STATE OF NEVADA DEPARTMENT OF HUMAN RESOURCES

STRATEGIC PLAN FOR SENIOR SERVICES

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The Honorable Kenny C. Guinn
Governor
State of Nevada

Michael J. Willden
Director
Department of Human

STRATEGIC PLAN CONCERNING THE HEALTH CARE NEEDS OF THE CITIZENS OF NEVADA

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I. Summary and Background

Introduction

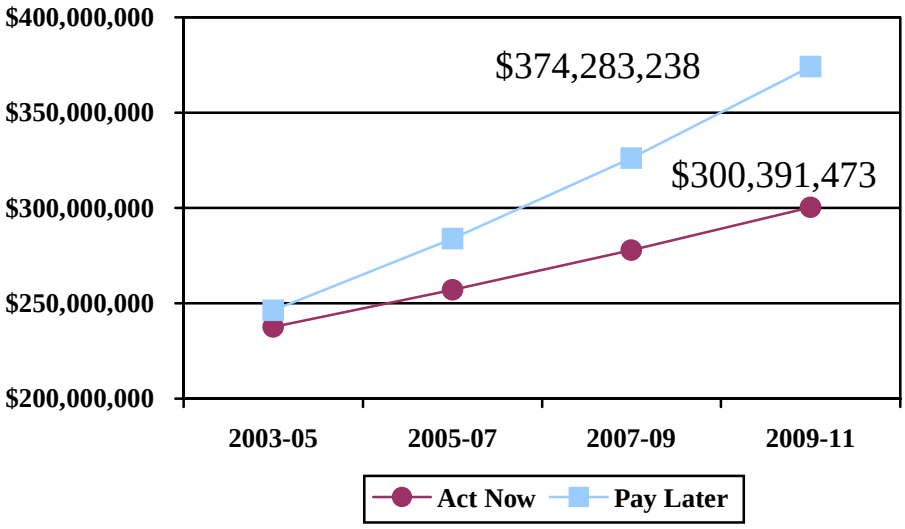
Nevada has a compelling opportunity for action. The recent, large influx of relatively young, affluent seniors will age in place. This group, combined with the historically smaller and older group of long-term resident seniors, can become an important future resource or a major burden.

That is the choice the State must now make. It stands on the threshold of inevitable growth in the number of frail seniors who will need care and services. The choice is between two different scenarios:

1) Continue the present system, still largely institutionally-based despite recent growth in home and community services; or

2) Developing the system desired by seniors and their families, which shifts the provision of services from skilled nursing homes to homes and the community.[1] This concept became the keystone of the *Plan.*

Figure 1. Total Nevada Long-Term Care Costs Under Two Scenarios



[1] This *Plan* calls for a scenario ("Act Now") in which *all* of the growth in the population of disabled or fragile Nevada seniors receiving publicly-funded long-term care is in home and community-based services. Figure 1 above shows the difference in public costs between the strategies laid out in the *Plan* and what would happen if skilled nursing facilities absorbed all of the growth related to population changes ("Pay Later"). Figures 2 and 3 on the next page show the differences in the number of people receiving each type of service under the two scenarios.

The good news is that Nevada seniors and their families are traditionally self-reliant. They want to care for themselves and each other and remain independent as long as possible. They are modest users of health and social services relative to residents of other states. These are the very precious assets upon which this *Plan* builds.

The bad news is that formal Nevada systems are already straining to meet senior citizens' needs. *If these needs are not addressed* over the next 10 years by thoughtful and creative approaches, the very families who are now assets will become over-burdened and depleted trying to meet their loved ones' needs without adequate formal support.

This *Plan*, authorized and funded in 2001 by the Nevada State Legislature in Assembly Bill 513, lays out a vigorous campaign to maintain the health and independence of seniors and their families. It proposes dynamic strategies and achievable, reasonably-priced targets appropriate for the State's history and strengths. The strategies and targets also address several major weaknesses Nevada shares with other states:

- an insufficient supply of home and community services—on average, less costly, but less familiar to physicians and families;
- over-reliance on more expensive medical and institutional services aimed at acute, episodic treatment rather than preservation of health and function or prevention of disease;
- poor coordination between the two types of services that works against meeting seniors' needs comprehensively.

The Senior Services Task Force that developed this *Plan* assumes the supply of nursing home beds will remain at the level it is today, while home and community-based services will increase. However, the Task Force also recognizes that reimbursement for institutional services must be adequate to support the quality of care required to meet regulations and the demands of the public.

Figure 2. Act Now Recipients

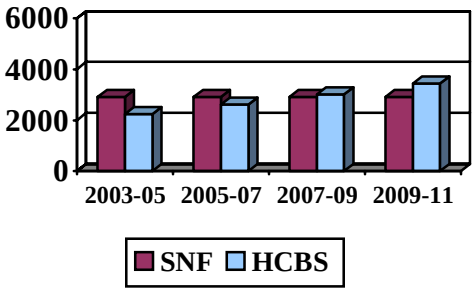
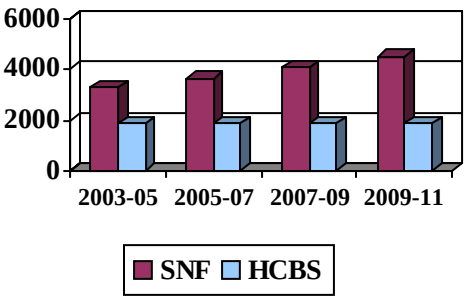


Figure 3. Pay Later Recipients



Guiding Principles, Core Values, and Over-Arching Strategies

The Senior Services Task Force has a compelling vision:

> All seniors in Nevada are knowledgeable, secure, respected and able to make choices toward health, hope and happiness. They have maximum independence, direct their own care, and are fully engaged in the occupation of life. A balanced care system is equally available to, and of equal quality for, all seniors. It has an adequate supply of the right resources with all types of services readily available.

The Task Force selected six over-arching strategies to create this system without undue reliance on increased public expenditures:

1. A dynamic information campaign will increase the public's awareness of aging and educate and empower individuals and their informal support systems, as well as the voluntary sector, to create a positive climate for aging in Nevada.

2. A combination of incentives, regulation, and advocacy (both State efforts and those supported by the State) will encourage private sector initiatives and other changes including: 1) development of appropriate housing and transportation services; 2) comprehensive, medical/social approaches to health care integration; 3) long-term care insurance; 4) new or expanded preventive health programs; 5) greater emphasis by local law enforcement officials on enforcing fraud and abuse statutes; and 6) more local regulation of air quality that causes lung disorders and other health problems.

3. A "single point of entry" system will enable all seniors and their families to much more easily access information about how to get assistance, care planning and care management, and other essential services.

4. Changes in reimbursement rates and development of career incentives will increase compensation and benefits and provide other inducements to develop and retain a highly-qualified, stable, frontline long-term care workforce.

5. Increased investment in home and community-based services will be accomplished through several means. These include accelerating the extension of such services to those above the Medicaid income level who are disabled or frail enough to be served in a skilled nursing home but prefer to remain at home, and quickly identifying seniors about to leave the hospital or enter a skilled nursing facility and offering them community-based services. These and related efforts will add momentum to the shift from institutional to home and community-based care.

6. New and timely data collection and analysis will provide vigorous accountability by allowing members of the Commission on Aging Strategic Health Plan Implementation Subcommittee to track, on a quarterly basis, whether the *Plan's* strategies are being implemented and the measurable targets they set are being achieved.

Summary Target Areas, Target Area Strategies, and Targets

TARGET AREA I: *More Nevada seniors live in the setting of their choice with support to remain as independent and healthy as possible.*

This target area calls for strategies and actions that directly support the overall outcome of independence that all senior Nevadans want, regardless of their health status and functional ability. This outcome simultaneously benefits seniors and those who must pay for their support.

Strategies:

A. Adopt a statewide policy regarding the proportion of Nevada seniors and people with disabilities who will receive publicly-funded long-term care in their own homes.

B. Develop an integrated Nevada data system with the capacity to track data for selected health and long-term care indicators.

C. Study the barriers and benefits of both integrated and segregated assisted living options for seniors with Alzheimer's Disease and related cognitive impairments.

D. Explore various approaches to assuring that seniors living in fully-accessible units have integrated or wrap-around services when they need them.

E. Expand current and add new efforts to divert entry of seniors from hospitals to nursing homes and relocate nursing home residents back to their homes, while adding ways to assure this can happen promptly, with no waiting.

Targets:

1. By June 30, 2010, 60% of the senior Nevadans who get publicly-funded long-term care are at home, while only 40% are in chronic care institutions.

2. By June 30, 2010, the Nevada hospital admission rate and average length of stay for seniors 65+ are 15% less than the baseline year, 2000.

3. By June 30, 2010, no Nevada seniors with Alzheimer's Disease are housed in out-of-state facilities.

TARGET AREA II: *More Nevada seniors engage in the occupation of life.*

Studies show that an important component of seniors' health is continuing social engagement. This target area outlines actions designed to help seniors, both those who are relatively independent and those who are more frail, to remain as active and involved in community life as possible. It also provides support for their caregivers to be healthier and contribute to the community.

Strategies:

A. Through the public education campaign, promote the use of formal, out-of-home respite options.

B. Increase the availability and use of a variety of assistive and adaptive devices (such as vision and hearing-related devices) that enhance independence.

C. Offer flexible respite care options to help elderly caregivers remain involved in their own lives.

Targets:

4. By June 30, 2010, 1,200 Nevada senior caregivers caring for a family member with a disability use at least one formal respite care option with benefits they and their families can depend on.

> ***"I got involved because I was a caregiver for a mother with Alzheimer's. I almost got divorced. I went through hell. I wanted to make things better."***

TARGET AREA III: *More Nevada seniors have improved health outcomes.*

The *Plan* recommends empowering seniors to take more responsibility for their own health and to act at a time when they are still relatively young and healthy. While there is no doubt the formal health system needs to change in the direction of better integration of health and medical approaches, dramatic system cost increases (combined with patients' desires for greater amounts of high technology care), have diverted attention from this important goal. We believe change will begin with the senior him/herself.

Strategies:

A. Educate seniors and their caregivers to define their health care needs comprehensively, to recognize the interaction between their mental health and all aspects of their physical health, and to better manage their own health and chronic conditions.

B. Expand participation in the Senior Rx Program to assist seniors to afford needed medications.

C. Expand medication management programs to improve health benefits and decrease the costs of prescription drugs.

D. Design and implement a comprehensive senior oral health strategy that includes adding oral health prevention and treatment for seniors using rural health centers and expanding waiver benefits to include twice-yearly preventive dental services for all senior participants.

Targets:

5. By June 30, 2010, the percentage of Nevada seniors 75+ who are severely disabled has declined from the baseline year 1997.

6. By June 30, 2010, 10,124 low-income seniors participating in the Senior Rx Program can afford the medications they need.

7. By June 30, 2010, Nevada seniors participating in the expanded medication management program have fewer hospital admissions than they had prior to enrolling in the program.

TARGET AREA IV: *More Nevada seniors live in homes that are safe, fully-accessible, and affordable.*

Private sector strategies are key to the success of the *Plan*, particularly in the area of housing development. In order for these to be successful, advocacy is needed to bring about education of private developers and initiate selective regulation. At the same time incentives must be created and offered to encourage development of the kind of housing seniors want. Public agencies will lead the way by assuring that the homes in which seniors live are as accessible as they can be to promote independence.

Strategies:

A. Require all new construction (public and private) aimed at a senior market to be fully-accessible.

B. Offer low interest bond financing for senior housing and long-term care projects.

C. Obtain adequate sponsorship and funding for life-sustaining heat and air conditioning repairs.

D. Retrofit existing senior units managed by public housing authorities so they are fully-accessible.

E. Assure that all Medicaid waivers include home repair and home modifications for senior participants.

Targets:

8. By June 30, 2010, 290,000 Nevada seniors pay no more than 30% of their income for housing and utilities.

9. By June 30, 2010, 700 Nevada seniors occupy public housing units that are fully-accessible.

TARGET AREA V: *More Nevada seniors who are frail or disabled go from one place to another when they need to.*

Transportation, of all the areas the Task Force examined, seemed one that was highly important and, at the same time, most problematic. Transportation is essential to independence. It is often difficult to arrange and extremely expensive when the senior can no longer drive. Its absence leaves the frail or disabled person stranded apart from community life. Much effort needs to go into studying and providing leadership for needed changes in transportation systems and their expansion to all in need.

Strategies:

A. Conduct an independent study of methods to strengthen Nevada transit programs and approaches so they provide improved quantity and quality of service to seniors and people with disabilities.

B. Assist all existing providers who transport Medicaid-eligible clients to become eligible for Medicaid reimbursement.

Targets:

10. By June 30, 2010, 19,300 frail Nevada seniors get where they need to go each year.

> ***"Those who have been left alone for any reason have a difficult time coping. In my own case the nearest relative is 225 miles away and is extremely busy with a full time job and volunteer work. Since I am nearly 88 years of age and am partially disabled, I am no longer allowed to drive."***

TARGET AREA VI: *More Nevada seniors get the benefits, services and supports they need.*

In this area, in particular, Task Force members were careful to prioritize and select the very most important services and issues for focused attention. The strategies and targets selected will benefit seniors at all income levels. It is clear that information, assistance, and care management (when it cannot be provided by a family member) are fundamental to being able to stay in one's home and community. The single point of entry system, already well-underway, will complement the over-arching strategy of a broad public education campaign.

Strategies:

A. Design, fund, and implement a single point of entry system for information, referral, assistance, care planning, and care management.

B. Analyze and recommend changes to State and County roles and responsibilities to assure Nevada seniors have equal access to, and eligibility for, home and community based services.

C. Implement recommendations from the Personal Assistance Services Advisory Council and study the relationship among personal assistance services, homemaker services, and in-home respite care to determine which funding sources pull in the greatest number of federal dollars relative to the investment of state funds.

Targets:

11. By June 30, 2010, 85,000 Nevada seniors and their family members use a single point of entry system to access information and referral for the array of available services.

12. By June 30, 2010, 9,120 frail or disabled Nevada seniors receive the care planning assistance and care management they need.

13. By June 30, 2010, 10,650 low-income Nevada seniors use personal assistance and or homemaker services.

"I can only wash dishes for a short period of time. I can't even sweep the floor. My physical limitations get in the way."

Biennium	Target 1	Target 2	Target 3	Target 4	Target 5
2001 – 2003	33% Home and Community Based Services (HCBS) 67% Nursing Homes (NH)	Establish baseline for hospital admission rate and average length of stay	43 seniors with Alzheimer's Disease or cognitive impairment are placed in out-of-state facilities	835 senior caregivers are receiving respite	Baseline unknown
2003 – 2005	39.5% HCBS 60.5% NH	Reduce by 3.75% of 2000 levels	34 seniors are placed out-of-state	926 senior caregivers	Determine baseline for severely disabled seniors 75+
2005 – 2007	46% HCBS 54% NH	Total reduction is 7.5% of 2000 levels	23 seniors are placed out-of-state	1,017 senior caregivers	Set percentage goal
2007 – 2009	52.5% HCBS 47.5% NH	Total reduction is 11.25% of 2000 levels	11 seniors with are placed out-of-state	1,108 senior caregivers	Survey seniors to determine change
2009 - 2011	60% HCBS 40% NH	Total reduction is 15% of 2000 levels	No seniors are placed out-of-state	1,200 senior caregivers	Verify percentage change

Biennium	Target 6	Target 7	Target 8	Target 9	Target 10
2001 – 2003	7,500 Senior Rx participants	Establish program and determine baseline. Set % goal for hospital admissions of medication management participants	260,134 seniors can afford housing	78 seniors live in fully accessible public housing units	Number of riders is unknown
2003 – 2005	8,500 Senior Rx participants	Track hospitalization rates of program participants	260,134 seniors can afford housing	100 seniors live in fully accessible public housing units	Determine # of riders using public transportation
2005 – 2007	9,041 Senior Rx participants	Track hospitalization rates of program participants	270,000 seniors can afford housing	300 seniors live in fully accessible public housing units	16,000 riders are using public transportation
2007 – 2009	9,582 Senior Rx participants	Track hospitalization rates of program participants	280,000 seniors can afford housing	500 seniors live in fully accessible public housing units	17,650 riders are using public transportation
2009 - 2011	10,124 Senior Rx participants	Determine % change in hospitalization rates and analyze budget savings	290,000 seniors can afford housing	700 seniors live in fully accessible public housing units	19,300 riders are using public transportation

Biennium	Target 11	Target 12	Target 13
2001 – 2003	Establish a Single Point of Entry (SPE) system	5,828 seniors receive care planning assistance and care management	6,572 seniors receive personal care/homemaker services
2003 – 2005	30,000 seniors and their family members use the SPE	6,651 seniors receive care planning assistance and care management	7,590 seniors receive personal care/homemaker services
2005 – 2007	48,350 seniors and their family members use the SPE	7,474 seniors receive care planning assistance and care management	8,610 seniors receive personal care/homemaker services
2007 – 2009	66,750 seniors and their family members use the SPE	8,297 seniors receive care planning assistance and care management	9,630 seniors receive personal care/homemaker services
2009 - 2011	85,000 seniors and their family members use the SPE	9,120 seniors receive care planning assistance and care management	10,650 seniors receive personal care/homemaker services

Summary of *Plan* Costs

This *Strategic Health Plan* sets forth a set of new and continuing investments totaling **$373 million** that will profoundly increase the health and independence of all Nevada seniors and their families. The *Plan* proposes the following investments:

Over-Arching Strategies

- **$1.03 million** ($240,000-$278,000 each biennium) to create a positive environment in Nevada that is powerfully supportive of the rapid aging of its population. This investment is in: 1) a dynamic sustained public information campaign to assure residents and public and private organizations make a proactive response to the "graying of Nevada"; and 2) staff to coordinate activities—including regulation and advocacy—of State and local governmental entities.

- **$150,000** to analyze the mix of strategies that will provide sufficient inducements to develop and retain a highly-qualified, stable, frontline long-term care workforce. This investment will fund a study of long-term care reimbursement rates and career incentives.

- **$5.7 million** to assure all Nevada seniors and their families can get the assistance, care planning and care management, and other essential services they need. This investment, funded by Federal Older Americans Act Title III-E, will support development of the Single Point of Entry system.

- **$268 million** to serve 1,152 more Nevada seniors, including many who are above the Medicaid eligibility threshold, with home and community-based services; to maximize federal funds for the expansion of these services; to assure that individuals leaving hospitals or wishing to leave skilled nursing facilities can be served at home or in community settings; to add additional benefits to the service packages of individuals served under Medicaid waivers to allow more of them to remain at home; and to assure equal access for individuals served by State and county home and community-based services programs. It will also support a 14.2% increase in the personal assistance rate as recommended by the Rates Task Force.

- **$1.8 million** to assure the strategies and targets contained in this *Strategic Health Plan* are actually achieved. These funds will support two population-based surveys; two staff positions and consulting time to track necessary data and *Plan* implementation; staffed meetings of the Commission on Aging's *Strategic Health Plan Implementation Subcommittee*; and development of a new *Strategic Health Plan* in 2011.

- **$50,000** to determine whether individuals with Alzheimer's Disease and related cognitive impairments are best served in integrated or segregated residential environments when their level of function does not allow them to remain at home in the full-time care of their families and others. This study is an important piece of an overall strategy to bring all Nevada residents with such conditions home from the out-of-state facilities where a number of them presently reside.

- **$9.5 million** to provide respite care to families caring for their loved ones with long-term care needs. This is already budgeted using a Tobacco Settlement Independent Living Grant, but is included, along with an inflation adjustment ($646,000, not previously budgeted) in the *Strategic Health Plan* costs.

- **$86.5 million** so that 2,600 more seniors will be able to: 1) afford the prescription drugs they need; and 2) avoid medication problems that have a serious, adverse effect on their health and on the use of hospital and other expensive medical services.

- **$20,000** to improve the oral health of Nevada's seniors. This investment funds development of a comprehensive set of strategies, including the most effective way to add oral health prevention and treatment at rural health centers.

- **$125,000** to enable seniors, particularly those who are most frail or live in rural areas, to get where they need to go, as independently as possible, by strengthening Nevada's transit programs. This investment funds a specialized consultant to evaluate the present transportation system; facilitate a process for better integrating and planning for statewide transportation services; identify best practices; analyze and recommend funding mechanisms and grant opportunities; and recommend changes in Nevada's transportation system.

Plan Purpose, Context, and Accountability

This *Plan* is a strategic health plan for Nevada seniors. Its legal standing is derived from Assembly Bill 513 of the 2001 Legislative Session that appropriated general funds to prepare the *Plan.* Its general purpose is to guide a variety of strategic public and private efforts between now and 2011 that will result in improved health for Nevada seniors.

A deeper purpose of the *Plan* is to foster an integrated approach to improving the lives of Nevada's seniors. This is a *Plan* for all Nevada residents: those in good health and those in poor health; those with substantial incomes and those without; those who have assets to protect and those who do not; those of all races and those speaking any language. Seniors and their families need to be supported first by their natural communities, and second by private sector organizations and State and local government. But individuals and the community must sense that some accountable body will step in when they are overwhelmed, their resources are exhausted, and private systems are not working. All of this is part of what we mean by *an integrated approach.*

Below, when we speak of long-term health care or long-term care, we mean care required over an extended period of time, mainly involving low-tech supportive services, often to treat chronic disease, functional limitations, or developmental disabilities. This care may also have medical components, but typically, those who need long-term care also require primary, acute and rehabilitative care when they are sick or injured.

The systems and providers that meet seniors' and others' long-term care and health care needs are intimately connected for the consumer and should also be integrated by the providers, funders, and policymakers. Were this actually happening for seniors and others with disabilities

in the society as a whole, much of the work proposed in this *Plan* would be unnecessary. For many reasons, this integration is not happening.

The national and state context, discussed below, provides fertile soil in which the seeds of seniors' discontent and suffering can grow. It also contains nutrients to feed solutions to the problems seniors and their families are experiencing. It will take a concerted effort, along with the strategies presented herein, to suppress the former and allow the latter to flower.

Health and Long-term Care

The term *integration* takes on additional meanings as we step over the threshold from life to health. This *Plan* is focused on *long-term* health care rather than on all health care or chronic disease management. It recognizes, however, that all realms of health are linked and that each affects consumers and each other in a myriad of complex ways. Not only are necessary connections *not being made* between individuals' long-term and other health care needs, but the fragmentation doesn't stop there.

It is mirrored by the separation of health care treatment from prevention of disease and promotion of positive health. It shades into a profound lack of connection between realms of social care and realms of health care. And more than that, when necessary components of life—that can contribute positively or negatively to health, such as housing, transportation, family relationships—are left out of a model of health, seniors are harmed, since most experience increasing health problems and challenges as they age. For example,

> In long-term care, housing conditions are as essential as services. The place where people live, including the physical and social environment, can greatly enhance or impede a person's functional disability, independence, and quality of life.[2]

At an individual level, integration means continuity of care and being able to see a familiar set of providers in both health and illness; it means not having to move away from one's community to get the services one needs; it means that one's family can be engaged in the kinds of support they can best provide but not overwhelmed by increasing daily care to the point of seeking institutional relief.

One final, more technical, area of potential integration should be mentioned. Medicare is the Federal health insurance program for those over the age of 65 and Medicaid is the Federal/State health insurance program for the poor of all ages. These programs are typically administered by entirely separate entities and in entirely separate ways.

Demonstrations, including the Social and Health Maintenance Organizations (Nevada's, operated by Sierra Health Services, is discussed in the Integrated Managed Care Section, p. 23) and others, bring these programs closer together and provide more integrated care. These demonstrations are being increasingly encouraged by the Federal government and private foundations. If promising, they will be implemented on a national basis. Both State government and seniors would benefit from integration of Medicare and Medicaid.

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[2] Stone, R., 2000, p. 6.

Nevada is interested in these approaches and should take every opportunity to pursue them.

Staffing Shortages

Dr. Robyn Stone believes that "the lack of a trained workforce is the biggest problem in long-term care policy, because the graying of America and the growth of a more chronically, rather than an acutely, disabled population, cry out for health and long-term care professionals who understand how to treat the whole individual and the family."[3]

Shortages of nurses (both registered and practical), home health aides, physicians, dentists, pharmacists, physical therapists, and dental hygienists in Nevada have been well-documented. For example, according to an article in the July/August 2002 issue of *Comstock's Business*, "Nevada nursing schools are only producing one-third of the new nurses needed to staff today's health care facilities."[4]

Less well-publicized, but even more fundamental to the health and well-being of Nevada seniors, is the future supply of qualified, stable, long-term care workers. The current shortage of personal care assistants, nurse's aides, and certified nursing assistants directly impacts seniors needing long-term care at home, in community programs, residential facilities, and institutions such as skilled nursing facilities and hospitals.

As the senior population grows, the number of seniors needing long-term care will increase. Unaddressed staffing shortages may well lead to a dire situation. Affluent seniors will be unable to purchase sufficient quality services to meet their needs. As the primary purchasers of care for low income seniors, Nevada State and county governments will be even less able to find the workers their lower income residents need.

Health Care Costs, Insurance Costs and the Uninsured Senior

According to the CEO of the Nevada Hospital Association, Bill Welch, "everything boils down to the economics of healthcare."[5] A crisis in health care economics has existed for the past decade and various cures have created as much pain as the disease itself. Increases in the cost of health care are not only causing higher out-of-pocket expenditures for consumers, but are actually driving more people into the ranks of the uninsured.

The high cost of health care is caused by the interaction of a complex set of factors. Important drivers include: heavy reliance on technology for diagnosis and treatment; research, development, and advertising costs associated with new drugs, and the tendency of physicians and consumers to rely heavily upon medication as a key treatment modality. Additionally, employer-based health insurance, which became widespread in the 1970's, shielded consumers from the true cost of the care they were using and often encouraged over-use of high-cost services. Both public and private insurance provide more extensive coverage for care in the most medical and highest-cost settings (hospitals, skilled nursing facilities) rather than other, perhaps

[3] Stone, R. 2000, p. 47.
[4] Welch, B., 2002, p.43.
[5] Welch, B., 2002, p.41.

equally appropriate settings that are more social or residential in nature (homes, board and care facilities, adult day centers).

Because health care is expensive, the insurance that covers the provision of such care is similarly expensive. For those working-age people, many of whom receive health care through their employers, this is not a critical issue as long as they retain employment with health insurance coverage. It is also not an issue for those who are very poor and eligible for Medicaid, the primary public insurance program for people under the age of 65. Since seniors are vulnerable to job loss and early retirement, they are also vulnerable to losing employer-sponsored health insurance and access to affordable health care. Two factors related to health insurance coverage affect individuals 55-64 before they are eligible for Medicare, especially if they are in poor health and unemployed or underemployed. These individuals often cannot find coverage of any kind if they have existing disease, and when coverage is available, it is likely to be unaffordable.

Medication Over-use and Interaction

Seniors take a great deal of medication as a result of standard practice in health care. That they may also request particular medications is related both to drug companies' advertising and to physicians' standard practice. Not enough attention is paid to monitoring the effects of medication and the interaction of one medication with another. Seniors and others who use multiple medications—especially if prescribed by multiple providers or purchased at more than one pharmacy—are at grave risk for health complications, injury, and even death by over-medication, drug-interactions, and adverse affects to medication. An April 1998 report in the *Journal of the American Medical Association*, "When Medicine Hurts Instead of Helps: Summary," estimated that 106,000 fatal adverse drug reactions occur annually. If adverse reactions to medications were classified as a distinct disease, this disease would rank as the fifth leading cause of death in the United States.[6]

People over 65 consume more prescription and over-the-counter medications than younger people. They are more likely to be taking multiple medications simultaneously for various health problems. When they experience an adverse drug effect, they are more likely to need hospitalization or suffer psychiatric problems than people at younger ages. Medications can cause confusion, impair function, and even trigger permanent disabilities. All of these reduce the independence of older people. Each year medications are implicated in tens of thousands of auto accidents, home injuries, falls, and fractures[7]. Frail or dependent elders with visual or cognitive impairment are at increased risk for adverse drug reactions as they may be unable to properly monitor their own drug intake and may be dependent on the monitoring and communication skills of caregivers.

Medication-related problems can be prevented through increased provider, patient, and caregiver education and improved medication management. An important strategy in this *Plan* is medication management.

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[6] http://www.agingresearch.org/brochures/medicinehurts/summary.html
[7] Ibid.

Liability and Malpractice

One of the key health care cost drivers nationally has been the soaring cost of medical malpractice insurance. We have become a risk-intolerant, litigious society on many fronts.

Nevada physicians face an insurance crisis as liability and malpractice premiums have more than doubled for some providers. The St. Paul Company, which had insured more than half of the state's doctors, pulled out of the malpractice insurance market altogether. The American Medical Association identified Nevada as one of 12 states experiencing a medical liability insurance crisis.[8] Skyrocketing premiums seriously threatened patient access to care as the number of providers willing to take on high-risk cases decline and the cost of premium increases is passed on to consumers.

The American Medical Association ranks Nevada 47th in doctors-per-100,000 residents (at 196 licensed physicians per 100,000 residents.)[9] Thus, access to health care providers was already an unmet need for many senior Nevadans before the insurance crisis, particularly in rural areas.

Nevada has made an affirmative response to this crisis by creating the state-operated Medical Liability Association in August, 2002, to provide malpractice insurance to Nevada physicians and enact new medical malpractice caps. The situation should be closely monitored to assure that these solutions are adequate.

Liability insurance for assisted living and group care facilities in Nevada is also a new and critical issue. A number of providers have stated they may go out of business since their rates do not presently cover a huge increase in the costs of their insurance coverage.

Olmstead

A landmark Supreme Court decision in 1999, known as the "Olmstead Decision," is helping to advance strategies and programs that let people with disabilities receive supports and services at home or in community-based programs instead of institutions.

The Olmstead Decision represents a recent culmination of significant change in public policy goals regarding people with disabilities that began three decades ago. This public policy is based on the four goals in the Americans with Disabilities Act. It is increasingly being recognized that this policy framework can, and should be, built into all aspects of states' health, human services, and other planning, service coordination, service provision, monitoring and evaluation functions.[10] The four core policy goals are:

- *Equality of Opportunity*: treating people on the basis of objective facts; providing reasonable accommodations; making programs accessible; guaranteeing inclusion and integration.

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[8] Albert, T., August 26, 2002.
[9] Willis, S.J., May 8, 2002.
[10] Silverstein, R., February 4, 2002.

- *Full Participation*: involvement in decision making at the program and systems level; ensuring informed choice; providing self-determination and empowerment; recognizing self-advocacy.

- *Independent Living*: recognizing independent living as a legitimate outcome of public policy; providing long-term services and supports including personal assistance services and assistive technology devices and services, providing cash assistance and other forms of support (such as health care, transportation, and housing).

- *Economic Self-Sufficiency*: recognizing economic self-sufficiency as a legitimate outcome of public policy; providing employment related support systems and services; providing cash assistance and work incentives to employers and employees.

The Olmstead Decision means, states may be found in violation of Title II of the Americans with Disabilities Act (ADA) if they provide care to people with disabilities in institutional settings when they could be served in home and community settings. This gives a context of urgency to the collection of certain baseline data and development of initiatives and strategies for preventing institutionalization and moving people out of institutions.

Two requirements for compliance with Title II of the ADA are: a) analyze what needs to be changed and develop a comprehensive plan, and b) move people off waiting lists at a reasonable pace.[11] This *Plan* advances both of these requirements.

Consumer-Directed Care

"Catalyzed by younger people with physical disabilities who strongly oppose institutionalization and want a range of home and community-based options controlled by consumers, a trend toward more consumer involvement and management has begun to emerge among the elderly,"[12] reports Dr. Robyn Stone. One of the areas in which this movement, called consumer-directed care, is most notable is in the area of personal assistance in the home. This is a service many consider to be the most fundamental building block in a strategy that helps older persons who are frail or disabled stay at home.

There are some very promising results from a California "independent provider program" in which clients hire, manage, and pay their own workers to provide their home care. The state maintains a registry of home care workers from which clients can choose and even allows them to hire family members as caregivers (as do 35 of the 50 states). An evaluation of the program found that clients in the consumer-directed model, compared with those receiving professionally managed services, had greater satisfaction with their services; more feelings of empowerment; and a perceived higher quality of life.[13]

"Cash and counseling" is, perhaps, the ultimate in consumer-directed care. In such programs, people with disabilities are offered cash benefits, usually along with guidance on how to find what they need and to purchase needed services. Three states—New Jersey, Arkansas, and

[11] Donlin, J., February 4, 2002.
[12] Stone, 2000, p. 25.
[13] Ibid.

Florida—are receiving Medicaid waivers under a grant from the Department of Health and Human Services and the Robert Wood Johnson Foundation to experiment with "cashing out" their home and community-based care programs.[14]

Advances in Technology and Design

Advances in technology such as increased access to computers, high-speed Internet access, and a corresponding increase in the sophistication of software design may lead to a significant increase in telemedicine applications in the near future. Telemedicine can range from phone conferencing between physicians at remote locations, to e-mail and newsletter updates for patients coping with disease, or video-conferencing that provides specialty services such as tele-radiology to a rural clinic. Telemedicine potentially increases access to health care services and information at a fraction of the cost of traditional, on-site care.

While recognizing how helpful telemedicine applications will be in the future, particularly for rural elderly, this *Plan* is not counting upon advanced technology improvements. However, its framers were very much aware of the need to incorporate in the *Plan's* strategies existing technology that helps people with disabilities remain more independent—from hearing and low vision aids to housing built upon universal design principles.

Universal design creates products and environments that are usable by all people, to the greatest extent possible, without the need for adaptation or specialized designs.[15] Examples of universal design features include lever-style door and faucet handles, entrance ramps, and shower stalls built flush to the floor. People of all ages and abilities benefit from the ease of use and accessibility features of universal design products.

Long-term Care Insurance

The private purchase of long-term care insurance by individuals and members of employee or other groups has been proposed as a partial solution to middle-class seniors and others either a) spending down their assets on long-term care and then accessing Medicaid long-term care benefits, or b) transferring assets to relatives to become Medicaid-eligible and then accessing Medicaid long-term care benefits. Therefore, some states have played an active role in the promotion of long-term care insurance policy purchase, especially by seniors. Yet, others, including Nevada, are considering just what role they should play with respect to long-term care insurance.

In theory, increasing the length of time that a person in need of long-term care can use their own resources (insurance benefits and assets) to pay for it potentially limits the liability of the state to pay for care. However, to date benefits paid under long-term care insurance policies have not measurably reduced Medicaid expenditures and there are reasons to believe this will never happen to any significant extent. There are two major reasons for this: 1) those who can afford to

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[14] Center on Aging, University of Maryland, Cash and Counseling Demonstration and Evaluation Program, March 2002, p. 1 and 3

[15] The Center for Universal Design, North Carolina State University, http://www.ncsu.edu/www/ncsu/design/sod5/cud/univ_design/princ_overview.htm.

purchase long-term care insurance are higher income than those who typically are or become eligible for Medicaid, and 2) despite healthy growth in the number of policies in force, relatively few seniors own long-term care insurance policies (only 4.1 million people compared to 23 million individuals who have private Medicare supplemental insurance or Medigap policies). According to the Centers for Medicare and Medicaid Services, in 2000, only 8 percent of nursing home revenues came from private insurance including both long-term care insurance and Medigap policies.

Nonetheless, promoting quality long-term care insurance policies is an important role for states and it is possible that some individuals who would have accessed state-funded services will not need to as a result of owning such policies. Involvement by states can be of at least three types: 1) educational, including publicizing both the reasons why purchase of long-term care insurance is beneficial and what types of policies give the greatest value; 2) incentives for purchasing long-term care insurance; and 3) legal or regulatory guidance and oversight that will protect its consumers by assuring the highest quality insurance products are available for purchase.

The Senior Services Task Force recommends that Nevada's primary role be of the first type, while at the same time contacting other states to learn the results of their efforts in incentives and regulation. The average resident of Nevada is not likely to be aware of the numerous benefits to purchasing policies. This *Strategic Health Plan* proposes a comprehensive public information and education campaign and it is under the discussion of that strategy that specific recommendations can be found related to educating the public about the benefits of purchasing long-term care insurance.

At the same time, it will be important for Nevada to develop its capacity to regulate the types of long-term care insurance policies sold in order to convince consumers that such policies are a good deal.

Nevada's Unique Economy and Demography

Two aspects of the Nevada context that drive many other characteristics of the state are its extremely rural nature (3.3 persons per square mile) and the enormous contribution made by tourism to the state's economy.[16]

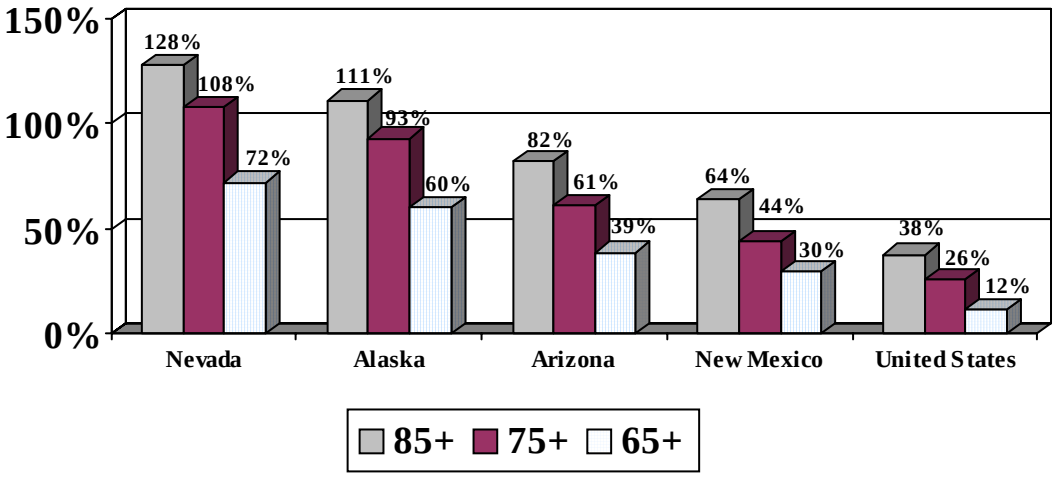
The state is a frontier with the exception of one large and rapidly-growing urban area, Las Vegas, and one smaller but growing area of Reno/Sparks and Carson City. Hence the nomenclature that is used to refer to the counties: Clark, Washoe, and "the rurals." Unique deals are cut for the financing of social and educational services because of huge Las Vegas-generated gambling revenue. To a lesser extent, this is also true for Washoe County, with Reno contributing a significant amount of tax revenue from tourism to the state's economy.

In addition, Las Vegas has experienced huge population growth. Overall, it had the fastest growth rate in the nation between 1990 and 2000. More relevant to this *Plan*, is the dramatic growth in the Nevada elderly population. Figure 4 on the following page shows Nevada's senior population increase compared to the other top three states with rapid growth between 1990 and

[16] U.S. Census and Nevada State Demographer, University of Nevada Reno, see Attachment F, Population Data Report for a detailed description of population statistics and data sources

2000. However, because Nevada has historically had a relatively small elderly population, its total number of seniors is lower than the national average. Only 11 percent of Nevadans are seniors, while the United States percentage is almost 12.5.

Figure 4. Percent Change in Elderly Population
Top Four States and U.S., 1990-2000



Further, the seniors who have migrated to Nevada are not typical of the state's senior population as a whole. They are more affluent and younger. They fit the "amenity-seeking" profile of young retirees who move for better climate, lower taxes, and good housing values. These individuals are likely to contribute more to the state's economy (in spite of many having selected Nevada in part as a low tax state) than they take back. For one thing, it is speculated, Nevada may experience the so-called "return migrant" phenomenon,[17] whereby older and less-healthy seniors return to their state of origin.

It should be noted that the reduction in tourism revenue after the events of September 11, 2001, impacted the Nevada economy at least as much as in most other parts of the country. How this will affect the State's economy over the longer-term is a major question for the state.

Nevada's Cultural Norms

The strong value placed on self-reliance is as striking a Nevada quality as its frontier geography. Families take care of their own, but they also care for others in their own communities to an extent that is not seen as often in states with more highly-developed public systems of care (though it is likely more common in rural states). This is an extraordinary strength. It has influenced Nevada's use of formal services and conserved state resources.

[17] Litwak and Longino, 1987.

In this context, note that:

- While nationally 60% of elderly individuals with disabilities living at home rely exclusively on family and friends for care, a 2000 Nevada study showed that family and friends were the exclusive caregivers for approximately 90% of the elderly individuals with disabilities who were surveyed.[18]

- The percentage of Nevadans who die at home was 32% in 1997, compared to 24% for the United States. The percentage of Nevadans who died in nursing homes was 16.5% in 1997, compared to 24% for the United States.[19]

- In 1999, Nevada's ratio of nursing home beds to population aged 65+ was 23 per 1,000, compared with 46 per 1,000 for the United States. Nevada's ratio of nursing home beds to population 85+ was 297 and Oregon's was 224. Therefore, its bed-to-population ratio is very much in line with at least one other state that has had an aggressive nursing home diversion program.[20]

Nevada's Health Indices

Some indicators of Nevadans' health status differ from those of the rest of the country in ways that are predominantly negative:

- Nevada's suicide death rate is higher than the national rate and, while data are not always in agreement, the rates for white males 65 plus are even greater.[21] It is also one of the leaders in deaths from motor vehicle accidents and homicide.[22]

- Nevada ranks slightly below the United States in the proportion of adults who do not engage in leisure-time physical activity and that proportion is increasing.[23]

- Nevada is above the national average in the percentage of individuals who smoke cigarettes and, therefore, has a significantly higher rate of deaths from chronic obstructive pulmonary disease than the United States.[24]

- The Nevada death rate from cirrhosis of the liver, which is largely attributable to heavy alcohol consumption, is significantly higher than the national rate.[25]

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[18] Cannon Center for Survey Research, University of Nevada Las Vegas, June 2000.
[19] www.chcr.brown.edu/dying/nvstate.htm
[20] Population data is from the Nevada State Demographer and data on number of nursing beds, from Harrington, et al., *Nursing Facilities, Staffing, Residents and Facility Deficiencies, 1993-1999, p. 22.*
[21] The most current mortality data for Nevada, including suicide by age, is available in *Nevada Vital Statistics, 2000*, published by the Nevada's Center for Health Data and Research, April 2002, p. 125, National data on suicide rates by states and the U.S. as a whole can be found in National *Vital Statistics Report*, Vol. 50, No. 15, September 16, 2002.
[22] The Nevada Bureau of Health Planning and Statistics, *Healthy People 2010 Nevada*, February 2002 contains data on deaths from motor vehicle accidents (p. 26), Homicide (p. 30), for Nevada and the United States.
[23] Ibid., p. 41.
[24] Ibid., pp. 42 and 50.
[25] Ibid., p. 47.

- Nevada is also above the national average in the percentage of individuals who do not have good access to health care, including those who have no health care coverage; have not had a routine physical examination in the past two years; report they have fair to poor health; and report cost as a barrier to health care.[26]

Integrated Managed Care

According to Bonnie Hillegas, Vice President, Care Management, Sierra Health Services, one of the unique aspects of the provision of health care to seniors in Nevada is the fact that Sierra Health Services Health Plan of Nevada (HPN) offers a social and health maintenance organization (S/HMO) as an option to Medicare-eligible individuals. This program began in 1996 and now has more than 40,000 enrolled beneficiaries. It is funded with a federal grant as a "second generation" S/HMO demonstration program. The grant and S/HMO status has allowed HPN to provide additional services not routinely covered by Medicare HMO plans or traditional fee-for-service. Such benefits include respite care, homemaker, personal care, extra therapy and emergency response, and safety equipment.[27]

Nevada's Social Service Providers

In part due to the rural (and even frontier) character of Nevada, and the lack of long-standing formal systems, the health and social service providers serving senior residents and their families have special qualities. The outsider is impressed by the fact that they are more closely-knit and depend more on both face-to-face and telephone communication than in other geographic areas with which we are familiar. These qualities have stimulated collaborative working relationships. They appear to be one of the factors allowing Nevada providers to accomplish so much with relatively few resources. Furthermore, these relationships have been an informal means through which senior services are integrated. It will be important to preserve these positive qualities, while developing the kinds of more formal structures and systems that will fit the needs of the rapidly-growing population of seniors.

Plan Accountability

The *Plan* was developed over a period of nearly a year with the help of a contractor, The Rensselaerville Institute, and a 16-member Senior Services Task Force charged with leadership of the process and oversight of the contractor. The Task Force met 14 times, for more than 80 hours in total.

Task Force members negotiated differences of opinion, set priorities, and provided very broad-based leadership. The names of the Task Force members are found in Attachment A. Other staff of the Division for Aging Services and Clark and Washoe counties, and several other individuals, also made significant contributions. AARP Nevada provided important advice to the process.

[26] Elias, J., n.d.
[27] Hillegas, B., February 27, 2002.

The Senior Services Task Force proposes to continue its oversight role as a subcommittee of the Commission on Aging. At least eight Task Force members and two Commission on Aging members should participate on the subcommittee. The subcommittee will meet quarterly to track progress on the *Plan's* six over-arching strategies and twenty-two target area strategies. More importantly, they will monitor the accomplishment of thirteen targets that reflect changes in the behavior or condition of seniors and their families as a result of successful implementation of strategies. These strategies and targets are the primary content of the *Plan* and a description of them follows.

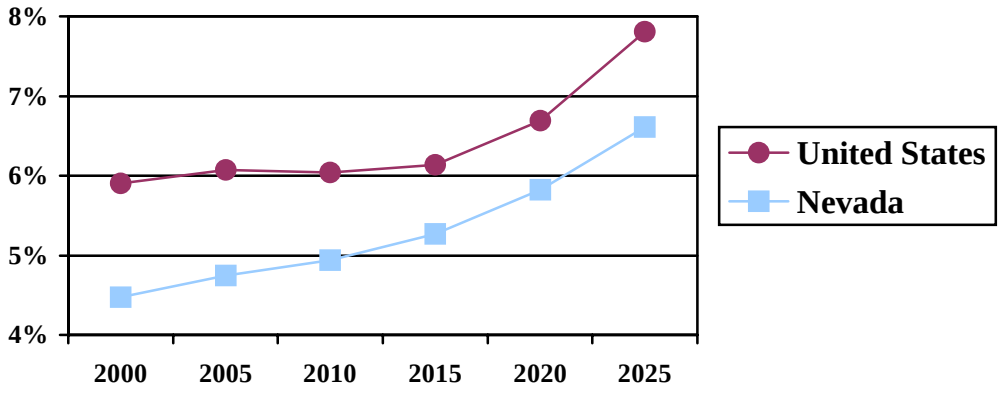
II. Nevada Seniors and Their Families

Nevada's Seniors Today and in the Future

Nevada is fortunate to have a growing number of people who are over the age of 65. Older residents bring stability and resources, both human and financial, to the community. Those over the age of 65 make up 11 percent of Nevada's total population. During the past decade, Nevada's elderly population grew nearly three times faster than the national rate of growth. Although the overall Nevada population also grew more rapidly than any other state (increasing by 66.3%), the number of people who are 85 and older increased from 7,500 to 17,000—a 128% increase. During the next 20 years, the elderly population will continue to grow at a rapid rate and after 2010 the baby boom generation will increase that rate significantly.

In spite of this rapid growth rate, Nevada seniors still make up a smaller percentage of the total population than the national average of 12.4 percent (see Figure 5 below for a comparison of Nevada's senior population growth with that of the United States from 2000 to 2025). Even with the projected rate of increase of elderly Nevada residents, it will be many years before the senior population could reach the percentage rates of states like Florida which have very high populations of older people.[28]

Figure 5. Percent Growth of 75+ Population
Nevada and U.S., 2000-2025



[28] U.S. Census and Nevada State Demographer, University of Nevada Reno, see Attachment F, Population Data Report for a detailed description of population statistics and data sources

In addition to the challenges and opportunities of a growing elderly population, the Nevada population is becoming more racially and ethnically diverse. Although Nevada has seen population increases of all groups, from 1990 to 2000 the Hispanic population more than doubled (204%), the Asian or Pacific Islander population increased by 192%, and the African American population grew by 66%. This trend toward a more diverse population is expected to continue for many years and by 2010 an estimated 40 percent of the population is projected to be non-white or Hispanic.

Nevada's population explosion has been caused primarily by in-migration. Over 71% of Nevada's population increase was the result of people moving to the State from other places. Many of these residents are seniors who were attracted to Nevada because of affordable housing. According to a study conducted by the National Association of Home Builders called "Seniors in the Market for Housing: 1999 through 2006," Nevada is the top state for attracting those over 55 to its housing market.

Although the number of seniors who live in rural areas is small, proportionally more seniors live in rural Nevada than in the state as a whole. Only 10.6% of the Clark and Washoe county population is over the age of 65, but 12.8% of people in all other counties are seniors. Mineral and Nye counties have the highest proportion of seniors with 19.8% and 18.4% respectively. Elko has the lowest proportion of seniors with only 5.8% of the population over 65.

Many Nevada seniors have the resources to live comfortably and are blessed with family members and friends who help them as they become more dependent on others for support. Additionally, more Nevada seniors have incomes above the poverty level, die at home, are cared for by friends and family, and own their own homes than in other parts of the country.

While most seniors share the Nevada tradition of self-reliance and independent thinking, others have great difficulty taking care of their personal needs. An estimated 51,000 people over the age of 65 need help with basic activities of daily living. As the population of seniors, especially those over the age of 85, continues to grow over the next 10 years, many more seniors will need help with personal care. Conservatively, the number of people over 65 needing help with daily activities will grow to 69,000 in 2010. Many of the people needing help with activities of daily living will receive that help from family and friends; an estimated 35 percent (24,150) seniors will need services and supports from the formal service system.

In spite of the fact that many Nevada seniors need help carrying out their daily tasks, thousands of them, together with other Nevada seniors over the age of 55, are productive, contributing members of the community. An estimated third of Nevada seniors 55 and over work for pay, another third volunteer in churches, hospitals or charities, and another third provide informal care for family members, friends, and neighbors.[29]

Nevada Seniors' Needs

One of the key assumptions used in preparing the *Strategic Health Plan for Seniors* is that seniors and their family caregivers, friends, and neighbors "drive" the *Plan's* strategies and

[29] Rowe, J.W., M.D. and Kahn, R. L., PhD., 1998.

actions. Consequently, a comprehensive process was undertaken to learn about the needs and concerns of Nevada's seniors.

Between November 2001 and June 2002, 2,035 Nevada seniors, service providers, and caregivers for seniors from every region of the State responded to questions about the needs and concerns of seniors (the complete summary is included in Attachment B to the *Plan).* A number of concerns were indicated by respondents as follows:

- Nevada seniors want to retain their health. They value their independence and want to be able to care for themselves and their loved ones at home.

- Many seniors need personal assistance and household help to remain in their homes.

- Caregivers desperately need respite from providing around-the-clock care.

- Many seniors are having a difficult time accessing health care, especially dental and vision services.

- Seniors are having trouble paying for basic expenses such as food, housing, medical bills, and utilities. They are especially concerned about the high cost of prescription drugs and need help to be able to afford their medications.

- Transportation becomes a huge obstacle for frail and dependent seniors and is a basic, unmet need for many seniors.

- Seniors want to remain engaged in the community through participating in senior center activities, exercise classes, volunteer opportunities, and through paid employment.

- Companionship is precious to isolated and "place-bound" seniors. Seniors find that a sense of humor, a positive attitude, and loving family and friends help them to make the most of their later years.

Additionally, two public meetings were held with Native American Indians from several Nevada reservations. The needs and concerns of Native American Indian elders living on reservations, in rural areas, and in urban settings were discussed at the Native American Indian Human Resource Caucus convened on January 30, 2002 and the Public Forum for Native American Indian Elders held on May 16, 2002. Meeting participants identified four critical needs:

- Native American Indian elders are concerned that elders die soon after placement in non-native institutions. They want 24-hour community based care that is close to home so that friends and family can visit elders in a supportive living environment.

- Health care clinics are needed that are close to home and have the capacity to serve community members in a timely way. Mental health services, substance abuse services, dental care, and transportation to health care services are especially needed.

- Better coordination of services and resources between Indian Health Services (IHS), Bureau of Indian Affairs, and the State is needed. For example, IHS pays for in-home care providers, but funding is needed from the State to train caregivers. Also, when multiple agencies or funding sources are used, administrative guidelines must be dovetailed so that a “double workload” is not created. Native American Indian elders are entitled to all services and resources offered to seniors by the State, but they cannot always access these services in rural areas and on reservations. State and tribal leaders need to determine how to fully use Medicaid resources and consider how all Native American and non-Native American health care facilities can be used for both populations.

- Native American Indians should be represented on state boards and within state agencies. Additionally, better linkages between state and tribal programs should be made so that issues and concerns can be discussed and addressed on a regular basis.

III. Over-arching Strategies

Introduction

The *Strategic Health Plan* calls for a strong and compelling course of action. A course, if taken, that will:

- Increase the health and independence of all Nevada seniors and those who care for them.
- Distinguish Nevada as a leader in forward-thinking, effective long-term care policy.
- Create preferred home and community-based service options for elderly Nevadans.
- Save the State needless expenditures for chronic care institutional services.

This *Plan* is not a "pie-in-the-sky," overly-complicated, or bureaucratic response to Nevada's long-term care challenges. Instead, it is a concrete set of specific strategic actions that will dramatically change the lives of Nevada's seniors and their caregivers for years to come.

All the strategies in the *Strategic Health Plan* rest on a set of assumptions:

- First and foremost, the needs and desires of seniors and their family caregivers are the primary "drivers" of *Plan* strategies.
- Seniors, their caregivers, and members of the communities they live in are interdependent and will be the *Plan's* beneficiaries when its strategies are implemented. *Plan* strategies and services will help all seniors and their caregivers to remain healthy and actively involved in the life of the community.
- When designing and implementing services and supports proposed in the *Plan*, the needs and concerns of people from a variety of races, ethnic and cultural backgrounds will be considered. Therefore, seniors of all ages, in all areas of the State, and from a variety of cultural and ethnic backgrounds will be able to access services and benefit from *Plan* strategies.
- It is both prudent and popular to invest public funds in home and community-based services.
- The State funds in the *Plan* purchase services for seniors who are at greatest risk of being placed in chronic care institutions.
- New public and private sources of revenue will be vigorously pursued and secured.
- All allowable federal matching funds will be collected and used to support *Plan* strategies and targets.

We believe the *Plan's* strategies are informed by the best and most current information available. Even these data, however, can be improved upon.

- Use and demand for services is projected using the best available data.
- Data from the 2000 United States Census, Nevada State demographer projections, and national and local studies are current and the best data sources for information about the characteristics of Nevada seniors and their caregivers.
- The State will complete a population survey twice during the *Plan's* implementation to better portray success in improving the health status of Nevada seniors, both those being cared for and those seniors who are caregivers.
- The State will improve its data collection systems within the next five years so that future planning can be done with the help of reliable service data that describes what services participants use.

With these assumptions in mind, the over-arching strategies, target areas, target area strategies, targets, and action steps on the following pages provide a road map for action that will result in the best possible outcomes for Nevada seniors.

The over-arching strategies that follow affect more than one area of the lives of seniors and their families. These strategies are broad and important.

Public Information and Awareness

Over-arching Strategy 1: A dynamic information campaign will increase the public's awareness of aging and educate and empower individuals and their informal support systems, as well as the voluntary sector, to create a positive climate for aging in Nevada.

Description: The Senior Services Task Force believes that lack of awareness negatively affects the ability of Nevadans to care appropriately for themselves and each other. A public information effort to increase awareness and build on the desire of Nevadans to care for themselves will address the following barriers:

- denial about their own and their loved ones' aging, disease, disability, and death;
- ignorance about both normal aging and disability;
- putting off even those steps they know they should take to keep themselves safe and in good health;
- unwillingness to take primary responsibility for maintaining their own health and ability to function independently;
- sensory losses (hearing, vision, and the like);
- reduced opportunities to exercise;

- other poor health habits that contribute to poor health and functional deficits, such as smoking and drinking;
- increasing isolation from the social mainstream as they age or become caregivers for someone who is disabled;
- difficulty in finding employment or other forms of activity that gave meaning to their lives when they were younger;
- lack of knowledge about resources, benefits, and services—both that they exist and how to select appropriate ones of high quality;
- no or misinformation about their insurance coverage and need for coverage in addition to that provided by public sources.

The Task Force believes it is possible to develop a sophisticated campaign that employs social marketing techniques to change attitudes and behavior and create more powerful and positive social norms than those that exist today. Most of the barriers listed above can be removed only through increased awareness, knowledge, information, and commitment to change behavior on the part of individuals. No amount of public care can restore the balance when individuals cannot do a good job of caring for their own health, or when they expect physicians and other providers to fix their problems without their active participation physically, mentally, and emotionally.

Most Nevada seniors care for themselves or have loving family members and friends to help them. Unfortunately, some seniors neglect their own care, suffer from mental illness that causes them to abuse themselves, or are subjected to abuse or neglect from paid caregivers, family members, or friends. Those suffering from elder abuse or neglect will receive help through better information about appropriate caregiving, increased knowledge about respite care options, improved enforcement of elder abuse laws, and increased reporting of abuse and neglect. Through the public information campaign and training of law enforcement agencies on how to recognize elder abuse and enforce laws, fewer seniors will suffer from abuse or neglect and get the support they need to safely remain in their homes.

Another important component of good health is eating regular and nutritious meals. Many seniors are unable to cook for themselves and need help with their meals. Home-delivered meals, meals prepared by caregivers, and meals provided at senior centers help to ensure good nutrition for seniors. Information about how to get nutritional support, along with many other important health service components such as information about the use of assistive and adaptive devices, will be part of the public information campaign and will be included in care planning for seniors who want to remain in the community.

When the ability to participate is no longer present, the social safety net must be there to help. But before that time, the job of public funding is to leverage other social resources. A large-scale public information campaign will need seed money from the State, in the form of staff support to obtain grants and other private resources.

Private Sector Development

Over-arching Strategy 2: A combination of incentives, regulation, and advocacy (both State efforts and those supported by the State) will encourage private sector initiatives and other changes including: 1) development of appropriate housing and transportation services; 2) comprehensive, medical/social approaches to health care integration; 3) long-term care insurance; 4) new or expanded preventive health programs; 5) greater emphasis by local law enforcement officials on enforcing fraud and abuse statutes; and 6) more local regulation of air quality that causes lung disorders and other health problems.

Description: A number of the target area strategies, particularly in the area of housing, transportation, and health care, require tapping into the myriad of private organizations with the capacity to bring about change for seniors. It will be important to work with hospitals, Sierra Health Services/Health Plan of Nevada (especially the Senior Dimensions S/HMO program), and other insurers and health care providers; with private housing developers; with transportation providers; with private charitable foundations; with private corporations; and with private media organizations.

It will be equally important to link these entities in as tightly as possible to public efforts on behalf of seniors and their families, including the State Health Division's Healthy People 2010 efforts; the State Housing Division, the Division of Insurance, and county governments, particularly Clark and Washoe. Other important private contacts include the executives of State-level associations: Nevada Health Care Association, Nevada Hospital Association, Assisted Living Association of Nevada and others.

Another vital aspect of this effort will be to involve people who are already actively advocating for changes in the health and social service system. Many Nevada organizations (such as AARP Nevada, Nevada Seniors Coalition, Nevada Council of Senior Citizens, and Seniors United) contribute countless volunteer hours in support of senior issues. Their expertise and support will be recruited to become partners in both the public information campaign and the private sector development strategies.

The thrust of these coordinating and exploratory activities is to fully understand and tap into the ability of the private sector to come up with appropriate solutions to problems *before* government entities attempt to do directly what others may be able to do at lower cost. The aging of Nevada's population is a phenomenon laden with both opportunities and risks. All public and private agencies have a stake in this phenomenon and should be working collaboratively. Funding for one full-time staff person is sought in order to carry out these responsibilities and those associated with over-arching strategy #1.

Single Point of Entry System

Over-arching Strategy 3: A "single point of entry" system will enable all seniors and their families to much more easily access information about how to get assistance, care planning and care management, and other essential services.

Description: In many ways, the most important resource for seniors, their family members and caregivers is information. Without knowledge about what services and resources exist to help seniors remain healthy and stay in their own homes, many seniors and their families may make decisions to move to chronic care facilities before it is necessary, or to go without needed health and social services.

Seniors, as well as social service and health providers, are keenly aware of the need to have easily accessible information about all of the available resources and services. During the past year, State Division for Aging Services, social service agencies, Clark and Washoe County, and the Sanford Center on Aging staff have begun a pilot project to create a Single Point of Entry system (a flow chart of the system is included in Attachment K to the *Plan*). They see the Single Point of Entry human service delivery system as the vehicle to improve access, reduce duplication, and cooperatively manage care for Nevada seniors and their families.

The envisioned system will allow anyone to access services as soon as they call or visit any senior services agency. Seniors, family members, and agency staff will be able to call a single 2-1-1 information number connected to all agencies in the State and linked to national information and assistance services and resources. Regardless of where the senior first makes contact, the same basic questions will be asked to start the process of helping seniors or family members find services or supports.

Additionally, all of the information can be accessed directly from the senior's computer at home or in local senior centers or other public sites. When the new Single Point of Entry system is fully developed, seniors will be able to sign up for services on the web. The initial screen will help to determine eligibility for services and will keep people from having to call several numbers to find out whether they are eligible to apply for a service.

Over time the system will serve as a tool to refer seniors to needed services and to assure that services have been delivered. Agencies will report back to the system that the senior is receiving the requested services. In the long run, reimbursable services from various fund sources can be completed over the system and information can be generated or stored in the centralized data base.

When seniors and/or their families need specialized care management assistance, they will be referred to appropriate public or private agencies to receive needed support. The Single Point of Entry System will provide information about what care management services are effective and will assure that care managers are trained to use all available community and social services resources to support seniors and their families.

Eventually, an information database will be created to identify what services are being delivered and what services are needed. The system will also be a tool to help policy makers determine what services they should fund to help seniors remain healthy and live in their own homes for as long as possible.

During the next few years, the Single Point of Entry system will be piloted at five or six sites in various parts of the state. Through the pilot, the agencies will test new software, determine how existing resources can be used to support the new system, and finalize all aspects of the design.

Training and support will be given to frontline workers to assure that the new system is responsive to the needs of callers.

As the system is developed, new ways to improve access to information and ongoing assistance will be tested and implemented. Nevada's planned Single Point of Entry System will build on the strengths of Information and Assistance systems in other states but will also focus on groundbreaking methods to better serve the information and service needs of Nevada seniors, their families, and caregivers.

Long-term Care Workforce

Over-arching Strategy 4: Changes in reimbursement rates and development of career incentives will increase compensation and benefits and provide other inducements to develop and retain a highly-qualified, stable, frontline long-term care workforce.

Description: While shortages of nurses, physicians, and other health professionals have been well-documented, paraprofessional caregivers provide most of the formal services needed by frail and disabled seniors. They help people bathe, eat, transfer, and toilet. The services caregivers provide enable those they serve to remain healthy and alive, while also directly affecting the quality of their lives.

These caregivers work for low pay and poor fringe benefits. Many cannot afford health insurance even when their employer subsidizes it.[30] Many leave the long-term care field for more lucrative and socially-supported careers, in part because they are unable to feed, house, and care for themselves and their families due to poor pay and limited access to benefits. Other reasons for the shortage of workers include the lack of respect and recognition for the work they do, the times of day and hours worked, and the physical and mental stress of the work.

The money spent by health and long-term care providers on recruitment, providing basic training to new employees, and other activities associated with high employee turnover, could have helped to cover wage increases for experienced employees in a more stable workforce. Caregivers who do remain in the profession carry a heavy caseload, may not receive adequate training, and often have to juggle more than one job to meet their family needs—all factors that diminish their ability to provide high quality care.

High turnover rates among long-term care workers mean that those receiving care must re-adapt frequently to new, often inexperienced care providers. Consumers are at risk of receiving inadequate care when it is delivered by inexperienced or poorly-trained workers. Even under the best of circumstances, new caregivers must learn how to meet the individual needs of each care recipient, a process that takes time away from care itself.

A frontline long-term care workforce must be cultivated, trained, and retained in order to meet the needs of seniors in Nevada now and in the future. These considerations drove the framers of this *Plan* to include $150,000 for a study of the incentives, job restructuring, and other

[30] http://www.urban.org/content/IssuesInFocus/Long-TermCarefortheElderly/Long-TermCareWorkerShortage/shortage.htm

approaches that will assure this happens. Members of the Senior Services Task Force agreed that with respect to guiding such a study, the training needs of the most basic entry-level workers are where the greatest emphasis should be placed, followed by those of Certified Nurse Assistants (CNAs).

Home and Community-Based Services Investment

Over-arching Strategy 5: Increased investment in home and community-based services will be accomplished through several means. These include accelerating the extension of such services to those above the Medicaid income level who are disabled or frail enough to be served in a skilled nursing home but prefer to remain at home, and quickly identifying seniors about to leave the hospital or enter a skilled nursing facility and offering them community-based services. These and related efforts will add momentum to the shift from institutional to home and community-based care.

Description: Medicaid is the Federal/State-financed program that covers health and long-term care services for individuals with low incomes, including the elderly. The Federal government sets the requirements for this program and picks up approximately half of the costs. Except for the past 20 years, the Medicaid program required states to provide care only in skilled nursing homes and to serve only those of very low income. Since that time states have had the opportunity to waive certain Medicaid requirements *for individuals who are very disabled and could be served in nursing homes.*

At the present time, the Federal government is providing a great deal of leadership for the enhanced and expanded use of Medicaid waivers. This is because they believe "there is tremendous potential to serve people who meet nursing facility level of care in private homes or in community residential settings that would be more acceptable to the beneficiary, *without increasing costs to the states*."[31]

Under these Medicaid waivers, a range of home and community-based services can be provided to individuals who would otherwise be over-income for Medicaid's medical services (but are still low income). In addition, services that would not normally be covered by the Federal share of Medicaid may be offered, as long as those receiving them are really frail or disabled enough to qualify for care in a skilled facility, but prefer to remain at home.

The point of the waivers is to stimulate creative state approaches to keeping frail or disabled individuals (elderly and other) in their homes for as long as possible. Not only is this thought to be desirable from the consumer's and family's standpoint, it also saves the states money, since many of those who enter nursing homes (for which the states pay half the cost) are poor but over-income for Medicaid's medical services. Were they not served under a waiver, the only way they could get the medical care they need would be to spend-down all their resources and enter a skilled nursing facility. Indeed the average cost per individual senior participating in a Nevada

[31]From the August 13, 2002, letter from the Centers for Medicare and Medicaid Services to all State Medicaid Directors. Italics added.

Medicaid waiver program in 2001 was just over $9,000, while it cost Nevada $30,100 to support an individual in a skilled nursing facility, according to Nevada Medicaid staff.[32]

Home and community-based Medicaid waivers are the most powerful financing tool that states have to implement an overall strategy to keep people in their homes, rather than in institutions. Nevada was slow to begin using Medicaid waivers, for a variety of reasons, including the way in which financing for skilled nursing home care for seniors is shared with Washoe and Clark counties. However, in the past biennium, the two waiver programs that serve seniors have expanded significantly. They served 1,400 individuals in 2001 and are projected to increase that number by 29% by the end of fiscal year 2003. Nonetheless, the Community Home-Based Initiatives Program (CHIP) waiver has a waiting list of approximately 700 individuals. Furthermore, the growth of the senior population and of those who will need skilled nursing home care, suggests that the Nevada Medicaid waivers need to be significantly enhanced during the next 10 years.[33]

For this reason, the Senior Services Task Force is recommending that the number of individuals served under the senior waivers continue to increase by an additional 29% between 2003 and 2011.

When planning for enhanced use of waivers, it is extremely important to keep these programs targeted to those who are truly at risk of skilled nursing facility placement. If this is not done, the state is likely to have significantly growing costs under Medicaid for both the institutional and home-dwelling senior populations. The following Medicaid enhancements and related strategies are proposed in this Plan because they either: 1) make it more likely that those served under the waivers will be the right individuals—those who would otherwise have entered an institution at greater cost, or 2) increase the power of the waivers to support people at home or in the community by adding new elements:

- Establish presumptive eligibility for waiver services in order to make sure individuals do not enter skilled nursing facilities unnecessarily;
- Add preventive dental services, home modification/repair services, and non-medical transportation services;
- Provide for staff and/or consultant time to work on optimizing the way in which the waivers are structured (re-doing the CHIP and Group Care waivers to merge them; making sure the service package is able to maximize the use of State funds and draw down all possible Federal match);
- Provide for staff that work pro-actively and expeditiously with hospitals and chronic care institutions to divert and relocate individuals who can remain in their own homes.

[32] Aiello, E., August 6, 2002
[33] Ibid.

A related strategy (VI-B), calls for analyzing and recommending changes to State and County roles and responsibilities to assure Nevada seniors have equal access to, and eligibility for, home and community-based services.

Data Collection and Plan Accountability

Over-arching Strategy 6: New and timely data collection and analysis will provide vigorous accountability by allowing members of the Commission on Aging Strategic Health Plan Implementation Subcommittee to track, on a quarterly basis, whether the *Plan's* strategies are being implemented and the measurable targets they set are being achieved.

Description: During the planning process it became clear to everyone involved that information about Nevada seniors and their families is limited. Data can be found in the Census and through other national and local sources. But the specific information that will allow people to verify that the *Plan's* strategies are being implemented and are succeeding to make changes in the lives of Nevada seniors is not presently available. Consequently, accountability for *Plan* implementation requires the following actions:

- In 2004 and again in 2010, a comprehensive population-based survey will be conducted. The surveys will solicit information from Nevada seniors and their family members related to health and long-term care indicators. The information can be used by policy makers, planners, and implementers to measure changes in the health of Nevada's seniors and determine results of *Plan* implementation.

- Each year the *Plan* will be re-evaluated and recommendations made for needed changes in *Plan* strategies or the level of State support needed to meet *Plan* targets. For example, the *Plan's* proposed funding increase for the Senior Rx program was based, in part, on elimination of the present waiting list. The waiting list could grow rapidly again after the first year of expansion and additional increases might be recommended. On the other hand, a new Medicare prescription drug benefit or a prescription drug waiver with federal matching funds could reduce or eliminate the need for this program. Other examples of important changes include the potential loss of Medicare funding for the Social and Health Maintenance demonstrations or a reduction or elimination of State Independent Living Grants (tobacco settlement funds).

- To assure continuous improvements in the State's data systems, the Task Force recommends that the State hire a full-time data analyst who will design and implement improved data systems and negotiate changes in data collection within State agencies and in County and non-profit agencies. The analyst will track measures for target accountability and oversee survey implementation and analysis.

- A special subcommittee of the Commission on Aging will be established to monitor the success of the *Plan.* The recommended subcommittee will be composed of eight Senior Task Force members and two Commission on Aging members. The Senior Task Force proposes that the subcommittee meet quarterly to evaluate the *Plan'*s success with the help of consultant support and a new Division for Aging Services staff person to oversee all aspects of *Plan* implementation.

- In 2011, a new Task Force will be commissioned and a strategic plan developed. By this time, *Plan* recommendations will have been implemented and the State will be ready to plan for the next challenge of meeting health and long-term care needs of its senior population. In the years between 2011 and 2020, many of the baby-boomers will be over the age of 65. The State will be faced with new challenges and opportunities. Depending on how vigorously the State has implemented the present *Plan's* strategies and targets, it should be ready to take on the new challenges and strategically plan for the next decade.

IV. Target Areas, Target Area Strategies, and Targets

The strategies that follow are specific to areas of seniors' and their families' needs and desires. The targets themselves stand as measures of whether or not some important, positive change is actually happening.

TARGET AREA I: *More Nevada seniors live in the setting of their choice with support to remain as independent and healthy as possible.*

This target area calls for strategies and actions that directly support the overall outcome of independence that all senior Nevadans want, regardless of their health status and functional ability. This outcome simultaneously benefits seniors and those who must pay for their support.

Strategies:

A. Adopt a statewide policy regarding the proportion of Nevada seniors and people with disabilities who will receive publicly-funded long-term care in their own homes.

   Description: By adopting an explicit policy, the State can verify each year how successful it has been in helping seniors with disabilities remain in their own homes and communities. Seniors prefer the option of remaining at home and, with careful targeting of services to those most likely to enter institutions, the State can offer more cost-effective and desirable home and community-based services.

B. Develop an integrated Nevada data system with the capacity to track data for selected health and long-term care indicators.

   Description: During the preparation of the *Strategic Plan for Seniors*, it became increasingly clear that the data systems used in Nevada are inadequate for planning and evaluation purposes. A comprehensive and integrated data system would allow the State to evaluate how long-term care resources and services are being used and by whom. To do a good job of verifying how effectively the *Plan's* strategies and targets are being met, the new system should include indicators of health and long-term care.

C. Study the barriers and benefits of both integrated and segregated assisted living options for seniors with Alzheimer's Disease.

   Description: Applying percentage estimates from a 1996 consensus panel organized by the Agency for Health Care Policy and Research, and population projections prepared by the Nevada State Demographer, an estimated 15,400 seniors in Nevada have Alzheimer's Disease. As Alzheimer's Disease progresses, many family caregivers have difficulty supporting their loved one at home. Few services and supports exist in Nevada to help people with Alzheimer's Disease and their families. Consequently, seniors are often placed in out-of-state or out-of-community institutions for care. Because the number of people with Alzheimer's Disease will increase over the next ten years, this strategy calls for the State to commission a study to determine the best way to address this growing need.

D. Explore various approaches to assuring that seniors living in fully-accessible units have integrated or wrap-around services when they need them.

Description: One of the key ways to keep seniors who are frail or disabled living in their communities is to have services and supports that are integrated within their home environment. Ideally, the services and supports are not just add-ons but are included in a comprehensively designed plan of care that integrates housing and other supports and allows seniors with disabilities to have maximum independence.

E. Expand current and add new efforts to divert entry of seniors from hospitals to nursing homes and relocate nursing home residents back to their homes, while adding ways to assure this can happen promptly, with no waiting.

Description: The Department of Human Resource's Community Integration and Diversion Project diverts people with disabilities from nursing home care when in-home care might be more appropriate and desired. To assure that seniors and people with disabilities do not enter and stay in institutional care, the State should expand current efforts by working with hospital discharge planners and social workers to develop a plan of care for each person with a disability. The plan of care should be designed to use services and supports in home and community settings. Additionally, a system of presumptive eligibility should be established to assure that public services can be delivered as quickly as possible to allow seniors to return home with the services they need. To implement expanded community integration and diversion activities, the State will need to add three new positions to the Facility Oversight and Community Integration Services unit in the Department.

Target 1: By June 30, 2010, 60% of the senior Nevadans who get publicly-funded long-term care are at home, while only 40% are in chronic care institutions.

Current Information:

In 2001, 1,406 senior Nevadans who were at-risk of entering chronic care institutions received publicly-funded home and community based services under two Medicaid waiver programs (CHIP and the Group Home Waiver)[34]. State Medicaid funding also paid for the care of approximately 2,918 seniors who were in nursing homes[35]. This means that 33% of seniors were living at home and 67% were living in institutional care. The State should implement additional strategies so that of those who receive publicly-funded long-term care, 60% will receive support while living in their own homes, and only 40% will receive support in chronic care institutions (primarily skilled nursing homes).

Currently, data is only available regarding the number of people in nursing homes. However, the expanded data system will include timely reporting of the number of seniors in chronic care institutions (such as psychiatric hospitals) both in and out of state.

[34] Aiello, op. cit.
[35] Ibid.

Eventually, Nevada's goal should be 85% at home and 15% in institutions, which is what a few other states have been able to achieve because they have funded diversion, relocation, targeted case management, and a variety of in-home and community-based services. This shift can be accomplished by holding the number of nursing home slots at the 2002 funded level and increasing home and community-based services and support for those who would otherwise enter chronic care institutions.

Plan Implications:

By adopting an explicit policy to strengthen the home and community-based service system and to reduce reliance on skilled nursing facilities, the State will need to make funding and policy decisions to support this change.

Verification:

Using State data on service usage, verify each year that the number of people receiving publicly-funded home and community based services is increasing as the population of frail seniors increases, and that the number of seniors in nursing homes remains constant.

Target 2: By June 30, 2010, the hospital admission rate and average length of stay is 15% less than the baseline year, 2000.

Current Information:

The average length of stay in hospitals in 2000 for seniors 65 and older was 5.72 days. The number of seniors 65+ who were admitted to the hospital in 2000 was 66,498 (this figure is an estimate based on the number of discharges in the year).

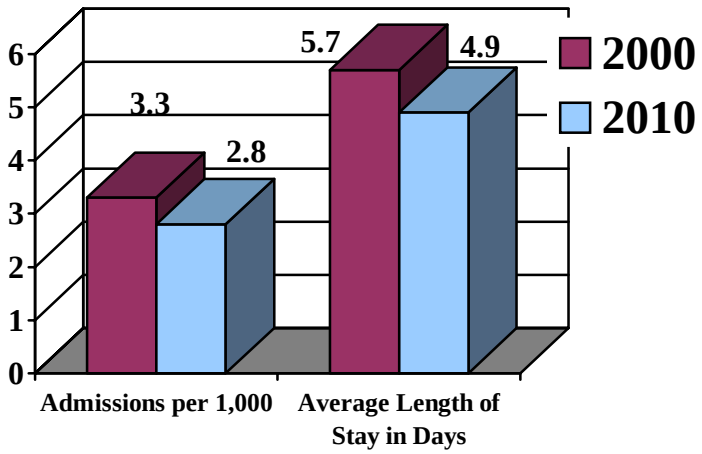
Plan Implications:

The Plan's emphasis on providing services in the community in order to avoid unnecessary institutional placement will have the effect of reducing the number of seniors 65 and over who are admitted to hospitals and shortening their stay in hospitals.

Verification:

Analyze health statistics on the number of hospital admissions and length of stay to verify the 15% drop in admissions. Figure 6 below shows the present admissions and length of stay data and what it would be in 2010 if the target is reached.

Figure 6. Nevada Hospital Admissions and Length of Stay for People 65+, 2000-2010



Target 3: By June 30, 2010, no Nevada seniors with Alzheimer's Disease are housed in out-of-state facilities.

Current Information:

In 2002, 43 nursing home residents over the age of 65 were placed in out-of-state facilities. Of these residents, 41 were placed in an out-of-state facility because they needed a secure facility due to wandering or behavior problems. State staff indicated that many Nevada facilities are reluctant to accept individuals with behavior issues and no Nevada facility was available to accept these residents.

Plan Implications:

Through studying the barriers and benefits of various types of housing options for seniors with Alzheimer's Disease and implementing recommended changes, alternatives to placing seniors in out-of-state facilities can be implemented.

Verification:

Each biennium, the number of out-of-state placements should be analyzed and progress toward eliminating these placements should be made until no seniors with Alzheimer's Disease are placed in out-of-state facilities.

TARGET AREA II: *More Nevada seniors engage in the occupation of life.*

Studies show that an important component of seniors' health is continuing social engagement. This target area outlines actions designed to help seniors, both those who are relatively independent and those who are more frail, to remain as active and involved in community life as possible. It also provides support for their caregivers to be healthier and contribute to the community.

Strategies:

A. Through the public education campaign, promote the use of formal, out-of-home respite options.

   Description: Often, family and friends who care for seniors who need extensive personal assistance never get a break from caregiving. These caregivers can become isolated, depressed, and anxious. Many caregivers are not aware of available respite services and do not understand how using formal, out-of-home respite options might allow the frail senior to participate in outside activities and help the caregiver cope with the stress of caregiving. The State should include promotion of out-of-home respite care options as part of the overall public education strategy.

B. Increase the availability and use of a variety of assistive and adaptive devices (such as vision and hearing-related devices) that enhance independence.

   Description: In order for Nevada seniors with hearing, visual, or other impairments to be active and engaged in life, many need information about assistive devices that could help them be as physically and cognitively fit as possible. Through the public information campaign and training efforts with in-home care providers, seniors can become aware of, and use, adaptive devices that will increase their independence.

C. Offer flexible in-home respite care options to help elderly caregivers remain involved in their own lives.

   Description: Because many seniors receive personal assistance from other seniors, every effort should be made to fund and create options for flexible respite care. By providing respite, senior caregivers can maintain an active and engaged life while providing care for their loved ones.

Target 4: By June 30, 2010, 1,200 Nevada senior caregivers caring for a family member with a disability use at least one formal respite care option with benefits they and their families can depend on.

Need:

Family members and friends are the primary caregivers for seniors, enabling many Nevada seniors who are disabled to live at home. A high proportion of seniors in Nevada rely exclusively on their families and other unpaid individuals for care. In a recent study conducted for the Nevada Division for Aging Services, survey respondents indicated that family and friends were the exclusive caregivers for approximately 90% of seniors with disabilities.[36] In a national study conducted by Family Circle and the Kaiser Family Foundation in September 2000, researchers found that caregiving can be an emotional roller coaster. Caring for a loved one demonstrates love and commitment but it also can lead to exhaustion, burn out, stress, and depression. Over 53% of those surveyed reported they were worried and 28% felt sad or depressed. Nevertheless, senior caregivers are not always aware of, able to find, or willing to use respite services. Senior caregivers should know about and have quality options for getting respite support to help them provide care with less stress.

Current Use/Supply:

Approximately 835 senior caregivers (36% of 2,320 caregivers) over the age of 65 are receiving formal respite care services to help with the care of their elderly relative.[37] Many other senior caregivers are providing informal personal care services without receiving respite support.

Action Steps:

- Consider the possibility of adding in-home respite services to the Medicaid State Plan.
- For rural areas, consider piloting a project that trains and reimburses family members, friends, and neighbors other than the primary caregiver to provide respite services.

Verification:

Conduct a survey of caregivers who use respite services and determine how many of the caregivers are seniors and whether they and their families have experienced tangible benefits from using respite care.

Estimated Costs:

The cost of this target is included in the overarching public information and awareness strategy to promote the use of respite services by senior caregivers. Respite services are available to senior caregivers through the CHIP waiver, Title III-B services, and Independent Living Grants administered by the Division for Aging Services.

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[36] Cannon Center for Survey Research, University of Nevada Las Vegas, June 2000.
[37] Colorado State University Cooperative Extension, 1999.

TARGET AREA III: *More Nevada seniors have improved health outcomes.*

The *Plan* recommends empowering seniors to take more responsibility for their own health and to act at a time when they are still relatively young and healthy. While there is no doubt the formal health system needs to change in the direction of better integration of health and medical approaches, dramatic system cost increases (combined with patients' desires for greater amounts of high technology care) have diverted attention from this important goal. We believe change will begin with the senior him/herself.

Strategies:

A. Educate seniors and their caregivers to define their health care needs comprehensively, to recognize the interaction between their mental health and all aspects of their physical health, and to better manage their own health and chronic conditions.

   Description: As part of the public information campaign, seniors will be given comprehensive information about preserving and enhancing their physical and mental health. One myth about aging is that seniors can only expect deterioration in their health status. Through aggressive public information efforts seniors will learn about the benefits of exercise, a healthy diet, and involvement in their community for increasing their mental and physical health. Through these efforts, seniors will also become more aware of how spiritual, social, and cultural enrichment activities can improve their health and well-being.

B. Expand participation in the Senior Rx Program to assist seniors to afford needed medications.

   Description: Many Nevada seniors have reported that they have difficulty living on limited budgets. The high cost of prescription drugs is placing an added burden on an otherwise stretched budget for many seniors. Because Medicare does not cover the cost of medications, many seniors cannot afford to purchase medications they need to maintain their health.

   This strategy increases funding for the State's Senior Rx program by adding people who are now on the waiting list for services to the program and expanding services each year to meet the needs of a projected growth in the elderly population. Additionally, this strategy adds funding to include a medication management component and staffing to the program that will help seniors better manage their medications and at the same time decrease the overall cost of the program through reduced insurance premiums.

C. Expand medication management programs to improve health benefits and decrease the costs of prescription drugs.

   Description: Promising results have already been achieved through a pilot project that has hired geriatric pharmacists to evaluate medications used by participants in the State's CHIP waiver program. The medication management program informs seniors and their caregivers about drug interactions, duplications in medications, and appropriateness of the medications taken. Already, many seniors are decreasing the number of medications they take and are learning how they can reduce their prescription drug costs by changing medications to lower cost, but equally effective, generic drugs.

In addition to including a medication management component to the Senior Rx program, the *Plan* recommends expanding the medication management program to include more participants in the CHIP waiver program as well as seniors on the State Medicaid Plan who have been in the hospital and are discharged. Over time, appropriate management of medications for seniors will increase their health status and, at the same time, reduce the overall cost of medications for the State.

D. Design and implement a comprehensive senior oral health strategy that includes adding oral health prevention and treatment for seniors using rural health centers and expanding waiver benefits to include twice-yearly preventive dental services for all senior participants.

Description: Nevada is experiencing a severe shortage of dentists, and seniors are particularly affected by the shortage. Nevada has 35 dentists per 100,000 residents, ranking Nevada 50th in the nation in the ratio of dentists per capita. Many seniors cannot afford dental care or find available dentists in their communities. Availability of dentists is particularly a problem in rural areas of Nevada.[38]

Unfortunately, Nevada seniors are less likely than seniors in other parts of the United States to have visited a dentist or have had their teeth cleaned within the past year. According to a national survey done through the National Oral Health Surveillance System in 1999, 39.1% of Nevadans over the age of 65 reported that they had not had their teeth cleaned within the past year compared to the national average of 27.5%. Additionally, people with incomes below $15,000 a year were even less likely to have had their teeth cleaned—66.5% had no dental cleaning within the past year. Nationally, 53.3% of those with incomes below poverty had not had their teeth cleaned.

Research has shown that a lack of proper dental care can be directly linked to other poor health conditions. Minor infections and diseases of the gums and mouth can lead to serious infections and diseases of the mouth and gums which can spread to other parts of the body. Therefore, preventive dental care can lead to better overall health status and well-being.[39]

This strategy has two components. The first is to study the feasibility of adding dentistry services to health clinics in rural areas and identifying additional actions that will increase available dental services. The second component is included as part of the overall Medicaid strategy which adds twice-yearly preventive dental services for all CHIP waiver participants.

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[38]UNLV Issue Brief: A Brief Summary of Important Issues Facing Nevada, *Nevada's Dentist Shortage,* November 2001.

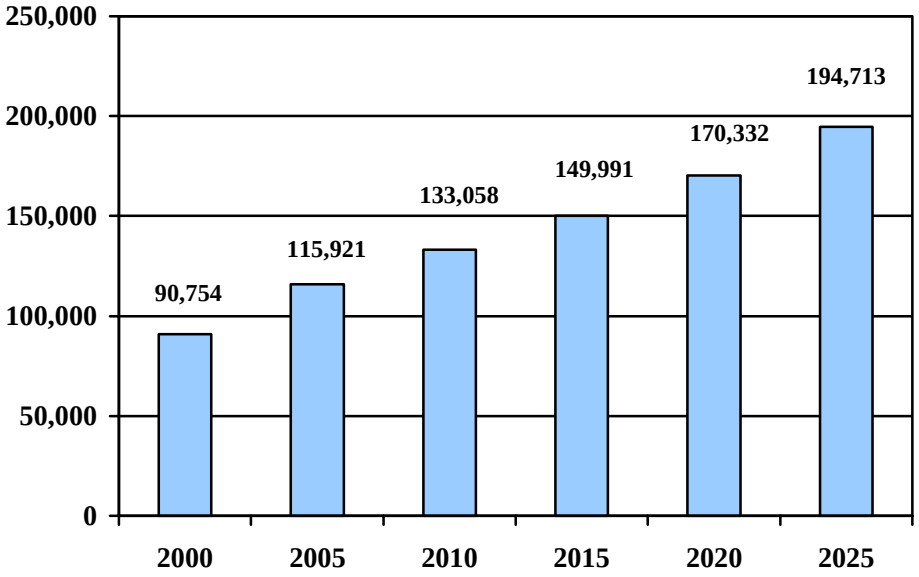
[39] National Center for Chronic Disease Prevention and Health Promotion, *Oral Health in America; Summary of the Surgeon General's Report,* May 2000.

Target 5: By June 30, 2010, the percentage of Nevada seniors 75+ who are severely disabled is less than the baseline year 1997.

Current Information:

The Census Bureau published the Survey of Income and Program Participation (SIPP) report in 1997 that displays information about disability by age for the nation. According to the Nevada State demographer, 95,823 Nevadans are over the age of 75 in 2002. Using the SIPP estimates, 48% (45,900) seniors over 75 are severely disabled. Figure 7 below shows the projected growth in the number of people 75 and over through 2025.

Figure 7. Growth of Nevada 75+ Population, 2000-2025



Plan Implications:

Through a concerted effort to build on the assets of the 75+ senior population and through implementation of specific strategies, overall health status of seniors will improve and disability levels will drop.

Verification:

Using information from a population-based survey of seniors in 2004, verify a drop from the 1997 SIPP estimate of 48% in the percentage of people 75+ with a severe disability.

Target 6: By June 30, 2010, 10,124 low-income seniors participating in the Senior Rx Program can afford the medications they need.

Need:

Nationally, the lack of coverage for medications is seen as one of the key problems with the Medicare program, and health coverage overall. In a customer information process that reached over 2,000 Nevada seniors, prescription drug benefits were mentioned as the second greatest concern or problem by seniors filling out comment cards and by those participating in focus groups. Additionally, a recent Clark County Senior Advisory Council report of senior concerns noted the high cost of medical care and medicine.

Over 150,000 seniors in Nevada have incomes between federal poverty level and $1,700 a month, the approximate eligibility level of the Senior Rx program. This group of seniors is particularly hard hit by the lack of coverage for prescription drugs. While more than two-thirds of these seniors are estimated to be healthy, another one-third has disabling conditions. Another serious problem faced by seniors who require medications is the lack of knowledge about the interactions of medications and the effect of taking incorrect dosages.

Current Use/Supply:

Approximately 9,500 very low-income seniors in Nevada have access to prescription medications through the Medicaid program. Each month the Senior Rx program serves a maximum of 7,500 seniors with incomes below $1,793 per month, except those eligible for, or receiving, Medicaid services. The Senior Rx program presently has a list of 1,000 seniors waiting to become participants in the program[40]. Additionally, some low-income people have private health insurance or participate in health programs such as Medicare HMOs that include prescription drug benefits.

[40] Smedes, J., July 2002

Action Steps:

- Increase the maximum number of people on the Senior Rx program by 1,000 in 2003 and by 6% each biennium to meet the needs of a growing population of seniors and eliminate the waiting list for services.

- Vigorously pursue preparing an application for a Medicaid waiver benefit for prescription drugs to offset the cost of the expansion and possibly further expand the program.

- Include a medication management component (similar to the Medication Management Pilot Program). The cost-savings anticipated from managing medications should make a case for premium reductions; therefore the use and costs of medications will be documented.

- Query participants about decreases in adverse medication effects.

Verification:

Determine each biennium if increases in the maximum participation levels have been achieved. Survey participants to determine if they are better able to afford prescriptions.

Estimated Cost:

As described under the strategy to expand participation in the Senior Rx program, the *Plan* proposes eliminating the waiting list for services and adding 1,000 participants to the Senior Rx program in the first biennium and a 6% increase in the number of program participants each biennium to address increases in the number of people who will be 65 and over. Increases in the budget will also be required for adding a half-time staff person, offering medication management services, and for a 5% cost-of-living adjustments each biennium.

Target 7: By June 30, 2010, Nevada seniors participating in the expanded medication management program have fewer hospital admissions than they had prior to enrolling in the program.

Current Information:

Participants in the Community and Home Based Initiative Program (CHIP) administered by the Division for Aging Services receive reviews by a geriatric certified pharmacist. Seniors diagnosed with diabetes, asthma, or congestive heart failure, who had been taking eight or more prescription drugs, were screened to participate in the program. One hundred participants have been screened for the pilot medication management project. Preliminary results for 80 seniors in the project have shown that:

- 71% of participants in the pilot project had one or more drug interactions taking place and several participants had from three to five interactions.

- 42% of participants were taking from one to eight duplicative medications.

- 15% were taking a drug determined to be inappropriate for elderly use.

- 23% of participants were advised to decrease the number of medications taken, and 20% of participants were advised to decrease the cost of medications.

- Two participants were identified as taking potentially lethal combinations of medications and their physicians, on the advice of the pharmacists, subsequently changed the participant's prescription.

Plan Implications:

By expanding the Medication Management Program to include more CHIP and Medicaid participants (particularly those seniors who have been hospitalized frequently in the last five years), the State should see both a reduction in the cost of medications for individual participants (and possibly for the programs overall) and a reduction in the rate of hospital admissions for seniors whose medications are reviewed by geriatric pharmacists.

Verification:

The strategy to expand the Medication Management Program will have a research component that will survey records of the population in the pilot to determine their hospitalization admission rate prior to the pilot. A year later, after participants have received medication management assessments, a review of their records will determine whether a reduction in hospitalization has taken place. The research will also include data on cost savings accrued as a result of changing or reducing medications.

TARGET AREA IV: *More Nevada seniors live in homes that are safe, fully-accessible, and affordable.*

Private sector strategies are key to the success of the *Plan*, particularly in the area of housing development. In order for these to be successful, however, advocacy is needed to bring about education of private developers and to initiate selective regulation, while at the same time developing and offering incentives for developers to create the kind of housing seniors want. Public agencies will lead the way by assuring that the homes in which seniors live are as accessible as they can be to promote independence.

Strategies:

A. Require all new construction (public and private) aimed at a senior market to build fully-accessible units.

   Description: More and more developers recognize the importance of building homes for the senior market that anticipates the senior's long-term health needs. Because the vast majority of seniors desire to live at home as long as possible, they want and need homes that are fully-accessible. As part of the overall strategy to encourage private sector development, efforts will be made to inform developers about the positive aspects of building accessible senior housing and methods for doing so cost effectively.

To promote accessible housing construction, a housing development specialist will be hired who will train and support developers and explore options for initiating regulatory changes that will encourage or require development of fully-accessible housing in senior communities. At the same time, the specialist will develop options for reducing, streamlining, or eliminating unnecessary requirements for developers, and recommend incentives for increasing accessible housing development.

B. Offer low interest bond financing for senior housing and long-term care projects.

Description: Other states such as California and Massachusetts have found innovative mechanisms to encourage the development of low-cost housing options for senior housing and long-term care housing projects. Through low-interest bond financing and other creative funding options, the supply of affordable housing will increase. The housing development specialist to be hired to explore ways to increase accessible housing will also work on researching and developing financing options that will increase affordable, low-income housing and long-term care projects. As part of this development, he or she will work with staff from several departments and divisions of the State and with private developers to initiate projects that will increase the low-income housing supply.

C. Obtain adequate sponsorship and funding for life-sustaining heat and air conditioning repairs.

Description: Many Nevada seniors have expressed concern about the high cost of utilities and the cost of repairs for heating and air conditioning units. Through efforts of the housing development specialist, new ways to assist seniors with these repairs will be explored and implemented and new funding or sponsorship will be obtained. The specialist will work with members of the Energy Commission to develop options and will coordinate efforts with the public information campaign to inform seniors about all available options for obtaining needed repairs.

D. Retrofit existing senior units managed by public housing authorities so they are fully-accessible.

Description: The number of fully-accessible, senior housing units owned and operated by the public housing authorities is only 78 units, approximately 5% of the entire low-income housing stock. Given the State's population explosion of those over the age of 85 and increased likelihood that these seniors have very low incomes and are disabled, the public housing authorities must act now to increase the number of fully-accessible housing units. Proposed efforts to help seniors remain in their own homes should be supported by public housing authority efforts to increase appropriate, accessible housing for seniors as they "age in place."

E. Assure that all Medicaid waivers include home repair and home modifications for senior participants.

Description: Similar to housing authorities, other public entities must recognize the importance of low-income seniors to be able to live in homes that are in good repair and that are accessible. This strategy calls for the State to add home repair and home modification services to Medicaid waivers so that seniors with disabilities will live in safe and accessible

housing that maximizes their independence and allows them to stay at home. Adding home repair services to all Medicaid waivers is part of the overall Medicaid strategy to increase, enhance, and improve waiver services so that fewer Nevada seniors will be placed unnecessarily in chronic care institutions.

Target 8: By June 30, 2010, 290,000 Nevada seniors can afford to pay for housing and utilities.

Need/Demand:

During 2001-2002, Nevada seniors in focus groups across the State talked about the "ability to pay for basics" as the greatest problem or concern and 200 seniors made comments about the high cost of utilities when filling out comment cards at senior fairs and group meetings.

According to a special 2000 census study on housing by income and age, 28,900 (13.2%) of Nevada seniors rent their homes. Of these renters, 53.8% or 15,500 paid more than 30% of their income for housing. In an AARP analysis of the 1995 Urban Institute American Housing Survey, an estimated 14% of homeowners paid more than 40% of their income for housing (the Department of Housing and Urban Development (HUD) defines "excessive expenditures" as 30% of income for renters and 40% of income for homeowners). Therefore, approximately 15,500 Nevada renters and 26,500 homeowners over the age of 65 spent more than 30-40% of their income on housing in 2000. If nothing is done to affect housing affordability by 2010, an estimated 62,030 Nevada seniors will pay an excessive amount for housing, and 260,135 will not. This target reduces the percentage of seniors who spend excessive amounts of income on housing from 20% in 2000 to 10% of seniors in 2010.

Current Use/Supply:

In 1998, the Meyers Group estimated that the supply of publicly-supported, available, accessible Nevada senior housing units that meet ADA requirements for handicap accessibility was 3,775. The number of senior housing units managed by the housing authorities is approximately 1,458 units. Some seniors also receive housing through Section 8 vouchers and other publicly-supported housing programs. Additionally, the private market produces affordable housing for low-income individuals.

Action Steps:

- Increase the number of options for financing housing for low-income seniors by using innovative funding mechanisms.

- Encourage private developers to build low income or mixed-income housing to increase supply.

- Inform seniors about low and moderate income housing options and link them to services through the single point of entry information and assistance system.

- Increase substantially the number of seniors taking advantage of the tax rebate program for low-income homeowners and renters by including a comprehensive outreach effort as part of the public information campaign.

- Increase awareness of the low-income energy programs for seniors through the public information strategy.

- Establish outcomes and responsibility for increasing affordable housing through a partnership with local housing authorities, the State Housing Division, Department of Employment, Training and Rehabilitation, Energy Commission, and the Division for Aging Services.

Verification:

Analyze information from the population-based survey completed in 2004 to determine the progress made in reducing the percentage of renters who are paying no more than 30% of their income, and homeowners who are paying no more than 40% of their income, for housing and utilities. Redo the population-based survey in 2010 to determine whether the target has been met.

Estimated Cost:

As strategies are developed and implemented the State may need to invest new resources to encourage private development of low-income housing and spend more money to fund low-income public housing.

Target 9: By June 30, 2010, 700 Nevada seniors occupy public housing units that are fully-accessible.

Need:

Over 50% of seniors who have incomes below the poverty level in Nevada have a disability. Therefore, it is safe to assume that at least half of the seniors in public housing (all of whom are low-income) have disabilities and should be living in housing that is fully-accessible. Additionally, the number of seniors in public housing who are over the age of 75 will increase during the next ten years as the 65–74 population grows older.

Current Use/Supply:

The Nevada housing authorities manage approximately 1,458 units of public housing (staff from each housing authority in the State reported the number of total units and accessible units). Of these units, 78 are estimated to be fully-accessible, only 5% of the total units.

Action Steps:

- Work with the public housing authorities to develop and implement a plan to increase the number of fully-accessible, existing units.

- Identify and secure resources to increase the supply of fully-accessible low-income housing units.

- Secure an agreement with the housing authorities and other low-income housing developers to assure that all new low-income housing units will be built fully-accessible.

Verification:

On a yearly basis, ask each housing authority to report the number of fully-accessible units they manage. Each year 100 fully-accessible new or existing units will be added to public housing properties.

Cost:

No new State resources will be required to meet this target. However, State Departments should form a partnership with the housing authorities and identify and secure CDBG and other resources to help the housing authorities develop fully-accessible housing units.

TARGET AREA V: *More Nevada seniors who are frail or disabled go from one place to another when they need to.*

Transportation, of all the areas the Task Force examined, seemed one that was highly important and, at the same time, most problematic. Transportation is essential to independence. It is often difficult to arrange and extremely expensive when the senior can no longer drive. Its absence leaves the frail or disabled person stranded apart from community life. Much effort needs to go into studying and providing leadership for needed changes in transportation systems and their expansion to all in need.

Strategies:

A. Conduct an independent study of methods to strengthen Nevada transit programs and approaches so they provide improved quantity and quality of service to seniors and people with disabilities.

   Description: The lack of adequate transportation services has been identified by seniors in surveys and focus groups throughout the State. New approaches and innovative programs are needed to improve the quantity and quality of transportation services for people of all ages with disabilities, and for seniors who are frail or disabled. Because of the rapid growth of Nevada's population, the public transportation system has not been able to keep pace with the population growth. Federal and state funding has been limited, yet the need for expanded transportation services has increased substantially.

   Consequently, this strategy proposes that the State hire an independent consultant in the second biennium. The consultant will evaluate the present transportation system, research and recommend approaches to increase transportation services, recommend transportation funding options and possible changes in transportation planning and delivery.

B. All existing transportation providers will become eligible for Medicaid reimbursement for medical trips.

Description: Transportation services for seniors who are frail or disabled are limited. Many low-income seniors, especially in rural areas and on reservations, are not able to obtain needed transportation services. These seniors are particularly vulnerable to being isolated and unable to obtain needed health and social services. As part of the overall Medicaid strategy to enhance and improve services, every effort will be made to assure that all existing transportation providers receive Medicaid reimbursement for medical trips. Additionally, the Plan proposes to include non-medically related trips as part of Medicaid waiver services in order to increase the independence and health of waiver participants.

Target 10: By June 30, 2010, 19,300 frail Nevada seniors get where they need to go each year.

Need:

A significant number of seniors, caregivers, and service providers in all areas of the State have identified transportation as a major concern. In a Clark County Advisory Council report, seniors said they needed more transportation services to remain independent and to avoid becoming "shut-ins." While the transportation resources in metropolitan areas are stretched, people in rural areas have been particularly concerned about the lack of transportation for seniors and people with disabilities. At a Native American Indian Public Forum held in May 2002, participants stated that transportation services are limited or non-existent on reservations. During the needs assessment process completed by the Rural Subcommittee of the Disability Task Force, subcommittee members and community residents repeatedly identified the lack of accessible public transportation as a major concern. People identified the inability of seniors who are frail and those with disabilities to get to medical appointments or to buy food as a serious problem and one that can lead to unnecessary institutionalization.

Current use/supply:

In Reno and Las Vegas a fixed route system serves the general public. This system serves urban seniors who choose not to drive or who cannot afford to drive. The vehicles included in this system are typically lift-equipped and, therefore, handicapped accessible, so the system can also be used by some seniors and others with disabilities who are able to get from their homes to bus stops. It is operated by the Regional Transportation Commissions (RTCs) and should be the system of choice for most non-driving seniors. Citi-Lift in Reno/Sparks and Citizen Area Transit (CAT) in Las Vegas provide curb-to-curb transportation service for seniors and people with disabilities who are too frail to use the fixed route system. Additionally, Senior Ride, a taxi voucher program operated in parts of Clark County and funded by the Taxicab Authority, allows seniors who are frail to purchase vouchers for taxi services.

The Nevada Department of Transportation (NDOT) serves seniors who live outside of these two urban areas in small urban and rural areas including Indian Reservations. NDOT operates both fixed route transportation through Public Rural RIDE (PRIDE) and curb-to-curb transportation through 32 elderly service providers in rural areas.

Information about transportation services in Nevada is limited because funding agencies have not always required service providers to report unduplicated riders, and data about current use and supply is not collected and reported to a central location. A matrix of transportation services is included in a *Plan* attachment and shows what data was able to be collected and displayed.

Action Steps:

- Establish agreements on financial responsibilities and methods for securing a variety of funding resources with transportation providers and programs to increase transportation services throughout the State.

- Pilot innovative transportation service options to meet needs in all geographic areas (especially in rural areas and reservations).

- Establish uniform reporting requirements to capture the number of unduplicated riders using public transportation.

Verification:

A group of transportation providers and consumers can verify that targets are set and responsibility for action is established. By 2004, a new reporting system to gather consumer data on the number of riders in the system will be in place. By 2006, an increase in the number of riders served will be documented in the system.

Estimated Costs:

The *Plan* proposes in the second biennium that the State hire a transportation consultant who will evaluate the present transportation system, facilitate a process for better integrating and planning for state-wide transportation services, identify best practices that could offer ideas for transportation improvements, analyze and recommend transportation funding mechanisms and grant opportunities, and recommend changes in Nevada's transportation system. An increase in the State budget for transportation is not recommended in the first biennium except as a part of the overarching Medicaid enhancement strategy so that seniors on the waiver can get transportation services for non-medically related trips. However, the State will most likely need to contribute new resources to the public transportation system for seniors and people with disabilities in 2005 and beyond to achieve the target. The State will be able to offset some of the increased costs with federal Medicaid match funding as more transportation providers become eligible to provide Medicaid services. Targeted use of federal Title III-B and Independent Living Grant resources can also be included as part of the strategic plan.

Newly-identified federal and local transportation funding should be pursued by the proposed development specialist to increase the overall funding level of public transportation. Additionally, the State should work with the Taxicab Authority to expand taxi voucher services in Clark County and initiate services in all other counties.

TARGET AREA VI: *More Nevada seniors get the benefits, services and supports they need.*

In this area, in particular, Task Force members were careful to prioritize and select the very most important services and issues for focused attention. The strategies and targets selected will benefit seniors at all income levels. It is clear that information, assistance, and care management (when it cannot be provided by a family member) are fundamental to being able to stay in one's home and community. The single point of entry system, already well-underway, will complement the over-arching strategy of a broad public education campaign.

Strategies:

A. Design, fund, and implement a single point of entry system for information, referral, assistance, care planning, and care management.

   Description: Currently, seniors in Nevada can receive pieces of information about services and resources from a variety of sources including State agencies, community social and health service providers, and from family and friends. But the lack of consistent, centralized information and assistance often results in seniors and their families being unable to find needed services and supports. The State should build on a pilot project for developing a single point of entry information and assistance system to develop and create a comprehensive, information, assistance, referral, and follow-up system. This system will be easy for seniors and their families to use and will be available on the worldwide web. It will also be tied to the national 2-1-1 information system so that seniors and their families can learn about national as well as local services, resources, and supports.

B. Analyze and recommend changes to State and County roles and responsibilities to assure Nevada seniors have equal access to, and eligibility for, home and community based services.

   Description: During the planning process, TRI became aware of issues related to public funding of aging services among the State, counties, and private non-profit agencies (particularly social and health maintenance organizations who deliver Medicare-funded community health services). These funding and service issues lead to unnecessary gaps in service delivery, create incentives for paying for the most expensive levels of institutional care instead of home and community-based care, and result in a lack of full utilization of all public resources. The *Plan* recommends that a new specialist be hired in the Department of Human Resources to determine what barriers exist that prevent the maximum use of all public resources and recommending funding and service options. Additionally, the State should purchase expert consulting services to analyze the present system, determine options for changing or improving present funding and administrative structures, and facilitating sessions between public funding agencies to explore creative options for better coordination and use of funds. The result will be that seniors throughout the State will have equal access and availability of home and community-based services. At the same time that service quality and availability is enhanced, a strong possibility exists for better using or saving valuable resources from various government and private non-profit agencies.

C. Implement recommendations from the Personal Assistance Services Advisory Council and study the relationship among personal assistance services, homemaker services, and in-home respite care to determine which funding sources pull in the greatest number of federal dollars relative to the investment of state funds

Description: A Personal Assistance Services Advisory Council has been looking at how personal assistance services are presently delivered through various State waiver programs and the Medicaid State Plan. This Council will soon be making recommendations that should be implemented to assure that low income seniors and people with disabilities get the required amount, quality, and type of personal assistance services that will allow them to remain in their own homes and communities.

In addition to the recommended consulting work under strategy B above, the consultant will also work with State and County staff to make sure that all federal dollars for home and community based services are being used effectively and that the best service models are implemented in all parts of the State and on Indian reservations. The consultant can help the State explore innovative partnerships with health clinics in rural Nevada and on reservations, determine how more Medicaid match resources can be secured for community services, and analyze how to best use personal assistance, homemaker, and respite services to meet *Plan* outcomes for the benefit of Nevada seniors and their families.

Target 11: By June 30, 2010, 85,000 Nevada seniors and their family members use a single point of entry system to access information and referral for the array of available services.

Need:

Many Nevada seniors have identified the lack of easily accessible information as a major concern. The rapid increase in Nevada's aging population will only exacerbate the need for up-to-date information and assistance to access available resources and services for seniors and those with disabilities. Fortunately, a pilot project has been initiated in the State to develop a single point of entry information and assistance system. The work of this collaboration will serve as a springboard for future State and local community action.

Current Use/Supply:

Nevada does not have an easily accessible, statewide system for acquiring information and assistance about available services and resources. The State Division for Aging Services responds to calls from seniors in all regions of Nevada and other agencies to provide information and assistance to people who request services, but seniors and their families often do not know whom to call and do not have a simple, consistent way to find out about available supports.

Action Steps:

- Secure a variety of funding resources to support information and assistance services throughout the State (including, in later years, businesses wanting to purchase information and assistance services for their employees).

- Build on the collaborative efforts of the pilot project to firm up a partnership of local providers who will implement the single point of entry access system based within every local community.

- Determine if any part of the information and assistance system can receive Medicaid match funding.

Verification:

Gather annual data from the web-based, single point of entry information and assistance system from providers across the State on the number of seniors receiving a short assessment and who are given information about services and resources.

Estimated Costs:

Several partner agencies have begun the work to develop the Information and Assistance system and expect to have the initial web-based system in place by 2004 with 25,000 seniors accessing the system in the first year. This initial work has been funded through federal caregiver services resources and most of the cost for the Information and Assistance system will be covered through this grant in the future. The total cost of the single point of entry system is not yet known, but State and local resources will be needed to provide ongoing training, keep information current and develop links to all available services for seniors, and specialized care management and support services for those with personal care needs. Eventually, the single point of entry system should be tied to the national 2-1-1 information and assistance system to assure access to national information about services and resources and to share Nevada information with seniors and their families in other states.

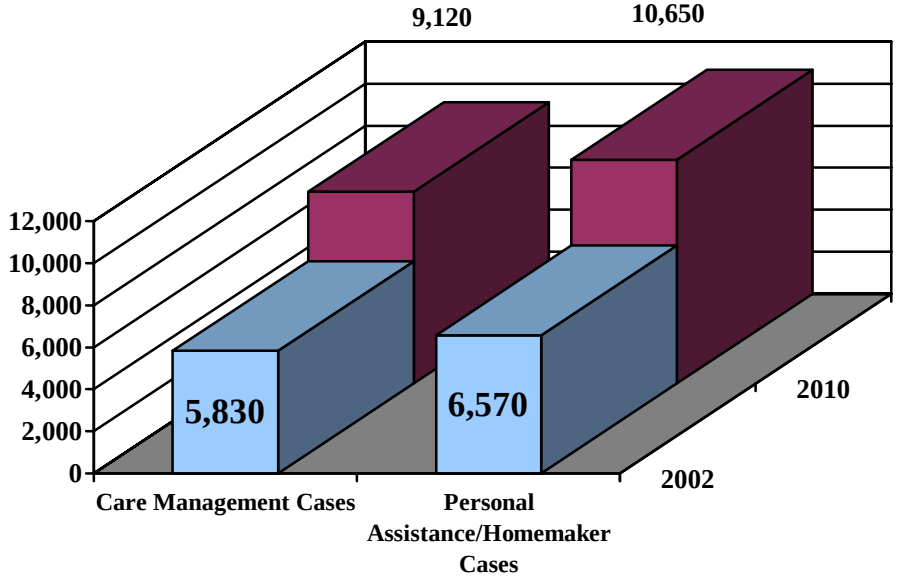
Target 12: By June 30, 2010, 9,120 frail or disabled Nevada seniors receive the care planning assistance and care management they need.

Need:

Although family members and other caregivers are the major support for frail or disabled seniors, the family needs help to evaluate the senior's ability to remain safely at home and to access all available resources and services. Many experts in the field of aging believe that one significant reason that older people enter institutions is that they are unaware of alternatives. With the help of care management services, seniors and family members can learn about all formal and informal services and supports, make a plan for how they can stay in their homes with the supports they need, identify problems and options to solve them, help assure that quality services are provided, and find options to help the family cope with caregiving responsibilities.

Currently, 1,240 people are on waiting lists to receive care management services through State, county, and a local social and health maintenance organization. Waiting lists for this service are a good indicator that more seniors and their families can use this support. As the population of seniors who are frail or disabled increases in the next ten years, the need will become even greater. By 2010, the population needing care management services will increase by an estimated 29%. Figure 8 below shows the number of people receiving care management and personal care/homemaker services now and those who will receive care in 2010 when the *Plan* is fully implemented.

Figure 8. Nevada Care Management and Personal Assistance Caseload Growth, 2002-2010



National evaluations of care management services indicate that clear targeting of resources to those most in need, small caseloads, and highly trained care managers are predictors of positive outcomes for seniors and their families who use care management services. Consequently, Nevada needs to determine whether care management services are being targeted appropriately and that the design of the single point of entry system identifies those who most need care management services. Also, the State and County should develop a comprehensive training program for care managers to assure that care management services meet national standards for effectiveness.

Current Use/Supply:

The State presently operates care management services through the Medicaid program, the CHIP and Adult Group Care waivers, and a care management program in the Division for Aging Services funded through Title III-B and Independent Living Grants. Through these programs, approximately 4,116 seniors were served in 2001/2002. The number of seniors receiving care

management is based on the following: 1) one percent of elderly on non-waiver Medicaid services times 13,150 seniors who were receiving Medicaid care management services in December of 2001, an estimated 132 cases; 2) an estimated 1,522 seniors receiving CHIP waiver services in 2002; 3) 227 seniors received care management on the Group Home waiver in 2002; 4) 1,480 received care management through Title III-B/ILG and 755 received care management through Title XX in 2002**.** An additional 232 seniors are on a waiting list for care management services under Title XX.

Additionally, Clark and Washoe counties provide care management services to 498 seniors with county funding and Senior Dimensions provides care management services to approximately 1,214 seniors and together have 1,008 seniors on a waiting list for services. A chart of senior home care services in the State is included as an Attachment L to the *Plan*.

Action Steps:

- Collaborate with County and other providers of care coordination to standardize screening tools, care plans, criteria for client selection, and management of waiting lists as part of the single point of entry system.
- Establish parity between State and County care management.
- Increase funding for care management as the population of seniors 75+ continues to rise.
- Explore possibility of funding from the private insurance market for care management services.
- Increase training of care managers who deliver services to seniors who are frail or disabled.

Verification:

Collect information on the number of seniors who are frail or have a disability and are receiving care management services. Sample care management clients and their families to determine how many were able to stay in less restrictive environments because of care management services.

Estimated Costs:

The cost of increased care management services is included in the proposed expansion of Medicaid waiver services. All seniors served by the CHIP and Group Home waiver receive comprehensive care management services that are critical to successful care planning and assessment, monitoring, and service management. The State must increase the number of care managers as it expands home and community-based services. The proposed expansion of waiver services will assure prompt service assessment and delivery. The waiver services are proposed to grow through 2010 and beyond to meet the needs of a projected 29% growth in the number of seniors who will need help with two or more activities of daily living and would enter a nursing home without publicly-funded personal assistance.

Target 13: By June 30, 2010, 10,650 low-income Nevada seniors use personal assistance and/or homemaker services.

Need:

Although the family is a valuable resource for providing much care for seniors with disabilities, the family cannot always provide all of the services family members need. Many seniors who are frail or disabled need help with basic activities of daily living (ADLs) such as bathing, transferring from the bed, dressing, eating, and using the toilet and/or with instrumental activities (IADLs) such as shopping and errands, house cleaning, laundry, and meal preparation. The National Institute on Disability, Department of Education and Rehabilitation completed a comprehensive analysis of personal care needs of various populations. This analysis shows that 7.2% of people over the age of 65 need assistance with ADLs and 16.2% need assistance with IADLs. In 2002, approximately 17,250 people 65 and older in Nevada need personal assistance with ADLs, and 38,900 seniors need help with IADLs. By 2010, these numbers will grow to over 23,000 and 52,000 respectively.[41]

The State legislature in Nevada has already shown its commitment to people needing personal assistance services by setting policy in SB 174 that assures "minimal, essential personal assistance services are available to all citizens of the State of Nevada with severe functional disabilities who, if provided access to those services, will avoid placement in institutional settings and remain safely in their homes and communities."

Current Use/Supply:

In March 2002, an estimated 1,010 seniors receive State-funded personal assistance services either through the Medicaid Personal Care Aide (PCA), 180 seniors, or the CHIP waiver, 830 seniors. Of the 609 people who were on the waiting list for services, 530 (87%) are estimated to need personal assistance services. An additional 330 seniors not on the waiver program receive personal assistance services through the Sierra Health Services Health Plan of Nevada Senior Dimensions program.

In 2002, an estimated 3,302 seniors receive State-funded homemaker services (see the Home Care Services in Nevada Attachment L for a detailed breakout). Clark and Washoe counties fund additional homemaker services for 569 seniors and the Senior Dimension program serves an estimated 837 seniors who are not eligible for, or not receiving, Medicaid services. Approximately, 525 (86%) seniors who are on the waiting list for CHIP waiver services need homemaker services and 631 seniors are on waiting lists for County homemaker services.

As of May 2002, the average wait time for waiver services in Reno is two months, Carson City is three months, and Las Vegas is eight months. Additionally, County social service staff involved in SSI eligibility report that it takes more than 100 days to receive approval and, in some cases, workers report that seniors wait up to two years for approval.

[41]Hardcastle, J., July 2002.

Many seniors needing personal care and homemaker assistance receive that care exclusively from family members. Approximately, 64% of care is provided by family members with no formal caregiving support. Only about 28% of care is provided through the formal system.[42]

Because of a slow economy, the supply of personal assistance workers and homemakers in many parts of the State seems steady and agencies and consumers are able to find workers when they have resources to purchase services through private or public fund sources. However, the supply of workers fluctuates with the economy and finding and retaining workers will become a problem in the future. Consequently, it is important to keep the pay for these workers in line with the work performed and to plan for cost-of-living adjustments to keep up with the rate of inflation.

Action Steps:

- Target State-funded personal assistance and homemaker services to those needing help with two to three ADLs or IADLs.
- Eliminate waiting lists for services.
- Decrease time seniors wait for personal assistance or homemaker services in all State-funded programs to no more than 60 days and less if the senior will enter or stay in a nursing home or hospital without needed services.
- Establish parity for the maximum number of allowable personal assistance service hours received among all State-funded programs.
- Establish presumptive eligibility for Medicaid services while waiting for SSI approval for those seniors not eligible for SSA.

Verification:

The target number of 10,650 seniors was calculated by determining the number of seniors receiving personal care or homemaker services in 2001-2002, adding the number of people on the waiting list, and increasing this number (7,823) by 29%, the projected percent increase of seniors who will need assistance to avoid institutionalization.

Each year State staff should calculate the number of people served by each of the government agencies and determine if progress is being made toward reaching this target. Additionally, consumers and their caregivers should be included in the population survey to be completed in 2004 and 2010 to understand how personal assistance and homemaker services are allowing consumers to stay at home and avoid institutional care.

Estimated Cost:

Each of the government and private funders should increase funding for these important services and collaborate to assure maximum use of all public and private resources to expand and

[42] Federal Interagency Forum on Aging Related Statistics, 2000.

enhance personal assistance and homemaker services. The cost for increasing the State's personal care and homemaker services is included in the overall Medicaid waiver strategy, and represents the most significant budget impact of the *Plan.*

These services are the most critical for avoiding entry into chronic care facilities and, therefore, the added cost should be offset by reducing the level of increased State expenditures for institutional care.

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SECTION VI:

Attachments

Attachment A

TASK FORCE MEMBERS

Name	Affiliation
Susan Rhodes	Clark County Social Services, Chair
Betsy Aiello	Division of Health Care Financing and Policy
Carolyn Grant	Assisted Living Association of Nevada
Dr. William Hausman	AARP
Don Hauth	Alzheimer's Association of Southern Nevada
Bonnie Hillegas	Sierra Health
Edrie LaVoie	Lyon County Human Services
Karen Mabry	Washoe County Senior Services
Connie McMullen	Reno Senior Advisory Council
Debbie Parra	Nevada Housing Division
Charles Perry	Nevada Health Care Association
Dottie Piekarz	Daybreak Adult Day Care Center
Jackie Ridley	Commission on Aging
Kathy Wolfe	Carson City Welfare/Human Services

Nevada Division for Aging Services staff

Mary Liveratti	Task Force Coordinator
Carol Sala	Community Based Care Unit Manager
Mel Phillips	Management Analyst (liaison to Task Force for Persons with Disabilities)

Attachment B

SENIOR STRATEGIC PLAN
SUMMARY REPORT OF CUSTOMER INFORMATION

Between November of 2001 and June of 2002, 2035 Nevada seniors, service providers, and caregivers for seniors[1] responded to questions about the needs and concerns of seniors in the state. Respondents also indicated which services and resources would be most helpful to seniors. Information was gathered through comment cards, a written survey, and focus groups.

Seniors expressed appreciation for many of the services they already use. They mentioned positively such programs as Senior Companions, Meals-on-Wheels, support groups, exercise classes and area senior centers. Seniors seem to especially value the social connections fostered by these services.

For many seniors, there exists unresolved tension between wanting to remain self-reliant or independent and their increasing physical limitations. Many also voiced concerns about maintaining good mental and physical health while living on a restricted income.

Comment Cards[2]

The Clark County Senior Advocate Program (a division of the Clark County Department of Parks and Community Services) distributes comment cards at senior fairs and senior group meetings in Clark County on an ongoing basis. Between November 2001 and April 2002, 1512 seniors attended a senior fair or group meeting where comment cards were collected by program staff.

Written Surveys[3]

Written surveys were distributed and collected by staff members from the Division for Aging Services. Survey participants were drawn from senior center sites in

[1] In some cases, demographic data about participants was collected. Tables that present these data are found in Attachment I.
[2] Detailed tables that summarize comment card responses are found in Attachment II.
[3] Detailed tables that summarize all responses to the written survey are found in Attachment III.

Reno, Sparks, Carlin, Elko, Ely/McGill, and satellite locations. Home-bound seniors and CHIP waiver recipients also completed surveys. In addition, surveys were distributed at Rural Health Task Force meetings throughout the state, generating responses from seniors in Elko, Eureka, Humboldt, Lander, Lincoln, Lyon, Nye, Storey, and White Pine counties. Survey questions were published in the *Senior Spectrum* newspaper in April inviting response. 394 completed written surveys were returned.

Focus Groups[4]

Focus groups were convened in various locations throughout the state by trained volunteer facilitators[5]. Facilitators gathered groups of 3-10 seniors, service providers, and/or caregivers and recorded their responses to seven questions. 129 people participated in 20 focus groups.

The 129 focus group respondents ranged in age from under 50 years old (service providers and caregivers) to over 85 years old. More were 75 to 79 years old than any other age category. 81% of respondents reported they were white or Caucasian. 21% of focus group participants are caregivers. Focus group respondents reside in 19 different Nevada cities and towns. It should be noted that about one-quarter of the participants did not disclose their age, race/ethnicity, or caregiver status (or were not asked to do so).

Summary of Findings from Comment Cards

The Clark County Senior Advocate Program distributes comment cards that ask seniors, "What could you use the most help with?" Staff members use the cards both to tally seniors' needs and to directly respond to individual seniors by connecting them with services and resources. Comment cards are returned that say "I don't need anything right now" as well as cards with more than one area of high need selected by a respondent. The most frequently cited needs are health care related services or resources and services or resources that allow seniors to remain in their own homes.

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[4] Detailed tables that summarize all responses from focus group participants are found in Attachment IV.

[5] Denise Klein of The Rensselaerville Institute conducted two training sessions for volunteer facilitators, one in Las Vegas on March 20th and a second in Reno on April 3rd.

What seniors could use help with	
366	Dental Services
283	Prescription Drugs
256	Vision Services
201	Utilities
198	Minor Home Repair

Summary of Findings from the Written Survey

The first question on the written survey asked: "Which of the following are you most concerned about right now?" Eleven common concerns were listed and respondents were instructed to select only one. The concerns "remaining or staying as healthy as possible" and "staying in my own home for as long as possible" together accounted for 58% of all responses.

Question 1: Areas of greatest concern	
163	Remaining or staying as healthy as possible
76	Staying in my own home as long as possible
26	Able to care for myself
24	Getting healthier
12	Getting from one place to another, when I want to

Questions two and three asked survey participants to identify important services or resources that would be helpful to themselves or to other seniors. Transportation and expanded medical services topped their list.

Questions 2 and 3: Important/helpful services and resources	
56	Transportation
53	Expanded medical services
29	Shopping/housework/errands
28	Affordable prescriptions/help with prescription costs
19	Senior Center/senior activities

> ***Those who have been left alone for any reason have a difficult time coping. In my own case the nearest relative is 225 miles away and is extremely busy with a full time job and volunteer work. Since I am nearly 88 years of age and am partially disabled I am no longer allowed to drive.***[6]

Summary of Findings from the Focus Groups

Question one asked participants to share the problem or concern related to aging that was most on their mind. Concern over finances or the ability to afford the basics was most frequently cited.

Question 1: Greatest problems or concerns	
19	Finances/ability to afford basics
15	Cost of prescriptions/medications
15	Maintaining good health
15	Remaining independent/don't want to rely on others
15	Worry about an aging loved one or caring for a loved one

[6] Quote from a survey participant.

Question two asked "What gets in the way when you try to complete every day tasks?" 45% of all responses related to physical or mental health.

Question 2: Get in the way of completing every day tasks	
22	Health
17	Vision or hearing loss
14	Body not working like it did
11	Mental health
10	Transportation

> ***My breathing and my movements. I can only wash dishes for a short period of time. I can't even sweep the floor. My physical limitations get in the way.***[7]

Questions three and four asked about important services and resources that would make it possible for seniors to remain independent, at home. As in the written survey, help with household chores and transportation were selected as the top two services needed.

Questions 3 and 4: Important service or resource	
50	Shopping/housework/errands
45	Transportation
20	Personal assistance/caregiver
15	Companionship
15	Money

[7] Quote from a focus group participant.

Question five asked "What is an important service or resource that would make it possible or easier for caregivers to continue to provide care for a loved one?" 43% of all responses centered on respite care, time away, or money to hire help.

Question 5: Important services or resources to help caregivers	
46	Respite/time away
13	Money to hire help
9	Support groups
8	Transportation

> ***There is not enough respite care for caregivers. It takes a lot to give full care, diapering, bathing and feeding. "24/7" care giving is very hard and I'm talking about other people too. I feel like I'm suffocating.***[8]

Question six asked, "What makes it difficult for you to get what you need?" Participants cited lack of money and not knowing about resources as their top two most common difficulties.

Question 6: Barriers	
39	Money/finances
24	Not knowing about resources/lack of information
16	Transportation
14	Health issues/pain
13	Unable to reach a real person by phone

[8] Quote from a focus group participant who was a caregiver.

Question seven asked participants about the "positives" in their lives. Retaining an optimistic outlook or a sense of humor and strong relationships with family and friends were most often mentioned.

Question 7: Positives in lives of focus group participants	
34	Outlook/attitude/humor
30	Family
19	Friends or companions
18	Health (having or taking care of health)
16	Exercise
16	Work or volunteer

I'm blessed. I was born during the depression and don't need much. I have a wonderful daughter. I survived the depression and the War.[9]

[9] Quote from a senior focus group participant.

Attachment C

DRAFT for PRIORITIZATION[1]

TARGET AREA I: The Outcome

More Nevada seniors live in the setting of their choice with support to remain as independent and healthy as possible.

Strategies:

- Adopt a statewide policy regarding the percentage of Nevada seniors and people with disabilities who will receive state-funded long term care in their own homes **(10)**
- Assure that existing and developing Nevada data systems have the capacity to track data for these indicators (Medicaid MMIS, annual skilled nursing facility survey) **(17)**

Targets:

1. By June 30, 2010, 15% of the senior Nevadans who get formal long term care are in chronic care institutions; 85% are at home. **(10)**
2. By June 30, 2010, the average age for admission to a Nevada skilled nursing facility is 90. **(22 – eliminated)**
3. By June 30, 2010, the Nevada acute care admission rate and average length of hospital stay for seniors 65+ is 15% less than the baseline year, 2000. **(12)**
4. By June 30, 2010, the percentage of Nevada seniors 75+ who are severely disabled has declined from the baseline year X **(21 – eliminated)**
5. By June 30, 2010, the percentage of Nevada seniors who report they are frequently depressed, anxious, or have trouble coping with stress is 20% less than the baseline year. **(27 – eliminated)**

TARGET AREA II: *More Nevada seniors engage in the occupation of life.*

Strategies:

- Promote much earlier in-home assessments for low vision; greatly expand the use of vision and hearing-related adaptive devices; and increase the availability and use of a variety of assistive devices that enhance independence **(17)**

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[1] The number following each strategy and target was the result of a discussion and ratings done by Senior Services Task Force members. Several important strategies did not make it into the final *Plan* because the Task Force desired to have fewer strategies and targets so the ones they adopted would stand out. In some cases, a target was eliminated because of the difficulty of getting baseline data or otherwise measuring its achievement.

[5] Low-income is defined as seniors who have incomes below the federal poverty level and $1,700 per month.

- Emphasize more, and more meaningful, volunteer and opportunities **(34 – eliminated)**
- Work collaboratively with Work Force Investment Act agencies (e.g., ONE STOPS) and the Senior Community Services Employment Program to educate both public and private organizations about the advantages of retaining older workers and the need to provide accommodations to attract them (e.g., part-time jobs) **(25 – eliminated)**
- Provide and promote defensive driving classes and special limited driver's licenses **(30 – eliminated)**
- Offer flexible respite care options to help elderly caregivers remain involved in their own lives **(11)**
- Encourage use of formal, out-of-home respite options to help frail and disabled elderly remain engaged **(16)**

Targets:

6. By June 30, 2010, 1,500 Nevada senior caregivers caring for a family member with a disability use at least one formal respite care option they can depend on that provides tangible benefits for themselves and their family member. **(14)**
7. By June 30, 2010, X# of senior Nevadans are employed in jobs that meet their needs. **(30 – eliminated)**

TARGET AREA III: ***More Nevada seniors have improved health outcomes.***

Strategies:

- Greatly heighten awareness of risks associated with medication over-use and interactions (both prescription and over-the-counter) **(10)**
- Expand opportunities for seniors to engage in regular and appropriate exercise **(12)**
- Improve awareness of the benefits of good nutrition, including increasing consumption of fresh fruits and vegetables **(25 – eliminated)**
- Train senior caregivers to better manage their own health and chronic conditions **(12)**
- Require all insurers and health institutions that receive Medicare and Medicaid reimbursement to report their performance on selected health outcome measures to the Nevada State Department of Health **(eliminated)**

Targets:

8. By June 30, 2010, X# low income Nevada seniors use preventive dental care on a regular basis and use acute dental services whenever needed. **(12)**
9. By June 30, 2010, 10,500 low-income seniors participate in the Senior Rx program to purchase prescription drugs and manage their medications.[5] **(13)**
10. By June 30, 2010, X# of Nevada seniors assess their health as good. **(25 – eliminated)**

TARGET AREA IV: ***More Nevada seniors live in homes that are safe, fully-accessible, and affordable.***

Strategies:

- Require all new construction aimed at a senior market to build fully-accessible units **(21)**
- Offer low interest bond financing for senior housing and long term care projects **(17)**
- Increase the number of fully-accessible new public housing units **(17)**
- Increase the number of fully-accessible units that also have integrated or wrap-around services **(19)**
- Assure that all Medicaid waivers have appropriate provision for home repairs and modifications **(13)**
- **Place holder for strategy** that speaks to developing integrated or segregated assisted living options for seniors with Alzheimer's Disease and any other assisted living recommendations that come from MALAC **(13)**

Targets:

11. By June 30, 2010, X# Nevada seniors live in homes that are in good repair. **(20 - eliminated)**
12. By June 30, 2010, X# Nevada seniors pay no more than 30% of their income for housing and utilities. **(13 - eliminated)**
13. By June 30, 2010, 700 Nevada seniors occupy public housing units that are fully-accessible. **(10)**
14. **Placeholder** for target related to assisted living for low income/Alzheimer's. **(13)**

TARGET AREA V: ***More Nevada seniors go from one place to another when they need to.***

July 21, 2002: TRI

Strategies:

- A coalition of transportation providers that understand the needs of frail and disabled elderly individuals will be responsible for monitoring the design and effectiveness of both the NDOT and RTC systems. **(eliminated)**
- All existing transportation providers will become eligible for Medicaid reimbursement for medical trips. **(13)**
- Study whether a single transportation authority with statewide authority and accountability would strengthen the system's ability to provide improved quantity and quality of service to seniors and people with disabilities. **(11)**

Targets:

15. By June 30, 1010, 19,300 Nevada seniors get where they need to go. **(10)**

TARGET AREA VI: ***More Nevada seniors get the benefits, services and supports they need.***

Strategies:

- Design, fund, and implement a web-based virtual single point of entry system for information, assistance, care planning, and care management. **(10)**
- Include a consumer education component in this system targeted at creating understanding by seniors and their family members about how to create and/or evaluate an individualized service plan that supports independent living. **(integrated into previous strategy)**
- **Place-holder** for recommendations from Personal Assistance Advisory Services Council. **(16)**

Targets:

16. By June 30, 2010, 85,000 Nevada seniors and their family members use a single point of entry system to access information and referral for the array of available services. **(10)**

17. By June 30, 2010, 8,000 frail or disabled Nevada seniors receive the care planning assistance and care management they need. **(14)**

18. By June 30, 2010, 2,000 low income Nevada seniors use personal assistance services. **(16)**

19. By June 30, 2010 2,975 low income Nevada seniors use homemaker services to help them remain as independent as possible. **(combined with previous target)**

Attachment D

SENIOR STRATEGIC PLAN
FINANCIAL ASSUMPTIONS AND PARAMETERS

Introduction

Our approach to developing financial projections for the Senior Strategic Plan has a number of general assumptions about need, demand, supply, use, and price. Supply and use of specific services are discussed in more detail in the section on Target Areas and Targets, as well as in the section on Medicaid strategies.

GENERAL ASSUMPTIONS:

Net costs are a function of the number of people who use or will use the service, the amount of service they use or will use, and the price of the service. Costs can be adjusted downwards as a function of what users pay as well as any off-setting revenue from cost-savings in related areas.

The number of individuals who will use the service in a given period of time is a function of: 1) the number who need it; 2) the number who know about it and choose it; 3) the supply of the service; 4) the rate with which service eligibility is determined and/or people move from waiting lists to service entry.

The number of individuals who demand the service may be increased by increasing the knowledge of either the consumers who need it or the family or professionals who refer those in need. Use of certain services may increase "artificially," as when skilled nursing facilities are used because more-needed/desired services are unavailable.

Decisions by funders to limit the supply of a benefit or service, or the speed with which eligibility for that service (and thus service initiation) occurs, can also affect the amount of expressed demand and, therefore, service use.

People typically choose services that will best meet their needs from the array of services and benefits they understand are available to them. Appropriate use of services is typically the result of:

- continuous planning based on knowledge of consumers' needs and desires;
- strategic actions taken to increase or decrease the supply of services;
- sound client assessment and eligibility criteria;
- streamlined eligibility processes;
- periodic program/service monitoring.

Definitions:

The following are definitions for categories of *Plan* assumptions and cost drivers:

- **NEED** estimates the size of the population(s) that could benefit from an approach, program, or service (regardless of whether it has ever been available or offered).
- **DEMAND** is either **EXPRESSED** (the individuals in addition to those currently using who have expressed a need or desire for the program or service and are on waiting lists) or **LATENT** (the individuals who would use the program or service were it to be available with no limits or within specified limits). When current demand in terms of individuals is not known, current use (as well as the number of individuals waiting for service on a formal waiting list times average use) serves as a surrogate.
- **SUPPLY** describes current or projected service system capacity (beds, slots, days of care, etc.).
- **USE** describes the numbers from the population who use or would use the service, as well as the number of units used.
- **PRICE** is the current or updated "rate" for a given unit of service.

In Section IV of the *Plan***,** in which Target Areas and specific, measurable targets for change are presented, assumptions are provided on a program by program and service by service basis. These assumptions describe:

- the likely increase in use that will occur even in the absence of any explicit intention to address population growth or satisfy more latent demand[1];
- how long it will take for supply of a given service or benefit to catch up to latent demand in cases where latent demand exceeds the current supply (given relevant shortages as well as significant increases in the population with needs).
- price based on: 1) existing or proposed new rates for State-funded services, or 2) reasonable estimates based on staff and other costs in today's market (for new programs and services).

In that section, as well, estimates of costs for a particular program or service may:

- note where it is possible to generate savings if expressed demand is less than the current supply of the service;
- note where it is possible to generate revenue through cost savings associated with reducing use or expressed demand for a presently-substituted service (e.g., excess hospital days because an individual is waiting for eligibility determination, home and community care);

[1] Where we have information about plans to address population growth or need, we will use this for our projections. Otherwise, we will use either trend data on actual caseload increases or a substitute caseload growth rate of 6% per biennium based on projected increases in the 65-plus population through 2010.

1. Need Assumptions

The size of the population of seniors who need services or would benefit from Plan strategies will vary depending on whether the service is for all seniors, low income seniors, frail seniors, or disabled seniors. The population size base for need estimates is as follows:

- Need for all seniors is based on the number of Nevadans age 65+ (current and projected by the State Demographer's Office).
- Need for low income seniors is based upon the number living at or below 150% poverty until the 2000 Census releases more detailed income figures.
- Need for frail seniors is based on the number of seniors 65-74, 75-84, and 85 plus who are at risk of nursing home placement and estimated growth of this population using the State demographers projections.
- Need for disabled seniors is based on the Census and SIPP[2] estimates of their number in Nevada. Depending on the program or service, we will use the number of severely disabled seniors, the number who need assistance with IADLs, or the number that need assistance with ADLs.

In the few cases where need has been measured (as through a special survey or research study), the research will be cited and the need figure adjusted accordingly.

2. Demand Assumptions

Demand will be addressed under each Target Area. We will use state or national data on need, as well as actual use in states that have attempted to meet need for particular types of services. In most cases, demand will continue to be limited based upon policy and budgetary considerations, but where a significant increase is likely to occur as a result of our recommendations, this will be noted.

A key overall assumption about demand is that a balanced system of formal, state-paid care for frail and disabled seniors should emphasize home and community-based services rather than institutional services. Both consumer preference and cost considerations make this a wise policy.

Our estimate is that the number of seniors relying on institutional care and formal home and community-based services is approximately equal (about 5,000 individuals[3]). A disturbing finding is that the nursing home caseload jumped 35% between 2000 and 2001. Unless that trend is reversed, seniors in Nevada could become much too reliant on an institutional system of care and State budget costs could increase substantially.

---

[2] Another national survey, *Survey of Income and Program Participation*, conducted by the U.S. Census Bureau.

[3] The figure for numbers of individuals using senior home and community-based services programs combine home health, adult day health, the two senior waiver programs, hospice and all other state-funded senior programs.

We believe this proportion can and should change, reaching a 60% (in home and community-based care) and 40% (in institutional care) balance by 2010. That will require considerable effort and emphasis to convert demand now directed to skilled nursing care to demand for home and community-based services.

We are also assuming that future demand for formal home and community-based services can be met, in large part, by an increase in the capacity of the informal system. This is not likely to happen, however, without the significant initiatives and supports recommended in the *Plan* strategies, both those that are over-arching and those that are specific to each Target Area.

3. Supply Assumptions

Data about the current supply of services is typically available for licensed health or residential facilities and is presented whenever it is relevant and available. Less is known about the capacity of current home and community-based service providers, unless these are licensed. Many relevant supply measures (such as the actual or potential supply of personal care assistants) are elastic. Assumptions about supply will be reflected in the *Plan* under each Target Area as appropriate.

4. Use Assumptions

Costs are driven both by the number of users and the amount of service they use. However, Nevada data systems typically cannot easily provide data organized by service users. Rather, they routinely produce data that are useful for payment/reimbursement. These data describe the amount of service units consumed each month and, hence, provide a duplicated number of individuals using services. A further consequence of not having data about all of the services used by a given individual is that numbers are duplicated across as well as within service types. While individuals may use, for example, both facility-based adult day care and respite care in the home, this is not apparent from the available data.

In the long-run, a data system that organizes service use around each user and reports that data regularly is important for understanding the true costs of serving individuals in varying settings. These data should be available with a few keystrokes. In the meantime, the current number of service units consumed/provided must serve as the primary measure and predictor of costs.

In a few program/service areas, trend data was available for a period long enough to calculate actual meaningful growth rates based on past performance. Otherwise, we have assumed growth rates of 6% per biennium in caseloads for most services. That is, unless decisions are made to alter current patterns of service use, these are the growth rates we assume will drive costs.

Since service supply and, therefore, use varies widely by area of geographic residence, we will present need and use estimates separately for Clark, Washoe, and the rural counties wherever relevant.

5. Price Assumptions[4]

We will use any new rates provided by EP&P Consulting, Inc. and the Strategic Plan Rates Task Force that are available by the end of July, 2002. Otherwise, we will base cost projections on an assumption that there will be average biennial inflation rate of 5% per biennium in either cost per unit or cost per case.

[4] We will be happy to modify any cost estimates, or cost estimate drivers, in the *Plan* using specific corrections provided by the Nevada Department of Administration.

Attachment E

Narrative Detail of Costs for Over-Arching and Target Area Strategies

1. Public Information Campaign and Private Sector Initiatives (Over-arching Strategies 1 & 2)
    - $240,000 for the 2003-05 biennium funds a $60,000 FTE and the equivalent amount for consulting. This is inflated by 5% each biennium.
2. Single Point of Entry (Over-arching Strategy 3)
    - $1,420,000 per biennium, already budgeted; fund source is Older Americans Act Title III-E.
3. Stable, Qualified, Long-Term Care Workforce (Over-arching Strategy 4)
    - $150,000 in the 2003-05 biennium funds a study by a workforce development consultant.
4. Home & Community-Based Services Investments (Over-arching Strategy 5)
    - $541,968 for the 2003-05 biennium funds 2 staff and a supervisor who will work on 1) optimizing the way in which the waivers are structured; making sure the service package is appropriate and funded appropriately; maximize use of State funds and draw down all possible federal match; and assure equal access by all residents to home and community-based services (see also Target Area Strategy VI.B), as well as associated fringes and operating costs, and $120,000 for purchasing consulting expertise. This is inflated by 2.5% each year or 5% each biennium.
    - $356,292 for the 2003-05 biennium funds 3 staff and associated fringes and operating costs to expand diversion and relocation efforts. Inflated by 5% each biennium.
    - $42,798,050 for the 2003-05 biennium funds caseload growth. A weighted formula based on the age distribution of the current nursing home population in the U.S., was constructed and used to calculate the growth of the elderly population at greatest risk of nursing home placement. Growth rates for the Nevada 65-74, 75-84, and 85+ populations for the period 2003-2011 were those of the State Demographer. The total projected growth of the population at greatest risk of nursing home placement is 29% from 2003 to 2011. This growth was evenly distributed back across each of the four biennia (03-05,05-07,07-09, 09-11) at the rate of 1.0725. The total biennial caseload receiving waiver services will increase from 9,379 at the end of June, 2003 to 10,352 at the end of June, 2011.
    - $2,721,506 for the 2003-05 biennium funds the estimated 88% (1,959 individuals) of the waiver caseload that receives personal assistance each year at an average cost of $695. The caseload grows from 1,959 to 3,018 by 2011. That $695 amount is inflated by 5% each biennium.
    - Enhancements for preventive dental, transportation to essential, non-medical services, and home modifications and repairs for waiver participants are calculated as follows:

a. Each waiver participant is budgeted to receive two preventive dental visits annually at $500 for the 2003-05 biennium (inflated by 5% each biennium thereafter).

b. It is estimated that 50% of the waiver participants will make four round-trips per month at an average cost of $15/trip (inflated by 5% each biennium)

c. It is estimated that 20% of the waiver participants will have home modifications or repairs at an average cost of $800/year (inflated by 5% each biennium).

5. Data and Plan Accountability (Over-arching Strategy 6)

- $1,792,853 over the four biennia funds accountability features as follows:

a. A data analyst position that will track measures for target accountability will cost $61,492/year for salary, fringe and associated costs. Inflated by 5% each biennium.

b. A Management Analyst III position will cost $66,117/year for salary, fringe, and associated costs. This position will staff the Task Force, manage consulting contracts for implementation and strategic planning support and the population survey.

c. Quarterly meetings of the Senior Services Task Force of the Commission on Aging are budgeted $2,500/quarter. Consulting staff are budgeted at $50,000 per year. These costs are inflated by 5% each biennium.

d. In 2004 ($120,000) and again in 2010 ($138,000), funds are budgeted for a population-based sample survey to gather baseline data and data to determine whether the *Strategic Health Plan* is meeting its targets.

e. $175,000 is budgeted for 2011 for the development of a new *Strategic Health Plan.*

6. $50,000 (Target Area Strategy I-C) is budgeted for the 2003-05 biennium to carry out a study of the barriers and benefits of integrated and segregated assisted living options for seniors with Alzheimer's Disease and related cognitive impairments.

7. $9,558,991 (Target Area Strategy II-C) over the four biennia supports the already-budgeted Respite Care Program, along with an adjustment of + 7% per biennium. This is a higher adjustment than for other programs because it is such a new program and it will take time to reach all those in need.

8. $86,499,076 (Target Area Strategy III-B) over the four biennia supports expansion of the Senior Rx Program to serve an additional 1,000 seniors in the first year by eliminating the waiting list for service. The budget also includes a 6% increase (the projected growth of the 65 plus population) in the number of seniors served. The budget is inflated by 5% each biennium to reflect a cost-of-living adjustment.

9. $20,000 (Target Area Strategy III-C) is budgeted for the 2003-05 biennium to purchase consulting services to develop an oral health strategy.

10. $125,000 (Target Area Strategy V-B) is budgeted for the 2005-07 biennium to purchase specialized transportation system design consulting services.

DETAIL OF COSTS FOR OVER-ARCHING AND TARGET AREA STRATEGIES

	A	B	C	D
1	**STRATEGY**	**Biennium**	**Cost**	**Adds Only**
2				
3	**Public Info & Private Sector Develop**	03-05	$ 240,000	$ 240,000
4		05-07	$ 252,000	$ 12,000
5		07-09	$ 264,600	$ 12,600
6		09-11	$ 277,830	$ 13,230
7	**Total 2003-2011**		**$ 1,034,430**	**$ 277,830**
8				
9	**Single Point of Entry**	03-05	$1,420,000	
10		05-07	$1,420,000	
11		07-09	$1,420,000	
12		09-11	$1,420,000	
13	**Total 2003-2011**		**$5,680,000**	
14				
15	**Stable, Qualified Work Force**			
16	**Total 2003-2011**	03-05	**$ 150,000**	**$ 150,000**
17				
18	**All Home & Community-Based**	03-05	$ 50,958,856	$ 15,732,271
19	**Services Investments**	05-07	$ 61,074,035	$ 10,115,179
20		07-09	$ 72,086,601	$ 11,012,566
21		09-11	$ 84,340,839	$ 12,254,238
22	**Total 2003-2011**		**$ 268,460,331**	**$ 49,114,254**
23				
24	**Data & Plan Accountability**	01-03	$ 135,720	$ 135,720
25		03-05	$ 435,218	$ 299,498
26		05-07	$ 336,979	$ (98,239)
27		07-09	$ 353,828	$ 16,849
28		09-11	$ 666,828	$ 313,000
29	**Total 2003-2011**		**$ 1,792,853**	**$ 531,108**
30				
31	**Alzheimer's Housing Options**			
32	**Total 2003-2011**	03-05	**$ 50,000**	**$ 50,000**
33				
34	**Respite**	01-03	$ 2,000,000	$ 2,000,000
35		03-05	$ 2,145,000	$ 145,000
36		05-07	$ 2,300,513	$ 155,513
37		07-09	$ 2,467,300	$ 166,787
38		09-11	$ 2,646,179	$ 178,879
39	**Total 2003-2011**		**$ 9,558,991**	**$ 646,179**
40				
41	**Senior Rx**	01-03	$ 15,345,000	
42		03-05	$ 18,377,750	$ 3,032,750
43		05-07	$ 20,323,992	$ 1,946,242
44		07-09	$ 22,620,603	$ 2,296,611
45		09-11	$ 25,176,731	$ 2,556,128
46	**Total 2003-2011**		**$ 86,499,076**	**$ 9,831,731**
47				
48	**Oral Health Strategy Study**			
49	**Total 2003-2011**	03-05	**$ 20,000**	**$ 20,000**
50				
51	**Transportation Study**			
52	**Total 2003-2011**	05-07	**125,000**	**$ 125,000**
53				
54	**All Strategy Costs by Biennium**	03-05	$ 73,796,824	$ 19,669,519
55		05-07	$ 85,832,518	$ 12,255,694
56		07-09	$ 99,212,932	$ 13,505,413
57		09-11	$ 114,528,407	$ 15,315,475
58	**Total All Costs**		**$ 373,370,681**	**$ 60,746,102**
59	**Check**		**$ 373,370,681**	**$ 60,746,102**

DETAIL OF COSTS FOR HOME AND COMMUNITY-BASED SERVICES INVESTMENT

	A	B	C	D	E	F	G	H
1	**Program**	**Staff**	**Date**	**People**	**Year Cost**	**Biennium Cost**	**Adds Only**	**Cost/Case**
2								
3	**Optimizing HCBS Funding**							**Waiver Only**
4	**2 staff**	$ 97,390						
5	**Supervisor**	$ 81,533	03-05		$ 270,984	$ 541,968	$ 541,968	
6	**Other**	$ 32,061	05-07		$ 277,759	$ 555,517	$ 13,549	
7	**Consulting time**	$ 60,000	07-09		$ 284,703	$ 569,405	$ 13,888	
8			09-11		$ 291,820	$ 583,640	$ 14,235	
9	**Total 2003-2011**	**$ 270,984**				**$ 2,250,531**	**$ 583,640**	
10								
11	**Diversion & Relocation Staff**							
12	**3 staff**	$ 146,085	03-05		$ 178,146	$ 356,292	$ 356,292	
13	**Other**	$ 32,061	05-07		$ 182,600	$ 365,199	$ 8,907	
14			07-09		$ 187,165	$ 374,329	$ 9,130	
15			09-11		$ 191,844	$ 383,688	$ 9,358	
16	**Total 2003-2011**	**$ 178,146**				**$ 1,479,508**	**$ 383,688**	
17								
18	**Growth in Home & Community**							
19	**Caseloads**		01	1406	$ 9,150			$ 5,352
20			01-03	1878	$ 9,379	$ 35,226,585		$ 5,486
21			03-05	2226	$ 9,613	$ 42,798,050	$ 7,571,465	$ 5,623
22			05-07	2600	$ 9,854	$ 51,238,456	$ 8,440,406	$ 5,764
23			07-09	3000	$ 10,100	$ 60,599,328	$ 9,360,872	$ 5,908
24			09-11	3430	$ 10,352	$ 71,017,362	$ 10,418,034	$ 6,055
25	**Total 2003-2011**					**$ 225,653,196**	**$ 35,790,777**	
26								
27	**Personal Care Rate Increase**				**State Plan**			
28								
29			03-05	1959	$ 695	$ 2,721,506	$ 2,721,506	$ 798
30			05-07	2288	$ 730	$ 3,339,682	$ 618,177	$ 818
31			07-09	2640	$ 748	$ 3,949,817	$ 610,134	$ 839
32			09-11	3018	$ 767	$ 4,628,856	$ 679,039	$ 860
33	**Total 2003-2011**					**$ 14,639,861**	**$ 4,628,856**	
34								
35								
36								
37								
38								
39								

DETAIL OF COSTS FOR HOME AND COMMUNITY-BASED SERVICES INVESTMENT

	A	B	C	D	E	F	G	H
40	**Enhancements**							
41	**Dental**							
42			03-05	2226	$ 500	$ 2,226,000	$ 2,226,000	
43			05-07	2600	$ 513	$ 2,665,000	$ 439,000	
44			07-09	3000	$ 525	$ 3,151,875	$ 486,875	
45			09-11	3430	$ 538	$ 3,693,735	$ 541,860	
46	**Total 2003-2011**					**$ 11,736,610**	**$ 3,693,735**	
47								
48	**Enhancements**							
49	**Transportation**							
50			03-05	2226	$ 720	$ 1,602,720	$ 1,602,720	
51			05-07	2600	$ 738	$ 2,014,740	$ 412,020	
52			07-09	3000	$ 756	$ 2,382,818	$ 368,078	
53			09-11	3430	$ 775	$ 2,792,464	$ 409,646	
54	**Total 2003-2011**					**$ 8,792,741**	**$ 2,792,464**	
55								
56	**Enhancements**							
57	**Home Mods/Repairs**							
58			03-05	2226	$ 800	$ 712,320	$ 712,320	
59			05-07	2600	$ 820	$ 895,440	$ 183,120	
60			07-09	3000	$ 841	$ 1,059,030	$ 163,590	
61			09-11	3430	$ 862	$ 1,241,095	$ 182,065	
62	**Total 2003-2011**					**$ 3,907,885**	**$ 1,241,095**	
63								
64								
65	**All Home & Community-Based**							
66	**Investments**		03-05			$ 50,958,856	$ 15,732,271	
67			05-07			$ 61,074,035	$ 10,115,179	
68			07-09			$ 72,086,601	$ 11,012,566	
69			09-11			$ 84,340,839	$ 12,254,238	
70								
71	**Total 2003-2011**					**$ 268,460,331**	**$ 49,114,254**	
72								
73	**Check**					**$ 268,460,331**	**$ 49,114,254**	

BACKUP DATA FOR ACT NOW AND PAY LATER SCENARIOS

	A	B	C	D	E	F	G
1	**Act Now - People**	**2001**	**2001-03**	**2003-05**	**2005-07**	**2007-09**	**2009-11**
2	SNF	2918	2918	2918	2918	2918	2918
3	Waiver	1406	1878	2226	2607	3007	3437
4	**Total**	**4324**	**4803**	**5151**	**5525**	**5925**	**6355**
5	Percent Waiver People	33%					54%
6							
7	**Act Now - Costs**	**2001**	**2001-03**	**2003-05**	**2005-07**	**2007-09**	**2009-11**
8	SNF	$87,775,502	$177,745,392	$186,632,661	$195,964,294	$205,762,509	$216,050,634
9	Waiver	$12,864,324	$35,226,585	$ 50,958,856	$61,074,035	$72,086,601	$84,340,839
10	Total	$100,639,826	$212,971,977	$237,591,517	$257,038,329	$277,849,110	$300,391,473
11				$24,619,541	$19,446,812	$20,810,781	$22,542,363
12							
13	**Pay Later - People**	**2001**	**2001-03**	**2003-05**	**2005-07**	**2007-09**	**2009-11**
14	SNF	2918	2918	3273	3647	4047	4477
15	Waiver	1406	1878	1878	1878	1878	1878
16	**Total**	**4324**	**4803**	**5151**	**5525**	**5925**	**6355**
17							
18	**Pay Later - Costs**	**2001**	**2001-03**	**2003-05**	**2005-07**	**2007-09**	**2009-11**
19	SNF	$87,775,502	$177,745,392	$209,352,054	$244,900,351	$285,389,365	$331,465,104
20	Waiver	$12,864,324	$35,226,585	$36,987,914	$38,837,310	$40,779,175	$42,818,134
21	Total	$100,639,826	$212,971,977	$246,339,968	$283,737,661	$326,168,540	$374,283,238
22				$33,367,991	$37,397,693	$42,430,880	$48,114,698

Attachment F

POPULATION DATA

Nevada Seniors and People with Disabilities

August 29, 2002

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Introduction

As part of development of the *Strategic Plans/Strategic Health Plans for Seniors and People with Disabilities*, The Rensselaerville Institute completed an analysis of the numbers and characteristics of seniors and adults with disabilities in Nevada. This is a report of some of the findings of that analysis. Many of the findings are presented in the 18 tables beginning on page 20. The Rensselaerville Institute sought comment on this report from the State Demographer's Office, other contractors developing plans for rural health and rates in Nevada, State staff, and task force members and made suggested revisions.

Along with data from other sources, the information in this report was used when developing targets for the *Plan* for seniors. The key findings from the population data are:

- The population of Nevada is increasing faster than the population of any other state.

- The population of Nevada is almost 2.2 million and is projected to grow by 486,000 by 2010. Most of that growth has been, and will continue, in Clark and Washoe counties.

- The population of Nevada is increasingly diverse and will continue to diversify throughout the present decade. Forty percent of the population is projected to be non-White or Hispanic by 2010.

- Approximately 98,000 Nevadans age 15 and over need personal assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADL). By 2010, an estimated 125,000 Nevadans will need such assistance.

- People with disabilities are three times more likely to be low income than people who do not have a disability. Those 65 and over are two times more likely to be low income.

- The elderly population of Nevada will continue to grow as the baby boom generation ages. By 2010, 132,000 Nevadans will be 75 and older.

1.0 Population Trends in Nevada

Compared to other states, Nevada still has a relatively small population. However, during the 1990s the population of Nevada grew at a phenomenal rate, increasing by 66.3% (1,201,833 to 1,998,257). This growth rate far exceeded that of any other state in the nation (see Figure 1 below).[1] The Nevada State Demographer's Office projects continued growth over the next decade, albeit at a slower pace, with the state population increasing to 2.67 million by 2010.[2]

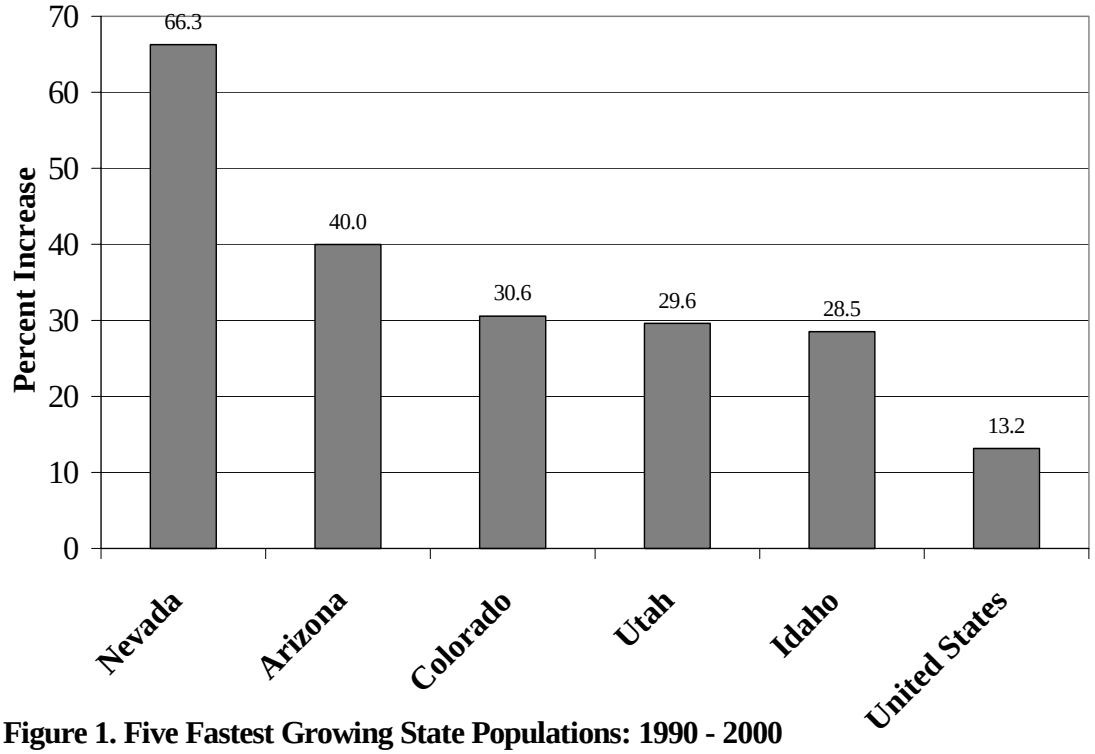

Figure 1. Five Fastest Growing State Populations: 1990 - 2000

1.1 *Population Growth by County: 1990-2000*

Most of the increases in population during the 1990s took place in Clark County, which grew from 772,933 to 1,377,350—a 78.2% increase (see Figure 2, page 6). Washoe County grew by 33% (255,582 to 340,092).

[1] U.S. Census 2000 PHC-T-2 Ranking Tables for States 1990 and 2000.
[2] Nevada Age, Sex, Race, and Hispanic Origin Estimates and Projections 1990 to 2010, the Nevada State Demographer's Office, University of Nevada, Reno.

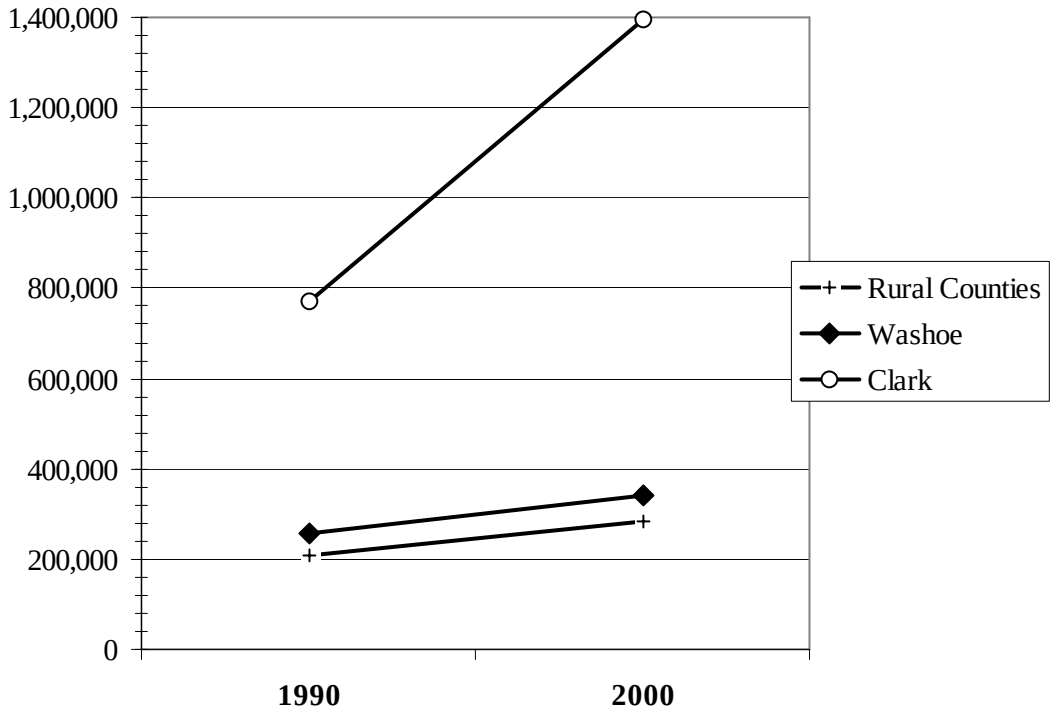

Figure 2. Population Growth 1990-2000

The majority of the rural counties gained population at a slower pace. However, Nye County grew by 81% (18,017 to 32,591) and Lyon County increased by 71% (20,620 to 35,235). Five counties - Esmeralda, Eureka, Mineral, Lander, and White Pine - lost population.

As a result of the massive in-migration to Las Vegas and its environs, more than two-thirds (70%) of Nevadans now reside in Clark County. The remaining one-third inhabitants are equally distributed between Washoe County and all 15 rural counties combined. Outside the two major population centers, Nevada is sparsely inhabited, with only 3.3 people per square mile.

1.2 *Population Growth by Age Group: 1990-2000*

Significant population increases have occurred in all age categories in the 1990s, including the elderly, as retirees flocked to the state. Population statistics prepared by the Nevada State Demographer's Office show that the preschool population (0-5) grew by 51%, the school-age population (6-18) by 76%, the adult population (19-

64) by 61%, and the senior population (65 and over) by 72% (see Table 3, page 22).[3] Nevada ranked first among all states in the percentage increase of the senior population during the 1990s. Three counties—Clark, Nye, and Lyon—recorded some of the fastest growing senior populations in the nation during the last decade of the twentieth century.[4]

1.3 *Population Growth by Race/Ethnicity: 1990-2010*

Between 1990 and 2000, the proportions of all racial and ethnic minority populations in Nevada increased significantly. The minority with the greatest gain in population was Hispanics, whose numbers increased by 204%—from 131,457 to 399,918.[5] Hispanics now make up 21% of the total Nevada population.

Other racial and ethnic groups showed significant gains in population as well. Asian/Pacific Islanders increased by 192% (37,839 to 110,578) and African Americans increased by 66% (83,686 to 138,552). Native American Indians and Whites had the smallest percentage increases, the former gaining by 51% (18,379 to 27,833) and the latter (those not included in the Hispanic or Latino count) gaining 39% (962,224 to 1,341,108).

The State Demographers Office projects these increases to continue during the present decade. In 2000, people of color made up 34% of the total population, up from 22% in 1990. By 2010, the non-White population is expected to make up 40% of the total population of Nevada (see Figure 3, page 8).

2.0 Nevada's People with Disabilities

From the long-form questionnaires used in the 2000 decennial census, the Census Bureau has estimated the number of people five and over who have a disability. These data are available for the United States, individual states, counties, and other selected regions.

[3] Nevada Age, Sex, Race, and Hispanic Origin Estimates and Projections from 1990 to 2022, Nevada State Demographers Office, University of Nevada Reno.
[4] US Census 2000: PHC-T-13 Population and Ranking Tables of the Older Population for the United States and Counties.
[5] US Census 2000 DP-1 Profile of General Demographic Characteristics for Nevada, and US Census1990 DP-1 General Population Characteristics for Nevada

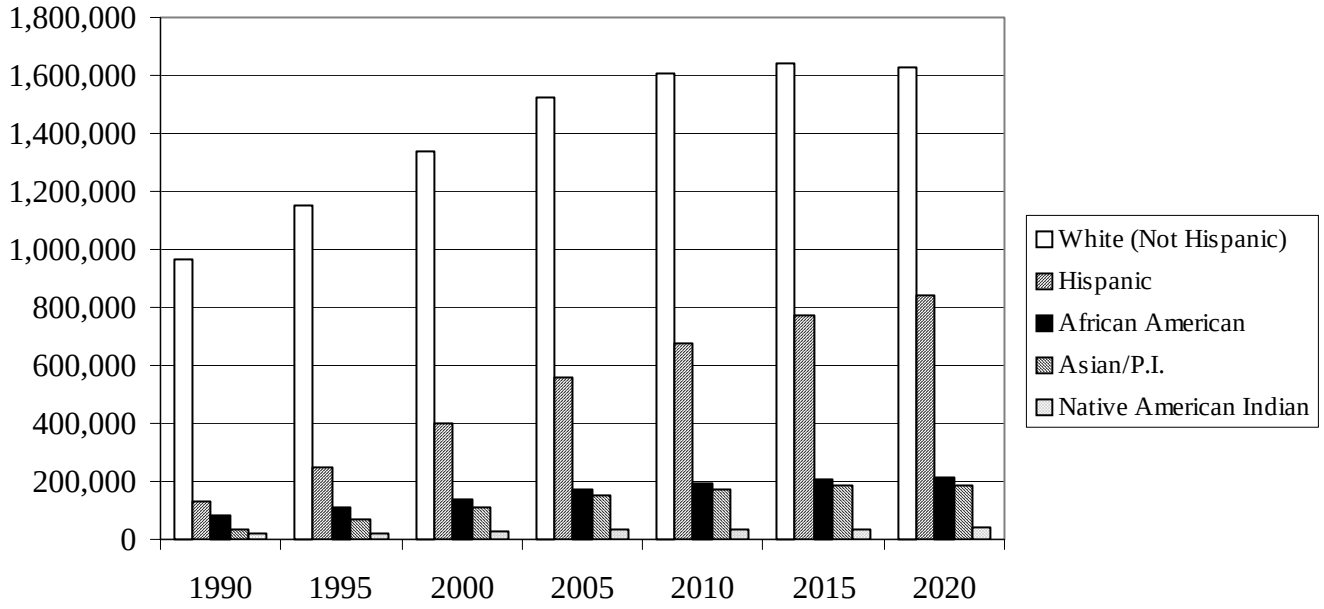

Figure 3. Nevada's Population by Ethnic Group

2.1 *Number of People with Disabilities in Nevada*

Census data for the State indicate that an estimated 376,000 Nevadans have some kind of disability. Approximately 33,000 Nevadans with disabilities are between the ages of 5 and 20; 256,000 are between 21 and 64; and 87,000 are 65 or older (see Figure 4, page 9).[6]

More than two thirds (70.3%) of Nevadans with disabilities reside in Clark County. One in six (15.6%) reside in Washoe County. Only 14% reside in all of the other 15 counties combined.

Although an estimated 78,864 Nevadans with a disability are 65 or over, more than half of all people with disabilities in Nevada are between 21 and 65—an estimated 145,427 individuals.

[6] U.S. Census Bureau, Census 2000 Supplementary Summary Tables, PO59, Sex by Age by Disability Status by Employment Status for the Civilian Noninstitutionalized Population 5 years and Over for the State of Nevada and Clark County and Washoe County only.

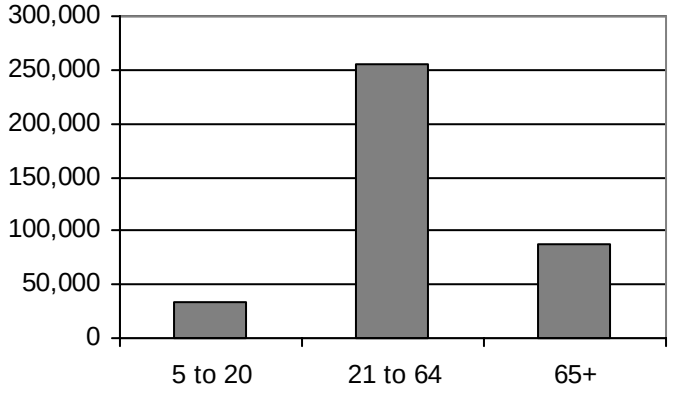

Figure 4. Nevadans 5 and Over with Disabilities, by Age Group

2.2 *Need for Personal Assistance*

The 2000 Census compiles only limited data on the characteristics of people with disabilities. For detailed information, the Survey of Income and Program Participation (SIPP), another national survey conducted by the U.S. Census Bureau, is the preferred source. SIPP data collected from August to November 1997 show the prevalence of different types of disability among all Americans, the degree of disability, and the need for personal assistance. The Rensselaerville Institute used those national rates to estimate the number of Nevadans with disabilities who need personal assistance.[7]

SIPP data indicate that approximately 354,000 Nevadans age 15 and over have some sort of disability and that 227,000 of these disabilities are "severe."[8] (Refer to sections 4.1, Definitions, and 4.2, Sources, for the U.S. Census and SIPP disability criteria and classification schemes.) Of those with a severe disability, approximately 68,000 need assistance with one or more Instrumental Activities of Daily Living (IADLs[9]) and 30,000 need assistance with one or more Activities of Daily Living (ADLs[10]). (See Figure 5, page 10) More than half of the individuals who need personal assistance in the State are 65 or over.

[7] U.S. Census Bureau, Americans with Disabilities: 1997 – Table 2. Prevalence of Types of Disability Among Individuals 15 Years and Over (August – November, 1997 data from the SIPP).
[8] The 1997 SIPP estimates of the number of adults with severe disabilities varies somewhat from the 2000 census estimates for the number of Nevadans with disabilities.
[9] Instrumental Activities of Daily Living (IADLs) are activities related to independent living. They include preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and using the telephone.
[10] Activities of Daily Living (ADLs) are activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, using the toilet and eating.

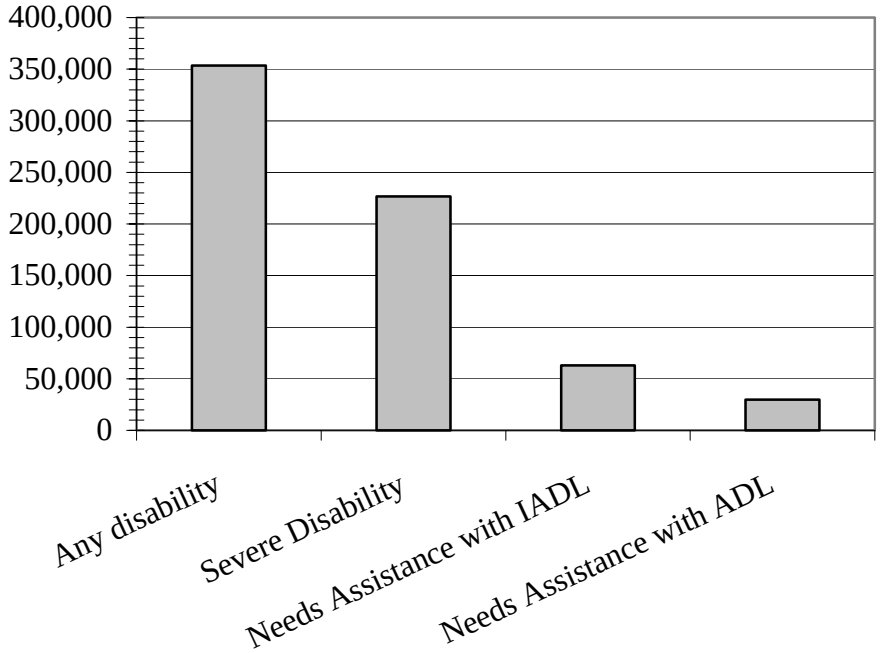

Figure 5. Nevadans 15 and Older with Disabilities by Disability Type and Personal Assistance Need

The National Institute on Disability and Rehabilitation Research analyzed 1990 and 1991 SIPP data and found that the most common condition causing ADL limitations is arthritis and rheumatism followed by back or spine problems.[11] Listed in the order of frequency, conditions causing need for help with ADLs are:

1. Arthritis or rheumatism
2. Back or spine problems
3. Other (not specified)
4. Heart trouble
5. Stroke
6. Lung or respiratory trouble
7. Paralysis of any kind
8. Stiffness or deformity of foot, leg, arm, or hand
9. Cancer
10. Diabetes
11. Broken bone/fracture
12. Senility/dementia/Alzheimer's disease
13. Mental retardation
14. Head or spinal cord injury

[11] A profile of adults needing assistance with Activities of Daily Living, 1991-1992, National Institute on Disability and Rehabilitation Research, UCSF, San Francisco, June 1997

15. Blindness or vision problems
16. Mental or emotional disorder
17. High blood pressure
18. Missing legs, feet, arms, hands, or fingers
19. Alcohol or drug problem or disorder
20. Kidney stones or chronic kidney trouble
21. Cerebral palsy

2.3 *Domains of Disability*

The SIPP also provides information about the numbers of individuals within three disability domains: communication (seeing, hearing, or speaking), physical (a specific physical condition or the inability to perform a specific activity), and mental (learning disability, mental retardation, autism, Alzheimer's or other dementia, or any other mental or emotional condition). Individuals may have a disability in more than one domain. Survey results also show the distribution of specific disabilities for the population 15 years of age and up (see Table 9, page 26).

Approximately 209,500 Nevadans 15 and over (13.4% of the total population of Nevada) have a disability in one domain . Of these, 1.4% are communication disabilities, 10.1% are physical, and 1.9% are mental.

Approximately 101,600 Nevadans (6.5% of the total population of Nevada) have a disability in two domains. Of these, 3.6% are communication and physical, 0.3% are communication and mental, and 2.6% are physical and mental. An additional 32,800 (2.1% of the total Nevada population) have a disability in all three domains—communication, physical, and mental.

In addition to the domains of disability, the SIPP includes information about how many people 15 and over use wheelchairs, canes, crutches, walkers, or hearing aids on a regular basis. An estimated 15,600 people 15 and over use a wheelchair, 45,000 use canes, crutches, or walkers, and 27,600 people wear a hearing aid. Of those using a hearing aid, approximately 11,400 of them have difficulty with hearing in spite of the use of a hearing aid. The number of people 15 and over with selected disabling conditions is also included in the SIPP. Using the SIPP data, an estimated 26,100 Nevadans have a learning disability, 10,300 are mentally retarded, 13,100 have Alzheimer's disease or some other form of senility or dementia (however, using a 1996 consensus panel an estimated 15,400 Nevada seniors 65 and

over have moderate to severe dementia)[12], and 25,300 people have another mental or emotional condition (see Tables 11 and 12, page 28).

In addition to the SIPP information, the Department of Human Resources Division of Mental Health and Developmental Services 2002 Needs Assessment indicates that approximately 83,048 people who live in Nevada may suffer from a serious mental illness (Mental Health Block Grant, p. 66). The Center for Mental Health Services (website) also estimates that of those 83,048 people, an estimated 25% (20,762) are homeless at any given time during the year.

The Division of Mental Health and Developmental Services' caseload data indicate the following diagnoses at time of admission to mental health programs for inpatient or outpatient services.

Diagnostic Category	Inpatient	Outpatient
Mood Disorders	48%	35%
Schizophrenia	17%	43%
Substance Related	10%	10%
Adj./Personality	7%	7%
Other Disorders	20%	5%

2.4 *Incomes of People with Disabilities*

In general, people with disabilities have significantly lower incomes than people without disabilities and they are much more likely to be living in poverty.[13] The poverty rate for adults 21-64 who have disabilities is more than three times that of people in the same age group who do not have disabilities (see Figure 6, page 13). Similarly, people without disabilities are almost four times as likely as people with disabilities to have annual incomes above $20,000.

[12] This estimate was based on figures from a 1996 consensus panel organized by the Agency for Health Care Policy and Research that estimated the percent of people in various age cohorts who had moderate to severe dementia. The incidence rates were applied to population projections prepared by the Nevada State demographer for 2002.

[13] Census 2000 Supplementary Survey Summary Tables, PO59, Sex by Age by Disability Status by Employment Status for the Civilian Noninstitutionalized Population 5 Years and Over in Nevada.

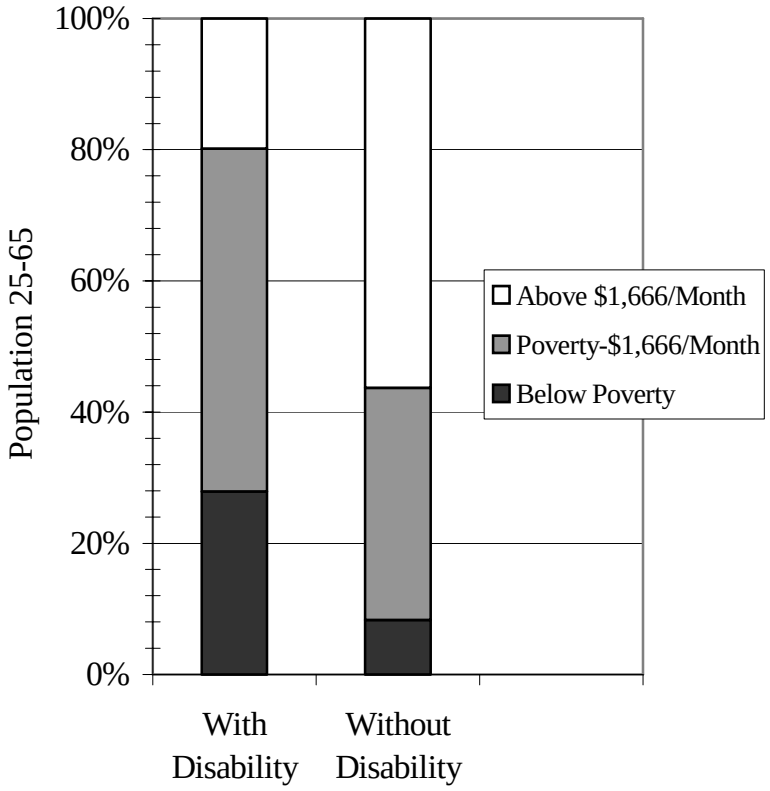

Figure 6. Income Ranges of Nevada's Adults 25-65

The number of people receiving Supplemental Security Income (SSI) is another indicator of how many low-income people are disabled or elderly. According to the Social Security Agency, in December 2001, 27,293 Nevadans received SSI payments. Of these SSI recipients, 7,227 are elderly and 20,066 are either blind or disabled (see Table 10, page 27).

The disparity in incomes between seniors with disabilities and those without disabilities is less dramatic but still considerable. Seniors with disabilities are more than twice as likely as seniors without disabilities to be living in poverty, and only half as likely to have incomes above $20,000 a year (see Figure 7, page 16).

2.5 *Native American Indians with Disabilities Living on Reservations*

Just under 10,000 Native American Indians reside on reservations and tribal lands in Nevada. Reservations supporting the largest populations are Duck Valley, Elko, Fallon Paiute-Shoshone, Fort Mojave, Pyramid Lake, Reno Sparks, and Walker River (see Table 14, page 30).[14]

The 1997 SIPP did not measure the percentage of Native Americans with disabilities. However, the 1995 SIPP found that nationally 10.5% of Native American Indians and Alaska Natives have severe disabilities, compared with 9.9% of Whites, 12.7% of Blacks, 7.9% of Hispanics, and 5.6% of Asian/Pacific Islanders. If the national severe disability rate of 10.5% for all Native American Indians and Alaska Natives is also accurate for just those Native American Indians living on reservations in Nevada, then approximately 1,050 people living on reservations and tribal lands in Nevada have severe disabilities.

In addition to those living on reservations and tribal lands, over 16,000 Native American Indians reside in cities and towns. Of those, 10,000 are in Las Vegas and 2,500 in Reno. Using the 1995 SIPP rate of 10.5%, 1,680 Native American Indians residing in cities and towns outside the reservations have a severe disability. Therefore, the estimated total number of Native American Indians in Nevada with a severe disability is 2,730. Another estimated 3,000 to 5,000 Native American Indians have a disability that is not classified as "severe" by SIPP. (Refer to sections 4.1, Definitions, and 4.2, Sources, for the U.S. Census and SIPP disability criteria and classification schemes.)

3.0 Nevada's Seniors

3.1 *Estimates of Senior Population By County*

The number of people 55 and over in Nevada is 409,066, 20% of the total population. The majority of seniors in Nevada reside in Clark County, which is now home to more than 275,000 people 55 and over. Other counties with sizeable populations of seniors include Carson City (13,200), Douglas (11,300), Elko (6,200), Lyon (8,600), Nye (10,664), and Washoe (66,793). The four most sparsely inhabited counties (Esmeralda, Eureka, Lander, and Storey) each have fewer than 1,000 residents 55 and over (see Table 15, page 31).[15]

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[14] U.S. Census Bureau, Summary File 1 by -Native American Reservation, DP-1 Profile of General Demographic Characteristics 2000.
[15] U.S. Census 2000 Summary Files, DP–1 Profile of General Demographic Characteristics, by county.

3.2 *Projections for the Senior Population*

During the 1990s, the number of people 55 and over increased by 74%—from 239,100 in 1990 to more than 415,100 in 2000. The State Demographer's Office projects that by 2010 there will be more than 629,200 people aged 55 and over residing in Nevada.

Of the 65 and over population, 33% (42,197) were 75 or older in 1990. By 2000 the percent of people 75 and over increased to 41% (90,754). By 2010 the population 75 and over is estimated to increase to 133,100. With expected increased longevity, this trend toward an older population could be even greater.

3.3 *Native American Indian Elders Living on Reservations*

According to the 2000 census, 1,689 elders (55 and over) reside on one of the 25 reservations or tribal lands in Nevada. By age group, 815 are 55-64, 539 are 65-74, and 335 are 75 or older (see Table14, page 30).

3.4 *Incomes of Nevada's Seniors*

The 2000 Census has not yet released detailed income data for the population of each state. However, the Bureau has reported the numbers of the Nevada population in each age group that are below poverty. In 2000, 7.7% of all Nevadans 55 and over (30,606) were living in poverty.

The percentage of the senior population of Nevada living in poverty appears at first to decline and then to increase with age (see Table 17, page 32). For those 55-64, the rate is 7.5%. For those 10 years older (65-74), the poverty rate drops slightly to 5.4%, but then it increases sharply for those 75 and over to 11.4%. Nevadans 75 and over are more than twice as likely to be living in poverty as those a decade younger. This suggests the possibility that the 75+ population in 2010 may have higher incomes on average than the present population 75 and older. In 2001 the poverty threshold used by the US Census Bureau was $761 a month for those 64 and under, and $708 a month for those 65 and over.

A higher proportion of seniors with disabilities live in poverty in Nevada than those without disabilities. Seventeen percent of Nevadans 65 and over who have a disability live below the poverty threshold, compared with only 6.9% of those who do not have a disability. Only 16.6% of Nevadans 65 and over who have a disability have incomes in excess of $20,000 a year, compared with 31.6% of those who do not have a disability (see Figure 7, page 16).

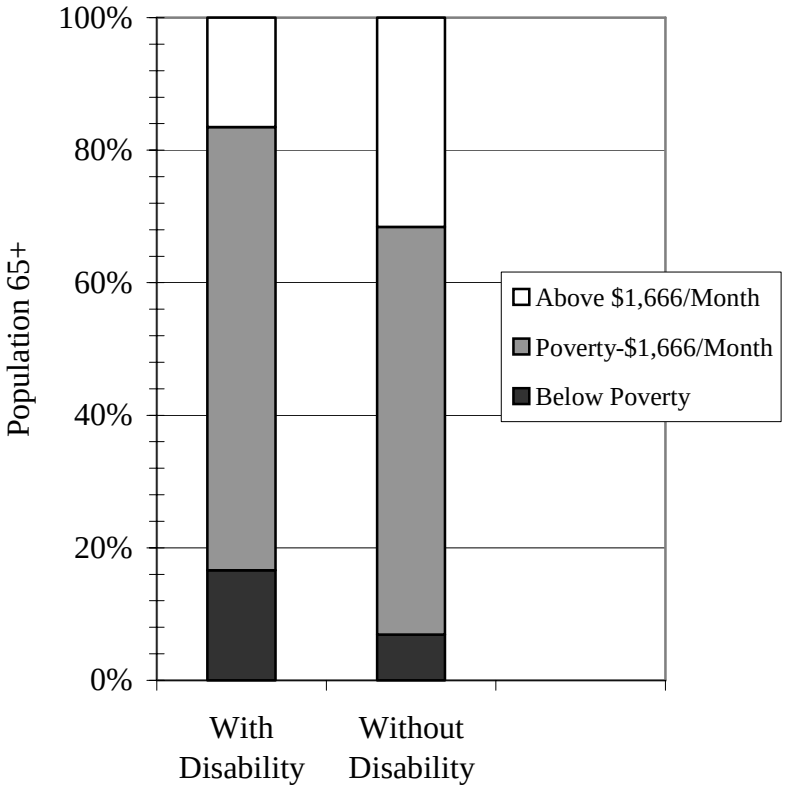

Figure 7. Income Ranges of Nevadans 65 and Over

4.0 Definitions and Data Sources

4.1 *Definitions*

During the 2000 decennial census, the US Census Bureau asked questions on the long form questionnaire about disability status. Using the Americans With Disabilities Act of 1990 (ADA) as a guide, the Census Bureau defined disability as a "long-lasting physical, mental, or emotional condition . . . [that] can make it difficult for a person to do activities such as walking, climbing stairs, dressing, bathing, and remembering."

Unless otherwise noted, when using counts and percentages for adults from the Census Bureau's Americans With Disabilities report, The Rensselaerville Institute applied the more restrictive definition of severe disability. This corresponds closely to the data from the U.S. Census Bureau's Census 2000 Supplementary Survey Summary Tables.

Just as there are slightly different criteria used for measuring disability, there are different criteria for defining "senior" or "elderly." For most purposes the Older Americans Act of 1965 uses age 60 to define eligibility for services. Other federal programs base eligibility on age 62 or 65. Some local programs use age 55. The American Association of Retired Persons solicits membership from those 50 and above. Therefore, to avoid confusion, The Rensselaerville Institute provided information by age group for this report, rather than using the more generic terms "elderly" or "seniors."

4.2 *Sources*

For this report, The Rensselaerville Institute used data from several sources:

- The Nevada State Demographer's Office provided population projections and estimates for 1990-2022 by age, sex, race and Hispanic origin.

- Data about the general demographic characteristics of Nevadans including ages, ethnicity, poverty status, the number of people in each county, the number of people with disabilities, and the number of Native Americans residing on reservations and tribal lands were obtained from the U.S. Census Bureau's Census 2000 Summary Files and Supplementary Survey Summary Tables. Additional data from the 2000 census, including more detailed income statistics, will be released over the next few months.

- The U.S. Census Bureau's Current Population Reports: P70-73 Americans with Disabilities, Household Economic Studies 1997, provided detailed information about the percentages of Americans in each age group who have disabilities; the prevalence of different types of disabilities; and the income levels of Americans with disabilities. These prevalence rates were used to make synthetic estimates of the income ranges and types of disabilities of Nevadans with disabilities. The Americans with Disabilities report was based on the Survey of Income and Program Participation (SIPP) that was conducted in the fall of 1997.

The decennial Census instrument, even the long form, includes a limited set of questions about disability. For this reason, the Survey of Income and Program Participation (SIPP) is the preferred source for examining most disability issues. The SIPP is a national household survey, conducted by the US Census Bureau, that contains questions about the ability to perform a number of activities. If an individual reports having difficulty performing a specific activity, a follow-up question is asked to determine if the difficulty is severe or not. Responses to these and related questions are used to arrive at two measures of disability status—any disability and severe disability. Individuals 15 years and older are classified as having a disability if they met any of the following criteria at the time of the survey:

a. Used a wheelchair, a cane, crutches, or a walker
b. Had difficulty performing one or more functional activity (seeing, hearing, speaking, lifting/carrying, using stairs, walking, or grasping small objects)
c. Had difficulty with one or more activities of daily living
d. Had difficulty with one or more instrumental activities of daily living

e. Had one or more specified conditions (a learning disability, mental retardation or another developmental disability, Alzheimer's disease, or some other type of mental or emotional condition)
f. Had any other mental or emotional condition that seriously interfered with everyday activities
g. Had a condition that limited the ability to work around the house
h. Had a condition that made it difficult to work at a job or business
i. Received federal benefits based on an inability to work.

Individuals were considered to have a severe disability if they met criteria a, f, or i, or had Alzheimer's disease, or mental retardation or another developmental disability, or needed help to perform one or more of the activities in criteria b, c, d, g, or h.

TABLES

Table 1. Population Growth by County: 1990 to 2000[16]			
County	**Population 1990**	**Population 2000**	**% Change**
Carson City	40,443	52,457	29.7
Churchill	17,938	23,982	33.7
Clark	741,459	1,375,765	85.5
Douglas	27,637	41,259	49.3
Elko	33,530	45,291	35.1
Esmeralda	1,344	971	(27.8)
Eureka	1,577	1,651	4.7
Humboldt	12,844	16,106	25.4
Lander	6,266	5,794	(7.5)
Lincoln	3,775	4,165	10.3
Lyon	20,001	34,501	72.5
Mineral	6,475	5,071	(21.7)
Nye	17,781	32,485	82.7
Pershing	4,336	6,693	54.4
Storey	2,526	3,399	34.6
Washoe	254,667	339,486	33.3
White Pine	9,264	9,181	(0.9)
Total	1,203,853	1,998,257	66

[16] U.S. Census Bureau, Census 2000 PHC-T-4 Ranking Table for Counties 1990 and 2000.

Table 2. Population of Clark County by City and Town: 2000[17]	
City/Town	**Population in 2000**
Boulder City	15,519
Henderson	198,691
Las Vegas	483,448
Douglas	15,605
North Las Vegas	124,936
Bunkerville	909
Enterprise	21,905
Glendale	75
Indian Springs	1,387
Laughlin	8,083
Moapa	736
Moapa Valley	9,088
Mt. Charleston	917
Paradise	172,297
Searchlight	767
Spring Valley	130,160
Summerlin	4,845
Sunrise Manor	160,231
Whitney	14,946
Total	1,366,557[18]

[17] Nevada County Population Estimates July 1, 1986 to July 1, 2000, The Nevada State Demographer's Office, University of Nevada, Reno

[18] Note: Tables 1 and 2 show a slight difference for the totals for the Clark County total population in 2000. Table 1 is based on the 2000 Census actual count, whereas Table 2 is based on the Nevada State Demographer's Office projection of the Clark County population. This projection was done before the 2000 Census.

Table 3. Population Projections by Age Group: 1990-2010[19]					
	1990	**1995**	**2000**	**2005**	**2010**
0-4	98,818	116,949	143,325	172,431	184,187
5-18	228,203	293,737	378,186	431,295	470,781
19-64	781,648	999,588	1,319,736	1,526,433	1,634322
65+	127,461	168,876	218,184	271,939	322,164
Total	1,236,130	1,579,150	2,059,431	2,402,098	2,611,454

Table 4. 2000 Nevada Population by Race/Ethnicity[20]	
African American	135,477
Asian/Pacific Islander	98,692
Hispanic or Latino	393,970
Native American Indian	26,420
White (not Hispanic or Latino)[21]	1,303,001
Total	1,998,257

[19] Nevada Age Sex Race and Hispanic Origin Estimates and Projections 1990 to 2022, The Nevada State Demographers Office, University of Nevada, Reno.
[20] U.S. Census 2000 DP-1 Profile of General Demographic Characteristics for Nevada and U.S. Census 1990 DP-1 General Population Characteristics for Nevada. Note that Tables 4 and 5 do not match because they reflect these two different data sources.
[21] Total White population not Hispanic or Latino is 1,303,001 plus 198,885 Hispanic/Latino White = 1,501,886 Whites.

Table 5. Nevada Population Projections by Race/Ethnicity: 1990-2020[22]							
	1990	**1995**	**2000**	**2005**	**2010**	**2015**	**2020**
White	962,224	1,152,099	1,341,108	1,521,962	1,608,311	1,638,058	1,627,429
Hispanic or Latino	131,457	251,455	399,918	561,167	677,569	769,348	842,254
African American	83,686	109,764	138,552	170,342	190,613	203,820	211,745
Asian/P.I.	37,839	71,288	110,578	150,675	172,685	183,589	185,869
Native American Indian	18,379	22,905	27,833	32,590	35,524	37,329	38,283
Total	1,235,575	1,609,506	2,019,989	2,438,742	2,686,711	2,834,158	2,907,599

[22] Nevada Age, Sex, Race, and Hispanic Origin Estimates and Projections 1990 to 2020, the Nevada State Demographer's Office, University of Nevada, Reno, 2002.

Table 6. Estimated Number of Persons Age 5 and Older with Disabilities in Nevada[23]				
	5-20 years	**21-64 years**	**65+ years**	**All Ages**
Carson City	812	5,620	3,132	9,564
Churchill County	408	2,454	1,247	4,109
Clark County	23,630	182,423	58,417	264,470
Douglas County	554	3,794	2,276	6,624
Elko County	688	4,696	1,251	6,635
Esmeralda County	23	162	66	251
Eureka County	32	233	79	344
Humboldt County	212	1,578	510	2,300
Lander County	52	895	169	1,116
Lincoln County	106	430	337	873
Lyon County	636	4,445	2,031	7,112
Mineral County	156	786	477	1,419
Nye County	410	5,779	2,409	8,598
Pershing County	104	633	249	986
Storey County	68	548	224	840
Washoe County	5,431	40,199	13,342	58,972
White Pine County	144	953	600	1,697
Nevada	33,466	255,628	86,816	375,910

[23] U.S. Census Bureau, Table DP-2. Profile of Selected Social Characteristics: 2000, Disability Status Of The Civilian Noninstitutionalized Population for Nevada and specific counties.

Table 7. Estimated People with Disabilities in Nevada Who Need Personal Assistance by Age Group[24]									
		Any Disability		Severe Disabilities		Needs Assistance with IADLs		Needs Assistance with ADLs	
Age	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**
15-24	257,175	10.7%	27,518	5.3%	13,630	1.0%	2,572	0.4%	1,029
25-64	1,087,821	19.0%	206,686	12.0%	130,539	2.8%	30,459	1.2%	13,054
65+	218,929	54.5%	119,316	37.7%	82,536	16.2%	35,466	7.2%	15,763
Total	1,563,925	22.6%	353,520	14.5%	226,705	4.4%	68,497	1.9%	29,845

Table 8. Estimated People with Disabilities 15 and Older in Nevada Who Need Personal Assistance with Specific IADLs and ADLs[25]	
IADLs	**ADLs**
50,000 need personal assistance going outside alone (3.2%)	14,100 need personal assistance getting around inside (0.9%)
29,700 need personal assistance managing money and bills (1.9%)	18,800 need personal assistance transferring (1.2%)
28,200 need personal assistance preparing meals (1.8%)	21,900 need personal assistance bathing (1.4%)
36,000 need personal assistance doing light housework (2.3%)	15,600 need personal assistance dressing (1%)
23,500 need assistance taking prescriptions (1.5%)	6,300 need personal assistance eating (0.4%)
7,800 need assistance to use an ordinary telephone (0.5%)	10,900 need personal assistance using the toilet (0.7%)
All IADLs:70,400 need assistance with one or more IADLs (4.5%)	All ADLs:29,700 need assistance with one or more ADLs (1.9%)

[24] Prevalence of Types of Disability Among Individuals 15 Years and over (August-November 1997 data from the SIPP).
[25] U.S. Census Bureau, Americans with Disabilities: 1997 – Table 2. Prevalence of Types of Disability Among Individuals 15 Years and Over (August-November 1997 data from the SIPP).

Table 9. Disability Domains of Nevadans 15 and Older[26] [27]		
	Percent Distribution	**Number**
Disability in one domain	13.4%	209,565
Communication	1.4%	21,895
Physical	10.1%	157,956
Mental	1.9%	29,714
Disability in two domains	6.5%	101,655
Communication and Physical	3.6%	56,301
Communication and Mental	0.3%	4,692
Physical and Mental	2.6%	40,662
Disability in three domains	2.1%	32,842
No disability	77.0%	1,219,863
Total	100.0%	1,563,925

[26] U.S. Census 2000 Summary File, DP1 Profile of General Demographic Characteristics, Nevada for the population age 15 and over.
[27] U.S. Census Current Population Reports P70-73, Americans with Disabilities, 1977.

Table 10. Number of SSI recipients in Nevada by eligibility category, age, and receipt of OASDI* benefits and amount of payments, by county, December 2001[28]								
		Eligibility Category		Age				
County	Total	Aged	Blind and disabled	Under 18	18–64	65 or older	SSI recipients also receiving OASDII	Amount of payments (thousands of dollars)
Total, Nevada	27,293	7,227	20,066	4,310	15,388	7,595	9,214	11,190
Carson City	583	115	468	73	391	119	218	232
Churchill	306	72	234	29	199	78	123	113
Clark	20,025	5,493	14,532	3,354	10,905	5,766	6,338	8,364
Douglas	170	35	135	38	94	38	63	62
Elko	377	90	287	40	241	96	160	136
Esmeralda	15	4	11	2	9	4	9	4
Eureka	20	8	12	3	9	8	11	7
Humboldt	169	44	125	17	106	46	76	61
Lander	61	18	43	6	37	18	28	22
Lincoln	55	18	37	5	31	19	25	18
Lyon	450	112	338	62	272	116	193	169
Mineral	125	27	98	11	85	29	48	46
Nye	410	75	335	57	275	78	173	156
Pershing	59	12	47	9	36	14	25	25
Storey	15	3	12	2	10	3	3	7
Washoe	4,255	1,052	3,203	581	2,560	1,114	1,643	1,703
White Pine	124	24	100	10	90	24	47	41
Unknown	74	25	49	11	38	25	31	26

*Old Age, Survivor, Disability

Table 10a. Number of recipients in state receiving SSDI as of December, 2001[29]	
Disabled Workers	34,000
Spouses of Disabled Workers	640
Children of Disable Workers	2,980
Total*	42,620

*Age and county breakouts not yet available.

[28] Social Security Administration, SSI Recipients by State and County, December 2001

[29] Social Security Administration Region 9, San Francisco Office of Public Affairs.

Table 11. Estimated People Using Special Aids[30]									
		Used a wheelchair		Used a cane/crutches/walker		Used a hearing aid		Had difficulty hearing even with hearing aid	
Age	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**
15-24	257,175	.3%	772	.1%	257	.3%	772	.1%	257
25-64	1,087,821	.6%	6,527	1.5%	16,317	.6%	6,527	2%	2,176
65+	218,929	3.8%	8,319	13%	28,461	9.3%	20,360	4.1%	8,976
Total	1,563,925	1%	15,618	2.9%	45,035	1.8%	27,659	.7%	11,409

Table 12. Estimated People with Selected Disabilities[31]									
		Learning Disability		Mental Retardation		Alzheimer's, senility, dementia		Other Mental/Emotional condition	
Age	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**
15-24	257,175	2.8%	7,201	.7%	1,800	.2%	514	1.3%	3,343
25-64	1,087,821	1.6%	17,405	.7%	7,615	.4%	4,351	1.7%	18,493
65+	218,929	.7%	1,533	.4%	876	3.8%	8,319	1.6%	3,503
Total	1,563,925	1.7%	26,139	.7%	10,291	.8%	13,184	1.6%	25,339

[30] U.S. Census Bureau, Americans with Disabilities: 1997 – Table 2. Prevalence of Types of Disability Among Individuals 15 Years and Over (August-November 1997 data from the SIPP).
[31] U.S. Census Bureau, Americans with Disabilities: 1997 – Table 2. Prevalence of Types of Disability Among Individuals 15 Years and Over (August-November 1997 data from the SIPP).

Table 13. Incomes of Nevadans With and Without Disabilities by Age		
	With Disability	**Without Disability**
Total 21-64[32]	145,427	1,027,737
Number Below Poverty[33] [34]	40,574	85,302
Percent Below Poverty	27.9%	8.3%
Number Between Poverty and $1,666/month	76,058	363,819
Percent Between Poverty and $1,666/month	52.3%	35.4
Number Above $1,666/month	28,795	578,616
Percent Above $1,666/month	19.8%	56.3%
Total 65-74	40,221	87,916
Number Below Poverty	6,677	6,066
Percent Below Poverty	16.6%	6.9%
Number Between Poverty and $1,666/month	26,908	54,068
Percent Between Poverty and $1,666/month	66.9%	61.5%
Number Above $1,666/month	6,636	27,781
Percent Above $1,666/month	16.5%	31.6%
Total 75+	38,643	48,221
Number Below Poverty	6,415	3,327
Percent Below Poverty	16.6%	6.9%
Number Between Poverty and $1,666/month	25,852	29,656
Percent Between Poverty and $1,666/month	66.9%	61.5%
Number Above $1,666/month	6,376	15,238
Percent Above $1,666/month	16.5%	31.6%

[32] Census 2000 Supplementary Survey Summary Tables, PO59, Sex by Age by Disability Status by Employment Status for the Civilian Noninstitutionalized Population 5 years and Over in Nevada. Note that the Census Bureau provides upper bound limits, lower bound limits and estimates for each age group.
[33] U.S. Census Bureau, Current Population Reports: Americans with Disabilities, Household Economic Studies, 1997.
[34] In 2001 the Poverty Threshold used by the U.S. Census Bureau was $761 a month for individuals 64 and under and $708 a month for individuals 65 and over.

Table 14. Native American Indians on Reservations and Tribal Lands in Nevada[35]							
	Under 5	**5-19**	**20-54**	**55-64**	**65-74**	**75 +**	**Total**
Battle Mountain Reservation	7	33	53	16	8	7	124
Campbell Ranch	25	284	102	14	14	7	446
Carson Colony	23	78	146	20	9	10	286
Dresslerville Colony	24	90	145	30	21	5	315
Duck Valley Reservation	69	505	482	115	57	37	1,265
Duckwater Reservation	7	96	62	14	11	7	197
Elko Colony	62	240	344	48	9	26	729
Ely Reservation	8	41	67	9	3	5	133
Fallon Paiute-Shoshone Colony	13	34	53	7	12	4	123
Fallon Paiute-Shoshone Res.	60	185	264	45	44	22	620
Fort Mojave Reservation	87	270	425	117	97	47	1,043
Goshute Reservation	11	32	49	6	5	2	105
Las Vegas Colony	9	34	54	5	6	0	108
Lovelock Colony	11	24	39	14	11	4	103
Moapa River Reservation	13	58	105	18	10	2	206
Pyramid Lake Reservation	146	480	771	162	102	73	1,734
Reno Sparks Colony	97	263	410	55	33	15	873
South Fork Reservation	1	35	53	16	14	4	123
Stewart Community	22	598	95	10	8	2	196
Summit Lake Reservation	0	1	14	0	0	0	15
Walker River Reservation	68	272	350	67	50	46	853
Wells Colony	10	14	25	1	3	1	54
Winnemucca Colony	2	18	34	4	2	2	62
Yerington Colony	16	42	59	12	5	5	139
Yomba Reservation	4	31	44	10	5	2	96
Total	795	3,758	4,245	815	539	335	9,948

[35] U.S. Census Bureau, Summary File 1 by Native American Reservation, DP-1 Profile of General Demographic Characteristics 2000.

Table 15. Senior Population by County and Age[36] [37]						
County	**55-59**	**60-64**	**65-74**	**75-84**	**85+**	**Total**
Carson City	2,949	2,412	4,096	2,950	791	13,198
Churchill	1,269	988	1,602	974	289	5,122
Clark	70,904	58,124	90,194	46,171	10,534	275,927
Douglas	2,717	2,285	3,835	1,992	430	11,259
Elko	2,126	1,426	1,580	816	218	6,166
Esmeralda	72	92	100	51	16	331
Eureka	108	81	134	61	10	394
Humboldt	743	559	708	402	103	2,515
Lander	343	230	238	117	48	976
Lincoln	278	263	373	230	70	1,214
Lyon	2,067	1,808	2,921	1,508	314	8,618
Mineral	318	301	558	348	99	1,624
Nye	2,357	2,323	3,964	1,721	299	10,664
Pershing	397	241	287	179	54	1,158
Storey	299	214	287	127	32	959
Washoe	17,629	13,367	20,216	12,082	3,499	66,793
White Pine	481	428	682	436	121	2,148
Total	105,057	85,142	131,775	70,165	16,927	409,066

[36] U.S. Census 2000 Summary Files, DP–1 Profile of General Demographic Characteristics, by county.
[37] Note that the totals on Tables 15 and 16 do not match because they reflect different data sources.

Table 16. Population Projections for Nevada's Seniors: 1990-2020[38]							
Age	**1990**	**1995**	**2000**	**2005**	**2010**	**2015**	**2020**
55-59	55,681	76,631	105,356	141,114	161,768	179,173	186,410
60-64	54,332	65,534	87,322	115,158	140,461	155,551	168,948
65-69	50,779	58,980	70,432	90,546	110,338	130,615	142,391
70-74	36,093	52,848	61,232	71,194	83,609	98,230	114,077
75-79	22,811	34,092	48,685	55,563	60,481	68,910	79,668
80-84	11,908	17,705	26,043	36,447	40,585	43,888	49,922
85+	7,477	11,300	16,026	23,912	31,992	37,193	40,741
55+ Totals	239,083	317,091	415,096	533,933	629,233	713,561	782,158

Table 17. Number of Seniors Below Poverty in Nevada[39]				
	55-64	**65-74**	**75+**	**Total**
Below Poverty	13,789 (7.5%)	6,941 (5.4%)	9,876 (11.4%)	30,606 (7.7%)
Above Poverty	171,176 (92.5%)	121,196 (94.6%)	76,988 (88.6%	369,360 (92.3%)
Total	184,965 (100%)	128,137 (100%)	86,864 (100%)	399,966 (100%)

[38] Nevada Senior Population Estimates, July 1, 1986 to July 1, 2020. The Nevada State Demographer's Office, University of Nevada, Reno.
[39] U.S. Census Bureau, Census 2000 Supplementary Survey Summary Tables, P114, Poverty Status in the Past 12 months by Sex and Age.

Attachment G

Summary of Issues and Trends from Existing Studies and Reports

May 2002

Introduction

As part of development of the *Strategic Plans/Strategic Health Plans for Seniors and People with Disabilities*, the Rensselaerville Institute conducted a review of published reports and studies. The purpose of this review was to identify and summarize the "macro" trends and issues related to seniors and people of all ages with disabilities. The review focused primarily on reports and studies listed by the State in Attachment D of the Request for Proposals. In addition, the review covered a few national reports particularly pertinent to Nevada, as well as key information from presentations made on February 4, 2002, to the Nevada Legislative Commission's Subcommittee to Study the State Program for Providing Services to Persons with Disabilities.

An Overarching Trend: The Olmstead Decision

The single most important trend that will shape the development of the *Strategic Plan for People with Disabilities* (and, to a lesser extent, perhaps, the *Strategic Plan for Seniors*) is the landmark U.S. Supreme Court decision in 1999, known as the "Olmstead Decision." This decision is helping to advance strategies and programs that let people with disabilities receive supports/services at home or in community-based programs instead of institutions.

The Olmstead Decision represents a recent culmination of significant change in U.S. public policy goals regarding people with disabilities that began three decades ago. This public policy is based on the four goals in the Americans with Disabilities Act. It is increasingly being recognized that this policy framework can, and should be, built into all aspects of states' health, human services, and other planning, service coordination, service provision, monitoring and evaluation functions.[i] The four core policy goals are:

- *Equality of Opportunity*: treating people on the basis of objective facts; providing reasonable accommodations; making programs accessible; guaranteeing inclusion and integration.

- *Full Participation*: involvement in decision making at the program and systems level; ensuring informed choice; providing self-determination and empowerment; recognizing self-advocacy.

- *Independent* Living: recognizing independent living as a legitimate outcome of public policy; providing long-term services and supports including personal assistance services and assistive technology devices and services, providing cash assistance and other forms of support (such as health care, transportation, and housing).

- *Economic Self-Sufficiency*: recognizing economic self-sufficiency as a legitimate outcome of public policy; providing employment related support systems and services; providing cash assistance and work incentives to employers and employees.

The Olmstead Decision means states may be found in violation of Title II of the Americans with Disabilities Act if they provide care to people with disabilities in institutional settings when they could be served in home and community settings. This gives a context of urgency to the collection of certain baseline data and development of initiatives and strategies for preventing institutionalization and moving people out of institutions. States will no longer be able to discriminate against people with disabilities by denying community-based services.

States must meet two requirements for compliance with Title II of the ADA. States must: a) analyze what needs to be changed and develop a comprehensive plan, and b) move people off waiting lists at a reasonable pace.[ii]

Key Population Trends[iii]

1. The population of Nevada is growing rapidly and the elderly population and population of people with disabilities are growing at a higher rate.

    - During the past decade *Nevada had the fastest growth rate in the nation***,** increasing by 66.3% (from 1,201,833 in 1990 to 1,998,257 in 2000).[iv]

    - The elderly are only 11% of the total population of Nevada, compared with 12.4% nationally, but growing much more rapidly than elsewhere. In fact, Nevada has the fastest growing aging population in the country. Between 1990 and 2000, the 65-plus population increased by 72% from 127,461 to 218,184. The 85-plus population increased by 128% from 7,463 to 16,989. *The rate of increase of the elderly population in Nevada is nearly three times the national rate.*[v]

    - Because the Nevada population is increasing at a rapid rate, *the number of people who need personal assistance with daily activities will continue to increase over the next ten years.* Approximately 98,000 Nevadans age 15 and older need personal assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). By 2010, an estimated 125,000 will need such assistance.[vi]

2. Nevada is becoming more racially and ethnically diverse at a greater rate than the nation. Between 1990 and 2000:[vii]

    - The Native American Indian population increased by 51% (from 18,379 in 1990 to 27,833 in 2000).

    - The Asian or Pacific Islander population increased by 192% (from 37,839 in 1990 to 110,578 in 2000).

    - The African American population increased by 66% (from 83,686 in 1990 to 138,552 in 2000).

- The Hispanic population increased by 218% (from 131,457 in 1990 to 399,918 in 2000).

- The White (those not included in the Hispanic or Latino count) population increased by 39% (from 962,224 in 1990 to 1,341,108 in 2000).

By 2010, the non-White population is expected to make up 40% of the total population of Nevada. *Special consideration of race and culture will need to be made when designing and implementing programs and services.*

3. Outside the two urban areas, Nevada is very rural with only 3.3 persons per square mile. Isolation is a major factor for seniors and people with disabilities in rural Nevada. *Few services exist to help rural Nevadans live independently:*[viii]

4. From 1990 to 1999, 71 percent of Nevada's population increase resulted from domestic in-migration (83 percent from 1980 to 1990); 19 percent from birth increase; and 9 percent from international migration.[ix] Only one in four Nevadans were born in the State. *Nevada has the highest ratio of transplants to native-born residents of any state***.**[x]

Key Findings: Issues

1. Indicators of Nevadans' health status differ from those of the rest of the country in ways that are predominantly negative:[xi]

   - Age-adjusted death rates for nearly all major chronic diseases are higher for Nevadans than for residents of other states.

   - Nevada leads the nation in the suicide death rate and follows only Washington D.C. and Louisiana in deaths from injury and firearms. Nevada is also one of the leaders in deaths from motor vehicle accidents and homicide.

   - Nevada is above the national average in the percentage of individuals who smoke cigarettes and drink excessively.

   - Nevada is *below* the national average in the percentage of individuals who are overweight.[xii]

2. Nevada is also above the national average in the percentage of individuals who do not have good access to health care, including those who:[xiii]

   - have no health care coverage;

   - have not had a routine physical examination in the past two years;

   - report that they have fair to poor health;

   - report cost as a barrier to health care.

3. In 1999, Nevada ranked 50th among states in per capita spending for all community-based care including home health services, personal care, and HCBS Waivers. Nevada per capita spending for community-based long-term care was only $11.05, compared with the national average of $60.45.[xiv] More recent data comparing Nevada to other states are not available, however, the State of Nevada has been increasing expenditures in the past two years and the ranking of the State may have improved as a result of this increase.

4. Although the State has been increasing the use of Medicaid Home and Community Based Services (HCBS) Waivers, Nevada is still not using HCBS Waivers as extensively as other states to maintain people in their own homes. The waiver financing mechanism is widely-used because it allows for Federal Medicaid match for many services (case management, homemaker assistance, home health aides, personal care, residential rehabilitation, day habilitation, respite care, transportation, supported employment, adaptive equipment, home modification, and occupational, speech, physical and behavioral therapy).

   - In 2000, Nevada ranked 49th among states in HCBS Waiver expenditures. It spent only $3.57 per person in the general population; Rhode Island, by contrast, spent $78.83. The average HCBS Waiver expenditure for all states in 2000 was $19.99.[xv]

   - Other states use HCBS Waivers to a much greater extent to keep people out of institutions. Some states have been very creative in their use of Waivers, for example combining waiver services with HUD Section 8 or Community Development Block Grants funds.[xvi]

5. Nevada's overall Medicaid spending is increasing at twice the national rate. Total Medicaid costs for all states are projected to grow by 7.0% from 2001 to 2002. In Nevada, Medicaid costs are projected to grow by 15% from 2001 to 2002. This is the fifth highest growth rate in the nation.[xvii] [xviii]

6. As it has since 1996, Nevada continues to rank last among all states in fiscal commitment to providing services for people with Mental Retardation and/or Developmental Disabilities (MR/DD).[xix]

   - In 2000, Nevada spent only $1.02 for MR/DD services per $1,000 of total state personal income. North Dakota, by contrast spent $7.16 on MR/DD services per $1,000 of state personal income. The national average was $3.67.

   - When broken down by type of service, Nevada ranked at the bottom in fiscal effort for community services and near the bottom in fiscal effort for institutional services.

   - Spending on MR/DD services did not keep up with inflation in Nevada between 1996 and 2000. While the Gross State Product grew by 21% during that period, MR/DD spending grew by only 17%.

7. In 2000, Nevada had the lowest out-of-home placement rate in the nation for people with MR/DD.[xx]

   - Community and institutional residential placements averaged 155 per 100,000 people throughout the United States, ranging from 60 in Nevada to 356 in North Dakota.

   - The number of people with MR/DD reported to be residing in nursing facilities declined by 62% between 1996 and 2000. Nevada's nursing home utilization rate for persons with MR/DD is now one of the lowest in the nation.

   In recent years, Nevada has been moving people who are diagnosed with MR/DD off waiting lists for services. But even with increased referrals to community resources, Nevada continues to rank low in the rate of community placement. Although 70 percent of total MR/DD placements in Nevada are in small community settings, Nevada still had the third lowest community placement rate in the nation in 2000. This was because Nevada had such a low total out-of-home placement rate. In 2000, the community placement rate for Nevada was 50 per 100,000 people. For the nation as a whole it was 108 per 100,000 people, ranging from 49 in Kentucky and Georgia (the only states lower than Nevada) to 267 per 100,000 in Minnesota.

8. A high proportion of elderly and other individuals with disabilities in Nevada rely exclusively on their families and other unpaid individuals for care.

   - In the nation as a whole, an estimated 60% of elderly individuals with disabilities living at home rely exclusively on family and friends for care.[xxi]

   - In a study conducted for the Nevada Aging Services Division in 2000, family and friends were the exclusive caregivers for approximately 90% of the elderly individuals with disabilities who were surveyed.[xxii]

9. While all of the long term care implications of the Olmstead Decision, particularly for the elderly, are still unfolding, some issues are emerging:[xxiii]

   - People living in institutions generate, on average, higher costs than those served at home and in the community. Sources report a range of cost for institutional care of between $94,348 per person per year to $98,550. Community-based care costs between $14,902 and $26,729.[xxiv] However, many individuals with complex medical problems, or a high need for personal care, who could be cared for at home are presently institutionalized. It is not clear what will happen to the cost differential when more of such persons are cared for at home, with community supports.

   - The number of people with disabilities is likely to grow as the baby boom generation ages. The demographics of increasing numbers of elderly may drive demand for increased services in a variety of long-term care settings.

- There is tension between advocates of integration and others in the field who believe that institutional care is a better option for some individuals with severe disabilities than home or community-based services.

- It is difficult to get an accurate model that predicts how many people with disabilities living in the community are actually at risk for institutionalization. The demand for long term care services, including residential services, is a complex area. It depends on the interaction of numerous medical and social factors, both within the individual and in the environment. Family support, in particular, is an important variable.

- In a recent decision, the Supreme Court addressed the issue of what constitutes disability. From that decision, the Supreme Court appears to be leaning toward a more stringent application of disability criteria. This has implications for the number of people who will be affected by ADA and Olmstead-driven policy.

- On the other hand, the Executive Order on *Community-based Alternatives for Individuals with Disabilities*, issued by President Bush on June 19, 2001, strongly affirms the commitment to community-based alternatives for people with disabilities and other Olmstead principles. The policy calls for timely compliance with Olmstead and swift implementation of actions that support prevention of institutionalization and de-institutionalization for people who prefer to receive home and community-based services. The Federal government stands ready to assist states to swiftly implement Olmstead so that "all Americans have the opportunity to live close to their families and friends, to live more independently, to engage in productive employment, and to participate in community life."

10. People with disabilities and the elderly typically need and use considerably more health care than the general population. While the State of Nevada does not mandate the use of managed care plans for Medicaid services, many seniors and people with disabilities are enrolled in managed care plans. However, many managed care plans tend to under-serve high users of care. Further, managed care intermediaries familiar with commercial insurance place most emphasis on acute and physician-directed care rather than on home and community-based care. For these reasons, the trend toward managed medical care is of great concern for people with disabilities and chronic illnesses.[xxv] [xxvi]

11. People with disabilities in Nevada frequently list lack of access to adequate and affordable health insurance as a barrier to employment. Because Medicaid is the only source of reimbursement for long-term services and supports such as personal assistance services, people with disabilities must go on SSI to receive coverage. SSI earning limits prohibit them from working.[xxvii] As a result of the federal "Ticket to Work" legislation, Nevada has begun to address this issue. During the last four months of 2001, the Division of Health Care Financing and

Policy held 37 community meetings and conducted a survey of 2,317 Medicaid recipients aged 16–64 and applicants for SSI and/or SSDI during fiscal year 2000-2001. Survey results show that:

- 38% of the survey population would work if their health benefits would not be affected.
- 46% have more than one disability.
- 53% require at least one support service.[xxviii]

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[i] Presentation by Robert Silverstein, Center for the Study and Advancement of Disability Policy, to the Nevada Legislative Commission's Subcommittee to Study the State Program for Providing Services to Persons with Disabilities, Las Vegas, Nevada, February 4th, 2002

[ii] Presentation by Jo Donlin, Senior Policy Specialist for Health Care, National Conference of State Legislators to the Nevada Legislative Commission's Subcommittee to Study the State Program for Providing Services to Persons with Disabilities, Las Vegas, Nevada, February 4th, 2002

[iii] These trends are more fully addressed in another deliverable shortly to be provided.

[iv] US Census 2000 PHC-T-2 Ranking Tables for States 1990 and 2000

[v] US Census 2000 PHC-T-13 Population and Ranking Table of the Older Population for the United States, States and Puerto Rico 1990 and 2000

[vi] US Census Bureau, Americans with Disabilities: 1997—Table 2. Prevalence of Types of Disability among Individuals 15 years and over (August-November 1997 data from the SIPP)*Demographics of Disability in Nevada*, Prepared for the Nevada Rehabilitation Division by Robert Metts et al., Bureau of Business and Economic Research, University of Nevada, Reno, Nevada, no date

[vii] US Census 2000 DP-1 Profile of General Demographic Characteristics for Nevada, and US Census1990 DP-1 General Population Characteristics for Nevada

[viii] *State Plan: Services for Nevada's Elders*, Nevada Division on Aging Services, Carson City, Nevada, August, 2000

[ix] *Statistical Abstract of the United States: The National Data Book, 2000,* Table No. 22 "Components of Population Change by State" 1990 to 1999," 25, U.S. Census Bureau, December 2000

[x] Steve Timko, "Majority of Nevada's residents are transplants from elsewhere," *Reno Gazette Journal*, August 6, 2001, 1A.

[xi] *Disability and Aging in Nevada*, Jeffrey Elias, Associate Director of Research Sanford Center on Aging, University of Nevada, Reno, n.d.

[xii] While this indicator has positive aspects, it may be due to the high rates of smoking and alcoholism.

[xiii] Ibid

[xiv] Presentation by Stephen Gold, Public Interest Law Center, to the Nevada Legislative Commission's Subcommittee to Study the State Program for Providing Services to Persons with Disabilities, Las Vegas, Nevada, February 4th, 2002

[xv] Ibid

[xvi] Stephen Gold, Las Vegas, Nevada, February 4th, 2002

[xvii] *States Expand Medicaid in the Face of Rising Costs*, Federal Funds Information for States Issue Brief 01-37, Washington, D.C., July 2001

[xviii] Further analysis of the actual and projected Medicaid cost increases will show how much of the increase is due to increased use of institutional care and how much to cost increases.

[xix] *The State of the States in Developmental Disabilities: 2002 Study Summary*, David Braddock et al., Coleman Institute for Cognitive Disabilities and Department of Psychiatry, University of Colorado, Boulder, January 2002

[xx] *The State of the States in Developmental Disabilities: 2002 Study Summary*

[xxi] *Testimony Before the Special Committee on Aging*, U.S. Senate, Statement of Kathryn G. Allen Director, Health Care – Medicaid and Private Health Insurance Issues, September 24, 2001.
[xxii] *Nevada Senior Care Givers Assessment of Needs*, University of Nevada Las Vegas, Cannon Center for Survey Research, June 2000
[xxiii] *Long-term Care: Implications of Supreme Court's Olmstead Decision Are Still Unfolding*: Testimony Before the Special Committee on Aging, U.S. Senate, September 2001
[xxiv] Data is taken from the January 1999 *State Legislative Report* of the National Conference of State Legislatures and from the *State of the States*, published annually by the University of Minnesota's Institute on Community Living.
[xxv] *Health Care in Nevada, the Disability Perspective*, Report of the Subcommittee on Special Populations, Donnie Loux, February, 1998
[xxvi] An innovative form of managed care, the Social/Health Maintenance Organization, combines social and medical services and funding. Sierra Health has 40,000 enrollees in its S/HMO, 2,000 of whom are eligible for both Medicaid and Medicare.
[xxvii] *Nevada's Forum on Disabilities Statement and Perspective on SSI/SSDI Work Incentives Reform*, April 1998
[xxviii] *Program Update* from John Alexander, Program Manager, Ticket to Work Medicaid Infrastructure Grant, Nevada DHR Division of Health Care Financing and Policy, 1/23/02

Attachment H

Major Trends and Issues as Seen by Key Informants

February 2002

INTRODUCTION

As part of development of the *Strategic Plans/Strategic Health Plans for Seniors and People with Disabilities*, the Rensselaerville Institute conducted interviews with key informants from Nevada and other parts of the United States. Potential interviewees were identified by Nevada Senior or Disability Task Force members and by other knowledgeable individuals. Interviews were conducted with 25 experts (see attached Lists of Key Informants). Twelve of these were from the aging field and 13 from the disability field. Key informants included researchers, educators, association directors, legal advisors, Area Agency on Aging directors, and program operators. Of the 25 key informants, six were from the state of Nevada and a few others claimed knowledge of Nevada trends and issues. Seven individuals specifically addressed issues related to children.

Interviews took place between January 15 and February 15, 2002. Potential key informants were called and/or sent an e-mail message asking for their help in identifying the major trends, shifts and issues affecting seniors or people with disabilities. All interviews were completed over the telephone. Interviewees were sent a copy of the questionnaire to familiarize them with the questions prior to the interview.

Interviewees were also asked to identify best practices that resulted in remarkable improvements for seniors and individuals with disabilities. TRI is now in the process of identifying and interviewing people responsible for these improvements and will be completing the report, *Cutting-Edge Programs.*
While many key informants agreed on some of the major trends and issues, others were mentioned by only a few respondents. A listing of all responses mentioned by at least two individuals is included at the end of this report.

Here is a summary of the key findings related to the major trends and issues:

MAJOR TRENDS

Shift from institutional care to home and community-based care. A majority of key informants (8 from the aging field and 7 from disabilities) mentioned the movement of people from institutional care to home and community-based care as a major trend in aging and disability services. Despite the fact that key informants found this a very significant trend, many also expressed concern that seniors and people with disabilities of all ages continue to enter institutions unnecessarily. In spite of the huge cost to states to provide institutional services (more than half of most long-term care dollars are spent on nursing home care),[1] many Medicaid options for funding home and community-based care are not used. Interestingly, Nevada spends much less on institutional long-term care than the national average but also spends much less on home and community-based care. In 1999, Nevada ranked 50th lowest in per capita spending for all community-based care including home health services, personal care, and HCBS Waivers.

[1] Interview with David Braddock, Professor, University of Colorado

Nevada per capita spending for community-based long-term care was only $11.05, compared with the national average of $60.45. [2]

Another key informant comment was that some states are using Medicaid options to serve children with disabilities in a home setting by not including income from parents or family members when determining eligibility for home-based services.[3]

The trend toward self-determination/consumer-directed care. A second major trend identified by key informants is the movement toward "controlling your own front door."[4] This was the most frequently identified trend for people with disabilities. Thirteen key informants (nine of whom were disability experts) mentioned it. Allowing people to determine all important aspects of their care (including the time and place of its delivery), in partnership with caregivers, is a strongly-emerging trend. A central tenet of consumer-directed care is that most personal service is not *medical*. Even as a part of daily life, however, its presence or absence affects consumer health.

Additional points made by key informants related to consumer-directed care:

- The whole family is the customer where children are involved. Caregivers and parents need to be partners in shaping the plan of care.[5]
- While it may be relatively easy to appreciate how consumer-directed care works for younger adults with disabilities, people are not equally confident when it comes to older people. One key informant stated she thought some people have an ageist point of view and assume older people cannot make decisions for themselves even when they have a level of disability comparable to that of a young adult with a developmental disability.[6]

The aging of the baby-boom generation and the increase in the number of people over the age of 85. Eight people involved with aging policy mentioned the aging of the "baby boom" population as a major trend, while only two from the disability field did so. In addition to the issues related to the number of people who will become old during the next 30 years, a large number of people are already reaching the age of 85. This demographic trend has major implications for the design and delivery of health and long term care services.

One positive trend mentioned by a few key informants is that there have been improvements in health. Elizabeth Kutza, Professor, Portland State University, explained it this way:

> National data show that functional disability is declining. In 1984, 25% of those surveyed stated they needed help with activities of daily living; in 1999 only 19% indicated needing help. Even in the 85-plus population, fewer limitations were reported. The share

[2] Presentation by Stephen Gold, Public Interest Law Center, to the Nevada's Legislative Commission's Subcommittee to Study the State Program for Providing Services to Persons with Disabilities, Las Vegas, Nevada, February 4, 2002
[3] Interview with Sarah Jane Somers, Attorney, National Health Law Programs
[4] Interview with David Braddock, Professor, University of Colorado
[5] Interview with Robin McWilliam, Senior Scientist, Frank Porter Graham Child Development Institute, University of North Carolina at Chapel Hill
[6] Interview with Elizabeth Kutza, Professor, Portland State University, College of Urban and Public Affairs

> of elderly in nursing homes has also declined from 5.5% in 1985 to 4.6% in 1995 and not just because of a shift to community based care.

However, even with the reductions in functional disability for the aging population, the number of people who will need health and long term care is increasing and will do so at a faster rate as the baby boom generation becomes elderly. As Charles H. Roadman, MD, President, American Health Care Association, quipped, "If you think the system is tough for 18 million people, wait until we have 39 million."

Technological and scientific advances. Seven key informants identified another promising trend: advances in science and technology are increasing our understanding of the brain and how it functions; helping us improve health as a result of genetic and drug research; and producing technology that assist people with activities of daily living.

MAJOR ISSUES

System reform is needed. Thirteen key informants expressed a belief that the health care system needed major reform. Key informants were particularly concerned about fragmentation of health care financing by multiple federal, state, and private entities and how this affects people of all ages when they need care. For example, if you are disabled and want to go to work, you can lose your Medicaid coverage, which makes it impossible to take a job without serious medical risks. Additionally, the cost of caring for a child with a disability at home can be extremely expensive. The high cost and unclear cost/benefit of long term care insurance was mentioned. A final concern was the trend toward more managed health care and service delivery that may not meet the needs of people with complex medical problems.

Caregiver availability and the need for caregiver support and training. Seven key informants in the aging field and three disabilities experts identified the growing problem of finding and keeping quality caregivers. Several mentioned that while these issues have been a concern for years, it is now becoming quite clear that this issue must be addressed. Caregivers, paid and unpaid, need special services, training, and support to be successful. Reliance on family members to care for people who are old or people of all ages who are disabled is less feasible than in the past. As Elizabeth Kutza points out:

> In 1960, 88% of children were in two-parent households. In 1988 only 60% of households had two parents. A change in fertility rates has also added to this trend—baby boomers have fewer than two children and the percentage of women not having children at all is one in five. At the same time, increased longevity has resulted in 70-year-old children with 90-year-old parents. Women who have increased their participation in the labor force cannot necessarily be relied on to provide the level of care for aging parents or family members of all ages with disabilities that women provided at an earlier time.

Federal, state, and local budget crises. Ten key informants identified budget crises at the federal, state, and local level as an issue. They were concerned that the recent recession, along with the high cost of caring for people with multiple needs, threaten the commitment of state and federal governments to support the needs of the elderly and people of all ages with disabilities.

Others believe that finding more ways to include cost-sharing in programs, and new ways to bring additional revenue into the system, is required.

Lack of affordable housing. Five key informants expressed concern about the lack of affordable housing and described other housing-related issues. Both aging and disability advocates talked about the critical need for more affordable, accessible housing for the elderly and people of all ages with disabilities. They also were concerned about the whole spectrum of costs associated with housing, including utilities and housing modifications. Another issue identified by one researcher is that retirement communities are becoming deeply needy places as people age-in-place and have many needs.[7]

Cultural and ethnic specific needs. An additional set of issues were raised about diversity and specific cultural or ethnic needs. David Baldrich, Executive Director, Native Indian Council on Aging, explained Native American Indian issues this way:

> Devolution and fragmentation of the Indian health care system is a major issue. In 1984 many services were delivered centrally but now the National Indian Health Service is backing out of health care. 450 tribes are providing their own health care.

State/tribal relationships have suffered from a lack of understanding by states about state versus federal responsibility for Native American Indians.

People with disabilities are the largest minority group in the country, according to several key informants. The growth of this population, along with the correlation between disability and poverty or low income, makes this an even greater concern.

TRENDS AND ISSUES SPECIFIC TO NEVADA

In addition to national trends and issues, some of the key informants talked specifically about issues and trends in Nevada. While many of the experts were concerned about the aging of the baby-boom generation, those who are familiar with Nevada are concerned about the explosive population growth in the state. Another population concern was expressed by Brian Lahren, Executive Director, Washoe Association for Retarded Persons:

> 20,000 people with a cognitive disability live in Nevada, but only 3,100 people are served. The state is putting mental health patients in jail—more patients are in prison than in mental health system facilities, indicating a crimininalization of mental illness.

Four key informants mentioned the need for “a single point of entry” to services in Nevada. Two key informants described a need for geriatric and disability specialists of all types and for all ages, as well as a variety of specialized training for providers in general. Additionally, Nevada key informants were concerned about:

- the high cost of utilities

[7] Interview with John Capitman, Professor, Heller School for Social Policy and Management, Brandeis University

- the need for a change in Nevada's tax structure
- the need for increased assisted living options (including the use of Medicaid resources) and regulation

ADVICE ON THE PLAN

Although they were not asked specifically to comment on the *Plans*, a few key informants gave advice about the Nevada strategic plan development:

- Bob Kafka, Director of American Disabled for Attendant Programs Today (ADAPT), recommended the Plan specifically state how many people are going to get out of institutions and when they are going to get out. He also strongly advised the State not to look at populations separately. He believes fragmentation within the disability community (mental retardation, mental health, developmental disabilities), as well as across the aging and disability communities, is a problem and should be addressed.
- Herb Sanderson, Director, Arkansas Area Agency on Aging, advised *Plan* developers to examine how the State is spending long-term care dollars. Nationally, only about 5% of elderly people are in nursing homes, but 78% of state long-term care dollars are spent on nursing home residents. The 95% of elderly people receiving care at home or in the community are receiving a small amount of the long-term care money and most people want to stay at home.

SPECIFIC RESPONSES OF KEY INFORMANTS:TRENDS AND ISSUES*

Trends

A trend from institutional care to home and community-based care (including changes related to the Olmstead decision) has been taking place over twenty years. However, many feel the change is not happening as extensively or as quickly as it should. (15 key informants; 8 from the aging field)

The movement toward self-determination and consumer-directed care is an important trend and some felt this will require more formal arrangements to allow people to assume risk in a self-directed system. (13 key informants; 9 from the disability field)

The aging of the "baby-boom generation" and the increase of those over 85 is a major demographic trend. Additionally, baby-boomers are more savvy and demand more from the health care system. (10 key informants; 8 from the aging field)

A deepening understanding of the brain, advances in genetic and drug research, and how to use technology to assist people with disabilities is a positive trend. (7 key informants)

The number of people in poverty with disabilities, and the elderly, is increasing. A growing gap in education and income levels exists between the well-educated and affluent and the less educated and poor. (4 key informants)

The recognition of additional disabilities such as head injury and autism, and the rapidly growing population of children identified with autism is a concern. (4 key informants)

A trend toward increased emphasis on measuring quality and results of services has taken place, but the emphasis has not yet resulted in significant change. (2 key informants)

A positive overall trend in the treatment of people with disabilities in the past 25 years has taken place, in part because of the American's with Disabilities Act and also because of the increased advocacy on the behalf of people with disabilities. (2 key informants)

An emphasis on increasing the overall quality of life of people, nurturing life-long learning, recreation, culture, and the arts, is evolving. (2 key informants)

Issues

The health care system is in need of major reform. Problems with losing Medicaid benefits if you work and are disabled, concern about the level and quality of care through managed care, the high cost of long term care insurance, the cost of caring for a child with a disability at home, and the high cost of prescriptions drugs were identified. (13 key informants; 7 from the disability field)

The supply of quality caregivers is diminishing and caregivers, both paid and unpaid, need more support and training to be successful. (10 key informants; 7 from the aging field)

Budget crises at the federal, state, and local levels are threatening funding for aging and disability services and entitlements. More work needs to be done on finding find new resources and cost-sharing within the system. (10 key informants)

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* Twenty-five individuals were interviewed—13 disability experts and 12 aging or long term care experts.

An increased tension exists around inclusion and integration of services for children who have serious mental or physical health problems. Another problem identified is the need for schools to give standardized tests to all children, including those with disabilities. Additionally, concern was raised about overall integration and support in schools including the need for more Spanish-speaking workers, for schools to become involved in the family's agenda, and for more deaf interpreters. (6 key informants)

Lack of available, affordable housing (including housing for those with disabilities) and rising utility costs are issues. (5 key informants)

Problems are created within the service system because of the separation and fragmentation of services for different disability groups and for the elderly and physically disabled. (5 key informants)

A need exists to increase the emphasis on work options and to increase earning power for people with disabilities. This becomes even more difficult because most jobs are now in the service industries. (4 key informants)

A concern about Social Security reform and its implications for the elderly and disabled was mentioned. (3 key informants)

Poor political leadership and overall public policy in long term care makes significant change less likely. (3 key informants)

Transportation and mobility issues for the elderly and disabled are growing. (3 key informants)

The use of cochlear implants has created opportunities for people who are deaf, but has also caused tension within the deaf community. (2 key informants)

Integration of acute and chronic care services using an interdisciplinary approach is needed. (2 key informants)

A growing number of pregnant and parenting women, and also people with mental illness, are incarcerated. (2 key informants)

The narrowing of the definition of disability by the Supreme Court and the erosion of the ADA is a concern. (2 key informants)

Trends and Issues Specific to the State of Nevada*

The net growth in population in Nevada is overwhelming. Additionally, the density of Las Vegas versus the rest of the state creates special challenges. (5 key informants)

Nevada needs a single point of entry for elderly and disabled people to access services. (4 key informants)

Nevada has a tremendous need for geriatric and disability specialists of all types. Overall, the State has underqualified people working with children with disabilities—both urban and rural. Nevada has no training program for two-thirds of disabilities, including autism and hearing and visual disabilities. (3 key informants)

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* Six key informants were from the State of Nevada and answered questions specific to Nevada and a few additional key informants claimed knowledge of Nevada and responded to one or more of the trends and issues questions .

The tax structure in Nevada needs to be changed. The State relies too heavily on revenue from gaming and mining. (2 key informants)

Many Medicaid services are unavailable in Nevada. (2 key informants)

More assisted living options for low-income people, and better regulation of facilities, are needed. (2 key informants)

Nevada provides poor services for children with disabilities, relies too heavily on rehabilitative services, and places too many children in nursing homes. (2 key informants)

All of the national trends and issues are multiplied in Nevada because the State is behind everyone else in developing a system. (2 key informants)

BOOKS RECOMMENDED BY KEY INFORMANTS

Condeluci, Al. *Beyond Difference*. Winter Park, FL: GR Press, 1995.

Condeluci, Al. *Interdependence: The Route to Community*. Winter Park, FL: GR Press, 1995.

Duncan, David James. *My Story as Told by Water*. San Francisco: Sierra Club Books, 2001.

Friedman, Thomas L. *The Lexus and the Olive Tree*. NY: Anchor Books, 2000.

Gladwell, Malcolm. *The Tipping Point: How Little Things Can Make a Big Difference*. Boston: Little, Brown, 2000.

Millenson, Michael L. *Demanding Medical Excellence: Doctors and Accountability in the Information Age*. Chicago: University of Chicago Press, 1999.

Putnam, Robert D. *Bowling Alone: The Collapse and Revival of American Community*. NY: Simon & Schuster, 2000.

Schwartz, David B. *Crossing the River: Creating a Conceptual Revolution in Community & Disability*. Cambridge, MA: Brookline Books, 1992.

KEY INFORMANTS-DISABILITIES

Name of Respondent	Title	Agency/Affiliation
Steve Gold	Attorney	Public Interest Law Center
Al Condeluci	Executive Director	United Cerebral Palsy Association
Bob Kafka	Director	American Disabled for Attendant Programs Today (ADAPT)
Jay Klein	Alliance Director	National Home of Your Own Alliance
Cheryl Fish-Parcham	Associate Director	Health Policy, Families USA
Paul Marchand	Executive Director	National ARC (National Association for Retarded Children and National Association for Retarded Citizens)
Jose Blackorby	Co-Director	Special Education Elementary Longitudinal Study (SEELS), SRI International
Dr. Robert Davila	CEO	National Technical Institute for the Deaf, Rochester Institute of Technology
Robin McWilliam	Senior Scientist Editor	Frank Porter Graham Child Development Institute, University of North Carolina at Chapel Hill, *Journal of Early Intervention*
Brian Lahren	Executive Director	Washoe Association for Retarded Citizens
Sarah June Somers	Attorney	National Health Law Program
David Braddock	Professor	University of Colorado
Tom Pierce, Ph.D.	Chairman	University of Nevada at Las Vegas, Department of Special Education

KEY INFORMANTS-AGING

Name of Respondent	Title	Agency/Affiliation
Richard Corrin Ladd	President	Ladd and Associates, formerly Director of Oregon State Senior & Disabled Services Division
Lawrence J. Weiss, Ph.D.	Director	Sanford Center for Aging
Phillip Shapiro, M.H.A.	President, CEO	Promenade on the River
Ernest K. Nielsen, Esq.	Attorney	Washoe County Senior Services
John Williams	Director	State of Utah, Division of Health Care Financing
Charles H. Roadman, MD	President and CEO	American Health Care Association
Herb Sanderson	Director	Arkansas Area Agency on Aging
Carla Sloan	Director	Nevada AARP
Elizabeth Kutza	Professor Director	Portland State University, College of Urban and Public Affairs Institute on Aging
Dr. John Capitman	Professor	Heller School for Social Policy and Management, Brandeis University
Cheryll Schramm	Director	Atlanta Area Agency on Aging
David Baldrich	Executive Director	Native Indian Council on Aging

Estimate of Number of Riders Using Public Transportation in 2010[1]

Attachment I.

Age of Senior	Number of Seniors[2]	Number/percent who do not drive[3]	Number **unable** to use fixed route service who don't have family or friends to transport them[4]	Number **able** to use fixed route service who don't have family or friends to transport them[5]	**Estimated Total Public Transportation Riders in 2010**
65-74	195,000	32,700 (17%)	5,850	3,950	**9,800**
75 and over	127,000	31,750 (25%)	6,100	3,400	**9,500**
Total	322,000	53,200 (20%)	11,950	7,350	**19,300**

[1]To determine how many people 65 years and older will use the public transportation system (either demand response curb-to-curb service or the public fixed route system), we used information from national studies that indicate the number of people who do not drive and how likely they are to get assistance from family and friends.

[2] Nevada Senior Population Estimates, July 1, 1986 to July 1, 2000. The Nevada State Demographer's Office, University of Nevada, Reno.

[3] According to the AARP Research Center, 7 million (20%) people over the age of 65 do not drive and 25% of those over the age of 75 do not drive.

[4] To calculate the number who are unable to drive, do not have family or friends to transport them, and need curb-to-curb transportation, we determined the number of people who need help with Instrumental Activities of Daily Living (IADLs) in each age category and multiplied this number by 30% (the number who are not able to get help from family and friends. An estimated 16% (20,320) of those 75 and over (127,000) will need help with IADLs. Of the 20,320, 30% will not be able to get help from family and friends. Therefore, 6,100 will need transportation services. An estimated 10% (19,500) of those 65-74 (195,000) will need help with IADLs. Of the 19,500, 30% will not be able to get help from family and friends. Thus, 5,850 people 65-74 will need transportation services.

[5] To calculate the number who do not drive and will use a fixed route service because they do not have family or friends to transport them (this assumes that most of them are frail and would prefer to get help with transportation from family or friends), we subtracted the number who are unable to use the fixed route system and do not drive from the number who do not drive in each age category and then multiplied by 30% (the number who do not have help from family and friends). For those 65-74, the number who do not drive is 32,700. Subtracting those who need help with IADLs, 19,500, from those who do not drive, 32,700, leaves 13,200 multiplied by 30% equals 3,950. For those 75+, the calculation is 20,320 minus 31,750 or 11,430 times 30% equaling 3,400.

Source: U.S. Census Bureau, Americans with Disabilities: 1997, Prevalence of Types of Disabilities.

Source: American Association of Retired Persons (AARP) and the Travelers Foundation, 1988. *A National Study of Caregivers: Final Report*. Washington D.C.

Attachment J

SENIOR TRANSPORTATION SYSTEM

Modalities	Operator	Senior Riders	Rides per Year/Seniors	Rides Denied	Funders	Geographic Area	Target Population
Demand Response: Paratransit	Citi-Lift		240,000	625	NDOT State County	Reno/Sparks	ADA paratransit regulations[1]. Includes riders under age 60.
	Citizen Area Transit (CAT)				NDOT State County	Las Vegas	Functional assessment of inability to ride the bus[2]

[1] All applicants for CitiLift eligibility must meet the Federal requirements for Americans with Disabilities Act (ADA) paratransit eligibility.
Eligible individuals must have one or more of the following:
Disabilities that prevent them from independently getting to/from a bus stop or through major transfer points
Disabilities that prevent them from independently boarding, riding, and exiting a bus
Disabilities that prevent them from independently recognizing the correct bus stops and key landmarks
2 The functional assessment is a mechanism to help determine whether the applicant has the ability to use CAT fixed route service and, if so, under what circumstances. Functional assessments are evaluations used to predict either physical or cognitive ability. They are designed and conducted by independent professionals. The physical functional evaluation consists of a simulated trip to and from the bus. This includes boarding a bus, negotiating a curb and curb cut, and crossing the street. Skills evaluated include balance, strength, coordination and range of motion. The Functional Assessment of Cognitive Transit Skills (FACTS) is administered to applicants with cognitive disabilities. FACTS is a validated assessment tool designed to assess the transit skills of a person by using a simulated bus trip. Skills evaluated include bus travel skills, community safety skills and general orientation. Variables in the environment as well as the applicant's ability to perform the tasks required to use the bus are considered.

Modalities	Operator	Senior Riders	Rides per Year/Seniors	Rides Denied	Funders	Geographic Area	Target Population
	Small Urban and Rural Transportation		322,479		NDOT State	Rural Areas	Elderly and handicapped
Volunteer	RSVP		1,600		Volunteers ILG NDOT	Rural Areas	Seniors
Taxi	Senior Ride Program	8,700[3]			Pooled resources of Taxi cab riders	Las Vegas	60 years old and older
Agency-owned vehicles	I Sight, Inc. Laughlin Sr. Association Nevada Rural Co. RSVP Storey County Senior Citizens Center	1344[4]	7,501		Div. for Aging Independent Living Grant	Rural Areas	

[3] Estimate based on data from Division for Aging indicating that an average of 5,283 seniors used the taxi service each month in 2000. The estimate assumes a 10% ridership growth and that the yearly number of seniors using scrip is 1.5 times the monthly average.
[4] Includes some volunteer transportation trips.

Modalities	Operator	Senior Riders	Rides per Year/Seniors	Rides Denied	Funders	Geographic Area	Target Population
Fixed Route: Bus	Citizen Area Transit (CAT)				NDOT State County	Las Vegas	General Public
	Citi-Lift				NDOT State County	Reno/Sparks	General Public
	Churchill Area Regional Transit					Fallon	General Public
	Douglas Area Regional Transportation						

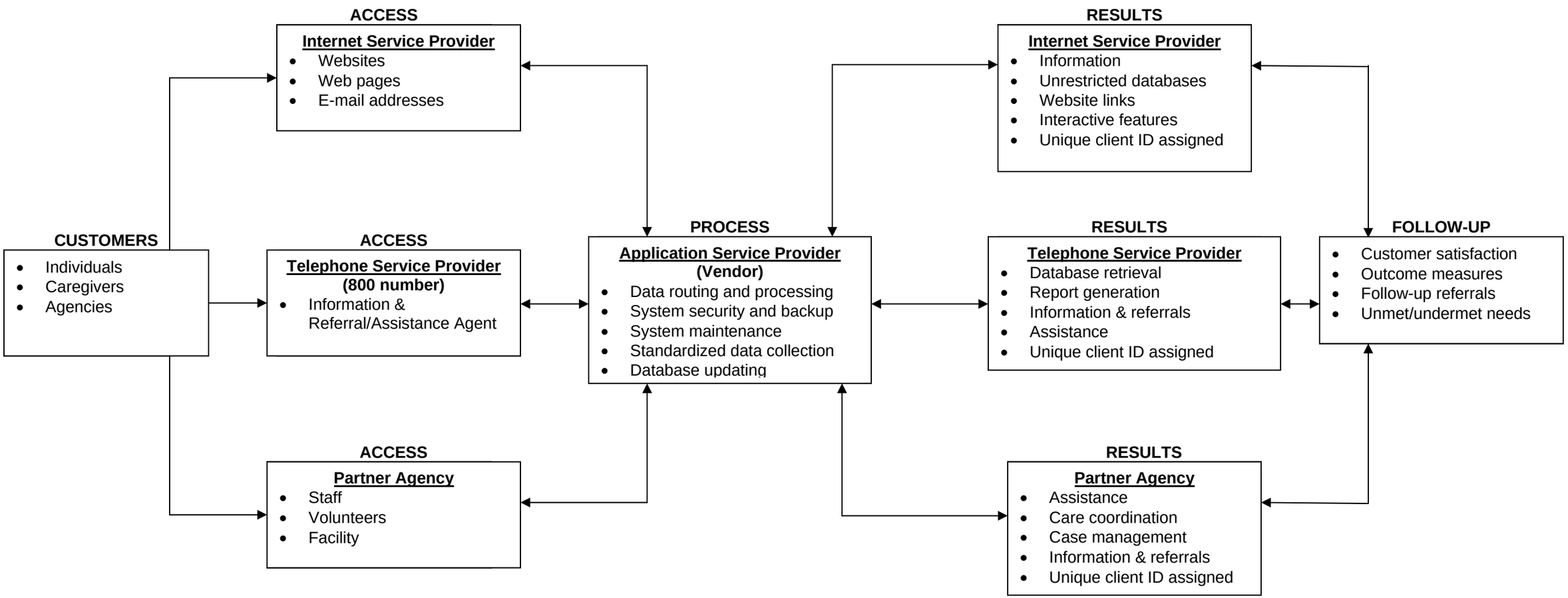
Modalities	Operator	Senior Riders	Rides per Year/Seniors	Rides Denied	Funders	Geographic Area	Target Population
	Carson City Community Transit					Carson City	General Public
	PRIDE				NDOT State Division for Aging	Reno to Carson City; Carson City to Minden & Fallon, Fallon to Fernley	TANF recipients; job seekers[5]
TOTAL							

[5] Potential for increased services to accommodate elderly and handicapped non-jobseekers.

DRAFT SINGLE POINT OF ENTRY SYSTEM FLOW CHART

Attachment K

This FLOW CHART is based on the following sequence of events: CUSTOMERS use one of three portals to access the system and its features through an APPLICATION SERVICE PROVIDER which also tracks the results.



10/17/2002

HOME CARE SERVICES IN NEVADA

Attachment L

Fund Source[1]	Personal Assistance		Homemaker		Care Management	
	Number of Cases	**Waiting List**	**Number of Cases**	**Waiting List**	**Number of Cases**	**Waiting List**
Title III-B/ILG			1,136		1,480	
Title XX			755	232	755	232
CHIP Waiver	1,324[2]	530	1,309[3]	524	1,522	609
Group Waiver					227	
Clark County			466	399	466	399
Washoe County			103		32	
Title XIX	180[4]		132		132	
Senior Dimensions	330[5]		837[6]		1,214[7]	
TOTAL	**1,834**	**530**	**4,738**	**1,155**	**5,828**	**1,240**

[1] This chart represents the number of cases served by various publicly-funded programs in Nevada. Data represents numbers of cases within one year for either the time period ending 12/31/01 or 6/30/02.
[2] Calculated at 87% of all waiver cases.
[3] Calculated at 86% of all waiver cases.
[4] Calculated at 20% of all Personal Assistance Title XIX cases.
[5] Number of cases in June 2002 who are not also receiving Medicaid services.
[6] Number of cases in June 2002 who are not also receiving Medicaid services.
[7] Calculated using estimates of the number of seniors who were receiving personal care attendant, homemaker, and respite services in June 2002 and would have received care management as part of determining their level of care.

Attachment M

CUTTING-EDGE PROGRAMS

INTRODUCTION

As part of development of the *Strategic Plans/Strategic Health Plans for Seniors and People with Disabilities*, the Rensselaerville Institute has completed this cutting-edge program report to stimulate ideas for change in existing programs or the development of new initiatives to be included in the *Plans.* During the Key Informant interviews conducted in January and February, interviewees were asked to identify best practices that resulted in remarkable improvements for seniors and individuals with disabilities. The suggested best practices, along with programs identified through other sources, were located and people responsible for the programs were interviewed to complete this report.

The report is organized under general headings that coincide with the Issues and Trends reports. Because many of the programs described are comprehensive in nature, the programs that follow could fit under more than one category.

HEALTH CARE/MANAGED CARE

Flex Care-Utah (Don Fennimore, 801 231-3855)

Flex Care is a long-term care HMO demonstration project initiated in 2001 for Medicaid recipients. The project includes a package of long term care services as an alternative to nursing homes for seniors and people with disabilities. The package provides consumers with a case manager and supports them in a variety of settings (independent living, assisted living, or group home). **Flex Care** uses a primary case management model, structured with teams, to coordinate the continuum of care. **Flex Care** uses the services of the PCP, social workers, nurses, physical therapists, mental health workers, occupational therapist, and homemaker/aid services to keep consumers in the least restrictive environment and living independently. This can include working on the consumers' care plans with their doctor, monitoring the quality of their living facility, aiding with family issues and personal problem-solving. **Flex Care** is currently operational in two counties in Utah for approximately 170 clients ages 28-101.

Program of All-Inclusive Care (PACE)-California (Jennie Chin Hanson,

415 292-8880)

PACE is a fully integrated, managed care system for very frail older persons. **PACE** programs enroll only people who are 55 years of age or older and frail enough to meet the State's eligibility standards for nursing home care. The program enables the frail elderly to remain as healthy as possible, at home in their communities and maintain their independence, dignity and quality of life. Since 1990, **PACE** has served over 11,000 enrollees in over 29 sites nationwide. The **PACE** Medicare capitation rate is 95% of Medicare expenditures for people who have equal frailty in the fee-for-service health care system. With the savings from reduced use of costly hospital and nursing home care, **PACE** gives enrollees services that are not ordinarily covered by Medicare and Medicaid, either by type of service or frequency (examples are meals,

transportation, ongoing physical and occupational therapy and non-prescription drugs). **PACE** focuses on the frail elderly, all-inclusive care, an interdisciplinary approach, full integration of acute and long term care, capitated financing, assumption of full financial risk, and high quality care**.** The program employs a team of primary care physicians and nurses, physical and occupational therapists, social workers, recreational therapists, home health aides, dietitians, and drivers to accomplish these various goals. There are 25 PACE sites and each site has about 200 enrollees. Limited new sites may be added each year.

On Lok-California (Carol Smith, 415 292-8888)

On Lok Senior Health is a comprehensive health plan that offers an alternative to nursing home care that enables people to remain independent and living at home as long as possible. It is the original program replicated through **PACE** (see above). **On Lok** covers acute and long term care services for frail older adults who are 55 years and older living in San Francisco. Participants have multiple medical problems or physical conditions that prevent independent living and enter the program considering nursing home care but would prefer to live at home. **On Lok** began in 1971 and means "place of peace and happiness" in Cantonese and this reflects the roots and philosophy of **On Lok**'s care. As a non-profit community organization, **On Lok**'s mission is to provide quality, affordable care for the well-being of frail elderly. The program operates seven days a week, 52 weeks a year for over 860 elders. Client benefits include: specially-equipped transportation services, medical and specialty care, full prescription drug coverage, ongoing physical and occupational therapy, adult day health services, social counseling services, care at home, inpatient care, and interdisciplinary care planning.

SeniorCare—Illinois' Section 1115 Pharmacy Waiver (Amina N. Everett, 217 782-1210)

Illinois has applied (and hopes to begin a program in June 2002) for a Medicaid waiver to purchase prescription drugs currently covered under Medicaid for low-income seniors. **SeniorCare** will provide a pharmaceutical benefit to Illinois seniors (65 years of age and older) with income at or below 200 percent of poverty. As many as 368,000 Illinois seniors will be eligible for the program. The proposed waiver program builds on an existing state-funded program, the Circuit Breaker Pharmaceutical Assistance Program, which provides limited prescription drug coverage to low-income seniors for specific chronic and catastrophic medical conditions. The Circuit Breaker program will continue to provide pharmaceutical benefits to seniors with incomes between 200 and 250 percent of poverty.

Illinois expects the waiver program will lower overall health costs for low-income seniors by giving them access to therapeutic drugs. The waiver should reduce the need for acute and long-term care services. Illinois expects the waiver program to reduce the rate at which seniors currently "spend down" their income to qualify for full Medicaid benefits, which includes prescription drug coverage. Additionally, the waiver program is expected to reduce Medicaid expenditures for the dual-eligible population and produce savings to Medicare by improving seniors' health through drug therapy rather than more costly inpatient health services.

Without access to drug therapy, individuals with acute and chronic conditions are more likely to require institutionalized care, increasing overall health care costs and possibly reducing quality of life for seniors. **SeniorCare** is proposed to last as a demonstration project for five years. Co-payments for seniors in **SeniorCare** are higher than for the lower-income Medicaid population. For individuals who maintain private health insurance, the SeniorCare program will provide the

option of receiving monthly rebate checks to assist with out-of-pocket private insurance expenses such as premiums, deductibles, and copayments for prescription drugs.

Illinois expects **SeniorCare** to achieve budget neutrality by reducing the rate of increase in use of non-pharmacy services such as hospital, long-term care, and nursing needs. The savings produced through reduced use of institutional services under Medicaid are expected to offset the costs of expanding pharmacy benefits to low-income seniors.

Sierra Health Services (SHS)-Nevada (Bonnie Hillegas, 702 242-7574)

Sierra Health Services has a Social HMO, begun in 1996, that has more then 40,000 members headquartered in Las Vegas, Nevada. Through its subsidiaries, **Sierra** provides and administers the delivery of managed care benefit plans for employers, government programs, and individuals. **Sierra** defines managed healthcare as quality care delivered in an organized and cost-effective manner, and requires providers, insurers and members to work together. **SHS's** wholly owned subsidiary Health Plan of Nevada, Inc. (HPN) offers this program under federal grant. In November 1996, HPN was selected by the Federal Government as the first participant in the second-generation "SHMO" demonstrations program. Enrolled beneficiaries receive enhanced services as determined through a process of care coordination.

This program has allowed HPN to provide additional services not routinely covered by Medicare plus choice plans or traditional fee-for-service. Such benefits include respite care, homemakers, extra therapy and emergency response, and safety equipment. The program identifies needs through a health risk screening process, routinely provides comprehensive assessments and requires a plan of care that includes consensus by the client, as well as the care team. At present HPN has more than 2,000 dually-eligible
Medicare/Medicaid members in this program. The **Sierra** family of companies includes health maintenance organizations, indemnity and Workers' Compensation insurers, a multi-specialty medical group, and home care companies.

Senior Care Action Network (SCAN) Health Care-California (Sam Ervin,
562 989-5221)

Started in 1982 as a grass roots organization, **SCAN** offers people with Medicare not only a comprehensive senior health plan that includes vision, dental care and unlimited prescription benefits, but also what is called Independent Living Power (ILP). This program offers personal care services that range from light cleaning to transportation escorts and, in some cases, provides the short term support needed after a hospital stay. These personal care services give customers the extra support needed to enable them to continue living independently at home. Some of the ILP services include care coordination, an emergency response system, caregiver relief, transportation escort, personal care, homemaker services, home-delivered meals, and inpatient custodial care. Under contract with Medicare, none of these services cost the participant more than $8.50.

Pioneer Network: Providence Mount St. Vincent-Washington (Marty Richards, 360 379-1250)

The Pioneer Network began in 1997 in response to the interests of nursing home reformers in changing the control-oriented culture of nursing homes around the country. The founding group met in Rochester, N.Y., with nearly 30 invited participants (lawyers, regulators, nursing home administrators, directors of nursing and social work, and advocates for residents and family

members. As they exchanged ideas and compared approaches, they conceived a movement that would involve them and invited others to become pioneers in the national effort to change the nature of, especially, facility-based long term care.

Today, approximately 200 facilities across the country belong to The Pioneer Network. The Network advocates the formation of partnerships among long term care stakeholders: residents, families, resident advocates, staff and surveyors. The right to take carefully-considered risks is just one of the basic privileges that is easier to restore in a collaborative climate. This new national movement is showing that institutional long term care can be different. Nursing homes and other continuing-care settings can become places in which we would all be proud to live or work. We can provide facility-based assistance to elders without sacrificing their dignity and their control over their own lives.

Mt St Vincent's (MSV), one of the network members, is an example of a facility dedicated to "humanizing" long term care. A vibrant and innovative facility serving over 400 older adults, MSV has 112 retirement apartments with an assisted living program, a nursing center for 154 residents, a 20 bed short-stay skilled nursing unit, adult day health services, a community based rehabilitation program, and an intergenerational learning center. The programs' hallmark is the hospitality and warmth of the facility and all its staff and its focus on integrating the spiritual, physical, and emotional needs of both residents and staff.

Founded in 1924. MSV celebrates life, living and individual capability. Its philosophy of care revolves around the core values of community, compassion, creativity, conservation, and commitment. It offers a "Resident Directed Care," empowering each resident to choose the daily routines and services s/he wishes to receive.

Resident groups are referred to as neighborhoods. Staffing is "flat" rather than hierarchical, with every staff member having the capability to take care of any issue, with any resident, at any time (with the exception of passing medications. This is made possible, in part, because each staff member is cross-trained as a nurse's aide.

HOME & COMMUNITY-BASED CARE

Medicaid Nursing Home Waiver-Arkansas (Herb Sanderson, 502 682-8520)

The Arkansas **Medicaid Nursing Home Waiver** has two programs: "Elder Choices" and "Alternatives." Both programs provide services to help people who are eligible to be in a nursing home remain in their homes. Elder Choices began in 1992 and is for those over 65. Currently 6,054 people participate in the Elder Choices program. Begun in 1997, Alternatives is for those age 19-64 and 785 people participate in the program. The benefits of these programs are that they overcome the nursing home bias and serve two groups of people with disabilities who are often under-served. The programs are also very flexible and accessible for the consumer, and program staff work with many different service providers in order to ensure the care is tailored to an individual's needs.

Alpha One, Home to the Community Project-Maine (Sue Grant, 800 640-7200)

Funded by the Robert Wood Johnson Foundation from 1997-2001, the Alpha One, **Home to the Community** project assisted adults with disabilities in nursing homes to return to the community. **The Home to the Community** project helped the consumer identify their goals and priorities and provided them with lists of available housing. Participants were placed on a

waiting list for their desired residence to ensure the best chance of getting the housing of their choice. The project assisted clients in overcoming barriers to living on their own not only with access to housing, but in-home services, transportation, adaptive equipment, and health care. The staff also helped identify specific personal care needs of the client, and provided them with a wide range of skills training from ironing to writing checks. The **Home to the Community** project also provided the clients with instruction about how to manage a personal care attendant. Personal attendant services are often the key to community life without which people would need to live in an institution. During the project, more than 55 nursing home residents evaluated their options and were assisted to make a transition to the community.

ADAPT (National Office, Mike Auburger, 303 733-9324; Texas Office, Bob Kafka, 512 442-0252)

In 1983 as a project of the Atlantis community in Denver, **ADAPT** began a national campaign for lifts on buses and access to public transit for people with disabilities. **ADAPT** is now a national, consumer-directed initiative that focuses on promoting services in the community instead of placing people with disabilities in institutions and nursing homes. **ADAPT** believes that attendant services (help with eating, dressing, toileting, moving around, etc.) are the cornerstone to community-based services for people with severe disabilities. **ADAPT** is working to get 25% of the Medicaid long term care funds redirected to pay for a national, mandated, attendant services program. **ADAPT** feels that because people with disabilities are labeled "sick," their needs are determined to be medical, and this has created a huge system of institutional facilities developed to provide for those needs. **ADAPT** wants to reverse this bias so that community-based attendant services are the common option, and nursing homes are reserved as a last resort.

Congress and the Administration have envisioned a new grant program, *Real Choice System Change Grant,* to assist states and disability and aging communities to work together to find ways to expand services and supports. The grant funds are meant to be used to bring about enduring system improvements in providing long-term services and supports, including attendant care, to individuals in the most integrated settings appropriate to their needs.

SINGLE ENTRY POINT SYSTEM

Information and Assistance Program-Georgia: (Cheryl Schramm,

404 463-3333)

Since 1980, the Georgia Area Agency on Aging (AAA) and the Atlanta Regional Commission have developed a statewide database of over 11,000 services in over 42 categories. The **Information and Assistance Program**, begun in 1980, is managed by the Georgia AAA, and serves ten counties and one-third of the elderly Georgian population. The service is extensive and is available to all Medicaid waiver recipients. Services in the database range from nursing home and assisted living facilities to in-home beauty and veterinary services. The referral system is highly specific. A phone screener determines the characteristics of the person requiring services, assesses what services are available and would meet the caller's needs, and refers the caller to available service options. The **Information and Assistance Program** is very consumer-oriented and enables people to have access to all types of services; on average the information line receives 2,500 calls per month. The **Information and Assistance Program** also has private subscribers like doctors, hospitals, and managed care companies who pay to have an

updated list of the services available through the database sent to them once a week. The program is both a private and public initiative and all the AAA's across the state participate in the program. The value of this program, as a hub of information that is easily accessed by the consumer, has recently been adopted in other states. The AAA's in all of Alabama, all of Iowa, and portions of Illinois, Kansas, and Missouri are using this model of information, assistance and referral.

TECHNOLOGY

Elite Care-Oatfield Estates-Oregon (503 653-7243)

Opened in 2001, **Oatfield Estates** is a residential care facility consisting of ten group homes, each with separate bedrooms, for 12 residents. **Elite Care's** mission is to fundamentally change and improve housing and health care for the elderly is based on six principles: family style interactions, role continuity, life engagement, residential scale, residential design, and neighborhood location. The structure of the **Oatfield Estates** facility is backed by an overriding philosophy: the importance and strength of power, language, context, competence, development, spirituality, and choice. **Elite Care** uses research from various disciplines to optimize opportunities for family-style social interactions. Residents manage their homes independently with an individual budget, schedule, and set of activities in order to ensure the uniqueness of each home and the overall character of the neighborhood. CARE (Creating an Autonomy-Risk Equilibrium), is **Elite Care's** comprehensive "smart home" technology system that serves residents who want bio-feedback and cues to prolong their independence, and staff who want ways to identify health problems and early, objective, quality-control measurements. CARE accomplishes these goals by gathering, storing, and transmitting health information in real time using digital technologies through the internet; providing behavioral cues to match an individual's changing cognitive and physical condition; enhancing social networks via the Internet and email; and regulating the ambient conditions in the residential environment. Some of the benefits of this system include beds with sensors that are able to detect a resident's weight and sleeping patterns, toilet sensors that can determine a person's pulse, body temperature, and level of dehydration, and motion sensors that detect if a person may have fallen. Also of benefit to the residents are the tracking badges they wear that serve as room keys, help buttons, and a way to send information to a central database in the facility that detects aberrations or emergencies. These tracking badges also let staff know how long a resident has been in a room, and enable residents to locate each other throughout the facility.

Comprehensive Health Enhancement Support System (CHESS)-Wisconsin (Betta Owens, 608 262-4746)

CHESS is computer-based system of integrated health services, developed in 1989, designed to help individuals cope with a health crisis or medical concern. The system is accessed from the safety of a patient's home via the Internet, or through software installed on an individual's computer. Those without a computer are loaned one, and **CHESS** has been installed in community centers, health centers, college dormitories, and in the workplace**. CHESS** combines the best features of computers and human support by providing timely, easily accessible resource information, social support, and decision making and problem solving tools when needed most. It combines various services and resources into one system that is responsive to the needs of various coping and information-seeking styles. Consumers of all ages and ability have found

CHESS to improve their quality of life, reduce demands on their physician's time, and reduce the cost of care.

CHESS tailors and personalizes information and support to help users better manage their health, and change behaviors that are harmful to their well being. It also protects the client's privacy, thereby encouraging openness and honesty in dealing with health concerns. **CHESS** presents reliable, well-organized, detailed health information in language that is comprehensible to people at most educational levels. Through specialized modules, consumers are helped with a variety of health issues. For example, a "Caregiving and Dementia" module was used by the Family Caregiver Alliance (described as another best practice) to help caregivers cope with caring for individuals with dementia. Caregivers use the CHESS module for social or emotional support and for making decisions about nursing home placement. In a study of 106 caregivers, over 90% reported having little outside support besides the **CHESS** module and felt the system helped them cope with their caregiving responsibilities.

Interagency Program for Assistive Technology (IPAT)-North Dakota
(Judy Lee, 701 265-4807)

IPAT was started in 1998 to reduce barriers and build the support systems necessary for individuals in North Dakota to obtain and use assistive technology devices and services. Regional coordinators arrange and provide AT training to parents and the community; arrange AT awareness activities; link individuals with AT concerns, ideas, or solutions with each other and other AT services; and provide assistance in identifying a match between the individual with disabilities or effects of aging, their environments and tasks, and potential AT solutions. **IPAT** also offers a help line providing free, statewide information and referrals about assistive devices to individuals of any age and any type of disability. Finally, a financial loan program makes secured personal loans available for the purchase of assistive technology devices.

CAREGIVERS

Family Caregiver Alliance (FCA)-California (Lynn Feinberg Friss,
415 434-3388)

Founded in 1977, the **Family Caregiver Alliance** was the first community-based nonprofit organization in the country to address the needs of families and friends providing long term care at home. **FCA** is currently a nationally recognized information center on long-term care. FCA also serves as a public voice for caregivers, illuminating the daily challenges they face, offering them assistance they desperately need, and championing their cause through education, services, research, and advocacy. **FCA** is often described as a "one-stop shopping center for caregivers" because of the wide array of services provided based on consumer needs. Some of these services include an information clearinghouse, bay area caregiver resource center, statewide resources consultant, corporate eldercare consultant, research and policy developments, education and training, and online services. **FCA** has a new project, Link2Care, which is a pilot program linking families with a more intensive level of online services (see CHESS above). The Link2Care program includes a secured website with decision support programs; a personal profile and action plan and an information library; consultation with experts in medicine, law, and related fields; moderated support groups; and a database of local community resources and other specialized information services.

HOUSING/HOUSING ASSISTANCE

Cal-Mortgage Section 232- California (Richard Sharon, 202 708-2866)

Initiated in 2001, **Cal-Mortgage Section 232** insures mortgage loans to facilitate the construction and substantial rehabilitation of nursing homes, intermediate care facilities, board and care homes, and assisted-living facilities. **Section 232** also allows for the purchase or refinancing, with or without repairs, of existing projects not requiring substantial rehabilitation. **Section 232** is intended to insure lenders against the loss on mortgage defaults, and it insures mortgages during the construction and rehabilitation of nursing homes and assisted living facilities. These insured mortgages may also be used to enable borrowers to buy or refinance their mortgage and install fire safety equipment. In the last year, **Section 232** insured mortgages for 198 health care facilities with 23,120 beds, totaling $1.3 billion.

Center for Housing and New Community Economics (CHANCE)—a partnership with ADAPT and the Institute on Disability (IOD)-New Hampshire (Don Vachon, drv@cisunix.unh.edu)

CHANCE was established in March 2001, and is intended to improve and increase access to integrated, affordable, and accessible housing that is coordinated with, but separate from, personal assistance and supportive services. **CHANCE's** purpose is to offer alternatives to approaches that segregate, congregate, and control people with disabilities. IOD and ADAPT intend to collaborate with a broad coalition of people and organizations concerned with housing, economics, personal assistance services, and advocacy. The coalition will include people with disabilities and their families, as well as people from federal, state, and local agencies. CHANCE's preliminary efforts will be focused on four major initiatives:

- Project Access: a national initiative designed to assist people with disabilities to move from nursing homes into the community. The U.S. Department of Housing and Urban Development and the U.S Department of Health and Human Services have established a partnership to implement this initiative.
- The Community Living Exchange Collaborative: a 3-year grant funded by the Centers for Medicare and Medicaid Services, to provide technical assistance with issues relating to system change. $64 million in grants was given to design and implement improvements in community long term support systems.
- Strategies, Barriers, and Outcomes of Home Ownership for People with Severe Disabilities: A three-year field research project funded by the National Institute on Disability Rehabilitation Research to systematically investigate the quality of life outcomes of home ownership for people with severe disabilities. The research will focus on the personal service, financial, and support network variables associated with achieving and maintaining successful home ownership.
- The National Home of Your Own Alliance Clearinghouse: a program that promotes home ownership and is based on the belief that non-traditional income streams and federal, state, and local subsidies can be structured to support homeownership for people historically excluded from the housing market. The National Clearinghouse has been maintained since 1998 through a website, toll-free information and referral line, and through electronic and regular mail.

Massachusetts Housing Finance Agency Elder CHOICE Program

(305 547-0418)

The Massachusetts Housing Finance Agency (MHFA) **Elder CHOICE** program helps developers build and operate housing for seniors who need assistance to live independently but do not need nursing home care. The program is unusual in that it provides assisted living services and reserves 20 percent of the units for low-income seniors who are Medicaid-eligible. The program has developed more than 700 units of housing with more planned, and won the Innovations in American Government Program Award from the Kennedy School of Government at Harvard University and the Ford Foundation in 1995.

To design and implement the program, and to speed project review, MHFA assembled a working group of specialists in areas such as design, housing management, service delivery, and local underwriting. The interdisciplinary group developed comprehensive, streamlined methods that have facilitated loan applications.

Financing for the **Elder CHOICE** program requires the creative use of multiple sources, including bond financing, equity for private developers, proceeds from the sale of Low-Income Housing Tax Credits, and other federal sources. Operating costs for the low-income units (which can run as high as $25,000 per unit including debt service) come from tenant rents in the market rate units, and the Group Adult Foster Care (GAFC) a Massachusetts Division of Medical Assistance Medicaid-funded nursing home diversion program that saves the state thousands of dollars per person per year. The GAFC contributes approximately $1,300 per month in operating income per resident to the project for services that include personal care, cooking, housekeeping, laundry and housekeeping, and transportation. Project staff also provide coordination for other community-based services, including primary health care.

Utility Credit Program-Washington (206 684-0500)

The **Utility Credit Program** started 25 years ago and provides substantial savings for low-income seniors and people with disabilities who receive City of Seattle utility services. Savings are on combined utilities (water, wastewater, and solid waste) and City Light electric bills. To be eligible, customers must be ages 65 and older, or under the age of 65 and disabled (disabled defined as receiving disability payments, visually impaired, or on a life support system.)

CARE ASSESSMENT

Assessing Care of Vulnerable Elders (ACOVE)-California (Dr. Neil S. Wenger, 310 794-2288)

The **ACOVE** project developed a comprehensive set of quality-assessment tools for ill older persons. Because “ill older persons” constitute a heterogeneous cohort that is not easily identified, **ACOVE** sought to identify high risk-community dwelling individuals and target the most important clinical conditions affecting them. The project goals were to develop a definition of “vulnerable elders,” identify important medical conditions affecting this group, develop a set of evidence-based, quality-of-care indicators relevant to vulnerable elders, and design tools to implement the quality-of-care indicator system. A set of 236 quality indicators covering 22 conditions was developed. Performance on the measures is used to assess the overall care delivered to vulnerable elders by a plan, a medical group, or health system, for specific conditions or domains such as prevention, diagnosis, and follow up, or within the context of larger groups.

SELF/CONSUMER DIRECTED CARE

Independent Choices-Arkansas (Kevin Mahoney, 617 552-4039)

This demonstration project began in 1998 and is an experiment in consumer-direction stemming from a national initiative formerly referred to as the "Cash and Counseling Model." The Cash and Counseling Demonstration was a policy-driven study of a consumer-directed approach to personal assistance services for elders and younger adults with disabilities. The "cash" portion of the project refers to the cash allowance each participant is offered to purchase and manage his/her personal assistance services. "Counseling" refers to services provided to participants to enable them to make informed decisions that work best for them, are consistent with their needs, and reflect individual circumstances. The Arkansas **Independent Choices** program is offering cash options to elders 65 and over and adults with disabilities age 18-64. Benefits from this program include increased consumer control, empowerment, and independence; for example the participants can hire and fire their assistants, and prioritize and spend money designated for care in the way they see fit. Through this consumer-directed model, a higher degree of cost-effectiveness and greater flexibility in service delivery is achieved by making available a broader range of service options and tailoring services to individual needs and preferences. The cash allowance is based on a personalized Cash Expenditure Plan developed by the participant, with advice and support from the Counseling/Fiscal Agency. Purchases enhancing the independence of the participant are considered an appropriate use of the fund and the cash expenditure plan has an average allowance of $350.00 per month. The cash expenditure plan may be disbursed among personal assistance services, other personal items, and a savings account.

Ask Me Project-Massachusetts (Christina Marchand, 410 571-9320)

Five years ago, the state of Massachusetts initiated a quality assurance project for disability services. A survey examining quality of life and quality of service variables was developed by people with developmental disabilities, for people with developmental disabilities, to be administered by people with developmental disabilities. Currently, every agency receiving state funding for a disability service is required to participate in the project. Approximately 1,000 people are interviewed each year. The survey can be adjusted and altered so as to be able to be successfully completed by people with all types of disabilities. People with developmental disabilities carry out the project, in all aspects, in every capacity.