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MINUTES

Name of Organization: Task Force on Alzheimer's Disease (TFAD)

Date and Time of Meeting: June 24, 2015
10:00 a.m.

Location:
Governor's Office of Economic Development
808 West Nye Lane
Carson City, NV 89703
(775) 687-9900

Governor's Office of Economic Development
Grant Sawyer Building
555 E. Washington Avenue, Suite 5400
Las Vegas, NV 89101
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To Join the Telephone Conference
Call-in Number: 877-336-1831
Access Number: 9186101

Agenda

I. Call to Order/Roll Call
Senator Valerie Wiener (Ret.), Chair

Members present: Sen. Valerie Wiener (Ret.), Peter Reed, Ph.D., Julie Kotchevar, Jeff Duncan (alternate), Jacob Harmon (alternate), and LeeAnn Mandarino (alternate)

Members participating by telephone: Gini Cunningham, Jane Fisher, Ph.D., and Jeanne Bishop-Parish (alternate)

Guest: Daniel Mathis

II. Public Comment (No action may be taken upon a matter raised under public comment period unless the matter itself has been specifically included on an agenda as an action item.)

No public comment.

III. Welcoming Remarks

Senator Valerie Wiener (Ret.), Chair

Sen. Wiener welcomed all and expressed appreciation for the high level of participation and engagement from everyone during the legislative session and beyond. She reminded the group of the upcoming tasks of reviewing and revising the State Plan as charged by statute.

IV. Approval of the Minutes from April 1, 2015 Meeting (**For Possible Action)**

Senator Valerie Wiener (Ret.), Chair

Dr. Jane Fisher motioned for the approval of the April 1, 2015 minutes. Dr. Peter Reed seconded. Minutes approved unanimously.

V. Status Report on Legislation

Senator Valerie Wiener (Ret.), Chair

Sen. Wiener presented the status report on legislation as follows:

AB 9—Recommendation 17—Sen. Wiener said that she had testified in the Assembly Judiciary Committee on this bill on Alzheimer's Advocacy Day. This bill was brought up initially to address those with assets under $10,000 with required reporting of those assets. If those assets were monitored and managed appropriately, those persons could possibly be allowed to stay at home with care. The bill was heard and many conversations took place with the courts. As a result, there was a shift from an 'accounting' of all people with assets under $10,000 to an open court review of the total well-being and status of the people who have those assets. Though this measure seemed to have consensus, it did not receive legislative support.

SCR2—Sen. Hardy's bill, including Recommendations 11-14—This addresses first responders and others in the State Plan regarding education, training, and awareness. This concurrent resolution passed and was enrolled on May 22, 2015, with the Secretary of State.

SB 196—Another one of Sen. Hardy's bill—This bill primarily focused on the stroke registry. However, in section 10, language from the bill states:
"unless a specific statute or regulation requires or authorizes a greater number of hours, a provider of healthcare may use credit earned for continuing education

related to Alzheimer's disease in place of not more than two hours each year of the continuing education that the provider of healthcare is required to complete, other than continuing education related to healthcare ethics."

This permissive provision gives flexibility to providers for Alzheimer's education up to two hours a year.

SB 177—The bill that the TFAD supported in Recommendation 8 in the State Plan. This is AARP's CARE Act, which listed the Task Force on Alzheimer's Disease (TFAD) as a supporter of the measure. This addresses working with caregivers to assist people as they transition out of care facilities. It helps inform and educate them, ensuring the highest level of care and standards. This measure was signed by the Governor on May 6, 2015.

Sen. Wiener further reported on two other bills which were not related to the TFAD State Plan, but may be of interest to group, including:

SB 262—This bill addresses the issue of selection criteria of non-residents or residents becoming sole guardians of wards in Nevada, along with added restrictions, which could affect people living with Alzheimer's disease and other forms of dementia, as they often need guardians. SB 262 was signed by the Governor on June 9, 2015.

AB 325—This bill provides for licensing and regulation of private professional guardians, including not allowing summary administration for wards to professionals and allowing out-state-residents to become full guardians of people in Nevada. AB 325 was signed by the Governor on June 8, 2015.

Of the measures related to the TFAD State Plan, the four that were in Sen. Hardy's resolution, SCR 2 and SB 196, all passed, along with SB 177 which we supported. Sen. Wiener again thanked the TFAD members for their engagement in advocating for these important measures from the State Plan. We were able to successfully address five recommendations, which required legislation, out of the twenty recommendations in the State Plan. This demonstrates significant work and success in our service on behalf of the people of Nevada.

VI. Updates and Discussion of Behavioral Health Placements/Facilities (Outcomes from the April 9, 2015 Hearing)

Daniel Mathis
President and CEO
Nevada Health Care Association

Daniel Mathis, President of the Nevada Health Care Association (NVHCA), introduced himself. He stated that the Nevada Health Care Association represents the state's post-acute care facilities, skilled nursing facilities, and assisted living centers.

Mr. Mathis gave an overview of the behavioral history in the state of Nevada. (Supplemental materials attached in the meeting file.) The following are highlights from the presentation:

- Over the last 20 years, Nevada Medicaid has funded out-of-state placement for behavioral issues.
- During the last ten years, the Nevada Department of Health Care Financing and Policy (DHCFP) has done some specific contracting with providers for behavioral specialty rates based on case-by-case basis.
- In 2013, San Francisco Attorney Dennis Herrera filed a class action lawsuit against the State of Nevada when patients from Rawson-Neal Hospital in Las Vegas were being sent to California improperly. As a result, many conversations and substantial work took place between the NVHCA and the American Health Care Association (AHCA) in California to ensure barring Nevada from similar patient discharge practices in the future.
- In 2014, DHCFP offered a tiered behavioral rate based on one-on-one staffing, but the providers did not like that approach so it was rejected by NVHCA.
- In 2015, DHCFP approved the current tiered reimbursement rate to providers with appropriate behavioral programming.
- The rates are reflected in the “DHCFP In-State Nursing Facilities Behaviorally Complex Rates Effective April 1, 2015”. These rates are in addition to the base rate for skilled nursing facilities.
- Some of the remnants of the one-on-one staffing requirements remain but they are not indicative of how the program is rolled out.
- Sample application and evaluation forms were highlighted. (Attached in meeting file.)
- Different reimbursement tiers get approved for a certain period of time, and these may be adjusted.
- There are no ‘diagnoses’ that would be dis-allowed for being included, but the determination would be based on behavior evaluation.
- A number of reports and evaluations will be requested by DHCFP for participation.
- After visiting facilities in the state to survey level of interest, DHCFP has reported that there are approximately 10 people in each facility who would qualify for one tier or another.
- NVHCA is also working with the Nevada Hospital Association on transitioning from a skilled nursing facility to a lower-level facility with the appropriate care. They are determining if the tiered rates can be used.

Mr. Mathis further explained to the TFAD the way Nevada pays skilled nursing through the supplemental payment calculation. Half of the calculation is based on patient acuity or the Case Mix Index (CMI). What has happened in the last few years to the Alzheimer's Unit is usually an Alzheimer's patient is a lower acuity index than a debilitative patient, which impacts their rate. So the facilities cater to the higher acuity patient, leaving those Alzheimer's patients to go to a lower level of care assisted-living or alternate housing with an Alzheimer's unit or memory care. A number of these have disappeared from the skilled nursing arena. With the changes, we will likely see a resurgence of appropriate care.

Mr. Mathis reemphasized that the DHCFP has been working on these rates for more than 10 years. Right now they're predicting about 500 bed days at an average rate of $200.00 a day and 365 days a year, which equals 36 million dollars. However, Mr. Mathis proposes that he thinks it'll be more likely 300 bed days at an average rate of $150.00 a day (between Tier I and II) times 365 days a year, which would equal around 16 million dollars a year. He further stated that, because skilled nursing has not had a rate increase in five years—and a five-dollar cut in 2011—the providers are eager to install appropriate programming and start serving the public.

Sen. Wiener asked Mr. Mathis at what point will we see the increases in the available beds. Mr. Mathis anticipates that there will be around seven to ten providers statewide that will aggressively take on the behavioral rate program in the next thirty days. He added that there have been meetings with the Governor and his staff, Richard Whitley, Department of Health and Human Services (DHHS) Director, and DHCFP to address the needs of the almost 100 Nevadans who reside in skilled nursing facilities outside the state.

NVHCA is also working with the hospitals to appropriately address concerns about people with cognitive disorders who end up in the emergency room. They want to ensure that these patients are transferred to the proper skilled nursing facility or lower-level facility to meet their needs. Continuum of care is the focus. NVHCA has been tracking about 1500 individuals who are "frequent flyers" to the emergency room to determine how to reduce the number of unnecessary returns to acute care. The same efforts could be undertaken on the behavioral side as well.

Sen. Wiener expressed her appreciation in hearing these new developments and asked Mr. Mathis to return to give us further updates in the future. In particular, the TFAD would be interested to hear about possible ways to bring those Nevadans sent out of state back home. Mr. Mathis pointed out that there is an additional piece of legislation that may be of interest to the group pertaining to this matter. AB 242 was signed by the Governor. It is a study of all post-acute care starting July 1, 2015. Everything from skilled nursing to assisted-living to the waivers will be reviewed. They want to figure out what the post-acute care scenario will look like for quality, reimbursement, and continuum of care. There could be some upcoming changes in the delivery of post-acute care services that could impact Nevadans. Mr. Mathis will report on this further in future meetings.

Peter Reed, Ph. D., inquired if once a determination of eligibility is made and the rate is applied whether there will be guidance given to the organizations and the providers around the care plan on the types of programs that will be most effective. Dr. Reed believes that often, with Alzheimer's and other forms of dementia, the behaviors are manifestations of some unmet needs of the care that is being provided. The individuals are communicating the unmet needs behaviorally, so it is a matter of improving the care and the support that they are receiving, which will reduce the manifestation of behavioral communications. Dr. Reed wanted to know, aside from getting the compensation, what are the providers getting specifically to meet the needs that are resulting in the behaviors? What approaches will ensure that the money is being used most effectively to help these people?

According to Mr. Mathis, when the program was first rolled out, it was based on one-on-one staffing and nothing else, but now the State has implemented a requirement that a behaviorist be engaged with programming and there are lots of different kinds of programming under consideration. Alzheimer's disease is an example of one program, but there are others like traumatic brain injuries, Huntington Chorea, and others. When Medicaid does a review, the expectation is that the provider will have the appropriate programming for the diagnoses and the behaviors exhibited.

A couple of behaviorist companies are updating their services with what the expectations will be. Furthermore, one of the facilities in the state has a behavioral facility in another state and has invited Mr. Whitley and Dr. Green, DHHS Chief Medical Officer, and others to see the type of programming and answer questions on compliance and what the expectations will be. Mr. Mathis reiterated that this is a new program for Nevada, and most of our providers in the state are not Nevada-based. They are chain businesses that have presence in other states where behavioral programming already exists. Providers are going to work with Mr. Whitley and his group to make sure that the programming they implement is appropriate and satisfies its review requirements.

Dr. Reed agrees that it will be beneficial to have behaviorists involved to create a behavioral intervention. He hopes that not only will there be an intensive focus on appropriate programming but also a widespread awareness and training among the direct care staff. Training on how to provide more appropriate care and minimize or prevent the behaviors in the first place would be critical. Mr. Mathis remarked that the skilled nursing facilities are mandated to require eight hours annually for each employee for training about Alzheimer's disease and other forms of dementia. Therefore, facilities can continually update their training and education. He added that, quality-wise, facility-specific data on programming and compliance will also be available to provide transparency to all. The NVHCA will look to organizations and committees like the TFAD for input to make sure that the education satisfactorily addresses the needs.

LeeAnn Mandarino commented that the Lou Ruvo Cleveland Clinic has programs that teach professionals diagnoses techniques and treatment techniques for Alzheimer's disease and frontotemporal dementia, Huntington's disease, and other diseases associated with dementia. Those programs are readily available and could be helpful to providers looking to qualify for the behavioral rate.

Mr. Mathis concluded his remarks by reemphasizing the significance of the establishment of these behavioral rates, which has taken more than 10 years of work. He acknowledged the Governor for recognizing the great need and having the courage to take action, even though this will require a large amount of State funding and engagement from DHCFP.

VII. Presentation and Discussion on "Driving and Dementia"

Dr. Jane Fisher
Department of Psychology
University of Nevada, Reno

Dr. Jane Fisher gave a presentation on the issue of driving and dementia in Nevada. (Notes are attached in the meeting file). Summary points from the presentation include:

1. Older adults are at greatest risk of involvement in fatal accidents, primarily occurring at intersections.
2. Persons with a neurocognitive disorder will eventually lose the ability to drive safely.
3. The subject must be considered carefully given the importance of driving for an individual's independence. Concerns include:
    - The issue becoming emotionally charged for individuals with Alzheimer's disease and other forms of dementia and family members due to impact on independence.
    - In Nevada and many other states, families are the best persons to determine if the individual is no longer capable of driving safely, but this becomes a highly contentious source of conflict.
    - Ideally, the person with dementia should make the decision to surrender his/her license while able to make this decision, but unfortunately that is often not the case.
    - Risks emerge when the individual is too impaired to make the decision but continues to drive.
    - Dangerous consequences may occur if the decision is not made in a timely manner and the individual continues to drive with impaired judgment.

Dr. Fisher stated that her team at the support center at UNR has worked to address this issue from several angles. They have looked at effective strategies in other states for determining whether or not someone's driving ability is impaired. Three questions emerged in this area:

1. What event or threshold should trigger consideration of driving restriction?
    - In most states, driving restriction is associated solely with age and not with the diagnosis. This is one question the TFAD might address.
2. If an individual experiences an event (e.g. diagnosis of neurocognitive disorders) or meets a specific threshold (e.g. in California if an individual is judged to be "moderately impaired," he/she would automatically lose driving privileges), what screening/assessment tools are most effective in assessing driving skill and safety?
    - The gold standard appears to be the implementation of various kinds of preliminary assessments, suggested by experts, and the on-road driving assessment. (A list of these can be seen on the CA.gov, California Department of Motor Vehicles report on "Dementia" attached on file.)
3. What criteria should be applied in determining that loss of driving privileges is appropriate to protect the safety of the person with dementia and the larger community?

Dr. Fisher reported that in other states:

- Age-triggered requirements are most common.
- Once an individual reaches a particular age, there is a shorter period between license renewals. In most states, the older the person is, the shorter the interval for the person to be re-evaluated. Interestingly, most of those age-related evaluations involve a written test, not an on-road assessment.
- Only 12% of states require physicians to report individuals who are cognitively or medically impaired. The medical impairment in some states is not specific to neurocognitive disorders, memory disorder, or dementia. If there is any concern, the physician is required by law to report the individual to the DMV.
- About 50% of states encourage physician-reporting but do not make it mandatory. The mechanism for reporting is not very streamlined. Because there is no centralized database, the process of reporting varies.
- Outcomes of data are hard to attain, in large part, because the diagnosis is often not clear. In some states, there is data reporting on the number of individuals who have lost privileges because of a medical condition but those data are not reported specific to neurocognitive disorders.

Sen. Wiener commented that Assemblywoman Robin Titus had a bill in this past session that dealt with diagnosis and reporting that may be a valuable resource on this topic. She asked staff to find information on this bill and add it to materials on this presentation.

Dr. Fisher invited Ruth Gay from the Alzheimer's Association of Northern California to share information about developments in California that may be instructive in guiding the TFAD on this issue. Ms. Gay explained what California has done, the State's expectations, and the related challenges. The following are summary points from her comments:

- In about 1995, California passed a mandatory reporting law. Any physician who made a diagnosis of Alzheimer's disease or any other forms of dementia was required to report it the Department of Public Health at that time, and then to the Department of Motor Vehicles (DMV).
- This requirement fell in the same category of diseases (e.g. Epilepsy, Multiple Scoliosis (M.S.), and others) where there is a lapse of consciousness.
- The Alzheimer's Association strongly supported this legislation because so many families came forward with significant concerns on the issue and their inability to take action when their loved ones refuse to cooperate. There were not many options for families to tackle this problem, so this law was a way for people who were identified to be called in and tested.
- According to the law, if someone were mildly impaired, the DMV would ask that he/she come in and be tested. If the person could pass the written test, he/she was then given the driving test. Then if the individual could pass the driving test, he/she could keep the license. Usually, this also triggered a review every six months to a year on the driving skills.
- A major challenge involved the medical assessment. If the doctor, in reporting, noted that the person was moderately or severely impaired, the license would be pulled without further involvement of the individual, and this person could lose his/her driver's license without even appearing at the DMV for assessment.
- Compounding the challenge, many doctors who do the reporting feel like they may not even be in the position to tell if someone is driving well or not, just by evaluating them in the office.
- It became very apparent that it would be very difficult for doctors to judge if there were no in-office tests to really assess whether an individual's driving skills are good or bad.
- To find a balance in the law, the question arose as to how to find a way to trigger testing for people to see how they're doing, not just remove the license.
- Over the last 20 years, many people were not identified for a variety of reasons. Some also lost their licenses without true need.
- Summarily, many challenges surfaced and the repercussions included some people withdrawing from diagnostic evaluations due to the fear of having their licenses revoked.
- Losing driving privileges is a very difficult and emotional loss for many people.

Ms. Gay reported that recently California has formed a task force to address and improve these concerns. They have developed specific guidelines for people to trigger testing for individuals. The CADMV has been working to develop tools to test driving skills on a computer screen, rather than putting them behind the wheel, to eliminate risk factors. They have also identified ‘specialists’ who work in larger DMVs who can discuss with people their concerns and needs pertaining to driving, provide testing, and suggest further resources to meet the families’ needs. The cost to establish these liaisons in the DMV offices is funded by the DMV as part of their programs.

Ms. Gay concluded that the ongoing issue seems to be the doctors not reporting or delayed reporting. She particularly pointed out that a doctor who reports to the DMV on a person with dementia is protected from liability. So there is an incentive for the doctor should something happen with liability.

Sen. Wiener remarked that the concerns regarding driving had been discussed in the ACR 10 Task Force, not as a recommendation, but for information. She would like to explore how to incorporate this into the State Plan, especially since Nevada is the second largest growth state for dementia behind Alaska, and these issues will become a growing challenge for the state.

Ms. Gay advised that a good place to start may be to look at what avenues may be available to families or physicians to have a driving license of a person with dementia pulled or tagged in some way. Also consider doing a survey of what options people have right now if there are concerns regarding driving. What is the process in Nevada now and how effective is it? What opportunities might there be for better enhancements of the skills for those who will be reviewing those people with potential driving impairment? What are the ways for physicians, concerned families, or individuals to report somebody?

Ms. Gay also shared that in California a person can submit a report confidentially if there are concerns about driving. They have developed a form that can be used for submission. The DMV can then follow up and investigate the case. Various input from different sources are required to verify the situation, and an appeal is included, should it be needed. This is at least one option a family can consider.

Dr. Fisher reported that the NVDMV website has a similar mechanism for unanimously reporting, but she is not sure what happens after a form is submitted. She noted that in northern Nevada, there are a few facilities that provide driving assessments through a simulator. The equipment is empirically based so the performance on the simulator is highly correlated with performance on the road.

Dr. Fisher recommended that the TFAD consider providing guidance to families on these issues. In her work, she has encountered many families who allowed loved ones to continue to drive, even though they truly should not be, simply for convenience. Families need to make proper considerations to do the right thing not just to accommodate their needs but also consider the consequences to the safety of others as well. She commented that guidelines for families could be included in the ADRC website being developed currently.

Sen. Wiener reiterated that guidelines, support for families, and education can be a starting point to integrate into a new recommendation, which can be further developed.

Jacob Harmon from the northern Nevada Alzheimer's Association added that complex dynamics exist between the person living with Alzheimer's disease and other forms of dementia, their families, their physicians, and the role of the State, which present a lot of challenges on these issues. Mr. Harmon encouraged the group not only to include family caregivers and physicians in this discussion, but also people who are living in the earliest stages of Alzheimer's disease and other forms of dementia. The Alzheimer's Association is working with many Nevadans with these conditions who are living alone, especially in rural areas. If their driving privileges are revoked prematurely, it places an undue burden on them and also State services. It would also be beneficial to involve people from the transportation sector to explore not only how to address the concerns, but also how to support those who legitimately are no longer able to drive. Mr. Harmon urged the group to consider a comprehensive solution.

Julie Kotchevar reported on a recent catastrophic incident in northern Nevada involving impaired driving which took the lives of two innocent children. The individual, who had lost his driving privileges on and off, had experienced a medical event and lost control. This incident has garnered a lot of attention and generated discussions in the community. The TFAD's focus on these issues is much needed and relevant.

Ms. Gay described a fatal incident in Clark County involving a man with apparent medical and mental impairments who continued to drive despite those challenges. In the legal process, his family was victimized and accused of irresponsibility, and all parties experienced much trauma. Debates ensued among the public and in the media. It's clear that the issue can produce many ramifications.

Gini Cunningham informed the group that the caregivers often look to the DMV for help with issues with drivers' licenses and what to do. Law enforcement entities and others also want more education to understand Alzheimer's disease and other forms of dementia in order to fulfill their role better. Sen. Wiener remarked that the recent passing of important legislation pertaining to education and training for first responders will improve how these needs are addressed.

Dr. Reed expressed appreciation for the valuable information that has been brought forward. He conveyed the need to consider a balance between safety, autonomy, and everyday rights. Dr. Reed further proposed to the group to consider forming a subcommittee to actively work on some possible recommendations to try and navigate the many facets of this complex issue.

Sen. Wiener proceeded with the idea of forming a subcommittee. Dr. Fisher was asked to lead, and she accepted. Dr. Reed and Ms. Cunningham agreed to participate as subcommittee members. Sen. Wiener charged the team to come up with an outline and preliminary draft of a new recommendation on driving, along with the indicator and potential funding. Explanatory language would be needed as well. Sen. Wiener asked the group to bring forward this work to be reviewed and voted on as an agenda item in the next TFAD meeting.

VIII. Presentation and Discussion on Outreach in Rural and Urban Nevada
Julie Kotchevar and Jeff Duncan
Aging and Disability Services Division

Julie Kotchevar was asked to talk about outreach in both rural and urban Nevada, including strategies that have been successful. She also mentioned ADSD has been supporting Ms. Cunningham's work on producing posters, brochures, and other awareness materials for distribution on a rural tour.

Ms. Kotchevar stated that she gathered information from various advocates in the ADSD programs, including those involved with Child Find, a children's program, as well as advocates for elders who participated in health fairs throughout different communities. Ms. Kotchevar presented six proven strategies the advocates found most successful. Samples of these items were shown to the group.

1. Both seniors and kids appreciate really nice leave-behinds. Items include light-up yo-yos, key chains, and pens (e.g. puzzle pens for the Autism Program) specific to the interest of the group. Good quality magnets are also very popular. Contact numbers for the programs are printed on these objects. Advocates found that people retain these items longer than brochures and papers.
2. Booklets are also appealing. A booklet on developmental milestones for babies was demonstrated. This had already been printed three times due to popularity. People find them very useful. ADSD has explored whether something similar could be made for seniors with signs of dementia and information on available senior resources. The format for this booklet came from the Centers for Disease Control and Prevention (CDC). The TFAD can look into more possibilities of using existing formats the CDC already possesses, which will reduce the cost for publication.
3. Add service offerings at health fairs (screenings, tests, demonstrations, etc.) to generate more interest. Also, be aware of cross-over attendees at health fairs, so the target audience can be expanded when different programs work together. (For example, family members can get

information for seniors who are not in attendance themselves if the information is available.)

4. Offer training for Continuing Education Units (CEUs). The turnout increases exponentially when these opportunities are presented.
5. Brands/symbols are important (e.g. the Early Intervention bear and Autism Treatment Assistance Program (ATAP) puzzle piece). Recognizing the significance and meaning of the symbols, as well as making sure that everything is really easy to read, concise, and attractive, capture much more interest.
6. Appropriately using technology and making sure it is easily accessible by the public and applicable to the population you are trying to reach is crucial (e.g. reach younger set by texting and social media). Cross-pollination methods for public announcements also proved worthwhile. For example, running an ad for a children's' program on PBS in northern Nevada during Masterpiece theatre, a more mature feature, actually generated more responses during that time than during Sesame Street. It was also very cost-effective and reached more homebound audiences.

Ms. Mandarino inquired whether these advertisements have been effective in driving people to the ADSD website. She would like to increase interest from people in the rural areas on webcasts, etc. Ms. Kotchevar reported that people do not actually like to go to the website but will call in, which is more ideal to establish relationships. ADSD will display a phone number rather than a website, and make sure that there is wonderful staff to provide support for those who call. Initially, most people prefer to talk with a live person and then, subsequently, they can be referred to additional materials online.

Ms. Cunningham testified that distributing materials in person, with the contact phone number on the back, and making personal connections, is the ideal method, as well as making follow-up phone calls to solicit further engagements. Ms. Cunningham reported that she has visited nearly 100 businesses, distributed about 125 brochures and 50 posters during her tour of the rural towns.

IX. Review and Discussion of 20 Recommendations in the State Plan, As Assigned to TFAD Members

Senator Valerie Wiener (Ret.), Chair

Sen. Wiener conducted the review and discussion of the State Plan by going over each recommendation as follows:

Recommendation 1: Information Referral System

Albert Chavez sent an update on the development of the ADRC website (attached on file). Information will be forwarded to the group.

Recommendation 2: Advanced Practice Registered Nurses (APRNs)

An APRN update (on PowerPoint) from Debra Scott of the Nevada State Board of Nursing Board was made available to group on the ADSD website (attached on file.) Sen. Wiener also shared information from a summary letter on the progress of APRNs (attached on file). She related that things are progressing well since the passage of AB 170 in 2013. The total number of APRNs as of June 2014 was 1105, which reflects a 20% increase over the previous year. Now we have 1162 as of May 2015. Sen. Wiener stated that in Nevada there is an increase in applicants from out of state where they do not have this kind of licensure. She quoted from Debra's letter, "One might assume that APRNs are migrating from more restrictive practice environments to Nevada to be able to practice their full scope." Sen. Wiener emphasized that AB 170 did not change the scope of practice, but allowed the APRNs to practice independently.

Recommendation 3: Telehealth and Telemedicine

Mr. Harmon relayed that Renown had a telehealth bill (AB 292), which he believed passed during the session. This bill focuses on reimbursement rates and developments related to telehealth.

Dr. Reed remarked that it's important to distinguish between telehealth and telemedicine. Project Echo is a telehealth system, because it provides education on a variety of different topics; telemedicine is the delivery of healthcare services through remote technology.

Sen. Wiener commented that we would need to look at revising the language for this recommendation to separate out those who provide telehealth services vs telemedicine.

Recommendation 4: Remove Age Barriers

Ms. Kotchevar provided a respite summary (attached on file). Ms. Kotchevar explained that in 2014, 379 consumers received respite services under ADSD waivers, including waivers for the frail elderly and waivers for Independent Nevadans who have physical disabilities. In addition, ADSD provided grants to community organizations and those are currently available through East Valley Family Services, Family Resource Center of Northeast Nevada, Nevada Senior Services, Alzheimer's Associations, Helping Hands of Vegas Valley, Seniors in Service, Catholic Charities, and Nevada Rural RSVP. ADSD also applied for and received a federal lifespan respite grant to help strengthen the current respite care system, as well as providing vouchers for emergency respite services for the next couple of years.

Sen. Wiener asked whether it would be fair to estimate that five percent of the total number of dementia-related consumers who received the services, as mentioned, was the younger-onset group. Ms. Kotchevar said she thinks the waivers applied to the older population, but the grants may involve the younger-onset individuals. She pointed out that no specific information was collected regarding the exact demographics of the distribution of the vouchers. Sen. Wiener wanted to confirm that no one was denied the respite care, regardless of age. Ms. Kotchevar stated that the age requirement was taken off of the programs, and people with Alzheimer's disease or other forms of dementia can qualify regardless of age.

Recommendation 5: Outreach to Cultural Communities

(Dr. Fisher had left the meeting.) Ms. Kotchevar reported that ADSD had broadened this to make sure that cultural competency was included in language going out for their grants. She has also spoken to the Department of Health and Human Services (DHHS) and received commitments from the Grants Management Unit to include cultural competency in their grant applications. Ms. Kotchevar said that this will be included in the next grant cycle, depending on the grant. Cultural competency will be listed in the grant requirements.

Recommendation 6: Affordability of Services

(Wendy Simons had been excused from the meeting.) Ms. Kotchevar told the group that ADSD had made a commitment to track and analyze national data. ADSD will provide a report prepared by University of Nevada Las Vegas (UNLV), which include an analysis of provider rates and reimbursements. In this past legislative session, ADSD had requested a provider rate increase for all of their providers; however, the budget addressed only an increase for developmental services providers who were paid 30% less than the Medicaid rates. This resulted in a small increase. ADSD is monitoring the national data and the state data, Medicare, and Medicaid to look at what the rates are for reimbursable services. Ms. Kotchevar mentioned that ADSD's providers for senior services have not had a rate increase for more than 10 years, so ADSD is monitoring this closely. It is also part of the ADSD Strategic Plan to make the reimbursement rates more equitable.

Recommendation 7: Establishing a Nevada Consortium to Promote Current and Future Research

The formation of a research consortium will be organized by the Cleveland Clinic Lou Ruvo Center for Brain Health. Ms. Mandarino said they will follow up on generating a list of attendees.

Recommendation 8: Specialized Care Pathways

No updates from Dr. Charles Bernick or Ms. Mandarino at this time. Ms. Kotchevar pointed out that the CARE Act (SB 177), incorporated in this recommendation pertaining to specialized care pathways, passed in the legislative session so that portion has been completed.

Recommendation 9: Quality Long-Term Care

Mr. Mathis provided information regarding long-term care in his presentation earlier, and will be updating the TFAD in future meetings as well.

Recommendation 10: Reducing Out-of-State Placement

The topic of reducing out-of-state placement was discussed in Mr. Mathis' presentation. Sen. Wiener commented that the TFAD would like to hear more from Mr. Mathis on the outcomes of the efforts by Mr. Whitley, Dr. Green, and their group regarding the returning of the 70-80 people who have been placed out of state.

Ms. Kotchevar inquired about the intention of this recommendation to change the culture so that people would not be sent out of state. She remarked that the TFAD had previously discussed adding an education piece to the recommendation, using the Civil Monetary Grants.

Dr. Reed reiterated that one of the intended outcomes from implementation of the behavioral rates would be to reduce out-of-state placements and get people home. One of the strategies would involve providing effective care, which can only be done through more comprehensive training on transforming the culture of care. Dr. Reed commented that it would be helpful if there were mechanisms to explore funding to engage people collaboratively in implementing these changes. The behavioral rate is a starting point for this.

Sen. Wiener said, according to Mr. Mathis' report, there may be a lot of movement in this area in the near future, which could perpetuate the blending of Recommendations 9 and 10.

Recommendation 11: Awareness and Education for Health Care Providers; Recommendation 12: Continuing Education Opportunities for Nurses and Other Health Care Professionals; Recommendation 13: Training for Hospital Personnel; Recommendation 14: Training Hours for First Responders

These are Sen. Hardy's recommendations, involving SCR 2, which was enrolled with the Secretary of State. This powerful resolution will make a positive impact going forward. Sen. Wiener commented that the TFAD will need to consult with Sen. Hardy on what is to be done further, and whether these recommendations should be combined in the same way they were presented in SCR 2. The CEU piece in Section 10 of SB 196 was also a success and will generate more interest in Alzheimer's-related education. Sen. Wiener said that we will need to continue to monitor these recommendations and determine additional steps we may want to take or suggest as an advisory panel.

Ms. Mandarino commented that the education credits will make a difference for the providers, if they are promoted more effectively. She told the group about another bill that involves getting extra credit hours for taking geriatric courses, and dementia would be included. It's a matter of creating a greater awareness for the providers. She will provide additional information to the group on this.

Recommendation 15: Respite Services

This recommendation pertains to evidenced-based caregiver programs. Sen. Wiener again expressed the need for further updates on this, along with other recommendations, as we approach time to modify the State Plan.

Dr. Reed stated that there is a new State-funded initiative, funded by the Administration on Aging (AOA), to enhance the State's capacity to serve people living with dementia, as well as caregivers, throughout the state and in communities. There are several evidence-based interventions, which are a part of that initiative, that are going to be rolling out this summer and over the next three years.

According to Dr. Reed, there is a current national initiative with the Alzheimer's Association to evaluate their existing caregiver support programs and demonstrate the efficacy and the impact of those programs. This will enable them to be regarded as evidence-based programs. Dr. Reed added that there is a lot of movement in identifying the appropriate programs and implementing those in Nevada.

Recommendation 16: Volunteers

Ms. Cunningham shared the developments in her work with rural outreach and recruitment of additional volunteers. She related that in-person presence makes a difference. She has attended numerous health fairs and volunteer days, which helped increase awareness in Alzheimer's disease and other forms of dementia, as well as ensured the public that the State cares about them. She has done a lot of writing and making connections with people throughout the state.

Ms. Cunningham reported that in Winnemucca, they are now aligned with the Cleveland Clinic and the Wednesday Lunch and Learn sessions are now available to interested parties. She will be working with the Wellness Coordinator at the hospital to get the word out about these great opportunities. This helps extend the health network in Winnemucca.

Ms. Cunningham stated that she has visited eight rural communities and will be traveling to eight more. She is also implementing the Music and Memory program, which is an additional way to get in touch with people. Ms. Cunningham said that the World Health Organization (WHO) has a checklist of essential features of age-friendly cities, which does not include many cities in the United States. Therefore, she wants to make sure that Winnemucca will meet these standards in a variety of ways.

Dr. Reed added that a report, distributed by Alzheimer's Disease International, encompasses a large international initiative to promote Alzheimer's-friendly communities. The report outlines characteristics of such communities and the resources to help develop them.

Recommendation 17: Small Estates

This recommendation deals with AB 9 guardianship and accounting/reporting. Sen. Wiener felt that the shift to an open review in court that addresses the total well-being of the individual was agreeable to all parties, but the bill did not move forward for some reason. However, there may be a chance for this to progress in the future.

Recommendation 18: Hospital Transitional Care Programs

We will need an update next time on this recommendation of Sen. Hardy's regarding the best-practice hospital transitional program.

Recommendation 19: Collaborations and Partnerships on Education and Training for Caregivers

Ms. Mandarino stated that she has reached out to first responders, including paramedics and Las Vegas Metropolitan Police, and discussed doing an education program with them on the signs and symptoms of dementia. Discussion also took place about incorporating information into the ADRC website for greater exposure. In addition, she talked about the creation and distribution of awareness materials, such as a poster about 10 Warning Signs of Alzheimer's disease put out by the Alzheimer's Association, and putting those in doctors' offices, especially Primary Care Physician offices. Other locations, such as urgent care and hospital emergency rooms, should also be considered.

Sen. Wiener asked Ms. Mandarino to work with ADSD to explore possibilities for support for funding and distribution of these materials. Ms. Mandarino explained the compass she has created, which shows how to navigate the disease, once a diagnosis is received, and resources available to assist in a variety of ways, including legal services, elder daycare, etc. This could be useful for distribution because it targets those who need the assistance the most.

Recommendation 20: Public Awareness Campaigns

Ms. Kotchevar commented that the State of Nevada has an Employee Assistance Program (EAP), which is a national program that serves large companies and organizations. It provides information on various needs from tax advice to counseling to alcohol and drug rehabilitation, etc. If we can get a contact for the EAP, this could be an avenue to present an Alzheimer's program.

Mr. Harmon remarked that the Alzheimer's Association already has a program in place called the Alzheimer's Workplace Alliance (AWA). They are actively doing trainings for Human Resource (HR) departments and employees of major corporations in and around the northern Nevada and northern California area, educating companies on how they can support their employees who are caring for their loved ones and educating employees about the resources that are available.

X. Consider Agenda Items for Next Meeting **(For Possible Action)**
Senator Valerie Wiener (Ret.), Chair

Agenda items for the next meeting may include:

1. Additional updates from Mr. Mathis
2. Subcommittee report on driving and dementia, which could be a new recommendation in the State Plan
3. State Plan review for possible modifications/additions
4. Caregiver support presentation

XI. Discuss and Vote on Next Meeting Date **(For Possible Action)**
Senator Valerie Wiener (Ret.), Chair

Dr. Bernick does not see patients on Friday and has requested that, if possible, the TFAD could schedule meetings to accommodate his schedule. Future dates proposed include:

1. Friday, August 21, 2015, 10:00-3:00 p.m. (video conference)
2. Friday, October 23, 2015
3. Friday, December 11, 2015 (possible face to face)
4. Friday, January 8, 2016

XII. Public Comment (No action may be taken upon a matter raised under public comment period unless the matter itself has been specifically included on an agenda as an action item.)

No public comment.

XIII. Adjournment

The meeting was adjourned at 12:55 p.m.