NEVADA LEGISLATURE
JOINT INTERIM STANDING COMMITTEE ON COMMERCE AND LABOR

(*Nevada Revised Statutes* [NRS] 218E.320)

MINUTES

April 4, 2024

The third meeting of the Joint Interim Standing Committee on Commerce and Labor for the 2023–2024 Interim was held on Thursday, April 4, 2024, 9:30 a.m. in Room 4401, Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. The meeting was videoconferenced to Room 3138, Legislative Building, 401 South Carson Street, Carson City, Nevada.

The agenda, minutes, meeting materials, and audio or video recording of the meeting are available on the Committee's meeting page. The audio or video recording may also be found at https://www.leg.state.nv.us/Video/. Copies of the audio or video record can be obtained through the Publications Office of the Legislative Counsel Bureau (LCB) (publications@lcb.state.nv.us or 775/684-6835).

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:

Senator Pat Spearman, Chair
Assemblywoman Elaine Marzola, Vice Chair
Assemblywoman Shea Backus
Assemblywoman Heidi Kasama
Assemblywoman Selena Torres

COMMITTEE MEMBER PRESENT IN CARSON CITY:

Assemblyman Philip P.K. O'Neill

COMMITTEE MEMBERS ABSENT:

Senator Roberta Lange (excused)
Senator Jeff Stone (absent)

LEGISLATIVE COUNSEL BUREAU STAFF PRESENT:

Cesar Melgarejo, Principal Policy Analyst, Research Division
Davis H. Florence, Senior Policy Analyst, Research Division
Bonnie Borda Hoffecker, Research Policy Assistant, Research Division
Sam Quast, Senior Principal Deputy Legislative Counsel, Legal Division
Joe Steigmeyer, Senior Deputy Legislative Counsel, Legal Division

Items taken out of sequence during the meeting have been placed in agenda order.
[Indicate a summary of comments.]

AGENDA ITEM I—OPENING REMARKS

Chair Spearman:

Good morning everyone, and welcome to this third agenda of the Joint Interim Standing Committee on Commerce and Labor. Before we begin, I would like to go over a couple of housekeeping items. The first one is, that it is a rather somber day—this is the 56th anniversary of the assassination of the Reverend Dr. Martin Luther King, Jr.; April 4, 1968. It was a very sad day in the history of our country because it was an assassination that was based on race and dialogues around that. In light of the challenges we face today, I would like to start with a moment of silence in honor of the work that not only Dr. King did, but all those who are still fighting for justice, equity, and equality.

[Chair Spearman reviewed meeting and testimony guidelines.]

AGENDA ITEM II—PUBLIC COMMENT

Chair Spearman:

We will start with public comment from those in the physical locations, and then move to public comment from anyone who has called in. Is there anyone here in Las Vegas who wishes to make a public comment at this time? I do not see anyone. Is there anyone in Carson City? Broadcasting, anyone on the line?

Broadcast and Production Services (BPS):

Thank you, Chair, the public line is open and working. However, there are no callers at this time.

Chair Spearman:

We will give it a couple of minutes. There will be another public comment period at the end of the meeting and remember, you can also submit a written statement which will be added to the record. Please submit your written statements no later than 48 hours after the meeting.

AGENDA ITEM III—APPROVAL OF THE MINUTES FOR THE MEETING ON FEBRUARY 29, 2024

Let us move on to approval of the minutes. Members of the Committee, are there any questions regarding the last meeting's minutes? If there are none, I will accept a motion to approve the minutes.

> VICE CHAIR MARZOLA MOVED TO APPROVE THE MINUTES OF THE MEETING HELD ON FEBRUARY 29, 2024.
>
> ASSEMBLYWOMAN KASAMA SECONDED THE MOTION.
>
> THE MOTION PASSED UNANIMOUSLY.

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AGENDA ITEM IV—PRESENTATION ON NATIONAL TRENDS IN OCCUPATIONAL LICENSING POLICY

Chair Spearman:

We will move to the presentation on national trends and occupational licensing policy. The focus of our meeting on occupational and professional licensing is one we have taken up for the last six or seven years, and it started primarily being something that would be available for military spouses. During the Coronavirus Disease of 2019 (COVID-19), it became a practical way to make sure medical resources were in the right place at the right time.

The Council of State Governments (CSG) will provide an overview of the trends and what safeguards there are for the consumers and needs of workers and businesses.

Matt Shafer, Deputy Program Director, National Center for Interstate Compacts, CSG:

It is a pleasure to be with you this morning talking about this very important topic. A little about CSG, if you have never heard of us before, we were founded in 1933. We are a nonpartisan membership association for elected and appointed state government officials.

You may be familiar with our Western office, which is based out of Sacramento. We are a policy organization that champions excellence in state government through sharing best practices and research. One program at CSG is the National Center for Interstate Compacts. This Compact Center is a technical assistance provider for the creation, enactment, and administration of interstate compacts. We are the only group which is providing technical assistance on interstate compacts. We do have expertise in this particular policy area.

Today, we are talking about trends in occupational licensing. I am going to focus on mobility and our expertise is in interstate compacts (Agenda Item IV). I will talk about a couple of other things that states are doing to address this mobility concern. Interstate compact means a contract between states. These compacts are legally binding amongst the states that enact them and they are also legislatively enacted. They are a creature of the state Legislature, which is the entity that is essentially signing your state up to participate in this legally binding agreement between states. Compacts have been used for centuries for several different reasons.

One example, is the driver's license. Rather than the federal government getting involved in driver's licenses, the states created the driver's license compact, which allows drivers to hold one license issued by the state and drive anywhere across the country. This is done through the driver's license compact. These occupational licensing compacts operate in a similar manner where the principle is one state-issued license, and the licensee can practice in all other states that are a part of the compact.

Over the past decade at CSG, we have seen an explosion of interest in states using compacts to solve issues around portability. The primary purpose is to facilitate multistate practice, allowing a practitioner to be able to practice in multiple states without having to navigate each state's state-specific licensure process. The analogy of the driver's license applies here; they maintain one state-issued license, and they can work in any state that is a part of the compact.

Compacts help maintain or, in some instances, improve public health and safety. This is largely due to the amount of information sharing that occurs amongst the member states.

Sharing things such as current investigations, final board action, and regulatory action against the licensee are all shared amongst the member states, which raises the bar in terms of regulation. It provides licensing boards with more information than they currently have access to.

The last point here is the preservation of state authority over professional licensing. It is not a takeover of any licensure pathways that currently exist in Nevada. They can have alternative pathways to practice; there are Nevada state-specific licensure pathways. The compact is an additional pathway to allow practitioners to be mobile or work in multiple states. The other thing to emphasize is these compacts never touch the scope of practice. Nevada continues to define for itself a state-specific scope of practice. That means under the Practice Act to perform certain procedures or have a certain scope. Nevada continues to define for itself what practitioners are allowed to do when they are in the State of Nevada.

It is a very important point to make—we are creating an alternative pathway to practice. While practitioners are in that state, they have to abide by the scope that the state has dictated. These compacts have been popular in recent years. We have 16 professional licensing compacts and over 300 pieces of legislation enacted in the past 8 years. There is a list of all of the active interstate compacts—nursing, medicine, and psychology lead the way. They are the oldest and the most mature compacts, and they have been around for about a decade. Physical therapy (PT) is close behind. The Compacts on the right side of your screen have lower membership because they are newer. The majority of them were created through a cooperative agreement with the Department of Defense (DOD) to create new licensure compacts to help military spouses. These compacts are relatively new, they have only been out to the Legislature for one legislative cycle. Typically, Compacts tend to take two to four years before they get a good number of states on board.

There is an overview of the state's membership in these licensure compacts. Nevada has enacted five compacts for Emergency Medical Services (EMS), massage therapy, medicine, psychology, and teaching. The Midwest and Southern states are particularly friendly to these compacts, but almost all states have adopted the compacts at this point.

I am not going to go through it point by point, but the purpose of this slide is to display our compact development process. It is not a situation where CSG goes into a room and writes a compact on behalf of the profession. It is a broad and inclusive process that includes stakeholders from these professions and the public at large. We have a broader stakeholder group that creates a framework for the compact. We convene legislative drafters to put pen to paper. We have a lengthy public comment period where the compact language can be reviewed, and we are receiving public comments about the provisions in the compact. We want as much input on the front end as possible since these are contracts. They cannot be changed substantively after they are finalized. We want as much input and inclusive dialogue as possible on the front end to avoid a situation where we have to change the compact after it is already finalized.

The second phase is when the compact moves to the legislative component. The CSG is available to provide education on all of the compacts. We do not actively advocate or lobby for compacts, but we are available as an educational resource as they are considered. Lastly, we transition to the governance of the compact, the implementation, and ongoing administration.

Let us talk about the benefits. The primary benefit is increased mobility. Practitioners are no longer bound to practice only where they hold a license. They can practice in other compact member states that have enacted the legislation. Telepractice is a driver of the prevalence

of these compacts. Think about some of the behavioral health professions that are looking at the compacts—professional counseling, psychology, and social work—high utilization of telepractice. The compact alleviates a lot of burdens associated with telepractice where you may need to be licensed in 20 or 30 states at one time if you are seeing clients from all over the country. The DOD is on the agenda for today, and they will speak more to this point about how compacts support military families. The DOD does say compacts are the best long-term solution for their military spouses in terms of reducing barriers to licensure for that population.

As benefits to boards, compacts create an agreement on uniform licensure requirements. In the compact language, it lists uniform standards all the states are agreeing to. Notice from the list of compacts provided on the previous slide, a lot of health care professions are looking at these, and it lends itself to the point that compacts thrive on uniformity. Where we see the most significant amount of uniformity across states in terms of their requirements is in health care professions. What it takes to be an occupational therapist in one state is standard across all the states. That is why there is a high uptake with health care professions looking at compacts.

A shared data system—the compact, through the implementation process, creates a shared data system all the states have access to, including sharing information such as investigative information; board disciplinary information, and licenses. All are shared in the data system. Boards that are a part of the compact are getting real-time updates about disciplinary issues happening across state lines. Lastly, increasing access to highly qualified practitioners. States like these compacts as a workforce development tool. We hear about workforce shortages, particularly in health care professions, and compacts are a way states can strengthen their health care workforce. We are certainly not saying compacts are a silver bullet or something that will solve all of the state shortages, but it is a policy option to explore when trying to alleviate burdens associated with health care workforce shortages.

As additional considerations, we at CSG are not saying compacts are a good fit for every state because there are a number of things to consider in terms of whether the profession is a good fit for a compact. They do take a significant number of resources to develop, create the language, go through the legislative process, and stand up in front of the commission; which is a governing agency that implements and administers the compact. That is a lot of resources that smaller professions may not have access to the type of resources to develop a large compact.

The size of the profession is also important to note. If it is a smaller profession, maybe a good percentage of the practitioners are located in one particular state. Then a compact may not be a good fit. We look for larger professions that are spread across all states in terms of where the practice is applied. Time constraints for the compact; it is a long process. We say it is three to five years from start to finish to develop a compact and get it operational. A lot of times states have emergent needs around the workforce. A compact for a specific profession where there is an emergent need for a workforce is not the best solution because of the time constraints involved in development. It does require legislative enactment, which comes with its own barriers in terms of navigating each state's political process and the legislative environment.

Lastly, concerns around differences in standards are the most significant issue we hear when states are considering compacts. States ask whether the standards match the standards of the other states that are a part of the compact. This addresses the point where health care tends to gravitate towards compacts because the standards are uniform across

states. When you are looking at other professions where there is not that uniformity, one state might have a higher standard or a lower standard that makes compacts difficult.

Not all compacts are the same. You cannot take a PT compact and sub an occupational therapist for the word physical therapist. Compacts are created to fit the specific needs of each individual profession. The nursing compact may be familiar, but it is unique to itself and each compact is specific and uniquely tailored to fit the needs of the profession. They have the same general principle in terms of how they facilitate cross-state practice, but there are specific nuances to each of these that are important to understand when you are considering each individual compact. That is an overview of interstate compacts.

I also want to talk about another big trend we have seen at CSG, which is the proliferation of universal recognition policy. Universal recognition essentially means if you have a license in good standing from another state, we will issue you our equivalent license if you move to our state. As of last year, 20 states including Nevada have enacted universal recognition, and a number of neighboring states around Nevada have considered universal recognition as well. There are unique features to these universal recognition policies. Some states have a residency requirement to physically relocate to use this policy and have an address in that new state.

A lot of these bills have a substantial equivalency requirement whereby the standards from the state where you are moving from have to be deemed substantially similar to the standards that are in Nevada. If you are moving from a state with a significantly lower standard, then you might not be able to utilize that specific policy. Same thing with the scope of practice; some states have in the bill itself that the scope of practice has to be similar. We see that when states have differences in terms of scope of practice. States want to make sure the scope is similar across states.

Some states include a recognition of experience in lieu of licensure. You are not actually required to actively hold a license from another state. They do say if you have been practicing three out of the last five years, for example, then you can utilize this policy in our state.

I want to talk about the differences between universal recognition and compacts. That is a question states ask. If the state does universal recognition, why is this compact needed? The key distinction is universal recognition is making it easier for out-of-state practitioners to work in Nevada when they move to Nevada. Universal recognition does not provide mobility benefits for current Nevada residents to work in other states. If you are a Nevada social worker and you want to telepractice in another state, universal recognition does not help you because it is only for people moving into Nevada. It is not a two-directional form of reciprocity which, compared to compacts, there is that bidirectional mobility. You are making it easier for people to move into Nevada, and also making it easier for Nevada residents to work in other states, either temporarily or through telepractice. The compact creates the shared data system, assists with telepractice, and allows for practicing in multiple states without having to apply to each individual state to work in that state. I would be happy to take any questions from the Committee, and thank you again for the opportunity.

Chair Spearman:

Committee Members, any questions?

Assemblywoman Kasama:

I am curious about the trend because it seems throughout the United States, we are individually creating compacts for different professions. Is there a trend to have one overarching license or compact that says if you are in good standing for any of these areas—has any state looked at it—and perhaps that is Arizona—for any licensed occupations, if you are in good standing, we are going to quickly give a blanket license to you for any of them? It seems we are hodgepodging individual occupations.

Mr. Shafer:

That is the purpose of universal recognition. If you have a license in another state that is in good standing, we will issue you our equivalent license when you move here or practice here. That is the purpose of universal recognition. In terms of compacts, they are tailored to specifically meet the needs of each profession. We may see states bundling compacts together into an omnibus bill or something similar. However, compacts are typically created for each profession because of the specific needs associated with that profession. If you have a profession like psychology, that compact is exclusive to telepractice. That might not be an apples-to-apples comparison for dentistry, where dentistry is hands-on, and there is not a lot of telepractice dentistry going on. That is why each compact is created specifically for the needs of that profession.

Assemblywoman Kasama:

For me to understand clearly, I am looking at the universal license recognition. I am looking at Arizona; since they are a neighboring state. That is a blanket for everything. That could be a hygienist, psychologist, or PT. They are saying all occupations. Is that correct?

Mr. Shafer:

Yes. Sometimes there are exemptions for particular professions. I think attorneys are typically exempt from universal recognition. Sometimes, medical doctors will also be exempt. Typically, the universal recognition will be specific to a title within the state statute—maybe the title that regulates health professions or the title related to other general occupations. What we typically see for universal recognition is its specific to a title or a chapter within the state statute, but often there are exemptions.

Assemblywoman Kasama:

Is there a trend across the states? Do you see upcoming legislation, or have you had requests from various states? Is there a trend to do more universal or individual compacts?

Mr. Shafer:

I would say they are both being thoroughly discussed at the moment. I think, because of the number of interstate compacts—there are 17 that currently exist—we see a lot more compact bills because of how many professions there are. At this point, I would have to go back and look at our research for the 2024 Legislative Session, but almost half of the states have done universal recognition at this point. There are a significant number of states considering both.

Chair Spearman:

Assemblyman O'Neill.

Assemblyman O'Neill:

I was curious about that overarching recognition. If you have a license to practice a certain profession and under the universal recognition you come to Nevada, do you still have to apply for a license here before you can practice or can you start practicing immediately while your license is being processed by whatever the controlling board is? Could you clarify that for me, please?

Mr. Shafer:

Under universal recognition, they would have to apply to the board because of that substantially similar requirement. The board of jurisdiction would have to determine that the applicant coming to Nevada has the requirements satisfied to get the license in another state that is substantially similar to Nevada. It is not the case that they would be able to start working immediately. That is another slight difference from compacts. If Nevada is in a nursing compact with Utah, for example, a Utah nurse could come and work in Nevada immediately without any kind of extra application process.

Assemblyman O'Neill:

That nurse under the universal recognition could not practice in Nevada until the nursing board approved and licensed her; and that could take days and/or months. Is that correct? But they would not have to go through testing again or their basic licensing testing. It is that recognition and approval of their Utah license.

Mr. Shafer:

Yes, that is correct. Universal recognition is trying to avoid having licensees need to go back to school and get additional education or retest. The board of jurisdiction still has to review an application and make a determination whether the requirements are substantially similar.

Assemblyman O'Neill:

Can I ask one more question, Chair?

Chair Spearman:

Yes.

Assemblyman O'Neill:

I appreciate the work you have done here on this presentation. I am a strong supporter of compacts and universal recognition if we could get people and expedite their licensing. You talked about the positives. Do you know of any negatives to a state joining the various compacts that have occurred?

Mr. Shafer:

I have a list of things that I went through in terms of whether or not a profession is a good fit for a compact. One of the things I talked about is perceptions around differences and standards. By joining a compact, states are accepting the fact that another state has legitimately licensed that person, regardless of the requirements they satisfied to get that license. If there are perceptions that Nevada has a higher standard for a particular

profession, that might be something Nevada would consider. Would we want to enter into this compact where a licensee has not met our State-specific standards? The State would be relinquishing the right to be able to pick and choose who they want to practice in Nevada. By joining the compact, that State is saying if this person has a license from another state and meets all the requirements set out in the compact—those standard uniform licensure requirements—then they can practice in Nevada. It is not necessarily a bad thing, but it is something for the Legislature to consider.

Assemblyman O'Neill:

Has any state joined a compact and then withdrawn from it because of some reason or an issue along those lines that you know of?

Mr. Shafer:

I mentioned there have been 312 compact bills enacted. There has only been one time that the compact has been repealed and the state has removed themselves from participating. That is the emergency medical services (EMS) compact in New Hampshire. They had issues with their Firefighters Union in New Hampshire, but that was the only instance so far where a state has withdrawn.

Assemblyman O'Neill:

They withdrew due to a Union demand, not an incident where somebody came and was not appropriately educated or misrepresented themselves.

Mr. Shafer:

That is correct. I do not have all the details to give you a firm answer as to why exactly they withdrew from the compact. I do not believe it was because of an unqualified practitioner who harmed someone. I know that is not the case.

Assemblyman O'Neill:

Very good. I appreciate the information. Thank you for allowing me the questions, Chair.

Chair Spearman:

Does anyone else have questions? I have a couple, and I want to pick up where Assemblyman O'Neill left off. You said in New Hampshire there were conflicting ideas about compacts and unions. How do compacts affect collective bargaining agreements (CBAs)?

Mr. Shafer:

From our experience, the compact that has the most involvement from a union standpoint is nursing. The argument you would hear from the nursing unions is that the compact would inhibit their ability to strike because states would be able to pull nurses from another state to fill those jobs when they are on strike. That is the argument you would hear from the nursing union. We have seen no evidence to support that notion. I do not have any more information to share. We have never seen that play out. The nursing compact has 41 member states, and we have not seen that in any circumstance.

Chair Spearman:

I have heard that argument from our nurses. One of the things they are concerned with is that nothing in the compact prohibits a medical facility from calling someone in if they strike. Are there any states that are working on legislation that would protect those units? If that is the only reason the compact will not work, are any states working on some type of legislation that would provide them the necessary protection so they would be able to feel comfortable supporting a compact?

Mr. Shafer:

I am not aware of any. I can reach out to our colleagues who staff the nursing compact and see whether they are aware of anything. I am not aware of anything at this time.

Chair Spearman:

Nevada is a graying state. By 2042, the majority of our population will be over the age of 55. That means there will be a lot more specialists who would need to be here. Are we looking at how the compacts could alleviate the burden in Nevada? We do not have a lot of specialists. Are there any states that are looking at using existing compacts to provide services for other members of that particular compact entity when they need someone?

Mr. Shafer:

I think the more states that join these compacts, the more mobility you will see across state lines and the bigger the impact on the workforce. These compacts are in their infancy in terms of being able to point to a specific workforce impact. There is only one peer-reviewed study that has been done on compacts—the Interstate Medical Licensure Compact. They did find a positive correlation between the number of service providers in the state and being a member of the compact. It was about a 5 percent increase in physician practice locations compared to states that were not in the compact. I think more will be coming out on that point in the future as these compacts get older and more mature, and more states start joining them. At this point, the list that I shared of all the compacts, only about half of them are currently operating. It is still early on in this process to be able to point to a specific workforce impact that these are having at the moment.

Chair Spearman:

Thank you. Not to put more on your plate, but that might be a good research project. A lot more people are moving west because of the weather. A lot more people are moving into Nevada because of the weather, and it allows their retirement checks to go further. We have a dearth of some specialties, and later we will be talking about brain health. We do not have as many people here that deal with that. The other one would be chiropractic. As populations shift, how can we incorporate what is happening with compacts so states are prepared for the onslaught?

Mr. Shafer:

It is certainly something we could look into. As I was saying during the presentation, these things are usually tailored to specific professions. Getting into specialties is not typically something the compacts have looked at. We are typically designed broadly for a large profession. That is certainly something that we can look into in the future.

Chair Spearman:

I am looking specifically at maternal health and the mortality rate among black women. If you have a state where the black and brown population is increasing, we already know that women in those communities are more likely to die in childbirth than those who are of European descent. If that level of granularity is impossible, I understand, but I am trying to think, about how can we use what you are doing and how the compacts might be able to help states look ahead and see what they need in the future. Not only 20 years from now, but some states are struggling because they do not have specialists right now.

Mr. Shafer:

That is one benefit of these compacts. If there is a specific specialty that you need, you would be able to look across the country and be able to attract those providers to work in your State if there is a particular need. An example is social work. A lot of times social workers deal with specific populations and have specific specialties. If I am a patient in need of social work services, under the compact I can survey social workers from across the country and pick one maybe that fits the best needs for me in my particular circumstance rather than being limited to somebody who is licensed in the state where I live. It is opening up opportunities for more of that type of specialized care.

Chair Spearman:

Thank you. Assemblyman O'Neill.

Assemblyman O'Neill:

I have a question on universal recognition. If I have the license and I come to Nevada, I cannot start practicing until I get licensed in Nevada. Correct?

Mr. Shafer:

Yes.

Assemblyman O'Neill:

With using the driver's licensing compact—a recognition that we have—I have moved from Florida to Nevada; I can drive on my Florida driver's license for a period of time until I get my Nevada license. Do you know of any states under the universal recognition that will allow the profession to practice—maybe if they put in a regulation that they have been practicing for five years or whatever—while their license is being reviewed here in Nevada? Could they work immediately in the field of social work, nursing, or dental hygienist, particularly under DOD, when they move? I know it takes some of the licensing agencies in Nevada six months or longer to review and issue licenses, and that is considered a short turnaround. Do any states allow that recognition while they are being processed?

Mr. Shafer:

I am not aware of any. I believe they are required to go through the application process and there is not the ability to practice immediately while their application is pending. We can dig into the bills and confirm that for you, but off the top of my head, I am not aware of any.

Assemblyman O'Neill:

Would you please deliver it back to the Chair, and she will disperse it to the Committee as a whole? I am interested in that because it is important. Chair and I agree that DOD support to get people working so as not to have to wait an exorbitant amount of time for their licensing to be issued. That is why I was comparing it to the driver's license.

Chair Spearman:

Committee Members any additional questions or comments? We appreciate the information. If you could do me a favor, and it is not something that I need next week, but if you could look around and see if there is any way to expand the trends so we can look at where the needs are. If there is a deficit and a surplus someplace else, maybe we can look at that and use compacts to alleviate that problem.

Mr. Shafer:

Yes, absolutely.

AGENDA ITEM V—PRESENTATION ON BARRIERS TO EMPLOYMENT FACED BY VETERANS, MILITARY PERSONNEL, AND THEIR SPOUSES

Chair Spearman:

We will go to the presentation on barriers to employment faced by veterans, military personnel, and their spouses. For those of you who do not know Kelli, you would think that she has five or six people working with her. She covers the Western Region, and does a heck of a job making sure we have the information necessary to support our military, their families, and their work while they support our country.

Kelli May Douglas, Pacific Southwest Regional Liaison, Defense-State Liaison Office, U.S. Department of Defense:

Our office is charged with working with all 50 state and territory policymakers on policies that we believe could and would make a significant difference in improving the quality of life for military families as they move in and out of states (Agenda Item V A). Understanding that many of the issues military families face are those that are under the purview of the states, we like to work together to see if we can find solutions. Our office has worked on issues around a variety of topics. More recently, the focus has been on easing barriers to employment for military spouses to include licensure. We are focused on improving the quality of education for military children as they move from state to state, consumer protections for veterans, voting protections for active-duty members who are overseas, and other various policies.

The reason why we are working on these issues and why the DOD is focusing on families and quality of life is because it has been recently reiterated by the Secretary of Defense and the Administration that taking care of families is at the core of ensuring national security. You can see the quotes here from the Secretary of Defense. "The Department of Defense has a sacred obligation to take care of our service members and families. Doing so is a national security imperative. Our military families provide the strong foundation for our force, and we owe them our full support." Dr. Jill Biden, leads an effort called Joining Forces, which is an initiative that has spanned across two administrations starting with the Obama Administration, supports military families in a variety of ways. It includes a focus on spouse, employment, economic security, and education for children. She said, "The families

of our service members and veterans, caregivers, and survivors may not wear a uniform…but they sacrifice for us all. They give their best to the U.S., and we owe them nothing but our best in return."

I want to frame out why we are doing what we are doing—validating the importance of these types of initiatives to the DOD and the Administration. In 2021, there was an amendment to the National Defense Authorization Act (NDAA), which ensures the DOD and the Secretaries of the Military consider certain military family readiness issues when they are making/basing decisions for military units and headquarters. Whenever there is a decision that needs to be made about where a base might be relocated or where additional missions of a particular base would be located—using the Space Force headquarters, for example—when the Space Force was stood up, there was a search to look for the most appropriate locations for the headquarters. Because of this requirement within the NDAA, all the military services and the DOD had to include not only mission basing/mission direct/mission related issues, and land use and availability of airspace, but had to include the extent to which states have ensured license portability for military spouses and ensured that the quality of education is up to par for the children before they decide to move in a new mission to a state. This is a requirement that we have to abide by. We have to look at what states have done and decide if Nevada, for example, is a good location to be sending families.

Our office works with states on ten key priorities every year that are identified by the military services, the installations of families and community members, and the input of the states. This is our current list for 2024. This list will be the same for the 2025 Session for Nevada. Only one of those issues is coming off. I highlighted the opportunities for Nevada, which as you can see, there is an opportunity in every topic of our priorities for the coming year. I know my presentation is on licensure, but since I have all of you here, I want to share with you our global focus for 2024 and 2025.

Regarding our 2024 update to our policy priorities on military spouse employment economic opportunities, a lot has happened since I addressed this Committee last, and I want to provide an update. Many military spouse professionals must relicense each time they transfer with their active-duty member. We continue our efforts through a spectrum of policy priorities to ensure that military spouses can achieve portability of their occupational licenses as they undergo their many permanent changes of duty stations (Agenda ItemV B). These include timely licensure portability, state accessibility measures, occupational licensing compact enactment, and implementation of the federal Military Spouse Licensing Relief Act (MSLRA).

As many as 34 percent of our military spouses need a state-issued license to work, and military spouses are ten times more likely than their civilian counterparts to move across state lines. I have a couple of other facts I want to share with you. Every other year, the DOD puts out a survey to active-duty military spouses. We also put out another survey to reserve spouses, but I want to focus on active-duty military spouses. In the most recent 2022 survey, we found 50 percent of military spouses have a bachelor's or higher degree and 21 percent are experiencing unemployment at any given time. In addition, 27 percent had to take a job outside their license field upon a permanent change of station (PCS) due to challenges in licensing.

I want to add another layer of why this is so important. In this recent survey, 20 percent of the military spouses who responded to this survey stated they are just getting by financially every month, and 25 percent stated they are food insecure every month. This is one way the DOD is attempting to work with states to reduce those numbers. I think we would all

agree, it is unacceptable for a family that is serving our country to be experiencing food insecurity every month. We are hoping that getting spouses to jobs quicker upon PCS will allow their family to continue to succeed and be financially secure as they move.

I want to move into the recent update, on January 5, 2023, when President Joe Biden signed into law the Veterans Auto and Education Improvement Act; Section 19 of this act contains the MSLRA, which intends to provide for licensing portability among all 50 states for all service members and military spouse licensed professionals, except for those who practice law. As states implement the provision of the MSLRA, they can help military spouses maintain professional and financial stability by enacting licensing compacts and ensuring that licensing agencies make their application processes accessible to military spouses.

I want to clarify in MSLRA there are two provisions. Provision A requires that states recognize the licenses of a military spouse coming in from another state, period—that is universal. It is the true definition of universal licensure, meaning there is no application process and they have to recognize the license from another state. Provision B gives an exemption for states if they have enacted a licensing compact in that occupation. If there is a military spouse who comes into Nevada—which has not enacted the psychology compact—a psychologist could utilize the MSLRA register with the State and begin practicing right away. That seems to be what the interpretation of the Department of Justice is. That can be tested, and it has been tested. Someone asked a question about a recent lawsuit. There was a lawsuit in Texas where the military spouse was a school counselor who prevailed in the case which was adjudicated last year. It sets the tone for the interpretation of the federal law. Basically, the court found the Texas Education Agency did not abide by federal law and provided an injunction to allow that military spouse to start working right away.

If there was a psychologist who came to Nevada and Nevada had enacted the psychology compact, then they would fall under the compact. There are some guardrails there—Nevada knows who is coming in. There are pros and cons, but I want to clarify when you hear the federal MSLRA, there are two parts. Part A provides a universal recognition, and Part B is an exemption unless there is a compact.

In terms of Nevada, from the DOD's perspective—I have worked with the Legislature for the past three sessions—I have heard there is an interpretation that Nevada has universal licensure. In our assessment over the last six years, we have not found that Nevada's current statute meets what the DOD was previously asking, which was a streamlined process for a military spouse to be able to obtain a license. Not an exemption from receiving a license, but an expedited, streamlined process where the burden of proof to provide documentation and gather transcripts and proof that they have worked for a certain period of time was not on the spouse at the time of application, which added months to their application process. Previously, we found in Nevada that the current statute does provide for some level of reciprocity, but it still requires an extensive process and requirements.

The biggest issue that we found as a barrier in Nevada was that substantial equivalency piece. It is huge and adds months for a board to evaluate a spouse's appropriate credentials for licensure. Additionally, we found there were other requirements in Nevada including having practiced for the immediate two out of the last five years. Also, the temporary license that was provided was what we consider to be too short, which was six months. Previously, I worked with Assembly Member O'Neill on trying to improve the current policy to get it to where we believe it would truly reduce barriers for military spouses. Those efforts were not successful in the previous legislative sessions. Then came the federal law. We have these pieces now and I think we are shifting. Our focus is on prioritizing the

passage of compacts. The DOD does consider compacts to be the gold standard of cross-state licensure, ensuring military spouses who are coming and going are able to more easily and smoothly transfer their license to another state.

I made a mistake here in the licensing compact. I do recognize that Nevada has passed five licensing compacts. We are not tracking the medical compacts. Of the 14 compacts that the DOD is currently supporting, Nevada has enacted 4 of them, including the EMS compact. I mistakenly did not catch the EMS compact that was passed. We would like to see more compacts being enacted. We believe it is the quickest, most streamlined way for a spouse to get to work while providing the State the guardrails that are what we believe is a win-win. Here we are listing the compacts that the DOD is supporting. Many of these we have actually funded, as Matt Shafer mentioned. I will add a checkmark there to EMS for Nevada. It is important to note that the new federal law expressly recognizes licensure compacts and gives them priority over the other provisions of the federal law. Towards that end, we believe states can best achieve national occupational licensing portability while maintaining their State sovereignty through the enactment of the compacts.

Finally, we cannot discuss military spouse employment and economic opportunities without discussing the critical need for families to be able to obtain quality, affordable childcare. Nevada has already implemented our community subsidy program entitled Military Child Care in Your Neighborhood-PLUS. We are currently reviewing statutes to determine if State licensure exemption for DOD/military-certified family childcare providers who live off base can receive a State exemption from childcare licensing, given they are already certified by the DOD. I have materials and information about that, and I want to highlight that childcare does tie into the economic opportunity for military spouses. There is a connection there and anything the State can do to improve access to affordable quality childcare for military families is going to help with part of the puzzle of making sure military spouses can get to work. Other points from that survey, I had mentioned earlier, 44 percent of spouses that responded to the recent survey stated that childcare is a barrier to their employment. Of those, 54 percent said availability was the barrier; 26 percent stated quality was a barrier; 34 percent stated affordability was the problem; 37 percent stated location was an issue; and 28 percent stated hours of operation were an issue for them in terms of being able to obtain childcare so they can work. I am going to close it out for questions.

Chair Spearman:

Thank you. Assemblywoman Backus.

Assemblywoman Backus:

I am interested in the federal law regarding the auto licensure versus the compact. It seems like auto licensure is easier for our military spouses. You made a comment about registering. Can you elaborate on what they do? For example, I am licensed as a nurse in Texas, and my spouse gets transferred to Nellis (Air Force Base), and I go to Nevada. How does that work? Because we do not have a compact here so it would it fall under auto licensure?

Ms. May Douglas:

I want to reiterate first the Department of Justice is the federal entity that oversees this law under the Service Member Civil Relief Act. The Department of Justice has a website with information on that court case that happened on requirements—it has some documents. I do want to refer you to the Department of Justice first, and I can provide the link. All the

states are taking a look at that federal law usually through their Attorney General's Office (AG). They are asking what they can do to implement this at the State level, and what we are seeing is a variety of different approaches. So far, at least in the Pacific Southwest region—for my region—California enacted policy last year with the express intent of implementing the federal law. Some states interpret the federal law as not having to register at all, like in Utah. With Utah's universal licensure provision, military spouses can come in and work. If they can get an employer to hire them, that is all they need. They do not have to register or anything. Other states, like California with the recent bills they enacted, provide a state license. It eliminates every other requirement. Basically, the spouse is coming in saying here is my license, here is my background check—you must have that—and they are given a California license. They did that.

Assemblywoman Backus:

I was wondering because I know the one thing that glares out to me, because I am a licensed attorney, is the practice of law was the one exclusion. I got nerdy and I wanted to look, and for those who may be listening to this presentation in Nevada, we have Supreme Court Rule 49.1 that allows our military spouses to secure a limited license to practice law in our State, and they have to go through the Nevada Bar. It is nice that we do cover that, even though it is missing in this federal law. I wanted to comment. Thank you for your presentation.

Ms. May Douglas:

I know the Military Spouse J.D. Network, led that effort in terms of working with the State Supreme Court to enact those rules. I have not looked at Nevada's rule in a long time. I do know that one thing they have gone back to the drawing board on with the states, depending on what limited means, if a state has supervision requirements that are not ideal. That is one thing they are asking states to look at. I am not familiar with Rule 49.1.

Chair Spearman:

Assemblywoman Torres.

Assemblywoman Torres:

I wanted to touch on something you quickly covered in the fourth slide about State policy priorities. You hit on the education stuff we have worked on in the last couple of sessions. I know we have made changes for military families as they are enrolling, and we have also given priority preference to military spouses who are educators when they enroll here in Nevada. I am wondering if you could give an update on those two different priorities, and what challenges and barriers students and spouses who are educators still experience.

Ms. May Douglas:

Nevada has done things recently that move us forward and progress in the area of education for the open enrollment flexibility. For example, we are trying to ensure military children have the same access to interdistrict and intradistrict transfer policies. The Governor did sign a bill last session—maybe the session before—which allows military students to preliminarily enroll in school ahead of arriving if they have a set of military orders bringing them to Nevada. As you mentioned, that bill also established a priority for military families applying for charter school enrollment. One opportunity we are working on is to expand that option to all schools, not only charter schools, as that military priority piece.

Assemblywoman Torres:

For clarification, is the issue that it would be exclusive to current magnet schools? Is that the remaining issue or where would the issue lie? We did do the priority enrollment for neighborhood schools. Is there an issue then with the magnet schools?

Ms. May Douglas:

I will have to double-check and make sure I am right on that. My understanding, at the time of my review of Nevada statutes, was the current priority was for charter schools. If it is expanded to all district schools, then I will correct that.

Assemblywoman Torres:

Another quick follow-up. Could you hit on the enrollment for educators inclusive of administrators, counselors, and social workers who work in schools?

Ms. May Douglas:

I believe it was Senate Bill 100, which was passed a couple of sessions ago, and we used that as a best practice when we were working. We had separated out teachers and school personnel from our licensing efforts because they tend to fall under the education versus commerce and labor statutes. At that time, we did use that bill which did allow for basically universal licensure for streamlined processing for all school personnel in Nevada. We looked at and used that as a best practice for teaching. That was a good step then and now with the teacher compact that I believe was also signed last session—which was exciting—I think Nevada was one of the first states that signed on to that. The compact solves the issue for teachers. Then the federal law comes into that, and it will be interesting to see how that is interpreted in Nevada.

Chair Spearman:

Any additional questions? I have a couple questions. I think what we are doing with the compact is really good. One of the things I have always been mindful of is when we retire we get pass and review and all these plaques and things, and our family that supported us during some very perilous times, gets a thank you—maybe flowers. Are there any states that—or is there any way that DOD could look at this—and for those that are participating in the compact, set up some type of retirement system for the spouses? Because that is really an issue. You have teachers—and I use teachers because they are usually the most prevalent, and you go from place to place, but they are never there long enough to get vested in any type of retirement system. That is the first question.

Ms. May Douglas:

Yes, Chair. I know there has been congressional efforts to allow military spouses to access the Thrift Savings Plan (TSP), which is the DOD's main retirement system. One interesting thing I found was one of the attempts was to allow military spouses to roll their retirement into their spouse's TSP, which was not a successful effort and probably for a lot of good reasons. I know for me, I have a TSP that I transferred all my education years into when I joined the federal service. It was a benefit to me to have my own TSP. Of course, using someone else's TSP is not a viable option. I also believe there have been efforts through Congress to create a way for a military spouse to have their own established TSP that could be fed into as they move from state to state. But as far as I know, that has not come to fruition and has not met with success. To your point, I was a military spouse teacher,

I traveled across the country, and the world, and taught overseas. I taught in seven different systems and had seven different retirement systems. Finally, having decided to move into federal service, it was beneficial for me to consolidate it all into one spot, but I know that is a challenge for those who are not in federal service. I recognize the concern.

Chair Spearman:

I think it was 2019 when we did a Senate Joint Resolution. I want to say it might have been six, urging Congress to do that as a way. If there is anything we can do; if there is something moving around in the system right now; if there is anything we might be able to do; I would like to hear about it and see how we might be able to support it—so we support our military spouses.

Ms. May Douglas:

I have seen a couple of different approaches from different states. Utah is looking at allowing a military spouse working in the state to be automatically vesting before they leave the state, so at least they have something to transfer. We will take a look at what other states are doing in terms of approaches. There is a congressional approach that can be taken, which has not been successful yet. There are also things I think states can do. and we need to brainstorm and think of ways that could get to that. Maybe not one answer, but a groupthink process where we put together a variety of approaches. I will go back to my leadership and see if I can share best practices.

Chair Spearman:

I appreciate that because even if they get vested in Nevada and they get vested in Ohio, it still might not be enough. Assemblyman O'Neill has a question.

Assemblyman O'Neill:

I appreciate you coming in person and presenting today. I may be putting you on the spot and I apologize, but you mentioned two bills, Assembly Bill 439 and SB 402. You did not mention what session they came out of, but I think that is probably 2021. Do you know why those bills failed to be enacted? That is the part that may be putting you on the spot.

Ms. May Douglas:

Yes, that is putting me on the spot, and I do not know the answer. I believe I was working with you on the first version; we believed it was a simple common-sense solution.

Assemblyman O'Neill:

That is what killed it. As soon as you say a simple bill, that is what kills it. There is no such thing, we will never use that again. I was curious because I did not remember either. I was hoping 2021 is correct.

Ms. May Douglas:

I believe AB 439 was in the 2019 Session, and SB 402 was in the 2021 Session.

Assemblyman O'Neill:

I appreciate that. I did not mean to put you on the spot, but I was hoping you could refresh my memory too.

Chair Spearman:

Mr. Melgarejo reminded me in 2021 we had SB 402, which was an omnibus bill. What we were trying to do was make sure there were a number of areas that were covered and it would include military spouses. I thought it was a pretty good bill, but we did not get anywhere with it. Assemblyman O'Neill is correct, maybe we will come up with an uncommon solution.

I have one more question. In 2015, I sponsored a bill to give priority placement to children of military families, especially Gold Star families, and we could not get it out of the Senate for some reason. Childcare was one of the issues. I consider all of these readiness issues, because if you are stationed at Nellis but work at Creech (Air Force Base) and are a single parent without childcare and your child is sick, that is an issue. Are we looking at anything; like a type of blanket priority placement? I believe even if we could not get it for someone else, gold star families deserve it. For those who are not familiar with the term Gold Star, those are families who have a loved one who was killed in combat. Anybody who has paid the ultimate sacrifice, I think that is the least, operative word "least," that we could do for them. I would be interested to see if there is anything we can do for priority placement.

We had a Gold Star mom testify that when the Chaplain knocked on the door, she did not want to answer. It took her a couple of weeks to find her footing, but she has four kids and she is trying to find out when is the body coming back and that sort of thing. If there is a way we can look at those issues? I think that would be helpful.

The last thing I was going to say is there was a letter sent to all states in 2021 from the Under Secretary and it talked about base realignment and closing (BRAC). A lot of people are not familiar with BRAC. Can you talk about what that means? What, if any, are the implications in terms of the economy now and in the future? And if they wound up on the blacklist?

Ms. May Douglas:

I do not want to get too far out of my lane, as you know there are lanes in the military. Going back to my point about the NDAA, which requires the military services and the DOD to consider certain quality-of-life initiatives in their mission-basing processes. When I say mission basing that includes BRAC. We now speak about the more global decision-making process the DOD goes through, which might include BRAC and closing realignment, but also includes the consideration of additional missions at a base or taking away a mission from a base. Any change will result in either an increase in service members and families stationed there or a decrease. That is the reason why we are required to consider these family-type issues, because the DOD does not want to send military families to a community that does not support them. If it is harder for a spouse to get a job, if the military children do not have access to the existing programs that other children have access to, then that is part of the consideration. I am not saying that will bar an assignment of service members to the state, but it is a consideration. Obviously, with fewer military missions there are impacts on the economy because the defense community brings in millions and millions of dollars to every state's economy through contracts, direct payments, taxes, et cetera.

Chair Spearman:

Committee, any additional questions? Thank you, and I hope your trip to Las Vegas was worth it.

AGENDA ITEM VI—PRESENTATION ON THE DENTIST AND DENTAL HYGIENIST COMPACT

Chair Spearman:

We are going to go now to the presentation of the Dentist and Dental Hygienists Compact.

Paul Klein, TriStrategies:

I am here on behalf of the Nevada Dental Association (NDA), and we appreciate the opportunity to talk about the Dentist and Dental Hygienist Compact. A couple things to note specific to this Compact is the in-depth and elaborate development process that was done to get the language together. They brought in a lot of stakeholders and dug in to get it to a place where a lot of people felt great about it. Specifically, that is why this Compact may be different from other compacts that you have considered and why the workforce supports it. I will be here to take notes and I am available for any follow-ups or materials that you may need or want after the hearing.

Matt Rossetto, Legislative Liaison, American Dental Association (ADA):

I help our states out with legislation and policy concerning the workforce in a variety of areas. One of those is the Dentist and Dental Hygienist Compact. I want to address a couple of the points that you brought up earlier about the workforce. Do we know where folks are coming from and what sort of portability is available? The good news is the ADA has done real work on this recently trying to identify trends and patterns of what is going on. I will start by mentioning the research the Health Policy Institute (HPI) released tells us that upwards of 15 percent of dentists will move their state of practice within their first five years. That is a level of mobility that we have never experienced in the profession before. This is one of the reasons the ADA is passionately committed to this Compact, because you are familiar with the term people voting with their feet, dentists and hygienists are doing the same thing. This is one of the ways that we can support our young members and students who are about to come out of school and are doing the moving. If we can make it easier for them to continue their profession and ease the continuum of care for the patient, we believe this is one way to do that.

It was asked whether we can track where dentists are going and where they are coming from. We can do that, and we can do it state by state. I have the numbers here for Nevada. Nevada is one of the states that from 2019 to 2022 did see a net drop in the number of dentists overall with a reduction of about 2.9 percent. We can tell you where dentists are coming from and where they are going. If they left Nevada, the top five went to California, Texas, Florida, Utah, or Oregon. If you are looking at who is coming to Nevada, they are coming from California, Texas, New York, Arizona, and Utah. None of those are huge surprises, but it is something we want you to know we are actively tracking, and this helps us respond policy-wise to what is going on at the national and state level. I will begin our presentation (Agenda Item VI A).

Chair Spearman:

We do not have the link to the fact sheet. Can you send that to us so we can follow along, please?

Mr. Rossetto:

I will send that to you. That is a resource that is customizable by every single state and HPI updates it regularly (Agenda Item VI B). We will start with the Dentist and Dental Hygienist Compact (Agenda Item VI C). Paul mentioned the development process and I will walk you through how and why we got here. This has been under discussion in dentistry for years, but the first major meeting of stakeholders took place five years ago in 2019. This group was convened with the help of CSG and included dentists, hygienists, dental students, dental educators, dental support organizations, dental boards, and everybody you would expect to be in on a good comprehensive compact for the profession as a whole.

The consensus from this meeting was that dentistry should continue to talk about going down this road. In 2020, it slowed down the development process but was picked back up in 2021, and the ADA and the American Dental Hygiene Association officially responded and applied for the creation of a compact which was accepted later that year. There were several other supporting organizations as we note there as well. This is a real-life example of what a technical assistance group does. This was a group of roughly 20 stakeholders from all over the profession. Dentists, board members, educators, staffers at the ADA, and in over three months, they took every major idea that should be in a compact and put it into plain language. There were representatives from several different state boards of dentistry contained within this group and those are all listed.

The next step in the development process was called the document team. That was taking the plain language—much like your drafting attorneys do turning your ideas into legalese. The team included attorneys, a subset of folks who were on the other team, and representatives from three dental boards who took the plain language and turned it into an actual draft compact document.

In the fall of 2022, the initial draft was circulated for review. This was not done to only stakeholders, this was done to the public at large. This was a public comment process that was available to anyone. There were weekly public meetings where the compact was described section by section. Internally at the ADA, staff went over this several times with State staff, executive directors, and all of the rest so that we could gather their input and their thoughts. During that eight-week public comment period, we received over 400 sets of comments. Based on those comments, adjustments were made to the draft. In January 2023, the compact was finalized, made public, and available for states to consider introducing as legislation.

Before we move on, I want to quickly recognize my colleague from the Association of Dental Support Organizations (ADSO), Matt Steele, who would like to make a brief comment and introduce himself and his organization.

Matt Steele, ADSO:

Thank you for a quick moment to jump in today. I am with the ADSO, and one of the stakeholder groups in the compact. I want to state our support for this. We have 330 plus supported dentists in Nevada and over 120 practices throughout Nevada. We support over 480 hygienists in the State with a total patient flow of about 1 million patients. Most of our

offices are scattered throughout the State, but we are particularly interested in this legislation because we would love to expand to areas where access to care is experiencing challenges right now. We have been working in other states, and we are excited about the prospect here in Nevada. I want to say we are excited to work with you here in the upcoming legislative session.

Mr. Rossetto:

I am now going to pass it on to my colleague from CSG, Matt Shafer, and he is going to go over the more technical elements of the compact itself. How the actual ins and outs of it works. At the end of his presentation, we will stand for any questions from Members.

Mr. Shafer, Previously Identified:

It is a pleasure to be addressing the Committee once again, this time specifically on the Dentist and Dental Hygienist Compact. Hopefully, based on the other speakers, you will be able to see how widely this is supported in dentistry. We have all sectors of oral health in line on the need for the compact, which is unique. A lot of times you will see dentists and hygienists on the opposite side of issues. But this time, there is unity around the need and purpose for this Compact.

I am going to talk about the technical aspects, and how it actually works from a functional standpoint. The Compact operates on what we call a compact privilege model where the dentist or hygienist holds an active and unencumbered license, and they apply for a compact privilege. This is essentially legal authorization to work in another state that is a part of the Compact where they do not hold a license. They undergo a Federal Bureau of Investigation (FBI) background check, and their eligibility is verified based on criteria I will share. They will pay fees to the remote state where they are applying to work and complete any necessary jurisprudence requirements. If Nevada has a requirement that all dentists have to pass a laws and rules exam or Nevada statutes assessment, they will have to complete that requirement and then they would be able to receive that Compact privilege.

To the previous agenda item where I spoke, we talked about how compacts alleviate the need for this application process, and you can start to work right away. I do understand this is a little bit to an extent of an application process and a verification that the person is in good standing. However, I would emphasize the time savings associated with using the Compact versus the traditional licensure route since it is streamlined through the compact data system and takes a matter of minutes. Your eligibility can be verified with a few clicks of a button. You are moving from a scenario where you are waiting on a licensing board to make a determination as we have discussed, that takes weeks, sometimes months, to a scenario where you are just checking the box—checking here are the states where you would like to work, and we make sure your license is in good standing and you meet all the criteria that happen in a streamlined manner through the compact data system and can be done. The PT compact says on its website that it can issue a privilege in ten minutes—much faster than going through the traditional route.

We will talk about the requirements to actually participate in the Compact. You must have a qualifying license issued by a state that is in the compact—an active and unencumbered license. If you have any kind of disciplinary actions or your scope of practice is impeded at all, you would not be able to use the Compact until your license is restored to a good standing—you are fully unencumbered. There are examination requirements. There is a national board exam that all 50 states require for licenses and that is included in the Compact. You have a degree accredited by the accrediting body for dentistry programs

called the Commission on Dental Accreditation (CODA). A successful completion of a clinical assessment is a test of your clinical skills. All 50 states require a clinical assessment for licensure. These are standard requirements that Nevada and all the other states already have in place. Lastly, I mentioned the point around a criminal background check, which is a requirement for the Compact to pass an FBI fingerprint-based background check.

Many of these benefits are going to be the same as in the presentation I gave on the previous agenda item. The primary benefits here are mobility, and the ease of mobility when you want to practice in multiple states. Maybe you do not want to change your residence, but you want to work across state lines in a neighboring state. It also facilitates mobility when you are picking up your practice and moving to a new state, which in turn expands your employment opportunities. Kelli May did a great job of describing the military's perspective on this issue. In reducing the burden of maintaining multiple licenses, we are talking about a reduction in continuing education that is required, paying duplicative licensure fees, and things like that. For the licensee, there is a significant benefit.

For the boards, I have talked about how compacts have a shared data system that is in place and sharing things around investigations and disciplinary actions. The compact is generally a vehicle for boards to cooperate across state lines around investigations and disciplinary matters that may be occurring in multiple states. The compact empowers the boards to work together collaboratively across state lines. For the State, we have talked about how this is a workforce development tool and simultaneously reduces barriers to employment while preserving State sovereignty over the Dental Practice Act when licensees are within Nevada's borders.

I want to talk about the Compact Commission. This is something where there can be misunderstanding and misinformation about what the Compact Commission is. The Compact is not owned and operated by CSG or the ADA. This Compact belongs to the member states that have enacted it. The governance structure that is set up through the Compact is called the Commission. Every state that passes the Compact gets to elect one person to sit on this Commission. We say it is a member of the state licensing authority, which would be a member of the Nevada Dental Board. The Compact creates rules and procedures to help the Compact function properly. What cannot happen is there could never be a Commission rule that impacts practice specifically in Nevada. There can never be a Commission rule that goes outside of the bounds of what is specified in the compact, that is how you get a compact privilege. Anything outside of that is off-limits for Commission rulemaking. We hear questions all the time about, is the Commission going to be dictating things to my state about how to practice looks. The answer to that is unequivocally "no." The Commission is not authorized, in any way, to do that. Their only purpose is to facilitate and administer the Compact and rules are limited to that. Only people using the Compact would be impacted by a Commission rule. I want to make sure there is clarity on that point.

A couple of things to emphasize is an additional optional pathway. Not a takeover of how dental licensing is done in Nevada currently, but a new pathway. This privilege model is utilized by a number of other professions. Psychology and PT are probably most closely aligned with what dentistry is doing. I know Nevada is a member of the Psychology Interjurisdictional Compact (PSYPACT). We do not believe there is a significant cost for the State to participate. There could be some cost associated with making sure the Nevada board can interface with the compact data system. Beyond that, there is a very limited cost in terms of State participation. I want to continue to emphasize that the State retains control over its Dental Practice Act and also the discipline of practitioners within their borders. If somebody comes to Nevada and violates Nevada's laws and rules, they are

subject to the Nevada Dental Board, and the Board can take action on their ability to practice in Nevada.

This Compact will be active when seven states have enacted it. It is brand new. This is one of the compacts we developed in cooperation with the ADA through the DOD program, that Kelli May mentioned in the previous agenda item. We have a map that shows where we are currently with legislation. We have five member states; Washington, Wisconsin, Iowa, Tennessee, and Virginia. We have a number of bills moving through the legislatures at the moment; we do anticipate we will hit seven states in the coming weeks. We have bills on the governor's desks at the moment awaiting signature for enactment. We are very confident we will get seven states this legislative session. I will stand for questions.

Chair Spearman:

Any questions Committee? Assemblywoman Kasama.

Assemblywoman Kasama:

Just a comment. I think these compacts are important. My daughter is a dental hygienist, and she was looking at relocating here. I cannot say this is the only reason, but she decided not to, because it is going through the regulations again after she spent so much time in Washington State. It does become a barrier for people moving and all our states are short of health care workers in any occupation. I am certainly supportive of trying to help with easier movement and supporting our health care workers as they move around; since I lost having two grand babies move here as well. It is very important to me.

Chair Spearman:

Additional questions Committee? Senator Ratti was the one that got us started on making sure we had dental hygienists here in the State. She was berated for that, and I want to thank her publicly because we are on the road. We want to thank you all for coming and presenting.

Mr. Klein:

Chair, can Ms. Solie add comments on behalf of the Northern Nevada Hygienists Association?

Chair Spearman:

Sure, please go ahead.

Caryn Solie, Registered Dental Hygienist (RHD), Dental Hygienists' Association:

Good morning. I thank you for a few moments of your time. I did submit a prepared statement (Agenda Item VI D). Because everything has already been so succinctly covered by the previous speakers, I would like to take a moment and share a little bit about the American Dental Hygienists Association (ADHA).

The ADHA has had a policy regarding portability of licensure for over 25 years. The Nevada Dental Hygienist Association in 2001 created policy here within our State association supporting portability of licensure and we reestablished our support for that in 2013. Last year, I do appreciate that the ADHA worked really hard in connection with all of the groups that crafted this Compact Agreement and brought it forward.

I would like to take a moment to point out a couple of things from a personal standpoint. In my 53-year career, I have had to take licensing examinations and do licensing requirements in five different states. At that time, those opportunities created a great bit of challenge because I moved to a state in October, and they only gave their licensing exam in September. For 11 months, I could not be employed, my family lost income and the state lost revenue. More importantly, there were patient care hours that were wasted and lost. Being able to have an opportunity to move to states more readily and provide care is truly something that is really important.

The cost to take the different licensing exams was very expensive, even though some of them were back in the day. Even now those things take a lot of time, the Nevada Dental Board takes a bit of time issuing licenses. To have something be more rapidly available is critical. I ask for your support. I am available to answer any questions.

Chair Spearman:

Committee do you have any questions or comments? Did I understand you saying a 53-year career?

Ms. Solie:

Yes, Madam Chair. I retired in December, but I still keep getting called back to my office to work. I am still getting in about a day every two weeks.

Chair Spearman:

Thank you for your service.

Assemblyman O'Neill:

I have one question. The Nevada Dental Board currently has the ability to recognize licenses from other states, correct? But if they are already licensed in another state, they can apply for the board here. Do they have to go through all the testing all over again or can they just be recognized?

Ms. Solie:

If it is all right, I will answer this. I did serve on the Nevada Dental Board for two terms. Yes, there is a mechanism, but again, it is timely. They must submit all of their data, and it has to go through the committee and then to the full board. Typically, it is a several-month-long process, if not more. Did I answer your question correctly?

Assemblyman O'Neill:

You even answered my second question—how long a time period. What was several months during your term?

Ms. Solie:

When I was on the Board, the last time 2013 to 2015, we tried to expedite it and we were trying to have a turnaround once everything had been received in the office for the application process. Once the staff guaranteed and authenticated all of their data, it would come to the board and they would have their license back to them within two to three weeks.

Since then, I know the Dental Board has had a lot of staff turnover and staff shortages. I anecdotally, this last summer, received questions from five or six different applicants from different states as well as from recent grads that it was taking anywhere from two to six months for them to get their license.

Assemblyman O'Neill:

Thank you for your service on this important topic of dental hygiene.

AGENDA ITEM VII—PRESENTATIONS ON THE BOARD OF EXAMINERS FOR SOCIAL WORKERS, THE SOCIAL WORK LICENSURE COMPACT, AND THE ASSOCIATION OF SOCIAL WORK BOARDS' EXAMINATION DISPARITIES IN PASS RATES FOR DIFFERENT DEMOGRAPHIC GROUPS

Chair Spearman:

We are going to move to a presentation on the Board of Examiners for Social Workers, the Social Work Licensure Compact, and the Association of Social Work Boards, examination disparities, and pass rates for different demographic groups.

Vikki Erickson, Licensed Clinical Social Worker (LCSW), Executive Director, Board of Examiners for Social Workers:

I have a prepared statement for the record (Agenda Item VII A). I would like to thank the Committee on behalf of the social work industry for allowing me to present today. We have seen significant interest in identifying opportunities for the industry of social work to expand and we do appreciate that support. The Board and the Association of Social Work Boards have an excellent working relationship. We appreciate the partnership and working through any unforeseen issues licensing social workers in Nevada, but also identifying potential opportunities that strengthen the industry and streamline the path to licensure.

Looking at the presentation you will receive from the Association, we agree the data is accurate. The only difference in this data I want to note is the presentation indicates there are about 4,000 licenses in the State of Nevada. However, as of this month, we are close to 4,700. First, I do want to thank Assemblyman O'Neill for an emergency bill last session. It did not move, but we remain grateful for the bill.

Looking ahead to the 2025 Legislative Session, the Board and the Association both are in support of the proposed interstate compact for social workers. As of today, four states have adopted a Compact including Utah. Please refer to the map that was submitted to Committee staff. When the Compact reaches seven states, the Compact will go into effect. It is then that the process begins of setting up the Social Work Compact Commission, which includes putting together a database of licensees. This process will take roughly a year to stand up.

I also want to bring to the Committee's attention that the Joint Interim Standing Committee on Health and Human Services will be hearing from the CSG regarding the Social Work Compact on Monday, April 8, 2024. We applaud the significant interest in social workers, and on Monday we will request a bill draft request (BDR) for the Social Worker Compact leading up to the 2025 Legislative Session from either Committee. Thank you for your time. I would also like to introduce Dr. Stacey Hardy-Chandler, Chief Executive Officer (CEO) of the Association of Social Work Boards and a Nevada social work licensee.

Stacey Hardy-Chandler, Ph.D., J.D., LCSW, Chief Executive Officer, Association of Social Work Boards (ASWB):

Although I am not coming from Nevada, as Vikki mentioned, I am a licensed clinical social worker in Nevada. I am a former faculty member from the University of Nevada, Las Vegas (UNLV) and also a graduate of the UNLV Boyd School of Law. I am honored to have this conversation and to share this information on behalf of ASWB. (Agenda Item VII B)

I want to start with a quick overview of what ASWB is. It is an association of boards just like there would be associations for medical, dental, or nursing. We support the Nevada Board of Examiners for social workers, as well as the boards in all 50 states, U.S. territories, and Canada. I like to emphasize that our role is in service to relieve some of the burdens of the board that provides licensure regulation. The focus of my presentation here is accountability. The ASWB has to report to its Board of Directors, which is elected by all of the state and provincial boards; and we are all accountable to the public. That is an important piece because as we talk about the examination, it is a tool of accountability. I will go quickly, but I welcome questions at the end, and I would also like to offer to come back to the Committee at the Committee's request; if that is necessary.

I want to highlight why social workers are licensed. That might be evident to some, and it may not be evident to others, but it is about upholding the confidence and trust of the public. When someone is getting a licensed social worker, the public knows what that means. I do not think there is a social worker who has not heard someone say, well I am like a social worker. We want to make sure the social work profession, its status, its knowledge base are all upheld. As it is worded in Nevada law is perfect. The practice of social work is hereby declared a learned profession, affecting public safety and welfare, and charged with the public interest; and is therefore subject to protection and regulation by the State. Perfectly captured.

When we think about human services, particularly, what might come to mind is counseling or psychology. What differentiates social work is that each step is its own distinct category of practice. You can practice as a bachelor's level social worker; you can practice as a master-level social worker; or you can practice as a clinical social worker. In other professions, the majority of people who enter are on a journey to become a clinician, a clinical social worker, a clinical counselor, or whatever the category might be for that discipline. In social work, that is one category of practice. But other social services beyond mental health are hallmarks of the social work profession. This is a quick snapshot of licensure in Nevada, and I want to move on to the various categories of licensure in Nevada, which honors the fact that social work has different categories of practice and sometimes it has been characterized that the master's exam, for example, is a stepping stone to the clinical. That is not always the case. You have social workers who practice as masters-level social workers for their entire careers. That is completely valid and legitimate in our profession.

I have had to highlight, in other spaces, that social work is a profession. By virtue of being a professional, I want to bring your attention to that regulation is responsible for verifying minimum competence. It really speaks to why an exam is important; it is critical to regulators in meeting the mandate of fulfilling their duty as regulators to verify that minimum competence.

Like other professions, we follow standards that guide how tests are developed for licensure. These are global standards, that again, are the same standards with some variation that are followed by nurses, occupational therapists, psychologists, and other

health and human service disciplines. We believe that the best combination of factors for social work regulators to make regulation decisions for licensure issuance includes all of those factors: education, the exam experience, if it is necessary, which is the case for the clinical level. Most states have something regarding moral character, a criminal background check, or something to that effect. All of these provide regulators with information to make these important decisions. For social work, we are charged with serving the most vulnerable populations. These decisions are very critical.

It is no accident that the Board is called the Board of Examiners for Social Work. Because that examination piece is the part that regulators oversee. They get transcripts from schools and reports from supervisors about the experience, but the part that speaks to what regulators oversee is the exam. This is a statement by an attorney who works with a number of associations talking about how exams are core to the regulatory duties that boards have. This emphasizes that those standards require that examinations be valid, reliable, and comply with their structure. I often ask people how many staff members they think write the exam from ASWB. Whatever number you have in mind the answer is add a zero. Sometimes the misconception is two people at ASWB are writing these professional exams that would not comply with the standards. Professional examinations are driven by members of that profession. By the way, I will say the exam is a singular thing but there are different categories of exams, and there are different forms that are equivalent to the same exam. It is more of an examination or competency measurement process than a single exam.

This highlights that there are typically up to 200 people who are involved in the exam development process. The staff at ASWB shepherd that process that is driven and led by practicing social workers. The people you see on this slide are consultants. They are critical in the examination development process, and I will talk about their role in a minute. Other than providing the administrative structure to make sure this happens, everyone else is either a volunteer from the profession, an external vendor, or an item writer, and they are external as well. Social work is one of the few professions that compensates their item writers, even though they are not employed by us for producing items.

I do want to highlight that we pay attention to graduation rates for our profession. It is a little hard to see in this graphic. The purple line is our item writers and the other two lines are graduation by demographics from social programs. We try very hard to have our item writers reflect our profession, not only in terms of these demographics but in terms of geographic location and in terms of areas of focus. They are a very diverse group.

This is very important to highlight because any competency exam or licensure starts with a practice analysis. It starts with a survey of the profession. The group that you see here are volunteers who oversee that part for us. Right now, a practice analysis is happening. Every five to seven years we survey the profession to say what is it now that social workers need to know as they enter the profession. Not specialization with particular groups, not working in particular settings, but on day one in any setting. What does a professional social worker need to know at whatever exam level that is? We certainly want to encourage all social workers to respond to the census that is out now because you can have input on the next iterations of competence measurements.

The exam writers are practitioners; we have them listed on the website so you can see their background and their locations, their integrity, and what they do is phenomenal. They are a phenomenal group of people. The other people I want to introduce you to are the Exam Committee. These are people who are another layer of checks and balances through

the exam development process. They too, are diverse in terms of area of practice, geographic location, demographics, and everything else.

You have met a lot of people. I am going to put together where they play a part in exam development. I believe people think about a test they might have put together for a class they taught or what might happen at the university level. But the standards require a much more involved process with many layers of checks and balances or anti-bias integration into how exams are developed.

It starts with who is writing the items. Again, these are social workers who are out in the field. There is a call that goes out and they are selected in order to represent the cross-section and the diversity of the social work profession. They are taught how to write exam items, how to write them clearly without microaggression and to leave out all of the jargon words. The reading level of the social work exam is about tenth grade. It is not reading comprehension; it is about decision making and that is a special kind of writing. They get that experience.

Moving to the middle column, they start to submit items and they go to those seven people you met in the beginning—the consultants. These are experts in the licensure exam items, they review them and they decide whether that item is going to move on to the next step. They also provide feedback to item writers that help them in their growth and development. Then if the consultants move the item on, it goes to that committee that you met for that category of practice. If you have an opportunity to observe an exam committee, this is the equivalent for us. It is the equivalent of what nurses call a sensitivity committee. They review each and every item—ego is left at the door. It is about the clarity of the exam to produce what the exam is supposed to do. When they review each and every item, they also make sure all of the items link back to the social work literature and research. Items cannot be what Stacy wants to put on a test; it has to link back to what the field is saying in that area. All items have citations in the social work literature.

After the Exam Committee, it goes into the psychometrics phase. All test items have to be psychometrically monitored for how they perform. Are certain demographic groups performing better on an item or worse? Or, "What is happening with that?" If it is uniform across the board, we call those good statistics. Finally, that item will make it on the scored side of the test. If it does not show good statistics, it can be deleted or sent back for revision, but most often deleted.

I know time is limited but to recap about the exam since that was one of the questions, there are 170 items at any time on any form of the exam; 20 of those items are mixed in and they are pretest. Historically, the items had four options. We only have a multiple-choice structure. There are some licensing exams that have different kinds of structures. We are phasing in a three-option multiple choice and that was a data-driven decision. People simply were not choosing that third wrong answer; it was not helping or hurting them, in the same period of time. There is a universal pass score, and I listened in on the discussion about the compact, and the test is exactly the same if I pass it in Nevada versus where I am now in the Washington metro area or British Columbia—same passing score. That helps with the portability.

There was a question about what was on the exam. As I mentioned earlier, all exam questions have to be built on that blueprint that comes from the practice analysis, which is the survey of the profession. The outlines from the past practice analysis are available online. You can certainly review those content areas, and a new blueprint will be developed out of the current practice analysis that is happening right now.

What do the questions look like? They are written with limited information and the person must choose among the available answers, and there usually is a prompt such as: "What would the social worker do next?" Or, "What is the best selection under the circumstances?" The amount of information varies, but remember the objective of the test is what should any social worker, regardless of specialization, regardless of what school they went to, regardless of populations they want to focus on day one—what should any social worker know?

The request was made for the pass rate information for Nevada. The pass rate information for all states is available online as of 2022. There was a lot going on in terms of understanding diversity and equity, and our Board of Directors in 2021, voted to make the investment in an analysis that disaggregated the data so that we could understand pass rates better and have conversations about what is going on with various groups. Here are the pass rates for Nevada. I added a box at the top for the national first-time pass rates by comparison. Nevada is doing a little bit better in the clinical exam, and a little bit worse than the national numbers for the master's exam and for the bachelor's exam.

I mentioned 2022, and the investment that our Board of Directors made. They had an external independent psychometric group produce a report with disaggregated pass rates by race, age, gender, and whether a person spoke English or not as a preliminary look at what might be happening in terms of access to licensure. We also produced an interactive map, you can go on that map and see how the State is doing with that breakdown. We also had that company produce reports for all 800 social work programs across the U.S. and Canada. This was a major investment in starting this conversation. Social work was the first health and human service association to publish the segregated data in this level of detail.

Here are the pass rates—you can look at pass rates and do it by the last four years or the last ten years. If you hover over Nevada, you will see this breakdown by race, gender, age, and language. This is part of why I am here to have this conversation. People are not passing across demographics at the same rates. We have people of color who are not passing the exam at the same rates as their white counterparts. This is an important conversation to have. With all of the safeguards and all of the anti-bias measures in the exam, we know that people do not come to the exam with the same access to opportunities, the same experience, or the same history. This is Nevada, but we have the information for the whole nation. When you dig a little deeper, you see differences by school. You can see places where schools are producing people who actually graduate the same across different demographics; then you have other schools where there is a humongous gap. This research is just starting, and we need to understand more about what is happening in different areas. Certain regions of the country also have lower pass rates. The pass rate gaps are bigger in the Southeast and they get smaller in the Northwest, and these indicate a lot of things that we need to understand.

You asked for more Nevada information. There are two schools of social work I taught at the UNLV in the School of Social Work. You see the pass rate data here. They are not the same by Nevada or UNLV and this is a snapshot, the full reports are available. I want to caution that there are a number of factors that impact this and one of the things we want to be an active part of is understanding how people come to the exams, and how they can best demonstrate their competence. We recognize that we are part of a larger system, and we are very committed to working with educators and researchers to get these contextual questions answered. That does not mean because there are systemic and institutional factors impacting these disparities that there is no work that we can do from the regulatory space.

I want to highlight in the remaining minutes, some of the things that we as regulators are doing on our part of this larger system to address this systemic issue. First, we are providing free exam resources to educators. We get a range from people saying licensing was discussed often as part of the educational experience and we get people—and this is anecdotal—who say licensing was never mentioned in the program. We have schools where there are faculty members who are licensed and others who are not. It is unlike medicine where all the doctors who teach have to be licensed. That is not the case in social work, we have an array. One of the things we want to do is make sure that educators wherever they are, have access to accurate information about the exams and about licensure so they can share that with their students.

We also recognize there is a lot of misinformation about regulation out there. We created an exam education series where we talked about all the aspects of the exam. We invited educators and we had hundreds of people show up. It was targeted at educators, but we did not exclude any other people who wanted to attend. Those reports remain available online for everyone to view because we think there is a huge need for regulatory education.

Internally, we are re-envisioning parts of the candidate experience when they go to take the exam. How can we improve that experience contextually? We know people are nervous when they come to exams, and how can we make that better? But at the same time, how can we safeguard the security of the exam?

As of January 2023, speaking of test concerns, we partnered with Fifth Theory, which is a minority-owned test mindset company. Anyone who does not pass the test can have access to the Fifth Theory assessment with feedback to resources. It is not about the content, it is not about teaching to the test, or anything like that. It is about the approach to test taking. We also engaged in a lot of research, including community conversations where we talked to social workers about their journey. This was qualitative research, but we have invested in quantitative research also. Working along with other members of the social work community because we know there is nothing that we can do alone, we have to work on this issue together. In terms of the histories that people bring to licensing and their experience through what regulators are going to oversee, which is 20, 30, or 40 years in the profession; we know we have to work together with other aspects of the professional community.

I mentioned the practice analysis, which we are calling the social work census, where people can actually contribute to what the next blueprint looks like. The next slides are some of the activities we have slated for 2024. This is the webinar series. Some of the things that I covered here, such as exam development, psychometrics fees, and special accommodations are made under the law. Social work offers, in addition to special accommodations, certain arrangements. People could make arrangements for special requests for temporary medical conditions like pregnancy. We also offer things beyond what the law requires and qualitative research.

We have a new test vendor. One of the reasons why we are partnering with PSI Testing Excellence is the option to look at potentially remote proctoring of exams to help with access to test taking. Could people potentially be taking licensing from their home? With the security in place, we believe they can, and we are looking to implement with PSI. I mentioned research, the social work senses that include the practice analysis, and it also includes a huge workforce study to understand who social workers are. This level of research has never been done before. It is huge. It is going across the United States and Canada. We urge social workers, licensed or unlicensed, and anyone who is affiliated with

the social work profession to respond so we understand what our workforce looks like and how it is evolving.

The Compact was mentioned, and we are certainly supporters of the Social Work Compact which, as Matt mentioned, is new. I believe we have four states on board, let me echo Vikki's support for Nevada. A slide note on Nevada's numbers versus bordering states. This is a map that we have available about social workers for 100,000 across the country.

To wrap things up, I want to go back to accountability. Regulators are accountable to the public. The process that we go through for the part that we oversee, the examination, is meticulous. But we know that we must work together with other aspects of the profession, with the public, to make sure that every candidate has an opportunity to demonstrate their competence.

I want to thank you again for inviting us to talk to you about this information directly. I am happy to answer any questions you have. Again, if you need for me to come back at some time in the future, I am certainly willing to do that as well.

Chair Spearman:

Thank you for your very thorough presentation. Committee Members any questions? Assemblywoman Backus.

Assemblywoman Backus:

I have one simple question. I thought the visual of the number of licensed social workers in the Western states was impactful but in comparison of the number of populations within those states that the social workers serve because when you look at it, Nevada is very glaring at a very low number. What does it look like based on population in those Western states? Is Nevada still falling short or are we at par?

Dr. Hardy-Chandler:

Looking at the map, and if you go to slide 43; it is kind of low. That is why I think the compact is a good thing to consider because of being able to work across boundaries. I am a social worker who left Nevada, but if I still care about a population and I want to practice there or my circumstances are such that I want to provide services there, I actually could do telehealth in Nevada. I think that is one of the things, because it falls on the lower end of social workers looking at the compact, it is not a panacea, but it is an opportunity for people to still serve Nevada even if they have left Nevada for whatever reason. That is a part of their practice target population. I hope that answered your question.

Assemblywoman Backus:

I appreciate it. It kind of does. I was looking at the proportion based on population, but you did answer my question. Thank you.

Dr. Hardy-Chandler:

It is a little on the low side.

Chair Spearman:

Any Committee Members have questions?

In 2019, I had a Youth Legislator bill talking about how we needed to make sure that people who were working with students were trained to the degree that a layperson, if you will, could. It would mean that they would be able to at least identify some ideations of depression and suicide. He began his testimony before the committee by reading his suicide note which coincidentally was written one year ago to the date that he was testifying for that bill. In it he said a lot of his friends—there are a lot of things that are going on and nobody picked up on it. He was at home, and he said if his mother had not gotten curious because she was not hearing anything up there, he had already taken the pills and laid down on his bed, that he would have been gone. Here is my question. We know that in Clark County there have been concerns, not just of teachers and parents, but of the community about what could be done working with social workers to help in these instances. I do not know if you have thought about that or if it is something that you would be interested in. Senate Bill 204 requires every school district in the State of Nevada to develop a training program that is for support staff, administrators, and teachers—that is everybody. I cannot tell you how or if it is being implemented. I know some school districts are doing it and some are not. Given the shifting demographics, not just here, not just in a broad scope with the western region. But here in Nevada, the demographics are shifting, not only concerning ethnicity but also age. Are you doing anything, or have you thought about doing something that could help us reach the people in need? Because I talked about young people, but on the other end of the spectrum, I think that Nevada is number two in the suicide rate for older adults. Some of that can be attributed to the fact that they are basically isolated from the support systems who live someplace cold like Cleveland or Detroit, but they moved here because it is warm. Can you speak to that?

Dr. Hardy-Chandler:

Nevada has done something that I think is incredibly important, when I renew my license, Nevada requires a suicide course for social workers to renew their license. That is important because social workers who are not licensed, are not connected to regulation, and do not have that accountability for their continuous learning. One of the things that I must do every time I renew my license is take a suicide course in order to get my license renewed. That is one step. I also think what you are talking about is very complex, and requires a lot of the pipeline type of work we are trying to do starting with the students. Starting with supporting them in their internships. I was the Director of Field Education for UNLV, and I want to take a moment to thank all of the other social workers in Clark County who oversaw students. I think that starting when they are in school is a wonderful opportunity to plant seeds for what I will call gero (gerontological) social work and working with older adult populations. All the factors that impact our community in Clark County and changing with the demographics. There is an opportunity to refine those experiences, not only in the curriculum, but refine those experiences in internships; you cannot graduate with a social work degree without having an internship, which is important. I think that is a great place to plant the seed. Once people graduate, the school is sort of left behind and it is the regulators who can support how the field evolves to meet the local needs. I think a good example of that is every jurisdiction can determine what is needed to renew licenses and jurisdictions have things like ethics and those things that are standard. Again, Nevada took the step of requiring suicide, which was not the case when I first got my license. I think things like dealing with aging populations, and those conversations in terms of continuing education and supervisory experience will be an important start. Certainly not the complete answer, but a great start for the evolving population.

Chair Spearman:

Committee Members any questions? We certainly appreciate the time that you all have taken to speak to us about that. Those two things are near and dear to my heart. On one hand, students K through 12 need help, and on the other hand, you have geriatric patients who need help as well. For those of you who are here or are listening online, we are going to have a presentation from the Cleveland Clinic Lou Ruvo Center for Brain Health here shortly. Perhaps there is information that we can marry between what you have given to us and what they are going to share with us.

AGENDA ITEM VIII—PRESENTATIONS CONCERNING SERVICES PROVIDED TO PATIENTS WITH DEMENTIA ASSOCIATED WITH ALZHEIMER'S OR OTHER SIMILAR DISEASES

Chair Spearman:

We are going to move on to presentations concerning services provided to patients with dementia associated with Alzheimer's or other similar diseases.

Paul Shubert, Chief, Bureau of Health Care Quality and Compliance, Division of Public and Behavioral Health, Department of Health and Human Services:

The Bureau of Health Care Quality and Compliance is a regulatory agency. We license and certify medical facilities and health care facilities, and we do inspections and investigations in those facilities to ensure proper care and services are being provided. (Agenda Item VIII A)

Today, the objectives are to discuss licensing requirements for nursing homes and other residential facilities that provide services to patients with dementia. While there are several different types of dementia, this presentation will focus on rules for facilities related to providing services to individuals with Alzheimer's disease and related dementia. There are three different types of licensed health care facilities. Nursing homes, residential facilities for groups or assisted living facilities, and homes for individual residential care that provide services to individuals with Alzheimer's and related dementia. Within these three facility types, the individuals live within the facility, and facility staffing is available 24/7 to provide supervision. I will discuss the major differences in these settings and the relevant regulations specific to dementia.

Some facility characteristics—nursing homes represent the highest level of care and services and have the most robust set of regulatory requirements. There are both federal certification standards for nursing homes, as well as State licensure requirements. There are several specific requirements designed to accommodate and protect residents suffering from dementia in nursing homes. There are residential facilities for groups, and they are State licensed only. Nevada recently adopted LCB File No. R043-22, and that expanded the ability of residential facilities to provide care to persons with mild dementia to ensure residents receive services in the least restrictive environment. These new regulations also require "resident-centered care" and focus on the needs of the individual rather than a one-size-fits-all approach to providing services.

Finally, there are homes for individual residential care. They are also State licensed only and can only have two licensed beds. These homes may provide services to residents with dementia, but the regulations are minimal and do not speak specifically to dementia. The regulations do assure that residents are assessed to determine each resident's ability to

function independently and require the Director to possess appropriate knowledge, skills, and abilities to meet the residents' needs.

Here are our statutes within Chapter 449, which are the health care facility statutes. The first one says that the Board of Health shall adopt separate regulations governing the licensing and adoption of residential facilities for groups, which provide care to persons with Alzheimer's disease or other severe dementia as described in paragraph (a) of subsection 2 of NRS 449.1845, which is the third one on the slide, and I will go to that one next. If, as a result of an assessment conducted, the provider of health care determines that a resident suffers from dementia to an extent that the resident may be a danger if the resident is not placed in a secure unit or a facility that assigns not less than one staff member for every six residents, any residential facility for groups in which the resident is placed must meet the requirements prescribed by the Board pursuant to subsection 2 of NRS 449.0302.

The first dementia statute [NRS 449.0302] and the third one [NRS 449.1845] relate to one another, and then there is the one in the center [NRS 449.094], which is more general. The Board of Health shall establish minimum continuing education requirements concerning the care of persons with any form of dementia, including, without limitation, dementia caused by Alzheimer's disease, for each person who is employed by a facility for skilled nursing, a residential facility for groups which provides care to persons with any form of dementia.

There are a couple of requirements that relate to one another with regard to residential facilities for groups. Then there is a general requirement that requires nursing homes and residential facilities to provide training on dementia care.

Let us talk about the specific requirements for nursing homes. Since all licensed nursing homes in Nevada are also certified to receive reimbursement for providing services through the Centers for Medicare and Medicaid Services, and since the federal regulations account for approximately 85 percent of all the inspection and investigation activity conducted in nursing homes, it is probably more efficient to discuss the federal requirements that accommodate residents with dementia rather than Nevada specific regulations. There is the following language that is found in the code of federal regulations at Section 483. There are numerous resident rights requirements such as the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.

There are also several regulations that specifically mention dementia, such as a resident who displays or is diagnosed with dementia receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Then there is a requirement for in-service training that must include dementia management training and resident abuse and prevention training. In all, there are 122 mentions of dementia in the federal nursing home regulations interpretive guidelines. It is quite a robust set of requirements that we assess facilities for compliance with when we go into them with regard to dementia.

Next, the specific requirements for residential facilities are found in Nevada Administrative Code (NAC) Chapter 449, and they contain several specific requirements for facilities licensed to provide services to persons with Alzheimer's disease or other severe dementia. The administrator of such a facility shall prescribe and maintain on the facility premises a written statement that includes evidence that the facility has established interaction groups within the facility which consist of not more than six residents for each caregiver during

those hours when residents are awake, a description of the manner in which behavior will be managed, the manner in which medication is managed, and the steps the members of the staff of the facility will take to prevent residents from wandering from the facility.

The administrator of a residential facility that provides care to persons with Alzheimer's disease who meet the criteria prescribed in paragraph (a) of subsection 2 of the NRS, that I previously spoke about, shall ensure that at least one member of the staff is awake and on duty at the facility at all times. In other residential facilities for groups, there is not a requirement for awake staff at all times. Whereas if a facility has the endorsement for Alzheimer's, then they must have an awake member of the staff 24/7.

These are additional requirements that were added to the NAC with LCB File No. RO43-22. The first one is person-centered service. Person-centered service plan is a plan developed for a resident in a residential facility that describes how the facility will provide for the needs of the resident. Then there is Tier 1 training, which means basic training for employees, training in responding to emergency training, and working with residents including without limitation, residents with dementia and their families, and an introduction to person-centered care. Then Tier 2 training speaks to the psychosocial aspects of dementia, current science concerning dementia, and signs and symptoms of dementia and working with persons who have dementia including without limitation, communication, providing person-centered care, assessment of persons with dementia, and planning the provision of care, and assisting with activities of daily living. The Tier 2 training must be provided by a nationally recognized organization focused on dementia, which may include the National Alzheimer's and Dementia Resource Center and the Alzheimer's Association; or their successor organizations; or an accredited college or university; or federal or state government.

Finally, regarding the homes for individual residential care, these are only two-bed homes. I cannot expand on requirements with regard to dementia because the regulations for these facilities do not mention dementia. So, they need to comply with the general statutes and resident rights requirements for the provision of care and services.

This has been a short presentation, but if you have any questions, I would be happy to answer them.

Chair Spearman:

Thank you. Committee, any questions? Does anyone have questions up North? I have one question. I keep saying this—we are aging; the State is aging; we are graying. Are we on track to have at least the minimum amount of people who are trained or can train here in Nevada as we approach 2042?

Mr. Shubert:

That is a difficult question to answer. I believe we have reduced some of the regulatory obstacles in ensuring that facilities can become licensed and provide the services. Ensuring that people receive the training, certainly the staff members that are working in those facilities must receive training and be qualified in order to provide the care and services. But it seems we are always playing catch up, and I think that is perhaps where we will be in the future unless there is some way of encouraging more providers to become licensed.

Chair Spearman:

Thank you, as always, for a very thorough presentation, and we appreciate it.

Next, we will have Dr. Wint from Cleveland Clinic, the Center for Brain Health. Welcome Dr. Wint. I am sorry that changing the time around did not allow for you to be here with us in person, but I thank you for going the extra mile.

Dylan Wint, M.D., Director, Cleveland Clinic Lou Ruvo Center for Brain Health:

Thank you, Madam Chair, and Members of the Committee. I appreciate the invitation to present on this very important topic today. Senator Spearman has asked me to present about the dementia journey, and the needs that arise in a patient and a family's progress through the stages of dementia. (Agenda Item VIII B)

[Due to copyright issues, the presentation (Agenda Item VIII B) is on file in the Research Library of the Legislative Counsel Bureau, Carson City, Nevada. For copies, contact the Library at (775) 684-6827 or https://www.leg.state.nv.us/Division/Research/About/Contact.]

I want to make sure before we go too far, that we are all on the same page in terms of the definition of dementia. Dementia officially is an acquired, objective decline in cognitive function that is sufficient to impede the performance of activities of daily living (ADL). It is important to recognize that it is acquired, which means a departure from previous levels of function. This would not include those, for example, who may have a developmental delay. It is objective. Dementia must be confirmed through standardized testing of cognition that demonstrates that an individual's cognitive performance is below where it should be for their age, and the disability must be related to cognitive performance. People with acquired, objective physical disabilities, for example, would not be considered to have dementia. Although some individuals with dementia do, as part of the processes that cause dementia, have physical disabilities or dysfunction as well. When we say it impedes the performance of activities of daily living, essentially, we are saying that someone who has dementia would be unable to live independently without assistance.

We put activities of daily living on two levels. The basic activities of daily living are the personal care activities: dressing, eating, walking or getting around, managing toileting, communication, and hygiene. Instrumental activities of daily living are higher-level activities that are necessary for someone to run a household. That would include procuring goods for the household through shopping, managing the household with housekeeping and accounting, managing preparing food and getting one's medications, as well as using the necessary technology, and being able to use transportation. That does not necessarily mean they have to be able to drive, but they must be able to get about in some fashion.

It is also important to recognize, as the previous speaker mentioned, that dementia is not a diagnosis, it is a syndrome, meaning it is a clinical state or clinical status, where someone's cognition precludes independent living. The most common cause of dementia by far is Alzheimer's disease, but there are many others and they each have their own specific presentations and causes of disability.

Finally, to make sure we are on the same page with talking about dementia, people do not suddenly wake up with dementia one day. Dementia results from an accumulation of negative influences on brain health that outweigh positive influences on brain health. This starts with genetics. There is an increased risk for dementia if you have not finished

high school, for example. The risk for those who have finished high school but have not finished college is also higher. There are modifiable risks that have to do with lifestyle and management of medical issues, and then nonmodifiable risks, things that we are born with, but influence our risk for developing dementia.

Someone's cognitive journey does not begin with dementia. Generally, people will have typical aging, and thankfully, although dementia is incredibly common, typical aging is the more common course for most people. These are people who do not have symptoms, are functioning normally on a daily basis, and are able to manage independent life; if you were to test their cognition, they would test normal. But about 15 to 20 percent of people as they age enter a status called mild cognitive impairment, where they or someone who knows them well does notice a change in their cognition. However, they are still capable of independent function perhaps with some backups or devices they use to support their function, but they can live on their own. If you were to test their cognition, they would test abnormal compared to other people their age. Then the final stage in the cognitive journey, so to speak, is dementia, where it is clear that the individual does have cognitive dysfunction. It is also clear that the individual was not able to maintain an independent existence and their testing would be abnormal.

I am going to focus on dementia specifically, that was the request. Within dementia, we also separate that into phases of mild dementia, meaning that someone is able to manage all of their basic activities of daily living—those personal care activities, dressing, grooming, hygiene, bathing, toileting, communication, and ambulation. Many people with mild dementia do not actually show symptoms very clearly because they are so capable.

When someone loses the ability to perform one or more of their basic activities of daily living—and most often this is the ability to dress themselves or to bathe without reminders—then we classify them as having moderate dementia. These folks can still do most of their basic activities; they may be doing their toileting and hygiene and feeding themselves and are able to communicate and get around, but at least one of those personal care activities is now lost. People with moderate dementia typically require constant or near-constant supervision. You can see how the care needs escalate very quickly when someone moves from the mild to the moderate stage. Usually, people spend about two years in mild dementia before progressing to moderate dementia.

With severe dementia, the individual needs assistance with all their basic activities of daily living, and they are not able to function independently. Obviously, they require constant supervision, but also a fair amount of hands-on assistance throughout the day with all their activities.

Finally, with end-stage dementia, individuals have stopped communicating. They not only cannot accomplish their basic ADLs independently, but they are also minimally able to even assist someone who is supporting them in those activities of daily living. Often, these folks are either bedbound or if they are not quite bedbound, they require a substantial amount of help to transfer and to ambulate.

As people transition from mild, to moderate, to severe, to end-stage dementia, the needs also evolve. This is not a monotonic increase in needs; it depends on the need and the stage of dementia. One example with medical expertise, there is a high need for medical expertise when people are mildly demented. As I mentioned, sometimes it is hard to tell that something is wrong with them. It requires a medical expert to detect the abnormal cognitive function, to precisely diagnose what is causing the dysfunction, and to initiate treatment. The medical needs decrease for the most part, in terms of expertise in dementia

management. There can be spikes in behavioral concerns or other medical issues that might arise where the input from a dementia expert is necessary, but generally, as someone progresses from mild to moderate to severe dementia, their need for dementia expertise decreases. However, once we start to approach end-stage dementia, now we need a different kind of medical intervention where there is a focus on comfort. There is a focus on preventing medical complications; like pressure ulcers, dehydration, and malnutrition. In the very end-stage, a hospice specialist may be appropriate.

The need for education varies quite a bit throughout the dementia course and varies quite a bit with the knowledge of the caregiver and the patient. There is a high need upfront when we are talking about the fact that the person has dementia when we are talking about what specific dementia the person has and why we think that, and when we are laying out a treatment plan, and coordinating with the patient and the caregiver to progress with treatment. Depending on what arises during the course of treatment, there may be other educational boosters that are needed.

Management of ADLs tends to increase slowly throughout the course of dementia because the ADLs that the patient can perform decrease over time. Emotional support varies quite a bit. For cognitive rehabilitation, the need is most intensive early in dementia, when a patient is still capable of learning new information. But towards the later moderate, severe, and end-stages, cognitive rehabilitation is not of much benefit to the patient or the caregiver. Again, these needs evolve depending on the specific need, the specific patient, the specific caregiver, and their setting.

To break it down a bit more, in mild dementia we tend to have a lot of high-cost needs, including specifying the diagnosis and potential disease-modifying treatment, arranging for safety measures, and potentially—if someone must be placed residentially—moving into an assisted living facility. The average cost—as I understand it—is about $3,500 a month for assisted living in Nevada. Some of these costs vary depending on how the support is provided. For example, disease education could potentially be provided through a web-based platform, where people learn at their own pace about the disease they have. Many of the associations that are associated with these diseases have excellent websites, that is pretty inexpensive. If you want me or one of my colleagues to sit down with a patient and give them disease education, that is going to be quite a bit more expensive. Another example is with advanced directives. If you want a dementia expert to talk through advanced directives with a patient at the point where they are mildly demented, that is going to be costly; it is an office appointment or a neurologic subspecialist. However, there are technological solutions as well as advanced directives and there are solutions in between. For example, with advanced directives at our facility, social workers generally discuss these with patients, or our nurses do. Disease education is very heavily dependent at our facility on nurses and social workers as well.

As someone progresses to moderate dementia, their needs begin to change and the caregivers' needs, in particular, begin to change. Remember now, we are talking about the patient who needs care for their body, and this is a patient who typically is almost certainly not driving anymore. They cannot contribute very much to shopping, and they may be losing their ability to do even the most basic household chores. You see this transition is a great deal of pressure on the caregiver to perform a lot of tasks they did not need to perform before. In addition, there can be increases in behavioral disturbances which can require specialists, geriatricians, psychiatrists, or a dementia expert. We also must think about the fact that someone with moderate dementia still needs the medical care and the dental care that they needed before they had dementia, but now their ability to cooperate

with and to participate in that care decreases. Often someone who is specially versed in taking care of individuals with dementia may be necessary.

Respite care becomes much more important for the caregiver where not only the emotional burden, but now the physical burden has dramatically increased. Training in how to help the patient perform activities of daily living, whether it is training in overcoming what often can be some resistance to help or training in how to manage things. A lot of men, for example, do not know what it takes to clean up a woman who has gone to the toilet. Even basic information like this can be delivered and must be delivered in order to enable caregivers to keep patients at home, which is the overwhelming preference of caregivers and patients predementia.

Residential facilities now would need to be dementia facilities, as the previous speaker mentioned, no longer assisted living facility. Some of the household or group homes can also take folks with dementia, but an assisted living facility would be unsuitable because they do not have the support that is necessary.

As we progress to severe dementia, the caregiver, most of the time, will need some kind of help, family or friend, personal care assistant, or placement in a memory care unit. Now, my understanding is that a nursing home placement in general in Nevada is somewhere between $7,000 and $9,500 per month. It is a very costly option, but inevitable at some point, if someone develops dementia. The kind of medical care now transitions to palliative care, comfort, and support for the caregiver. It is very important that the general medical needs of the patient are attended to because complications of missed medical illnesses can be very expensive at this point.

Finally, in end-stage dementia, we recommend individuals enter hospice care. There are no treatments specific to end-stage dementia that would not have been employed already. The ADL management—now we are talking about a patient who is in need of assistance with transferring; the sheer physical labor that is necessary often requires help. In fact, the Ruvo Center's founder, Larry Ruvo, points out all the time that his mother, Angie Ruvo, had to undergo emergency back and knee surgery about two weeks after her husband died because she had been lifting him to turn him over, to feed him, lifting him out of bed, lifting him back into bed—and she never walked again after those surgeries. These complications can be devastating if caregivers do not have the support, and if they cannot afford a memory care unit.

I have numbers from the Alzheimer's Association that talk about where we stand in Nevada. There is a huge strain on the system. This map shows that Nevada's expected increase in the Alzheimer's disease population over the nine years from 2017 to 2025—is going to be over 40 percent. It is one of the highest in the country, I think third only to Alaska and Arizona. Nevada is already, in 2023, seeing 142 million hours given by family and friends who are caregiving for patients. That is the equivalent of 68,000 full-time jobs over the year and $2.7 billion of unpaid care. There are about 50,000 people estimated to have Alzheimer's dementia in Nevada with 84,000 caregivers for those individuals.

Nevada's Medicare 30-day readmission rate for individuals with dementia is the highest in the country; one in four of dementia patients who are discharged from a hospital in Nevada are back within 30 days. When Medicare counts readmission, they are talking about the same problem or complication of the problem. This is not a new problem; they are coming back for the same problem that they were discharged with less than a month before.

For the charges and the amount of money we spend on hospital readmissions and emergency room charges, we are number three in the country, spending $41,608 per year on those readmissions and emergency room visits. Our Medicaid payments have also gone up more than in any other state for people who are living with Alzheimer's dementia.

It is estimated that we will need more than three and half times the number of geriatricians that we currently have by 2050. If we want to serve 10 percent of the individuals projected to be in the State, 65 and older. If we want to serve 30 percent, we will need almost three times that. For personal care assistance and similar personnel, we will have to increase by about 51 percent by 2030, if we want to serve the needs that are projected.

This seems almost overwhelming. We will definitely need increased capacity to manage dementia. Managing dementia itself may not be the place where we can get the most yield. By the time someone has dementia, they are on a course that is essentially/inevitably leading them towards severe and end-stage dementia—with the attendant costs and increase in strain and pressure on the system. We may be better off looking at preventing dementia, at least while we try to increase our capacity to manage dementia. We may also be better off not necessarily, trying to expand our capacity to be able to handle everyone, but establishing best practices, to improve quality, and use that improved quality as a benchmark or standard for trying to increase the amount or the quantity of services.

All of this requires coordination and navigation, both on the individual patient level, coordinating and navigating the various services they need, but also at the level of medical care systems. Our system, although it is built to take care of folks with dementia, runs into coordination and navigation problems all the time. When we talk about the various organizations at the scale of a state or a country, the need for coordination and navigation multiplies exponentially. Well-modeled and meaningful incentives may enable us to build the quality and then the quantity we need to take care of folks with dementia. As the slides show, these pressures are likely to get worse. In terms of cost, we have disease-modifying treatments that while they are effective and helpful, hopefully will delay or prevent people from getting to those severe end stages, which cost a lot. The current disease-modifying medication is about $25,000 per year for the drug, maybe another $10,000 per year for other tests. When you are looking at someone in a skilled nursing facility, we are talking about $80,000 to $100,000 a year to maintain them in a residence.

Our population is aging; Nevada's population is particularly aging, and I think people are developing increased, perhaps inflated, expectations for what their State will do for them— what medical providers are able to do for dementia. People hear all the time about cures coming down the road, the decade of the brain, and a moonshot for dementia. I have to admit that it sometimes feels as if we have not achieved very much, despite all the effort that has gone in. But people expect results from the effort, and we have to try and meet those expectations. That is the end of my formal remarks. I am happy to take any questions.

Chair Spearman:

Thank you, Dr. Wint. There is a treasure trove of information in the slides. Could you send that to us? Several of the members have asked for that, and I am one of them. I think that it has given us a really good insight. I have some questions, but let me ask the Committee. Do any Members have questions? Anybody up North? You said something startling, you said one of the things that could lead to dementia would be if you did not finish high school. Can you say more?

Dr. Wint:

Not finishing high school is a risk factor for developing dementia. That does not mean that if you do not finish high school, you will develop dementia; but you are more likely to develop dementia if you have not proceeded through high school. There is a somewhat linear relationship between the degree of educational achievement and engagement and the risk of developing dementia.

We think it represents something called cognitive reserve, which essentially, the more you build up your brain's abilities, do good things for your brain, the less you expose your brain to negative influences. Once a pathology starts—Alzheimer's disease, Lewy body disease, or whatever—that brain is more resilient against that pathology. Individuals with the same amount of Alzheimer's disease in their brains may differ in the degree to which it manifests because they are more resilient. You know, if Shaquille O'Neal lost 50 percent of his strength and I lost 50 percent of my strength, it would have a much bigger impact on my ability to perform basic tasks than it would on Shaquille O'Neal. Because he has so much reserve strength, even at 50 percent, he is probably still running better than a lot of us. Does that make sense?

Chair Spearman:

It does. You did not have to throw shade on the running part. You said we do not have nearly the amount of care providers we need. One of the ways we could deal with this is prevention, as a State, would be to form collaborations to build capacity for this, in terms of prevention, intervention, and then once the person has entered into the dementia cycle or phase.

Dr. Wint:

I think one of the ways we could add the most to both prevention and care for folks once they get dementia, is mental health. Depression is a very big risk factor—untreated depression is a very big risk factor for the incidence of dementia. At the prevention end, detecting and treating depression would reduce the risk of developing dementia. Then once people do develop dementia—in fact, psychiatrists are probably second to neurologists in terms of the amount of training we receive for diagnosing dementia and then managing the behavioral complications of dementia. The top three reasons people end up placed in residences are inability to ambulate, loss of toileting control (bowel or bladder continence), and behavioral symptoms. Improving our mental health infrastructure, I think, might be a pretty big bang for the buck.

So much of the early prevention of Alzheimer's is really about lifestyle. In addition to education, reductions in heavy drinking, reduction in smoking, and encouraging aerobic exercise, are some methods by which we could significantly reduce the risk. The quality and quantity of food we ingest are also quite important in risk reduction. Most of these are in folks middle age and on. The education, of course, is an early life factor. Aerobic exercise is probably an early life factor or at least it is easier to get a middle-aged person aerobically exercising if they have been doing it before. Middle age is when we start to see these risks. Then general medical treatment; hypertension and diabetes are also risk factors for developing dementia. Again, the way that we view these is as individual influences, negative or positive, through the life cycle of an individual's brain. You want to try and reduce the number of negative influences and increase the number of positive influences as much as possible.

Chair Spearman:

One last question. What is vascular dementia?

Dr. Wint:

The brain is very greedy for blood; it requires a lot of blood to keep the brain running. The blood is delivered essentially through an arterial tree. Vascular dementia is when that arterial tree is not delivering sufficient blood to the brain; that can come in a few forms. One is a stroke, a sudden loss of blood flow to a region of the brain that results in that part of the brain dysfunctioning. If it is a part of the brain that is important for cognition, then you could have dementia from a stroke. Another way is a reduction in blood flow through the small vessels that supply the brain. They become picked off, but like twigs, each one of these twigs getting picked off may not have much in the way of symptoms or impact. But as they accumulate, you start to get a sick-looking tree and therefore a brain that is not getting the nutrients that it needs. Vascular dementia can also occur if the blood vessels rupture—a hemorrhage. Then there are cases where individuals are continuously getting a trickle of blood and it may be they need to open an artery—carotid arteries, large arteries in the neck. Sometimes if people have a severe narrowing, they can actually have symptoms of dementia because they are simply not getting enough blood in real time; and once that is opened up, they can improve. Vascular dementia is the second most common reason that people develop dementia.

Chair Spearman:

I am going to make a statement, if it is true, then yes or no. It seems to me you mentioned two diseases, high blood pressure and diabetes. I have heard those present themselves first for a lot of the diseases that we have. The demographic groups that are more likely and increasing, in terms of high blood pressure and diabetes, are in black and brown communities.

Dr. Wint:

Yes, that is correct.

Chair Spearman:

Thank you Dr. Wint for your presentation. With that, I think I will give you a call—I have more questions, but I will give you a call later. We thank you for that.

Dr. Wint:

Thank you, Chair.

Chair Spearman:

I saw the look on some of the Committee Members' faces, and I think there will probably be at least three bill draft requests (BDRs) coming out of Dr. Wint's presentation.

AGENDA ITEM IX—PRESENTATION FROM THE STATE CONTRACTORS' BOARD CONCERNING FRAUDULENT CONTRACTORS AND THE ACTION TAKEN BY THE BOARD TO ADDRESS CASES OF FRAUD

Chair Spearman:

Let me say before you get started, Margi I appreciate your diligence, you and your staff, in terms of working through a lot of the issues that we have had here. I think the most productive session we had was maybe in 2019 or 2017, when we did a whole lot of things, and hopefully, the next most productive session will be in 2025. With that, please begin.

Margi A. Grein, Executive Officer, State Contractors' Board:

Good afternoon, Chair Spearman, Vice Chair Marzola, and Members of the Committee. Thank you for the opportunity of letting us provide you with information today on our efforts to combat and address unlicensed and fraudulent contracting activities. I have with me today my Deputy Executive Officer, Dave Behar, who previously served as our Director of Investigations.

Our primary mission is to protect the health, safety, and welfare of the public (Agenda Item IX). We currently serve and address the needs of over approximately 18,000 active licensees across the State, while also assisting the public who engages in residential and commercial contracts.

While our process for licensed contractor complaints affords many opportunities for consumers to seek financial recovery through the Board's Residential Recovery Fund, when eligible, our largest concern resides with the work performed by unlicensed contractors. In these circumstances, the Board will still investigate the complaint, but instead of ordering corrective action when issues are validated, cases are referred to the local District Attorney's Office (DA) or the AG for prosecution. Even with many of these processes and protections in place, fraudulent activity remains a reality in the construction industry.

Currently, our most concerning trend is the financial harm resulting from contracts for residential solar. The fraudulent activities are being experienced among licensed and unlicensed contractors who engage in practices that do not align with industry standards or statutory requirements. Although we have made progress in passing legislation recently that heightens the contract requirements for solar projects, it is still not enough to combat the complexity of the issues we are facing. Today's presentation is intended to provide you with the foundation of our investigative process, highlight the types of fraudulent activities we are seeing, and share with you our ongoing efforts being implemented to keep the members of our community safe. With that, I will turn it over to Mr. Behar.

David Behar, Deputy Executive Officer, State Contractors' Board:

Good afternoon, Chair Spearman, and Members of the Committee. I am here today to provide you with an overview of the Nevada State Contractors Board's investigative process, with an emphasis on unlicensed and fraudulent activity, as well as a brief update on the impact of our 2023 legislative bills.

The mission of our Board is to promote public confidence and trust in the competence and integrity of our licensees while protecting the health, safety, and welfare of the public. Our focus is centered on consumer protection, licensing and regulation, investigations and complaints, and providing adequate public awareness.

Our compliance enforcement and complaint processes involve a variety of issues involving workmanship, money owing, and industrial regulations, such as out-of-scope or permit issues. As part of our investigative process, we often conduct job site visits and informal citation conferences, while administering discipline through administrative citations and also disciplinary hearings.

Our criminal enforcement is primarily focused on unlicensed contracting and advertising. We also do proactive enforcement efforts, stings with a number of our law enforcement partners, and we also pursue cases that seek prosecution and restitution for some of our victims who have been taken advantage of. Additionally, our Fraud Unit conducts additional investigations that deal with more complex matters that might involve things such as the diversion of funds, theft, and even forgery.

As part of our consumer awareness efforts, we regularly conduct workshops with members of the public throughout the State. Along with additional outreach programs, we offer a variety of resources to individuals and members of the industry. We have brochures and pamphlets. We have also most recently encouraged a widespread media campaign that has included public service announcements with both our Governor and Attorney General. We conduct social media updates on a regular basis on a number of platforms, and we have also provided consumer alerts to individuals to give them recent updates on new legislative issues and other matters that might be of interest to them.

One of the areas of focus for us is that currently, the statute of limitations for filing a criminal complaint against a contractor is two years after the commission of an offense. Any changes to this would require legislative approval, and that is the current statute that exists.

Something we take seriously is abuse that might occur to our elders and seniors in our community. As part of our initial investigative process, our Board asked complainants to indicate if they are 60 years of age or older on our complaint forms. During that submittal process, they have an opportunity to mark that form, it will indicate that on our behalf. The Board utilizes our authority as well oftentimes to assess a maximum fine if we determine that a violation identified that an individual was over 60 years of age. We also take that same approach with a number of our prosecutorial partners and they also have an opportunity, if a criminal case is brought to them, to also bring advanced penalties against somebody.

One of the more recent initiatives that we are most proud of, and that we have implemented, is an increase in public awareness and visibility with respect to unlicensed contractors on our violator website. This program has provided a platform for the public to avoid some of our most egregious unlicensed contractors that have preyed on members of our community in both the northern and southern part of our State. This program has allowed us to post the actual photos and a summary of the illicit activity of these most egregious contractors, so when a member of the public might be looking to hire somebody, they have an opportunity to view our website and see if any of the people that they are looking to hire might have already been violators with the Contractor's Board.

This next slide (slide 10) provides a breakdown of our criminal complaint statistics during FY 2022–2023. As you can see, the number of total complaints we received during that time frame was 777. Of those, 524 were for contracting without a license, 237 were for unlawful advertising, and 16 were for fraud. The second column shows the number of total complaints that we closed; highlighted there are 11 of them that were closed because they were over the statute of limitations.

As Executive Officer Grein indicated in her opening remarks, the Board has seen a significant increase in the number of total complaints related to residential solar. In an effort to help combat this issue, we are frequently engaged in information-sharing sessions and the development of enforcement strategies with the AG and other members to help protect consumers. These ongoing efforts have included enhanced protections under legislation that was put into effect on January 1, 2024, which mandated new requirements for licensed contractors who perform work on residential solar photovoltaic systems.

Another collaborative effort we are proud of that has been undertaken by the Board has been the expansion of our interagency, Underground Economy Task Force. The purpose of this Task Force was to combat unlicensed contracting, as well as fraud and other illegal construction activities. This coordinated group consists of various agencies and stakeholders across our State, such as Business and Industry, the AG, OSHA (Occupational Safety and Health Administration), as well as the Labor Commission. Members of this Task Force meet on a rotating basis in both Northern and Southern Nevada and work collectively to combine our resources to help stop unlicensed contracting across our State with an emphasis on those who are impacting the economy in illegal ways.

Other measures we take in an effort to ensure that our licensing requirements are met by those applying for a licenses; we have specific requirements that must be met by those who are applying. These include the passing of trade and law exams, the ability to demonstrate financial responsibility, and a verifiable proven level of experience in a particular construction field. The misrepresentation of this information or someone's criminal history by applicants can oftentimes be grounds for an actual denial of a license or an administrative citation that is issued by our Board.

At the Committee's request, I would also like to briefly provide an update on the impact of our 2023 legislative bills. Starting with AB 22, was implemented on October 1, 2023, and its purpose was to revise provisions governing the actions that our Board is authorized or required to take after the issuance of a cease and desist order for unlicensed activity. To date, this bill has allowed criminal investigators the opportunity to prioritize and address unlicensed contracting on a multitude of levels to protect consumers and licensed members of the industry. It has also helped to provide us with a path for first-time violators.

Assembly Bill 23, which was also implemented on October 1, 2023, revised provisions relating to the resolution of certain administrative citations through what is called an informal citation conference. To date, this bill has been extremely effective in helping to timely resolve administrative citations, and provide clarification to both licensed and unlicensed contractors regarding best practices and the regulatory requirements under NRS 624. It has improved the efficiency of our disciplinary processes, and it has also helped to minimize unnecessary hearings as well as fees and costs to those who had been issued a citation. The bill has allowed for administrative citations to either be affirmed, amended, or withdrawn following an informal conference.

Since its inception, these are the most recent statistics since October; we have held 15 conferences—as the word has spread that this is an opportunity for somebody to challenge a citation, we expect an increase in this number. Again, it can either be affirmed, withdrawn, or amended.

Assembly Bill 27, which was implemented in May of 2023, revised the provisions relating to contractors who provided management counseling services on construction projects by requiring a general building contractor who provides management and counseling services

on a project to have an active license in the same classification or subclassification that were required to be held by that prime contractor.

Assembly Bill 29, which was also implemented in October, revised the grounds for disciplinary action against a licensed contractor who provided a false or misleading statement in connection with the application of another person. To date, this bill has effectively been used by our staff to deter licensed contractors from providing fraudulent or misleading statements, and to assist others in obtaining licensure without having the proper experience. Contractors who would falsely provide this information could receive an administrative citation or even additional disciplinary action. It has been a good deterrent to prevent people from doing that.

Lastly, AB 39, which was implemented also on October 1, 2023, established mandatory elements to be included in contracts for work concerning certain residential improvements and provides for disciplinary action for someone who fails to comply with that. To date, this bill has effectively been introduced as part of an overall strategy to help improve consumer protection for the public with respect to residential construction. Since its implementation, our Board has taken an aggressive stance in conducting workshops, webinars, industry bulletins, a number of association meetings, and other measures to help assist consumers and provide them with current knowledge regarding the new requirements that would be required by a contractor regarding residential contracts.

This slide is a checklist our Board has put together. We have done a number of things to provide that to the public, and we have also posted that on our website as an additional resource for anybody who has questions regarding that.

Thank you again for allowing me the opportunity to present to you today, and I am happy to answer any questions you might have.

Chair Spearman:

Thank you. Committee Members do you have any questions? Assemblywoman Kasama.

Assemblywoman Kasama:

It still seems—you mentioned solar—there are a lot of high-pressure tactics on homeowners when people come in. Is there any thing in statute, for some of these contracts for the right of rescission? I have heard from constituents, they come to the house at 10 o'clock and they are there for two or three hours, pressuring them to sign the contract and then they leave and then the person says, "Oh, my goodness, what have I done?" Is there any time frame that they can have a rescission of that contract?

Ms. Grein:

Yes, under Chapter 598 for the AGs statute, they put in provisions with the right for rescission, I believe it is up to three days to cancel that contract. But we are seeing—I am sure you have all experienced as well at your own homes—high-pressure sales tactics, especially solar right now. They are at the door; they are bombarding you with phone calls. We are probably going to be putting forth legislation to address that even further this next session.

Assemblywoman Kasama:

It is a three-day right of rescission?

Ms. Grein:

Yes, it is.

Assemblywoman Kasama:

Wonderful, thank you.

Chair Spearman:

Assemblywoman Backus.

Assemblywoman Backus:

Thank you and welcome, Mr. Behar, to our Legislative Interim Committee. I have questions, and I think it goes along with what you were saying in the presentation. One was taking a look at the criminal statute of limitations where there are prosecutions of unlicensed contractors. That basically only allows two years from the date of the offense. I am assuming if the date of the offense is when an unlicensed contractor entered a contract with a homeowner—that would be the date of offense. However, under NRS 624, consumers could have up to four years to file a complaint with you. It is possible that time period could miss an unlicensed contractor—it could be even a person who is a habitual violator—who can sneak by the system because of the statute of limitations. Am I understanding that correctly?

Mr. Behar:

Yes, that is the current way the statute reads.

Assemblywoman Backus:

That is what I was looking at because I was thinking, and I think people have heard it before. My area of practice is—I do some construction law. I have also recently seen where maybe an unlicensed contractor could enter a settlement agreement and that could also delay time. If they enter a settlement agreement and they do not do what they are supposed to do, they could likewise get extended beyond that two-year period and not get prosecuted. There is nothing to capture those people who may be taking advantage of a consumer.

Mr. Behar:

That is correct. One of the things we are trying to do to help raise awareness of that, is we have done a lot on the media side to make sure people are encouraged to check somebody's license, to be proactive, before they hire somebody, to help avoid those types of situations.

Assemblywoman Backus:

You are going right into my next area of questioning, consumer awareness. I know Director Grein has been out in the community trying to educate people, but then some people still do not know this. This is kind of personal too because I have noticed on houzz.com, for example—and I do not know if there is any way we could address this—because I know on houzz.com, some unlicensed contractors will take advantage and advertise blatantly on houzz.com. Have you guys—I do not know if there is any way—or

maybe even looking legislatively, if there is anything we can do because I know you all have your rules under NRS 624. But it seems there are these public outlets that an innocent consumer can go to and be taken advantage of in an environment they feel safe in.

Mr. Behar:

One of the efforts we have recently undertaken is a much more robust, aggressive stance toward being proactive in those particular areas with social media. Everybody does everything on their phone or through a computer nowadays and everybody is chatting and recommending contractors to each other. Without revealing too much, we take a very aggressive approach to that to try to broaden the message and to bring awareness. We are also very much on top of a number of publications that get spread out throughout our State. Individuals will come directly to your home, for example. We take a broad look at all of those things to try to help prevent that from happening.

Assemblywoman Backus:

One of the things I was thinking of is because this happened to one of my coworkers. They thought they had a licensed contractor come out and one of their employees was utilizing the licensed contractor's information. I think that licensed contractors kind of felt obligated. They did not want to get in trouble with the Contractor's Board, I think they are trying to do what is right. Have you guys thought about any legislation? Such as, hold harmless? Or somewhere there could be a way to meet, so we are encouraging contractors to tattle on these unlicensed contractors, whether it is reporting them—because I am worried in that situation. The contractor may not sell out its employees because they do not want to get in trouble. Yet that person is getting skills to further take advantage of homeowners without using a license or trying to use another person's license.

Ms. Grein:

The proposal I am submitting to our Board for consideration, is one of the items.

Assemblywoman Backus:

Thank you, because I see it with these—it was a solar contractor where the employee was out there, kind of going wild. Thank you so much for that.

Chair Spearman:

I want to follow up. Then, Assemblyman O'Neill, I will be coming up north. I think with my layman's mind here—I am not an attorney and I never played Perry Mason or Perriette Mason. Is there something—like child abuse and that sort of thing—there is a duty to report? Is there anything like that in statute? Maybe it is a better question for Legal, but is that something we might be able to do, to address the concern that Assemblywoman Backus went through?

Ms. Grein:

We would certainly be interested in looking into that.

Chair Spearman:

Assemblyman O'Neill.

Assemblyman O'Neill:

You said the statute of limitations is two years from the signing of the contract. Is there an extension on that if the work done—the homeowner would not have seen the substandard work or work done not in agreement with the contract—like flooring or electrical wiring that is behind walls or under flooring, that is not up to standard—and it takes several years for it to be discovered. There is no recourse at all that can go through the Contractors Board. Did I understand that correctly?

Mr. Behar:

Again, people will have up to four years to file that complaint if it is with a licensed contractor and sometimes the issue may not initially be noticed—as you are pointing out.

Assemblyman O'Neill:

What if it is beyond the four years? I mean, child abuse probably is not a perfect example, but they have years to come forward on that. You may not find out that your plumbing work, or electrical work, or even the flooring was substandard for years later—when you go to remodel or there is a fire or some other issue that comes up for that—beyond the four-year statute. In other words, is there any recourse at all for the homeowner who has paid good money for this work to be done that was not done?

Ms. Grein:

I believe some of those remedies might come under Chapter 40 rather than Chapter 624 after the statute of limitations had run.

Assemblyman O'Neill:

Good enough, thank you.

Chair Spearman:

Assemblywoman Torres.

Assemblywoman Torres:

Thank you for the presentation. It is great to see you both again. My question is specifically going back to the conversation regarding solar. In my community—and I think in a lot of vulnerable communities—one of the things we are seeing with these solar vendors is the door-to-door knocking, coming around saying you have to convert to solar—has been the messaging. I received a paper that came to my house that said because of a bill that we passed in 2021, we have to convert to solar by 2030, which is not the bill that we passed. But then when that information is going around, there is a lot of misinformation in the community. I think they are specifically targeting vulnerable communities, the elderly and maybe, and "BIPOC" (black, indigenous, and other people of color) communities. What do we do? Is there a way for those companies to be reported? What would that look like? How do people who are good citizens get that information? What are they supposed to do with it? Likely these are not licensed contractors.

Mr. Behar:

We work very closely with the AG, Bureau of Consumer Protection. One of the things I would recommend if somebody felt they have been taken advantage of is to contact them directly and provide that information to them. We are also working collectively with them to try to combat some of that with these door-to-door sales tactics. A lot of false promises are made to people with respect to rebates—they are going to lower your energy bill, things of that nature, then they will work to try to get somebody quickly into a long-term loan. That is where we are seeing a significant amount of damage done to consumers, particularly—as you pointed out—to the more vulnerable members of our community or seniors, who will find themselves in a long-term loan—an 80-year-old individual that has gotten themselves wrapped into a 30-year loan, for example.

Assemblywoman Torres:

I think a couple of months ago they went to my dad's house and my dad said, "We have to convert to solar energy." I asked, "Oh Dad, let me look at this first." I think they are being very intentional. Is there anything we can do? Once they have already done the damage, you can report it. How do we stop these bad actors before they have even done the damage?

Ms. Grein:

I think it is an ongoing education effort and that would probably involve the Public Utilities Commission of Nevada (PUCN), maybe NV Energy, as well as our elected officials. We are trying to get the word out as much as we can. One thing that we find effective is when we get the media to report on one of these, then a lot of people may see that on TV. We need to inform the public. I have had those same flyers come to my door. "Do you know what the power company is doing to your power bill?" And "You have to do this." It is an ongoing effort and many people that we can reach, and we are trying to extend that effort. I think some of the problem is these salespeople who come to the door may be working for multiple companies. We changed the law last session, so they are supposed to be W-2 employees, instead of going door-to-door as a 1099 with no loyalty to anyone in particular—trying to get their sales commission. That went into effect on January 1, 2024, as well. Hopefully, we will see the results of that, but we are far from it. It is continually getting worse as far as what we are seeing with this particular industry. We are looking for answers.

Chair Spearman:

Thank you. Additional questions Committee? I have a couple. Ms. Grein, you mentioned something about DA prosecuting, and I think it might go along with what Assemblywoman Backus was saying—someone else asked—once you discover that you have been scammed, the clock starts there or not. Because this is what I have heard, that even if they report it sometimes to the DA, nothing happens. I am not shading on DAs; I am not doing that at all. I am saying, is there anything we might be able to do to make sure there is clarity in terms of those two years? I, for one, think it needs to be longer because sometimes the way they do these things, you do not even know there is a problem until after they finish. You do not even know that they have not done something right until a pipe bursts, or until your foot goes through the floor, or the solar thing burns your house, or whatever. I am wondering what can be done if it is discovered two and a half years or four years afterward, what can be done?

Ms. Grein:

Perhaps it might be best for us to get clarity on that. Maybe I could request an advisory or AG's opinion to get clarity on that subject because then we would have something in writing, that we would know we could continue that effort.

Chair Spearman:

Sam, do you want to chime in on this?

Mr. Quast:

Specifically, we are talking about unlicensed contracting and under NRS 624.800, the statute of limitations for a variety of different violations of the contractor provisions that are punishable as a misdemeanor. The first violation of unlicensed contracting is punishable by a misdemeanor, that is two years. But in NRS 171.095, it provides for an extension of that two-year period if the offense is committed in a secret manner. If it is committed in a secret manner, that would extend the period to two years after the discovery of the offense. There is not a lot of case law about what actually constitutes a secret manner when it comes to these contractor provisions. Most of that stuff is sexual assault, sexual abuse, that kind of thing. Saying specifically what constitutes a secret manner in the context of this is a bit difficult, but it is generally when a crime is committed in a deliberately surreptitious manner that is intended to and does keep all those committing the crime unaware that an offense has been committed. If it was in those circumstances, it would then extend it out to two years after the offense was discovered, but I should say that the Legislature can adjust those or clarify them as they wish.

Chair Spearman:

That may address what Assemblywoman Torres said about her dad saying, "We have got to get it done." If there was someone else that possibly did it and they are beyond that three-day right to refuse, that could apply to that. Yes, I mean, with clarification, it sounds like it does. I think what we have to do is tighten it up some.

Mr. Quast:

It could perhaps apply in that situation. It would likely depend on the specific facts of the case, and this would be something that the State would have to then prove that it was committed in a secret manner to toll that statute of limitations.

Chair Spearman:

What if they have something that looks like a license, but it is not a license? What if they are using someone else's business seal and the person thinks they are looking at a real license? I am trying to remember a conversation that I had. If they are doing that and they show it to someone and they say, "Oh, okay. I know that company." Does that make sense to you? They show you something that looks like a license and looks legal, but it is not.

Mr. Behar:

Oftentimes we will encounter unlicensed contractors who will show somebody a business license, for example, and an average person may think that is actually a contractor's license that allows them to do construction for them. That perhaps, as was previously discussed, could be considered a secret manner in which somebody tried to conceal something that is

ultimately probably a matter of interpretation based on the individual circumstances of the case.

Chair Spearman:

Thank you. Additional questions?

Assemblywoman Backus:

I have a question. I was trying to look it up myself, but on your most wanted list—you showed it in a slide to give people a visual—and it is also displayed in your office so people can see who those habitual unlicensed contractors are in the community. With respect to those, how does someone get on that most-wanted list? Are those guys getting criminally prosecuted? Do they have warrants? I am wondering what gets you on that most-wanted list.

Mr. Behar:

What we have tried to do with that is pick our worst habitual offenders who have had high dollar amounts or have really targeted the most vulnerable members of our community—our elderly folks and things of that nature. That is what we have used that for. Yes, the majority of them have been prosecuted through either the AG or the DA.

Chair Spearman:

Thank you, I appreciate it. Does anyone up north have any questions? It does not look like we have any more questions. I am pretty sure there is going to be a Committee BDR because the things we have been hearing require that. I am not speaking for anybody but me, but I think there is a special place in hell for people who do that to unassuming seniors. I saw something on one of the channels—Darcy Spears I think—was helping a lady who was scammed and did not know it. Those people that are running around talking about solar; we need to make sure we have in statute that they will be prosecuted to the fullest extent of the law—and unequivocally, very plain. That is my comment. You can respond or not, but that is my comment.

Ms. Grein:

Thank you. We appreciate your comments and your time today, and thank you for allowing us to come in and present. We are always here if any of you have any questions.

Chair Spearman:

Thank you for waiting so patiently.

AGENDA ITEM X—PUBLIC COMMENT

Chair Spearman:

With that, we are up to public comment. Is anyone here in Las Vegas to give public comment? I am looking at Carson City, I do not see anyone. BPS, do we have anyone on the phones?

BPS:

If you would like to participate in public comment, please press *9 on your phone to take your place in the queue.

David White, DDS, Member, Nevada Dental Association (NDA), and Chairman, Council of Government Affairs:

Hello, I am calling in on behalf of myself as a dentist, as well as an NDA member and Chairman of the Council of Government Affairs. I want to go ahead and lend our support to the Compact. We have had a great collaborative effort with the hygienists and ADSO and large group practices. We are experiencing an extreme shortage of hygienists in our region. This is creating a problem because of the collaboration or the synchronicities that we know are happening between oral health and medical health. In particular, right now it is very difficult for a new patient to be seen by a hygienist. Recently, I had a patient come to my office from Lovelock who needed to receive chemotherapy and they were not able to get the cleaning they needed to get done; so there was a delay in their medical treatment.
The Compact will help. Unfortunately, it is one of many solutions that we need to solve this hygiene [hygienist] shortage. We want to go ahead and throw our support behind that, and we look forward to working to correct this shortage.

BPS:

There are no more callers wishing to participate at this time.

Chair Spearman:

Thank you for your diligence, for your attention, and for everybody who is listening online, thank you for that as well. We look forward to seeing you all here next time on May 23, 2024.

AGENDA ITEM XI—ADJOURNMENT

There being no further business to come before the Committee, the meeting was adjourned at 1:35 p.m.

Respectfully submitted,

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Bonnie Borda Hoffecker
Research Policy Assistant

_____

Cesar Melgarejo
Principal Policy Analyst

APPROVED BY:

_____

Senator Pat Spearman, Chair

Date: _____

MEETING MATERIALS

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
Agenda Item IV	Matt Shafer, Deputy Program Director, National Center for Interstate Compacts, The Council of State Governments (CSG)	PowerPoint Presentation
Agenda Item V A	Kelli May Douglas, Pacific Southwest Regional Liaison, Defense-State Liaison Office, United States Department of Defense (DOD)	PowerPoint Presentation
Agenda Item V B	Kelli May Douglas, Pacific Southwest Regional Liaison, Defense-State Liaison Office, U.S. DOD	2024 State Policy Priorities
Agenda Item VI A	Matt Shafer, Deputy Program Director, National Center for Interstate Compacts, CSG	PowerPoint Presentation
Agenda Item VI B	Matt Shafer, Deputy Program Director, National Center for Interstate Compacts, CSG	Fact Sheet
Agenda Item VI C	Matt Shafer, Deputy Program Director, National Center for Interstate Compacts, CSG	Dentist and Dental Hygienist Compact
Agenda Item VI D	Caryn Solie, RDH, Nevada Dental Hygienist's Association Government Affairs	Written Testimony
Agenda Item VII A	Vikki Erickson, Licensed Clinical Social Worker (LCSW), Executive Director, Board of Examiners for Social Workers	Written Testimony and Compact Map

Agenda Item VII B	Stacey Hardy-Chandler, Ph.D., J.D., LCSW, Chief Executive Officer, Association of Social Work Boards	PowerPoint Presentation
Agenda Item VIII A	Paul Shubert, Bureau Chief, Health Care Quality and Compliance, Department of Health and Human Services	PowerPoint Presentation
Agenda Item VIII B	Dylan Wint, M.D., Director, Cleveland Clinic Lou Ruvo Center for Brain Health	PowerPoint Presentation This is on file in the Research Library of the LCB, Carson City, Nevada. For copies, contact the Library at (775) 684-6825.
Agenda Item IX	Margi A. Grein, Executive Officer, State Contractors' Board	PowerPoint Presentation

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