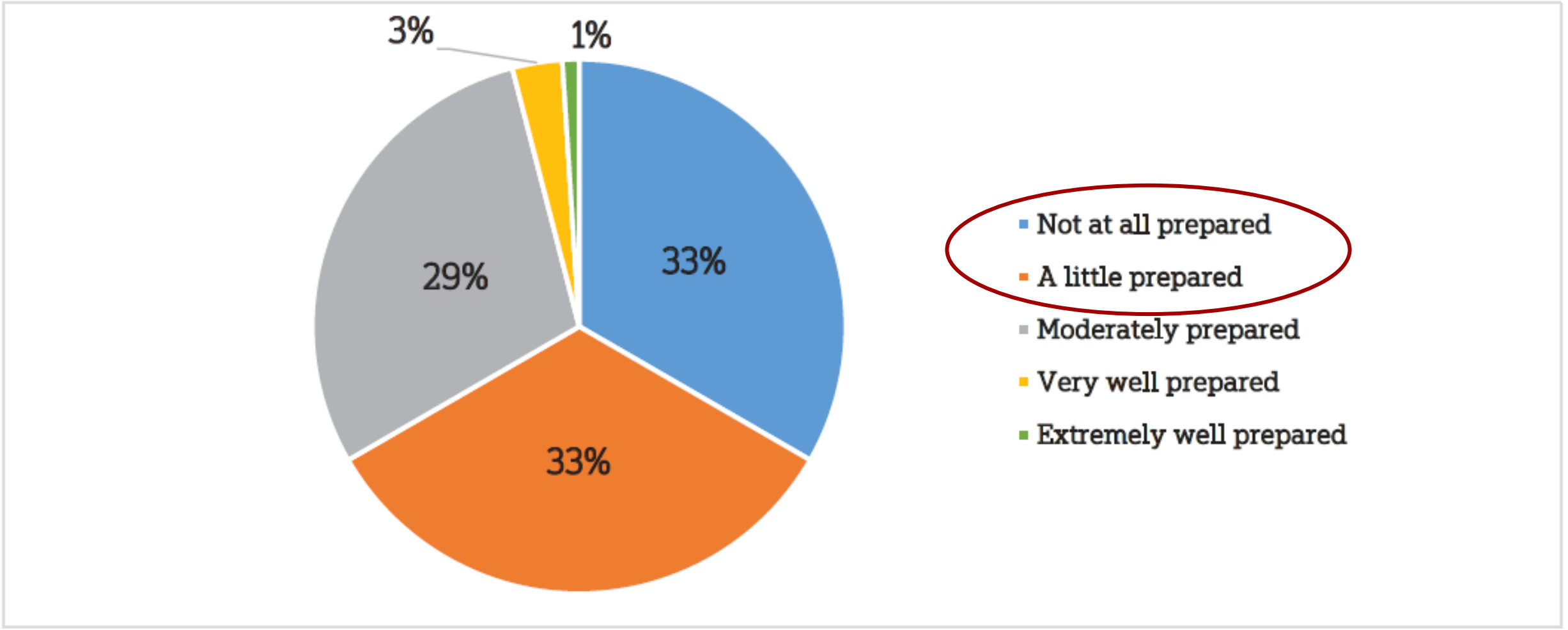
I. An industry ripe for disruption

II. Quality and safety in long-term care facilities

III. Pandemic-resilient long-term care system
Designed to age with dignity


POLL

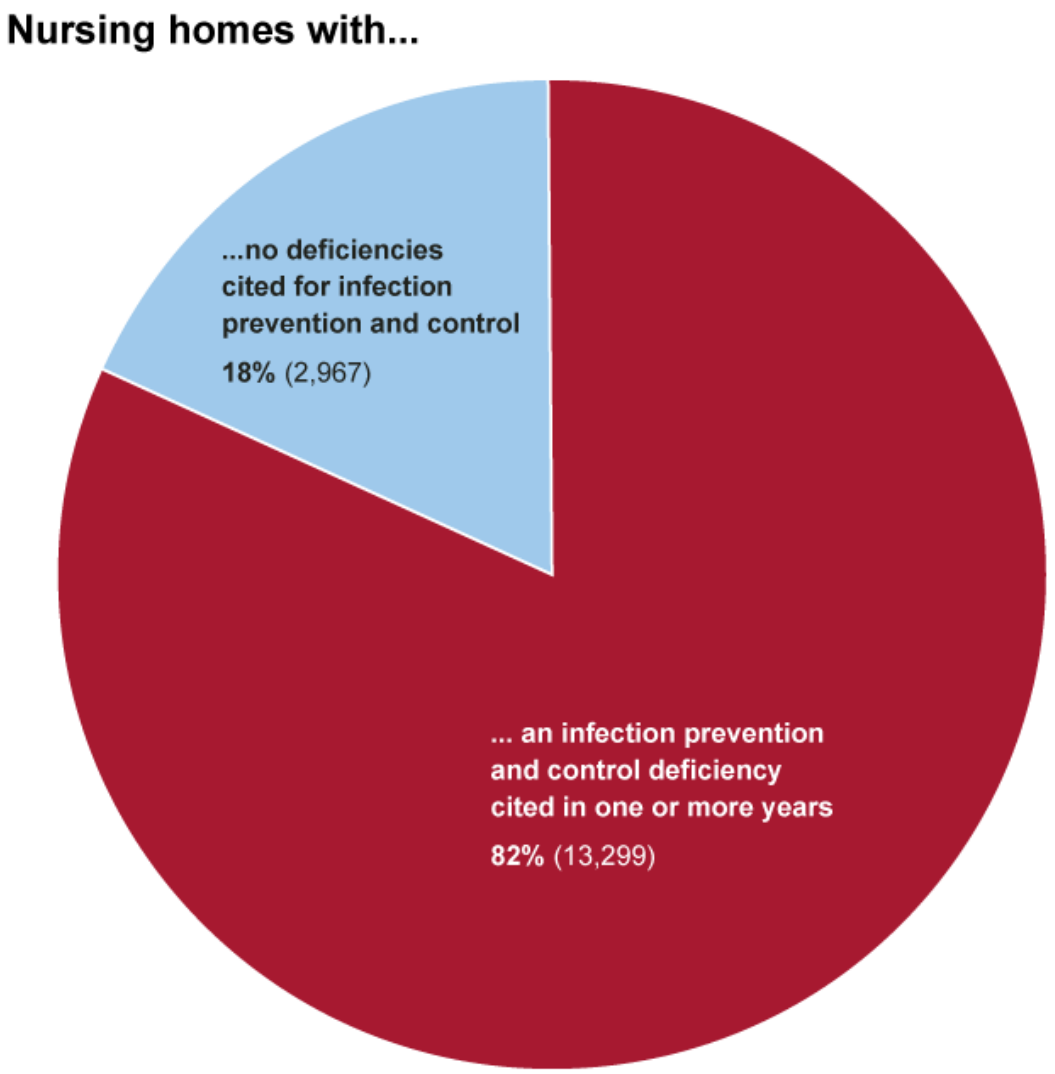
Two-thirds of Americans age 40 and older feel the country is not prepared for the rapid growth of the older adult population.



Question: The population of older adults is expected to nearly double and will make up about 22 percent of the U.S. population by the year 2040. How prepared is our country for the needs of this growing population of older adults?

Source: AP-NORC Long-Term Care Poll conducted March 2-29, 2017, with 1,341 adults age 40 and older nationwide

Pre-COVID, 2013-2017



Source: GAO analysis of Centers for Medicare & Medicaid Services' (CMS) data. | GAO-20-576R

Table 4: Comparison of the Percentage of All Surveyed Nursing Homes and Those with No, a Single Year, or Multiple Years of Infection Prevention and Control Deficiencies Cited, by Characteristic, 2013 through 2017

		Sub-groups of all surveyed nursing homes, 2013-2017		
Characteristic	All surveyed nursing homes, 2013-2017	Nursing homes with no infection prevention and control deficiencies cited	Nursing homes with infection prevention and control deficiencies cited in a single year	Nursing homes with infection prevention and control deficiencies cited in multiple years
Number of nursing homes	16,266	2,967	4,309	8,990
Percentage				
Type of ownership[a]				
For-profit	67.9	60.8	63.5	72.3
Nonprofit	23.5	29.7	27.0	19.8
Government-owned	6.0	6.0	6.2	5.9
Mixed ownership[b]	1.2	1.0	1.4	1.2
Location[a]				
Urban	68.4	68.9	67.0	69.0
Rural	27.5	26.7	28.2	27.5
Transitioning area[c]	2.8	2.6	3.0	2.7
Number of Medicare and Medicaid certified beds[a, d]				
Small (Less than 50)	13.0	19.1	14.6	10.2
Medium (50 to 99)	36.5	36.2	37.4	36.2
Large (100 to 199)	43.4	37.0	40.6	46.8
Very large (200 or more)	7.1	7.7	7.4	6.8
Special Focus Facility program designation during the time period reviewed[e]				
Participated in program	2.5	1.0	1.6	3.4
Average of Five-Star System overall quality ratings over the time period reviewed[a, f]				
1 star	5.5	2.1	2.9	7.9
2 stars	21.2	9.2	15.7	27.8
3 stars	26.1	19.1	24.8	29.1
4 stars	28.1	33.2	31.6	24.8
5 stars	17.3	32.7	22.5	9.7

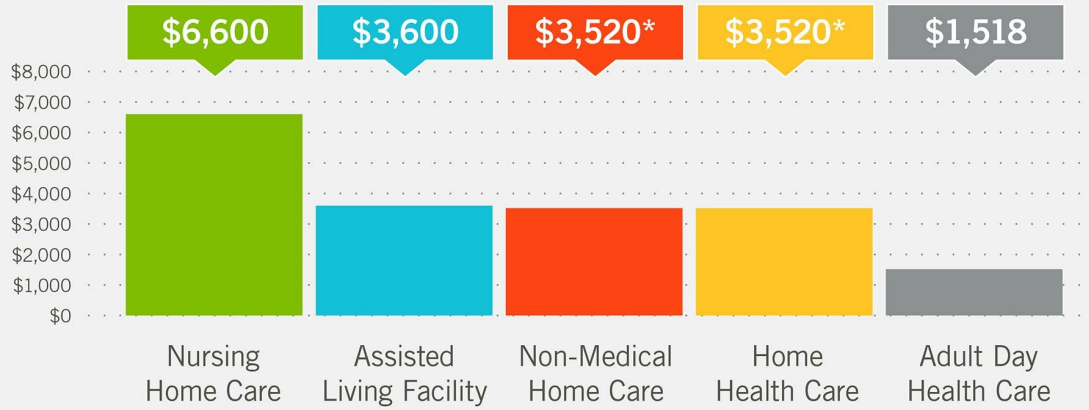
Source: GAO analysis of Centers for Medicare & Medicaid Services' (CMS) data. | GAO-20-576R

LONG-TERM CARE

What Is It, and How Much Does It Cost?

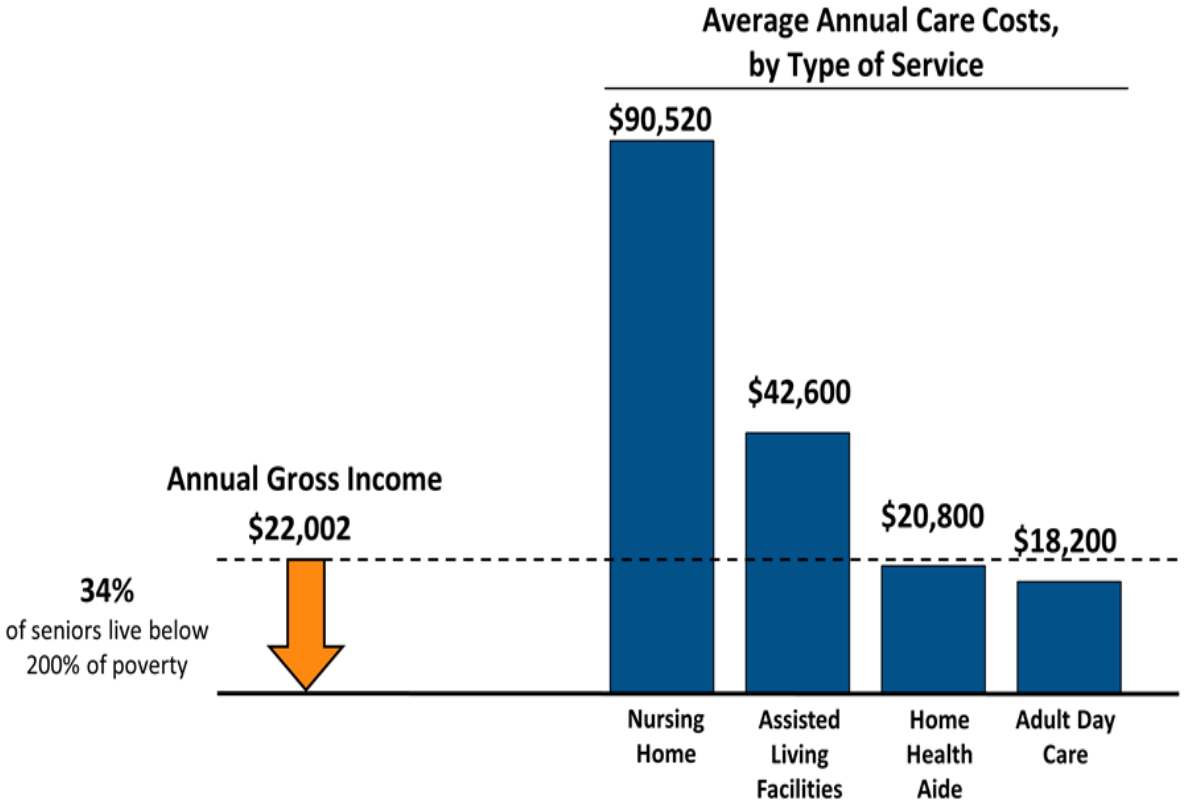
At least **70 percent** of people 65 years and older will need long-term care services at some point in their lives.[1] The cost of long-term care depends on three main factors: the kind and length of care needed, the provider chosen, and the location. Here is a breakdown of some long-term care services in the United States.

MONTHLY AVERAGE RATE OF LONG-TERM CARE SERVICES IN THE U.S.[2]



*22 workdays/month

Long-Term Care Costs Can Exceed Seniors' Income



SOURCES: MetLife Mature Market Institute. *The 2012 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs*, November 2012, available at: https://www.metlife.com/mmi/research/2012-market-survey-long-term-care-costs.html#keyfindings; U.S. Census Bureau, *Current Population Survey*, 2012 Annual Social and Economic Supplement, Table POV01.

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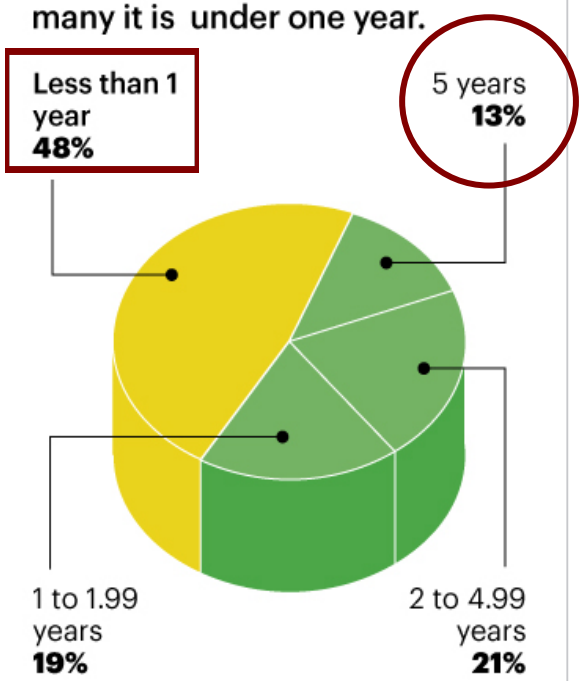
The Unpredictability of Long-Term Care

HOW LONG ...

The duration of paid care among 65-year-olds who will need it someday varies widely, but for many it is under one year.



PERCENTAGES EXCEED 100% BECAUSE OF ROUNDING. SOURCE: DEPARTMENT OF HEALTH AND HUMAN SERVICES

HOW MUCH ...

The median annual cost of nursing home care depends on your state.

U.S. OVERALL $85,800

Most expensive state in cont
CONN
$150,2

Cheapest state:
TEXAS
$54,800

PRICES ARE FOR A SEMIPRIVATE R
THE MEDIAN ANNUAL COST IN AL
$292,000. SOURCE: GENWORTH

YOUR COSTS

One in four people now age 65 will face over $50,000 in life-time out-of-pocket long-term care expenditures.

Out-of-

Share of people

Nursing Home Payor Breakdown

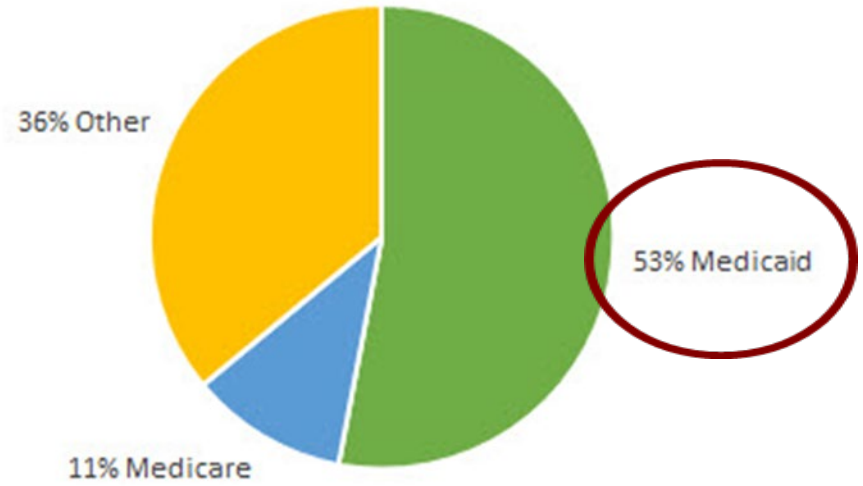
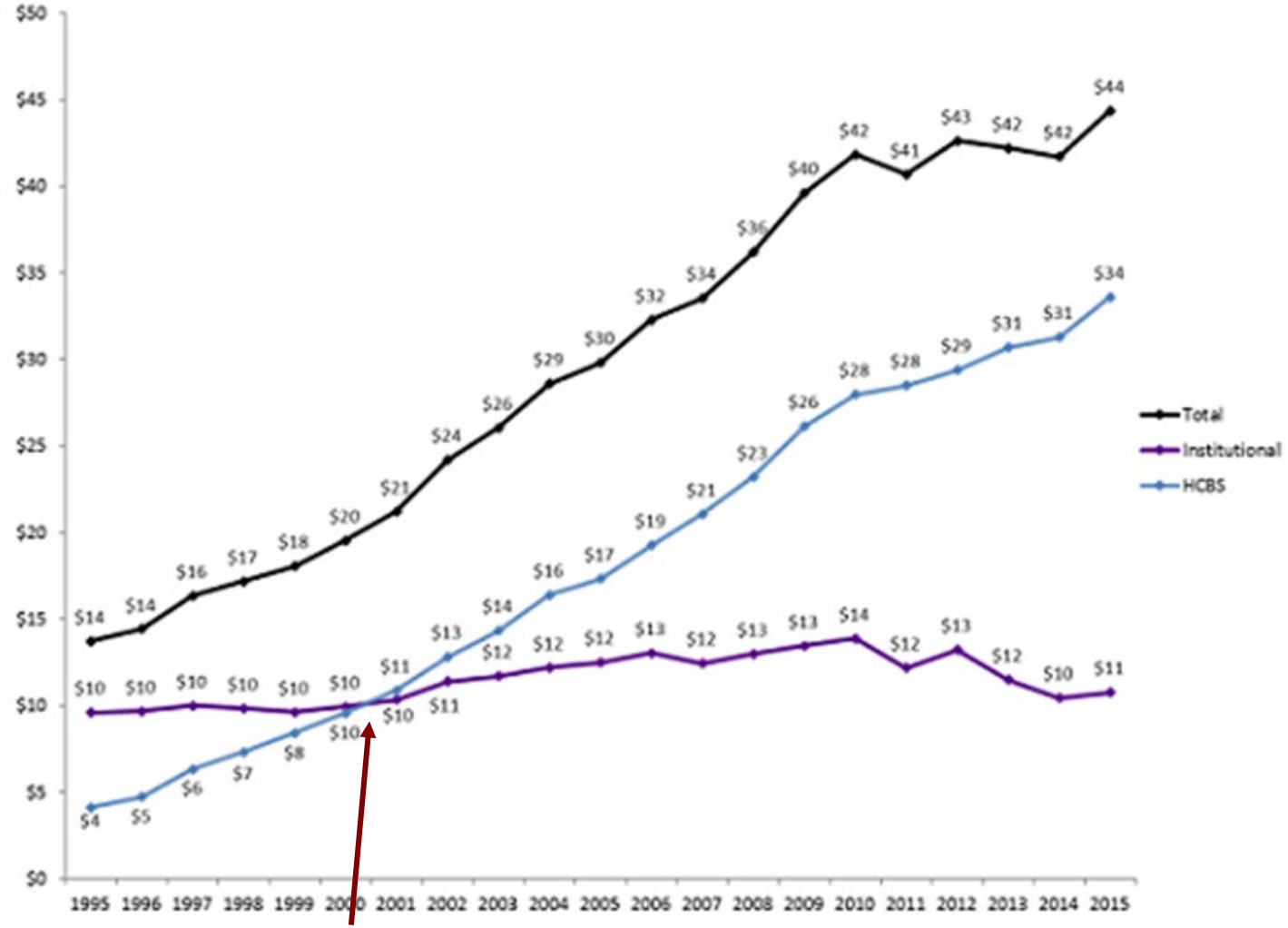


Figure 12. Medicaid LTSS Expenditures Targeted to People with Developmental Disabilities, by Service Category, FY 1995–2015 (in billions)



Institutional includes ICF/IID.

HCBS includes supports targeting people with intellectual disability, autism spectrum disorder, and/or other developmental disabilities.

https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf

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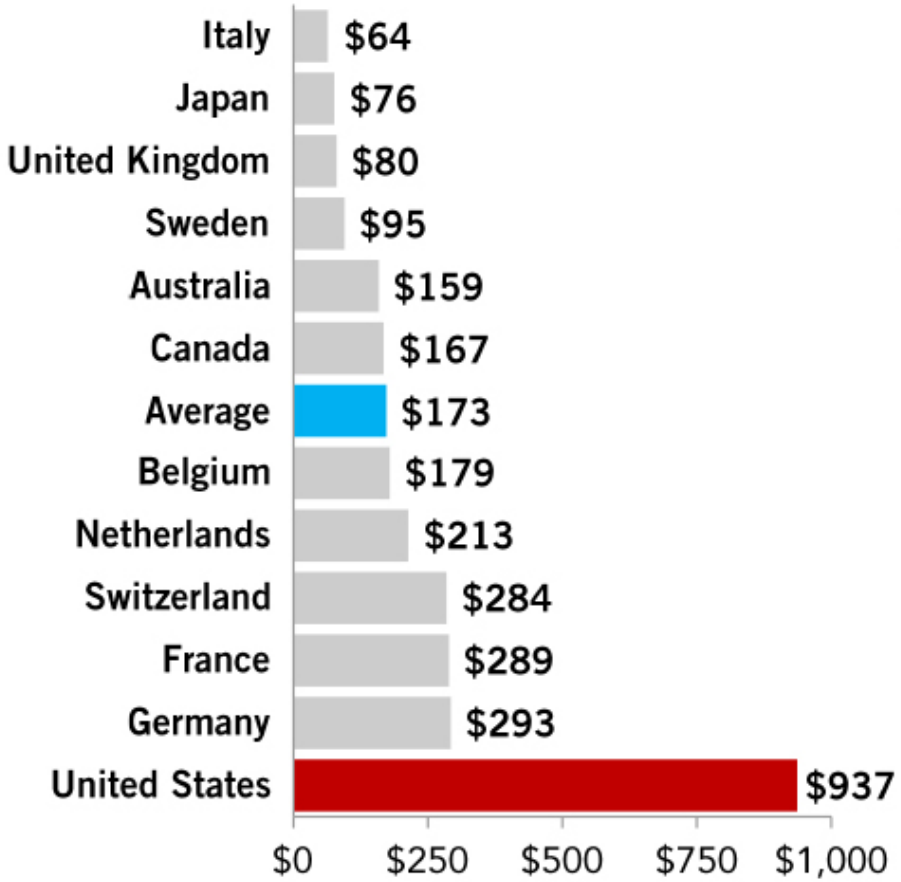
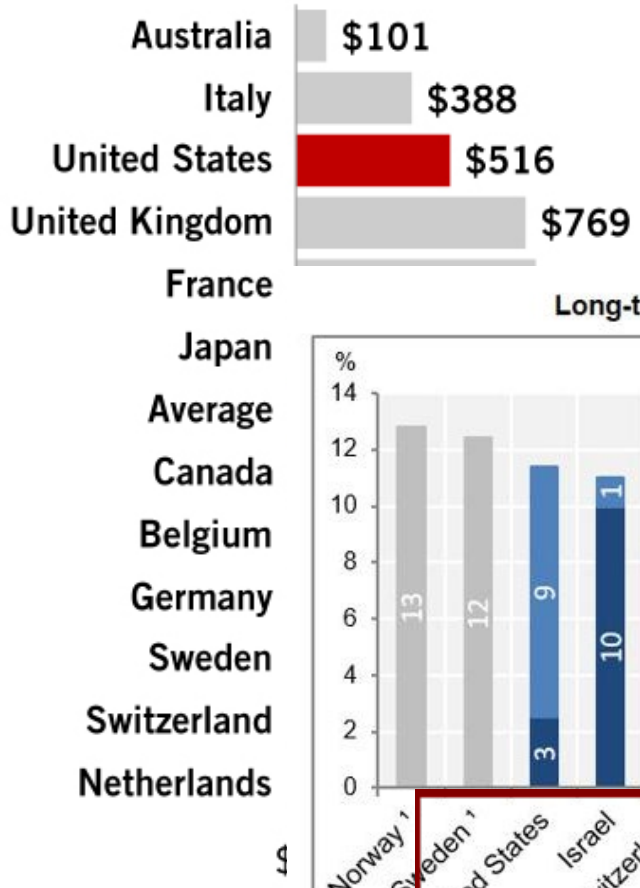
The United States spends more on administrative costs, but less on long-term healthcare, than other wealthy countries

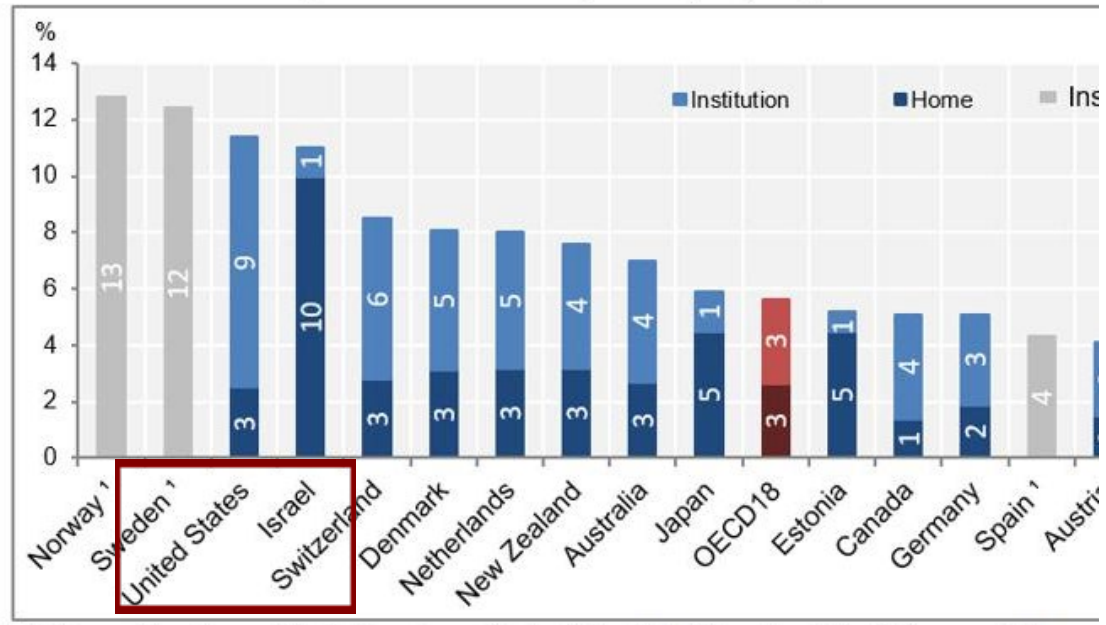
Administrative Costs per Capita (Dollars)



Long-Term Care per Capita (Dollars)



Long-term care workers per 100 people aged 65 and over, 2015



SOURCE: Organisation for Economic Co-operation and Development, *OECD Health Statistics 2020*,
NOTES: The five countries with the largest economies and those with both an above median GDP a
were included. Average does not include the U.S. Data are for 2019 or latest available. Chart uses p
dollars.

1. In Norway, Sweden and Spain it is not possible to distinguish LTC workers in institutions and at home.

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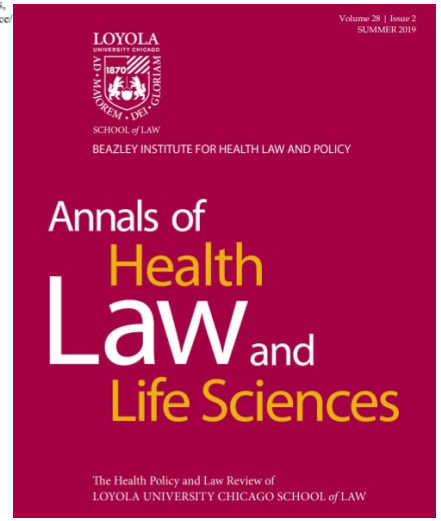
Long-term care needs to be adequately funded with effective regulatory oversight irrespective of whether it is delivered in a facility or through home-and-community-based services.

"All the money my parents saved over their lifetimes and planned to pass onto their children and grandchildren was spent in two years on nursing home care. The day my mother passed was the day she became Medicaid eligible."

\- Frank Petruzzi, Youngstown, Ohio
(retired attorney)



Preparing to Age in Place: The Role of Medicaid Waivers in Elder Abuse Prevention

*Tara Sklar, JD, MPH and Rachel Zuraw, JD, MBe**

I. INTRODUCTION

"All the money my parents saved over their lifetimes and planned to pass onto their children and grandchildren was spent in two years on nursing home care. The day my mother passed was the day she became Medicaid eligible."

\- Frank Petruzzi, Youngstown, Ohio
(retired attorney)

Financing for long-term care in America has been described as the greatest gap in retirement planning.[1] The population growth trajectory shows a large and increasing need for accessible long-term care options as the cost of care continues to climb.[2] Aging in place is gaining primacy as a path forward, enabling older adults to remain in their home as they age; this practice can contain costs associated with long-term care, and it is responsive to popular preferences of adults aged sixty-five and over.[3] However, there is still much to learn about how to manage aging in place to provide the greatest benefit to this population.

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* Tara Sklar, Professor of Health Law, University of Arizona James E. Rogers College of Law and Rachel Zuraw, Lecturer, University of California, Berkeley, School of Law. Special thanks to Elise Phalen for her excellent research assistance. We appreciate the helpful comments and suggestions from Barbara Atwood, Jordan Neyland, Christopher Robertson, Nadia Sawicki, Roy Spece, Sidney Watson, participants at Loyola University of Chicago School of Law, 2018 Beazley Symposium on Health Care Law and Policy, the 2019 Association of American Law Schools, Law, Medicine, and Health Care Works in Progress Session for New Law and Medicine Scholars, and the 2019 Arizona Law Scholarly Workshop.

1. Richard L. Kaplan, *Retirement Planning's Greatest Gap: Funding Long-Term Care*, 11 LEWIS & CLARK L. REV. 407, 450 (2007).
2. Carli Friedman et. al., *Aging in Place: A National Analysis of Home- and Community-Based Medicaid Services for Older Adults*, J. DISABILITY POL'Y STUD. 245, 245 (2018).
3. *Id.* at 249, 254; *The Value of Aging in Place*, USC LEONARD DAVIS, https://gerontology.usc.edu/resources/articles/the-value-of-aging-in-place/ 2, 2019).

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Caregiver

- Background checks
- Qualifications
- Eligibility for relatives

Quality Assurance

- Monitoring, including frequency and method
- Required to look for signs of elder abuse
- Mandatory reporters

Complaints and Investigations

- Access to report
- Investigation response

State, Waiver, and Year of Implementation	Caregiver Selection	Quality Assurance	Complaints and Investigations
Minnesota Elderly Waiver 1982	**Screening:** Background check required, cross-referenced against vulnerable adult database **Qualifications:** High school degree, one-year experience **Relatives:** Covered if relatives are qualified	**Monitoring:** Phone calls; onsite visits 2x per year **Signs of elder abuse:** Financial exploitation emphasized **Mandatory reporters:** All professionals engaged in care	**Access:** Dedicated 24-hour number with Adult Abuse Reporting Center **Response:** Health & Human Services
Connecticut HCBS for Elders 1987	**Screening:** Background check, cross-referenced against abuse registry **Qualifications:** Aged 18 years or over, experience with cognitive behavioral intervention	**Monitoring:** Onsite [illegible] **Signs of elder abuse:** Serious incidents of abuse, include use [illegible] client's belongings, money, or [illegible]	**Access:** Dedicated after hours number for elder mistreatment in the home **Response:** Elderly Protective Services
Kansas HCBS for Frail Elderly 1987	**Screening:** [illegible] and investigations conducted for questionable [illegible] **Qualifications:** None specified **Relatives:** Covered, but [illegible] spouse or guardian	**Monitoring:** Regular onsite visits **Signs of elder abuse:** Explicit focus on financial abuse **Mandatory reporters:** Health care providers and administrators, bank officers, and legal representatives	**Access:** Complaints sent to Medical Assistance Customer Service **Response:** Response in 3-days
Iowa HCBS Elderly 1[illegible]	**Screening:** Background check required for all who provide waiver services **Qualifications:** Aged 18 years or over **Relatives:** Covered, but prohibit spouse or guardian	**Monitoring:** Ongoing to review appropriateness of services **Signs of elder abuse:** N/A **Mandatory reporters:** Financial institution employees and anyone who believes incident of abuse, neglect, exploitation	**Access:** Dedicated 24-hour number with Dependent Adult Protective Services **Response:** Adult assessment with social worker
California [illegible] Services Program 1991	**Screening:** None specified **Qualifications:** None specified **Relatives:** Covered, but prohibit spouse or guardian	**Monitoring:** Onsite visits 4x first year, then onsite 1x per year; review conducted by a team **Signs of elder abuse:** Abuse, neglect, and unsafe environment **Mandatory reporters:** All individuals providing care	**Access:** Varies by county to report elder mistreatment in the home **Response:** Adult Protective Services
Nevada Frail Elderly 1992	**Screening:** None specified **Qualifications:** Must have professional license **Relatives:** Not specified	**Monitoring:** Monthly contact by phone; onsite visits 4x per year; annual Quality Assurance Patient Experience Survey **Signs of elder abuse:** Abuse, neglect, exploitation, isolation **Mandatory reporters:** Case managers and service providers	**Access:** Offer a toll-free number **Response:** Elder Protective Services
Utah Waiver for Individuals 65 or Older 1992	**Screening:** Background check **Qualifications:** Aged 18 years or over, literate, social security number, first aid certification **Relatives:** Covered, but supervision required	**Monitoring:** Monthly contact; onsite visits 4x per year **Signs of elder abuse:** Abuse, neglect, or exploitation **Mandatory reporters:** Anyone with reason to believe there are incidents of abuse is required to report	**Access:** Toll-free and 24-hour number, also offer a link to report online **Response:** Adult Protective Services

Increased invisibility and minimal regulatory oversight

DATAWATCH NURSING HOMES

HEALTH AFFAIRS > VOL. 38, NO. 7 : PHYSICIANS, NURSES, DISPARITIES & MORE

Daily Nursing Home Staffing Levels Highly Variable, Often Below CMS Expectations

Fangli Geng, David G. Stevenson, and David C. Grabowski

Trends in Geriatrics Graduate Medical Education Programs and Positions, 2001 to 2018

Gerontology & Geriatric Medicine
Volume 4: 1–4
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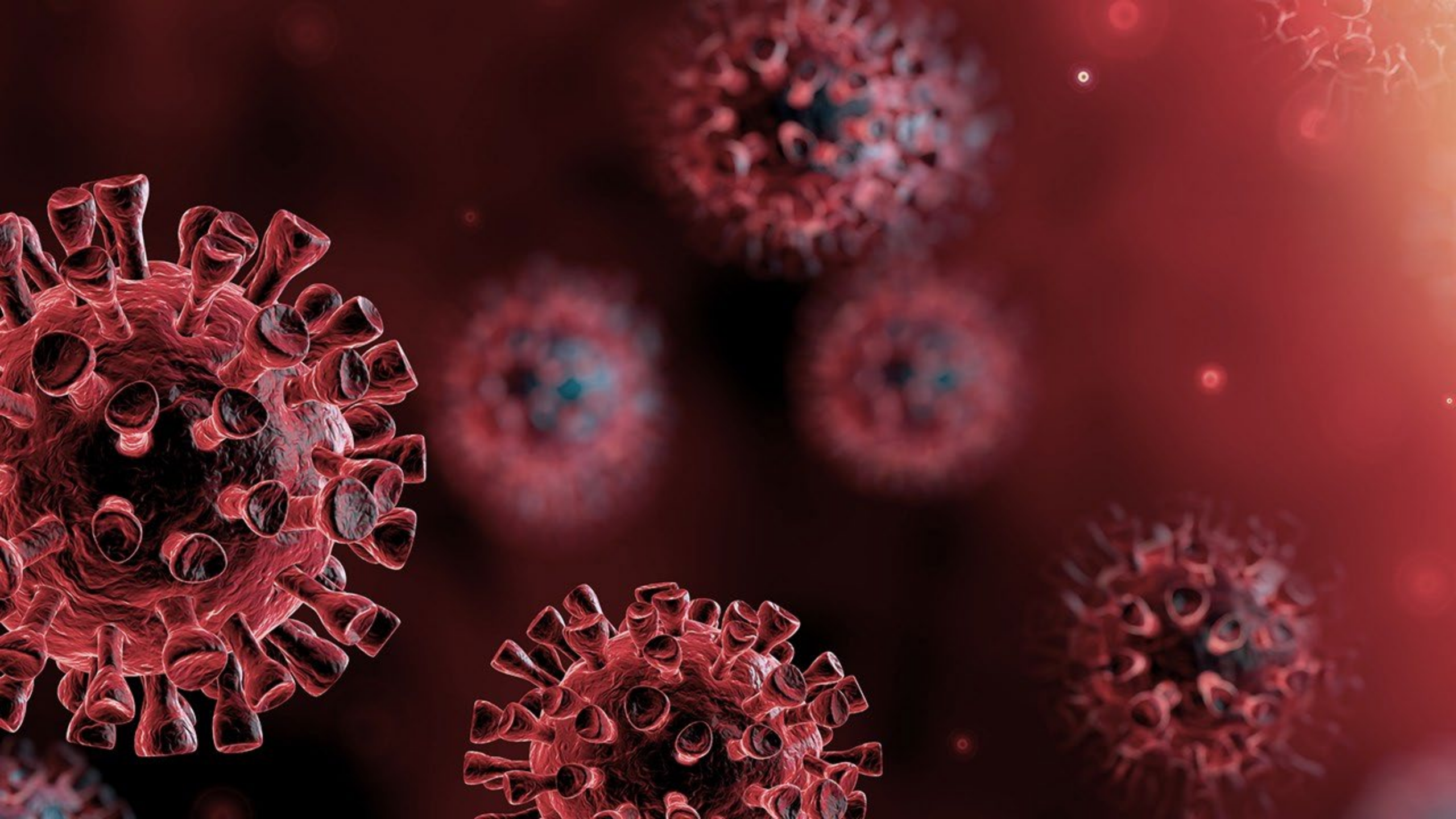
DOI: 10.1177/2333721418777659
journals.sagepub.com/home/ggm
SAGE

Aldis H. Petriceks, BA[1], John C. Olivas, BS[1], and Sakti Srivastava, MBBS, MS[1]

There are fewer Geriatrics positions in 2017-2018 than there were in 2001-2002, a population-adjusted decline of 23.3%.



US life expectancy drops a year in pandemic, most since WWII

A new report finds that life expectancy in the United States dropped a staggering one year during the first half of 2020 as the coronavirus pandemic caused its first wave of deaths

By **MARILYNN MARCHIONE AP Chief Medical Writer**

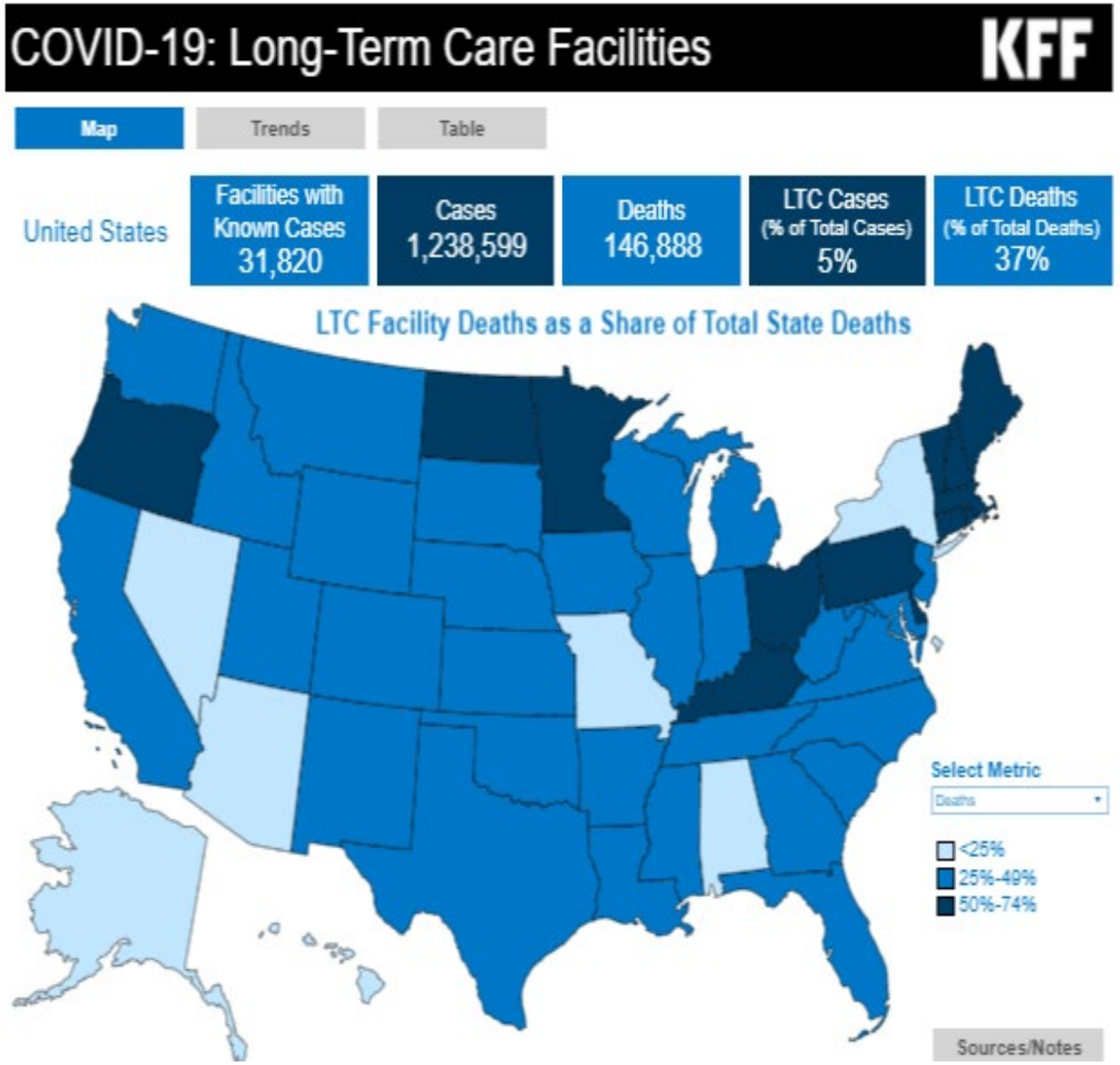
February 18, 2021, 6:58 AM ET • 4 min read

A Grim Measure of Covid's Toll: Life Expectancy Drops Sharply in U.S.

American life expectancy fell by one year, to 77.8 years, in the first half of 2020. It may rebound as the pandemic's end approaches.

Yet, represent less than 1% of the US population.

Metrics in Long-term Care Facilities



Three states: LTC COVID-19 deaths account for over 70% of COVID-19 deaths in the state (NH, RI, and CT).

18 states: Over half of all COVID-19 deaths occurred in LTC.

Industry is ripe for disruption

Establish Trust:
Prepared to respond to emergencies

Develop Staff:
Purpose-driven, caring, and passionate

Provide Technology:
Increase connections, aid efficiency, and optimize health

Independent Nursing Home COVID-19 Commission

Sep 16, 2020

Commission provided 27 recommendations:

- improve infection prevention & control
- safety procedures
- quality of life

Guidance to owners and administrators

Obtain data that is more meaningful for action and research

Train, support, protect, and respect **direct-care providers**

Transparent and accessible communications with residents, their representatives and loved ones, and the public

The Washington Post

Democracy Dies in Darkness

As covid-19 cases surge, global study paints grim picture for elder-care homes

By **Adam Taylor**

Oct. 16, 2020 at 11:58 a.m. EDT

"Elder-care facilities may see significant changes — and not just in the short term. The International Long-Term Care Policy Network predicts higher costs and lower demand for elder-care services may not be a blip but could last for 'many years to come.'"

Overview

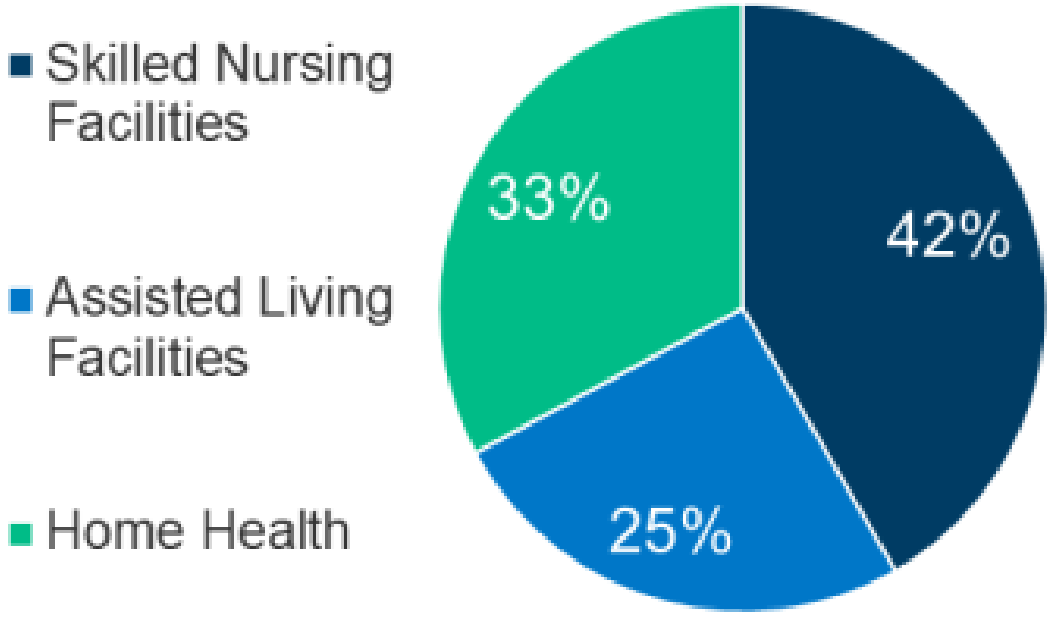
I. An industry ripe for disruption

II. Quality and safety in long-term care facilities

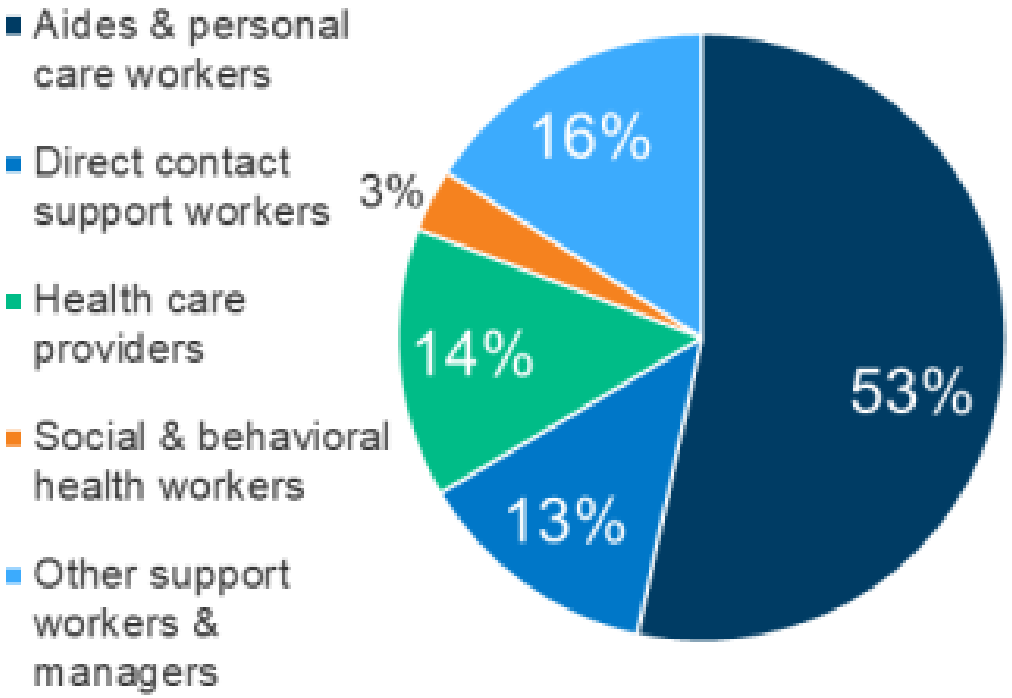
III. Pandemic-resilient long-term care system
Designed to age with dignity

Of the Nation's 4.5 Million Long-Term Care Workers, Two-Thirds Work in Facility Settings and Half are Aides and Personal Care Workers

Type of Long-Term Care Setting



Type of Long-Term Care Worker

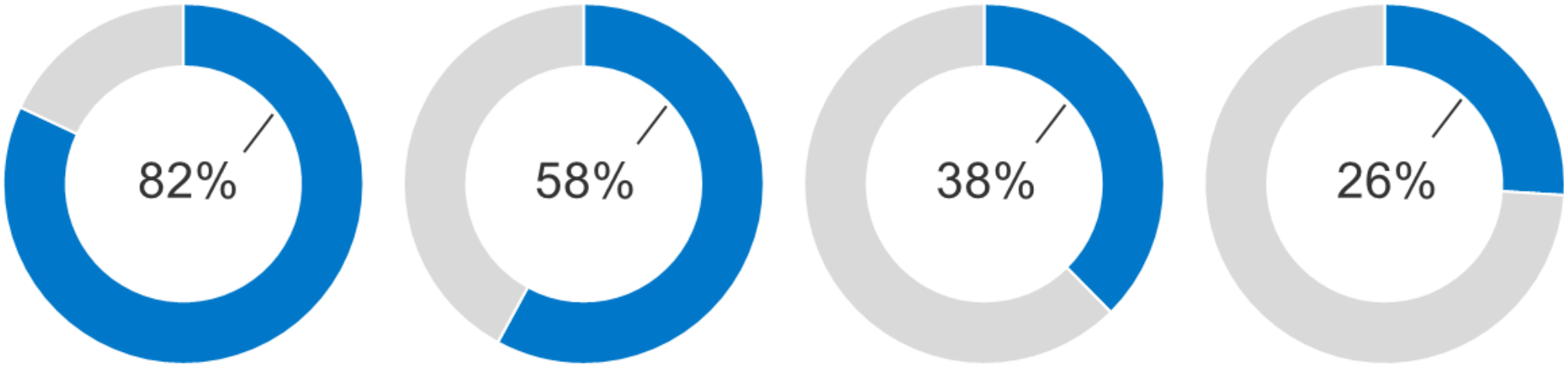


Long-Term Care Workforce in 2018 = 4.5 million

SOURCE: KFF analysis of American Community Survey, 2018.

KFF
HENRY J KAISER FAMILY FOUNDATION

The Long-Term Care Workforce is Predominantly Female and Low Wage; Nearly 4 in 10 are Age 50+ and 1 in 4 are Black



Women

Annual wages less than $30,000

Age 50+

Black non-Hispanic

Long-Term Care Workforce in 2018 = 4.5 million

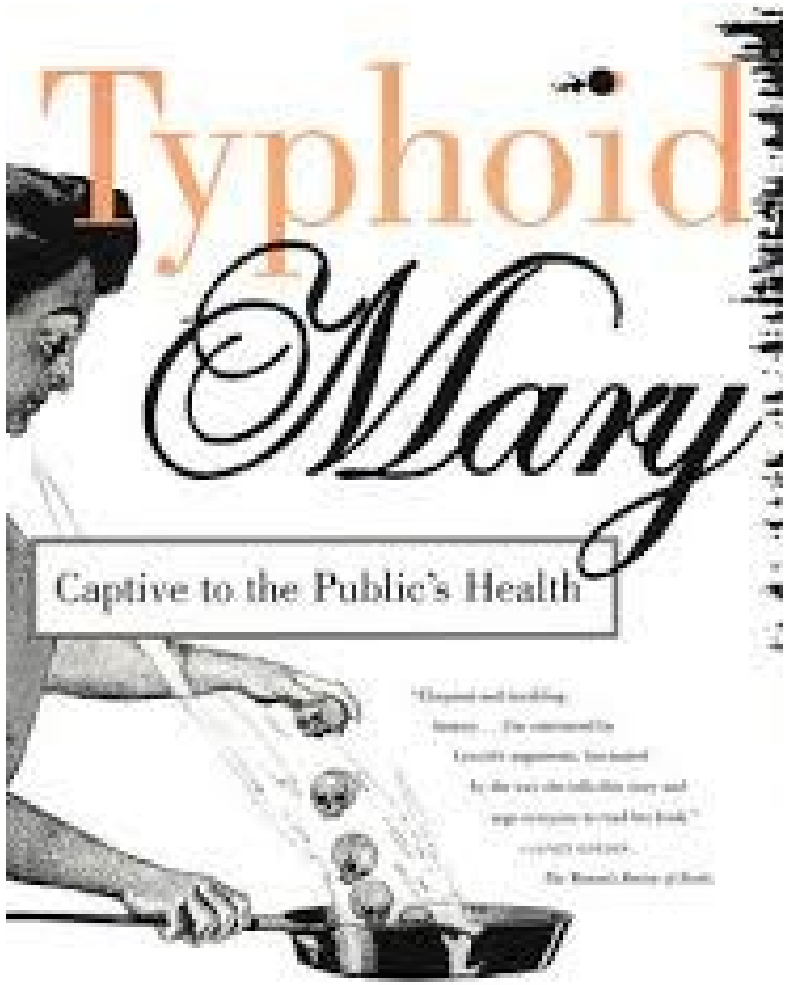
SOURCE: KFF analysis of American Community Survey, 2018.

KFF
HENRY J KAISER FAMILY FOUNDATION

At least 20% of aides work in more than one LTCF

NJ Health Commissioner rejected the suggestion to limit where certified nursing aides may work.

*"There's a reason why they're working in several places. It's because the **wages are not enough** to support what they need to support their families, put food on the table, and they're **working their little hearts to the bone here, just trying to survive**."*



Latina woman in Fairfax County, Virginia.

"We have to go out to work," she said. "We have to pay our rent. We have to pay our utilities. ***We just have to keep working*****."**

New York Times, July 5, 2020

We are repeating the pattern of punitive disease control:

The focus is on **protection against individuals** who threaten the public's health, rather than the **conditions** workers find themselves forced to endure.

“Superspreaders”

Nursing home staff networks and COVID-19

M. Keith Chen[a,1,2], Judith A. Chevalier[b,c,1], and Elisa F. Long[a,1]

[a]Anderson School of Management, University of California, Los Angeles, CA 90095; [b]Yale School of Management, Yale University, New Haven, CT 06511; and [c]National Bureau of Economic Research, Cambridge, MA 02138

Edited by Jose A. Scheinkman, Columbia University, New York, NY, and approved November 17, 2020 (received for review July 21, 2020)

PNAS 2021 Vol. 118 No. 1

estimated 49% of nursing home cases attributable to cross-facility staff movement, attention to highly connected nursing facilities is warranted.

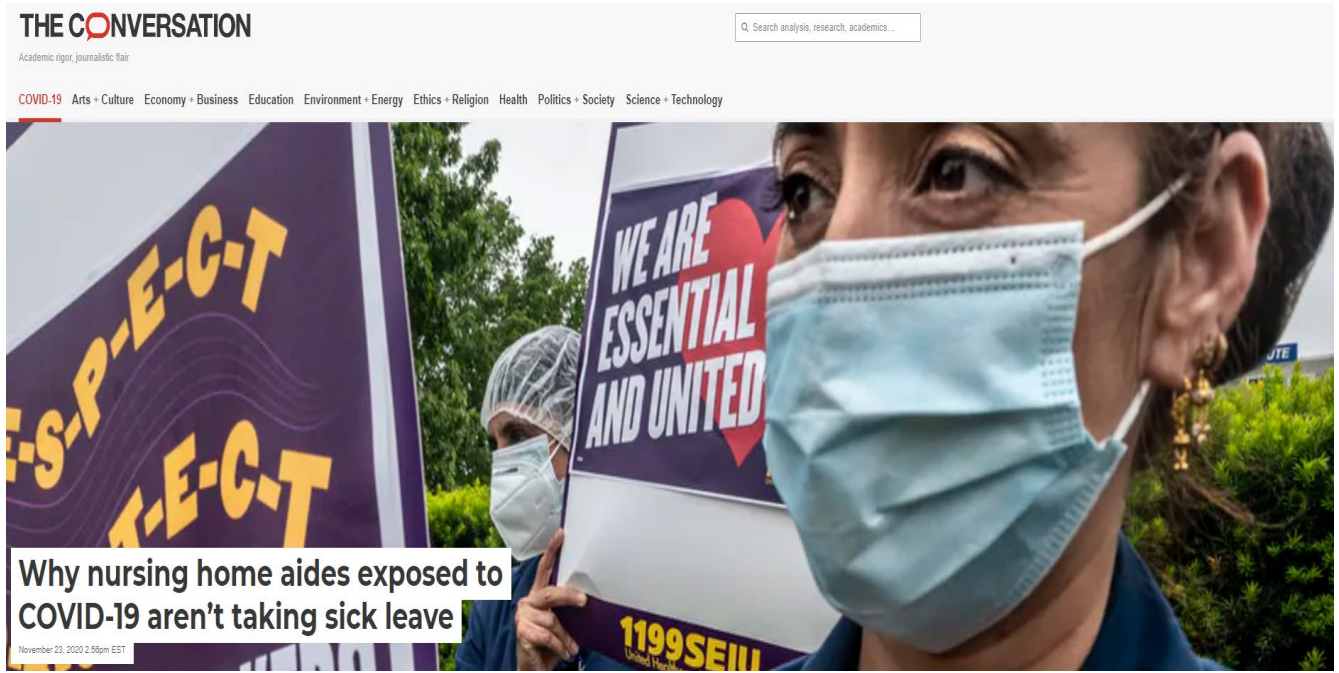
Forthcoming in the Spring 2021 Special Issue of the Journal of Elder Policy
"Protecting Adults During a Pandemic: Challenges and Opportunities for Societies"

The Return of Typhoid Mary? Immigrant Workers in Nursing Homes

Shefali Milczarek-Desai* and Tara Sklar**

The University of Arizona, James E. Rogers College of Law

reviews



The conditions that led to the LTC outbreaks

Presenteeism: When staff who work in multiple facilities and continue to work even after being exposed to or falling ill from COVID-19.

Presenteeism occurred despite the first "universal" paid sick leave federal law Families First Coronavirus Response Act (FFCRA), required 14-days paid sick leave for COVID-19 related reasons.

Plus, there are over 40 state and local paid sick leave laws across the country, but…

- Awareness
- Eligibility
- Fear of retaliation
- Fear of deportation

How to make paid sick leave laws work as intended?

- Need enforcement and resources to conduct investigations
- Local education outreach to immigrant communities, such as "know your rights" campaigns

The reaction

New York passed: [Emergency or Disaster Treatment Protection Act of 2020]

New York Experience:
Saving hospitals with nursing homes

"No resident shall be denied re-admission or admission to a nursing home solely based on a confirmed or suspected diagnosis of COVID-19."

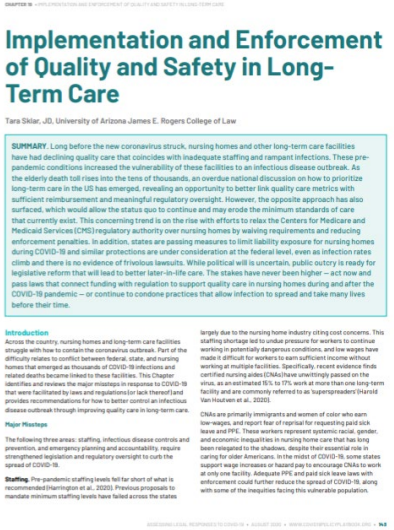
(Executive Order issued 3.10.20 and rescinded 5.10.20)

Governor Cuomo insisted that it's "**not our job**" to ensure that the nursing homes had adequate PPE."

6,326 hospital patients were admitted to 310 nursing homes

The peak single day in resident COVID-19 deaths was April 8:

- 4,000 deaths followed after that date



Implementation and Enforcement of Quality and Safety in Long-Term Care

Tara Sklar, JD, University of Arizona James E. Rogers College of Law

SUMMARY. Long before the new coronavirus struck, nursing homes and other long-term care facilities have had declining quality care that coincides with inadequate staffing and rampant infections. These pre-pandemic conditions increased the vulnerability of these facilities to an infectious disease outbreak. As the elderly death toll rises into the tens of thousands, an overdue national discussion on how to prioritize long-term care in the US has emerged, revealing an opportunity to better link quality care metrics with sufficient reimbursement and meaningful regulatory oversight. However, the opposite approach has also surfaced, which would allow the status quo to continue and may erode the minimum standards of care that currently exist. This concerning trend is on the rise with efforts to relax the Centers for Medicare and Medicaid Services (CMS) regulatory authority over nursing homes by waiving requirements and reducing enforcement penalties. In addition, states are passing measures to limit liability exposure for nursing homes during COVID-19 and similar protections are under consideration at the federal level, even as infection rates climb and there is no evidence of frivolous lawsuits. While political will is uncertain, public outcry is ready for legislative reform that will lead to better later-in-life care. The stakes have never been higher – act now and pass laws that connect funding with regulation to support quality care in nursing homes during and after the COVID-19 pandemic – or continue to condone practices that allow infection to spread and take many lives before their time.

Introduction

Across the country, nursing homes and long-term care facilities struggle with how to contain the coronavirus outbreak. Part of the difficulty relates to conflict between federal, state, and nursing homes that emerged as thousands of COVID-19 infections and related deaths became linked to these facilities. This Chapter identifies and reviews the major missteps in response to COVID-19 that were facilitated by laws and regulations (or lack thereof) and provides recommendations for how to better control an infectious disease outbreak through improving quality care in long-term care.

Major Missteps

The following three areas: staffing, infectious disease controls and prevention, and emergency planning and accountability, require strengthened legislation and regulatory oversight to curb the spread of COVID-19.

Staffing. Pre-pandemic staffing levels fell far short of what is recommended (Harrington et al., 2020). Previous proposals to mandate minimum staffing levels have failed across the states largely due to the nursing home industry citing cost concerns. This staffing shortage led to undue pressure for workers to continue working in potentially dangerous conditions, and low wages have made it difficult for workers to earn sufficient income without working at multiple facilities. Specifically, recent evidence finds certified nursing aides (CNAs) have unwittingly passed on the virus, as an estimated 11% to 17% work at more than one long-term facility and are commonly referred to as 'superspreaders' (Harold Van Houtven et al., 2020).

CNAs are primarily immigrants and women of color who earn low-wages, and report fear of reprisal for requesting paid sick leave and PPE. These workers represent systemic racial, gender, and economic inequalities in nursing home care that has long been relegated to the shadows, despite their essential role in caring for older Americans. In the midst of COVID-19, some states support wage increases or hazard pay to encourage CNAs to work at only one facility. Adequate PPE and paid sick leave laws with enforcement could further reduce the spread of COVID-19, along with some of the inequities facing this vulnerable population.

COVID-19 and Nursing Homes in New York

Nursing Home Investigation Report by State AG Letitia James, January 2021.

Department of Health undercounted LTC COVID-19 deaths by 50%

Widespread non-compliance with infection control protocols and low staffing levels

Failure by nursing homes to comply with requirements relating to communication with family members caused unnecessary distress

→ Recommend enactment of mandated adequate staffing ratios, along with better staff training and resources around infection control protocols

Lack of coordination between health care settings, and the long-term care industry.

Nearly 5,900 LTC COVID-19 deaths in Indiana, excluded as much as 22% of long-term care deaths.

Inadequate staffing, due in part to the **shifting** of nursing home funds to the county hospitals.

In 2019: Indiana received more supplemental Medicaid funding for nursing homes than any other state ($679 million), but ranks 48th in the country for staffing. 70% of those funds were redirected away from nursing homes.

Indiana's LTC residents represent 1.5% of the state's population but approximately 50% of COVID-19 deaths.

FOR IMMEDIATE RELEASE
May 22, 2020

Contact: HHS Press Office
202-690-6343
media@hhs.gov

HHS Announces Nearly $4.9 Billion Distribution to Nursing Facilities Impacted by COVID-19

Today, the U.S. Department of Health and Human Services (HHS) is announcing it has begun distributing billions in additional relief funds to skilled nursing facilities (SNFs) to help them combat the devastating effects of this pandemic. Nursing homes play a pivotal role in providing skilled care to our nation's vulnerable seniors. During this pandemic, nursing homes have faced unique challenges as their population of high risk seniors are more vulnerable to respiratory pathogens like COVID-19. This funding, which supplements previously announced provider relief funds, will be used to support nursing homes suffering from significant expenses or lost revenue attributable to COVID-19.

Distribution Methodology

Each SNF will receive a fixed distribution of $50,000, plus a distribution of **$2,500 per bed.** All certified SNFs with six or more certified beds are eligible for this targeted distribution.

Even if the New York Attorney General and other advocacy groups got everything they wanted to improve quality and safety in long-term care…

would it be enough to build a pandemic-resilient long-term care system?

Measures That Could Be Effective

1. Promote staff entry and retention in the sector by improving the conditions of work
2. Prevent LTC worker infection with community tailored approaches
3. Further decrowd homes by continuing limits on occupancy and securing temporary housing
4. Detect LTC worker infection and prevent importation into LTC homes by prioritizing workers for testing and turnaround time, and by guaranteeing workers paid sick leave
5. Continue enhancing IPAC by securing one specialist per 200 beds in LTC homes
6. Pursue a more balanced and nuanced approach to public health measures and infection prevention in LTC homes
7. Implement strategies to expedite administration and improve vaccine acceptance in the LTC sector
8. Continue optimizing data on LTC homes for the duration of the COVID-19 pandemic

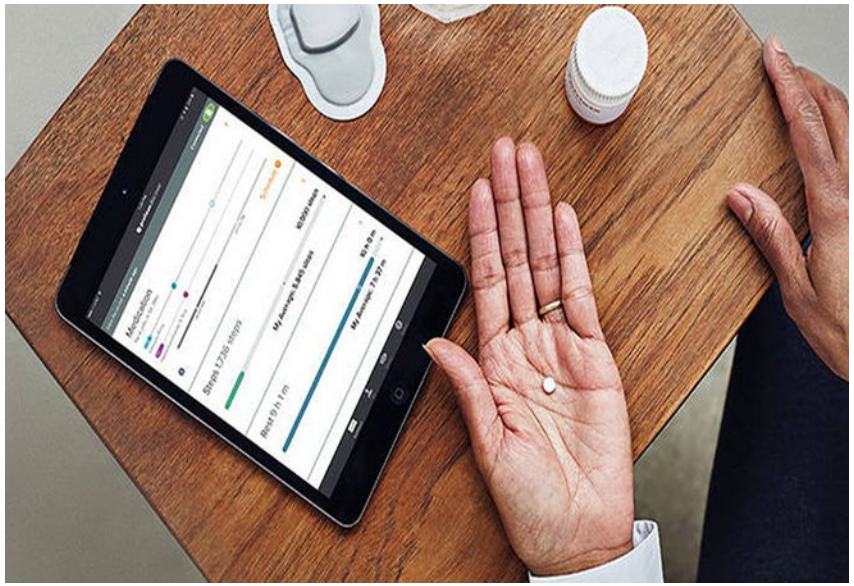
Higher wages, paid sick leave laws, adequate staff ratios, funding, and regulatory oversight

Imagine 20-40 years in the future…

Long-term care as the frontier of data-driven healthcare

Rise of telehealth

Adoption of digital health technologies into the home-space



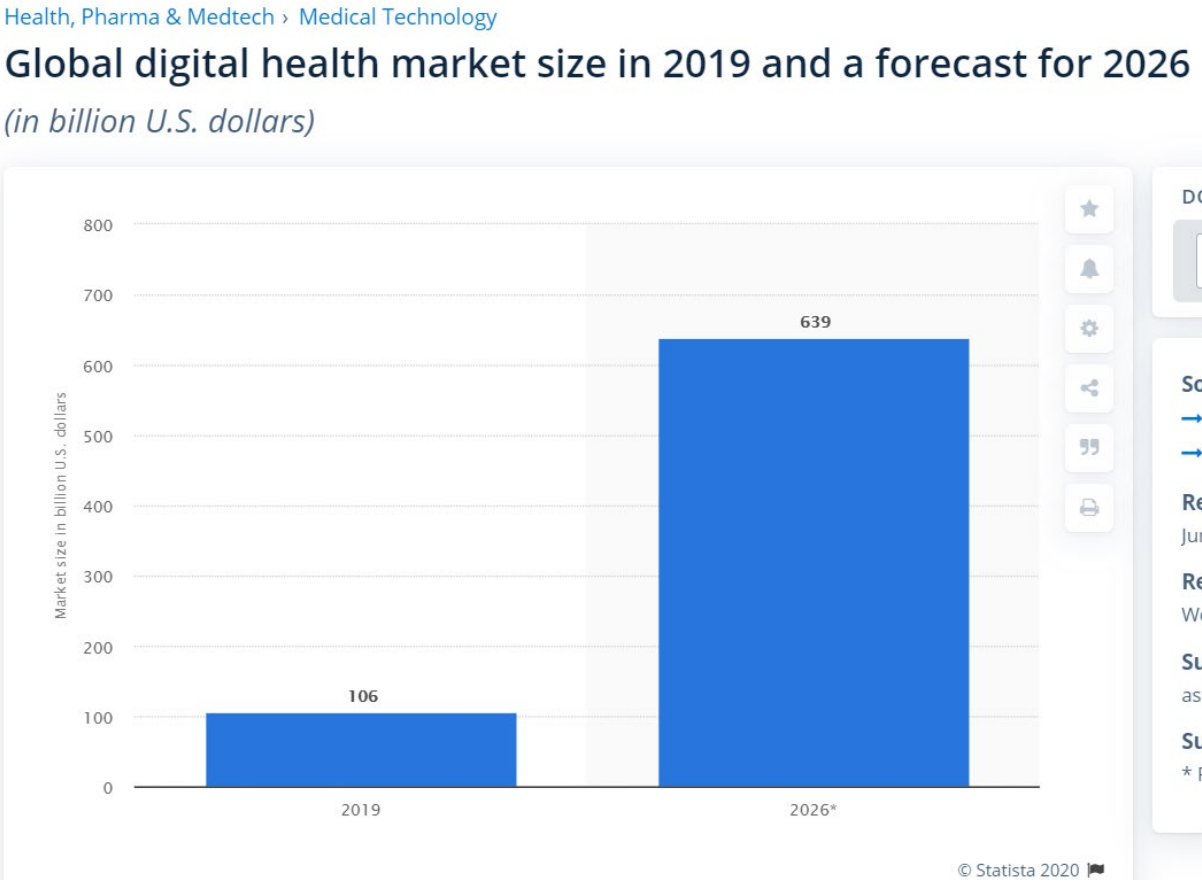
Magnifies a broader concern, which is: can a data-driven system, which prioritizes 'efficiency', adapt to the special needs of a vulnerable population in a fair and equitable way?


POLL

Promises and growth

Promises

- Prolong independent living
- Improve quality and safety, while saving costs
- Reach more patients
- Reduce inconvenience
- Increase social distance



University of Michigan National Poll on Healthy Aging (October 3, 2019)

Over half of older adults reported willing to have a telehealth visit last year, but **only 4%** had one.

Reasons for reluctance:

Lack of awareness

Not feel connected to provider

Worried about “seeing or hearing” the doctor

Privacy (mixed)

"Fifty percent of patients leave office visits not understanding what the physician has told them."

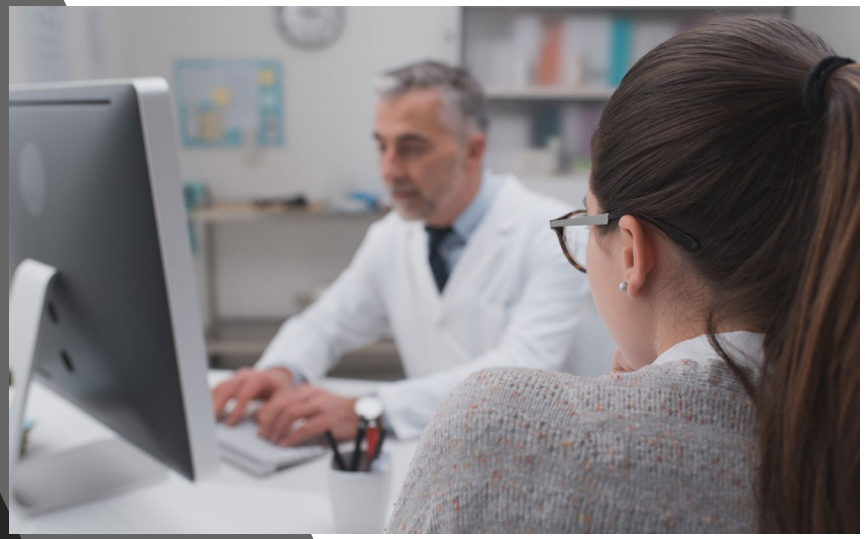
The NEW ENGLAND JOURNAL of MEDICINE

Perspective

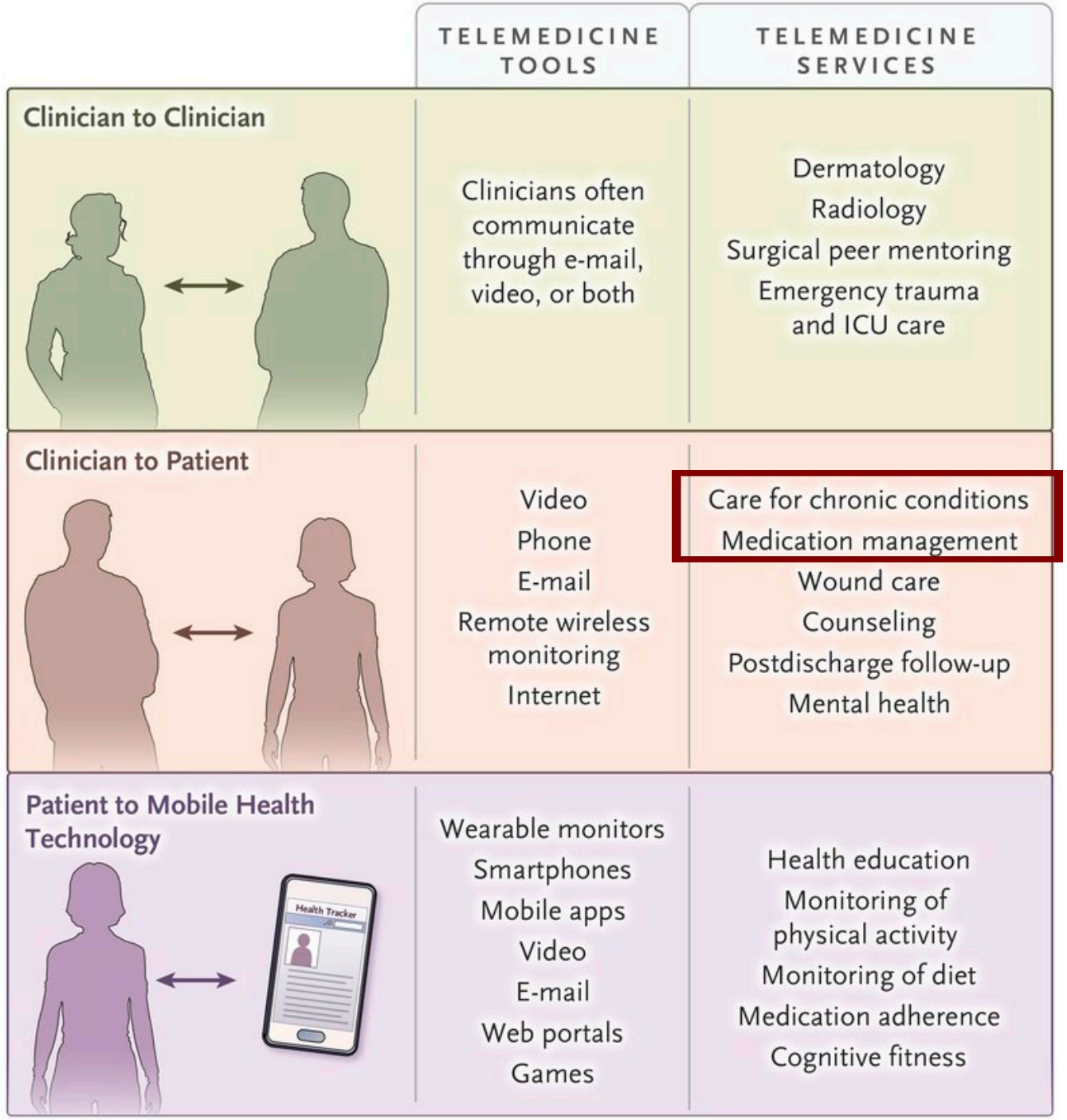
THE FUTURE OF PRIMARY CARE

Transforming Practice

Thomas Bodenheimer, M.D.



Examples of how digital health and telemedicine connect



N Engl J Med 2017; 377:1585-1592
DOI: 10.1056/NEJMsr1503323

Store and Forward

Patient provides information

Provider reviews & recommends

Telehealth & COVID-19

Prior to Public Health Emergency Declaration:

Reimbursement for telehealth services was limited to certain services and by location restrictions.

March 30, 2020:
CMS encourages physicians to provide telehealth services instead of in-person care.

AARP®

Getting Your Telehealth Appointments Covered by Medicare

Wondering if your insurance will cover a virtual visit? Here's what you need to know

by Deborah Pike Olsen, **AARP (https://www.aarp.org)** August 31, 2020 Comments: 0

Over 10.1 million Medicare beneficiaries have received telehealth during COVID

CMS expanded reimbursement to include 135 additional health services, including home visits, and physical, occupational and speech therapy.

CMS has proposed covering new services on a permanent basis.

"*Telemedicine has proven to be a boon for patients and physicians*."

- CMS Administrator Seema Verma

February 2021

California Department of Health Care Services recommends expanded telemedicine services should remain permanent once the public health emergency is lifted.

“access to quality health care services and helping to ensure equity in availability of modalities across the delivery systems”

Epidemic of immobility

"I feel like I'm in jail" claimed a 67-year old woman. *I can't sit up or go to the bathroom without them coming after me."*

- Melissa Bailey, Kaiser Health News

Older adults report feeling trapped, chained to their chairs and beds for hours on end by themselves.

When a Push Becomes a Shove: Nudging in Elderly Care

Tal Shachar, Harry Radzyner Law School Interdisciplinary Center, Herzliya (IDC) and The Zvi Meitar Institute for Legal Implications of Emerging Technologies, and
Dov Greenbaum, Harry Radzyner Law School Interdisciplinary Center, Herzliya (IDC), The Zvi Meitar Institute for Legal Implications of Emerging Technologies, and Yale University

While science and medicine continually push the limits of the human life span, there has been less success in overcoming some of the worst ailments of old age, particularly various forms of dementia. Thus, for example, while the incidence of other chronic diseases has fallen substantially since 2000, the incidence of Alzheimer's has increased more than 100%, and nearly one-third of all seniors now die with some form of dementia (Alzheimer's Association 2018).

A rapidly aging population presents many problems for modern societies, and as Pharma seeks long-term cures, technology can sometimes help deal with the immediate and debilitating symptoms associated with dementia. Such technologies include tracking devices, home care robots, communication devices, and increasingly sensitive sensors to monitor the well-being of the elderly, many of whom may no longer be capable of looking after themselves.

Like many areas of health care, some of the symptoms can also be ameliorated via nudging. While Engelen (2019) discusses some ethical implications generally associated with nudging in healthcare, the number of case studies he discusses is limited, and these studies do not include the promising area of nudging in geriatric care.

In examining the use of nudging in this area, we found that there are a growing number of both hi- and low- tech solutions already employed and designed to nudge elder patients to do what is best for them. Our concern is to make sure that they are ethical.

Nudges are most often simply changes in a person's environment, particularly in the presentation of multiple options—the choice architecture, in the lingo of behavioral economists—that attempt to induce desired outcomes without otherwise coercing the individual or introducing excessive incentives (Thaler and Sunstein 2008). Nudges exploit our predictable heuristics, our irrationality, biases, inertia, or even our inattention (Sunstein 2016). In some cases, they are simply warnings or information labels. In retail, it is often the location of a particular good, and in government policy, nudging frequently occurs in a citizen's decision-making process wherein the provided default answer is the desired answer.

No matter what the methodology, however, nudging can be an optimal tool for dealing with dementia, a condition that is often associated with neuropsychiatric symptoms such as anxiety and aggression (Seitz 2016), where formerly independent individuals are often reduced to being unable to care for themselves or their loved ones, devastating their sense of dignity and autonomy. Helping the elderly achieve their goals without overtly forcing them to do so, while endeavoring to maintain their dignity and autonomy (or, arguably, at least the perception thereof), would seem to be an ideal path in this area of care.

In the case of the elderly, a simple nudge could include an otherwise unsophisticated automated reminder to call loved ones or to take medication. Smartphones, smart watches, and even clocks can be employed to gently remind an elderly patient of what they planned to do. Two noteworthy technologies, MedCenter devices (Knighton et al. 2018) and MedMinder (Shavelsky et al. 2012), are a bit more technologically advanced nudging tools with a similar purpose. They provide audio messages or reminder phone calls to the patient and/or their loved ones to prompt them to do important and essential or even

Address correspondence to Dov Greenbaum. Department of Molecular Biophysics and Biochemistry, Yale University, New Haven, CT, USA E-mail: dov.greenbaum@yale.edu

A checklist to determine whose best interest the sensor is meeting:

- ❑ Autonomy
- ❑ Dignity
- ❑ Welfare
- ❑ Informed Consent
- ❑ Coercion
- ❑ Manipulation
- ❑ Ulterior Motivation
- ❑ Infantilizing

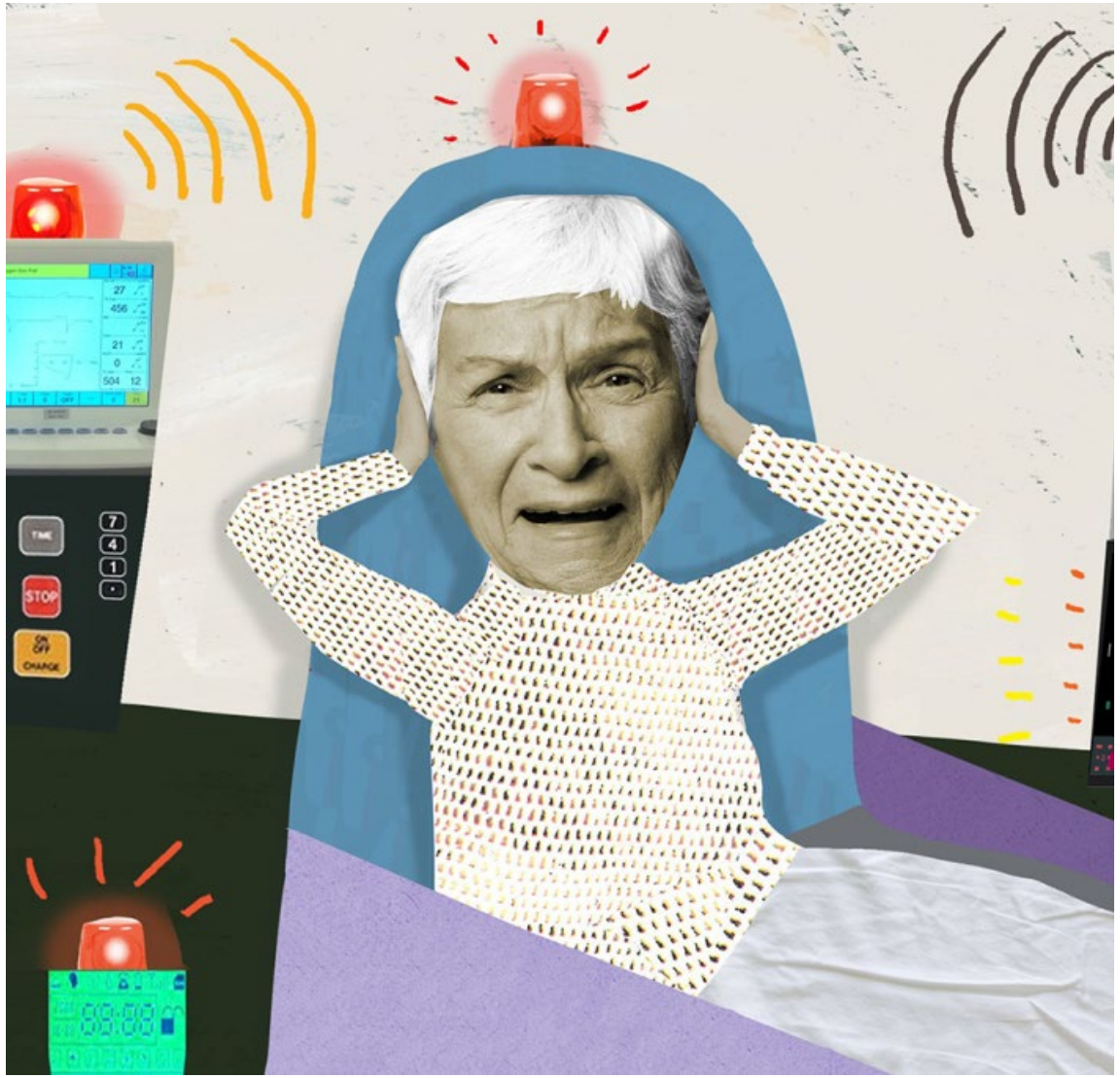
Hype and risks

Immobilize vs improve health outcomes

Lack of standards around privacy, security, usability, and clinical validity

Risk reduced autonomy & greater neglect; Heightened isolation & helplessness

Reflect values & preferences of older adults



INDIANA HEALTH LAW REVIEW
ROBERT H. MCKINNEY
School of Law

DIGITAL HEALTH PRIVACY AND AGE: QUALITY AND SAFETY IMPROVEMENT IN LONG-TERM-CARE

RACHEL ZURAW*
TARA SKLAR**

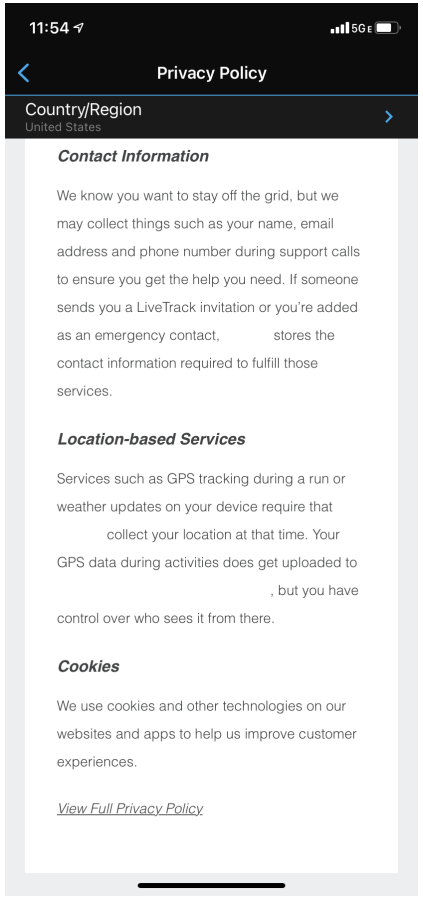
TABLE OF CONTENTS

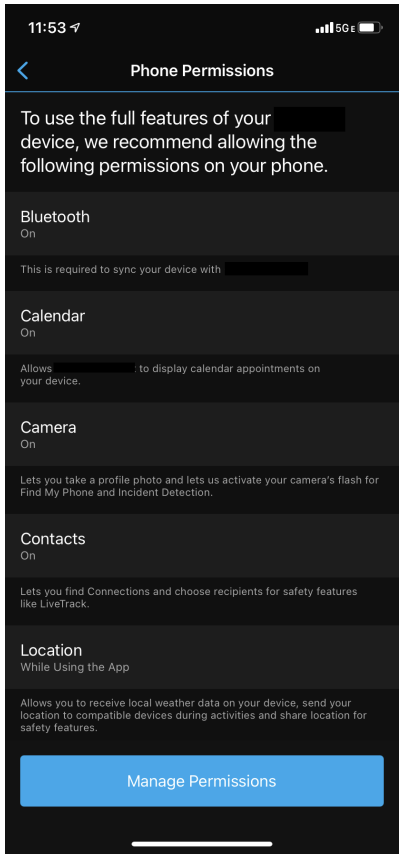
INTRODUCTION

"*With enormous governmental expenditures for community-based, long-term care taxpayers and their representatives will demand quality as the ever-growing number of consumers of these services.*"[1]

Professor Eleanor Kinney pioneered an area of research in community-based, long-term care that is at a critical point today: the standardization of services to

"*With enormous governmental expenditures for community-based, long-term care taxpayers and their representatives will demand quality as the ever-growing number of consumers of these services.*"[1]





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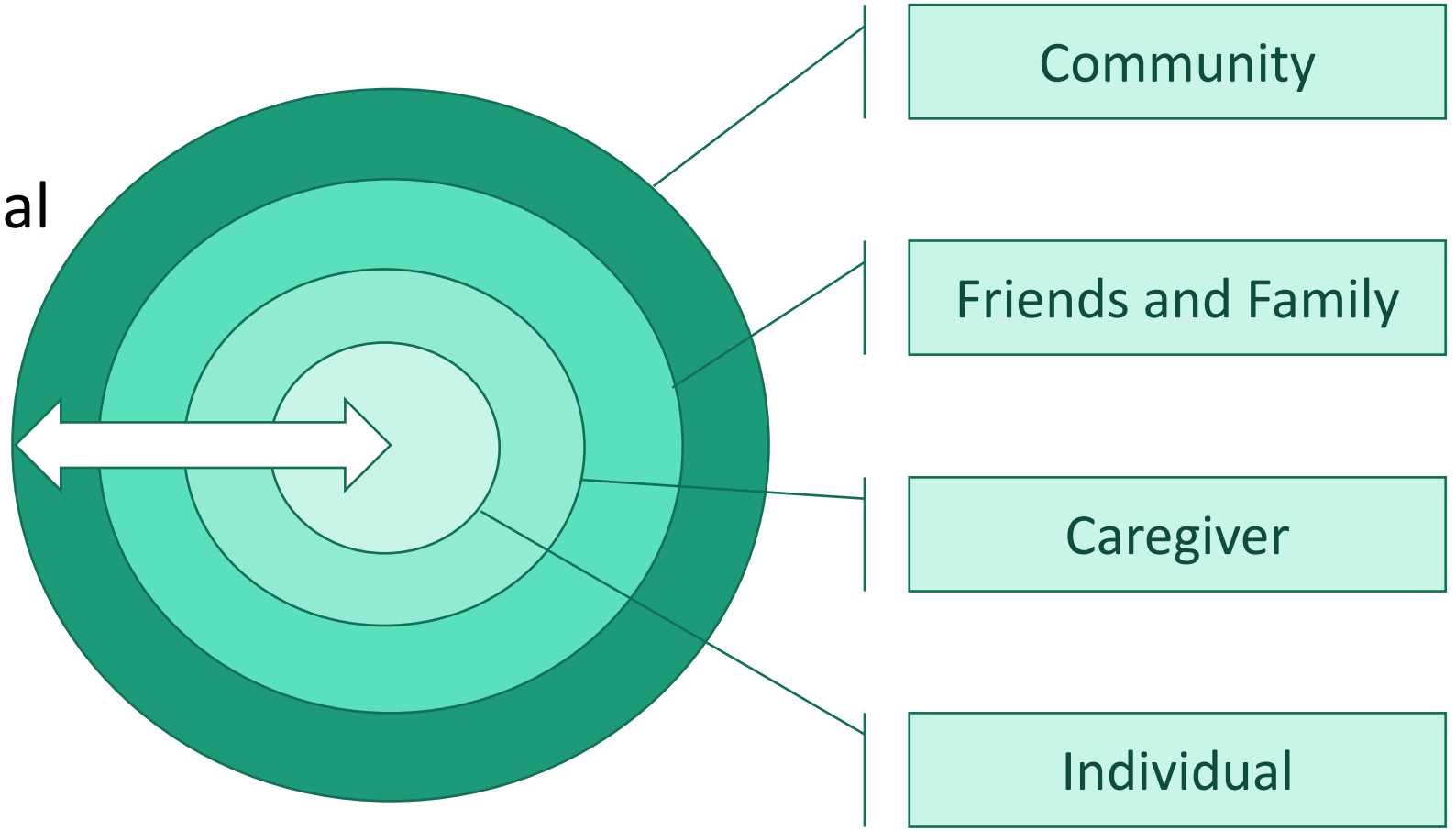
Informed Consent in the Digital Era

- Click through nature
- High physical, cognitive, health and digital literacy barriers
- Hidden texts
- Exacerbation of inequities in access, autonomy and ability

Relational Consent

- Diverges from Traditional Individual Autonomy
- Moves closer to shared decision-making
- Delivers usable product
- Applies broadly



Sensor data (digital health) and privacy

Protecting Personal Health Data Act
(introduced bipartisan S.1842 in June 2019)

1. Personal data can only be collected for a **specific purpose**.
2. The person must be **informed of and consent** to the purpose for which their data is collected.
3. Only as much **data as is necessary** to achieve that purpose should be collected.
4. The collected data **must be deleted** at the request of the participant, or when it is no longer needed for the purpose which it was collected.

Health Justice

A framework based on **equity** principles

"All humans to flourish"

The same chance to be free from hazards, and attain health potential, to fully participate in society at **any age.**

Requires the development of laws and policies that prevent health inequity and increase individual capability.

Overview

I. An industry ripe for disruption

II. Quality and safety in long-term care facilities

III. Pandemic-resilient long-term care system
Designed to age with dignity

COVID-19:
Epidemic of the invisible and the forgotten…

Building a pandemic-resilient long-term care system
Designed to age with dignity

Need a national strategy that includes care for the caregivers

NEJM

POINTS OF VIEW

Caring for the Caregivers — Covid-19 Vaccination for Essential Members of the Health Care Team

Meghan C. Halley, Ph.D., M.P.H., and Christina Mangurian, M.D., M.A.S.

Article Metrics

February 12, 2021
DOI: 10.1056/NEJMpv2101339

The New York Times

Opinion

50 Million Americans Are Unpaid Caregivers. We Need Help.

Biden must make good on his promise to support families with sick loved ones.

By Kate Washington
Ms. Washington is the author of a forthcoming book on caregiving. A dining critic at The Sacramento Bee, she has cared for her husband for six years through his treatment for lymphoma, a stem-cell transplant and chronic illness.

Feb. 22, 2021

The Vatican wants the world to rethink how it cares for the elderly after Covid-19 ‘massacre’

Nicole Winfield - Associated Press

February 09, 2021

> "It is therefore very appropriate to begin immediately a careful, far-sighted, and honest reflection about how contemporary society should grow close to the elderly population, especially the weakest,"

The Nun Study

Researchers followed 678 nuns over the age of 75 for 20 years, then conducted autopsies on their brains after death.

Despite plaques and brain shrinkage – signs of unquestionable Alzheimer's – nuns showed no signs of having the disease while they were alive.

Findings: High level of cognitive reserve may prevent onset of Alzheimer’s.

- More years of formal education
- Engage regularly in mentally stimulating activities
- Abundance of neural connections

The 10 Age-Friendly University Principles

1. To encourage the participation of older adults in all the core activities of the university, including educational and research programs.

2. To promote personal and career development in the second half of life and to support those who wish to pursue second careers.

3. To recognize the range of educational needs of older adults (from those who were early school-leavers through to those who wish to pursue Master's or PhD qualifications).

4. To promote intergenerational learning to facilitate the reciprocal sharing of expertise between learners of all ages.

5. To widen access to online educational opportunities for older adults to ensure a diversity of routes to participation.

The 10 Age-Friendly University Principles

6. To ensure that the university's research agenda is informed by the needs of an aging society and to promote public discourse on how higher education can better respond to the varied interests and needs of older adults.

7. To increase the understanding of students of the longevity dividend and the increasing complexity and richness that aging brings to our society.

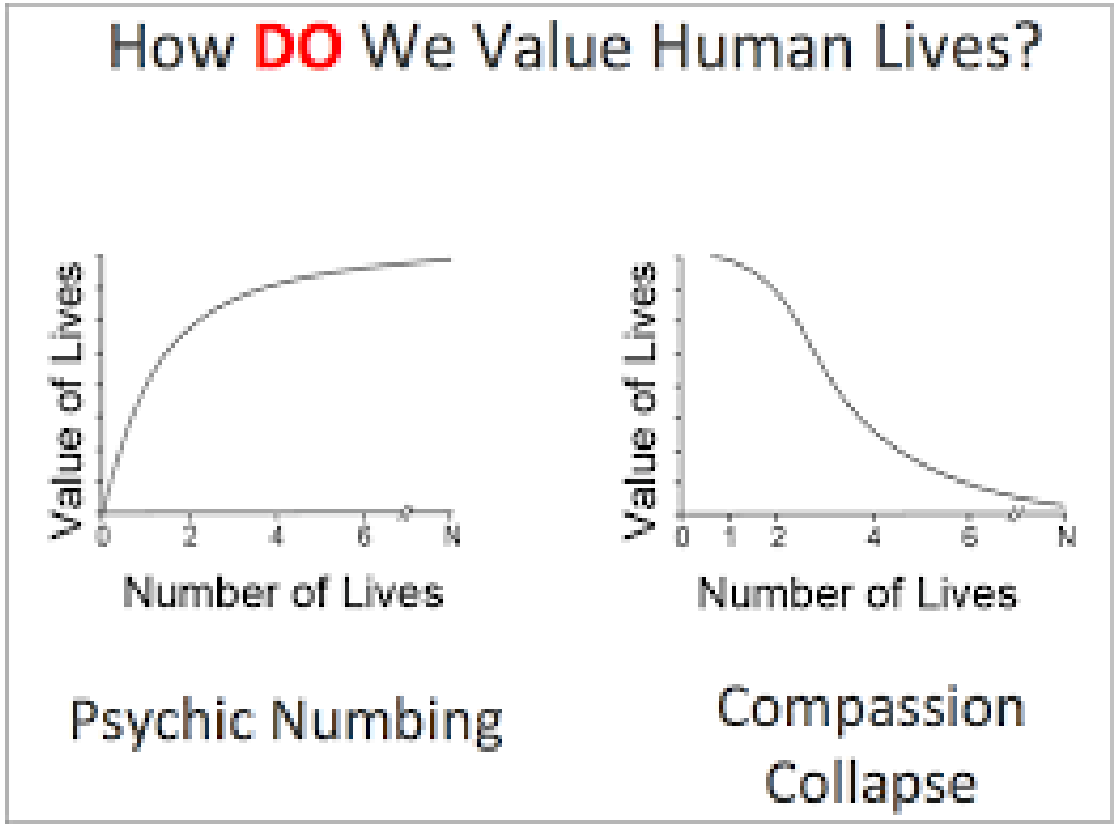
8. To enhance access for older adults to the university's range of health and wellness programs and its arts and cultural activities.

9. To engage actively with the university's own retired community.

10. To ensure regular dialogue with organizations representing the interests of the aging population.

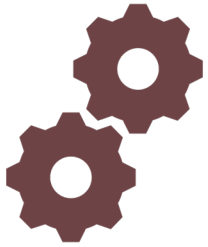

POLL

Psychic numbing and an inflection point



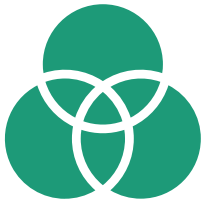
"Even partial solutions can save lives."

- Paul Slovic



Industry is ready for a disruption

Quality and safety
in all long-term care settings



Technology advances align with
access, participation, and privacy

Lifelong engagement

Aging with dignity and independence

The ability the live life to its fullest

In the place you call home

Regardless of age, illness, or disability

THE UNIVERSITY OF ARIZONA
JAMES E. ROGERS COLLEGE OF LAW
Health Law

Thank you

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