MINUTES OF THE MEETING
OF THE
LEGISLATIVE COMMITTEE ON HEALTH CARE
(*Nevada Revised Statutes* 439B.200 through 439B.240)
March 7, 2000
Carson City, Nevada

The fourth meeting of Nevada's Legislative Committee on Health Care for the 1999-2000 interim was held on Tuesday, March 7, 2000, at 9:30 a.m., in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. This meeting was videoconferenced to Room 4401, Grant Sawyer State Office Building, Las Vegas, Nevada. Pages 2 through 3 contain the "Meeting Notice and Agenda" for this meeting.

COMMITTEE MEMBERS PRESENT IN CARSON CITY:

Assemblywoman Ellen M. Koivisto, Chairman
Senator Bernice Mathews
Senator Maurice E. Washington
Assemblywoman Vivian L. Freeman

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:

Senator Raymond D. Rawson, Vice Chairman
Assemblywoman Merle A. Berman

LEGISLATIVE COUNSEL BUREAU STAFF PRESENT:

Marla McDade Williams, Senior Research Analyst, Research Division
Risa B. Lang, Principal Deputy Legislative Counsel, Legal Division
Leslie Hamner, Senior Deputy Legislative Counsel, Legal Division
Paige Clyde, Senior Research Secretary, Research Division

MEETING NOTICE AND AGENDA

Name of Organization:	Legislative Committee on Health Care (*Nevada Revised Statutes* 439B.200)
Date and Time of Meeting:	Tuesday, March 7, 2000 9:30 a.m.
Place of Meeting:	Legislative Building Room 3138 401 South Carson Street Carson City, Nevada

Note: Some members of the committee may be attending the meeting, and other persons may observe the meeting and provide testimony, through a simultaneous videoconference conducted at the following location:

Grant Sawyer State Office Building
Room 4401
555 East Washington Avenue
Las Vegas, Nevada

A G E N D A

I. Opening Remarks by the Chairman

Assemblywoman Ellen M. Koivisto

*II. Approval of Minutes of the Meeting Held on January 26, 2000, in Las Vegas

*III. Presentation Concerning Observations of Current Status and Outline of Future Plans for the School of Medicine, University of Nevada, Reno (UNR)

Dr. Robert Miller, Dean

*IV. Presentation Concerning the Nevada Kids Count Report and Data Concerning Uninsured Children in Nevada

R. Keith Schwer, Ph.D., Executive Director, Center for Business and Economic Research, University of Nevada, Las Vegas

Marlys Morton, Coordinator, Nevada Kids Count Project

*V. Presentation and Recommendations Concerning Rural Health Issues

Caroline Ford, M.P.H., Assistant Dean/Director, Rural Programs, Center for Education and Health Services Outreach, UNR School of Medicine

Gerald Ackerman, Associate Director, Rural Programs, UNR

Grant Asay, President, Nevada Rural Hospital Project

Ken McBain, Director, Nevada Rural Health Centers, Inc.

*VI. Presentation and Recommendations Concerning Improving and Expanding Respite Care for Lay Persons Who Provide Care for Individuals with Alzheimer=s Disease

Don Hauth, Southern Nevada Public Policy Chair, Alzheimer=s Association Southern Nevada Chapter

*VII. Presentation and Recommendations Concerning AEnd-of-Life@ Care Issues, Including Suggested Amendments to Sections of Chapter 449 of the *Nevada Revised Statutes* Dealing with AWithholding or Withdrawal of Life-Sustaining Treatment@

Mr. Blair Moon, Reno, Nevada

*VIII. Discussion of APill Splitting@ Recommendations

*IX. Discussion of Future Topics

X. Public Testimony

XI. Adjournment

*Denotes items on which the committee may take action.

Note: We are pleased to make reasonable accommodations for members of the public who are disabled and wish to attend the meeting. If special arrangements for the meeting are necessary, please notify the Research Division of the Legislative Counsel Bureau, in writing, at the Legislative Building, 401 South Carson Street, Carson City, Nevada 89701-4747, or call Paige Clyde, at (775) 684-6825, as soon as possible.

Notice of this meeting was posted in the following Carson City, Nevada, locations: Blasdel Building, 209 East Musser Street; Capitol Press Corps, Basement, Capitol Building; City Hall, 201 North Carson Street; Legislative Building, 401 South Carson Street; and Nevada State Library, 100 Stewart Street. Notice of this meeting was faxed for posting to the following Las Vegas, Nevada, locations: Grant Sawyer State Office Building, 555 East Washington Avenue; and Clark County Office, 500 South Grand Central Parkway.

OPENING REMARKS BY THE CHAIRMAN

Chairman Ellen M. Koivisto opened the meeting and asked the secretary to call the roll.

APPROVAL OF MINUTES OF THE MEETING HELD ON JANUARY 26, 2000, IN LAS VEGAS, NEVADA

The Chairman called for approval of the minutes of the committee's third meeting.

ASSEMBLYWOMAN FREEMAN MOVED TO APPROVE THE MINUTES OF THE COMMITTEE'S MEETING HELD ON JANUARY 26, 2000, IN LAS VEGAS, NEVADA. SENATOR WASHINGTON SECONDED THE MOTION, WHICH PASSED UNANIMOUSLY. SENATOR MATHEWS ABSTAINED FROM THE VOTE.

PRESENTATION CONCERNING OBSERVATION OF CURRENT STATUS AND OUTLINE OF FUTURE PLANS FOR THE SCHOOL OF MEDICINE, UNIVERSITY OF NEVADA, RENO (UNR)

Dr. Robert Miller

Dr. Robert Miller, Dean, University of Nevada, Reno School of Medicine (UNSOM), addressed the committee on issues relating to the UNSOM Missions (See Exhibit A, Tab III, page III-1), which are education, research, and services.

He stated that education occurs at many different levels including medical students, residents, continuing medical education (CME), and Doctor of Philosophy (Ph.D.).

Another important mission of the medical school is research. Research is broken down into two forms:

- Basic science – Laboratory research in the areas of microbiology and physiology is conducted in Reno, Nevada, and utilizes grant funding.

- Clinical research – Involves patients who volunteer to participate in clinical trials, pharmaceutical studies, and outcome studies.

Continuing, Dr. Miller noted that research space is a serious issue. He stated that the Reno UNSOM campus has not received new research space for the past 15 years and that the University of Nevada, Las Vegas (UNLV) campus has no research space for its medical school.

Discussion ensued regarding research issues necessary for supporting the UNSOM's clinical research infrastructure. It was Dr. Miller's opinion that the UNSOM improve its clinical research infrastructure in order for its clinical trials to function. He also recommended that the UNSOM increase its own collaboration and increase collaboration with other institutions as well.

Dr. Miller reported that the third mission of the UNSOM is service. This includes patient care and outreach programs. The UNSOM is noted for its strong outreach program utilized by both rural and urban communities. This program is known as the Area Health Education Centers program (AHEC).

Continuing, he commented on the UNSOM's educational program, which currently contains a pool of approximately 203 in-state applicants and previously contained 201 in-state applicants during 1999. Dr. Miller noted that during the past two to three years the general number of medical school applicants has declined substantially; however, the number of UNSOM applicants has remained constant.

Dr. Miller reported that the general grade point average (GPA) of UNSOM applicants is 3.5 with an average of 3.7

GPA for accepted applicants. He stated that those numbers compare favorably to the average GPA of medical applicants across the country. The UNSOM Medical College Aptitude Test (MCAT) average is 8.7 with a 9.4 MCAT average for accepted applicants, which compared to the national average of 9.7.

Dr. Miller commented on medical school students and their opinions of medical school. Their opinions are referenced in the Medical School Graduate Questionnaire, which compare opinions of the UNSOM applicants to those of the national applicants (See Exhibit A, Tab III).

Continuing, Dr. Miller discussed educational issues. He reported that:

- The UNSOM has a solid and successful educational program based on a 100 percent pass rate of the University School of Medicine Licensing Examination;
- Students are required, multiple times, to complete this examination during their medical training; and
- Currently, he does not foresee any major changes in store for the UNSOM program relating to educational issues.

Continuing further, he stated that one significant program issue is a divided campus. This issue presents both problems and challenges for the UNSOM because it requires students to travel back and forth between two campuses: the University of Nevada, Reno (UNR) campus; and the UNLV campus. He stated that this issue would be addressed once the UNSOM reviews its strategic plan already in progress.

Other issues discussed by Dr. Miller included student indebtedness as a result of tuition costs and minority recruitment.

Responding to Assemblywoman Freeman, Dr. Miller stated that financially the UNSOM is not offering and is unable to offer the same incentive programs as other colleges. Applicants also take into consideration a college's reputation such as Harvard University versus the UNSOM.

Dr. Miller expressed to Senator Mathews the UNSOM's support in working with the committee to implement a program that will help increase its number of minority students.

Continuing, Dr. Miller stated that the main form of service administered is clinical practice. Clinical practice responsibilities include:

- Primary care;
- Tertiary care;
- Indigent care;
- Faculty salary support; and
- Subsidization of education and research.

Chairman Koivisto asked whether the transplant program administered by the University Medical Center, Las Vegas, was still in effect. Dr. Miller reported that the UMC has recruited a transplant surgeon and the program will be reinstated.

Responding to Assemblywoman Freeman, Dr. Miller stated that AHEC is responsible for educating non-physicians and currently has an outreach program for addressing those issues. He noted that the UNSOM has been active in making recommendations to the Nevada Legislature and Governor Kenny Guinn regarding how the tobacco funding should be spent.

Continuing his testimony, Dr. Miller stated that other service issues that should be addressed include: increasing

demands on clinicians to generate revenue; diminished time for research and teaching; career satisfaction; and faculty practice plan reviews.

Dr. Miller reiterated that the bulk of clinicians' salaries are generated through clinical practice. The UNSOM's problem is that it uses extra revenue from its clinical practice to subsidize its research and educational missions. As a result, this places an increased demand on the UNSOM practitioners to see more patients and to generate additional money with this reduced method of reimbursement. Consequently, it impairs the practitioner's ability and time to teach and perform research. However, he noted that faculty members do have alternative options such as transferring to another school or employment in private practice.

Dr. Miller reported that the UNSOM's general issues include: newness; small size; geographical separation; cultural differences; and a changing health care environment.

Continuing further, Dr. Miller discussed the concept of an academic medical center consisting of several health related schools incorporating the following:

- Teaching;
- Research;
- Service;
- Medical;
- Pharmacy;
- Dental;
- Nursing; and
- Technical schools.

An academic medical center also includes hospitals teaching other hospitals where education faculty and private practitioners work. These hospitals are located in a single geographical area, which allows for collaboration between basic scientists and clinicians within any given school.

Responding to Senator Mathews, Dr. Miller stated that, currently, the City of Las Vegas is the most logical location for developing an academic medical center, as it is the largest city in the United States, with the exception of Phoenix, Arizona, which does not have this kind of center.

Chairman Koivisto questioned whether the State of Nevada would someday include a pharmaceutical school. Responding, Dr. Miller stated that the Board of Regents has discussed the idea and are in favor of it, however, no firm decisions have been made at this time.

Dr. Miller referenced an example of a prime academic medical center, located in Houston, Texas, as one of the most preeminent medical centers in the United States contributing approximately $10 billion per year to Houston's economy.

In response to a question by Senator Mathews, Dr. Miller noted that he is not aware of how much money is required to develop an academic medical program, but from his experience, most of the funding is derived from private philanthropy.

Responding to Senator Mathews, Dr. Miller stated that UNR does not plan on moving its medical school to Las Vegas because it contains strong and structurally sound programs such as its rural outreach program and basic science program. He stated that, in his opinion, Las Vegas is where the most rapid academic medical growth will occur.

Assemblywoman Freeman expressed her concern regarding the "business approach" to an academic form of practice in Nevada due to the state not having acquired a philanthropic reputation. Responding, Dr. Miller stated that his explanation of the business approach is by means of managing resources appropriately, especially in regard to limited resources.

Continuing, Assemblywoman Freeman and Dr. Miller addressed the issues of space and land. Dr. Miller reported that the City of Las Vegas donated 11 acres of land to the UNR Medical School and 12 or more to the UNLV. He stated that the land previously donated to UNR for its academic medical center would be a sufficient amount of space needed for its program.

Senator Rawson expressed concern that the donated acreage may not be large enough to provide an efficient and functional academic medical facility, and he asked whether the UNR and UNLV Medical School's Administration Departments are seeking other space alternatives.

In response, Dr. Miller said that department representatives from UNR and UNLV have met to discuss possible land and space alternatives, however, at this time no decisions have been made. In regard to the budget process and the building of additional medical academic facilities, Dr. Miller reported that university department representatives do not currently have a specific plan formatted or submitted for review for the next budget cycle.

Senator Washington questioned whether the UNR School of Medicine would utilize private industry for the purpose of providing additional academic services. Dr. Miller stated that the School of Medicine requires a substantial plan be established in order to provide further academic opportunities and would benefit in creating some form of incentive program that would attract private industry providers.

Dr. Miller concluded his presentation by stating that Nevada should be proud of its medical school, faculty, programs, and students. He noted that the school has opportunities for growth and expansion in the area of medical academics in both Northern and Southern Nevada.

PRESENTATION CONCERNING THE NEVADA KIDS COUNT REPORT AND DATA CONCERNING UNINSURED CHILDREN IN NEVADA

Dr. R. Keith Schwer

Dr. R. Keith Schwer, Ph.D., Executive Director, Center for Business and Economic Research (CBER), UNLV, appeared before the committee regarding the Nevada Kids Count Project and *2000 Kids Count Data Book*. Dr. Schwer introduced Marlys Morton, Coordinator, Nevada Kids Count Project, who addressed the committee regarding the project.

Marlys Morton

Ms. Morton began her testimony by explaining that Kids Count is a project of the Annie E. Casey Foundation, which was initiated in 1996 as a national and state-by-state effort to track the status of children residing in the United States. Nevada is the last state in the Union to gain entrance into the Kids Count network. She stated that by providing policymakers and citizens with benchmarks of child well-being, Kids Count seeks to enrich national, state, and local discussions concerning ways to secure a better future for all children.

The project is a statewide, collaborative effort to develop, collect, present, analyze, and disseminate the best available data for the purpose of measuring educational, social, economic, and physical well-being of children in the State of Nevada. Partners of the project include:

- UNR Cooperative Extension;
- The School of Social Work located at UNLV;

- Title IV-B, the Division of Child and Family Services (DCFS) Family Support and Family Preservation Steering Committee; and

- The Nevada Kids Count Advisory Council.

Ms. Morton noted that the *2000 Kids Count Data Book* provides the community with a statistical portrait of the well-being of children in Nevada, and it contains reliable, objective information in the following areas:

- Demographic data;

- State to national comparisons; and

- Selected Nevada trend data.

Interjecting, Dr. Schwer provided committee members with an overview of the book and reported that it contains six areas of concentration and presentation. Those areas are:

- Early child care and education;

- Economic well-being;

- Regular education;

- Juvenile justice;

- Child safety; and

- Health.

He noted that a copy of the book may be obtained from the Internet at www.unlv.edu/projects/kidscount/, and each segment of the book contains a section, which identifies the following:

- Definitions currently used;

- The significance of the data selected for presentation;

- The risks and impact associated with the selected data;

- The influence on children; and

- The identification of related tables.

Dr. Schwer reported that the book is different from last year's publication because it contains information pertaining to health and Nevada's level of uninsured children (See Exhibit B, page 12).

Concluding his remarks, he stated that the project is important for its long-term policymaking and is an effort to provide accurate, reliable, and valid information. He noted that the Kids Count Advisory Council has completed a planning project and will continue to expand its efforts to provide service to Nevada's children.

Discussion ensued regarding the data included in the book. Dr. Schwer stated that the book includes information pertaining to citations reflected in the *1998 Kids Count Data Book*.

Senator Rawson commented on issues concerning the health of Nevada's children. He stated that the Nevada Kids

Count Project is one the committee should act on and requested that the committee propose the drafting of a bill for the 2001 Legislative Session to continue the funding required by the Nevada Kids Count Advisory Council for the publication of its data book. In addition, he noted that the research that is conducted as a result of this funding should attempt to identify existing services for children and whether there are waiting lists for such services.

Senator Rawson suggested that the committee provide additional funding in the amount of $50,000, starting July 1, 2000, for the CBER. He stated that he would like to have the committee construct a permanent funding program totaling $150,000 per year for utilization by Nevada's Department of Human Resources (DHR) and allocated by Nevada's universities for the continuation of the Nevada Kids Count Project.

Senator Rawson explained that a change in the Nevada Kids Count funding occurred due to the termination of its previous nonprofit charity status. As a result, additional funding was requested.

Marla McDade Williams

Marla McDade Williams, Senior Research Analyst, Research Division, Legislative Counsel Bureau (LCB), commented in regard to the budget allocation previously submitted to the Legislative Commission.

She reported that the committee submitted a budget request for review, in an approximate amount of $29,000, to the Legislative Commission, which was later approved. However, Ms. Williams stated that if budget modifications are necessary, the budget request would be returned to the Legislative Commission for enhancement but only if the amount previously requested exceeded the committee's budgeted amount.

Concluding her remarks, Ms. Williams stated that the budget request would either have to be changed within its current parameters or reserved and enhanced in addition to submitting some form of budget justification for approval to the Legislative Commission.

Discussion ensued regarding allocation of funds from health insurance premium taxes that are designated for funding the activities of the health care committee.

In response to Senator Rawson, Ms. Williams stated that the funds exist, are stored in the health care fund, and are available for use by the committee. Therefore, if the committee wanted access to those funds, it would be required to revise its budget.

> **SENATOR RAWSON MOVED THAT THE HEALTH CARE COMMITTEE SUPPORT ACTIVITIES OF THE NEVADA KIDS COUNT PROJECT IN DEVELOPING SPECIAL INFORMATION FOR THE COMMITTEE'S USE; ALLOCATE UP TO $50,000 FOR SUPPORT OF SUCH ACTIVITIES; APPROACH THE LEGISLATIVE COMMISSION FOR THE PURPOSE OF A BUDGET MODIFICATION; EFFECTIVE ON JULY 1, 2000. ASSEMBLYWOMAN FREEMAN SECONDED THE MOTION.**

Following discussion of Senator Rawson's motion, Chairman Koivisto requested that Dr. Schwer provide the committee with a proposed budget.

> **UPON THE CALL OF THE MOTION AND A SECOND, THE MOTION PASSED UNANIMOUSLY.**

In addition, Senator Rawson requested that the committee add to its final work session for consideration, the drafting of an appropriation measure for continued support of the development of the Nevada Kids Count Data Book.

PRESENTATION AND RECOMMENDATIONS CONCERNING RURAL HEALTH ISSUES

Caroline Ford

Caroline Ford, M.P.H., Assistant Dean/Director, who runs the Office of Rural Health in the Center for Education and Health Services Outreach, UNSOM, began her testimony by reporting that the Lovelock Community Hospital

was on-line via the Internet and would be included in discussions pertaining to rural health issues.

Ms. Ford stated that she has been called upon to address eight rural health topic recommendations relating to Assembly Concurrent Resolution No. 36 from the 1999 Legislative Session, which sought to direct the Legislative Commission to conduct an interim study of the availability of health care in rural areas of this state. However, this resolution failed in the Assembly Committee on Elections, Procedures, and Ethics. The eight recommendations are:

1. To assist rural communities in understanding and preparing for potential facility conversions;

2. To assist in the development of networks that support their facilities;

3. To improve and integrate emergency medical services (EMS);

4. To address telecommunication/telemedicine issues in Critical Access Hospital (CAH) Program areas;

5. To provide technical assistance, determine hospital financial feasibility, and provide ongoing assistance with business operations;

6. To deliver public health services;

7. To deliver primary care services; and

8. To deliver EMS to long-term care facilities.

Ms. Ford reported that rural areas within Nevada encompass 86 percent of the land mass and approximately 13 percent of its population (See Exhibit A, Tab V, page V-1). Next, she directed the committee's attention to her handout (See Exhibit C, Item 1, page 1), which lists three specific county classifications: urban, rural, and frontier.

She noted that most of the information pertaining to Carson City declared the city as a rural county but stated that the city would eventually be converted into an urban county due to its population density. However, Ms. Ford stated that this change would not take effect until after the 2000 Census was finished and review of Nevada's population numbers completed.

With respect to population density, Ms. Ford noted that the density of the designated rural and frontier areas are approximately 1.7 persons per square mile (See Exhibit C). Therefore, the health care systems in these areas operate differently from each other.

She further stated that some of the rural area facilities are approximately one to one and one-half hours apart; however, in wilderness areas they may be five hours apart. As a result, questions arose as to what type of services should be placed and administered within those areas and the correlation of distinctions formed between rural versus frontier designations (See Exhibit C, Item 4).

Responding to questions by Senator Washington, Ms. Ford stated that a few counties still consider the concept of providing a "wilderness" service approach due to population density. An example of a wilderness service approach would be a veterinarian providing medical services to people.

Ms. Ford reported that approximately 85 percent of Nevada is classified as a Federal Health Professions Shortage Area (HPSA) or a Medically Underserved Area (MUA).

Senator Washington and Ms. Ford briefly discussed funding and reimbursement issues pertaining to federal funding and Nevada's population designation areas.

She stated that if a program contains too many practitioners within its county limit, it would "fall out" of the population designation and lose all reimbursement rights. She also said that the Federal Government's responsibility includes setting criteria for, and the categorization of, specific populated areas.

Continuing, Ms. Ford reported that Nevada has nine rural health centers and two independent rural health clinics (See

Exhibit C, Item 1, page 3). She stated that most of Nevada's rural practices are "organized" or "solo" (private) practices, which are classified as the "last frontier of medicine."

Further, she noted that Nevada has two Indian Health Service areas, which include the Owyhee and Schurz Service Units.

In addition, each of these units comprise eight tribal health clinics throughout the state (See Exhibit C, Item 1).

She reported that Owyhee encompasses central and northeastern parts of Nevada, and it has the only Indian community-based hospital remaining in Nevada. Schurz encompasses the southern and western areas of Nevada.

Commenting further, Ms. Ford noted that, historically, all rural hospitals in Nevada were public, not-for-profit facilities and were built with Hill Burton funds during the 1940s to 1960s. Of those facilities, seven are taxing district public facilities, two are owned by for-profit entities, one is owned by a not-for-profit corporation, and one is a public facility without a taxing district. During the early 1990s, many public facilities converted to taxing district hospitals to help support their operation costs.

Grant Asay

Responding to questions by Assemblywoman Freeman, Grant Asay, President, Nevada Rural Hospital Project (NRHP), stated that the Tonopah hospital sold its assets and was purchased by a private company in Ohio. Ms. Ford interjected and said that the hospital had recently applied for not-for-profit status.

Senator Washington questioned Ms. Ford in regard to the Boulder City hospital. Ms. Ford commented on the definition of a rural hospital. She reported that her office recognizes the isolation issue of this hospital due to its location, that the health center currently uses the facility for a training site for medical students, and the hospital is an official member of the NRHP.

Continuing, Ms. Ford conducted an overhead presentation on rural hospitals, clinics, and centers (See Exhibit C, Item 1, pages 2 through 5 for details).

Responding to a question by Senator Washington, Gerald Ackerman, Associate Director, Rural Programs, UNR, stated that the current rural dental problem is a serious issue that needs to be addressed. He reported that people residing in rural communities requiring services due to dental emergencies have to travel great distances to receive treatment.

Assemblywoman Freeman interjected and reported that Washoe County uses a van for the specific purpose of providing dental services to children within various high-risk schools. This is a public-private partnership between Saint Mary's Health Network, the county, and other local facilities within Reno. She questioned Ms. Ford on how the rural health center would utilize its American Dental Outreach Program funds for providing dental services to rural communities.

Ms. Ford responded by stating that her office would assist in identifying high priority sites and in reviewing the infrastructure of those sites for the purpose of patient recruitment, scheduling, and transportation.

Assemblywoman Freeman, Ms. Ford, and Mr. Ackerman briefly discussed issues concerning Medicaid dental reimbursement and recruitment. Mr. Ackerman stated that the rural health care program is currently working with Senator Rawson regarding the dental recruitment issue. He opined that current recruitment problems are due to an insufficient amount of dental hygienists, along with an inadequate incentive program for obtaining hygienists who are willing to work in rural communities.

Ms. Ford expressed her concern regarding how the rural health centers might accomplish supplying an adequate amount of dentists, dental hygienists, and stable services to the rural communities in Nevada.

Senator Rawson addressed the committee in regard to the upgrading of rural practices. He stated that part of the dental incentive program is to contract with dentists. He advised that any dentist who contracts with the new dental school would receive $50,000 worth of upgrades to his/her dental equipment, which is an incentive for placement in

the rural communities.

In addition, Senator Rawson reported that Truckee Meadows Community College has started a dental hygiene program and will soon be offering a general practice dental residency program.

Gerald Ackerman

Gerald Ackerman (previously identified) explained how the Nevada rural health program's network was first developed. He stated that the network was created in collaboration with all Nevada rural hospitals and with the NRHP having applied for federal funds. The system was developed upon the University and Community College System's "Backbone for Education" (See Exhibit C, Item 5).

He then noted the Nevada Rural Health Center's two urban hub sites (See Exhibit C, Item 1, page 6).

John Smith

John Smith, Administrator, Pershing General Hospital, addressed the committee concerning the Lovelock Community Hospital, and he noted some of its services:

- Linkage to CME and Continuing Education (CE) programs;
- Nursing home assistant programs; and
- Access to the telemedicine system.

As a result of access to the telemedicine system, Mr. Ackerman reported that the hospital is able to utilize its facility to provide direct programs rather than travel out of the area for training. In addition to offering various learning programs for its faculty, the hospital is open to members of the public, such as the community health nurse and staff of the local school district, for educational programs in the community.

Mr. Ackerman stated that as a result of the telemedicine system medical students are able to:

- Spend additional time within a community;
- Utilize hospitals for training;
- Connect with the Reno and Las Vegas hospitals; and
- Attend all course work.

He reported that UNLV has currently offered Elko the following programs:

- A nurse practitioner program;
- A distance nursing program;
- Lab technology courses; and
- Respiratory therapy courses.

Ms. Ford and Mr. Ackerman briefly discussed "critical mass" relating to medical applicant enrollment. Ms. Ford noted that the UNSOM commits to continuing education even at the loss in numbers of enrolled students. She opined that any program in rural Nevada is successful even if only one student has enrolled.

Mr. Ackerman concurred with Ms. Ford in regard to the loss in numbers of currently enrolled students within rural areas.

Ms. Ford discussed a study, "The Importance of the Health Care Sector on the Economy of Nye County, Nevada," (See Exhibit C, Item 2), which illustrates the importance of health care on the economies of this rural Nevada county. She indicated that she would be using the findings in this report to illustrate to both counties and the state the importance of sustaining rural health in these areas.

Further, her office would be working with its partner, the UNR Cooperative Extension Office, to develop similar studies for other rural counties in the state. She offered to discuss this issue further with anyone who might be interested in more specific information about this and the other studies that will be done.

Directing the committee's attention to her handout (See Exhibit C, Item 3), Ms. Ford noted that there are several new programs in reference to the eight topics previously mentioned.

The first program is the CAH Program, which evolved in the State of Montana approximately ten years ago. It provides a basic array of services, is coupled with Medicare reimbursement, and is a functional and financially stable rural facility.

She explained that within the core of this program exist limitations such as:

- A 96-hour average length of stay;
- A limited number of beds totaling 15 acute care beds with an additional 10 beds designated for swing use only;
- 24-hour emergency care availability;
- At least a 35-mile commute from another hospital or CAH; and
- A minimum level of services including: transfer agreements, quality assurances, credentialing, EMS agreements, and telecommunication provisions.

Continuing, Ms. Ford reported that the Nevada Rural Health Plan has received an approved application from the Health Care Financing Administration (HCFA), United States Department of Health and Human Services, to operate its program in Nevada. The project has reviewed hospital financial feasibility studies regarding operation efficiencies, and it was granted access to federal funding for technical assistance programs.

Ms. Ford noted the other two programs of importance, which are the EMS program, and the telecommunications/telemedicine program.

Ms. Ford provided the committee information on program benefits acquired by Nevada Rural Health Centers, Inc. (NVRHC, Inc.) (See Exhibit C).

Commenting further, she directed the committee's attention to documentation regarding the state's Tobacco Settlement (See Exhibit C, Item 6). She reported that the Interim Finance Committee (IFC) of the Nevada Legislature would review the settlement in April of 2000, and that $1 million has been appropriated to the State Office of Rural Health by Congress during the last session for the following three program areas:

- EMS;
- Telecommunications; and
- Rural hospital financing.

This settlement also focused on issues of national significance relating to:

1. Federal Communications Commission Universal Service Funds as they apply to rural health care;

2. Community outcomes and impacts;

3. Demonstration project of system integration between schools, libraries, and rural health care;

4. Telecommunications/telemedicine linkages to Las Vegas; and

5. Labor and delivery services to Reno.

Ms. Ford then summarized the developmental funding streams within each program area, and she noted that her office would continue to provide an administrative approach for obtaining sustainability in funding disbursement, performance measures, outcomes, and impacts.

Assemblywoman Freeman recommended that Ms. Ford's office address the Task Force for the Fund for a Healthy Nevada (NRS 439.625, "Task force for fund: Creation; membership; compensation of members; administrative support and technical assistance, regarding disbursement of the tobacco money") for possible changes to the licensure laws in Nevada border towns and the coordination of services provided.

Responding, Ms. Ford concurred with Assemblywoman Freeman and reported that her office currently supplies a quarterly report to the DHR regarding disbursement of the tobacco money and plans to coordinate some form of interaction with the Task Force regarding such issues.

Senator Washington questioned Ms. Ford about the demonstration project of system integration and whether her office would contract with private telecommunication companies to provide infrastructure to the remote communities.

In response, Ms. Ford stated that her office is currently investigating system design and working with engineers to acquire what services are available and at what expense. She suggested that the Legislature become more involved with the Public Utilities Commission of Nevada to make its "wishes" known regarding administration of funds of the Task Force For the Fund For a Healthy Nevada.

Areas of possible funding may include:

- Enhanced 911 service; and

- The laying of infrastructure lines to isolated areas for rural health care access.

Assemblywoman Freeman and Mr. Asay briefly discussed the availability, accessibility, and quality of facilities providing long-term care. Mr. Asay noted that one issue specifically targeted for review is the application/eligibility process for Medicaid-payer candidates. He noted that the main concern for hospitals and providers is long-term care.

Ms. Ford requested the committee's consideration of a "Rural Health Care Improvement Act for 2001." Further, she stated that she would like to see several areas of priority addressed in regard to policy and funding, inside and outside of state agencies.

Summarizing topic areas, Ms. Ford stated her primary concerns as:

- Education and training;

- Special population health care needs;

- Health services delivery; and

- Reimbursements.

Finally, she stated that there are other rural health issues needing to be addressed and that she would attend the next Legislative Committee on Health Care meeting to give further presentation on this topic.

Senator Rawson suggested that the following rural issues be addressed at the next meeting:

- Rural emergencies;
- Transportation time; and
- Obstetric and dental issues.

In addition, he suggested that the State of Nevada take the responsibility for providing minimal equipment to rural hospitals so they may continue operation. Ms. Ford concurred with Senator Rawson.

Continuing, Senator Rawson further suggested that the Office of Rural Health supply the committee with a basic request plan followed by a final request plan for review. Chairman Koivisto also suggested that this office compile and submit a priority list to the committee for review.

Assemblywoman Freeman questioned Ms. Ford in regard to the Critical Shortage Areas (CSA) of obstetrics and gynecology and whether the UNSOM has been given the responsibility of supplying those services. In response, Ms. Ford stated that the UNSOM is currently operating a demonstration project with three aspects:

1. Review education and training;
2. Remain current in applicable concepts and skill building; and
3. Place nurse practitioners and nurse midwives into rural communities to broaden their access and expand the ability to provide a greater frequency of services.

Discussion ensued regarding telecommunication networking. Ms. Ford stated that the University and Community College System of Nevada network for telecommunication was created upon an educational platform. This platform development has allowed the extension of other services such as telemedicine and administrative networking. The intent of this program is to:

- Develop telecommunications and telemedicine connections among rural practitioners;
- Address patient care as a method to retain rural patients in their home communities; and
- Retain health care revenues with rural practitioners and facilities.

Continuing, she commented on the financial feasibility of local hospitals and stated that limited funds through the Tobacco Settlement will assist financial feasibility issues, however, only temporarily.

There was general discussion on the efforts in recruitment and retention of qualified health professionals in health care services. Ms. Ford suggested the following:

- Expansion of the Nevada Health Service Corps to provide loan repayment and scholarship funding, development, and implementation for a physician assistant training program;
- A complete revision of the UNSOM's curriculum focused upon primary care medicine and community training sites with integrated physician specialties in primary care medicine;
- Expansion of the Western Interstate Commission on Higher Education program to provide services to high priority communities; and

- Support of the committee regarding the Millennium Scholarship Fund and directing that money toward the health professions training.

Commenting further, Ms. Ford briefly discussed the possibility of acquiring used medical and laboratory equipment from other health care facilities that have been upgraded. The problem is that the distributed equipment is outdated.

Ms. Ford also addressed the issue of transportation because the transportation systems in rural Nevada are fragmented and nonexistent in many areas. She requested this problem receive immediate attention and resolution.

Concluding her remarks, she proposed to the committee that the "Rural Health Care Improvement Act of 2001" be established and acted on without further delay and that the committee hold one half-day workshop to address rural health priority concerns.

Interjecting, Mr. Asay addressed a problem specifically relating to the hospital located in Caliente, Nevada. After having assessed the hospital, he reported that it was within 30 days of closure. As a result, the NRHP provided both technical and financial assistance to the facility. However, the assistance was temporary, leaving the hospital no choice but to operate on a day-to-day basis. He stated that if this hospital were to close, the county would be left with no medical facility.

He stated that rural hospitals are dependent upon long-term care services for survival. He reported that 90 percent of all long-term care patients rely fully on Medicaid to cover their costs of care, that the current Medicaid methodology does not pay the facility costs for providing services, and that Medicaid pays approximately 70 percent of the cost for those services.

He expressed concern regarding reimbursement issues and stated that if Medicaid reimbursement remains the same, costs will not be recouped, and urban long-term care facilities will stop accepting Medicaid patients who have higher acuity levels.

Mr. Asay asked the committee to support adequate funding for Medicaid so that rural communities may have a "cost-based" reimbursement system for long-term care services. He suggested that the Federal Government fund at least one-half of the cost for the long-term care facilities, which constitutes a small portion. In conclusion, he stated that this form of relief would continue hospital operations and provide a strong industry for the rural communities.

Assemblywoman Freeman commented regarding the long-term care facilities in rural Nevada. She questioned how effective the Children's Health Insurance Program (CHIP) is in providing home-based services; what services best serve the state and communities; what would be most effective with a limited number of dollars; and what forms of care are needed in the rural areas.

Responding to questions by Assemblywoman Freeman, Ms. Ford explained that those services and requests are predicated on community needs assessments and what services hospital facilities should be providing.

Assemblywoman Freeman and Mr. Ackerman briefly discussed the issue of providing services to rural communities by utilization of state and tobacco dollars and whether the for-profit industry would take responsibility over the rural areas. Responding, Mr. Ackerman commented that he did not foresee the for-profit industry taking responsibility for Nevada's rural areas.

Ken McBain

Ken McBain, Director, NVRHC, Inc. began his testimony by reporting that NVRHC, Inc. has provided primary health care services to rural Nevada since 1977 and was one of the first federally funded community health center programs established under the Public Health Service Act of 1976.

Mr. McBain noted that the NVRHC, Inc. is among 1,300 community, migrant, and homeless health center programs nationwide that serve as safety net providers for nearly 20 million Americans, and it operates nine clinic sites throughout Nevada's rural areas. In 1999, NVRHC, Inc. provided 37,000 patient visits (serving over 16,000 individual patients). Of those, approximately 38 percent were children and over 50 percent of them had an income at

or below 200 percent of the federal poverty level.

He stated that NVRHC, Inc. is receiving federal community health funding, which will be used to initiate clinic operations in both Las Vegas and other areas of Clark County, and it will take effect in April of 2000. Mr. McBain reported that NVRHC, Inc. is projecting almost 57,000 patient visits within Clark County during the next 14 months. He added that NVRHC, Inc. just implemented operation of a mobile mammography unit that will travel statewide, and he said that those services are available to all persons, regardless of their ability to pay.

Continuing, he stated that the mission of NVRHC, Inc. is to address the health care needs of Nevada's underserved, the uninsured and underinsured, indigent, Medicaid and Medicare beneficiaries, and the rural and frontier populations who have limited or no access to medical services.

Mr. McBain reported that when the Carson City clinic opened three years ago, the State's Health Division conducted a needs assessment. The assessment identified over 14,000 people, out of a population of approximately 50,000 in Carson City, who have limited or no access to primary care. He stated that the 14,000 people consisted of Medicaid and Medicare patients, persons who are uninsured, and children.

He further stated that, excluding Clark and Washoe Counties, Nevada has four rural and 11 frontier counties that contain a population density of less than 1.5 persons per square mile. Those statistics underscore the nature of rural Nevada, the people who live there, and the economics of rural health care delivery, he said.

Mr. McBain noted the five core elements of a health care delivery system:

1. Emergency medical services (EMS);

2. Comprehensive in-patient care;

3. Outpatient primary care;

4. Home health care; and

5. Specialty medical services.

However, he stated that there are many additional adjunct and support components to a health care system. He added it is crucial that the community work together during this time of dwindling resources and growing needs.

Continuing, he directed the committee's attention to a map (See Exhibit D, Item 1), which shows the principal elements of Nevada's rural health delivery system. This network is the safety net for programs such as the CHIP and Medicaid programs, which consists of:

- Community health centers;

- Rural and county funded hospitals and clinics;

- Tribal health centers; and

- Other public and private service delivery agencies.

In addition, he reported that there are three major elements of the rural health care delivery system that are not referenced in Exhibit D, Item 1. They include:

- Home health agencies;

- The EMS network; and

- The State's network of eighteen public health clinics administered through the Health Division's Bureau of Community Health Services.

Most of those clinic sites are staffed with approximately 30 nurses and nurse practitioners. He stated that in viewing those sites it may look like there are many safety net providers, however, when factoring in the limited available services, distances and the scarcity of populations, a person would discover that the needs greatly exceed the available services.

Continuing further, Mr. McBain discussed the economic base for Nevada's rural areas in conjunction with the economics of rural health. He reported that in most other states, rural areas present a larger than normal population of Medicare, Medicaid, and other uninsured, low-income residents, and rural Nevadans are underserved due to the lack of available medical services. In eight of Nevada's rural communities, the sole provider of medical care are his clinics, which in some areas, are located approximately 114 miles from the nearest hospital facility.

Mr. McBain noted the three rural economic base areas in Nevada as: mining, tourism, and gaming.

As a result of those base areas, 83 to 85 percent of Nevada's rural residents are employed and receive health care. However, the other 15 to 17 percent of Nevada's rural residents rely on community health centers, rural hospitals, and rural clinics to provide health care, regardless of their payment abilities.

According to those statistics, Mr. McBain stated, Nevada's current uninsured population numbers range from 17 to 26 percent, which represents more than 300,000 Nevadans, with the largest numbers existing in the urban cities.

He further stated that the State of Nevada has historically provided little financial support for medical services to the underserved, and none of the community health centers has received direct state funding. Many states have targeted specific general revenue dollars to support safety net providers while others have earmarked tax revenues (Arizona's tobacco tax) to fund centers.

In the past, Nevada's rural health care delivery system was the responsibility of the counties. Counties have stepped forward and devoted substantial funds to support the county hospital network and keep rural hospitals solvent. They have also taken the responsibility of supporting community health center operations through the provision of clinic facilities and operating capital, which currently exceeds the NVRHC, Inc. federal funding amount.

However, Mr. McBain questioned how long those counties might last due to financial burdens and the increasing need for rural health care delivery. He expressed concern that the counties may have already reached their capacities.

Continuing, Mr. McBain commented on two examples of Nevada's rural health care delivery system and the clinics operated by NVRHC, Inc. in those communities:

- Beatty, in southern Nye County; and

- Gerlach, near the Black Rock Desert in northern Washoe County.

He reported that the providers working in those areas put in more than 40 hours of clinic time every week and are on call for 24-hours a day, 122 days a year. He said that there are not enough residents to ensure a solid, financial basis of operation (See Exhibit D).

Mr. McBain reported that the NVRHC, Inc. strives to develop collaborative relationships with other entities, such as the EMS team, and is closely involved in the statewide efforts for integration. In addition, he stated that the NVRHC, Inc. also works with the Center for Health, Education and Services Outreach, and the AHEC programs to help bring telemedicine capability to Nevada's rural facilities. Such relationships are essential for developing a comprehensive delivery service that is capable of reaching all rural Nevadans. Mr. McBain asserted that, "top down fiscal support from the state is needed to cement those emerging networks."

Mr. McBain stated that it is his opinion that the provision of health and social services in rural areas is not economically viable under the best of circumstances and cannot exist without public support due to the limited

populations that preclude fiscal viability. Even the most basic of rural health care services are dependent on the ongoing support of public funding to one degree or another.

He concluded that, to date, the accepted responsibility and support for improving the healthcare status of the rural populations has come exclusively from federal and county sources, not from the state. As a result, he stated that the counties and the Federal Government have made it clear to all their funded programs that they must seek out alternative sources of funding to ensure sustainability and expansion.

In summary, Mr. McBain noted the three questions remaining for discussion by Nevada's leadership:

1. What level of responsibility is the state willing to adopt for its medically underserved?

2. What role should the state adopt in the rural health delivery system?

3. How, and to what extent, is the state willing to provide the necessary dollars to guarantee a reasonable level of medical services to its rural residents?

He stated that he would be asking, by formal request, for the committee's support of federal legislation for the reauthorization of the National Health Service Corps, coming before Congress next year, and continued support of the program that brings "J- 1" physicians to the United States. He told the committee that without such programs, Nevada's rural health care system and some of its urban areas would be inoperable.

Chairman Koivisto requested Mr. McBain supply the committee with a list of specific recommendations for legislation. Responding, Mr. McBain stated that the NVRHC, Inc. would be reviewing proposals for legislative action and would supply the committee with a list of recommendations.

Assemblywoman Freeman questioned Mr. McBain regarding the NVRHC's, Inc. request for legislative funding, who its competitors are, and where its support comes from. She also suggested that he approach his legislative delegation and request full support in regard to the issues brought forth and then request the committee's assistance.

Responding to Assemblywoman Freeman, Mr. McBain stated that the issue is the need of services for the underserved and uninsured. He reported that the competitors for funding include the universities and Medicaid, and Nevada is unique due to the extent in which the private medical community is not accepting Medicaid and Medicare patients.

As a result, he said, this state has a shortage of health care professionals. Thus, the programs currently operating, and used to generate new professionals, are hardly able to sustain the state's growing service needs.

PRESENTATION AND RECOMMENDATIONS CONCERNING IMPROVING AND EXPANDING RESPITE CARE FOR LAY PERSONS WHO PROVIDE CARE FOR INDIVIDUALS WITH ALZHEIMER'S DISEASE

Donald E. Hauth

Donald E. Hauth, Southern Nevada Public Policy Chair, Alzheimer's Association Southern Nevada Chapter, appeared before the committee. He introduced other parties who were present with him: Phyllis Montavon, Executive Director, Southern Nevada Chapter; Larry Struve, Northern Nevada Public Policy Chair, Northern Nevada Chapter; and Dr. Michael DePriest, a Las Vegas resident.

Mr. Hauth discussed concerns regarding Alzheimer's disease and began his presentation by stating the association's main purpose (See Exhibit E):

1. To address the need for increased and expanded respite care for caregivers; and

2. To meet the need of Nevada's rapidly increasing Alzheimer's population.

Continuing, he commented on the association's background regarding the growth of Nevada's senior population

groups (See Exhibit A, Tab VI, and Exhibit E).

The Alzheimer's Association's National Chapter conducted a study using a control group consisting of caregivers of Alzheimer's patients and provided to them flexible respite care. Another group did not receive respite care. This study concluded that by using flexible respite care, caregivers were able to keep their loved one at home for an additional 329 days.

Mr. Hauth stated that, according to a 1998 report, approximately 44 percent of Nevada seniors stated that Alzheimer's patient care is a "major concern." He reported that senior citizens from various cities around Nevada expressed their concerns regarding Alzheimer's care as:

- Carson City - Expanded home health care,
- Elko - Home care cutbacks;
- Tonopah - Home health care.

In 1990, UNLV conducted a study on caregivers and submitted a research paper. This study found that adult day care is the number one service requested by southern Nevada caregivers.

Commenting further, Mr. Hauth discussed the costs associated with Alzheimer's disease. Caregiving for Alzheimer's patients creates tremendous costs for employers, he said. As a result, the National Press Club conducted a study known as the "Koppel Study" (See Exhibit A, Tab VI). This study concluded $26 billion in employer losses (See Exhibit A, Tab VI).

Mr. Hauth stated that the cost of care for an Alzheimer's patient is higher. Alzheimer's patients generally experience 75 percent higher hospitalization costs and suffer a 400 percent longer hospital stay than do admissions of elderly patients without Alzheimer's.

He noted that the Alzheimer's Association has stated that by delaying institutionalization of Alzheimer's patients by as little as one month could save $1.2 billion annually. A one-month delay would save on average $1,863 for an Alzheimer's patient.

According to the Aging Services Division, Nevada's Department of Human Resources, Mr. Hauth reported that a survey was conducted by the Community Home-based Initiatives Program (CHIP) that concluded $14 million would be saved in Nevada by delaying institutional placement of Alzheimer's patients. He also reported that a one-year institutional cost for an Alzheimer's patient averages $41,000.

Further, Mr. Hauth noted that Alzheimer's care requires a more extensive method of attention versus that from a normal nursing home. This kind of care may require patients to be placed into controlled facilities where they will not wander. Therefore the patient's cost for care is much higher. For this reason, home health care would save the taxpayers money.

Continuing, Mr. Hauth commented on caregivers of Alzheimer's patients. He stated that Alzheimer's care is required 24-hours a day and requires extensive surveillance by the caregiver. A 1996 telephone poll, conducted by the National Alliance for Caregiving revealed the following:

- 41 percent of caregivers for the elderly had children under the age of 18;
- 99 percent of caregivers were depressed occasionally or frequently;
- 64 percent of caregivers worked full or part-time;
- 36 percent of caregivers reported a loss of income;

- Caregivers spent an average of 69 to 100 hours each week for direct care; and

- Elder caregivers experienced a 63 percent higher mortality risk than non-caregivers.

Mr. Hauth emphasized the stress and difficulties in caring for an Alzheimer's patient along with raising teenagers. He reported that senior caregivers experience a greater degree of difficulty and problems than those of a younger caregiver while caring for an Alzheimer's patient. An example is "biological vulnerability," such as a stroke or heart attack (See Exhibit A, Tab VI).

Continuing, he stated that a study conducted during 1989 with regard to the Medicaid Region IX of HCFA, which encompasses Arizona, California, Hawaii, and Nevada, revealed 433 licensed adult day care centers in operation. However, out of those four states, Nevada had only six. Currently, it is his understanding there are only eight.

As the senior population grows and the need for home health care increases, 15 home health agencies closed or stopped accepting Medicaid patients. Nevada's Aging Services Division reported that an 18 percent increase in caseloads is expected for the year 2000. He also stated that, according to the United States Census, the number of nursing home residents would increase approximately 400 percent by the year 2020.

Senator Washington questioned Mr. Hauth regarding the opening and operation of an Alzheimer's adult day care, relating to local, state, and federal requirements. Responding for Mr. Hauth, Phyllis Montavon, stated that she did not have an answer to his question. However, she stated that there are specific regulatory licenses that must be obtained by an adult day care facility prior to its opening and operation, and she suggested that an individual go to the Bureau of Licensure and Certification of the Health Division to request such information.

There was discussion about the regulatory requirements concerning adult day care facilities and regulations required for Alzheimer's facilities.

Mr. Hauth then proposed the following recommendations:

1. To expand eligibility for programs;

2. Establish a voucher system for caregivers;

3. To provide flexible programs for relatives who provide care; and

4. To authorize a technical advisory committee.

Mr. Hauth stated that most of the group care home waivers include an age range of 65 years of age and over. However, he said that the typical Alzheimer's patient's age is 50 to 90. Therefore, he requested that programs eliminate this age requirement to aid in the preparation for eligibility expansion. He stated that voucher systems are important and required due to the diverse needs of caregivers, in addition to:

1. Allowing caregivers to match services to their needs; and

2. Providing a wider range of services to caregivers.

Discussion ensued regarding Alzheimer's recommendations. Mr. Hauth commented on the establishment of providing flexible programs for relatives who provide care to Alzheimer's patients. He stated that money would be saved if it were provided to caregivers instead of adult day care centers because caregivers would be able to keep their loved ones at home.

He suggested that some form of legislation be authorized for the establishment of a technical advisory committee or subcommittee to the standing health care committee.

Mr. Hauth suggested that some of the committee's tasks might be to:

1. Recommend the delivery of services in the most effective and efficient manner possible;

2. Identify additional sources of federal and private sector funding;

3. Promote public and professional awareness and education related to Alzheimer's disease;

4. Identify service delivery mechanisms that enhance the quality of life for people with Alzheimer's disease and their caregivers;

5. Evaluate and coordinate implementation and recommendations of the standing health care committee; and

6. Evaluate models from other states.

Assemblywoman Freeman requested that Mr. Hauth clarify what a day care center is, whether it is classified as a 24-hour facility, and if it is defined somewhere in state law.

Responding to questions by Assemblywoman Freeman, Ms. Montavon commented that, in terms of state law, she did not have an answer for her. However, she did provide clarification of an adult day care center as a center where family members can take their loved one while they are at work and have "peace of mind" by knowing that their loved one is being cared for in a safe environment.

Continuing, Ms. Montavon stated that in addition to adult day care, the Alzheimer's Association is currently reviewing services that may be provided relating to respite care, such as:

- 24-hour care;

- Home health care;

- Group home care;

- Assisted living residences; or

- Skilled nursing facilities.

Members of the committee confirmed with Mr. Hauth the type of service requested by the Association as respite care, and requested that the following information be submitted to the committee prior to its June 2000 meeting:

1. A list of comparisons from other states that shows operational forms of care, and at what cost;

2. A list of committee members who would serve on a Technical Advisory Committee, and their responsibilities; and

3. An enhanced recommendation list including additional information pertaining to eligibility expansion.

The committee also suggested that the association contact the Task Force For the Fund For a Healthy Nevada, and request to be placed on the next agenda.

Senator Washington expressed his concern regarding the following:

- The day care application process, from the time of application to actual operation;

- The possibility of centers being sued due to a lack of particular care; and

- Statistics pertaining to those issues.

Responding to Senator Washington's concerns, Mr. Hauth stated that those are some of the reasons why the Alzheimer's Association is requesting that a technical advisory committee or subcommittee be established, and he said that states with successful programs started out by forming such committees.

Dr. Michael DePriest

Dr. Michael DePriest, Ph.D., Las Vegas, Nevada, addressed the committee concerning Alzheimer's disease. He concurred with Mr. Hauth's remarks and stated that after having performed research and working with hundreds of Alzheimer's patients for the last three years, he found little treatment is currently available. He stated that if Alzheimer's patients were allowed to remain at home during treatment it would improve their quality of life and would save money.

Reiterating a statistic noted by Mr. Hauth, Dr. DePriest stated that in delaying nursing home placement by one month, the state would save over $1,800. He said that multiplying this figure by 40,000, the approximate number of Alzheimer patient's in Nevada, a person would quickly begin to realize just how much money would be saved.

Concluding his remarks, Dr. DePriest indicated that, by providing voucher programs and respite care, Nevada would benefit significantly.

Assemblywoman Freeman asked Dr. DePriest whether he was aware of a new regulation regarding restraints, which states that Alzheimer's patients are exempt, and she asked if he had information related to this matter. In addition, she discussed information enclosed in a letter from Mr. Richard J. Panelli, Chief, Bureau of Licensure and Certification, regarding exemption of Alzheimer's patients and asked Dr. DePriest how that might impact his practice or other practices.

Responding, Dr. DePriest reported that, in regard to patient exemption and restraint measures, psychiatric facilities have new HCFA regulations that require different levels of care for restraint purposes. In addition, he also stated that he did not have information to offer concerning Alzheimer's patients living in nursing home facilities because his practice deals with clinical research on an outpatient basis only.

Chairman Koivisto also requested that Dr. DePriest supply the committee, before the June 2000 meeting, with a list of specific recommendations for review.

Larry Struve

Larry Struve, Northern Nevada Public Policy Chair, Alzheimer's Association Northern Nevada Chapter, then appeared before the committee. He reported that the Alzheimer's Association's Public Policy Committee has been in operation less than a year. Therefore, the association is just beginning to learn the specific issues and the importance of advocacy on behalf of Nevada's population segment. He reported that, due to the complex nature of this issue, it is difficult for individuals to approach the committee with statistics and data that might facilitate public policy.

Continuing, Mr. Struve asked the committee to focus its attention on the Alzheimer's issues as a "bundle." With respect to the statistics noted by Mr. Hauth, he reported that the National Alzheimer's Association has projected its number of patients to quadruple in the next 50 years. As a result, in the future Nevada might be dealing with as many as 160,000 Alzheimer's patients versus the current 40,000, which would constitute a significant portion of Nevada's population.

With respect to the above-mentioned statistics, Mr. Struve commented on the problems related to those figures, and he noted public and staffing concerns with regard to:

- The number of patients that are targeted for programs such as voucher programs and respite care; and

- The types of services desired and necessary.

Mr. Struve pointed out that the Alzheimer's Association is struggling with those same questions. Thus, he recommended that the committee consider the establishment of a technical advisory committee or permanent

subcommittee of the standing health care committee to supply some form of legislative aid to the southern Nevada Alzheimer's Association.

In addition, Mr. Struve commented that Alzheimer's issues involve more than just respite care. He emphasized that individuals without adequate training, who are willing to work for minimum wage, are the individuals caring for Alzheimer's patients. He reported that the Alzheimer's Association's Northern Nevada Chapter's current regulations do not address patient care in day care facilities but only address concerns such as sanitation.

Further, Mr. Struve reported that Mr. Panelli (previously identified) stated that the regulations that govern the operation of day care facilities are outdated and have not been addressed since 1986. He also reported that the Alzheimer's Association supports the bureau in having the Legislature's IFC authorize additional examiners to perform routine facility inspections, which under 1999 legislation now require licensing. Thus, routine facility operation inspections and agency staffing issues will need to be reviewed over the next several years.

Continuing, Mr. Struve commented on centralized case management. He reported that the Alzheimer's Association's Northern Nevada Chapter is extremely interested in the concepts of this management program for reasons such as a family member having received the news that their loved one has been diagnosed with Alzheimer's disease.

As a result, Alzheimer's family members are faced with an array of places they need to go to find information on how to get help. Therefore, the concept of "one-stop shopping" where an individual will find a trained ombudsman or social worker, who will help get them to the right agencies and who has the authority to perform follow-up sessions on distressed families, is an idea that Nevada should explore and implement without further delay.

Mr. Struve noted that the Alzheimer's Association is working with the Aging Services Division on the issues addressed. He opined that use of the Tobacco Settlement money and through an independent living grants program, the association might obtain assistance to help allocate various concepts of a centralized case management program. Thus, case management costs would be saved in addition to providing structured and efficient care so that Alzheimer's patients might have a prosperous life.

Finally, Mr. Struve stated that establishing a technical advisory committee, as a permanent part of the legislature, would help provide education to the citizens of Nevada. He suggested that the committee take the Alzheimer's Association's recommendations for review before the 2001 Legislative Session.

Concluding his remarks, Mr. Struve stated that the Alzheimer's Association would continue working on its statewide and national efforts to provide testimony at the 2001 Legislative Session, and due to the unique growing problems related to Alzheimer's disease, this issue deserves public policy attention.

Chairman Koivisto suggested to Mr. Struve that the association contact the Task Force for the Fund for a Healthy Nevada and request to be placed on its next agenda.

Assemblywoman Freeman and Mr. Struve briefly discussed national and statewide efforts for providing education, centralized case management programs, and public policy attention, and noted that a case management program should contain certain elements of operation, such as a team concept, and a "one-stop shop."

He further commented that a senior center would be an ideal place for the establishment of such a program. Assemblywoman Freeman concurred, and she stated that upon consideration of such requests, the Alzheimer's Association must supply the committee with a proposed plan to clarify the following:

1. Determination of an appropriate location;

2. Promotional advertisement; and

3. Interaction with other agencies to facilitate operation.

Assemblywoman Freeman then questioned Mr. Struve about the candidates for its proposed advisory board.

Responding to Assemblywoman Freeman's questions, Mr. Hauth noted the following probable candidates:

- Dr. Michael DePriest (previously identified);

- A member from the American Association of Retired Persons; and

- A member from the Alzheimer's Association.

He further stated that those are only some of the consumer-directed, consumer-based services being provided, recommended that Nevada examine how other states use models to provide legislative representation, and stated that Nevada should have full legislative representation including legislators from the rural districts.

Senator Mathews commented on caregiver's concerns and anxieties. She added it is crucial that Nevada obtain some level of funding for respite care.

PRESENTATION AND RECOMMENDATIONS CONCERNING "END OF LIFE" CARE ISSUES, INCLUDING SUGGESTED AMENDMENTS TO SECTIONS OF CHAPTER 449 OF THE *NEVADA REVISED STATUTES* DEALING WITH "WITHHOLDING OR WITHDRAWAL OF LIFE-SUSTAINING TREATMENT"

Blair Moon

Blair Moon, a resident of Reno, Nevada, outlined the experiences he encountered during his wife's lengthy illness, hospitalization, surgery, and death two years ago due to cancer.

Issues and concerns were related regarding his wife's hospitalization. Even though he had advised the physician and staff that a Declaration of Affidavit was filed with the hospital and no life support measures were to be used, his wife was placed on life support following surgery (See Exhibit A, Tab VII).

Mr. Moon requested the committee's assistance in proposing new legislation dealing with the issues of life support procedures. In particular, he suggested that Nevada law be amended to allow prosecution of physicians and facility administrators when they fail to comply with the legally executed documents concerning withdrawal of life support systems.

Assemblywoman Freeman summarized that this issue basically deals with the current state statute regarding power of attorney and the "right-to-die." In her discussion with various physicians and the UNSOM, she learned that many physicians ignore those requests included in a patient's file.

Risa B. Lang

Risa B. Lang, Principal Deputy Legislative Counsel, Legal Division, LCB, responded to Chairman Koivisto's request stating that she would work with the committee and Mr. Moon with respect to the issues he brought forth at this meeting.

She reported that currently there are many statutes dealing with requests from patients and their families. She also reported that penalties exist within those statutes for physicians who are unwilling to transfer the care of a patient to another physician, and if a particular physician is not willing to follow directions from the patient (See Exhibit A, Tab VII).

Interjecting, Mr. Moon commented that he already spoke with two separate attorneys regarding that statute, which was last revised in 1991, and reported that those particular physicians would only be prosecuted on a gross misdemeanor. As a result, Mr. Moon reported that both attorneys stated that pursuing a gross misdemeanor was not worth their time or effort.

Ms. Lang suggested that Mr. Moon specifically identify his wishes, i.e., whether current penalties are severe enough then one option would be to have them increased. She added that these are options the committee might consider

recommending.

Continuing, she stated that in terms of changing current statutes, a person must first identify the problem and then determine where implementation should occur.

DISCUSSION OF "PILL SPLITTING" RECOMMENDATIONS

Marla McDade Williams

Marla McDade Williams, Senior Research Analyst, Research Division, LCB, began testimony by directing the committee's attention to a document titled "Summary of Testimony and Suggested Recommendations Concerning Pill Splitting" (See Exhibit A, Tab VIII).

She stated that she spoke with Keith W. Macdonald, Executive Secretary, State Board of Pharmacy, who indicated at the last meeting that he would provide additional information on states that might have regulated "pill splitting." He was unable to locate any additional states that have regulations. The National Conference of State Legislatures was also unable to locate any specific legislation governing this issue.

Ms. Williams noted that there were three recommendations brought forward for discussion by members of the public at the previous meeting during which this topic was discussed (See Exhibit A, Tab VIII, pages 4 and 5). Three recommendations were addressed in testimony:

1. The first recommendation came from Mr. Macdonald regarding the introduction of a bill for the 2001 Legislative Session. In addition, Ms. Williams noted that Mr. Macdonald submitted a letter from the Nevada State Board of Pharmacy dated March 3, 2000, regarding additional recommendations presented for consideration (See Exhibit F).

2. The second recommendation came from Jim Wadhams, Wadhams and Akridge, on behalf of the Nevada Association of Hospitals and Health Systems, which contains a letter dated February 4, 2000, (See Exhibit A, Tab VIII, Attachment A) that identifies suggested language changes for the NRS if committee members choose to pursue recommendation number two previously discussed.

3. The third set of recommendations consists of alternatives for the committee to consider if it decides it is not comfortable acting on previous amendments to the NRS.

Continuing, Ms. Williams questioned, upon the committee's final review, whether members of the committee wanted her to include the above-referenced summary of recommendations (See Exhibit A, Tab VIII) into its final work session document; if there would be public citizens asking to address those specific recommendations who opine that such recommendations be revised or changed; and would the public request to offer additional testimony on whether or not the committee should act on those issues.

Assemblywoman Freeman suggested that the committee hold the summary until its final work session and said that she wanted to hear other people's comments in regard to the issues previously discussed.

Fred Hillerby

Fred Hillerby of Reno, Nevada, appeared before the committee and commented on the issue of pill splitting. He suggested that various doctors, pharmacists, and the State Board of Medical Examiners discussed the issues presented, and requested additional information for further review before some form of legislative remedy is administered.

In response, Chairman Koivisto agreed that if some form of legislative remedy is required, they may address those concerns during the committee's June meeting.

DISCUSSION OF FUTURE TOPICS

Chairman Koivisto addressed possible topics for the upcoming meetings of April 18 and June 6, 2000 (See Exhibit

G).

PUBLIC TESTIMONY

Mary Jean Thomsen

Mary Jean Thomsen, Community Advocacy Coordinator, Northern Nevada Center for Independent Living (NNCIL), commented in regard to disability issues that surround the Personal Care Assistant (PCA) Program (See Exhibit H).

She asked the committee's assistance in assuring the disabled community that Medicaid would not disregard them again. In her opinion, the PCA back-up service problem is not solved.

Chairman Koivisto and Ms. Thomsen briefly discussed HCFA issues and current PCA rates in regard to the regulatory public hearing, which was held on March 15, 2000.

Ms. Koivisto questioned Ms. Thomsen whether the NNCIL would request the committee to draft a bill to establish a separate program for back-up services. Responding, Ms. Thomsen stated, "yes," if that is what is required. However, she emphasized that her main request is to inform Medicaid that any money received should only be applied to the following PCA service areas:

1. Training;

2. Supervision; and

3. Assistance.

There was additional discussion about PCA rate increases, and whether the committee should address this issue further.

Chairman Koivisto suggested that Ms. Thomsen present such issues to the IFC because that is where she would find financial oversight support.

In response to Chairman Koivisto's suggestion, Senator Washington recommended that the committee send a staff member to assess the March 15, 2000, regulatory meeting. Chairman Koivisto agreed.

Concluding her remarks, Ms. Thomsen asked the committee if they would support her when she approaches the IFC to request administration of oversight and regulation regarding the PCA back-up service issue. Senator Washington and Assemblywoman Freeman responded by saying, "yes."

ADJOURNMENT

There being no further business to come before the committee, Chairman Koivisto adjourned the meeting at 4:20 p.m.

Exhibit I is the "Attendance Record" for this meeting.

Respectfully submitted

Paige Clyde
Senior Research Secretary

Marla McDade Williams
Senior Research Analyst

APPROVED BY:

_____
Assemblywoman Ellen M. Koivisto, Chairman

Date: _____

LIST OF EXHIBITS

Exhibit A consists of a one-volume packet that provides background information on selected agenda items. Those documents were provided by Marla McDade Williams, committee staff advisor, for members' reference.

Exhibit B is spiral bound book titled "2000 Nevada Kids Count Data Book County, Regional and State Profiles of Child and Family Well-Being in Nevada," submitted by Marlys A. Morton, Coordinator, Nevada Kids Count.

Exhibit C is a folder of information submitted by Caroline Ford, M.P.H., Assistant Dean/Director, Rural Programs, Center for Education and Health Services Outreach, University of Nevada Reno School of Medicine, and contains the following items:

1. A booklet titled "University School of Medicine."
2. A document titled "The Importance of the Health Care Sector On the Economy of Nye County, Nevada," by Thomas R. Harris, Gerald Ackerman, and Caroline Ford.
3. A document titled "Nevada Critical Access Hospital Program."
4. A document titled "Designation of Frontier."
5. A document titled "University of Nevada School of Medicine Demonstration Project for Integrated Telehealth Development."
6. A document titled "Proposed Tobacco Settlement Distribution."

Exhibit D is the testimony (with an attachment) of Kenneth A. McBain, Executive Director of Nevada Rural Health Centers, Inc. Also included with this exhibit is a map, titled "Nevada Primary Care Safety Net Providers."

Exhibit E is testimony titled "Caregiver Support to Meet Nevada's Needs" given by Donald Hauth, Southern Nevada Public Policy Chair, Alzheimer=s Association Southern Nevada Chapter.

Exhibit F is a letter dated March 3, 2000, to Marla McDade Williams, Senior Research Analyst, Research Division, Legislative Counsel Bureau, from Keith W. Macdonald, Executive Secretary, Nevada State Board of Pharmacy, regarding "Pill Splitting."

Exhibit G is a list of potential issues for the April 18, 2000, meeting of the Legislative Committee on Health Care (*Nevada Revised Statutes* 439B.200), prepared by staff of the committee.

Exhibit H is a document dated March 7, 2000 titled "Legislative Interim Health Care Committee," presented by Mary Jean Thomsen, Northern Nevada Center for Independent Living.

Exhibit I is the Attendance Record for this meeting.

Copies of the exhibits are on file in the Research Library of the Legislative Counsel Bureau, Carson City, Nevada. You may contact the library at 775/684-6827.