NEVADA LEGISLATURE
NEVADA SILVER HAIRED LEGISLATIVE FORUM

(*Nevada Revised Statutes* [NRS] 427A.320)

DRAFT MINUTES

June 22, 2022

The third meeting of the Nevada Silver Haired Legislative Forum for the 2021-2022 Interim was held on Wednesday, June 22, 2022, at 10 a.m. in Room 4401, Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. The meeting was videoconferenced to Room 3138, 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 Forum'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).

FORUM MEMBERS PRESENT IN LAS VEGAS:

Fran Almaraz, Senate District 10, Forum President
Marilyn E. Jordan, Ed.D., Senate District 11, Forum Vice President
Peggy Leavitt, Senate District 12
William Marchant, M.D., Senate District 5
Fred L. Silberkraus, Senate District 20
Rodger Troth, Senate District 18
Rosie Tyler, Senate District 1, Southern Facilitator
Austin Wand, M.D., Senate District 9

FORUM MEMBER PRESENT IN CARSON CITY:

Lucille Adin, Senate District 13, Northern Facilitator

FORUM MEMBERS ATTENDING VIA REMOTELY:

Joann M. Bongiorno, Senate District 7
Mercedes Maharis MA MS MA, Senate District 3
Lisa Laughlin, Senate District 15
Laura Leavitt, Senate District 8

FORUM MEMBERS ABSENT:

Doris Ahrens, Senate District 19 (Excused)
John Paul (Jack) Ginter, Jr., Senate District 14 (Excused)
Thelma Robertson, Senate District 21 (Excused)
Betty Rumford, Senate District 6 (Excused)
Valarie Woods, Senate District 4 (Excused)
Senate District 2, Vacant
Senate District 16, Vacant
Senate District 17, Vacant

LEGISLATIVE COUNSEL BUREAU STAFF PRESENT:

Ashlee Kalina, Senior Policy Analyst, Research Division
Patrick B. Ashton, Principal Policy Analyst, Research Division
Julianne King, Assistant Manager of Research Policy Assistants, Research Division
Bryan Fernley, Legislative Counsel, Legal 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

President Almaraz:

Good morning, and welcome to the third meeting of the Nevada Silver Haired Legislative Forum.

[President Almaraz provided an overview of meeting guidelines and procedures, including those related to public comment. She noted meeting materials are available on the Forum's meeting page and asked Forum members to review a handout in their packets concerning procedures.]

AGENDA ITEM II—PUBLIC COMMENT

President Almaraz:

Members, please keep in mind that public comment is only for members of the public. We will start with public comment for those in the physical locations and then move to those who have called in.

Is there anyone in Carson City who would like to provide public comment? Seeing no one in Carson City, is there anyone in Las Vegas who would like to provide public comment?

Toni Arcadipane, Doctoral Candidate, Public Policy, University of Nevada, Las Vegas:

My area of focus details the impact of long-term care costs on middle class seniors and families. In addition to my personal experience navigating long-term care in Nevada, I have spent the last two years researching this topic. There is a crisis in America, and Nevada is not immune from this crisis. This crisis impacts the forgotten middle class and how they will pay for long-term care costs. Research shows that this group gets ignored and is underserved in today's long-term care market, and it is a problem that is going to explode over the next 20 years.

There is a natural tendency to believe that you will always be able to maintain your independence and take care of yourself and your family; however, at least 70 percent of the population will find themselves or a family member needing some type of long-term care and facing the struggles of paying for this care. That means that approximately 11 of the 16 people in this meeting today may need long-term care in their lifetime. In addition, many Americans do not know what long-term care includes, or they mistakenly believe Medicare or their employer or private health insurance will cover these costs. Unfortunately, for some seniors, living a longer life comes with an increased opportunity to experience medical conditions that are more prevalent as people age. Health challenges may range from limited movement to more serious health issues, such as diabetes, severe injury, and cognitive issues, to name a few. These conditions may result in the need for some form of long-term care. The decrease in long-term care insurance policies being purchased, the misunderstanding of who pays for long-term care costs, and unaffordable long-term care insurance premiums have resulted in many middle-class Americans being unprepared and unable to cover these care costs. There are some funding options available to assist with paying for long-term care costs; however, most have strict income requirements, making them inaccessible to the middle-class senior.

As of 2021, there are just over 506,000 seniors aged 65 and over living in Nevada; 70 percent, or 354,000, may require some type of long-term care in their lifetime. Approximately 90 percent of these seniors’ income is above the poverty line and will not qualify for financial assistance to help pay for these costs. Presently in Nevada, the monthly median cost of long-term care ranges from $1,800 a month for adult daycare on the low end, to $10,300 for nursing home care each month. Many seniors will have to pay for these costs privately, rely on caregiver support from family and friends, which is not always available, or they will have to spend down their assets to qualify for financial assistance, increasing the financial burden placed on the state's budget.

There is no easy fix to this problem, but one fact stands out. The cost of long-term care services continues to increase. The members of this Forum have the power to help find a solution to this problem. Let us work together and have Nevada be a frontrunner in identifying a solution to this problem and to request a task force be implemented to target this issue in Nevada. Thank you for your time.

President Almaraz:

Is there anyone else in Las Vegas who would like to provide public comment at this time? Broadcast and Production Services (BPS), is there anyone on the line?

BPS:

The public line is open and working; however, there are no callers at this time.

AGENDA ITEM III—APPROVAL OF THE MINUTES FOR THE MEETINGS ON APRIL 7, 2022, AND MAY 12, 2022

President Almaraz:

The next agenda item is approval of the minutes for the meetings on April 7, 2022, and May 12, 2022. Are there any questions regarding the minutes? Seeing none, I will entertain a motion to approve the minutes.

> VICE PRESIDENT JORDAN MOVED TO APPROVE THE MINUTES OF THE APRIL 7, 2022, AND MAY 12, 2022, MEETINGs.
>
> MS. LUCILLE ADIN SECONDED THE MOTION.
>
> THE MOTION PASSED UNANIMOUSLY.

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AGENDA ITEM IV—PRESENTATION ON CURRENT CHALLENGES AND OPPORTUNITIES FOR LONG-TERM CARE IN NEVADA

President Almaraz:

Agenda Item IV is the presentation on current challenges and opportunities for long-term care in Nevada.

Marie Coe, Interim State Long-Term Care Ombudsman, Aging and Disability Services Division (ADSD), Department of Health and Human Services (DHHS):

As the interim State Long-Term Care Ombudsman, and on behalf of the 16,613 residents living in long-term care, we would like to thank you for the opportunity to discuss the current challenges and opportunities in long-term care in Nevada. Today, we will be discussing the Long-Term Care Ombudsman Program first, move on to community-based care, and wrap up with caregivers' support services. We will have an opportunity for questions, and our contact information as well as acronyms will also be provided in this presentation (Agenda Item IV A-1). One of our supervisors, Erica Billinger, is available and in person in Las Vegas, and she will be able to further speak with you about the long-term care challenges.

Erica Billinger, Supervisor, Long-Term Care Ombudsman Program, ADSD, DHHS:

I will start off with the overview of the Long-Term Care Ombudsman Program. We are authorized under the Older Americans Act (H.R.3708, 89th Congress) (OAR). Federal law requires each state to have a long-term care ombudsman program. The Long-Term Care Ombudsman Program receives complaints and conducts investigations. We assist residents with concerns related to day-to-day care, health, safety, and personal preferences. We provide information to the community regarding long-term care in Nevada. We provide education to residents, families, facility staff, and others on a variety of issues related to aging, long-term care, and resident rights and provide in-service training for long-term care professionals regarding trends and best practices to improve the quality of care for residents. In addition to that, we also conduct regular unannounced visits to facilities.

We have three different types of facilities. We have the home for individual residential care, our HIRC homes. We have the residential facilities for groups, which are also referred to as assisted living facilities. Those have Alzheimer's endorsements for residential facilities for groups. With those Alzheimer endorsements, it is mandated that there is one staff member for every sixth resident, and then we have our skilled nursing facilities. Any information regarding our facility types can be found under Chapter 449A of NRS.

Regarding our long-term care issues, we will start with discharges from facilities. Our skilled nursing facility concerns are that residents who are sent to an acute setting, such as the hospital or behavioral health, are not permitted to return to the facility if there is an undesirable behavior. The residents should be provided a discharge letter with information to contact the Long-Term Care Ombudsman Office as well as file an appeal. Next are the letter of agreements. Group homes have an increase of admissions for residents who transfer from the hospital under a letter of agreement from the hospital. The letter of agreement is a contract between the hospital and the group home provider, which indicated a higher monthly payment for resident care than the resident can afford. When the contract ends, the resident is evicted for nonpayment.

Now I will discuss the discharge and eviction rights for long-term care settings that do not fall under the Nursing Home Reform Act (NHRA) (H.R.3545, 100th Congress). The settings rule for residents on the Medicaid waiver program have protections if they are denied for services. However, they do not have an appeal process if they received an eviction letter. This is the case for residents in group homes, assisted living, and HIRC home settings. Skilled nursing facility residents fall under the NHRA.

The ongoing pandemic recovery has created workforce challenges. The nursing home industry has shed roughly 235,000 jobs since March 2020, according to an analysis of the

United States Bureau of Labor Statistics data. According to an article from AARP, dangerous working conditions, poor pay and benefits, limited advancement, and burnout are all factors. The National Consumer Voice for Quality Long-Term Care looked at the Centers for Medicare and Medicaid Services (CMS) reporting data and found that bedsores, weight loss, depression, and the use of antipsychotic medication all rose during the pandemic.

Residents and skilled nursing facilities who receive financial support by Medicaid are entitled to $35 in personal needs allowance to be used for items such as clothing, personal items, and incidentals. With inflation increasing costs of everyday items, $35 must be saved for many months to be able to replace basic clothing for residents. The personal needs allowance rate has not changed since 1991. The Long-Term Care Ombudsman Program is recommending a change for residents who receive a federal benefit rate, such as Social Security or disability income, to receive 15 percent of this income as a personal needs allowance and allow an annual assessment of the personal needs allowance. Currently, many states have increased the personal allowance as well as implemented an annual assessment. Arizona's allowance is set at 15 percent of the federal benefit rate and is currently at $126.15. Colorado updates annually and is currently at $93.17.

The Ombudsman Program experienced significant staffing shortages during the hiring freeze implemented during the Coronavirus Disease of 2019 (COVID-19) pandemic. At this time, 19 of the 20 long-term care ombudsman positions are filled. There are currently two vacant positions in the program. There has been an increase in facility visits in cases due to the increased number of ombudsmen since May 2, 2022. The two open positions with the Ombudsman Program are currently in our Elko region, and [there is also] an administrative assistant to provide support to our program.

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

I will be introducing the programs that are offered through my unit as well as data demonstrating our current wait list and caseload challenges and various other issues we have seen over the past few years.

Community based care, referred to as CBC, is the operating agency for the home and community-based services waiver for the frail elderly, referred to as the FE waiver, and the home- and community-based services waiver for persons with physical disabilities, referred to as the PD waiver. Each waiver is administered by the Division of Health Care, Financing and Policy (DHCFP), DHHS, also known as Medicaid. Between the two agencies, ADSD and the DHCFP, we collaborate to develop the policy and procedure of these waivers to ensure the most adequate opportunity for services is made available to those most vulnerable within our state. Each waiver has the eligibility requirements set forth in the waiver application, which allows those who meet a nursing facility-level of care access to in-home services. Each waiver requires that an individual be at or below 300 percent of the Social Security income threshold and requires at least one ongoing waiver need. Additionally, the FE waiver requires an individual be aged 65 or older. The PD waiver requires that an individual have a documented physical disability by a medical professional.

The CBC also administers and operates three state-funded programs, including the Community Service Option Program for the Elderly, referred to as COPE; the Personal Assistant Services Program, referred to as PASS; and the Taxi Assistance Program, referred to as TAP. The COPE and PASS programs are very similar to the FE and PD waivers. For example, the FE waiver requires that an individual be at or above the age of 65, and the PASS program requires an individual have a documented primary physical disability. However, these programs do allow for a higher income threshold to allow more entrance to the programs that are state funded. We allow those that are waiting on a waiver waitlist access to these programs to benefit from services provided in home while waiting for a slot to become available for that waiver. We also serve individuals.

As stated previously, the COPE and the PASS programs are state-funded programs intended to serve those waiting for a waiver slot to open so they can have entrance to that Medicaid-funded program. It is also intended for those who are above the income threshold or maybe have too many resources for them to benefit from receiving services in the community. The TAP program is a service that allows individuals in Clark County the option to purchase discounted taxi coupons to be available for use with Clark County taxicab providers. The service is available to those over the age of 60 and those with a permanent disability.

Next, we are going to look at our HCBS, which is the home- and community-based services waiver waitlist. You will see that there are two different columns with two different colors. Those will be demonstrated throughout the conversation today. For the waiver programs, we are approved a number of slots each year through the Legislature. The Nevada Medicaid Office and the ADSD work with the Office of Analytics, DHHS, to provide projections on how many waiver slots would be needed in the following years, taking into consideration population growth and how many individuals are on the current wait list. These numbers are submitted to the Legislature by the Office of Analytics. When the budgets are approved, the final slot count is released, and we know how many slots we can anticipate filling over the next biennium. This chart is for Fiscal Year (FY) 2021–2022 to date. The FE waiver, which is on the left side of the columns, has 395 individuals on the wait list as of May 2022. The PD waiver on the far right has 139 individuals waiting as of 2022. The orange color signifies those who have waited fewer than 90 days, and the blue color is those who have waited more than 90 days. We have seen an increase in the waitlist counts over the past few months, mostly based on staff shortages and a decline in service provider options in the community. I will get into those later in the presentation.

This shows those who are in a pending status for the FE and PD waivers. The left side is signifies the FE waiver; the right side signifies the PD waiver; and the color indicates specific time frames for each waiver. It follows the same format. It is for FY 2021–2022 to date. This has the same number data range that the other slides have. It signifies those that are in a pending status. That means that these are individuals who have been awarded a waitlist slot, and we are ready to proceed further. We have submitted an application to the Division of Welfare and Supportive Services (DWSS), DHHS, to perform a financial review for eligibility, and we are also waiting for Nevada Medicaid to make a final approval for these individuals. These are all required steps taken within the waiver application to get people eligible for the program. The reason we have 45 days called out on this slide is that the DWSS office has 45 days to process an application. The 45 days signifies how much time has elapsed since we have received a slot, awarded the slot, and are waiting for the next steps to be taken. There can be varying reasons why an application would be pending more than 45 days. Commonly, an individual may have a financial trust, or there may be some financial documentation that we are working with the individual and their family to obtain.

This covers our COPE and PASS program waitlists. These are the two state-funded programs that have services very similar to the FE and the PD waiver. It also signifies federal FY 2021–2022 to date. The left side is the COPE demonstration, and the right side is our PASS program. We can see based on this that the caseload sizes are much smaller. This has been standard over the past several years, based on the need and the entrance within these programs. As of May 2022, we had 17 individuals waiting for the COPE program and six for the PASS program. Many of these individuals are waiting for similar reasons with the welfare application on the prior slide. We are gathering financial documentation and perhaps working with the physician to gather the medical records needed to determine their physical diagnosis.

The program capacity slide demonstrates how many slots are available for each home- and community-based service waiver that CBC oversees as well as the PASS and the COPE program. I will point out the significant difference in caseload capacity for the FE and PD waivers, which have Medicaid-funded monies associated with them, versus the state-funded COPE and PASS programs. The blue column on your left demonstrates the budgeted caseload size. Each number represents the number of slots available for each program. The orange is going to be currently where we are at with each program. For example, for the home- and community-based service waiver for the FE, we are budgeted at 2,713 slots. We are currently serving 2,530 individuals.

Let us talk about the challenges CBC has seen over the past several years. We have faced challenges, which are no different than national challenges and challenges within other agencies within the state. Currently, CBC has a 61 percent vacancy rate within our intake team. This causes delays in processing applicants to get through the process for waiting for a slot or to move to the next process prior to being eligible for the program they have applied for. Our ongoing case management position has a 26 percent vacancy rate. The cause and effect of these vacancy rates are seen on the waitlist slides shown previously. Without case managers, we are unable to process all slots allocated to the programs and, in turn, individuals wait longer for services. Additionally, we have seven vacant support positions which include administrative support and supervisory roles.

Our providers we partner with are facing many of the same challenges relating to staffing concerns. They are struggling to hire caregivers, and many times we find that the administrator of the agency is performing direct services him or herself just to make sure that the individuals they serve are getting what they need. They are on the floor doing the job.

Rates have always been a hot topic. They have always been a conversation starter for many of our providers. The rates do remain low, which causes a ripple effect on direct care. The rates cover the providers' administrative overhead as well as the wage that is provided to the caregiver. When we reimburse, for example, $17 an hour must cover the administrative overhead as well as the hourly wage.

The CBC has witnessed an unsustainable provider landscape. Many providers have reached their peak of services they are able to offer and are not taking on more clients. This presents challenges to our case managers who reach out to providers weekly to staff and see where they are at with their availability of services. Many times, we hear from providers that they cannot take anymore, they do not have staff to provide the services, and they do not have the capacity. Our case managers are looking for service providers weekly to see who we can get staffed for various needs in the community. Many times, we will see that an individual receives partial service delivery, and that is, again, due to the capacity. For example, if they are authorized for 30 hours per week, the provider may only be able to provide 20 hours per week. The recipient is left deciding which services are the most needed at that time. A lot of times, we rely on nonpaid caregivers such as family, friends, neighbors, and other supports that are available in the community.

I am going to talk about caregivers' support services that are offered through ADSD. The ADSD can offer respite services to individuals through the CBC programs, but we also specifically fund caregiver support services through subawards to community partners. These subawards include a variety of caregiver support services, such as respite, support groups, and education. Education is a broad category that can include services that help family caregivers maintain their caregiver role. Many of these education programs are evidence-based interventions. Respite is funded either as a direct service where a community partner hires respite workers and/or recruits volunteers or through issuing vouchers.

In state FY 2022–2023, ADSD has awarded a total of $3.2 million for caregiver support services, which is about $700,000 more than what was allocated for FY 2021–2022. The total requested by applicants and the caregiver support category was $4.9 million.
The funding for these services mainly comes from the OAR, but funds for Healthy Nevada independent living grants and State General Funds are also used to support these services.

Despite our increase in funding, we are seeing an increased demand for services. It is difficult for us to quantify this demand, as our system does not readily identify caregivers and document them. Most documentation across programs is focused on the care of the recipient. There are also growing workforce shortages and an increased demand for higher rates and/or higher voucher services.

Finally, across many programs, especially public programs such as the waivers, there is a narrow view of what respite is or who can provide this service. One of the largest providers of respite services is personal care agencies. However, respite can be provided to family caregivers in a number of different ways.

We are happy to answer any questions for members.

President Almaraz:

We are going to open it up for questions.

Dr. Wand:

Do you have any solutions to increase staffing? It is a huge issue everywhere, and not only for the administrative, but certainly, like you pointed out, the actual caregivers. I think we need to tackle that problem. Are there any good solutions?

Ms. Wren:

That is an excellent question related to an increase in staff shortages. This is a national issue that we are seeing across the board. Many of our caregiver agencies are seeing a shortage in who is applying for these services as well as who is staying with these. As far as the caregiver agencies, I know that the University of Nevada, Reno is working on some studies to see what kind of increases can be made to sustain provider support. Within the agency, we are working together to see what kind of solutions we can come up with, such as training for caregivers, respite—which was mentioned earlier—and really broadcasting that service to make that available to folks so they do not receive that caregiver burnout. We are also working with Nevada Medicaid and other entities regarding a rate study to see if there are any increases that can be requested to see if that would help sustain the provider workforce. Regarding the staffing shortages within CBC, we are working with our human resources department and with the Division of Human Resource Management, Department of Administration, for advertising these jobs to different universities and entities to get the information out that we are looking for licensed individuals for the social worker positions. We are trying to work with community partners to advertise these jobs.

Ms. Adin:

How do you handle the situation when you have the patients already, but they are not able to get the care they need because of the shortage? How do you handle that? It is a bad situation.

Ms. Wren:

This is a challenge that we are facing daily, unfortunately. We have licensed individuals who do the case management activities, so they can reach resources within the community and within our Division to see about getting additional services in the home. Many times, when an individual who is not receiving the amount of care they need—such as my example of requiring 30 hours and receiving 20—we will increase our contact with that individual to make sure that their health and safety is assured while they are in their home. We may reach out monthly instead of quarterly, for example. If they have our phone number, we may talk to them weekly. It really depends on an individual basis. That is something that we have been struggling with as an agency. Making those weekly contacts with our enrolled provider community to make sure they have that availability is the first step. As soon as we find out that there is a provider available, we make sure that the individual identified with the highest need receives that service from that provider.

Ms. Laughlin:

I have two points of clarification that I wanted to ask about. Ms. Wren, when you refer to providers, you said that some of them are not taking more cases because of staff shortages and payments. Are you talking about providers in terms of agencies like home health care agencies and hospice support, or individuals, or all the above? That is one question. The other point of clarification I wanted was on the waivers that the state is providing, and you are allowing people on the waiting list to access the services. Are they paying for that service, or are you assuming they are going to get approved, so they are basically accessing it early? I am just trying to understand that process.

Ms. Wren:

I will start with your first question regarding how a provider is identified within my unit. Unfortunately, I think we forget that we have internal state speak. When I say a "provider," that is generally going to be your personal care agency. It is going to be any company that is enrolled with Nevada Medicaid or enrolled with ADSD to provide a service and be reimbursed for said service. Some of our partner units will say community partners" or "provider agencies." So, yes, that is exactly who that is.

For your second question regarding individuals on the waitlist for the waiver, when I say that they can access services while waiting, that would be access through the COPE and PASS programs, which are state-funded programs. For example, an individual who is waiting for the FE waiver will meet the same requirements as the COPE program due to the income, the age limit, and the physical need. While they are waiting for a waiver slot to become available, we can put them on to our COPE program, or for the physically disabled, they can go on the PASS program. They can access services through State General Fund reimbursed services for the same provider community.

Ms. Laughlin:

Excellent, thank you. Essentially, the state and federal funding programs are working together as people are waiting. Thank you for the clarification.

Dr. Jordan:

My question is for Miss Coe regarding the personal needs allowance, $35 a month. That has not been moved or changed since 1991. Could you share with us what steps have been taken to try and raise that price?

Ms. Coe:

My understanding is that DWSS has attempted to increase the personal needs allowance in the past. I do not have the information on why it was not increased in the past, and I will be looking into that. However, other states around the country have addressed this issue. As you know, $35 per month is very low for somebody to buy clothing and essential personal items that they may need, and just frankly, to go out to lunch. It is not enough for somebody. Their care needs are met in the facility. Their rent is covered by their pay source, whether it be Medicaid or through a private insurance company, but that does not cover their personal needs, which is why we are bringing it up today.

Dr. Jordan:

I thank you for that. In 30 years, we cannot do better than $35 a month for personal needs? I can think of one personal need item that could be $25, and there goes your whole monthly allowance. I do sincerely hope that we address that issue and that you get back to us on the next steps for what is going to happen. This is not acceptable for the state of Nevada at all.

Ms. Coe:

Thank you. I agree.

Ms. Peggy Leavitt:

This question is also about the personal needs allowance; I assume it goes to Ms. Coe as well. During my social work years, I managed two children's programs: (1) the Southern Nevada Children's Home, which was state-sponsored; and (2) Child Haven, which is the county. In neither of those programs did we have adequate money for clothing, personal items, and incidentals. We were heavily dependent on donations. Most of the clothing that our children had were donated, and a lot of the donations that we got were new clothing. People were very generous when they knew the need. Is that something that can be done? I realize that both of my programs were in a location where people were aware of them, and you have people scattered all over the place, but if there was some place where there could be a donation center—in my experience, when people are aware of the need, they are very generous. When they would become aware of this miserly little income that is given to these people, I can see that people would come out in droves to help.

Ms. Coe:

I am aware of a program. You may have heard of it. It is called, "Be a Santa to a Senior." Once a year, people will gift things like clothing, blankets, pillows, things that the personal needs allowance would be spent on throughout the year. However, this is once a year, and donations for individuals who are adults—they would have to constantly submit what they are requesting versus being able to buy it as an independent adult themselves and have the rights to do that. They would have more independence. They are allowed to leave these facilities; however, when they leave, they have no income to do the things they like—not only for clothing and things, but also to go and access the community and see a movie or visit the museum. This income can provide for things like that, which cannot be a donated item. I agree with you that there needs to be more awareness about the ability to donate to adults in these settings because there is a need for them to have basic items that the community could rally and help provide for them.

Mr. Troth:

I want to go back to the $35 personal needs allowance. Who pays that? Is that Medicaid federal tax dollars that comes to those programs? Is that the amount that Nevada folks are receiving at this time?

Ms. Coe:

The $35 comes from the resident’s income. Our recommendation is to allow the resident to keep a greater amount of that income. Many residents in skilled nursing facilities are on institutional Medicaid. As was initially stated by public comment, the cost of care may be $10,000 a month, and a small amount is paid for by the resident through either their Social Security, a pension, or a disability income, and that $35 is what they are allowed to keep out of that income. We are asking for—similar to Social Security, which is reviewed every year, and disability as well—the resident to be able to keep a percentage instead of a stated dollar amount of that income, which would be reviewed annually and be a higher amount for them to spend on their needs. Their personal needs allowance would also increase with that review and, similar with other states, they have a 15 percent allowance that they are providing to the residents to keep. That amount is much higher. Nevada is one of three states that are at this low dollar amount for their residents to keep.

Mr. Troth:

Thank you for that. So, it comes from whatever sources, and that could be multiple sources, that are providing that. Who can change that percentage? Is that the Nevada Legislature?

Ms. Coe:

I will have to get back to you on who can change the amount. I believe it must go through Nevada Medicaid, but I will confirm that.

Mr. Troth:

Is Nevada Medicaid controlled by the state Legislature?

Ms. Coe:

Yes.

Mr. Troth:

To the best of your knowledge, were the amounts from Arizona and Colorado increased through legislative action?

Ms. Coe:

Yes.

Mr. Troth:

Madam President, can I ask some more questions?

President Almaraz:

I will go to Dr. Jordan first and then come back to you, Mr. Troth.

Dr. Jordan:

As I understand it, each state determines the amount of money. For example, Social Security increased 5.3 percent in 2022, and none of this has changed or helped or aided any of our residents. As a representative for our seniors, we need to address this issue. I can think of a million things that one item would cost more than $35. This needs to be brought to the state Legislature as soon as possible. Are you aware of any bills or anybody that is moving to do something about this?

Ms. Coe:

I am not aware of any other forum that is bringing this as a bill.

Ms. Laura Leavitt:

I am going back to the provider shortage that was mentioned earlier. This is coming up in another presentation. Is the staff shortage partly due to how little the providers and caregivers who work for the providers are getting paid? That is $10 to $11 an hour. There are several pushes to have that increased to $15 an hour.

Ms. Wren:

To my knowledge, the low reimbursement wage for staff is one of the reasons we have heard throughout.

Ms. Laura Leavitt:

Do you know where that is being addressed? Is that in Senate Bill 340 (2021)?

Ms. Wren:

I would have to get back to you on that. I do not know if there is a specific area that controls the wage. I know that the rates for the services rendered through Nevada Medicaid is the reimbursement rate that is issued to the agency. That rate is to control the administrative overhead as well as the hourly wage. Nevada Medicaid does not control the actual wage that is reimbursed. That is dependent on each agency themselves as an independent party. Anything outside of Nevada Medicaid, I would not be able to answer. I can do some research and see if I can bring some information back.

Ms. Laura Leavitt:

Thank you. Ten to $11 an hour is not something that would mean a long-lasting job, I would think. There are jobs at Panda Express currently advertising for $19 an hour. I just want to mention that.

Mr. Troth:

I have a question regarding slide 12 on the CBC programs. For those three programs, how often is the criteria reviewed and adjusted for people looking to get into those programs? Do you have any idea?

Ms. Wren:

The criteria are set within the waiver application, which is a document approved by the CMS. This is reviewed and reapplied for every five years. It has a five-year benchmark. There are some standards that are within the federal requirements for each waiver type, depending on the population you serve, so some of that mirrors those entrances, such as the level of care. That is a requirement for every 1915 (c) waiver, which is to have a nursing facility-level of care. The income thresholds can be reviewed by each state, if that is something that is of interest. It has not been rereviewed. It currently mirrors the nursing facility-level of income requirements, which is 300 percent of Social Security income.

Mr. Troth:

Is most of this federal government-directed criteria?

Ms. Wren:

I would say it is a good, healthy mix. The federal government has what is called a waiver application. It is kind of like your policy on how to write your waiver application, and it does have certain requirements within it. The CMS does try to give states leeway to build the program according to the need within the state, which is what these waivers have been built on. That is where the 300 percent threshold comes in.

Mr. Troth:

Which agency in Nevada would have input to that?

Ms. Wren:

The administrator for the home and community-based waivers is the DHCFP, also known as Medicaid, and the operating agency is the ADSD. It is a partnership; however, the DHCFP has the authority to make the final changes and submit to CMS for approval.

Mr. Troth:

Regarding caregiver support services—I am going to ramble about a couple things here, and then I would like to hear whether you all have some ideas. A lot of the services that are provided are by some type of private company. What is the state's opinion and your opinion—and I know you have to be careful on some of that—of where the industry is? We have had some comments, and I think we are going to talk about it later, on pay scales. There is a lot of money involved in how to do this. Obviously, people are not going to do things for minimum wage. Does private insurance, government funds, and the mixture of money available . . . . It does not sound like that is being either utilized or not utilized enough to provide level compensation for competent support and help in some of these programs. Do you look at that or struggle with that? You have caseworkers who cannot find services for people. Are insurance companies not always available to do that? Is there a regulation that keeps them from being more profitable in doing some of this?

Ms. Wren:

Many of the services that are offered through Nevada Medicaid for the waiver populations and the state-funded options that we went over today are not through private insurance. Many private insurance companies do not reimburse for personal care-related services. Respite generally falls into that. A lot of these are dependent on your federally funded revenue as well as your State General Fund. There is a connection with these services between the federal funding and the state-funded programs to ensure that they are doing what they need to support our vulnerable populations. The private insurance is not generally a mix into that. I will say that Medicare recently adopted many of these programs into their reimbursement structure, so that has assisted individuals with gaining access to services. However, the access is limited by provider availability, so that continues to be a struggle.

Ms. Laughlin:

I have one more point of clarification. I have the same question about how often the waivers are reviewed. Do you have any statistics on how long people are on these programs—obviously, they may differ because some are frail and elderly, and some have some special needs. Are they on and off, or once they are on, are they generally on for five to ten years?

Ms. Wren:

We have data, but I do not have it today. I can get that and provide that to the Forum. We see a lot of individuals once they are approved for a waiver, and they are generally on until they are into the next stage, either in a nursing facility or, unfortunately, they pass away. It is usually long-term assistance that we provide. We have some individuals on our PD waiver that have been on for longer than ten years. Our systems go back, I believe, to 2006. I will have to get that for you. We have individuals that were on before we got the new system, so we have some long-term individuals on our systems. Most of the frail elderly, by nature, is going to be on the services for a shorter duration. Again, they either go into a long-term service area, move out of state, or they are no longer with us. We do see that that is not as long. I will definitely get some information back.

President Almaraz:

I have a question about TAP. In Clark County, the Regional Transportation Commission (RTC) of Southern Nevada has a bus program to help seniors and the physically disabled. It is around $3 each way. Sometimes, that $6 is a lot of money for someone who is disabled. I wonder if that is included in this taxi program.

Ms. Wren:

The TAP is funds received through the Taxicab Authority, and it is only for taxicab services. The RTC would be excluded.

President Almaraz:

I have one more question on the personal needs allowance. Can you give us possibly what an average amount of funds a person might need per month, so that if we decide to ask our Legislature to do something about this, we might have a number in mind?

Ms. Coe:

As far as an average of what a person might need, it is up to the individual and their spending habits. Someone might not have a haircut every single month, where other people might have a haircut every month. What I might be able to do is give you an average of what all the other states are also doing. We can have an average number of the personal needs allowance. I can collect all that data. I can also have our ombudsmen, who are going out into the field, do some surveillance and talk to the residents directly about the personal needs allowance and gather that data and bring it back to you.

Mr. Troth:

Madam Chair, I would suggest we ask them to do that. That would give us data and information.

President Almaraz:

As you are gathering that data, maybe you could give us some sort of a list of these personal items that are not provided where they are residing that they might need. What are they spending this $35 on? That would be very helpful.

Ms. Coe:

I can provide that list to you.

Dr. Wand:

I have a question about the seniors who are already in long-term care facilities, nursing homes, and so forth, and are paying for them with their own funds. What happens to those people if they run out of money?

Ms. Coe:

For people in skilled nursing facilities—let us say a person had a house that was sold, and that money is now being spent towards their care, if all that money is spent down, and their monthly income qualifies for institutional Medicaid, then the facility would assist them to apply for institutional Medicaid. They would still be entitled to have a personal needs allowance based on their ongoing income. Typically, somebody who is retired has Social Security or maybe a pension from an employer. It is not a lot, and it does not cover the cost for skilled nursing facilities, so all that income goes to the nursing home for their care. At the moment, they are only allowed to keep this $35 per month.

President Almaraz:

Thank you for this presentation. I think this personal needs allowance has struck a nerve with some of us. We would probably like to further look at that and what can be done. again. I appreciate you being here.

After the meeting, Ms. Coe submitted a follow-up memorandum that addressed the questions asked by Forum members regarding the following topics: (1) personal needs allowance: (2) staffing shortages and reimbursement rates; and (3) length of stay on a waiver program (Agenda Item IV A-2).

AGENDA ITEM V—OVERVIEW OF SENATE BILL 340 (2021), WHICH ESTABLISHES A HOME CARE EMPLOYMENT STANDARDS BOARD TO INVESTIGATE AND DEVELOP RECOMMENDATIONS REGARDING CERTAIN MATTERS RELATED TO THE WAGES AND WORKING CONDITIONS OF HOME CARE EMPLOYEES

President Almaraz:

We are moving on now to Agenda Item V, an overview of SB 340 (2021), which establishes a Home Care Employment Standards Board to investigate and develop recommendations regarding certain matters related to the wages and working conditions of home care employees. We will now have Ms. Kayla Samuels and Ms. Terri Henwood of the Division of Public and Behavioral Health (DPBH), DHHS, present an overview of SB 340 from the 2021 Legislative Session with information about the Home Care Employment Standards Board (HCESB). We will take questions from members at the end of the presentation.

Kayla Samuels, Management Analyst I, DPBH, DHHS:

Originally, my copresenter was supposed to be Cody L. Finney, M.P.H., Deputy Administrator for the DPBH and chair of the HCESB. Unfortunately, she was unable to join us today, so Terri Henwood has kindly stepped in. We will be going over the HCESB (Agenda Item V). On the agenda, we are going over SB 340, including its origin and what it specifies as far as members and the purpose of the HCESB. We will then be going over the HCESB's progress so far, including recommendations to Richard Whitley, M.S., Director, DHHS, and our next topics of focus. After that, we will be reviewing oversight of personal care agencies performed by the Bureau of Health Care Quality and Compliance (HCQC), DPBH, DHHS, including powers and duties of the HCQC, common sanctions, and the penalty process.

Senate Bill 340 was created in 2021 by the 81st Legislative Session. It authorizes the director of DHHS to establish a HCESB for the purpose of reviewing investigation of and making recommendations for the improvement of working conditions in the critical home care industry. On June 9, 2021, Governor Steve Sisolak signed SB 340 into law; thereafter, DHHS Director Richard Whitley authorized the creation of the HCESB.

Per the bill, members include the Director or his or her designee, who serves as chair, and a nonvoting member. Currently, that is Cody Finney, Deputy Administrator of the DPBH. The board also includes the following voting members: the labor commissioner, three representatives of home care employers appointed by the Director, three representatives of home care employees appointed by the Director, and three persons who receive or are representatives of persons who receive services from a home care employee appointed by the Director.

According to SB 340, the HCESB shall investigate matters relating to the wages and working conditions of home care employees in Nevada and the compliance of home care employers. They are also tasked with developing recommendations regarding the minimum wage that may be paid to a home care employee in Nevada or the safe and helpful working conditions for home care employees. It also specifies that no later than one year after the first meeting, the HCESB shall submit its findings and recommendations to the Director. That report is due this December.

The scope of investigation tasked to the HCESB includes:

- The adequacy of wage rates and other compensation policies of home care employers to ensure the provision of quality services and sufficient levels of recruitment and retention of home care employees;

- The sufficiency of levels of recruitment and retention of home care employees;

- The adequacy of the role of home care employees and making decisions affecting their wages and working conditions;

- The adequacy and enforcement of training requirements for home care employees;

- The impact of home care programs, the larger system for long-term care in Nevada, and any efforts to reach the goal of rebalancing long-term care services toward home- and community-based services on the wages and working conditions of home care employees;

- The impact of systemic racism and economic injustice on home care employees and the adequacy of efforts to alleviate such impact through the development of career paths through partnerships between labor management and other methods; and

- The adequacy of payment practices and policies of the state as such practices and policies relate to the reimbursement of home care employers for the provision of services under the home care program.

Next, we will go over the progress that the HCESB has made thus far. So far, the HCESB has made a recommendation that the *Nevada Administrative Code* (NAC) 449.3973 detailing the duties and responsibilities of the administrator be updated so that required trainings must be paid for by employers. In addition to that recommendation, the following recommendations regarding the Medicaid Home and Community Based-Services Plan have been made:

- That DHHS reopen the deadline for employers to apply for the first round of $500 supplemental payments;

- That a notice is sent to employers saying that they are expected to apply for the $500 supplemental payments for employees;

- That it is made mandatory for employers to apply for the future rounds of $500 supplemental payments to employees; and

- That Nevada Medicaid is required to obtain reports from personal care agencies receiving 15 percent supplemental payment on how they are spending that additional funding in the near future.

The Board plans to address adjustments to the rates for Medicaid waivers and personal care worker wages as well as evaluate a survey for personal care employers and employees that has been distributed to gather evidence to inform future recommendations. The goal of this Board is to develop recommendations relating to all areas in the established scope of investigation that was addressed earlier. I will turn it over to Terri Henwood for the rest of the presentation.

Terri Henwood, Health Facilities Inspector III, Supervisor, Bureau of HCQC, DPBH, DHHS:

I am a supervisor with the HCQC, DPBH. We are responsible for licensing facilities and going in and inspecting facilities and ensuring compliance with the regulations. Today, I am going to talk to you about our powers and duties based on NRS. I will be going over those two oversights with you.

The first of our powers and duties of HCQC is NRS 449.0307, which states upon receipt of an application for a license, HCQC may conduct an investigation into the premises, facilities, qualifications of personnel, methods of operation, the policies, and purpose of any person proposing to engage in the operation of a personal care agency. I would like to discuss the process with all of you, the lifespan, if you will, of an application and what an application goes through to get to our department. First and foremost, if a personal care agency would like to operate, they submit an application. That is where NRS 449.0307 kicks in. That application comes through our licensing department. Our licensing department has its own procedure, which is to review the application and make sure that it meets all the requirements for the licensing department's standards. Once it fulfills those responsibilities, our regulatory department gets a notification of that application, and then it is ready. Once it is ready, it will be assigned to a surveyor who goes out to inspect the premises, facilities, qualifications of personnel, methods of operation, and policies. I wanted to go over that because sometimes it just gives the authority, and it does not describe the actual process, and that is our process. We try to do that as quickly as we possibly can because we know that personal care agencies are ready to be licensed and ready to provide care to clients.

The second power and duty of HCQC I would like to review with you today is the complaint process. *Nevada Revised Statutes* 449.0307 also states that upon receipt of a complaint against a personal care agency, HCQC may investigate the premises, the facilities, the qualifications of personnel, their methods of operation, policies and procedures, and records of the facility or any other facility which might have information pertinent to that particular complaint. Just like I went over the lifespan of an application, I would like to go over the lifespan of a complaint as well. Once a complaint is made to our department, that complaint goes through a variety of channels. First and foremost, it goes through our complaint department channel, who reviews the complaint and then assigns it to me or another supervisor. At that point, we receive it, we review it to see that the allegations that are made are categorized appropriately for investigation. We prioritize this complaint from anywhere from 3 to 45 days based on severity of the complaint allegations. We then schedule it for a surveyor to go out and investigate the premises, which NRS states.

I would like to move on to the next slide, which states common sanctions applied by our department to personal care agencies. I would like to say, before I go over this, that our department is very invested in working with the providers or the licensees, and we want to work with them before we get to a sanction-type of a place. One of the things that we work with the facilities on is trying to come into compliance, but sometimes it does not work that way, and sometimes the agencies do not come into compliance; therefore, sanctions are required. Sanctions can be imposed for a number of reasons. I wanted to provide some examples of why a sanction would be on the table. One is if we go out on a complaint and substantiate that complaint for some type of egregious reason, such as abuse or neglect. If there are high severity levels of citations and our inspectors go out onto the premises and find that there is deficient practice, it is not just the deficient practice, but also the severity of that practice and how many people are affected. Repeated offenses—like abuse and neglect—are another example of reasons for sanctions. Those are some potential examples or reasons for sanctions.

Before we get into denial, suspension, or revocation of a facility, we try to go more of a least restrictive route. Some of those options, which include the directed plan of correction, a ban on admissions, a monetary penalty, may be imposed as a lesser restrictive option before denying, suspending, or revoking a license. That is really a last resort. Have we had to do it? Yes, we have, but we try to bring the facility into compliance by asking them to either have a directed plan of corrections that will address the problem, oppose a ban on their admissions, or possibly dole out a monetary penalty. But, even before those sanctions, we try to work with the facility.

I would like to discuss one more process with you that many of you may have heard of or experienced, which is the unlicensed facility process. For many of our providers that are licensed, this is a very frustrating experience when there are unlicensed facilities out there. We do have a process for this. Before we believe that an agency is operating a facility without a license, we usually get a tip off or a complaint, which states that there is an address, and they may believe that an unlicensed facility is operating. An unlicensed facility would be a facility that is providing some kind of care, including medication management, hygiene, and assistance with daily living skills. Care must be being provided in that home. Once we have that complaint or referral, we issue an order. We assign it to our investigators. Our investigators go out, review, and inspect the premises, and if they find that indeed, this is an unlicensed facility, an order to cease and desist the operation of that facility is provided at that time. The order is served by personal delivery, as the inspectors are on site, or by certified or registered mail. The order is effective upon that service. At that point, the agency could choose to cease operation, and the penalty process would end right there, but the agency could also apply for a license within 30 days, and the penalty process would also end there. They have a couple of options once provided that cease and desist notice. If the agency does not voluntarily cease operating the facility or apply for licensure within the 30 days after the date of the service of the order, then HCQC would bring in action in a court to address that agency. There is a process that goes on. It is a swift process. However, it is up to the agency to decide on which avenue they are going to go.

If, unfortunately, an action must be brought in court, HCQC will show the court that the agency is operating without a license. We would provide our evidence in the form of observation, interviews, and record reviews. If there are record reviews, we would present that. The court then may urge the agency against operating the facility or potentially impose a civil penalty on the operator to be recovered by HCQC of no more than $10,000 for the first offense. I wanted to point out that that is potentially what could happen. Of course, just like sanctions, our department likes to work with providers out there to not get to that point. But if it does get to that point, the final step in the process is that HCQC deposits the civil penalty into a separate account in the State General Fund to be used to administer provisions of NRS 449.001 through 449.430. These NRS have oversight for protection of the health, safety, wellbeing, and property of patients and residents of the facility.

We have a question-and-answer period on the next slide. That would conclude the presentation for HCQC.

Ms. Samuels:

We will now take some questions from anyone who has them. I will put the contact information for both Cody and myself up in a moment as well.

President Almaraz:

Forum members, do you have any questions?

Dr. Marchant:

Please go to the last slide where if the agency applies for a license within 30 days, the penalty process ends. At that point, does that mean it goes back to the investigation of the application and the process starts over?

Ms. Henwood:

I hope I am answering your question correctly. Once they determine that they will go ahead and follow through with the application process and they have the 30 days, they will go through the licensing unit of our department and submit the application, and we would monitor this facility the entire way.

Dr. Marchant:

Have you ever had a facility apply within 30 days and not be ultimately licensed?

Ms. Henwood:

Not to my knowledge. We would monitor this facility the entire way. The facilities that make the effort to apply for the license, our department sees that as a show of good faith, and we do attempt to work with them. That is not to say that it may take a little bit longer because they are not qualified per se in our regulatory standards, but we do attempt to work with those facilities. Not to my knowledge have we had someone apply for licensure and be denied.

Dr. Marchant:

The plan is to get them open and not close them unnecessarily.

Ms. Henwood:

Correct.

Ms. Laura Leavitt:

On the creation of this Board from SB 340, one of the slides indicates that they would investigate matters relating to the wages and working conditions of the home care employees in Nevada and develop recommendations regarding the minimum wage. It then indicates further down that they are also looking at the sufficiency of recruitment and retention and that this may not go to Director Richard Whitley until December. Will that be in time for them to make recommendations for the next Legislature, or do you know if they may come back with something sooner and that is just what is written in the law? Because it is at a crisis state now with providers and caregivers, from my understanding.

Ms. Samuels:

As it currently stands, when the Board makes a recommendation to the Director, that recommendation is passed on to the Director and his team as soon as possible. It does not necessarily wait until the report at the end of December. That report will be just a culmination of the findings; however, the recommendations made carry on immediately. After it is approved or denied from the Director, it is then carried on through the available avenues by the state to be enacted or at least start that process.

Ms. Laughlin:

My questions are also about SB 340. I will piggyback a little bit with the last question about the recommendation for increased minimum wage, which I do not disagree with because it is a skill—we need to pay these people—but I am trying to figure out the whole circle in terms of money. There is also a reference to low reimbursement for providers. It seems like we have a funding circle problem. I wanted to get your insight on that and how we are trying to work through that. On slide nine, there were three points about $500 supplemental payments that facilities are expected to ask for that money, but there was also a reference to the employers paying for training and education, which is great, but does that supplemental funding pay for that education, or are those two separate? I am not sure how that all goes together.

Ms. Samuels:

I will tackle your questions in the different parts. For the increased minimum wage as well as the rates, the Board is planning to address that at the next meeting, which is next Tuesday, June 28, at 2:00 p.m. over Zoom. For anyone interested in attending that meeting, it is open to the public. I encourage you to do so if you are interested. They are addressing both the recommended minimum wage as well as a recommendation for increasing the rates from Medicaid. As far as the $500 supplemental payments, that was from the Medicaid Home and Community Based-Services Plan, and the 15 percent supplemental payment to the providers is separate from the retraining requirement. The training requirement is in NAC. The recommendation was to change that statute to reflect that employers are expected to pay for all required training.

Ms. Henwood:

Yes, she said it perfectly. That is correct. I would also like to piggyback that she did mention at the end that we are working on regulatory language to address the recommendation that the provider pay for the training. We are in the process of that as well.

Mr. Silberkraus:

Under your slide "Powers and Duties of HCQC Upon the Receipt of a Complaint," if the complaint is made either by a resident, family member, or friend, is there confidentiality so that there is no repercussion?

Ms. Henwood:

That is a good question, and it is something we take very seriously. There is 100 percent confidentiality. We get this concern a lot when we get call-ins. It is a very real concern because, as you mentioned, if it is a resident of an agency or a family member of a client, they are very concerned about that and concerned about the welfare of their loved one or concerned about themselves. If they are in the facility at the moment and want to make a complaint about conditions of that facility, there is a real concern. One of the things that our department takes into consideration when we go out is that confidentiality. We get questions at the facility about who made the complaint. It is a very frequent question from providers. I understand that side too, but we are bound to keep all complaints confidential.

Mr. Troth:

On slide 12, under powers and duties, there is some discussion about training and standards. I assume the state is providing the standards. Is that in NRS? What is the training requirement? Who is directing? Who provides? Who created that curriculum for the training for these types of positions and workers?

Ms. Henwood:

I will try to answer that as concisely as possible. We have a variety of NAC regulations that address training. There are several trainings that our attendants undergo. There is training at the beginning of hire that is housed in one NAC. There are regulations for annual trainings, tuberculosis testing, physical examinations, and cardiopulmonary resuscitation (CPR). There are quite a few regulatory requirements regarding training. These trainings at the time of hire include several different personal care topic areas, if you will, related to providing bowel and bladder care to providing hygiene care. There are also regulations that prohibit certain services so that everyone is aware of the services they can provide that are a nonmedical nature and the services that they are not allowed to provide, such as insulin injection, such as medication administration. There are several of those NACs. If the Forum would like a list of the different NAC sections, I could provide that to the Forum via email, but there are several. It is a good question.

Mr. Troth:

That was my question—whether those are in statute and/or regulations. As a potential worker in this community, are there trainings in the program? Are high schools, college programs, and other private people training future employees in those fields that help with that?

Ms. Henwood:

These trainings can be provided by the provider themselves. We do not have a regulation that states where they need to have these trainings. We just state in the regulations what topic areas need to be covered and how to document that. There are several avenues that providers take. They can take these trainings online. They can have it in house, or they can go out to other entities in person to obtain the training, as long as it is in the training area that is deemed by the regulation. Unfortunately, HCQC does not endorse any one training area, but our providers usually will take examples from their counterparts and find that training. We have not had too many problems with that.

Mr. Troth:

I have one last follow-up. Is the state the only one that does this the licensing process for this type of health care that we are talking about? Do any of the counties or cities get involved in the licensing of these types of facilities because they are in a lot of the municipalities and counties and they are all licensing all kinds of different businesses, and this is a business. What is that relationship in the process of this type of health care that we are talking about?

Ms. Henwood:

The personal care agencies are a health care facility that are licensed solely by the state.

Ms. Laughlin:

I am just curious if SB 340 or these regulations affect private people who are perhaps caring for their parents in their home. It sounds to me like we are mostly talking about providers and agencies, but I am just curious if they intentionally or unintentionally get round up in these anywhere.

Ms. Samuels:

From my understanding of what has happened within the Board, private care workers and private care agencies in general tend to have after-effects from any government or Medicaid changes that occur. It tends to have a trickle-down effect with that. As far as the Board activities, they are focused on private care providers and their working conditions. If someone is getting a Medicaid reimbursement, whether they are affiliated with an agency or not, that is where it affects them.

Ms. Laughlin:

So, essentially it ties to funding. If they are getting paid through the state Medicare, Medicaid, whatever, then they are required to be compliant with everything we are talking about. If I move down to Las Vegas and take care of my father for three months on my own time, that is a different scenario.

Ms. Samuels:

To my understanding, yes. If you are receiving any kind of reimbursement or payment from Medicaid or the government, then this all applies.

Ms. Henwood:

I would agree with that.

President Almaraz:

At the community college here, they have a class where you can become a certified nursing assistant (CAN). Is that the type of worker that is in home health care? I know they work in the hospitals. They work in doctor's offices. They are not really a nurse, but they are trained in care. Is that the kind of skilled person that you are talking about?

Ms. Samuels:

They are two separate things. Senate Bill 340 specifically addresses home care, not home health care—they are two separate things. Under SB 340, home care encompasses personal care, attendant care, homemaker, companion, respite, and chore services. Those CNA classes would not apply.

President Almaraz:

I am confused. Are they nonskilled workers? They have no training, but they just decide they want to help someone in their home?

Ms. Samuels:

Home care and those who work in home care under personal care agencies are required to have a certain amount of training specified in NRS and NAC. The difference, from my understanding, is that those home health workers are trained in a more medical field where they do things such as administer certain medications or other things that you would find in a hospital, whereas home care workers are more, like I said, personal care, attendant care, and chore services, where they are coming in, helping with everyday services such as cooking, cleaning, toileting, things of that nature.

Ms. Tyler:

I think you are mentioning a home health aide, and that is something that can be covered by Medicare if you have a licensed person in the house. My question is, is the state involved in helping different agencies or different companies that they are contracting with and funding? Are they involved in helping them to recruit the appropriate people? I do know that it does, in many cases, require licensed people, but there are so many other support staff who can be involved that do not require a license. Are there programs to recruit or to encourage home health aides, caregivers, and things of that nature, available? How is the state involved? I am still not sure of who is funding what. How much of this is federal government, and how much is the state actually involved with?

Ms. Henwood:

As far as recruitment for HCQC, we do not currently have any programs that help facilities to recruit employees or train employees. The regulations require the variety of different areas in what nonmedical topic areas are required for attendants who would like to go into this field. This training can be provided to the attendant in house, or other training out in the community can be considered as acceptable. We do not currently have any recruitment programs per se, but I do believe that the HCESB is in the process of reviewing those issues. I do not know where that avenue will take our Board, but it is something we can bring up at our Board.

Ms. Samuels:

To add to that, in the scope of investigation for the HCESB under SB 340, one of those is the sufficiency of levels of recruitment and retention of home care employees. That is on the docket for the Board to address. One of the tools we are using to address that is the survey that has gone out to both home care employers and employees. We hope to address that soon, but at this moment, there is not a recommendation.

Ms. Tyler:

How does the state determine that the funds being given to different agencies and companies of that nature are effective and making a difference? How are they monitoring the care that is being given and/or the lack of care? How do they correct that if they are not monitoring it or if they leave it up to the individual companies to make the rules?

Ms. Henwood:

I can only speak to HCQC's regulatory division. We are monitoring those facilities right now on a periodicity rate of every six years. That has changed over time. Where there used to be a periodicity rate of every 18 months for personal care agencies to ensure that everyone is trained and the clients within the programs are receiving the care that they agreed to and that the provider agreed to provide. I can only address the monitoring on our end, on a regulatory end, which is every six years right now for personal care agencies.

Ms. Adin:

I had a comment about a private health care facility called Little Angels. It is run by a husband and wife. I received a complaint about them. They are not getting nutritious meals and the health care they need. I was wondering, when it is a husband and wife-run facility, and they have three patients in the house, how is that monitored?

Ms. Henwood:

We are monitoring at a periodicity of every six years. If a complaint is presented, we go out more frequently when that complaint comes in. Our website has a complaint documentation area where the public can make a complaint online; it comes directly to our complaint department. The only way we would know that there is an issue at a facility would be if the resident themselves, a family member, or a concerned community member contacts our office to make the complaint. We would then turn that into an investigation and go out to the facility. That could happen not just every six years. Every six years is a full inspection of the facility. We could have been out at a facility yesterday, and a complaint may come in today for the exact same facility, and we will go out on that complaint. We are not bound on when we must go out. We just need to have the information from the community to be able to do our jobs.

Dr. Marchant:

I have a question about training that is coming out of my professor bag at this point. When one of the health care workers goes through the various prescribed training procedures, is there an examination at the end of it, or do we just get a piece of paper that says they have sat through the thing in a classroom? It is a little difficult for me, for example, to see that somebody could learn cardiopulmonary resuscitation (CPR) by watching it online.

Ms. Henwood:

There is a competency exam. Not only are our attendants supposed to be trained in specific areas—it is not just the certificate that we inspect for. Once that training is complete, we would want to see that the attendant is competent in that area. The facilities have a variety of ways that they can show that an attendant is competent in a specific area. Some do a postexam, and some do an in-person demonstration. Unfortunately, our regulations do not designate what type of competency must be completed, but just some type of competency. We see a lot of the postexam and the in-person demonstration. As Kayla mentioned, if there is training in preparing meals, they would want to demonstrate that back to show that they can do that task. As far as CPR, it must be taken in person and through the National Red Cross. First aid can be done online, but not the in-person CPR; that has to be done in person.

Dr. Marchant:

I am reassured. Thank you.

President Almaraz:

Are there background checks done on the facility and on the workers? As a second part of that, is there protection for the workers? I sat through many of the hearings for that bill, and many of the workers were subject to physical abuse.

Ms. Henwood:

I would like to tackle your first question, and then I will hand it over to Kayla. The first question, I believe, was about background checks. There is a statute that [applies] not just to personal care agencies but also to assisted living facilities, which we license, and to skilled nursing facilities, which we also license. There is a background check requirement law and not only fingerprinting, but a criminal history statement that acknowledges an employee has not been convicted of a laundry list of crimes is completed at the time of hire before they can provide services to clients and then every five years.

Ms. Samuels:

Madam Chair, may I ask for clarification on your second question regarding the protection for the workers?

President Almaraz:

Is the Board addressing anything to provide protection for these workers when they go, usually alone, into a home to provide services? In the hotel industry now, they are providing some sort of a panic button for the housekeepers [to use] if they walk into a room and someone attacks them. Is there anything being thought about or discussed in your Board meetings to provide any kind of protection for the workers? Because in those hearings, there were some horror stories about how some of these workers had been attacked.

Ms. Samuels:

Thank you so much for the clarification. To my knowledge, it has not directly been brought up in the Board thus far, and I came into this position a little late in the process, around April. One of the scopes of the investigation is the adequacy of the role home care employees have in making decisions affecting things such as their working conditions. When we address that topic, I am more than happy to bring that up to the Board for its consideration.

Ms. Laura Leavitt:

I just wanted to make sure I understood that you indicated that monitoring went from 18 months to six years. Is that correct?

Ms. Henwood:

Yes, that is correct. Once upon a time, our periodicity was 18 months, and it was put into legislation. Our periodicity is now six years. Again, that was before my time as well. I apologize that I am not being much of a historian here, but that is the course as I know it. Currently, we are inspecting personal care agencies every six years.

Ms. Laura Leavitt:

You do not know the background on that? I wonder why they would go from 18 months to 6 years. That is more than double. That is what, triple?

Ms. Henwood:

I would be happy to look into it and provide clarification, if that would be acceptable.

President Almaraz:

Seeing no other questions, thank you, Ms. Samuels, and Ms. Henwood, for a very enlightening presentation. We look forward to the follow-up that you are going to do with some of the Forum members.

Forum members, before we continue, we are going to take a short break.

[President Almaraz called for a brief recess.]

AGENDA ITEM VI—PRESENTATION ON ALZHEIMER’S PATIENTS AND SERVICES IN NEVADA

President Almaraz:

We have Agenda Item VI, a presentation on Alzheimer's patients and services in Nevada. We will receive a presentation from Mr. Charles Duarte, the Nevada Director of Public Policy and Advocacy from the Alzheimer's Association. He will give a presentation on the status of Alzheimer's patients and services in Nevada. Mr. Duarte, please proceed when you are ready.

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

I have been working in health care for about 35 years, including 15 years running Medicaid programs, including the Nevada Medicaid program. I spent 12 years as the administrator for Nevada Medicaid and three years as the administrator for Hawaii Medicaid. I may be able to address some of the questions you previously asked of some of the presenters. I think those presentations were a good setup for what I am about to tell you today. In my current capacity, I also serve as the Vice Chair of Nevada’s Task Force on Alzheimer's Disease, ADSD, DHHS, and as the Chair of the legislative subcommittee of the Nevada Commission on Aging (COA), ADSD, DHHS.

Madam President, with your permission, can I address a couple of issues that came up in the prior presentations? It may help your members.

President Almaraz:

Yes, please.

Mr. Duarte:

There was a question regarding who pays the personal needs allowance. That is paid by Medicaid. If there is going to be an increase in the personal needs allowance, it will be a cost to the state and to the counties. That does not mean it should not go up; it should go up. It just means there will have to be an investment. The COA heard from experts in DWSS as well as Nevada Medicaid about the increase in personal needs allowance for nursing facility residents. There is a cost. They presented an estimate of that cost, so hopefully this will move forward. It is one of the recommendations by the legislative subcommittee to increase the personal needs allowance to something around $50 to $60 a month.

Regarding personal care services, there were quite a few questions about rates and who pays and how that money gets to employees. I might point the Forum to a terrific study that was done by the Guinn Center in Las Vegas. They are a nonpartisan think tank, and they produced a report in 2020 called *Helping Hands: An Assessment of Personal Care Aide Workforce in Nevada*. Essentially, they pointed to the problems that you folks have touched on. That is, low wages and the fact that personal care aides themselves are disproportionately women of color and their average wages are around $11 an hour. One of the things that was pointed out is that for those wages to go up, the Nevada Medicaid program, and hence, the state and federal government, would have to pay reimbursement rates more. There are really two sources of payment and only two payers that pay for personal services in the home—Medicaid and out of pocket. Medicaid is the biggest payer, so they would have to increase their payments to these agencies so that it could hopefully filter down to those employees' increased wages. There was a reference to a $500 supplemental payment that the state was making. That is a part of the American Recovery and Reinvestment Act of 2009 (H.R.1, 111th Congress), and it is a one-time payment. It is not going to be any future payment. If rates are going to be going up on the Medicaid side, it must be a part of the governor's budget and the legislative budget, and it could be a significant cost. It is one of those investments that we are going to have to make.

One of the things I will touch on today is this care gap that you folks have been talking about. There are 13,000 personal care attendants in Nevada. By 2050, we are going to need 10,000 more. Experts are saying that that number of 13,000 is not going to increase, so there is a significant care gap that is going to have to be addressed. Those will have to be addressed through working conditions and wages. It is a serious concern.

Training is also a concern for the Alzheimer's Association. We really want a dementia-capable workforce. Right now, there is really no training requirement for in-home care providers around dementia services and how to communicate with somebody with dementia and how to deal with someone with dementia. That is another one of our priorities.

I am going to now head into my presentation (Agenda Item VI). There are a few things I want to talk about today. I want to talk about some facts and figures on a national level, and then I want to get granular and talk about some facts and figures around Alzheimer's disease and other dementias in Nevada. I would like to touch on some of our state policy priorities and about the Alzheimer's Association and some of the services we provide.

I know there are several doctors on the Forum, but I do want to touch on this because it is a question that is asked a lot. What is dementia, and what is Alzheimer's disease? Dementia is an umbrella term that encompasses multiple forms of the disease. There is vascular dementia, Lewy body dementia, other forms of dementia. Alzheimer's disease is the most prevalent, accounting for 60 to 80 percent of all dementias. If somebody has a diagnosis of Alzheimer's disease, it is a form of dementia, but there are other forms.

Here are some national facts and figures. There are more than six million Americans living with Alzheimer's disease right now, and that number is going to be going up rapidly.

Currently, there are 11 million Americans providing unpaid care for people with Alzheimer's disease. I will touch on this in Nevada specifically in a bit. Those caregivers provide an estimated 15 billion hours of care valued at about $257 billion.

Many individuals who meet the diagnostic criteria for Alzheimer's disease are not diagnosed by a physician. Quite often, somebody may have the disease but has never sought a diagnosis and never talked to a provider, nor have their family members. Often, they are not diagnosed. Fewer than half of Medicare beneficiaries who may have a diagnosis of Alzheimer's disease are aware of it. That is because the provider has never told them, nor have they told the family member about that diagnosis. For some reason, that diagnosis is sometimes held away from the person living with dementia or Alzheimer's disease as well as their family and caregivers.

In the last 20 years, we have seen a decrease in deaths associated with other chronic conditions. Alzheimer's disease has seen an increase of 145 percent between 2000 and 2019. The death rates are going up as opposed to the death rates for other chronic diseases, which are going down, including cancer. One in three seniors dies with Alzheimer's disease or another form of dementia. That may not show up in their death certificate. Quite often, what happens is they all die of another condition. For example, pneumonia, aspiration pneumonia, or they will choke on something. It may be another direct cause of death, but that is certainly not the reason for the death. It is because of Alzheimer's disease.

The burden of Alzheimer's disease is not shared equally amongst the different demographics across our nation, so the burden to families is not shared equally as well. About two-thirds of Americans with Alzheimer's are women. Blacks are two times more likely than whites to have Alzheimer's disease or another dementia. Hispanics are one and one-half times more likely. However, despite that disparity, two-thirds of blacks, 40 percent of Native Americans, and 39 percent of Hispanics believe it is harder for them to get good care for Alzheimer's disease.

In 2021, Alzheimer's disease and other dementias cost the nation $355 billion. By 2050, that rate will go up to more than a trillion dollars. This is an important slide because this is how the cost of Alzheimer's disease is shared amongst payers. Medicare pays for a lot of the costs associated with the care of somebody with dementia; however, Medicaid has a huge share of that as well. Medicaid pays for all the long-term care services. Keep in mind that Medicare does not pay for long-term nursing home care or group homes or other kinds of long-term services and supports, but Medicaid does. The second largest share is out-of-pocket expense. For families who have somebody living with them or they are caring for a loved one or spouse with Alzheimer's disease or another form of dementia, a lot of that cost burden is out of pocket.

[Here are] some specific Nevada facts and figures. For people who are 65 years and older with Alzheimer's disease, there are about 49,000 of them living in Nevada right now. In the next three years, that number is going to go up 31 percent to 64,000. It is the third-fastest rate of growth of Alzheimer's disease in the nation. We are following behind Arizona and Rhode Island. A lot of the deaths that occurred associated with Alzheimer's disease and COVID-19 occurred in nursing homes in 2019, and a lot of those patients had Alzheimer's disease.

In Nevada, there are 2,167 people in hospice programs with the primary diagnosis of Alzheimer's disease. In terms of hospitalizations, it is one of the highest in terms of the rates of hospitalization. Hospitals use the term "bed days." There are 1,711 bed days for 1,000 people with dementia. That is an extremely high rate.

The cost to the state Medicaid program is very high as well. There was a question about who pays for this. About 63 percent of every dollar spent is federal on Medicaid; however, the state government, the Nevada Legislature, must come up with that other 37 cents on the dollar. A huge piece of this cost, $203 million in the cost of care for people with dementia, is paid for by state government and state tax dollars—not just federal tax dollars. It is also one of the highest costing diseases per capita. It costs Medicare about $37,000 per year for somebody with Alzheimer's disease compared to about $21,000 per year for somebody without it.

We have talked a lot about professional or pay caregiving, but there is a lot of unpaid caregiving. In Nevada, about 48,000 individuals provide unpaid care to someone living with dementia. It is estimated that that accounts for about 78 million hours of unpaid care—that could be a spouse, a family member, a friend, or a neighbor. If you try to value it, that is $1.3 billion dollars a year in unpaid care provided by caregivers in Nevada. The other problem we have is that 80 percent of those who are providing care have problems themselves. They have chronic conditions or multiple chronic conditions because of the burden of caregiving to somebody with dementia who may have that disease for a long period of time. The caregivers themselves often suffer from depression.

Mild cognitive impairment is a term that is used for pre-symptomatic dementia. Sometimes it could be due to other forms of dementia or medical conditions, and often it is Alzheimer's disease. About 10 to 15 percent of people who say they have mild cognitive problems go on to develop dementia.

In terms of the gap in care that is growing, it is not only the personal care attendants or in-home attendants that we are seeing a care gap develop, but it is also around trained professionals. It is estimated that, given the fact that Nevada's rate of growth of individuals over 65 years of age is the fastest in the nation, we are going to need an additional 267 percent increase in geriatricians to take care of those seniors in the next 25 years. In addition, people who diagnose dementia, generally a primary care provider, can provide an initial screening and make recommendations for a differential diagnosis, but that differential diagnosis of dementia is usually done by a neurologist and/or a neuropsychologist. It can be done by a trained geriatrician. Nevada, amongst 20 other states, is considered a "neurology desert," which means that we do not have enough neurologists to do the job.

There is a survey that is conducted every year by the DHHS in Nevada. It is called the Behavioral Risk Factor Surveillance System. There are two modules in that survey that are pertinent to the work that we do at the Alzheimer's Association. One is called the Subjective Cognitive Decline Survey. This cognitive decline survey asked people 45 years and older if they were having increasing problems, self-reported problems, with memory cognition or that type of thing. One in seven people aged 45 and older say they are having problems with cognition. When you look at the age cohorts of these, it is interesting because one in seven, or 16 percent, of people aged 45 to 65 say that they are having problems. Even at a young age, people are starting to recognize that they may have problems. That is not to say that someone self-reporting cognitive decline is going to go on to dementia, but there is a fairly high probability that they will go on to some sort of cognitive problem. The most important thing with this statistic is that of those people that say they have problems with cognition, less than half have ever talked to a medical provider about that problem. That is why this disease goes undiagnosed so often. Nearly a quarter of those with subjective cognitive decline in these surveys say that it interferes with social activities, work, volunteering, and other types of things, and 28 percent say they need help with household tasks. That is a growing number.

Given all of that, the Alzheimer's Association has a number of state policy priorities, and I would like to touch on them. We have three that we are highlighting. We do not limit ourselves to three in the state of Nevada—we can do more—but these are the three that we are looking at.

We are looking to expand access to an early and accurate diagnosis. That means augmenting the services that a neurologist or neuropsychologist would provide for diagnosis, but also training our primary care workforce to help with screening and initial diagnosis of dementia. We are proposing something called the Nevada Memory Network for that. I will talk a bit about that in a minute.

We have touched on the importance of caregivers throughout today's meeting. We have talked a lot about paid caregivers, but we have also touched on the fact that there are a lot of unpaid caregivers. We must recognize the value that they bring not only to that person living with dementia, but also to state government because they help offset the cost of Medicaid by keeping people out of nursing homes, which Medicaid almost always pays for. Keep in mind, about 60 percent of nursing home beds in Nevada is paid for by Medicaid, which is federal and state money. Keeping people out of nursing homes is an important aspect of saving money, and supporting family caregivers is important to that end.

The other thing we would like to do is to put a dementia crisis program in place. I had the privilege of sitting in on meetings between Adult Protective Service workers, Mobile Outreach Safety Team members who are represented by law enforcement and social workers, and county social workers. Over the last year, we have had this discussion, through an ongoing meeting of a coalition, to talk about some of the issues. What they came up with was the fact that there is an increasing number of encounters between somebody who may have dementia and law enforcement or an emergency room. Oftentimes, those end up with negative outcomes. Somebody with dementia who has eloped from a nursing home or a family home and is wandering on the street is certainly upset. When a law enforcement officer sometimes encounters them—and you have heard about this in the news, including in Las Vegas recently—that person with dementia might act out. Acting out for somebody with dementia is just a form of communication, meaning, "I am scared. I am nervous. I am in pain. I am hungry." They act out in certain ways, and not recognizing that, they often end up in an encounter with law enforcement who ends up putting them in handcuffs and taking them to either a jail, a hospital, or a psychiatric facility, all of which are the wrong places for somebody with dementia. We are talking about and have some support for a program called Dementia Care Specialists. It was a program that was tested out of Wisconsin and has been implemented in four or five other states. It provides a point of contact for law enforcement, county social workers, and others when they have an encounter with somebody who has dementia. This person is trained to help de-escalate that encounter, to help with crisis stabilization, and to provide ongoing community support to them, and if they have a family caregiver, to them and their family. We would like to support dementia care programs.

The Nevada Memory Network is based on proven work out of Emory University, the University of California, San Francisco, and the University of Wisconsin. We are looking at enhancing our primary care provider (PCP) screening and education to do dementia care screening. There are some programs across the state—both our public schools of medicine do that—but we want to further enhance that. We also want to establish clinics or hubs where diagnoses of dementia can occur. We have two terrific hubs, but we need more of them, and that is the problem. One is in Reno at the Renown Institute for Neurosciences, and the other is in Las Vegas at the Cleveland Clinic Lou Ruvo Center for Brain Health. We want to expand on their capacity to see more patients and provide more diagnostic care.

We want to have a warm handoff to the PCPs with a care plan, and we want to help that caregiver who may be involved understand that care plan. Finally, we want a care navigator to help that patient/caregiver dyad, those partners, to get access to community-based supports and ongoing services.

This is a model of what we are talking about. The PCP does an initial screening. They send it to the memory assessment clinic where they do a diagnosis, develop a care plan for the caregiver and the patient, hand it back to the PCP, and then a care navigator is engaged with the PCP and that household to provide ongoing community supports.

We also talked about the importance of family caregivers. What we want to do at the Alzheimer's Association is to enhance the work of family caregivers, most of whom are currently unpaid. This is based on work out of Indiana, Georgia, Washington, Missouri, and a number of other states. We want to improve the Nevada Medicaid Home and Community-Based Waiver program for the Frail Elderly. This is done through providing additional supports and training for that family caregiver that is very specialized. We also want to make sure that that family caregiver has communication with the state case manager in these programs, so that they can put notes into a case management system, and that case manager can know on an ongoing basis what is going on with that patient and can provide specialized training to that caregiver. We really want to make sure that the caregiver is getting as much support as possible.

A couple of other ways we want to make sure that that is encouraged is we want to make it easier for that caregiver, that family member, to get paid. Currently, Nevada Medicaid pays for that, but they will not pay for a spouse. A lot of caregivers are spouses, and they often give up their own careers to become a full-time caregiver to somebody living with dementia. We want to be able to pay them to be a caregiver. We also want to pay other family members or friends to be caregivers and make it simpler to do that.

Finally, we want to provide respite care to family caregivers, and we want to make sure that we are staying on top of their mental health and even provide a health coach to them so that they know how to deal with their stress as a caregiver and also have access to respite services.

I mentioned the dementia specialist program. This is based out of work in Wisconsin, and I already discussed the fact that it provides crisis intervention, crisis stabilization, and long-term support to people. We also see this position as providing screenings and referrals out in the community. There are some excellent tools and new technologies that are being developed to do a very accurate screening at least at the level of dementia, but not necessarily a specific type of dementia. Screening has become an important role for these positions as well.

The Alzheimer's Association's vision is a world without Alzheimer's disease and all other dementias. We maintain a 24/7 helpline at 1 (800) 272-3900. Any time of day, seven days a week, you can call and talk to a licensed professional about your needs. They will help you with information as well as educational resources for caregivers. Our website, ALZ.org also has a huge array of resources for caregivers and individuals in the early stages of disease. Those are all free, online, and available for people; all they have to do is access our website at ALZ.org/education.

We maintain partnerships with a number of clinical research firms and agencies, including the National Institute of Health (NIH). We have a program called Trial Match. This allows people who are living with disease but people who may not have any dementias to be participants in dementia drug treatment trials.

We host the largest international scientific conference on Alzheimer's disease, the Alzheimer's Association International Conference (AAIC). The Alzheimer's Association is the largest individual organization in terms of research funding, only behind NIH in the United States. We have our Walk to End Alzheimer's, our fundraising event, which will be in October in Las Vegas and in the Reno-Sparks area.

That is it for me. I will be happy to answer any questions.

President Almaraz:

Thank you for that presentation. Forum members, are there any questions?

Ms. Adin:

I have a number of questions that all might be related. My first one is, why is Alzheimer's such a growing pandemic now, and what caused it?

Mr. Duarte:

There is a combination of factors. One is our aging population. For a long time, we have seen this increase in the baby boomer population. One of the major factors that contributes to Alzheimer's disease is not just genetics, but age. When you break down some of the factors with the risk of Alzheimer's disease, number one is age. There are other factors, like education, social engagement, physical activity, and genetics. With our growing population, there is more frequent issues with dementia. Historically, this is something that has not been diagnosed, or people have resisted getting a diagnosis. I think more and more—and thank goodness for this—through awareness campaigns, people are asking their doctors about it. Doctors are more willing to provide the screening that is necessary and refer them for a diagnosis. That is a second reason why we are seeing an increase. The third reason has to do with lifestyle. There are risk factors associated with poor diet, lack of exercise, and other types of risk factors like drinking, injury to your brain, and factors that contribute to the risk of Alzheimer's disease. Now we are just recognizing it. One of my colleagues says, "Alzheimer's disease is a disease of middle age that you only see in old age." Those kinds of lifestyle factors in middle age can have an impact later in the form of dementia or Alzheimer's disease. I hope that answers your question.

Ms. Adin:

Yes, you did. Thank you.

Dr. Wand:

That was an excellent presentation. I have one question and one comment. First, you mentioned that so many people were hospitalized with Alzheimer's disease. I understand you can have physical disease and all kinds of problems with how Alzheimer's manifests, but there are some people who just have Alzheimer's disease and do not necessarily need to be hospitalized. I am wondering if you can save some resources if some of these people who have Alzheimer's disease do not necessarily need to be hospitalized.

My comment is that I think you made an excellent point on the contributing factors. We really do not know the cause of Alzheimer's disease. There are ongoing studies and high-end research using magnetic resonance imaging (MRI) and physiological imaging of the brain, but we really do not know the cause of it. One of the factors is lifestyle, which you pointed out—exercise. It is hard to show the proof of it, but it is well shown that if you exercise on a regular basis, you decrease your chances of developing dementia and Alzheimer’s. The lifestyle issue is an important issue. Everyone knows how bad smoking is but being a couch potato is maybe just as deadly. Not exercising is not only bad for your physical health, but it is bad for your mental health. We have a community that engages on a regular walking basis, and it shows that it really helps the whole community and society if you just stay healthy.

Mr. Duarte:

To piggyback on your comment, social engagement is one of the factors that contributes to a lessening of the risk of Alzheimer’s disease. You mentioned a group walking club, which creates social engagement opportunities for people to talk and maintain personal relationships and exercise, and both of those contribute to the lowering of the risk of Alzheimer’s disease.

With respect to hospitalizations, I am not an expert in those statistics, but from some of the data that I see, a lot of those hospitalizations are secondary to things like behaviors. If somebody is demonstrating a risky behavior in a nursing facility, they may get admitted to a hospital to treat them for behavioral issues. Oftentimes, they end up getting overmedicated—or other chronic conditions. Alzheimer’s disease, particularly in late stages, will result in individuals who may have problems with falls, which is another increased cause of hospitalization, as well as pneumonia. All of those may be secondary, but they really are not secondary because it is Alzheimer’s disease that has been the primary contributor to those issues occurring and the hospitalizations as well. Alzheimer’s disease itself does not necessarily result in hospitalization. Oftentimes, people pass away peacefully at home or in the nursing home, but it is those secondary things that occur because somebody cannot eat properly, cannot ambulate, cannot toilet, cannot do a lot of things without good support. Oftentimes, that ends up in injury and disease.

Vice President Jordan:

Thank you for your presentation. My question comes from some of your data that says that we are a neurology desert. I looked this information up, and it is projected that by 2025, we are going to have 128,000 people suffering from this serious disease, but only 97 possible neurologists throughout the state. What is your organization and the state of Nevada doing to recruit people to help us work with our senior citizens in Nevada to reduce this problem?

Mr. Duarte:

In terms of the Alzheimer's Association, we work on policies that help support the increase in access to an early diagnosis. I mentioned the fact that one of our policy priorities—and I hope to have some legislation around this in the next session—is to get some funding to support an increase in the number of neurologists and neuropsychologists in Nevada. Neurologists and neuropsychologists are not a dime a dozen. They are difficult to recruit. We do not hold out hope that we are going to be able to bring in neurologists and neuropsychologists to the state, but what we are really hoping to do is to augment the training that we provide to PCPs to help with those diagnoses. A medical director at the Cleveland Clinic Lou Ruvo Center for Brain Health told me that he firmly believes that 50 percent of the diagnoses that he makes for Alzheimer's disease can be done by a trained PCP, a family doctor. If we are going to be looking at bringing in resources, it must focus on that primary care home for people. We are trying to bring in resources through legislation that I mentioned—the Nevada Memory Network—but again, that will cost money. That will be an investment, and we will see if the Legislature wants to make that investment.

What the state is doing is—honestly, they are trying. They have longer payment programs, and if you are a geriatrician or want to be a geriatrician, you can apply for loan repayment programs. The Board of Medical Examiners encourages physicians to get training in dementia and Alzheimer's disease. They have a program that the Nevada Legislature passed in 2003 that allows for every two hours of continuing medical education in Alzheimer's disease or dementia to count as four hours of continuing medical education credits. It is not much, but that is what the state is doing as far as I know.

If I can mention a couple other things, our two schools of public health have done a good job of trying to increase the number of residents who go into the field of geriatrics. They have grants from the Health Resources and Services Administration, U.S. Department of Health and Human Services (HHS), to support this activity of increasing the number of physicians trained in geriatrics. In Reno, we have Project Echo, which is an online webinar-based training program for PCPs around dementia care. That happens two to three times a year, I believe. It is a six-week course for PCPs. There are other activities going on, particularly through our public schools of medicine, to train PCPs.

Dr. Jordan:

Eight neurologists would have to deal with 10,000 people. That is an awfully big number. I feel that that is something that we should pay attention to. Yes, we have an increase in the number of folks experiencing that and all aspects of the different kinds of dementia, but we need to have some people who can diagnose it. As you said earlier, we do not have people getting diagnosed, so a lot of people are walking around with the possibilities, but there is nobody to help them.

Mr. Duarte:

Exactly. I think that becomes an important issue when we start looking at drug treatments that are coming down the pipeline through the U.S. Food and Drug Administration (FDA), HHS. There are a number of clinical trials of new drugs. One was recently approved by the FDA, although some folks feel that it had a minimal impact and only an impact on delaying Alzheimer's disease for those in the mild cognitive stage. There are other drugs in the pipeline, but to get the drug, you have to have a diagnosis; to get a diagnosis, you have to have a specialist look at you. I think the pressure is going to be increasing to have those types of specialties and training expanded. I think we cannot discount the importance of our PCPs and other practitioners in helping with that diagnostic work.

Mr. Troth:

That was an excellent presentation. I have a series of questions. Regarding your Nevada priorities, do you have any idea what it would cost to fund dementia care specialists?

Mr. Duarte:

Based on the work in Wisconsin that I have been able to look into, it is about $100,000 a year per each position. It includes things like access to equipment, benefits, et cetera. What we are talking about here are masters-level social workers—not clinical social workers—but masters-level individuals in the health field. Each position would probably cost about

$100,000 a year. But, if they can delay the onset of placement in a nursing home by 18 months, they would save tens of thousands of dollars a year per person.

Mr. Troth:

Are you advocating for that to be government money of some type?

Mr. Duarte:

Yes, that is correct.

Mr. Troth:

Do you think the Nevada Legislature has an appetite for something like that?

Mr. Duarte:

That is a very good question. Oftentimes, people look at a piece of legislation, and if it has a dollar amount attached to it or a cost, they shy away from it. I think they must look at the alternatives. What I presented before was that the Nevada Medicaid program, which is partly funded—and it is not an insignificant amount—by legislative state dollars. They pay $233 million a year for dementia care, and one-third of that is state dollars. Imagine if we could avoid even a small percentage of that by investing in these types of positions. I think it could create tremendous cost savings, which is why very conservative states like Wisconsin and Georgia have invested heavily in these positions. They recognize that it saves money in the long run. It saves the state money in terms of inappropriate hospitalizations and Medicaid costs. It is an investment, but it does have cost savings, and it avoids future costs.

Mr. Troth:

Is your organization lobbying next session for that particular concept?

Mr. Duarte:

I am not the lobbyist yet. I will be registering as a lobbyist during the 2023 Legislative Session, but the answer is yes, we are going to be asking for this. I am currently talking with ADSD to see if they could include the Dementia Care Specialist program as a part of their budget. I have a meeting with the director of DHHS, Richard Whitley, on July 5 to talk about this. The Nevada Commission on Aging has also recommended these positions as a part of their legislative priorities in the next session, so hopefully we will have a legislative sponsor or a committee sponsor to move this forward.

Mr. Troth:

Thank you. I have a couple more questions. Going to the family caregiver waiver discussion, is it going to be a state or federal issue to allow spouses and guardians to receive pay for caregiving?

Mr. Duarte:

Under current Medicaid regulations, spouses and guardians are considered legally responsible individuals and are precluded from being paid; however, many other states have passed waiver programs. These are Medicaid waiver programs. A waiver is the state going to the secretary of HHS and saying, “Secretary, we want to waive certain federal regulations to make sure we can provide a program that is appropriate for the people in Nevada.” That is what a waiver is. Other states have requested the secretary to waive those requirements and allow legally responsible individuals, i.e., spouses and guardians, to be paid family caregivers. At the federal level, there is one recognition that must occur, and that can be done in a process that Medicaid does, which is called the State Plan Change. The Legislature can choose to recognize that through legislation. What we are asking is for the Nevada Legislature in the next session to sponsor a bill, to move a bill forward, that would create the opportunities for these structured family caregiver programs to be developed and to allow spouses and guardians to be paid caregivers. The Nevada Commission on Aging is moving this forward as a recommendation. We have a possible bill sponsor who wants to carry this bill into the next session. We believe that it will have either a cost savings or a minimal cost, so we are hopeful that this will move forward in the next session.

Mr. Troth:

I appreciate that. Those are good answers. I have one last question. This is about your organization, the Alzheimer's Association. I think we need more of these types of groups that do different things. Can you give us an idea of how your organization is funded and where you get your money? I know you fundraise. Are you getting other supplements from other corporations or state government agencies to fund your Association?

Mr. Duarte:

The vast majority of our dollars come from donations. We raised a lot of money through our activities, including our Walk to End Alzheimer's. We had an event yesterday called the Longest Day. A lot of our operational costs are funded by those types of activities across the nation. We do apply for state grants, and some of those grants support some of our services. For example, in Nevada, we have the privilege of getting grant funding from the ADSD to provide vouchers to family caregivers so they can pay for respite and take a break from caregiving. That is an example of the type of grants that we do. The other thing we do is provide research dollars. Most of our research dollars come from donations. We use those dollars to help support our research activities at the NIH, as well as private research institutions. Less than 1 percent of our money comes from big pharmacy companies. We try not to be obliged to organizations that may be seeking some sort of quid pro quo from the Association or some sort of endorsement for the work that they are doing. We try to keep those requests to a minimum. Most of our dollars come from donations as well as grants that we get from states across the nation.

Ms. Laughlin:

I have one question and one comment. I am thinking about the neurology shortage and am glad to see some creative problem solving here because I suspect that it is not even just a matter of recruiting. I suspect there is a shortage of residency programs in the nation. I do not see how we will even be able to, as a nation, get the number of neurologists we need without more residency programs, so I am glad you are looking at new ways to diagnose this. My other is just a point of clarification because I was struck by the increase in Alzheimer's disease deaths. You may have started to touch on this. Explain to me how you die from Alzheimer's as a primary condition? Or, is it that Alzheimer's is not being diagnosed as a primary condition, and it is something secondary that is killing them that is associated with Alzheimer's? The statistic was so huge that I was trying to understand it.

Mr. Duarte:

I am not an expert in this data, but I can tell you what I have read and what the Association has published around the increase in death rates associated with Alzheimer's disease. Both points you made are correct. There is an increased number of individuals who are getting diagnosed and go into the hospital with Alzheimer's disease, or a nursing home most likely, with a primary diagnosis of Alzheimer's disease, and die because of the disease itself. This disease is fatal, and it is progressive. The disease will result in the inability to eat and the inability to do a lot of different functions. That in and of itself will result in death. If they cannot take in water properly and cannot eat, it will result in starvation and death. The other very common problem is something called aspiration pneumonia, which is the result of the inability to control your swallowing and control your drinking. That is a brain function. It results in food and/or water and bacteria getting into your respiratory system. That is a large cause of death rates associated with Alzheimer's disease. We have increasing diagnosing of Alzheimer's disease, albeit it is still not at the point where we would like to see it, but also the fact that Alzheimer's disease greatly contributes to these kinds of secondary factors, such as such as failure to thrive, the inability to eat, and aspiration pneumonia.

Ms. Laughlin:

I think many people would be surprised by that, but it makes sense. The brain is the function of everything in your body, so if it cannot eat, you cannot swallow, you cannot live.

Ms. Adin:

The presentation was very informative. What are the signs, and when do you think one should be evaluated to get this diagnosis? I am forgetful now, and I was wondering is that one of the signs of Alzheimer's?

Mr. Duarte:

Thank you for that question. It is a very important question and an extremely common one. The Alzheimer’s Association puts out a presentation for lay people called “The Ten Warning Signs.” In that presentation, we make a distinction between normal aging and what could be problems caused by the early onset of dementia. The fact that you forgot your keys someplace twice this week does not mean that you have dementia. The fact that I cannot remember somebody's name that I just met two minutes ago does not mean I have dementia. But, increasingly, if you have problems with cognition, memory, thinking, or executive functions like reasoning that become more and more frequent, it is important you talk to a family member or a spouse and ultimately to a provider. It is something that is cumulative. The Association puts on an excellent educational program for lay people called “The Ten Warning Signs,” and that can help an individual make that distinction between what is normal aging and what could be—not necessarily is—the early signs of dementia.

Ms. Adin:

Thank you. I needed to know that.

Mr. Duarte:

Go to ALZ.org/education and “The Ten Warning Signs” is right there.

President Almaraz:

You are talking about pay for family member caregivers. Will that be based on income? Anything Medicaid is usually based on income.

Mr. Duarte:

Medicaid eligibility would be for that patient, the person receiving care; that is based on income. However, if a spouse or guardian is providing care, the Medicaid program can set up criteria by which to pay them; that could include income. Other states have found that most often, somebody's spouse, guardian, daughter-in-law, or a daughter—whomever it might be—must give up their careers and time in the workforce to be a caregiver. The disease progresses to the point where it goes from mild to moderate to extreme. As that disease progression occurs, the individual is going to ultimately need almost 24-hour care. The ability of that person to provide in-home support and get paid for it is the fact that they probably happen to give up their job. What some states like Missouri have done is they say, "You cannot be working outside the home in another role if you are a paid family caregiver." Some states have set up criteria that, "If this is going to be your job, we will pay you, but you cannot be doing three other jobs on the side." There are criteria that can be developed.

President Almaraz:

I have friends who are spouse caregivers. What they really would like to have is one day off. I do not know if that is like what we were talking about with the home health care or if it would work into this program that you are talking about regarding being paid, but just to have someone come in one day so that they can have a day off to do what they need to do. I do not know if you have considered anything like that in your in your legislative priorities.

Mr. Duarte:

Yes, absolutely. There are two things I can comment on there. With the proposal I talked about today, the structured family caregiving proposal for Medicaid, an important aspect of this is that the caregiver him or herself is in contact with the state social worker who is monitoring the condition or the needs of that person, including respite. We recommend, and what some states have done, is to say at least one day a week they are getting someone to come into the home, or they are paying for that person to be taken outside the home to something like an adult daycare facility, so that the caregiver can have respite and maintain some sort of social connection and do the work to maintain their households or whatever that case might be. The answer is yes on the Medicaid program. Currently, the ADSD pays for respite for people who may not be taking care of someone on Medicaid, but they have voucher programs. The Alzheimer's Association in Nevada is a recipient of those grants. We administer them and provide vouchers to people who are caregivers. The caregiver can then pay for somebody to come into the home and give them some respite or relief, or they can pay for the patient to go to an adult daycare facility for that day so they could still have respite. The answer is yes. That is an important aspect of helping caregivers do their job because if not, their mental health and their physical health will suffer, and they will diminish in their ability to be a caregiver.

Mr. Troth:

I have one more question. You sat through some of the previous presentations we had. It sounds like you have been doing this for a long time. What are the private sector, business-type things going on out there? We know that in health care itself with aging populations, there are some expansions, and a lot of things are going on. What are some of the things that are keeping private industry—and obviously, they want to make a buck and need to be profitable—from progression and growing and making some of that available through insurances, whatever we do as an American, as a citizen or person, to try and find health care for some of these things? We talk about government funding all the time. I have a concern about that becoming the only answer. What are some thoughts that you have on some of that?

Mr. Duarte:

In a prior life, I was a marketing director for a Blue Cross Blue Shield plan and sold long-term care plans to people that Blue Cross Blue Shield had developed. Toni Arcadipane, who testified in public comment earlier today, hit the nail on the head. The private sector, and particularly the insurance market, has not been able to provide a private, sustainable solution to long-term care needs of families. Oftentimes, if you must buy a long-term care policy, you must buy it when you are very young; you get medically underwritten. If you buy it when you need it, of course then, it is unaffordable. The markets themselves have not responded well or have not been structured in a way that insurance can take care of it.

In terms of private sector providers, I think the unfortunate thing is that private insurance companies do not pay for long-term care services. Neither does Medicare pay for long-term care services. When you look at the fact that these services are not part of the employer-sponsored health care pro model, the insurance model, it really leaves just two significant payers. One is Medicaid, because its job is to provide long-term services and supports for people who cannot afford it. That has been its mandate by Congress since 1965. Fortunately, or not, the private sector insurance model has not been able to address long-term care. Congress did in 1965 with the establishment of Medicaid. You are talking about a sector of the health care market that is going to be predominantly funded by government-sponsored programs for now into the future, unless there can be some solution on the private sector side, and I have not seen any in the 40 years that I have been working in this business.

We have been talking a lot about personal care attendant services. To be clear, a personal care attendant is somebody who has some training, goes into a home and helps people with activities of daily living, bathing, toileting, dressing, grooming, and ambulating but also other types of activities like chores in the house, cooking, shopping, et cetera. When you look at the payer for that, there are two payers: out-of-pocket costs and Medicaid. Private insurance, long-term care insurance, pays for some of that, but it is a very small percentage. Only a small percentage of the population can afford long-term care insurance. It ends up being Medicaid and out-of-pocket costs to families. I can tell you from the caregivers who are part of our programs and former caregivers whose loved ones have passed away from Alzheimer's disease tell me that it has bankrupted them. It has interfered with their ability to earn a living. It has disrupted their careers. Our ability to support them is extremely important as a way of reducing state and federal costs by investing in those programs. It is going to be an investment of state and federal dollars, but if we invest a dollar up front in some of these measures, we are going to save tens of thousands of dollars from the back end. It is a cost-effective strategy.

In the years that I have been involved with this, I have not seen substantial private sector solutions. There are solutions in other nations. Most of them involve some sort of taxing authority to fund a long-term care program for seniors, but you are talking about a nationalized program. Japan is one country, but there many others.

President Almaraz:

Mr. Duarte, thank you for the work you do in Nevada on behalf of the Alzheimer's Association. We appreciate the information you have shared. Thank you for your presentation and your time.

Mr. Duarte:

Thank you very much for the opportunity. My contact information is included on this presentation. I would be happy to receive any emails or phone calls from folks with subsequent questions.

AGENDA ITEM VII—FACILITATOR REPORTS CONCERNING ISSUES OF IMPORTANCE TO SENIOR

President Almaraz:

We are going to move on to Agenda Item VII, the facilitator reports concerning issues of importance to seniors. Before we have Ms. Adin and Ms. Tyler do their presentations, I am going to ask Dr. Jordan if she has anything.

Dr. Jordan:

Thank you, Madam President. During this past month, we have spent a great deal of time, both Ms. Tyler and Ms. Adin, chatting about what we could do. We looked into a number of the agencies throughout Nevada, and we came up with a very interesting list. We have: 85 independent living facilities, more than 160 assisted living facilities, 73 memory care facilities, 11 nursing home adult care facilities, 35 centers for hospice, and 68 respite care facilities. Surprisingly enough, many of these facilities are unavailable for visitation or discussion due to staffing issues, but mostly due to COVID-19 restrictions. Many of the facilities are on lockdown, and it is difficult to go and visit. I was able to talk to maybe ten different facilities and ask what they consider to be their major challenges for long-term care. The following are examples: an increasing aging population, and number one was staffing shortages. There was a tremendous number of staffing shortages. Many of the staffing shortages are due to turnover and poor salaries. An issue that I thought was most interesting was the overall quality of care. If you have five people with one staff person, and you elevate to 15 or 20, that is not going to be quality of care. The integration of services was also an issue. When somebody moves from one place to another, or they move from independent living into skilled nursing, there is a lack of coordination. That seems to be an issue that needs to be addressed. The financing cost, of course, is always a care cost.

Those are some of the things that we discussed and information I had from the different centers. I look forward to asking the members of the Forum that if they have an opportunity to visit any of the centers or are in touch with any of the centers to please fill us in on some issues that might be relevant and some of the care services that members in the facilities want addressed, so we can pick up and move forward on some of them.

President Almaraz:

Thank you. We will hear from Ms. Adin, our Northern Facilitator first. Ms. Adin, do you have anything for us?

Ms. Adin:

I have a couple of things that I would like to bring to your attention. Since there are only two members from the north that participated in the Forum, I did not know where to start on this task. I took it upon myself to call nursing homes and visit a couple of them. I had the same problem. You cannot visit most of them because of COVID-19. The one I had a problem with, I bought up in the meeting today earlier. That was Little Angels. They have a problem there. Cascades has COVID-19, so they cannot visit them. We should all come up with a proposal that we would like to present to the Legislature that we want to pass regarding the health care of seniors. That is something all of us need to think about and come up with suggestions, so we can go over them and have something to present to the Legislature. That is all I have, Madam Chair.

Ms. Tyler:

I visit my senior center quite frequently because I go there for exercise. One of the main things they pointed out to me is the long-term care costs, insurance, and things of that nature. It was brought to my attention that Medicaid, even though they pay a certain amount, they can put a lien on a senior's home. The question came up, "But what happens with the spouse? They are still there." Those are troubling issues when it comes to long-term care and long-term care insurance. Apparently, there is not an available option where you are able to say, "Keep your property," or things of that nature. Another thing too is the definition of "long-term care." How long is long-term care, per se? Is it short, intermittent, or really long, for years, for example? A senior can be in a skilled nursing facility for a year and go back home, but, if your home is already taken—I use the word "taken," but they say, "No, it is not taken, they put a lien on it"—whatever money they have spent out, they take it back. What does that do for the family as well as their spouse?

I got an email from Mercedes Maharis. I do not know if she is here or not, but she said she visited a few facilities in her area. One senior center is closed because of the lack of participation. She said they were changing the centers to active adult centers. She also mentioned several other concerns, which we are already talking about, such as the rising cost of health care. That basically includes long-term care facility utility costs, rising food costs, and rising gasoline. Everything is rising, but the benefits for your Social Security. With senior transportation, apparently there is a problem with getting seniors back and forth to the community centers and other places. Uber and Lyft drivers prefer out-of-town visitors, businessmen, or something of that nature. They actually avoid coming to certain areas or providing certain services. Those are the things that she mentioned that she would like us to look into.

President Almaraz:

Thank you, Facilitators. Members, does anyone have any comments or anything to add?

Ms. Maharis:

I found out the only center in my district, [audio cut out] and he is very concerned about what will happen when people cannot ambulate anymore. I do not have the answer to that. They do have 100 plus/minus people a day at the one center in Senate District 3. I think the concern is that this may eventually close down itself, and I hope not.

President Almaraz:

Thank you, Ms. Maharis.

AGENDA ITEM VIII—PUBLIC COMMENT

President Almaraz:

We will now move to public comment. We will hear from those in the physical locations and then move to those who call in. Please remember to clearly state and spell your name for the record. Is there anyone in Carson City who would like to provide public comment at this time? Seeing none, is there anyone in Las Vegas who would like to provide public comment? I see no one in our audience here. Broadcast and Production staff, please add the first caller with public comment to the meeting.

BPS:

The public line is open to working; however, there are no colors wishing to testify in public comment.

President Almaraz:

We will close public comment.

Are there any comments from the members before we adjourn? Seeing none, I do have a couple of comments. We have seen and heard during our meetings a lot of information about seniors and senior living. I think some of these programs and presentations have resonated with some of us, so I would like Forum members to go back through the presentations and pick out something that you feel we would be able to have the Legislature enact—something that would enrich the lives of seniors—and bring that to the next meeting so that we can begin to discuss what we are going to ask for our bill draft request.

During the next Forum meeting, we are going to hear about how seniors are being scammed and what can be done about that.

That concludes our meeting for today. Our next meeting will be Thursday, July 14, 2022, starting at 10:00 a.m. This meeting is adjourned.

Thank you all very much for your questions and observations. I will see you in July.

AGENDA ITEM IX—ADJOURNMENT

There being no further business to come before the Forum, the meeting was adjourned at 1:39 p.m.

Respectfully submitted,

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Julianne King
Assistant Manager of Research Policy Assistants

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Ashlee Kalina
Senior Policy Analyst

APPROVED BY:

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Fran Almaraz
Forum President

Date: __________________________________

MEETING MATERIALS

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
Agenda Item IV A-1	Marie Coe, Interim State Long-Term Care Ombudsman, Aging and Disability Services Division (ADSD), Department of Health and Human Services (DHHS); Crystal Wren, Social Services Chief II, Community Based Care, ADSD, DHHS; and Erica Billinger, Supervisor, Long-Term Care Ombudsman Program, ADSD, DHHS	PowerPoint Presentation
Agenda Item IV A-2	Marie Coe, Interim State, Long-Term Care Ombudsman, ADSD, DHHS; and Crystal Wren, Social Services Chief II, Community Based Care, ADSD, DHHS	Follow-Up Memorandum
Agenda Item V	Kayla Samuels, Management Analyst I, Division of Public and Behavioral Health (DPBH), DHHS; and Terri Henwood, Health Facilities Inspector III, Supervisor, Bureau of Health Care Quality and Compliance, DPBH, DHHS	PowerPoint Presentation
Agenda Item VI	Charles (Chuck) Duarte, Nevada Director of Public Policy and Advocacy, Alzheimer's Association	PowerPoint Presentation

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