

The Nevada State Plan to Address Alzheimer's Disease
Status Report, June 2014

Recommendation 1:

Nevada's Care Connection: Aging and Disability Resource Center program



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Goal of the ADRC Program

- Offer one stop shop access to a seamless system of support that is consumer driven so individuals are empowered to make informed decisions about the services and supports they need or want.



Virtual Resource Center www.NevadaADRC.com

- The website provides urban, rural, and frontier consumers with access to information, services, and tools at any time of day, seven days a week (24/7).
- This web-based tool also serves a need for those who prefer internet-based access, as well as serving those whose geographic location limits walk-in access.

Virtual Resource Center

- Resource Directory
- Training and Education
- Learn About
- Sub-Sites

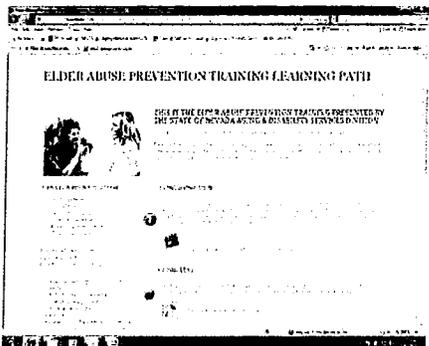
Home Page



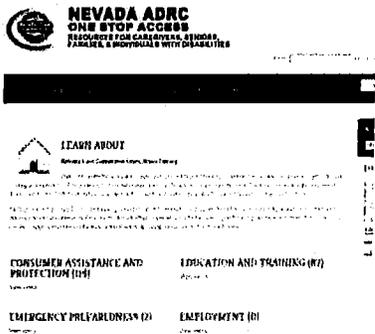
Resource Directory



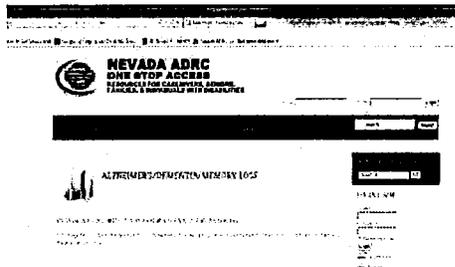
Training and Education



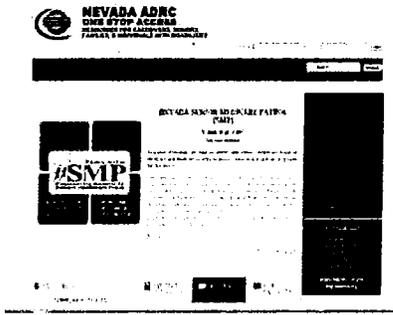
Learn About



Learn About – web links



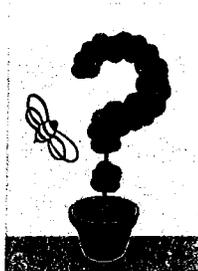
Sub-Sites



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www.nevadaadrc.com

Questions



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Recommendation 2:

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Recommendation 2: Nurse Practitioners

Description: Authorize Nurse Practitioners to have independent practices to provide better access to care.

Lead Person: Senator Valerie Wiener (Ret.)

Time Frame:

Comments: **01/15/20014.** AB 170, passed during the 2013 Legislative Session, allows Nurse Practitioners to have independent practices. State Board of Nursing to adopt regulations. At the next TFAD meeting, the Board will provide an update.

State Plan Area: Access to Services (Rural)

1. What is the current status?

Regulations have been promulgated and adopted: (<http://leg.state.nv.us/Register/2013Register/R114-13A.pdf>). The Board of Nursing is planning to submit a short regulation, which will add evidence of registration with Nevada's Prescription Monitoring Program to the required portfolio each Advanced Practice Registered Nurse (APRN) must maintain.

2. Suggestions to improve recommendation:

Not at this time. According to the Board of Nursing, it is too early to assess what additional legislation might be needed.

3. What are identified ways to achieve the recommendation?

The Board of Nursing is already seeing improvement in access to care, especially in rural areas because of AB 170.

4. Is legislative action necessary to achieve the recommendation?

Not at this time.

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Recommendation 3:

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No Update Is Available At This Time

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Recommendation 4:

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Recommendation 4: Remove Age Barriers

Description: Remove age barriers that typically keep people with younger-onset Alzheimer's disease and related disorders from receiving services. (Adopt language of the Older American's Act).

Lead Person: Senator Valerie Wiener

Time Frame:

Comments: **01/15/2014.** Passage of AB86 in the 2013 Legislative Session allows for younger-onset individuals with Alzheimer's disease to access respite services funded by the Fund for a Healthy Nevada. Could this work for Meals on Wheels?

State Plan Area: Access to Services (Early Onset)

1. What is the current status?

Assembly Bill 86 of the 2013 Legislative Session allowed respite care for ***informal caregivers, which includes families***, caring for someone under the age of 60 with Alzheimer's disease and other related dementia disorders. (NOTE: In the language above--"Comments"--it references services for *younger-onset individuals with Alzheimer's disease*.) AB 86 eliminated the age restriction that was then in statute. Prior to AB 86, the law did not provide respite services for this age group.

While working on this recommendation as a Task Force, created under Assembly Concurrent Resolution 10 of the 2011 Legislative Session, we learned that some families were so desperate for respite that they would drop off their loved ones at a hospital emergency room just so they could find a moment of peace in their own lives. It was clear then, as now, that the impact of Alzheimer's disease on the families of those afflicted can devastate them at many levels--emotionally, mentally, and physically--putting their own health and well-being at risk.

Therefore, AB 86, signed into law on May 21, 2013, provided essential respite services to these informal caregivers.

Of note, Maria Mazurowski, a caregiver who--along with her teenage daughter-- testified before both the ACR 10 Task Force and both houses of the legislature, was the first to access these respite services for herself and her three children (also full-time caregivers for their dad, who first experienced younger-onset Alzheimer's disease in his early 50s).

2. Suggestions to improve implementation.

Ruth Gay, who, as Director of Public Policy and Advocacy for the Alzheimer's Association of Northern California and Northern Nevada, served on the ACR 10 Task Force, recently shared this message with LCB staff (at my request to learn more about the status of this issue--and whether we need to make changes regarding services).

In her email to LCB's Roger McClellan, which he forwarded to me, Ruth shared:

"While the Aging Network has always been involved with meeting the needs of both care recipients and family caregivers, by creating the "National Family Caregiver Support Program," Congress explicitly recognized the important role that family caregivers occupy in our nation's long-term services and supports system. As of the 2006 Reauthorization of the Older Americans Act, the following specific populations of family caregivers are eligible to receive services:

Adult family members or other informal caregivers, age 18 and older, providing care to individuals of any age with Alzheimer's disease and related disorders.

Again, according to Ms. Gay:

"Each family caregiver presents his or her own unique needs and preferences for the types of programs and services they wish to receive at any given point in time. Further, the programs and services that are available vary from state to state and community to community. Fortunately, a number of national organizations and programs exist to help inform and support program development and innovation."

Recommendation: Based on the passage of AB 86--and federal law--my recommendation would be to continue working closely with DHHS to monitor the implementation of AB 86 to assess how well access to respite services is working. We should determine:

- How many informal caregivers have requested respite?
- How many have received it?
- How is this service being promoted to families and informal caregivers of younger-onset AD patients?
- What other services, provided by the Older Americans Act, are being accessed by informal caregivers, including families, of younger-onset Alzheimer's patients in Nevada? Provide number of requests, number of those receiving the services, and which services.

3. What are identified ways to achieve the recommendation?

Quarterly reports from DHHS on the four recommendations (see #2)

4. Is legislative action necessary to achieve the recommendation(s)?

Should not be required to accomplish these recommendations.

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Recommendation 5:



University of Nevada, Reno
Latino Outreach

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2012 Demographics

Race/Ethnic Origin	Clark County	Nevada
White (a)	73.22%	77.17%
Black or African American (a)	11.33%	8.93%
American Indian and Alaska Native (a)	1.22%	1.63%
Native Hawaiian and Other Pacific Islander (a)	0.83%	0.77%
Two or More Races	4.11%	3.83%
Hispanic or Latino (b)	22.83%	27.33%
White alone, multiHispanic or Latino	46.77%	52.93%

(a) includes persons reporting only one race.
 (b) Hispanics may be of any race, so also are included in applicable race categories.
 Source: Source U.S. Census Bureau, State and County QuickFacts. Data derived from
 Population Estimates, American Community Survey, Census of Population and Housing, State and County Housing
 Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners,
 Building Permits



Effective Outreach

- NCSC staff consulted with community stakeholders & national experts
- Organizations with current presence in Latino community
- Looking beyond healthcare and social service providers
- Determining target population
- Information/services available in Spanish
- Press

N

Effective Outreach cont.'d

- **NCSC examples: churches, possibly offering free screenings**
- **Plan to collaborate with Alzheimer's Association- Desert Southwest and Northern California Chapters, Nevada Lifespan Respite Coalition, Nevada Aging and Disability Services Division (ADSD)**

N

Barriers

- **Lack of awareness about available services**
- **Lack of services available in Spanish**
- **Pathology & burden-oriented language**
- **Informal support > formal support?**

N

Cultural Adaptation of Services

- **Culturally enhanced interventions are more effective in improving health outcomes (Barrera et al., 2013)**
- **5 stages within the cultural adaptation process**
 1. Information Gathering
 2. Preliminary Design
 3. Preliminary Testing
 4. Refinement
 5. Cultural Adaptation Trial

N

References

- Barrera, J. M., Castro, F. G., Strycker, L. A., & Toobert, D. J. (2013). Cultural adaptations of behavioral health interventions: A progress report. *Journal of Consulting and Clinical Psychology, 81*(2), 196-205.

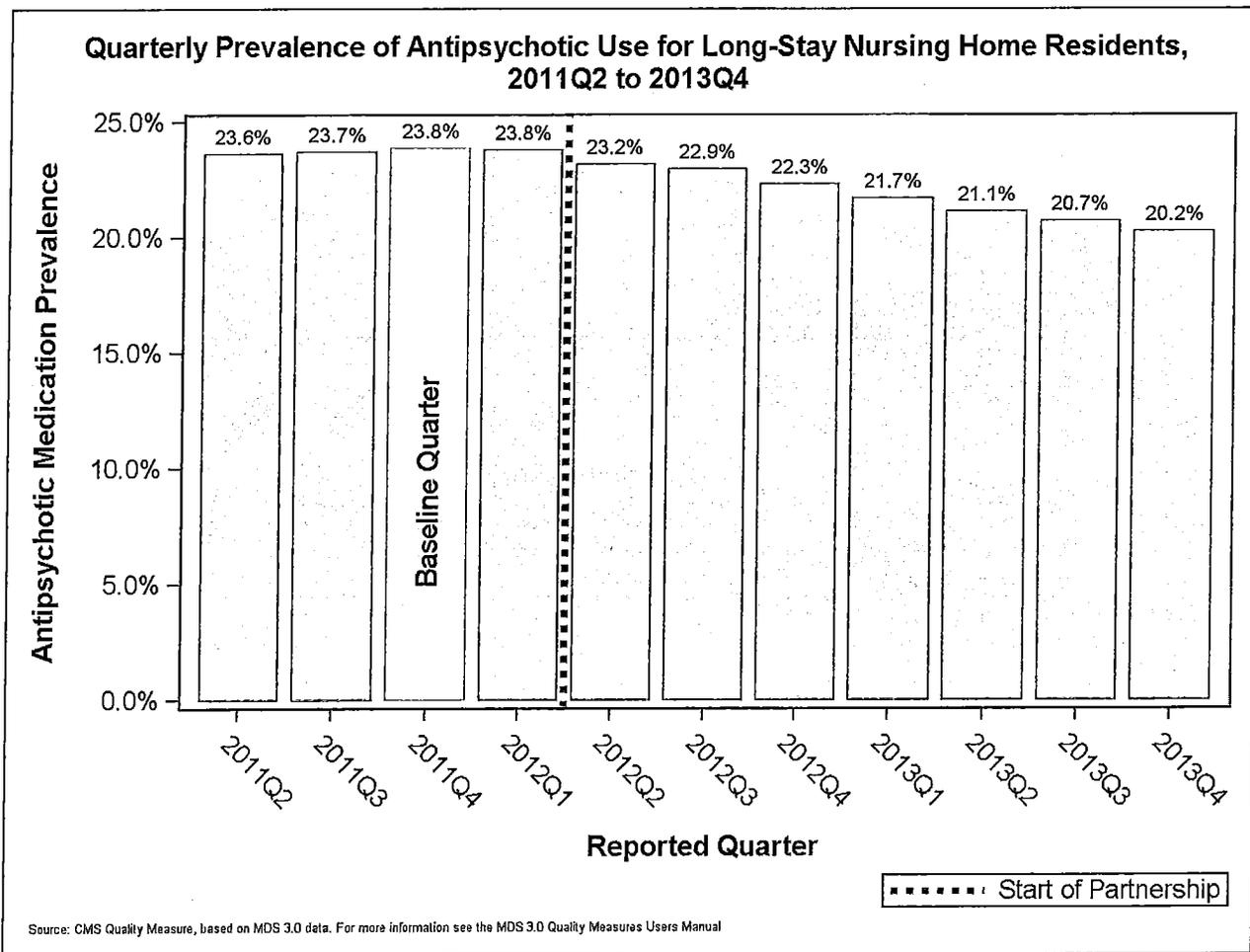
Partnership to Improve Dementia Care in Nursing Homes Antipsychotic Drug use in Nursing Homes Trend Update

The National Partnership to Improve Dementia Care in Nursing Homes is committed to improving the quality of care for individuals with dementia living in nursing homes. The Partnership has a mission to deliver health care that is person-centered, comprehensive and interdisciplinary with a specific focus on protecting residents from being prescribed antipsychotic medications unless there is a valid, clinical indication and a systematic process to evaluate each individual's need. The Centers for Medicare & Medicaid Services (CMS) promotes a multidimensional approach that includes; research, partnerships and state-based coalitions, revised surveyor guidance, training for providers and surveyors and public reporting.

CMS is tracking the progress of the Partnership by reviewing publicly reported measures. The official measure of the Partnership is a the percent of long-stay nursing home residents who are receiving an antipsychotic medication, excluding those residents diagnosed with schizophrenia, Huntington's Disease or Tourette's Syndrome. In 2011Q4 23.8% of long-stay nursing home residents were receiving an antipsychotic medication; since then there has been a decrease of 15.1% to 20.2% in 2013Q4. Success has varied by state and CMS region, with some states and regions having seen a reduction of greater than 20%.

A three-quarter measure is posted to the Nursing Home Compare website at www.medicare.gov/nursinghomecompare. The long-stay measure on Nursing Home Compare, is the exact same measure as below, except each facility's score is averaged over the last three quarters in order to give consumers information on the past history of each facility.

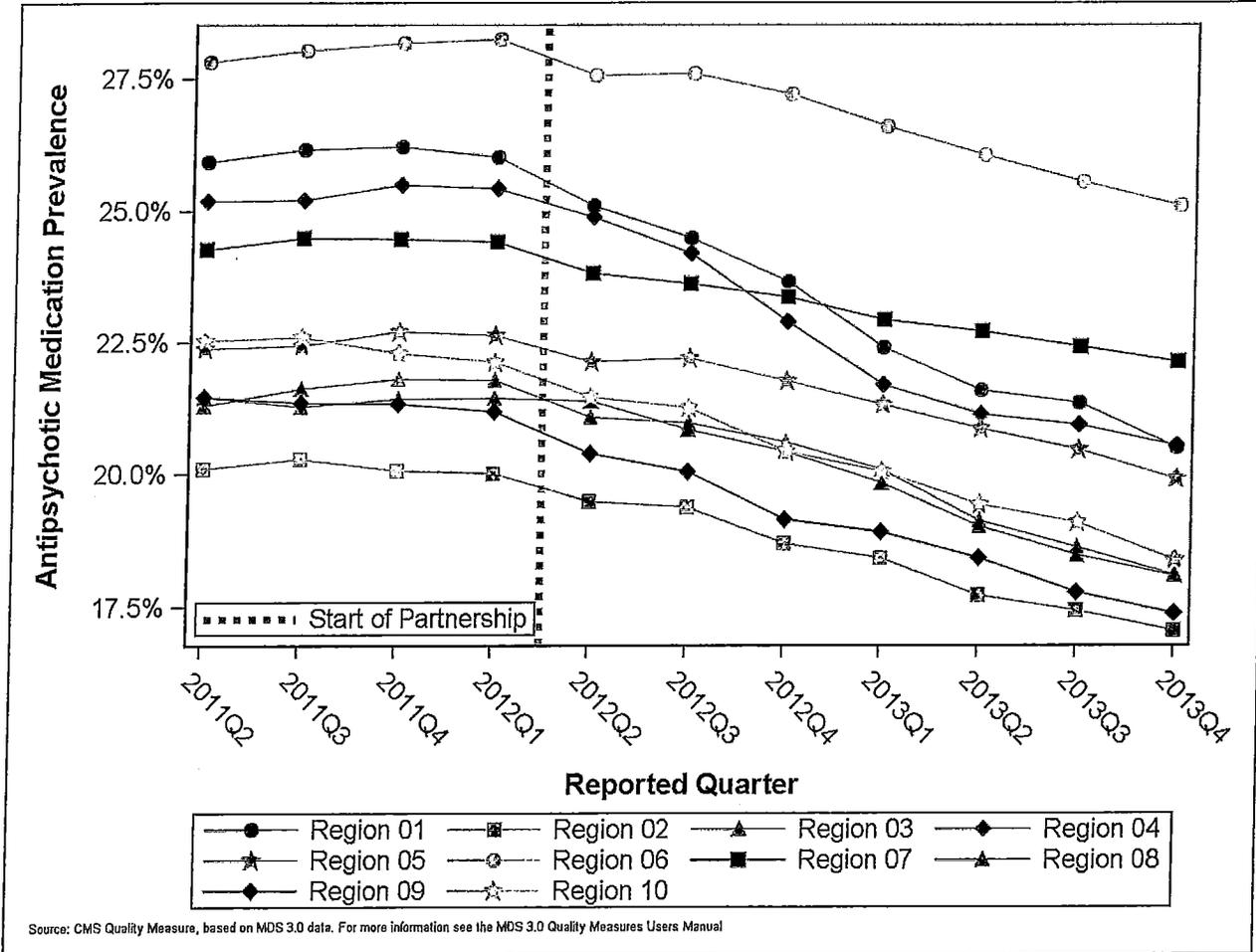
For more information on this National Partnership, please send correspondence to dnh_behavioralhealth@cms.hhs.gov.



Partnership to Improve Dementia Care in Nursing Homes Antipsychotic Drug use in Nursing Homes Trend Update

Quarterly Prevalence of Antipsychotic Use for Long-Stay Residents, CMS Regions 2011Q2 to 2013Q4

CMS Region- and State-specific data are displayed below. These data show the change in the single-quarter prevalence of antipsychotic medication use amongst long-stay residents since 2011Q2 and shows the change since the start of the Partnership



Region	2011Q2	2011Q3	2011Q4	2012Q1	2012Q2	2012Q3	2012Q4	2013Q1	2013Q2	2013Q3	2013Q4	Percentage point difference (2011Q4-2013Q4)	Percent change
National	23.6%	23.7%	23.9%	23.8%	23.2%	23.0%	22.3%	21.7%	21.1%	20.8%	20.3%	-3.60	-15.1%
Region 01	25.9%	26.2%	26.2%	26.0%	25.1%	24.5%	23.7%	22.4%	21.6%	21.4%	20.5%	-5.71	-21.8%
Region 02	20.1%	20.3%	20.1%	20.0%	19.5%	19.4%	18.7%	18.4%	17.7%	17.4%	17.1%	-3.02	-15.0%
Region 03	21.3%	21.6%	21.8%	21.8%	21.1%	21.0%	20.6%	20.1%	19.1%	18.6%	18.1%	-3.71	-17.0%
Region 04	25.2%	25.2%	25.5%	25.4%	24.9%	24.2%	22.9%	21.7%	21.1%	20.9%	20.5%	-4.97	-19.5%
Region 05	22.4%	22.5%	22.7%	22.7%	22.1%	22.2%	21.8%	21.3%	20.9%	20.5%	19.9%	-2.80	-12.3%
Region 06	27.8%	28.1%	28.2%	28.3%	27.6%	27.6%	27.2%	26.6%	26.1%	25.6%	25.1%	-3.09	-11.0%
Region 07	24.3%	24.5%	24.5%	24.4%	23.8%	23.6%	23.4%	22.9%	22.7%	22.4%	22.1%	-2.34	-9.5%
Region 08	21.5%	21.3%	21.4%	21.5%	21.4%	20.9%	20.4%	19.8%	19.0%	18.5%	18.1%	-3.35	-15.6%
Region 09	21.5%	21.4%	21.3%	21.2%	20.4%	20.1%	19.2%	18.9%	18.4%	17.8%	17.4%	-3.94	-18.5%
Region 10	22.5%	22.6%	22.3%	22.1%	21.5%	21.3%	20.4%	20.1%	19.5%	19.1%	18.4%	-3.89	-17.5%

Partnership to Improve Dementia Care in Nursing Homes
Antipsychotic Drug use in Nursing Homes Trend Update
Quarterly Prevalence of Antipsychotic Use for Long-Stay Residents, States 2011Q2 to 2013Q4

State	2011Q2	2011Q3	2011Q4	2012Q1	2012Q2	2012Q3	2012Q4	2013Q1	2013Q2	2013Q3	2013Q4	Rank in 2013Q4 (lower=better)	Percentage point difference (2011Q4-2013Q4)	Percent change
ALABAMA	27.0%	27.4%	27.3%	27.5%	26.5%	26.0%	24.0%	22.9%	22.2%	22.3%	22.2%	42	-5.13	-18.8%
ALASKA	15.6%	15.1%	13.7%	13.4%	13.0%	13.6%	12.4%	12.5%	11.8%	15.0%	12.8%	2	-0.89	-6.5%
ARIZONA	22.4%	22.5%	22.7%	22.7%	21.7%	21.6%	20.9%	20.4%	20.2%	19.9%	20.7%	33	-2.07	-9.1%
ARKANSAS	25.7%	27.0%	26.1%	26.1%	25.3%	25.8%	25.5%	25.1%	24.4%	23.8%	22.8%	44	-3.28	-12.6%
CALIFORNIA	21.7%	21.6%	21.6%	21.3%	20.4%	20.1%	19.2%	19.0%	18.4%	17.7%	17.1%	14	-4.46	-20.7%
COLORADO	19.8%	19.7%	19.9%	19.9%	20.3%	19.6%	19.4%	18.5%	17.5%	17.0%	16.4%	11	-3.48	-17.5%
CONNECTICUT	25.8%	26.1%	26.0%	25.8%	25.0%	24.3%	23.2%	22.4%	21.6%	22.0%	21.0%	34	-5.09	-19.5%
DELAWARE	21.1%	21.0%	21.3%	21.8%	22.6%	21.9%	20.9%	18.0%	16.8%	16.8%	15.5%	7	-5.76	-27.0%
DISTRICT OF COLUMBIA	21.4%	20.0%	20.0%	19.4%	18.8%	19.4%	18.2%	17.4%	17.6%	15.9%	14.5%	4	-5.48	-27.4%
FLORIDA	24.2%	24.3%	24.5%	24.6%	23.8%	23.5%	23.3%	22.7%	22.1%	21.8%	21.2%	37	-3.26	-13.3%
GEORGIA	28.4%	28.4%	28.7%	28.7%	28.0%	27.1%	24.2%	22.7%	21.8%	21.4%	21.1%	35	-7.56	-26.4%
HAWAII	11.4%	12.2%	12.5%	13.5%	15.3%	13.2%	11.7%	11.0%	11.4%	12.1%	11.6%	1	-0.87	-7.0%
IDAHO	26.4%	25.7%	25.3%	26.4%	25.1%	24.5%	23.9%	23.1%	21.9%	20.7%	19.3%	26	-6.07	-24.0%
ILLINOIS	26.0%	25.8%	25.7%	25.6%	25.3%	25.7%	25.5%	25.0%	25.2%	24.8%	24.0%	48	-1.68	-6.5%
INDIANA	23.0%	23.6%	24.0%	24.1%	22.9%	23.1%	22.2%	21.7%	20.9%	21.0%	20.2%	32	-3.79	-15.8%
IOWA	22.2%	22.3%	22.3%	22.0%	21.7%	21.1%	20.6%	20.2%	20.2%	19.9%	20.0%	29	-2.31	-10.3%
KANSAS	26.1%	26.5%	26.1%	26.1%	25.2%	25.3%	25.1%	24.2%	23.9%	23.5%	23.0%	45	-3.12	-11.9%
KENTUCKY	25.5%	25.2%	26.0%	26.0%	25.2%	24.4%	23.1%	21.9%	22.0%	21.8%	21.6%	38	-4.38	-16.8%
LOUISIANA	29.7%	29.9%	29.7%	29.7%	29.1%	28.9%	28.6%	27.8%	27.0%	26.6%	26.5%	50	-3.24	-10.9%
MAINE	26.4%	26.7%	27.2%	26.9%	25.9%	25.1%	24.2%	22.6%	21.7%	21.3%	20.1%	30	-7.11	-26.1%
MARYLAND	19.5%	19.8%	19.8%	19.6%	18.5%	17.8%	17.7%	17.3%	16.7%	15.6%	15.9%	9	-3.92	-19.8%
MASSACHUSETTS	26.6%	26.7%	26.7%	26.6%	25.4%	25.1%	24.5%	22.9%	22.2%	21.8%	21.2%	36	-5.51	-20.6%
MICHIGAN	16.2%	16.0%	16.4%	16.4%	15.8%	16.0%	15.5%	14.9%	14.4%	14.1%	13.9%	3	-2.45	-15.0%
MINNESOTA	18.9%	19.0%	19.0%	18.8%	18.1%	18.0%	18.0%	17.9%	17.3%	16.7%	16.6%	13	-2.48	-13.0%
MISSISSIPPI	26.6%	26.8%	26.6%	26.3%	26.6%	26.1%	25.3%	24.7%	24.4%	25.3%	24.3%	49	-2.32	-8.7%
MISSOURI	25.5%	26.0%	26.1%	26.0%	25.3%	25.2%	24.9%	24.6%	24.4%	23.7%	23.1%	46	-3.02	-11.6%
MONTANA	21.6%	22.0%	21.5%	21.5%	19.5%	19.7%	19.5%	19.7%	19.2%	18.1%	17.2%	15	-4.28	-19.9%
NEBRASKA	22.7%	22.4%	22.3%	22.9%	22.6%	22.6%	22.9%	22.5%	22.2%	22.8%	22.7%	43	0.40	1.8%
NEVADA	22.2%	20.7%	20.3%	20.5%	21.1%	19.7%	20.2%	20.1%	20.4%	19.9%	19.7%	28	-0.55	-2.7%
NEW HAMPSHIRE	25.7%	25.4%	25.5%	25.1%	24.0%	23.8%	23.7%	22.7%	21.1%	21.2%	20.1%	31	-5.40	-21.2%
NEW JERSEY	17.0%	18.2%	17.9%	17.8%	17.5%	17.4%	17.1%	16.6%	15.9%	15.4%	15.1%	5	-2.80	-15.6%
NEW MEXICO	22.4%	22.3%	21.7%	22.0%	20.0%	20.4%	22.2%	20.3%	20.7%	17.7%	18.1%	18	-3.57	-16.5%
NEW YORK	22.0%	21.6%	21.3%	21.4%	20.8%	20.6%	19.7%	19.5%	18.9%	18.7%	18.2%	19	-3.10	-14.6%
NORTH CAROLINA	21.1%	20.8%	21.4%	21.3%	20.7%	19.9%	18.0%	16.5%	16.0%	15.8%	15.6%	8	-5.81	-27.1%
NORTH DAKOTA	20.8%	21.4%	21.3%	21.2%	20.6%	20.4%	19.8%	19.1%	18.5%	18.3%	18.7%	23	-2.61	-12.3%
OHIO	24.9%	25.0%	25.4%	25.4%	25.0%	24.8%	24.5%	24.1%	23.3%	22.7%	22.0%	41	-3.40	-13.4%
OKLAHOMA	26.7%	26.8%	27.3%	27.5%	27.3%	26.6%	25.5%	23.0%	22.7%	22.3%	21.7%	40	-5.59	-20.5%
OREGON	20.6%	21.0%	21.5%	21.3%	20.0%	19.9%	19.2%	19.1%	18.6%	18.8%	18.3%	20	-3.20	-14.9%
PENNSYLVANIA	21.6%	22.1%	22.3%	22.2%	21.7%	21.7%	21.1%	20.5%	19.4%	19.2%	18.8%	24	-3.54	-15.9%
RHODE ISLAND	23.0%	23.8%	24.0%	23.9%	23.1%	21.7%	20.2%	20.3%	19.3%	18.4%	17.5%	16	-6.49	-27.0%
SOUTH CAROLINA	20.6%	20.5%	20.7%	20.6%	20.7%	20.2%	18.3%	17.2%	16.9%	15.9%	15.5%	6	-5.23	-25.3%
SOUTH DAKOTA	21.8%	21.8%	21.5%	21.5%	21.3%	21.4%	20.5%	20.0%	18.8%	18.1%	18.6%	21	-2.95	-13.7%
TENNESSEE	29.3%	29.5%	30.0%	29.3%	29.0%	27.7%	27.2%	25.0%	23.9%	24.0%	23.4%	47	-6.58	-22.0%
TEXAS	28.4%	28.5%	28.8%	28.9%	28.2%	28.3%	28.0%	27.9%	27.3%	27.0%	26.5%	51	-2.35	-8.1%
UTAH	26.9%	24.7%	27.1%	26.9%	27.1%	26.3%	26.4%	25.0%	24.5%	23.6%	21.7%	39	-5.45	-20.1%
VERMONT	25.5%	26.1%	25.4%	25.7%	26.2%	24.9%	23.4%	20.3%	20.2%	20.2%	18.8%	25	-6.57	-25.9%
VIRGINIA	22.4%	22.8%	23.0%	22.9%	21.8%	21.9%	22.1%	22.1%	21.0%	20.5%	19.7%	27	-3.39	-14.7%
WASHINGTON	22.8%	23.0%	22.3%	21.8%	21.7%	21.6%	20.6%	20.2%	19.7%	19.1%	18.6%	22	-3.71	-16.6%
WEST VIRGINIA	20.1%	20.3%	20.5%	21.5%	20.4%	20.7%	20.4%	19.8%	19.0%	18.0%	16.5%	12	-4.00	-19.5%
WISCONSIN	18.7%	18.7%	19.0%	18.9%	18.9%	19.0%	18.0%	17.7%	17.4%	16.8%	16.3%	10	-2.76	-14.5%
WYOMING	17.8%	18.4%	16.8%	16.9%	19.4%	16.8%	17.5%	17.0%	16.5%	17.2%	17.9%	17	1.11	6.6%

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Recommendation 6:

The Nevada State Plan to Address Alzheimer's Disease
Status Report, June 2014

No Update Is Available At This Time

The Nevada State Plan to Address Alzheimer's Disease
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Recommendation 7:

The Nevada State Plan to Address Alzheimer's Disease
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Recommendation 7: Nevada Consortium

Description: Establish a consortium to maximize current and future efforts in our State to address Alzheimer's disease and related disorders.

Lead Person: Dr. Bernick

Time Frame:

Comments: 01/15/2014 Combine with #8; Chair to discuss with lead person

State Plan Area: Quality of Care

1. What is the current status? There are many individuals and entities that are involved in research, and development of improved methods of care, in Alzheimer's disease (AD). There are a number of examples of collaborative efforts to face issues in AD services (e.g. Nevada Lifespan Respite Care Coalition) but there are also areas where collaboration is less than optimal (may be related to competition for grants/funding, lack of knowledge of what others are doing, time constraints in participating in associations).
2. Suggestion/s to improve recommendation: Developing a specific, inclusive, state sponsored (thus neutral) Nevada Consortium on Alzheimer's disease and dementia. This entity would have several divisions focused on different aspects of AD issues (i.e. research, community services, long term care, etc.) that entities (probably limited to not for profit) could join. A very basic goal of the consortium would be to facilitate networking among those in the field and eventually lead to specific joint projects and recommendations for continuing the state plan (? could eventuall replace the Task Force).
3. What are identified ways to achieve the recommendation? An initial step would be to invite a representative from agencies and organizations that are involved in AD research and care to attend an organizational meeting of the consortium, perhaps tied to a presently existing meeting on aging by the state.
4. Is legislative action necessary to achieve the recommendation?

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Recommendation 8:

The Nevada State Plan to Address Alzheimer's Disease
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Recommendation 8: Research Opportunities

Description: Investigate and encourage expanded research opportunities throughout Nevada to study current and develop medications that treat Alzheimer's disease and related disorders. Also, promote the dissemination of information about treatments available.

Lead Person: Dr. Bernick

Time Frame:

Comments: **01/15/2014** Combine with #7; Chair to discuss with lead person

State Plan Area: Quality of Care

1. What is the current status? Currently, there are certain reservoirs of research in Alzheimer's disease (AD) throughout the state, primarily involving the major universities and the Cleveland Clinic Lou Ruvo Center for Brain Health. In addition, in the Las Vegas area, several independent practices are sites for pharmaceutical trials. There are few truly collaborative research studies across these institutions

The primary factor that delays completion of clinical trials is difficulty in recruiting participants. One specific approach to address this issue was the creation of the Cleveland Clinic Research Network that engaged community physicians who are seeing patients with or at risk of AD. Research network physicians are informed of the studies that are enrolling patients and criteria for referral. Network physicians then refer appropriate patients for trials; in return, they have the opportunity to attend, at no cost, semiannual educational CME seminars that cover the *state of the art* on diagnosis and treatment of AD

2. Suggestion/s to improve recommendation:
 - a) Develop a web based site where investigators in AD can list/post the research they are doing (this exists at a national level for clinical trials either through the NIH *ClinTrials* site or the Alzheimer's Assn *Trial Match*) The site would just focus on what is happening within the state.
 - b) Develop *core* facilities at various research facilities throughout the state. For example, having a facility (university or Cleveland Clinic) that would have expertise in brain imaging or biomarker analysis would allow collaborative relationships within the state rather than with outside entities

c) Create a patient registry for individuals who may be interested in participating in clinical trials. This could then be utilized by sites trying to recruit for particular studies.

3. What are identified ways to achieve the recommendation?

- a) An entity would have to be charged with, and funding obtained, to create and maintain the website (? through the state)
- b) Developing core facilities would be a more long ranged goal and would depend on obtaining funding and expertise to maintain the core facility.
- c) As in (a) an entity would need to be identified to develop and maintain the registry

4. Is legislative action necessary to achieve the recommendation?

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Recommendation 9:

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Recommendation 9: Long-term Care Funding Streams

Description: Review current funding streams to support the development of quality long-term care facilities in Nevada. Provide funding or incentives to develop or increase inpatient capacity for placement into existing facilities.

Lead Person: Ms. Simon

Time Frame: Continued effort

Comments: **01/15/2014** Continue to work with DHHS to maximize and clarify coverage

State Plan Area: Quality of Care

1. What is the current status? **DHHS/DHCFP has created a "behavior rate" for skilled nursing facilities that will increase reimbursement in a "tier" methodology. This is the culmination of an effort that began in 2004. Reimbursements will be: Tier 1= \$108.60, Tier II= \$217.20, Tier III= \$318.56. These are all daily rate increases above the base rate currently paid by Medicaid. Facilities will need an assessment and documentation to support their request for the Tier determined for an individual**

2. Suggestion/s to improve recommendation: **At this time, the details are being worked out but are very positive. Providers are pleased and there is indication of movement in the direction of establishing behavioral units to prevent medicaid clients from being sent out of state.**

3. What are identified ways to achieve the recommendation? **Application and compliance forms are being developed by DHCFP and completed by the facility.**

4. Is legislative action necessary to achieve the recommendation? **No.**

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Recommendation 10:

**Preliminary Report to Nevada Task Force on Alzheimer's Disease
June 14, 2014**

Topic: Reduction of Out of State Placement

Prepared by: Jane E. Fisher, Ph.D. (Department of Psychology, University of Nevada, Reno)

There are several national, statewide, and local initiatives relevant to this goal.

Background: Available data indicate that out of state placement of Nevadans with a neurocognitive disorder is based on the person being judged as engaging in extreme, unpredictable aggression, and/or extremely disruptive or dangerous behavior.

Nevadans who are placed out of state have histories of being placed and rejected by multiple facilities due to behavior that is judged to be unmanageable. One recent and important State initiative that may affect the need for out of state placement is being lead by the NV Division Health Care Financing and Policy. The goal of this initiative is to "incentivize in-state providers to provide care, rather than sending Medicaid recipients with medical-based behavior disorders out-of state for care" by increasing the daily Medicaid rate for persons who meet criteria for status as "Behaviorally Complex Individual" (BCI). The criteria for BCI status will convey to the Task Force the behaviors that increase the risk of out-of-state placement. The criteria are:

exhibiting extreme, unpredictable aggression; recipients who have been treated for their severe medically-based behavior disorder or other medical conditions across multiple medical, institutional and/or correctional environments with little or no success; or recipients exhibiting behaviors extremely disruptive or dangerous to themselves, other recipients or Nursing Facility staff (see NV DHCFP criteria for Medicaid "Behaviorally Complex Add-On Rate";

https://dhcfp.nv.gov/meetings/2014/Agenda_05-15-14/BCR%20Request%20and%20Review%20Form%202014.pdf

Relevant to the goals of the Task Force in considering the well-being of Nevadans with neurocognitive disorders are the following:

- An extensive review of the research literature from the past 20+ years reveals that there is no evidence that Alzheimer's disease or other forms of dementia cause people to engage in extreme, unpredictable disruptive or aggressive behaviors.

- The heterogeneity of behavioral repertoires across persons with neurodegenerative disorders and a growing body of literature providing evidence that these behaviors can be significantly modified or prevented all together even though no treatment for the neurocognitive disorder has occurred support the conclusion that these behaviors are not caused by the neurodegenerative disorder.
- Behaviors perceived by caregivers as “extreme”, “unpredictable”, “disruptive” or “aggressive” develop in a minority of affected persons after declines in verbal abilities lead to problems in communication and the ability to tact, describe, and effectively respond to private events (e.g., pain, discomfort, distress)
- The lack of effective response to reversible adverse medical and environmental events is directly related to the development of behavioral and affective changes that are judges as problem behaviors in persons with dementia
- A diagnosis of a degenerative neurocognitive disorder can have a stigmatizing effect wherein all behavior and affective changes are attributed to the neurocognitive disorder rather than reversible conditions (e.g., pain, infection, physical discomfort, distress, boredom, etc.). The default ascription of behavior change to the diagnosed neurocognitive disorder results in a lack of treatment for the adverse medical or environmental event that is actually causing the change in behavior or affect.

Recommendation: The goal of a statewide initiative should be to prevent the conditions that lead to persons with dementia ever reaching “BCI” status. This can be accomplished through three levels of prevention:

Primary prevention: The goal would be to set up conditions that promote the health and quality of life and prevent excess disability in Nevadans with neurocognitive disorders. From a primary prevention perspective the goal would be to prevent problem behaviors from ever emerging. Several public and private entities within Nevada are already heavily involved in local and/or statewide efforts that promote these conditions including (but not limited to):

- Alzheimer’s Association Desert Southwest and Northern California Chapters
- NV Aging and Disability Services Division
- UNR Nevada Caregiver Support Center Restraint Free Care Program
- Nevada Geriatric Education Center
- Lou Ruvo Center for Brain Health
- Nevada Lifespan Respite Coalition
- Adult Day Programs

With the ultimate goal of preventing BCI status it is recommended that these and other stakeholder agencies provide information to the family and professional caregiver communities to:

- Increase understanding of how cognitive disorders affect the behavior of persons with dementia with the goal of promoting perspective taking, preservation of the personhood, preventing stigmatization, and effective responding to the needs of persons with neurocognitive disorders.
- Improve caregivers' ability to distinguish normal changes in behavior and affect from abnormal changes (e.g., abrupt changes in normally stable, high frequency adaptive behaviors or precipitous declines in verbal behaviors) that signal a potential adverse event.
- Increase knowledge of what conditions should be ruled out (e.g., pain, infection, medication side effect, physical discomfort, delirium, dehydration, distress or boredom due to environmental conditions, etc.) when behavioral and affective changes are observed and how to collaborate with healthcare providers in achieving this goal
- Increase understanding of "optimal" care, quality of life, and outcomes when an individual has been diagnosed with a neurocognitive disorder and the conditions that increase likelihood of a good quality of life for individuals with neurocognitive disorders
- Increase ability of caregivers to respond to the behavior of persons with neurocognitive disorders in ways that support and maintain healthy, adaptive behavior and prevent excess disability including behaviors that lead to BCI status. Providing direct instruction and individualized guided practice to caregivers are evidence based approaches to reaching this goal.

Secondary prevention: In cases where challenging behaviors have developed it is recommended that resources be readily available to family and professional caregivers to return the affected individual to behavioral health and prevent further preventable decline. Specific recommendations include:

- Consistent with federal and state goals of reducing overmedication of persons with neurocognitive disorders and the overuse of psychotropic medication in reducing problem behavior it is recommended that a clearinghouse for information on evidence based non-pharmacological alternatives and services for reducing or preventing problem behaviors and promoting behavioral health be established.
- A behavioral health toolkit be developed for statewide dissemination.
- The State expand support for the training of family and/or professional caregivers in evidence based treatment of challenging behaviors. The current formulas for publicly funded behavioral health services (Medicare and Medicaid) cover direct service to the diagnosed individual. In the case of verbally impaired persons with neurodegenerative disorders the training of caregivers in evidence based behavioral intervention is often the most effective (and only practical) means of improving outcomes for the diagnosed individual.

Tertiary prevention: The following options should be explored in order to determine the most effective means of addressing cases where an individual meets criteria for BCI and is at immediate risk for out of state placement:

- Evaluate the out-of-state placement rates for the year (or two year) period pre and post implementation of the higher BCI Medicaid daily rate in order to determine the effectiveness of the BCI initiative.
- Examine the cost and practicality of funding an interdisciplinary consultant team of experts in evidence based behavior management of problem behavior in persons with neurocognitive disorders to provide consultation to facilities providing care to persons with BCI status.
- Provide training in evidence-based approaches to reducing problem behavior and promoting behavioral health in persons with neurocognitive disorders to facilities willing to accept BCIs. Given: a) the growing evidence that problem behaviors in the population of persons with neurocognitive disorders are due to adverse events, and b) the goal of implementing interventions that *maintain* behavior rather than contribute to further loss of behavior (i.e., “excess” disability), training should include altering the language used to describe problem behaviors so that the residents’ perspective and needs are recognized. For example “physical aggression” may be “self-protective behavior”. Verbal and vocal behaviors (including “extreme disruptive sounds, noises, screaming”) may be adaptive responses to pain, discomfort, under-stimulating or overwhelming environments or other adverse events. Sexual behaviors and disrobing (“Regressive Behavior”) are usually normal responses to physiological conditions. When these behaviors occur in persons with neurocognitive disorders it is typically the setting (not the behaviors) that result in problems.
- Review available data on the cost-effectiveness of models of caring for BCI that have been developed and adopted in other states.

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Recommendation 11 & 14:

11
14



Nevada State Board of Medical Examiners

June 13, 2014

Honorable Valerie Wiener
State Senator (Ret.)
3540 W. Sahara Avenue
Las Vegas, NV 89102

Dear Senator Wiener:

This correspondence is to serve as the Nevada State Board of Medical Examiners' (Board) response to a solicitation for input from the Board as to ways to "help people with or helping those who have Alzheimer's Disease." The Board believes there are a few ways it currently contributes, and might further contribute, to this effort.

First, the Board already has in place a modality which encourages its licensees to enroll in continuing medical education (CME) courses that relate to geriatrics or gerontology. Nevada Administrative Code 630.155 provides:

Continuing education: Credit for continuing education class on geriatrics and gerontology.

1. Except as otherwise provided in subsection 2, if a holder of a license to practice medicine takes a continuing education class on geriatrics and gerontology, the holder is entitled to receive credit towards the continuing medical education required pursuant to NAC 630.153 equal to twice the number of hours the holder of the license actually spends in a continuing education class on geriatrics and gerontology.

2. During any biennial licensing period, a holder of a license to practice medicine may receive a maximum credit pursuant to subsection 1 of 8 hours of continuing medical education for 4 hours of time spent in a continuing education class on geriatrics and gerontology.

3. As used in this section, "continuing education class on geriatrics and gerontology" means a class that meets the requirements of:

(a) For a class of continuing medical education, NAC 630.153; and

(b) For a continuing education class on geriatrics and gerontology, NRS 630.253.

It is the Board's position that CME connected to Alzheimer's disease, and related disorders, would certainly fall under this section.

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Second, the Board publishes a quarterly newsletter which very often includes articles from guest authors on timely and current issues impacting our licensee base and others in the medical community. We believe soliciting writings from subject matter experts in the field of Alzheimer's disease would be a reasonable and logical avenue to enlighten the medical community in this regard. Moreover, even absent a guest author, the Board is certainly willing to incorporate publications or treatises which address the issue of Alzheimer's disease into its newsletter on a regular basis. And the Board will be placing a reminder of the previously cited regulation in its next newsletter to encourage licensees to direct some of their CME efforts towards geriatrics or gerontology training in anticipation of next year's licensure renewal cycle.

Third, the Board believes that its newest licensure category, special purpose licensure, more commonly understood as telemedicine licensure, will provide potentially great resources for those afflicted with Alzheimer's disease, by allowing a medical practitioner/specialist located anywhere in the world to treat a Nevada patient via telemedicine.

The Board welcomes any recommendations that may come from your Task Force on Alzheimer's Disease and would certainly like to actively participate in your ongoing efforts. Please do not hesitate to contact me directly if further clarification or assistance proves necessary.

Respectfully,



Douglas C. Cooper, CMBI
Executive Director
Nevada State Board of Medical Examiners

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Recommendation 12 & 13:

Hi Dr. Hardy

I really don't have any suggestions, but have information about some work that is being done at UNLV. Susan VanBeuge is working on a HRSA grant with colleagues at UNLV which has been funded to teach providers in Nevada about interprofessional collaboration while caring for patients with Alzheimer's disease (AD) and other dementias. Their original grant was for diabetes but they were able to secure additional funding for AD in this fiscal year, thus able to expand our work and education of Nevada health care providers. This is a grant through the Nevada Geriatric Education Consortium (NGEC) and they are in year 4 of 5. They taught their first course with AD curriculum in February 2014 and will be teaching three more courses in the next fiscal year (July 1-June 30).

Just an FYI. Thanks for asking.

Debra Scott, MSN, RN, FRE
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Recommendation 15:

The Nevada State Plan to Address Alzheimer's Disease
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No Update Is Available At This Time

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Recommendation 16:

Gini Cunningham in collaboration with Sherry Mock, Humboldt Volunteer Hospice
Recommendation 16: Explore the use of volunteers to provide support for family caregivers by collaborating with community organizations and faith-based groups.

As the requirements of caregiver and care partner become more and more overwhelming it is essential to have connections and resources to help individuals and families in a variety of ways. These assistants may be family members, friends and neighbors, church or civic group members, and other members of the community who want to make a difference in the lives of others.

Recruiting Members/Volunteers through:

- Church groups
- Senior centers
- Health care providers such as nurses who receive stipends and incentives for community outreach
- Court officials with individuals on probation who need community service hours
- Court officials with individuals from drug court, etc. who need community service hours
- Colleges and universities departments especially those who have students studying health related fields, social services, psychology
- Local offices such as the Chamber of Commerce and the courthouse where brochures and flyers on volunteer opportunities are available
- Area high schools where honor students and others want to be involved in community service
- Advertisements and announcements in local newspapers, newsletters, and other community publications
- Hospice and other care facilities
- Community Action and Community Coalition groups
- Service organizations such as the Rotary, Lions, and Scouts

Team Leader(s):

Communities and neighborhoods will need a team leader who is in charge of recruiting, organizing training, and supervising the volunteer program. These leaders may come from the Alzheimer's Association, Alzheimer's Support Group Facilitators, a community volunteer, or other individual interested in coordinating this program. A widespread outreach program would become a tremendous task but it could be coordinated with other service organizations to alleviate some of the stress. Leaders need to have:

- A background check
- Leadership training
- Supervisory training and support

- Educational training with on-going updates
- Support from Alzheimer's Association, the Task Force, Aging and Disabilities Services Division, Hospice, and other social services organizations

Background Checks:

Because of the nature of this volunteer work a background check may often (maybe always) of extreme importance. Fingerprinting through local government offices is recommended so that a background check can be performed. Perhaps part or all of this service could be waived for volunteers.

Retaining Volunteers includes:

- Application procedure that produces optimal match
- Training and education opportunities via community outreach programs and tele-health conferences
- Trainers and supervisors who insure proper placement, guidance, and follow-up connections and re-connections
- Training and education opportunities for volunteers and caregivers through community service at local colleges and universities
- Continuing communication to assure that caregivers are up-to-date on the latest and most critical information
- On-line services and information centers

Volunteers are internally rewarded by the unique sense of making a difference in the lives of others. It is also vital that there is appreciation for the time, effort, and heart volunteers provide. This does not mean financial compensation but thanks for a task completed, a dedication to personal service.

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Recommendation 17:

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Recommendation 17: Mandatory Reviews

Description: Enforce mandatory administrative or judicial reviews of all persons with dementia under guardianship who are involuntarily placed out of state. Reviews should take place at least every six months.

Lead Person: Senator Valerie Wiener

Time Frame:

Comments: **01/15/14.** This item requires funding. Should the language "encourage" rather than "enforce" mandatory administrative or judicial reviews? TFAD would like a presentation from Sally Ramm, Senior Legal Advisory for ADSD.

State Plan Area: Quality of Life

1. What is the current status?

Current law requires mandatory annual reports on the finances and the personal well-being of all people under guardianship in Nevada with estates of more than \$10,000. While many guardians file these reports, the courts do not have the resources or the methodology to check every report. Usually, the reports are checked only if a court hearing is required for another issue.

If "enforced," the counties would be impacted fiscally in at least two ways. First, the court budgets would have to accommodate the creation of a compliance office to track all guardianships to make certain that: a) the appropriate reports are filed and b) that the reports are reviewed and any irregularities are reported to the judges. Secondly, the public guardians' budgets would be impacted by the need to make two trips to inspect the "reasonableness of care" for all wards placed out of state each year. Currently, most guardians of these wards make only one trip per year.

NRS 159.076 states that if the ward has an estate of \$10,000 or less, the guardian can use that money to provide for the ward and not provide any additional reports to the court regarding the ward's finances until the guardianship is dissolved. This is called an order for "summary administration" and applies when the ward does not own a home or other real property.

A small amount of savings, when combined with regular income, can help keep a ward in a familiar setting. However, with no supervision of how the money in the estate is

spent, some guardians have been known to spend the savings and then move the ward to an unfamiliar and less expensive setting where the ward's income supplements the guardian's living expenses. This is not examined by the court as a financial issue if there has been a summary order regarding the ward's estate.

Additionally, there have been cases involving guardians who have received this type of order and proceeded to sell everything the ward owns within a short period of time. If the ward recovers or is subsequently judged to be capable of returning home, there is nothing left of his/her former life.

2. Suggestions to improve recommendation.

a. Address the issue of "summary administration" as it applies to persons suffering from dementia, including Alzheimer's disease and/or persons who have been placed in facilities outside the state.

b. Request district courts to more closely supervise guardians whose wards suffer from dementia, including Alzheimer's disease, to ensure that required reports are filed according to law.

3. What are identified ways to achieve the recommendation?

a. Legislation (see #4)

b. Ask Legislature to send a letter to all district courts in Nevada to request that they closely supervise all guardians whose wards suffer from dementia, including but not limited to Alzheimer's disease, to insure that all reports on the person and estate of the wards are filed and reviewed according to existing law.

4. Is legislative action necessary to achieve the recommendation?

a. NRS 159.076—The court may grant a summary administration if, at any time, it appears to the court that, after payment of all claims and expenses of the guardianship, the value of the ward's property does not exceed \$10,000 (following is new language) *except: (a) If the person is suffering from dementia, including but not limited to Alzheimer's disease or (b) If the person has been placed in a facility outside the state of Nevada.*

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Recommendation 18:

Nevada State Plan to Address Alzheimer's Disease
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Recommendation 18: Hospital Transitional Care Programs

Description: Establish hospital transitional care programs that include information on community resources for caregivers and persons with dementia. Investigate federal funding opportunities through Medicare Innovations or Centers for Medicare and Medicaid Services to develop a transitions planning program or to avoid the hospital setting altogether.

Lead Person: Senator Valerie Wiener

Time Frame:

Comments: **01/15/14.** TFAD would like a presentation on Money Follows the Person and other Medicaid initiatives.

State Plan Area: Quality of Life

1. What is the current status?

During the April 23, 2014, TFAD meeting, Jennifer Frischmann and Palisa Sturgis, Division of Healthcare Finance and Policy, made a presentation to the Task Force. Ms. Frischmann discussed Home- and Community-Based Services and federal regulations. Ms. Sturgis discussed funding opportunities for the Money Follows the Person (MFP) Grant.

Additional concerns that need to be addressed, according to Ms. Tina Gerber-Winn, DHHS Aging and Disability Services Division, involve: a) where to go with the opportunities provided through CMS as a whole and b) how to provide transition assistance to those individuals who do not have Medicaid. Dr. Bernick shared concerns about access to the CMS grant for people who are released to nursing homes rather than state facilities.

Ms. Sturgis explained the State's Facility Outreach and Community Integration Services unit, in place since 2002, attempts to prevent or divert people from entering an institution and also helps in transitioning individuals. This includes outreach to hospitals, nursing homes, and rehabilitation facilities.

Task Force members raised concerns about waiting lists and the lack of providers (beds and facilities).

Ms. Sturgis stated that the MFP Grant's goal is to rebalance the infrastructure within Nevada and to increase the number of dollars and services that are spent in community settings rather than in state institutional settings.

2. Suggestions to improve recommendation.

If the language of this recommendation is pursued, legislatively or otherwise, it is very important to pursue long-term solutions. To accomplish this, it is important to establish collaborative studies, with numerous stakeholders, including State and federal agencies, private sector, nonprofits, and others. They would be charged with determining, without limitation, current and anticipated needs (urban and rural), existing resources (State, federal, private, and other), and potential resources for expanding needs.

A possible clarification for this recommendation would require a statutory definition of "unsafe discharge" (or, possibly, in legislative language, what is a "safe discharge"). Input for creating this definition should include, without limitation: a) the Division of Public and Behavioral Health/Bureau of Health Care Quality and b) the Compliance and Aging and Disability Services Division/Long-Term Care State Ombudsman.

Also, recently, some hospitals have discharged patients to their homes without checking to see if anyone is there to assist the patients after discharge. The patients often have a small quantity of medicines that were prescribed in the hospital, but these patients cannot get out of their homes to acquire additional medication or food. If the patients have been provided home health care, the provider has to find a way to get help for them. If patients have not been provided home health care, they have to do these tasks for themselves. NRS 439.877(2)(c), which is under the heading of "Health and Safety of Patients at Certain Medical Facilities" could be changed to address these concerns.

3. What are identified ways to achieve the recommendation?

- a. Legislation (see #4)
- b. Ask the Legislature to send letters to the Division of Public and Behavioral Health and the Division of Health Care Financing and Policy urging them to: a) establish hospital transitional care programs, b) increase the number of home-based services and long-term care facilities with Alzheimer's certification, and c) establish a central location where available and appropriate placements can be accessed. This letter would stress the importance of providing methods and means by which people with dementia, including Alzheimer's disease, can avoid relocation trauma and out-of-state placement.

4. Is legislative action necessary to achieve the recommendation?

- a. NRS 439.877(2): The patient safety checklist adopted pursuant to subsection 1 must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:
 - (c) A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 1. Proper instructions concerning prescription medications;
 2. Instructions concerning aftercare; and
 3. Any other instructions concerning his or her care upon discharge.

(new language)

- (d) *A checklist to be used when discharging a patient from the facility which includes, without limitation, verification that:*
 1. *The patient will be able to provide for the Activities of Daily Living by him/herself or that assistance will be provided for an appropriate length of time.*

2. *An investigation is done by hospital personnel to insure the appropriateness and safety of the residence into which the patient is being discharged.*

NOTE: "appropriateness" and "safety" might require a statutory definition. (See #2, paragraph #2) This would help ensure certain standards are established and met.

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Recommendation 19:

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Recommendation 19: Employee Assistance Programs

Description: Collaborate with the business community to create employee assistance programs that include education and training for caregivers.

Lead Person: Dr. Bernick

Time Frame:

Comments: **01/15/14** Lou Ruvo has a robust outreach department. Chair will ask Dr. Bernick to lead this recommendation.

State Plan Area: Public Awareness

1. What is the current status?

Over the past two months, I have participated as a member of a workgroup convened by ReACT (organization description is below) to accomplish the task of conceptualizing and visually depicting the "caregiver journey". This project was developed to address the need for increased awareness among employers about the impact of caregiving in the work place and create a dialogue about the ways in which employers can help their employees with caregiving needs. The target audience for this prototype is employers including HR leadership, executives and managers as well as innovators that could develop products or services to better support employees fulfill their caregiving responsibilities. This group has met twice and will hold its final working session in June, with a July launch date. It is envisioned that this tool will be helpful as a first step to engage employers to consider education and training options for their employees.

2. Suggestion/s to improve recommendation:

Members of the Nevada State Plan to Address Alzheimer's Disease can assist in the process of identifying members of the business community who would be willing to serve as initial collaborators in this type of project. Companies can have existing programs to assist employee caregivers or be willing to engage in developing an individualized program.

3. What are identified ways to achieve the recommendation?

An initial step has been to identify materials and resources that would be of value to employers to assist their employees who are caregivers. I have been working with a volunteer from the Cleveland Clinic Lou Ruvo Center for Brain Health to research and compile these materials. Once the new ReACT model is completed, the next step will be to develop a plan to identify and approach members of the business community.

4. Is legislative action necessary to achieve the recommendation?

There is no legislative action necessary at this time.

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Recommendation 20:

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Recommendation 20: Awareness Campaigns

Description: Foster the development of three awareness programs to provide information about the earliest signs of dementia and to rebuke the stigma of Alzheimer's disease and related disorders. Target audiences: Professionals that may have contact with persons with dementia (health providers, bankers, emergency responders, lawyers), the general public, and family & caregivers.

Lead Person: Dr. Bernick

Time Frame:

Comments: 01/15/14 Lou Ruvo has a robust outreach department. Chair will ask Dr. Bernick to lead this recommendation.

State Plan Area: Public Awareness

What is the current status?

- Emergency Responders: Action Plan – Incorporate dementia training in continuing education programs of first responders.
 - *Met/spoke with Metro and Southern Nevada Health District. Both are eager to incorporate a dementia program into their continuing education programs.*
 - *Suggested creating a CD or record an education program (like those held at the center) on dementia symptoms, management, and resources for wider distribution to EMT, Advanced EMT, and paramedics. Put on their intranet for easy access; make this a required course to watch.*
 - *Metro CIT program managers would like a speaker to present on dementia several times a year. Invited them to the **Dementia 2014** CME conference. This conference was recorded and can possibly be distributed, however it is a very medically-based conference. Possibly upload to well-characterized websites.*

- Bankers, lawyers and other professionals. Action Plan: Outreach
 - *Distribute educational CDs to bank branches and law offices. No action taken yet. Plan includes creating a CD describing early signs and symptoms of dementia for distribution.*
 - *Invite this group to dementia conferences held at the Lou Ruvo Center for Brain Health, social service learning programs, plays, Alzheimer's Association Town Square Meetings. Invited some of these groups to the **Dementia 2014** conference. This conference was recorded and can possibly be distributed however it is a very medically-based conference. Possibly upload to well-characterized websites.*

- Discuss including dementia/guardianship seminars in the UNLV Law School course curriculum and in continuing education classes. *No action taken yet. Plan includes outreach to these groups.*
- Family and caregivers. Action Plan: Outreach.
 - Post posters in physician offices about the symptoms of dementia so individuals have the information to advocate for themselves and family members. *No action taken yet*
 - Distribute a navigational tool (*see attached*) in primary care physician offices, internists, etc. to describe next steps and available community resources.
 - Invite the public via community newspaper calendars to dementia conferences held at the Lou Ruvo Center for Brain Health, social service learning programs, plays, Alzheimer's Association Town Square Meetings.
- Physician and allied health care workers. Action Plan: Incorporate dementia training in continuing education programs.
 - Encourage the Nevada Board of Medicine to add requirements for dementia CME, CE, and CEU. (Perhaps swap the ethics credit or homeland security credit mandates and replace with dementia since it is a growing public health concern).
 - Offer quality CME to medical professionals to learn about the symptoms, diagnosis, and treatment of AD and related disorders. *Invited some of these groups to the **Dementia 2014** conference. This conference was recorded and can possibly be distributed or uploaded to well-characterized websites.*