

COMMITTEE TO STUDY THE NEEDS RELATED TO THE BEHAVIORAL AND COGNITIVE CARE OF OLDER PERSONS

RECOMMENDATIONS FOR CONSIDERATION



**Prepared by the Fiscal Analysis Division
April 4, 2018**

Committee to Study the Needs Related to the Behavioral and Cognitive Care of Older Persons

Recommendations for Consideration

During the last two committee meetings, the Committee has sought recommendations from the various presenters. In addition, a Solicitation of Recommendations was sent to various community stakeholders, seeking formal recommendations for the Committee to consider. A total of 46 recommendations have been made. These recommendations have been provided below and are organized into five topical categories:

- Diagnosis and Treatment
- Training
- Caregiver Support
- Housing
- Legal Issues

Please note that within the categories identified above, the recommendations are in no particular order of importance or priority.

The recommendations vary in details that have been provided by the recommender, the number of organizations that provided similar recommendations, the level of services already provided by the state, and how the recommendation addresses the provisions of Senate Bill 121. In order to communicate this information for each of the recommendations, Fiscal Staff has provided an example below of how each recommendation is organized:

Example:

Recommendation #: This is a synopsis of the recommendation that has been provided by either a presenter from one of the Committee's prior meetings, or a community advocate.

Organizations that proposed recommendation #, or a similar recommendation:

- This section identifies the organization that made the recommendation and the methodology by which the recommendation was made (either through a presentation to the Committee or through a response to the Solicitation for Recommendation).
- If there were multiple organizations that made similar recommendations, each organization will be bulleted. **(If the recommender provided additional information, or provided the web address where additional information could be found related to their recommendation, instructions on where to access that information will be included after the name of the organization and the font will be bolded.)**

If Fiscal staff is aware of a program that currently performs this recommendation, or something similar, Fiscal staff will provide information in red on the existing programs or services.

Possible section of the bill addressed with Recommendation #: If the recommendation addresses a certain section of Senate Bill 121, the section of the bill in which the recommendation pertains to will be identified in blue.

TOPIC AREA: DIAGNOSIS AND TREATMENT

Recommendations 1 – 12 relate to the diagnosis and treatment of older persons with behavioral and cognitive health issues, or recommended resources for the diagnosis and treatment of older persons with behavioral and cognitive health issues.

Recommendation 1: To encourage Nevada professionals to obtain the necessary expertise and form multidisciplinary teams, the Cleveland Clinic recommends the state provide support (competitive grants or contracts) for training in programs focused on recognizing, diagnosing, treating and preventing behavioral and cognitive problems in older persons.

Organization that proposed Recommendation 1:

- Cleveland Clinic – Dr. Dylan Wint - Response to the Solicitation for Recommendation **(Details regarding this recommendation have been included on pages 21-22 of the Recommendations for Consideration.)**

Possible section of the bill addressed with Recommendation 1: Section 2(5)(d) - The provision of education and training for health care professionals in the screening, diagnosis and treatment of behavioral and cognitive diseases prevalent in older persons.

Recommendation 2: Develop practice guidelines for primary care physicians to diagnosis Alzheimer’s disease and other forms of dementia.

Organization that proposed Recommendation 2:

- Splaine Consulting – Michael Splaine – January 29, 2018 presentation to the Committee

Possible section of the bill addressed with Recommendation 2: Section 2(5)(d) - The provision of education and training for health care professionals in the screening, diagnosis and treatment of behavioral and cognitive diseases prevalent in older persons.

Recommendation 3: Fund evidence-based behavioral health demonstrations, or pilot projects, targeted to deliver better care to older adults that can be incorporated into Nevada's delivery system.

Organization that proposed Recommendation 3:

- Nevada Senior Services – January 29, 2018 presentation to the Committee

Nevada is one of eight states participating in a two-year demonstration program to certify community behavioral health clinics emphasizing high quality and evidence-based practices. Certified Community Behavioral Health Clinics (CCBHCs) are designed to provide a comprehensive range of mental health and substance use disorders services to vulnerable individuals including: adults with serious mental illness, children with serious emotional disturbances, and those with substance use disorders. CCBHCs are responsible for providing nine types of services, with an emphasis on the provision of 24-hour crisis care, care coordination, and integration with physical health care. In return, CCBHCs receive an enhanced Medicaid reimbursement rate based on the costs of expanding services to meet the needs of these complex populations. The state began awarding certifications in July 2017.

Recommendation 4: To encourage Nevada professionals to obtain the necessary expertise and form multidisciplinary teams, the Cleveland Clinic recommends providing a Medicaid reimbursement premium for billing providers who receive evidence-based education and training in the management of behavioral and cognitive care for older persons.

Organization that proposed Recommendation 4:

- Cleveland Clinic – Dr. Dylan Wint - Response to the Solicitation for Recommendation **(Details regarding this recommendation have been included on pages 21 - 22 of the Recommendations for Consideration.)**

Possible section of the bill addressed with Recommendation 4: Section 2(5)(c) - The potential for establishing a higher rate of reimbursement by Medicaid for nursing facilities prepared and trained to support older persons with behavioral and cognitive health issues, thereby allowing such older persons to remain in their own communities rather than being placed in out-of-state facilities.

Recommendation 5: To encourage Nevada professionals to obtain the necessary expertise and form multidisciplinary teams, the Cleveland Clinic recommends providing a Medicaid reimbursement premium to facilities that employ professionals who have been trained or educated in the management and treatment of persons with behavioral and cognitive health issues.

Organization that proposed Recommendation 5:

- Cleveland Clinic – Dr. Dylan Wint - Response to the Solicitation for Recommendation (Details regarding this recommendation have been included on pages 21 - 22 of the Recommendations for Consideration.)

Possible section of the bill addressed with Recommendation 5: Section 2 (5)(c) - The potential for establishing a higher rate of reimbursement by Medicaid for nursing facilities prepared and trained to support older persons with behavioral and cognitive health issues, thereby allowing such older persons to remain in their own communities rather than being placed in out-of-state facilities.

Recommendation 6: Create a mobile crisis unit trained to treat people with dementia in the person's home, or in a facility setting, to minimize the need to hospitalize or relocate the person to an unfamiliar, and often more costly, service setting.

Organization that proposed Recommendation 6:

- Health Management Association – January 29, 2018 presentation to the Committee

The Division of Public and Behavioral Health provides, or sub-grants, funds to counties to operate mobile units providing mental health services, referred to as the Mobile Outreach Safety Team (MOST). MOST is a partnership between mental health providers and local law enforcement agencies, and the team works to identify and divert individuals from the criminal justice to the mental health system. The 2017 Legislature approved Senate Bill 192, which provided funding to expand MOST operations from 8 a.m. to 12 a.m., seven days a week, including holidays, in Clark and Washoe counties.

Recommendation 7: Develop more in-residence substance abuse treatment programs for older persons who do not have transportation available to attend treatment programs outside of their homes.

Organization that proposed Recommendation 7:

- HealthInsight – January 29, 2018 presentation to the Committee

Recommendation 8: Expand the role of community paramedics in medically under-served communities to include routine healthcare services.

Organization that proposed Recommendation 8:

- Health Management Association – January 29, 2018 presentation to the Committee – See pages 23 - 38 which includes a [policy brief](#) collaboratively developed by the University of Minnesota, University of North Carolina at Chapel Hill and the University of Southern Maine.

Recommendation 9: Provide free prescription drugs to individuals who are frequently admitted to inpatient psychiatric facilities and who have limited financial resources, or who are known to be homeless.

Organization that proposed Recommendation 9:

- HealthInsight – January 29, 2018 presentation to the Committee

Inpatient psychiatric facilities operated by the state have on-site pharmacies and dispense free medication to individuals who are uninsured or unable to access services in the community, either due to a lack of provider availability or an unwillingness to treat severely mentally ill individuals. State operated inpatient psychiatric facilities include the Rawson-Neal Psychiatric Hospital in Las Vegas and the Dini-Townsend Psychiatric Hospital in Washoe County. Additionally, two state operated outpatient clinics in East Las Vegas and Henderson provide prescribed medications to individuals accessing services at those clinics.

Recommendation 10: Develop pharmacies at inpatient psychiatric facilities to make prescription drugs more accessible for individual that do not have reliable transportation and will likely not have the means to get their medication upon discharge.

Organization that proposed Recommendation 10:

- HealthInsight – January 29, 2018 presentation to the Committee

As indicated in Recommendation 9, all state inpatient psychiatric facilities currently have on-site pharmacies. The state does not have a mechanism to deliver medication to individuals with unreliable transportation.

Recommendation 11: Promote collaboration between health care organizations and homeless shelters to ensure homeless people with dementia are receiving the proper treatment.

Organization that proposed Recommendation 11:

- HealthInsight – January 29, 2018 presentation to the Committee

Recommendation 12: Provide grants for respite care for the affected older person with an emphasis on “Therapeutic Respite” such as music therapy or occupational therapy, and “Educational Respite” where caregivers receive evidence-based education in cognitive and behavioral care for older persons.

Organization that proposed Recommendation 12:

- Cleveland Clinic – Dr. Dylan Wint - Response to the Solicitation for Recommendation **(Details regarding this recommendation have been included on pages 21 - 22 of the Recommendations for Consideration.)**

Possible section of the bill addressed with Recommendation 12: Section 2 (5)(a)(2) - The provision of training in select evidence-based community programs for caregivers, social service providers, health care workers and family members.

TOPIC AREA: TRAINING

Recommendations 13 – 20 relate to the training of caregivers and professionals who work with older persons with behavioral and cognitive health issues, as well as recommendations to increase the workforce of professionals who assist and treat older persons with behavioral and cognitive health issues.

Recommendation 13: Provide public service announcements regarding preventative measures people can take to maintain brain health over a lifetime.

Organizations that proposed Recommendation 13, or a similar recommendation:

- Splaine Consulting, Michael Splaine – January 29, 2018 presentation to the Committee
- Health Management Association – January 29, 2018 presentation to the Committee

Possible section of the bill addressed with Recommendation 13: Section 2(5)(d) - The provision of education and training for health care professionals in the screening, diagnosis and treatment of behavioral and cognitive diseases prevalent in older persons.

Recommendation 14: Expand the use of train-the-trainer programs, such as Respite Education & Support Tools (REST), where individuals are trained to provide respite training to others in their community.

Organization that proposed Recommendation 14:

- Health Management Association – January 29, 2018 presentation to the Committee
Additional information can be found at <http://restprogram.org/>. (A flyer advertising the REST program offered in November 2017 by the Division of Aging and Disability Services has been provided on page 39 of the Recommendations for Consideration.)

The State of Nevada currently participates in the REST program through the Division of Aging and Disability Services and its community partners. Each month training is provided at various locations. For example, 16 companions were trained on January 27 at Humboldt General Hospital through Age & Dementia Friendly of Winnemucca. A companion class is scheduled to take place at Humboldt General Hospital on April 14 through the Division of Aging and Disability Services.

Possible section of the bill addressed with Recommendation 14: Section 2(5)(a)(2) - The provision of training in select evidence-based community programs for caregivers, social service providers, health care workers and family members.

Recommendation 15: Encourage schools that provide postsecondary education in law to ensure that the programs include specific training related to Alzheimer's disease and other forms of dementia.

Organization that proposed Recommendation 15:

- Task Force on Alzheimer's Disease - Senator Valerie Wiener (retired) – January 29, 2018 presentation to the Committee and in response to the Solicitation for Recommendation **(Details regarding this recommendation have been included on page 41 of the Recommendations for Consideration.)**

Recommendation 16: Encourage the Nevada Bar Association, through its Board of Continuing Legal Education, to promote awareness and education related to Alzheimer's disease and other forms of dementia.

Organization that proposed Recommendation 16:

- Task Force on Alzheimer's Disease - Senator Valerie Wiener (retired) – January 29, 2018 presentation to the Committee and in response to the Solicitation for Recommendation. **(Details regarding this recommendation have been included on page 41 of the Recommendations for Consideration.)**

Recommendation 17: Create new positions, such as Community Health Workers, Discharge Planners and Social Workers, to assist people in the community with dementia.

Organization that proposed Recommendation 17:

- HealthInsight – January 29, 2018 presentation to the Committee

Recommendation 18: Develop incentive programs to attract quality health care providers to the state.

Organization that proposed Recommendation 18:

- HealthInsight – January 29, 2018 presentation to the Committee

Recommendation 19: Establish a state match program between the Department of Health and Human Services, the State Board of Nursing, and federal partners to address the state's health provider shortage in under-served areas such as rural and frontier communities. The match money could be offered as loans or scholarships to Advanced Practice Registered Nurses (APRN) who commit to the specified loan or scholarship terms and required service provisions to provide health care services in under-served areas of Nevada.

Organization that proposed Recommendation 19:

- Task Force on Alzheimer's Disease - Senator Valerie Wiener (retired) – January 29, 2018 presentation to the Committee and in response to the Solicitation for Recommendation (**Details regarding this recommendation are included on page 41 of the Recommendations for Consideration.**)

Nevada participates in the Western Interstate Commission for Higher Education (WICHE), which provides educational assistance to four students seeking a Master of Science in Nursing (\$6,000 per year). In addition, the 2017 Legislature approved funding for WICHE to continue providing 8 slots in FY 2018 and added 9 slots in FY 2019 (total of 17 slots) for the two-year program that allows registered nurses to complete course work in preparation of testing for national certification to become Advanced Practice Registered Nurses (\$7,700 per year).

Recommendation 20: Target wage increase through Medicaid programs to expand the workforce of health care professionals in Nevada.

Organization that proposed Recommendation 20:

- Health Management Association – January 29, 2018 presentation to the Committee

TOPIC AREA: CAREGIVER SUPPORT

Recommendations 21 – 30 relate to programs, services, training, education and resources that may be provided to caregivers of older persons with behavioral and cognitive health issues.

Recommendation 21: Implement the National Family Caregiver Support Program, under Title III-E of the Older Americans Act. This is a federal program that provides services to adult family members who provide in-home and community care for a person age 60 or older.

Organization that proposed Recommendation 21:

- Health Management Association – January 29, 2018 presentation (**Details regarding this recommendation are included on pages 43 - 46 of the Recommendations for Consideration.**)

The National Family Caregiver Support program is currently offered through the Division of Aging and Disability Services. These federal funds are allotted to the states proportionately based on the population of individuals 70 years of age or older in each state. Approximately \$1.2 million in Title III-E funding was budgeted in each year of the 2017-19 biennium to be received through the ADSD – Federal Programs and Administration budget.

Possible section of the bill addressed with Recommendation 21: Section 2(5)(a)(2) - The provision of training in select evidence-based community programs for caregivers, social service providers, health care workers and family members.

Recommendation 22: Create a “no wrong door” linkage and referral system to expedite help for individuals in need of financial or informational resources related to caring for older persons with behavioral or cognitive health issues.

Organization that proposed Recommendation 22:

- Health Management Association – January 29, 2018 presentation to the Committee

Possible section of the bill addressed with Recommendation 22: Section 2 (5)(b) - Potential sources of state funding to assist Nevada Care Connection and Nevada 2-1-1 in the creation of a “No Wrong Door” program to assist caregivers of older persons with behavioral and cognitive health issues.

Recommendation 23: Provide caregivers with training to identify the root cause of difficult behaviors demonstrated by individuals with dementia.

Organizations that proposed Recommendation 23, or a similar recommendation:

- Splaine Consulting – Michael Splaine - January 29, 2018 presentation to the Committee
- Dr. Peter Reed – University of Nevada, Reno, Sanford Center for Aging – March 5, 2018 presentation to the Committee

Possible section of the bill addressed with Recommendation 23: Section 2(5)(a)(2) - The provision of training in select evidence-based community programs for caregivers, social service providers, health care workers and family members.

Recommendation 24: Adopt evidence-based options to improve the services that are available for individuals, such as the Resources for Enhancing Alzheimer’s Caregiver Health (REACH), a National Institutes of Health program that tests and evaluates the effectiveness of different interventions with regard to support for caregivers.

Organization that proposed Recommendation 24:

- Health Management Association – January 29, 2018 presentation to the Committee **(Details regarding this recommendation are included on pages 47 - 55 of the Recommendations for Consideration.)**

The REACH program is currently offered through Nevada Senior Services.

Possible section of the bill addressed with Recommendation 24: Section 2(5)(a)(2) - The provision of training in select evidence-based community programs for caregivers, social service providers, health care workers and family members.

Recommendation 25: Expand access to respite with state funds. States such as Minnesota and Washington are leveraging Medicaid funding through section 1115 waivers to expand respite services.

Organization that proposed Recommendation 25:

- Health Management Association – January 29, 2018 presentation to the Committee

The Division of Health Care Financing and Policy operates three waiver programs, including the Home and Community Based Waiver (HCBW) for the Frail and Elderly, which provides coverage for respite. According to the Medicaid Services Manual: 1) Respite care is provided on a short-term basis because of the absence or need for relief of the primary caregiver; 2) Respite care may occur in the recipient's private home; and 3) Respite care is limited to 336 hours per waiver year. The HCBW for the Frail and Elderly is limited by legislative mandate to a specific number of recipients who can be served through the waiver per year.

Possible section of the bill addressed with Recommendation 25: Section 2(5)(a)(5) - The creation of a sliding fee scale to address the affordability of respite services.

Recommendation 26: Create a program similar to the Kapuna Caregivers program operated in Hawaii, where certain eligible caregivers are provided up to \$70 per day in benefits to take care of their family members.

Organization that proposed Recommendation 26:

- Health Management Association – January 29, 2018 presentation to the Committee **(Details regarding this recommendation are included on page 57 of the Recommendations for Consideration.)**

Recommendation 27: Promote consumer-directed care to allow individuals to identify paid caregivers from among family and friends.

Organization that proposed Recommendation 27:

- Health Management Association – January 29, 2018 presentation to the Committee

Recommendation 28: Create a grant program to provide financial assistance to middle-class caregivers who are not eligible to receive benefits from Medicare or Medicaid.

Individual that proposed Recommendation 28:

- Donna DePauw - Caregiver – January 29, 2018 public comment

Recommendation 29: Provide support through Medicaid, grants, or contracts for courses in evidence-based, caregiver-implemented interventions for cognitive and behavioral care for older persons.

Organization or Individual that proposed Recommendation 29:

Cleveland Clinic – Dr. Dylan Wint - Response to Solicitation for Recommendation **(Details regarding this recommendation have been included on pages 21 - 22 of the Recommendations for Consideration.)**

Possible section of the bill addressed with Recommendation 29: [Section 2\(5\)\(a\)\(2\) - The provision of training in select evidence-based community programs for caregivers, social service providers, health care workers and family members.](#)

Recommendation 30: Reconsider Senate Bill 196 of the 2017 Legislative Session, which would have required certain employers in private employment provide paid sick leave for, among other reasons, the care of a family member with a health condition.

Organization that proposed Recommendation 30:

- AARP – March 5, 2018 presentation to the Committee **(Details regarding this recommendation are included on pages 59 - 65 of the Recommendations for Consideration.)**

TOPIC AREA: HOUSING

Recommendations 31-41 relate to either providing housing for older persons with behavioral and cognitive health issues, or providing programs and services that allow older persons with behavioral and cognitive health issues to remain in their homes.

Recommendation 31: Enhance telehealth capabilities to include remote monitoring and distance education for health care professionals, and nonprofessional caregivers. Increase the use of telemedicine services by individuals with training, experience and expertise in cognitive and behavioral care for older persons.

Organizations that proposed Recommendation 31, or a similar recommendation:

- Health Management Association – January 29, 2018 presentation to the Committee
- Cleveland Clinic – Dr. Dylan Wint - Response to Solicitation for Recommendation **(Details regarding this recommendation have been included on pages 21 - 22 of the Recommendations for Consideration.)**

The 2015 Legislature approved \$2.5 million over the 2015-17 biennium to purchase video equipment and fund public medical education expansion through Project Echo Nevada for telehealth linkage that connects university faculty specialists with primary care providers in rural underserved areas.

Recommendation 32: Provide community-based residential facilities (group home) located in rural communities that have the ability to provide long-term care for a small number of individuals with dementia.

Organizations that proposed Recommendation 32, or a similar recommendation:

- Alzheimer's Association – January 29, 2018 presentation to the Committee
- Splaine Consulting - Michael Splaine – January 29, 2018 presentation to the Committee
- Health Management Association – January 29, 2018 presentation to the Committee

Recommendation 33: Develop increased Long-Term Support Service capacity for "hard to place" individuals, including those with Severe Mental Illness who develop dementia, in order to reduce the number of individuals who are relocated out-of-state for specialized care.

Organization that proposed Recommendation 33:

- Health Management Association – January 29, 2018 presentation to the Committee

Recommendation 34: Create local county levy programs to offer Medicaid's 1915(c) waivers to allow home and community-based services, such as personal care and homemaker services, to assist individuals who are not yet eligible for Medicaid. Certain sections of the Medicaid Home and Community-Based Services (Section 1915 (c)) can be waived if the applicant of the waiver can: 1) Demonstrate that providing waiver services would not cost more than providing these services in an institution; 2) Ensure the protection of people's health and welfare; 3) Provide adequate and reasonable provider standards to meet the needs of the target population; and 4) Ensure that services follow an individualized and person-centered plan of care.

Organization that proposed Recommendation 34:

- Health Management Association – January 29, 2018 presentation to the Committee

Recommendation 35: Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to likely assist in promoting the objective of the Medicaid program. In certain circumstances, the Center for Medicare & Medicaid Services (CMS) considers waivers to expenditures not typically approved to be covered by Medicaid. Health Management Association (HMA) recommends the state apply for a Medicaid Section 1115 waiver to provide a target set of in-home services for individuals with dementia who are not otherwise eligible for Medicaid. The HMA indicated that this approach slows down the individual's decline and their need for full Medicaid benefits by providing some targeted benefits earlier, such as respite.

Organization that proposed Recommendation 35:

- Health Management Association – January 29, 2018 presentation to the Committee

Recommendation 36: Ensure parity in reimbursement between institutions and community-based providers serving behaviorally complex older adults.

Organization that proposed Recommendation 36:

- Nevada Senior Services – January 29, 2018 presentation to the Committee

Possible section of the bill addressed with Recommendation 36: Section 2(5)(c) - The potential for establishing a higher rate of reimbursement by Medicaid for nursing facilities prepared and trained to support older persons with behavioral and cognitive health issues, thereby allowing such older persons to remain in their own communities rather than being placed in out-of-state facilities.

Recommendation 37: Expand community-based care options for older adults who want to remain in their home and shift the state's financial obligations away from hospitalization or institutionalization.

Organization that proposed Recommendation 37:

- Nevada Senior Services – January 29, 2018 presentation to the Committee

Possible section of the bill addressed with Recommendation 32: Section 2(5)(c) - The potential for establishing a higher rate of reimbursement by Medicaid for nursing facilities prepared and trained to support older persons with behavioral and cognitive health issues, thereby allowing such older persons to remain in their own communities rather than being placed in out-of-state facilities.

Recommendation 38: Provide mobile adult day care services in areas of Nevada that do not have permanent adult daycare facilities.

Organizations that proposed Recommendation 38, or a similar recommendation:

- Health Management Association – January 29, 2018 presentation to the Committee
- Nevada Senior Services – March 5, 2018 presentation to the Committee

Recommendation 39: Provide needs-based subsidies for caregivers who enroll their care recipient in a day care program, where the employees have been trained professionally in the treatment of persons with behavioral and cognitive health issues.

Organization that proposed Recommendation 39:

Cleveland Clinic – Dr. Dylan Wint – Response to the Solicitation for Recommendation **(Details regarding this recommendation have been included on pages 21 - 22 of the Recommendations for Consideration.)**

Recommendation 40: Develop or streamline transportation services for individuals with cognitive health issues to attend doctor’s appointments or other health-related appointments.

Organization that proposed Recommendation 40:

- HealthInsight– January 29, 2018 presentation to the Committee

Recommendation 41: Provide individuals with intellectual disabilities over the age of 50 with professional health care supports, trained personal care attendants, and expanded services provided to the individual in their home or community-based group home, to allow those individuals to continue to be supported in the community as opposed to long-term care facilities.

Organization that proposed Recommendation 41:

- Alexandria Crossley, RN, BSN, BA, Crossley Nurse Consultants – Respondent of the Committee’s Solicitation for Recommendation **(Details regarding this recommendation are included on pages 67 - 68 of the Recommendations for Consideration.)**

TOPIC AREA: LEGAL ISSUES

Recommendations 42-46 address legal issues that older persons with behavioral and cognitive health problems experience in Nevada.

Recommendation 42: Identify a process to ensure individuals who are taken into custody through a Legal 2000 hold, but are later determined to be exempt from being held due to their dementia diagnosis, are reported to the Division of Aging Services so the individual may be returned to their home or assisted in finding appropriate housing.

Organizations that proposed Recommendation 42, or a similar recommendation:

- Division of Aging and Disability Services – January 29, 2018 presentation to the Committee
- Alzheimer’s Association – January 29, 2018 presentation to the Committee

Recommendation 43: Create a process whereby the power of attorney can be easily changed for individuals as their dementia progresses.

Organization that proposed Recommendation 43:

- Division of Aging and Disability Services – January 29, 2018 presentation to the Committee

Recommendation 44: Change guardianship laws so individuals with dementia can make decisions on their own for as long as they can make decisions. Facilitate supportive decision making that can be designated to specific people by the individual with dementia.

Organization that proposed Recommendation 44:

- Division of Aging and Disability Services – January 29, 2018 presentation to the Committee

Recommendation 45: Revise NRS 253.220 to provide language that would close the Public Guardian referral gap for individuals over the age of 60 where law enforcement, protective services, or judicial officers in other matters may recommend the service of the Public Guardian.

Organization that proposed Recommendation 45:

- Division of Aging and Disability Services – Response to the Solicitation for Recommendation **(Details regarding this recommendation are included on pages 69 - 71 of the Recommendations for Consideration.)**

Recommendation 46: Provide clarifying language to the provisions of chapter 159 of *Nevada Revised Statutes*, related to guardianship jurisdictions, in situations where a protected person has been relocated to a residence outside of the state for purpose of care for a period longer than 6 consecutive months. Clarify that under these circumstances, an individual may continue to be under the guardianship jurisdiction of Nevada.

Organization that proposed Recommendation 46:

- Division of Aging and Disability Services – Response to the Solicitation for Recommendation **(Details regarding this recommendation have been included on pages 69 - 71 of the Recommendations for Consideration.)**

RECOMMENDATIONS

The most effective behavioral and cognitive care for older persons is accomplished through multidisciplinary approaches—a collaborative multidisciplinary team that is able to holistically manage patient needs (Galvin, Valois, Zweig 2014). Multidisciplinary teams require each member of the team to have expertise in managing the issues that the team was developed to address, but communication and fluid boundaries make the whole more than the sum of its parts. Unfortunately, Nevada lacks sufficient expert providers to develop effective multidisciplinary teams, but the state can develop strategies that encourage providers and care teams to obtain the necessary education and training.

A basic multidisciplinary team consists of a physician, nurse practitioner or physician assistant, care coordinator (usually a registered nurse), and social worker. The ideal multidisciplinary team also includes a medical assistant, neuropsychologist, health educator, and rehabilitation professionals (physical, occupational, and/or music therapists).

To encourage Nevada professionals to obtain the necessary expertise and form multidisciplinary teams, we recommend:

1. A Medicaid reimbursement premium for billing providers who receive evidence-based education and training in appropriate management of behavioral and cognitive care for older persons
2. Medicaid reimbursement premium for facilities—outpatient clinics, rehabilitation facilities, elder day programs, residential facilities, and inpatient units—who employ professionals who have demonstrated education, training, and/or experience in behavioral and cognitive care for older persons. Such professionals should include medical staff, nurses, and hands-on providers (nursing assistants, medical assistants, mental health technicians, etc). The reimbursement premiums should be subject to:
 - a. Number or proportion of providers trained in behavioral and cognitive care for older persons
 - b. Specific and documented care plans for cognitive and behavioral challenges in patients/residents at these facilities
 - c. Low levels of antipsychotic use
 - d. Low frequency of behavioral health hospitalizations
 - e. Specifically identified multidisciplinary care team, with documentation of collaboration and communication about patients/residents with behavioral and cognitive dysfunction
3. State support (competitive grants or contracts) for training programs focused on recognizing, diagnosing, treating, and/or preventing behavioral and cognitive problems in older persons
 - a. Continuing education courses, with particular encouragement of multidisciplinary courses. Topics should include, but not be limited to:
 - i. Proper use of medications for cognitive and behavioral care in older persons
 - ii. Nonpharmacologic cognitive and behavioral care for older persons
 - iii. Accurate diagnosis of cognitive disorders in older persons
 - iv. Accurate diagnosis of behavioral disorders in older persons
 - b. In-service workshops at facilities—outpatient clinics, rehabilitation facilities, elder day programs, residential facilities, and inpatient units—that serve older persons
 - c. State-sponsored “summits” on multidisciplinary behavioral and cognitive care for older persons

The vast majority of cognitive and behavioral care for older persons is actually provided by nonprofessional family caregivers. The need for medical interventions, residential placements, and hospitalizations can be reduced by training family and other nonprofessional caregivers in evidence-based techniques for managing these issues. To enable and empower caregivers, and reduce the cost of cognitive and behavioral care for older persons, we recommend:

1. Grants for respite, with particular emphasis on:
 - a. "Therapeutic respite," wherein the affected older person receives evidence-based therapeutic intervention (e.g., music therapy, occupational therapy)
 - b. "Educational respite," wherein the caregiver receives evidence-based education in cognitive and behavioral care for older persons
2. Need-based subsidies to caregivers for enrollment of elders with cognitive or behavioral dysfunction in day care programs that participate in education and training, as outlined above, for their employees
3. Support through Medicaid, grants, or contracts for courses in evidence-based, caregiver-implemented interventions for cognitive and behavioral care for older persons

The majority of our state's land area is rural, but houses older persons who need behavioral and cognitive care. The expertise in this type of care is concentrated in a few populated centers in the state. All of Nevada's citizens deserve the opportunity to benefit for improved behavioral and cognitive care. We recommend state support—through reimbursement premiums, contracts, and/or grants—for efficient methods using existing technology to increase rural access to education and expertise specific to cognitive and behavioral care for older persons

1. Distance education for professionals
 - a. Tele-conferences
 - b. Online continuing education
 - c. Written materials
2. Distance education and support for family and other nonprofessional caregivers
 - a. Tele-support groups
 - b. Online educational materials
 - c. Individual tele-support
 - d. Written materials
 - e. Online libraries
3. Telemedicine services by individuals with training, experience, and/or expertise in cognitive and behavioral care for older persons
 - a. Behavioral neurology and neuropsychiatry consultations
 - b. Social work consultations
 - c. Geriatric psychiatry consultations
 - d. Distance homecare



Community Paramedicine in Rural Areas: State and Local Findings and the Role of the State Flex Program

*Karen B. Pearson, MLIS, MA, John A. Gale, MS, George Shaler, MPH
University of Southern Maine*

PURPOSE

Community paramedicine is a quickly evolving field in both rural and urban areas as Emergency Medical Services (EMS) providers look to reduce the use of EMS services for non-emergent 911 calls, overcrowding of emergency departments, and healthcare costs. In rural areas, community paramedics help fill gaps in the local delivery system due to shortages of primary care physicians and long travel times to the nearest hospital or clinic.

This study examined the evidence base for community paramedicine in rural communities, the role of community paramedics in rural healthcare delivery systems, the challenges faced by states in implementing community paramedicine programs, and the role of the state Flex programs in supporting development of community paramedicine programs. Additionally, the study provides a snapshot of community paramedicine programs currently being developed and/or implemented in rural areas.

APPROACH

Our approach combined a survey of state EMS officials and directors of state Offices of Rural Health (SORHs) and/or state Flex coordinators with in-depth follow-up interviews between January and September 2013 of these state-level personnel and local EMS and hospital providers in selected states. We also reviewed state Flex grant applications from 2010-2012 to examine state work plans and funding to support community paramedicine initiatives. Additionally, we conducted a literature review of peer-reviewed healthcare journals as well as articles and reports from the trade literature and the EMS industry which focused on the integration of EMS into local healthcare delivery systems.

BACKGROUND

Medicare Rural Hospital Flexibility Program Context

The Medicare Rural Hospital Flexibility Program (Flex program), created by Congress in 1997, provides grants to 45 state Flex programs to support the implementation of initiatives to strengthen the rural health care infrastructure. Participating state Flex programs are required to undertake activities to support hospitals and communities in the following core areas:

1. Improving the quality of services provided by Critical Access Hospitals (CAHs);
2. Improving the financial and operational performance of CAHs;
3. Developing local/regional systems of care with CAHs as the hub,

Key Findings

- Many rural community paramedicine programs are in pilot stages.
- Most community paramedics work within an expanded role rather than an expanded scope of practice, the latter requiring legislative or regulatory change.
- Funding and reimbursement for community paramedicine services are major challenges for the sustainability of community paramedicine programs.
- Data collection is vital for community paramedicine programs to be able to show value, including shared saving and patient outcomes.
- Collaboration at local and state levels is essential for best practice, and partnering with the State Office of Rural Health is especially helpful in the early development and outreach efforts for rural community paramedicine programs.

enhancing the community engagement of CAHs, and integrating EMS into those local and regional systems of care;

4. Facilitating the conversion of eligible hospitals to Critical Access Hospital status.

The third core area of integrating EMS into the local and regional system of care suggests a conceptual home for the community paramedicine approach and emerging models as well as a strategic home for how Flex programs can respond to community paramedicine initiatives. Previous work by the Flex Monitoring Team¹⁻⁴ has identified the persistent challenges state Flex programs have faced in supporting the improvement and integration of EMS and the development of regional systems of care.

Rural Context

Access to health care services in rural areas is challenged by fragmented and uncoordinated delivery systems, poorly resourced primary care services, geographically isolated providers, and rural populations that tend to be older and sicker than in urban areas.⁵ Hospital readmission rates are high for all Medicare beneficiaries; research has shown that nearly one in five patients are readmitted within 30 days of discharge, with many more returning to the emergency room.⁶⁻⁹ Additional demographics show that a large segment of the U.S. population lives in medically underserved rural areas, with rural counties accounting for 63-77% of designated Health Professional Shortage Areas.^{10,11} Rural adults residing in these shortage areas were also less likely to have a regular primary care provider.¹² According to the 2010 National Advisory Committee on Rural Health and Human Services, there were only 55 rural primary care physicians for every 10,000 people in rural areas compared to the estimated 95 per 10,000 needed.¹³ For 57 million Americans, a trip to the physician's office may require a lengthy drive and considerable expense.^{11,14,15} One-fifth of the U.S. population lives in rural, remote, and/or frontier areas, yet only 10% of the nation's physicians practice in these areas.^{16,17} A coordinated system of care is part of a strategy for health improvement and was recently cited as a strategy for reducing hospital readmissions by bridging the gaps between settings of care.^{18,19}

Filling the Gap: Community Paramedicine

Community paramedicine provides a way to fill this gap in rural areas that either have limited primary care services or lack them entirely. According to the *National Consensus Conference on Community Paramedicine*, "Community paramedicine provides care for patients at home or in other non-urgent settings outside of a hospital under the supervision of a physician or advanced practice provider.

Community paramedicine can expand the reach of primary care and public health services by using EMS personnel to perform patient assessments and procedures that are already in their skill set."²⁰

The specific roles and services of a community paramedic are determined by community health needs and in collaboration with local public health departments and medical directors.²¹

While there is no universal definition, there are common themes which define both the field of community paramedicine and the role of the community paramedic:

- An **emerging field** in healthcare where Emergency Medical Technicians (EMTs) and Paramedics operate in expanded roles in an effort to connect underutilized resources to underserved populations.²¹ Community paramedics are also seen as part of an emerging concept of **mobile integrated healthcare** which proposes to integrate the larger spectrum of community healthcare and technology: telemedicine, mental health, social services, nurse triage lines, and public safety.²²
- A **model of care** whereby paramedics apply their training and skills in "non-traditional" community-based environments (outside the usual emergency response/transport model). The community paramedic may practice within an "expanded scope" (applying specialized skills/protocols beyond that which he/she was originally trained for), or "expanded role" (working in non-traditional roles using existing skills).²³
- An **organized system of services**, based on local need, which are provided by EMTs and paramedics integrated into the local or regional health care system and overseen by emergency and primary care physicians.²⁴

These definitions arise from numerous organizations, focus groups, and EMS-focused agenda documents which describe EMS systems and guide efforts to strengthen and improve EMS.^{21,21,25-37}

According to a recent survey of EMS professionals, community paramedicine programs that emphasize reducing readmissions were identified as one of the most common models in rural areas, with "primary care/physician extender" models most common in the frontier areas.³⁸

However, community paramedicine is not the only model to seek to fill the gap and provide coordination of care in rural areas. Other models include Community Health Aides, Community Health Workers, Community Care Teams, and most recently, Primary Care Technicians. A recent

article in *Health Affairs*³⁹ presents the case for using primary care extenders (“technicians”) from the field of EMS as a new model to help fill the gap in primary care coverage. Thus, the role and functions of these primary care technicians matches those of a community paramedic: they receive clinical training, provide in-home visits, work under medical direction, manage patients with chronic conditions, and help to prevent hospital readmissions.

Scope of the Problem: Issues and Challenges Facing Community Paramedicine in Rural Areas

One of the challenges facing the field of community paramedicine is the potential overlap with other health care professionals such as those mentioned above as well as home health care professionals. Wang⁴⁰ notes that in pilot community paramedicine programs or those that are rapidly implemented, the lack of clarification on the expanded roles for the community paramedic may cause resistance from other health care professionals.

Issues of recruitment, retention, and medical direction are dominant in any discussion of rural EMS, along with geographic barriers, inadequate opportunities and limited financial resources for training.^{20,41,42} Community paramedicine programs will need to address these challenges as well as issues of licensure, scope of practice,⁴¹ integration, and, importantly, reimbursement.⁴⁴

EMS services have predominantly focused on the transport of patients for emergent conditions. Over time, however, the use of EMS and ambulance services for non-emergent, low-acuity situations (sprains, flu-like symptoms, etc.) has increased.⁴⁴ For example, in Nebraska, 62% of all emergency transports in 2011 were considered non-emergent.⁴⁵ Although the Centers for Medicare and Medicaid Services (CMS) modified the Ambulance Fee Schedule in 2002 for EMS emergency transport to include inter-facility specialty care transport, the model for EMS still remains transport-based and reimbursed accordingly; non-transport services are not typically reimbursed by third party payers. The concept of EMS providing a “treat and referral” or a “treat and release” service was not built into the EMS payment model, yet this type of service, in many cases, is currently being provided by rural EMS personnel.^{25,29,42,46} Innovative financial models for non-emergency transport are also being considered at the federal level.⁴⁶

STATE AND LOCAL PERSPECTIVES ON COMMUNITY PARAMEDICINE

In the fall of 2012, we emailed a preliminary survey to directors of all state EMS agencies and SORHs to identify states with rural community paramedicine programs. Based on responses, we conducted phone

interviews with key state and local stakeholders to gather further information about these programs. As of September 2013, we had interviewed 35 community paramedicine stakeholders in 17 states. Additionally, we interviewed the both the co-founder of the International Community Paramedicine organization and the Director of Provincial Programs for the Emergency Health Services in Nova Scotia for background information on the development of community paramedicine programs (see Appendix A).

In general, the majority of the rural community paramedicine programs about which we learned are in development or pilot stages. Colorado has the longest history of rural community paramedicine development. Minnesota has the most developed community paramedicine programs, but they are primarily based in the metropolitan area around Minneapolis; they have recently expanded to rural areas. Maine launched 12 pilot community paramedicine programs in 2013, with all but two in rural areas.

We categorized our interviews with the states according to the following themes, which will be discussed in more detail below.

- Collaboration and Stakeholder Involvement
- Expanded Role vs. Expanded Scope, Medical Direction, and Legislative Barriers
- Education and Training
- Funding and Reimbursement
- Integration with Other Health Providers and the Rural Healthcare Delivery System
- Data Collection and Outcomes Evaluation
- Role of the SORH and the state Flex program

Collaboration and Stakeholder Involvement

Overall, we learned from our interviews with state officials and local EMS providers that stakeholder involvement and buy-in are essential elements in the successful implementation of a community paramedicine program. In Colorado, for example, a number of important associations are at the table in discussions related to community paramedicine programs. The Colorado Department of Health and Environment is a key stakeholder. Additional stakeholders include the Colorado Rural Health Center, the nursing association, and the medical society. The Colorado Rural Health Center, the administrative home for the SORH and Flex offices, has provided meeting facilitation and financial support to the community paramedicine program as well as incorporating presentations from staff of the Western Eagle County Ambulance District (WECAD) community paramedicine program at their annual Rural Health conference.

Maine is an example of how existing state-level relationships have helped to quickly and substantially implement 12 Community Paramedicine pilot sites across the state. Both the state EMS director and the director of the Rural Health and Primary Care program at the Maine Centers for Disease Control & Prevention (SORH) reinforced the fact that their long-standing collaboration has allowed them to convene joint meetings of Critical Access Hospital quality improvement groups and EMS personnel to discuss issues related to community paramedicine.

In Georgia, stakeholder groups convened by the SORH have developed planning grants funded by the SORH for community paramedicine pilot sites. The Wisconsin SORH, working with the Baraboo County EMS, has obtained buy-in from stakeholders including the county and local public health departments, the visiting nurses association, the Ho-Chunk tribal nation, and, importantly, the local hospital, which has given permission to allow access to their electronic health record (EHR) once the community paramedicine program is up and running.

In Nebraska, the Rural Nebraska Regional Ambulance Network (RNRAN) took the lead in moving the community paramedicine program along. The stakeholder group included the state EMS/Trauma program staff, paramedics, state EMS Medical Director, the director of Creighton University's EMS educational program, home health, EMS coordinator at a large urban hospital, a community college representative, and the Elkhorn Logan Valley Public Health department. The SORH was also included in this effort. Nebraska has three community paramedicine programs underway: one rural (Kearney), one suburban (Scottsbluff), and one urban (Omaha, which is currently under development).

Although the following states did not have community paramedicine programs underway at the time of our study, the SORH/Flex program and/or the state EMS offices in Arizona, Iowa, North Dakota, and New Hampshire are each collaborating to bring interested parties together in their states to discuss community paramedicine issues, set strategies, and determine priorities for community paramedicine programs and pilot sites.

Expanded Role or Expanded Scope, Medical Direction, and Legislative Barriers

There is some concern across the states that establishing a community paramedicine program might require authorizing legislation for a new

scope of practice for paramedics, or, at a minimum, an additional level of licensure. The majority of state EMS directors with whom we spoke are opposed to legislative changes regarding the community paramedic's scope of practice, and many note that their current statutes allow for an expanded role—outside of emergency transport—for the paramedic. Both Basic and Advanced level paramedics are the primary personnel considered for community paramedic services due to the advanced training they receive. State EMS scope of practice regulations will determine the extent to which EMTs can perform these services.

The key is to provide medical direction and oversight for the paramedic when providing community-based services. Medical direction is most often provided by the EMS Medical Director, a licensed physician who provides oversight and medical control for the paramedic. This level of oversight is built into all current community paramedicine programs, and medical direction can come from the EMS medical control, the hospital emergency physician, or the primary care provider (PCP). However, it is still an issue in some of the more rural areas where there is a shortage of full-time medical directors.²⁰

At the local level, EMS chiefs and medical directors are also hesitant to increase the paramedic's scope of practice. They understand that, with additional education and clinical training on chronic disease management, paramedics can utilize their existing skills in a community or home setting. EMS providers and state EMS directors were both quick to assure us that this expanded role for community paramedics was not taking away jobs from other health care professionals, such as home health providers, but, rather, was filling the gaps in the healthcare delivery system to meet the specific needs of the rural community.

Maine and Wisconsin both required legislative action in order to authorize the development of community paramedicine pilot programs; no changes were made in paramedic licensure. Minnesota's legislature established a reimbursement mechanism through Medicaid for services provided by community paramedics. Minnesota's legislation changed the list of Medicaid-approved services. Nebraska also received legislative approval in 2012 to change the definition of emergency medical services without expanding the scope of practice.

Education and Training

Community paramedicine is also viewed as a way of recruiting and retaining paramedics.⁴⁷ In many rural areas where call volume is low, it provides rural paramedics with a means to keep their clinical skills

sharp. For those paramedics looking to further their career opportunities, several educational institutions (e.g. Colorado Mountain College in Colorado and Hennepin Technical College in Minnesota) have developed community paramedicine certificate programs.²⁷ Most require a designated number of classroom (or online) hours in addition to a clinical rotation.¹⁷ Hennepin Technical College's Community Paramedic curriculum includes 112 hours of classroom instruction (64 hours of face-to-face or via interactive television and 48 hours of online instruction) and 196 hours of clinical training, which can be arranged in eight EMS regions in the state.

In the case of Humboldt County, Nevada, EMS personnel take online courses through Colorado Mountain College and complete their clinical training at the local hospital. Three Abbeville County (South Carolina) paramedics as well as the agency's EMS director and deputy director have also taken the online coursework provided by Colorado Mountain College. Following their local clinical rotations, they completed their clinical training with MedStar Mobile Healthcare in Fort Worth, Texas. MedStar also provides a 2-day intensive training on community paramedicine for EMS personnel, hospital administrators and communications staff.

In Prosser, Washington, the local CAH which operates the EMS service worked locally with Heritage University in Yakima to develop its own training program. Heritage University patterned their program on the Colorado Mountain College curriculum, which emphasizes communication skills, disease-specific education, wound care, and patient education information.

In Maine's 12 recently-launched community paramedicine pilots, the local EMS agencies either provide the training in-house with their partner healthcare organization or have their paramedics take courses at nearby community colleges. Currently, there is no statewide training program or requirements.

Each of the pilot community paramedicine sites in Nebraska have completed approved national curriculum and training requirements.

Funding and Reimbursement

While there are many advantages to community paramedicine's approach to an integrated system of care, several challenges exist, chief among them funding and reimbursement.^{48,20} Funding for many community paramedicine programs is provided primarily from local resources, with many local EMS agencies covering the cost of the community paramedic out of their operational budgets.

State support (funding and/or reimbursement) for pilot projects is either very limited or non-existent.

Currently, only Minnesota has managed to secure state (Medicaid) reimbursement for community paramedic services. Some hospitals that own their own ambulance services provide financial support for their community paramedicine programs in the belief that they will ultimately generate cost savings through reduced readmissions. (Nebraska, Nevada, and Maine are examples). South Carolina (Abbeville Area Medical Center and County EMS) and Washington (Prosser Memorial Hospital and EMS) are using foundation and federal grant funds, respectively, for their pilot community paramedicine programs. Colorado's funding stream for their community paramedicine program includes local foundation support; additionally, they are looking to local hospitals to reimburse for community paramedic services to offset the cost of an additional FTE community paramedic.

Each of the Maine community paramedicine pilot projects is self-funded according to the pilot project application guidelines. One pilot project, based in a municipal fire-rescue unit is funded by the municipality; others EMS agencies that are hospital-owned are funded for their community paramedic personnel and equipment needs through the general operating budgets of the hospital. The EMS-based pilot projects provide their own funding to support the project.

Concerns were raised in many of our interviews about the willingness of hospitals and EMS agencies to continue to support community paramedicine programs in the absence of long-term secure third party reimbursement.

Another more promising reimbursement strategy is that of cost-avoidance—or shared savings, a strategy being developed in urban locations. This shared savings strategy is one in which the community paramedicine program shares the savings for reducing readmissions; if the patient is readmitted within 30 days, the community paramedic program does not get paid. We learned that Lifeguard Ambulance Service is working with St. Vincent's Hospital in Birmingham, Alabama on a pilot hospital readmission prevention project with two urban and two rural hospitals. The participants are exploring different shared savings strategies including bundled payments and an at-risk payment methodology where Lifeguard would receive a percentage of the cost savings for each patient not readmitted within 30 days, with no payment if the patient is admitted within that 30-day window. Lifeguard's payment methodologies have attracted interest from payers and area hospitals in the Birmingham area.

Similarly, MedStar has engaged in numerous discussions and negotiations on a shared savings model with hospitals, hospice agencies, and an

Accountable Care Organization (ACO) which has a risk-sharing arrangement with a Medicare managed care organization. MedStar is currently reimbursed through a “fee-for-referral” approach and is moving toward a shared savings model in which they would split the savings with the hospital 80/20 for preventing a readmission within 30 days.^{49,50}

The only rural example of a negotiated shared savings arrangement, that we are aware of, is Colorado’s Eagle County Ambulance District (formerly WECAD) which has an arrangement with an area hospital to recoup a portion of the savings that results from preventing readmissions. As mentioned previously, they are also pursuing reimbursement arrangements with another area hospital, which will allow for expansion of FTEs for community paramedics.

Integration with Other Health Providers and the Rural Healthcare Delivery System

One common theme that arose during our interviews was the importance of developing community paramedicine services within the context of a community’s unique identified needs. Community paramedicine experts recommend undertaking a community health assessment prior to developing a program at the local level.^{21,35} Using information on identified needs, community paramedics can work with their medical directors as well as local emergency department and PCPs, public health departments, home health agencies, and other providers to develop services to address those needs.

Based on our interviews, services commonly provided by community paramedics include physical assessment; medication compliance and reconciliation; post-discharge follow-up (within 24-72 hours as directed by the hospital, PCP, or medical director); chronic disease management (usually for congestive heart failure, AML, or diabetes); patient education; home safety assessment/fall risk prevention; immunization/flu shots; and referrals to either medical or social services. (See Appendix C.)

According to our respondents, care coordination is the focus of many integration activities between community paramedics and other local health care providers. For example, the Abbeville Area Medical Center (a CAH in South Carolina) is collaborating on activities with Abbeville County EMS to provide expanded care coordination services including the use of community paramedics for community and home-based care. Community paramedics will conduct physician-ordered home visits for patients identified by the hospital or EMS.

Prosser Memorial Hospital in Washington, also a CAH, is the recipient of a three-year CMS Innovation Grant to implement a hospital-based community paramedic program, targeting patients at high risk of

readmission, who were then placed into one of three cohorts: 1) Patients who had been hospitalized 5 or more times in the past 18 months. 2) Surgical patients with high risk of infection, and 3) Patients the doctors considered to be at high risk for readmissions. Initial results showed that nearly one-third of the patients identified across the three cohorts needed some type of intervention from the community paramedic, with the most common being reminders to take medications and helping schedule follow-up doctor visits.⁵¹

The goal of Eagle County Ambulance in Colorado is to integrate community paramedics into the local system of care; for example, trained community paramedics will assist the PCP to ensure patients receive proper follow up care. To that end, Eagle County Ambulance prepared a Community Paramedic Protocols Manual⁵² to guide community paramedics in their work with PCPs. Eagle County community paramedics are trained to assist with wound care, post-discharge follow-up, chronic disease management (asthma, diabetes, obstructive sleep apnea, etc.) and provide home visits/assessments in response to a medical provider’s order. They partner with home health providers, and link the patient information back to the PCP or connect the patient to a PCP if they don’t have one.

Maine’s 12 pilot community paramedicine programs, still in the early stages of operation, plan to provide a variety of care coordination services, from chronic disease management to medication reconciliation and home safety checks. All 12 programs have identified the need to work with PCPs and the hospitals to address the ongoing needs of patients with diabetes, congestive heart failure, chronic obstructive pulmonary disease and asthma as a way to help reduce hospital admissions or readmissions.

Data Collection and Outcomes Evaluation

Results from our interviews suggest that data collection and program evaluation are important considerations for community paramedicine providers and state policymakers in the development of local programs. Evaluation data on program performance and outcomes are necessary to demonstrate program value to funders, hospitals, and third party payers and build an evidence base for community paramedicine programs. Ideally, our respondents noted that this should be done during program development to establish required data elements, relevant outcomes, and data collection strategies.

As they work on the development and implementation of their community paramedicine programs, states and localities are also working on their data collection efforts. The data collected

for these programs depend on the type of services provided, and whether they are affiliated with a CAH or hospital system. (See Appendix B for types of services and Appendix C for types of data collected.) Some programs focus on process measures such as patient satisfaction,⁵³ and ensuring that all patients served by community paramedics without a medical home have one within a certain number of visits. Other programs look to reduce hospital readmissions, the risk of injuries sustained in falls among elderly patients, and medical and prescription costs; as such, their data collection strategies will reflect the desired outcomes of their programs.

The community paramedicine program at Prosser Memorial Hospital has already realized a significant decrease in cohort 2 (surgical patients with high risk of infection) due to the follow-up wound care provided by the community paramedics.

Several EMS agencies have modified or are in the process of modifying their run reports to allow for documentation of the community paramedic home visit. Eagle County Ambulance ties their community paramedicine visit information on their run reports into the regional Health Information Exchange (HIE). Maine is working at the local and state levels to incorporate EMS information into HealthInfoNet, the state's HIE. Georgia's State Office of EMS and Trauma has created a separate electronic EMS pre-hospital care report for community paramedics, based on non-transport issues, which can be emailed or faxed to the hospital or the PCP, depending on where the initial order originated. It is also logged into the state run report database.

The Abbeville, South Carolina CAH is using its two-year grant from the Duke Endowment to implement a community paramedicine project in partnership with the local EMS agency. They plan to track individual health outcomes on an anticipated patient population of 100-300 residents of Abbeville County who are frequent users of inpatient, outpatient, emergency department, and emergency medical services. They will also track realized cost savings. Specifically, they project a 6% increase in patient satisfaction rates, a 20% reduction in the number of non-emergent 911 ambulance transports, and savings of more than \$25,000 for prevented ED admissions for non-emergent conditions. The South Carolina Rural Health Research Center will be conducting the program evaluation.

Role of the State Office of Rural Health and the State Flex Program

According to our interviews, partnering with SORHs is helpful in all phases of community paramedicine program development, but is especially useful in early development and outreach efforts. SORHs can

help provide seed funding, technical assistance, outreach, and facilitation of stakeholder meetings

Additionally, our interviewees noted that partnering with local, regional, and state stakeholders not only provides buy-in for community paramedicine programs, but also establishes a network of resources to support the implementation and sustainability of local community paramedicine programs, with continuity and potential replication across the state.

State Flex programs are required to include at least one of the following activities in their work plans under the core area of Health Systems Development and Community Engagement:⁵⁴

1. Support CAHs, communities, rural and other hospitals, EMS, and other community providers in developing local and/or regional health systems of care;
2. Support inclusion of EMS into local/regional systems of care and/or regional and state trauma systems;
3. Support CAHs and communities in conducting or collaborating on assessments to identify unmet community health and health service needs.
4. Support CAHs and communities in developing collaborative projects/initiatives to address unmet health and health service needs.
5. Support the sustainability and viability of EMS within the community. [Optional Objective]

In 2010-2011, five state Flex programs undertook community paramedicine activities as part of their work plans to support rural health systems development and EMS. In 2012, the number nearly doubled, with nine states including community paramedicine initiatives in their state Flex grant applications. Six of those states provided targeted funding for community paramedicine training and training materials; all nine provided facilitation of stakeholder meetings and outreach efforts.

POLICY CONSIDERATIONS

Community paramedicine programs have the ability to fill gaps in rural health care delivery systems, providing a role in the care coordination of patients at risk for hospital readmission, and meeting the needs of the rural community where there is a shortage of primary care providers. Integrating community paramedics into the delivery system is one of the challenges. State EMS agencies and SORHs are vital players in disseminating information about community paramedicine programs and bringing stakeholders to the table, including local EMS agencies, home health agencies, public health departments, social service agencies, Critical Access

Hospitals, Rural Health Clinics, and Federally Qualified Health Centers among others.

Financial support for community paramedic services is another significant challenge, especially in rural areas. SORHs and state EMS agencies can work together with local and regional hospitals, primary care providers, and insurance companies to develop incentive structures and reimbursement mechanisms to allow community paramedics to assess and treat patients in their homes. Securing Medicaid reimbursement for services provided by community paramedics may require changes in state legislation or regulation. The Minnesota experience provides a model for such changes, in which only the list of Medicaid-approved services was changed to encompass those provided by community paramedics. An approach which does not require legislative changes is the shared savings model currently in use by Eagle County Paramedic Services in Colorado and MedStar in Texas, and is under consideration in Alabama. This negotiated contract approach provides incentive to prevent hospital readmissions.

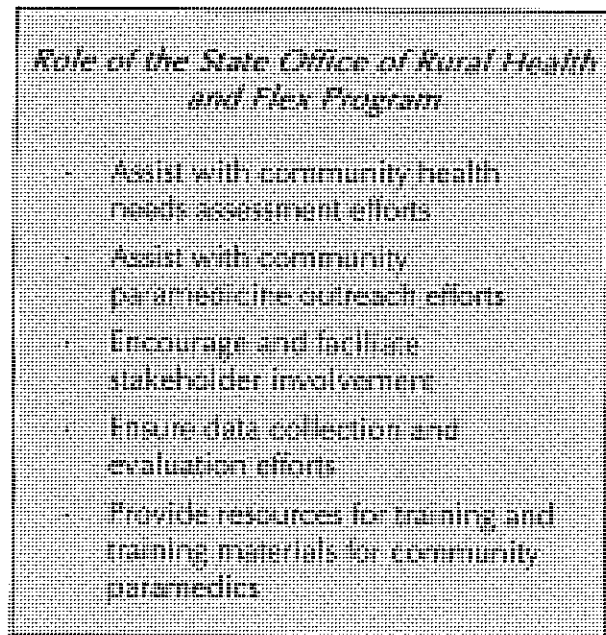
Patient centered medical homes (PCMHs), health homes, and ACOs may offer opportunities to integrate community paramedics into the healthcare delivery system. Collaboration appears to be an important key for the success of community paramedicine programs based on our interviews. Additionally, partnering with a hospital may provide more options for reimbursement strategies.

Data collection and evaluation strategies are crucial elements to be considered during the development of a community paramedicine program and necessary to document the value of the service to the local delivery system as well as for policymakers, funders, and third party payers. An evaluation plan focusing on initial, intermediate and long-term process and outcome measures will provide important data necessary to develop long term support for community paramedicine programs. These evaluation results will also contribute to the development of the evidence-base for community paramedicine, and thus provide SORHs and Flex programs with documentation and models to support the facilitation and viability of community paramedicine programs.

In order to demonstrate cost-savings and value to rural communities, community paramedicine programs will need to quantify the detailed costs for their services, and understand the local market conditions and service territory.²⁰ Additional important data elements include numbers of visits, types of visits, percentage of readmitted patients, and numbers of ED transports avoided.

Finding a "home" to serve as a public repository for information on all aspects of community

paramedicine is a necessary outgrowth of this emerging field. Such a repository will be of interest to other state and federal agencies and local communities. Information and resources relevant to community paramedicine posted to a publicly available website could include data and resources on medical direction, data collection, regulatory and statutory issues, and funding and reimbursement issues.



To view or download the full report, please visit the Flex Monitoring website at <http://flexmonitoring.org>

For more information, please contact Karen Pearson at karenp@usm.maine.edu

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Appendix A. State and Local Respondents

State	SORH / Flex	State EMS	Local EMS	Other	Notes "other" category personnel
AL	x		x	x	QI Director, St. Vincent's Hospital
AZ	x	x			Both Flex Coordinator and SORH Director
CO	x		x		
GA	x	x		x	President, EMS Association
IA	x	x			
ID			x		Email
ME	x	x	x	x	Pilot CP project coordinators
MN	x				SORH Director plus 3 SLORH staff members
ND	x				
NE			x	x	Scottsbluff EMS Director; NE Region EMS Specialist
NH		x			Written response on behalf of SORH
NV			x		
NY				x	Medical Faculty U-Rochester Medical School
PA	x				
SC	x		x		
TX			x		Director, MedStar Mobile Healthcare
WA				x	QI Director, Prosser Memorial Hospital
WI	x		x		
Nova Scotia					Director of Provincial Programs, EHS, Dept. Health & Wellness
Community Paramedic.org					Co-Founder

Appendix B. Goals and Types of Community Paramedic Services

Goals	
Care Coordination	
Prevention of Hospital Readmission	
Reduction in Non-Emergent 911 Calls and Transport	
Services	
Assessment	Medication Administration
Blood Draws/Lab Work	Medication Reconciliation
BP/Vitals	Newborn Wellness Checks
Chronic Disease Management	O ₂ Saturation Checks
Diabetes Care	Patient Education
EKG	Referral (Medical or Social Services)
Falls Prevention	Transport to Doctor Appointments
Flu Shots	Weight Monitoring (CHF fluid retention)
Gait Assessment	Wellness Screening
Home Safety Assessment	Wound Care
Immunizations	

Appendix C. Types of Data Collected

Modified Run Report
Patient Satisfaction with CP/EMS
Provider Satisfaction with CP/EMS
Number of Scheduled PCP visits within 7 days
Number of Referrals to Other Services
Number of Hospital Admissions within 30 days
Number of Home Visits
Number of Assessments for Fall Risk
Number of Prevented Admissions for Non-Emergent Conditions
Number of Ambulance Transports for Non-Emergent 911 Calls
Number of 911 Calls from Frequent Users
Number of Patients Provided Medication Reconciliation and Management
Number of Patients Provided Disease-Specific Education and Treatment Management

Appendix D. Maine Community Paramedicine Pilot Programs

Maine Community Paramedicine Pilot Programs	Affiliation	Date of Operation	Urbanicity	Activities
Calais Fire and EMS	Municipal (Fire-Rescue)	June 2013	rural	In-home management of chronic diseases (CHF, COPD, hypertension); physical assessments/vital signs; medication reconciliation/compliance; home safety assessments, blood draws; 12-Lead EKG
Castine Fire Rescue	Volunteer	August 2013	rural	Focus on prevention; chronic disease management; monitor vital signs; home safety checks; medication reconciliation; diet/weight monitoring; wound care; other physician-directed care/treatment within scope of practice
Charles A Dean EMS	Hospital-based	December 2013	rural	In-home management of chronic diseases (CHF, COPD/Asthma, Diabetes); medical assessments; wound care/assessment; medication reconciliation/compliance; home safety assessments, phlebotomy, blood glucose analysis; non-emergent cardiac monitoring and infusion maintenance. All within ME Scope of Practice
Crown Ambulance	Hospital-based	September 2013	rural	Chronic disease management/monitoring (Diabetes, CHF, post MI conditions and other coronary syndromes; COPD/Asthma); blood glucose testing; wound assessment; routine eye exams; draw labs as needed; weight monitoring; medication reconciliation; spirometry testing and management of O2 delivery services
Delta/Winthrop EMS (2 services combined)	Private EMS Service	March 2013	urban	Address needs of recently discharged patients and recovering surgical patients; episodic assessment of patients with multiple comorbidities (i.e. CHF, COPD); weight/O2 saturation assessments; home safety assessments for at-risk patients; wound assessment;
Lincoln County Health Care	(mix of hospital and healthcare system and several local EMS services)	January 2014	rural	Post-discharge services; monitoring of chronic illnesses (i.e. Diabetes, CHF); readmission preventions; wound care assessments; diagnostic testing
Mayo EMS	Hospital-based	September 2013	rural	Address needs of cardiac (including post MI/Cardiac rehab) and diabetic patients with routine screenings, ECGs, medication reconciliation; blood glucose measurements/trends

Appendix D, continued

North Star EMS	Hospital-based	September 2013	rural	Reduce # of ER visits and hospital admissions by monitoring at-risk patients with multiple medical conditions; patient education; post-discharge surgical patients without home health services; home safety assessment; medication reconciliation; episodic assessments of weight, BP, oximetry, heart rate
Northeast Mobile Health	Private EMS Service	May 2013	urban	Reduce hospital admissions/readmissions by monitoring patients with chronic diseases and those with high risk of traumatic injury; patient evaluation/assessment; fall risk assessment; patient education; well-being checks
Searsport	Private EMS Service	September 2013	rural	Develop and implement fall prevention program; facilitate immunization and dental clinics; track patients with chronic diseases (esp. diabetes); well-check visits and assessments as directed by physician
St. George EMS	Volunteer (some paid staff)	September 2013	rural	Address identified community needs of diabetes, respiratory distress, hypertension, post surgical/post discharge patients; blood draws; episodic assessment/care; medication reconciliation/compliance or other services directed by the PCP
United Ambulance	Private EMS Service	August 2013	urban	Focus on non-emergent 911 callers to decrease the number of time the ambulance is utilized for these situations; work to reduce re-hospitalization rates for chronic disease patients (CHF, COPD, Diabetes); well-being checks; home safety inspection (including fall risk assessment); blood glucose monitoring and patient assessment

Appendix E. Selected Resources

Source	Web Address	Description
Community Paramedic website	http://www.communityparamedic.org/	Links to information and resources on community paramedic courses and curriculum
Community Paramedicine Insights Forum	http://cpif.communityparamedic.org/	Monthly webinars on practical experiences and issues related to community paramedicine
Community Paramedicine: A Promising Model for Integrating Emergency and Primary Care	http://www.ucdmc.ucdavis.edu/phi/Programs/CAHPF/resources/PHI_CommunityParamedicineReport_Final%20070913.pdf	Provides a brief history of EMS in California, overview of community paramedicine nationally and internationally, and summary of California stakeholder discussions on role of community paramedicine in the state
HRSA Community Paramedicine Evaluation Tool	http://www.hrsa.gov/ruralhealth/pdf/paramedicvtool.pdf	Community assessment tool for developing a community paramedicine program
International Roundtable on Community Paramedicine	http://ircp.info/	Website to promote international exchange of information on community paramedicine
MedStar Mobile Healthcare: AHRQ Service Delivery Innovation Profile	http://www.innovations.ahrq.gov/content.aspx?id=3343	Summary of MedStar's urban mobile health programs using community paramedics
Minnesota Community Paramedic Initiative	http://gatheringofeagles.us/2013/Saturday/ConteratorCP.pdf	Conference presentation in 2013 providing background and information on the Minnesota CP program
Mobile Integrated Healthcare/Community Paramedicine online interactive map	http://paramedicfoundation.org/inemsf-survey/	Map and description of all community paramedicine programs reported through the survey by NAEMT. Locations organized by urban, suburban, rural, and super rural
NAEMT Community Paramedicine/Mobile Integrated Healthcare Survey Summary (Oct. 2013)	http://www.naemt.org/Files/11.1.13_CommunityParamedicineReport.pptx	Powerpoint summary of the MIH/CP survey; See link to interactive map above
National Agenda for Community Paramedicine Research	http://depts.washington.edu/uwrhrc/uploads/CP_Agenda.pdf	Goal was to discuss ways to foster rigorous evaluation and research on community paramedicine
National Consensus Conference on Community Paramedicine: Summary of an Expert Meeting	http://depts.washington.edu/uwrhrc/uploads/CP_Report.pdf	Conference attendees representing EMS, SORH, local CP programs, healthcare professions and organizations, met in 2012 to identify consensus areas of policy and practice around six key issues for community paramedicine
State Perspectives Discussion Paper on Development of Community Paramedic Programs	http://www.nasemso.org/Projects/RuralEMS/documents/CPDiscussionPaper.pdf	Published by the Joint Committee on Rural Emergency Care (JCREC), National Association of State Emergency Medical Services Officers (NASEMSO) and the National Organization of State Offices of Rural Health (NOSORH)
Western Eagle County Community Paramedic Program Handbook	http://www.naemt.org/Libraries/NAEMT%20Documents/WECAD%20Community%20Paramedic%20Handbook.sflb	Provides guidance for local EMS agencies to partner with local public health department to develop a community paramedic program

Building Networks of Support for Caregivers



Delivering education and support to those offering a break to caregivers.

REST, Respite Education and Support Tools, is a nationally-recognized interactive two-day train-the-trainer course that prepares those who will train respite care workers in their own communities.



REST Training Information

November 2-3, 2017

9:00 a.m. — 5:00 p.m.

Navada Aging and Disability Services Division

Vassar Cardone Non-Profit Building

1301 Cardone Ave. Lower Level Room 3
Reno, NV 89502

Training Fee: \$595*

Cascades of the Sierra

**Spanish
Language
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Dolores M. Ward Cox, Education
Coordinator at dmcward@unr.edu or
775-313-1449.

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Manager at kfitgerald@restprogram.org or
530-397-5458.

For more information, visit

www.restprogram.org

FROM: Task Force on Alzheimer's Disease
Senator Valerie Wiener (Retired), Chair

March 24, 2018

RECOMMENDATION #1: State Match Program for APRNs

Support the establishment of a state match program between the State's Department of Health and Human Services, collaborating with the State Board of Nursing, and federal partners. This match program is intended to address the state's health provider shortage in under-served areas, including, but not limited to, rural and frontier communities. Match money, which could be offered as loans or scholarships, would be made available to APRNs, who commit to the specified loan or scholarship terms and required service provisions as they relate to providing health care services to areas in Nevada with healthcare professional shortages.

Indicators: Primary Care Workforce Development Office (DHHS), working with State Board of Nursing, would monitor the number of APRNs serving under-served areas in Nevada, including, but not limited to, rural and frontier communities.

Funding: Health Resources and Administration Grants; other gifts, grants, donations, and appropriations.

* RECOMMENDATION #2: Legal Education and Dementia

Encourage schools that provide post-secondary education in the law to ensure that the programs include specific training related to Alzheimer's disease and other forms of dementia. Such dementia-related curricula should address, though they are not limited to, education about competency and guardianship.

Indicators: Increased number of quality educational opportunities, both pre- and post- professionally, offered in schools of post-secondary education; increased number of students who complete this coursework.

Funding: State appropriations to higher education; gifts, grants, and donations.

* RECOMMENDATION #3: Continuing Legal Education and Dementia

Encourage the Nevada State Bar Association, through its Board of Continuing Legal Education (CLE), to promote awareness and education related to Alzheimer's disease and other forms of dementia. These CLE programs would provide licensed legal professionals with ongoing education about recent developments, research, and treatments of Alzheimer's disease and other forms of dementia.

Indicators: State Bar monitoring the number of legal professionals who take and complete these CLEs.

Funding: Gifts, grants, and donations.

* NOTE: The Committee to Study the Needs Related to the Behavioral and Cognitive Care of Older Persons has requested two recommendations from TFAD. We believe that Recommendations #2 and #3 can be combined.

[42 U.S.C. 3030m]

DISTRIBUTION TO AREA AGENCIES ON AGING

SEC. 362. The State agency shall give priority, in carrying out this part, to areas of the State—

- (1) which are medically underserved; and
- (2) in which there are a large number of older individuals who have the greatest economic need for such services.

[42 U.S.C. 3030n]

**PART E—NATIONAL FAMILY CAREGIVER
SUPPORT PROGRAM**

SEC. 371. SHORT TITLE.

This part may be cited as the “National Family Caregiver Support Act”.

[42 U.S.C. 3001 note]

SEC. 372. DEFINITIONS.

(a) **IN GENERAL.**—In this part:

(1) **CHILD.**—The term “child” means an individual who is not more than 18 years of age.

(2) **INDIVIDUAL WITH A DISABILITY.**—The term “individual with a disability” means an individual with a disability, as defined in section 3 of the Americans with Disabilities Act of 1990 (42 U.S.C. 12102), who is not less than age 18 and not more than age 59.

(3) **OLDER RELATIVE CAREGIVER.**—The term “older relative caregiver” means a caregiver who—

(A)(i) is age 55 or older; and

(ii) lives with, is the informal provider of in-home and community care to, and is the primary caregiver for, a child or an individual with a disability;

(B) in the case of a caregiver for a child—

(i) is the grandparent, stepgrandparent, or other relative (other than the parent) by blood, marriage, or adoption, of the child;

(ii) is the primary caregiver of the child because the biological or adoptive parents are unable or unwilling to serve as the primary caregivers of the child; and

(iii) has a legal relationship to the child, such as legal custody, adoption, or guardianship, or is raising the child informally; and

(C) in the case of a caregiver for an individual with a disability, is the parent, grandparent, or other relative by blood, marriage, or adoption, of the individual with a disability.

(b) **RULE.**—In providing services under this part, for family caregivers who provide care for individuals with Alzheimer’s disease and related disorders with neurological and organic brain dysfunction, the State involved shall give priority to caregivers who provide care for older individuals with such disease or disorder.

[42 U.S.C. 3030s]

SEC. 373. PROGRAM AUTHORIZED.

(a) **IN GENERAL.**—The Assistant Secretary shall carry out a program for making grants to States with State plans approved under section 307, to pay for the Federal share of the cost of carrying out State programs, to enable area agencies on aging, or entities that such area agencies on aging contract with, to provide multifaceted systems of support services—

- (1) for family caregivers; and
- (2) for older relative caregivers.

(b) **SUPPORT SERVICES.**—The services provided, in a State program under subsection (a), by an area agency on aging, or entity that such agency has contracted with, shall include—

- (1) information to caregivers about available services;
- (2) assistance to caregivers in gaining access to the services;
- (3) individual counseling, organization of support groups, and caregiver training to assist the caregivers in the areas of health, nutrition, and financial literacy, and in making decisions and solving problems relating to their caregiving roles;
- (4) respite care to enable caregivers to be temporarily relieved from their caregiving responsibilities; and
- (5) supplemental services, on a limited basis, to complement the care provided by caregivers.

(c) **POPULATION SERVED; PRIORITY.**—

(1) **POPULATION SERVED.**—Services under a State program under this part shall be provided to family caregivers, and older relative caregivers, who—

- (A) are described in paragraph (1) or (2) of subsection (a); and
- (B) with regard to the services specified in paragraphs (4) and (5) of subsection (b), in the case of a caregiver described in paragraph (1), is providing care to an older individual who meets the condition specified in subparagraph (A)(i) or (B) of section 102(22).

(2) **PRIORITY.**—In providing services under this part, the State, in addition to giving the priority described in section 372(b), shall give priority—

- (A) to caregivers who are older individuals with greatest social need, and older individuals with greatest economic need (with particular attention to low-income older individuals); and
- (B) to older relative caregivers of children with severe disabilities, or individuals with disabilities who have severe disabilities.

(d) **USE OF VOLUNTEERS.**—In carrying out this part, each area agency on aging shall make use of trained volunteers to expand the provision of the available services described in subsection (b) and, if possible, work in coordination with organizations that have experience in providing training, placement, and stipends for volunteers or participants (such as organizations carrying out Federal service programs administered by the Corporation for National and Community Service), in community service settings.

(e) **QUALITY STANDARDS AND MECHANISMS AND ACCOUNTABILITY.**—

(1) QUALITY STANDARDS AND MECHANISMS.—The State shall establish standards and mechanisms designed to assure the quality of services provided with assistance made available under this part.

(2) DATA AND RECORDS.—The State shall collect data and maintain records relating to the State program in a standardized format specified by the Assistant Secretary. The State shall furnish the records to the Assistant Secretary, at such time as the Assistant Secretary may require, in order to enable the Assistant Secretary to monitor State program administration and compliance, and to evaluate and compare the effectiveness of the State programs.

(3) REPORTS.—The State shall prepare and submit to the Assistant Secretary reports on the data and records required under paragraph (2), including information on the services funded under this part, and standards and mechanisms by which the quality of the services shall be assured. The reports shall describe any mechanisms used in the State to provide to persons who are family caregivers, or older relative caregivers, information about and access to various services so that the persons can better carry out their care responsibilities.

(f) CAREGIVER ALLOTMENT.—

(1) IN GENERAL.—

(A) From sums appropriated under section 303(e) for a fiscal year, the Assistant Secretary shall allot amounts among the States proportionately based on the population of individuals 70 years of age or older in the States.

(B) In determining the amounts allotted to States from the sums appropriated under section 303 for a fiscal year, the Assistant Secretary shall first determine the amount allotted to each State under subparagraph (A) and then proportionately adjust such amounts, if necessary, to meet the requirements of paragraph (2).

(C) The number of individuals 70 years of age or older in any State and in all States shall be determined by the Assistant Secretary on the basis of the most recent data available from the Bureau of the Census and other reliable demographic data satisfactory to the Assistant Secretary.

(2) MINIMUM ALLOTMENT.—

(A) The amounts allotted under paragraph (1) shall be reduced proportionately to the extent necessary to increase other allotments under such paragraph to achieve the amounts described in subparagraph (B).

(B)(i) Each State shall be allotted $\frac{1}{2}$ of 1 percent of the amount appropriated for the fiscal year for which the determination is made.

(ii) Guam and the Virgin Islands of the United States shall each be allotted $\frac{1}{4}$ of 1 percent of the amount appropriated for the fiscal year for which the determination is made.

(iii) American Samoa and the Commonwealth of the Northern Mariana Islands shall each be allotted $\frac{1}{16}$ of 1 percent of the amount appropriated for the fiscal year for which the determination is made.

(C) For the purposes of subparagraph (B)(i), the term "State" does not include Guam, American Samoa, the Virgin Islands of the United States, and the Commonwealth of the Northern Mariana Islands.

(g) AVAILABILITY OF FUNDS.—

(1) USE OF FUNDS FOR ADMINISTRATION OF AREA PLANS.— Amounts made available to a State to carry out the State program under this part may be used, in addition to amounts available in accordance with section 303(c)(1), for costs of administration of area plans.

(2) FEDERAL SHARE.—

(A) IN GENERAL.—Notwithstanding section 304(d)(1)(D), the Federal share of the cost of carrying out a State program under this part shall be 75 percent.

(B) NON-FEDERAL SHARE.—The non-Federal share of the cost shall be provided from State and local sources.

(C) LIMITATION.—A State may use not more than 10 percent of the total Federal and non-Federal share available to the State to provide support services to older relative caregivers.

[42 U.S.C. 3030s-1]

SEC. 374. MAINTENANCE OF EFFORT.

Funds made available under this part shall supplement, and not supplant, any Federal, State, or local funds expended by a State or unit of general purpose local government (including an area agency on aging) to provide services described in section 373.

[42 U.S.C. 3030s-2]

TITLE IV—ACTIVITIES FOR HEALTH, INDEPENDENCE, AND LONGEVITY

SEC. 401. PURPOSES.

The purposes of this title are—

(1) to expand the Nation's knowledge and understanding of the older population and the aging process;

(2) to design, test, and promote the use of innovative ideas and best practices in programs and services for older individuals;

(3) to help meet the needs for trained personnel in the field of aging; and

(4) to increase awareness of citizens of all ages of the need to assume personal responsibility for their own longevity.

[42 U.S.C. 3031]

PART A—GRANT PROGRAMS

SEC. 411. PROGRAM AUTHORIZED.

(a) IN GENERAL.—For the purpose of carrying out this section, the Assistant Secretary may make grants to and enter into contracts with States, public agencies, private nonprofit agencies, in-



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Resources for Enhancing Alzheimer’s Caregiver Health (REACH): Overview, Site-Specific Outcomes, and Future Directions

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Established in 1995, Resources for Enhancing Alzheimer’s Caregiver Health (REACH) is a unique, multisite research program sponsored by the National Institute on Aging and the National Institute on Nursing Research. The primary purpose of REACH is to carry out social and behavioral research on interventions designed to enhance family caregiving for Alzheimer’s disease (AD) and related disorders. Specifically, REACH has two goals: to test the effectiveness of multiple different interventions and to evaluate the pooled effect of REACH interventions overall. REACH developed from a National Institutes of Health initiative that acknowledged the well-documented burdens associated with family caregiving as well as the existence of promising family caregiver interventions reported in the literature.

Six sites (Boston, Birmingham, Memphis, Miami, Palo Alto, and Philadelphia) developed and evaluated a variety of multicomponent interventions for family caregivers of persons with AD at the mild or moderate level of impairment. The interventions implemented across the six sites included: (a) Individual Information and Support Strategies, (b) Group Support and Family Systems Therapy, (c) Psychoeducational and Skill-Based Training Approaches, (d) Home-Based Environmental Interventions, and (e) Enhanced Technology Support Systems (see Table 1). Although the interventions were derived from diverse theoretical frameworks, they are all consistent with basic health-stress models in which the goal is to change the nature of specific stressors (e.g., problem behavior of the care recipient), their appraisal, and/or the caregivers’ response to the stressors. All of the REACH interventions were guided by detailed treatment manuals and certification procedures that ensured that the interventions were delivered as intended and consistently over time at each site. Careful attention was also paid to the issue of

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treatment fidelity. Different strategies were used at each site to induce and assess all three fundamental aspects of treatment implementation: delivery, receipt, and enactment (Burgio et al., 2001). In addition, because the caregiving experience in race and ethnic minority families is particularly neglected in this field, a strong emphasis was placed on the inclusion of African American and Hispanic caregivers (see Tables 2 and 3 for descriptions of caregivers and care recipients). Thus, assessments as well as interventions were tailored at each site to meet the needs of culturally diverse racial/ethnic majority and minority populations, briefly described in Table 1.

All of the REACH sites shared several common goals, including: (a) designing theory-driven caregiving interventions to test hypotheses about intervention processes and their effect on family caregivers, (b) specifying intervention components that help us understand the pathways through which interventions produce desired outcomes, (c) developing a standardized outcome protocol to assess the impact of different strategies on caregivers and their care recipients within each site and across sites, and (d) creating a common database and measurement intervals that would facilitate the pooling of data across sites. In addition, standard selection criteria were adopted by REACH (Wisniewski et al., in press).

Although REACH has some of the features of a traditional multisite randomized controlled clinical trial (e.g., random assignment of participants to treatment and control conditions, common database and outcome measures, and identical measurement intervals across sites), it differs on one key dimension—the interventions varied across sites. REACH was designed to examine the feasibility and outcomes of multiple different intervention approaches, rather than to provide definitive information on the efficacy of one specific intervention strategy for enhancing caregiver outcomes. The strength of this approach is that it efficiently yields information about the effectiveness of different approaches to AD caregiving as well as the combined effects of active treatment versus controls.

Four articles currently in press provide a detailed description of the REACH program overall (Wisniewski et al., in press), as well as report treatment effects based on two widely used indicators of caregiver status, depression, and burden (Gitlin et al., in press; Belle et al., in press). Wisniewski et al. (in press) provides a detailed description of the project and the interventions, the randomization strategies used, the standardized battery of measures, and the characteristics of the 1222 caregivers and care recipients recruited into the study. Using a preplanned meta-analytic approach (Gitlin et al., in press), and based on a conceptual framework that enables cross-site comparisons of intervention components (Czaja, Schulz, Lee, & Belle, in press; Belle et al., in press), the following results were obtained:

- Among all caregivers combined, active interventions were superior to control conditions in reducing caregiver burden.
- Among all caregivers combined, active interventions that emphasize active engagement of caregivers had the greatest impact in reducing caregiver depression.
- Women and those with high school or lower education who were in active interventions reported reduced burden compared with similar individuals in control conditions.
- Caregivers in active interventions who were Hispanic, those who were nonspouses, and those who had less than a high school education reported lower depression scores than those with the same characteristics who were in control conditions.

The purpose of the six articles that follow is to report the site-specific effects of the REACH interventions. Although the analyses reported by Gitlin et al. and Belle et al. provide an overall view of active treatment versus controls across all sites, they are limited with respect to exploring the impact of individual interventions, the range of outcomes examined, and the

depth of analyses carried out at each site. The papers that follow provide a detailed description of each intervention and the associated treatment effects at each of the six sites.

The first article (Mahoney et al., 2003) reports the results of the intervention study carried out in the Boston, Massachusetts area and shows that wives who exhibited low mastery and high anxiety benefited the most from an automated telecare intervention. A behavioral skills training intervention carried out in Birmingham, Alabama showed differential effects for African American and non-spouse caregivers (Burgio et al., 2003), with each of these groups showing greater benefits than comparison groups of White and spousal caregivers, respectively. Burns et al. (2003) examined long-term outcomes among caregivers residing in the Memphis, Tennessee area and showed that a long-term education intervention based in a primary care setting was effective in reducing caregiver stress and burden. The Miami intervention study (Eisdorfer et al., 2003) demonstrated that information technology has a promising role in alleviating the distress and depression among White and Cuban American AD caregivers. Researchers from Palo Alto, California (Gallagher-Thompson et al., 2003) were able to demonstrate improved coping among female caregivers who participated in an intervention designed to enhance skills for managing distress. Finally, an environmental skill-building intervention carried out in Philadelphia, Pennsylvania (Gitlin et al., 2003) resulted in less upset with memory-related behaviors and improved affect in intervention care-givers when compared with individuals in the control condition. Also, women in intervention tended to benefit more than men did in areas of mastery and ability to manage daily caregiving tasks. Overall, these studies provide a rich array of effective intervention strategies that can be used to enhance different outcomes for caregivers of persons with dementia. They also emphasize the interactive nature of different treatment approaches with caregiver characteristics and provide important leads about which types of interventions work with which types of caregivers.

The lessons learned from REACH were instrumental in designing the follow-up study, REACH II. In contrast to REACH, the primary goal of REACH II is to test a single intervention at multiple sites with an ethnically diverse caregiver population. Thus, REACH II is a traditional randomized clinical trial with all sites implementing the same intervention and collecting the same data. The design of the intervention was based on a careful analysis of outcomes in REACH as well as a review of the current literature in this area (Schulz, et al., 2002; Sörensen, Pinquart, Habi, & Duberstein, 2002). The overriding message from both of these sources is that caregiving presents multiple challenges that are not easily addressed. As a result, there is no single, easily implemented, and consistently effective method for achieving clinically significant effects among care-givers or care recipients.

One of the disappointments in the caregiving intervention research literature has been the relative lack of success in achieving clinically meaningful outcomes. Researchers have achieved small-to-moderate statistically significant effects on a wide variety of indicators such as depressive symptoms, burden, and other indicators of psychological well-being. The lack of strong findings is in part due to the misapplication of intervention approaches borrowed from medical and psychotherapeutic trials. With rare exception, caregivers typically do not fall into single syndromal clinical categories that lend themselves to a clearly targeted intervention. For example, although most caregivers have elevated levels of depressive symptoms, they do not meet criteria for clinical depression. Thus, unless one targets specific subgroups of caregivers who are clinically depressed, the ability to demonstrate large effects is constrained by the moderate level of the problem being addressed and the limited range of improvement possible. In general, caregivers can be characterized as having problems in multiple interrelated domains that exist at varying, but typically not extreme, levels of intensity. The intervention approach selected for REACH II is based on this assumption and is designed to maximize

outcomes in multiple different domains by tailoring the intervention to respond to individual variation in risk.

Many caregiving interventions involve several treatment elements aimed at simultaneously addressing multiple problems. Multicomponent interventions delivered in high doses are generally more effective than more narrowly targeted interventions (Schulz, 2000; Sørensen et al., 2002). Although we subscribe to the multicomponent approach to caregiver interventions, we diverge from the existing literature in an important way. Based on our assessment of the existing literature and the experience of REACH, we believe a “one size fits all” approach to caregiver interventions is likely to be ineffective. Because of the diversity of challenges inherent in the caregiving situation, interventions need to allow for some degree of tailoring of intervention components to meet the specific needs of the individual. Thus, we subscribe to a structured—but at the same time, tailored—approach to delivering interventions that are responsive to individual risk profiles.

In order to assess the variability in the needs of caregivers/care recipients, we use a risk appraisal approach in REACEI II to determine how much emphasis we place on each of the treatment components. Our intervention approach targets multiple components of the stress-health process and focuses on five areas linked to caregiver health outcomes: safety, self-care, social support, emotional well-being, and problem behaviors. The risk appraisal helps us prioritize these intervention components. Thus, the intervention is standardized with respect to the treatment components available, but varies with respect to the dosing or depth of treatment delivered for each of the available treatment components. For example, persons in active treatment who have minimal problems with depression will receive only a small dose of the intervention component designed to enhance emotional well-being. This will enable the interventionist to concentrate on those areas where risk factors are highest. In order to deliver the intervention in a cost-effective manner, we use a combination of in-home visits augmented by telephone-based technology found to be effective in REACH.

We are currently in the early stages of implementing REACH II, and it is therefore too early to report findings from this effort. However, we strongly believe that the REACH II research program will generate effective intervention strategies for care-givers of persons with dementia, and at the same time will advance the science of conducting complex randomized clinical trials in the social and behavioral sciences.

Acknowledgements

This research was supported through the Resources for Enhancing Alzheimer’s Caregiver Health (REACH) project, which is supported by the National Institute on Aging and the National Institute of Nursing Research (Grants: U01-NR13269, U01-AG13313, U01-AG13297, U01-AG13289, U01-AG13265, U01-AG 13255, and AG 13305).

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Appendix

REACH Research Group—Participating Institutions and Principal Staff

University of Alabama (Birmingham and Tuscaloosa, Alabama)

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External Advisory Committee

Patricia Archbold, DNSc, Oregon Health Sciences University; Larry Beutler, PhD (former member), University of California, Santa Barbara; Joel Greenhouse, PhD, Carnegie Mellon University; J. Neil Henderson, PhD, University of South Florida; Ira Katz, MD, PhD, University of Pennsylvania; M. Powell Lawton, PhD, Philadelphia Geriatric Center (deceased); Len Pearlman, PhD, University of Maryland; May Wykle, PhD, Case Western Reserve University.

Table 1

REACH Interventions by Site

Site	Description of Active Interventions and Control Conditions	Site-Specific Outcomes
Birmingham	<i>Skill Training Condition</i> — Problem-solving training designed to increase caregivers' ability to manage care recipients' behavioral excess and deficits, and to increase caregivers' ability to cope with these and other daily stressors. <i>Control: Minimal Support Condition</i> — Telephone-based minimal intervention that provides caregivers with contact and support such as active listening and empathy and written information about dementia and caregiving.	Behavioral skills training intervention showed differential effects for African American and nonspouse caregivers with each of these groups showing greater benefits than comparison groups of White and spousal caregivers, respectively.
Boston	<i>REACH for TLC (Telephone Linked Computer) System</i> — Telephone-based intervention designed to reduce caregiver stress. The system provides automated monitoring of caregiver stress levels, a voice-mail caregiver bulletin board, an ask-the-expert call option, and care recipient behavioral distraction to reduce disruptive behaviors. <i>Control: Usual Care</i> — Caregivers receive written information on dementia caregiving and referral resources.	Wives who exhibited low mastery and high anxiety benefited the most from an automated telecare intervention.
Memphis	<i>Behavior Care</i> — Caregivers receive written information plus skills training and materials in patient behavior management (periodic consultations and phone calls with behavior management interventionist to manage care recipients' behaviors). <i>Enhanced Care</i> — Caregivers receive written information and skills training plus behavioral modification strategies to decrease stress for the caregiver (relaxation training, coping strategies). <i>Control: Usual Care (Information and Referral)</i> — Caregivers receive written information on dementia caregiving and referral resources.	A long-term education intervention based in a primary care setting was effective in reducing caregiver stress and burden.
Miami	<i>Family-based Structural Multi-system In-home Intervention (FSMII)</i> — In-home family systems therapy designed to reduce caregiver's distress of managing and living with care recipient, and enhance family functioning. <i>FSMII + Computer Telephone Integration System (CTIS)</i> — Designed to augment FSMII with a computerized telephone system. The CTIS system is used to facilitate communication among the therapist, caregiver, family, and other support systems by providing messaging, conferencing, access to prestored information, and respite functions. <i>Control: Minimal Support Condition</i> — Telephone-based, minimal intervention that provides caregivers with contact and support such as active listening and empathy and written information about dementia and caregiving.	Caregivers in the combined family therapy and technology intervention experienced a significant reduction in depressive symptoms at 6 months. The 18-month follow-up data indicated that the intervention was particularly beneficial for Cuban American husbands and daughter caregivers.
Palo Alto	<i>Coping With Caregiving Class</i> — Psychoeducational class designed to teach caregivers coping and mood management skills. <i>Enhanced Support Group</i> — Support group patterned after local community support groups (standardized meeting frequency, duration, length of time in group and educational materials). <i>Control: Minimal Support Condition</i> — Telephone-based, minimal intervention that provides caregivers with contact and support such as active listening and empathy and written information about dementia and caregiving.	Improved coping among female caregivers who participated in an intervention designed to enhance skills for managing distress.
Philadelphia	<i>Environmental Skill-building Program</i> — Home-based intervention that provides caregivers with skills and technical support to modify the home to manage excess care recipient behaviors. Problem areas addressed may include managing ADLs, excess agitation, wandering or incontinence, and caregiver need for respite. <i>Control: Usual Care</i> — Caregivers receive written information on dementia caregiving and referral resources.	Environmental skill-building intervention resulted in less upset with memory-related behaviors and better affect in intervention caregivers when compared with individuals in the control condition. Also, women in intervention tended to benefit more than men did in areas of mastery and ability to manage daily caregiving tasks.

Note: ADLs = activities of daily living.

Table 2
Descriptive Profile of the Caregivers Participating in the Interventions at the Six REACH Intervention Sites

Characteristic	REACH Sites						Total N = 1222							
	Birmingham N= 140	Boston N= 100	Memphis N = 245	Miami N = 225	Palo N = Alto= 257	Philadelphia N = 255								
Age	n	%	n	%	n	%	n	%						
Mean, SD	62.9	12.9	62.6	12.7	62.3	13.0	68.5	11.4	57.3	13.9	61.1	14.3	62.3	13.6
Median, range	64	28, 88	65	22, 85	63	24, 89	70	39, 92	56	23, 90	60	28, 95	65	22, 95
Sex, male	30	21.4	22	22.0	53	21.6	57	25.3	0	0.0	65	25.5	227	18.6
Marital status	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Never married	9	6.5	13	13.0	18	7.4	12	5.3	32	12.5	44	17.3	128	10.5
Married/living as married	99	71.2	68	68.0	173	70.6	184	81.8	178	69.3	148	58.0	850	69.6
Widowed	11	7.9	6	6.0	22	9.0	6	2.7	8	3.1	18	7.1	71	5.8
Divorced	16	11.5	11	11.0	23	9.4	22	9.8	33	12.8	35	13.7	140	11.5
Separated	4	2.9	2	2.0	9	3.7	1	.4	6	2.3	10	3.9	32	2.6
Ethnicity	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Caucasian	80	57.1	79	79.0	143	58.6	112	49.8	147	57.2	123	48.2	684	56.0
Black	60	42.9	16	16.0	97	39.8	0	0.0	0	0.0	122	47.8	295	24.2
Hispanic	0	0.0	2	2.0	2	.8	113	50.2	110	42.8	5	2.0	232	19.0
Mexican	0	0.0	0	0.0	0	0.0	0	0.0	77	70.0	0	0.0	77	33.2
Cuban	0	0.0	0	0.0	1	50.0	113	100	2	1.8	0	0.0	116	50.0
Hispanic Other	0	0.0	2	100	1	50.0	0	0.0	31	28.2	5	100	39	16.8
Other	0	0.0	3	3.0	2	.8	0	0.0	0	0.0	5	2.0	10	.8
Income	n	%	n	%	n	%	n	%	n	%	n	%	n	%
<\$20,000	47	34.6	31	32.0	91	37.3	87	41.2	76	29.6	115	46.6	447	37.5
\$20,000-\$39,999	48	35.3	35	36.1	93	38.1	67	31.8	90	35.0	79	32.0	412	34.6
\$40,000 or more	41	30.1	31	32.0	60	24.6	57	27.0	91	35.4	53	21.5	333	27.9
Years providing care	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Mean, SD	3.6	3.0	5.3	4.1	4.1	4.1	3.9	3.0	5.1	6.0	4.3	3.8	4.3	4.2
Median, range	3.0	0, 17	4.5	1, 26	3.0	1, 32	3.0	1, 26	3.0	1, 40	3.0	1, 20	3	0, 40
CES-D (out of 60)	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Mean, SD	13.9	10.0	13.6	11.0	12.6	9.9	18.1	11.8	17.7	12.5	14.9	11.6	15.4	11.5
Median, range	12	0, 41	11	0, 54	11	0, 56	16	0, 49	16	0, 52	13	0, 54	13	0, 56
% ≥ 16	54	38.6	31	31.6	74	30.2	117	52.0	12.9	50.2	94	36.9	499	40.8

Notes: SD = standard deviation REACH = Resources for Enhancing Alzheimer's Caregiver Health CES-D = Center for Epidemiologic Studies—Depression score.

Table 3
Descriptive Profile of Care Recipients Participating in the Interventions at the Six REACH Intervention Sites

Characteristic	REACH Sites						Total N = 1222
	Birmingham N=140	Boston N=100	Memphis N = 245	Miami N = 225	Palo Alto N= 257	Philadelphia N = 255	
Age	78.9	78.0	78.2	80.1	78.1	80.7	79.1
Mean, SD	8.4	8.4	7.4	7.5	9.4	7.9	8.2
Median, range	51, 102	53, 99	57, 95	51, 95	44, 95	81	51, 10
Sex, male (n, %)	38.6	52.0	109	108	51.8	86	33.7
Mini-Mental State Exam (out of 30)	7.3	11.2	6.8	13.6	7.7	12.2	7.5
Mean, SD	0.29	0.27	0.28	0.29	0.28	0.27	0.29
Median, range	3.7	8.9	10.1	14.0	4.4	13.0	7.0
Revised Memory and Behavior Problems Checklist (out of 24)	0.22	0.22	0.21	0.23	0.28	0.27	0.29
Mean, SD	3.4	4.0	4.2	4.0	4.4	3.9	4.2
Median, range	2.0	3.4	10.0	9.4	1.3, 2.2	9.0	10.2
Limitations in Activities of Daily Living (out of 6)	0.6	0.6	0.6	0.6	0.6	0.6	0.6
Mean, SD	7.4	7.4	7.5	6.5	7.3	7.6	7.3
Median, range	3, 8	3, 8	2, 8	2, 8	2, 8	8.0	1, 8
Limitations in Instrumental Activities of Daily Living (out of 8)	1.1	1.1	1.0	1.0	1.0	1.0	1.0
Mean, SD	3.8	3.8	3.8	3.8	3.8	3.8	3.8
Median, range	3, 8	3, 8	2, 8	2, 8	2, 8	8.0	1, 8

Notes: REACH = Resources for Enhancing Alzheimer's Caregiver Health SD = standard deviation.



Kupuna Caregivers Program



In July 2017 Governor David Ige signed into law, HB 607 appropriating \$600,000 to the Executive Office on Aging (EOA) to establish the Kupuna Caregivers program, aimed at supporting working caregivers. Recognizing the tremendous contributions of caregivers, the bill provides financial assistance to support employed caregivers to remain in the workforce, **provided certain criteria are met**. EOA and the county Area Agencies on Aging are working to develop and implement the program.

ELIGIBILITY

- Qualified Caregivers must be employed at least 30 hours a week by one or more employers and provide care directly to a care recipient.

- A Care Recipient is someone who:
 - Is a citizen of the United States or a qualified alien
 - Is 60 years of age or older
 - Is not covered by any comparable government or private home and community-based care service, except kupuna care services
 - Does not reside in a long-term care facility and
 - Has impairments of at least:
 - Two activities of daily living or
 - Two instrumental activities of daily living or
 - One activity of daily living and one instrumental activity of daily living or
 - Substantive cognitive impairment requiring substantial supervision

ASSISTANCE

Qualified caregivers may receive up to \$70 per day in benefits (*subject to the availability of funds and paid directly to contracted service providers, not the caregiver*) to cover costs for adult day care, chore services, home-delivered meals, homemaker services, personal care, respite care, or transportation.

Assistance may also be provided now through other ADRC programs.

TIMELINE

EOA plans to launch the Kupuna Caregivers program in 2018.

Contact your county Aging and Disability Resource Center at:

ADRC Statewide Phone Number: 643-2372

ADRC TTY Line: 643-0899

<http://www.hawaiiadrc.org>

Senate Bill No. 196—Senators Ford, Woodhouse, Spearman, Ratti, Farley; Atkinson, Cancela, Cannizzaro, Denis, Manendo, Parks and Segerblom

Joint Sponsors: Assemblymen Frierson, Benitez-Thompson, Yeager, Carrillo, Elliot Anderson; Araujo, Bilbray-Axelrod, Cohen, Daly, Diaz, Flores, Fumo, Jauregui, Joiner, Neal, Spiegel, Sprinkle, Swank and Thompson

CHAPTER.....

AN ACT relating to employment; requiring certain employers in private employment to provide paid sick leave to each full-time employee of the employer under certain circumstances; providing an exception; providing a penalty; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires employers in private employment to pay employees certain minimum compensation and to provide certain benefits, including overtime compensation and meal and rest breaks. (NRS 608.018, 608.019, 608.250) **Section 1** of this bill requires a private employer who has 25 or more employees in private employment in this State and who has conducted business in this State for at least 12 consecutive months to, at a minimum, provide full-time employees paid sick leave that must be earned at a rate of not less than 1 hour per 40 hours worked and may be used by an employee beginning on the first anniversary date of his or her employment. **Section 1** sets forth that an employee is a full-time employee of the employer if the employee works at least 1,600 hours for the employer during a 12-month period beginning on the date the employee is hired. **Section 1** also provides that an employer may: (1) limit the use of the paid sick leave to 40 hours per year; and (2) set a minimum increment that an employee may use the accrued sick leave at any one time, not to exceed 2 hours. **Section 1** additionally requires an employer to maintain records of the accrual and use of paid sick leave for each employee for a 3-year period and to make those records available for inspection by the Labor Commissioner. **Section 1** requires the Labor Commissioner to prepare a bulletin setting forth these benefits and requires employers to post the bulletin in the workplace. **Section 1:** (1) provides an exception for employers who provide at least an equivalent amount of sick leave or paid time off; and (2) excludes from the requirements of this bill certain employees who perform work on an occasional or irregular basis, perform physical work at a construction site that results in the construction, alteration or destruction involved in the construction project, perform work for a hospital, a facility for long-term care or a provider of health care on an occasional or irregular basis or work less than 12 consecutive months for the employer. Finally, **section 1** prohibits this bill from being interpreted as allowing an employee to be compensated more than once for the same hour of leave.

Existing law requires an employer to establish and maintain records of wages for the benefit of his or her employees. (NRS 608.115) **Section 1.5** of this bill requires this record to include the total hours of sick leave available for use by each employee.

Section 2 of this bill requires the Labor Commissioner to enforce the provisions of **section 1**, and **section 3** of this bill makes a violation of the provisions of **section 1** a misdemeanor and authorizes the Commissioner to impose,



in addition to any other remedy or penalty, a penalty of up to \$5,000 for each violation. (NRS 608.180, 608.195)

EXPLANATION - Matter in *bolded italics* is new; matter between brackets ~~omitted material~~ is material to be omitted.

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

Section 1. Chapter 608 of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in this section, every employer who has conducted business in this State for at least 12 consecutive months shall provide paid sick leave to each full-time employee of the employer as follows:

(a) A full-time employee is entitled to accrue paid sick leave at a rate of not less than 1 hour for every 40 hours worked by the full-time employee.

(b) Accrued paid sick leave must carry over for each employee between his or her years of employment, not to exceed a total accrual of 80 hours of accrued paid sick leave.

(c) Paid sick leave must be compensated at the rate of pay at which the employee is compensated at the time such leave is taken, and paid on the same payday as the hours taken are normally paid. For the purposes of this calculation, the compensation rate for an employee who is paid by salary, commission, piece rate or a method other than an hourly wage must be calculated by dividing the employee's total wages paid for the immediately preceding 90 days by the number of hours worked during that period.

(d) An employer may limit the amount of paid sick leave an employee uses to 40 hours per year.

(e) An employer may set a minimum increment of paid sick leave, not to exceed 2 hours, that an employee may use at any one time.

(f) An employer is not required to compensate an employee for any accrued unused sick leave upon separation from employment.

2. An employee of an employer may use accrued sick leave as follows:

(a) An employee must be allowed to use accrued sick leave beginning on the first anniversary date of his or her employment.

(b) An employee may use accrued paid sick leave:

(1) For the diagnosis, care or treatment of an existing health condition of, or preventive care for, the employee or a member of the employee's family or household; or



(2) *To obtain counseling or assistance or to participate in any court proceedings related to domestic violence or sexual assault.*

(c) *To the extent possible, an employee shall give reasonable advance notice to his or her employer of the need to use accrued paid sick leave.*

(d) *An employer shall not:*

(1) *Deny an employee the right to use accrued sick leave in accordance with the conditions of this section;*

(2) *Require an employee to find a replacement worker as a condition of using sick leave; or*

(3) *Retaliate against an employee for using sick leave.*

3. *The Labor Commissioner shall prepare a bulletin which clearly sets forth the benefits created by this section. The Labor Commissioner shall post the bulletin on the Internet website maintained by the Office of Labor Commissioner, if any, and shall require all employers to post the bulletin in a conspicuous location in each workplace maintained by the employer. The bulletin may be included in any printed abstract posted by the employer pursuant to NRS 608.013.*

4. *An employer shall maintain records of the accrual and use of paid sick leave for each employee for a 3-year period following the entry of such information in the record and, upon request, shall make those records available for inspection by the Labor Commissioner.*

5. *The provisions of this section do not:*

(a) *Limit or abridge any other rights, remedies or procedures available under the law.*

(b) *Negate any other rights, remedies or procedures available to an aggrieved party.*

(c) *Prohibit, preempt or discourage any contract or other agreement that provides a more generous sick leave benefit or paid time off benefit.*

(d) *Prohibit an employer from creating and enforcing a policy that prohibits the improper use of paid sick leave.*

6. *This section does not apply to:*

(a) *An employer who, by contract, policy or other agreement, provides full-time employees with a paid sick leave policy or a paid time off policy that provides for at least 40 hours of paid leave per year.*

(b) *An employee who:*

(1) *Is a day or temporary worker who performs work on an occasional or irregular basis for a limited period of time;*



(2) *Actually performs physical work at a construction site that results in the construction, alteration or destruction involved in the construction project; or*

(3) *Performs work for a hospital, a facility for long-term care or a provider of health care on an occasional or irregular basis as needed by the hospital, facility for long-term care or provider of health care.*

(c) *An employee who works less than 12 consecutive months for his or her employer.*

7. *The provisions of this section must not be interpreted to allow an employee to be compensated more than once for the same hours of leave.*

8. *For the purposes of this section, an employee is a full-time employee of an employer if the employee works at least 1,600 hours for the employer during a 12-month period beginning on the date of employment.*

9. *As used in this section:*

(a) *“Employer” means a private employer who has 25 or more employees in private employment in this State. The term does not include a nonprofit religious, charitable, fraternal or other organization that qualifies as a tax-exempt organization pursuant to 26 U.S.C. § 501(c).*

(b) *“Facility for long-term care” has the meaning ascribed to it in NRS 427A.028.*

(c) *“Hospital” has the meaning ascribed to it in NRS 449.012.*

(d) *“Provider of health care” has the meaning ascribed to it in NRS 629.031.*

Sec. 1.5. NRS 608.115 is hereby amended to read as follows:

608.115 1. Every employer shall establish and maintain records of wages for the benefit of his or her employees, showing for each pay period the following information for each employee:

(a) Gross wage or salary other than compensation in the form of:

- (1) Services; or
- (2) Food, housing or clothing.

(b) Deductions.

(c) Net cash wage or salary.

(d) Total hours employed in the pay period by noting the number of hours per day.

(e) Date of payment.

(f) *Total hours of paid sick leave available for use by the employee.*



2. The information required by this section must be furnished to each employee within 10 days after the employee submits a request.

3. Records of wages must be maintained for a 2-year period following the entry of information in the record.

Sec. 2. NRS 608.180 is hereby amended to read as follows:

608.180 The Labor Commissioner or the representative of the Labor Commissioner shall cause the provisions of NRS 608.005 to 608.195, inclusive, *and section 1 of this act* to be enforced, and upon notice from the Labor Commissioner or the representative:

1. The district attorney of any county in which a violation of those sections has occurred;

2. The Deputy Labor Commissioner, as provided in NRS 607.050;

3. The Attorney General, as provided in NRS 607.160 or 607.220; or

4. The special counsel, as provided in NRS 607.065,

↪ shall prosecute the action for enforcement according to law.

Sec. 3. NRS 608.195 is hereby amended to read as follows:

608.195 1. Except as otherwise provided in NRS 608.0165, any person who violates any provision of NRS 608.005 to 608.195, inclusive, *and section 1 of this act*, or any regulation adopted pursuant thereto, is guilty of a misdemeanor.

2. In addition to any other remedy or penalty, the Labor Commissioner may impose against the person an administrative penalty of not more than \$5,000 for each such violation.

Sec. 4. This act becomes effective:

1. Upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks necessary to carry out the provisions of this act; and

2. On January 1, 2018, for all other purposes.



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Office of the Governor

June 1, 2017

The Honorable Aaron Ford
Nevada State Senate Majority Leader
The Nevada Legislature
401 South Carson Street
Carson City, NV 89701

RE: Senate Bill 196 of the 79th Legislative Session

Dear Leader Ford:

I am herewith forwarding to you, for filing within the constitutional time limit and without my approval, Senate Bill 196 ("SB 196"), which is entitled:

AN ACT relating to employment; requiring certain employers in private employment to provide paid sick leave to each full-time employee of the employer under certain circumstances; providing an exception; providing a penalty; and providing other matters properly relating thereto.

It is the goal of all policy makers to support legislation that benefits Nevada's workforce and families. SB 196 seeks to accomplish this goal by requiring businesses with twenty-five or more employees to provide paid sick leave to full-time employees.

Of course, the mandates of SB 196 come with a substantial cost to businesses, particularly small businesses. In addition, the decision to provide employee benefits is one reserved to a business owner who must respond to the demands of a competitive job market.

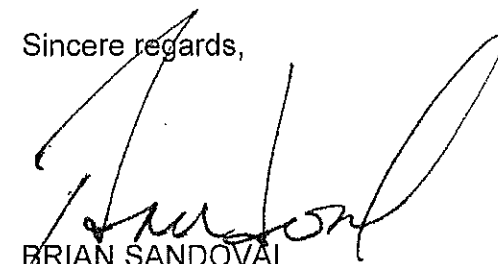
Indeed, among others, the Las Vegas Metro Chamber of Commerce, Latin Chamber of Commerce, Henderson Chamber of Commerce, Reno-Sparks Chamber of Commerce, and the Nevada Retailers Association, who represent thousands of businesses across Nevada, all registered their opposition to SB 196 because of the impact on their members. Some indicated that the unintended consequences of this bill would be reduced hours, fewer employees, more temporary employees, and higher administrative costs.

Nevada is experiencing record economic growth. Weekly wages, small business employment, and overall employment are at all-time highs. Nevada is being recognized as a business friendly state and is experiencing new and diverse economic expansion.

SB 196 presents a substantial economic burden on small business, upsets competition for employees, and could hinder Nevada's business friendly reputation.

For these reasons, I veto SB 196 and return it without my signature or approval.

Sincere regards,



BRIAN SANDOVAL
Governor

Enclosure

cc: *The Honorable Mark Hutchison, President of the Senate (without enclosure)*
The Honorable Jason Frierson, Speaker of the Nevada Assembly (without enclosure)
The Honorable Barbara Cegavske, Nevada Secretary of State (without enclosure)
Claire J. Cliff, Secretary of the Senate (without enclosure)
Susan Furlong, Chief Clerk of the Assembly (without enclosure)
Brenda Erdoes, Esq., Legislative Counsel (without enclosure)

Date: 3/22/18

To: Senator Joyce Woodhouse, Chair, Legislative Committee to Study the Needs Related to the Behavioral and Cognitive Care of Older Persons

From: Alexandria Crossley, RN, BSN, BA, Crossley Nurse Consultants

Subject: Recommendation for Possible Considerations by the Committee

Thank you for the opportunity to share data and ideas regarding the needs in our community. I am a Registered Nurse, working with the adult, Intellectual disability/developmental disability (IDD) population living in supported living arrangements in the community. I have worked with this population for over 25 years throughout Nevada. One of the concerns that has remained unaddressed under our current available services, is the changing needs of the IDD population as they age.

There are over 4800 adults with Intellectual disabilities here in the state of Nevada. 552 of these individuals are over age 50 years. With this population, studies have shown that cognitive and physical decline of aging begins at a much younger chronological age than the general population.

Most of these individuals have benefitted from the improved quality of life afforded them by systems such as the Medicaid Waiver for Persons with Intellectual and Developmental Disabilities. As such, they have experienced improved health and wellness, extending their life expectancy beyond previous generations. Unfortunately, current systems do not accommodate the changing needs of this population as they age. Many of these Individuals require increased supports for activities of daily living, medical needs and medications and treatments. Under current systems, these Individuals live and work in the community, sharing homes in the community with other adults with similar needs, and supported 24/7 by staff trained to work with adults with IDD. The staff, however are not medical professionals, nor do they have training or clearance to perform any medical support tasks above and beyond basic medication supports.

As this population ages, which as I pointed out previously, tends to be at an earlier onset than the general population, their increasing health and cognitive needs cannot be met under current system limitations. This results in individuals being hospitalized for acute conditions, and then facing the reality of not being able to return to their homes and staff that have been their constant for years. Hospitals face difficulty in placing these Individuals in traditional Long term care facilities, due to the lack of understanding and supports available within these facilities to address not only the health care needs, but also the needs unique to persons with IDD. In addition, this population has not done well in traditional long term care facilities, often becoming isolated and rapidly declining in health status. As a result, these Individuals are remaining in hospitals beyond necessity, or returned to their homes only to be returned to the hospital when their health care needs cannot be met, and a decline ultimately occurs.

The current system of residential living in the community with lay staff supports is an excellent place for these Individuals to age in place. In order to put the additional supports needs in place on a routine, long term basis, changes to funding and limits to professional and adjunct services must occur. With professional health care supports, trained personal care attendants, and expanded services in the homes, with support needs being determined on an individualized need, this sector of our aging population can continue being supported in the communities, homes, and with the support staff that they have known, while having their increasing needs related to aging, met.

The costs of increasing the scope of services available, within the already funded systems, are far less than the costs of facility long term care, repeat hospitalizations, and most importantly, is in the best interests of these Individuals quality of life throughout their lifespan.

The need to advocate for this population is urgent. Many of these Individuals have never had family involvement, and those whose families have been actively involved, are finding that their parents and elder siblings have been lost in death or have health declines of their own, and leaving them without a voice to promote for their needs.

This need, and finding solutions for this increasing gap in services is one I feel passionately about. I greatly appreciate your interest in our aging population in general, and attention specifically to this unique subgroup within our aging population.

Thank you for this opportunity to share this concern with you and possibly the Legislative Committee.

I have included my contact information, in the event you have any questions or thoughts on this matter.

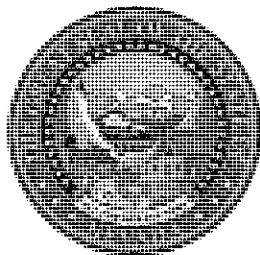
Sincerely,

Alexandria Crossley, RN, BSN, BA

Crossley Nurse Consultants, Prof. Corp.

Acrossley_bsn@hotmail.com

702-275-4874



DEPARTMENT OF HEALTH AND HUMAN SERVICES
AGING AND DISABILITY SERVICES DIVISION
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Guardianship in Nevada

[RECOMMENDATIONS FOR THE COMMITTEE TO STUDY THE NEEDS RELATED TO THE BEHAVIORAL AND COGNITIVE CARE OF OLDER PERSONS]

(1) Public Guardian Referrals and NRS 253

At this time, multiple Public Guardian offices across the state opt not to receive referrals regarding those in need in their community, citing a prohibition on receiving confidential information (bank statements, medical records, etc.) before being officially appointed to serve in some capacity by the court. A stop gap currently employed through a partnership between Elder Protective Services, the Nevada Attorney General's Office, and the Attorney for the Rights of Older Persons and Persons with Physical Disabilities, Intellectual Disabilities or a Related Condition has been to cite, via petition, the Public Guardian to court appointment so that they may receive such records.

There is no state funding for this workaround for statutorily mandated components for such a petition, including but not limited to certified mailings with return receipt requested, extensive research (possible skip trace searches) to determine family members entitled to notice, etc. It also delays the necessary intervention of the Public Guardian where otherwise authorized in NRS 253 and NRS 159.

It is proposed, therefore, that the Committee recommend language amended into NRS 253.220 to close the Public Guardian referral gap for individuals over the age of 60 where law enforcement, protective services, or judicial officers in other matters may recommend the service of the Public Guardian.

Amendment is suggested as follows (highlights are new language):

NRS 253.220 Investigation of financial status, assets and personal and family history of person for whom public guardian has been appointed. A public guardian may investigate the financial status, assets and personal and family history of any person for whom the public guardian has been appointed as guardian or for whom a referral has been received from law enforcement, elder protective services, or a judicial officer in conjunction with a criminal or civil matter relating to a potential protected person,

without hiring or being licensed as a private investigator pursuant to chapter 648 of NRS. In connection with the investigation, the public guardian may require any ward or any spouse, parent, child or other kindred of the ward or potential protected person referred as above to give any information and to execute and deliver any written requests or authorizations necessary to provide the public guardian with access to records, otherwise confidential, which are needed by the public guardian. 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 in conjunction with the above, NRS 179A.100(7)(g), and related protective statutes. If referrals are not taken as stated herein and the referring party is required to cite the public guardian in to a case to serve, the public guardian shall be ordered to reimburse the referring party for the actual fees and costs of such citation proceedings.

(2) Continuing Guardianship Jurisdiction Related to Out of State Placement

Part of Nevada Revised Statutes 159, where adult guardianship “lives” (NRS 159A is the chapter for minor guardianships, or guardianships over individuals before the age of majority) includes the “Adult Guardianship and Protective Proceedings Jurisdiction (Uniform Act).” A Uniform Act is something that has been drafted for states to potentially adopt, or adopt with adjustments unique to their state, to encourage best practices and similarities across the country. Adopted in 2009, this uniform act deals with inter court communication, cooperation with other courts, and taking testimony in another state.

Regarding jurisdiction, the law in Nevada provides that a Nevada court can appoint a guardian if:

- (a) Nevada is the proposed protected person’s home state;
- (b) Nevada is where the proposed protected person has property and their actual home state has opted not to take jurisdiction because that other court has chosen Nevada to be more appropriate;
- (c) Nevada is where the proposed protected person has a “significant connection” and the actual home state has declined to take jurisdiction because they believe Nevada to be the more appropriate forum; or
- (d) The proposed protected person does not have a home state.

(NRS 159.1998).

NRS 159.018 provides that a home state “means the state in which the proposed [protected person] was physically present for at least 6 consecutive months, including any temporary absence from the state, immediately before the filing of a petition for the appointment of a guardian.”

It follows that jurisdiction can be maintained under similar circumstances. This means that residence outside of the state for a period of longer than 6 consecutive months could leave a family in the situation of having to seek guardianship in the state where an out of state

March 26, 2018

Page 3

placement has been made. This incurs greater cost and doesn't seem to be what is intended by such placement. Clarity in our statutes is needed so that judges have guidance when out of state moves for care purposes are requested and ultimately granted.