MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Eightieth Session
March 27, 2019

The Senate Committee on Health and Human Services was called to order by Chair Julia Ratti at 4:13 p.m. on Wednesday, March 27, 2019, in Room 2135 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412E of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Julia Ratti, Chair
Senator Pat Spearman, Vice Chair
Senator Joyce Woodhouse
Senator Joseph P. Hardy
Senator Scott Hammond

GUEST LEGISLATORS PRESENT:

Senator David R. Parks, Senatorial District No. 7
Senator Melanie Scheible, Senatorial District No. 9

STAFF MEMBERS PRESENT:

Megan Comlossy, Committee Policy Analyst
Eric Robbins, Committee Counsel
Michelle Hamilton, Committee Secretary

OTHERS PRESENT:

Brooke Maylath, President, Transgender Allies Group
Jennifer Howell, Washoe County Health District
Briana Escamilla, Human Rights Campaign
Elisa Cafferata, Planned Parenthood Votes Nevada
André Wade, State Director, Silver State Equality
Penny James
Sherrie Scaffidi, Director, Transgender Allies Group

Mackenzie Baysinger, Human Services Network
Caroline Mello Roberson, NARAL Pro-Choice Nevada
Joelle Gutman, Washoe County Health District
Michael Hackett, Nevada Primary Care Association
Joan Hall, Nevada Rural Hospital Partners
Suzanne Bierman, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Helen Foley, Center for Assisted Living
Sarah Green, Vice President of Operations, Mission Senior Living

CHAIR RATTI:
I will open the work session on Senate Bill (S.B.) 174.

SENATE BILL 174: Makes various changes relating to services provided to persons with autism spectrum disorders. (BDR S-680)

MEGAN COMLOSSY (Policy Analyst):
I will read the summary of the bill from the work session document (Exhibit C).

SENATOR HARDY MOVED TO DO PASS S.B. 174.

SENATOR WOODHOUSE SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR RATTI:
I will open the work session on S.B. 192.

SENATE BILL 192: Revises provisions relating to health care. (BDR 53-781)

MS. COMLOSSY:
I will read the summary of the bill and the conceptual amendment from the work session document (Exhibit D).

SENATOR WOODHOUSE MOVED TO AMEND AND DO PASS AS AMENDED S.B. 192.

SENATOR RATTI SECONDED THE MOTION.

THE MOTION CARRIED. (SENATORS HARDY AND HAMMOND VOTED NO.)

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CHAIR RATTI:
I will open the work session on S.B. 202.

SENATE BILL 202: Revises provisions relating to persons with disabilities. (BDR 38-685)

MS. COMLOSSY:
I will read the summary of the bill from the work session document (Exhibit E).

SENATOR HARDY MOVED TO DO PASS S.B. 202.

SENATOR SPEARMAN SECONDED THE MOTION.

THE MOTION CARRIED UNANAMOUSLY.

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CHAIR RATTI:
I will open the work session on S.B. 216.

SENATE BILL 216: Revises provisions relating to autism spectrum disorders. (BDR 38-33)

MS. COMLOSSY:
I will read the summary of the bill and the conceptual amendment from the work session document (Exhibit F).

SENATOR WOODHOUSE MOVED TO AMEND AND DO PASS AS AMENDED S.B. 216.

SENATOR SPEARMAN SECONDED THE MOTION.

THE MOTION CARRIED UNANAMOUSLY.

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CHAIR RATTI:
I will open the work session on S.B. 270.

SENATE BILL 270: Requires the Department of Health and Human Services to establish and administer the Nevada Crisis Response System. (BDR 38-792)

MS. COMLOSSY:
I will read the summary of the bill and the conceptual amendment from the work session document (Exhibit G).

SENATOR WOODHOUSE MOVED TO AMEND AND DO PASS AS AMENDED S.B. 270.

SENATOR HAMMOND SECONDED THE MOTION.

THE MOTION CARRIED UNANAMOUSLY.

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CHAIR RATTI:
This closes the work session. I will open the hearing on S.B. 284.

SENATE BILL 284: Creates the Advisory Task Force on HIV Exposure Criminalization. (BDR S-742)

SENATOR DAVID R. PARKS (Senatorial District No. 7):
Senate Bill 284 seeks to make recommendations for revisions to existing statutes and regulations through the re-creation of an Advisory Task Force.

During the early years of the human immunodeficiency virus (HIV) infection and acquired immune deficiency syndrome (AIDS) epidemic, states including Nevada, implemented HIV-specific criminal exposure laws. These laws imposed criminal penalties on people living with HIV, who know of their HIV status and who potentially expose others to HIV.

In 1990, the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act provided states with funding for HIV/AIDS treatment and care and required every state receiving federal funds to certify that its criminal laws were adequate to prosecute any HIV-infected individual who knowingly exposed another person to HIV.

In our legal system, criminalization of potential HIV exposure is largely a matter of state law and not federal legislation. An analysis by the Centers for Disease Control and Prevention and the U.S. Department of Justice found 67 laws had been enacted in 33 states, explicitly focused on persons living with HIV. The majority of these laws were passed before antiretroviral therapies were developed that reduce the HIV transmission risk to zero. Currently, it is possible to be HIV positive and have no detectable presence of the virus.

As a person who helped develop Nevada HIV/AIDS statutes and regulations in the late 1980s and 1990s, this is an issue that I have wrestled with for the last three Legislative Sessions. Today, an informal coalition of healthcare professionals across the State have been working to address this issue and develop recommendations for consideration by the Legislature.

Senate Bill 284 will create a task force of concerned individuals appointed by the Governor to address both the criminalization and stigma surrounding HIV and AIDS.

Since S.B. 284 was introduced, an amendment to the bill (Exhibit H) has been introduced. The amendment revises the summary on S.B. 284. We would like it to reference the term "modernization" and not "criminalization" since the AIDS Task Force efforts will be directed toward statutes and regulations that deal with the disease as it affects society today and not how it impacted society nearly 40 years ago.

CHAIR RATTI:
Do we have anyone to testify in support?

BROOKE MAYLATH (President, Transgender Allies Group):
We are in support of S.B. 284.

JENNIFER HOWELL (Washoe County Health District):
We are in support of S.B. 284 and have submitted support testimony (Exhibit I).

BRIANA ESCAMILLA (Human Rights Campaign):
We are in support of S.B. 284 with the amendment.

ELISA CAFFERATA (Planned Parenthood Votes Nevada):
We are in support of S.B. 284.

ANDRÉ WADE (State Director, Silver State Equality):
I have submitted written testimony (Exhibit J). We are in support of S.B. 284 with the amendment.

PENNY JAMES:
I am in support of S.B. 284. I have submitted written testimony (Exhibit K). For 24 years, my uncle was HIV positive. I stayed with him when he was hospitalized. After about six months in the hospital, a doctor looked him in the eye and said, "How did you get this?" The doctor was perhaps 26 years old and looked at my uncle with hatred in his eyes. The doctor told me to leave the room. I left. He cut my uncle open. When I returned, my uncle was cut open and the doctor had just laid something over the wound. My uncle had a pile of blood under him and was in a lot of pain, but could not vocalize it. I feel he was mistreated because of the stigma attached to HIV.

CHAIR RATTI:
I will close the hearing on S.B. 284 and open the hearing on S.B. 364.

SENATE BILL 364: Prohibits discrimination against and provides protection for persons who reside in or receive services from certain facilities. (BDR 40-757)

SENATOR PARKS:
Senate Bill 364 makes revision to statutes prohibiting discrimination against and provides protections for persons who reside in or receive services from certain healthcare facilities.

MS. MAYLATH:
I would like to share a bit of my personal background and professional experience (Exhibit L).

Senate Bill 364 proposes to add specific non-discrimination language to the licensing of healthcare facilities in Nevada. My examination of the existing licensing chapter reveals comprehensive language already exists for the licensing of a psychiatric hospital, which means this Legislation already has Nevada specific precedence.

For years, lesbian, gay, bisexual, transgender, queer, questioning (LGBTQ+) patients have been met with aversion by many medical professionals.

SHERRIE SCAFFIDI (Director, Transgender Allies Group):
I will read some stories of discrimination by medical professionals to members of our community, Exhibit L. You can read further details in the court case *Rumble v. Fairview Health Services* (Exhibit M). Because of this treatment, patients are hesitant to seek medical help.

MS. MAYLATH:
Previously in this Committee, we discussed a case about our friend Cassie, a transgender woman who suffered from a gunshot wound, Exhibit L.

This bill simply mandates that every person treated in a healthcare facility be treated with dignity and respect, in a manner that promotes healing and comfort.

CHAIR RATTI:
Is there anyone in support of S.B. 364?

MS. ESCAMILLA:
We are in support of S.B. 364. The Human Rights Campaign represents about 15,000 members and supporters in Nevada. There are over 100,000 LGBTQ+

people in Nevada. They should not fear discrimination when they seek healthcare coverage.

MS. CAFFERATA:
I am here on behalf of Planned Parenthood Votes Nevada. Our health centers have nationally undergone an initiative to make sure all of our healthcare providers are trained how to deal with issues of cultural competency, specifically the health care that transgender people need. We support S.B. 364.

MACKENZIE BAYSINGER (Human Services Network):
We support S.B. 364.

CAROLINE MELLO ROBERSON (NARAL Pro-Choice Nevada):
We are in support of S.B. 364. We are an organization that represents 45,000 folks from all over Nevada who are battle born and feminist strong. That includes all backgrounds as well as transgender.

SENATOR PARKS:
Senate Bill 364 relates to the protection of vulnerable persons. It prohibits a medical facility from engaging in certain discriminatory actions and requires such facilities take measures to protect the privacy of persons receiving care from these facilities, and requires administrators and employees of such facilities to receive training.

CHAIR RATTI:
I will close the hearing on S.B. 364 and open the hearing on S.B. 344.

SENATE BILL 344: Revises Medicaid reimbursement rates related to family planning services. (BDR 38-743)

SENATOR MELANIE SCHEIBLE (Senatorial District No. 9):
Senate Bill 344 provides when different facilities are providing the same family planning care or procedures, they get reimbursed the same rate by Medicaid.

MS. CAFFERATA:
I am here on behalf of Planned Parenthood Votes Nevada. I am going to highlight my testimony (Exhibit N) and what we hope to accomplish. I know this Committee has heard a great deal of testimony about the challenges Medicaid reimbursement rates present to all healthcare providers. What the Committee

might not know is different healthcare providers, who provide the same healthcare service, get reimbursed under fee-for-service at different rates. For example, if a nurse in her own practice does an extended new client visit, she would be reimbursed at $48.47 per hour; whereas, the same nurse in a family planning clinic, which is Type 17 Special Clinics, would be reimbursed at $38.08 per hour. This example and other differences are outlined in (Exhibit O). This creates quite a difference in the amount of money the health center receives.

This presents an issue for health centers throughout Nevada that are trying to provide quality care in a sustainable way. The solution adopted by several states is to provide an enhanced rate for family planning providers.

Many women would rather go to a health center that provides family planning because they feel their concerns will be confidential. These women prefer a health center over a Federally Qualified Health Center, where they could be surrounded by toddlers, seniors or dental patients. They just want to have their reproductive healthcare concerns addressed. This bill would allow the afore-mentioned health centers to see more patients in an efficient way, thereby increasing access for women to get the care they need.

Senate Bill 344 requires Nevada to pay the nonfederal share of expenses to establish the rates of reimbursement for family planning services provided on a fee-for-service basis by a clinic that specializes in providing family planning services. The rate would be equal to, or greater than, the rates of reimbursement provided for such services provided on a fee-for-service basis by such a clinic on June 30, 2019, or 105 percent of reimbursement provided on the current Medicare fee schedule for such services.

Most of the Medicaid population are served under managed care contracts and not fee-for-service. Primarily fee-for-service programs are effective in rural Nevada. They only impact special populations in Washoe County and Clark County. The last time I looked this up, there were 17 specialty clinics in Nevada. Three of the 17 specialty clinics are Planned Parenthood; however, Planned Parenthood does not qualify for the fee-for-service reimbursement rate. Even though this bill will not assist Planned Parenthood, we support it because it increases access to health care. It helps community health nurses and basic healthcare providers in rural Nevada.

SENATOR HARDY:
Who pays for the higher reimbursement rate?

MS. CAFFERATA:
Nevada would have to pay the nonfederal share to bring the reimbursement rate up to what is written in the bill. The rate would most likely be 105 percent of the Medicare rate and would come out of the State Medicaid budget.

SENATOR HARDY:
Where is the fiscal note?

CHAIR RATTI:
We have not received the fiscal note at this time.

SENATOR HAMMOND:
You mentioned that Planned Parenthood would not benefit from this. Is that correct?

MS. CAFFERATA:
Planned Parenthood in Reno takes Medicaid, but it is through a managed care organization contract. Planned Parenthood does not currently take fee-for-service.

SENATOR HAMMOND:
This bill addresses an issue that only affects rural areas. Is that correct?

MS. CAFFERATA:
Yes. We have testified about the lack of family planning in all of Nevada. This particular bill will specifically benefit rural Nevada healthcare folks.

I want to follow-up on the question about costs. When we looked at a family planning waiver to expand access to family planning, what you find in the Medicaid budget is you are actually saving money. You are allowing women to space having children and have children when they want to have them. You come out with a net savings. We believe this will represent a cost savings to Nevada.

CHAIR RATTI:
Does anyone want to testify in support of S.B. 344?

MS. MELLO ROBERSON:
I am here on behalf of NARAL Pro-Choice Nevada, which is an organization dedicated to promoting the reproductive freedom for all Nevadans. That includes the right to plan your own families and space your own pregnancies. This is an essential service and improving outcomes is a priority, especially for rural Nevadans.

JOELLE GUTMAN (Washoe County Health District):
We are in support of S.B. 344. The health and positive impacts of being able to plan one's family are numerous, including higher graduation rates, lower use of State and federal assistance programs and overall better health outcomes. The Guttmacher Institute estimates for every $1 invested in family planning, the taxpayer saves $7. Services provided by Title X family planning clinics alone yielded $5.3 billion in total savings for publicly funded family planning in 2010. In Nevada, 20 percent of teen births were by teens who already had a child. In 2010, $60 million was spent on teen childbearing in Nevada. In 2010, 52 percent of pregnancies were unintended, costing Nevada $103 million. Improved reimbursement can increase care from family planning specialists for women who receive Medicaid.

MS. MAYLATH:
On behalf of all the transgender women and men who live in Nevada, we support this bill, because family planning is just as important to the transgender community as it is to all men and women.

SENATOR HARDY:
My question is for Washoe County Health District. Tell me about rural health clinics in Washoe County where this would apply. Is there one in Gerlach?

MS. GUTMAN:
I am not aware of a health clinic in Gerlach. I represent the Washoe County Health District and we provide family planning services for all of Washoe County. Most of our clients are not fee-for-service. We are here in solidarity. Many rural residents in other counties who do not have access to family planning services often have to get those services in Washoe County.

SENATOR HARDY:
So the rural county residents have to go to Reno?

MS. GUTMAN:
Yes.

MICHAEL HACKETT (Nevada Primary Care Association):
I am here on behalf of the Nevada Primary Care Association. We want to be on the record in support of S.B. 344.

CHAIR RATTI:
Does anyone want to testify neutral on S.B. 344?

JOAN HALL (Nevada Rural Hospital Partners):
We are neutral; however, we agree with the concept of the bill. It does not help rural hospitals or their affiliated rural health clinics. The rural health clinics are paid a lump sum amount. This bill would help private providers in rural areas, of which we have few.

SENATOR HARDY:
Are we talking about places in the rural communities that are solely for family planning? I am not aware that there are any.

MS. HALL:
In the communities I represent there are not any.

SENATOR HARDY:
Do you represent 17 counties?

MS. HALL:
I represent 12 counties.

SUZANNE BIERMAN (Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services):
I want to note that these services are currently covered by Nevada Medicaid and a change in the reimbursement rate would require a change to the State plan which would require federal approval.

CHAIR RATTI:
We are ready for closing comments and can the Committee get more clarity of fee-for-service, which appears to be limited? Is there a concrete example of who that would be?

SENATOR SCHEIBLE:
You are correct, this bill does affect a small group of providers. We started by looking at a larger problem and could not solve the problem with one bill. This bill carves out one section of providers who we could help with a legislative solution.

MS. CAFFERATA:
According to the caseload of people who are served under the fee-for-service program in the Medicaid Office, there are 189,000 people in Nevada. I do not know specifically where those folk reside. We will follow-up on this issue.

CHAIR RATTI:
On this line of questioning, the Committee will work with Senator Scheible and the Department of Health and Human Services (DHHS) to see if we can get greater clarity as to where those 189,000 people are receiving their services.

SENATOR HAMMOND:
These are just clinics that provide help on family planning; they do not perform abortions?

MS. CAFFERATA:
There are existing prohibitions in Medicaid regulations, and there is an extremely limited number of cases where the money could be used to cover an abortion. We are not talking about abortion providers; we are talking about breast examinations, cancer screenings, birth control and things of that nature.

SENATOR SCHEIBLE:
What we want to accomplish, especially for women in rural communities who cannot afford to go to their family doctor or nurse practitioner every time they need to renew their birth control prescription, is a clinic where they can go to talk to a nurse or doctor and get birth control. If those clinics cannot keep their doors open, then they cannot afford to serve the people who depend on them most.

CHAIR RATTI:
I will close the hearing on S.B. 344 and open the hearing on S.B. 362.

SENATE BILL 362: Revises provisions concerning the placement of persons with dementia in a residential facility for groups. (BDR 40-611)

SENATOR JOSEPH P. HARDY (Senatorial District No. 12):
Senate Bill 362 comes from a medical observation that if a person has mild dementia, they do not have to be locked up.

HELEN FOLEY (Center for Assisted Living):
In September of this last year, a technical bulletin was issued by Dr. Julie Kotchevar, Administrator for the Division of Public and Behavioral Health. The bulletin outlined when an individual who was in a residential facility for groups had to be placed in a facility that had an endorsement required for facilities with Alzheimer's residents. Endorsements for facilities with Alzheimer's residents have been around for a couple of decades. Unfortunately, how the law was written and is now interpreted, was if anyone had even a mild cognitive impairment, they would have to be placed in a facility that had an Alzheimer's endorsement. These facilities are required to provide a much higher level of care, which includes a one to six care ratio and are locked facilities.

I talked to Dr. Kotchevar about this issue and the technical bulletin was never intended to have that type of person go to the most severe setting. Senate Bill 362 was written to fix this issue; unfortunately, when it was released by the Legislative Counsel Bureau it needed some corrections. I have submitted a proposed amendment (Exhibit P) to fix these issues.

Every time someone is placed in a residential facility for groups, there is a physical assessment done by a physician. After that, they are given a yearly assessment. Sometimes, with Alzheimer's or different types of dementia there can be a noticeable decline in a person's health and mental capacity. The standard should be, if that person is a threat to themselves or a threat to someone else or is that person a flight risk. If any of these things are going on, we want the physician to recommend that person be placed in a higher level facility.

In the proposed amendment, Exhibit P, section 1 added:

> When a person is admitted to a residential facility for groups, a physician shall assess each resident. If he believes that the person needs a higher level of care, the doctor will indicate that accordingly and provide the results of the assessment to an administrator of the residential facility for groups. In addition, such an assessment shall be conducted through an annual history and physical and when there are signs of deterioration identified by administration, staff or the resident's family. This can be included in the required admission documents, standard physician's determination forms, or any medical notes.
>
> If as a result of the assessment, the physician determines that the resident:
>
> (a) Suffers from dementia to an extent that the resident may be a danger to himself or herself or others if the resident is not placed in a secure unit or a facility that assigns not less than one staff member for every six residents, any residential facility for groups in which the resident is placed must meet the requirements prescribed by the Board pursuant to subsection 2 of NRS 449.0302 for the licensing and operation of residential facilities for groups which provide care to persons with Alzheimer's disease or other severe dementia.
>
> (b) Does not suffer from dementia as described in paragraph (a), the resident may be placed in any residential facility for groups.

That is basically the amendment. There is some language in section 4, subsection 2, paragraph (b) of the amendment, describing a person with Alzheimer's disease or other severe dementia.

We tried to make this as practical and reasonable as possible. We believe about 75 percent of individuals who are in assisted living facilities have some cognitive impairment to a point where they need to be monitored. However, they are not a threat to themselves or others and are not a flight risk. When, and if, they become that way, then they would need to go to a higher level of care.

We also do not want to leave the decision specifically in the hands of the administrator of that facility, because there is a monetary incentive to leave the patient where they are. In the worst of settings, that could happen. We wanted the decision to be made by the physician, any other providers of care and, certainly, that person's family.

What we discovered after the technical bulletin was, if someone needed that higher level of care, it could cost the family upward of $6,000 more per month over what they were currently paying. What we do not want to happen is a family telling a doctor not to give the diagnosis of cognitive impairment or Alzheimer's, because they cannot afford to have the family member in a higher level facility. It is important for these facilities to know the medical diagnosis of each person so they can adequately care for them.

SARAH GREEN (Vice President of Operations, Mission Senior Living):
I have been in the industry for the past 20 years as a provider. I have worked as an administrator to a vice president level. I have also experienced having a family member who was living completely independent to being referred to hospice care. When you experience this industry as a person and as a family member, it gives you a different perspective.

We are here today because of the technical bulletin that came out in September 2018. It was unexpected to the industry and it conflicted with current rules, regulations and expectations which were in place for physicians, the communities, the providers, etc. I want to emphasize S.B. 362 references residential and group homes. It is targeted toward assisted living. The assisted living and group homes provide assistance for seniors. Senate Bill 362 does not refer to nursing homes or full-on care. We are referring to assisting active seniors with daily living.

The technical bulletin came out and talked about seniors in the residential homes in group settings who had a diagnosis of dementia to Alzheimer's, to cognitive impairment. The term "cognitive impairment" is so broad. I think about everyone in this room who has lost their keys or cell phone today or are not sure where they left their car in the parking lot. When we talk about senior living, is it a simple element of not knowing where their keys are that has prompted the "cognitive impairment" or, truly, are they a risk to themselves? Are they at risk of wandering out of the facility or harming themselves and not

being able to maintain their quality of life? That is when "cognitive impairment" needs to be addressed.

The current rule already in place is the physician providing an assessment prior to admission. All residential facilities commonly called communities are required to have a physician do a complete history and physical within 30 days prior to admission. Further, the rule is the physician must provide an annual review and submit it to the community. In addition, the current rule is the community must administer an assessment that walks through all elements of daily living at time of admission, no less than annually, or because of a change of condition. The term "change of condition" means something changed; perhaps a stroke happens and the patient's level of care needs to be addressed.

This technical bulletin potentially means the average senior who is walking around, driving, shopping and participating in family activities could be required to go to a secured memory care unit. This is not appropriate. The term "endorsed community" means a secured unit, where windows cannot be opened above six inches, it takes a passcode to get in and out and staffing ratios are one to six. This restricts a senior's right to live.

The other important element in a secured memory care unit is the physical aesthetics endorsement of the community, such as increased firewalls. These elements would have to be met if an assisted living facility wanted to convert to a secured memory care unit. I believe the DHHS said it would waive the endorsement fee for licensure. This is a minimal cost when compared to the costs of adding sheetrock in order to meet the two hour fire requirement.

If the senior is not to the point where they need a secured unit, let the physician and outside entities participate on appropriate placement.

SENATOR HAMMOND:
This bill makes sure that a doctor, independent of the facility, is making the diagnosis and there is still an annual review. Is this close to what this bill does?

SENATOR HARDY:
Yes.

CHAIR RATTI:
Does the bill require the physician be independent?

MS. FOLEY:
It would be an independent physician, because medical care is not provided at these facilities. The facilities provide medication management, but these facilities do not have staff physicians.

CHAIR RATTI:
What was the reason or specific incident that led to the technical bulletin? It appears this technical bulletin may have been issued to correct a problem and, if so, how was that problem corrected?

MS. GREEN:
As a provider in Nevada, we were not consulted prior to the issuance of the technical bulletin. I can speak from my own beliefs, as well as my exposure to the industry. My assumption would be this technical bulletin was the result of elopements, meaning seniors wandering away from a community and/or home and the search element that followed. My assumption is this technical bulletin was the result of a senior or seniors who wandered away from an established community.

CHAIR RATTI:
Would it be fair to say an annual assessment is adequate and perhaps there are times to call for earlier assessments? In this situation, can anyone ask for an assessment, at any time, to get a third party trained professional to determine if that person requires another form of care?

MS. GREEN:
That is correct. It needs to be based on the senior and their aging process, rather than a sole diagnosis. Diagnosis is a huge label and the physician needs to assess it with input from the community and the family in terms of what the patient's daily activities look like. In addition, a change of condition is more imperative than the annual assessment. A change of condition can happen at any time. It could be a stroke, a urinary tract infection that goes septic or a routine surgery.

CHAIR RATTI:
From past testimonies in regard to cognitive care, I have heard that it is not a single event, but rather a slow decline. Even the family who are caregivers do not notice it, because there are micro changes over the course of six months that could add up to a significant change. What are the safeguards for people who have that slow, cognitive decline that the family may not notice or be in denial or caregivers who may not notice the changes? What is the trigger? Is it an event, such as they wandered off? How do we know we are catching them when we need to catch them?

MS. GREEN:
There are many factors that fall under the dementia umbrella. The disease process is very different based on what form they have, what part of the brain it is attacking and how. What all parties need to be aware of is the deterioration. When are they changing? How are they changing? Were they previously independent, coming down for meals and now the family has to remind them it is meal time? Maybe the family has to remind them a second time or walk with them. That deterioration is a collaboration of everyone saying he or she is different than they were last month. Let us sit down and address it now. Let us tell the physician and get their input.

CHAIR RATTI:
That sounds rational and logical from a system point. What is in the system to make sure that happens?

MS. GREEN:
What is in the system is the care plan. The care plan is established by the family, the resident and the community, meaning the administration, nurse, wellness director or whatever each community has in place. The care plan reviews the activities of daily living from the beginning of the day to the end of the day and the normal baseline of that day. When the community sees there are alterations to that baseline, it is their responsibility to sit down and address this with the family and any responsible parties involved.

CHAIR RATTI:
Is that a common standard of care based on licensure or is that something that is in the *Nevada Revised Statutes* (NRS)?

MS. GREEN:
That is in NRS. There are requirements for the physician at time of admission and the annual review. The community responsibilities are at the time of admission and no less than annually. The term utilized is the "change of condition". The change of condition does not have to be major, but it can mean the resident no longer fits the mold for the care plan put in place for their needs. I also want to point out that placing a senior in a secured unit will take away more of their decision-making ability. This will have an instantaneous, detrimental, negative impact on their cognitive and emotional state.

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CHAIR RATTI:
Seeing no further business, we are adjourned at 5:51 p.m.

RESPECTFULLY SUBMITTED:

_____
Michelle Hamilton,
Committee Secretary

APPROVED BY:

_____
Senator Julia Ratti, Chair

DATE:_____

EXHIBIT SUMMARY				
Bill	**Exhibit / # of pages**		**Witness / Entity**	**Description**
	A	2		Agenda
	B	7		Attendance Roster
S.B. 174	C	1	Megan Comlossy	Work Session Document
S.B. 192	D	3	Megan Comlossy	Work Session Document
S.B. 202	E	1	Megan Comlossy	Work Session Document
S.B. 216	F	1	Megan Comlossy	Work Session Document
S.B. 270	G	3	Megan Comlossy	Work Session Document
S.B. 284	H	4	Senator David R. Parks	Proposed Amendment
S.B. 284	I	1	Jennifer Howell / Washoe County Health District	Testimony
S.B. 284	J	3	André Wade / Silver State Equality	Testimony
S.B. 284	K	1	Penny James	Testimony
S.B. 364	L	3	Brooke Maylath / Transgender Allies Group	Testimony
S.B. 364	M	63	Brooke Maylath / Transgender Allies Group	Court Case
S.B. 344	N	1	Elisa Cafferata / Planned Parenthood Votes Nevada	Testimony
S.B. 344	O	4	Elisa Cafferata / Planned Parenthood Votes Nevada	Testimony
S.B. 362	P	9	Helen Foley / Center for Assisted Living	Proposed Amendment