NEVADA LEGISLATURE
LEGISLATIVE COMMITTEE ON SENIOR CITIZENS, VETERANS AND ADULTS WITH SPECIAL NEEDS

(*Nevada Revised Statutes* [NRS] 218E.750)

MINUTES

March 22, 2022

The first meeting of the Legislative Committee on Senior Citizens, Veterans and Adults With Special Needs for the 2021–2022 Interim was held on Tuesday, March 22, 2022, at 10 a.m. in Room 4412, Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. The meeting was videoconferenced to Room 3137, Legislative Building, 401 South Carson Street, Carson City, Nevada.

The agenda, minutes, meeting materials, and audio or video recording of the meeting are available on the Committee's meeting page. The audio or video recording may also be found at https://www.leg.state.nv.us/Video/. Copies of the audio or video record can be obtained through the Publications Office of the Legislative Counsel Bureau (LCB) (publications@lcb.state.nv.us or 775/684-6835).

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:

Assemblywoman Michelle Gorelow, Chair
Assemblywoman Venicia Considine
Assemblyman Richard McArthur

COMMITTEE MEMBERS ATTENDING VIA REMOTELY:

Senator Patricia (Pat) Spearman, Vice Chair
Senator Carrie A. Buck
Senator Melanie Scheible

LEGISLATIVE COUNSEL BUREAU STAFF PRESENT:

Ashlee Kalina, Senior Policy Analyst, Research Division
Cesar O. Melgarejo, Senior Policy Analyst, Research Division
Jan Brase, Research Policy Assistant, Research Division
Eric W. Robbins, Principal Deputy Legislative Counsel, Legal Division
Brody Leiser, Chief Principal Deputy Fiscal Analyst, Fiscal Analysis Division

Items taken out of sequence during the meeting have been placed in agenda order.
[Indicate a summary of comments.]

AGENDA ITEM I—CALL TO ORDER, OPENING REMARKS, AND INTRODUCTIONS

[Chair Gorelow called the meeting to order. She welcomed all who were participating in the meeting.]

Chair Gorelow:

I would like to take a few moments to introduce members of the Committee and Committee staff. Members, please introduce yourself and indicate the district you represent as well as the goals you have for the Committee for the 2021–2022 Interim. We will begin with our Vice Chair, Senator Spearman.

Vice Chair Spearman:

I represent Senate District 1, which is more than 90 percent of North Las Vegas, and have been representing this District since 2012. I am really concerned about and want to make sure that during this interim we are focusing on some of the specific things that have affected not our veterans solely, and not our seniors solely, and not our adults with special needs, but I believe those three demographics overlap. We have veterans who are seniors who have special needs; we have people who have special needs who are veterans. I am looking to make sure everything we discuss and all of the recommendations we put forth for the next legislative session are taking into account not just the concentric circles, but how they all overlap. I want to make myself available for any questions or any type of expertise I might be able to lend as a veteran. Thank you, Madam Chair.

Chair Gorelow:

Senator Scheible.

Senator Scheible:

I am a state Senator for District 9, which is in the southwest part of Las Vegas. I am excited to serve on this Committee to learn more about how our state is serving veterans, people with disabilities, and the aging community; and to continue working to make our state a better place.

Chair Gorelow:

Senator Buck.

Senator Buck:

I am the sitting Senator for Senate District 5 in Henderson. I look forward to learning a lot about our senior community, veterans' issues, as well as potential mental health care for these various constituencies.

Chair Gorelow:

Assemblywoman Considine.

Assemblywoman Considine:

I am Venicia Considine, Assemblywoman for District 18, which is on the east side of Las Vegas and parts of Henderson. I am honored to be on this Committee. I look forward to learning more about this Committee and working on quality-of-life issues for senior citizens, veterans, and adults with disabilities.

Chair Gorelow:

Assemblyman MacArthur.

Assemblyman MacArthur:

I am happy to be here. I represent Assembly District 4, which is in the far northwest part of Las Vegas. This Committee is new for me. I am interested in finding out all the information we have on senior citizens, veterans, and that sort of thing.

Chair Gorelow:

This is my first session chairing this amazing Committee. I represent Assembly District 35; that is Mountain's Edge in Southern Highlands, so I am in the far southwest. I work for a nonprofit that provides health care to children in southern Nevada. For around 20 years I have worked a lot with health care for women and children, especially children with disabilities, and I find there are a lot of crossovers when we talk about our pediatric population and our seniors, adults with special needs, and even our veteran population. I look forward to having robust conversations this interim and putting together some great legislation for next session.

I would like to take a moment to introduce staff. First, we have Ashlee Kalina, with the Research Division, LCB, who is the lead policy analyst for the Committee with Cesar Melgarejo, Senior Policy Analyst, Research Division, also assisting. We have Eric Robbins, who is our Legal Counsel, and Jan Brase, in Carson City, is the Committee secretary. We also have Kimbra Ellsworth, the fiscal analyst assigned to the Committee; however, Brody Leiser will be standing in for Ms. Ellsworth today. I thank the staff for all you do to support this Committee in the interim. Your assistance is truly invaluable. We would also like to extend a thank you to the Broadcast and Production Services Division (BPS), LCB, and the Las Vegas Administrative Division of the LCB for all their behind-the-scenes work in videoconferencing and helping the meeting run smoothly.

[Chair Gorelow reviewed guidelines for participating in the meeting.]

AGENDA ITEM II—PUBLIC COMMENT

Chair Gorelow:

The second agenda item is public comment.

[Chair Gorelow reviewed instructions for providing public comment.]

Chair Gorelow:

We will first take public comment on the phone. Do we have anybody on the phone for public comment?

Raquel O'Neil, Licensed Clinical Social Worker, President, Blindconnect:

I am coming before you this morning with a couple of opening stories—real-life stories to draw your attention to some needs in our state.

First, in 2006, Angela Hoffman was an individual who lost her eyesight in her 30s. She had coped with a progressive vision loss; she was successful in her marriage and with her children. Eventually, after losing the rest of her eyesight, she was searching for resources and help. She learned that she would have to go out of state for rehabilitative services to learn how to cook eggs for her children again, or provide them help with their homework, or even walk to her mailbox to find out where to get her mail—she learned that these services would cost her family $40,000 to $60,000. As she did not want to go through vocational rehabilitation in order to stay home and raise her family, unfortunately, in the prime of Angela's life, we lost her—she decided to commit suicide due to her vision loss.

Secondly, I would like to tell you the story of José. José is an individual who lost his eyesight in May 2021 to diabetic retinopathy. He is 44 years old, and after losing his eyesight, he was immediately hospitalized. During his hospitalization, they were unsure of how to monitor his blood sugar due to his vision loss. The hospital retained him in the mental health facilities for four and a half months until he was able to secure a rehabilitation space at Blindconnect.

Blindconnect is a nonprofit organization that has served Nevada since 1998. Our mission is to provide the much-needed rehabilitation services for Nevada citizens experiencing vision loss. In our United States, when an individual loses a limb or a part of physical functioning, the person typically goes to acute care facilities and rehabilitation services, receiving daily support and rehabilitation therapies like occupational therapy and physical therapy. However, when you lose your eyesight as a small child, adult, senior, or veteran, you do not get those same services. Many people all over the State of Nevada lose their eyesight at an ophthalmological visit and cannot even drive themselves home, but home is where they are told to go. Blindconnect is here to offer rehabilitation services that are vital to people losing the loss of their eyesight.

We would humbly request that this Committee review rehabilitation services for the blind in Nevada. I have provided some attached documents for your review (Agenda Item II). We are humbly requesting that you look at providing funding for Blindconnect to continue to do what we do best, which is provide hope for a brighter future for Nevada citizens who are experiencing vision loss.

Chair Gorelow:

Thank you.

Dora Martinez, Nevada Disability Peer Action Coalition:

Good morning, Chair Gorelow, and the rest of your most exciting and outstanding interim Committee. Thank you for not getting rid of this important Committee; this is where seniors, veterans, and people with disabilities can come and be heard—where, hopefully, our voices and our opinions are counted.

I am going to the Washoe County Commission meeting—our freedom to vote is at stake. I want to say thank you so much for all that you do. I also want to bring attention—I am a blind mom, a proud mom of two kids in the National Guard and the United States Army.

One of our friends, who is part of my Nevada Disability Peer Action Coalition, asked me to tell a little bit of her story. She is visually impaired and hard of hearing. When the Regional Transportation Commission of Washoe County (RTC) bus drivers went on strike three times last year and at the beginning of this year, she was unable to secure transportation to her dialysis. Not all Medicaid or Medicare insurance covers transportation. To Cheyenne Pasquale, Rique Robb, and other people who are scheduled to present in this agenda, we humbly ask that transportation and home care visits be added in Medicaid so even if RTC Access—paratransit for Washoe County—or RTC Ride are not available due to a strike or lack of drivers—because they do not give them respectable wages—people will be covered so they do not lose their dialysis appointments, eye doctors' appointments, pharmaceutical pickup, or any of that sort of thing. We all know the U.S. Postal Service is slow, so when people cannot get their medication delivered on time and RTC Access is not working, adding transportation would allow people to get an Uber or Lyft to get their medication.

Thank you so much for all that you do. Happy spring and happy disability awareness month.

Chair Gorelow:

Thank you, Ms. Martinez. Next caller.

BPS:

Chair Gorelow, the line is open and working; however, there are no additional callers.

Chair Gorelow:

Thank you. Is there anyone in Las Vegas who would like to provide public comment?

Britni Richards, Area Director, Chrysalis Las Vegas:

I want to thank the Chair and the Committee for your time today. Chrysalis Las Vegas is a member of SNAP—the Southern Nevada Association of Providers. My agency specifically works with the Aging and Disability Services Division (ADSD), Department of Health and Human Services (DHHS). Across the State of Nevada right now, Chrysalis is the largest provider serving people with intellectual disabilities in their homes and workplaces. We employ about 500 people to provide these supports—we support people with cleaning, we provide supervision, personal hygiene, cooking, medication, medical appointments, behavior management, outings, integration into their communities, and simply getting up and getting dressed for their day.

I want to tell you about my experiences with how the staffing crisis over the last two years has impacted individuals with disabilities and the staff that care for them. The staffing shortages have made it extremely difficult to find and keep qualified people to work with Nevada's most vulnerable population and citizens. Staff that do stay are sacrificing at great personal lengths to take care of the people they love and support. These heroes are burnt out and struggling because there are not enough people to care for our disabled population. Across Nevada, disability agencies' staff turnover is at 132 percent. Worse, the staff vacancies are currently at 22 percent—more than 1 out of every 5 positions are vacant right now.

I can tell you about Shayla, who has postponed her family's moving day since December at her own personal expense and put herself in a hotel because she could not justify leaving her individuals with intellectual disabilities to move her family. I could tell you about Ronisha, who finally had a day off and was called back to her workhouse because the staff there was overworked and the relief that was supposed to show did not. So, she went and paid, at her expense, to get a babysitter and go back to the house to take care of her individuals with disabilities.

I can go on and on and on. I have a list of stories of all the things our teams are doing in heroic efforts to take care of our disabled community. They are sacrificing their own personal lives to help the people we serve. My agency and many agencies have done everything in our power from the top down to support the staff. The administration and I, myself, routinely work shifts in these homes to make sure the staff and the individuals have exactly what they need. Nevada's disability providers are the safety net. We are thankful that ADSD has told us that, hopefully, by the month's end we will be receiving American Rescue Plan Act of 2021, Pub. L. 117-2, 135 Stat. 4 (2021), or ARPA, funds to supplement home and community-based services (HCBS) with a temporary 26.9 percent. We ask that it be considered that these funds become ongoing, because one-time funds are good for bonuses, but not for wages.

Chair Gorelow:

Thank you. Would anyone else like make public comment in Las Vegas? Seeing none, we will move to Carson City. Is there anyone in Carson City who would like to make public comment? Seeing none, thank you.

AGENDA ITEM III—OVERVIEW OF THE COMMITTEE'S RESPONSIBILITIES AND ACTIVITIES

Chair Gorelow:

The next agenda item is an overview of the Committee's responsibilities and activities. We will have our Committee Policy Analyst, Ashlee Kalina, provide the overview.

Ashlee Kalina, Senior Policy Analyst, Research Division, LCB:

Good morning, and thank you, Chair Gorelow. As nonpartisan staff of the LCB, I can neither advocate for nor oppose any of the proposals that come before you. My role is to assist the Committee as a whole, and each of you as individual legislators, while also providing policy and research needs to help you make informed decisions about the issues reviewed and studied by this Committee.

Before you is a copy of the Committee's work plan, which is also available on the Committee's webpage (Agenda Item III). The work plan provides background information on the powers and duties of the Committee, a glimpse of the work of the Committee during the previous interim, our proposed meeting schedule, and Committee staff contact information. I want to take a few minutes to cover some highlights.

First, we will go over the responsibilities of the Committee. *Nevada Revised Statutes* 218E.760 establishes the general powers of the Legislative Committee on Senior Citizens, Veterans and Adults With Special Needs. The Committee is charged with reviewing, studying, and commenting on issues related to senior citizens, veterans, and adults with special needs. These general powers are outlined on the first and second pages of the work plan.

In addition to the powers outlined in the previously mentioned section of NRS, the Committee has a duty to review certain statutory reports from the Purchasing Division and the State Public Works Division of the Department of Administration. These divisions are required to report to the Committee on the number and dollar amount of purchasing contracts and contracts awarded to local businesses that are owned by service-disabled veterans. These reports are required to be submitted to the Committee during the interim period.

Pages 2 and 3 contain information about the bills proposed by the Committee during the last interim. I would like to point out that of the eight bill draft requests (BDRs) proposed by the Committee for the 2021 Legislative Session, two bills—Assembly Bill 407 and AB 439—did not move beyond the first house committee passage deadline. Assembly Bill 407 would have facilitated a vulnerable adult's ability to obtain a protective order on their own and allow Adult Protective Services (APS), ADSD, DHHS, to petition the court on the person's behalf. Assembly Bill 439 would have required state occupational licensing boards to streamline the process for military spouses to obtain professional licenses.

Assembly Bill 443 from the 2021 Nevada Legislature changed the number of bills allocated to the Committee from ten to six. The Committee may submit up to six BDRs for consideration by the 2023 Legislative Session. These must be submitted to the Legal Division of the LCB on or before September 1, 2022.

On page 3 of the work plan you will find the proposed Committee meeting dates for the 2021–2022 Interim. This Committee has been allocated funds to meet four times during the interim. A work session will be conducted at the last Committee meeting, which is currently scheduled for Tuesday, August 16, 2022.

Finally, you will find a list of our Committee staff and their contact information. There is also a page that outlines potential topics for discussion at the future Committee meetings. As I mentioned in the beginning, I am available to assist the Committee and its members on any issues related to matters before the Committee. In addition, the employees of the Research Division are available to provide information and assistance on a confidential basis to individual members of the Legislature on any topic.

Chair Gorelow, this concludes my presentation. I welcome any questions.

Chair Gorelow:

Are there any questions from the Committee? I do not see any.

AGENDA ITEM IV—PRESENTATION REGARDING THE PROGRAMS AND SERVICES PROVIDED BY THE AGING AND DISABILITY SERVICES DIVISION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Chair Gorelow:

We will go on to the next agenda item, which is a presentation regarding the programs and services provided by ADSD, DHHS. Jessica Adams, Deputy Administrator, ADSD, DHHS; Rique Robb, Deputy Administrator; and Carrie Embree, Governor's Consumer Health Advocate, are with us today via Zoom.

Carrie Embree, Governor's Consumer Health Advocate, Office for Consumer Health Assistance, ADSD, DHHS:

We appreciate this opportunity to share with the Committee information about ADSD—who we are and what we do. We will cover a variety of topics this morning (Agenda Item IV).

The Division is dedicated to providing individuals and families with effective supports and services. Our programs, services, and staff consistently seek to understand and be responsive to the individual. The Division serves populations from birth to death—we do this by providing services in the individuals' homes, supporting caregivers, and providing advocacy services.

The Office for Consumer Health Assistance (OCHA) has a team of six consumer health advocates that specialize in educating and advocating for all Nevadans regarding their health care needs. The most common complaints we educate and provide advocacy for include billing issues and access to healthcare, such as assistance finding specialty providers and/or medical treatments. For example, we had a case where an individual reached out to OCHA and shared that he was recently diagnosed with a rare life-threatening disease. His health plan approved a specialized treatment at the Mayo Clinic, which is out of state, and the Mayo Clinic scheduled the treatment. All the logistics for this individual to transfer out of state and receive this treatment were set up and arranged. However, as the day got close for this individual to travel, the Mayo Clinic notified him that the health plan had not provided the authorization needed to cover the treatment. So, this individual had to either cover the treatment himself or try to get it resolved with the health plan. This individual reached out to his health plan to try to get this sorted out, but it was not working, and time was of the essence in this situation. The individual reached out to OCHA, and an advocate was able to intervene and advocate for him with the health plan in order to get that authorization in place at the Mayo Clinic in time for him to receive the treatment.

The consumer health advocates also complete arbitration to resolve disputes between out-of-network providers and health care and health plans for consumers who go to the emergency room for medically necessary emergency services. Nevada law prevents consumers from receiving a surprise bill from the out-of-network provider or hospital where they received medically necessary emergency services. As a result, in Fiscal Year (FY) 2022—through February—these arbitrations have saved consumers $212,881.

The Office of the State Long-Term Care Ombudsman (LTCO), ADSD, DHHS, provides advocacy for individuals living in skilled nursing facilities, group homes, and homes for individual residential care. You will hear a bit more from our State Long-Term Care Ombudsman, Jennifer Williams-Woods, later in this presentation. In federal FY 2020, the top five complaints for residents in skilled nursing facilities were discharge and eviction, dignity and respect, physical abuse, financial exploitation, and care planning. For residents in group homes and homes for individual residential care, the five top complaints that our LTCO advocated for individuals for were financial exploitation, discharge and eviction, gross neglect, dignity and respect, and resident representative or family conflicts.

Jennifer Richards is the rights attorney with ADSD. You will be hearing more from Ms. Richards in future meetings. The rights attorney provides regulatory policy and advocacy for ADSD. The rights attorney also provides technical assistance and education within ADSD's programs such as APS, LTCO, OCHA, Developmental Services, and Community Based Care (CBC). This advocacy often involves complex legal issues such as evictions, power of attorney, and guardianships.

Adult Protective Services investigates reports of maltreatment of vulnerable adults aged 18 and older. Investigations began within three working days of receipt of the report. Reports concerning high risk of maltreatment are responded to within 24 hours; most often, these high-risk reports are responded to the same day as the report is received. Adult Protective Services also provides ancillary services such as emergency homemaker services, a psychiatrist to complete mental health evaluations, and a forensic medical specialist. Of the allegations APS investigates, the highest number of reports are for self-neglect. This is followed by abuse, exploitation, neglect, and isolation. The lowest number of reports come in for abandonment.

These four programs—OCHA, LTCO, the right's attorney, and APS—have specialized knowledge and expertise advocating for Nevadans. In so doing, they refer individuals to other programs within ADSD. I am now going to turn the presentation over to Ms. Adams to share more information about other programs and services. Thank you.

Jessica Adams, Deputy Administrator, Community Based Care and Development Services, ADSD, DHHS:

Today, I am going to be presenting information on our Developmental Services and CBC programs.

Developmental Services serves people of any age with an intellectual or developmental disability. An intellectual disability is characterized by significant limitations in both intellectual functioning and adaptive skills. It typically occurs before the age of 18 and is considered a lifelong condition. Developmental disabilities are severe chronic disabilities attributed to neurological or genetic disorders found to be closely related to an intellectual disability because the condition results in impairment of general intellectual functioning and/or results in adaptive behavior deficits similar to that of a person with an intellectual disability. Developmental disabilities must occur before the age of 22. Once a person is qualified for developmental services, the person is served through one of three regional centers. The Sierra Regional Center (SRC) serves Washoe County; the Desert Regional Center (DRC) serves urban Clark County; and the Rural Regional Center (RRC) serves the rest of the state through eight offices, with the central office based in Carson City and offices going up the northern part of the state all the way out to Elko and then down in the southern rural areas of Mesquite and Pahrump. Developmental Services serves roughly 7,500 people; of those people, about 77 percent are adults over the age of 18, with the other 23 percent under 18 years of age. Our largest population is with the DRC, with about 69 percent of people residing in urban Clark County.

Within the regional centers we have service coordination; anyone who qualifies for a regional center is assigned a service planner who can help that family or the individual find the services they may need. They can help with things like meetings with schools, helping somebody connect with vocational rehabilitation—basically anything that person may need as a result of the disability. Within the regional centers, we also have a psychological services unit that consists of licensed psychologists and mental health counselors. They can do assessments, counseling, special training, and other things along those lines. Additionally, we have nurses who mostly help with things like discharge planning or helping families with any special care needs that a person may have.

We have two family support programs. First, we have respite, where $125 per month goes to the family. The family can choose how they want to spend the money—whether to a program or an individual person—to provide the brief break in care that the family may need. We also have something called the self-directed family support program, which is $450 per month for a family to buy specialized services that are not going to be covered by any other program. Examples include things like music therapy and horseback riding therapy.

The family preservation program is $374 per month—that goes to any person living in their family home who has a severe or profound intellectual disability. These individuals often have a higher level of need, and we can give the family a small amount of money to be able to help pay for their care needs in the actual home.

Our biggest programs are our supported living arrangement programs and jobs and day training programs. These are done by a network of contracted providers across the state; they can make sure people, mostly adults, are living full lives. Supportive living arrangements are residential programs that can be on a large spectrum of service from a few hours per day, to a few hours per week, all the way up to 24-hour services in a home setting. Jobs and day training services can be all sorts of different services that give a person something to do during the day. It can be learning more life skills; it can be learning additional work skills so they can hopefully get a job out in a competitive environment. We also have services that can help keep a person in his or her competitive job.

Behavioral consultation and nutritional counseling are services that are contracted out to provider agencies. You will be hearing more about these services in the next presentation on home- and community-based waivers (HCBWs). The waiver is one of the main funding sources of these services that we contract out to different agencies.

The DRC in Las Vegas operates the only state-run intermediate care facility (ICF) for people with intellectual disabilities. We are licensed for 48 beds; we currently have 40 people residing on the campus. There are two reasons why we are not at full capacity. First, we have 11 separate homes on the campus—1 of these homes had to be used as a quarantine isolation area due to the Coronavirus Disease of 2019 (COVID-19), and another home has been in an Americans with Disabilities Act (Pub. L. 101-336, 104 Stat. 327 [1990]), or ADA, remodel as part of a long-term project working through each of those homes. So, we do not have enough beds to be able to serve all 48 people at this point in time.

The other main issue we are experiencing at the ICF is a major staffing shortage. Developmental support technicians do the day-to-day, 24-hour services; we are currently vacant 28 jobs, which is about 25 percent of all of the techs we need to operate the actual campus. The ICF provides 24-hour services—this is a facility-based setting, as opposed to a home- and community-based setting—and there must be active treatments happening to make sure we are promoting functional skills. This includes a whole lot of different services: nursing; counseling; physical therapy; speech therapy; basically, anything a person needs to be able to be healthy and reside successfully at the ICF.

I will move on to CBC. The two main programs operated by CBC are our other two 1915(c) HCBWs that operate in this state. The Frail Elderly waiver is for people who are over the age of 65 and qualify for Medicaid. You will be hearing more about all of these services again in the next presentation. The Persons with Physical Disabilities waiver serves anybody who has a physical disability. The purpose of all these programs is to make sure the person can reside successfully in the community, as opposed to needing an institutional setting, such as a skilled nursing home. All services are based on need and determined by the social health assessment, which is done on at least an annual basis.

Community Based Care operates a few more programs—these are all state-funded programs. The Community Service Options Program for the Elderly currently has 82 people in the Program. They must be 65 years of age or older and are typically low-income persons who are not qualifying for Medicaid for whatever reason. The people can receive small amounts of services such as personal care services, homemaker services, and respite—things that are going to allow them to remain in their homes. The Personal Assistance Services Program, or PAS, includes anyone 18 years of age or older who does not qualify for Medicaid and goes up to higher income limits because this is not a service that is often covered by private insurance agencies. Mostly, the services revolve around the personal care that a person needs to stay in the home. The Taxi Assistance Program, or TAP, only operates in urban Las Vegas. People can buy discounted coupon books for taxi fares. They get a coupon worth $20 of taxi fare and only pay $5 or $10 for that coupon, based on their income.

Ms. Robb will talk about the rest of our programs.

Rique Robb, Deputy Administrator, Aging, Physical Disabilities, and Children's Services, ADSD, DHHS:

I am going to start by talking about our Planning, Advocacy, and Community Based Services Unit, also known as PAC. You just heard about the variety of services and programs offered by the CBC Unit, Developmental Services, and OCHA. This PAC Unit is unique—we have a variety of functions which include oversight of strategic planning, various state plans, advocacy bodies, as well as contracts to support our community provider network. We also oversee Nevada 211, which consists of an information referral call center and a website for Relay Nevada. We oversee the sign language interpreter registry for the deaf and hard of hearing and also have an interpreter mentoring program. We also have the program for senior and disability prescription drugs, which has been a Medicare Part D support program over the last several years.

Federal grants and state funding account for approximately $28 million annually; these are federal pass-through dollars and state general funds. We fund those out to our community providers who provide the actual direct service. The PAC Unit is an indirect service program—basically our grants management unit for ADSD. That pass-through funding goes directly to community partners, nonprofits, and the different counties throughout the state, and they provide vital in-home and community-based services for older adults, people with disabilities, and family caregivers.

During the pandemic, PAC was granted approximately $18 million in emergency funding directly from the federal government for COVID-19 response to support vulnerable individuals during the pandemic. As we all know, our older Nevadans were the most vulnerable population that we needed to support. The PAC Unit was able to jump in, create multiple programs on the fly, and support the entire system for our most vulnerable groups.

We have multiple programs that are on a day-to-day basis, such as in-home services and nutrition. The Unit supports all the funding for the Older Americans Act (Pub. L. 89–73, 79 Stat. 218 [1965]) that goes for home delivered meals and congregate meals. During the pandemic, we were not able to utilize congregate settings, so we had to take other opportunities to ensure those older Nevadans received their meals delivered to their homes. We also have transportation; caregiver support; and the Nevada Care Connection—which offers navigation assistance to long-term support services—where individuals can call or go into a center and receive supports for their families for whatever their needs may be in their homes or through group settings. Our assistive technology and independent living services are to support individuals to remain in their homes to live as independently as possible. We also provide legal assistance and health promotion services.

The next program I will be discussing is Nevada Early Intervention Services (NEIS), which serves our most vulnerable, youngest Nevadans—from birth to 3 years old. Those individual children receive supports and services based on a diagnosed disability or developmental delay. These children may be medically fragile. We also support children who are in the child protective system. We support them in service coordination and special instruction. We have on-site audiologists and, depending upon the needs of the children and their developmental delays, they may receive occupational, physical, or speech therapies to support them to become age appropriate within their development. I would like to highlight that we have had a lot of changes over the years, and this program has not been looked at since the Patient Protection and Affordable Care Act (Pub. L. 111-148, 124 Stat. 119 [2010]), or ACA, was put in place, so we are currently in the process of doing a full system analysis of NEIS. Our hope is that we will be able to look at the full spectrum of services we provide and ensure we have an appropriate structure for the community and state providers who provide those services. We are also in the process of working through a request for proposal (RFP) with the Purchasing Division to look at a comprehensive case management system which will ensure better efficiencies as well as supports for those families who receive care within NEIS. We have single points of entry for both the southern and northern Nevada areas.

The last program I will be talking about is the Autism Treatment Assistance Program (ATAP). This is an assistance program to support families to obtain services and therapies for individuals under the age of 20 who have been diagnosed with autism spectrum disorder to support these individuals to have independent opportunities as they go into adulthood. The main focus that we work on is applied behavioral analysis, or ABA, therapy. We support the families in obtaining a provider who is certified and able to support that family based on the individual's needs. Additional types of treatments are funded, such as intensive parent training, which has really increased over the last two years with the pandemic since we were unable to go into the individual homes. We were able to do some additional training to support those families as we move forward. We also received a rate increase in the last biennium to support our registered behavioral technicians to provide the ABA therapies in the individual homes. I am excited to say we have been working to reduce the wait list for ATAP services and we are being quite successful at that at this time.

You will hear more about this as we move forward, but I want to take a moment to mention that we have felt the effects of COVID-19. The critical staffing shortages have affected our vacancy rates. We have anywhere from 15 to 50 percent vacancy rates, based on the programs that we provide through ADSD. We truly have felt the impact of that; it is our hope that with this next legislative session, we will be able to address those concerns. The critical shortages in staffing and the challenges we have faced have had an impact on our division caseloads.

This is the first of our four presentations today. Thank you for hearing us today; we are open for any questions you have.

Chair Gorelow:

Going back to the DRC, you mentioned one of the homes was being remodeled to be ADA compliant. Do you have an anticipated date on when that will be completed?

Ms. Adams:

The work was finished, but when the Bureau of Health Care Quality and Compliance (HCQC), Division of Public and Behavioral Health (DPBH), DHHS—which licenses that home—went in last week to do an inspection, it unfortunately found some more things that need to be fixed. So, at this point, I do not have a date.

Chair Gorelow:

Let me open the questions to other Committee members, and then we will circle back because I have a couple more. Are there other Committee members who have questions? Senator Spearman.

Vice Chair Spearman:

One of the things that became quite noticeable during COVID-19 is the unevenness of the health care delivery system with respect to Black, Indigenous, and People of Color (BIPOC) communities. You gave a good, detailed report about the response for COVID-19. I am anxious to understand how that impacted not just BIPOC communities but also members of the LGBTQ community from an emotional and psychological standpoint, because it was my experience that there was a great deal of suffering and confusion as to where they might be able to go for resources, where they might go for help. I think our basic response was a big umbrella, one over the world, with certain places addressing issues for the masses of community. But many people in BIPOC communities were either not able to get to those places or the level of trust was not there. Sometimes it is just a matter of us at the state level not understanding where those people are located and how we might be able to do better at interacting with them. Have we done anything to break it down demographically?

Ms. Robb:

I think this is an ongoing opportunity for us. I would not be able to answer you today on the specifics, but it is something we are working on and will continue to work on. We are learning more about those communities and where we should and can go to support them. We will be happy to take that back as a group and see what information we can pull together for you, Senator.

Vice Chair Spearman:

I ask that question because this is an ongoing concern for me. Even during the last interim, this Committee and others continue to ask the question, "What, if anything, have we done to address concerns with any degree of specificity for BIPOC and other marginalized communities?" Especially in Senate District 1, I was getting a lot of calls from people who had no idea where to go for resources. Even when they went to the places where it was suggested they could receive information on resources, sometimes people were unaware of the specific nuances that affected people in those communities. I am not just talking about ethnicities. I am also speaking about many people in the LGBTQ community—particularly the "T" part of that.

I have been singing this refrain for the last three years. I appreciate the willingness to take it back. I am hoping that when you raise this issue again, you would point out that this is the same question I have been asking since 2020—"How have we, or are we, developing anything that speaks to them?" We talk about things in general, but there are still communities in certain demographic arenas that are not being helped at all because we have not developed any significant outreach program to: (1) identify what the issues are; (2) find people who are already in those communities trying to help work on those challenges; and (3) make sure that programmatically, from DHHS's perspective, that information is trickling down. It is a concern I have had since 2020, and it is one that continues. I appreciate your willingness to take it back. I am hoping we will be able to come up with some type of answer that addresses the challenges that are still being felt. If we do not address the issues that have been present since 2020, the ARPA money that is coming in will be woefully short of where the needs are in those communities because we continue to do a “one over the world” approach, and people in those communities do not have the same level of trust in the health care system as some in other communities.

Chair Gorelow:

Do we have any other questions from the Committee? Seeing none, I am going to ask a question about the ATAP. You mentioned there was a wait list but that it has been decreasing. How many are on the wait list? What are you doing to decrease that wait list? What happens to a person after age 20? Where does that person go for services?

Ms. Robb:

When I came into this position—about four and one-half years ago—we had close to 900 children on the ATAP wait list, and we only had about 25 children on that wait list this week. We are now serving over 900 children, instead of having 900 children on the wait list. We have been doing multiple things. We had an audit from the 2021 Legislative Session that has helped us to reach out; we had a full analysis through that audit, and it helped us with working with Medicaid and other community providers to get the word out. We also received a rate increase for registered behavioral technicians from $31.30 to $52.04 per hour to ensure we are providing ABA therapy to those individuals. That has also helped us increase in our provider capacity—we were challenged with provider capacity based on that rate—for ABA services and support. We believe that has had a significant impact to our wait list. Obviously, it is something we will continue to work through, but we have been affected by the critical staffing shortages as well. We are excited to say we have approximately 20 children on our current wait list, but we are still working through hiring appropriate developmental specialists to provide those services, as well as the other providers, to ensure we can remain having a low wait list for ATAP.

Chair Gorelow:

What happens to the children at age 20 when they move into adulthood? Where do they go?

Ms. Robb:

There are multiple pieces to that. Some of those children are dually eligible for an ATAP service and Developmental Services. We work closely, as an agency, to ensure we provide those supports, so as they reach adulthood, they have additional support as well. I will turn to Ms. Adams to explain how Developmental Services provides those supports.

Ms. Adams:

As Ms. Robb said, some of the individuals who are served by ATAP are also going to qualify for one of the regional centers. Those who qualify are typically going to go into one of the programs I talked about like supportive living arrangements and job and day training. We are going to keep providing services and supports to that person for the rest of their life. Unfortunately, there are not a whole lot of services for people with autism after the age of 20 in this state who do not reach the level of care needs to qualify for a regional center.

Chair Gorelow:

Thank you. I see no other questions.

AGENDA ITEM V—PRESENTATION ON HOME AND COMMUNITY-BASED SERVICES PROGRAMS INTENDED TO ADDRESS THE NEEDS OF PEOPLE WITH FUNCTIONAL LIMITATIONS IN THE HOME AND COMMUNITY

Chair Gorelow:

For our next order of business, we will hear from additional representatives from ADSD who will provide an overview of the HCBS programs available to individuals with functional limitations in Nevada.

Jennifer Frischmann, Quality Assurance Manager, ADSD, DHHS:

With me today I have Crystal Wren, the Chief of CBC, and Megan Wickland, who serves as the Developmental Services Quality Assurance (QA) Manager.

Our agenda today is going to be a brief overview of HCBS (Agenda Item V). I would like to clarify that the services we are talking about are not the same ones you heard in the previous presentation with the PAC Unit—these focus on Medicaid HCBS and HCBWs.

Studies have shown that people have better health outcomes when services are provided in their own homes or residences within the communities they are familiar with. Home and community-based services provide opportunities for those individuals to remain in their homes, and we wrap services around them rather than have them institutionalized or in other isolated settings. These programs can serve targeted populations—we will be talking specifically today about people with intellectual or developmental disabilities, those with physical disabilities, and the frail elderly. It should be noted that HCBS are generally nonmedical services—services that traditional commercial insurance companies typically do not cover. These services are person-centered and tailored to the individual receiving the service. You heard Ms. Adams talk earlier about the role of the service coordinator and the social health assessments—that is how we base these services.

The process of issuing HCBS waivers started around 1981. There was an institutional bias that meant those individuals who needed support and were receiving supports in skilled nursing facilities or other institutions could only get those supports in those settings, and when they wanted to return to the community, Medicaid did not cover any of those needed services. Basically, with the ADA and the *Olmstead v. L. C., 527 U.S. 581*, decision, there were changes to Section 1915(c) of the Social Security Act (42 U.S.C § 1396n [2010]) that allowed states to ask for waivers to their Medicaid services.

What can be waived? Basically, you can waive "statewidedness"—states can choose and target areas of the greatest need. For example, if you only had a provider in southern Nevada, in Las Vegas, you could have a waiver that only served folks in Las Vegas. You also have comparability of services—when someone is on Medicaid, it does not matter where they reside; everyone receiving state plan Medicaid services receives the same services. The waivers allow states to target certain populations. For example, states can use this authority to target services to the elderly, technology-dependent children, people with behavioral conditions, or people with intellectual disabilities. Waivers also allow us to waive income and resource rules that apply in the community; they let states provide Medicaid to people who would otherwise be eligible only in an institutional setting, often due to the income and resources of the spouse or parent.

I want to make a point that all individuals on the waiver also receive full Medicaid benefits—they get the whole array of state plan Medicaid services as well as additional waiver services. The waivers work in conjunction with state plan Medicaid. A good example of that is personal care services (PCS). In Nevada, PCS are part of the Medicaid state plan and can be authorized up to 36 hours per week; however, if the service coordinator or the social worker feels the individual needs additional care—maybe the individual had a recent hospitalization, a surgery, or is getting over an illness—the social worker is authorized to provide attendant care services.

It is also important to point out that the Division of Health Care Financing and Policy (DHCFP), DHHS, is the administering agency, and ADSD is the operating agency for these waivers. The actual waiver is signed off on by DHCFP—it is basically DHCFP's contract with the Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services (HHS). The Division of Health Care Financing and Policy administers the program, and we operate it—we provide the service coordinators and the social workers to provide those services.

Waivers are intended to give states flexibility to serve new populations and provide services in innovative ways. As I just said, the state cannot pay for the same services as the state plan, but it can help supplement Medicaid state plan services. Waivers cannot pay for anything that would be duplicative from any other federal funding source—such as programs under the Individuals with Disabilities Education Act (Pub. L. 101-476, 104 Stat. 1103 [1990]) or Title IV E of the Social Security Act (42 U.S.C §§ 670–679c [2018])—and we cannot pay for any service to individuals residing in an institution, such as a nursing home, a hospital, a jail, or an intermediate care facility. Also, waivers need to be cost neutral—the total annual cost of the waiver program cannot exceed the total cost of those individuals if they were institutionalized.

In about 2014, CMS released what, at that time, was called the "new rule for home and community-based settings," which goes into effect in March 2023. I will describe some key provisions of the "new rule." The biggest one is—those who are receiving services through HCBS waivers must have full integration within their community, just as those that do not receive services through HCBS. The settings must:

- Be selected by the individual from multiple options;
- Ensure the individual's rights to privacy, dignity, and respect;
- Optimize individual initiative and autonomy;
- Facilitate individual choice;
- Ensure the individual receives services in the community to the same degree of access as individuals not receiving Medicaid HCBS; and
- Ensure that a lease, residency agreement, or other form of written agreement will be in place for folks residing in congregate settings, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant laws. For eviction purposes, the person receiving waiver services has to have the same rights as an individual not receiving HCBS services living in that setting.

I will provide a very high-level overview of the waiver intake and approval process. Aging and Disability Services is the first touch point for someone who wants to become waiver eligible. The social worker or the service coordinator does the intake process to make sure the individual meets the waiver criteria. That application is then sent to the Division of Welfare and Supportive Services (DWSS), DHHS, which looks at the financial eligibility to make sure the person is eligible. The final entity in the loop is DHCFP; once it gets through ADSD and DWSS, the application goes to Nevada Medicaid for final approval, as DHCFP is the administering agency.

Financial eligibility—this, again, is a very high-level overview; each case is different. When in doubt, have someone apply for the waiver, and DWSS will complete the final financial eligibility. In general, individuals:

- Must be at or below 300 percent of the Social Security Income, or SSI, federal benefit rate for their household size;
- Cannot have more than $2,000 in resources;
- Must be a resident of the State of Nevada; and
- Must be a United States citizen or lawful permanent resident.

Each state has different waivers—for example, some waivers target brain injuries, HIV/AIDS, or technology-dependent children. In Nevada, we have three waivers:

- Our frail elderly waiver, that serves individuals 65 years old or older who meet a nursing facility level of care;
- Our physically disabled waiver that serves individuals of all ages who have a documented physical disability that meets a nursing facility level of care; and
- Our intellectual/developmental disability, or IDD, waiver that serves individuals of all ages who have a documented intellectual or developmental disability.

Ms. Wren will go further into depth on the frail elderly and physically disabled waivers.

Crystal Wren, Social Services Chief II, ADSD, DHHS:

I oversee the operations for the HCBS waivers for the frail elderly and persons with physical disabilities. I am going to talk about the intake process, of which Ms. Frischmann gave you a high-level overview. I am going to go a little deeper to demonstrate what those social workers do for an applicant for the frail elderly or physically disabled waivers. When someone is interested in one of these waivers, the individual submits a CBC program application to the local ADSD office. Once received, the intake specialist will telephone the applicant to verify the information and schedule an in-person assessment. The in-person assessment includes a level of care screening to ensure the applicant meets the criteria for the waiver. If a waiver slot is available, the intake specialist will also complete the financial application and send that with supporting documentation to DWSS for processing. If a waiver slot is not available, the intake specialist will request that the individual be placed on the wait list according to the person’s priority level. Once approved, the intake specialist will assign this case to an ongoing case manager, where services may begin.

The ongoing case manager will determine the service need based on the assessment completed and the needs of the individual. Once approved for the waiver, the case manager will schedule another in-person assessment to complete a social health assessment, which will include an evaluation of the individual service needs and goals. This assessment includes an overview of the activities of daily living—referred to as ADLs—and instrumental activities of daily living, or IADLs. Activities of daily living include bathing, dressing, grooming, toileting, eating, mobility, and transfers. Instrumental activities of daily living include meal preparation, homemaker services, laundry, and shopping for an individual.

Once the needs have been determined, a person-centered plan is developed with the individual at the center of the plan—the person is part of that piece throughout the development; it is the individual's plan, and we want to make sure the person has a say. The plan lays out the individual's needs, the goals, and any referrals needed to support the person in the community and allow the person to stay in his or her home. The case manager will provide the individual with a list of Medicaid-approved providers based on the needed service. For example, if the person needs homemaker services, we will provide a list of approved homemaker providers to the individual so the individual can contact the providers and do an interview to make sure that provider suits his or her needs and interests. If needed, we are there to assist; we do not choose a provider on the person's behalf—it is person-centered, and we want to make sure the person has a voice. Once the provider is selected, the case manager will request an authorization and services can start for that individual.

The services offered under the frail elderly and physically disabled waiver are home-based in nature. There is an array of home-based selections such as case management, chore, homemaker, and attendant care. There are also some community-focused programs and some residential settings. I will define these more:

- Case management is offered to everyone on the frail elderly or physically disabled waiver. The service helps to support individuals through authorizations, resource referrals, and connections within the community, and acts as a second voice, if needed, through the process;
- Chore is authorized as a one-time service intended to support a task that is outside the scope of the personal care service approved authorizations. Examples of chore include carpet cleaning and shampooing, perhaps for a needed deep clean, and removal of debris and clutter to keep individuals safe in their homes, such as in a hoarding situation, for example. We can authorize a company to come in and help remove that debris so there is no fall risk;
- Adult companion is a service intended to provide oversight and socialization for an individual in his or her own home;
- Respite is authorized as a relief for the primary caregiver. It includes ADL and IADL care; and
- The personal emergency response system, also referred to as PERS, is a button device that a lot of folks wear as a lanyard or necklace. There are also wrist devices and some devices that are on a person's nightstand. The PERS device can detect falls and can be pushed in case of an emergency; it alerts the company to send emergency medical crews or police, if needed.

The following services are available only to those on the physically disabled waiver:

- Attendant care, as Ms. Adams mentioned earlier, is an extension of our state plan personal care services. She gave a good example of when we would authorize additional services; if the person has exhausted what the state plan can offer, the licensed case manager can authorize additional services as the case manager sees fit to keep that person safe in his or her home;
- Home delivered meals are authorized for those who have a nutritional risk and are delivered to the individual's home. They are often delivered in bulk, such as 15 or 30 meals at a time, depending on what the individual requests. It allows the individual to work with the provider to ensure his or her nutritional needs—for

example, a diabetic menu, low salt options, or vegetarian options—are met and personal preferences are supported;

- Specialized medical equipment—this service is not used as frequently as it used to be. I am happy to say Medicare has increased the number of devices covered by Medicaid, so this only comes in when we have a device that is not covered. Specialized medical equipment can be used to pay for something for an individual to be safe in his or her home; and
- Environmental adaptations are for those who need a modification to their homes, their residences, or perhaps the place they rent, to allow them to stay safe in their homes. Common adaptations include ramps for wheelchairs or to eliminate stairs, doorway widenings, roll-in showers, thresholds, and grab bars—you name it, they will authorize it.

This last set of services is those that are offered in the community or a congregate setting.

Augmented personal care is the name associated with group home coverage. Augmented personal care and assisted living are relatively the same service, it depends on the providers and how they enroll with Medicaid. Both services offer 24-hour in-home service for individuals who are not appropriate to reside in their private residence and who still meet the qualifications for waiver. Reimbursement for these services includes ADL and IADL care; however, room and board is not allowed to be reimbursed through Medicaid—that is a private agreement arranged between the individual or his or her representative and the agency.

Adult day care is offered in a congregate setting and includes interactions with the individual and his or her peers, allowing for socialization and oversight as needed. Many loved ones use adult day care as a respite option. Instead of having someone come to their home, it affords them the opportunity to be around other individuals their age and gives them the socialization that all of us need. A benefit for adult day care is that many of our providers are also adult day health care providers, so as folks within the day care setting graduate to the next need, they do not have to transition to a new setting—they are able to stay within that location they are comfortable with and retain the amount of care they need.

As of January 2022, we had 2,648 individuals on the frail elderly waiver and 235 individuals on our wait list. For the physically disabled waiver, as of January 2022, we had 1,124 individuals on the waiver and 84 on the wait list.

I will now turn it over to Megan Wickland to talk about Nevada's other waiver option.

Megan Wickland, Developmental Services QA Manager, ADSD, DHHS:

I will provide an overview of our IDD waiver. To be eligible for our waiver, a person has to first be eligible for developmental services. Individuals need to apply at the regional center where they live; the intake specialists will then meet with them to gather supporting documentation to determine if they have a qualifying diagnosis. If more information is needed, the regional center can conduct psychological testing and assessment to help inform eligibility. Once found eligible, a case is opened and assigned to a service coordinator. One of the key components to what we do is person-centered planning. You have heard that mentioned previously—it is a process that identifies the person's strengths, needs, preferences, and desired outcomes that help support them to have positive control over the life they choose and find satisfying. That person-centered plan drives the supports and services they receive and outlines the waiver services.

We have 11 waiver services that we contract with community providers to deliver. I am going to go through each one of these for you today.

We have four types of job and day training services:

- Day habilitation service provides meaningful activities to people in the community that help foster the acquisition, retention, or improvement of skills such as daily living skills and socialization skills. This can include retirement activities for people who no longer want to work. These services are not vocational in nature;
- Prevocational services provide work experience, including volunteer work. They teach general employment-related skills, such as the ability to communicate with a supervisor, coworkers, and customers. They can include workplace conduct and dress, following directions, and similar things;
- Supported employment has two categories. The first is individual and is for recipients who need more one-on-one ongoing intensive support to obtain or maintain a job. That could include job coaching to help focus on a specific task. The second is group-supported employment. That provides training and work experience in a regular business, industry, or community setting that supports groups of two to eight workers with disabilities. For example, we have mobile work crews where people work either in janitorial work or landscaping; and
- Career planning is a comprehensive employment planning and support service that helps people identify an employment goal and a plan to achieving that goal. That could include job exploration or job shadowing.

Next, we have our supported living arrangement services. This includes residential support services and residential support management. These services are provided on a continuum from intermittent—where a person would receive services in his or her own home or apartment, or the person’s family’s home, if that is where the person is living—and a provider comes in for a designated number of hours each week or month based on the person's needs. We also have shared living services where one or two people live with a family or a couple and share life experiences where natural supports are built in. Last on the continuum, we have our 24-hour supported living arrangement services that support up to four people living in a home together with staff available 24/7. These services are designed to ensure the health and welfare of the person through direct services and protective oversight that assist the person to learn, improve, retain, or maintain skills needed to be as independent as possible in the community.

Our residential support managers assist the person with basically managing the residential supports—they do a variety of tasks including developing plans, training staff on implementing those plans as they work with the individuals, and helping apply for resources and benefits in the community.

Our next waiver service is behavioral consultation, training, and intervention. This is designed to increase positive alternative behaviors and decrease and address challenging behaviors through behaviorally based assessment and intervention. It is a well-rounded approach to serving the person and his or her team through that training and consultation component.

Next is our counseling services, which provide problem identification and resolution in areas of interpersonal relationships, independence, and community participation. Counseling can be done via individual or group counseling; it is provided by licensed professionals in psychology, counseling, or other related fields.

Nursing services has three components:

1. Medical management is performed by either a licensed registered nurse (RN) or a licensed practical nurse (LPN) and is geared towards the development of health services support plans, observation, and assessment. The nurses do training to the direct support staff for family members to help carry out treatment plans and also provide monitoring and assessment of the recipient's health condition;
2. Nursing assessments are only done by a licensed RN. The assessment identifies the person's needs and abilities; the assessment information provides recommendations for medical and mental health care follow-up. That information is shared with the person's team for review and is included in the person-centered-plan; and
3. Direct services can be performed by either a licensed RN or LPN. These are direct skilled nursing services intended to allow the person to live safely within the community. The services can be provided at home or in the work setting, as determined by the person-centered plan.

We also have nonmedical transportation that supports people and accessing services, activities, and resources in the community. These can include bus passes.

Our last waiver service is our nutrition counseling service. This is provided by registered dietitians to support the health and nutritional needs of recipients through assessment, nutritional plan development, and training and education of the person and those working with them.

As of January 2022, we currently have 2,582 individuals on the waiver and 412 individuals on our waiver wait list statewide.

That concludes our presentation. Do you have any questions for us?

Chair Gorelow:

Committee members, any questions?

Assemblywoman Considine:

I had some questions about the waiver wait list. What are the options for the folks on the wait list? Do they need to remain in an institution? Are there any other services available to them or are they waiting until they are called?

Ms. Frischmann:

There are two answers to that. I will refer to the frail elderly and physically disabled waivers first. Unfortunately, as Ms. Wren said, we have two state run programs—our PAS program and our Community Service Options Program for the Elderly (COPE)—that can bridge the gap for those waiting for services, waiting to get on the waiver. But those are the only two programs that we have. They do not have to reside in an institution if they are not currently in an institution; so, that is not a requirement. Individuals with the IDD waiver can be receiving state plan services, the 11 waiver services Ms. Wickland mentioned. We fund those with the state’s General Fund for those waiting for a waiver slot or maybe only need a small number of services, so we do not take up a wait list or a waiver slot for them.

Assemblywoman Considine:

I do not know if the PERS systems are attached to people’s home phones or if they are on their cell phones, but I do know there has been an issue recently about 3G. Have all of these been confirmed to be above 3G so there is not a situation where somebody presses the button, and it does not work anymore?

Ms. Wren:

I have not been notified by any of my case managers that they have had issues. I will follow up with our providers to ensure they have been updated to the current 5G. I know our providers are very good at staying up to date on technology and they are oftentimes ahead of technology that we have been aware of in Nevada. I will follow up on that.

Chair Gorelow:

Any other questions? No? Okay, thank you for your presentation.

AGENDA ITEM VI—PRESENTATION ON EXISTING DEMOGRAPHICS OF NEVADA SENIORS

Chair Gorelow:

Our next presentation will be from Jeff Duncan and Cheyenne Pasquale, Unit Chief and Planning Chief, respectively, with ADSD, regarding senior citizen demographics in Nevada. Mr. Duncan, please proceed when you are ready.

Jeff Duncan, Unit Chief, ADSD, DHHS:

We appreciate the opportunity to present to you today on our *Elders Count Nevada: 2021 Report*.

Now that you have heard about many of our programs, we now want to walk you through the “who” and “why” we serve. Our agenda today includes a brief overview of our *Elders Count Report* and then we will highlight key sections of the Report. We have included a resource slide in our presentation (Agenda Item VI).

Before I give a brief overview of the 2021 Report, we want to thank many who served on our collaboration team. We work closely with the Center for Healthy Aging and the Office of Statewide Initiatives at the University of Nevada, Reno (UNR), School of Medicine. Of course, individuals from ADSD were part of the team. We also worked very closely with the Office of Data Analytics, DHHS; individuals at DPBH; our state demographer; and our Medicaid Division.

This Report will provide you data highlights. I want to mention it is a snapshot—we will not go into the full detail of the Report about our older adult population. We have broken it down to six key sections: population; economics; health status; health risk and behaviors; health care; and infrastructure. In total, there are 63 charts in the Report; of course, we are not going to be able to highlight all those for you today, but you will get a link to the Report. This Report not only helps our agency with planning and program development, but it also improves the awareness of the unique needs and challenges faced by Nevada's older adult population. It also should help give our Legislature, state entities, and the community a snapshot of Nevada's older adults. We would like to note that we are currently planning for our 2023 Elders Count Report—it is currently underway and will be published this fall. In addition to the sections already listed in the 2021 Report, we will be including new sections in the 2023 Report on adults with disabilities and a section on dementia.

We want to highlight that between 2011 and 2018, the overall Nevada population increased by a little over 11 percent. During the same time frame, individuals 65 and older increased by 40 percent and individuals 85 and older increased by 25 percent. In addition, the 55 and older population—which is aging into the Medicare population—increased by 28 percent. Nevada's growth rate for individuals 85 and older is nearly double the national rate. In fact, Nevada's population is expected to continue to age at higher rates through 2030.

We want to point out that Nevada's percentage of older adult migrants continues to rise, especially in southern Nevada. You might also find it interesting that the largest older adult group migrating to rural counties or communities is in the 55 to 64 age range. Our numbers indicate the percentage of older adults in those communities will rise in the next five to ten years.

We can look at our age group distribution in five-year cohorts. While we are experiencing a swelling of older adult population growth now because of the Baby Boomer generation, another swell is predicted in the 25 to 34 age range.

The overall population is more diverse than nationally; Nevada has a higher proportion in minorities in all categories except for Black and African American, and populations such as Hispanics and Asians are significantly higher than the national average.

In Nevada, 14.3 percent of the people who live alone are 65 years of age and older. Of that, over 53 percent are females, compared to 30 percent for males. There are slight differences from the national averages, with Nevada males trending higher and females trending lower.

Ms. Pasquale will walk you through the remainder of the presentation.

Cheyenne Pasquale, Planning Chief, ADSD, DHHS:

We are going to move into the economics section of the Report.

In Nevada, 9.6 percent of the people aged 65 and older are living in poverty. In the rural areas, that percentage jumps up to 10.4 percent. Additionally, we will likely see our percentage of Nevada's population aged 65 and older increase because 11.8 percent of the population aged 45 to 64 are currently falling under the poverty threshold.

In a comparison of expenditures by U.S. region, in the West region—which includes Nevada—it is not surprising that housing is the largest, and we expect we might see that grow. Given the current housing crisis that Nevada is facing, with the 2023 update, we also suspect the rate of homelessness or those on the verge of homelessness when entering programs will increase.

Next, we will talk about health status and health risks and behaviors. According to the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC), HHS, heart disease has been the leading cause of death in the United States for decades, followed by cancer. This remains true in Nevada, with the percentage of deaths related to heart disease and cancer slightly higher in Nevada than the U.S. average. I will note

COVID-19 has skewed this data and is now, I believe, in the top three causes of death for older adults.

The rate of adults aged 65 and older accessing mental health treatment is significantly lower than the 55 to 65 age group. However, Nevada's rate of suicide among older adults is significantly higher than the U.S. rate.

The rate of falls increases dramatically as people age, doubling between the age group of 75 to 84 and the 85 and older age group. Falls are particularly dangerous after an acute care hospital stay and contribute to increased 30-day hospital readmissions among Nevada's older adults.

Overall, while the rates of drug overdose related to inpatient admissions for Nevadans aged 55 and older is relatively small, there is an alarming increase in the rate per 100,000 for people aged 55 and older. Additionally, the rate of hospitalizations is 58 percent higher for the older age group and correlates with the increased rate of falls for this age group.

For substantiated cases and types of elder abuse, it is interesting to note the most reported case type is self-neglect, but the highest substantiated case type is abuse.

Next, we are going to jump into healthcare. In the age distribution of Medicaid and Children’s Health Insurance Program, or CHIP, enrollees, age 65 and older is approximately 7 percent of the Medicaid population, but this is the larger share of the dual eligible population, which accounts for approximately 32 percent of Medicaid spending.

Health care expenditures by type—Nevada is comparable to the rest of the United States, with hospital care being the largest expenditure.

The value of community-based services in both expenditures and quality of life is undeniable, although-long term care facilities are still a critical part of the health care infrastructure for many older adults. In-home services are nearly half the average cost per year than a skilled nursing facility.

In terms of nursing facilities, nursing homes in Nevada have outpaced the United States in severe deficiencies and substandard quality of care since 2011. This demonstrates the need for extensive review of nursing home regulations to improve care for residents, which have been amplified by the COVID-19 pandemic.

Next, we are going to move into infrastructure. Nevada is experiencing a shortage of primary care physicians, as compared to the United States, with our rate of physicians as low as 107.4 per 100,000.

The workforce grew by 18.5 percent and the population grew by 21.8 percent—our workforce is not growing at the same rate as our population, which can indicate a shortage.

In our presentation, we have provided a few additional resources for your reading pleasure. We will take any questions.

Chair Gorelow:

Committee members, are there any questions? Senator Spearman.

Vice Chair Spearman:

Thank you for the presentation. It was a stark reminder of a briefing that we received between 2013 and 2015, regarding the greying of Nevada. We know we do not have enough primary caregivers for the general population, and it is exacerbated when you start breaking it down demographically for those who are 50 and over. Have we looked at any way we might be able to mitigate the impact of the lack of the number of necessary physicians available for our seniors? Have we looked at what that looks like for various demographic categories—not just BIPOC, but also sexual orientation, differences in family structures, or lack thereof? Seniors who are in their 60s or 70s did not have the same luxury as those who are coming up with respect to being able to adopt children to have an extended family. Have we looked at what the needs may be right now and what they could be? Nevada is greying and that greying will take place across all demographic structures. What do we need to be doing now, as legislators or as policymakers, to reduce or mitigate the impact, or some of the negative impacts, that come along with the lack of resources?

Mr. Duncan:

I have seen you on interim committees and watched the Legislature over the years. I have also witnessed our advisory bodies that try to advocate to bring additional physicians to the state. I cannot see that our agency has a a lead role in that, but we like to be at the table to provide the information about the populations we serve. I cannot speak to anything specifically on our network taking the lead on that, other than we work closely with the interim committees such as this one, the Legislature, and our advisory bodies.

Vice Chair Spearman:

For the last several sessions, we have been trying to look at things with respect to making sure that professional boards are doing the right thing when people apply for licensure. Perhaps there is something you might be able to do to help us ensure licensing procedures are properly conducted, and for those who have a right to get a license in the State of Nevada, make sure those are done as expeditiously and safely as possible. Maybe there is some type of intersectionality in terms of what you need to provide the services you need for seniors and some things we, as policymakers, might be able to do in the upcoming session.

Chair Gorelow:

Thank you, Vice Chair Spearman. Does anyone else have any questions?
Assemblyman McArthur.

Assemblyman McArthur:

On one of the slides, you referred to the poverty threshold. What is that threshold?

Ms. Pasquale:

I do not have that number readily available, but I can follow up with that.

Chair Gorelow:

Are there any other questions from the Committee? Seeing none, I have a concern. I am quite alarmed at the numbers for nursing home severe deficiencies and substandard quality of care in Nevada. Do you have any specific information on what those deficiencies are and what harm or immediate jeopardy was caused by those deficiencies?

Mr. Duncan:

I would like to ask Ms. Williams-Woods to answer that question.

Jennifer Williams-Woods, State Long-Term Care Ombudsman, Office of the State Long Term-Care Ombudsman, ADSD, DHHS:

The deficiencies are issued by HCQC, and while the LTCO advocates for individuals in long-term care settings, we do not have exact authority to impose, regulate, or enforce those deficiencies. However, as Ms. Embree mentioned earlier in her presentation, we do see trends in long-term care, and those would be the types of issues we look at. As she mentioned, discharge issues, transfers, exploitation, and physical and verbal abuse are some of the top concerns we have. We collaborate with APS as well to assist in those situations with our residents in long-term care. I do not have specific information regarding those deficiencies—perhaps HCQC could provide some additional information at a future interim Committee meeting.

Chair Gorelow:

Yes, I think it would be a good idea to have them come and talk more about that to see what we might be able to look at to decrease some of those severe deficiencies and the substandard quality of care.

AGENDA ITEM VII—PRESENTATION ON THE STATE OF THE CORONAVIRUS DISEASE OF 2019 FOR SENIORS, ADULTS WITH DISABILITIES, AND THOSE IN LONG-TERM CARE FACILITIES

Chair Gorelow:

At this point, we will have a presentation by representatives of ADSD regarding the status of COVID-19 for senior citizens, adults with disabilities, and those in long-term care facilities.

Tammy Sever, Social Services Chief, APS, ADSD, DHHS:

On behalf of myself and my copresenters—Gujuan Caver, who is the Clinical Program Manager with DRC, and Jennifer Williams-Woods, our Long-Term Care Ombudsman—we appreciate this opportunity to discuss the service impacts COVID-19 had on Nevada's older adults and people with disabilities (Agenda Item VII). During this presentation, we will discuss how COVID-19 impacted ADSD's programs, our clients, and providers and how ADSD responded to the pandemic. We will also share with you some brief COVID-19 data and funding opportunities that became available over the last couple years. I will now turn over the presentation to Mr. Caver, who will discuss the impacts to the service delivery.

Gujuan Caver, Clinical Program Manager II, ADSD, DHHS:

I want to discuss the impact COVID-19 has had on the individuals we support, our programs, and staff who work within our programs. Some of the information you hear about each will be similar as I summarize each item; the majority of this information focuses on the initial impact of COVID-19 to all three.

The individual impact of increased isolation—our service providers, such as personal care attendants, adult companions, homemakers, and chore, were limited or did not support people in their own homes. Community congregate sites such as senior centers, adult day care, and job and day care programs were initially unavailable for people to attend. Family members and/or natural supports, in some cases, were afraid and/or sick themselves and did not visit people who lived in their own homes.

The impact in terms of those who were in congregate settings or long-term care environments—people residing in these environments experienced isolation due to our staff and family members or other natural supports being unable to visit them or having reduced frequency of visits during the initial stages of COVID-19. Also, social interactions for people living in these environments were affected, primarily due to social distancing rules and COVID-19 guidelines.

In terms of the individual impact of health and welfare, people who needed care beyond what they traditionally received in their homes or congregate environments experienced delays in admissions from hospitals and routine preventative care—telehealth was difficult for some. People in facilities did not receive the same protective oversight measures, for example, their rights may not have been properly assessed. Visitation from case managers and family members were also decreased and/or did not occur as typically scheduled prior to the pandemic.

With regards to our program impact, our offices were closed abruptly, which did not allow our staff proper transition time to move from working in an office environment to, in many cases, working at home. We saw staff who were used to working in face-to-face environments with clients move to a virtual environment using virtual technology and/or telecoms. Because staff began working from home, this required our Information Technology (IT) Department to quickly ensure staff had the proper IT equipment remote devices, which also put a strain on our IT Department.

Our staff, as I indicated previously, went from a primarily face-to-face delivery system to a virtual phone delivery system. Meetings that typically had occurred in person became virtual phone meetings. Coordination of services for people became challenging for staff due to the lack of providers—in other words, providers we were used to working with who could support people were limited with their own staffing issues.

Our intermediate care facility, as discussed earlier, had issues similar to those experienced by some of the long-term care and congregate environments in terms of the effects on the individuals living in the ICF. The individuals experienced isolation from outside activities, such as not being able to go to their jobs and day programs, go shopping in the community, or go out to eat—their basic routines were completely interrupted.

Regarding the ICF staff and programming, as discussed earlier by Ms. Adams, the ICF experienced vacancies, which continue to this day. The ICF staff were considered essential workers and needed to be at the ICF during the initial and continued stages of the pandemic, which resulted in low staff morale. There was a shortage of personal protective equipment, or PPE, which was greatly affected by individuals who had COVID-19; the staff who worked with them needed additional PPE items because the individuals had COVID-19.

Ms. Sever:

Statewide, people over 60 years of age accounted for 16 percent of total confirmed COVID-19 cases and 79 percent of total deaths. Some of our individual departments were able to collect data. Our agency also had issues dealing with COVID-19. From April 2020 to present, our ICF had 90 confirmed cases, including staff and residents. Our Developmental Services, including the DRC in the south and the RRC and SRCup north, also had COVID-19 among the people they served, provider staff, and staff themselves. Our CBC Unit had 451 confirmed cases among persons served and, unfortunately, 126 deaths from complications of COVID-19.

The *Elders Count Nevada Repor*t by our Office of Data Analytics includes a graph which shows older adults not only faced higher rates of infection but also mortality. Death rates more than tripled between the age group of 70 to 74 and the 75 and older age group; COVID-19 was also the third leading cause of death for people over 55 and older in 2020.

I will now turn over the presentation to Ms. Williams-Woods.

Ms. Williams-Woods:

I am going to review ADSD's response to COVID-19.

First and foremost, we were able to receive the federal funding which many of you may be aware of. We received nearly $25 million to provide assistance to various programs. With the first rounds of the disbursement, we had the Families First Coronavirus Response Act (Pub. L. 116-127, 134 Stat. 178 [2020]) and the Coronavirus Aid, Relief, and Economic Security (Pub. L. 116-136, 134 Stat. 281 [2020]), or CARES, Act. We also provided assistance from the CARES Act with the No Wrong Door Program and our Aging and Disability Resource Centers, or ADRC, system. With the Consolidated Appropriations Act, 2021 (Pub. L. 116-260, 134 Stat. 1182 [2020]), we had the Older Americans Act (Pub. L. 89-73, 79 Stat. 218 [1965]), and the Social Security Act Title XX dollars rolling in as well. Lastly, we had the ARPA, which was also part of funding the Older Americans Act, which provided additional services and an increase for the services we provided. We also put forth dollars for the public health workforce.

The majority of our dollars went to food security. As you heard earlier, many of our seniors, especially, had issues accessing food services. The next largest amount was spent for health promotion, and then it was broken down pretty closely between caregiver services, the Nevada Care Connection, and other services available within the state.

As we started our initial response to the COVID-19 pandemic, our CBC staff looked at all the active recipients and their risk levels, support systems, availability of supplies, and other health and safety concerns to make sure we were reaching those most at risk. Of those individuals, 240 were identified and contacted in the first week of shutdown, which was about March 10, 2020. Over 3,400 recipients were contacted between March 16 and March 31, 2020; throughout the pandemic, our ADSD staff maintained contact with all clients and focused mainly on those high-risk clients without much of a support system and needing the most assistance. Most importantly, our APS staff made sure to continue their home visits during the pandemic—they may have looked a little differently and taken place on porches or outside to maintain the safety of both the clients and our APS staff.

We had a lot of innovations. We came together quickly; that is what we do—we are flexible, and we work well to do things on the fly, come together, and work with our community partners. One of the great outcomes of that would be our Nevada COVID-19 Aging Network Rapid Response, or Nevada CAN, a coordination of service providers to provide a rapid response to the immediate needs for food, medication, telehealth services, and social support programs. Many of us in the room were part of these various work groups to come together and brainstorm how folks could access those services better; through that we had some very innovative programs to reach those individuals who are isolated to decrease the isolation and loneliness that many of us think of when we think of our populations and COVID-19.

They were flexibilities in the Older Americans Act program, so we pivoted from home-delivered meals and home delivery grocery programs, simplified the application process, and made other flexibilities to support our older adults. We had additional legal service grant funding to respond to civil needs, such as evictions, for those having difficulty paying their rent to keep them in their homes for as long as possible.

The Long-Term Care Ombudsman Program used the CARES Act funding to purchase tablets for every long-term care facility in the state—that includes our skilled nursing facilities, residential facilities for groups, and homes for individual residential care. We also purchased visitation booths, which were clear plexiglass three-sided stations that the residents could sit behind and access their family members in person, which could not be done for quite some time. That helped alleviate and increase the access to the residents from our program and others, and also the family members, most importantly.

To keep the residents entertained even though, as Mr. Caver mentioned, congregate activities could not take place, we provided some activities for them to do. We also provided contact information to the Ombudsman Program so we could still have that lifeline to them. Our staff, as mentioned previously, switched to making phone calls and using tablets to make video calls to the residents and staff in leu of facility visits since we were shut out for quite some time. Weather permitting, we were able to conduct window and outdoor visits to speak with residents when we could.

With our CBC waivers, there was a lot of flexibility with Appendix K, which allowed us to have some alternative methods for service delivery. Our adult day care and jobs and day program providers were able to provide services in the clients' homes using telephone, Zoom, Microsoft Teams, and any other video or audio communication available. Legally responsible individuals were allowed to be reimbursed for services to the clients, which was a change. As we mentioned previously, face-to-face interactions were modified to use those various other instruments to maintain communication and continue with our person-centered plan. Lastly, retainer payments were allowed to be made to job and day program providers when an individual was hospitalized or absent due to closure for COVID-19 for up to 30 consecutive service or billing days.

We can now entertain any questions. We also have Ms. Carrie Greeley here from our CBC program to answer questions as well.

Chair Gorelow:

Thank you for your presentation and for your hard work during these unprecedented times. There was no playbook for you to go by—we appreciate all the hard work of you and your staff. Committee, do we have any questions? I see none.

AGENDA ITEM VIII—PRESENTATION ON AN OVERVIEW OF FEDERAL AND STATE INITIATIVES PERTAINING TO SENIORS

Chair Gorelow:

For the next item of business, we have Mr. Barry Gold, Director of Government Relations with AARP Nevada, to give an overview of federal and state initiatives pertaining to senior citizens (Agenda Item VIII).

Barry Gold, Director, Government Relations, AARP Nevada:

I would like to thank you for inviting AARP to participate on behalf of the 345,000 AARP members. I want to briefly mention the history of this Committee. I remember when former Assemblywoman Kathy McClain was running around, trying to get this passed, and she actually did. We have been working with this Committee ever since then, getting some important issues heard for seniors, veterans, and adults with special needs, which often do not find themselves in front of the other committees. This is a great Committee, and I am so glad to continue to participate. Later in the presentation, I will talk about the piece of legislation that saved this Committee.

The information you heard this morning was fabulous—there was a lot of great information, a lot of interesting things were said. I would like to mention that I serve on the Commission on Aging; we look at a lot of those issues and a lot of those things you heard. There is ongoing oversight and evaluation of a lot of things ADSD and Medicaid are doing. I want to assure you that there are people out there keeping their eyes on this and making sure that our older adults, people with disabilities, adults with special needs, and veterans are being looked at.

I want to talk about a lot of the legislation in 2021 that affected older adults—this is by no means a comprehensive list (Agenda Item VIII). There were a lot of things. Many lobbyists came up to me during the session or called me to look at their bills; yes, there were effects on older adults in some things, but they may have been outside our public policy focus or only had a minor effect. I am going to focus on a lot of things AARP looked at and some of the other things.

I will start with AB 35 (2021), which changed the eligibility requirements for some of the services from the Fund for a Healthy Nevada, which is the funding source. The bill lowered the eligibility from the age of 62 to 60; it was brought forth by ADSD. It was a great bill that combined some programs and now is for seniors and people with disabilities.

Assembly Bill 76 (2021) was an enabling piece of legislation that allowed the Department of Veterans Services (DVS) to operate an independent adult day care center. You heard about adult day care centers; now, DVS can open its own, which is great because they have a separate funding source, and it would not cost the state money. You heard that sometimes there are waiting lists for adult day care. If DVS goes down that road and opens a center, veterans who need adult day care could possibly get those services without going on a waiting list. It would save the state money in the state program, so it is a win for everybody.

Assembly Bill 177 (2021) is what I call the Rx labeling bill. It allowed language to be put on a prescription pill bottle on how to take the prescription drugs, so it is not just the name of the drug, it is how to take it, such as "take one three times a day." That is important. I have said before that life-saving prescription drugs do not work if the person cannot afford them.

Life-saving prescription drugs also do not work if the person does not know how to take them. Assemblywoman Teresa Benitez-Thompson was behind AB 177. It is really going to be helping; I do not know how it is being used, but what a great idea. People can pick up their pill bottle and know if they need to take one pill once per day or two pills three times per day, and they can read it in their own language.

Assembly Bill 190 (2021) was the caregiver sick leave bill. Sixty percent of caregivers are still employed. If they already earn and receive sick leave or sick pay, paid or unpaid, they can use a portion of that to care for someone else. We learned how important that was during the pandemic when people were taking care of each other.

Assembly Bill 216 (2021) allowed for a cognitive assessment and care planning for younger people that allowed them to be added to the state plan services. Before, you had to wait until you were 65, and by then it may have been too late. If we can do these cognitive assessments on people with different forms of cognitive impairment, it would really help them get the assessments they need and some of the care planning, which could really help the quality of their lives as they age.

Assembly Bill 217 (2021) is what I like to call the unlicensed caregiver training bill. This took a few sessions to get done, and we finally found a way to get everybody to agree on it. People in nursing homes that get Medicare or Medicaid funding must have certain training required by statute; they know what it is, but for a lot of the smaller facilities—maybe some group homes or other smaller facilities—there is nothing in statute on what kind of training they need and how often they need it. I like to say we are good at fingerprinting and background checks, but not a lot else. If you are going into a place or you are putting your mom or your dad there, you want to know that the people inside those doors know what they are doing. The Board of Health will make regulations on the type of facilities—who it applies to, what topics and what training they are going to receive, as well as finding Internet sources for free or low-cost training so it is not going to be very expensive to make sure these people get the training they need. Also, with what was going on with the pandemic, it is about infectious disease programs. Many of these facilities might have had tuberculosis controls, but not infectious disease programs—like cleaning and wiping down surfaces—that we all learned a lot about. The bill also contained parts about how to have oversight over this training.

Assembly Bill 344 (2021) was what I call the hospital transition bill. They were going to look for funding, and I think ADSD is moving forward with this—it is for people going from the hospital to their homes, not into facilities. It includes caregivers and older and disabled people to develop programs to help include people in the plans and give better plans, because if you can have a good plan to send a person home from the hospital, the person is going to stay home and not have any admissions. That was another good bill.

Assembly Bill 433 (2021) is why we are all here today—that was the bill that changed the interim structure. The bill eliminated a lot of committees, but many different people spoke up and said we need to save the senior committee because it is so important for the seniors, veterans, and adults with needs. This one was saved, which is why we are able to be here today.

Senate Bill 5 (2021) was the telehealth bill. Basically, it said insurance would pay for audio-only telehealth. That is really important because not everybody has a computer with a camera or a smartphone with a camera—for whatever reason, some people may only have a telephone. We found out how important telehealth was early in the pandemic when everybody was told to stay home and not go anywhere; it allowed them to get health care and other things. The bill also helped create a dashboard on access, on who was using telehealth; we urged that the dashboard should include gender, race, income, and other categories. We urged them to also collect data on caregivers who were accessing it and age—were younger people looking at it or older people? You have heard about 211—the information and referral line—most of its users are older people. It is nice to know who is using these services.

The next one was SB 19 (2021), a background check bill that allowed the state system to coordinate better with the federal system to make sure we are doing good background checks on people to know for sure, again, when you have someone going to a facility, the people who are working there are trustworthy.

Senate Bill 340 (2021) was the home care board bill. That included some oversight of personal care and respite workers. That bill is a little bit controversial; I will not go into it right now—it talked about wages for personal care, some training, and other issues. There is some concern, perhaps, that it is going to be helpful in terms of making sure that you earn a living wage and there are places to look at in case things happen wrong, but some of the providers are concerned that if they have to pay too much, they could go out of business. So, this is one of those things where there is a balancing act. The bill does impact older adults who are going to be receiving care from these home care workers, personal care workers.

Senate Bill 341 (2021) is the disparities bill; it is about programs and training. It allows the state to look for grants that look for health care and behavioral health outcomes. It requires reports to the Legislature on the efforts to reduce disparities in health care—SB 341 specifically mentioned kidney disease and disparities in that regard. The bill also looked at other state programs in reducing disparities; it talks about training for state employees on dealing with disparities and trying to get equitable healthcare outcomes.

Senate Bill 380 (2021) is the Rx transparency bill. We were the first state in the country to have a transparency bill saying that if diabetes drug prices rose over a certain threshold, the companies had to report why—what was behind that cost. Two years later, we added asthma, but that was not good enough. So, last session we covered all prescription drugs that are over $40 in what is called the single course of therapy—one month of treatment—that went up over 10 percent in one year or 20 percent in two years. They must provide to the state information on why. The information is going to be presented at a public hearing; it includes manufacturers, wholesalers, and pharmacy benefit managers, or PBMs. The prescription drug process chain is a complex one, so it includes everybody to know what is happening. The bill talks about penalties and what they are used for—before, penalties, if they did not do it, were only used for education about diabetes and asthma. Now, we are collecting information about all prescription drugs so they can use that information for more.

Senate Bill 396 (2021) is the Rx purchasing bill that allows the state and public entities to enter into group purchasing. That is why the governor announced that Nevada was joining the Northwest Prescription Drug Consortium, which is a fabulous thing that Oregon and Washington started—it is by states for states. It has changed its name and is now called ArrayRx. It includes every prescription drug approved by the U.S. Food and Drug Administration, HHS. There are no formularies if you enroll. Once the state enrolls in ArrayRx, anyone, regardless of whether you have insurance or not, can enroll. There are also discounts on generic drugs and nongeneric drugs. If you have insurance, you can decide—if your insurance is cheaper, you can use your insurance; if your insurance is more money, you can use them as well. As we have all seen, sometimes your insurance company makes you pay a little more for generics. This is a great way to get some lower-cost prescription drugs into the hands of people, and that is so important. Prescription drugs are the largest driver of the cost of health care.

Senate Bill 420 (2021) is the public option bill, which was discussed a lot. It asks the state to design, establish, and operate a public health insurance option that people can buy. It also says they may offer it to small businesses; that is a decision they are looking at. They are looking at cost reduction and how that is going to happen—it has to reduce costs over a certain threshold of 5 percent over certain things and 15 percent over the cost of the four years it is going to be in operation. Right now, a required analysis is being done. There is a lot of input, and I have been following those meetings and learning all about that. It does not start operating until 2026, so we will see how that goes. We must do something to lower the cost of prescription drugs—there is no reason why Americans pay three times as much as any other country. Senate Bill 420 also talked about pregnant women and doulas—this is not something AARP paid a lot of attention to, although we do represent people over age 50 and there may be some 50-year-old women getting pregnant or some doulas who need to get paid, so we looked at that. Also, all Medicaid managed care organizations that contract with the state had to submit a good faith RFP to participate, so we guaranteed the people we were contracting with would at least want to play.

The other thing I will mention, in terms of health, that passed during the session, was HCBS funding. You have heard a lot about HCBS; they said it is half the price—it is about four-to-one or five-to-one—people who can be taken care of at home as opposed to being in a nursing home. I will never say nursing homes are not necessary—there will always be some people who require 24-hour skilled care, and that may be the best place for them—but staying at home is better, easier, and cheaper for a lot of people. When I talk to groups, I ask how many would like to be in a nursing home, and not a hand goes up because people understand they would much rather be taken care of at home with independence and dignity, which is where they want to be. This past session, I was so pleased during the budget hearings that the decision was made to fund both the growth and to eliminate the waiting list for the HCBS programs. They also funded the staff to implement it. The waiver slots, or positions, represent people. If you give the state 150 more slots and the agency does not have the staff to actually implement it, it does not work. We want to thank Assemblywoman Teresa Benitez-Thompson for understanding and making sure the staffing got there. Now we will truly be able to take care of people where they need to be.

There were bills about topics other than healthcare.

Assembly Bill 321 (2021) was the election bill that made the changes done during the 32nd Special Session dealing with people getting mail ballots for the elections permanent. It also talked about early voting sites—it required a certain number in certain counties. The bill talked about deadlines for when the mail ballots had to be returned, how you could opt out of a mail ballot, and a little bit about signature verification. I am not going to talk about that controversial subject, but AB 321 did discuss it a little bit. The bill affects older adults because we all know who votes—older adults. We need to make sure they can make their voices heard in whatever way they are most comfortable doing.

Assembly Bill 388 (2021) was the broadband bill. It created a voluntary fund to make grants to help people look at what was going on with broadband; it also required a report on underserved areas. That is really important, but I have better news to talk about when I talk about federal initiatives.

Senate Bill 150 (2021) was the tiny house bill. It allowed people in populations in cities and counties to change their zoning to allow tiny home parks. We all know affordable housing is a big issue in our state; this is a new, unique form of affordable housing—it is an interesting idea.

Senate Bill 284 (2021) was about obtaining and using affordable housing tax credits. I am not going to say much more about that; if you want to know more about that bill, ask former Senator Julia Ratti. I listened to her in the hearing, and she talked about housing tax credits, and I said, "Oh, I understand how those work." When I walked out of the room, I thought, "What did she talk about?" It is a very complex thing. We need people who understand the tax credits and affordable housing because something must be done.

Senate Bill 311 (2021) allows rural housing authorities to create nonprofits to own and operate affordable housing for low- and moderate-income people. Again, ask former Senator Ratti; she can tell you more about that.

What are some of the things that did not happen for older adults?

One of them you heard about before was AB 407 (2021), orders of protection for vulnerable adults. This Committee submitted that BDR, but it did not make it because it was released very late and there were some language things that needed to happen. It was one of those bills that involves attorneys and lawyers, and sometimes it takes them a little while to agree upon the language. Assembly Bill 407 came out so late that there was not enough time to do that, but I know they are still working on it. There are 28 states that have something similar in place, and it is important to have something specific to vulnerable adults. Jennifer Richards is still working on this bill; I spoke to her yesterday. If you want to know more about that, do another BDR, and get this across the finish line, they would really like to have that. A national expert on justice and aging said this type of order is a critical tool for restorative justice.

Senate Bill 56 (2021) was a bill for audio-only telehealth for behavioral health, saying they had to do behavioral health that way. You get into the issue of behavioral health parity, and sometimes that is a big black hole. Senate Bill 56 did not make it across, but SB 5 did, so we got one of the audio-only bills. But, being fair to behavioral health, we have all learned how things are going to happen.

Senate Bill 218 (2021) was about tenants' rights. It was a very comprehensive bill, and sometimes the more things you throw into it … . It did not make it across the finish line.

Senate Bill 200 (2021) was one of my favorites—it was work and save. Work and save is a plug and play system for employees who have no way to save through their employers. It is an auto 401K/auto individual retirement account (IRA) program that costs the employer nothing. The employers do not contribute—they offer it to their employees who decide whether they want to do it. A little bit of money comes out of the employee's check and is not matched by the employer. A fiscal agent does it; it is a public-private partnership, and that way, people can start saving for retirement so when they retire, they have means instead of needs. Several states passed this before the pandemic; a few states have even passed it during the pandemic. There is a very interesting program in Oregon—which was the first one—that said you can join their program. Sometimes there is a startup cost of $1 million or more, which makes states hesitant, but if you can join another program, that is another way to look at that.

I want to talk about state initiatives—things happening around the state. AARP sent letters to the governor talking about Medicaid redeterminations. During the public health emergency, states were not allowed to disenroll people from Medicaid, and that was important because there was so much going on, people needed health care. After the public health emergency is over, they are going to start doing the redeterminations, and people might get disenrolled—their incomes might be too high, or other things may come up. Some exceptions were made to allow people to enter Medicaid. So, we sent a letter saying we need to make sure we do not disenroll people inappropriately. Maybe they moved and we do not have their address—not everybody who is on Medicaid is good at answering mail and looking at things or doing the complex steps that are required.

We are working with Medicaid and Welfare, and they are doing outreach to make sure they have everyone's addresses; they can do automatic referrals using information from other programs, such as income levels, so it is not such an onerous process to get involved. Another thing that is important is people might be disenrolled because their income is too high. They lost their jobs during the pandemic so they were eligible for Medicaid, and now they have a job again so they are not eligible, but they may not have insurance. These people will be auto-referred to Nevada Health Link, the health insurance exchange, so they can buy insurance.

We sent another letter to the governor and Director Richard Whitley of DHHS about booster shots in nursing homes. You heard about the COVID-19 response in nursing homes—we did better than most states in terms of nursing home deaths. In some states, 30 to 40 percent of deaths in the state were in nursing homes. We were much lower; at different times during the pandemic, we were somewhere between 8 and 12 percent, which is good. Part of that is because we have so few nursing homes here because we do HCBS. We did okay with the first initial vaccine, but with booster shots, it is appalling—the last time I looked, I think we were third from the bottom in residents who have had regular shots and booster shots, and staff was only doing a little better. We need to find a way to reach out; AARP is working with the Nevada Vaccine Equity Collaborative and Immunize Nevada on developing some messaging to reach out to the nursing homes in terms of how we get boots on the ground to give these people shots and make sure booster shots get done as well. The initial shots were good, but we know these are the most vulnerable people, who, if they get it, are liable to have the worst outcomes. So, what can we do and how can we do that? Who do we reach? With nursing home residents, there is an interesting question about guardianship—if they have guardians, then the guardians are the decision makers of whether they get a shot. If the staff asks a resident if he or she wants a booster shot, and the resident says, "I do not like shots," that does not work. We need to figure out a way to do that, and they are going to help us do that, because they have done messaging that works, and they also know how to get boots on the ground in the facilities.

Some of the state initiatives we are working on include work and save; as I mentioned earlier, it is going on in several states, both last year and this year. We will see if there are sponsors in the state who are still looking at it. This bill usually takes a few sessions to get it across, but I know the treasurer is very interested in this; it saves the state money and enables stable retirements for people in the future.

I already talked about HCBS—across the country we are looking at protecting funding; rebalancing and making sure there are more people at home where it is cheaper than at nursing homes; and looking at the waiting lists.

People are also looking at prescription drugs—rate-setting boards, price boards, co-pays, price gouging, transportation, importation. There are a lot of things happening on a state level. Did you know there is an importation bill on the books in Nevada? I do not see a lot of heads shaking. There was an importation bill a dozen years ago or more that said the State Board of Pharmacy could license online Canadian pharmacies, and people could go there to do that. What a unique way to do that. I believe three pharmacies applied, but they never advertised or pushed it. As far as I know, it is still on the books, but other states are doing some other things for importation; we need to look for that. There are few states doing price gouging, so if there is any price gouging going on, the attorney general can look at that.

Broadband is another important thing states are working on. We sent a letter to the governor about broadband and ARPA funding. As I mentioned in another place, the governor announced he is going to spend $500 million in ARPA funding on making sure broadband is accessible to people all over the state. That is a big deal because there is a digital divide in our state.

There are state initiatives around access to quality affordable health care; consumer protection; payday lending; renters' fraud; utilities; and affordable housing, including accessory dwelling units. I know there is a lot of talk about what I will call "rent stabilization" or "price controls on rents." That is something that typically is not a statewide idea—some people have talked to me about making sure there is no state presumption, that they are going to stop, they are going to allow municipalities to do that. That is something to consider, because we must figure out something. Somebody had their rent raised like 6,000 percent or something outstanding—that is an indication they want you to move—but people should not have that happen to them.

I will also mention one other thing that has to do with nursing homes, and that is the Nurse Licensure Compact—we did not even get a hearing last session. Several of the bordering states have the Compact. We talked about the doctor shortage—we also have a terrible nursing shortage. You have heard about how University Medical Center nurses had forced mandatory overtime, and they were not happy about that. So, we need to at least give it a hearing and let people talk about the Nurse Licensure Compact—licensed, trained nurses who may want to work here.

I will now talk about federal items. There is a lot of state and local funding from the ARPA. The ACA marketplace exchanges, like Nevada Health Link, expanded eligibilities to get subsidies and premiums were limited to 8.5 percent of income. They help people by providing insurance, which is important. Medicaid is important because the Federal Medical Assistance Percentage, or FMAP, which is the federal matching program for the states, was increased if people would do certain things for HCBS. They submitted a spending plan and everything in the spending plan got approved by the state, but they are taking it to the Interim Finance Committee, or IFC, a little slowly, and there are things coming that are going to take some time. The provider rates that were cut during the special session have been restored and made whole so they can stay in business. They did a one-time $500 workforce payment so people could stay in their jobs as personal care workers; Nevada was not the only state that did that. More of those are going to come. When I talked to the Medicaid Division, I was told the spending plan was approved and will be brought to IFC slowly, one at a time.

The ARP had expansion involved—we are a Medicaid expansion state, so that did not apply to us, but it encouraged states to do that to get people insurance. The ARP also had pension plan relief, which helped multiemployer pension plans. The Butch Lewis Emergency Pension Plan Relief Act of 2021 (S. 547 [117th Congress]) has provided $94 billion in saved pensions for about 3 billion people. If you want more information, I would be glad to talk to my national office for more information because the office tracks a lot of that.

Another thing that came from the ARPA funds was the emergency rental and homeowner assistance. I know a lot of different agencies and some of the legal aid centers spent a lot of time connecting people to these plans so they could stay in those homes, which was important.

The Infrastructure Investment and Jobs Act (Pub. L. 117-58, 135 Stat. 429 [2021]), which provided state and local funding, had a lot to do with transportation, public transit, safe streets, and transportation alternatives. I mentioned broadband deployment and infrastructure. The governor announced he is going to spend $500 million on infrastructure and more to make sure people did that with digital equity and training. That is important. A permanent subsidy program was created called the Affordable Connectivity Program, or ACP. It replaced the Emergency Broadband Benefit Program, or EBB. The ACP gives a $30 per month discount or $75 in tribal areas and includes a $100 discount on a device. There are income and other criteria for that; if you need more information, you can go to ACPbenefit.org.

Many of the things that happened federally funded things during the pandemic. The Build Back Better Act (H.R. 5376 [117th Congress])—which is stalled right now and we do not know when it is going to come up—had some great things for prescription drug costs. This included Medicare negotiation, $35 insulin co-pay—which is a life-changer for people on insulin—and a $2,000 cap for out-of-pocket Part D drugs. There also was a hearing benefit; that is another dream come true. The Build Back Better Act is stalled right now—we do not know what is going to happen to it. Paid sick leave was originally in there—it was very controversial; a few people said that was a sticking point, so we will see if that stays or not. Nursing home staffing was also in there.

Besides the nursing compact, something else I wanted to mention regarding state initiatives is making sure there is an RN on staff at all times. Sometimes they have an RN and sometimes they have an LPN—we should make sure there is always an RN on staff. We should also perhaps look at staffing ratios because we had trouble with nursing homes being short-staffed. You must be very careful with staffing ratios because sometimes they become the ceiling and not the floor, so that is something to look at and make sure it is sufficient.

Housing was also included in Build Back Better Act, but right now it is stalled.

The other things that happened federally were stimulus payments; AARP was very involved in the last round of stimulus payments for $1,400, and we wanted to make sure dependents also got the $1,400, including adult dependents. They were not included more. We also wanted to make sure people on SSI, and Social Security Disability Insurance, or SSDI, and veterans were eligible.

Another bill that we wanted in the Build Back Better Act, but it is also moving separately, is something called the Credit for Caring Act of 2021 (S. 1670 [117th Congress]). Caregivers spend an average of 24 percent of their income caring for other people they know—this is a $5,000 federal tax credit for caregiving. There are eligibility requirements, and you must do certain things, but it is a way to help caregivers who spend 24 percent of their income. People of color spend more than that—they spend up to 30 or 35 of their income. AARP is still working on getting that across the finish line as are many states. Nevada does not have state income tax, so we are not going to work on that, of which we are glad.

The other thing that happened federally was the Fraud and Scam Reduction Act (H.R. 1215 [117th Congress]), which allows the Federal Trade Commission to do more for response and prevention. That passed recently and is a great thing that will help people.

If you have any questions, please ask. Thank you for inviting AARP to participate in this process. We look forward to working with the Committee. I would like to thank LCB staff for everything they do; they make this process so much easier for everyone. You heard a presentation earlier on ADSD's COVID-19 response. I would like to thank ADSD and Dena Schmidt, individually, as the Director of ADSD, for what they did to make sure services were there. They put together Nevada CAN, which was a fabulous program that put providers, community providers, advocates, and other people together to make sure we were getting out there to make sure people who needed help got help. On behalf of the 345,000 AARP members, thank you.

Chair Gorelow:

I really appreciate this presentation; it was a great overview. Committee, any questions? Vice Chair Spearman, please go forward with your question.

Vice Chair Spearman:

Thank you, Mr. Gold. I appreciate your thoroughness. I echo your gratitude regarding how ADSD has helped during the pandemic. I know there was some consternation and, for some reason, controversy about mail-in voting. I want to say thank you for working with some of the veterans' organizations to make sure we were able to get that done. I have heard from veterans and veterans who are in the category of seniors as well, for whom knowing they will have it as a permanent option—at least right now—has been very gratifying. I also had the opportunity to talk to a Gold Star widow last Saturday about the mail-in voting option.

I received a text the other day from someone trying to figure out how they might be able to pay for hearing aids. I would like to challenge you to ask the national AARP office to stay on top of the Build Back Better plan. I have no idea why hearing aids are controversial to people, especially when we have medical evidence to show that when hearing loss is not dealt with, it also advances dementia, Alzheimer's, and some other cognitive issues in older people. We have got to get this done. There are too many people who need hearing aids. An inexpensive pair costs around $3,000. I talked to someone yesterday who was quoted $8,000—that is probably more than eight months of Social Security income for most people who rely on Social Security for their financial livelihood.

In 2019, we passed pay equity in Nevada. I am going to ask if you can get with the Nevada Equal Rights Commission and see how that might be fairing, because one of the things that was a motivator for me in carrying the bill is that more women retire in poverty than men. More than 70 percent of the time, it is because they were not paid equitably. Pay equity is especially important now with respect to housing insecurity, food insecurity, and that sort of thing. I want to make sure we are doing everything we can do to monitor this—to make sure good actors are being thanked and bad actors are being put on notice about pay equity.

Mr. Gold:

Thank you for bringing up hearing aids. AARP also worked with the Food and Drug Administration (FDA), which is coming out with a regulation for over-the-counter hearing aids. I do not know exactly how much they are going to be, but they will be less pricey.

I know from experience that they are very expensive. Having the over-the-counter kind—although I do not know how they compare—is something people can access that would be cheaper. We were instrumental in pushing that because something needs to be done.

We are not giving up on the Build Back Better Act. If you have seen some of the commercials that are playing in Las Vegas lately about prescription drugs, we are very intent on doing something to lower the cost of prescription drugs as well and looking at that comprehensive package of health care.

Chair Gorelow:

Are there any other questions from the Committee? Seeing none, thank you again for your presentation.

AGENDA ITEM IX—DISCUSSION OF ELDER QUALITY OF LIFE ISSUES AND HEALTH CARE CONCERNS IN NEVADA

Chair Gorelow:

For the next item on our agenda, we have Dr. Peter Reed, Director of the Sanford Center for Aging at the UNR School of Medicine to discuss elder quality of life issues and health care concerns in Nevada. Please proceed with your presentation when you are ready.

Peter Reed, Ph.D., M.P.H., Director, Sanford Center for Aging, UNR, School of Medicine:

I am the Director of the Sanford Center for Aging, a professor of public health, and Chair of the Nevada Task Force on Alzheimer's Disease. I have been asked to talk today about quality of life and well-being among elders and to highlight some of the initiatives the Sanford Center offers to support quality of life. I am going to talk more to the big picture. I have been listening in all day to your hearing, and I want to thank you for your continued attention; you have been inundated with all kinds of information, a lot of good presentations with facts, figures, and information on bills. I want to talk more conceptually. First, I am going to share my views on different dimensions of quality of life and well-being, so we are all on the same page with what that means. I also want to talk about some of the key resource needs for supporting quality of life and well-being and how we can do that through the aging services and health care continuum. Then, I will describe some of the key initiatives at the Sanford Center for supporting quality of life.

To get started, I do not need to go into a lot of details on population needs. There were wonderful presentations earlier from our colleagues at the state agencies talking about the demographics within our state—particularly the *Elders Count Report*—and outlining a lot of the different health needs. I would say that we live in a very rapidly aging state; our population is getting older, and along with the aging process come some key health concerns. Those include comorbid chronic diseases, dementia and Alzheimer's disease, frailty, and polypharmacy. All of these different concerns that come along with the aging process have the potential to compromise health and well-being and to compromise independence and ADLs. Because of the decrease in independence in ADLs that comes along along with some of these conditions, there is a need to provide supports and services to enable people to continue to live well. We have to talk about some of the challenges for meeting those needs across the continuum. When I talk about the continuum of services, I am referring to the community-based aging services—you heard a lot about those earlier—and long-term supports and services. People receive long-term care as well as clinical and health care services that are available, and there is a need for these elements to be well integrated.

I want to start by focusing on quality of life and well-being. As you may imagine, quality of life can be very subjective for people. We all have our own definition of what our own quality of life is and what we want it to look like, but when I think of quality of life as a professor of public health and someone who works in a school of medicine, I am thinking about health-related quality of life. For me, that is about the outcome of health conditions, the ability to live one's life as the person chooses, and to live where the person chooses. Do you have the ability—do you have a strong enough health-related quality of life—to live the life you would choose, where you would choose to live? That ability is enabled or constrained by a variety of different dimensions. When I think about health-related quality of life, I am thinking about physical health or the different diseases, disease states, that may compromise our physical abilities and ADLs. I am thinking about emotional and mental health; when you think about mental and behavioral health, there is a big concern there for elders. I am thinking about cognitive health, and I draw a distinction between cognitive health, or the functioning of the brain, which can be compromised by conditions such as Alzheimer's disease or dementia, and emotional or mental health, which are different psychiatric conditions that can compromise that. I am also looking at social health. Do we have a network of people to whom we can seek support and receive that support? Of course, financial health is an important element of our overall quality of life, as is environmental health and the conditions in which we live. Many people also talk about spiritual health—having a sense of connectedness and meaning and purpose. So, for me, when I think of quality of life, it is really those dimensions: physical health; emotional health; cognitive health; social health; financial health; environmental health; and spiritual health. All of those dimensions need to be present to a certain degree to enable people to be able to choose how they are going to live and where they are going to live. Those dimensions are the elements that get compromised when someone develops a chronic disease, dementia, or frailty, so those are the kinds of things that we are implementing supports and services to enable people to maintain their independence and their quality of life across those different dimensions.

However, I draw distinction between quality of life and well-being. I do this for a very specific reason. When I think of well-being, I think about the dimensions of ourselves or the dimensions of a person that transcend those health-related conditions that can compromise our well-being. I am talking about well-being using a model developed by a group called Eden Alternative International. Eden Alternative describes well-being as having:

- Identity or a sense of personhood, and being known to others;
- An opportunity for growth and continued learning and development;
- Autonomy, or self-determination, the ability to make decisions for yourself;
- Security, feeling safe, feeling that you have an environment in which you are comfortable;
- Connectedness with others, having opportunities to connect with other people who bring meaning into your life;
- Meaning and purpose; and
- Joy.

I believe these domains of well-being can be supported at a high level, despite the aging-related changes that come along with chronic diseases and dementia. Despite physical and cognitive limitations, we can still support well-being such that people have a sense of identity, growth, autonomy, security, connectedness, meaning, and joy. When I think about how we develop programs and deliver services to older adults, I certainly am thinking about those elements of health-related quality of life that I mentioned before—supporting physical health, supporting cognitive health—but I am also thinking about how we can transcend the challenges that come along with physical and cognitive limitations and help support overall well-being. The question I ask, then, is how can we support Nevada's elders? How can we meet these basic human needs by creating conditions that really support quality of life and well-being? The answer I keep coming back to is that we need a well-integrated, well-resourced continuum of supports and services that are built around the needs of the person. We need a system that is built to support people in receiving services in the manner that they choose to receive them and when they need them, such that the elders themselves are directing their own experience within our support services network, so that they are truly person-directed.

So, what do those needs look like? I think that ultimately—in the current time, in my interpretation—a lot of this comes down to workforce. There is the first element of the workforce, in terms of ensuring that all of the elements of the continuum of services that are needed to provide support are present. Without those services present, people are not able to access the support they need. But it is not just having these services accessible—it is also ensuring the workforce has the knowledge and skills needed to deliver these services effectively and that the workforce understands all the other services that exist so there is integration across all of these different elements. We can train our existing and our future workforce to understand the needs of elders and to understand the service delivery strategies that are going to use person-centered approaches to enable people to have high-quality life and well-being. We not only need the people, or the professionals, the workforce, but we need people with the right knowledge, the right skills, and that can only come not only from offering programs and services but by training the people who deliver those programs and services to be effective.

Aging is a whole life experience. You all know that. Each one of you is aging. I am delighted to share that tomorrow, if you are fortunate enough to make it through the night, you will wake up a day older and you will continue aging for the rest of your natural life. Our goal here is not to extend life indefinitely, but to promote quality of life and well-being in a way that enables people to live well. Aging is a whole life experience, so there are both needs and resources that are needed to meet those needs across the entire lifespan and in all the dimensions of the human experience.

I have talked a couple times about the continuum of services. There are lots of different elements to this. You have heard a lot about these earlier in the presentations from ADSD, but I want to briefly touch on a couple of the ones that I see as key elements of this continuum of services. I think of major dimensions to this.

The first are the community-based aging services offered by professionals through state, county, and local levels from both government agencies and nonprofit agencies. These include information and referral sources; opportunities for social support and meaningful relationships; food security; transportation; respite care; adult day care; health and wellness programs; financial and legal planning; lifelong learning and civic engagement; and many others. There is an aging services network in the State of Nevada from the state level to the county level to the local level, with government and nonprofit agencies delivering these services—from a variety of different funding sources—every day to enable elders to live well and to get the support they need to remain in their homes and communities.

The other bucket that I will move to—still within those HCBS—are home-based care options and opportunities. This includes home health, home care, and homemaker services. I want to draw a distinction, because there is often confusion between home care and home health. When I refer to home care, I am talking about in-home personal aids that support people in their ADLs—in-home care to support people with their everyday lives. When I refer to home health, I am talking about medical and skilled medical services that are being delivered within the home. There are different funding sources for those different services, but they are both ways to help to enable people to "age in place," or to remain in their homes in the community and get the support they need to live well.

However, and as Mr. Gold mentioned previously, there are times when people need to transition out of their homes—the level of support that they need exceeds what is possible from their family or from paid professionals coming into their homes, so they often will move into residential long-term care settings. That includes independent living, group homes, assisted living, and skilled nursing homes. These are places where people live and, hopefully, are living in the least restrictive environment possible for them to receive the support they need to live well and the services they need to engage in their ADLs, aligned with their own individualized needs. That is where this idea of person-centered or patient-centered approaches to care really come into play. We want to know everything there is to know about a person and match the level of support the person is receiving to the person's level of need, as well as the person's strengths and what the individual can do, so that we can maximize the person's independence.

I want to mention the other element to this continuum of supports. I just walked through HCBS and long-term care in the aging services realm, but there are also health care and clinical services available to support people as well. When I think about elders, I think about primary care—not just physicians, but also nurse practitioners and physician assistants—geriatrics care, our health care providers specializing in care of older adults; and for our purposes of looking at elder health and well-being, neurology—looking at the ability to provide support for cognitive health. Primary care, geriatrics, and neurology are clinical disciplines that need to be embedded across that continuum of aging supports and services, both on the community support side and the clinical side.

The real question then is how we ensure that all of these different elements I just described are not only robust and well-supported but also connected to each other so that from a patient-centered perspective, from a person-centered perspective, they know how to access an immediate service but then get connected to all of the other things they may need to maintain their quality of life. Connecting those dots across that entire continuum, that entire system of support, in my view, needs full integration and collaboration, but also training. People become very myopic, professionals become very myopic and specialized in the work that they do, and they sometimes are not as familiar with the other resources and opportunities being provided by others that could benefit the work that they are doing themselves. As an example, think of a diabetes self-management program, which would be a community-based health and wellness program to give people living with diabetes training they need to manage their own conditions. It would include education, self-efficacy, skills, and knowledge. If a physician who is working with a patient who has diabetes is only looking at the medical management side and is not aware of the opportunity for the patient to enroll in a self-management program to learn skills for themselves, that is a missed opportunity. It is about connecting those dots so we are taking advantage of all of the resources from a person-centered perspective; that goes across that entire continuum of services and supports.

I have talked about what I see as the critical needs for elders and that larger system of support, but I was also asked to share a bit about the initiatives at the Sanford Center for Aging and the kinds of things we contribute to this system of support.

First though, I want to talk about COVID-19. You have heard several times about an initiative in Nevada called Nevada CAN, which was led by ADSD under the leadership of Dena Schmidt. I was privileged to have the opportunity to work with Administrator Schmidt in developing and delivering Nevada CAN. It was mentioned before, but it was really understated. This was a rapidly developed innovation here in Nevada that gained national attention. I got my stay-at-home order from UNR on March 17, 2020—Saint Patrick's Day. We were told to go home and not come back. Within two weeks, a planning period had taken place, and the State of Nevada launched Nevada CAN—its website went live on April 1, 2020, after a two-week planning period. It created a triage system for mobilizing community-based aging services organizations and ensuring that elders across the state could stay home and stay connected to the food they needed, the health care they needed, and the social support they needed. During the roughly 18- to 20-month period from April 1, 2020, to the end of 2021, there was a tremendous amount of support provided to older adults. Pop-up food delivery groups came together; the primary one was called Delivering with Dignity, which, as the food and medication delivery arm of Nevada CAN, delivered close to 600,000 meals to older adults during that 18-month period. I was privileged to lead the telehealth action team; we delivered over 20,000 telehealth visits to older Nevadans through the partners that were part of that telehealth group. There was an innovation called the NEST Collaborative, or Nevada Ensures Support Together, which offered virtual social support; they delivered over $5,000 for virtual social support to elder Nevadans. This initiative was developed so quickly and was so innovative that we were invited to testify about this initiative to the U.S. Senate Special Committee on Aging in June 2020. I had the honor of offering that testimony to the Special Committee about Nevada CAN. I feel it is something you need to be aware of and should be very proud of—that Nevada, through its work in supporting elders during COVID-19, was nationally recognized as a leader in innovation and rapid action, and that is because of Nevada CAN. I am not taking credit for Nevada CAN as the Sanford Center for Aging; it was very much a statewide collaborative activity, led by ADSD and including dozens and dozens of organizations and partners.

The Sanford Center for Aging offers a wide range of direct services. We have the Sanford Geriatric Specialty Care Center, a clinic where we have an interdisciplinary comprehensive geriatric assessment for older adults; it is part of University Health, which is part of Renown Health as of this last October. We see patients with multiple chronic conditions, dementia, and frailty. We get to know everything there is to know about them and we provide a care plan that goes back to their primary care provider (PCP) for them to implement in recommendations and supporting people. Our clinic is supported by Nevada's ADSD and DPBH; we are grateful for the support we get from the state in delivering those clinical services. We offer community-based wellness programs supported by the U.S. Administration for Community Living, HHS, as well as Nevada's DPBH. Through these we offer health education for older adults on specific conditions and for specific opportunities—that includes diabetes self-management; diabetes prevention; fall prevention; chronic pain; self-management; and strength and conditioning programs. There is a wide range of different health education opportunities to support quality of life for elders. We also offer direct in-home support through a program called Senior Outreach

Services, which is funded by ADSD. This offers one-on-one in-home companionship and social support for low-income, homebound elders in Washoe County.

We offer transportation services, with support from ADSD, and medication therapy management (MTM) services, with support from ADSD and DPPH. Our MTM is worth calling out because it is an innovative program through which we have a certified geriatric pharmacist who does comprehensive reviews of the medications that someone is taking and looks for negative interactions between those. I mentioned earlier the importance of understanding polypharmacy among older adults. Many times, people will have multiple health care providers who are prescribing different prescriptions or different medications without coordinating with each other, and these can cascade—they interact and create all kinds of problems. There is one story that I always share—several years ago we had a client in our MTM program, an older woman taking 42 different prescription medications prescribed by 7 different doctors. That is exactly what we are trying to identify—the risks associated with the negative interactions and how the medication profile someone is taking aligns with their health status and their health needs. Those are the direct services that I want to mention at this time.

The training that we do is important. As I said, the way we are going to ensure we have a well-integrated, well-connected system of support that intersects with the aging services world and the clinical world is through training. We offer a variety of different training initiatives. The signature initiative we are engaged in is called ICECAP Nevada, which stands for Improving Care of Elders Through Community and Academic Partnerships. I want to be sure you are aware of this because it is funded through the U.S. Health Resources and Services Administration (HRSA), HHS, with a grant through the Geriatrics Workforce Enhancement Program (GWEP). There are two of these grants in the State of Nevada—we have one at the UNR Sanford Center for Aging and there is also a GWEP Grant at the geriatrics group at the University of Nevada, Las Vegas (UNLV), School of Medicine. Between these two—these are five-year awards that we both received—HRSA is funding about $1.5 million in geriatrics training each year for five years in the State of Nevada. It is highly unusual that any state would receive two of these awards; in fact, the HRSA request for proposal said only one would be funded in each state, but somehow the good proposal writing out of UNLV and UNR was able to bring two of these into the State of Nevada. I encourage you to check out the good work happening at UNLV, as well as what we are doing at UNR. These programs are providing training to PCPs on how to offer what is called "age-friendly health systems," or using a framework called "the four M's" in their clinical work. The four M's stand for: (1) what matters to the patient; (2) mobility; (3) mentation, or dementia and depression; and (4) medications. As I said earlier, these are the critical things we need to be thinking about—frailty, medications, dementia—and then making sure that it is being driven by the patient, that what matters to the patient is front and center within this. We are teaching PCPs about these four M's of providing good elder care.

I want to make an interesting point, which is that HRSA used to exclusively fund, and still does, to a certain degree, support specialists in geriatrics, training geriatricians—physicians specializing in geriatrics—geriatric social workers, and geriatric pharmacists. There was a big portfolio of that. But about seven or eight years ago, the focus was shifted because of a realization that nationwide—and it is true here in Nevada, for sure—we will never be able to train enough specialists to care for the elders that are coming with the aging of the population. Therefore, the focus was shifted and these GWEP grants are intended to train PCPs to increase their basic level of competence in serving their older adults, to recognize when they need to refer people to specialists, but to use the specialists for the most highly complicated situations and to enable basic geriatrics competence among primary care teams.

That is the goal of ICECAP Nevada—it includes a certificate program for PCPs, as well as health professions. We also deliver this training through Project ECHO, or Extension for Community Healthcare Outcomes, which is a telehealth education initiative at the UNR School of Medicine. We are training rural providers; our series is focused on dementia, and we offer it twice per year. We also, through this initiative at UNR, have an innovative program called Bravo Zulu, which was developed by the Nevada DVS, one of our partners on this award. It is a training program for professional and family caregivers of veterans who are living with dementia. It is a highly innovative 12-hour training program to give care providers the skills and knowledge they need to support people living with dementia, layered with veteran culture so they understand the unique needs of veterans who may be experiencing dementia.

At the Sanford Center we also have our Nevada Geriatric Education Center, supported by ADSD. They provide trainings for rural health care professionals, a geriatric lecture series, and training to ADSD staff under various contracts. We are teaching students at UNR about gerontology for our gerontology academic program and we have the OLLI Program, or the Osher Lifelong Learning Institute, which provides adult education for elders living in the community. About 1,500 members participate in OLLI and are able to receive education courses on all kinds of different topics. That is a robust way for us to provide community education for elders for their own continued growth, learning, and development.

What do I see as the biggest gaps? Of course, we just talked about a whole host of different things—the whole continuum of services; the need for integrating community-based and clinical services to support older adults—but one of the biggest gaps I see statewide right now is a lack of clinical services for people living with dementia. We do have some resources—certainly the Cleveland Clinic in Las Vegas has a very thorough and comprehensive approach to supporting people living with dementia—but statewide and in general, I think there is a tremendous need to increase the emphasis on early detection of dementia, on accurate diagnosis of dementia, and ongoing care management, community education, and support. There are a lot of resources—there is an initiative called Dementia Friendly Nevada, which exists through a program called the Dementia, Engagement, Education, and Research (DEER) Program at the School of Public Health, UNR, and is supported by ADSD. They are building community strength for enabling people living with dementia to live well. There are certainly a variety of community supports and lots of good community services. You will hear from Charles Duarte of the Alzheimer's Association about some of these needs. I think the clinical services for dementia are what we really need to build on. Then we need to connect the enhanced clinical capacity with our already robust community supports and services and integrate all of those so that they are accessible and available from a person-centered and person-directed perspective.

One of the ways we do that is through the work of the Nevada Task Force on Alzheimer’s Disease. I serve as the chair of that Task Force. Chair Gorelow has just joined us as a representative of the Legislature on the Task Force—we are excited to have you join that work. We are currently working on developing our new state plan for Alzheimer's Disease—that will be released in January 2023. The plan will have many different programmatic and policy recommendations that I commend to you as you are looking for information about what needs to be done here in Nevada related to dementia. Again, I see that as one of our biggest gaps—needing to enhance and build up clinical services for early detection, diagnosis, and ongoing care management.

To conclude, for as much as we do at the Sanford Center and across the aging services network in Nevada, we know this is not sufficient. It does not cover everything. Aging is a complex human experience, and we need a complex but well-integrated, effective system of support to meet the needs of that human experience. I believe that to support quality of life and well-being as I described them, we need a robust, well-integrated system that brings together community supports with clinical services, and these must work in concert across these sectors to support a person-centered—or better yet, person-directed—experience in which they can access the services they need, when they need them, so they can live the life they choose, in the manner they choose, in the location they choose.

Thank you.

Chair Gorelow:

Committee members, do we have any questions? Vice Chair Spearman, please go forward with your question.

Vice Chair Spearman:

My first question is one I asked of Mr. Gold with AARP. We know the population is aging. What we do not know, or I do not know that we have addressed, is how do we make sure we are recruiting the kinds of medical services and doctors, technicians, nurses, the whole medical team. Is there anything we can do to make sure we are recruiting experts in these various areas that will already be here as our population ages?

I liked your statement that come this time tomorrow, you will be a day older. I think one of the things that we do not do well in our society is to honor aging and honor our elders. I have a theory that if you do not die young, you are going to get old; it is surprising how quickly that happens—you are 20 years old today and before you know it you are 50 years old. How can we make sure we are recruiting the kinds of experts in the medical field dealing with geriatric medicine, so we have the skill sets and the numbers of people we need here in Nevada?

What can we do now to begin to create an environment of cultural competency that respects the aging process and the wisdom that many times goes with it? Right now, the road it looks like we are going down now is, "Anybody over the age of 40, get out here, and maybe you do not matter." That is being a little facetious, but that is the direction I am going in right now.

Dr. Reed:

Those are complicated topics. I want to start with your second question, which is about what the field calls "ageism." Ageism is a form of discrimination, just like any other. In our culture, in our society, we have a penchant for embracing youth and beauty as the standard for all people, and therefore denying elders the opportunity to truly thrive as active citizens. They often have their views and perspectives diminished; they are discriminated against in a variety of different settings. As you said, there sorts of thresholds, like anyone over age 40, but as I look around the room, I see many people over age 40. I think many of you would agree with me that there is no age at which you lose your productivity; there is no age at which you lose your interest in normal, everyday activities. I think it is about educating the public as much as it is the professional workforce in the aging services and healthcare realms about the need to be person-centered, that each person is unique and different, and age is another one of those characteristics that needs to be respected from a culturally competent perspective. One thing I do argue in my discussions about ageism is that what is interesting about age is that it is the one characteristic that gets discriminated against that we all share. It also is the one characteristic in which if you do not see yourself in that form of discrimination today, then discriminating against those people is in essence discriminating against your own future self. It is a very complicated issue and one I think does need a lot of attention. While this is not what Mr. Gold was here to talk about today, I know AARP has a wonderful program called Disrupt Aging, which is a training program and a national campaign to help younger generations recognize the value of elders in our society. I think that is something that needs to be a part of any training program that we offer for folks, but also our general messaging to the public.

In terms of recruiting health care professionals to support older adults, I think it is as much about recruiting people into the health disciplines as it is into the geriatric specialties. I have embraced the philosophy that HRSA put forward, that I mentioned in my remarks, that we will not be able to train enough specialists to support the aging of the population, and what we need is all healthcare professionals to understand their role in supporting older adults and to understand what they can do in treating and caring for older persons. I think the workforce issue, as much as it is about recruitment, is about training. We need to increase our recruitment of health professionals overall. We need to get a stronger pipeline of people coming into all the healthcare disciplines. Then, we need to be sure all of those healthcare disciplines, at every level, are receiving education and training about geriatrics and aging. We cannot count on specialists to be the sole providers for one-fifth of our population.

Vice Chair Spearman:

That goes along with the next thing I was going to say. A couple of sessions ago, we had a bill that required cultural competency training for everyone in the medical profession or in medical facilities. Perhaps that is something we need to look at including in the cultural competency requirements.

You mentioned something about COVID-19 and "long haulers." I am seeing more and more people who survive COVID-19, but the long hauler vicissitudes are exacerbating some illnesses that naturally come with aging. Is there anything from a policy perspective that we need to look at with respect to health care both now and in the future? Is there something this Committee should look at with respect to bringing forward some type of BDR or legislative language that would help in that respect?

Dr. Reed:

I am not sure I have a specific legislative suggestion for you in this regard. I will say that most of the chronic diseases that older adults experience is the result of the accumulation of risk throughout their entire lives—physical activity; diet; and social determinants of health, the conditions in which they have lived their lives. These are the things that result in diabetes, hypertension, and chronic obstructive pulmonary disease, or COPD, later in life. I think that if we could use both a reactive approach, meaning we are supporting people who have those conditions through secondary prevention and health care—increasing the resources available through things like chronic care management, which is a Medicare benefit, enrolling and promoting people in getting chronic care management services or ongoing care coordination for those specific chronic diseases once they have them. From a healthcare perspective, that could be really beneficial. However, we need to not only be reactive, we need to be proactive, moving upstream, putting more investment into health education and community-based wellness programs. I recognize this is a lifelong accumulation of risk, but really, I am thinking about people in their 40s, 50s, and 60s who need the knowledge, the skills, and the tools to engage in physical activity, better diets, healthier foods, and other things to help reduce the development of those conditions. I think that could be really beneficial.

Vice Chair Spearman:

We talked a lot about aging in general; there is a part of the whole discussion that is left out either by design or default. The question is—what does that look like for BIPOC communities and specifically for LGBTQ? When you look at loneliness and isolation, members of the LGBTQ community are three times more likely to complete suicide than their heteronormative counterparts. When you look at quality-of-life issues, you still talk about the same ratio—three to four times more likely not to have those sorts of things. Assemblywoman Benitez-Thompson had a bill in 2015 or 2017 that required some additional training and continuing education units with respect to recognizing suicide ideation, but it was across the population. What we have seen in COVID-19 is that isolation has exacerbated those statistics, so people who are isolated now—whether they are in the general population or the LGBTQ population—are four times more likely to have suicide ideations and three times as likely to have a plan and then carry out that plan to complete the suicide ideation. What is it that we need to know and be looking at as policymakers? Can any of this be addressed when we start talking about curriculum at the schools of medicine here in Nevada, both public and private?

Dr. Reed:

I want to start my response where you started, which is the BIPOC communities and aging services. In my career working with aging services professionals, both in health care as well as in the community supports, I have never come across a person who does not embrace and recognize the need for promoting diversity and inclusion among the people we are serving and to ensure that all the programs we are developing are accessible to all, irrespective of race, sexual orientation, et cetera. Economic diversity is one of the greatest aspects of diversity that we deal with in aging services. There is a goal within aging services programs of serving the broader community and doing so in a way that is reflective of the demographics of society. One of the challenges we have is not our intention or our good hopes for doing so, but really building the necessary long-term, trusting relationships with communities of color and other diverse communities such that they see the programs that we are offering as appropriate and beneficial to them. I think that can only come through fostering more discussion, more robust engagement, and really thinking together about what is going to best meet the needs of communities.

From the Task Force on Alzheimer's Disease side, our Vice Chair is Tina Dortch, who is with the Office of Minority Health and Equity, DHHS, and she has led the development of our recommendations related to cultural competence and ensuring that Alzheimer's Disease and dementia-related supports and services are appropriate for a variety of different diverse communities. We have a very particular emphasis on that. I think it is something that needs to go deeper than just a recommendation in a state plan. It is about the relationships at the community level that need to be fostered to help communities understand the relevance of the programs available to them and to help the professionals operating those programs understand how to best engage with communities that are traditionally underserved.

If I could get a little further into your next elements, as you pointed out, that knowledge needs to be disseminated within the curricula of all the health professions. We have a very strong Office of Diversity and Inclusion at the UNR School of Medicine which is led by Dr. Nicole Jacobs. She develops all manner of diversity initiatives for engaging our students to help them recognize the need for learning about how to serve diverse communities and for our faculty and faculty development programs to help us build our capacity to extend that knowledge out into the community, both through clinical services and through relationships with a whole host of different partners.

I think there is a high level of commitment to support these things. It is a journey of learning that is still under way, in terms of how we do that most effectively, but it is something that is infused both in the curricula as well as the professional work of both current and future professionals in healthcare.

Chair Gorelow:

Thank you, Vice Chair. Those were some really great questions. Does anybody else on the Committee have questions?

Dr. Reed, thank you for your presentation; it was very thought provoking.

AGENDA ITEM X—PRESENTATION ON ALZHEIMER PATIENTS AND SERVICES IN NEVADA

Chair Gorelow:

For our next agenda item, we have Mr. Charles Duarte, Nevada Director of Public Policy and Advocacy for the Alzheimer's Association to present on the current status of Alzheimer’s patients and services in Nevada. We would also like to welcome Ms. Cathy Maupin, a caregiver and volunteer for the Alzheimer's Association. We will take questions at the conclusion of the presentation. You may begin when you are ready.

Charles Duarte, Nevada Director of Public Policy and Advocacy, Alzheimer's Association:

I will do my best to be brief and provide information that is helpful to the Committee. You have already heard a lot of good testimony today.

A lot of us come to our work at the Alzheimer's Association because of connections we have through family and friends. For me, it was my father, who passed away in 2003 from Alzheimer's, and currently, a very good friend of mine, who is my age, is living with younger onset dementia. My guest, Cathy Maupin, has a similar journey that she wants to share with you folks. Cathy is an advocate, educator, support group facilitator, and a volunteer extraordinaire for the Alzheimer's Association. She also advocates on federal policy for us with members of Congress. We are very grateful to have Cathy here to tell you about her story. At the conclusion of her comments, I will start the formal part of my presentation.

Cathy Maupin, Volunteer and Support Group Facilitator, Alzheimer’s Association:

I am here today to provide insight into the role of a caregiver and the experiences I have had in dealing with this disease. What is it like to be a caregiver? I am going to give you an analogy. As a parent, I rejoiced in all the achievements of my children: learning to walk; talk; dress themselves; eat; brush their teeth; use the bathroom; and to read and write. Caring for someone with Alzheimer's is the exact opposite. Even though I was her daughter, I became the parent to my mother. I despaired as I watched my mother lose her ability to walk, to talk, to dress herself, and to brush her teeth. She became incontinent. She forgot how to read and write, and she depended upon me to help her with all the ADLs. I dressed her; I fed her pureed foods with a spoon because it was hard for her to swallow. I pushed her around in a wheelchair. My children reached out their arms to hug and to love me; my mom had no idea who I was, and she shunned my hugs. I delighted in my children gaining their independence; I cried as my mother lost hers. Nancy Reagan called this disease the “long goodbye,” but I call it “death by inches” because I watched and grieved as my mother lost little bits and pieces of herself every week, every month, every year, for 22 years, until she simply existed—silent, unmoving, completely helpless, existing in her own world, totally dependent upon me and caregivers for everything. She could not even open her eyes.

Alzheimer's is a cruel disease for the person who has it, but it is a cruel disease for the caregiver. For caregivers it is physically demanding, emotionally devastating, and financially disastrous. I see evidence at every support group meeting the toll this disease takes on my caregivers. Many of my members are seeing a counselor to address their emotional health issues. They feel hopeless, guilty, depressed, isolated; and some have even been suicidal. Some attend Alcoholics Anonymous meetings because they use alcohol to deaden their fears or to seek sleep or an escape from the daily demands of caregiving. Some have substance abuse issues and have gone into rehab. Physically, some of my members have suffered from heart and vascular problems due to stress and lack of sleep. Some have hip, knee, and back issues from lifting wheelchairs and their loved ones. Imagine what it is like to have a hip or knee surgery and be caring for someone you love. Almost all experience exhaustion as they care for a loved one 24 hours per day, 7 days per week. Many of the caregivers in my support group are caring for a loved one alone with no family to provide support or respite for them, or they are at odds with family members who do not understand this disease, offer no help, and challenge everything the caregiver does. Rather than pull families together, Alzheimer's often rips families apart, which then further adds to the caregiver's isolation and the emotional and physical stress of caregiving. Many of the caregivers in my group have had to quit their jobs due to the demands of caregiving, which leaves them in trouble financially. Many are losing the most financially productive years in their careers; retirement savings are then also decreased. Some take care of their loved one during the day and work from home at night, often getting only three hours of sleep—sometimes none. Paying for in-home health, daycare, or respite care further strains already tight budgets.

I am here to say that caregivers need help. They need an accurate and timely diagnosis of loved ones so that medical, legal, and financial plans can be put in place. In 22 years, I was never once told that my mother had Alzheimer's and vascular dementia. I saw her diagnosis in medical records when they were lying open on a counter while a doctor took a phone call. We could have planned so much better if I had known what her diagnosis was. Medical personnel need education about this disease, especially how to manage hospitalized Alzheimer's patients. I had a support group member recently be asked to stay 24 hours per day to take care of her father while he was hospitalized for pneumonia. They said they were short-staffed, and they could not handle his getting out of bed and ripping out his IVs and oxygen. She could not possibly stay for 4 or 5 days, 24 hours per day. Respite care, mental health services, substance abuse services, affordable legal services, and other resources geared toward caregivers would be helpful in keeping caregivers healthy and engaged in caregiving. I am hopeful that during this coming session of the Legislature we can find ways to provide the help and support our caregivers need.

I am so grateful for the time that you have given me today to listen to my story. Should you have any questions, I would be happy to answer them for you when you are ready.

Mr. Duarte:

Thank you, Cathy. It is a pleasure to be here today to hear your story and be able to talk about some of the needs the people we advocate for have right now, including their families and caregivers (Agenda Item X A-1) (Agenda Item X A-2) (Agenda Item X A-3) (Agenda Item X A-4) (Agenda Item X A-5).

I want to thank Chair Gorelow and Vice Chair Spearman for the work they did last session on forwarding AB 216 (2021), which Mr. Gold mentioned in his presentation, to help individuals who are not Medicare-age get access to cognitive assessments and care planning. It has yet to be implemented by DHCFP, but we look forward to its implementation and hopefully can help in getting that information out to the physician community, which could use those services to help with their senior patients.

Before I go any further, I want to mention that at the end of my presentation, I will address, or hopefully make some suggestions, related to Senator Spearman's questions about geriatric workforce training and outreach and education to communities of color and the LGBTQ communities.

I think it is important to define terms; we must understand the difference between *Alzheimer's disease* and *dementia. Dementia* is an umbrella term for symptoms such as a decline in memory, reasoning, or thinking. Dementia is not normal aging. *Alzheimer's disease* is a specific type of dementia and accounts for about 60 to 80 percent of all dementia cases. You can also see dementia-like behaviors in other diseases—some of which are treatable—like depression, stroke, thyroid disease, even urinary tract infections. That is why it is so important that when you experience problems with cognition, thinking, reasoning, memory, or your loved one has problems like that, to see a doctor and get a diagnosis, because some of these things can be treated. For the Alzheimer's Association, the emphasis on an early and accurate diagnosis is important for other reasons; in particular, to allow somebody who may have dementia or Alzheimer's disease the opportunity to be a full participant in their care planning in the early stages of the disease. So, we advocate for an expansion of access to early diagnosis.

The Alzheimer's Association puts out a report every year called *Alzheimer's Disease Facts and Figures*. Most recently, it was reported that an estimated 6 million Americans are living with Alzheimer's disease, and those numbers are rapidly increasing. It is estimated that by 2050, those numbers are expected to reach almost 13 million individuals. The other thing that is important for people living with dementia or Alzheimer's disease is the importance of caregivers—in particular, family caregivers and friends. The Alzheimer's Association estimates that there are over 11 million Americans who are providing unpaid care to individuals living with dementia. It is estimated that they provide more than 15 billion hours of unpaid care; if you were to try and put a value on it, it would reach nearly one-quarter of a trillion dollars per year. That is incredible amount of support that the health system and organizations are getting from unpaid caregivers. This is why we support caregiving and caregivers through the Association's work.

Getting a dementia diagnosis, as some have already mentioned, is not an easy task. Individuals who would otherwise have a diagnosis of or meet the criteria for Alzheimer's disease or other dementias are not diagnosed by a physician. That is related to a variety of different reasons and has been studied. Some of that includes a lack of access to care, fear, or even thinking that it is part of normal aging, which it is not. The other important aspect here, and Cathy spoke to this earlier, is that research shows that half of Medicare beneficiaries with a diagnosis of Alzheimer's disease or another dementia in their charts are not even told they have dementia; so quite often they are never told, nor is a caregiver ever told, that this person has dementia. Having an early and accurate diagnosis provided to the patient and the caregiver is extremely important and one of the reasons we advocate for it.

We were a little disappointed in the *Elders Count Nevada: 2021 Report* because there was zero mention of Alzheimer's disease or dementia in that Report. It is such an important part of aging and more prevalent as our senior population, particular in Nevada, ages. Mr. Duncan mentioned they are going to add it to the 2023 report, and we are grateful for that addition. It is important to know that for other diseases like heart disease, for example, we have seen deaths decrease in the last 20 years, but there has been an increase of almost 145 percent in deaths from Alzheimer's disease. Likewise, we have seen deaths from different types of cancers decrease while deaths from Alzheimer's disease increase. That is probably an underestimate because, again, it is often difficult to get a diagnosis, and if you do, you may not even know or be told that you have the disease.

In fact, one in three seniors dies with Alzheimer's or another dementia. I specifically use the words dies "with" Alzheimer's disease because if you talk to a physician or clinician, or even the family members who have gone through that journey with a loved one, oftentimes somebody who has Alzheimer’s disease does not die from the disease itself—it causes other problems. Very frequently it is things like aspiration pneumonia or failure to thrive—because the person cannot eat or drink anymore—that really is the direct cause of death, but it is the Alzheimer's disease or dementia that leads to that conclusion.

Senator Spearman has asked these questions repeatedly today, and I want to make sure that we put this out there. Last year, the Alzheimer's Association, as part of its 2021 facts and figures report, put out a special report and specifically called out discrimination in care. One of the things put out in this report is the unequal burden of Alzheimer's disease amongst different communities or populations. We know Blacks are about two to two and one-half times more likely than Whites to have Alzheimer's disease or another dementia. Hispanics are one and one-half to two times more likely than Whites, and yet these same groups believe it is harder to get good care for themselves. It should be noted that because of the disproportionate burden of Alzheimer's disease on communities of color, caregivers in those communities are also disproportionately affected.

As part of the 2021 facts and figures report on discrimination and care, surveys were done by the Association of different groups. What they found striking was that 50 percent of Black Americans, 42 percent of Native Americans, 34 percent of Asian Americans, and 33 percent of Hispanic Americans believe discrimination is a barrier to good care for dementia or Alzheimer's disease. The fact that they are not seeking care or getting a diagnosis may in part be due to this belief that they are being discriminated against, and it is a strong belief that is often borne out by research.

The cost burden of Alzheimer's disease is extremely high for the United States. It is considered the most expensive disease. In 2021, the United States spent a combined $355 billion on Alzheimer's disease, a lot of that in the long-term care arena. By 2050, that number is expected to increase to more than $1 trillion a year. In addition—and Cathy mentioned this as well—we often hear from caregivers that because of the burden of care, they have to quit their jobs or take part-time jobs. Having to be a caregiver over an extended period—often in middle of life—can result in financial devastation. A huge out-of-pocket expense is borne by families and individuals with the disease to pay for care. Out of the $355 billion of annual Alzheimer's care that I mentioned, 21 percent of that is borne by individuals and families through out-of-pocket expenses—things that Medicare and health insurance will not cover. It has a huge disproportionate burden as well on communities of color when they have to deal with out-of-pocket expenses.

Next, I am going to talk about some specific Nevada facts and figures. The greying of Nevada is an issue that we are going to be talking about today and one that we are going to continue to contend with. Every year, as part of the facts and figures report, the Alzheimer's Association puts out state specific information. This information comes from the 2021 facts and figures report; I will mention some updated information from the 2022 report, which was issued on March 15.

Nevada has the third fastest rate of growth of individuals with dementia in the United States, just behind Vermont and Arizona, which are, respectively, number two and number one in the nation. We are expected to see a 31 percent increase in the growth of individuals living with dementia or Alzheimer's disease by 2025. Not 2050—2025. Right now, it is estimated that the number of individuals 65 years of age and older with Alzheimer's is around 49,000 Nevadans. That number will increase to 64,000. A special study was also done of individuals with dementia in nursing homes, and the excess number of deaths that occurred with individuals who had a diagnosis of Alzheimer's disease or another dementia who were in nursing facilities in Nevada. There were 678 basically COVID-19 related nursing home deaths for individuals with Alzheimer's disease in nursing facilities. I have mentioned this before—in Nevada, there has been a 248 percent increase in Alzheimer's-related deaths since 2000; in the last 21 years, there has been a 248 percent increase in Alzheimer's deaths in the State of Nevada.

In terms of the cost burden on Nevada, again, Alzheimer's is extremely expensive. For Medicare in Nevada the average annual cost of care is $36,000. Medicaid pays over $203 million for individuals with Alzheimer's disease, and most of this is in the long-term care and support aspects of their program. Patients with Alzheimer's also are expensive users of hospital services, often visiting the emergency room. The cost burden on our state health system as well as the federal health system—Medicare—is tremendous.

I mentioned caregivers being an important part of the advocacy work we do at the Alzheimer's Association. There are an estimated 48,000 Nevadans who are providing unpaid care to individuals living with dementia. The Association estimates they are providing an equivalent of 78 million hours per year of unpaid care, which is valued at $1.3 billion. We also know from surveys of caregivers in Nevada that 80 percent of them have a chronic medical condition; 18 percent of them have depression. Nevada is the tenth highest state in the nation in terms of number of hours of unpaid caregiving provided to people living with dementia.

I mentioned there was some more recent data released in the 2022 facts and figures report. I could not incorporate them into the slides of the presentation before the report was released, but I will now give an update on some of these facts and figures for Nevada. I mentioned that 80 percent of Nevada caregivers have one or more chronic conditions. In terms of the need of geriatricians—specially trained physicians in geriatrics—we are anticipating that by 2050 we will need to see an increase of about 267 percent in the number of geriatricians serving Nevadans who may have dementia. In the 2022 report there is also a reference to a study done on neurology deserts. I believe Dr. Reed mentioned that geriatricians and neurologists are really the individual specialists involved in differential diagnosing of different types of dementias and are critical to that type of diagnostic work. Nevada is considered 1 of 20 states that are neurology deserts, so it is going to become more and more important for us to train physicians—particularly family physicians and other PCPs, including nurse practitioners and physician assistants—to be more competent in the care of their aging patients.

Every other year, DHHS conducts a survey on what is called subjective cognitive decline. Basically, that means self-reported memory problems that have been getting worse over the past year. This is part of a very broad survey called the behavioral risk factor surveillance system, and one of the areas they look at is cognitive decline for individuals 45 years of age or older. Of those individuals, one in seven report subjective cognitive decline, a problem with memory or reasoning that is getting worse; 82 percent of these people who report subjective cognitive decline also have a chronic medical condition. It is also interesting, and also somewhat disturbing, that less than half of those people who experience and report subjective cognitive decline actually talked to anybody, including a family member, about their concerns, and 50 percent do not talk to a health care provider about it. This leads to a gross underdiagnosing of Alzheimer's disease and dementia, or late diagnostic work, which occurs in individuals in middle stages of the disease, where it is much more obvious and at a point where they really cannot be fully involved in their own care planning and financial affairs.

Next, I am going to talk about some of the work I do here in Nevada and our state policy priorities. I will say right up front that some of these things are not cheap, but given that the aging of our state and the aging population that we need to try to serve, I think it is important that we hear some of these ideas and find ways for us to make them more affordable because we know Nevada Medicaid spends over $200 million per year on long-term care, nursing home care making up the biggest part of that spend. Looking at ways to invest in programs and services upstream from downstream events like nursing home care is extremely important, and a relatively small investment for the future needs of Nevadans.

The Association has four public policy platforms. These are a consistent set of state policy priorities that we implement across chapters and across states. They include: (1) increasing public awareness for the importance of an early diagnosis; (2) building a dementia-capable workforce; (3) increasing HCBS; and (4) enhancing the quality of care in a residential setting. As public policy folks at the state level, we try to translate this into actions that can be taken by either legislative or appropriation actions that can be taken by state legislatures or by the governor in the development of their budget work.

I am going to talk about three policy priorities. I can say up front that we are grateful that the Cleveland Clinic Lou Ruvo Center for Brain Health and AARP Nevada support these three initiatives. I will talk in more detail about each of these, and they are not in any order of importance. Number one is better access to early and accurate diagnosis. I will talk about a proposal for establishing a Nevada Memory Network. Number two, better Medicaid supports for family caregivers. I will talk about different programs across the nation which can serve as models for modifying our existing home- and community-based waiver for the frail elderly. Third, helping individuals and families who are dealing with a dementia crisis. We will talk about the experience of other states and programs that have been borne out to be very successful in other states.

My first proposal is the Nevada Memory Network. I have been privileged to work with Dr. Reed and the Sanford Center for Aging, as well as the Renown Neurology Department, and have had initial talks with the Cleveland Clinic Lou Ruvo Center about establishing a more robust network of memory clinics. These are memory assessment clinics, or MACs, which would serve multiple purposes. This is based off proven work that has been done at Emory University; the University of California, San Francisco (UCSF); and the University of Wisconsin. I can also say that we have good “bones” in Nevada; as Dr. Reed mentioned, we have very good schools of medicine that include GWEP Grants. We have partners like the Lou Ruvo Center for Brain Health; the UNLV Department of Brain Health, which is doing excellent research; and the Sanford Center for Aging. So, we have good bones to build on, and that is what we want to propose here.

We are having very serious conversations right now between the Sanford Center for Aging and the Renown Neurology Department about establishing this. Las Vegas is fortunate to have the Lou Ruvo Center, which provides these memory assessment services. We need to develop a more complete capability in northern and rural Nevada—through this initiative we hope to do that. We know PCPs will form the basis of any network for doing cognitive assessments. One of the things that we know is essential, as Dr. Reed talked about, is primary care education, using experts at the MACs—which would include neurologists, neuropsychologists, and other clinicians—to really help primary care practices effectively screen patients so that when they make a referral to a MAC, it is a quality referral with good information backing up that service. It is a two-way street between the MAC and the PCP. It is extremely important that the patient and caregiver are included in any kind of cognitive assessment work. When the patient and the caregiver go to the MAC, they are both assessed in terms of their capabilities and needs, and then a full comprehensive diagnostic workup is done by the MAC. When that is done, the caregiver and the patient are given that information and then that care plan is handed off back to the PCP to take care of that patient in the community where they live. The PCP can provide ongoing medical support with help from the neurologists or neuropsychologists at the MAC.

The work at Emory University and UCSF has also shown that care navigators are very important. Care navigators are basically social workers who really support people with a diagnosis, as well as their caregivers, in the community to make sure they are getting the social services and supports they need and monitoring the care and well-being of the caregivers themselves, not just the patients. We have heard how often caregivers suffer because of the burden of care they are providing. This cycle of care is extremely important. As I said, we are looking at developing a model based off good work that has been done in other states.

The other program I want to mention is the family caregiver waiver. We heard good presentations this morning from DHHS staff, particularly those in ADSD, about the work they are doing keeping people out of nursing homes and providing in-home supports for individuals, including those who are on the Nevada Medicaid HCBW for the frail elderly. This program augments the work going on in that frail elderly waiver and provides a way of assessing caregiver needs particularly. This is being done in other states. The National Academy for State Health Policy, or NASHP, which puts out a report on excellent programs across the nation, has researched this, and Georgia stands out as one of those areas where they are doing excellent work. They are keeping in touch with the caregiver—the state social worker or case manager stays in close contact through a case management system with the caregiver, who puts in notes about what the patient or beneficiary needs in terms of ongoing care, but also what the caregiver needs. The state social worker or case manager puts together a training program—not just a service program, but a training program—for the caregiver to help the caregiver do the job he or she needs to do that is person-centered for not only the patient receiving the services but also for the caregiver. This structured process of training and caregiver support is what states are doing to more effectively take care of individuals and keep them in their home. They are also making it easier to pay family caregivers to do this work. In Nevada, we do that same thing. It is not as easy as in other states to get paid as a family caregiver, and sometimes it is not allowed to have a spouse or guardian provide that care, but in some states that are doing a good job of this they are allowing spouses and guardians to serve as paid caregivers. We would look to ADSD to basically augment the waiver that is already in place; hopefully this would not be extremely expensive to do. It would provide the supports and training people need to be more effective caregivers.

The final proposal I want to talk about is called a dementia care specialist program. I have an opportunity to sit in on a coalition of care providers; social workers; and mobile outreach safety team members, which include law enforcement officers; on a monthly call chaired by

Jessica Flood Abrass. Jessica is one of our rural behavioral health coordinators; she does an excellent job of coordinating these calls. We have heard from county social workers and law enforcement about increasing incidences of dementia-related crises they get involved with. These are individuals displaying behaviors that are putting them at risk or putting others at risk. As with mental health crises, this often results in somebody with a potential dementia diagnosis getting handcuffed, thrown in the back of a patrol car, and taken to a hospital emergency room where they may not be able to make a diagnosis. The person may be provided some psychiatric medication management—which is inappropriate—or end up in a mental health hospital ward. All of these are inappropriate interventions. Law enforcement and county social workers recognize this, but they do not have somebody in the field helping them with these crisis situations, who can serve as a resource for ongoing support. We looked to the State of Wisconsin, which developed this. Back in 2016, the Legislature heard about these kinds of crises from law enforcement and social work staff and funded six positions, which were called dementia care specialists. These were master's level-trained people who served as a frontline on dementia crises interventions and postcrisis stabilization work. They were also involved in training communities to be more dementia-friendly and dementia-capable, including some of these community organizations like mobile outreach safety teams. These have been so effective that the Wisconsin Legislature, in its 2020 Session, approved 64 dementia crisis specialist positions—one specialist per county. They felt it was such an important aspect of the work needed for people experiencing these types of crises—whether it is in the home, in the community, or even a nursing home—that they funded a position in each county.

The states of Georgia and Maryland are looking at this program, as we are. The Alzheimer's Association in Nevada is working very closely with the UNR DEER Program and ADSD. We are working with and talking with law enforcement and county social workers about moving a similar program forward—certainly not as ambitious as 64 positions, but we want to start someplace. We are looking at grant funding with the help of ADSD, but that grant support would need to be continued with appropriations and ongoing financial support from the Legislature. Again, this is based off a proven model out of Wisconsin that other states are looking to emulate because of the growing incidences of dementia crises that are occurring across their states and—we are hearing—across Nevada.

The work we do at the Association is not only state level work—we do federal work. Cathy is one of our ambassadors, which means she works closely with one of our members of Congress, U.S. Representative Mark Amodei (R-Nevada), who has been very supportive of the Association's policy positions and funding. One of the things we have worked hard on is looking at increasing research funding at the federal level and at the National Institutes of Health (NIH), HHS, around Alzheimer's disease and dementia. This year we are happy to report that an additional $289 billion was added, which brought the total amount of research dollars at NIH to about $3.4 billion for Alzheimer's research. We helped get established the Building Our Largest Dementia Infrastructure for Alzheimer's, or BOLD, Act (Pub. L. 115-406, 132 Stat. 5362 [2018]), which looks at developing an infrastructure for all Alzheimer's care. Nevada is a recipient of a BOLD Act grant from the CDC, and each year we ask Congress to fully fund that. I am proud to say the Association and its advocates have been able to continually fund this federal program.

One of the things Senator Spearman mentioned was the disproportionate impact that these kinds of diseases have on communities of color. That has been noted in research as well. A lot of clinical trials do not have the necessary communities of color as a significant part of their clinical trial programs. The Alzheimer's Association is working with Congress to pass the Equity in Neuroscience and Alzheimer's Clinical Trials Act, or ENACT Act (S. 1548 [117th Congress]; H.R. 3085 [117th Congress]), which will look at enhancing clinical trial staff training and reducing burden on communities of color in particular. We want to expand outreach to underrepresented populations to be part of clinical trial programs.

We are trying to get legislation passed to improve Medicare services to people living with Alzheimer's disease and their families. We know what people need in terms of services when they have a diagnosis of Alzheimer's disease or one of their family members has that diagnosis. These services are:

- Doctor visits;
- Cognitive assessments;
- Care planning;
- Adult day services;
- Home health services;
- Medications;
- Ongoing caregiver assessments;
- 24/7 access to provider;
- Skilled therapy;
- Community-based resources; and
- Coordinated care.

We want to be able to offer these services as a complete package through the Medicare program because right now, Medicare does not pay for:

- Adult day services;
- Ongoing caregiver assessments;
- 24/7 access to provider;
- Community-based resources; or
- Coordinated care.

We are looking at a comprehensive approach to Alzheimer's care that covers all these services. That is the legislative work we are doing at the national level.

I am going to talk very briefly about the Alzheimer's Association and the work we do. Our mission is a world without Alzheimer's disease and all other dementia. Probably the most important asset we offer is our helpline, which is free of charge and available 24 hours per day, 7 days per week at 1-800-272-3900. Anybody can call, including caregivers and individuals who might be experiencing early stages of the disease with concerns. You can actually talk to a trained clinician and often a licensed clinical social worker; it is available in multiple languages. We offer in-person as well as online training sessions. As you heard, Cathy is a support group facilitator; she is also an educator and provided some of these sessions in-person when we were we were doing in-person training. That is another important aspect of the work that we do. It is all free. We also offer the TrialMatch Program—it is an easy-to-use clinical study matching service for people living with dementia but also for healthy volunteers without dementia. We host the Alzheimer’s Association International Conference, the world's largest and probably most influential science meeting dedicated to advancing dementia science. I believe last year there were almost 50,000 virtual attendees to that conference. You are probably familiar with our walk. I want to thank Chair Gorelow for being involved in our walk. Our walk is one of our major fundraising events. It is usually held in October in Las Vegas. We are the largest Alzheimer's advocacy organization in the world. We are very proud of the work we do.

I want to address some of the questions Senator Spearman asked earlier.

With regard to our work at the Alzheimer's Association, we have been partnering with ADSD and DPBH on an aggressive outreach campaign. We have grant funding from DPBH to provide information, particularly to communities of color and LGBTQ communities, through a digital media campaign. We brought the media assets to Nevada that the Alzheimer's Association developed and tested in several other states; it was free to the state. The grant funding was used for a digital media campaign. This all happened at the time of COVID-19; in-person meetings were completely done away with, so we put a very aggressive media campaign together in 2021. We had about two million ads placed. We were focused on media outlets that serve diverse communities—communities of color as well as the LGBTQ communities. We had over 14,000 individuals click on those ads to get more information. We are very proud of the work we have done, and we are continuing that outreach work right now in partnership with DPBH.

Senator Spearman asked what can be done to better educate our clinical workforce to be more dementia competent or capable. One of the things the Nevada Legislature did in 2003 was consider a bill that would change the relicensing requirements for physicians to require a certain number of hours of geriatric training. That was winnowed down, and basically the bill encouraged the Board of Medical Examiners to provide that type of training. The Board created an incentive program so somebody who had one hour of geriatrics training would get two hours of continuing medical education credits, up to four hours. I do not know how successful that has been, I have not asked the Board for any utilization information on that but putting in some sort of stricter requirement around geriatrics training for relicensing—not just of physicians, but nurse practitioners, physician assistants, and others—may be something to consider down the road. While incentives work for some, they do not work for everybody and may not completely fill the need. We have not pursued that at the Association, but I looked into some of the relicensing rules here in Nevada.

I am happy to answer any questions.

Chair Gorelow:

Thank you for that input. Ms. Maupin, thank you for sharing your story. Going back to other dementia diagnosis, I have a question for clarification. I know the autism population can only be diagnosed by certain physicians. A primary or pediatrician may suspect autism but cannot officially diagnose. Can PCPs make an official diagnosis of dementia?

Mr. Duarte:

Primary care physicians can make a diagnosis; often they do not because a comprehensive differential diagnosis requires quite a bit more than what a PCP can provide in his or her clinical practice. In recent discussions with Dr. Dylan Wint, one of the medical directors at the Lou Ruvo Center for Brain Health, as well as Dr. Jon Artz, a neurologist at Renown, I have been learning about how difficult and challenging it can be to give a diagnosis. Not only is a neurologist involved in making that differential diagnosis, but a comprehensive battery of psychological tests is given to the individual by a neuropsychologist to rule out other types of disease or make a differential diagnosis to separate the different types of dementia. Obviously the most common is Alzheimer's disease, but there are other types, such as vascular dementia, and different types of disease. So, while any physician can, they often do not because they cannot make that differential diagnosis without referring to a trained geriatrician or neurologist and sometimes the involvement of a neuropsychologist.

Chair Gorelow:

Do you think that might be part of the reason why patients and caregivers are not given a diagnosis or even a suspicion of a diagnosis? I am bothered that while many families know something is going on with their loved one, they are not getting that diagnosis, so therefore they are not making that plan of care later on. I know with my dad, when he was going through some dementia issues, he could tell you the date, he could tell you the president, but he could not tell you my name or that he even had grandchildren. He was never diagnosed, and I suspect that may have been part of the struggles that my mom was going through.

Mr. Duarte:

I do not know all the specific reasons—I think there are a lot of different reasons. There is some research around why people do not get a diagnosis. Some of its fear—Alzheimer's disease and most dementias are progressive, fatal conditions. There is no effective treatment right now to reverse or stop the progression of the disease entirely. There are some new drugs coming out that have an impact on the early stages of the disease. I think some of it is fear, some of it is access. Some of it, like I mentioned earlier, is belief that, particularly communities of color, cannot get proper care for dementia.

I will use the experience of my own physician; she is a family physician who had a fellowship in geriatrics. The way she explained it to me was that she tells people she thinks their loved one may have a form of dementia or Alzheimer’s disease and they do simple types of testing to do that screening, but they end up referring the patient in for differential diagnosis. The PCP can rule out some of these other treatable conditions—things like urinary tract infection, thyroid condition, hypertension, or depression—or rule them in and not provide a specific diagnosis of what type of dementia but say this person may have dementia and then refer them to a specialist for that comprehensive workup.

Chair Gorelow:

Thank you, that helps. Any other questions from Committee members? Vice Chair Spearman.

Vice Chair Spearman:

That was a very thorough presentation. Some questions come to mind. First, there are some ways that we might be able to do some capacity building, but I am not sure we have thoroughly explored them. Another thought that comes to mind is, sometimes if we, as the Legislature, do not strongly encourage people to do so, some of the things that might be put in place right now, which would help us down the road, may not get done. What do we need to look at in terms of public policy? Since we have the Office of Federal Assistance, Office of the Governor, looking at all the grants and other options for getting money into the state to address certain needs, is there any way we might be able to work with that Office to look at capacity building with places like Nathan Adelson Hospice? That seems a little extreme, but I know with certain diagnoses, you can get more than a few weeks or a couple of months of assistance with a loved one who is at home. Another thing would be to work with some of the organizations such as Silver State Equality, The Center in Las Vegas, and with the Gathering Place. I know of four or five different agencies or organizations that are working with the LGBTQ community and others—communities of color, specifically—to try to lessen the impact of things like dementia and Alzheimer's. So, capacity building—what can we do related to that? Is there any way to begin to bring some of the organizations together that are already in communities of color so we might be able to get a better handle on this? What public education needs to take place?

Finally, how do we bring all of this together and keep it at the forefront of policymakers' minds, so that it is not just the flavor of the month when we start talking about geriatric care, when we start talking about the BIPOC community? As Nevada's population greys, our population is also becoming more diverse. To our own detriment, we have not done the things necessary to put a foundation in place so we can properly care for the communities I have talked about. We do so not just to our detriment in terms of quality of health care, but, if you stop and think about it, these are things we ought to be doing now so the cost of health care is not exacerbated by our negligence now. That is what I have been trying to get at each time I have asked those questions today. If we do not do things right now, there is a lost opportunity cost that we will face in the future that can be avoided if we pay attention to the facts that we are greying and we are becoming more diverse. It might not be something that we thought about in the 1950s, but by God we need to be thinking about it right now, because people are here now and these populations are increasing, and if it were not for the grace of God, there go I. That is how I look at it.

Mr. Duarte:

There were a lot of aspects to those questions, and I will try to touch on each of them. Regarding policy, one of the things we are working at the Association with our efforts locally is to look at the training of individuals who are providing care at different levels, including personal attendant care in homes, in group care facilities, or nursing homes. Equally important is training for clinicians who might be working in emergency departments and encounter individuals who may be experiencing a dementia crisis or dementia-related delirium and do not know how to treat them or do not know what assets are out there for the safe discharge of these people.

From a policy perspective, it is important to work on training and, if necessary, making it a requirement for different health professions to include geriatrics training and specifically dementia training. Creating incentives is great, and we should include those, but sometimes you must require it. The Association is not afraid of that; if you need advocates to help with that effort, we are happy to oblige.

Regarding capacity building, with the relaxing of some of the pandemic restrictions, I look forward to meeting with people who are active in this field and who really want to reach communities of color. I would be happy to meet with folks wherever they are in Las Vegas or northern, or rural Nevada. I am a Native Hawaiian, I know there are a lot of native blood Hawaiians like myself living in Las Vegas, and we are part of that Asian Pacific Island community that is disproportionately impacted by dementia. I am happy to meet with folks in the community to talk about that from my perspective as a Brown person.

In terms of meeting with LGBTQ communities, you have a tremendous resource at UNLV. The UNLV Brain Health Department does excellent research around Alzheimer's education and dementia care. There is also a specific faculty member at the UNLV School of Public Health named Dr. Jason Flatt who has done extensive research and work in the field of aging amongst LGBTQ communities and individuals. They often are affected by different aspects of caregiving and are often isolated in their role as a caregiver or somebody living with dementia. Dr. Flatt is another excellent resource you may want to call on to talk more specifically about research-informed work around reaching and helping LGBTQ individuals living with dementia or their caregivers.

To bring it all together, Dr. Reed talked about his work as chair of the Task Force on Alzheimer's Disease, and I think the plan he talked about, and the revisions of that plan, are extremely important. Too often, we develop plans as commissions or task forces that just sit there, and they do not inform policy or funding. My role as a member of the Task Force—I work with Dr. Reed and Tina Dortch, who is the vice chair of the Task Force and works at the Office of Minority Health—is to take those recommendations and make them happen through agency budgets, agency policies involved with regulation, and proposals for legislation. Using that state plan to inform policy and funding is extremely important. Again, it could just sit there, or it could be used as an asset and a resource to a committee like this one or to inform decisions by DHHS.

Like I said, the *Elders Count Nevada: 2021 Report* did not contain the word dementia or Alzheimer's disease. I raised that concern during a Commission on Aging meeting; I chair the Legislative Subcommittee of that Commission. We were shocked that it had no mention of it. I am glad DHHS was open to adding it to the 2023 report. That is the type of attention and work that needs to happen. I think the Task Force and the Commission can help inform policy and help you move policy forward, as well as funding for programs that are important.

Chair Gorelow:

Anyone else with a question or comment? Seeing none, thank you again for your presentation.

AGENDA ITEM XI—DISCUSSION OF POSSIBLE TOPICS FOR FUTURE MEETINGS AND MEETING DATES

Chair Gorelow:

Before we close out with our public comment, I want to take a moment to allow the members to provide suggestions for possible future meeting topics. Vice Chair Spearman.

Vice Chair Spearman:

We have touched again on some of the inequities that exist in our various communities; that may be something we want to look at. In 2020, we passed the resolution that racism is a public health crisis, and I think, despite all the good work the folks have done in the agencies, we are still lacking a concerted effort to understand what is happening in our BIPOC communities and in other [inaudible] communities such as the LGBTQIA community. As I keep saying, if we do not start looking at that and seeing how we can do some things now, that dereliction will be to our detriment in the future. Let us pull apart what we have heard in terms of policy, what is working in the broader population; then the question is about what that looks like in terms of the BIPOC and LGBTQIA communities—what does that look like as we start talking about aging with pride, as we start looking at workforce development. What do we need in place and how do we use and leverage this information so we can work with other resources in our community—College of Southern Nevada, UNLV, et cetera—to start training some folks who are losing their jobs in gaming and perhaps want to go into health care. Maybe they do not want to be neuroscientists, but maybe they want to look at ways they can augment some of the services that exist right now for seniors and those with special needs.

Chair Gorelow:

Thank you for that feedback. Other Committee members? Please feel free to reach out to me if anything comes to you later. We have a lot on our plate for this interim, but we are open to suggestions and hopefully can add some more topics to the conversation.

AGENDA ITEM XII—PUBLIC COMMENT

Chair Gorelow:

Our last agenda item is public comment. We do not have anybody in Las Vegas or in Carson City.

Broadcast Services, is there anyone on the phone?

Dora Martinez, Nevada Disability Peer Action Coalition:

Good afternoon. First, I want to thank you and all your colleagues in the 81st Legislative Session, especially Assemblywoman Lesley E. Cohen, for passing AB 121 (2021).

Right now, we are at the Washoe County Board of Commissioners meeting giving public comment about our right to vote. I want to thank you because voting at home is safe for people with disabilities and elderly folks. I could register to vote safely at home with an accessible format. Kudos to Nevada’s secretary of state. I just want to bring this to your attention. Elderly folks are vital to our community—I have a mom and dad and uncle—but when the rights and needs of people with disabilities are met, that checks the box for everybody. Please, when you talk about policies, have us in mind as well.

As I said in my first public comments, I also advocate for equal and accessible transportation for all. Thank you Chair Gorelow, Vice Chair Spearman, and all the rest of the Committee members.

Chair Gorelow:

I would like to take a moment to thank all of our Committee members. Thank you to staff for your hard work in putting the meeting together. I also want to thank all our presenters today and those who attended the meeting and provided public comment. Our next meeting will be April 12 starting at 10 a.m.

AGENDA ITEM XIII—ADJOURNMENT

There being no further business to come before the Committee, the meeting was adjourned at 3:36 p.m.

Respectfully submitted,

____

Steven Jamieson
Research Policy Assistant

____

Ashlee Kalina
Senior Policy Analyst

APPROVED BY:

____

Assemblywoman Michelle Gorelow, Chair

Date: __________________________________

MEETING MATERIALS

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
Agenda Item II	Raquel O'Neil, Licensed Clinical Social Worker, President, Blindconnect	Written Public Comment
Agenda Item III	Ashlee Kalina, Senior Policy Analyst, Research Division, Legislative Counsel Bureau	Committee Brief
Agenda Item IV	Carrie Embree, Governor's Consumer Health Advocate, Office for Consumer Health Assistance, Aging and Disability Services Division (ADSD), Department of Health and Human Services (DHHS)	PowerPoint Presentation
Agenda Item V	Jennifer Frischmann, Quality Assurance Manager, ADSD, DHHS	PowerPoint Presentation
Agenda Item VI	Jeff Duncan, Unit Chief, ADSD, DHHS	PowerPoint Presentation
Agenda Item VII	Tammy Sever, Social Services Chief, Adult Protective Services, ADSD, DHHS	PowerPoint Presentation
Agenda item VIII	Barry Gold, Director, Government Relations, AARP Nevada	PowerPoint Presentation
Agenda Item X A-1	Charles Duarte, Nevada Director of Public Policy and Advocacy, Alzheimer's Association	PowerPoint Presentation
Agenda Item X A-2	Charles Duarte, Nevada Director of Public Policy and Advocacy, Alzheimer's Association	Nevada Alzheimer's Statistics
Agenda Item X A-3	Charles Duarte, Nevada Director of Public Policy and Advocacy, Alzheimer's Association	2022 Alzheimer's Disease Facts and Figures

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
Agenda Item X A-4	Charles Duarte, Nevada Director of Public Policy and Advocacy, Alzheimer's Association	*2022 Alzheimer's Disease Facts and Figures Special Report*
Agenda Item X A-5	Charles Duarte, Nevada Director of Public Policy and Advocacy, Alzheimer's Association	*Special Report—More Than Normal Aging: Understanding Mild Cognitive Impairment*

The Minutes are supplied as an informational service. All meeting materials are on file in the Research Library of the Legislative Counsel Bureau, Carson City, Nevada. For copies, contact the Library at (775) 684-6827 or https://www.leg.state.nv.us/Division/Research/Library/About/Contact/feedbackmail.cfm.