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

Seventy-Eighth Session
March 16, 2015

The Committee on Health and Human Services was called to order by Chair James Oscarson at 10:29 a.m. on Monday, March 16, 2015, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4406 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), 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 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
Assemblywoman Ellen B. Spiegel
Assemblyman Michael C. Sprinkle
Assemblyman Tyrone Thompson
Assemblyman Glenn E. Trowbridge

COMMITTEE MEMBERS ABSENT:

Assemblyman John Moore (excused)

GUEST LEGISLATORS PRESENT:

Assemblyman Randy Kirner, Assembly District No. 26

STAFF MEMBERS PRESENT:

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

OTHERS PRESENT:

Valerie Wiener, Chair, Task Force On Alzheimer's Disease
Peter Reed, Ph.D., M.P.H., Director, Sanford Center for Aging, University of Nevada, Reno; Vice Chair, Task Force on Alzheimer's Disease
Connie McMullen, representing Personal Care Association of Nevada
Tammy Sisson, representing Lend-A-Hand Senior Services; Member, Personal Care Association of Nevada
Kyle Devine, Chief, Bureau of Health Care Quality and Compliance, Division of Public and Behavioral Health, Department of Health and Human Services
Wendy Simons, Private Citizen, Reno, Nevada
Allan Ward, Board Member, Personal Care Association of Nevada
Kim Spoon, M.S.W., National Master Guardian, Guardianship Services of Nevada
Barbara Deavers, Private Citizen, Reno, Nevada

Chair Oscarson:
[Roll was taken. Committee rules and protocol were explained.] Since today is Alzheimer's Day at the Legislature, we are grateful to have former Senator Valerie Wiener here. We are going to have a short presentation on the effects and efforts of the Task Force on Alzheimer's Disease led by former Senator Wiener.

Valerie Wiener, Chair, Task Force on Alzheimer's Disease:
I have joining me Dr. Peter Reed, who is the vice chair of the Task Force on Alzheimer's Disease. He is located in the north and is a very important voice on the Task Force of ten people who live, breathe and thrive on this issue. I want to share a brief history about who we are, what we have done, and what we are doing here at the Legislature today (Exhibit C).

We are young, originally formed in 2011 based on a very brief, one-page resolution, Assembly Concurrent Resolution No. 10 of the 76th Session, sponsored by then-Assemblywoman Debbie Smith. The resolution was very pointed in its request that a task force be formed to establish a state plan to address Alzheimer's disease in Nevada. From 2011 into the summer of 2012, that task force had not yet been formed. However, the interim Legislative Committee on Health Care made a decision to give them a bill draft. That bill draft was great except there was no "them" at the time, so in June 2012, Chair Mastroluca asked me if I would chair the task force. My response was, "I am wrapping up my legislative duties and am expected to be constitutionally divorced from office on Election Day 2012." Therefore, my answer was, "Yes." We met five times, which were very extensive meetings, to deal with these issues. As required by that very small A.C.R. No. 10 of the 76th Session, we produced a state plan to address Alzheimer's disease. We had three work groups that worked offline with large groups of people with interests in particular areas, such as access to care, quality of care, and the quantity of care, to raise public awareness, because it is something people are quite cautious about having conversations about. It is uncomfortable for many, and our job, with a smile on our face, is to educate the population about what it is and what we are doing about it.

Often I will refer to Alzheimer's or I will refer to dementia, so I am going to share with you what it took me a year to resolve because I had never asked the question. There are about 50 types of dementia, some a little more exotic than others. Alzheimer's comprises about 70 percent of the dementia cases, so if I say them interrelatedly, you will understand I am talking in a more general category or more specifically to Alzheimer's, and because 70 percent of the dementia cases are Alzheimer's, you often hear them interchanged.

Today in Nevada, about 30,000 people have been diagnosed with Alzheimer's, and that is a huge number. It is a 38 percent increase over the previous ten years. To show how it is expanding in Nevada, we are expected to see a 75 percent increase by the year 2025. It has been noted that this is the most extensive health condition of all those you may study, review, or consider in legislation; this trumps all of them. Several of the traditional chronic diseases combined that we discuss in policy do not equal the cost of Alzheimer's care. Currently there are treatments but no cure.

The A.C.R. No. 10 of the 76th Session Task Force had one bill, which ended up being the bill that created the legislative statute statutory task force that I represent here today before you. We are housed in the Department of Health and Human Services under the Division for Aging and Disability Services (DADS). There are ten task force members who are appointed, two of them legislators, and this lends extraordinary significance to the work we do because we have access and opportunity for conversation with policymakers.

We could not do our work without the amazing and loving support of the staff from DADS who go above and beyond to make sure that our record is accurate, that the work we do is meaningful, and that we stay on task.

I helped draft the bill that created the Task Force, and one of the things that I thought was important, having 16 years of legislative experience, is accountability. We are required to provide an annual report and an updated plan by February 1 of every year, and we have been on time. What we do all year is get ready for the next report, so we are already working on the next year by revising the recommendations and coming up with funding streams and indicators for progress. Are these working? Is this happening?

We had three bills last session, including one bill that dealt with Senate Bill No. 69 of the 77th Session to allow advanced practitioners of nursing to have independent practices. Our primary concern was access for care and service in more remote communities. Although our bill did not pass, a mirror piece of legislation by Assemblywoman Maggie Carlton, Assembly District No. 14, Assembly Bill No. 170 of the 77th Session did, so that was addressed, and we feel that was a success.

We also had the bill to create the Task Force that Dr. Reed and I represent, and that passed. We had another one that was very emotional for us because of the testimony we heard up to the point of getting it passed in the legislative body. Families of younger onset Alzheimer's, and this is under 65 years of age, did not have access to any services. About five percent of Alzheimer's cases have a younger onset and, when diagnosed, they happen more quickly. They do not take up to ten years to manifest, rather it is usually more quickly and pretty dramatic. We had a northern Nevada family whose father was 52 and had full-blown Alzheimer's with children ages 10, 14, and 21 in the household. They became full-time caregivers, which meant they did not have a life anymore. The older ones took jobs because they could not go to school. We were successful, and we are very grateful for the support the Legislature rendered in passing that legislation. They were the first family to sign up for that care. It was very rewarding for us to give them respite care. They now get to breathe a little bit.

The Task Force on Alzheimer's Disease is constantly managing our recommendations. We originally started with 117 and have pared it down to 20. There is nothing magical about 20; it is just what we have. We are back on Alzheimer's Day this session, and we are thrilled to be here, wearing purple, so you know who we are. Six of our recommendations have been included in legislative measures. One was this morning, Assembly Bill 9, which the Assembly Committee on Judiciary heard, and one that is in our recommendations under the Affordable Care Act, Senate Bill 177, which has already been heard. It is one of our concerns about providing knowledge to caregivers as people transition out of hospitals to other rehabilitation facilities or to home care. This afternoon, Senate Concurrent Resolution 2, sponsored by our task force member Senator Joseph P. Hardy, addresses four of our concerns. Those deal with training, education, and more training for people who are dealing with dementia care. That includes the medical providers, not only doctors and nurses, but also what we do not think about, the first responders who often have the initial exchange or opportunity. It might be a fire fighter or police officer for an emergency in the home. This bill will urge and encourage adequate training so that they can recognize someone who may have a dementia challenge. There are certain and immediate ways to determine some of those signs that they will be taught. Because it has been one of our priorities, some of that is already taking place in fire stations and police departments around Nevada. We are encouraging it for everybody. We are excited for that bill this afternoon.

Our task force has ten people who are passionate about being the voice in places like the Legislature, town hall meetings, facilities, and in front of professionals. They are the voice for the voiceless, allowing people to be heard who will probably never be heard again and do not have the capacity to know that they need to have someone advocate for them. We expect that the number of people diagnosed with dementia will increase 75 percent by 2025. That is now. We are here to represent not just those who have been diagnosed or are yet to be diagnosed, but to also represent the caregivers, who are most often the families who cannot even step outside the front door to be heard. They need to have someone say, "This is what it looks like in a family. This is what it looks like in a neighborhood and in a community." We are here to say we are available, we are accessible, and we want to inform you if you have questions on the recommendations or the plan. We are here because these are Nevadans, and they are our neighbors, our friends, and our family. It is up to us to be out there and speak for them, and that is what we are here to do today.

Chair Oscarson:
As a former member of this Committee, while I did not get to serve with you, your handprints are on many things. It is pleasure to have you.

Assemblyman Jones:
Is this dramatic increase in diagnoses that you are referring to due to more people moving into the state, like snowbirds, or is it due to different diagnostics? What is the reasoning behind it?

Valerie Wiener:
I will answer part of it and then turn it over to Dr. Reed, as this is what he does. He works with this on a more intense basis than I do. I am one who does not do this every day but am privileged to chair all those who do work with it every day. The increase is a combination of things. We are one of the fastest-aging populations in the country, both by people who are here and certainly by those who move in. Even as we had some slump in the economy, I remember that at one time our state was the fastest-growing population of people over 65 in the world. I am sure we are probably getting there again, which is part of it. We live longer, and that is part of it. Diagnosis is coming sooner. However, it is not just Nevada. This is growing very, very quickly, and if not already, it may become the fastest growing health challenge in this country. You can spend 10 or 20 times as much on health care for someone diagnosed with one of the 50 forms of dementia like Alzheimer's, as you do on many of the other chronic diseases, and there is no cure.

Peter Reed, Ph.D., M.P.H., Director, Sanford Center for Aging, University of Nevada, Reno; Vice Chair, Task Force on Alzheimer's Disease:
I would echo what Senator Wiener said. One thing I would like to clarify is that number of 37,000 people living with Alzheimer's in the state of Nevada is actually not diagnosed cases. That is a prevalence estimate, and we know that the data shows that about half of people living with Alzheimer's are not diagnosed. However, that number is going to grow significantly over the next ten years, as much as 75 percent, to 64,000 people living with Alzheimer's in the state. The cause of that is the aging of the population. Ten thousand baby boomers are turning 65 every day, and Alzheimer's disease is an aging-related disease. Your risk of developing it increases as one ages. We are the second-fastest aging state in the country, and because of that, we have the second-fastest rate of growth in Alzheimer's disease.

Assemblyman Jones:
Generally, when people are diagnosed to the point where they require care, how much longer do they usually live?

Peter Reed:
Typically, they live 8 to 12 years after diagnosis, but we know that people live many years before they are diagnosed. Alzheimer's disease is something that gradually affects the brain over time and perhaps as many as 20 years after developing symptoms. However, there is a lot of research into early detection, so we can develop imaging technologies and biomarker technologies to identify the pathology of the disease prior to it manifesting itself in terms of symptoms. If we can catch them early enough, then when we do develop a

disease-modifying drug, we will be able to arrest the progression of the disease, and they will be able to maintain their quality of life.

Valerie Wiener:
We are available. The extraordinary impact of this disease is not something we can turn aside because it is uncomfortable having conversations about it. As Dr. Reed said, the earlier we can learn about someone having it, the better quality of life we can give that person. What I have often said is unlike the traditional, chronic diseases we talk about with devastating physical impacts, such as cancer, heart disease, and diabetes, they can get proper medical care and support through different organizations even if they do not have a caregiving family. However, with Alzheimer's disease, this is a disease of family. When we talk about 37,000, the vast majority of those people are in their homes. That means that the family or volunteers are the people who are under the radar in terms of recognition for the amazing work they do and what they provide. Once someone is diagnosed with Alzheimer's disease and they have family, it becomes a disease of family unlike any other illness that we are aware of. It is long lasting, so this is bigger than the diagnosis; it is about families and communities. That is why it touches all of us in some way and why we are passionate about talking about it, explaining it, answering questions, and seeking answers ourselves.

Chair Oscarson:
We appreciate your passion and your educating people about a subject that at some point in time will probably touch all of us. I will now open the hearing on Assembly Bill 222. We are fortunate to have the chairman of the Committee on Commerce and Labor with us today, Assemblyman Kirner, and Ms. McMullen.

Assembly Bill 222: **Revises provisions governing the imposition of administrative sanctions against facilities for the dependent. (BDR 40-645)**

Assemblyman Randy Kirner, Assembly District No. 26:
With me I have Connie McMullen with *Senior Spectrum Newspaper* and Tammy Sisson, who is with Lend-a-Hand Senior Services. This is an issue I have brought by request, so I am going to let them provide most of the testimony. However, it is interesting for me, having listened to the previous speakers talk about Alzheimer's disease, to realize I am not in good shape. I have had both of my parents go through those years, and I do know that they live a long time, as to your question, Assemblyman Jones, and oftentimes, it is a very difficult time for children taking care of their parents. One of the things that we tried to do in our family was to keep them in their home as long as possible, giving them their own familiar grounds.

Connie McMullen, the Personal Care Association of Nevada:
I represent Personal Care Association of Nevada, which provides care to approximately 37,000 people statewide. I am testifying in favor of Assembly Bill 222, which would impose a fine on personal care agencies and other facilities for the dependent that fail to obtain a license to do business with the Bureau of Health Care Quality and Compliance (HCQC) in the Division of Public and Behavioral Health. [Ms. McMullen continued reading from written testimony (Exhibit D).]

When I proposed the idea of this bill draft—and now bill—to Assemblyman Kirner, I had asked that only personal care agencies be written into the bill. However, the Legislative Counsel Bureau consequently included all the facilities for the dependent. There are seven of them. Two of them, the homes for individual residential care and the group care facilities, are already currently mandated to be penalized monetarily. I am asking for the personal care agencies to be the same. I have not heard any opposition to the four other categories. I do have an amendment, but if I hear no opposition, I am okay going forward. I think all people who take care of the vulnerable, whether they are older or younger, should have a penalty for noncompliance.

Assemblyman Jones:
I have a question on the definition of all personal care facilities. It is quite expansive when you say all. That would mean that if somebody is helping one person—an example is my grandmother who used to rent one of her rooms out, and she would help people who were having situations—would she have to get a license underneath this law? You said two people, but now you want all. That seems to be pretty broad.

Connie McMullen:
I said two people in regard to the homes for individual residential care. That is where somebody has a small group home in a neighborhood and is providing care by renting out a room, feeding them, and other care. We call that category a home for individual residential care (HIRC). When I am talking about personal care, that is an agency that comes in your home on a scheduled-time basis so many times a week. Tammy Sisson can address this, too, as she owns a business. They provide care. If you are providing care to maybe one or two of your neighbors or a family member, you are considered a casual caregiver. This law does not apply to them. We had that question come up initially in 2002 whether they should be licensed. The casual caregivers are written out of the context of the *Nevada Revised Statutes* (NRS). I understand that a lot of people take care of other people in the community. This is for those people who are doing business. Some of them provide care to as many as 500 people a year

and employ that many, too. These are the people who are professional caregivers.

Assemblyman Thompson:
How often does this occur? How many people may be in noncompliance?

Connie McMullen:
That is a good question, and we do not know, primarily because it is happening all too regularly. It was mentioned that I have a small business in the news media, so I do get a lot of the Attorney General's emails. They prosecute on a regular basis somebody every month. It is hard to know because many of them fly under the radar until it is brought to the attention of the Bureau of Health Care Quality and Compliance (HCQC). A lot of times, members of Primary Care Access Network (PCAN) will pick up their literature, and they will know that they are not licensed. I personally will not do business with a company saying they are licensed when they are not. It is easy to find out. You go on the HCQC website and all the licensed facilities are listed. However, I imagine it is hard for the Nevada Division of Public and Behavioral Health to catch them all. I hope that they are here today to answer to that, and if not, I will find out for you.

Assemblyman Thompson:
That was my follow-up. Who has the ultimate information? Is it the city business licensing or the state business licensing? Going back to Assemblyman Jones' question, it has always been mass confusion about group homes, who that involves, and how many people can be in the home. However, I think you clarified that part. I just wanted to know if the state or some of the city business license agencies are here to support this.

Assemblyman Kirner:
Some of these questions can be answered by Tammy Sisson, who runs the kind of business that we are addressing today. [Ms. Sisson submitted written testimony (Exhibit E).]

Tammy Sisson, representing Lend-A-Hand Senior Services; Member, Personal Care Association of Nevada:
The answer to your question, Assemblyman Thompson, is these are agencies. These are companies that hire people, employ people, and go out and assess clients all unrelated to them. This has no impact on family caregivers or a friend of a friend. These are people who actually create a business. What they are going out and doing is opening up these companies, starting to bill clients, and bringing in revenue. Then we, as a member of PCAN, call them and tell them they have to have a license and then report it to the Bureau of Health Care

Quality and Compliance. However, what we are finding is that since they have already gotten their feet wet, they are ready to go but with no protection for the senior. In licensing, the packet that the state gives them is very comprehensive and very simple. As a licensed agency, I am the one who initiated the bill originally. It has just been amazing. It has brought about regulation accountability and has really protected our seniors. The population that we deal with is so vulnerable; they will do anything for someone to help them.

Assemblywoman Titus:
You used the terms comprehensive and simple. Is that not an oxymoron?

Tammy Sisson:
As I look at it, when you open up a business like this, you have to have your training in place. Caregivers have to be trained on pertinent areas for the population that they serve and have their background checks and drug tests done. The packet from the state lists those step by step. They actually help you to do it. They have classes that have a question and answer forum, so it is very supportive. To me as a business owner, it is self-explanatory.

Assemblywoman Titus:
I just wanted to make it clear because I think there should not be any obstacles to get the licenses, and I just brought that out because, although it may be comprehensive, it sounds like you are making it as easy as possible for these folks to get licenses because you want to expand the programs. Our senior population, as we just heard, is going to increase dramatically, and with other medically related dementia issues and health care issues, we need as many agencies as possible that can help these folks stay in their homes or go into assisted living or day care. We want to make sure that we are not obstructing this process. As long as the state and the agencies can do the licensures, we do not want these folks to not get their licenses because it is onerous on them. We would hate to see any obstacles.

Assemblyman Gardner:
To go through these regulations, is it a time issue? Is it a dollar issue? If it were dollars, how much would that cost? What kind of barriers do we have? We want our elderly people taken care of. We also want to make sure that there is competition because they are such a rapidly growing entity. Can you give us an idea of what kinds of things they have to go through?

Tammy Sisson:
When you apply for an application, there is a fee of $3,800. In the survey, you have all your policies and procedures written and your staff in place. Most people have one or two caregivers, or it is a husband and wife team to

start with. The state comes out, surveys you, and looks at all the pertinent information that has been requested and required, making sure that you have it in place, and then you receive your license. The entire process takes about six to eight weeks.

Kyle Devine, Chief, Bureau of Health Care Quality and Compliance, Division of Public and Behavioral Health, Department of Health and Human Services:
In regard to Assemblyman Gardner's question, we do everything possible at the state to make the processes easy for these agencies, while maintaining the assurance that we are meeting minimum qualifications. In the event that we see difficulty, we reach out to the agency with whatever we need to do to help them get through that process. Our purpose is for compliance. It is not to limit the agencies, as we know that they are definitely needed in our communities. We do everything possible to bring them into compliance when they are not and to guide them through the application process.

Assemblywoman Dickman:
It seems like $3,800 is a lot of money for a small or one-person business. It is obviously not $3,800 a year, but is there an annual license fee?

Kyle Devine:
There is an annual renewal fee that is less than the initial application fee. The annual renewal cost is $1,275. This only applies to those personal care agencies that are agencies, not individual persons. Those costs cover the costs of the Bureau of Health Care Quality and Compliance doing the inspections, investigating complaints, and processing all the licensure paperwork.

Assemblywoman Dickman:
Let us say someone has a small group home: for example, three people. Do they have to pay those fees as well as the company that has 500 people?

Tammy Sisson:
Group homes have different fee structures. This is basically for when you send caregivers into the home. As an agency, we usually charge anywhere from $20 to $25 an hour, billed by the hour, and paid for by the client. Therefore, the licensing fees are not cost-prohibitive. Some clients are 24-hours-a-day, seven-days-a-week. We are finding that these agencies are starting up and getting clients, and then the Bureau comes in and tells them they are not licensed. I want to have a barrier to entry, which states that first you go through the process. You apply for a license first, so that we can have accountability across the board for everyone.

Assemblyman Jones:
It says in A.B. 222 relating to a facility, but you are saying it has to do with people that go into the home, but all through the bill, it says "facility for the dependent." That is how it is defined. It does not say anything about paying by the hour to send somebody out. Are we looking at a different bill?

Tammy Sisson:
No. When the licensure was first initiated, they put us under facilities for the dependent. We are not facilities for the dependent, but if you look on the front of the bill at the Legislative Counsel's Digest, line 4, it says "an agency to provide personal care services in the home." I know that is conflicting.

Assemblyman Jones:
Yes, I know what a facility for the dependent means. We can look those words up, but a facility is a place where people go to one location, not outsourcing, so that does not make any sense whatsoever.

Kyle Devine:
Putting personal care agencies under dependent care is more or less just a classification. When we speak of the definition of facility, it includes personal care agency. It is just a way that we classify agencies and facilities. Non-long-term care facilities are under the dependent care facility, therefore, under the definition of a dependent care facility. Those agencies are included as dependent care facilities for keeping order of what we do and for keeping things consistent.

Assemblyman Jones:
However, if they are not properly described in the statute, how are we then to trust you that it is being properly administered in the way you intend? Trust me, as a business owner, I have had the fire department, World Health Organization, and Occupational Safety and Health Administration coming in, all saying that they were just here to help. Well when they come through, for lack of a better term, many times, they are like tyrants, and I feel like giving up. Okay, 50 people are without a job now. Boom, you are gone if I do decide to give up. It is simple English. "Facilities for the dependent" is not what you just described. I do not know how you can say they classify. It does not make any sense to me.

Kyle Devine:
The definition of a personal care agency is in the statute as a dependent care agency. It does define what that agency is and what it does.

Tammy Sisson:
In the bill, it is on line 4 of the Legislative Counsel's Digest where it says "an agency to provide personal care services."

Assemblyman Jones:
I am looking at the actual statute. Can you show me in the statute or the bill?

Connie McMullen:
We will look it up, but describing personal care is in the statute. I would also like to make a correction. The fee for a personal care agency initially is $1,374 and then annually, it is $687. All the fees and the fee schedules for medical and nonmedical facilities are listed on the state website. They are all different.

Kirsten Coulombe, Committee Policy Analyst:
The NRS reference is NRS 449.0045, Assemblyman Jones. Of the seven listings, it is the fifth, "an agency to provide personal care services in the home." If you are looking at the bill under the Legislative Counsel's Digest, it is line 4.

Assemblyman Jones:
I understand it is in the Legislative Counsel's Digest. I am asking where the reference is in the bill. The bill says specifically "facility for the dependent." That is new language written more than once. How are we interpreting something that is just in the Legislative Counsel's Digest into the bill and then saying that these different rules apply to it?

Chair Oscarson:
We need to get this clarified in an offline discussion with Assemblyman Jones. We can get a definition from legal counsel if we need to.

Assemblywoman Benitez-Thompson:
My question is related to the scope. I appreciate what you offered at the beginning, Ms. McMullen, that you are waiting to see if folks have heartburn in one of the seven categories and that you are focused on one category. It has been discussed what those seven categories are, according to NRS and the *Nevada Administrative Code* (NAC). Mr. Devine, there were some media reports during the interim about the number of inspectors you had working to keep up with all of the inspections that are required. I feel like this is an obligation that your department is very willing and able to handle. I want to have it on the record that your offer to inspect and hold people accountable to the NAC and the NRS is not necessarily burdensome to your agency. This just gives you the ability to find people who are out of compliance, correct?

Kyle Devine:
You are absolutely right. We are currently doing this in all of our facilities. When we get a complaint of an unlicensed facility, we go out and do the inspections. Then, with the current staff that we have, we are doing this as best we can with the resources that we have.

Assemblywoman Benitez-Thompson:
In the line of work that I do in hospice as a social worker, families are often asking, when their family member starts receiving the service, who they can call to get more services in place. We are calling agencies like Lend-A-Hand and others. People often want to take shortcuts. They want to save money, such as looking on Craigslist. The scariest thing in the world is to have a stranger come into your home who is not properly licensed and certified. We want to be able to refer our families to properly licensed and certified agencies. Otherwise, we are leaving a lot of different professionals very vulnerable if they are not properly licensed and certified. As a social worker, I want to be able to make referrals to licensed agencies and help my families get the care they need.

Assemblywoman Spiegel:
Does anyone know if the state verifies facilities' licenses before making Medicaid payments? What happens if it turns out that the facility is not licensed?

Kyle Devine:
It is not appropriate for me to answer on behalf of Medicaid. I know that they do look at licensing regarding reimbursement, but the answer needs to come from Medicaid.

Chair Oscarson:
Could you get us the information of whom we could ask in that regard and give it to Ms. Coloumbe?

Kyle Devine:
Yes, I can.

Chair Oscarson:
Is there testimony in support of A.B. 222?

Wendy Simons, Private Citizen, Reno, Nevada:
I am speaking here on behalf of myself. However, in the past, I was Chief of the Bureau of Health Care Quality and Compliance. This issue did come before us many times. Most particularly, we solved it with Assembly Bill No. 50 of the 76th Session for the unlicensed residential care facilities and homes for

individual residential care. However, in my duration, we licensed 97 personal care agencies. I believe there are now between 97 and 130 agencies. The behavioral pattern that I saw during my tenure was employees who worked for an agency for a period of time would then go out and get a business license, thinking they were licensed with a disregard to getting the state health facility license, which clearly defines more training requirements and more accountability. It was a problem that was brought to me when I was in that seat. We did not have the teeth to bring forward that a person could be fined an extraordinary amount.

Those behaviors do continue. I think it is predictable, also, from the standpoint that California operated as a state without having requirements for agencies to be licensed and then recognized that they had a lot of unscrupulous individuals out there providing care to the vulnerable population. In that regard, they just recently set forth requirements for licensure of these types of agencies. Sadly, it is unfortunate that we have to have a deterrent methodology for people to have accountability and professionalism in their delivery of services. However, we did find with the homes for individual residential care and the adult group cares, that when there was a potential $10,000 fine for operating without a license, there was improved compliance.

I also was a facility owner, and Assemblyman Jones, I also had all of those agencies come in. I operated assisted living agencies for 35 years and was totally respectful when they said they were the government and were there to help me. By the same token, as responsible citizens, we do want to protect the vulnerable, as Assemblywoman Benitez-Thompson mentioned. One additional thing that I have observed, both as a provider and for duration of time I was at the Bureau of Health Care Quality and Compliance, was individuals who would get one license for one entity and then go out and market that they were a licensed facility while operating four or five that were not licensed. It was a false presentation that was an ever-present challenge in that world of people misrepresenting the standards they had met. This measure is something worthy of consideration and now, as a citizen, advocating on behalf of our elders, I wanted to express my support.

Allan Ward, Board Member, Personal Care Association of Nevada:
I am the owner of Home Instead Senior Care in Reno and Carson City and am also a board member on the Personal Care Association of Nevada, our statewide association. We are licensed and, having been regulated now for seven years. We are trying to enforce the regulations. We are challenged because you have bad actors out there operating without a license, more than likely without two-step tuberculosis tests, drug testing, Federal Bureau of Investigation national background checks, training, follow-up, et cetera. Then when

something happens, the entire industry gets a black eye. The individuals, the consumers coming in, begin to have trust issues with the care needs that they have. The problem that we have had is there are no teeth to enforce the laws and regulations that have been put in place. These fines are just one of a multiple-problem approach to education and training for both consumers and professionals coming into the industry. These will not only penalize the bad actors, but they will also act as a deterrent. Those revenues from fines will be used for that education. Right now, when they do not have a license, they cannot be fined and, hence, our fees are increased to pay for those investigations. The good actors continually pay for the bad actors.

Kim Spoon, M.S.W., National Master Guardian, Guardianship Services of Nevada:
I am a private professional guardian who has been doing this kind of work for 23 years. As part-owner of a business called Guardianship Services of Nevada, I am a huge consumer of group homes and personal care agencies. I have been using these agencies for years, and 80 percent of our clients are using personal care agencies or group homes. I cannot tell you how often we have had to come in as guardians and remove people from personal care-stated agencies or group homes that have not followed the licensure, the practice, and the rules and regulations needed to protect our people. It is not just seniors but also the mentally ill, the disabled, and so forth. I want to give my support to this bill because anytime that we can protect the people who are out there and the families who do not have the abilities, such as we do as an agency, to understand the difference between the commodities that these people can give under a licensure, we should. This is so important for the families who already have so much going on in their lives. They are usually trying to find something in a very short time to help their family. As was said before, when they are getting names and initially cannot find someone, they become desperate and may not find someone who actually has the licensure and the background that these people can provide that do follow the law. It can be devastating to everybody involved. I want to give our support to this bill.

Barbara Deavers, Private Citizen, Reno, Nevada:
I am here as a senior citizen and one who has had secondhand involvement with the personal care agency services in our state. I have also worked with seniors in the past, both in a personal care agency and also with a state agency. For personal care, this bill is important because I would much rather, as a senior, be able to go out to businesses and know that they are licensed, that their staff has been properly trained, and that they have gone through all the different tests that they are required to do. You see a lot of different vans driving around town for house cleaning, personal care, or whatever, and you have no guarantees of what their backgrounds are. However, if you go through a

personal care agency, which I had to do for my boyfriend who was a stroke victim, then you know that they have had training. You know that you have recourse that if something happens, you can call up that agency and say, "Hey, your aide screwed up, and this is why." However, if you have someone who is not licensed, then you have no recourse; that is where it ends. In addition, if you have a personal care agency and do not get recourse through the agency, you can call the Bureau of Health Care Quality and Compliance and give an official verbal complaint. They will go out and research that. I am in support of this bill for the good of our seniors who may not be as aware of the services and what they entail, as all of us would be.

Chair Oscarson:
Are there any others in support here in Carson City or Las Vegas? [There were none.] Are there any people in opposition? [There were none.] Are there any in a neutral position? [There were none.]

Assemblyman Kirner:
My closing comments are a personal story. My father was a victim of a nonlicensed caregiver who milked my dad of $50,000 and all his properties. The caregiver was not licensed, and she was found out. She was then prosecuted in San Bernardino. This is a big issue for us. Our population is getting older. I am leading the way as part of the baby boomers. All this bill says is that we need to have the people who do this kind of service licensed. If they are not licensed, then they should be held to the same standard as other caregivers. They should pay the appropriate fines. They need to register and fulfill the requirements of licensure. That is what we are saying.

Chair Oscarson:
We will bring up Assembly Bill 222 in a work session. I will close the hearing on A.B. 222. I will now open the hearing on Assembly Bill 248. Assemblywoman Titus will present this bill.

Assembly Bill 248: **Revises provisions governing reporting of information by physicians to the Department of Motor Vehicles concerning patients with epilepsy. (BDR 40-930)**

Assemblywoman Robin L. Titus, Assembly District No. 38:
I am an assemblywoman but am here before you representing family practice doctors and physicians around the state. Senator Joseph P. Hardy, the originator of this bill, apologizes that he could not be here. It is with great satisfaction that I brought this bill forward because this bill was originally presented to the Assembly in 2003. [Assemblywoman Titus continued reading from her presentation (Exhibit F).] There is an excellent article published on the

National Institute of Health website from the American Epilepsy Society in 2009 that addresses the driving issues in epilepsy (Exhibit G). [Assemblywoman Titus finished reading her presentation (Exhibit F).]

I did contact the Department of Motor Vehicles (DMV) and asked how many folks they have registered as possible epileptic patients, and they said they do not separate that out. When people surrender their license due to medical reasons, they do not break that down as to whether it is because of eyesight, dementia, or other physical impairments. However, they did tell me that currently, they have about 1,457 licenses surrendered due to a medical reason. Somebody questioned how many accidents there had been, and that is referred to in the article that I sent you (Exhibit G). There has really been no documentation that there is an increase in accidents or any accidents that render to seizure activity. A statement that Dr. Krumholz made was that most of the laws were done on opinions but not on scientific evidence (Exhibit G). We are just trying to clear this up. If you were in the Assembly Committee on Ways and Means meeting today, you would have heard that Assemblywoman Marilyn Kirkpatrick had a constituent contact her about an eight-hour wait that they had at the DMV office getting a license in Las Vegas. One of the things that I hope to do with this bill is limit some of the DMV work if it can go back to a patient/doctor relationship.

Assemblyman Sprinkle:
Does the actual legal definition of epilepsy only include tonic-clonic types of behavior, or it is inclusive of focal seizures or things of that nature that are more isolated?

Assemblywoman Titus:
I cannot answer that question, and we do not have legal counsel here at this time. I am not sure of the absolute definition, but it is a broad definition and not defined in the statute that I have here.

Assemblyman Sprinkle:
Is this bill suggesting that depending on the relationship and advice of the physician, it might be okay for somebody that does have the propensity to having full tonic-clonic, which means completely incapable of controlling their own body, to drive a vehicle? Is that correct?

Assemblywoman Titus:
Absolutely, and we have thousands of patients out there that have major grand mal tonic-clonic seizures that are driving after a certain period where they have not had a seizure. The type of seizure is not the limitation to the driving; it is all about whether or not it is under control.

Assemblyman Sprinkle:
My guess would be that the original intent of the legislation, way back when it was first drafted, was to try to prevent people from being able to drive with that condition.

Assemblyman Trowbridge:
I think your bill is great, and I am going to support it. However, there are two pages of *Nevada Revised Statutes* (NRS) citations. What do they all generally address? This question is not just for me but for people at home who do not have access to the NRS.

Assemblywoman Benitez-Thompson:
NRS Chapter 239 is the public record section. Legal counsel is not here and may correct me, but to be exempt from public record, you have to have a specific statute citation. What Assemblywoman Titus is asking for in this bill is that in section 1, subsection 4 "a statement signed by the physician," be treated as a health document and like other health documents, not be subject to the rules under public records.

Chair Oscarson:
Ms. Lang will let us know if there is anything different from what Assemblywoman Benitez-Thompson stated.

Assemblywoman Spiegel:
I have a friend with epilepsy who goes back and forth about whether or not he has the ability to drive. As I was reading the bill, I did not see a requirement for there to be reporting back to the DMV when a physician says that the patient is then able to drive again. I do not know if I missed it, or if it is not in there.

Assemblywoman Titus:
The way that I interpret the intention is that it would not have been reported initially if it is under control. It is just so that there is not going to be a record that I then have to report back on and say now it is all okay. That is part of the hurdles, but the one thing I did like about this is that as physicians, we have mandatory reporting requirements if we think somebody is unsafe to drive. This does not prohibit that and, certainly, if somebody is not compliant with me, I am going to report him. The big thing for me is that the bill still has that segue to report. However, if I have a patient/doctor relationship and I feel my patient is safe to drive, I am going to assume that responsibility. I will have a recorded document that relieves me of some liability. However, we want to make the highways safe, and the purpose of this bill is to make highways even safer. Folks like your friend and many of my patients will not be afraid to come to me

and say, "Hey, I am having seizures." That is the big fear that I have, and I see it. I know it happens.

Assemblywoman Spiegel:
If Doctor X reports in that a patient is having seizures but gets them on medication, and the patient, through medication, gets the seizures under control, he would then be able to drive because he had gone for a period of time without having seizures. If it had already been reported to the DMV that he was ineligible to drive, should not it then be reported back to them that this person now appears to be under control?

Assemblywoman Titus:
The process, as it works today and would continue to work, is that the onus is on the clients or the patients. Once their driver's license has been suspended for whatever reason, to get it reinstated they would need to get a form from DMV and bring it to their provider who then has to sign that the medications they are taking do not prohibit them, or their illness does not prohibit them, from driving. They then have to take the form back to the DMV. The onus is not on the provider to do that for them. There is paperwork that we have to fill out routinely when somebody has a recovery, whether it is a stroke patient or whatever, that perhaps has not driven for a while. They take it back to the DMV.

Chair Oscarson:
For the record, we did receive confirmation from Risa Lang, Committee Counsel, and your explanation, Assemblywoman Benitez-Thompson, was exactly right.

Assemblyman Sprinkle:
You made a comment that during the physician/patient relationship, any physician would assume the responsibility. Yet in the same sentence, you said liability protection is built into this. It seems contradictory to me that if you are trying to protect the physicians from either making the wrong decision or not doing what is correct, that statement assumes that there is the potential for somebody driving when they should not be. Is the responsibility with the physicians or is it not, and if it is, then why do they need the liability protection?

Assemblywoman Titus:
The way that I read this and see it, the bill says in section 1, subsection 6, "The provision by a physician of a copy of a statement… is solely within his or her discretion. No cause of action may be brought against a physician based on the fact that he or she did not provide such a copy" of that contract if the DMV asks. That is one thing, so we are protected for that. If Doctor X reports that

somebody cannot drive, we are protected by that. If I feel that somebody is safe to drive and then he has an accident, I am not sure that the language in this bill protects anybody from liability. In the world today, we are never ever protected from all potential things that could happen. I cannot answer that specifically as far as whether or not I am protected if he has an accident and I have said he was safe to drive. For example, I do commercial driver's license physicals, and at that moment of time when I did a physical, I felt that the driver was in good condition, passing all the tests that I did. He then literally died of a heart attack in my parking lot. Therefore, can I cover all possible things that could happen? I cannot. Can I be protected from liability for all possible things? I cannot. However, I think the intent of the bill is that it is a patient/doctor relationship, and that is what we are trying to get at. We are trying to do the best thing for society in general.

Assemblyman Jones:
I appreciate your bringing this bill forward for a couple of reasons. It puts the discretion of whether or not there is a situation with a trained professional, as opposed to a bureaucrat. Secondly, the bill is based on studies and statistics comparing the other states and removing theory and potential probability. That is very important because then we are actually enacting a law that is based on facts, not on potentials that do not exist. Thank you for that.

Assemblywoman Benitez-Thompson:
When we talk about physician, would your preference be a patient's neurologist, the primary care physician, or anyone who is licensed as a physician?

Assemblywoman Titus:
The current statute states that all physicians have to report. I take care of many seizure patients, as do neurologists and internal medicine physicians. The statute does not clarify nor does it separate out types of physicians.

Assemblywoman Benitez-Thompson:
Are you comfortable with it being that broad?

Assemblywoman Titus:
Yes, I am.

Assemblywoman Benitez-Thompson:
In reading the article that you sent us, it talks about the status quo in other states and, specifically, the study talks about the fact that most states have a time frame from the last seizure as a marker by which they determine safety and probability for having another seizure (Exhibit G). It says here that the

one-year mark tends to be the consensus among the literature that you reduce the probability of crashes by 80 percent. Has there been consideration, as opposed to leaving it solely to the discretion of the physician, of combining the discretion of the physician with some kind of guidelines incorporating that one-year mark?

Assemblywoman Titus:
I appreciate your question because I also looked at that. The current way we do it is if they are seizure-free for six months, they can have their license back. The one-year is certainly a diminishing return. The further out you are, the less likely you are going to have seizures. I have had conversations with patients about stopping their seizure medication after so many years, say five years out, and doing a trial without medication. If I do that, for my own personal comfort level, I say, "If we are going to try to take you off this medication, I think you should not drive for at least six months to make sure you are not going to have a seizure while you are driving." As a health care provider, you know that every single patient interaction is a different interaction. All patients' causes are different and unique to them. Having it at the discretion of the providers, who use their best clinical judgment in cooperation with their clients or patients and not having a statutory requirement other than due diligence and good health care, makes it best.

Assemblywoman Benitez-Thompson:
To clarify section 1, subsection 6, this talks about, once again, the discretion of the physicians as to whether or not they need to submit the notification of the patient to the DMV. I know that my colleague, Assemblywoman Spiegel, mentioned that earlier. I want to echo her point, that if a physician recommends no driving, even if the patient does not want to sign the form to acknowledge that, perhaps that is an appropriate trigger in time to report the information to the DMV. I see in the language, in section 4 at the back of the bill, that if physicians think a patient is operating a vehicle when he should not be, they report it. Perhaps the language should be at the front of the bill and at the back of the bill to make sure that we have bookends for our due diligence.

Chair Oscarson:
Is there any testimony in support of this bill?

Wendy Simmons, Private Citizen, Reno, Nevada:
As a citizen, I came across this bill today when I came for the Task Force on Alzheimer's Disease. I would like to share that back in 2003 when Senator Hardy first brought this bill forward, I had the privilege of testifying on its behalf. I have a son, now 38 years old, who experienced his first seizure in a horse show. It was a partial complex, so it was an absent seizure, not

a tonic-clonic. He forgot to lope when he was supposed to in competition, and that is how we discovered it. Between his journey of seizure control and my related conversations with Senator Hardy, I really want to commend Assemblywoman Titus and all of the secondary signers on this for bringing this very important measure forward. My son is seizure-controlled now and has been for quite some time. He works in a health care facility and is doing well. After 33 days of depth electrode studies at University of California, Los Angeles to determine the focal point of the seizures and explore other measures, we ended up with a pharmacological solution.

However, what I do want to share with you as a parent and an advocate for individuals with seizures, there is, as Assemblywoman Titus cited, a tremendous fear for any kind of medication adjustment. Frankly, I feel he could probably have some of his medications reduced because he has been seizure-controlled for ten years. However, he will not even go there, which means that we are looking at liver strain and damage due to the medications that he has been taking over the course of time. He does not want to risk having a seizure that would force the doctor to report him for having one and pull his driver's license, which is critical to his current career.

I also served as a parent advocate, and we had several advisory groups for Dr. Mindy Schwartz when she was here. I can tell you story after story of individuals with seizures who will not advise their doctors that they have had a small incident that could be beautifully adjusted, mainly because they do not want the doctors to be put in a position of not being the patient manager but rather the reporter to DMV. On behalf of perhaps many in the future who have better opportunities to have seizure-control, this is a very important measure.

Chair Oscarson:
Your institutional knowledge as a former Chief of the Bureau of Health Care Quality and Compliance helps us a lot. Is there any other testimony in support? [There was none.] Is there any opposition? [There was none.] Is there any neutral testimony? [There was none.]

Assemblywoman Titus:
Thank you for allowing me to bring this bill forward. I was honored to do it. When I approached Senator Hardy about any important bills that he had in the past that he did not have room for this year, I offered to help him bring them forward. This bill had been vetted, went through hearings, and had been amended. What you are seeing today is the bill that had been worked through and questions asked. However, it was killed, so hopefully we can bring something positive forward.

Chair Oscarson:
Seeing no further testimony, I will close the hearing. I will open the floor for public comment. [There was none.] This meeting is adjourned [at 11:55 a.m.].

RESPECTFULLY SUBMITTED:

Karen Buck
Committee Secretary

APPROVED BY:

Assemblyman James Oscarson, Chair

DATE: ____________________

EXHIBITS

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

Date: **March 16, 2015** **Time of Meeting:** **10:29 a.m.**

Bill	**Exhibit**	**Witness / Agency**	**Description**
	A		Agenda
	B		Attendance Roster
A.B. 222	C	Valerie Wiener, Task Force on Alzheimer's Disease	Task Force on Alzheimer's Annual Report
A.B. 222	D	Connie McMullen, Personal Care Association of Nevada	Testimony
A.B. 222	E	Tammy Sisson, Lend-a-Hand Senior Services	Testimony
A.B. 248	F	Assemblywoman Titus	Testimony
A.B. 248	G	Allan Krumholz, American Epilepsy Society	Driving Issues Link