SKILLED NURSING FACILITIES AND PROBLEMS OF THE AGED AND AGING

Bulletin No. 77-7

LEGISLATIVE COMMISSION
OF THE
LEGISLATIVE COUNSEL BUREAU
STATE OF NEVADA

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FILE NUMBER.....106

ASSEMBLY CONCURRENT RESOLUTION—Directing the legislative commission to study skilled nursing facilities.

WHEREAS, The overall national population, because of lower birth rates and greater longevity, is becoming increasingly older; and

WHEREAS, The population 65 years of age and over increased by 25 percent from 1960 to 1971; and

WHEREAS, Federal medical care payments to the elderly have led to a rapid growth over the past 5 years in nursing homes and similar care facilities; and

WHEREAS, The growth in number of nursing homes across the nation has not in all cases been matched by maintenance in the quality of care provided, and the situation has led in some states to major scandals; and

WHEREAS, It is in the interest of all Nevadans, and especially elderly Nevadans, that the quality of institutional care for the elderly in Nevada be examined by the legislature; now, therefore, be it

Resolved by the Assembly of the State of Nevada, the Senate concurring, That the legislative commission study the quality and availability of skilled nursing care facilities in Nevada and the adequacy of Nevada law for insuring the protection of the health, safety, physical and mental well-being of those individuals accommodated in such facilities; and be it further

Resolved, That a report of the findings and recommendations be submitted to the 59th session of the legislature.

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Assembly Concurrent Resolution No. 52—Assemblymen Coulter, Murphy, Hayes, Benkovich, Wittenberg, Sena, Polish, Christensen, Wagner and Weise

FILE NUMBER 146

ASSEMBLY CONCURRENT RESOLUTION—Directing the legislative commission, with the cooperation of the aging services division of the department of human resources, to conduct a study of the problems of the aged and aging.

WHEREAS, Approximately 15 percent of Nevada residents of age 60 and older are below the poverty level established by the Bureau of the Census; and

WHEREAS, It is estimated that almost half of Nevadans 60 years of age or older are in low income brackets; and

WHEREAS, Aging and aged citizens of our state face a myriad of problems in the areas of health and nutrition, transportation, housing, recreation, employment and income; and

WHEREAS, It is appropriate for the State of Nevada to insure that its older citizens maintain in their later years the dignity and well-being which they devoted most of their youth and middle years to earning; now, therefore, be it

Resolved by the Assembly of the State of Nevada, the Senate concurring, That the legislative commission is hereby directed to conduct a study of the problems of the aged and aging in Nevada; and be it further

Resolved, That the legislative commission enlist the cooperation of the aging services division of the department of human resources; and be it further

Resolved, That the legislative commission utilize such expertise as is available on the subject within the University of Nevada System; and be it further

Resolved, That the legislative commission report the results of its study and make appropriate recommendations to the 59th session of the Nevada legislature.

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REPORT OF THE LEGISLATIVE COMMISSION

To the Members of the 59th Session of the Nevada Legislature:

This report is submitted in compliance with Assembly Concurrent Resolutions Nos. 33 and 52 of the 58th session which directed the legislative commission to study skilled nursing facilities in Nevada and the problems of the aged and aging.

This report sets forth procedures, summarizes visits to long-term care facilities and to rural Nevada communities and presents the findings and recommendations of the subcommittee appointed to conduct the study.

Assemblyman Darrell H. Dreyer served as chairman of the subcommittee with Senator Richard H. Bryan as vice chairman. Other subcommittee members were Senator Joe Neal and Assemblymen Marion D. Bennett, Eileen B. Brookman, Steven A. Coulter, Patrick M. Murphy and Nash M. Sena.

The subcommittee wishes to acknowledge the presence and participation of senior citizens and providers of services at public hearings. In particular, the subcommittee is grateful for the information and assistance provided it by the divisions of aging services, health and welfare in the department of human resources.

The report is transmitted to the members of the 1977 legislature for their consideration and appropriate action.

Respectfully submitted,

Legislative Commission
Legislative Counsel Bureau
State of Nevada

Carson City, Nevada

SUMMARY OF RECOMMENDATIONS

A. Institutionalized Care for the Aging.

1. A letter be sent to all high schools, community colleges and the University of Nevada System to explore the feasibility of making courses and intern programs available in total health care of the aging, including gerontology; and a request be made of the University of Nevada for information regarding its philosophy on making it mandatory for licensed practical nurses (LPN's) and registered nurses (RN's) to take courses in geriatrics. The subcommittee recommended that this information be received before the 1977 legislative session.

2. A pilot traveling inservice training program be established to teach untrained workers in nursing homes about care of the aging patient; and that $150,000 be appropriated for the biennium to be used as funding for a traveling nurses' aide pilot program; the traveling nurses program be required to report back to the legislature on the effectiveness of the program, the feasibility of reimbursement to the state in future years for program costs and recommendations concerning certification.

3. A public guardianship bill be supported, using the Council of State Governments' "Public Guardianship Act" as a model.

4. Duly authorized employees of the department of human resources be allowed to make unannounced inspections of health and care facilities to evaluate the care provided residents.

5. The department of human resources be mandated to conduct public hearings and adopt a state "bill of rights" for residents in all licensed care facilities which are not presently covered by state statute or federal regulation.

6. Letters be written to the respective state agencies involved in licensing and reimbursement, urging that more attention be given to the following problems:

a. Therapy and exercise programs in nursing facilities.

b. Problems of inactivity among nursing home residents.

7. The state should support the home health care program in the rural counties as a viable alternative to institutionalization.

8. The legislative commission conduct a feasibility study to explore the possibility of establishing a state geriatric center.

B. Problems of the Aged and Aging.

1. The United States Congress be memorialized to lift the ceiling entirely on maximum earned income allowed to recipients of Social Security.

2. The legislature enact generic drug substitution legislation similar to A.B. 436 of the 58th session.

3. Group insurance policies in Nevada be required to include options to convert to individual policies upon termination of the insured person's membership in the group.

4. Nevada's hearing aid specialist law be amended along the lines of Oregon's 1975 law regulating hearing aid dealers.

5. Legislation be endorsed which will provide greater assistance at all levels under the Senior Citizens' Property Tax Assistance Act.

6. A letter be written to the department of education recommending utilization of youth through the schools to provide home services to senior citizens.

7. Support be given to legislation abolishing the sales tax on food.

8. Legislation be supported and endorsed to fund a mobile health care unit.

REPORT TO THE LEGISLATIVE COMMISSION OF ITS SUBCOMMITTEE ON SKILLED NURSING FACILITIES AND PROBLEMS OF THE AGED AND AGING

I. INTRODUCTION

The 58th session of the Nevada legislature adopted two study resolutions pertaining to Nevada's senior citizens. Assembly Concurrent Resolution No. 33 directs the legislative commission to "study the quality and availability of skilled nursing care facilities in Nevada" and the adequacy of Nevada law in safeguarding the well-being of residents in such facilities. Assembly Concurrent Resolution No. 52 directs the legislative commission to study problems of the aged and aging in Nevada. The findings and recommendations made pursuant to these resolutions are to be reported to the 59th session of the legislature.

To carry out this assignment, the legislative commission appointed a subcommittee composed of the following legislators:

Assemblyman Darrell H. Dreyer (Las Vegas), Chairman
Senator Richard H. Bryan (Las Vegas), Vice Chairman
Senator Joe Neal (North Las Vegas)
Assemblyman Marion D. Bennett (Las Vegas)
Assemblyman Eileen B. Brookman (Las Vegas)
Assemblyman Steven A. Coulter (Reno)
Assemblyman Patrick M. Murphy (Reno)
Assemblyman Nash M. Sena (Henderson)

II. SUBCOMMITTEE PROCEDURE

The first decision made by the subcommittee was to extend that portion of the study on skilled nursing facilities to include intermediate care facilities and adult group care facilities. In the subcommittee's view, this course of action better reflected the intent of Assembly Concurrent Resolution No. 33 to study care for institutionalized elderly. Furthermore, the broad mandate of Assembly Concurrent Resolution No. 52 to study the problems of the aged and aging also served as authorization to study the various levels of care for the elderly.

The subcommittee held a series of public hearings in northern and southern Nevada, meeting in Carson City on September 26

and 27, 1975, in Las Vegas on November 14 and 15, 1975, and in Reno on January 23, 1976. Information was presented to the subcommittee at these hearings primarily from both senior citizens and providers of services to senior citizens.

On January 24, 1976, subcommittee members and staff were accompanied by medical care service workers, division of welfare, department of human resources, on unannounced visits to nursing and adult group care facilities in the Reno area. In addition individual subcommittee members visited nursing homes on their own during the course of the study.

On March 26 and 27, 1976, the subcommittee divided into teams of two legislators with one staff person per team and held informal hearings in four rural areas of Nevada. Visits were made to Elko, Ely, Hawthorne and several small communities in Lincoln County.

The subcommittee held its final meeting on June 29, 1976, in Las Vegas. Prior to this work session, a preview of the subcommittee's worksheet was sent to selected state agencies providing services to senior citizens for their comment. Copies of the worksheet were also distributed to other interested parties such as the Association for Health Facilities, Inc. and the Board of Hearing Aid Specialists.

The report is divided into two parts; the first section details the subcommittee's study of nursing homes and adult group care facilities and the second section covers its study of the problems of the aged and aging.

III. SKILLED NURSING FACILITIES, INTERMEDIATE CARE FACILITIES AND ADULT GROUP CARE FACILITIES

A. Overview.

Institutionalized care for the aging in Nevada can be categorized by levels of care--skilled nursing facilities (SNF), intermediate care facilities (ICF) and adult group care facilities (AGCF). Skilled nursing facilities provide skilled nursing care and medical attention on an ongoing basis. Intermediate care facilities provide 24-hour patient supervision and personal and health care. Adult group care facilities provide personal services, meals and more limited care than the other two levels.

In Nevada there are 19 SNF's, nine ICF's and 21 AGCF's. In Nevada, the division of health inspects these facilities for purposes of licensure and the division of welfare inspects them for purposes of financial reimbursement.

In Nevada 35 percent of Nevada's total Medicaid budget or about $6 million per year is spent on long-term care patients (in SNF's or ICF's). Nevada's nursing homes are reimbursed on a cost plus a $1 per patient per day allowance for profit. In addition, Medicaid reimburses facilities for property related costs of facilities at a maximum rate of $4.70 per patient per day (see Appendix A). Approximately 80 percent of the long-term care facilities in the state are funded by Medicaid. A portrait of the population in Nevada long-term care facilities reveals that the average age of residents is 82 and that there are two females to every male resident. Of the residents in nursing homes, approximately 20 percent come from homes, 60 percent from general hospitals, 10 percent from mental hospitals and 10 percent from other nursing or boarding homes. According to the medical services office of the welfare division, approximately 55 percent are mentally impaired and fewer than 50 percent can walk. Only 40 percent of patients in these facilities are ever totally rehabilitated and half the patients have no viable relationship with close relatives (see Appendix B).

B. Visitation to Facilities.

On January 25, 1976, the subcommittee went in teams of two, plus one staff person, plus one medical services worker to visit long-term and adult group care facilities in the Reno area. In addition, two subcommittee members included a visit to an intermediate care facility in their team visit to Elko.

The purpose of the facility visits was for the subcommittee to get a firsthand view of the physical conditions of nursing homes and the quality of care of patients. Since all subcommittee members and staff are laypersons, the subcommittee's findings simply consisted of general impressions of residents' environments (see Appendix C for record of visits).

Visits to the facilities were unannounced and only one facility appeared to be expecting subcommittee members. On the whole, the physical surroundings of the higher level care facilities appeared to be much more attractive than lower level facilities. As would be expected in the SNF's, a hospital environment prevailed. Several of the adult group care facilities had more homelike appearances with gardens and pets on the premises. Activity levels varied with different facilities, although watching television seemed to be the predominant pastime for those residents doing anything besides lying in bed. These observations, of course, simply represent one Saturday visit by the subcommittee.

C. Findings and Recommendations.

1. Education and training of personnel in nursing homes. One of the most frequently reported problems at subcommittee hearings was the lack of training of nursing home personnel in the care of the aged. Medicaid reimburses facilities for 3 hours of nursing or direct service care per patient per day. Aides and orderlies have the most frequent contact with patients, yet receive little training in the care of the aged.

   At the physician level, information presented the subcommittee by nursing home administrators indicates that getting physicians to visit patients in the facilities as required by federal regulations is extremely difficult. There is a shortage of geriatric specialists nationwide, and physicians placing patients in nursing homes may be surgical specialists without the time or expertise to follow up on maintenance care (see Appendix D for letter from the Nevada state medical association). Dr. Thomas Scully, acting dean of the University of Nevada, Reno school of medical sciences informed the subcommittee than UNR has approximately 20 course hours dealing with geriatrics in some aspect and one full-time course entitled "Health Concepts in Gerontology." The medical school now has two faculty members specializing in gerontology.

   Insofar as nurses' training is concerned, a spokesman for the Orvis School of Nursing apprized the subcommittee of the fact that the care of older patients is

incorporated as part of the study of the life cycle in human development, as well as in clinical experiences.

The most severe lack of training in care of the elderly is at the aide and orderly level. Related problems include the high turnover rate for this level of personnel, low pay, improper care in the handling of patients and poor attitudes.

Mrs. Myrl A. Nygren, coordinator of health facilities, health division, department of human resources, reported to the subcommittee that training of nursing home personnel is a major problem. There exists a shortage of orderlies, aides and physical therapists. She suggested that inservice training should be accomplished by a team including a physical therapist, speech therapist, occupational therapist and gerontological psychologist.

Ms. Ellen Pope, a spokesman for the licensed practical nurses association, told the subcommittee that the effectiveness of the practical nurse's performance depends on the quality and number of aides. She suggested to the subcommittee that it consider establishing an inservice training program of traveling instructors to facilities.

Nursing home administrators agreed that more training for aides would be desirable. One southern Nevada nursing home administrator indicated that the average length of stay at his facility was 14 to 15 months for LPN's and 6 months or less for aides. A Fallon administrator of a convalescent home informed the subcommittee that federal requirements mandate some inhouse training which his facility provides through use of a film and some instruction. He admitted that training is a serious problem and stated that he felt inservice training is needed three times a year.

Fred Hillerby, executive director, Nevada hospital association, informed the subcommittee that the majority of nursing assistants in nursing home facilities are not trained prior to on-the-job experience. In his opinion, the facilities themselves should offer increased pay as an incentive for training, and the

state aid to the medically indigent (SAMI) program should consider additional incentives to facilities with trained employees. The thrust of Mr. Hillerby's comments before the subcommittee was that positive incentives, not punitive regulations, should be adopted to improve long-term care.

The subcommittee agreed that more emphasis on geriatrics is needed in RN and LPN teaching programs.

Therefore, the subcommittee recommends that:

(a) A letter be sent to all high schools, community colleges and the University of Nevada System to explore the feasibility of making courses and intern programs available in total health care of the aging, including gerontology; and

(b) A request be made of the University of Nevada for information regarding its philosophy on making it mandatory for LPN's and RN's to take courses in geriatrics. The subcommittee recommended that this information be received before the 1977 legislative session.

Regarding the training of aides in nursing homes, the subcommittee discussed the relationship of training, low pay and high turnover rates. The subcommittee questioned the ability of the legislature to require certain wages for one class of workers and also questioned whether or not higher salaries would result in increased costs to patients. The subcommittee felt that a traveling team of nurses to provide instruction to nursing home workers would be beneficial in increasing the quality of patient care. While the subcommittee felt the state should fund initially a pilot program of this nature, it agreed that the agency administering the program should seek reimbursement from the Federal Government or from the nursing homes.

Therefore, the subcommittee recommends that:

(a) A pilot traveling inservice training program be established to teach untrained workers in nursing homes about care of the aging patient; and

(b) That $150,000 be appropriated for the biennium to be used as funding for a traveling nurses' aide pilot program.

The subcommittee discussed a certification program to accompany the inservice training program but concluded that a decision on certification should await the results as to the effectiveness of the pilot training program.

Therefore, the subcommittee recommends that:

(c) The traveling nurses' program be required to report back to the legislature on the effectiveness of the program, the feasibility of reimbursement to the state in future years for program costs and recommendations concerning certification.

2. Guardianship for senior citizens.

The need for some provision for guardianship was brought to the attention of the subcommittee in presentations from nursing home administrators. They posed the situation of a patient who has a stroke and loses a portion or all of his mental capacities and has no close family or friends to take care of personal business. Mail, bills, insurance and bank accounts all need attention and the facility administrator feels reluctant to assume these responsibilities in light of possible conflicts of interest. Charles C. Perry, Jr., president of the Association for Health Facilities, Inc., indicated to the subcommittee that he felt there were inadequate guidelines for nursing home administrators concerning the handling of patients' money. Long-term care facilities establish trust accounts for their patients, and while the administrators keep records of transactions, they are not bonded. An example of an unsatisfactory situation of this nature is one southern Nevada nursing home facility whose administrator indicated that a portion of patient funds is placed in a checking account and a portion may be placed into an out-of-state savings account. The interest on the savings is purported to be used for activities benefiting all patients, but apparently no individual accounting of interest is made.

The subcommittee recognized the need which some older persons have for assistance in handling personal and financial affairs and felt that any law creating positions of public guardianship should cover both the estate and person. Furthermore, the subcommittee was persuaded that by making such an office salaried, the conflict of interest problem would be eliminated. Furthermore, persons with insufficient assets to provide income to a private guardian would be eligible for public guardian services.

The subcommittee discussed the Council of State Governments' proposed model law on public guardians. The initial version of the model law established the position of public guardian within each court which has original jurisdiction in hearings relating to guardianship over the person or estate of an incapacitated person. A later version of the model bill offers alternative administrative structures for the office. One option is for the county commissions to appoint the public guardian. The court then may appoint the public guardian as the individual guardian of any elderly person who has petitioned for a guardianship or has had someone petition on his behalf.

The model bill requires public guardians to be bonded and generally gives public guardians the same powers and duties as private guardians.

Therefore, the subcommittee recommends that:

> A public guardianship bill be supported, using the Council of State Governments' "Public Guardianship Act" as a model.

The bill prepared by the subcommittee's legal staff provides that the establishment of the office of public guardian for elderly persons is required in counties of 100,000 population or more and is permissive in counties of less than 100,000 population. The subcommittee's bill gives the board of county commissioners the authority to appoint the public guardian and to fix his compensation, which is to be paid out of the county general fund. The administrative costs of the office are not chargeable against the income or estate of the elderly person unless the court

determines that the person is financially able to pay all or part of these costs.

The office of public guardian is a 4-year appointment. Court appointments of public guardians for individual wards may be terminated by the court if services are no longer necessary.

3. Inspections of care facilities for the aging.

Currently, there are two state agencies primarily involved in nursing home inspections--the health division and the welfare division. The bureau of health facilities of the health division inspects SNF's, ICF's and AGCF's yearly for licensing and renewals. The bureau may perform followup inspections. Information presented to the subcommittee indicates that most inspections are made between the hours of 8 a.m. and 5 p.m. and because facilities know the date of license renewal; the general time of year for an inspection is fairly predictable as well.

As reimbursement administrator for the Medicaid program, the medical care section of the welfare division sends medical review teams to inspect skilled nursing and intermediate care facilities twice yearly. These teams generally include a doctor, nurse, pharmacist and medical social worker. Program nurses from the medical care section make weekly visits to these facilities.

The subcommittee discussed several other states' approaches to inspections of nursing facilities. The subcommittee rejected the formal complaint and followup approach to inspections on the basis that Nevada's current inspection law is preferable in that it does not require initiation of a formal complaint. However, the subcommittee felt that NRS 449.230 is too restrictive in limiting the authority to enter and inspect homes to the health division. Persons from other divisions of human resources, such as the nursing home ombudsman, may also have good cause to inspect a long-term or adult group care facility.

Therefore, the subcommittee recommends that:

> Duly authorized employees of the department of human resources be allowed to make unannounced inspections of health and care facilities to evaluate care provided residents.

4. Bill of rights for the institutionalized elderly. Federal regulations require a patient's bill of rights in skilled and intermediate care facilities. State regulations for intermediate care facilities require that the written policies of facilities themselves set forth the rights of residents. The subcommittee expressed its concern that all levels of institutions caring for the elderly set forth the rights of residents.

   The subcommittee questioned the statement made by one typical nusing home administrator that most patient complaints are invalid and are made to attract attention. In the course of its deliberations, the subcommittee discussed model legislation and legislation from other states which set forth the rights of residents of care facilities. Among those rights considered were the residents' right to privacy, right to a financial accounting of funds deposited with the facility and the right to information about treatment plans. The subcommittee agreed that the department of human resources should be mandated to hold hearings and adopt a bill of rights for residents of licensed care facilities in Nevada. Means to enforce these rights were also to be developed in the course of the hearings.

   Therefore, the subcommittee recommends that:

> The department of human resources be mandated to conduct public hearings and adopt a state "bill of rights" for residents in all licensed care facilities which are not presently covered by state statute or federal regulation.

5. Activity related problems in care facilities for senior citizens.

Information presented to the subcommittee at public hearings suggested that while most facility residents cannot provide activity opportunities for themselves, their physical and emotional health is related to participation in activities. If the cost of formal activity directors is too costly, the use of senior citizens' groups and other volunteers was presented as an alternative option. The subcommittee also heard complaints that physical therapy and exercise programs were inadequate to meet patient needs.

The subcommittee determined on the basis of information presented at hearings and from observation during visits to care facilities that the nonmedical care in these institutions needs improving. In the subcommittee's opinion more attention should be given to the quality of care given the resident in addition to facility adequacy and compliance with regulations.

Therefore, the subcommittee recommends that:

Letters be written to the respective state agencies involved in licensing and reimbursement, urging that more attention be given to the following problems:

(a) Therapy and exercise programs in nursing facilities.

(b) Problems of inactivity among nursing home residents.

6. Alternatives to institutionalization.

The subcommittee was interested in exploring alternatives to institutionalized care particularly after observing the hospital environments of most nursing homes.

Susan Gaucher, spokesman for the Nevada nurses' association, informed the subcommittee that the primary health care services available to the elderly are limited to SNF services. Her association favors funding sources of health care services to clients in noninstitutional settings.

Rural hospitals agreed that especially in areas where there are no nearby convalescent centers that there are few options for senior citizens who may be ill, but do not require intensive care. The administrator of the Lyon County Health Center told the subcommittee that patients in her hospital have a problem when they leave the hospital and still need intermediate care; home health services were cited as an alternative. It was pointed out to the subcommittee that in rural areas such as the White Pine area, older persons may not be sick enough to be hospitalized, yet need assistance in their own homes.

One alternative to institutionalizing older persons needing limited care is currently provided to welfare eligible persons by homemaker services in the division of welfare. Mrs. Eleanor Kolbe, coordinator of homemaker services in the welfare division, described this program to the subcommittee. Homemaker services is not medically oriented; services may include household chores, personal care and assistance in keeping doctor's appointments. Mrs. Kolbe told the subcommittee that 90 percent of her clients are elderly, blind or disabled and that without homemaker type services would likely require institutionalization.

A private, profitmaking organization providing at-home care to the elderly in Nevada is Homemakers Upjohn, Inc. This company was described to the subcommittee as a provider of nonskilled nursing and home services. Mr. Robert Baareman, zone manager for Homemakers Upjohn, compared the cost of institutionalized care at a minimum of $600 per month to services in the home at a cost of $133.33 per month based on 17 chore and 17 homemaker hours per month. Costs to private clients vary according to the area of the state and the nature of the service. The state homemaker program contracts with Homemakers Upjohn to provide services to some of its clients.

For eligible patients, Medicaid reimburses SNF facilities at an average rate of $780 per patient per month; ICF II facilities are reimbursed at the average rate of $630 per patient per month. AGCF's are reimbursed through Supplemental Security Income at a rate of $275 per eligible patient per month.

A third alternative currently available to Nevadans is Nevada Home Health Services, Inc., a nonprofit, home health agency. Nevada Home Health Services serves ten rural Nevada counties and Carson City. Levels of care offered include skilled nursing services, home health aid services, homemaker services and therapist services. Current patient load is 176 clients per month; staff includes 10 full-time nurses and 12 to 14 part-time aides and homemakers who together travel 7,500 miles per month. Home Health Services indicates that out of its gross revenue of about $296,000, $17,000 comes from the Federal Government, $51,000 comes from county payments, grants and interest account for $9,300 and the balance comes from billings to patients.

The subcommittee agreed that senior citizens would be happier and more independent if they remained in their homes as long as possible. The subcommittee determined that the state should supplement this kind of program but that the budget request should come from the health division.

Therefore, the subcommittee recommends that:

> The state should support the home health care program in the rural counties as a viable alternative to institutionalization.

The subcommittee further agreed that another alternative to institutionalized care for the aging might be a geriatric center for senior citizens. A center of this nature would encompass day or temporary care for seniors, outpatient therapy and research and training in gerontology.

Therefore, the subcommittee recommends that:

> The legislative commission conduct a feasibility study to explore the possibility of establishing a state geriatric center.

IV. PROBLEMS OF THE AGED AND AGING

A. Overview.

Nevada bureau of vital statistics estimates that the 1976 population of persons 60 and over is 62,810 or approximately 10 percent of the state's total population. While the national increase from 1970 to 1974 in persons aged 60 and over was 9 percent, Nevada's increase over the same period was 32 percent. Problems faced by this group were surveyed by the department of psychology, University of Nevada, Las Vegas, for the division of aging services, department of human resources. The results of these interviews with sample populations aged 55 and over were published in 1975 as the Needs Survey of Nevada's Aging. The survey cites income, health, transportation and housing as the four major problems which Nevada's senior citizens face. Senior citizens responded that their most expensive budget items are food and clothing, housing is second and medical expenses are third. One fourth of the retired or unemployed persons in the sample group indicated that they would like to hold a job, and the main reason given is the need for money. Survey results show that the older a person is, the lower his income; 36 percent of survey participants over 70 had incomes at the poverty level and another 24 percent were in only a slightly higher income group. The greatest single source of income for senior citizens in the sample was social security.

The UNLV study showed that the most frequent illness reported was arthritis or bursitis, followed by high blood pressure and shortness of breath. Approximately 60 percent of the persons surveyed were taking doctors' prescriptions. Respondents in Clark County stated a greater need for physician services and prescriptions than did Washoe County respondents.

Insofar as transportation needs are concerned, 10 percent of those surveyed indicated that they did not have adequate transportation. Most persons surveyed used the automobile for transportation; one-fourth of the sample indicated there is no bus stop within walking distance.

The most frequently listed type of dwelling by respondents to the survey was the single home. Only 1.3 percent of persons surveyed lived in senior public housing, although

one-fourth indicated that they would live in public housing if it were provided.

While the rural sample used in the UNLV study was quite small, the authors indicated that the major need areas are medicine, transportation and legal assistance. The rural areas voice a greater need for chore and home repair services than the urban areas and greater difficulty in obtaining medical services.

It is interesting to note that awareness of existing social services to alleviate these problems is low. The UNLV study indicated that only 23.6 percent of the sample had ever tried to find out about services and programs for senior citizens. When asked what social services are most needed, the preponderance of Clark County responses said medicine and doctors. In the Washoe County sample, respondents listed transportation and social activities as most needed services.

B. Visits to rural areas.

After three public hearings in the urban areas of the state, the subcommittee visited Elko, Ely, Hawthorne and Lincoln counties in teams of two. These visits were coordinated through senior citizen nutrition sites and centers in each area. Subcommittee members had lunch with senior citizens in each area and held informal hearings after work. Three teams viewed skilled or intermediate nursing beds housed in general hospitals and the Elko team visited a free standing intermediate care facility. Certain problems of senior citizens in the rural areas were identical to concerns expressed at hearings in urban Nevada.

Other difficulties facing the rural senior citizen, such as physician shortage, are shared by rural residents of all ages.

The following problems were presented to the subcommittee in the course of the rural visits:

1. High electric bills.

2. Housing (availability of decent rentals).

3. Medical care for those needy, but not indigent.

4. Need for chore services and general services to allow elderly to remain at home.

5. Transportation.

6. High cost of hearing aids, dental care, eyeglasses.

7. Federal Title III money is limited to 3 years--funds for programs after federal money runs out.

8. Problem of small rural hospitals' meeting government standards.

9. High cost of drugs.

10. Shortage of physicians.

C. Findings and Recommendations.

1. Employment of senior citizens.

Currently in Nevada it is unlawful to discriminate in the hiring, discharging or compensation of employees on the basis of age. NRS 613.330 applies to private, state and local government employees with 15 or more employees. However, age 65 is widely accepted by employees as normal retirement age. NRS 284.3781 provides that persons 65 years of age or older may continue in classified state service on a year to year basis. In practice, each agency works out continued employment on a case by case basis between supervisors and employees. Federal law also prohibits age discrimination in employment, but limits the prohibition to individuals between 40 and 65 years old (United States Code Annotated, Title 29, Sections 623 and 631).

Information was presented to the subcommittee in the course of public hearings that employment for senior citizens is beneficial in two ways: it increases their income and thereby alleviates some nutritional and transportation problems and it provides seniors with a sense of dignity and independence.

Dr. Robert J. Hall, a UNLV professor of psychology, told the subcommittee that because income is going

to become a more critical problem for the elderly, training for second careers before retirement should be considered.

John B. McSweeney, administrator of the division of aging services, department of human resources, suggested that the subcommittee repeal mandatory retirement at age 65.

The subcommittee discussed and rejected the idea of a quota system requiring a certain percentage of state employees to be senior citizens. Reviewing suggested proposals from other states, the subcommittee explored the possibility of establishing a formal year to year review of employees after age 65. This proposal was rejected on the grounds that the solution would be degrading and worse than the problem.

Recognizing that state and federal law prohibits discrimination in employment on the basis of age, the subcommittee acknowledged that the problem exists but did not feel that the legislature could remedy it.

The subcommittee also noted that the maximum earned income which a Social Security recipient may receive without diminishing his Social Security benefits is $2,760, or $230 per month. Unearned income such as interest on savings has no effect on Social Security benefits. Finding this ceiling on earned income detrimental to senior citizens who wish to work, even on a part-time basis, the subcommittee favored removing the ceiling altogether.

Therefore, the subcommittee recommends that:

> The United States Congress be memorialized to lift the ceiling entirely on maximum earned income allowed to recipients of social security.

2. Need for Low Cost Drugs.

The subcommittee was told repeatedly in public hearings that senior citizens have difficulty purchasing prescription drugs. The problem appears to be more

serious in rural areas where competition is low and pharmacists cannot buy in sufficient quantities to offer reduced prices. In light of the fact that the UNLV needs survey showed that 60 percent of the senior citizens interviewed take doctors' prescriptions, the subcommittee determined that there is need for low cost prescription drugs, especially for the elderly.

The subcommittee discussed the concept of generic drug substitution and approaches by other states, such as California and Rhode Island. Generic drug legislation generally permits or requires drug dispensation by generic or chemical name in lieu of trade or brand name. Assembly Bill 436, introduced in the 58th session of the Nevada legislature, authorizes pharmacists to fill prescriptions for brand name drugs with generic drugs of the same chemical entity, dosage, form and strength. Substitution is not allowed if the prescriber so indicates on the prescription. The theory behind generic drug substitution is that physicans most frequently prescribe by brand names which may cost patients more than the same drug prescribed by its generic name. Arguments against generic drug substitution are that pharmacists will be reluctant to substitute drugs in physicians' prescriptions and that drugs may be chemically the same and yet have different effects because of absorption rates.

It was the consensus of the subcommittee that the need for low cost drugs among the elderly warrants legislative efforts to lower these costs. The subcommittee felt that cooperation with the Nevada Pharmaceutical Association should be sought.

Therefore, the subcommittee recommends that:

> The legislature enact generic drug substitution legislation similar to A.B. 436 of the 58th session.

3. Insurance Problems of the Aging.

Presentations before the subcommittee and individual constituent complaints repeatedly brought out the insurance problems which Nevada's senior citizens face. Arbitrary cancellation of policies on the

basis of a person's age, sales of special kinds of insurance and unnecessary sales by unscrupulous salesmen were typical grievances heard by the subcommittee.

Dr. Dick F. Rottman, commissioner of insurance, elaborated on these problems before the subcommittee. He pointed out that while most senior citizens can afford automobile and home insurance, many cannot afford the high cost of private health insurance. Dr. Rottman explained that as a person ages, the frequency and severity of illnesses increases. Since most aging persons who buy policies are more likely to require benefits, insurance companies regard this "adverse selection" process in terms of potential losses and may refuse to insure older persons. Dr. Rottman informed the subcommittee that current group insurance policies in Nevada do not have adequate conversion privileges. Thus, a person may be insured for years by a company under group insurance and then be dropped when he retires.

In the subcommittee's view, a person should be allowed to convert his group coverage to an individual policy without taking another physical examination upon termination and especially upon retirement. The subcommittee felt that the conversion privilege would at least insure that older individuals can obtain insurance. It was the opinion of the subcommittee members that converted group policies could also assist the elderly in supplementing Medicare benefits.

Therefore, the subcommittee recommends that:

> Group insurance policies in Nevada be required to include options to convert to individual policies upon termination of insured persons.

4. Standards for Hearing Aid Fitting.

Providers of services to senior citizens recommended that the subcommittee consider strengthening consumer protection in the acquisition of hearing aids. The subcommittee discussed current Nevada laws and regulations on hearing aid specialists. A board of hearing aid specialists is responsible for setting standards for hearing aid specialists, applicants for licenses

and apprentices. Basically, applicants for hearing aid specialist licenses must have either 10 years' experience in good standing or satisfactory completion of the National Hearing Aid Society Home Course or a master's degree in clinical audiology. While the board establishes minimum testing procedures for all new hearing aid fittings, these procedures may be waived "where the attention span of the individual is so limited that it is impossible to run all of the above-mentioned tests," or when an individual has been previously fitted with a hearing aid.

The subcommittee viewed Nevada's current standards for fitting hearing aids as inadequate to protect the older person from door-to-door hearing aid sales. After reviewing proposed model legislation from the Council of State Governments on the subject, the subcommittee discussed Oregon's new law on hearing aids since it represents a compromise between Nevada's law and the very stringent model legislation proposed by the Council of State Governments.

Oregon strengthened its law on hearing aid dealers in the following manner:

a. Hearing aid dealers must submit written statements prior to consummation of sales which must include, among other things, the terms of guarantee or warranty; a statement that a hearing aid is used or reconditioned if that is the case; and a statement that it is desirable that a person seeking help with his hearing consult an ear doctor.

b. Registered hearing aid dealers may have their their certificate revoked or suspended for false or misleading advertising.

c. Purchasers of hearing aids may rescind their purchase within 45 days of delivery if they subsequently consult a physician who advises against the purchase or use of a hearing aid.

It was the consensus of the subcommittee that a bill similar to Oregon's legislation would serve to protect all hearing aid purchasers and especially senior citizens.

Therefore, the subcommittee recommends that:

> Nevada's hearing aid specialist law be amended along the lines of Oregon's 1975 law regulating hearing aid dealers.

5. Housing for Senior Citizens.

The finding of the UNLV needs survey that housing is one of the four major problems facing Nevada's senior citizens was borne out in presentations before the subcommittee. The manager of senior housing projects for the city of Las Vegas told the subcommittee that limited income makes it difficult for seniors to find and afford private housing. She stated that the waiting period for senior housing in Las Vegas is 2 years. The executive director of the Reno housing authority relayed similar information to the subcommittee, adding that senior citizens need cluster housing. The director of the Rural Housing Authority told the subcommittee that 60 to 70 percent of Nevada's substandard housing is in rural areas.

In its visits to the rural part of Nevada, the subcommittee observed that construction of new housing is a problem and that there appears to be very little rental housing available.

The subcommittee first discussed the possibility of a property tax incentive to builders of housing for senior citizens, but declined to pursue that approach in light of questions raised by legal staff on the constitutionality of unequal property taxes. The subcommittee then discussed the possible effects on senior citizens of new federal money available to Nevada for rent subsidies to low income persons.

Finally, the subcommittee chose to use the existing Senior Citizens' Property Tax Assistance Act to alleviate housing problems of the aging, at least to some degree.

Therefore, the subcommittee recommends that:

> Legislation be endorsed which will provide greater benefits at all levels under the Senior Citizens' Property Tax Assistance Act.

6. Need for the Inhome Services.

In its visits to the rural areas of Nevada, the subcommittee learned that one of the needs of the aging is for assistance with small jobs around the house such as yard work, housecleaning, repair work and errand running. It was suggested to the subcommittee that students could help provide these services as part of their education in such courses as shop and home economics. The subcommittee agreed that the idea is a sound one and that it could benefit the youth as much as the aged. Several persons responding to the preview of the subcommittee's worksheet commented that schools and private youth groups should initiate programs of this nature and that senior citizens should be utilized in the school system by contributing their expertise in various areas.

The subcommittee agreed that a program of this kind does not require legislation but should be brought to the attention of the department of education.

Therefore, the subcommittee recommends that:

> A letter be written to the department of education recommending utilization of youth through the schools to provide home services to senior citizens.

7. Electric and Gas Bills.

One of the frequent complaints heard by the subcommittee was that utility rates are spiraling upward while the senior citizens' income remains fixed. One proposal explored by the subcommittee was creation of lifeline utility rates. This concept, which has been enacted into law by California and considered by several other states, is based on the premise that persons on limited, fixed incomes require a certain amount of electricity for day-to-day living. Thus, a flat rate is established for the minimum amount of electricity necessary to heat a home, to cook and wash and so forth. In the opinion of various subcommittee members, lifeline utility rates would be preferable to existing declining block rate structures, whereby the more electricity used, the less the cost to the user.

In light of the fact that another interim subcommittee, the legislative subcommittee on electric and gas utilities and the public service commission, was charged with studying the gamut of utility rate schemes, the subcommittee decided to defer the study of lifeline rates to that subcommittee.

In response to that request, the chairman of the utility subcommittee responded that the continued flattening out of the residential rate structure had been recommended to his subcommittee by an outside consultant. The utility subcommittee also considered the possibility of lessening the burden of expensive utilities to senior citizens by apportioning unused funds from the senior citizens' tax rebate program to hard-pressed older citizens. This task could be accomplished with no additional administrative cost to the department of taxation, according to that agency. It was the consensus of the subcommittee that it would not propose lifeline utility legislation in deference to the legislative commission's subcommittee on electric and gas utilities and the public service commission. The subcommittee endorsed the concept of lifeline utility rates and urged further study of that approach by state agencies.

8. Sales Tax on Food.

Information presented to the subcommittee at public hearings indicated that the removal of sales tax on food has a high priority with Nevada's senior citizens. The administrator of the aging services division endorsed this proposal in remarks to the subcommittee, saying that one-third of the health problems of the aging are believed to be related to poor nutrition.

The subcommittee discussed legislation from the 1975 session which would have removed the sales tax on food had it passed. S.B. 386 from the 58th session of the Nevada legislature would have placed the question of removing taxes on food on the ballot. If food were simply exempted from the sales and use tax, local school support tax and county-city relief tax, the revenue loss would have been approximately $13 million in fiscal year 1975-76. S.B. 386 provided for an offset of revenue loss by increasing all three levels of "sales" tax.

Therefore, the subcommittee recommends that:

Support be given to legislation abolishing the sales tax on food.

9. Need for Preventative Medicine by Senior Citizens in Rural Areas.

In public hearings and in visits to rural areas of Nevada, the subcommittee learned that the physician shortage in rural areas is particularly hard on senior citizens who are hindered from traveling to doctors by inadequate transportation. While the average physician ratio in Nevada is 1:935, all but one county in rural Nevada have lower physician-patient ratios than the average (see Appendix E). Two rural counties have no physicians. The same situation exists with licensed nurses. Many of the rural counties have substantially fewer RN's and LPN's than the average for the state (see Appendix F). Furthermore, most rural health services are located in the ten towns that have general hospitals.

A chart developed for the subcommittee by the bureau of vital statistics estimates that approximately 11,000 elderly Nevadans and 78,000 Nevadans of all ages live in communities of less than 1,000 persons (see Appendix G).

Critical rural health manpower shortage areas as identified by the state comprehensive health planning agency are outlined below:

AREA	POPULATION	PHYSICIANS	MILES TO THE NEAREST ORGANIZED OUTPATIENT DEPT.	LOCATION OF ANY NEIGHBORHOOD HEALTH CENTERS
Mineral and Esmeralda Counties (2 County Area)	7200	2	132	0
Elko (Wells Medical Service Area)	1081	0	50	0
Eureka County	800	1	240	0
Lander County	2600	1	217	0
Nye County	5000	2	236	0
Lincoln County	2200	1	175	0
Pershing County	2600	2	92	0
Humboldt County (Northern Section)	7700	3	237	0

To help alleviate the hardships which shortages of medical care cause for rural senior citizens, the subcommittee recommends that: legislation be supported and endorsed to fund a mobile health care unit. This mobile unit will bring professional and paraprofessional preventative medicine to the elderly in rural areas.

Such a mobile unit could be operated for an estimated $175,500 for fiscal year 1976-77; and allowing for moderate inflation, $184,000 during 1977-78. The cost of such a vehicle and

equipment is estimated to be $80,000. These estimates are based on the following assumptions:

1. The operation of the mobile unit is to be under the general supervision of a nurse practitioner.

2. The balance of the staff is to consist of an LPN, a technician, a driver and one clerical support position.

3. The unit will contract with doctors for professional health services in various areas as required.

4. Space for waiting rooms, eye examinations and so forth will be leased or rented.

5. The mobile unit will include X-ray, eye and hearing testing equipment, other equipment generally necessary to perform a physical examination, some laboratory capability and medical records storage. Also, required will be portable chairs, tables, room divider and communication equipment.

V. CONCLUSIONS

After public hearings in three cities, visits to rural communities and unannounced tours of institutions caring for the elderly, the subcommittee concluded that many of the problems facing senior citizens in Nevada are those faced by everyone and yet magnified because of fixed incomes and declining health and mobility. The subcommittee's charge was broad, as was the range of problems which emerged in the course of the study. In the area of institutionalized care, the subcommittee heard many more grievances than it could resolve. For example, the subcommittee was informed that private patients in facilities pay more than Medicaid patients and may be charged for extra items or services unwanted or unneeded. The subcommittee discovered that senior citizens become frustrated with bureaucratic guidelines such as different age requirements for various programs.

In the course of its study, the subcommittee also recognized that numerous problems facing senior citizens cannot be resolved by legislative action. How can the lack of participation by relatives in the lives of nursing home residents be remedied? How can people be encouraged to develop leisure

activities and secondary vocations so that later years will not be spent in boredom and isolation?

On the positive side, the subcommittee became aware of successful public and private efforts to enhance the quality of life for seniors. For example, a federally funded, state operated, nutrition program serves meals to approximately 1,850 senior citizens 5 days a week. This program appears to be making an important contribution to the physical and mental well-being of many older Nevadans. The subcommittee learned that in Las Vegas, the nutrition program is extended to Saturdays through the generosity and concern of one restaurant owner.

Subcommittee hearings also provided a needed public forum for expressing grievances and for exchanging information about existing programs for the elderly.

Furthermore, involvement in hearings by state agencies providing services to the aging led to constructive problem solving. A few examples of these side benefits should be mentioned. At the subcommittee's first hearing in Carson City, a busload of senior citizens arrived from Reno. Fifty percent of these senior citizens had never before attended a public meeting. At a small informal meeting in Panaca, the subject of the high cost of drugs arose. One senior citizen informed several other persons at the meeting that certain drugs can be ordered at a discount through the American Association of Retired Persons. At a hearing in Las Vegas, an adult group care administrator informed the subcommittee that the welfare division's form for the referral of patients to institutions did not have a space to check for placement in lower level adult group care facilities. This omission on the form was brought to the attention of the welfare division and corrected.

APPENDICES

A. Long-Term Care Cost Controls

B. Long-Term Care Provided Under Nevada Welfare Medical Services Title XIX, Medicaid

C. Report of Subcommittee Visits to Reno and Elko Long-Term Facilities

D. Letter from Nevada State Medical Association Regarding Physicians' Visits to Nursing Homes

E. County Practicing Physician Ratio

F. County Licensed Nurses Ratio

G. Estimates of Numbers of Nevadans Living in Communities of Less than 1,000 in 1976

APPENDIX A

OCT 28 1975

VI

DEPARTMENT OF HUMAN RESOURCES
WELFARE DIVISION - MEDICAL CARE SECTION
251 JEANELL DRIVE - STATE CAPITOL COMPLEX
CARSON CITY, NEVADA 89701

of nevada

October 28, 1975

MEMO

TO: Ed Schorr, Deputy Fiscal Analyst
Legislative Counsel Bureau

FROM: Minor L. Kelso, Chief
Medical Care Services

SUBJECT: LONG TERM CARE COST CONTROLS, TITLE XIX

1. This responds to your request for an explanation of cost controls and auditing methods employed under Title XIX with Long Term Care Facilities. The following comments pertain:

   a. Title XIX pays reasonable costs on an audited cost basis. Costs are located in five areas, with a dollar maximum within each cost area:

      (1) Administration $4.20 P.p.d. (per patient day)
      (2) Raw Food $2.00 P.p.d.
      (3) Housekeeping $4.70 P.p.d.
      (4) Property Related $4.70 P.p.d.
      (5) Profit Incentive $1.00 P.p.d.
      (6) Nursing Care: see below

   b. Details of control within cost areas:

      (1) Quality Care implemented by having no dollar maximums of nursing salaries. The only condition imposed is that the program will not participate in salaries generated by providing more than 3.00 hours of nursing care P.p.d. (per patient day). Director of Nursing and Therapist hours are not used in computing the 3.00 hours of care P.p.d. Therapists, consultants, and routine supplies are paid at cost - subject to test of reasonableness.

      (2) Reimbursement for property related costs (taxes, insurance, interest, depreciation, and return on equity) are based on the Fair Market/True Cash value of the property and equipment used for patient care - as determined by the County Tax Assessor's office. Methodology:

         (a) Assessed Value* ÷ 35% = Fair Market Value
         (b) Fair Market Value x 18% = Allowable Return
         (c) Allowable return ÷ actual patient days, OR 92% of available patient days (whichever is greater) = rate per patient day
         (d) Current rate per patient day cannot exceed $4.70 P.p.d. (Welfare Board Policy)

*Determined during each audit by verification with appropriate tax assessor and tax rolls.

(3) Costs which are not considered in Cost Reimbursement:

(a) Advertising (other than recruitment)
(b) Public Relations (other than name and address)
(c) Bad Debts
(d) Donations
(e) Collection Costs
(f) Ancillary Costs (Lab, Prescriptions, physical therapy) which are paid individually when prescribed by patient's physician and authorized by Medical Care unit.

(g) Wages and hours of private duty patients
(h) Personal expense items of staff personnel
(i) Property related costs (paid for under State formula separately)
(j) Costs not related to patient care in a facility.

(4) Revenue producing items which must be used to offset costs to arrive at a reimbursable cost:

(a) Rental income (beauty shop, gift shop, etc.)
(b) Revenue from meals sold to guests, and employees
(c) Telephone charges paid directly by guests, patients, or staff
(d) Purchase discounts or trade allowances
(e) Property related costs of non-nursing home facilities
(f) Vending machine commissions

c. The various specific areas to which cost analysis is applied are located in a "Chart of Accounts". The Chart of Accounts identifies the details of control within each area. See Appendix "A" for listing of specific areas located within the Chart of Accounts (complete Chart of Accounts available if desired).

2. The above information reflects current procedures. On or about 1 July 1976 there will be minor changes to reflect federal regulations that will be forthcoming at that time. The dollar impact with the Title XIX program in Nevada will be negligible. By contrast, if the proposed Federal Regulations prevail, many States will suffer considerable fiscal impact, in that their formula for payment does not currently reflect true reasonable costs.

MLK:dd

cc: George E. Miller, State Welfare Administrator
Roger S. Trounday, Director, Department of Human Resources

CHART OF ACCOUNTS (HEADINGS ONLY)

I. ADMINISTRATION:

A. Salaries and Wages:

1. Administrator
2. Clerical/office

B. Vacations, Holidays, and Sick Leave (not claimed in Salary and Wages)

C. Contracted Labor (casual, e.g., "Kelly Girls")

D. Payroll Taxes:

1. F.I.C.A. (employer's share)
2. State Unemployment Taxes
3. Federal Unemployment Taxes
4. Workmen's Compensation (N.I.C.)

E. Employee Health and Accident Insurance (Employer's share)

F. Office supplies

G. Printing

H. Telephone and Telegraph

I. Public Relations (name and address of facility only)

J. Employee Hiring (Classified Advertising)

K. Travel Expense

L. Auto expense (includes depreciation)

M. Postage and Freight

N. Dues and Subscriptions

O. Equipment Rental (non-patient)

P. Interest expense (non-property)

Q. Management Fee, if providing necessary services

R. Audit/Accounting Fee

S. Malpractice Insurance

T. Legal Fees

U. Miscellaneous (List and Identify)

V. Licenses

II. ROOM AND BOARD:

A. Dietary:

1. Salaries and Wages
2. Contracted Labor (Dietitian)
3. Raw Food
4. Supplies (including replacements)
5. Food Sales (Income account)
6. Miscellaneous (List and Identify)

B. Housekeeping:

1. Salaries and Wages
2. Housekeeping Supplies
3. Housekeeping Services (identify)

C. Laundry:

1. Salaries and Wages
2. Laundry supplies (including replacements)
3. Laundry services (identify)
4. Equipment rental (non-patient)
5. Personal laundry charges (Income account)

D. Plant Operation:

1. Salaries and Wages
2. Plant maintenance supplies
3. Maintenance purchased services (identify)
4. Utilities
5. Sewer Use Tax (if any)
6. Garbage removal

III. HEALTH CARE:

A. Nursing Services:

1. Salaries and Wages:

a. Director of Nursing
b. Registered Nurses
c. Licensed Practical Nurses
d. Aides (orderlies)
e. Contracted Services (nurses registries - casual)

2. Supplies:

   a. Departmental Supplies (not billed to patients)
   b. Central Supply (not billed to patients)

3. Equipment rental - patients (not billed to patients)

B. Therapy Services:

1. Physical Therapy:

   a. Salaries and Wages
   b. Supplies
   c. Equipment rental - patients
   d. Purchased services

2. Occupational Therapy:

   a. Salaries and Wages
   b. Supplies
   c. Equipment rental - patients
   d. Purchased Services

3. Speech Therapy:

   a. Salaries and Wages
   b. Supplies
   c. Equipment rental - patients
   d. Purchased services

4. Inhalation Therapy:

   a. Salaries and Wages
   b. Supplies
   c. Equipment rental - patients
   d. Purchased services

5. Recreational Therapy:

   a. Salaries and Wages
   b. Supplies
   c. Equipment rental - patients
   d. Purchased services

C. Other Services:

1. Pharmacy
2. Radiology
3. Laboratory
4. Medical, Surgical, and Central Supply
5. Medical Doctor Fees
6. Utilization Review Committee Fees (Medicare)
7. Personal Needs - patients (beautician, barber, etc.)

APPENDIX B

Outline of comments by Minor Kelso, Chief, Welfare Medical Services, before Committee on "Skilled Nursing Facilities and Problems of the Aged and Aging." 27 September 1975

LONG TERM CARE
PROVIDED UNDER
NEVADA WELFARE MEDICAL SERVICES
TITLE XIX - MEDICAID

I. BRIEF OVERVIEW OF MEDICAID IN NEVADA:

A. Medicaid is under Welfare Division in Nevada. State administered, not Federal.

B. Medicaid provides full range of medical service to eligible recipients. 20,000 in Nevada.

C. Average medical cost per year per recipient, approximately $850.00; per OAA $1500.00.

D. Federal government has taken over eligibility and payment for Blind, Disabled and Old Age Assistance categories. Aid to Dependent Children remains under State control. However, Medicaid provides medical services to all categories.

E. Cost of medical care nearly equals financial aid.

II. LONG TERM CARE FACILITIES/UTILIZATION:

A. 1158 SNF beds in State.

B. 320 ICF beds in State, including 54 ICF MR beds in 2 facilities.

C. 10 free standing facilities; 9 part of hospitals.

D. Title XIX occupies 80% of Long Term beds in State.

E. SNF beds 95% occupied.
ICF beds 99% occupied.

F. Facilities under construction:

50 beds - Reno Convalescent

99 SN beds - Drs. Zellhoefer/Sol DeLee, Las Vegas
50 SN beds - Ruby Mountains Manor, Elko
99 bed facility, Ely (40 SN; 30 ICF; 29 Group)

III. PORTRAIT OF THE NURSING HOME POPULATION:

A. Average age is 82; 95% are over 65 and 70% are over 70.

B. Most are female with ratio of 2:1 to males.

C. 63% are widowed; 22% never married; 10% are married.

D. 50% have no viable relationship with a close relative; another 30% have only collateral relatives near their own age.

E. Approximately 20% come from their own homes or relatives homes; approximately 60% come from general hospitals; 10% come from State mental hospitals; 10% come from other nursing homes or homes for aged, boarding homes, etc.

F. Average length of stay - 2 1/2 years.

G. Most patients have an average of 4 chronic crippling disabilities:

1)	Cardiovascular disease	65%
2)	Senility	20
3)	Fractures	11
4)	Arthritis	10

H. 55%+ are mentally impaired; less than 1/2 can walk
55% require assistance with bathing
47% need help in dressing
11% need help in eating
33% are incontinent

I. The average nursing home patient takes 4.4 different drugs/day - some take 2-3 times/day; 70% take 5 or more drugs.

J. Most nursing home patients do not have visitors.

IV. NEVADA MEDICAID LONG TERM CARE PROGRAM:

A. Services paid for on audited cost basis: average for SNF $23.00 per patient day; $18.00 for ICF. Considerably above national average. 35% of 1975 $16,000,000 annual budget will be spent on Long Term Care.

B. Audited cost method of payment assures actual costs are met, and at same time limits nursing home to a reasonable profit.

C. Medical Review Team (MRT) surveillance includes weekly visits by program nurses.

D. Long Term Care Committee works with program to improve care.

E. Quality of nursing homes in Nevada exceeded by no other State.

V. PROBLEMS:

A. Medicare limitations on benefit period. Some liberalization with services.

B. Doctor participation poor. Hopefully Medical Director requirement under Titles XIX - XVIII will help.

C. Federal failure to coordinate requirements under XVIII - XIX. Regulations too lax concerning standards. Consequence in Nevada is that Welfare Medical Services has requirements that exceed Federal minimums.

D. Potential problem: If National Health Insurance (NHI) is administered by Federal Government, quality of nursing home care in Nevada will suffer.

APPENDIX C

REPORT OF SUBCOMMITTEE VISITS TO RENO LONG TERM FACILITIES

1. Team I, Chairman Dreyer, Senator Neal, Ms. Belknap, Mr. Sheffield and Ms. Love.

   (a) Mar-Von #1, 300 La Rue Street, Reno, Nevada. This facility is an adult group care facility. Owners report an 18-resident capacity with three staff persons. Residents appeared to be generally cheerful and some were engaged in purposeful activity such as handiwork. Toys were available in some of the rooms.

   Most residents were watching TV. Pets are permitted at the facility and the presence of several cats was noticed. There was a garden area outside for use in the spring. The rooms seemed well-lighted and cheerful in appearance. Kitchen and bathrooms were clean and neat. Bells to ring for assistance were located in bathrooms. Meals were ready to be served on trays. One room had a noticeable odor. A fire escape plan was posted.

   (b) Comer House, 1059 Haskell Street, Reno, Nevada. This facility is also at the adult group care level. While the facility appeared to be neat, the halls and bathroom were dark and furnishing looked rather bare. When the team arrived, most residents were seated in a living room awaiting lunch and not doing much of anything. Two residents were reading, one person was doing barbering. Later on, the TV was turned on, but it was difficult to ascertain if residents seated before it were actually engaged in watching the program. Lunch was about to be served at communal tables. A sprinkler system was easily identified.

   (c) Mar-Von #2, 75 Caliente Street, Reno, Nevada. This unit is the brother adult group care facility to Mar-Von #1 and primarily houses men plus one married couple. Sprinklers were in evidence as was a posted fire plan. The kitchen was very clean, although the general appearance of the residents, themselves, was more unkempt than at Mar-Von #1. The cook at this facility showed enthusiastic interest in the welfare of the residents. Again bells were located in bathrooms. The team took note of the presence of a locked medicine cabinet. Some activity was observed, such as

several men watching TV and one person working with business papers. A pet dog was on the premises. Meals evidently are served on trays.

(d) Riverside Hospital for Extended Care, 2865 Idlewild Drive, Reno, Nevada. This facility was the only skilled nursing facility (one ward was an intermediate care facility) which Team I visited. In contrast to the more homelike environment of the adult group care facilities, Riverside seemed more like a hospital, which might be predicted from the level of care provided. Over 115 beds and numerous wings contributed to this atmosphere. The grounds and building are most attractive. The head nurse of the facility was at the hospital when the team arrived; she candidly admitted that she did not usually work on Saturdays. She took the team through the hospital and answered questions asked by members of the team. During the course of the team's tour, an incident arose when a patient complained that he had asked for a pair of scissors and had been told he could not receive them until the following Monday. The head nurse explained that the problem arose from the fact that money set aside for the SAMI patients' personal use was limited to $25 per month and a check had to be made on the amount left in his fund. There was some activity going on in the facility, particularly among those patients with visitors. The small size of the formal activity room was commented on by members of the team. Only one patient was making use of it at the time of the visit. Dining facilities were large and pleasant in appearance. According to the head nurse at Riverside, patients with greater mental alertness dine in a separate room from those of a lesser degree of mental alertness.

(e) El Portal Boarding Home, 3036 Plumas, Reno, Nevada. The final adult group care facility which Team I visited offered a very attractive cottage-like living arrangement for residents. Grounds and rooms appeared clean and neat. The facility has room for 38 patients who live in small groups. Male residents did seem to be actively engaged in

watching a basketball game on TV. One man was reading and indicated that he was also writing a book. Several patients were seated in groups talking, although some were lying in bed. Patients in this facility have easy access to a bus stop which goes to nearby shopping facilities. The management at El Portal is less than a year old with no prior experience in the field. They seemed to be interested in each resident individually and were most eager for team members to visit each resident in the facility.

It should be noted that judging levels of activity and quality of care was difficult for the lay members of the team. In the first place, the very arrival of the team generated activity. Persons doing nothing began doing something simply by talking with team members.

2. Team II, Assemblymen Bennett and Coulter, Ms. Martin, and Mrs. Torvik.

   (a) Riverhaven, 727 Riverside Drive, Reno, Nevada. This is a group care facility consisting of two homes and 17 guests. In one of the homes only four people lived and there were no fire sprinklers installed as the law provides that this is only necessary when more than four people are living in a house. Most people were just sitting around, with little or no conversation taking place. They do play bingo every Wednesday and prizes are given to the winners. This was a very clean, pleasant appearing facility overlooking the Truckee River; however, the guests gave the appearance of being resigned to living in a home for the elderly without much enthusiasm or incentive to do anything.

   (b) Northern Nevada Mental Retardation Center, 2240 Glendale Road, Sparks, Nevada. This is an intermediate care facility for severe and moderately retarded people, mostly under the age of 40. There were 28 people who lived at the center. They have a training program which includes teaching the retarded to cook, clean, do handyman type work and general housekeeping. In fact, one of the patients was leaving the next day as he had been hired for a job in Utah. There were two registered nurses at the facility and a nurse who comes in on Saturday and Sunday mornings to dispense

medication. The building was very clean, beds were made and patients dressed; however, there was a slight musty odor throughout the building. The patients were either working around the building, watching TV or generally busy. They seemed most happy.

(c) Golden Age Gardens, 387 Gould Street, Reno, Nevada. This facility was a combination intermediate care and adult group care home. Although the building and its surrounding were not the best which Team II visited, the patients seemed to be quite happy and content. Most people were sitting around; some were watching TV. They have weekly bingo games and, at the time, the owners were seeking a new social activities director. The intermediate care facility had 30 patients, 17 part-time and full-time staff, with an R.N. on duty 8 hours a day, 7 days a week and an LPN on the other shifts. There was a strong Chlorox smell in the intermediate care area. The group care facility had 23 people and there was a great deal of camaraderie between these people. There were some additions and construction going on within the building and many of the rooms were being repainted and decorated. The facility held up to 27 patients.

(d) Reno Convalescent Center, 1300 Mill Street, Reno, Nevada. This facility was a skilled nursing facility designed for maximum level of care. The hospital was in the process of being expanded and there will be room for 120 patients when it is completed. At this time there were 77 patients and 65 full-time aides. There were 22 private patients who pay $28 per day. The state pays $26.07 for patients under Medicaid. Mrs. Norma Beales, Administrator, showed the team around the facility, which is owned by an out-of-state corporation. There is a training program for aides but there is a heavy turnover as the wages are $2.85 per hour. Most people were sitting around in rooms and a few were watching television. There was a large activity room with daily afternoon activities scheduled (bingo, church services, crafts). One of the rooms which was being added was a new dining room for the patients who needed the least amount of care. The urine odor in the intensive care section was extremely strong; however, staff was in the process of changing linens and making the beds.

3. Team III, Assemblymen Murphy and Sena, Ms. Hampton and Mr. Schorr.

(a) Physicians' Hospital for Extended Care, 2045 Silverada Boulevard, Reno, Nevada. This is a skilled nursing facility. The team arrived at about 9:30 a.m. and found little activity. It was the team's impression that the staff expected the visit but not that early. Staff was having a meeting. One woman was found uncovered and the M/R nurse who was accompanying the team alerted the hospital staff. The team talked with a man from Lovelock who wanted to know if he had the right to change doctors. His doctor told him he could not leave for the day and return to the facility. He apparently was a Medicaid patient and federal regulations prohibit patients leaving the facility and returning. This is not the case under the state program. He seemed rational and understood when the prohibition was explained to him. He stated that he expected some form of retribution from the staff for talking with the team. By the time the team reached the final wing, patients were in the hall in their wheelchairs. A man was vacuuming the hall and staff was scurrying about.

(b) Montello Manor, 1815 Montello Drive, Reno, Nevada. This was an adult group care facility which was old but clean and freshly painted. It had ten beds; however, residents did not have private rooms. It was very homelike and the residents seemed cheerful.

(c) Odd Fellows Sierra Homes, Incorporated, 1155 Beech Street, Reno, Nevada. This is another adult group care facility which the team found to be very large, clean and cheerful. Residents have private rooms and much of their own furniture.

(d) Riverside Hospital for Extended Care, 2865 Idlewild Drive, Reno, Nevada. This facility is for skilled nursing level of care. They seemed to be expecting the team's visit. Mrs. Hahn, Director of Nursing, was present although she does not work on Saturday. The turnover of staff was very high. Mrs. Hahn was listening to conversations the team had with the staff.

REPORT OF SUBCOMMITTEE TEAM VISIT TO
ELKO INTERMEDIATE CARE FACILITY

SUBCOMMITTEE MEMBERS PRESENT:

Assemblyman Steven A. Coulter
Assemblyman Patrick M. Murphy

LEGISLATIVE COUNSEL BUREAU STAFF PRESENT:

Molly M. Torvik, Secretary

The subcommittee members and staff were met at the airport by Mr. "Dex" Farrell, Director, R.S.V.P., who transported the group to Ruby Mountain Manor, a skilled nursing, intermediate and group care facility in Elko. This was the only nursing facility in the rural areas visited by the subcommittee teams on that day. The subcommittee found the following:

1. The facility is owned by a corporation made up of businessmen from the Reno area. It has 88 skilled and intermediate certified beds with 72 of these beds occupied at this time.

2. There were two television rooms; however, very few people were sitting around watching television. There was a chapel where a man was enjoying himself playing a piano. The recreation room held many games (ring toss, darts); plants were being started from seeds by many of the patients; a couple of people were working on a large jigsaw puzzle and many arts and crafts projects were evident throughout the room.

3. The therapy room had a whirlpool bath and some very impressive exercise machines. Mrs. Lowry, the director of nurses, informed the subcommittee members that Mr. Wayne Miller, a physical therapist from the Elko Hospital, visited the facility at least once a week.

4. One lady was having her hair set in the beauty parlor and the subcommittee members noticed that attendants were washing, combing and setting many patients' hair in their rooms. A few of the men patients were also being shaved by attendants.

5. There were shelves from floor to ceiling in the entry of the facility which held all different types of magazines and

general library books (encyclopedias to paperback fiction). This reading material was readily available to anyone in the facility who wished to use it.

6. There were railings down both sides of all halls for the patients' support, a pay telephone in the hallway placed at wheelchair height and a soda pop dispenser at a convenient location.

7. There were two dining rooms and Mrs. Lowry said that there were only two patients who were unable to go to the dining room for meals.

8. There were three blind people who lived at the facility.

9. The kitchen and pantry areas were exceptionally clean and neat. Meat is purchased from Sierra Meat Company and is served three times daily (breakfast, lunch and dinner). There are three coffee hours each day (9:30 a.m., 2:30 and 7 p.m.) where coffee, tea or juice is served.

10. There was an ongoing activity program which included bingo, slide shows and church services.

11. Mrs. Lowry stated that the facility had no problem getting local doctors for emergencies and the facility has its own transportation which takes patients to the local clinic for checkups and medical needs. A pill count is taken after each shift (three times daily). Patients' pills are kept in a locked cabinet at the nurse's station. Narcotics are kept in a locked box inside the locked cabinet. A time chart is posted which specifies each patient's medicine and the time at which it is to be administered.

Overall, the facility was neat and clean smelling. It had large windows which overlooked the Ruby Mountains and the City of Elko. The patients seemed to be happy and most were out of their rooms visiting each other in the halls and recreation room.

APPENDIX D

NEVADA STATE MEDICAL ASSOCIATION

January 21, 1976

Assemblyman Darrell H. Dreyer
Chairman
Legislative Commission's Subcommittee on
Skilled Nursing Facilities and Problems
of the Aged and Aging
% State of Nevada Legislative Counsel Bureau
Legislative Building
Capitol Complex
Carson City, Nevada 89710

Dear Assemblyman Dreyer:

This is to acknowledge your invitation for a representative of the Nevada State Medical Association to attend the interim meeting of the subcommittee on January 23rd in Reno. This request was discussed at the meeting of the Association's Executive Committee in Las Vegas on January 17th. Because of the American Medical Association Leadership Conference which begins in Chicago on Friday, we are unable to arrange for a personal representative at this meeting. We would like, however, to accept your offer to present some written comments for the subcommittee's record.

A statement is attributed to nursing home administrators that it is difficult to get physicians to visit the patients. One of the problems comes from the fact that patients are quite often placed in nursing homes or convalescent hospitals by the last physician who treated them. This might well be a surgical specialist who handled an acute condition. Such a physician neither has his practice geared nor the type of training necessary to deal efficiently with patients that subsequently require maintenance care, for the most part.

Thus, the admitting physician in many instances is not the family doctor and there may indeed not be any family doctor at all.

In some Nevada communities, there is no suitable nursing facility. When patients in such a community need to be transferred to a nursing facility, perhaps a hundred or more miles away, it is not a realistic expectation that the referring doctor will continue to look after them.

We did not have the opportunity to survey our membership widely on this subject. In Las Vegas, several of the nursing facilities are served by physicians who specialize in nursing home patients. Two physicians in Las Vegas do nothing else but take care of this type of patient. Several others do it part-time.

It is possible for these doctors to conduct such a practice because the nursing homes fully cooperate, obtaining authorization from the patients or the families for the doctors to see and treat any patient who does not have his own doctor in regular attendance. The nursing facility staff also "preps" each patient for the doctor's visits by thorough updating of records, symptoms, etcetera, and by accompanying the doctor on his rounds to list observations and to carry out prescribed therapy regimens.

It is the recommendation of the Nevada State Medical Association's Executive Committee that nursing facility administrators expressing frustration about this type of patient be asked to carefully explore the availability of these geriatric specialists in their communities. This would seem more productive than badgering orthopedists, dermatologists, ophthalmologists, or whatever, that may be listed as the last attending physician to the patient. With that exploration of availability (in which the local medical societies can be of some assistance) the administrators would be well advised to survey the ability and attitude of their facility and staff to cooperate with doctors calling on their patients. Nursing homes vary a great deal in this regard, according to members of the Association we have consulted.

A second aspect of this question involves a difference between most physicians and nursing home personnel about the necessity of certain physician visits. There is pressure on the administrators from Medicare and Medicaid programs to have their patients seen by a physician once per month. This arbitrary standard seldom fits with the medical necessity of a case. While some patients require one or more physician visits each month, most do not. In spite of the legal

definitions of various nursing and other non-acute hospital facilities, a great number of the patients in them require little more than custody. We do not support the waste of tax funds or professional resources that are implied by asking physicians to perform and charge for services they do not feel are clinically indicated.

Nursing home patients obviously do need attention in many forms. They need nourishing food, a sanitary and cheerful environment, mental stimulation and affection. These needs have to be communicated to them through the nursing home personnel and through family and friends. Well administered nursing homes provide an atmosphere where families and friends are encouraged and welcome and comfortable in visiting the patients. The amenities of the home itself should offer diversions and challenges in dimension and variety enough to permit each patient to engage in whatever initiative he is capable of.

A major problem, then, as far as we can define it, is the institutional problem of making possible high morale for persons made lonely and physically restricted by their age or illness. While all patients are somewhat affected by the assurance of a doctor's visit, regardless of the treatment rendered, we would resist the use of physicians as placeboes in nursing homes.

Thank you again for your thoughtful invitation.

Sincerely,

Douglas Hackett
Associate Director

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APPENDIX E

COUNTY LICENSED PHYSICIAN RATIO

County	Population	Total No. of Active Physicians	Ratio
Carson City	21,800	27	1:807
Churchill	12,200	5	1:2440
Clark	306,100	302	1:1014
Douglas	9,600	4	1:2400
Elko	15,300	13	1:1177
Esmeralda	800	0	0:800
Eureka	800	1	1:800
Humboldt	6,700	3	1:2233
Lander	2,600	1	1:2600
Lincoln	2,200	1	1:2200
Lyon	10,200	2	1:5100
Mineral	6,700	2	1:3350
Nye	5,000	2	1:2500
Pershing	2,600	2	1:1300
Storey	800	0	0:800
Washoe	134,300	216	1:622
White Pine	10,000	5	1:2000
State Total	547,700	586	1:935

Source: available information for 1974 - updated to 1975 where information was available.
Nevada State Plan for Health, Vol. I, July 1975, State Comprehensive Health Planning Agency.

APPENDIX F

County Licensed Nurses Ratio

County	Population	Licensed RN's	Ratio	Licensed LPN's	Ratio
Carson City	21,800	112	1:195	57	1:382
Churchill	12,200	33	1:370	49	1:249
Clark	306,100	1179	1:260	614	1:499
Douglas	9,600	24	1:400	8	1:1200
Elko	15,300	56	1:273	82	1:187
Esmeralda	800	2	1:400	0	0:800
Eureka	800	5	1:160	1	1:800
Humboldt	6,700	22	1:305	7	1:957
Lander	2,600	10	1:260	7	1:371
Lincoln	2,200	11	1:200	4	1:550
Lyon	10,200	22	1:464	38	1:268
Mineral	6,700	23	1:291	18	1:372
Nye	5,000	13	1:385	10	1:500
Pershing	2,600	12	1:217	7	1:371
Storey	800	3	1:267	2	1:400
Washoe	134,300	907	1:148	459	1:293
White Pine	10,000	34	1:294	24	1:417
State Total	547,700	2,468	1:220	1,387	1:395

Source: Nevada State Board of Nursing

Nevada State Plan for Health, Vol. I, July 1975. State Comprehensive Health Planning Agency.

ALL INCORPORATED PLACES & UNINCORPORATED PLACES OF 1000 OR MORE

BASED ON 1970 CENSUS AND 1976 ESTIMATED OF THE POPULATION

COUNTY / PLACE	1970 POPULATION	1976 POPULATION	1976 POPULATION AGE 60 AND OVER
CARSON CITY	15,468	29,079	2,893
CHURCHILL	10,513	11,655	1,553
FALLON CITY	2,959	3,280	437
FALLON NAS	1,045	1,159	154
BALANCE	6,509	7,216	962
CLARK	273,288	345,797	29,040
BOULDER CITY	5,223	6,609	555
EAST LAS VEGAS	6,501	8,226	691
HENDERSON	16,395	20,745	1,742
LAS VEGAS	125,787	159,161	13,366
NELLIS	6,449	8,160	685
NORTH LAS VEGAS	36,216	45,825	3,848
PARADISE	24,477	30,971	2,601
SUNRISE MANOR	10,886	13,774	1,157
VEGAS CREEK	8,970	11,350	953
WINCHESTER	13,981	17,690	1,486
BALANCE	18,403	23,286	1,956
DOUGLAS	6,882	12,089	1,314
GARDNERVILLE-MINDEN	1,320	2,319	252
BALANCE	5,562	9,770	1,062

Source: Bureau of Vital Statistics, Division of Health, Department of Human Resources.

ELKO	13,958	18,209	2,170
CARLIN	1,313	1,713	204
ELKO	7,621	9,943	1,185
WELLS	1,081	1,410	168
BALANCE	3,943	5,143	613
ESMERALDA	629	584	111
EUREKA	948	981	138
HUMBOLDT	6,375	7,658	1,017
WINNEMUCCA	3,587	4,309	572
BALANCE	2,788	3,349	445
LANDER	2,666	2,986	314
BATTLE MOUNTAIN	1,856	2,079	219
BALANCE	810	907	95
LINCOLN	2,557	2,392	391
CALIENTE	916	857	140
BALANCE	1,641	1,535	251
LYON	8,221	9,116	1,134
YERINGTON	2,010	2,229	277
BALANCE	6,211	6,887	857
MINERAL	7,051	7,660	828
BABBITT	1,579	1,715	185
HAWTHORNE	3,539	3,845	416
BALANCE	1,933	2,100	227

Source: Bureau of Vital Statistics, Division of Health, Department of Human Resources.

NYE	5,599	5,000	596
GABBS	874	780	93
TONOPAH	1,716	1,532	183
BALANCE	3,009	2,688	320
PERSHING	2,670	2,652	435
LOVELOCK	1,571	1,560	256
BALANCE	1,099	1,092	184
STOREY	695	1,051	216
WASHOE	121,068	162,097	19,446
RENO	72,863	97,556	11,703
SPARKS	24,187	32,384	3,885
SUN VALLEY	2,414	3,232	388
BALANCE	21,604	28,925	3,470
WHITE PINE	10,150	9,481	1,107
EAST ELY	1,992	1,861	217
ELY	4,176	3,901	455
MCGILL	2,164	2,021	236
BALANCE	1,818	1,698	199
TOTALS	488,738	628,487	62,810
IN NAMED TOWNS	411,136	531,275	51,704
BALANCE	77,602	97,212	11,106

Source: Bureau of Vital Statistics, Division of Health, Department of Human Resources.

RECOMMENDED LEGISLATION

SUMMARY--Makes appropriation for traveling team to teach nursing home assistants proper care of elderly. (BDR S-96)
Fiscal Note: Local Government Impact: No.
State or Industrial Insurance Impact: Contains appropriation.

AN ACT making an appropriation for a traveling team to teach nursing home assistants proper care of elderly persons; and providing other matters properly relating thereto.

WHEREAS, The lack of training of aides and orderlies in nursing homes is a serious problem; and

WHEREAS, The aides and orderlies are frequently involved in direct handling of elderly patients, yet these assistants generally have had no training in geriatrics and proper care of the aged until their on-the-job experience; and

WHEREAS, The present situation risks inadequate and improper patient treatment; and

WHEREAS, The situation could be improved by in-service instruction provided by a team of traveling nurses; now, therefore,

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. There is hereby appropriated from the state general fund to the department of human resources the sum of $150,000 for the biennium beginning July 1, 1977, and ending June 30, 1979,

to establish a pilot, traveling nurses' program to teach untrained workers in nursing homes proper care of the aging patient.

Sec. 2. Any unencumbered balance of the appropriation made in section 1 shall not be committed for expenditure after June 30, 1979, and shall revert to the state general fund.

Sec. 3. The department of human resources shall prepare a report:

1. Showing the effectiveness of the pilot, traveling nurses' program;

2. Evaluating the feasibility of requiring professional certification for nursing home aides and orderlies; and

3. Discussing the feasibility and explaining any feasible method of obtaining reimbursement from the nursing homes of all or part of the cost of the program in future fiscal years,

and shall submit the report with appropriate recommendations to the 60th session of the Nevada legislature.

SUMMARY--Creates office and defines duties of public guardian. (BDR 20-99)
Fiscal Note: Local Government Impact: Yes.
State or Industrial Insurance Impact: No.

AN ACT relating to guardians; creating the office of public guardian and defining its duties; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 253 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 12, inclusive, of this act.

Sec. 2. 1. The board of county commissioners of any county having a population of 100,000 or more shall establish the office of public guardian.

2. The board of county commissioners of any county having a population of less than 100,000 may establish the office of public guardian.

3. The board of county commissioners shall appoint the public guardian for a term of 4 years from the day of appointment.

4. The compensation of a public guardian shall be fixed by the board of county commissioners and paid out of the county general fund.

5. For purposes of this section, population is determined by the last preceding national census of the Bureau of the Census of the United States Department of Commerce.

Sec. 3. 1. Upon taking office, a public guardian shall file with the county clerk a general bond in the amount of $100,000 payable to the State of Nevada with sureties approved by the board of county commissioners. The premium for the bond shall be paid from the general funds of the county and be conditioned upon the public guardian's faithful performance of his duties.

2. The general bond and oath of office of a public guardian are in lieu of the bonds and oaths required of private guardians.

Sec. 4. 1. If any vacancy occurs in the office of public guardian before the expiration of a normal term, the vacancy shall be filled promptly by the board of county commissioners.

2. The district court may designate any qualified person to serve as acting public guardian until a vacancy in such office is filled.

Sec. 5. Within the limits of appropriations for his office, a public guardian may:

1. Employ subordinates necessary for the proper performance of his duties.

2. Contract for the services of consultants or assistants.

Sec. 6. A public guardian shall keep financial and other appropriate records concerning all cases in which he is appointed as an individual guardian.

Sec. 7. 1. A resident of Nevada who is 60 years of age or older is eligible to have the public guardian appointed as his individual guardian if he:

(a) Has no relative or friend able and willing to serve as his guardian; or

(b) Lacks sufficient assets to provide the requisite compensation to a private guardian.

2. A person so qualified, or anyone on his behalf, may petition the district court of the county in which he resides to make the appointment.

Sec. 8. A person appointed as public guardian or designated as acting public guardian succeeds immediately to all powers and duties of the individual guardianships created by appointments of the public guardian as guardian for particular wards.

Sec. 9. A public guardian shall investigate the financial status of any person for whom the appointment of the public guardian as his guardian is requested. In connection with the investigation, the public guardian may require that person to execute and deliver any written requests or authorizations necessary to provide the

public guardian with access to records, otherwise confidential, needed to evaluate eligibility. The public guardian may obtain information from any public record office of the state or any of its agencies or subdivisions upon request and without payment of any fees.

Sec. 10. 1. If a public guardian is appointed as an individual guardian the costs incurred in the appointment proceedings and the administrative costs of the guardian's services are not chargeable against the income or the estate of the ward unless the court determines at any time that the ward is financially able to pay all or part of the costs.

2. The financial ability of the ward to pay such costs shall be measured according to his ability to compensate a private guardian. This ability depends upon:

(a) The nature, extent and liquidity of the ward's assets;

(b) His disposable net income;

(c) The nature of the guardianship;

(d) The type, duration and complexity of the services required; and

(e) Any other foreseeable expenses.

Sec. 11. The reasonable value of a public guardian's services rendered without cost to a ward shall be allowed as a claim against the estate upon the death of the ward.

Sec. 12. The court may, at any time, terminate the appointment of a public guardian as an individual guardian upon petition by the ward or any interested person or upon the court's own motion if it appears that the services of the public guardian are no longer necessary.

Sec. 13. NRS 160.040 is hereby amended to read as follows:

160.040 1. Except as hereinafter provided it [shall be] is unlawful for any person to accept appointment as guardian of any ward if such proposed guardian shall at that time be acting as guardian for five wards. In any case, upon presentation of a petition by an attorney of the Veterans' Administration under this section alleging that a guardian is acting in a fiduciary capacity for more than five wards and requesting his discharge for that reason, the court, upon proof substantiating the petition, shall require a final accounting forthwith from such guardian and shall discharge such guardian in the case.

2. The limitations of this section [shall] do not apply where the guardian is a bank or trust company acting for the wards' estates only.

3. An individual may be guardian of more than five wards if they are all members of the same family.

4. The limitations of this section do not apply to the Nevada commissioner for veteran affairs [.] or to a public guardian.

SUMMARY--Clarifies authority of state personnel to inspect health and care facilities. (BDR 40-95)
Fiscal Note: Local Government Impact: No.
State or Industrial Insurance Impact: No.

AN ACT relating to health and care facilities; clarifying the authority of certain personnel of the department of human resources to enter such facilities in performance of official duties; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 449.001 is hereby amended to read as follows:

449.001 As used in NRS 449.001 to 449.245, inclusive, and section 3 of this act, unless the context otherwise requires, the words and terms defined in NRS 449.002 to 449.018, inclusive, have the meanings ascribed to them in [such] those sections.

Sec. 2. NRS 449.150 is hereby amended to read as follows:

449.150 The health division may:

1. Upon receipt of an application for a license, conduct an investigation into the premises, facilities, qualifications of personnel, methods of operation, policies and purposes of any person proposing to engage in the operation of a health and care facility. Such facility is subject to inspection and approval as to fire safety standards, on behalf of the health division, by the state fire marshal or his designate.

2. [Inspect every licensed health and care facility as often as is necessary to assure that there is compliance with all applicable rules, regulations and standards.

3.] Employ such professional, technical and clerical assistance as it deems necessary to carry out the provisions of NRS 449.001 to 449.245, inclusive.

Sec. 3. Chapter 449 of NRS is hereby amended by adding thereto a new section which shall read as follows:

Every licensed health and care facility may be inspected at any time, with or without notice, as often as is necessary:

1. By the health division to assure that there is compliance with all applicable rules, regulations and standards; and

2. By other employees of the department of human resources, to the extent authorized by the director of the department, for the purpose of carrying out their official duties.

SUMMARY--Requires state board of health to establish certain rights for patients or residents of health and care facilities. (BDR 40-92)
Fiscal Note: Local Government Impact: No.
State or Industrial Insurance Impact: No.

AN ACT relating to health and care facilities; requiring the state board of health to adopt regulations establishing certain rights applicable to patients or residents of such facilities.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 449.037 is hereby amended to read as follows:

449.037 1. The state board of health shall adopt:

(a) Licensing standards for each class of health and care facility covered by NRS 449.001 to 449.240, inclusive, after considering any recommendations the health facilities advisory council may make.

(b) [Rules and regulations] Regulations governing the licensing of such institutions, after considering any recommendations the health facilities advisory council may make.

(c) After public hearing, a regulation establishing minimum rights, with enforcement provisions, to privacy, visits and associations, financial accounting, grievance procedures, treatment information and similar matters, applicable to every patient or resident of a health and care facility who is not protected by a federal regulation imposing a higher standard.

(d) Such other [rules and] regulations as it deems necessary or convenient to carry out the provisions of NRS 449.001 to 449.240, inclusive.

2. The state board of health shall require that the practices and policies of each health and care facility must provide adequately for the protection of the health, safety, physical, moral and mental well-being of each individual accommodated in the facility.

SUMMARY--Directs legislative commission to study feasibility of establishing state geriatric center. (BDR 97)

CONCURRENT RESOLUTION--Directing the legislative commission to study the feasibility of establishing a state geriatric center.

WHEREAS, Many of the citizens of Nevada, because of advancing age, are unable to care for themselves properly but can be cared for in the homes of relatives or, with a minimum of aid, in their own homes; and

WHEREAS, Research in the fields of geriatrics and gerontology offers the prospect of long, productive and rewarding lives for senior citizens; and

WHEREAS, Both in proportion to the general population and in absolute numbers, predictably there will be substantially more future senior citizens living in this state; and

WHEREAS, The health and well-being of senior citizens can be enhanced by the provision of outpatient therapy, which may result in fewer medical problems of a major nature, requiring expensive and difficult confinements and medical treatment; and

WHEREAS, Many of the people who care for older relatives would benefit greatly from a facility for short-term care of their charges; and

WHEREAS, Many beneficial services could be provided older Nevadans and those who help them and care for them, and these services could best be delivered through the offices of a state geriatric center; now, therefore, be it

RESOLVED BY THE OF THE STATE OF NEVADA, THE CONCURRING, That the legislative commission is hereby directed to conduct a study of the feasibility of establishing a state geriatric center, which would include within the scope of its activities:

1. Study and training in gerontology;
2. Research in geriatrics;
3. Therapy for elderly outpatients; and
4. Temporary care of elderly persons,

and report the results of the study with appropriate recommendations to the 60th session of the Nevada legislature.

SUMMARY--Calls upon Congress to amend Social Security Act. (BDR 94)

JOINT RESOLUTION--Calling upon the Congress of the United States to amend the Social Security Act by eliminating the reduction in old-age benefits on account of earnings.

WHEREAS, The Social Security Act was passed by the Congress of the United States for the purpose, among others, of fostering the well-being and independence of older Americans; and

WHEREAS, The Social Security system has been set up in a manner which, in at least one respect, penalizes older Americans who are possessed of the initiative and ability to continue working; and

WHEREAS, Federal old-age benefits are reduced when the recipient has certain earnings, and in 1976 benefits were reduced in the case of each person (under 72) who earned more than $2,760, the reduction being 1 dollar for each 2 dollars of earnings over that amount; and

WHEREAS, Reductions will be imposed similarly in future years under the present law, and these deductions tend to make persons less willing to lead active, productive lives after beginning to receive Social Security benefits; and

WHEREAS, The Social Security system discriminates effectively against work, in that the reduction is for wages or earnings

from self-employment while no reductions are imposed for income derived from savings, investments, pensions, insurance, royalties or other forms of passive income; and

WHEREAS, In contrast to the negative effect of these reductions on incentive, other social programs are being undertaken at various levels of government and by private enterprise to provide older Americans with suitable and stimulating activities; and

WHEREAS, Older Americans who wish and are able to remain active in work should be encouraged to do so for their own well-being and in order that the nation may draw upon this reserve of talent, experience and knowledge; now, therefore, be it

RESOLVED, BY THE OF THE STATE OF NEVADA, JOINTLY, That this legislature, on behalf of the people of the State of Nevada, respectfully calls upon the Congress of the United States to amend the Social Security Act by eliminating the provisions which require the denial of benefits to older Americans on account of their earnings; and be it further

RESOLVED, That a copy of this resolution be prepared and transmitted forthwith by the legislative counsel to the Vice President of the United States, as President of the Senate, to the Speaker

of the House of Representatives, and to each member of the Nevada congressional delegation; and be it further

RESOLVED, That this resolution shall become effective upon passage and approval.

SUMMARY--Allows prescriptions for drugs to be filled by generic name. (BDR 54-89)
Fiscal Note: Local Government Impact: No.
State or Industrial Insurance Impact: No.

AN ACT relating to pharmacy; allowing pharmacists to fill prescriptions according to generic name under appropriate conditions; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 639 of NRS is hereby amended by adding thereto a new section which shall read as follows:

1. Except as provided in subsection 2, a prescription for a drug designated by a trade or brand name may be considered as an order for the drug by its generic name and may be used as an authorization for dispensing a drug which is of the same chemical entity, dosage form and strength as the drug designated and which will cost the patient less than the drug designated. The pharmacist who selects the drug to be dispensed pursuant to this section assumes the same responsibility for selecting that drug as would be incurred in filling a prescription for a drug prescribed by its generic name.

2. The pharmacist may not fill a prescription using another drug of the same generic name if the prescriber indicates on the prescription that a substitution is not allowed.

3. Whenever a drug is selected by generic name and dispensed pursuant to this section:

(a) The cost of the drug to the patient shall be reduced by at least the difference between the wholesale prices of the brand or trade name product designated and the drug dispensed;

(b) Directions for use of the cost-saving drug dispensed shall be communicated to the patient; and

(c) The name of the dispensed drug shall be indicated on the prescription label except where the prescriber orders otherwise.

4. For the purposes of this section, "generic name" means the chemical or generic name of those drug products having the same active chemical ingredients.

SUMMARY--Requires group health insurance policies to include provisions for conversion to individual policies. (BDR 57-100)
Fiscal Note: Local Government Impact: No.
State or Industrial Insurance Impact: No.

AN ACT relating to group health insurance policies; requiring group insurers to permit persons whose group coverage is terminated to convert to an individual policy; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 689B of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 14, inclusive, of this act.

Sec. 2. 1. All group health insurance policies delivered or issued for delivery in this state providing for hospital, surgical or major medical expense insurance, or any combination of these coverages, on an expense-incurred basis shall contain a provision that the employee or member is entitled to have issued to him by the insurer a policy of health insurance when the employee or member is no longer covered by the group policy.

2. The requirement in subsection 1 does not apply to policies providing benefits only for specific diseases or accidental injuries, and it applies to other policies only if:

(a) The termination of coverage under the group policy is not due to termination of the group policy itself unless the termination of the group policy has resulted from failure of the policyholder to remit the required premiums;

(b) The termination is not due to failure of the employee or member to remit any required contributions;

(c) The employee or member has been continuously insured under the group policy for at least 3 consecutive months immediately before the termination; and

(d) The employee or member applies in writing for the converted policy and pays his first premium to the insurer no later than 31 days after the termination.

Sec. 3. The insurer shall:

1. Issue the converted policy without evidence of insurability;

2. Base the cost of the initial and renewal premiums for the converted policy upon standard morbidity assumptions applicable to:

(a) Individually underwritten risks;

(b) The age of the person to be covered; and

(c) The type and amount of the insurance to be provided.

flush The experience of converted policies shall not be the sole basis for establishing rates. The frequency of premium payments shall

be the same as is customarily required by the insurer for the policy form and plan selected except that premium payments shall not be required more often than quarterly.

3. Provide that the effective date of the converted policy is 12:01 a.m. on the day after the termination of insurance under the group policy; and

4. Provide that the converted policy covers the employee or member and his dependents who were covered by the group policy on the date of its termination. At the option of the insurer, a separate converted policy may be issued to cover any dependent.

Sec. 4. 1. The insurer is not required to issue a converted policy to any person who:

(a) Is covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy, a hospital or medical service subscriber contract, a medical practice or other prepayment plan, or by any other kind of plan or program;

(b) Is eligible to be covered for similar benefits under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or

(c) Has similar benefits provided for or available under the requirements of any state or federal law,

if any benefits provided under the sources listed in this subsection, together with the benefits to be provided by the converted policy, would result in overinsurance according to the insurer's standards.

2. Before denying a converted policy to an applicant because he has coverage as described in paragraph (a) of subsection 1, the insurer shall notify him that the converted policy will be issued only if the other coverage is canceled.

Sec. 5. 1. A converted policy issued under section 2 of this act may include a provision permitting the insurer to request from the insured, in advance of any premium due date, information as to whether he is covered for similar benefits under any of the sources listed in section 4 of this act.

2. The insurer may not refuse to renew the policy or the coverage of any person insured under it unless:

(a) Benefits provided under the sources listed in subsection 1 of section 4 of this act, together with the benefits provided by the converted policy, would result in overinsurance according to the insurer's standards;

(b) The holder of the converted policy has refused to provide requested information as to such sources; or

(c) Fraud was committed in applying for any benefits under the converted policy.

3. Before refusing to renew a converted policy because of over-insurance, the insurer shall notify the insured that the converted policy will be renewed only if the other coverage is canceled.

Sec. 6. An insurer is not required to issue a converted policy which provides benefits in excess of those provided under the group policy from which conversion is made, and a converted policy may contain any exclusion or benefit limitation contained in the group policy.

Sec. 7. A converted policy shall not exclude a preexisting condition not excluded by the group policy, but a converted policy may provide that any hospital, surgical or medical benefits payable under it may be reduced by the amount of any benefits payable under the group policy after its termination. A converted policy may provide that during the first policy year the benefits payable under it, together with the benefits payable under the group policy, shall not exceed those that would have been payable if the policyholder's insurance under the group policy had remained in effect.

Sec. 8. 1. A person who is entitled to a converted policy shall be given his choice of at least three types of policies offering benefits on an expense-incurred basis.

2. The converted policy shall include major medical or catastrophic benefits if they were provided under the group policy.

3. For those insureds eligible for Medicare, the insurer shall provide a supplement to Medicare as the converted policy.

Sec. 9. Subject to the conditions set forth in sections 2 to 14, inclusive, of this act, the conversion privilege shall also be made available:

1. To the surviving spouse, if any, upon the death of the employee or member, with respect to the spouse and any child whose coverage under the group policy is terminated by reason of such death, or if there is no surviving spouse, to each surviving child whose coverage under the group policy terminates by reason of such death, or, if the group policy provides for continuation of dependents' coverage following the employee's or member's death, at the end of the continued coverage;

2. To the spouse of the employee or member upon termination of coverage of the spouse while the employee or member remains insured under the group policy, if the spouse ceases to be a qualified family member under the group policy, and to any child whose coverage under the group policy terminates at the same time; or

3. To a child solely with respect to himself upon termination of his coverage because he ceases to be a qualified family member under the group policy, if a conversion privilege is not otherwise provided with respect to the termination.

Sec. 10. The insurer may elect to provide group insurance coverage in lieu of the issuance of a converted individual policy.

Sec. 11. A notification of the conversion privilege shall be included in each certificate of coverage. A written notice of the existence of the conversion privilege shall also be given to the employee or member at least 15 days prior to the expiration of the 31 days permitted a person to make a written application for the converted policy. If written notice of the right to convert is not given as required under this section, an additional period shall be allowed the person to apply for the converted policy. The additional period expires 15 days after written notice of the conversion privilege has been given, or 60 days after the expiration of the 31-day period whichever is earlier.

Sec. 12. A converted policy which is to be delivered outside this state must be in such form as would be deliverable in the other jurisdiction as a converted policy if the group policy had been issued in that jurisdiction.

Sec. 13. The insurer may elect to extend coverage of an insured under the existing group policy for a period not to exceed 3 months following the day of the person's eligibility for a converted policy if the conversion privilege is offered upon termination of the extended coverage.

Sec. 14. The insurer may continue coverage identical to that provided under the group policy instead of issuing a converted policy. Coverage may be offered by amending the group certificate or by issuing an individual policy and shall otherwise comply with every requirement of sections 2 to 14, inclusive, of this act.

Sec. 15. This act shall become effective on January 1, 1978.

SUMMARY--Regulates trade practices of hearing aid specialists.
(BDR 54-98)
Fiscal Note: Local Government Impact: No.
State or Industrial Insurance Impact: No.

AN ACT relating to hearing aid sales; requiring hearing aid specialists to give purchasers an informational statement; providing for rescission of such sales under certain conditions; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 637A of NRS is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this act.

Sec. 2. 1. A hearing aid specialist shall not sell a hearing aid to any person unless he has exhibited to the person a written statement, and the person has read and signed the statement, containing the following information:

(a) The hearing aid specialist's name and business address;

(b) The make, model and serial number of the hearing aid and whether it is new, used or reconditioned;

(c) The terms of any guarantee or warranty;

(d) The address of the board of hearing aid specialists; and

(e) This caution, in boldface letters:

It is desirable that a person seeking help with his hearing problem consult a physician and obtain a clinical hearing evaluation. Although hearing aids are often recommended for hearing problems, another form of treatment may be necessary.

2. A copy of the statement shall be furnished to the purchaser and the original shall be retained by the hearing aid specialist. The board of hearing aid specialists may, at any reasonable time, examine any such statement and signature in the business files of a hearing aid specialist.

Sec. 3. 1. Any person who purchases a hearing aid from a hearing aid specialist may, within 45 days after the date of the purchase, rescind the transaction if:

(a) A physician advises against the purchase and use of a hearing aid and specifies in writing the medical or audiological reason for the advice;

(b) The hearing aid specialist has made any false or fraudulent statements concerning the hearing aid; or

(c) The statement required by section 2 of this act has not been given to and signed by the purchaser of the hearing aid.

2. The purchaser must give written notice of the reasons for the rescission to the hearing aid specialist by delivering,

mailing or telegraphing the notice and must return the hearing aid to him in good condition.

3. If a purchase is rescinded pursuant to paragraph (a) of subsection 1, the hearing aid specialist shall refund any payment made by the purchaser but may deduct therefrom:

(a) A reasonable rental for the hearing aid in an amount not exceeding 10 percent of the purchase price; and

(b) The reasonable cost of any earmolds.

4. If the purchase is rescinded pursuant to paragraph (b) or (c) of subsection 1, the hearing aid specialist shall refund the purchaser's entire payment.

Sec. 4. NRS 598.180 is hereby amended to read as follows:

598.180 "Door-to-door sale" means any sale, purchase, lease or rental of any consumer goods or services with a purchase price of $25 or more which is the result of any door-to-door solicitation or personal solicitation by the seller or his representative, whether at the specific invitation of the buyer or not, and which is made at a place other than the place of business of the seller [. The term "door-to-door sale" does not include] except a transaction:

1. Made pursuant to a preexisting retail charge agreement or pursuant to prior negotiations between the parties at or from a retail business establishment having a fixed permanent location

where the goods are exhibited or the services are offered for sale on a continuing basis.

2. In which the consumer is accorded the right of rescission by the provisions of the Consumer Credit Protection Act (15 U.S.C. § 1635) or regulations issued pursuant thereto.

3. In which the buyer has initiated the contact and the goods or services are needed to meet a bona fide immediate personal emergency of the buyer, and the buyer furnishes the seller with a separate dated and signed personal statement in the buyer's handwriting describing the situation requiring immediate remedy and expressly acknowledging and waiving the right to cancel the sale within 3 business days.

4. Conducted and consummated entirely by mail or telephone, and without any other contact between the buyer and the seller or its representative prior to delivery of the goods or performance of the service.

5. In which the buyer has initiated the contact and specifically requested the seller to visit his home for the purpose of repairing or performing maintenance upon the buyer's personal property. If in the course of the visit, the seller sells the buyer the right to receive additional services and goods other than replacement parts necessarily used in performing the maintenance or in making the repairs, the sale of those additional goods or services would not fall within this exclusion.

6. Pertaining to the sale or rental of real property, to the sale of insurance or to the sale of securities or commodities by a broker-dealer registered with the Securities Exchange Commission.

7. Pertaining to the sale or rental of vehicles as defined in NRS 482.135.

8. Pertaining to the sale or rental of mobile homes.

9. Pertaining to the provision of facilities and services furnished by utilities under the jurisdiction of the public service commission of Nevada.

10. Pertaining to the sale of hearing aids by a licensed hearing aid specialist.

SUMMARY--Makes an appropriation for mobile health care services to rural elderly persons. (BDR S-93)
Fiscal Note: Local Government Impact: No.
State or Industrial Insurance Impact: Contains appropriation.

AN ACT making an appropriation for a program of mobile health care services to elderly persons in rural areas.

WHEREAS, Physician shortages in rural Nevada affect elderly persons whose accessibility to transportation is limited; and

WHEREAS, The ratio of physicians to population is lower than the average for Nevada in all rural counties but one, and these counties have substantially fewer registered nurses and licensed practical nurses than the average for the state; and

WHEREAS, A mobile health unit with a registered nurse, support staff and necessary equipment could fill a deficiency in the health care services now available to Nevada's rural elderly; now, therefore,

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. There is hereby appropriated from the state general fund to the health division of the department of human resources for a program of mobile health care services to elderly persons in rural areas:

1. The sum of $80,000 for purchasing and equipping a mobile health care vehicle.

2. The sum of $175,000 for the fiscal year 1977-78 and the sum of $184,000 for the fiscal year 1978-79 for staffing and operating costs of the program.

Sec. 2. Unencumbered balances of the appropriation made in section 1 shall not be committed for expenditure after June 30, 1979, and shall revert to the state general fund.