MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-Eighth Session
February 9, 2015

The Committee on Health and Human Services was called to order by Chair James Oscarson at 1:32 p.m. on Monday, February 9, 2015, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/78th2015. In addition, copies of the audio or video of the meeting may be purchased, for personal use only, through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

COMMITTEE MEMBERS PRESENT:

Assemblyman James Oscarson, Chair
Assemblywoman Robin L. Titus, Vice Chair
Assemblyman Nelson Araujo
Assemblywoman Teresa Benitez-Thompson
Assemblywoman Jill Dickman
Assemblyman David M. Gardner
Assemblyman John Hambrick
Assemblywoman Amber Joiner
Assemblyman Brent A. Jones
Assemblyman John Moore
Assemblywoman Ellen B. Spiegel
Assemblyman Michael C. Sprinkle
Assemblyman Tyrone Thompson
Assemblyman Glenn E. Trowbridge

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Kirsten Coulombe, Committee Policy Analyst
Risa Lang, Committee Counsel
Karen Buck, Committee Secretary
Jamie Tierney, Committee Assistant

OTHERS PRESENT:

Jane Gruner, Administrator, Aging and Disability Services Division, Department of Health and Human Services
Julie Kotchevar, Deputy Administrator, Aging and Disability Services Division, Department of Health and Human Services
Herbert E. Randall, Ed.D., President, Nevada Silver Haired Legislative Forum
Heather Korbulic, State Long Term Care Ombudsman, Aging and Disability Services Division, Department of Health and Human Services
Connie McMullen, Member, Nevada Commission on Aging
Peggy Lear Bowen, Private Citizen, Reno, Nevada
Jeffrey B. Klein, FACHE, President and CEO, Nevada Senior Services, Inc.

Chair Oscarson:
[Meeting called to order. Committee rules and protocol explained.] Thank you, seniors, for being here. We know it is Senior Day. We will look forward to the presentations today and hope they are beneficial to you and that your time is well spent. Today we are going to have a review of the Aging and Disabilities Service Division (ADSD). Jane Gruner, the administrator, and Julie Kotchevar, the deputy administrator, will be joining us from ADSD. We look forward to hearing what you have to say.

Jane Gruner, Administrator, Aging and Disability Services Division, Department of Health and Human Services:
Aging and Disability Services (ADSD) represents Nevadans who are aged or have a disability, regardless of age, and assists the broader community that touches their lives. In other words, we are that person that does that intermediate piece to help them find their services if they are needed. The ADSD strives to create an environment that enables Nevadans that we serve to

be self-sufficient, independent, and safe. In July of 2013, ADSD became one by bringing Early Intervention and Developmental Services into the ADSD, creating a life span division that would serve all of those populations. Part of the reason was to promote community living environments at a much higher level, so we could guarantee quality and, hopefully, more sustainable services for people, provide responsive and effective services, and expand our outreach efforts. As part of that, we elected to do a strategic planning session. We hired a facilitator to come in and work with our staff, our community providers, and our consumers. We did town hall meetings, focus groups, and surveys across the state of Nevada to find out what our consumers were truly looking for and in what way they really wanted to receive their services. Part of it was that they wanted to have a seamless service system so that they could call one place and find out what services were available and what those contact numbers were. They also wanted to know how they could actually engage in the service system before, or at least in the initial phases of when, they would need the service. Part of it was to improve access, and from that we created a strategic plan, which can be found on our website. We use that strategic plan to build our budget as well as in all the work that we do with our community providers and our consumers. As you see, our consumers really have a voice, and they are ready to make sure that everyone understands what they need. They were very helpful as we went through the strategic planning process.

On page 2 (Exhibit C), you will see our organizational structure. This is the infrastructure for the state. That really comes down then on all of our initiatives and includes our consumers and our community providers. The state staff helps ensure quality, and they help ensure that the people that qualify are able to get those services. However, it is really our community providers and our consumers that do the bulk of the work. Our community providers are the ones who are doing direct services for the most part, although we are very collaborative in trying to use common sense in how we deliver services.

On page 3 (Exhibit C) you will see the ADSD Mission and Vision. This is what guides our service system. An example of this is that we recently worked with Nevada Medicaid and received a Balancing Incentive Program grant through Centers for Medicare and Medicaid Services and have used that to go back through our strategic plan. One of the areas that every consumer valued was that they wanted it to be person-centered. We have used the Balancing Incentive Program grant to hire consultants to do person-centered training for all of our division. Then it will fall down to all of our providers. We are doing a "train the trainer" so that we will actually be able to continue ongoing without adding any outside cost because it will be our own staff doing the training for all of our consumers and our community providers. Our focus again is to help our staff to see people first and then to also make sure that, foremost, they are helping people with dignity, independence, and self-determination.

On page 4 (Exhibit C) you will see ADSD strategic planning goals. These goals again were created by collaborating with our consumers and our communities. The first is to increase funding and services to meet national or state accepted funding levels by population. This is essential if we are going to have quality services. When our provider rates do not keep up with the going rate for our state, then it is hard to ensure quality. When we do not have quality, it puts people at risk. Therefore, it is essential because these are the people that are doing direct services with people and sometimes in very intimate ways. It is also essential that we have people that are well-trained and able and ready to do the service.

We adopted and implemented a universal person-centered framework, which is an evidence-based practice. That is what we are actually in the beginning of. We had our first training last week. It was well accepted by our staff, and we are really looking forward to making that a very valuable part of our service system.

Our next goal was to establish standardized, evidence-based service delivery systems, and that is across all of our populations. In doing evidence-based practice, there is a guarantee for our state that these are services that have been identified as being successful and that they work. It is money well spent when you know that it is a proven system.

Another was to adopt a report criteria that demonstrates outcomes and efficiencies. We are using data that is collected from our service system to guide our processes and to guide what we will support. Part of that is we have also implemented a new computer system for our intellectual disabilities side, in which our providers bill directly, so it is electronic. Right now, it is all paper. It will improve the system tremendously. That would include all of our serious incident reports for when things happen so there will no longer be a lag time. We are about 12 months away from the implementation of that system.

The last was to develop a system to recruit and retain a highly-trained, adaptive-skilled workforce. That is probably one of our highest goals because it is getting harder and harder to find professionals that want to do this work. We are working with our university systems; the Department of Employment, Training and Rehabilitation (DETR); and any community-based organization that would like to work with us to develop the skills within many different organizations, so that we have more people to pull from. Some of our partners that we are working with right now are actually in the audience, Nevadans for the Common Good, a faith-based group. We will be working with them to develop training for their churches and other organizations to help do some of the respite services or at least be able to offer those services to people within their communities.

Next, I will have Julie Kotchevar go over our operations and lay out how you might see that service in your own community.

Julie Kotchevar, Deputy Administrator, Aging and Disability Services Division, Department of Health and Human Services:
Our services are broken into four major areas [page 5, (Exhibit C)], the first being Nevada Early Intervention Services, which provides treatment to infants and toddlers with disabilities. That includes babies who are born very premature, our 30 week babies, to children later on who develop a disability or lag behind in development. Therefore, we provide a variety of services using both state staff and community partners. That includes things like occupational physical therapy, pediatric services, and specialized instruction to help families coach their children further along in development.

We also have the Autism Treatment Assistance Program (ATAP), which helps families to access autism treatment. It is intensive behavioral treatment for children from whenever they are diagnosed until age 19. We do not provide services for the entire length of time. The average length of time in intensive treatment for us is about four years. Generally then, children will either achieve their best outcomes, or we transition them to more supportive services through Developmental Services.

Our next large group is our regional centers that provide assistance to people who have intellectual disabilities and related conditions. They provide a variety of services like service coordination, family supports, and residential supports, so that people can live in the community with whatever level of support from just a few hours of support to intensive 24-hour awake support. However, it allows them to remain out of institutions and in the community. We also provide jobs in day training, nursing services, and quality assurance. Desert Regional Center in Las Vegas is the home of our intermediate-care facility for people with an intellectual disability, for those who do require that higher intensity of treatment.

Our last group would be our aging services and our services for persons with physical disabilities. The aging services provides services for seniors so that they may remain in their homes for as long as possible with things like homemaker services and attendant care. We also do similar services for people with more severe physical disabilities, so that they may remain in their homes, attend school, or work. We have a variety of programs that receive grant money from the Older Americans Act to help fund things like senior nutrition, Meals on Wheels, and a variety of senior respite or other community-based programs where we use community partners who we highly value to do many of those services to support seniors.

Assemblyman Sprinkle:
Going back one slide [page 4, (Exhibit C)], you had talked about developing a system to recruit and retain a highly-trained, adaptive-skilled workforce. I am wondering if you could go into that in a little more detail, but far more importantly, if you could describe to me some of the problems you see currently in not being able to retain the kind of skilled workforce that is obviously needed for the type of work that your department does.

Jane Gruner:
Part of the skilled force that we are not able to recruit for right now is the professional staff: social workers, psychologists, developmental specialists that provide much of the oversight, and the Elder Protective Services. Part of it is that the pay scale is not commensurate with our other areas that are now available to those professionals.

Assemblyman Sprinkle:
Are there others besides the one specific issue?

Jane Gruner:
The other part would be that our community providers are no longer able to pay the rate that would bring in a more highly skilled workforce that has the experience and training to provide the services that we are asking them to provide like behavioral therapy and more of the health-related services.

Assemblyman Sprinkle:
Would you say, especially with this discussion and what we are talking about here today, you see a growing need for these services coming into the future?

Jane Gruner:
Nevada is in the top three states growing senior-wise, so I do foresee that Nevada is going to need additional service providers to support seniors as they live in their community homes. It is a better deal for everybody if we can keep seniors in their homes and not in institutional levels of care, which become very expensive. I think most of the seniors that are in this room would probably agree with me that all of them want to stay in their homes as long as they can. That is going to take many additional types of service providers who are able to

go in and ensure safety and help them with the needed areas to keep them in their homes.

Julie Kotchevar:
I would also like to point out another one of the things we struggle with when we do have turnover. If you can imagine, it would be difficult to adjust to a new person every few months when you need someone to do intimate attendant work in your home. Trying to keep down that sort of turnover rate for the people that we serve is incredibly important, but it is also important to have highly trained and highly skilled staff for behavioral therapy. For example, it typically requires a master's degree for some of our physical therapists or occupational therapists. That is advanced training, and so that really becomes a struggle for us to keep pace with those demands.

Chair Oscarson:
You are saying, because there is certainly some disparity, that while we will have the money discussion later, this is still a policy discussion. Your policies do intermingle with some of those things, but we need to remember and be careful that we do not get too far in the weeds about the monetary component of this. I appreciate your comments and appreciate your passion.

Julie Kotchevar:
Our next slide on page 6 (Exhibit C) is a list of our agency accomplishments. We really want to highlight the work that we hadve done since we integrated. That was a very significant task. One of the areas that we looked at was collaborating and strategic planning to achieve successful outcomes. We completed plans including the ADSD strategic plan, which we use to guide our service system, the strategic plan for autism services, and the strategic plan for Alzheimer's disease. We have made contributions to the Behavior Health and Wellness Council. We are also right in the middle of working on the Task Force for Integrated Employment to create integrated employment opportunities for persons with intellectual disabilities. We have been working collaboratively with all of our sister agencies as well as vocational rehabilitation in the Department of Education to find innovative solutions for some of the challenges faced by our consumers.

We have worked very hard to eliminate long-standing areas of noncompliance. I am very proud of our early intervention system staff that worked diligently over the last biennium to eliminate the wait list for services and is actually timely now on referrals and planned development and services. We are very proud of them for all of that hard work that they and our community partners did.

We work to train staff and community partners toward our value system and our mission. We received a grant, as Ms. Gruner talked about, to fund the person-centered thinking, which is a significant initiative for our agency to really focus on patients and what their needs and services are, that they really desire to support their lives in the way that best fits them and their families. We have also been piloting evidence-based services across our service system, including intensive behavioral therapy and early intervention, integrated employment in developmental services, and services to support a dementia-capable system for seniors. Therefore, we have been taking the outcome of evidence-based practice and focusing on outcomes, then applying them across the lifespan of services that we provide.

We have been seeking alternative sources of funding to support the changing needs. Having received a number of grants this year, we are very proud of our grants unit for seeking out any available funding to help support the changing needs. We have received grants to help create a dementia-capable system of care, a life-span respite grant, a no-wrong-door grant to create better access to services since access to available services has become a growing issue, and the Balancing Incentive Program designed to create a stronger and more accessible long-term services and support system. We expanded our childcare development program to be statewide. That helps to integrate infants and toddlers into day care centers with their typically developing peers, both to help them have typically developing play partners and also to help families of a child with a disability get used to putting their child in day care, so that they can return to work.

Chair Oscarson:
I have a question for you about the integration component where you say you are integrating the children. Are you integrating them into normal classrooms, or are you integrating them with peers of their same disabilities?

Julie Kotchevar:
It is into normal childcare centers, early intervention centers for children under the age of three, so it is childcare centers. In Elko, in particular, we were really struggling to get childcare centers to take some of our children with more difficult disabilities. Great Basin College actually created a two-year-old room which is specifically for children who are two years old. We helped fund that so that both the people who attend the college can have a two-year-old room, which is quite exciting for college students, and then our kids have the ability to play with typically developing peers and have that experience.

Our next slide [page 7, Exhibit C)] is really one to touch on the issues that are impacting the ADSD. We are seeing a significant population growth in the number of seniors. In 2000, about 15 percent of Nevadans were 60 or older. By 2030, it is expected that 25 percent of Nevadans will be seniors. The growth in the incidence of Alzheimer's disease and dementia is 1 in 9 people over the age of 65. Our service system needs to change in order to be able to support a service system that can help support people with dementia and their caregivers.

Persons with intellectual disabilities are aging as are the parents who care for them. We are seeing now in our service system persons with intellectual disabilities who are living much longer than they used to, which is absolutely wonderful. However, then the family members who care for them are also becoming seniors, which is presenting an interesting opportunity for us to provide the entire family with services. Growth in the demand of services for children with Autism spectrum disorder (ASD), for which the incidence rate has been growing, has increased our wait list for services fairly significantly. Those are sort of the larger issues that are facing our ADSD.

Jane Gruner:
We also have one bill that will be before you. Assembly Bill 29 is basically making sure that the *Nevada Revised Statutes* that guide the ADSD are in line with some of the areas that were not as clear after our merge, and so we are cleaning up some of the language in A.B. 29.

Chair Oscarson:
I think we are hearing that bill on Wednesday, so we will see you back. I had a question about ADSD. With the significant increase in children that are being diagnosed with ASD, is there new criteria that have been adhered to those diagnoses, and is there anything attributable to the significant jump? Was it that they were not being diagnosed, or are they now being diagnosed a little more aggressively than they had been in the past? I get the idea that if there was a diagnosis that you would work with them sooner rather than later because the later outcomes are much more expensive than the earlier outcomes are. However, was there anything that you had seen that might be attributable to that increase in diagnoses?

Julie Kotchevar:
There is actually quite a bit of research into this significant increase in incidence rate. In Nevada, we actually have a diagnosis rate that is quite a bit lower than the incidence rate for autism as a whole. Therefore, I do not believe that children are being overdiagnosed, or we at least have not seen overdiagnosis. We do monitor the diagnoses fairly well, so I do not think that is happening. What researchers are finding is that it is really two-pronged. There was quite a bit of work done on how diagnoses happen. They got much better at

developing diagnostics that could actually measure autism. So people who have been diagnosed in the past as having an intellectual disability are being correctly diagnosed as having autism instead. People who were maybe misdiagnosed as having an attachment disorder or a mental illness are being correctly identified as having autism instead. Therefore, the diagnostics definitely improved and contributed to the growth in the incidence rate.

However, there is a growth beyond that, so they are looking at both genetic and environmental factors to see what it is that is actually increasing the incidence rate of autism. The rate has actually tracked fairly closely with the same rates in childhood allergies, type 1 diabetes, and childhood asthma. Thus, they are looking to see if there is something environmental that is impacting children to increase the rate of autism. Yes, it is partly diagnostics, but it is also partly a change in the diagnoses.

Chair Oscarson:
Could you at some point in time provide this Committee with what the numbers are over the last ten years, for example, of the diagnoses of ASD and then move forward?

Julie Kotchevar:
I can go back as far as the Centers for Disease Control and Prevention records do, which I think started in 2007. I would have to verify, but we can go back as far as the surveillance does.

Chair Oscarson:
If you could compare the national average to our average, that would be helpful as well, and how many cases we currently have. I know you have it listed here, but if you could do that, that would be great.

Assemblyman Araujo:
I have two questions. The first one is just a clarifying question. In your second to last slide [page 7, (Exhibit C)] under growth in the incidence of Alzheimer's disease and dementia, I was wondering if the statistics in the first two bullet points, 1 in 9 people over the age of 65 have Alzheimer's disease and one-third of folks aged 85 or older have Alzheimer's disease, are relative to Nevada, or is that nationwide?

Julie Kotchevar:
Those are national statistics, but they are incidence rates, so there is no reason to assume that they would not apply equally to our population. The only difference would be that we would have a higher actual number because we

have a higher number of seniors, but the incidence rate itself would be the same.

Assemblyman Araujo:
For the last section in reference to the children with ASD, do you have any type of a partnership with the school districts, or are you working to develop programs within the schools to help the children?

Julie Kotchevar:
We work collaboratively with the schools, when able, to provide our treatment in the school setting. We also collaborate with the school districts for out-of-home treatment. The two largest districts, Washoe County and Clark County, used to participate much more in that. They have pulled back recently. Therefore, we are really just working to help sustain a stable environment for children that we treat in their school systems.

Assemblyman Thompson:
You and Ms. Gruner work with a very important population. You are at both ends of the spectrum. My question follows up on my colleague's about autism. The "points of discovery" is the term that I am going to use. Assemblyman Araujo was talking about partnership with the school district. Are you also seeing it being detected through community-based organizations, as not everybody would say that his or her child is autistic? I am sure that there is a big denial factor in there. So where are some of the common points of discovery in agencies?

Julie Kotchevar:
We do a number of things. We work with physician groups to try and get every pediatrician in the state of Nevada to give a Modified Checklist for Autism in Toddlers. That is a screening for autism that can be done in a well-baby check. We try to get them through early intervention. Through outreach, we do Child Find activities where we go into day care centers. It is easier for us to do an assessment and tell a family that their child might have a disability than it is for day care providers, who have a financial relationship with that family. Therefore, we try to do that for them. To identify that, we do health fairs, and we work with the school districts. Typically what we find is that the severity of the autism will determine how early a child is diagnosed. Children that are severe will be diagnosed prior to age five unless we can get them through a screening earlier. Then children who are more on the other end of the spectrum will more likely hit that when they get into school and start interacting with that structured school system. Then there will be a diagnosis. We try to blanket as many sources as possible to get those early screenings done and get the diagnosis because early treatment will have better outcomes.

Assemblyman Thompson:
Data is very important for us to help you with doing the work that you do. Here [page 7, Exhibit C)] where it says in Nevada we have over 6,000 children diagnosed with autism, do you have an ethnic and/or regional breakdown of where those children are? We can then help you to let people know that it is okay to get their children checked and to make sure they continue with the care.

Julie Kotchevar:
We do have a regional breakdown, and we will say that there is no disparity in diagnoses across racial or socioeconomic groups for autism. However, there is in access to care and early diagnosis. Therefore, we have been launching a number of campaigns to try and reach the parts of the population who do not necessarily come into care as easily to try to get that to them and work with community-based groups, but we can get you the regional breakdown.

Assemblyman Jones:
I understand this in not a budget committee, but the Governor has made a big push to do quite a bit of funding for autism. What will be the result or what will you do differently if that funding were to come through?

Julie Kotchevar:
The funding is a combined budget initiative, so a good portion of it is going to the Medicaid program to help provide access to behavioral therapy for children in the Early Periodic Screening and Diagnosis and Treatment program. Then a portion of it is also coming to our ATAP, which helps families to access services regardless of insurance. They do not have to be in Medicaid, although they can be. Combined, we hope to serve up to 2,464 children, which will significantly increase from the 500 we currently serve. That should increase the outcomes of independence for those children and decrease their need for long-term services and supports going forward.

Assemblyman Jones:
In my business, I have donated quite a bit in the past to Opportunity Village, and I think it is very good. It is a private organization. How does your organization work with someone like Opportunity Village?

Jane Gruner:
We contract with Opportunity Village to provide direct services for the intellectual disability group of individuals that we work with for jobs and day training in the supported employment. They are developing employment for our intellectually disabled individuals to be able to obtain work.

Assemblywoman Benitez-Thompson:
As I look at the four different areas of services you provide [(page 5, Exhibit C)], correct me if I am wrong, but in early intervention services, autism treatment, developmental services, and aging and disability services, there are wait lists for all of those services, are there not? I cannot think of one service that you provide that does not have an excess of demand.

Jane Gruner:
We currently do not have a waiting list for early intervention.

Assemblywoman Benitez-Thompson:
However, you do for developmental services and, then as I like to always highlight in aging services, for the low income or impoverished seniors who are currently waiting for safe and stable housing or for supportive services to keep them safe in their home, correct?

Jane Gruner:
That is correct.

Chair Oscarson:
Back to your senior services, you oversee the Meals on Wheels program, correct?

Jane Gruner:
That is correct.

Chair Oscarson:
Do you have any numbers with you, or can you get us numbers? I would like to see the increases in those services that you are providing, as well. I know that they have increased, in my community anyway, significantly, and there are folks who are unable to get those services simply because of the funding mechanisms, and some of those services are not available. If you could let me know what those are, or if you have that number, that would be great, Ms. Gruner. I would appreciate knowing where we are, where we are going, and where we need to be.

Jane Gruner:
Let me explain how that works. We get money from the federal government through the Older Americans Act. That money is then granted out to organizations. Those organizations find match money, which helps provide more services. There are still seniors waiting to get the meals. We have congregate meals, and then we have home delivery meals. For home delivery meals, we serve 3,735 individuals.

Chair Oscarson:
Is that statewide?

Jane Gruner:
That is statewide.

Chair Oscarson:
Do you know if there are numbers of folks waiting? Do they report that information to you?

Jane Gruner:
Yes, they do, and I will get you that information.

Chair Oscarson:
Great presentation, and again, I echo the sentiments of my colleagues. You have big shoes you have to walk in to take care of our elderly and our younger population. What a great opportunity for us to work and move forward with these individuals. We appreciate what you all do and look forward to hearing from you in the future.

Jane Gruner:
Thank you very much for the opportunity.

Chair Oscarson:
We are going to move forward and hear our first bill today, Assembly Bill 28. It revises the duties of the State Long-Term Care Ombudsman. We are going to have a presentation from Las Vegas from Dr. Herbert Randall. He is the president of the Nevada Silver Haired Legislative Forum. After that, we will have public comment, members' comments, and move forward in that way. We also have a letter [from John Yacenda, (Exhibit D)] that is on NELIS and will be a part of the record as well.

Assembly Bill 28: **Revises the duties of the State Long-Term Care Ombudsman. (BDR 38-415)**

Herbert E. Randall, Ed.D., President, Nevada Silver Haired Legislative Forum:
The Legislature created the Nevada Silver Haired Legislative Forum in 1997 to identify and make recommendations on issues of importance to aging persons. However, the Forum has not authorized any bill draft requests (BDR). That was corrected in 2013, thanks to the initiative of State Senator Mark Manendo and the unanimous support of the Assembly and the State. We are now authorized one BDR each legislative session. We will try not to squander it. [Dr. Randall continued to read from written testimony (Exhibit E).]

Assemblywoman Spiegel:
In your bill on page 2, you speak about providing training for the officers, directors, and employees of facilities of long-term care. Is there also a component that would educate residents, prospective residents, and their families that the residents have these rights? Is there information on how they would go about making changes to their daily routines as their care evolves over time?

Heather Korbulic, State Long Term Care Ombudsman, Aging and Disability Services Division, Department of Health and Human Services:
We do provide education to residents and potential residents and their families about how to navigate the long-term care system and what their rights are in the system.

Assemblywoman Spiegel:
As this training is expanded, will it carry through?

Heather Korbulic:
Yes, that is correct.

Chair Oscarson:
It says you wanted to develop a course, made available to officers, directors, and employees of facilities for long-term care, to encourage such facilities to provide services. Are there any nonprofits or volunteer boards for any of these places that are currently providing these services?

Heather Korbulic:
Do you mean are they acting as 501(c)(3) nonprofits?

Chair Oscarson:
Right, and is it a nonprofit where the board is not compensated?

Heather Korbulic:
I would not know the answer to that, but I am aware that some, very few, of the long-term care nursing homes are not for profit.

Assemblyman Moore:
Why is this bill necessary? In other words, could this be accomplished in the *Nevada Administrative Code* (NAC) rather than in the *Nevada Revised Statutes*?

Heather Korbulic:
The ombudsmen work as dictated and mandated by the Older Americans Act, which requires that we do resident-driven advocacy, so we teach and start from

a place of empowerment, confidentiality, and choices. This is training that we have been presenting for many years and continue to present when facilities request us to do so.

Assemblyman Moore:
Could it be accomplished within the NAC as well?

Heather Korbulic:
I do not know the technicalities, but I am assuming so.

Assemblyman Thompson:
The training says "develop," so it sounds like you already have a course in place. Is it a best practice, something on the federal or national level that they recommend for communities, that is totally packaged with everything that you need to ensure that the officers, directors, and employees have that training? Is it more like a certification type of training? Is it annual, or how often do they have to go through the training?

Heather Korbulic:
The Long-Term Care Ombudsman program contracted and continues to send our staff to national conferences about person-centered care and culture change. Culture change is basically a theory and a philosophy that creates homelike environments, rather than institutional environments, where residents' preferences are first and foremost. It is person-centered care. We have put together training that is about person-centered care, person-centered activities, person-centered dining, and person-centered and consistent staffing. We do provide that training when requested. It is not a certification process to my knowledge. There is no requirement for any long-term providers to take person-centered care training.

Assemblyman Trowbridge:
I am 100 percent in support. However, I believe you are setting a bad practice, a precedent that might make it more difficult for you at the conclusion of the legislative session when you want to add another duty for the Ombudsman to do. Someone is going to say that you cannot do that, and you have to go back to the Legislature to get permission to expand the duties. Therefore, I wonder why you want to set up such a practice.

Heather Korbulic:
This is the Silver Haired Legislative Forum's bill draft request. I am here answering questions and providing assistance.

Herbert Randall:
We are not trying to complicate it. We are trying to assist to make sure that there is better training for those working with the assisted-living centers. If we had any idea we were complicating things, we probably would have gone in a different direction. I am not sure exactly how this would be complicating things.

Assemblyman Trowbridge:
It might be that someone said by doing this, you are establishing a precedent. Someone that might oppose expanding the services might say that you have to get permission before you can expand the duties of the Ombudsman. Let me repeat that I support it completely. I just do not want to stop you in the 18 months while the Legislature is not in session.

Herbert Randall:
The answer from the Legal Division of the Legislative Counsel Bureau was that they felt that the words in the NRS needed revision to be a little stronger and to encourage this type of training. I see what you are saying, and I understand that. We did get a legal opinion on this, and they thought that it needed to be revised to be stronger and give more encouragement for this.

Assemblyman Trowbridge:
Lawyers write laws, and I am always concerned when someone says to write another law. I do not want to be back next year saying what we should have done was to take this out of the section and leave it up to the NAC where it could be handled more simply. However, I will support A.B. 28.

Chair Oscarson:
Your Silver Haired Legislative Forum came forward with these recommendations. With a lot of thought in your meetings, that is how you came up with the bill draft you have before us. Is that correct?

Herbert Randall:
That is correct. We are allowed and encouraged to submit a report of our findings to the Legislative Commission and the Governor in each even-numbered year. Our report for 2014 was presented to the Commission and sent to the Governor. We will be meeting with the Governor's Chief of Staff on Friday to discuss it further. There were nine recommendations in there, most of those based around elder abuse. That was the theme of the past year-and-a-half as we looked at different things. We learned very quickly, those of us who did not know, you cannot legislate away elder abuse. However, you can take chunks in improving things. That is what these recommendations were mostly about, and

this one seemed to rise to the top of something that could be done. It was specific and would make a difference.

Chair Oscarson:
I want to make clear for the record that you have one BDR you can move forward as the Silver Haired Legislative Forum. You had nine priorities, and you picked this one as your top priority, the one you moved forward with. That is why we are hearing it today.

Assemblywoman Titus:
I am the medical director of the South Lyon Medical Center long-term care unit. We have really converted the way we think about patient care in the last several years. Thanks to a lot of input from folks like you, we are proud to say that we are a person-centered care unit now. What that means is a lot of these folks may not want breakfast at 7 a.m. So instead of waking everybody up and taking them to the dining room, we let them wake up when they want to and have a breakfast of what they want to eat, within health concerns. It has really made a change for the good. However, I need clarification from a medical standpoint, and a definition. There is significant difference in liability and regulation between assisted-living facilities and long-term care facilities. They fall under different regulation. The wording says, "assists facilities for long-term care patients," but then we are throwing out the term "assisted-living facilities." They are not the same. Are we trying to educate long-term facilities, or are you going to use the umbrella of assisted-care facilities to educate them on what person-centered care is?

Heather Korbulic:
We present this information to all four long-term care license types, so that is skilled nursing facilities, assisted-living, group homes, and then the two-bed homes, homes for individual residential care. All of them function under the NRS Chapter 449 and NAC Chapter 449 and have different requirements based on their level of care.

Assemblywoman Titus:
You are offering to go into the assisted-living facilities and the group homes so that they, too, can be on board with this?

Heather Korbulic:
That is correct.

Assemblywoman Titus:
Would there be a fiscal note, or are they going to be charged for this? Will there be any accreditation as Assemblyman Thompson asked about? How formal will your course be?

Heather Korbulic:
Because of the way I read the bill, there is not a requirement that long-term care providers take this, so there is no current fiscal note attached to it. If there were a requirement that the long-term care facilities needed to take this, then we would have to put a fiscal note for more staff.

Chair Oscarson:
Legal tells me that you are required to develop it, but they are not required to take it.

Heather Korbulic:
That is how I see it.

Chair Oscarson:
It would be up to the individual facilities to determine if they want to do that. I would think that it would certainly be something they would want to look at and take into account. People would take it into account when they are taking their loved ones to those places to see the additional training and things that they have on their resumes.

Assemblywoman Benitez-Thompson:
This bill is a great concept, and we cannot do enough to drive our practices towards person-centered theory and making sure that our statutes support that trend. Can you tell me how many ombudsmen we currently have?

Heather Korbulic:
There are 9.5 ombudsmen that work in the field. The half of a person is a person who works out of Elko and has another half-time job.

Assemblywoman Benitez-Thompson:
If I remember correctly, there is a decrease in one ombudsman potentially budgeted in the next budget cycle. Is that right?

Heather Korbulic:
I have not heard that, so I hope not.

Assemblywoman Benitez-Thompson:
Your primary obligation as an ombudsman is to respond to complaints by folks who are residents in the four different licensing types. That keeps you quite busy. Is that correct?

Heather Korbulic:
Absolutely.

Assemblywoman Benitez-Thompson:
I love the concept of this bill. I am wondering if there is perhaps a way to create more community partnerships to make sure that we can do something like this, because I imagine that your free time is very limited, considering all you have on your plate. However, it certainly is the direction we need to go.

Chair Oscarson:
In the facilities that you see, are there currently ombudsmen on staff to handle some of those circumstances, and then they work with you?

Heather Korbulic:
No long-term care facilities that I am aware of have ombudsman staff. Only my staff that works for the state Aging and Disabilities Services Division is available to those residents who are in long-term care.

Chair Oscarson:
It is my understanding that you have worked closely with the Silver Haired Legislative Forum on this bill, correct?

Heather Korbulic:
That is correct.

Chair Oscarson:
I appreciate all your input and what you are doing in the community. Now we will take public comment. I have several folks who are in support of the bill. Please do not duplicate remarks. If you are in support and you just want to say so, we have your names on the record as well.

Connie McMullen, Member, Nevada Commission on Aging:
When I became a Commission on Aging member about two and a half years ago, the first request Jane Gruner, the Administrator, put out to me was, would I like to go visit a nursing home and to learn how this ombudsman program worked. I said sure. It was the first time I was ever offered this in the 14 years that I have been a volunteer for the state of Nevada. I went to one in Reno. After an hour and a half, we had visited every single resident in this nursing

facility, many of them long-term residents—over three years. At that point, I would say they were considered residents of this facility. The ombudsman that took me had a definite belief in culture change, dealing with person-centered care. All persons were handled in a way and talked to in a way as if this was their home. They were not living in an institutional environment. They were living as a full-time resident. They had nobody to take care of them in their own homes. As a least restrictive environment, maybe this was it for them. For some people, they cannot live in any other setting. What was unique about this program was one individual that we visited had been there for three years. His daughter bought him a Hot August Nights tee-shirt because of this special event that occurs here in northern Nevada, which had just happened. This was very special to him because over the course of three years, his clothing was disappearing, especially when it went out for laundry. Lo and behold, his Hot August Nights shirt disappeared. This advocate ombudsman went to the administrator. She said he did not come in without clothes. He needs clothes and make sure he has clothes. There was nobody else in this facility that would advocate for this individual, and given that this was his home for the moment, it would be inhumane not to.

The next resident was objecting to cold eggs that they were getting two hours after breakfast. The next resident was complaining that they were not necessarily getting their medications. That is a violation. You kind of get the gist of where I am going. Each resident had a different concern. Person-centered care does not focus around the environment's rules that they have to get up and do this at this time or that they can only bring so many clothes at this time. If a resident has personal likes and dislikes, the focus is on the person as a human being. That is what this whole trend is about.

It is a little bit more than a trend now. The Centers for Medicare and Medicaid are developing new regulations that deal with Medicaid in the next three to four years. A lot of it is a focus on person-centered care. Often because training does require a certain amount of time and money, mostly by state staff and government, the philosophy of culture change for person-centered care comes from the very top down to the very bottom, to every staff member. We are really trying to see that happen in Aging and Disability Services where the little ones all the way to the oldest ones are getting the greatest care and that it is person-centered. The concept of this bill that we are discussing, Assembly Bill 28, is great. Do we want to legislate everything? Maybe you have a point that we should not. However, if there is a way to encourage people in our environment to do the right things for people of all ages with disabilities in varying degrees, then this is it.

Chair Oscarson:
We will call anybody who wants to testify in opposition to the bill. [There was no one.] Is there anybody in Las Vegas that wants to testify in favor or in opposition?

Herbert Randall:
We have five more Forum members here that are very much for it.

Chair Oscarson:
Seeing nobody against, do we have anybody in a neutral position that would like to testify? [There was no one.] We can close the hearing. The Committee will take this up at a work session later on. Now we go to regular public comment.

Peggy Lear Bowen, Private Citizen, Reno, Nevada:
I am not speaking to Assembly Bill 28 specifically; I am speaking specifically to concerns that have entered into my life and into Nevadans' lives in all of our communities. That is when the hospital that you are required to go to by your insurance company is owned by the same company. That means this: The first thing they look at is, as an older American, if you are on Medicare. The state of Nevada recently required in 2012 that their retirees as state employees and non-state employees that are part of the system, that they purchase Part B of Medicare. The way it works is like this: If you go to the hospital, in some communities in particular, you are brought in by ambulance, and you have had a transient ishcemic attack, a minor stroke. You are 96 years old, so I am not talking about me yet, and you will not be admitted unless, at that moment, the hospitalist determines that you are in a life-threatening situation. If you are in a life-threatening situation and you are admitted, your insurance company pays 80 percent, and you are responsible or your stop-gap measure, whatever you have, is responsible for 20 percent. You are otherwise sent home until you have a more life-threatening situation, or you are admitted for observation where Medicare pays 80 percent and your supportive insurance company pays the 20 percent. You might be denied services.

You might come by ambulance with a concussion, but you are given protocol, and you go home for bruises and contusions because that is not life threatening, whereas a concussion might be considered life threatening and you would have to be admitted under life-threatening. The hospitalist makes the determination, not the emergency room doctor, as to your care. I went to the Retired Public Employees of Nevada Christmas luncheon this year, and we lost over 100 members this year. They died. We have had people in our community up in the north who have been in exactly this situation who have had to desperately fight for their lives to stay in a hospital setting because they could not survive at home on their own with whatever condition they had. They had to use the term "unsafe discharge" from the emergency room in order to stay because they put them on notice that they would be sued if they died. That was the major point we need to view as legislators start looking at insurance companies that also own the hospital, and you are required to go to the hospital because people are sent home to die because they are not said to be in a life-threatening situation.

Jeffrey B. Klein, FACHE, President and CEO, Nevada Senior Services, Inc.:
I want to briefly comment on Jane Gruner's report and the Division on Aging. We have the great privilege of working with Ms. Gruner and her team. It is unusual to be able to come to a government session someplace in America and say, "The folks we work with are great. They care, they engage, and they collaborate. They work as partners with those of us who are in the community-based services side of life and work as a partner to try to solve the problems." We are very appreciative of the initiative Ms. Gruner reported to you today and very supportive of all of them.

With respect to several of the specifics, just an additional comment. The home community-based waiver program, which is extremely important in this day and age that Ms. Gruner reported on, currently has a waiting list of well over 500 persons. That waiting list runs a year, which means a number of those people will be institutionalized instead of maintained in their homes if we cannot find a way to get resources to them. That institutionalization, if they have dementia, means an out-of-state placement. Right now, we have about 85 of our Nevada residents that the State of Nevada is paying for, creating jobs in Arizona, California, and Utah. On behalf of their citizens, I would thank us, but for us, we need to see how we can keep those resources in the state and our folks in their homes by looking at making the waiver work better for Nevada's citizens.

Secondly, just by way of some additional information, we have talked about Alzheimer's and some of the specific populations that the Division serves. There was a study by the Centers for Disease Control and Prevention recently that we are very proud of and will enter into the record. I say proud because it points at parts of Nevada Senior Services, but it also talks about the state of Nevada and its population compared to the federal population. I want to underscore Ms. Gruner's comment about the aging of our society, but more importantly even, the facility of that aging. A very significant percentage of our society is in that portion of the population that is most fragile and most frail. That portion of the population is aging the fastest, which means the burden on resources and services is the greatest and will continue to increase.

A couple of quick statistics and then I will conclude, but I think you will find this interesting. Nationally, 32 percent of persons enrolled in adult day health care have Alzheimer's. In the state of Nevada, it is 47 percent. At our facility, one of the few that really specializes in taking late-stage cases, it is 81 percent. Nationally, depression as a diagnosis in adult day health care is 24 percent. In our case, it is 70 percent as an admitting diagnosis. Of people admitted to hospitals, 6 percent nationally have had an admission within 90 days of coming to an adult day health care center. In Nevada Senior Services, it is 21 percent of our population. Nationally, 18 percent of Medicare patients are readmitted into a hospital within 30 days of discharge, with 36 percent for the state of Nevada and 40 percent for Nevada Senior Services. The last statistic is what I consider the frailty statistic. Many of us who have parents and have friends who are elders and those who have people with disabilities will really appreciate these numbers as an indication of how important this issue is to Nevada. If we look at activities of daily living nationally, 25 percent of folks entering adult day health care have problems with eating. In Nevada, it is 40 percent, and in our case, it is almost 90 percent. Nationally, 36 percent have issues with toileting, 52 percent statewide in Nevada, and in our case, it is 76 percent. Twenty-eight percent have mobility problems transferring in and out of a chair. It is 36 percent for the state and 60 percent for us. Lastly, walking and locomotion, nationally it is 47 percent and 70 percent for us.

This gives you an idea of the frailty issues that is being incurred by our citizens in the state and the importance of the work that the Aging Disability Services Division does to help address these things. We look to the Legislature for their important role in working as a partner with our community to help address these things as the session moves forward and as our citizens require your attention.

Chair Oscarson:
Do you have that broken down by geographic area within the state?

Jeffrey Klein:
I do not, but I can get that for you.

Chair Oscarson:
That will be very helpful to see where the hot spots are that are having those kinds of issues, because I would suspect that there are certain areas that are driving that train more than others do. Those are the ones we need to provide to Ms. Gruner and her staff to be able to concentrate on them much more. I am sure she is probably aware of them, but if we can see them, that would be helpful.

Assemblyman Jones:
Do you have any idea why our statistics are so bad, so over-inflated compared to other states?

Jeffrey Klein:
We have the perfect storm in Nevada. In many communities around the country, like New York and the two coasts, populations moved into those states and began to age out. They have an infrastructure for it and then, as they got older, began to look for places to retire. In Nevada we have a major influx of people who are approaching their senior years, the last 15 or 20 years in particular, and those people who came to us at 55 looking for a wonderful state to retire in, low cost of living, personal tax structure, and so on moved here. We got this tremendous influx. We had developers, the Del Webb communities as an example, who began to develop housing for seniors. We became a mecca for seniors. The population that would have been in New York or Pennsylvania or the Midwest, is now living with us. As they enter those years, they are getting the natural results of aging and frailty that come from that in the older population. We have seen a major increase and a decrease in some other parts of the country because that portion of the population has left them.

A second issue is our infrastructure. Our infrastructure has not had the opportunity to grow the way it has in states that have had long-standing populations and where communities have been able to catch up. Frankly, our level of services is much lower than that of other parts of the country. Let me give you an adult day care example. The Robert Wood Johnson Foundation did a study 10 years ago and said we needed 45 new adult day health care centers based on population as part of a national study. In the years between 2008 and 2014, the Bureau of Health Care Quality and Compliance granted 50 adult day care licenses in the state of Nevada. Eighteen of us are left. Our organization remains the only not for profit in the south and one of three in the state. What has happened, and a lot of that has been rate increases, as a result of that issue, is the infrastructure has shrunk. We also lack critical human resources, geriatricians, therapists, and so on. We tend to be more prone to people not seeking and gaining the care they need early, which makes them sicker, more fragile, and more at risk by the time we reach them. It is kind of a perfect storm. I think we have an opportunity as a state to head some of this off. We are in the early stages of the big tsunami wave. By working together, we can head some of this off. If we do not head it off, then the implications, as the population expediently changes in demographics, become dramatic. Thus, we end up with a much bigger problem on the back end.

Chair Oscarson:
Some of those things that Ms. Gruner talked about, some of those analyses and the things that she is doing, will assist us as a Committee in the future with those needs. We will be able to access what those needs are and, as the population shifts and changes, how we will need to respond to that. Meeting is adjourned [at 2:54 p.m.].

RESPECTFULLY SUBMITTED:

Karen Buck
Committee Secretary

APPROVED BY:

Assemblyman James Oscarson, Chair

DATE: ______________________________

EXHIBITS

Committee Name: **Committee on Health and Human Services**

Date: **February 9, 2015** **Time of Meeting:** **1:32 p.m.**

Bill	**Exhibit**	**Witness / Agency**	**Description**
	A		Agenda
	B		Attendance Roster
	C	Jane Gruner, Administrator, Aging and Disabilities Services Division, DHHS	Power Point Presentation
A.B. 28	D	John Yacenda	Letter of Support
A.B. 28	E	Herbert E. Randall, Ed.D., President, Nevada Silver Haired Legislative Forum	Testimony