DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
ASSISTED LIVING ADVISORY COUNCIL MEETING
DRAFT SUMMARY MINUTES
Date: January 17, 2019
Time: 10 AM
Meeting locations Videoconference to:

Division of Public and Behavioral Health
Bureau of Health Care Quality & Compliance
727 Fairview Drive, Suite E
Carson City, Nevada 89701

Division of Public and Behavioral Health
Bureau of Health Care Quality & Compliance
4220 South Maryland Parkway, Building D,
Suite 810
Las Vegas, Nevada 89119

Attendance:
Southern ALAC Members:
Linn Thome, Merrill Gardens, Co-Chair
Simona Cocea, Desert Springs Senior Living
Shawn McGivney, Tender Loving Care Senior Residence
Dora Valentin Tompkins, Angel Care Residential Home
Nicole Graham, Silver Sky at Deer Springs
Phil Glessner, Mimi's Care Home
Julie Peterson, Vintage Park

Northern ALAC Members:
Gina Stutchman, Co-Chair
Paul Bailey, Baileys Group Home
Margaret McConnell, BELTCA
Chris Mirando, RFA, Majestic Management of Pahrump, Inc.
Vangie Molino, Vista Adult Care
Diane Roberts, Washoe County
Patrick Ward, Five Star Senior Living
Jeanne Bishop Parise, Park Place Assisted Living

Ex Officio Member:
Robert Kidd, CEO, Perry Foundation

Others attending:
Annie Chapin, Aging and Disabilities Services Division ADSD
Helen Foley, Nevada Assisted Living Association (NALA)
Sandy Lampert, Executive Director, BELTCA
Nathan Orme, Health Care Quality and Compliance (HCQC)
Rolan Tejada, ADSD
Rebecca Tessa, ADSD
Darryl Fisher, NALA Board Member, Mission Senior Living
Alex Wampler, ADSD
Nenita Wasserman, HCQC
Jennifer Williams-Woods, ADSD

Excused: Margaret McConnell, BELTCA
Wendy Knorr, Atria Senior Living

Approval of minutes for the meeting of October 18, 2018. *Linn Thome Co-Chair*
PUBLIC COMMENT/FOR POSSIBLE ACTION
Jennifer Williams Woods – page 9 of minutes – she stated should read she's just as frustrated "as" providers (not "with" providers.)

SHAWN MCGIVNEY MOVED TO APPROVE MEETING MINUTES WITH RECOMMENDED CHANGES. THE MOTION WAS SECONDED BY JULIE PETERSON. MOTION PASSED UNANIMOUSLY.

Approval of new recorder or assignment to member(s) to add detail to the meeting minutes as requested by Shawn McGivney. ***Linn Thome Co-Chair***

Shawn McGivney suggested to improve record keeping that a position of recorder be appointed.

Shawn McGivney stated that it was discussed to assign a recorder to take notes to support and better correlate what was discussed in addition to Nenita's minutes.

GINA STUTCHMAN MADE A MOTION TO APPROVE THE POSITION OF RECORDER TO BE FILLED BY MEMBERS ON A ROTATING BASIS. SECONDED BY SHAWN MCGIVNEY. MOTION CARRIED UNANIMOUSLY.

Dora Valentin Tompkins volunteered with Jeanne Bishop Parise. They agreed to submit a draft Nenita Wasserman within 10 days of the meeting.

Shawn McGivney asked if there will be public time today to discuss items not listed on the agenda and was directed to the end of agenda under the item for public comments.

Make recommendation for renewal of two-year term as member of ALAC. Term expires January 2019. Linn Thomé, Merrill Gardens.

Linn Thomé stated that she is resigning as the Southern Chair but would like to remain a member.

SHAWN MCGIVNEY MOVED TO APPROVE LYNN THOME FOR AN ADDITIONAL TWO-YEAR TERM; HAVING SERVED WITH EXEMPLARY SERVICE. DIANA ROBERTS SECONDED THE MOTION. MOTION PASSED UNANIMOUSLY.

Nominate and Possible Election of new Co-chair for the North. (Gina Stutchman steps down as co-chair of North but remains a member.) ***Linn Thome'***

Gina Stutchman steps down after this meeting as Northern Chair but remains as member.

SHAWN MCGIVNEY MOVED FOR JEANNE BISHOP PARISE TO BE NORTHERN CHAIR. GINA STUTCHMAN SECONDED THE MOTION. MOTION PASSED UNANIMOUSLY.

Health Care Quality and Compliance update: ***Steve Gerleman, Pat Elkins, HCQC***
a) Status of the requested written response to NALAs letter which was included in the record from the October 2018 meeting

b) Status of plans regarding Paul Shubert's letter addressing SODs Scope and Severity after the expiration on 6/2019
c) Education and Information updates - *Nathan Orme, HCQC*
HCQC update:

Steve Gerleman turned this portion of the meeting over to Paul Shubert who stated that a response was sent to members, posted to Web Site and sent out on List Serv. Within his response he explained several different options available to facilities:

1. Physician's Placement Determination Form (included in response to the NALA response letter),
2. For a facility to apply and actually become an Alzheimer's facility and get the Alzheimer's certification (the $250 fee would be waived); and the last option
3: Find other placement for those residents who need that higher level of supervision. Brief overview of status given.

Questions from members:

Darryl Fischer asked what was the problem and what precipitated this? Are there dementia care issues surrounding diagnoses currently? Steve Gerleman responded yes, citations are being made regarding dementia residents being in inappropriate setting related to the regulations. The regulation indicates that if a person is suffering from dementia related to Alzheimer's they need to be in an Alzheimer's unit.

Darryl Fisher questioned if these were in a non-secured setting? Steve Gerleman stated again that these residents were in facilities that are not appropriate for the regulation; Darryl Fisher commented so not having issues with the care?

Shawn McGivney prefaced his comments with his credentials as having completed a Board Certified fellowship in Geriatric Medicine. There is a wide range of suffering associated with the Dementia Label for example HTN to Chronic Illness. He asked who is making the determination of suffering with the Dementia Label if not the physician? There is such a wide range of suffering. Who is making the determination of the alleged suffering. He said it is troubling to him and asked what has changed and when?

Linn Thome said that her concern that there a people who are seen by a doctor so they have very mild dementia but do not belong in a secured unit. She gave an example of someone who loses keys not diagnosed to people seen by doctor but are mild Dementia to those placed in Secure Unit. Since they want to keep people in the least restrictive environment, how are providers to make the determination, when doctors don't have or take the time to make the determination?

Darryl Fisher stated that here's where the rubber meets the road: His communities have 124 residents by diagnosis living with Dementia in Assisted Living outside of Secure Memory Care who will now need to be in ALZ Secure. They have never been cited. He asked is HCQC willing to change the definition?

Paul Shubert commented that so you have 124 residents who have a diagnosis of dementia outside of memory care and are not in a memory care unit. So what you are asking whether we are we open to changing the definition? If they are changing the definition of facility type, that is still regulatory,yes, that maybe something that needs to happen, to see this go through a rule-making

process and then find a process of assessment for facility type and processes. They need to find a solution that works. What they don't want to happen is they are not assessed and someone wanders and go in harm's way - then it's too late. That is where they go back to the physician.

Jennifer Williams Woods stated that she, Jennifer Cushman, and Elder Rights Attorney met with Paul Shubert yesterday to make sure that they all were on the same page. They met to get some clarification. When she first read the technical bulletin, she took it like the providers that anyone with diagnosis needed to be in secure unit. In having the meeting with Paul Shubert, he doesn't want anyone to have to move but to do the proper physician determination for placement, make sure that it's the most appropriate place. We just want to make sure they are secure in their settings. If not, then look at getting the Alzheimer's endorsement (as the fee is now waived) or find other placement and that providers to continue to monitor as Dementia advances, so that they are appropriate to stay through monitoring and assessment.

Darryl Fischer commented this is the normal process they go through.

Jennifer Williams Woods said that it is not much of a change. If there is a concern regarding the resident, then monitor. There should be a baseline assessment and if the patient starts changing they will have something to look at. It is just making sure you have that documentation in the patients charge.

Jennifer Williams Woods asked if an inspector goes in and witnesses some behavior, will the facility be cited or will they make suggestions to comply. Paul Shubert responded that the inspectors would make a citation, they do not make suggestions.

Jennifer Williams Woods said that if a resident has diagnosis, then get them assessed with a physician familiar with that person then monitoring behavior. If behaviors trigger, i.e. going by door, then reassess. Surveyors want to see all with a baseline assessment, and as things change, on-going assessments in files… as changes – encourage guardians to find better placement. So, yes, if you are doing this, no change, just make sure correct documentation is in the file.

Diane Roberts said if inspector witnesses a behavior who will decide? Will the facility be cited? Steve: Yes, we only cite.

Gina Stutchman said if there is a letter of communication in file with resident, meeting with family, appointment with doctor, etc., so effort IS in place to get to safety. But if those are in the records, then no citation. Is that correct?

Paul Shubert said so you have identified this person has dementia and you are moving towards an appropriate placement and you are talking to the family. If we are looking at a person who is going to be needing higher care, documentation, physician may say time to go or not.

Gina Stutchman said a provider is guided, the physician says yes or no… specialized doctor, may be hard to get those appointment…

Steve Gerleman commented that if the patient is at a facility for period of time then yes, cite. Other then discretion to occur… inspector calling supervisor when behavior is observed. Surveyors need to make decision on own in field. Every situation different – evaluate and make decision based on circumstance.

In response to an identified member who stated regulators are not trained as physicians; how can surveyors override a physician, Paul Shubert commented that HCQC trains their surveyors. Surveyors have tools, they ask questions from resident and staff and score that but they will not state who has what type of dementia. They rely on facility to get the physician involved to make a determination. He noted that every situation is different and a decision is based on the circumstances.

Shawn McGivney said he wanted to go back to the beginning and said that he did not believe that they got the facts correct. All patients who come in have a physician exam. The fact is that all patients start that way. If something changes, changes require time. There has to be a pattern, a surveyor cannot see a pattern by just seeing a person once. Nevada has a system in place that is the best in the nation. Already 100 percent required to have H&P and doctor gives certification on appropriateness of placement. Reassessment… change – requires time, there has to be a pattern of negative consequences found by surveyor. For example. An annual note is required, that's the system in place so the annual doctor exam shows continuing ability to stay/not stay. The physician says so, not the surveyor. It's the doctor who can be sued. The level of enforcement is what is changing and have no idea why. It can't just be determined that enforcement will increase – seniors have rights too. Does change in enforcement behavior violate the *Olmstead and Older Americans Act*. Until pattern of behavior of negative consequences affects person and community, then no problem. Seniors have rights and they have the right to make a choice. It's hard unless pattern exists to be violating rights and mandate removal.

Diana Roberts asked if there is a person in an assisted living environment and then this person has dementia but no behavioral issue and happens to have a UTI that's creating a behavior, not related to Dementia. The UTI may be treated, but then the facility just got cited on a one day review of the surveyor being in the facility it is not an ongoing problem.

Paul Shubert said that those situations happen all the time and it is unfortunate that the deficiency happened on the day the surveyor went but the citation would be made and expect the physician to get an assessment on that person.

Paul Shubert responded yes, then the provider can go to physician and can show documentation say of this UTI. He noted surveyors can't come back to see after UTI cleared. They will do what they need to do to protect the patient.

Steve Gerleman stated that this came forth from an elopement with harm. HCQC is trying to find a way to work with everyone. A lot of people are not getting the Alzheimer's training and not picking up on it because sometimes the pattern could be insidious and not recognize it.

Darryl Fischer said that he appreciated this, but if one looks at actuarial studies, elopements will happen again. No regulations guarantee that there will be no elopements. We want everyone to be safe and there is a process in place. The process is in place with Physician Order and Assessment, Care Plan and monitoring.

Gina Stutchman said HCQC received Attorney General confirmation that the diagnosis is sufficient evidence to determine placement. She commented how can AG make this statement if no incompetence has been determined? What did AG say about the rights of the person with the diagnosis if confined with no guardian?

Paul Shubert commented that most people think an Alzheimer's facility has to be a locked environment; it doesn't. He said that alarms and buzzers are okay.

Gina Stutchman commented that alarms and buzzers still restrict a patient from their ability to leave. She asked how does the industry get around the legality of confining someone by buzzers and alarms to not allowing someone to leave if they have a mild dementia diagnosis. She asked was the AG given both sides of the equation? Were they asked how does this combine with the rights of the patient? How does the other side of resident rights apply?

Paul Shubert said the question simply was what is the threshold to enforce the regulation?

Gina Stutchman commented that the rights of the people who are being surveyed was not addressed.

Shawn McGivney said that the Industry at the last ALAC meeting requested the public complaints/ the reports of the incidents that are trying to be addressed by new level of enforcement and still have not received that information. He requested copies of all complaint reports state-wide from the past three years be shared with the group. He said they need to look at the Independent Review Process or the Informal Dispute Resolution with the surveyors. If cited for something incorrectly what is the recourse for the facility.

Steve Gerleman stated that skilled nursing facilities (SNF) are required to self-report elopements. He said he would receive a call of a person who eloped from Henderson and our regulations at your level do not require locked. SNF and Advanced Medical. He said they are equating things that don't add up.

Shawn McGivney state that he did request copies of complaints and was told a motion for that cannot be made because it is not on the agenda but noted that Gina Stutchman did make that request at the December 5, 2018 meeting. She was told HCQC has final say on the agenda.

b) Status of plans regarding Paul Shubert's letter addressing SODs Scope and Severity after the expiration on 6/2019

Paul Shubert explained that HCQC is not assigning Scope and Severity – just listing to get facility to get doctor to assess and keep safe. He doesn't know if it will be extended out or will work with industry on changed regulations.

Shawn McGivney asked if HCQC would work with industry regarding the language on physician, patterns, etc. In response, Paul Shubert said he could not comment on that one way or another. He explained that approval comes from higher up or HCQC would be neutral. It also could be in regulations, not necessarily in laws. Safety is the common ground – how to get there.

Paul Shubert commented he can't speak to bdrs. All bills that they review are neutral. He would appreciate language that you are of the opinion would work for the industry for regulations to present to Board of Health then appropriate approvals and language.

Shawn McGivney asked if ALAC should contact the Attorney General's office with concern of overreaching on enforcement on federal rights laws.

Vangie Molino, also with AHONN asked if HCQC was relying on diagnosis only. She explained that they take care of 90 percent of their dementia residents on Medicaid Waiver. She stated if the patients have to be moved, where will they be placed.

Paul Shubert commented that if the majority of your population have dementia they could look at the second option and get the Alzheimer's Endorsement for a facility.

Vangie Molino said that most facilities are trying to get the Alzheimer's Endorsement but it is very expensive and not affordable. She commented that one AHONN member spent $20,000 to qualify for the endorsement and asked how do you get that money back. To make it, follow all the rules, 1 to 6, another person at night to be awake, and other expenses when Medicaid pays $1200-1800 Level 1 or 2, how can a facility survive?

Shawn McGivney stated another option, that Paul Shubert didn't mention is to give 30 day notice, and send the patient to the hospital.

Vangie Molino said the hospital refuses them, so referred the question back to Paul Shubert.

Shawn McGivney commented that if they can't pay, all you have to say is see you and call 911. He commented that is a legal action. He also referenced 30-day notice for process but again reiterated that if you can't provide that level of care you are obligated to send them to a safe place.

Helen Foley commented that this is a huge issue. There is not an adequate solution within the regulatory process. None of them are at risk of hurting themselves, or others. She commented that Steve Gerleman said that there was one elopement in the North which resulted in harm and suddenly this whole industry is being flipped upside down. She said they are talking about RFFG who have been working very well; they are not talking about CBLA. She noted that they have been talking for an hour and are nowhere near finding a solution. If the AG said that diagnosis is enough, yet, doesn't discuss early onset, vascular dementia, doctor watching, or family in place. All are at risk of being thrown out and incarcerated at the highest level of care. Then to have HCQC say they are not going to take a position and no certainty the Ombudsman will help, the assisted living facilities need a solution. NALA says to request a legislative response. Helen Foley emphasized that HCQC needs to find a solution.

Jennifer Williams Woods responded to Helen Foley and said she is looking at resident rights. She added that what Paul Shubert has not stated is that if you had a diagnosis of dementia, you have to leave the group home. If the physician states it is okay to remain in facility, then it is okay. So, if there are no issues, they can stay. On those bad days, that means if cited, you have to re-assess the patient. No one may have experienced harm – why do we wait until someone is killed? You are all correct – all should have procedures in place.

Daryll Fisher said that he agreed and said why would you ask the AG if you can make citation or require ALZ locked based on diagnosis alone if the above is true?

Jennifer Williams Woods explained the initial bulletin was a knee-jerk reaction but we have moved away from that. She said in reality, it is not changing so much, but are moving away from rash actions. She understands the provider's frustrations but HCQC is following what is the current process, assessments, small fraction of what to cover. She commented she can hear the passion.

Helen Foley asked why did bulletin come out?

Paul Shubert said he was of the opinion that the determination document is not required on all residents in all facilities. He said that perhaps a portion of you are providing the best case scenario, but HCQC does not always find the best case scenario.

Shawn McGivney said that HCQC should cite if they don't have the physician's determination, not because of the diagnosis.

Jeanne Bishop Parise said does the doctor's order for placement and history and physical, suffice and meet requirement?

Paul Shubert responded that behaviors observed will continue to make a difference and will still cite if behavior in between.

c) Education and Information updates - *Nathan Orme, HCQC*

Nathan Orme said he will work to better communicate with everyone on this topic. He asked everyone to make sure their email is up-to-date in the system and to also sign up for the listservs. He also reminded everyone to check their spam boxes. He explained that anyone can sign up for the listserv and if you are having problems doing so, just send him an email at nkorme@health.nv.gov and he will add you to the non-medical listserv. He created a shorter url for ease DPBH.nv.gov/assisted living which takes you straight to group home regulations, etc.

Nathan Orme stated that he is tracking bills of interest and tracking and can give an update at the next meeting. He added that you can go to Nevada State Legislature's web page – https://www.leg.state.nv.us/ and look on the right hand column and select NELIS: there you can track up to 10 bills for free, you will receive email updates on them.

Summary and update related to assisted living facilities from Board of Examiners Long Term Care Administrators (BELTCA*) Sandy Lambert, BELTCA ChairMember.*

Sandy Lambert, Chair of BELTCA together basically much more popular based on those states and how reciprocity can work. Licensees have to be approved through NABS. Nevada is the first state in country to issue license provided licensure by statute. Residential – number of beds administrators can be responsible for has changed slightly from 100 to 150 beds For administrators who have multiple facility is 150 beds. PDUs for renewal need to be and may have me spend more than 8 hours in one 24 hour period.

NAC 654.250 Limitations on administration of multiple facilities; required notification to Board; secondary administrator's license; fee; administrative fine for violation; surrender of license; waiver; disciplinary action. (NRS 654.110**,** 654.140**,** 654.190**)**

1. Except as otherwise provided in subsection 8, a person licensed as a nursing facility administrator or health services executive may not be the administrator of record of more than one nursing facility at the same time for more than 90 days in a calendar year.

2. If a person licensed as a nursing facility administrator or health services executive is the administrator of record of more than one nursing facility, the person must:

(a) Immediately notify the Board that he or she is the administrator of record of more than one nursing facility; and

(b) Obtain a secondary administrator's license for each additional nursing facility for which he or she is the administrator of record by paying a nonrefundable fee of $100 for each license.

 The Board may impose an administrative fine on a licensee for failure to comply with paragraph (a). The amount of such a fine will be at least $500 for a first violation and at least $1,000 for a second or subsequent violation, but will not exceed $10,000 for each violation.

3. Except as otherwise provided in subsections 4 and 8, a person licensed as an administrator of a residential facility for groups or health services executive who is the administrator of record for more than one facility may be an administrator of record for not more than 150 beds located in not more than five residential facilities for groups. For purposes of this subsection, multiple facilities located on the same campus are deemed to be a single facility.

Gina Stutchman requested that the link be sent to Nenita Wasserman so she could send it out to members where the language has changed.

Sandra Lampert of BELTCA commented the new Health Services Administrator License allows for continuum of care, more portability, reciprocity from state-to-state. Nevada is the first state to approve through Legislation. License #1 issued.

Jeanne Bishop Parise stated that she just passed her HCBS portion test. Sandy said that she will have License #2 then.

On Residential Facility side: A few changes have happened - restriction on number of beds has changed to no limit in one facility from 150 bed limit is no longer in place. For administrators that have multiple facilities, then maximum beds is 150 with no more than five locations.

CEU's: Maximum of 8 credit hours in a twenty-four hour period for online.

315 licenses were issued with 20 beds or less and 29 issued with 20 plus beds.
There are 287 licensed administrators currently.

Summary and update on items related to assisted living facilities. *State Long Term Care Ombudsman- Jennifer Williams-Woods*

Jennifer Williams Woods noted they have a caregiver conference coming up 2/7/2019 UNLV; 2/2019 Reno; she'll moderate, lively passionate conversation, keep in mind that we had a long conversation about the Alzheimer's topic. There will be 7 CEUs available in one day. Will have the Bureau there, so not to censor, but probably not the best environment to pose questions on Alzheimer endorsement.

In Las Vegas: 3/25 - 26/2019 – Positive Approach to Care – Train the Trainer in Vegas, looking for a location… looking someone to host, want near downtown; need a training space 1000 sqf. 7 a.m. to 5:30 p.m. for two days and 2-3 breakout rooms, providing meals would be nice, she's working with Robert Kidd, they may be able to help with food; she'll send via Nenita, they'll have to secure the location soon. Please help me find a location in the south.

Summary and update of new restrictions related to assisted living facilities from ADSD on the new restrictions. *Jennifer Frischmann ADSD and Crystal Wren, Chief of Community Based Care.*

This item was not discussed as it was inadvertently left on the agenda from the previous meeting.

Report on assisted living related programs at Perry Foundation. *Robert Kidd, President and CEO, Perry Foundation*
Robert Kidd, President and CEO, Perry Foundation. Their Expo is in the works for April 2019, traditionally offer ethics and regulations CEUs. Richard Whitley agreed to be a keynote speaker at June Endeavor Awards.

A member asked for an update on their Med Tech program, Robert Kidd said he is going back and forth with Medication Management of HCQC. There have been a major issues and this item is still pending. There was a big push for you to provide these classes. Robert Kidd explained that they submitted the application but now instructors are not certified even through they are registered nurses, they have to take the training as well.

Home Based and Community Waiver Information. *Anna Olsen-Figueroa, Social Services Manager, Home and Community Based Waiver Program*

Annie Chapin commented Anna Olsen Figueroa was not available so she was here today to fill in. There are five programs in the Community Based Waiver Program.

In December caseload: 2,266 people in waiver, 120 slots available for the program, there are many people on the wait list and cannot fill the vacancies all at once. There were 60 approvals for that program, average wait time is 187 days and 41 closures. There are 504 people on the wait list at this point. 61 percent have to wait over 90 days.

Vangie Molino said that when they see people come in, they cannot apply for the waiver until they are in Group Home. Vangie said it takes 90 days for them to be approved so who will be paying them.

Annie Chapin said they can start the process before but Welfare won't approve until they are in the group home.

Vangie Molino said that they do not make a lot of money on these clients.

Jeanne Bishop Parise commented for SNF's person can be community eligible for Medicaid and then Welfare switch to Institution eligible on day of admission. Could that be done for assisted living.

Annie Chapin said that is a DWSS process.

Gina Stutchman suggested to invite Welfare to be on the next agenda. Jennifer Williams Woods recommended to invite a supervisor, someone who could answer and could bring back.

Helen Foley commented this shows how broken the system is. The state should fix this issue. It falls on poor group homes.

Shawn McGivney said all licensed GH and PCA that don't get the 100 million goes to CBLA part of that is overlapping. Annual renewals, in nursing homes have to renew it. There are many reasons to look into adjusting it.

Discuss and make recommendations of topics for Administrator to take the State Board of Health.

Shawn McGivney noted that the Nevada Assisted Living Association (NALA) did take many concerns regarding CBLA regulations to the State Health Board.

Assisted Living Industry updates.
• Discussion on current trends.
• Regulatory Issues/Concerns from Provider Perspective

There were no updates under this item.

Meeting dates for 2019 at 10 a.m.: April18; July 18; October 17

Public Comment (No action may be taken on a matter raised under this item of the agenda until the matter itself has been specifically included on an agenda as an item upon which action will be taken.)

Shawn McGivney read and handed in his prepared public comment for the record. He verified that HCQC is actively involved with CBLA and HCQC is assigning staff to CBLA industry.

Shawn McGivney expressed that he is concerned that the move in supervising CBLA even partially, from DRC to HCQC sets up a new conflict of interest for HCQC. That is also suggested in the hospital discharge bulletin and again in their response.

Paul Shubert interjected they came from Southern Nevada Adult Mental Health SNAMHS and Northern Nevada Adult Mental Health Services, not from DRC.

Shawn McGivney stated that when HCQC says in their response that may or may not have similar standard we all know Unlicensed, state certified, CBLA now offer a clear second standard of care for the same non-medical care needs of protective supervision, medication management and individuated personal care compared to the higher, safer, standards in licensed NRS 449 RFFG care.

Shawn McGivney remarked that he found it very misleading to focus on "behavioral health treatments" as the sole or main factor when that is provided in ALL facility types as BST / PST. If the general caregivers in CBLA are providing BST / PST "behavioral health treatments" and only that what training do they have? In fact, we believe CBLA is paid an hourly rate for supervision and caregiving at $15 and $19 per hour respectively.

Shawn McGivney went on to say BST also is paid IN ALL Settings licensed and unlicensed at $37 per hour.

Paul Shubert stated that he cannot comment on what they are paid.

Shawn McGivney stated that if CBLA is not doing "supervision" nor caregiving why are they paid hourly for those? If CBLA is paid an hourly rate for supervision and caregiving why are they paid hourly for those services? If CBLA is paid an hourly rate for supervision and caregiving and BST / PST how is the medication management paid for? In licensed care it is included in the flat rate billing. It would be helpful to ALAC members for transparency to know both what services are provided and how they are paid in CBLA so the consumers and professionals who have to explain the differences to their residents can offer an informed choice. Also, it seems fair to provide those details to allow RFFG who want to switch to CBLA to know who they are and rates are different.

Shawn McGivney stated he wonders how HCQC as a mandatory reporter is handling this conflict when there are two standards of care for the same care needs and the continued negative string of outcomes for the relatively under-served group of disabled people in CBLA when a safer more complete, licensed care choice exists in licensed care? Only licensed offers safety of nonmedical services.

Shawn McGivney noted that both offer independence, dignity, freedom, to come and go but only licensed care offers the care and safety that is promised in both as non-medical care including supervision, medication management and caregivers when needed. Indeed, if you only need freedom to come and go you are independent and transitional living. You do not need help with medications or personal care. But if you need those you seem to need the higher standards in licensed care that practically offer those services.

Shawn McGivney commented that denying that continues to put those placed in the lower level of Unlicensed CBLA care at unnecessary risk. That is most troubling when there exists a proven safe, licensed, choice.

Shawn McGivney remarked that the response sent to this board seems to confirm continued confusion or reluctance to clearly describe the difference in non-medical services by HCQC on how or if the two regulatory systems of care are indeed different for the same non-medical care needs of supervision, medication management and caregiving. If the disabled mentally ill residents in CBLA do not need supervision, nor medication management nor caregiving help why are they paid hourly for those specific services?

He goes on to say that he does believe mental illness is expected to vary. When a mental illness varies it is critical to have the supervision necessary to evaluate the need for "as needed" medications and then have the structured system to administer them. He believes not having supervision like that in licensed care is a large part for re admissions and negative outcomes that have increasingly been seen in unlicensed, state certified SLA which as of 7/2017 is called CBLA.

Shawn McGivney stated that perhaps HCQC can respond in writing to clarify the two clear overlapping standards of care in Medication management in unlicensed CBLA and Licensed RFFG including how you can reasonably give as needed "PRN" medications in CBLA without 24 hour Supervision? The hospital bulletin says if you need supervision you need licensed care but then later in the same sentence says you can get medication management implying it does not require 24-hour supervision. How can any individual know in advance when the "as needed" will be needed? Clearly HCQC must know the difference in simply filling a pill box which is offered in licensed home health care and does not require 24-hour supervision and the standard of medication management that requires supervision. Help us clarify in the hospital discharge

bulletin or in general and in your response how HCQC can imply in any way that CBLA is offering medication management implying it is similar to that in supervised, licensed care? If the hospital bulletin meant to say you can only get a pill box filled by a licensed home health care agency in CBLA then it would be clearer to say that. Using the same term "medication management' in both unlicensed and licensed care seems misleading and seems to continue to pose unnecessary risk of negative outcomes and re admissions for those with mental illness who need the supervision and as needed medications.

Paul Shubert stated HCQC will generate a response. He said that they do not engage in the reimbursement with those facilities. He said that SNAMHs and NNAMHs can address how they pay.

Amir Bringard stated the difference insofar that CBLA can have counselors coming in – behavioral health and case worker in home i.e. Mojave Health – CBLA Transitions into community.

Shawn McGivney commented that BST used in all setting, licensed and unlicensed. That's my quandary. CBLAs don't have to have 24-hour care – most can live with mental health diagnosis. Treatment plan documenting service plans.

Amir Bringard commented that some CBLA's do have 24-hour care and can provide 24-hour care. Client goes to job in community.

Shawn McGivney stated that if they are paying for protective supervision and individualized personal care, that's what licensed providers provide.

Jeanne Bishop Parise wanted to know with regards to AB46 definitions the Fire Safety Evacuation assessment and Transitional Stay assessment with regards to Average Daily Census and Average Lengths of Stay information could be used to extrapolate.

Jeanne Bishop Parise asked about how long transitional stay was?

Paul Shubert said he did not know of any specific time frame.

It was suggested to Shawn McGivney to submit his list of questions to HCQC.

Adjournment.

There was a motion and a second to adjourn the meeting. Motion passed unanimously.

The meeting adjourned at approximately 12:06 p.m.