

Maryland Commission on Aging
North Laurel Community Center, 9411 Whiskey Bottom Road, Laurel Maryland
May 29, 2019
Minutes

Members Present

Rose Maria Li, Chair
Marianne Hyang Nam Brackney
Hon. Jordan Harding
Joy Hatchette
Hon. Benjamin Kramer
Jay Magaziner
Dot Principe
George Rebok
Carmel Roques
David Roth
Hon. Kathy Szeglia

Members Absent

John Haaga
Mary Ellen Thomsen

Staff

Rona E. Kramer, Secretary of the Maryland Department of Aging (MDoA)
Rosanne B. Hanratty, Staff to Commission

Guests

Nai Ching Chen, Administrator, mdlogix
Ranada Cooper, Program Manager, Long Term Care Unit, Office of Health Care Quality (OHCQ),
Maryland Department of Health (MDH)
Carol Fenderson, Deputy Director of State Programs, OHCQ, MDH
Luisa Franzini, University of Maryland School of Public Health
Jeff Gross, Chief Enforcement Officer, Compliance and Enforcement Unit, Maryland Insurance
Administration (MIA)
Catherine Hill, Executive Director, Women's Legislative Caucus
Hon. Trent Kittleman, Maryland House of Delegates
Caryn Lasser, Deputy Secretary, MDoA
Wesley Queen, University of Maryland School of Public Health
Allen Tien, , Clinical Associate Professor, Behavioral Health Medicine and Psychiatry, West
Virginia University School of Medicine; President and Chief Science Officer, mdlogix
Lydia Williams, Guardianship, Legal and Elder Abuse Programs Manager, MDoA
Hon. Ron Young, Maryland State Senate

Greetings and Introductions

Dr. Li introduced Senator Kramer and Delegate Szeglia, newly appointed members of the Commission on Aging. She also introduced two additional members of the General Assembly in attendance: Senator Ron Young of Frederick and Delegate Trent Kittleman of Howard County, president of the Women's Legislative Caucus, as well as Catherine Hill, Executive Director of the Women's Legislative Caucus. Other Commission members and guests in attendance introduced themselves, including Dr. Luisa Franzini, Chair of Health Policy and Management, University of Maryland School of Public Health (invited by Mayor Harding); and Wesley Queen, Coordinator of the Legacy Leadership in Policy Program of the University of Maryland School of Public Health.

Dr. Franzini noted that the Center for Aging at the University of Maryland School of Public Health was founded in 1974. As Director beginning in 2018, she has been charged with revitalizing and reimagining the Center. To that end, she initiated a survey of faculty on the College Park campus to identify researchers doing work in the aging sphere. She ascertained that approximately 30-40 researchers and faculty across many departments—including English, Hearing and Speech, Biology, Engineering and Technology, and those in the School of Public Health—are working in the area of aging studies.

Observing that she believes the greatest strength in such efforts is that they are multidisciplinary, she said she will next host interdepartmental brainstorming sessions among the College Park and Baltimore faculty who have an interest in research, teaching and other activities in the field of aging. As well, she noted that Public Health students are available for internships in organizations and agencies, including those devoted to aging services, to assist in their learning through research and related activities.

Dr. Franzini introduced Wes Queen, Coordinator of the Legacy Leadership Program in Public Policy at the School of Public Health. He explained that the program places recent retirees on a volunteer basis in the Maryland General Assembly and individual legislators' offices during the 90-day legislative session. Mayor Harding noted that he had been a participant in the program.

Approval of the Minutes for the February 25, 2019 meeting of the Commission on Aging

The minutes were approved, pending a correction by Secretary Kramer.

Secretary's Remarks

Secretary Kramer said that the 2019 session of the General Assembly had gone well and that she had successfully countered efforts to reduce funding for MDoA's statewide Durable Medical Equipment (DME) program. The non-means-tested DME program will make available free re-used, sanitized, re-conditioned DME. The equipment will be appropriately matched to the needs and characteristics of users. In contrast to the MDoA DME program which is designed to provide equipment quickly to those who need it, there may be lengthy waits for equipment provided through public and private reimbursement programs--resulting in continued lack of, or limitations in, mobility and accompanying reductions in physical and social functioning.

In addition, Secretary Kramer said that the Community for LifeSM program continues to expand with the addition of Allegany County as a participant. She added that MDoA has a new Director of Fiscal Management, who has held a similar position with the State Unit on Aging in South Carolina. In addition, a staff person to coordinate volunteer programs statewide will join the Department, providing expertise and utilization of best practices in implementing local volunteer programs.

Secretary Kramer noted inaccurate media reports of unexpected cuts in funding for nutritional programs in some jurisdictions. When she assumed leadership of the Department, she instituted formulas to more equitably and accurately distribute nutrition and other program funds. Such formulas eliminate over- and under- funding of jurisdictions and reflect changes in populations of older adults by locality. She said that the application of such formulas has been phased in over four years and resulting changes in local funding were neither sudden nor unpredictable. She also noted that the *Maryland Hears* program is close to implementation. It will provide hearing devices in congregate housing settings, with the goal of maintaining older adults' independence for longer periods of time. The program's success in doing so will be tracked. Secretary Kramer thanked elected officials in attendance. She explained that her brother, Senator Kramer had introduced and/or cosponsored several consumer protection bills focusing on older adults when he served in the House of Delegates and that she had sponsored some of these same bills when she served in the State Senate. Participating in these legislative efforts served to pique her interest in the area of aging. Delegate Szeliga said that her personal experiences, including the fact that her grandmother lived to 103 and her parents are residents of a Continuing Care Retirement Community (CCRC) where her mother has served on the resident board, have generated her interest in issues affecting older adults. The remaining Commissioners in attendance introduced themselves and provided information about their academic, professional and community service backgrounds and interests in the field of aging.

Secretary Kramer introduced Caryn Lasser, who was recently named Deputy Secretary of the MDoA. Deputy Secretary Lasser most recently served as Deputy Chief of Staff for Allan Kittleman, the previous Howard County Executive.

Panel on Elder Abuse—Facilitator--Joy Hatchette, Associate Commissioner, Consumer Education and Advocacy, MIA.

Panelists: Jeff Gross, Chief Enforcement Officer, MIA; Lydia Williams, Program Manager, Guardianship, Legal Services and Elder Abuse Programs, MDoA; Carol Fenderson, Deputy Director, State Programs, OHCQ), MDH; Ranada Cooper, Program Manager, Long Term Care Unit, OHCQ

Mr. Gross

Mr. Gross explained that, as Chief Enforcement Officer, he oversees MIA investigations of individuals and producers the MIA has reason to believe are engaging in fraudulent and/or abusive practices. Investigations are generally initiated upon receipt of complaint(s) and are undertaken by a staff largely composed of individuals with backgrounds in insurance or law enforcement.

Mr. Gross provided examples of fraudulent and abusive practices that the MIA has investigated including those by independent “public adjusters” (who do not work for insurers) and may charge upwards of 35% of proceeds ostensibly to assist insureds in securing settlements. Abusive practices by such adjusters have included inducing individuals to enter into contracts-- with three-day cancellation periods-- for services but not returning executed copies of the contract for five days, rendering it impossible to void the contracts. Mr. Gross also described the activities of fraudulent health insurers who may prey upon older adults, for example younger spouses of Medicare beneficiaries. The products offered for sale may be presented as major medical plans but amount to nothing more than indemnity plans—not true insurance-- covering limited diagnoses. Agents or advisors marketing such plans are skilled in gaining the trust of older adults. The MIA, in turn, may have difficulty obtaining the cooperation of the adults to whom the plans had been marketed because they may be ashamed of having been victimized.

Other abusive activities described by Mr. Gross included fraudulent investments, often of an older adult’s death benefits, in what amount to Ponzi schemes in which the benefits are never actually invested but instead are stolen by the perpetrators. Though successful investigations of such criminals occur, the amounts recovered for victims may total a small percentage of the amount embezzled. Another abuse described by Mr. Gross involves sale of annuities, in which a customer may mistakenly assume the annuities are administered by the selling agent, but are, in fact, administered by an insurer. Unscrupulous insurers and agents convince annuitants to upgrade repeatedly, resulting in sizable profits for the sellers but surrender charges that undermine the size of any annuity. One producer, Mr. Gross described, was indicted on federal charges, had his license to sell annuities revoked but continued to profit from his activities by selling and reselling his client list, leaving annuitants open to repeated victimization.

Mr. Gross noted that the MDoA-administered federally-funded State Health Insurance Program (SHIP) local coordinators and volunteers who provide counseling on Medicare benefits to older adults at senior centers play a vital role in assisting the MIA to pursue fraud investigations. SHIP counselors often secure the trust of older adults who have been victimized. Because of such trust, SHIP counselors may be able to gain a victim’s cooperation, which might otherwise be withheld due to shame or fear of re-victimization, with MIA investigations.

In response to questions, Mr. Gross said MIA conducts approximately 300 investigations annually, spanning all lines of insurance, though many more fraudulent and abusive schemes go unreported. Dr. Magaziner described research that indicates that individuals who have been the victims of fraud may have increased susceptibility to subsequent frauds because of neuropathological changes and noted that researchers hope to increase understanding of vulnerability and develop methods to intervene before victimization has occurred. Mr. Gross expressed interest in such research, but noted that MIA investigators almost invariably are involved in the “back end”—when individuals have already been victimized.

Dr. Li wondered whether steps could be taken to prohibit the selling and reselling of client lists that were assembled through fraudulent means. Such steps might require legislative action.

Ms. Williams

Ms. Williams outlined MDoA's role in preventing and responding to elder abuse. She said such abuse takes many forms, including "scams" by phone or electronic means. For example, perpetrators purporting to be from the Internal Revenue Service or the Social Security Administration may convince victims to surrender Social Security numbers and other identifying or financial information in response to false threats that their Social Security benefits may be suspended or that they will suffer arrest for underpayment of taxes. Such information is then used to defraud the victim. Ms. Williams cautioned that a number of scammers obtain information about individuals and their families on social media such as Facebook, and use the information to engage in activities such as the "grandparent" scam, in which grandparents are contacted by scammers falsely alleging that their grandchildren (who have been identified on social media) are in danger or in immediate need. The grandparents then wire money or provide credit card information to the perpetrators.

Ms. Williams noted the role of grants awarded to Area Agencies on Aging (AAAs) under Title VII of the Older Americans Act (OAA) focusing on efforts to prevent elder abuse in the community [https://www.elderabusecenter.org/default.cfm_p_oaatitle7.html]. While the amounts awarded under the Title VII grants are relatively small, she and the AAAs have been able to supplement and reinforce the grants through the use of existing resources such as the federal Consumer Financial Protection Bureau (CFPB) publication *Money Smart for Older Adults*.

Ms. Williams described additional efforts to prevent elder abuse such as Project SAFE (Stop Adult Financial Exploitation). Project SAFE is a coalition of 16 organizations, including the Maryland Departments of Human Services and Aging, the Maryland Association of AAAs (M4A), the Comptroller of Maryland, and AARP Maryland that share a common goal of preventing and remedying financial exploitation of vulnerable adults. Project SAFE and other partners sponsor an annual PROTECT week focusing on protecting older adults from financial exploitation. This year's PROTECT week corresponds with observance of World Elder Abuse Awareness Day, on June 15.

Ms. Williams noted the importance of making provisions for future health care decisions and re-examining those provisions periodically. She said that National Health Care Decisions Day is marked annually on April 16. She noted that families are often involved in decisions about health and other issues and that it is important to understand that estimates indicate that two-thirds of perpetrators of fraud against older adults are family members. Social isolation of an older adult enhances the ability of family members and other perpetrators of fraud to be successful. Senior centers, programs for older adults, and other avenues of social engagement are key in prevention and/or identification of fraud and other types of elder abuse.

Prevention of fraud and other abuses are essential to quality of life and life expectancy. Ms. Williams cited estimates that once older adults have been the victims of abuse, they are 300% more likely to suffer an early death.

Ms. Fenderson and Ms. Cooper

Ms. Fenderson stated that OHCQ functions include facility licensing; making recommendations to the Centers for Medicare and Medicaid Services (CMS) regarding certification of facilities, such as nursing homes and assisted living (AL) programs, to participate in the Medicare and Medicaid programs; conducting surveys to determine facility compliance with state and federal regulations that set minimum standards for delivery of care; and educating providers, consumers, and other stakeholders. There are both federal and state regulations that apply to nursing homes; there are state regulations that apply to AL facilities but no federal regulation of AL communities.

Ms. Fenderson said that the OHCQ AL Unit is responsible for oversight of all AL programs in the state. The unit completes surveys for licensure, re-licensure, allegations of unlicensed AL programs, and AL-related complaints. She provided information about how to make a complaint in the handouts that she distributed (appended). Complaints received by the AL unit are triaged daily, with complaint response timeframes determined by complaint severity, ranging from two days for the most serious and immediately harmful complaints to thirty days for the least serious. If any complaint is substantiated, the provider is required to submit a corrective action plan within 10 business days. The plan must include information on how and when remediation will occur, as well as how a recurrence of the situation triggering the complaint will be prevented. Follow-up on the corrective action plan always occurs during the next full AL facility survey.

AL facilities are required to self-report certain incidents and in FY 2018 the combined total of complaints and self-reported incidents was 1,315, with 1,137 of the total being complaints. 218 initial surveys and 570 renewal surveys were conducted during the same time period. Overall, during FY 2018, the three most frequently cited deficiencies in AL facilities were those relating to the general physical plant, the functions of the “delegating nurse,” and medication management and administration.

Ms. Cooper described a similar process for nursing homes. Annual re-certification surveys are required under federal regulations, in addition to those undertaken because of complaints. Complaints are triaged by severity and responded to in two days or under for those potentially representing immediate jeopardy, ten days for less serious complaints, and forty-five days or the next onsite survey for the least serious. Follow up to all complaints is also made at the next annual survey.

In FY 2018, there were 3,621 facility-self-reported incidents and complaints in nursing homes. There were 1,058 allegations of resident abuse during the same time period. The two most frequently cited federal deficiencies were in nursing services and quality of care. Federal nursing home deficiencies are rated based on scope and severity. Scope is the prevalence of the

deficiency—based on the number of residents affected by the deficient practice; severity is an assessment of the actual or potential harm to residents caused by the deficient practice. In FY 2018 there were 47 instances of actual harm and immediate jeopardy deficiencies (the most severe) cited in Maryland nursing homes. OHCQ coordinates with and refers to the Nursing Home Board of Examiners, the Board of Nursing, local law enforcement and the Attorney General’s Office, as appropriate.

Similar to the AL complaint and survey process, nursing homes have ten days to respond to a deficiency with a corrective action plan. CMS is encouraging state licensing entities to engage in a root cause analysis when assessing deficiencies, as well as utilizing data analysis to identify potential patterns and address these. OHCQ now has a dedicated health policy analyst doing such analysis. Both the state and CMS may assess civil money penalties for deficiencies. OHCQ administers a grant program, funded by a portion of the civil money penalties assessed against nursing homes or AL facilities, designed to improve quality of care in the facilities.

In response to questions, Ms. Cooper explained that in addition to OHCQ surveyors, CMS has its own surveyors. CMS may conduct surveys once OHCQ has conducted a survey so some facilities may have multiple surveys during a given time period.

Presentation—Addressing the Problem Iceberg, Generating and Using Real-time Data to Improve Processes and Outcomes for Aging Populations—Allen Y. Tien, MD, MHS, Clinical Associate Professor, Behavioral Health Medicine and Psychiatry, West Virginia University School of Medicine

Dr. Rebok introduced Dr. Tien as a colleague of almost 30 years, and one who is doing groundbreaking work on linking early detection and screening of behavioral and mental health problems with health referrals, with clear implications for aging and mental health. Dr. Li explained that she invited Dr. Tien to share insights about how a web-based platform can be effectively used in various settings to identify, manage, and track outcomes for aging patients in a community setting.

Dr. Tien conceptually envisions public health and safety issues for older adults as an iceberg with the most visible conditions--such as cognitive decline, increasing suicide rates, chronic health conditions, and comorbidities--being recognized and addressed. However, the underlying issues lurking below the surface—such as depression, abuse, scams, financial problems, substance misuse, chronic pain, hearing issues and poor nutrition, as well as disparities such as education and income (social determinants of health)—are not being recognized nor addressed fully or are going completely unrecognized and unaddressed.

Using a life-course perspective incorporating biological, social and psychological perspectives and processes that operate from pre-birth through older adulthood, Dr. Tien seeks to integrate a health science process orientation and data infrastructure. His tools address both the visible problems with which persons across the lifespan may present to clinicians and others, and the less visible (or un-assessed) problems that underlie those with which persons may present.

One of the front-end user friendly tools that mdlogix has developed is BH-Works which includes tools for comprehensive validated behavioral health screening and outcomes tracking, screening for social determinants of health, referral and care coordination, and case management and population dashboards to report real-time outcomes. Dr. Tien outlined several ways in which the systems have been utilized including in behavioral health screening and integration into primary care. For example, his system was effective in screening for alcohol misuse and depression risk; Medicare patients using the tool were generally amenable to completing screening on a tablet or laptop. Patients indicated that they appreciated such screening. Physicians found it useful because the screening tool provided information that was actionable, and generally obviated the need to conduct longer, sometimes uncomfortable, in-person screening.

BH-Works has also been used to screen for mental health comorbidities with physical chronic health conditions. There are significant financial incentives for providers to offer chronic care management programs but a neglected aspect of such programs is treatment for the possibly co-occurring behavioral health condition. For example, Dr. Tien's screening data indicated that approximately 30% of those with diabetes may have depression and/or anxiety but only about 5% of those with diabetes are being treated for depression and/or anxiety. The average cost for treating a person with diabetes (without complications) is \$811 annually but that cost rises significantly if the person has a serious persistent mental illness or a substance use disorder (\$1,775 and \$1,848 annually, respectively) and is \$3,623 for treating the diabetes in a person with a serious persisting mental illness combined with a substance use disorder.

Dr. Tien explained that Bon Secours Health System has used BH-Works systems to screen for mental health conditions in a study of social determinants of health in emergency departments and community settings under an initiative called "Community Works." NAMI Maryland is using the systems for its Maryland Healthy Hearts and Minds Initiative--which consists of a free 8-hour interactive training program, guided by peers who are also managing their own mental and physical health conditions--designed to empower individuals with mental illnesses to make lifestyle choices that may prevent chronic disease. The program is accessed via an online portal to track the health status of participants before and after the workshops are completed.

In response to questions, Dr. Tien said that he has found the not-for-profit sector most receptive to trying BH-Works. For example, he is partnering with Volunteers of America Chesapeake in an eco-systems effort to work with a group of individuals being released from prison to support for three years their re-entry into society, rather than an isolated shorter job training program.

Other Business

Mayor Harding suggested that more attention be given to communicating the great work of the MDoA and the Commission on Aging. Dr. Li indicated that time will be allotted on the next meeting agenda to give Mayor Harding more time to discuss his ideas for strengthening outreach to communities throughout the State about MDoA programs and accomplishments.

Dr. Li said that the next meeting of the Commission is expected to focus on the Community for LifeSM program and evaluation considerations.

Adjournment

The meeting was adjourned at 12:30 pm.

Minutes prepared by Rosanne B. Hanratty