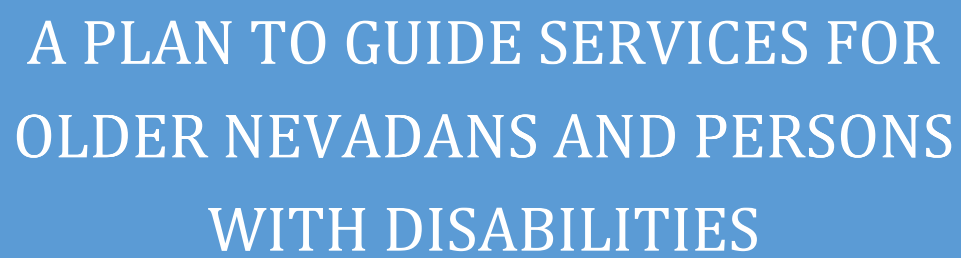


A PLAN TO GUIDE SERVICES FOR OLDER NEVADANS AND PERSONS WITH DISABILITIES

2016-2021

ACKNOWLEDGEMENTS

The following individuals participated in or contributed to the development of the strategic plan.

Dr. Edward Ableser,
Aging & Disability Services Division

Jill Berntson,
Aging & Disability Services Division

Margot Chappel,
Aging & Disability Services Division

Jane Gruner,
Aging & Disability Services Division

Julie Kotchevar,
Aging & Disability Services Division

Connie McMullen,
Commission on Aging

Cara Paoli,
Aging & Disability Services Division

Brian Patchett,
Commission on Services for Persons with Disabilities

Susan Rhodes,
Consultant

Jon Sasser,
Commission on Services for Persons with Disabilities

Karen Taycher,
Commission on Services for Persons with Disabilities

Dr. Stephanie Woodard,
Division of Public and Behavioral Health

Social Entrepreneurs, Inc., a company dedicated to improving the lives of people by helping organizations realize their potential, provided support in the development of this plan.

Table of Contents

Acknowledgements i

Background and Purpose 1

Preamble 3

Snapshot of Those Served by This Plan 4

- Children with a Disability 5
- Noninstitutionalized Senior and Aging Population 5
- Noninstitutionalized Population with Any Disability 6
- Nevadans with an Intellectual and/or Developmental Disability (I/DD) 7
- Medicaid Recipients 9

Summary of Key Issues 10

Goals to Address Key Issues 12

Goals, Objectives and Strategies 13

Outcomes and Accountability 25

Priorities Moving Forward 26

Appendices 29

- Appendix A – Definitions 29
- Appendix B – Value Proposition 37
- Appendix C– List of Reports Reviewed in the Meta-Analysis 42
- Appendix D – Assessment of Goals from 2002 and 2003 44

Background and Purpose

This plan is designed for Nevadans.

It sets priorities and recommendations related to services and supports throughout the state. It incorporates compliance of the Olmstead decision as a core component of its approach. However, it goes beyond Olmstead, setting forth a vision and approach to serve older Nevadans and persons with physical, intellectual or other mental disabilities. The plan is intended to improve the system for children, adults, and their families. It is the guiding document for use throughout the Department of Health and Human Services. Nevada's Aging and Disability Services Division is ultimately responsible for promoting its implementation.

The plan sets forth the principles and approaches that will change the culture of service provision in Nevada. It is designed to address the persistent lack of funding available to meet the needs of older Nevadans and persons with disabilities. The paucity of funds results in stakeholder groups competing for limited resources. Policy makers, providers, and advocates have combined efforts with a spirit of collaboration to develop this plan.

Fundamentally, the plan seeks to raise up and address the importance of the dignity of all Nevadans--to create an environment that values young and old, able-bodied, persons with disabilities, and those with mental illness, recognizing they all make up the fabric of Nevada and are critical to our success as a state and as a community of equals.

Mission

The mission of this plan is to ensure that older adults and persons with disabilities have the opportunity to achieve optimal quality of life in the community of their choice.

Guiding Principles

This plan was developed using guiding principles for providing services and supports to older Nevadans and for individuals with disabilities. Guiding principles are the values or mutually held beliefs that are used for all decision making related to the organization.

Independence: People should have options and the ability to select the manner in which they live.

Access: People's needs are identified and met quickly.

Dignity: People are viewed and respected as human beings.

Integration: People can live, work, and play as a part of their community.

Quality: Services and supports achieve desired person-centered outcomes.

Sustainability: Services and supports can be delivered over the long term so individuals can be self-sufficient.

Mission

The mission of this plan is to ensure that older adults and persons with disabilities have the opportunity to achieve optimal quality of life in the community of their choice.

Quality of Life

Goal #1 Strong, Supportive Systems

Goal #2 Access and Engagement

Goal #3 Meaningful Community Integration

Goal #4 Strengthening Other Systems to Address Barriers

Goal #5 Accountability

Achievement of this goal will require support from and coordinated efforts with DHHS partners at the local and state level.

PREAMBLE

This plan is intended for use throughout DHHS.

It builds upon previously adopted strategic plans for seniors and persons with disabilities.

It is intended to be inclusive rather than focusing on exclusive subpopulations, with the understanding that communities throughout the state benefit from the people that reside in the community, offering diversity and a richness of experience.

This plan provides innovative solutions to solve gaps that are a result of the current state structure. A No Wrong Door approach streamlines access to information, services, and supports for people of all ages, incomes and abilities.

An overarching critical issue that must be addressed is the need for integration of services. This means a seamless, person/family-centered delivery system beginning with assessment, care coordination, treatment/supports and accountability. The goals in this plan are predicated on this design.

To fully address the populations impacted by the plan, it is important to understand the following key concepts and terms. These terms and definitions can be found in Appendix A.

- Persons with Disabilities
- Types of Disabilities
- No Wrong Door
- Olmstead Decision
- Person centered Planning

Snapshot of Those Served by This Plan

The following information is excerpted from a databook developed for the Strategic Planning and Accountability Committee workgroup:

12.1% of Nevadans have a disability

35.6% of seniors in Nevada have one or more disabilities

18.52% of adults live with a mental illness

1.8%

Nevadans with a Disability

- Of the 12.1% of Nevadans with a disability, **1.8%** of them were served by ADSD in 2014.

1.4%

Senior Population with a Disability

- Of the 35.6% of the senior population with a disability, **1.4%** of them were served by ADSD's Frail and Elderly caseload in 2014.

6.9%

Adults with a Mental Illness

- Of the 18.52% of adults with a mental illness, **6.9%** of them were served by the Statewide Mental Health Agency in 2014.

Source: ADSD Caseload Data Compared to Disability Prevalence Data

Children with a Disability

In Nevada, there were approximately 195,000 children under the age of 4 and another 565,000 between the ages of 5 and 19. Studies conducted by the American Pediatric Association have indicated that approximately 13% of children under the age of 3 have a developmental delay. In Nevada, this would create a potential pool of 25,350 children who may have a developmental delay. The ability to serve these children is measured by a factor called the penetration rate. Nevada's penetration rate is 1.3% of the total population. In comparison, the national average penetration rate is 2.79% of young children with an individual family service plan (IFSP).

Source: ADSD Integration Plan, 2014

Noninstitutionalized Senior and Aging Population

County	All Ages	Ages 55+*	Ages 65+	Percent of Seniors
Carson	52,771	17,483	9,304	17.9%
Churchill	23,473	7,231	4,003	16.7%
Clark	1,979,680	476,860	244,584	12.4%
Douglas	46,728	18,760	10,553	22.6%
Elko	50,379	10,402	4,360	8.8%
Esmeralda	1,025	421	263	25.2%
Eureka	1,745	498	234	13.2%
Humboldt	16,780	3,945	1,634	9.7%
Lander	5,894	1,619	853	14.8%
Lincoln	4,928	1,579	899	17.5%
Lyon	51,128	16,815	9,190	17.9%
Mineral	4,524	1,712	950	21.0%
Nye	42,598	18,292	11,159	26.1%
Pershing	4,866	1,780	892	13.9%
Storey	3,917	1,884	930	23.7%
Washoe	426,939	113,086	56,704	13.3%
White Pine	8,981	2,892	1,450	14.9%
Nevada – Total	2,726,356	693,158	357,962	13.1%

Source: (U.S. Census Bureau, 2016)

*Category for ages 55+ includes the institutionalized population. Age breakout for 55+ in the noninstitutionalized population was unavailable.

Seniors make up 13.1% of Nevada's population. The percentage of seniors by county ranges from 8.8% to 26.1% throughout the 17 counties with the smallest percentage of seniors in Elko County (8.8%) and the largest in Nye County (26.1%).

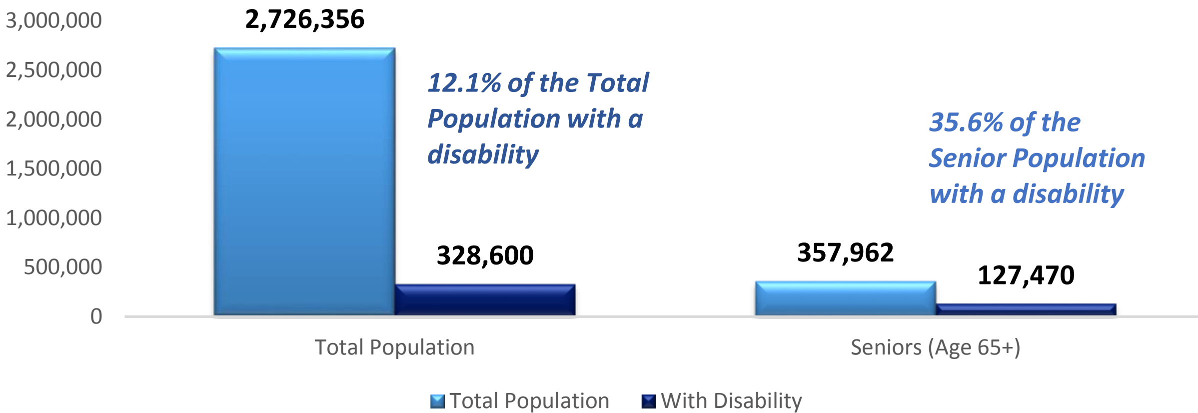
Noninstitutionalized Population with Any Disability

County	All Ages			Ages 65+		
	Total	With Disability	Percent	Total	With Disability	Percent
Carson	52,771	8,116	15.4%	9,304	3,780	40.6%
Churchill	23,473	4,417	18.8%	4,003	1,644	41.1%
Clark	1,979,680	228,406	11.5%	244,584	86,555	35.4%
Douglas	46,728	7,055	15.1%	10,553	3,524	33.4%
Elko	50,379	5,783	11.5%	4,360	1,862	42.7%
Esmeralda	1,025	172	16.8%	263	63	24.0%
Eureka	1,745	151	8.7%	234	80	34.2%
Humboldt	16,780	1,833	10.9%	1,634	691	42.3%
Lander	5,894	613	10.4%	853	296	34.7%
Lincoln	4,928	700	14.2%	899	185	20.6%
Lyon	51,128	9,084	17.8%	9,190	3,689	40.1%
Mineral	4,524	1,246	27.5%	950	538	55.6%
Nye	42,598	10,331	24.3%	11,159	4,734	42.4%
Pershing	4,866	974	20.0%	892	472	52.9%
Storey	3,917	755	19.3%	930	301	32.4%
Washoe	426,939	47,413	11.1%	56,704	18,483	32.6%
White Pine	8,981	1,551	17.3%	1,450	573	39.5%
Nevada – Total	2,726,356	328,600	12.1%	357,962	127,470	35.6%

Source: (U.S. Census Bureau, 2016)

In Nevada, 12.1% of the population had a disability with the percentages ranging from 8.7% to 27.5% throughout the individual counties.

Compared to the total population, a much larger percentage of the senior population had a disability at 35.6% statewide. Percentages of seniors with disabilities ranged from 20.6% to 55.6% throughout individual counties.



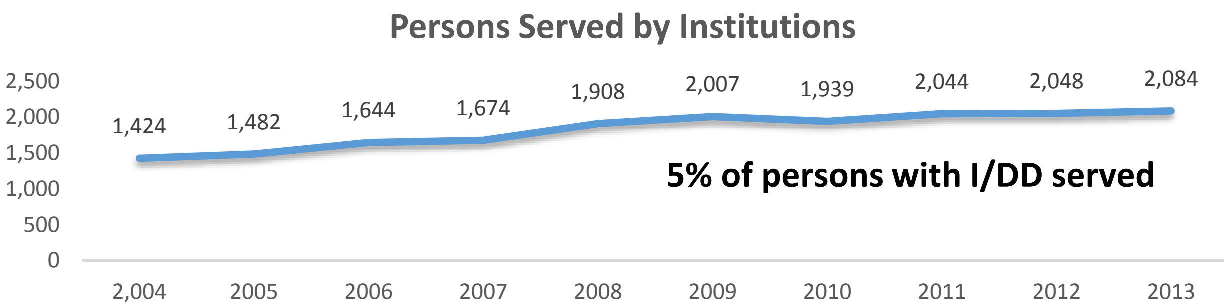
Beyond the number and percent of the population with a disability, it is also important to recognize the growth in this population over time. The US Census Bureau contained age-breakout disability data for the years 2012 to 2014. For those three years, the number and percentage of people with disabilities increased. Persons of all ages with disabilities increased from 10.8% in 2012 to 12.1% in 2014 while persons aged 65 or older with disabilities increased from 34.5% to 35.6%.

Year	Noninstitutionalized Population	All Ages with Disability		Noninstitutionalized Population (Age 65+)	Ages 65+ with Disability	
		Number	Percent		Number	Percent
2012	2,668,199	289,082	10.8%	325,288	112,139	34.5%
2013	2,694,751	309,210	11.5%	340,926	119,129	34.9%
2014	2,726,356	328,600	12.1%	357,962	127,470	35.6%

Source: (U.S. Census Bureau, 2016)

Nevadans with an Intellectual and/or Developmental Disability (I/DD)

The graph below demonstrates growth within the institutional population of people with I/DD as well.

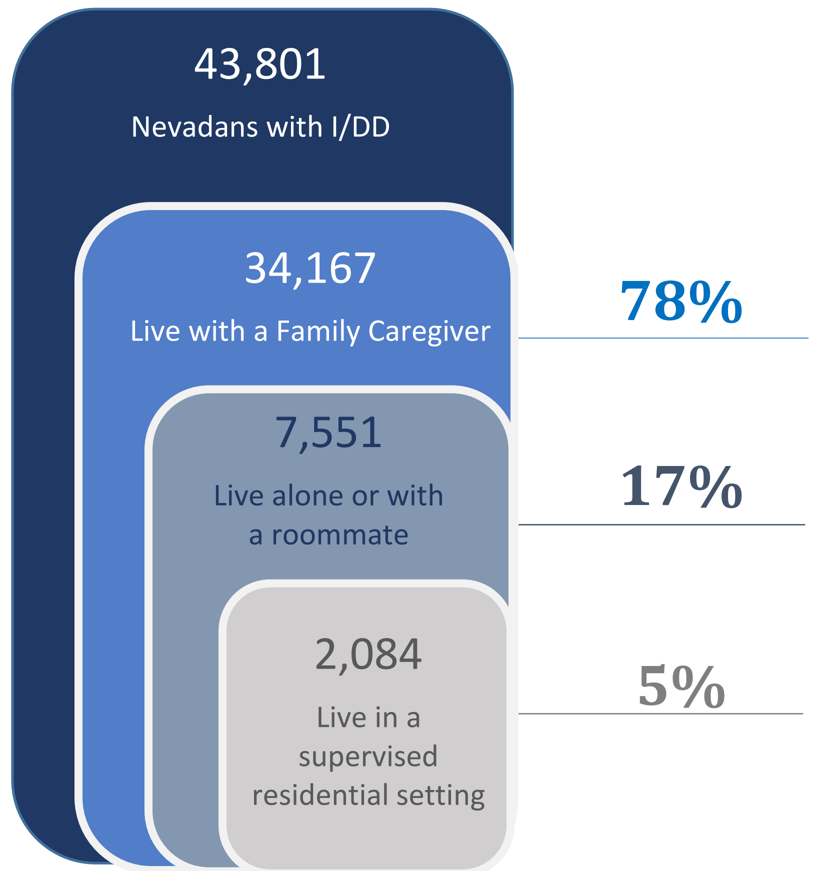


In fiscal year 2013, there were an estimated 43,801 persons with I/DD.

Of the 43,801 people with I/DD, 17% of them lived alone or with a roommate while 83% lived with a family caregiver or in a supervised residential setting. There were 34,167 (78%) of those with I/DD who were living with a family caregiver.

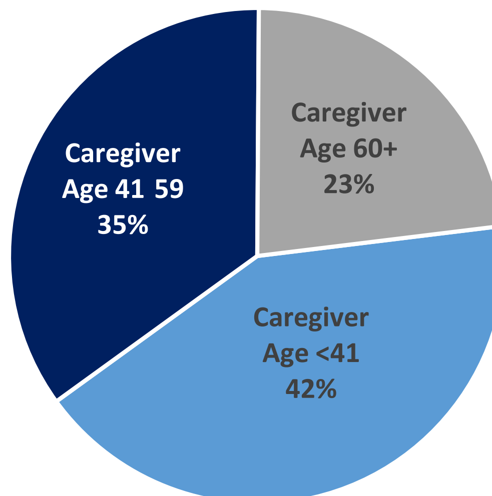
The majority of those with I/DD were living with a family caregiver who was less than 41 years old (42%). Almost a quarter (23%) of family caregivers were seniors while 35% were between the ages of 41 and 59.

Of the 34,167 Nevadans with I/DD living with a family caregiver, 7% were supported by state I/DD agencies.



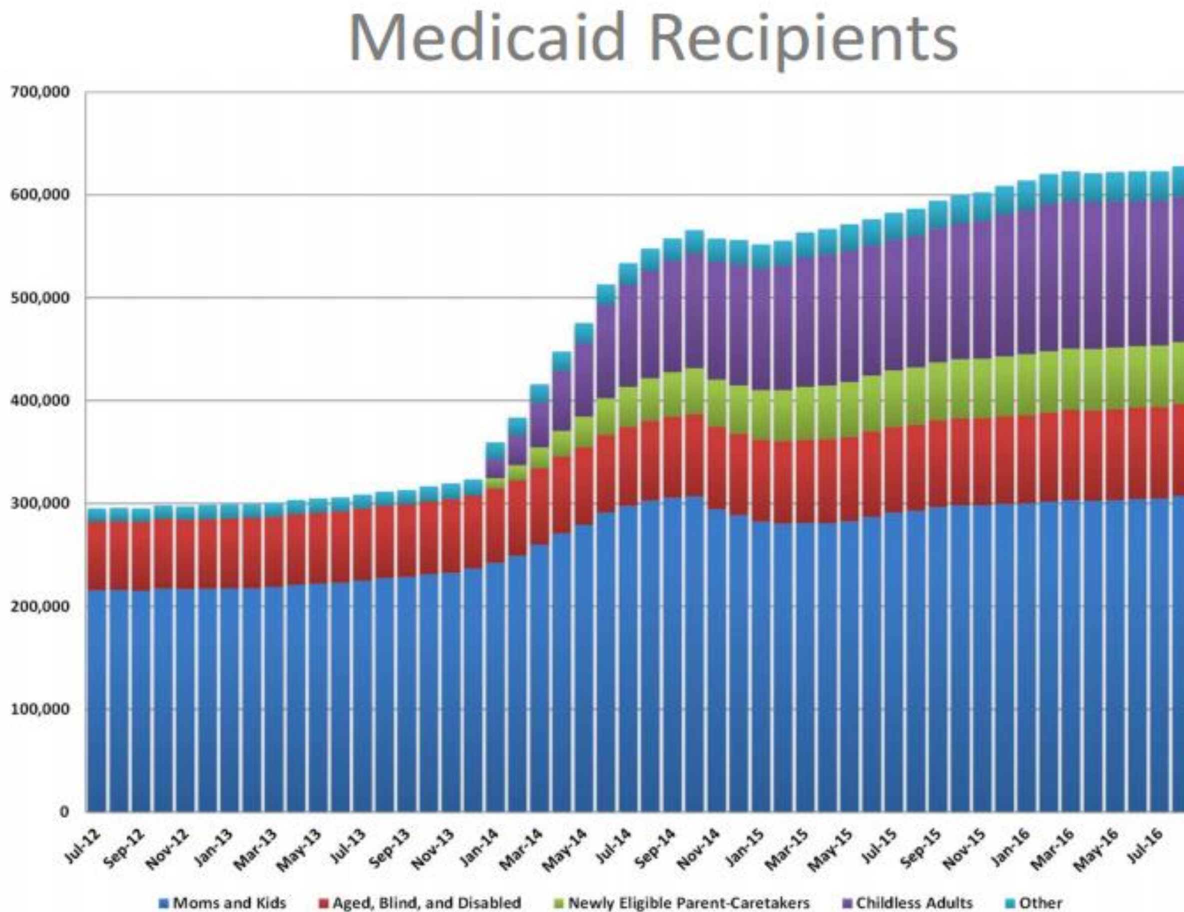
Age of Family Caregivers of Individuals with I/DD

34,167 persons with I/DD living with Family Caregiver



Medicaid Recipients

At the time of plan development, the Affordable Care Act is in place and Nevada is a Medicaid expansion state. The number of people served by Medicaid make up a significant portion of those receiving services addressed in this plan.



Source: (Department of Health and Human Services, 2016)

Starting in January of 2014, Medicaid recipients included newly eligible parent-caretakers and childless adults. Since then, the number of Medicaid recipients increased from about 350,000 to over 600,000 in 2016.

Summary of Key Issues

Critical Issue #1 — Strong, Supportive Systems

- Need for high quality of care.
- Need for greater state and community capacity to implement person-centered planning (PCP).
- Need for greater state and community capacity to implement No Wrong Door (NWD).
- Need for greater communication, coordination, and collaboration across systems to facilitate transitions across the lifespan.

Critical Issue #2 — Access and Engagement

- Need for timely care.
- Need for a full spectrum of services from screening and prevention to direct services.
- Need for a wide-spread awareness of services, how to find them, and how to navigate systems to receive them.
- Need for an understanding by providers and the community of what challenges certain circumstances pose.
- Need for better collaboration between private and public systems to facilitate transitions and remove barriers.

Critical Issue #3 — Meaningful Community Integration

- Need for education and job training opportunities for youth and adults with a disability.
- Need for employer engagement and collaboration.
- Need for volunteer or continued employment opportunities for older Nevadans.
- Need for a variety of living options outside of institutional care.
- Need for more support for caregivers of older Nevadans and persons with disabilities.
- Need for social interaction opportunities and safe environments.
- Need for health and behavioral health prevention, identification and services.
- Need for additional access to education and training to more fully engage in their community.

Critical Issue #4 Strengthening Other Systems to Address Barriers

- Need for sufficient, qualified workforce to serve older Nevadans and persons with disabilities.
- Need for sufficient provider rates and systems to secure all necessary and available funding to meet need.
- Need for transportation to access services and achieve optimal quality of life.
- Need for safe, stable, and affordable community-based housing options.
- Need for affordable services which support older Nevadans and persons with disabilities.
- Need to align Nevada Department of Health and Human Services to an integrated service delivery model.

Critical Issue #5 Accountability

- Need for data and systems to ensure service delivery systems are accountable.
- Need for good customer service to be embedded throughout the service delivery systems.
- Need to establish measurable indicators and outcomes to assess quality.
- Need to link evidence-based practice to benchmarks and outcomes.

GOALS TO ADDRESS KEY ISSUES

The following goals have been established based on the critical issues as described in the preceding section.

Goal #1 Strong, Supportive Systems

- Fund and implement an integrated, high-quality, person-centered service delivery system.

Goal #2 Access and Engagement

- Facilitate timely, responsive services to achieve person-directed goals.

Goal #3 Meaningful Community Integration

- Increase opportunities and supports that promote social connection and enhance self-determination and personal dignity.

Goal #4 Strengthening Other Systems to Address Barriers

- Expand systems and supports to ensure that older adults and persons with disabilities have the opportunity to achieve optimal quality of life in the community of their choice.

Goal #5 Accountability

- Establish and report on Nevada's progress to implement an integrated, high-quality, person-centered service delivery culture across systems throughout the state with measurable indicators and outcomes that address the unmet need for services.
- Use data to drive quality improvement and decision making regarding resource allocation and policy within the state to meet the needs of Nevadans while upholding guiding principles and ensuring accountability for implementation of the plan.

Goals, Objectives, and Strategies

The goals, objectives, and strategies needed to achieve the mission of this plan include:

Goal #1: Strong, Supportive Systems

Fund and implement an integrated, high quality, person-centered service delivery system.

Outcomes/Objectives

- ✓ Provide person/family-centered planning for all consumers with the philosophy embedded in the culture and policies of the service delivery system.
- ✓ Promote integrated healthcare and healthy living options.
- ✓ Enhance and strengthen systems related to:
  1) Crisis services,
  2) Community-based supports,
  3) Community engagement and
  4) Cross-agency coordination of data and services.

Strategies	Implementation Plan
1. By June 30, 2018, identify valid, reliable, evidence-based comprehensive assessments with fidelity for children and adults implemented universally across systems.	1.a Research tools to assess persons holistically. 1.b Identify criteria for tool to implement across systems and all age groups. 1.c Select tool to implement statewide. 1.d Pilot implementation of tool. 1.e Create implementation plan for adoption throughout the state.

Goal #1: Strong, Supportive Systems Fund and implement an integrated, high quality, person-centered service delivery system.	
2. By June 30, 2021, implement a self-determined, person-centered plan (PCP) that is informed by the assessment and reflective of the person and families' needs and choices.	2.a Ensure that the voice of stakeholders and consumer advocates in Nevada is reflected in the funding and delivery model of home and community-based services, such as consumer-directed care. 2.b Maximize informal supports and individual choice. 2.c Develop sufficient in-state resources including services for behaviorally complex and medically fragile care in order to reduce the number of out-of-state placements. Strengthen the evaluation process for out-of-state placements prior to placement occurring. 2.d Sustain regional, multi-disciplinary teams that include public guardianships, law enforcement, the judicial system, behavioral health, community-based service providers, and hospital discharge planners to implement policies to prevent unnecessary placements and promote hospital and emergency department diversion programs. 2.e Design and implement supports-based budgeting to deliver an array of options determined by the assessment with individual choice using a per person budget.
3. By June 30, 2021, ensure sufficient resources to implement a self-determined, person-centered plan by taking steps to maximize federal and other funding.	3.a Draw down Nevada's maximum allocation of vocational rehabilitation funding. 3.b Add all optional Medicaid state plan services that support community integration (such as 1915i, j and k habilitative services), applied behavioral analysis for all age groups, and services covered by waivers but not currently covered by the state plan. 3.c Use all funded waiver slots. 3.d Obtain sufficient slots to ensure no wait longer than 90 days. 3.e Review duration and intensity of services and supports. 3.f Develop cooperative agreements between intergovernmental entities to maximize investments and ensure timely, expedited service delivery including transitions between DHHS divisions, Department of Education and school districts, county social service agencies, Vocational Rehabilitation, Department of Public Safety, Department of Corrections. 3.g Develop formal agreements between public and private entities to maximize investments and ensure timely, expedited service delivery.

Goal #1: Strong, Supportive Systems Fund and implement an integrated, high quality, person-centered service delivery system.	
4. By December 31, 2019, implement systems and processes to identify unmet need and expand service delivery system to create a true continuum of care while allowing for innovation	4.a Evaluate existing state plan services to remove barriers. 4.b Support successful pilot projects or innovations to scale statewide to meet unmet needs, such as: • Temporary assistance for displaced seniors (TADS) • Taxi program • Children's mobile crisis response teams • Certified Community Behavioral Health Clinics 4.c Develop, implement and mandate an effective data sharing and management system that promotes data sharing across systems to ensure information follows the consumer, demonstrates benefits and efficiencies, and is subject to confidentiality laws.
5. By June 30, 2021, incentivize providers to deliver high-quality services with bonus-based rewards for performance	5.a Benchmark and rebalance provider rates each biennium, ensuring sufficient wages to caregivers. 5.b Establish realistic evidence-based requirements of licensing and certification for service providers. 5.c Promote license reciprocity for providers of needed services. 5.d Adopt and implement national standards of performance. 5.e Eliminate redundancies in oversight and modernize technology to assist in comprehensive oversight.
6. By June 30, 2019, amend NRS and NAC to eliminate barriers to accessing services	6.a Evaluate statutes and codes that inadvertently create barriers and expand criteria to provide an integrated system for serving physical, developmental, behavioral and mental health issues. 6.b Evaluate licensing requirements that are onerous and duplicative for providers to afford ease of access for facilities and providers to receive and maintain licensing. 6.c Evaluate professional licensing requirements that are onerous and exclusionary to promote reciprocity and scope of practice. 6.d Add evidence-based services to the state plan to serve those in need beyond age 21 and for children with diagnoses who would benefit from those services.

Goal #1: Strong, Supportive Systems

Fund and implement an integrated, high quality, person-centered service delivery system.

	6.e Maximize the ability of providers to offer 629 services for persons with disabilities such as taking vital signs, testing glucose, and changing catheters as well as other services in the least restrictive settings including those that are home and community-based. 6.f Review statutes and regulations pertaining to the utilization and collaborative leveraging of tax funded dollars. 6.g Explore the use of variances and exceptions as designated by DHHS Divisions.

Goal #2: Access and Engagement

Facilitate timely, responsive services to achieve person-directed goals

Outcomes/Objectives

- ✓ Implement No Wrong Door for consumers to access all available services.
- ✓ Improve access to services within 90 days of request or sooner as required by law or by established need.
- ✓ Eliminate wait list and reduce wait time for eligibility determination and needed services.
- ✓ Expand the continuum of care to prevent unnecessary institutionalization.
- ✓ Improve use of assistive technology to enhance individuals' quality of life.

Strategies	Implementation Plan
1. By June 30, 2019, ensure that all state contracted community service providers support the philosophy of Nevada's No Wrong Door (NWD) and implement NWD plan.	1.a Promote physical and virtual points of entry to facilitate access. 1.b Amend NRS and NAC to support NWD. 1.c Engage non-state funded providers in training related to NWD. 1.d Align efforts across Divisions within DHHS to support NWD.

Facilitate timely, responsive services to achieve person-directed goals	
2. By June 30, 2021, ensure equity of access	2.a Provide access to culturally and linguistically competent services. 2.b Ensure equity of access to all eligible individuals to address and minimize health disparities. 2.c Ensure access to assistive technology, translators, and interpreters to facilitate enrollment and service delivery. 2.d Maximize use of all available services. 2.e Evaluate the feasibility of expanding the independent contract model for delivery of personal care services.
3. By June 30, 2018, prevent unnecessary institutionalizations.	3.a Educate, coordinate, and enhance systems to intervene and prevent unnecessary institutionalization including the criminalization of persons with disabilities. 3.b Implement regional multi-disciplinary teams that includes public guardianships, law enforcement, the judicial system, behavioral health, community-based service providers, and hospital discharge planners to implement policies to prevent unnecessary entry to institutions.
4. By June 30, 2020, establish presumptive eligibility for Medicaid including Waivers.	4.a Research other states' implementation of presumptive eligibility. 4.b Engage DHCFP experts to evaluate presumptive eligibility opportunities for children with disabilities, adults with disabilities, and older Nevadans. 4.c Create plan to expedite eligibility and access to waivers across state services beginning with frail and elderly, persons with physical disabilities and then children with disabilities including autism. 4.d Implement technological processes to grant presumptive eligibility.

Goal #3: Meaningful Community Integration

Increase opportunities and supports that promote social connection and enhance self-determination and personal dignity.[1]

Outcomes/Objectives

- ✓ Develop and promote innovative opportunities to engage in lifelong learning and education.
- ✓ Improve transitions and life outcomes for individuals and their families.
- ✓ Improve transitions, employment outcomes, and choice of employment for all choosing to work regardless of age or disability.

Strategies	Implementation Plan
1. By June 30, 2018, support implementation of the Integrated Employment and WIOA Plans.	1.a Partner with Integrated Employment Subcommittee of Committee for Services for Persons with Disabilities (CSPD) to build provider capacity to serve persons with I/DD for work-based learning. 1.b Provide training and technical assistance to providers to develop a business plan that positions the providers to meet CMS final ruling. 1.c Expand provider base to increase options for people with disabilities. 1.d Engage business and industry to create jobs and volunteer opportunities in the community. 1.e Partner with Department of Education and Vocational Rehabilitation to implement pilot projects statewide to promote transitions to competitive, integrated employment. 1.f Provide ongoing peer and community support when competitive, integrated employment positions are secured. 1.g Promote education and training for persons with disabilities based on their person-centered plan.

[1] * Meaningful community integration is dependent on having places to live in the community as addressed in goal 5

Goal #3: Meaningful Community Integration Increase opportunities and supports that promote social connection and enhance self-determination and personal dignity.[1]	
2. By December 31, 2018, support caregivers to enable older Nevadans and persons with disabilities to remain in the community.	2.a Adopt policies to enable caregivers to obtain/retain employment. 2.b Increase respite options for caregivers. 2.c Increase other caregiver support options including companion care, personal care, homemaker services, support groups and information, and referral. 2.d Promote utilization of advanced directives. 2.e Promote utilization of durable power of attorney forms with providers.
3. By June 30, 2018, implement peer support programs throughout the service delivery system.	3.a Develop peer mentors/supports as a resource for individuals to navigate the service delivery system (aging persons and persons with disabilities including behavioral health). 3.b Ensure sufficient training and reimbursement to promote peer support programs. 3.c Educate individuals on options related to becoming a peer mentor. 3.d Promote peer mentors/support programs statewide with individuals, families and community-based services.
4. By June 30, 2018, engage key stakeholders who can play a role in preventing early institutionalization in accordance with the Olmstead Decision.	4.a Engage with Department of Education to establish policies and procedures to prevent or reduce early institutionalization in accordance with the Olmstead Decision. 4.b Engage with county agencies including juvenile justice and child protective services to establish policies and procedures to prevent or reduce early institutionalization in accordance with the Olmstead Decision. 4.c Implement policies and procedures to prevent or reduce early institutionalization.

Goal #3: Meaningful Community Integration Increase opportunities and supports that promote social connection and enhance self-determination and personal dignity.[1]	
5. By December 31, 2019, promote supports for older Nevadans at risk or in need of guardianship.	5.a Train law enforcement and prosecutors statewide to identify persons with dementia and in the area of elder abuse or neglect. 5.b Explore alternative solutions to guardianship including durable power of attorney. 5.c Support development and delivery of legal services to vulnerable older Nevadans who may be at risk of guardianships. 5.d Educate guardians on importance of social connection and community involvement and dignity of risk. 5.e Advocate for implementation of the recommendations from the Nevada Supreme Court's Commission on Guardianships. 5.f Support systems to implement self-advocacy and peer supported advocacy for those at risk of guardianship.
6. By December 31, 2020, make services and supports available to promote quality of life for individuals who don't access traditional services.	6.a Fund independent living services for persons without a vocational goal. 6.b Promote and implement policies to allow older Nevadans to age in place. 6.c Increase personal needs allowance minimum and percentage of income for nursing home residents. 6.d Allow higher earners to buy into Medicaid (Health insurance for working families, Ticket to Work).

Goal #4: Strengthening Other Systems to Address Barriers

Expand systems and supports to ensure that older adults and persons with disabilities have the opportunity to achieve optimal quality of life in the community of their choice.

Outcomes/Objectives

- ✓ Promote affordable and accessible housing within a community setting that provides a safe environment in which consumers are safe to engage with their community.
- ✓ Creation of flexible, timely transportation options.
- ✓ Strengthen workforce providing services and state systems.

Strategies	Implementation Plan
1. By December 31, 2019, partner with other state and county programs to develop affordable, accessible housing.	1.a Increase multi-generational service delivery solutions including development of affordable assisted living options including multi-generational, supportive matching of persons in need. 1.b Enhance community-based housing modification programs. 1.c Promote permanent supportive housing programs statewide.
2. By June 30, 2020, expand transportation solutions to be flexible and responsive to the unique needs of older Nevadans and persons with disabilities.	2.a Partner with existing traditional and non-traditional transportation providers to identify ways to increase transportation options. 2.b Promote ride-sharing alternatives statewide. 2.c Evaluate and advocate to change policies that create barriers to providing transportation. 2.d Work with stakeholders to reform taxi assistance programs throughout the state. 2.e Work with Medicaid to expand the scope of transportation services available to older Nevadans and persons with disabilities.
3. By December 31, 2017, work with Department of Corrections to establish policies and procedures to reduce segregation in accordance with the Olmstead Decision.	3.a Contact Department of Corrections to identify lead to evaluate policies. 3.b Conduct orientation on Olmstead. 3.c Create workgroup of SPAC/DPBH Olmstead planning group to meet with Department of Corrections lead. 3.d Evaluate policies and procedures in place for strengthening or revision. 3.e Draft policies and procedures to reduce segregation.

Goal #4: Strengthening Other Systems to Address Barriers Expand systems and supports to ensure that older adults and persons with disabilities have the opportunity to achieve optimal quality of life in the community of their choice.	
4. By December 31, 2017, develop sustainability plan for tobacco settlement funded programs.	4.a Identify planning team for sustainability planning process. 4.b Evaluate current funded programs to identify existing funding streams that could supplant tobacco settlement funds. 4.c Identify priorities for future funding based on services without other funding sources. 4.d Identify strategies to diversify funding for services dependent on tobacco settlement funds. 4.e Adopt plan.
5. By June 30, 2017, ensure that all personnel can practice at the top of their scope of practice or license including caregivers.	5.a Track current bill drafts to identify licensing changes proposed during 2017 legislative session. 5.b Advocate for bills that promote practicing at the top of scope of practice.
6. By June 30, 2019, strengthen geriatric studies curriculum across health and human service university studies including social workers, physicians, behavioral health providers, nurses.	6.a Meet with school districts to incorporate more geriatric-specific studies in high school career and technical programs. 6.b Meet with university and college representatives to assess current status of geriatric studies curriculum. 6.c Implement standard training practices to deliver geriatric-specific curriculum to direct service providers. 6.d Engage schools of social work to integrate geriatric studies into core curriculum. 6.e Engage schools of nursing to integrate geriatric studies curriculum into core curriculum. 6.f Promote partnerships between schools, universities, and behavioral health programs to deliver geriatric-specific training for behavioral health providers.

Goal #5: Accountability

- Establish and report on Nevada's progress to implement an integrated, high quality, person centered service delivery culture across systems throughout the state with measurable indicators and outcomes that address the unmet need for services.
- Use data to drive quality improvement and decision making regarding resource allocation and policy within the state to meet the needs of Nevadans while upholding guiding principles and ensuring accountability for the implementation of the plan.

Outcomes/Objectives

✓ Measure and report on National Core Indicators to demonstrate responsiveness to the needs of older Nevadans and persons with disabilities.
  - Those receiving services
  - Those on a wait list
  - Those in institutional settings
  - Those not receiving services or receiving them from informal systems

Strategies	Implementation Plan
1. By December 31, 2019, implement National Core Indicators to measure progress toward implementing the plan including client-centered satisfaction data.	1.a Develop program-level questions for National Core Indicators to measure program outcomes. 1.b Publish state dashboard reports and utilize results to inform policy. 1.c Link state dashboard data to program level results. 1.d Use data including NCI results to demonstrate accountability in implementing the plan and identify additional opportunities to achieve optimal quality of life in communities.
2. By June 30, 2020, develop recommendations for service delivery changes based on data collected and unmet need.	2.a Develop innovative, modernized technology systems to ensure accountability. 2.b Measure and report annually on the length of time it takes to access services and determine who doesn't receive services within 90 days. 2.c Measure and report annually on spot-check results of state and community-based services.

Goal #5: Accountability

- Establish and report on Nevada's progress to implement an integrated, high quality, person centered service delivery culture across systems throughout the state with measurable indicators and outcomes that address the unmet need for services.
- Use data to drive quality improvement and decision making regarding resource allocation and policy within the state to meet the needs of Nevadans while upholding guiding principles and ensuring accountability for the implementation of the plan.

Objective	Strategies
3. By June 30, 2017, with assessment ongoing, establish an advisory workgroup comprised of members of the COA and the CSPD with representation from DPBH to aid in implementing the DHHS plan for older Nevadans and persons with disabilities.	3.a Identify key stakeholder representation needed for Advisory workgroup. 3.b Identify process to select advisory workgroup members and terms of membership. 3.c Convene workgroup and orient members to determine scope of advice to provide on implementation of plan. 3.d Fund and secure an outside evaluator to assist the workgroup in evaluating implementation of the plan, unmet need, and progress in addressing Olmstead issues. 3.e Assess and report to the governor and legislature each January on the progress in implementing the plan for the previous calendar year. 3.f Revise plan annually based on results.
4. By June 30, 2017, promote the plan throughout DHHS.	4.a Schedule meetings with Division Administrators and Deputies to present the plan. 4.b Solicit feedback and ideas for implementation within Divisions. 4.c Provide feedback from Divisions to Advisory workgroup to incorporate into workgroup activities. 4.d Partner with DPBH to promote Olmstead throughout DHHS.

OUTCOMES AND ACCOUNTABILITY

The following outcomes are measurable indicators that will demonstrate achievement of the goals of this plan. Timing to accomplish the goals is listed by year, but progress toward the goals will be reported annually via the workgroup established to oversee implementation of this plan. Each outcome will include a baseline metric established in 2017 that will be used to measure progress. Outcomes were selected for their ability to be measured and the degree to which they serve as a proxy measure for multiple goals in the plan.

Outcomes	Target Date to Be Accomplished
1. The National Core Indicators Report for Aging and Disabilities demonstrates improvement or maintained levels in: a. Proportion of people who are involved in making decisions about their everyday lives including where they live, what they do during the day, the staff that supports them, and with whom they spend time b. Proportion of people who have adequate transportation c. Proportion of people who get needed assistive devices (wheelchairs, grab bars, home modifications, etc.) d. Proportion of people who feel safe at home e. Proportion of people who have access to mental health services when they need them f. Proportion of people who can choose or change the kind of services they receive and who provides them	2018
2. Competitive provider rates in place	2019
3. Performance-based contracts in place	2019
4. Presumptive eligibility for Medicaid including waivers	2020
5. Decrease in percentage of unmet need for services in this plan	2020
6. Increased competitive integrated employment rate for persons with disabilities	2020
7. Increased consumer satisfaction within DHHS for total population seeking services	2020
8. Reduction in out-of-state placements	2021
9. Reduction in numbers institutionalized[2] in Nevada	2021
10. Wait times for services less than 90 days	2021

[2] Including those unnecessarily segregated, such as individuals residing in facilities for I/DD, psychiatric hospitals, nursing homes and board and care homes, or individuals spending their days in sheltered workshops or segregated day programs.

Priorities Moving Forward

The following timeline is based on the implementation steps needed to accomplish the strategies for each goal.

Timeline of Activities

Goal #1: Strong, Supportive Systems

Fund and implement an integrated, high quality, person-centered service delivery system

1. By June 30, 2018, identify valid, reliable, evidence-based comprehensive assessments with fidelity for children and adults implemented universally across systems.
2. By June 30, 2021, implement a self-determined, person-centered plan (PCP) that is informed by the assessment and reflective of the person and families' needs and choices.
3. By June 30, 2021, ensure sufficient resources to implement a self-determined, person-centered plan by taking steps to maximize federal and other funding.
4. By December 31, 2019, implement systems and processes to identify unmet need and expand service delivery system to create a true continuum of care while allowing for innovation.
5. By June 30, 2021, incentivize providers to deliver high-quality services with bonus-based rewards for performance.

Goal #2: Access and Engagement

Facilitate timely, responsive services to achieve person-directed goals

1. By June 30, 2019, ensure that all state contracted community service providers support the philosophy of No Wrong Door and implement Nevada's No Wrong Door (NWD) plan.
2. By June 30, 2021, ensure equity of access to all eligible individuals to address and minimize disparities in accessing care.
3. By June 30, 2018, prevent unnecessary institutionalizations.
4. By June 30, 2020, establish presumptive eligibility for Medicaid including waivers.

Goal #3: Meaningful Community Integration

Increase opportunities and supports that promote social connection and enhance self-determination and personal dignity.[3]

1. By June 30, 2018, support implementation of the Integrated Employment and WIOA Plans.
2. By December 31, 2018, support caregivers to enable older Nevadans and persons with disabilities the ability to remain in the community.
3. By June 30, 2018, implement peer support programs throughout the service delivery system.
4. By June 30, 2018, engage key stakeholders who can play a role in preventing early institutionalization in accordance with the Olmstead Decision.
5. By December 31, 2019, promote supports for older Nevadans at risk or in need of guardianship.
6. By December 31, 2020, make services and supports available to promote quality of life for individuals who don't access traditional services.

Goal #4: Strengthening Other Systems to Address Barriers

Expand systems and supports to ensure that older adults and persons with disabilities have the opportunity to achieve optimal quality of life in the community of their choice.

1. By December 31, 2019, partner with other state and county programs to develop affordable, accessible housing.
2. By June 30, 2020, expand transportation solutions to be flexible and responsive to the unique needs of older Nevadans and persons with disabilities.
3. By December 31, 2017, work with Department of Corrections to establish policies and procedures to reduce segregation in accordance with the Olmstead Decision.
4. By December 31, 2017, develop sustainability plan for tobacco settlement-funded programs.
5. By June 30, 2017, ensure that all personnel can practice at the top of their scope of practice or license including caregivers.
6. By June 30, 2019, strengthen geriatric studies curriculum across health and human service university studies including social workers, physicians, behavioral health providers, and nurses.

[3] * Meaningful community integration is dependent on having places to live in the community as addressed in goal 5

Goal #5: Accountability

- Establish and report on Nevada's progress to implement an integrated, high quality, person centered service delivery culture across systems throughout the state with measurable indicators and outcomes that address the unmet need for services.
- Use data to drive quality improvement and decision making regarding resource allocation and policy within the state to meet the needs of Nevadans while upholding guiding principles and ensuring accountability for the implementation of the plan.

1. By December 31, 2019, implement National Core Indicators to measure progress toward implementing the plan including client-centered satisfaction data.
2. By June 30, 2020, develop recommendations for service delivery changes based on data collected and unmet need.
3. By June 30, 2017, with assessment ongoing, establish an advisory workgroup comprised of members of the COA and the CSPD with representation from DPBH to aid in implementing the DHHS plan for older Nevadans and persons with disabilities.
4. By June 30, 2017, promote the plan throughout DHHS.

APPENDICES

Appendix A – Definitions

Older Nevadan and Persons with Disabilities

An older person is defined in Nevada law as a person who is 60 years of age or older.

Persons with disabilities: Federal laws define a person with a disability as "Any person who has a physical or mental impairment that substantially limits one or more major life activities; has a record of such impairment; or is regarded as having such an impairment."

The 2016 Older Americans Act Reauthorization Act of 2016 (OAA Act) reauthorizes programs for FY 2017 through FY 2019. It includes provisions that aim to protect vulnerable elders by strengthening the Long-Term Care Ombudsman program and elder abuse screening and prevention efforts. It also promotes the delivery of evidence-based programs, such as falls prevention and chronic disease self-management programs.[4]

Vulnerable Persons

NRS 200.5091 Policy of State. It is the policy of this State to provide for the cooperation of law enforcement officials, courts of competent jurisdiction and all appropriate state agencies providing human services in identifying the abuse, neglect, exploitation, isolation and abandonment of older persons and vulnerable persons through the complete reporting of abuse, neglect, exploitation, isolation and abandonment of older persons and vulnerable persons.

(Added to NRS by 1981, 1334; A 1997, 1348; 2005, 1107; 2015, 804)

NRS 200.5092 Definitions. As used in NRS 200.5091 to 200.50995, inclusive, unless the context otherwise requires:

1. "Abandonment" means:

(a) Desertion of an older person or a vulnerable person in an unsafe manner by a caretaker or other person with a legal duty of care; or

(b) Withdrawal of necessary assistance owed to an older person or a vulnerable person by a caretaker or other person with an obligation to provide services to the older person or vulnerable person.

2. "Abuse" means willful:

(a) Infliction of pain or injury on an older person or a vulnerable person;

(b) Deprivation of food, shelter, clothing or services which are necessary to maintain the physical or mental health of an older person or a vulnerable person;

(c) Infliction of psychological or emotional anguish, pain or distress on an older person or a vulnerable person through any act, including, without limitation:

[4] Retrieved on November 17, 2016 from: http://www.aoa.acl.gov/AoA_Programs/OAA/Reauthorization/2016/Index.aspx

(1) Threatening, controlling or socially isolating the older person or vulnerable person;

(2) Disregarding the needs of the older person or vulnerable person; or

(3) Harming, damaging or destroying any property of the older person or vulnerable person, including, without limitation, pets;

(d) Nonconsensual sexual contact with an older person or a vulnerable person, including, without limitation:

(1) An act that the older person or vulnerable person is unable to understand or to which the older person or vulnerable person is unable to communicate his or her objection; or

(2) Intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh or buttocks of the older person or vulnerable person; or

(e) Permitting any of the acts described in paragraphs (a) to (d), inclusive, to be committed against an older person or a vulnerable person.

3. "Exploitation" means any act taken by a person who has the trust and confidence of an older person or a vulnerable person or any use of the power of attorney or guardianship of an older person or a vulnerable person to:

(a) Obtain control, through deception, intimidation or undue influence, over the older person's or vulnerable person's money, assets or property with the intention of permanently depriving the older person or vulnerable person of the ownership, use, benefit or possession of his or her money, assets or property; or

(b) Convert money, assets or property of the older person or vulnerable person with the intention of permanently depriving the older person or vulnerable person of the ownership, use, benefit or possession of his or her money, assets or property.

As used in this subsection, "undue influence" means the improper use of power or trust in a way that deprives a person of his or her free will and substitutes the objectives of another person. The term does not include the normal influence that one member of a family has over another.

4. "Isolation" means preventing an older person or a vulnerable person from having contact with another person by:

(a) Intentionally preventing the older person or vulnerable person from receiving visitors, mail or telephone calls, including, without limitation, communicating to a person who comes to visit the older person or vulnerable person or a person who telephones the older person or vulnerable person that the older person or vulnerable person is not present or does not want to meet with or talk to the visitor or caller knowing that the statement is false, contrary to the express wishes of the older person or vulnerable person and intended to prevent the older person or vulnerable person from having contact with the visitor;

(b) Physically restraining the older person or vulnerable person to prevent the older person or vulnerable person from meeting with a person who comes to visit the older person or vulnerable person; or

(c) Permitting any of the acts described in paragraphs (a) and (b) to be committed against an older person or a vulnerable person.

The term does not include an act intended to protect the property or physical or mental welfare of the older person or vulnerable person or an act performed pursuant to the instructions of a physician of the older person or vulnerable person.

5. "Neglect" means the failure of a person or a manager of a facility who has assumed legal responsibility or a contractual obligation for caring for an older person or a vulnerable person or who has voluntarily assumed responsibility for his or her care to provide food, shelter, clothing or services which are necessary to maintain the physical or mental health of the older person or vulnerable person.

6. "Older person" means a person who is 60 years of age or older.

7. "Protective services" means services the purpose of which is to prevent and remedy the abuse, neglect, exploitation, isolation and abandonment of older persons. The services may include:

(a) The investigation, evaluation, counseling, arrangement and referral for other services and assistance; and

(b) Services provided to an older person or a vulnerable person who is unable to provide for his or her own needs.

8. "Vulnerable person" means a person 18 years of age or older who:

(a) Suffers from a condition of physical or mental incapacitation because of a developmental disability, organic brain damage or mental illness; or

(b) Has one or more physical or mental limitations that restrict the ability of the person to perform the normal activities of daily living.

(Added to NRS by 1981, 1334; A 1983, 1359, 1652; 1995, 2250; 1997, 1348; 1999, 3517; 2003, 491; 2005, 1108; 2015, 804)

Types of Disabilities

NRS 426.068 "Disability" defined. "Disability" means, with respect to a person:

1. A physical or mental impairment that substantially limits one or more of the major life activities of the person;
2. A record of such an impairment; or
3. Being regarded as having such an impairment.

(Added to NRS by 2003, 2973)

NRS 426.082 "Person who is blind" defined. "Person who is blind" means any person whose visual acuity with correcting lenses does not exceed 20/200 in the better eye, or whose vision in the better eye is restricted to a field which subtends an angle of not greater than 20°.

(Added to NRS by 1981, 1916)—(Substituted in revision for NRS 426.041)

NRS 426.520 "Person who is blind" further defined. "Person who is blind" means a person described in NRS 426.082 and any person who by reason of loss or impairment of eyesight is unable to provide himself or herself with the necessities of life, and who has not sufficient income of his or her own to maintain himself or herself.

(Added to NRS by 1957, 781; A 1959, 148; 1963, 920; 1965, 771; 1967, 1162; 1973, 1388; 1981, 1917; 2005, 114)

NRS 426.084 "Person who is deaf" defined. "Person who is deaf" means any person who, by reason of the loss or impairment of hearing, has an aural disability which limits, contributes to limiting or which, if not corrected, will probably result in limiting the activities or functions of the person.

(Added to NRS by 1981, 1916; A 2003, 2630)—(Substituted in revision for NRS 426.055)

NRS 426.431 "Person with a permanent disability" defined. "Person with a permanent disability" means a person:

1. With a disability which limits or impairs the ability to walk, as defined in NRS 482.3835; and
2. Whose disability has been certified by a licensed physician as irreversible.

(Added to NRS by 1999, 1158)

NRS 427A.029 "Frail elderly person" defined. "Frail elderly person" means a natural person 65 years of age or older who:

1. Has a physical or mental limitation that restricts the ability of the person to live independently and carry out activities of normal daily living; and
2. Has been or is at risk of being placed in a facility for long-term care.

(Added to NRS by 1987, 973)

NRS 427A.122 "Elderly person" defined. As used in NRS 427A.122 to 427A.1236, inclusive, unless the context otherwise requires, "elderly person" means a person who is 60 years of age or older.

(Added to NRS by 1999, 126)

NRS 427A.791 "Person with a physical disability" defined. As used in NRS 427A.791, 427A.793 and 427A.795, unless the context otherwise requires, "person with a physical disability" means a person with a physical disability that substantially limits the person's ability to participate and contribute independently in the community in which he or she lives.

(Added to NRS by 2009, 2384)

NRS 427A.7951 "Person with a disability who needs independent living services" defined. As used in NRS 427A.7951 to 427A.7957, inclusive, unless the context otherwise requires, "person with a disability who needs independent living services" means a person with a physical disability, as that term is defined in NRS 427A.791, including, without limitation, a person who is blind, as that term is defined in NRS 426.082, who is in need of independent living services and who does not have a vocational goal.

(Added to NRS by 2015, 1432)

NRS 427A.800 “Traumatic brain injury” defined. As used in this section and NRS 427A.850 and 427A.860, “traumatic brain injury” means a sudden shock or damage to the brain or its coverings which is not of a degenerative nature and produces an altered state of consciousness or temporarily or permanently impairs the mental, cognitive, behavioral or physical functioning of the brain. The term does not include:

1. A cerebral vascular accident;
2. An aneurism; or
3. A congenital defect.

(Added to NRS by 2009, 2393; A 2013, 216)

NRS 427A.865 “Missing endangered older person” defined. “Missing endangered older person” means a person who is 60 years of age or older whose whereabouts are unknown and who:

1. Has been diagnosed with a medical or mental health condition that places the person in danger of serious physical harm or death; or
2. Is missing under suspicious or unexplained circumstances that place the person in danger of serious physical harm or death.

(Added to NRS by 2011, 829)

NRS 433.099 “Intellectual disability” defined. “Intellectual disability” means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

(Added to NRS by 1975, 1591; A 2013, 662) — (Substituted in revision for NRS 433.174)

NRS 433.164 “Mental illness” defined. “Mental illness” (as currently defined in NRS) means a clinically significant disorder of thought, mood, perception, orientation, memory or behavior which:

1. Is listed in the most recent edition of the clinical manual of the International Classification of Diseases, ICD-9-CM, code range 295 to 302.9, inclusive, 306 to 309.9, inclusive, or 311 to 316, inclusive, or the corresponding code in the most recent edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, Axis I; and
2. Seriously limits the capacity of a person to function in the primary aspects of daily living, including, without limitation, personal relations, living arrangements, employment and recreation.

(Added to NRS by 1975, 1591; A 2003, 1941)

NRS 435.007 Definitions. As used in this chapter, unless the context otherwise requires:

1. “Administrative officer” means a person with overall executive and administrative responsibility for those state or nonstate intellectual disability centers designated by the Administrator.
2. “Administrator” means the Administrator of the Division.
3. “Child” means any person under the age of 18 years who may be eligible for intellectual disability services or services for a related condition.
4. “Department” means the Department of Health and Human Services.
5. “Director of the Department” means the administrative head of the Department.
6. “Division” means the Aging and Disability Services Division of the Department.
7. “Division facility” means any unit or subunit operated by the Division for the care, treatment and training of consumers.
8. “Intellectual disability” means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.
9. “Intellectual disability center” means an organized program for providing appropriate services and treatment to persons with intellectual disabilities and persons with related conditions. An intellectual disability center may include facilities for residential treatment and training.
10. “Medical director” means the chief medical officer of any program of the Division for persons with intellectual disabilities and persons with other related conditions.
11. “Mental illness” has the meaning ascribed to it in NRS 433.164.
12. “Parent” means the parent of a child. The term does not include the parent of a person who has attained the age of 18 years.
13. “Person” includes a child and any other consumer with an intellectual disability or a related condition who has attained the age of 18 years.
14. “Person professionally qualified in the field of psychiatric mental health” has the meaning ascribed to it in NRS 433.209.
15. “Persons with related conditions” means persons who have a severe, chronic disability which:
    (a) Is attributable to:
        (1) Cerebral palsy or epilepsy; or
        (2) Any other condition, other than mental illness, found to be closely related to an intellectual disability because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual disability and requires treatment or services similar to those required by a person with an intellectual disability;
    (b) Is manifested before the person affected attains the age of 22 years;
    (c) Is likely to continue indefinitely; and
    (d) Results in substantial functional limitations in three or more of the following areas of major life activity:

(1) Taking care of oneself;
(2) Understanding and use of language;
(3) Learning;
(4) Mobility;
(5) Self-direction; and
(6) Capacity for independent living.

16. "Residential facility for groups" means a structure similar to a private residence which will house a small number of persons in a homelike atmosphere.
17. "Training" means a program of services directed primarily toward enhancing the health, welfare and development of persons with intellectual disabilities and persons with related conditions through the process of providing those experiences that will enable the person to:
    (a) Develop his or her physical, intellectual, social and emotional capacities to the fullest extent;
    (b) Live in an environment that is conducive to personal dignity; and
    (c) Continue development of those skills, habits and attitudes essential to adaptation in contemporary society.
18. "Treatment" means any combination of procedures or activities, of whatever level of intensity and whatever duration, ranging from occasional counseling sessions to full-time admission to a residential facility.

(Added to NRS by 1975, 1617; A 1979, 1325; 1981, 1579; 1985, 1761; 1999, 2594; 2011, 435; 2013, 669, 3032)

No Wrong Door

No Wrong Door **(NWD) is a philosophical approach to services.** It supports streamlined access to long-term services and supports (LTSS) for older adults and individuals with disabilities.

NWD systems are *"designed to serve as highly visible and trusted places where people of all ages, incomes and disabilities get information and one-on-one person-centered counseling on the full range of LTSS options."*

Olmstead Decision[5]

On June 22, 1999, the United States Supreme Court held in Olmstead v. L.C. that unjustified segregation of persons with disabilities constitutes discrimination in violation of title II of the Americans with Disabilities Act. The Court held that public entities must provide community-based services to persons with disabilities when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be

[5] Retrieved on September 19, 2016 from: https://www.ada.gov/olmstead/olmstead_about.htm

reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity.

The Supreme Court explained that its holding "reflects two evident judgments." First, "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable of or unworthy of participating in community life." Second, "confinement in an institution[6] severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."

Person-centered Planning

Person-centered planning is a process-oriented approach to empowering people with disability labels. It focuses on the people and their needs by putting them in charge of defining the direction for their lives, not on the systems that may or may not be available to serve them. This ultimately leads to greater inclusion as valued members of both community and society.

The term "person-centered plan" is used in many fields (e.g. health care, nursing care, aging, mental health, employment, education). Although the details of person-centered planning are expressed differently in these contexts, all of these approaches aid practitioners and communities in developing whole life, person-driven approaches to supporting people who experience barriers to full engagement in community living. The fundamental principle is that government and service providers begin by listening to individuals about what is important to them in creating or maintaining a personally-valued, community life. Planning of supports and services is not driven or limited by professional opinion or available service options but focused on the person's preferences and whole life context. Effective support and services are identified to help people live, learn, work, and participate in their preferred communities and on their own terms. Many state and federal policies now mandate person-centered delivery of long-term services and supports. In January 2014, the Centers for Medicare and Medicaid Services (CMS) issued a rule that applies to all Home and Community-Based Services; this rule provides a description of a person-centered service plan. The full rule, 42 CF.R. Pt. 430, 431 et al, is available at http://www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf (§441.725 contains the description of a person-centered service plan).

[6] Note that for the purposes of this plan, institutions are defined to include schools, jails, prisons, hospitals, nursing homes, sheltered workshops and other settings that are not based or integrated in the community.

Appendix B – Value Proposition

According to the National Council on Disability (NCD), an independent federal agency, "Individuals with complex needs can be effectively served in community settings in a cost-efficient manner." NCD notes it is challenging to compare institutional versus community settings costs because providing services to individuals with more complex behavioral and medical needs costs more than providing services to people with greater independent functional skills. This gets further complicated when you compare people with intellectual or developmental disabilities (I/DD) who are integrated into the community to the higher proportion of people in institutions who have complex medical or psychological needs. NCD goes on to note that the "disparity increases throughout the process of deinstitutionalization as the residents of institutions with the least complex disabilities often transition before those with more complex or coexisting disabilities."

Community-based services include a broad combination of service types, from minimal intermittent supports to residential and day program services, whereas institutions traditionally offer an established service package. This makes comparison difficult because often only a part of the range of community services is comparable with the services received in a large institutional setting.

People who oppose deinstitutionalization argue that a cost comparison must look at what the same services provided in the institution would cost in the community (Walsh, 2003). However, that comparison isn't appropriate as often when someone is discharged from an institution because they don't require the same exact services they needed in the institution. Because institutions provide an established set of services, they may be providing services the person does not want or need, and fail to provide things the person may require to live more independently in the community. Ultimately, the plan should encompass everything the person must have in order to be healthy and safe in the community.

Medicaid HCBS Waivers cover the cost of services provided in a community-based residential setting but do not cover room and board. In most cases, residents pay a large portion of their Social Security Disability Insurance Income or Supplemental Security Income to cover the cost of housing. Additional funding may come from state or federal housing funds and other state funds.

Even when comparing the costs of institutional and community-based care, including all funding streams, researchers find community care is less costly. For example, Lakin et al. (2008) used data from the National Core Indicators project and Medicaid cost data to study the relative cost of HCBS and ICF/DD. The findings indicated that HCBS Waiver services, including other Medicaid services (medical, prescription drugs, social services, personal care, etc.) were substantially less costly than ICF/DD services. The differences were evident not only in overall average expenditures but also in virtually all comparisons for individuals with similar characteristics.

Cost-effectiveness is possible for three basic reasons:

- Despite the level of need exhibited by people currently living in institutions, states have had great success (as measured by independent means) providing effective care in the community without some of the clinical services and physical plant features required by regulation in the institutions (Gettings, 2003).
- Once person-centered planning is fully developed, states are finding that a significant number of people with developmental disabilities and their families or guardians begin to request less intense levels of specialized care over time than typically is provided in institutions (Gettings, 2003).
- One of the major costs of providing services and a major component of the cost differential between institutional and community-based care as well as the variation across states is staffing level and cost of staff. As highlighted in many studies over time, from the Pennhurst study (Conroy and Bradley, 1985) to more recent studies (Stancliffe and Lakin, 2005), there are significant differences in salary and benefit levels between institution and community-based services because generally, public employees are unionized and have richer compensation packages than community-based staff. Advocates need to be aware of this disparity. The low pay and benefits for the direct care workforce in the community often lead to high turnover rates and vacancies.

Gettings, R. M., R. Cooper, and M. Chmura. (2003). Financing Services to Individuals with Developmental Disabilities in the State of Illinois. National Association of State Directors of Developmental Disabilities Services, Inc. Accessed January 25, 2011. http://www.state.il.us/agency/icdd/communicating/publications.htm

Average Annual Cost of State Institutions Compared to HCBS Waiver Services by State, 2009

	State Institutions*	Home and Community-based Waiver Services*
Nevada	$182,865	$45,941

Source: *Lakin et al. (2010); **HCBS per service recipient extracted from http://rtc.umn.edu/risp/build/index.asp

In essence, for every dollar spent on HCBS services, Nevada would save three dollars for institutional care.

A Georgia study found that providing comprehensive mental health services to mentally ill people involved in the criminal justice system cut the number of days that participants spent in the hospital by 89%, and the number of days spent in jail by 78%. In all, the program saved more than $1 million in its first year.

A study comparing the community-based, long-term care program called Aging in Place (AIP) and nursing home care in terms of cost to the Medicare and Medicaid programs found that total Medicare and Medicaid costs were $1,591.61 lower per month in the AIP group ($p < 0.01$) when

compared with the nursing home group over a 12-month period. The findings suggest that the provision of nurse-coordinated HCBS and Medicare home health services has potential to provide savings in the total cost of health care to the Medicaid program while not increasing the cost of the Medicare program.

Aging in Place Versus Nursing Home Care Comparison of Costs to Medicare and Medicaid, Research in Gerontological Nursing 5(2):123-9 · August 2011 DOI: 10.3928/19404921-20110802-01

A jail diversion program in Massachusetts serving 200 mentally ill people — at an initial cost of $400,000 — saved $1.3 million in emergency health services and jail costs, according to the Massachusetts Department of Mental Health.

Studies that Support the Value Proposition

1. H. Stephen Kaye, Charlene Harrington, and Mitchell P. LaPlante. 2010. "Long-Term Care: Who Gets it, Who Provides it, and How Much?" *Health Affairs* 29:1, 17–8, 21.
2. MetLife Mature Market Institute. 2012. "Market Survey of Long-Term Care Costs," 4.
3. Federal Interagency Forum on Aging-Related Statistics. 2012. "Older Americans 2012: Key Indicators of Well-Being," 57.
4. Kaye et al., 2010, 18.
5. U.S. Department of Health and Human Services. 2013. "What's Medicare?" 1–4
6. Mitchell LaPlante. 2013. "The Woodwork Effect in Medicaid Long-Term Services and Supports," *Journal of Aging &Social Policy*, 25:2, 161–80.
7. Karen Dorman Marek, Frank Stetzer, Scott J. Adams, Lori L. Popejoy, and Marilyn Rantz. 2012. "Aging in Place Versus Nursing Home Care: Comparison of Costs to Medicare and Medicaid," *Research in Gerontological Nursing* 5:2, 123–9.
8. Terence Ng, Charlene Harrington, and Martin Kitchener. 2010. "Medicare and Medicaid in Long-Term Care." *Health Affairs* 29:1, 22–8.
9. Martin Kitchener, Terence Ng, Nancy Miller, and Charlene Harrington. 2006. "Institutional and Community-Based Long-Term Care," *Journal of Health and Social Policy* 22:2, 31–50.
10. H. Stephen Kaye, Mitchell P. LaPlante, and Charlene Harrington. 2009. "Do Noninstitutional Long-Term Care Services Reduce Medicaid Spending?" *Health Affairs* 28:1, 262–72.
11. Kitchener et al., 2006.
12. Janet O'Keeffe, Paul Saucier, Beth Jackson, Robin Cooper, Ernest McKenney, Suzanne Crisp, and Charles Moseley. 2010. "Understanding Medicaid Home and Community Services: A Primer," 21–36; Allen J. LeBlanc, M. Christine Tonner, and Charlene Harrington. 2001. "State Medicaid Programs Offering Personal Care Services," Health Care Financing Review 22:4, 155–73.
13. Pamela Doty. 2000. "Cost-Effectiveness of Home and Community-Based Long-Term Care Services," U.S. Department of Health and Human Services.
14. Andrea Wysocki, Mary Butler, Robert L. Kane, Rosalie A. Kane, Tetyana Shippee, and Francois Sainfort. 2012. "Long-Term Care for Older Adults: A Review of Home and Community-Based Services Versus Institutional Care," Comparative Effectiveness Review No.81.

15. R. Kane and R. Ladd. 1998. "The Heart of Long-Term Care," New York: Oxford University Press. As cited in Doty, 2000.

16. Kaye et al., 2009.

17. Kitchener et al., 2006.

18. Karen Dorman Marek, Lori Popejoy, Greg Petroski, David Mehr, Marilyn Rantz, and Wen-Chieh Lin. 2005. "Clinical Outcomes of Aging in Place," *Nursing Research*, 54:3, 202–11.

19. "Arizona Long Term Care System," County Supervisors Association of Arizona website (www.county-supervisors.org/uploads/ALTCS%20Overview.pdf). Accessed 31 October 2013.

20. Tanaz Petigara and Gerard Anderson. 2009. "Program of All-Inclusive Care for the Elderly," *Health Policy Monitor Survey* No.13.

Appendix C– List of Reports Reviewed in the Meta-Analysis

This following list includes all reports reviewed in the companion document, *Needs, Priorities and Recommendations: A Meta-analysis Summary Report for Services and Supports for Nevada's Aging Population and Persons with Disabilities, 2016.*

1. Department of Health and Human Services, Task Force on Alzheimer's disease. (2016) Task Force on Alzheimer's Disease Annual Report.
2. Nevada Department of Health and Human Services, Division of Public and Behavioral Health. (June 2015). *Nevada Substance Abuse, Mental Health and Suicide Prevention Needs Assessment Report 2015.*
3. Nevada Commission on Autism Spectrum Disorders. (2015) *Nevada Autism Spectrum Disorders Strategic Plan, 2015-2020.*
4. Packham, J., Griswold, T., Jorgensen, T., Ethchegoyhen, L., Marchand, C. (2016). *Physician Workforce in Nevada.* Reno, NV: University of Nevada, Reno.
5. Regional Transportation Commission. (2015) Coordinated Human Services Public Transportation Plan.
6. Nevada Taskforce on Integrated Employment. (2015) *Nevada's Strategic Plan on Integrated Employment: 2015-2025.*
7. Office of the Governor. (2016) Generations to Come: Nevada's Strategic Planning Framework, 2016-2020.
8. Nevada Department of Health and Human Services, Division of Public and Behavioral Health*. (2014). Behavioral Health Services System in the State of Nevada.*
9. Nevada's Aging and Disability Services Division. (2014). *Nevada's Strategic Plan for Integration of Developmental Services and Early Intervention Services into ADSD.*
10. Nevada Department of Health and Human Services, Division of Public and Behavioral Health. (2015). *Nevada Interagency Council on Homelessness: Strategic Plan.*
11. Social Entrepreneurs, Inc. (2015) Nevada's No Wrong Door Strategic Plan 2015-2018: Long Term Services and Supports.
12. State of Nevada and UNR School of Social Work. (2016) Nevada Children's System of Care Expansion Strategies.
13. Sanford Center for Aging. (2013). *Elders Count Nevada.* University of Nevada Reno.
14. Nevada Department of Health and Human Services. (2016). *2016 Statewide Community Needs Assessment.*
15. A) Washoe County Senior Services. (2014) Master Plan for Aging Services. Goals and Objectives.
    B) InfoSearch International. (2013) Understanding the Needs of Seniors in Washoe County, Nevada: A Random Survey of 600 Seniors Age 60+. Reno, Nevada.
16. Nevada Disability Advocacy & Law Center. (2014) Town Hall Meeting Summary Report: A Discussion of Services Needed by Individuals who are Blind or Visually Impaired.
17. Ramm, S. (2016) Nevada's Olmstead Report.

18. Records, T. (2015). Nevada and Olmstead – A Continuous Examination. July 17, 2015.
19. State of Nevada. (2016) Nevada's Integrated Workforce Plan: 2016-2021.
20. Interagency Council on Veterans Services. (2016) Nevada Veterans Comprehensive 2016 Report.
21. Health Services Advisory Group. (2015) State of Nevada, State Fiscal Year 2014-15, Provider Network Access Analysis.
22. Nevada Aging and Disability Services Division. (2016) State Plan for Aging Services October 1, 2016 – September 30, 2020.
23. Nevada State Department of Health and Human Services (DHHS) Office of Community Partnerships and Grants and Social Entrepreneurs, Inc. (2016) Nevada 2-1-1 Strategic Plan 2016-2020.
24. State of Nevada. (2016) Nevada State Systems Improvement Plan (SSIP), Part C, Phase II, Federal Fiscal Years 2014-2018.

Appendix D – Assessment of Goals from 2002 and 2003

A survey was administered electronically via key members of the Aging and Disabilities Services Strategic Planning and Accountability Committee Work Group. The purpose of the survey was to evaluate goals established in the 2003 and 2004 plans for persons with disabilities and older Nevadans. The assessment helped to develop a five-year, integrated Strategic Planning and Accountability Plan that would address key issues and strategies to guide Nevada toward accessible, person/family-centered systems that provide services when they are needed. A total of 130 participants responded to the survey.

Progress and Rank on Nevada's Goals

		Agree	Disagree
Goal 1	60% of the senior Nevadans who get publicly-funded long-term care are at home, while only 40% are in chronic care institutions. (56 respondents)	**25%**	**48%**
Goal 2	The hospital admission rate and average length of stay is 15% less than the baseline year, 2000. (46 respondents)	**24%**	**37%**
Goal 3	No Nevada seniors with Alzheimer's Disease are housed in out-of-state facilities. (46 respondents)	**17%**	**61%**
Goal 4	1,200 Nevada senior caregivers caring for a family member with a disability use at least one formal respite care option with benefits they and their families can depend on. (67 respondents)	**31%**	**45%**
Goal 5	The percentage of Nevada seniors 75+ who are severely disabled is less than the baseline year 1997. (40 respondents)	**13%**	**48%**
Goal 6	10,124 low-income seniors participating in the Senior Rx Program can afford the medications they need. (67 respondents) **(Ranked 3rd to be included in the next Strategic Plan)**	**30%**	**45%**
Goal 7	Nevada seniors participating in the expanded medication management program have fewer hospital admissions than they had prior to enrolling in the program. (45 respondents)	**20%**	**38%**
Goal 8	290,000 Nevada seniors can afford to pay for housing and utilities. (78 respondents) **(Ranked 1st to be included in the next Strategic Plan)**	**13%**	**71%**
Goal 9	700 Nevada seniors occupy public housing units that are fully accessible. (71 respondents)	**24%**	**51%**
Goal 10	19,300 frail Nevada seniors get where they need to go each year. (77 respondents) **(Ranked 4th to be included in the next Strategic Plan)**	**23%**	**60%**

		Agree	Disagree
Goal 11	85,000 Nevada seniors and their family members use a single point of entry system to access information and referral for the array of available services. (80 respondents)	**20%**	**54%**
Goal 12	9,120 frail or disabled Nevada seniors receive the care planning assistance and care management they need. (75 respondents)	**25%**	**43%**
Goal 13	10,650 low-income Nevada seniors use personal assistance and/or homemaker services. (66 respondents)	**29%**	**36%**
Goal 14	Social policy, program structure, regulation and planning affecting the lives of children and adults with disabilities will fully reflect their views, culture, and involvement. (85 respondents)	**31%**	**44%**
Goal 15	Service provision to people with disabilities in the most integrated, appropriate settings will be assured through the application and resulting service plans of individualized, setting- neutral assessments and expedited service entry. (89 respondents)	**21%**	**46%**
Goal 16	Children and adults with disabilities of all ages will receive services expeditiously and in the most integrated environments appropriate to their needs. (91 respondents) **(Ranked 2nd to be included in the next Strategic Plan)**	**23%**	**55%**
Goal 17	Children and adults with unique needs will obtain services in a timely and appropriate manner. (93 respondents) **(Ranked 5th to be included in the next Strategic Plan)**	**18%**	**61%**
Goal 18	The risk of institutionalization will be decreased in the general disability population by improving and protecting critical health care services. (89 respondents)	**30%**	**35%**
Goal 19	Children and adults with disabilities will not be placed at risk of institutionalization while living independently and/or inclusively in their communities for lack of adequate information and support and will easily and appropriately access the services they require. (93 respondents)	**20%**	**53%**
Goal 20	People with disabilities and families of children with disabilities will knowledgeably and appropriately choose and direct the services they receive and receive them at each critical juncture of life. (92 respondents)	**24%**	**42%**
Goal 21	The state system of service delivery and long-term care will be managed and monitored so that services in most integrated settings become the norm throughout Nevada. (87 respondents)	**24%**	**49%**

		Agree	Disagree
Goal 22	Independent in-state compliance monitoring and mediation of Olmstead and Americans with Disabilities Act issues will be funded and implemented. (72 respondents)	**26%**	**42%**

According to survey respondents, no goal from the 2003-04 plans has been fully accomplished and every goal was ranked by at least some respondents as a goal to be included in the 2016-21 strategic plan.