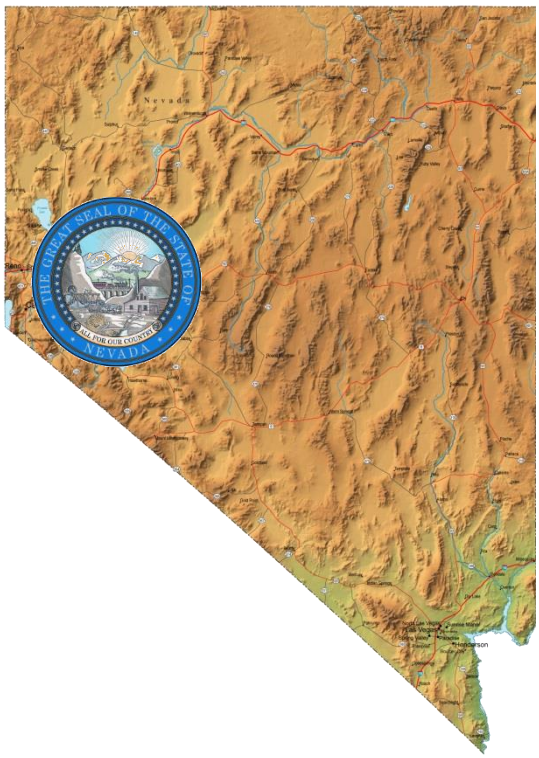
Legislative Counsel Bureau

Health Care

BULLETIN NO. 15-14



January 2015

LEGISLATIVE COMMITTEE ON HEALTH CARE

BULLETIN NO. 15-14

JANUARY 2015

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SUMMARY OF RECOMMENDATIONS

LEGISLATIVE COMMITTEE ON HEALTH CARE

Nevada Revised Statutes 439B.200

This summary presents the recommendations approved by the Legislative Committee on Health Care (LCHC) (*Nevada Revised Statutes* [NRS] 439B.200) at its June 2, 2014, and August 26, 2014, meetings. The LCHC submits the following recommendations and bill draft requests (BDRs) to the 78th Session of the Nevada Legislature.

PROPOSALS RELATING TO BEHAVIORAL HEALTH

1. **Redraft** Senate Bill 323 (2013), which authorized the Division of Public and Behavioral Health (DPBH) of the Department of Health and Human Services (DHHS) to enter into a contract with a person, organization, or agency to carry out or assist in carrying out a program that allows certain defendants declared incompetent to receive outpatient treatment to restore competency while incarcerated in jail or prison. **(BDR 14–68)**

2. **Send a letter** to the DHHS and the Department of Employment, Training and Rehabilitation encouraging collaborative efforts to develop and expand supported employment programs for mentally ill persons.

3. **Send a letter** to the Senate Committee on Finance and the Assembly Committee on Ways and Means expressing the Committee's support for increasing the number of school-based psychologists, counselors, and social workers to help coordinate services and supports and to create effective links between schools and the community mental health system.

4. **Send a letter** to the Senate Committee on Finance, the Assembly Committee on Ways and Means, the DHHS, and Nevada's Department of Veterans Services expressing the Committee's support for mental health and other specialty courts. The letter will encourage collaboration to develop or support the development of:

    a. Aggressive aftercare programs to check in with participants and encourage them to stay connected to necessary services, especially with medication management;

    b. Additional supported housing options to increase stability;

    c. Institutional support for the specialty court system;

    d. Patient-aligned care teams in southern Nevada;

e. Specialized psychiatric nursing homes for chronically ill patients who have previously been placed in group homes and have had frequent emergency readmissions to a mental health hospital or a detention center; and

f. A forensic psychiatric facility in southern Nevada.

5. **Amend NRS** by revising the emergency admission process outlined in Chapter 433A ("Admission to Mental Health Facilities or Programs of Community-Based or Outpatient Services; Hospitalization") of NRS, related to emergency admissions in the following manner:

a. Amend NRS 433A.160 and NRS 433A.200 to expand the types of professionals who may initiate taking a person into custody and who may file a petition for the involuntary court-ordered admission of a person to a mental health facility or hospital. In addition to the existing professionals authorized, add a physician's assistant who is licensed pursuant to Chapter 630 ("Physicians, Physician Assistants, Medical Assistants, Perfusionists and Practitioners of Respiratory Care") or Chapter 633 ("Osteopathic Medicine") of NRS.

b. Add a new section to Chapter 433A of NRS authorizing a physician, a physician's assistant, psychologist, social worker, registered nurse (including an advanced practice registered nurse), or an accredited agent of the DHHS to certify that a person admitted to a public or private mental health facility or hospital for evaluation, observation, and treatment is no longer likely to harm himself or herself or others if allowed his or her liberty. This certificate should meet the same requirements as a certificate for emergency admission filed pursuant to NRS 433A.160. This certificate is the same as the release of such a person pursuant to NRS 433A.195. Such a person may still be hospitalized if the person has other conditions requiring hospitalization. **(BDR 39–64)**

PROPOSAL RELATING TO CHILDREN'S HEALTH

6. **Draft a letter** to the State Board of Health (Board) requesting that the Board consider the following guidelines in the adoption of licensing standards, practices, and polices of child care facilities pursuant to NRS 432A.077:

a. Require child care entities governed by *Nevada Administrative Code* (NAC) 432A.380 to:

i. Establish age-appropriate portions;
ii. Limit the amounts of foods with added sugars or low nutritional value, with specific requirements regarding milk, milk products, and juice;
iii. Encourage staff to set good examples by:
1. Eating with the children (currently in NAC);

2. Eating items that meet the United States Department of Agriculture Child and Adult Care Food Program (CACFP) standards; and
3. Teaching children appropriate portion sizes;

iv. Use meal patterns established by the CACFP;
v. Develop a feeding plan with the child's parent that includes:
1. Introduction of age-appropriate solid foods; and
2. Encouragement and support for breastfeeding (offering on-site arrangement for mothers to breastfeed).

b. Strengthen the standards for child care facility programs governed by NAC 432A.390 by defining the following terms in accordance with physical activity guidelines based on the developmental age of children:

i. Moderate physical activity;
ii. Vigorous physical activity;
iii. Muscular strengthening activities;
iv. Bone-strengthening activities;
v. Sedentary activities; and
vi. Screen/media time.

c. Require child care facility programs governed by NAC 432A.390 to:

i. Provide a program of physical activity that includes moderate to vigorous activity for all children, in addition to daily periods of outdoor play (weather permitting);
ii. Require caregivers/teachers to participate in activities, when it is safe to do so; and
iii. Prohibit withholding or forcing physical activity as a form of discipline.

7. **Draft a letter** to the Division of Child and Family Services, DHHS, expressing support for the continuation and expansion of mobile crisis programs throughout the State of Nevada to improve the quality of children's mental health care by providing immediate care and treatment in a variety of settings, including but not limited to, homes, schools, homeless shelters, and emergency rooms. Mobile crisis response programs reduce unnecessary psychiatric hospitalizations and placement disruptions of children and youth, and reduce the need for youth to go to emergency rooms or detention centers to have their mental and behavioral health needs addressed.

PROPOSALS RELATING TO THE HEALTH CARE WORKFORCE

8. **Send a letter** to the Senate Committee on Finance and the Assembly Committee on Ways and Means expressing the Committee's support for the development and expansion of Graduate Medical Education (GME). The letter will specifically request that as funding is available:

a. The number of residency slots within Nevada be increased. To fund a residency, an estimate of $100,000 to $110,000 a year was provided.

b. Medicaid funding for GME be revised to establish a method that reimburses hospitals with Medicaid payments that cover a proportionate share of the cost of the program.

9. **Send a letter** to Nevada's Congressional Delegation advocating for:

a. No additional GME funding cuts; and
b. Redistributing full-time equivalent resident slots to Nevada hospitals.

10. **Send a letter** to the DHHS and the Nevada System of Higher Education expressing the Committee's support for increasing the health care workforce in Nevada by formalizing the role of community health workers (CHWs) and encouraging the development of community paramedicine. Specifically as it relates to CHWs, the Committee supports the development of a CHW type that meets the requirements for Medicaid reimbursement. This effort should consider the necessity and feasibility of:

a. Changing the Nevada Medicaid State Plan to include CHWs as a provider type;
b. Establishing additional reimbursement mechanisms to support prevention services by CHWs;
c. Creating and expanding training programs for CHWs at the university and/or the community college level;
d. Creating a governing body to oversee CHW activities;
e. Educating providers and the community about the role of the CHW; and
f. Developing a pipeline of individuals interested in becoming a CHW.

11. **Redraft** Senate Bill 324, First Reprint (2013), which authorized certain qualified professionals who hold a license in another state or territory of the United States to apply for a license by endorsement to practice in this State. In addition, the measure authorized certain regulatory bodies to enter into a reciprocal agreement with the corresponding regulatory authority in another state or territory of the United States for the purposes of authorizing a licensee to practice concurrently in this State and another jurisdiction and the regulation of such licensees. In addition to other provisions, the measure authorized a medical facility to employ or contract with a physician to provide health care to patients of the medical facility. **(BDR 54–62)**

PROPOSALS RELATING TO RURAL AND COMMUNITY HEALTH CENTERS

12. **Send a letter** to the Senate Committee on Finance and the Assembly Committee on Ways and Means expressing the Committee's support for the expansion of Rural and Community Health Centers in Nevada. The letter will:

a. Convey the significant role Rural and Community Health Centers play in meeting the needs of the uninsured and underinsured.

b. Convey the significant return on investment received by states that have committed state funding to support the development or expansion of Rural and Community Health Centers by:

   i. Establishing a state-funded Primary Care Grant that is used in part to support capital needs;
   ii. Establishing competitive awards to support the start-up of a new health center and the expansion of existing health centers; and
   iii. Providing funds to support technical assistance to develop proposals to secure federal funds through the New Access Program.

c. Encourage priority be given to provide financial support for these endeavors as it becomes economically feasible.

13. **Include a statement of support** in the final report for the development of an expedited credentialing process for providers who join the staff of an established Community Health Center.

14. **Redraft** Senate Bill 340, Second Reprint (2013), which proposed the creation of the Office for Patient-Centered Medical Homes and the Advisory Council on Patient-Centered Medical Homes. The redraft will exclude the provisions related to medical records. **(BDR –63)**

PROPOSAL RELATING TO HEALTH INSURANCE COVERAGE

15. **Amend NRS** to require any insurer issuing a policy of insurance to contract with any qualified providers who meet the terms of the insurer if:

a. The Division of Insurance, Department of Business and Industry, has determined that the insurer has an inadequate number of the specified provider types for all insurance including those required to have an adequacy review; or

b. The area in which the services are to be provided has been designated by the Health Resources and Services Administrations, U.S. Department of Health and Human Services, as a Health Professional Shortage Area. **(BDR 57–65)**

PROPOSAL RELATING TO THE EMERGENCY USE OF EPINEPHRINE AUTO-INJECTORS IN NEVADA

16. **Amend NRS** to authorize certain entities or organizations at which allergens capable of causing anaphylaxis may be present, including, but not limited to, amusement parks, recreation camps, restaurants, sports arenas, and youth sports leagues, to obtain and maintain a supply of epinephrine auto-injectors for emergency administration. Authorize a trained employee or agent of the entity or organization to administer an epinephrine auto-injector under certain circumstances. **(BDR 40–66)**

PROPOSAL RELATING TO TELEMEDICINE

17. **Draft a letter** supporting the advancement of Telemedicine in Nevada. Acknowledging the efforts of the Nevada Broadband Task Force and other entities in promoting telemedicine as a "standard of care" and recognizing how telemedicine supports:

    a. The expansion of services to patients in rural and urban communities;
    b. Inadequate provider distribution;
    c. Access to high-quality, cost-effective care;
    d. The reduction of health care spending caused by treatment delays;
    e. Increased convenience when:
        i. Licensed health care facility limits are removed;
        ii. Health care provider licensing is clarified; and
        iii. All telemedicine-enabled care is able to be provided;
    f. Increased innovation and investment when reimbursement parity is provided for covered services;
    g. Strengthening the health care infrastructure; and
    h. Economic development by preserving and increasing health care related jobs and keeping patients' care in Nevada.

PROPOSALS RELATING TO AUTISM TREATMENT AND SERVICES IN NEVADA

18. **Draft a letter** to the DHHS encouraging the Department to:

    a. Develop mechanisms to provide readily available access to the Modified Checklist for Autism in Toddlers screenings that assess risk for autism spectrum disorder in rural Nevada and a mobile diagnostic clinic for those who have red flags identified by the screenings. In rural Nevada, accessing a diagnostic evaluation is a significant barrier to treatment.

b. Allow Autism Treatment Assistance Program (ATAP) funds to be used to support diagnostic clinics across rural Nevada, if it is determined to be feasible and appropriate.

c. Encourage coordination between ATAP, Nevada Early Intervention Services, and rural school districts with the intent of promoting autism diagnoses and treatment and helping coordinate providers and services to increase access to treatment and services in rural communities.

d. Require Nevada Medicaid to cover Applied Behavior Analysis (ABA) services as soon as possible by:

   i. Seeking clarification from Centers for Medicare and Medicaid Services regarding whether ABA can be included in the Nevada Medicaid State Plan via a plan amendment;
   ii. Preparing and submitting such an amendment;
   iii. Initiating the process of certifying providers of ABA services and establishing rates;
   iv. Providing ABA services to Early and Periodic Screening, Diagnostic, and Treatment children;
   v. Making the necessary request to shift available funding during this biennium to cover these services; and
   vi. Developing a budget for the next biennium that includes sufficient funding for Medicaid coverage of ABA and to eliminate the ATAP waiting list.

19. **Revise the following provisions of NRS** related to autism services and insurance coverage:

Sunset the requirement that autism behavior interventionists be certified by the Board of Psychological Examiners on July 1, 2017. Continue to require autism behavior interventionists to work under the supervision of a licensed and Board Certified Behavior Analyst or a Board Certified Assistant Behavior Analyst. Beginning July 1, 2017, require autism behavior interventionists to obtain the Registered Behavior Technician credential established by the Behavior Analyst Certification Board.

a. Revise the requirement in various insurance statutes that an autism behavior interventionist be certified as a condition to insurance coverage for autism spectrum disorders and instead require as a condition to insurance coverage for autism spectrum disorders that autism behavior interventionists receive the Registered Behavior Technician credential established by the Behavior Analyst Certification Board. This revision is effective beginning July 1, 2017.

b. Remove the $36,000 per year cap on benefits for services related to applied behavior analysis treatment. **(BDR 54–67)**

PROPOSALS RELATING TO PERSONS WITH ALZHEIMER'S DISEASE

20. **Draft a letter** to all district courts in Nevada strongly requesting that they closely supervise all guardians, whose wards suffer from dementia, including, but not limited to, Alzheimer's disease to insure that all reports on the person and estate of the ward are filed and reviewed according to existing law.

21. **Amend NRS** 159.076 to prohibit a court from granting a summary administration if:

    a. The ward is suffering from dementia, including but not limited to Alzheimer's disease; or

    b. The ward has been placed in a facility outside the State of Nevada. (BDR 13–04)

22. **Draft a letter** to the Division of Public and Behavioral Health and the Division of Health Care Financing and Policy, DHHS, urging them to:

    a. Establish hospital transitional care programs;

    b. Increase the number of home-based services and long-term care facilities with Alzheimer's certification; and

    c. Establish a central location where available and appropriate placements can be accessed.

    This letter will stress the importance of providing methods and means by which people with dementia, including Alzheimer's disease, can avoid relocation trauma and out-of-state placement.

REPORT TO THE 78TH SESSION OF THE NEVADA LEGISLATURE BY THE LEGISLATIVE COMMITTEE ON HEALTH CARE

I. INTRODUCTION

The Legislative Committee on Health Care (LCHC), in compliance with *Nevada Revised Statutes* (NRS) 439B.200 through 439B.240, oversees a broad spectrum of issues related to the quality, access, and cost of health care for all Nevadans. The LCHC was established in 1987 to provide continuous oversight of matters relating to health care.

The LCHC for the 2013–2014 Interim was composed of six members. The members of the LCHC were as follows:

Senator Justin C. Jones, Chair
Assemblywoman Marilyn Dondero Loop, Vice Chair
Senator Joseph P. (Joe) Hardy, M.D.
Senator Joyce Woodhouse
Assemblywoman Teresa Benitez-Thompson
Assemblyman James Oscarson

The following Legislative Counsel Bureau staff members provided support for the LCHC:

Marsheilah D. Lyons, Supervising Principal Research Analyst, Research Division
Sally Trotter, Principal Administrative Assistant, Research Division
Risa B. Lang, Chief Deputy Legislative Counsel, Legal Division
Eric Robbins, Deputy Legislative Counsel, Legal Division

The LCHC held eight meetings, including two work sessions. All public hearings were conducted through simultaneous videoconferencing between legislative meeting rooms at the Grant Sawyer State Office Building in Las Vegas, Nevada, and the Legislative Building in Carson City, Nevada. The summaries of testimony and exhibits are available online at: http://www.leg.state.nv.us/Interim/77th2013/Committee/StatCom/HealthCare/?ID=55.

II. REVIEW OF COMMITTEE FUNCTIONS

The primary responsibilities of the LCHC include: (a) reviewing and evaluating the quality and effectiveness of programs for the prevention of illness; (b) reviewing and comparing the costs of medical care among communities in Nevada with similar communities in other states; and (c) analyzing the overall system of medical care in the State. In addition, members strive to promote a health care system that avoids duplication of services and achieves the most efficient use of all available resources. The LCHC may also review health insurance issues, as well as examine hospital-related issues, medical malpractice issues, and the health education system.

Further, certain entities are required by statute to submit reports to the LCHC, including:

- A report of the activities and operations of the Division of Health Care Financing and Policy (DHCFP), Department of Health and Human Services (DHHS), concerning the review of health care costs. The report must be submitted on or before October 1 of each year as required by NRS 449.520.

- An annual report concerning the review of the health and health needs of the residents of this State and a system to rank the health problems of the residents of this State, including, without limitation, the specific health problems that are endemic to urban and rural communities, and the allocations of money from the Fund for a Healthy Nevada pursuant to NRS 439.630 to determine whether the allocations reflect the needs and the residents of this State.

- A quarterly report, as required by NRS 450B.795, from the State Board of Health regarding its findings in the study concerning the cause of excessive waiting time for a person to receive emergency services and care from a hospital after being transported to the hospital by a provider of emergency medical services.

III. DISCUSSION OF TESTIMONY AND RECOMMENDATIONS TO THE 2015 NEVADA LEGISLATURE

A variety of issues were addressed at the meetings of the LCHC. This document summarizes only those issues for which the LCHC made recommendations. These issues relate to:

A. Behavioral health services;

B. Children's health;

C. The health care workforce in Nevada;

D. Rural and community health centers;

E. Health insurance coverage;

F. Emergency use of epinephrine auto-injectors (EpiPens);

G. Telemedicine;

H. Autism treatment and services in Nevada; and

I. Persons with Alzheimer's disease.

At the seventh and eighth meetings, the members conducted work sessions at which they adopted eight recommendations to be included in eight bill draft requests (BDRs). The BDRs concern: (1) behavioral health; (2) health care workforce; (3) patient-centered medical home model of care; (4) health insurance coverage; (5) autism treatment and services; (6) guardianship for persons with dementia; and (7) use of EpiPens in emergencies in public or private settings. Lastly, members authorized the Chair to include a statement of support in the final report and send 13 letters on behalf of the LCHC.

A. BEHAVIORAL HEALTH SERVICES

In Nevada, the Division of Public and Behavioral Health (DPBH), DHHS, is responsible for a host of public health programs including oversight and operation of State-funded, community-based outpatient, inpatient, and forensic mental health programs and services. The State mental health system includes four service areas: (1) Southern Nevada Adult Mental Health Services; (2) Northern Nevada Adult Mental Health Services; (3) Rural Mental Health Services; and (4) Forensic Mental Health Services.

The LCHC heard testimony regarding challenges in the behavioral health system and delays in service delivery to mentally ill residents of the State. According to the National Alliance on Mental Illness's *Grading the States 2009 Report Card*, in 2006, Nevada's mental health care system received a D grade. Three years later, the grade remained the same. The report notes that Nevada has struggled to keep pace with population growth and demand for mental health services. According to the report and testimony provided to the LCHC, Nevada urgently needs to restore inpatient staffing, capacity for case management, medications and therapy, and supportive housing options. However, the report noted the State's innovations in transparency, urgent walk-in and medication clinics, and mental competency health courts.

Admissions and Release

The demand for mental health services to meet the needs of a growing population in Nevada is most evident to individuals and the families of individuals in a mental health crisis. According to information provided to the LCHC, crisis prevention services, such as screening and early intervention, are inadequate in both rural and urban areas of the State. Emergency rooms (ERs) serve as entrances into the mental health system. The term "Legal 2000" is a colloquial reference to a form (revised in 2000) used to initiate the emergency admission of an allegedly mentally ill person who is a danger to himself or herself or others, to a public or private mental health facility or hospital for evaluation, observation, and treatment. *Nevada Revised Statutes* 433A.160 establishes the procedure for these emergency admissions —commonly called "involuntary admissions"—which may be initiated without a warrant.

Nevada requires that allegedly mentally ill persons be screened to determine that there are no physical conditions, as opposed to mental conditions, warranting their behaviors or symptoms. In an effort to meet this requirement, emergency transporters and law enforcement officials

have routinely transported these individuals to hospital emergency departments for medical clearances. Due to a variety of factors, including the lack of resources for outpatient mental health care, this has frequently contributed to overcrowding in ERs, particularly in southern Nevada.

Testimony noted that at least 57 percent of patients on a Legal 2000 do not meet the criteria for acute inpatient admission to a psychiatric unit. Limited authority to decertify these patients contributes to ER overcrowding. Testimony presented to the LCHC indicated that the medical clearance structure in NRS should be amended to provide for the assessment and decertification of a patient in an ER. Testimony stressed that the patient would still need to be discharged from the hospital by the ER doctor. In addition, a revision was requested to authorize physicians' assistants to initiate a Legal 2000.

In addition to the ongoing challenges in the system, several concerns emerged during the interim that urged the LCHC to address specific needs within the behavioral health system. These issues also prompted Governor Brian Sandoval to establish the Governor's Behavioral Health and Wellness Council by Executive Order 2013-26. Staff of the DHHS and the DPBH worked collaboratively with the LCHC and the Council. The Council proposed several recommendations to improve Nevada's behavioral health system. The report and recommendations can be found at: http://health.nv.gov/BHWC/Reports/2014-05_ReportAndRecommendationsToGovernorSandoval.pdf.

During the interim, a series of articles in the *Sacramento Bee* suggested there was an inappropriate discharge of patients by the DPBH, many of whom were transported to Sacramento, California. This investigative report prompted the DPBH and several regulatory agencies to review various components of the behavioral health system in Nevada. Because of the reviews, improvements were made to Rawson-Neal Psychiatric Hospital's discharge planning process, medical staffing, and governance.

Determining Competency

Additionally, during the interim period, the LCHC heard testimony concerning a lawsuit regarding the amount of time an inmate waits in jail before receiving an evaluation. Evaluations are done to determine capacity for restoration of legal competency to stand trial and for treatment of clients adjudicated "Not Guilty by Reason of Insanity" so they may return safely to the community. Lakes Crossing Center (LCC), located in northern Nevada, is the designated facility pursuant to NRS 178.400, 433.227, and 433.233 for Nevada courts to direct individuals to be restored to competency in order to stand trial for alleged crimes. Testimony presented to the LCHC indicated that LCC receives patients from all over Nevada. However, approximately 60 percent of the patients come from Clark County, 20 percent from Washoe County, and 20 percent from the additional counties in Nevada. Clients from southern Nevada are transported by plane to LCC.

Jail-based competency restoration programs are an emerging option. This type of program provides restoration services in county jails, rather than in community-based settings or mental health facilities. Jail-based restoration programs must provide mental health services that are consistent with competency restoration services provided in state mental health facilities. Information provided to the LCHC indicated that jail-based restoration saves resources in the form of transportation and bed costs, and significantly cuts down on wait times to receive services. It may also keep limited hospital placements open for more severe cases.

According to a September 2013 DPBH, DHHS *Audit Report No. 14-02*, conducted by the Division of Internal Audits, Department of Administration, the DPBH could reduce costs to the State by $1.2 million annually. Competency treatment programs in local jails could reduce the number of beds needed each day at LCC by up to 17. The LCC estimates that as many as 30 percent of its patients could be treated in jail-based competency programs in urban counties. In addition, the report notes, the Muri Stein Hospital's planned opening in 2016 will expand the forensic psychiatric bed capacity to southern Nevada and may reduce LCC's bed requirements in northern Nevada by as many as 23 beds per day.

In an effort to address the immediate and ongoing behavioral health system challenges, the LCHC agreed to:

1. **Redraft** Senate Bill 323 (2013), which authorized the DPBH, DHHS to enter into a contract with a person, organization, or agency to carry out or assist in carrying out a program that allows certain defendants declared incompetent to receive outpatient treatment to restore competency while incarcerated in jail or prison. **(BDR 14–68)**

2. **Send a letter** to the DHHS and the Department of Employment, Training and Rehabilitation encouraging collaborative efforts to develop and expand supported employment programs for mentally ill persons.

3. **Send a letter** to the Senate Committee on Finance and the Assembly Committee on Ways and Means expressing the LCHC's support for increasing the number of school-based psychologists, counselors, and social workers to help coordinate services and supports and to create effective links between schools and the community mental health system.

4. **Send a letter** to the Senate Committee on Finance, the Assembly Committee on Ways and Means, the DHHS, and Nevada's Department of Veterans Services expressing the LCHC's support for mental health and other specialty courts. The letter will encourage collaboration to develop or support the development of:

    a. Aggressive aftercare programs to check in with participants and encourage them to stay connected to necessary services, especially with medication management;

    b. Additional supported housing options to increase stability;

c. Institutional support for the specialty court system;

d. Patient-aligned care teams in southern Nevada;

e. Specialized psychiatric nursing homes for chronically ill patients who have previously been placed in group homes and have had frequent emergency readmissions to a mental health hospital or a detention center; and

f. A forensic psychiatric facility in southern Nevada.

5. Amend NRS by revising the emergency admission process outlined in Chapter 433A ("Admission to Mental Health Facilities or Programs of Community-Based or Outpatient Services; Hospitalization") of NRS, related to emergency admissions in the following manner:

a. Amend NRS 433A.160 and NRS 433A.200 to expand the types of professionals who may initiate taking a person into custody and who may file a petition for the involuntary court-ordered admission of a person to a mental health facility or hospital. In addition to the existing professionals authorized, add a physician's assistant who is licensed pursuant to Chapter 630 ("Physicians, Physician Assistants, Medical Assistants, Perfusionists and Practitioners of Respiratory Care") or Chapter 633 ("Osteopathic Medicine") of NRS.

b. Add a new section to Chapter 433A of NRS authorizing a physician, a physician's assistant, psychologist, social worker, registered nurse (including an advanced practice registered nurse), or an accredited agent of the DHHS to certify that a person admitted to a public or private mental health facility or hospital for evaluation, observation, and treatment is no longer likely to harm himself or herself or others if allowed his or her liberty. This certificate should meet the same requirements as a certificate for emergency admission filed pursuant to NRS 433A.160. This certificate is the same as the release of such a person pursuant to NRS 433A.195. Such a person may still be hospitalized if the person has other conditions requiring hospitalization. **(BDR 39–64)**

B. CHILDREN'S HEALTH IN NEVADA

The LCHC heard testimony regarding the health status of children in Nevada, perinatal health and birth outcomes, and childhood disease and prevention efforts.

This testimony included a discussion regarding childhood obesity and overweight. Testimony noted that national standards on childhood obesity are consistent with Nevada's standards. Among Nevada's children aged two years to less than five years, 14.6 percent were overweight and 13.6 percent were obese, according to the Centers for Disease Control and Prevention (CDC), 2010 Pediatric Nutrition Surveillance System. In an attempt to address the issue, a statewide group formed to observe childhood obesity in early childcare and education settings in Nevada. The group referenced *Caring for our Children:*

National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs as a guide to best practices. According to testimony, Nevada's regulations only meet 3 of the 47 standard components for preventing childhood obesity in early childhood education settings. A recommendation was made to add the standards to NRS or to the *Nevada Administrative Code* (NAC).

Statistics from 2009 to 2012 pertaining to child and adolescent health were presented. Testimony noted an increase in the rate of mental illnesses in adolescents and children during this period. Information provided to the LCHC indicated that mobile crisis response programs reduce unnecessary psychiatric hospitalizations and placement disruptions of children and youth, and reduce the need for youth to go to ERs or detention centers to have their mental and behavioral health needs addressed. In addition, as the State works to increase capacity for community-based care, mobile crisis teams help to meet the immediate demand for services.

Following deliberation on these recommendations, the Committee agreed to:

1. **Draft a letter** to the State Board of Health requesting that the Board consider the following guidelines in the adoption of licensing standards, practices, and polices of child care facilities pursuant to NRS 432A.077:

    a. Require child care entities governed by NAC 432A.380 to:

        i. Establish age-appropriate portions;
        ii. Limit the amounts of foods with added sugars or low nutritional value, with specific requirements regarding milk, milk products, and juice;
        iii. Encourage staff to set good examples by:
            1. Eating with the children (currently in NAC);
            2. Eating items that meet the United States Department of Agriculture Child and Adult Care Food Program (CACFP) standards; and
            3. Teaching children appropriate portion sizes;
        iv. Use meal patterns established by the CACFP;
        v. Develop a feeding plan with the child's parent that includes:
            1. Introduction of age-appropriate solid foods; and
            2. Encouragement and support for breastfeeding (offering on-site arrangement for mothers to breastfeed).

    b. Strengthen the standards for child care facility programs governed by NAC 432A.390 by defining the following terms in accordance with physical activity guidelines based on the developmental age of children:

        i. Moderate physical activity;
        ii. igorous physical activity;
        iii. Muscular strengthening activities;
        iv. Bone-strengthening activities;
        v. Sedentary activities; and
        vi. Screen/media time.

c. Require child care facility programs governed by NAC 432A.390 to:

   i. Provide a program of physical activity that includes moderate to vigorous activity for all children, in addition to daily periods of outdoor play (weather permitting);
   ii. Require caregivers/teachers to participate in activities, when it is safe to do so; and
   iii. Prohibit withholding or forcing physical activity as a form of discipline.

2. **Draft a letter** to the Division of Child and Family Services, DHHS, expressing support for the continuation and expansion of mobile crisis programs throughout the State of Nevada to improve the quality of children's mental health care by providing immediate care and treatment in a variety of settings, including but not limited to, homes, schools, homeless shelters, and ERs. Mobile crisis response programs reduce unnecessary psychiatric hospitalizations and placement disruptions of children and youth, and reduce the need for youth to go to ERs or detention centers to have their mental and behavioral health needs addressed.

C. THE HEALTH CARE WORKFORCE IN NEVADA

Nevada is experiencing significant shortages of qualified, competent health care workers in virtually every health care profession including nurses, pharmacists, physicians, medical coders, radiology technologists, laboratory technologists, and health information technicians. The situation in Nevada reflects a national phenomenon and the shortage is of great concern to many because it compromises access to quality patient care. In recent years, legislative and executive efforts to address this challenge have yielded an increase in the number of licensed health care professionals in Nevada. However, the increase has not kept pace with the growing demand generated by general population growth in the State, the rapidly aging population, and increased access to health insurance, as a result of the Affordable Care Act (ACA).

According to the U.S. Health Workforce–State Profile of Nevada, August 2014, produced by the National Center for Health Workforce Analysis, Bureau of Health Workforce, Health Resources and Services Administration, U.S. Department of Health and Human Services, Nevada's health workforce falls short of national averages for licensed health professionals across a variety of fields. Compared to other states, the number of health care providers per 100,000 Nevada residents ranks near the bottom for many health professions. In 2012, Nevada's physician-to-population ratio ranked 47th compared to states nationwide. With 224 physicians per 100,000 Nevada residents, the State would need an increase of 21 percent to meet the regional rate of 270 physicians per capita, or 46 percent to reach the national rate of 327 physicians per capita.[1] Similarly, the State's registered nurse-to-population ratio ranks 51st, with 610 nurses per 100,000 people, compared to the national rate of 839 nurses per 100,000 people.[2] Nevada's health workforce supply falls short of national averages for licensed health professionals across the fields of primary care, nursing, oral

[1]UNSOM *2014 Physician Workforce in Nevada*
[2]CQ Press State Stats: Rate of Registered Nurses: http://library.cqpress.com/statestats/document.php?id=series-1733.

health, mental and behavioral health, public health, pharmacy, physical and occupational therapy, laboratory, and radiology.

These shortages are exacerbated in rural and frontier areas of the State. For example, most regions of rural and frontier Nevada are designated as primary care Health Professional Shortage Areas (HPSAs). Approximately 182,000 rural residents (67 percent) live in a primary care HPSA and 810,000 urban residents (33 percent) live in a primary care HPSA, including 139,000 residents of Washoe County and Carson City.[3]

The LCHC heard testimony reiterating that the major forces influencing the supply of health care workers are: (1) higher education; (2) health professional licensing and regulation; and (3) state and federal policy.

Education Requirements and Licensing

Regarding higher education, the LCHC received information about current and proposed programs to expand undergraduate and graduate medical and health professions programs offered by the Nevada System of Higher Education (NSHE) and private institutions such as Touro University, Nevada, and the Roseman University of Health Sciences. In addition, the LCHC heard testimony regarding the essential partnerships educational programs have with hospitals, physicians, and other health care professionals to train new medical and health professionals. In addition to other initiatives, the LCHC was encouraged to support: (1) an expansion of public medical education in Nevada; (2) increased development of graduate medical education (GME); (3) expansion of access to care in rural and medically underserved areas; and (4) expansion of the J1-Visa program.

Health professional licensing and regulation discussions included deliberation of educational requirements for entering a health profession, scope of practice regulations for non-physician primary care providers, and reciprocity between Nevada and other states' licensing authorities.

Community Health Workers and Paramedics

The LCHC heard testimony regarding community health workers (CHWs) and the role they might play in providing temporary relief for the shortage of health care workers. The American Public Health Association defines a CHW as a person who:

- Is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served;
- Serves as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery; and

[3]UNSOM *2014 Physician Workforce in Nevada*

- Builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy.

Information was presented regarding other states that have successfully used CHWs in the health care delivery system. The LCHC was encouraged to support: (1) the development of training, certification, and a scope of practice for CHWs; (2) workforce development resources; (3) the addition of a sustainable mechanism for funding; and (4) the creation and implementation of guidelines for common measures to be used in the evaluation of and establishment of relationships with CHWs. Presenters emphasized the effectiveness of CHWs' interventions on persons with chronic diseases, seniors, and the disabled.

In a similar vein, the LCHC heard testimony regarding innovations in community health services, with an emphasis on community health paramedics. The LCHC heard testimony about community health paramedicine programs established in a rural and an urban area of the State. Community health paramedics are paramedics who are specially trained to provide in-home services to improve the transition from hospital to home, to reduce hospital readmissions, and to improve access to quality care for people in rural and underserved areas. Community health paramedics may assist with medical care plan adherence, medication reconciliation, point-of-care lab tests, and personal health literacy.

The LCHC heard from representatives of the first community health paramedics program in the State established at Humboldt General Hospital in Winnemucca, Nevada. Testimony indicated that the goal of the program is to increase health and decrease readmission rates by using paramedics as physician extenders, and offering additional patient-centered service. Currently, the services provided are free; however, for the program to be sustainable and duplicable, funding and reimbursement options need to be developed.

The second program presented is broader in structure but provides similar services. The Regional Emergency Medical Services Authority and Care Flight received a Center for Medicare and Medicaid Services (CMS) Health Care Innovation Grant Award to implement various community health programs and a new Health Care Innovation Center. As a result of the grant, three new interdependent services exist in Washoe County: (1) ambulance transport to alternative destinations of care; (2) specially trained community health paramedics who provide in-home services; and (3) a nurse health line service. The LCHC was encouraged to support the development of these types of programs to help meet the need for health care services across the State.

State and Federal Policies Impacting the Supply of Health Care Workers

The final influence on the supply of health care workers relates to state and federal policy, which was deliberated by the LCHC in discussions regarding Medicaid reimbursement policies, federal support for health professions education and training, state and federal student

loan forgiveness/repayment policies, public and private reimbursement of telehealth, and government support for health professions recruitment and retention efforts.

After hearing testimony regarding these issues, the LCHC agreed to:

1. **Send a letter** to the Senate Committee on Finance and the Assembly Committee on Ways and Means expressing the Committee's support for the development and expansion of GME. The letter will specifically request that as funding is available:

    a. The number of residency slots within Nevada is increased. To fund a residency, an estimate of $100,000 to $110,000 a year was provided.

    b. Medicaid funding for GME be revised to establish a method that reimburses hospitals with Medicaid payments that cover a proportionate share of the cost of the program.

2. **Send a letter** to Nevada's Congressional Delegation advocating for:

    a. No additional GME funding cuts; and

    b. Redistributing full-time equivalent resident slots to Nevada hospitals.

3. **Send a letter** to the DHHS and NSHE expressing the Committee's support for increasing the health care workforce in Nevada by formalizing the role of CHWs and encouraging the development of community paramedicine. Specifically as it relates to CHWs, the LCHC supports the development of a CHW type that meets the requirements for Medicaid reimbursement. This effort should consider the necessity and feasibility of:

    a. Changing the Nevada Medicaid State Plan to include CHWs as a provider type;

    b. Establishing additional reimbursement mechanisms to support prevention services by CHWs;

    c. Creating and expanding training programs for CHWs at the university and/or the community college level;

    d. Creating a governing body to oversee CHW activities;

    e. Educating providers and the community about the role of the CHW; and

    f. Developing a pipeline of individuals interested in becoming a CHW.

4. **Redraft** Senate Bill 324, First Reprint (2013), which authorized certain qualified professionals who hold a license in another state or territory of the United States to apply for a license by endorsement to practice in this State. In addition, the measure authorized certain regulatory bodies to enter into a reciprocal agreement with the corresponding regulatory authority in another state or territory of the U.S. for the purposes of authorizing

a licensee to practice concurrently in this State and another jurisdiction and the regulation of such licensees. In addition to other provisions, the measure authorized a medical facility to employ or contract with a physician to provide health care to patients of the medical facility. **(BDR 54–62)**

D. RURAL AND COMMUNITY HEALTH CENTERS

Pursuant to Senate Bill 448 (Chapter 267, *Statutes of Nevada 2013*), the LCHC was directed to consider methods to promote federally qualified health centers and rural health clinics in this State as part of the LCHC's review of health care during the 2013–2014 Legislative Interim.

The LCHC heard testimony regarding:

1. The strategies used by other states that have had success with federally qualified health centers and rural health clinics and how those strategies could be used to increase the number of federally qualified health centers and rural health clinics in this State.

2. The locations in this State, which have been designated as medically underserved urban or rural communities, and which would benefit from federally qualified health centers or rural health clinics.

3. The likely impacts of establishing one or more new or existing facilities as federally qualified health centers or rural health clinics, including, without limitation, the economic impacts and the impacts on access to primary care services for recipients of Medicare and Medicaid, the underinsured, and the uninsured.

According to testimony, Nevada now has four Community Health Centers (CHCs) (i.e. federally qualified health centers), with 23 sites statewide. In addition, two new access points were granted in 2013. Medical, dental, and integrated mental and behavioral health services are the primary care services offered at CHCs. According to the 2013 Uniform Data System, Health Resources and Services Administration, 72,100 patients in Nevada were seen at CHCs in 2013, including 4,621 homeless patients and 352 veterans. Of these 72,100 patients, 67 percent were racial or ethnic minorities, 97 percent of patients had income below 200 percent of the federal poverty level and 46 percent were uninsured.

The LCHC received *The Economic Impact of Nevada's Community Health Centers*, which provided information on the community, economic, and tax impact of Nevada's primary care centers. Recent studies show that, on average, each patient receiving care at a CHC saved the health care system 24 percent, annually.[1] With 66,200 patients served in Nevada CHCs in

[1]Richard et al. "Cost Savings Associated with the Use of Community Health Centers". *Journal of Ambulatory Care Management*, Vol. 35, No. 1, pp. 50–59, January/March 2012.

2013, this amounts to an estimated annual savings of $84 million at $1,263 saved per patient.[1] In addition, testimony noted that in 2013, two senior CHCs had a $69.9 million economic impact in Nevada and were responsible for over 700 jobs.

The LCHC heard testimony regarding rural health clinics (RHCs). Rural health clinics are defined as primary care-based clinics located in rural underserved areas that receive cost-based reimbursement. Currently 4,000 RHCs are located in the United States. Rural health clinics must be located in a non-urbanized area as defined by the U.S. Census Tract and in a designated medical shortage area. According to testimony, 8 of the 11 rural health clinics in Nevada are owned by a Nevada critical access hospital; the other 3 are owned by a Nevada rural sole community hospital.

Proponents for increased CHCs and RHCs advocated for payment reform to address important components of patient-centered medical homes, such as:

- Care management and care coordination;
- Behavioral health integration;
- Team-based care including the use of CHWs;
- Expedited health care professional credentialing for CHCs; and
- A primary care pool.

In addition, proponents stressed the need to advocate for changes in the RHC licensing requirements and to establish an expedited credentialing process for providers who join the staff of an established CHC.

Recognizing the influence of RHCs and CHCs, the LCHC approved the following action:

1. **Send a letter** to the Senate Committee on Finance and the Assembly Committee on Ways and Means expressing the Committee's support for the expansion of RHCs and CHCs in Nevada. The letter will:

    a. Convey the significant role RHCs and CHCs play in meeting the needs of the uninsured and underinsured.

    b. Convey the significant return on investment received by states that have committed state funding to support the development or expansion of RHCs and CHCs by:

        i. Establishing a State-funded Primary Care Grant that is used in part to support capital needs;

[1]Ku et al. *Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers Through Health Reform*. Geiger Gibson/RCHN. Community Health Foundation Research Collaborative. Policy Research Brief No. 19. June 30, 2010.

ii. Establishing competitive awards to support the start-up of a new health center and the expansion of existing health centers; and
iii. Providing funds to support technical assistance to develop proposals to secure federal funds through the New Access Program.

c. Encourage priority be given to provide financial support for these endeavors as it becomes economically feasible.

2. **Include a statement of support** in the final report for the development of an expedited credentialing process for providers who join the staff of an established CHC.

3. **Redraft** Senate Bill 340, Second Reprint (2013), which proposed the creation of the Office for Patient-Centered Medical Homes and the Advisory Council on Patient-Centered Medical Homes. The redraft will exclude the provisions related to medical records. **(BDR 40–63)**

E. HEALTH INSURANCE COVERAGE

As health insurance coverage opportunities increase through an expanded Medicaid program and access to coverage through the Silver State Health Insurance Exchange, there is an increased need for providers to meet the demand. In addition, vast areas in Nevada are designated by the Health Resources and Services Administrations, U.S. Department of Health and Human Services, as a Health Provider Shortage Area (HPSA).

Recognizing these factors, a recommendation was made that the LCHC consider proposing an "Any Willing Provider" law. "Any Willing Provider" statutes, sometimes referred to as "Any Authorized Provider," are laws that require health insurance carriers to allow health care providers to become members of the carriers' networks of providers if certain conditions are met. Such statutes prohibit insurance carriers from limiting membership within their provider networks based upon geography or other characteristics, so long as a provider is willing and able to meet the conditions of network membership set by the carrier. Twenty-seven states currently have "Any Willing Provider" statutes.[2]

Following deliberations regarding health care professionals, access to care, and insurance coverage, the Committee agreed to:

- **Amend NRS** to require any insurer issuing a policy of insurance to contract with any qualified providers who meet the terms of the insurer if:

  a. The Division of Insurance, Department of Business and Industry, has determined that the insurer has an inadequate number of the specified provider types for all insurance including those required to have an adequacy review; or

[2] http://www.ncsl.org/research/health/any-willing-or-authorized-providers.aspx.

b. The area in which the services are to be provided has been designated by the Health Resources and Services Administrations, U.S. Department of Health and Human Services, as a HPSA. **(BDR 57–65)**

F. EMERGENCY USE OF EPINEPHRINE AUTO-INJECTORS (EpiPens)

The Committee heard testimony regarding the effectiveness of Senate Bill 453 (Chapter 269, *Statutes of Nevada 2013*), which authorized the use of emergency epinephrine at schools in Nevada. Several school districts provided information regarding their use of EpiPens in emergency situations since passage of S.B. 453. During the 2013–2014 School Year, Clark County School District indicted that the stock EpiPens had been used a total of 20 times. Washoe County noted that as of February 21, 2014, two doses had been given in response to an emergency. The Elko School District noted that two doses had been given to date (March 5, 2014) and two doses were given last year.

The LCHC was urged to consider supporting enabling legislation to provide EpiPens on college campuses and to make them available to the public. Findings from a 2009 to 2010 study of 38,480 children (infant to 18 years) indicated that 8 percent had a food allergy, 38.7 percent of food allergic children had a history of severe reactions, and 30.4 percent of food allergic children had multiple food allergies.[3] Worldwide, in up to 50 percent of individuals who experience a fatal reaction to an insect allergy, there is no documented history of a previous systemic reaction.[4]

Considering the success of a similar measure and the prevalence and severity of allergies, the LCHC agreed to:

- **Amend NRS** to authorize certain entities or organizations at which allergens capable of causing anaphylaxis may be present, including, but not limited to, amusement parks, recreation camps, restaurants, sports arenas, and youth sports leagues, to obtain and maintain a supply of EpiPens for emergency administration. Authorize a trained employee or agent of the entity or organization to administer an EpiPen under certain circumstances. **(BDR 40–66)**

G. TELEMEDICINE

The LCHC heard testimony regarding the development of various telehealth programs over the past 20 plus years from an initiative begun by the Nevada Area Health Education Center system, starting with connections to rural sites through telephones, U.S. mail service and fax machines. Developed as the Computerized Assistance Medical Information Link to receive practitioner requests for medical literature, the library service of the University of Nevada,

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[3]Gupta, Ruchi S., et al."The Prevalence, Severity and Distribution of Childhood Food Allergy in the United States," *Pediatrics, Vol. 128, No. 1, July* 2011,pp. e9-e17.

[4]Pawankar, Ruby, et al., WAO *White Book on Allergy 2011-2012: Executive Summary*. World Allergy Organization, 2011.

School of Medicine (UNSOM) provided the medical resources back to the community. Evolving with technology, the system eventually added the Nevada Telecommunications Network to serve the needs of education, administration, and telemedicine services. The Network recognizes significant partnership resources, in particular, Nevada Rural Hospital Partners.[1]

The Nevada Broadband Task Force presented information regarding broadband growth from 2010–2013, and anticipated growth to reduce broadband gaps. Testimony emphasized the importance of telehealth to address the challenges of workforce development, education, health, and the aging workforce in Nevada. Two challenges to telemedicine in Nevada were emphasized–broadband connectivity and regulatory challenges. The LCHC was briefed on a project to provide broadband connectivity between Reno and Las Vegas with a planned completion date of the end of 2014. A request was made that the LCHC consider parity legislation to:

- Recognize telemedicine as a "standard of care";
- Expand services to patients in rural and urban communities;
- Increase convenience by removing licensed health care facility limits;
- Improve access and quality by allowing all telemedicine-enabled care; and
- Expand access by clarifying health care provider licensing.

The LCHC was encouraged to support: (1) reimbursement parity for covered services; (2) timely access to high-quality, cost-effective care; and (3) economic development to preserve and increase health care related jobs in Nevada.

In addition, the LCHC heard testimony regarding Project ECHO (Extension for Community Health Outcomes) Nevada. Project ECHO uses off-the-shelf video conferencing tools to connect a health care specialty team with primary care providers across the State to co-manage complex patients. Project ECHO is not telemedicine because there is no patient-provider interaction and, therefore, has no Health Insurance Portability and Accountability Act or licensure issues. Project ECHO links teams of UNSOM clinical faculty or voluntary community specialists in Reno and Las Vegas with primary care providers in rural and frontier hospitals and clinics. Broad spectrums of specialty care needs are addressed through Project ECHO Nevada teams and clinics. Addiction; allergy treatment; asthma and pulmonary care; cardiology; child, adult, and family mental health and psychiatric care; dermatology; high-risk pregnancy; and HIV/AIDS are just a few of the issues Project ECHO Nevada has addressed. Project ECHO sites exist in 18 locations throughout rural and frontier areas of Nevada.

Following deliberations on the issue, the Committee agreed to amend NRS as follows:

[1] http://medicine.nevada.edu/statewide/rural-health/telehealth.

- **Draft a letter** supporting the advancement of Telemedicine in Nevada. Acknowledging the efforts of the Nevada Broadband Task Force and other entities in promoting telemedicine as a "standard of care" and recognizing how telemedicine supports:

  a. The expansion of services to patients in rural and urban communities;

  b. Inadequate provider distribution;

  c. Access to high-quality, cost-effective care;

  d. The reduction of health care spending caused by treatment delays;

  e. Increased convenience when:
     i. Licensed health care facility limits are removed;
     ii. Health care provider licensing is clarified; and
     iii. All telemedicine-enabled care is able to be provided;

  f. Increased innovation and investment when reimbursement parity is provided for covered services;

  g. Strengthening the health care infrastructure; and

  h. Economic development by preserving and increasing health care related jobs and keeping patients' care in Nevada.

H. AUTISM TREATMENT AND SERVICES IN NEVADA

A representative of the Nevada Commission on Autism Spectrum Disorders testified regarding the prevalence of autism. The CDC released new prevalence rates for autism, which indicate about 1 in 68 school age children are on the spectrum. The upsurge of people with Autism Spectrum Disorders (ASD) has affected access to services, increased expenses, stretched provider capacity, increased wait lists, and threatened the long-term viability of all State programs. Presenters addressed: (1) gaps in coverage and capacity for individuals with ASD; (2) the profound benefits of treatment to children under 46 months old; and (3) advances in screening and diagnosis tools, which provide the ability to identify children with ASD at an earlier age. At the same time, it was noted that the Autism Treatment Assistance Program (ATAP) is on target to meet the needs of 50 percent of the children on the wait list.

Additionally, it was noted in Nevada there continues to be gaps in coverage and capacity to address the needs of individuals across the lifespan and spectrum of ASD. Some of the gaps emphasized include:

- Lack of Medicaid coverage for evidence-based treatment specific to autism, such as Applied Behavior Analysis (ABA) therapy;

- Insurance barriers;
- Insufficient workforce and staffing issues to support children with insurance coverage;
- Lag between initial concerns, identification (failed screen and diagnosis), and access to research levels of evidence based treatment; and
- Sustainability.

Proponents for changes to the process recommended that ABA therapy be covered as an early preventive service by a Medicaid waiver. It was proposed that changes be made so children could be covered by private insurance. In addition, a recommendation was made to remove the requirement for certification by the Board of Psychological Examiners for Certified Autism Behavior Interventionists (CABIs).

Similar to services in other areas of health care, rural communities experience even greater shortages when attempting to access screening and treatment for ASD-related services. Proponents for increased services in rural areas of the State offered the following suggestions:

- Provide for ABA coverage in the Nevada State Medicaid Plan;
- Reinstate the self-directed community-based waiver program and job development training services;
- Remove limits on insurance benefits for autism treatment and access to benefits;
- Base insurance coverage on skills acquisition and development rather than age;
- Create better coordination between Nevada's Early Intervention Services (EIS) diagnosis and referral to ATAP;
- Work to rid the stigmatism of autism;
- Provide screenings by local pediatricians; and
- Implement a collaborative program between rural school districts and ATAP.

The LCHC heard from a broad spectrum of interested parties, including health care providers, parents, advocates, and members of professional groups. Following deliberations, the LCHC agreed to:

1. **Draft a letter** to the DHHS encouraging the Department to:

    a. Develop mechanisms to provide readily available access to the Modified Checklist for Autism in Toddlers screenings that assess risk for ASD in rural Nevada and a mobile diagnostic clinic for those who have red flags identified by the screenings. In rural Nevada, accessing a diagnostic evaluation is a significant barrier to treatment.

b. Allow ATAP funds to be used to support diagnostic clinics across rural Nevada, if it is determined to be feasible and appropriate.

c. Encourage coordination between ATAP, EIS, and rural school districts with the intent of promoting autism diagnoses and treatment and helping coordinate providers and services to increase access to treatment and services in rural communities.

d. Require Nevada Medicaid to cover ABA services as soon as possible by:

   i. Seeking clarification from CMS regarding whether ABA can be included in the Nevada Medicaid State Plan via a plan amendment;
   ii. Preparing and submitting such an amendment;
   iii. Initiating the process of certifying providers of ABA services and establishing rates;
   iv. Providing ABA services to Early and Periodic Screening, Diagnostic, and Treatment children;
   v. Making the necessary request to shift available funding during this biennium to cover these services; and
   vi. Developing a budget for the next biennium that includes sufficient funding for Medicaid coverage of ABA and to eliminate the ATAP waiting list.

2. **Revise the following provisions of NRS** related to autism services and insurance coverage:

Sunset the requirement that autism behavior interventionists be certified by the Board of Psychological Examiners on July 1, 2017. Continue to require autism behavior interventionists to work under the supervision of a licensed and Board Certified Behavior Analyst or a Board Certified Assistant Behavior Analyst. Beginning July 1, 2017, require autism behavior interventionists to obtain the Registered Behavior Technician credential established by the Behavior Analyst Certification Board.

a. Revise the requirement in various insurance statutes that an autism behavior interventionist be certified as a condition to insurance coverage for ASD and instead require as a condition to insurance coverage for ASD that autism behavior interventionists receive the Registered Behavior Technician credential established by the Behavior Analyst Certification Board. This revision is effective beginning July 1, 2017.

b. Remove the $36,000 per year cap on benefits for services related to ABA treatment. **(BDR 54–67)**

I. PERSONS WITH ALZHEIMER'S DISEASE

A representative of the Task Force on Alzheimer's Disease, which was created by Assembly Bill 80 (Chapter 409, *Statutes of Nevada 2013*), provided information concerning the background and activities of the Task Force during the current interim. Recommendations

from The Nevada State Plan to Address Alzheimer's Disease were presented for consideration by the LCHC, which included:

- A request for funding and legislation for a statewide referral resource for people with Alzheimer's disease;

- Requiring mandatory administrative or judicial review for people with dementia who are under guardianship; sending a letter to all district courts to encourage review of guardianships for people who are suffering from dementia to assure all existing resources are utilized for their care; and proposing legislation to amend NRS 159.076 requiring federal review of guardianships in relation to people who have dementia;

- Creating a transitional program from hospitals to least restrictive settings and a statutory definition of a safe discharge; and, forwarding a letter to the DPBH and the DHCFP encouraging the creation of a transitional program, increasing the number of home-based services and long-term care facilities, and establishing a central location where placements could be accessed;

- An amendment to NRS 439.877(2), which creates a safe patient checklist for people leaving institutions and include a definition of what constitutes an "appropriate" discharge; and

- Support and funding for the creation of a program to increase awareness of Alzheimer's disease among the public.

Testimony indicated that current law requires mandatory annual reports on the financial and personal well-being of all people, with estates of more than $10,000, who are under guardianship in Nevada. When the estate is less than $10,000 guardians can use the money to care for the ward and not provide any additional reports to the court regarding the ward's finances until the guardianship is dissolved. Testimony noted that even a small amount of savings could be combined with regular income to keep a ward in a familiar setting. However, with no supervision, sometimes the ward's savings is spent by a guardian. In addition, testimony noted that, on occasion, guardians sell off a ward's assets in a short period. In these instances, if the ward recovers or is determined capable of returning home, there is nothing left when the ward returns home. This is not examined by the court as a financial issue if there has been a summary administration regarding the ward's estate.

In addition, testimony emphasized the lack of providers and placement options for people suffering from dementia. Proponents stressed the need to encourage long-term care organizations to develop inpatient facilities and for existing facilities to increase inpatient capacity for placement of individuals with dementia, including Alzheimer's disease and related disorders.

The LCHC considered the recommendation presented by the Task Force to address these issues. Following discussion, the LCHC agreed to:

1. **Draft a letter** to all district courts in Nevada strongly requesting that they closely supervise all guardians, whose wards suffer from dementia, including, but not limited to, Alzheimer's disease to insure that all reports on the person and estate of the ward are filed and reviewed according to existing law.

2. **Amend NRS** 159.076 to prohibit a court from granting a summary administration if:

   a. The ward is suffering from dementia, including but not limited to Alzheimer's disease; or

   b. The ward has been placed in a facility outside the State of Nevada. (**BDR 13–504**)

3. **Draft a letter** to the DPBH and the DHCFP, DHHS, urging them to:

   a. Establish hospital transitional care programs;

   b. Increase the number of home-based services and long-term care facilities with Alzheimer's certification; and

   c. Establish a central location where available and appropriate placements can be accessed.

   This letter will stress the importance of providing methods and means by which people with dementia, including Alzheimer's disease, can avoid relocation trauma and out-of-state placement.

IV. CONCLUSION

This report presents a summary of the bill drafts requested by the LCHC members for discussion before the 2015 Nevada Legislature. In addition, this document provides information identifying certain other issues that were addressed during the 2013–2014 Interim. Persons wishing to have more specific information concerning these issues may find it useful to review the "Summary Minutes and Action Report" and related exhibits at: http://www.leg.state.nv.us/Interim/77th2013/Committee/Scheduler/committeeIndex.cfm?ID=55.

V. APPENDICES

APPENDIX A

Nevada Revised Statutes 439B.200

NRS 439B.200 Creation; appointment of and restrictions on members; officers; terms of members; vacancies; annual reports.

1. There is hereby established a Legislative Committee on Health Care consisting of three members of the Senate and three members of the Assembly, appointed by the Legislative Commission. The members must be appointed with appropriate regard for their experience with and knowledge of matters relating to health care.
2. No member of the Committee may:
   (a) Have a financial interest in a health facility in this State;
   (b) Be a member of a board of directors or trustees of a health facility in this State;
   (c) Hold a position with a health facility in this State in which the Legislator exercises control over any policies established for the health facility; or
   (d) Receive a salary or other compensation from a health facility in this State.
3. The provisions of subsection 2 do not:
   (a) Prohibit a member of the Committee from selling goods which are not unique to the provision of health care to a health facility if the member primarily sells such goods to persons who are not involved in the provision of health care.
   (b) Prohibit a member of the Legislature from serving as a member of the Committee if:
      (1) The financial interest, membership on the board of directors or trustees, position held with the health facility or salary or other compensation received would not materially affect the independence of judgment of a reasonable person; and
      (2) Serving on the Committee would not materially affect any financial interest the member has in a health facility in a manner greater than that accruing to any other person who has a similar interest.

4. The Legislative Commission shall review and approve the budget and work program for the Committee and any changes to the budget or work program. The Legislative Commission shall select the Chair and Vice Chair of the Committee from among the members of the Committee. Each such officer shall hold office for a term of 2 years commencing on July 1 of each odd-numbered year. The office of the Chair of the Committee must alternate each biennium between the houses of the Legislature.

5. Any member of the Committee who does not become a candidate for reelection or who is defeated for reelection continues to serve after the general election until the next regular or special session of the Legislature convenes.

6. Vacancies on the Committee must be filled in the same manner as original appointments.

7. The Committee shall report annually to the Legislative Commission concerning its activities and any recommendations.

(Added to NRS by 1987, 863; A 1989, 1841; 1991, 2333; 1993, 2590; 2009, 1154, 1568)

APPENDIX B

Status of Bill Draft Requests From the 2011–2012 Interim

STATUS OF BILL DRAFT REQUESTS
FROM THE 2011–2012 INTERIM

BDR	Summary	Bill	Status
40–500	Allows physicians to dispense drugs donated for use in the Cancer Drug Donation Program.	S.B. 81	Chapter 44, *Statutes of Nevada 2013*
40–501	Revises provisions relating to certain providers of emergency medical services.	S.B. 100	Chapter 226, *Statutes of Nevada 2013*
54–502	Revises provisions governing the unlicensed practice of certain health-related professions.	S.B. 220	Chapter 406, *Statutes of Nevada 2013*
54–503	Revises provisions relating to enforcement authority of certain health-related licensing boards.	S.B. 219	Pursuant to Joint Standing Rule No. 14.3.1, no further action allowed
15–504	Creates specific crimes for performing certain medical procedures without a license.	S.B. 199	Chapter 230, *Statutes of Nevada 2013*
38–505	Revises provisions concerning persons legally responsible for the psychiatric care of a child who is in the custody of an agency which provides child welfare services.	A.B. 149	Pursuant to Joint Standing Rule No. 14.3.1, no further action allowed
38–506	Revises provisions relating to the placement of a foster child with fictive kin.	A.B. 92	Pursuant to Joint Standing Rule No. 14.3.1, no further action allowed
R–507	Encourages the Department of Health and Human Services and the Insurance Commissioner to work with health care providers and insurers to develop a patient-centered medical home model of care.	S.C.R. 4	File No. 34, *Statutes of Nevada 2013*

APPENDIX C

Suggested Legislation

The following Bill Draft Requests will be available during the 2015 Legislative Session, or after "Introduction" can be accessed at the following website: http://www.leg.state.nv.us/Session/78th2015/BDRList/.

BDR 54–62	Revises provisions governing licensing and practice of certain medical professionals.
BDR 40–63	Provides for the regulation of patient-centered medical homes.
BDR 39–64	Revises provisions governing involuntary admission to certain facilities of persons believed to have mental illness.
BDR 57–65	Requires certain insurers to contract with any qualified provider of health care in certain circumstances.
BDR 40–66	Provides for certain businesses to obtain and use auto-injectable epinephrine in certain circumstances.
BDR 54–67	Revises provisions relating to certain persons who provide services to persons with autism.
BDR 14–68	Allows for a program to provide outpatient treatment to competency to incarcerated criminal defendants.
BDR 13–504	Amends provisions concerning estates under guardianship.