# NEVADA LEGISLATURE
# NEVADA SILVER HAIRED LEGISLATIVE FORUM

(*Nevada Revised Statutes* [NRS] 427A.320)

## MINUTES

**June 26, 2024**

The fourth meeting of the Nevada Silver Haired Legislative Forum for the 2023–2024 Interim was held on Wednesday, June 26, 2024, at 10 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 Forum'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).

### FORUM MEMBERS PRESENT IN LAS VEGAS:

Marilyn E. Jordan, Senate District 9, Vice President
Peggy Leavitt, Senate District 20
William Marchant, Senate District 12
Fred L. Silberkraus, Senate District 5
Frank B. Slaughter III, Senate District 11
Roger Troth, Senate District 18

### FORUM MEMBERS PRESENT IN CARSON CITY:

Lucille Adin, Senate District 13, Northern Facilitator
Mary Fesenmaier, Senate District 17

### FORUM MEMBERS ATTENDING REMOTELY:

Joann M. Bongiorno, Senate District 10
Cher Daniels, Senate District 14
Laura Leavitt, Senate District 8
Bob Linden, Senate District 7
Elizabeth Martinez, Senate District 2
Fayyaz Raja, Senate District 6

## FORUM MEMBERS ABSENT:

Fran Almaraz, Senate District 21, Forum President (Excused)
Margaret Batts, Senate District 4 (Excused)
Valarie Woods, Senate District 3 (Excused)

## LEGISLATIVE COUNSEL BUREAU STAFF PRESENT:

Ashlee Kalina, Constituent Services Analyst/Program Facilitator
Destini Cooper, Senior Policy Analyst, Research Division
Julianne King, Assistant Manager of Research Policy Assistants, Research Division
Bryan Fernley, Chief 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—CALL TO ORDER

***Vice President Jordan:***

Welcome to the fourth meeting of the Nevada Silver Haired Legislative Forum. We certainly want to let our President know we wish her a speedy recovery and look forward to seeing her at our next meeting.

[Vice President Jordan reviewed housekeeping measures.]

## AGENDA ITEM II—PUBLIC COMMENT

[Vice President Jordan reviewed public comment guidelines.]

***Vice President Jordan:***

We will start with those in the physical locations and then move on to anyone who has called in. Is there anyone in Las Vegas who would like to provide public comment at this time? Is there anyone in Carson City who would like to provide public comment at this time?

***Ms. Fesenmaier:***

Transportation for medical appointments is only provided one, two, or three times a week in some areas and not at all in other areas. This does not address the needs of people who might have radiation, dialysis, or even things like chemotherapy, rehab, et cetera. Shopping opportunities only occur once a month. I cannot imagine needing fresh fruits, vegetables, and so on and only be able to go to the grocery store once a month. This should be doubled at the very least.

***Vice President Jordan:***

Thank you for those comments. Our Broadcast and Production Services (BPS) staff will interact with those phoning in for public comment. Please add the first caller with public comment to the meeting.

***BPS:***

Vice President, your public line is open and working, but you have no callers at this time.

***Vice President Jordan:***

Seeing as there are no callers, we will move to our first order of business.

## AGENDA ITEM III—APPROVAL OF THE MINUTES FOR THE MEETING ON MAY 22, 2024

***Vice President Jordan:***

Next is the approval of our May meeting minutes. Forum Members, do you have any questions regarding the minutes? Hearing none, I will entertain a motion to approve the minutes of the Forum meeting on May 22, 2024.

DR. MARCHANT MOVED TO APPROVE THE MINUTES OF THE MEETING HELD ON MAY 22, 2024.

MS. PEGGY LEAVITT SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

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## AGENDA ITEM IV—OVERVIEW OF PUBLIC TRANSPORTATION PROGRAMS FOR SENIORS AVAILABLE THROUGH NEVADA'S REGIONAL TRANSPORTATION COMMISSIONS

***Vice President Jordan:***

Next is an overview of public transportation programs for seniors available through Nevada's Regional Transportation Commissions (RTCs). We have presentations from RTC of Southern Nevada and RTC of Washoe County. We will take questions from Forum Members at the end of the presentations.

***Terri Reed, Administrator of Paratransit and Special Services, RTC of Southern Nevada:***

Thank you for having us today. I am excited to share with you a bit more about who the RTC is, our role in the community, as well as share some insights on our ongoing initiatives and services for the community. (Agenda Item IV A) [Due to copyright issues, the presentation is on file in the Research Library of the LCB, Carson City, Nevada. For copies, contact the Library at (775) 684-6827 or https://www.leg.state.nv.us/Division/Research/About/Contact.]

Before we begin, I want to share more on who the RTC of Southern Nevada is and what we are responsible for. The RTC of Southern Nevada is the regional planning agency. We oversee public transportation, the bike share system in downtown Las Vegas—among other cycling initiatives—as well as roadway planning, funding traffic management, and the implementation of the regional plan for Southern Nevada. We are essentially the transit agency, metropolitan planning organization, and traffic manager for the entire region all under one roof.

At the RTC, it is our responsibility to provide transportation options for our residents and visitors. These options include our fixed route bus service, paratransit, as well as special programs for our seniors, veterans, and other community initiatives we take part in. The RTC's vision is to provide a safe, accessible, and efficient regional transportation network that enhances the quality of life (QOL) for Southern Nevada's residents and visitors. Transit is an important component of this vision, as it helps to reduce traffic congestion.

For those who are unfamiliar with our service area, the map shown provides the most accurate representation of our current service area. We are aware there are areas in our region that we have not been able to sufficiently service, like Anthem and Southern Highlands. Regional Transportation Commission paratransit services are currently determined by our fixed route or city bus services. Unfortunately, we cannot grow as quickly as our city has. Events like this allow us to receive feedback from our residents on what we can improve. We strive to be efficient in our transit systems growth. The RTC has a thorough evaluation of route additions and cuts. We look at population density, business

growth, economic development opportunities, and how developing areas in our region will need to connect to other routes.

Our traditional bus service is often referred to as fixed route, which is a bus operating along a route on a fixed schedule. The system offers quick and affordable service that can help you travel throughout the Valley using one of our 39 routes, including going to shopping centers, clinics, restaurants, the airport, and the Strip. Fares for fixed route bus services cost $2 for a single ride or $5 for a 24-hour pass. If purchasing your fare on our bus, you need to have the exact fare amount ready, which is $2 for a single ride or $5 for a day pass. For seniors with a reduced fare identification (ID) provided by the RTC, the fare is half price, so it is $1 for a single ride and $2.50 for a day pass.

The RTC provides paratransit service, which is a reservation-based shared-ride door-to-door program available to customers who are physically or cognitively unable to independently use the RTC's fixed route system. To be eligible for the RTC's paratransit service, customers must go through an evaluation process based on one's ability to use the fixed route system. This service operates 24 hours a day, 365 days per year within the urbanized areas of Clark County. We also have RTC OnDemand service which offers rides at the customer's request instead of forcing riders to plan a trip around a bus schedule. Regional Transportation Commission OnDemand will pick you up from your doorstep and connect residents of west Henderson and the Southwest Valley to transit stops and other popular destinations.

If you are interested in applying to become certified for paratransit services, you will need to request an application from the RTC certification office. Customers who have requested an application for paratransit services may be required to participate in an in-person interview and may require a functional ability assessment to determine if they are eligible for services. If required to go through the assessment, the RTC will provide complementary transportation to and from the appointment. If using paratransit, customers can call up to three days in advance to schedule a ride. A much more convenient option is our paratransit mobile app, also known as myRTCpara. The app allows customers to schedule and track the ride directly from your phone. Scheduling and paying for the trip can also be conveniently accessed through our web portal at rtcsnv.com. Paratransit rides one way are $3. Customers may also purchase in person at the RTC administrative building, by mail, or online at our paratransit web portal. Even if paratransit certified, you may still choose to use a fixed route system for some trips. One perk is the customers who are paratransit certified may ride the fixed route system for free.

We have a non-dedicated service. The RTC’s paratransit contractors partner with non-dedicated service providers. Currently, SilverRide and UZURV provide an added mobility option that complements the Americans with Disabilities Act (ADA) paratransit service. Riders who opt in can expect either an RTC paratransit vehicle or a UZURV or SilverRide vehicle to arrive during their scheduled pickup window. While these programs may not be directly requested, they can be used as a way to supplement paratransit rides. If a non-dedicated service vehicle is selected, the client will receive a text from the RTC advising that the trip was moved. They will also receive a follow-up text from the vehicle with trip, vehicle, and driver details. The selected vehicle will be clearly identified with the logo from one of our service partners. To be eligible for participation in the program, customers must also meet the following criteria: be able to travel independently, which means it may not be suitable for persons with intellectual or memory deficits; at this time, wheelchair, scooters, or non-collapsible walkers cannot be accommodated; customers must have a smartphone with text capability.

We also have a Mobility Training Program. Mobility training is a free one-on-one or group training program to help seniors, students, and people with disabilities learn to use the RTC transit service safely and properly. Mobility training is meant to help develop the skills and confidence needed to travel independently. For those who may not be familiar with using public transportation, the RTC offers this and one other program. The time spent on training is customized to fit the client's individual needs. An RTC instructor will spend as much or as little time as needed to get you to the point where you are comfortable traveling independently.

In Fiscal Year (FY) 2022–2023, the RTC provided more than 49,000 trips to seniors through services dedicated to improving the QOL for our residents. For a little background, Silver STAR is a service open to the entire community but was designed with seniors in mind. The service stops at senior living communities and various shopping areas. Every Silver STAR route connects with regular RTC fixed route service to provide a broad range of destinations for passengers. Riders can use transit passes for boarding, and each Silver STAR vehicle can accommodate up to two wheelchairs at a time. We also have Flexible Demand Response, known as FDR. This is a door-to-door transit service provided by the RTC that allows residents to call and schedule rides on a public transit system that would not otherwise be available in their area. Flexible Demand Response also intersects RTC fixed route transportation routes throughout the service area. This allows riders to use fixed route service to meet transportation needs that take them outside their neighborhood communities throughout Clark County. This service is currently available in the Sun City Anthem, Sun City Summerlin, and Centennial Hills communities.

Beyond our traditional public transit, we have some senior-specific loop route transit services called Silver STAR. This program has 12 routes around the Valley to provide transportation to stops near communities, community centers, and shopping locations. Silver STAR passengers can use any of our transit passes for boarding or pay 50 cents cash on board. These vehicles and all our fixed route vehicles are ADA accessible and can accommodate mobility devices and specific shopping carts.

Our other training program is Seniors on the GO. The RTC offers training specifically for seniors on how to use public transit with the Seniors on the GO Program. Seniors on the GO offers you everything you need to know about riding the city buses like how to board the bus, pay your fare, and plan your trip. If you would like to request a group training, you can go to our website rtcsnv.com and request a Seniors on the GO training session.

Our next program is specifically for veterans. The RTC Veterans Medical Transportation Network (VMTN) is designed to assist veterans with free transportation service to Veterans Affairs (VA)-approved medical appointments. Eligible veterans may receive a free monthly transit pass to be able to use the RTC fixed route system. Those veterans who are paratransit certified may participate as well and use the RTC's paratransit services for free transportation to and from their medical appointments. To sign up, customers would need to fill out an application on our website, present a Nevada driver's license, and present a copy of a VA medical card or honorable discharge paperwork. The Veterans Reduced Fare Program enables U.S. Armed Forces veterans residing in Clark County to receive a 50 percent discount on regular transit fares. Veterans must obtain an RTC veterans ID card. There is also the Downtown and Veterans Medical Center Express, which provides direct transit access from the RTC's downtown Bonneville Transit Center to the front door of the Veterans Medical Center in North Las Vegas. Additional RTC transit routes access other federal medical facilities, such as the O'Callaghan Federal Medical Center [Mike O’Callaghan Military Medical Center] and various VA primary care clinics.

The Ride On-Demand Program is an on-demand transportation service available to a select route of RTC paratransit customers. This program allows customers to schedule a ride within minutes without having to wait for a pickup time. Clients may book trips 24 hours a day, seven days a week by using the Lyft or RTC On-Demand apps, by booking on the RTC On-Demand website via computer or tablet, or by calling the Ride On-Demand customer service line. The wait time may be as little as five minutes. Ride fares are often the same as RTC paratransit. On-Demand service results in greater convenience and flexibility when scheduling medical appointments, work schedules, shopping, et cetera.

Are there any questions?

***Mr. Slaughter:***

When you said $2 per ride, is that cash? Could they have an app?

***Ms. Reed:***

For fixed route, we have cash or apps. For paratransit, we have cash, coupons, or they can buy an online pass that is paperless. When you ride, since we know who the customers are, we will deduct rides from the monthly allowance that you purchase.

***Mr. Slaughter:***

How often is paratransit used in the percentage of people in Clark County?

***Ms. Reed:***

Paratransit is used daily. The service is 24 hours a day, seven days per week. We currently schedule—if I recall correctly, this morning we were at about 5,400 trips, and that was just today.

***Ms. Peggy Leavitt:***

I live in Boulder City, and I am on the Southern Nevada Regional Transit Board. You did not mention that, which I think is another service you provide. That is invaluable to the seniors in Boulder City, Mesquite, and Laughlin. I think the Silver Rider is an amazing service you do. I do not know that you are addressing the regional needs, but it provides a great service to our seniors. I see it. Those Silver Riders at the Senior Center at Albertsons take people to medical appointments, and they are active in our community. I know from sitting on the Board that Mesquite and Laughlin also have great services.

***Ms. Reed:***

We will make note of that. I appreciate that.

***Vice President Jordan:***

Are there any other questions? We certainly appreciate your discussion this morning, Ms. Reed, on the transportation program for seniors. We are grateful you are here, and we look forward to hearing from you, visiting with you, or providing questions at a future date. Seeing that there are no more questions. we will move on to the next presentation.

***Paul Nelson, Government Affairs Officer, RTC of Washoe County:***

Good morning. We have many programs and discounts that serve our seniors. We understand public transportation is a quality-of-life issue for a lot of people in our community, and that is no different for many of our seniors. In fact, one of our busiest routes, if you take away Virginia Street and Fourth Street and Prater Way, our Route Two is generally the first or second busiest route we have in the entire system. That stops at our senior center every half hour. That is a popular bus system. It is important for people to get wherever they need to go—doctor's appointments, grocery stores, and many other things. With that, I will turn it over to Jim Gee. He will give the presentation.

***Jim Gee, Director of Public Transit, RTC of Washoe County:***

Members of the Forum, good morning. I am here to discuss the public transit options specifically for senior citizens in Reno and Sparks, Nevada and Washoe County. (Agenda Item IV B) [Due to copyright issues, the presentation is on file in the Research Library of the LCB, Carson City, Nevada. For copies, contact the Library at (775) 684-6827 or https://www.leg.state.nv.us/Division/Research/About/Contact.]

First, I would like to talk about the backbone of our transit system, which is our fixed route system. This is the traditional system we have. That is large buses, up and down city streets stopping at marked bus stops. For us, it generated about 5.2 million trips last year. About 60 percent of those trips are work trips. I like to note a lot of those work trips are also senior trips because what we have seen in our community is we have a growing population of baby boomers who are reaching retirement age, but they are not retiring yet. They do not have the desire to retire, or perhaps they do not have the financial means to retire, so we see people working later in life. At the same time, they are also having age-related disabilities, so they are looking for options to find ways to get around the community where they do not have to drive. They still need to work, and they still want to participate in the community. At RTC Washoe, that audience becomes huge for us. It is a good way for us to continue to grow our ridership.

Our most popular service in Reno are two Bus Rapid Transit lines. One is the Virginia line, which goes north and south around Virginia Street. It is our north/south corridor. The second is the Lincoln line, which essentially follows our east/west corridor.
Service is every ten minutes. For us, these two backbones generate a lot of ridership because what we focus on—and this tailors to our messaging to senior citizens—is a service that is safe, reliable, and friendly. Those three things are what we preach to our drivers and our employees: safe in that we want to make sure you have a safe experience; reliable—in this case every ten minutes, but on time and there when we say we are going to be there; and friendly because we want to make sure our drivers and anyone who represents RTC is doing so in a positive manner.

Our fixed route—like Southern Nevada, we offer reduced fare for senior citizens. Our regular fare is $2, a day pass is only $3, and seniors, the disabled, and veterans can receive half-price fares. For only $1.50, a senior can ride on the bus essentially all day. We like that because it gets them out in the community. We see a lot of seniors, especially the last couple of weeks when it is really hot, will use the bus as a cooling station, or they will use it to get to someplace cool with air conditioning. Because of our messaging and our emphasis on reliability, we have had 22 straight months of ridership growth on the fixed route side. A big part of that growth has been senior citizens.

We also have a service called ACCESS. ACCESS is our service specifically for the disabled. It is a prescheduled service. It is an application-based service similar to what Southern Nevada provides where you have to go through a screening process. Once you are determined to be eligible, the bus will come to your door, pick you up, and take you anywhere within the Reno-Sparks metropolitan area. It is only $3 a ride per trip, so it is an affordable way to get around the community. We have a lot of medical appointments. We have a lot of dialysis appointments, for example. Incidentally, the number-one trip purpose for using ACCESS is still work. It is seniors who are working even though they have disabilities, but they are still out in the community.

We also have a newer service called Microtransit. We brand it as FlexRIDE. Essentially, this is RTC's version of Uber or Lyft. It is an on-demand service, and it will come pick you up without reservations and take you anywhere within a specific geographic zone. We have four geographic zones around the Reno area. For passengers who wish to go across town, we will connect them to an RTC ride or an RTC ACCESS vehicle. For the most part, this is providing independence for seniors within a specific suburb, for example. They wake up and want to go, and they do not have to rely on their family member. They do not have to rely on a vehicle that is shared by others, like a facility vehicle. It gives them a lot of independence. We like to talk about how our FlexRIDE is superior to Uber and Lyft because we address the shortcomings that we hear, especially from our seniors about Uber and Lyft. First of all, our pricing is consistent; it is $3 per ride. Uber and Lyft will have peak fares and inconsistent fares. Secondly, our drivers are trained, and it is a consistent driver experience. They are trained to deal with folks with disabilities. They have proper testing and proper backgrounds. Thirdly, the vehicle itself is consistent. We have vehicles that are accessible for the disabled. They have wheelchair lifts. We can give folks a safe, consistent environment they can use to move around the community.

To teach folks how to use all our public transit services, we have an aggressive Travel Training Program. Similar to Southern Nevada, it can be anywhere from an individual one-on-one appointment to a group appointment where we will go out and do outreach at the senior living complexes, for example. If you think of yourself as a senior citizen who perhaps has not ridden a bus in many years, it can be an intimidating experience. You do not know how to pay, you do not know how to tell the driver to be let off, you do not know how to use the different services, or what services make the most sense. Having this Travel Training Program, we can answer all your questions on a one-on-one basis. A lot of times what folks want is that one-on-one basis so I can ask my questions, get them answered, and be more comfortable when I take those transit rides.

One of our most recent special programs, and frankly, one of our best special programs, is a combination of what we call Senior Ride Taxi Bucks with Uber and Lyft options. Every senior, veteran, or disabled person in Washoe County can sign up and receive $60 every month in transportation. That transportation could be used for cab rides, Uber, or Lyft. That $60 gets loaded onto a card that gets put out to seniors, disabled, and veterans each month. Those seniors can choose how to use that $60. It might be trips to the pharmacy. It might be trips to the barbershop. We have some that use it to get to the airport to avoid airport parking. It is their choice on how they use the dollars. It is a great program because it gives them independence with a network of vehicles that are already out there in the community that they can generally easily learn how to use. We are excited about that.

Another thing we do in Washoe County is have a special program where we provide funding for nonprofit vehicles. There are several nonprofits in the community that are also providing necessary essential services to seniors and veterans, such as Access to Healthcare Network and Volunteers of America. We work with them on making sure they have the vehicles they

need to be able to provide their services. This past year, those vehicles provided an extra 14,000 trips and serviced an extra 2,700 folks. Those are vehicles that likely these nonprofits may not be able to normally receive. It is a benefit to RTC because it helps alleviate the demand on our ACCESS and special services, but most importantly, it is a benefit to our community because a rising tide lifts all boats. The more services that are out there for folks in our community, and the better access they have, the better our community is.

Finally, one of the things we stress as an organization is to be a good community partner. We are always looking for opportunities to work with nonprofits, social service agencies, and groups to be able to be that good community partner. For example, recently, we did a Stuff A Bus Program for seniors with a lot of different partners. We filled the bus with food, hygiene products, and items senior citizens need in our community. We are always looking to continue to do more of those items.

With that, I would be happy to answer any questions you may have about services in Washoe County.

***Vice President Jordan:***

Forum Members, do we have any questions?

***Ms. Adin:***

If a senior has a doctor's appointment, do they have to pay for that ride?

***Mr. Gee:***

They do. We do not have different price points for different types of trips. We focus on keeping fares as affordable as possible. For example, ACCESS would be $3 per trip. On the regular fixed route bus, it would be $1 per trip or $1.50 for the entire day. We try to make it as affordable as possible.

***Ms. Peggy Leavitt:***

It seems like in both Southern Nevada and Northern Nevada, the services are comprehensive. For the person who had public comment, was that question answered? With respect to seniors who can only get groceries once a month and people who are on cancer treatments and cannot get to the doctor as often as they need to go? Because I was trying to figure that out as these presentations were going on. It seems like the services are fairly comprehensive.

***Ms. Fesenmaier:***

My concerns are for areas like Yerington, Hawthorne, Fallon, and Silver Springs. I live in Smith Valley. There are no services Topaz Ranch Estates (TRE), which is actually in Douglas County adjacent to Smith Valley, has no services at all to get to medical appointments and grocery shopping. We need to expand this in the State to frontier areas. I am not even what is considered a frontier, so they must be in dire straits.

***Vice President Jordan:***

Are there any additional questions? I did not hear Mr. Gee or Ms. Reed talk about time of day. Are the bus service schedules 24/7? What days of the week are they functioning?

I think this is key. Many people like to go to their religious facilities on Sundays and Saturdays. I would like an answer to that question, particularly the time of day the transportation system runs for seniors.

***Ms. Reed:***

Paratransit in Southern Nevada is 24 hours, seven days per week. Period. We have zero denials.

***Mr. Gee:***

Same answer for RTC Washoe. The service is seven days a week, 24 hours a day. We have no denials on paratransit at all.

***Vice President Jordan:***

That is valuable information. Hearing no other questions, we will move on. We appreciate both the north and the south represented today speaking on behalf of RTC. We look forward to hearing from you again.

## AGENDA ITEM V—OVERVIEW OF EMPLOYMENT, AGE DISCRIMINATION, AND POLICIES TO SUPPORT A MULTIGENERATIONAL WORKFORCE

[This agenda item was taken out of order.]

***Vice President Jordan:***

At this time, we will have an overview of employment, age discrimination, and policies to support a multigenerational workforce.

***Angela Rowe, Policy Specialist, Employment, Labor and Retirement Program, National Conference of State Legislatures (NCSL):***

Thank you for inviting me to join you today. I focus mostly on pension and retirement-related issues. For those of you who may not know, NCSL is a nonpartisan member-driven organization. We support and represent the legislatures in the 50 U.S. states as well as the territories and commonwealths of the U.S. On the policy and research side, we provide services to legislators and legislative staff. This includes legislative tracking, looking for bills, keeping updated on what bills are introduced and enacted, research requests, technical assistance, legislative testimony, and a variety of different written resources and publications. We also organize convenings, meetings, trainings, and conferences. These are services that are always available to you and Members of the Forum. Today, I am going to give a brief presentation on unretirement trends in the U.S. (Agenda Item V)

In recent years, reemployment after retirement, which is commonly referred to as unretirement, has become an increasingly common trend in the U.S. There are studies that assert retirees returning to work is no longer just a trend but is a permanent feature of our evolving workforce. It is currently estimated between 20 to 25 percent of retired workers currently work full-time or part-time with another 7 percent that are actively looking for employment. Around one in eight retirees are considering returning to work in 2024. According to the Pew Research Center, Americans over 75 are the fastest growing age group in the workforce. Numbering nearly 11 million, the population of older workers has quadrupled in size since the 1980s. There are some 19 percent of workers over 65 that are

employed today, but this does not necessarily mean all these workers have unretired. It may simply mean they have deferred retirement for a variety of reasons. A few things to note as related to having an increasingly older workforce, people, as we know, are living longer and are more likely to be healthy into old age, which makes it much easier for folks to extend their working lives, and the nature of jobs have changed. We have seen remote work, part-time work, and more flexible schedules. We have also seen less physically strenuous job options. This results in more options for retirees and older workers.

Retirees may return to work for a wide variety of reasons. This can include financial necessity as well as emotional and social fulfillment. We will talk more in-depth about some of those reasons. Unretirement trends also vary by gender and marital lines. Interestingly, single retirees and women are generally more likely to cite income as their primary motivator for returning to work. Men are more likely to cite social connections, so [they are] looking for that engagement, connection, and sense of community. The recent wave of retirement in the last two to three years has largely been attributed to inflation, lessened Coronavirus Disease of 2019 (COVID-19) pandemic concerns, and a tight labor market. There have also been some recent policy changes that have discouraged early retirement. The changes to our Social Security system, which raised the full retirement age from 65 to 67, has likely encouraged older adults to delay retirement and continue working. We have also seen a lot of retirement plans that impose penalties for retiring early.

Why are retirees returning to work? There are a lot of financial reasons as well as social and emotional benefits that are commonly cited as reasons for retirees reentering the workforce. Quite simply, when it comes to financial reasons, many retirees return to work simply because they need the money. This has become increasingly common with inflation and the cost of living increasing. This has made it hard for a great number of retirees to maintain their lifestyle and meet their needs when they have a fixed income. Another big reason retirees may need to supplement their retirement income is a lack of sufficient retirement savings. There has been recent research from The Pew Charitable Trusts and labor economists that assert America is currently facing a retirement savings crisis. Most Americans, and this is especially true for economically vulnerable households, are not saving enough for retirement. This means they are either not able to save enough or in many cases, they do not have access to an employer-sponsored retirement plan. This is common with gig workers, in the private sector, as well as independent contractors. They either do not have access to a retirement plan or are not able to save enough to meet the recommended income replacement ratio of around 75 to 80 percent. Some retirees also return to work to bolster that retirement portfolio. They want more savings. This is especially true for workers that have hybrid retirement plans or 401(k)-type plans because these plans do not guarantee benefits for life. As the average life expectancy is increasing, it becomes more of a concern that retirees could outlive their retirement savings. There is an increasing number of folks returning to the workforce to bolster that retirement portfolio.

Some returned to work for reasons related to their Social Security benefits, mainly, to avoid having those benefits being reduced. There have also been retirees that are returning to work for health care benefits. Some retirees have cited their employer-related health care benefits or even their other postemployment benefits (OPEB) are better than Medicare coverage or may cover things like medication or certain types of treatment that are a bit more limited than Medicare. When it comes to social and emotional benefits, there are a lot of reasons. Mental stimulation is a big one. Simply put, many retirees get bored after retirement, and working provides continued mental stimulation that ultimately keeps them sharper and more fulfilled. In a lot of ways, it keeps them healthier for longer. Meaning and fulfillment is another big reason. More and more retirees are returning to work to pursue new passions. Especially since they may have more time, or they may have more freedom

and flexibility to pursue hobbies or interests they did not have or could not do during their prime working years. Social engagement is another big reason. Many retirees feel increasingly isolated or may feel isolated after retirement and miss the social engagement that working affords. Returning to work may help retirees feel more connected, may help them feel more engaged, enable them to continue enjoying a sense of community, and shared purpose as well. Also, keeping busy and staying productive instead of potentially being idle at home. The changing nature of work has made it a lot easier for retirees to return to work. As I mentioned briefly before, remote work schedules, flexible work schedules, part-time work, and job options that are more varied that do not require physical labor have made returning to work more enticing for retirees.

Unfortunately, the fiscal impacts are difficult to ascertain because they are specific to the state and to the plans' postretirement policies and regulations. There is no single agency that tracks postretirement earnings of public retirees. In addition, earnings cap calculations are complicated, and they vary widely by individual. Self-reporting is not a reliable way to track these earnings. There is also the consideration, which is again difficult to ascertain, regarding whether the cost of hiring and training new workers is greater than or outweighs the cost of rehiring retirees that have established skills, experience, and institutional knowledge. There is also a concern of double dipping. This is essentially where a retiree may continue to work in the same job, often by retiring and then being rehired in the same job, while receiving pension benefits from that same job. I would say this is not as often a concern, at least not as much now as it has been in the past, as most retirement plans have limitations to prevent double dipping. They also have penalties for exceeding those limits. Many states and plans may also allow workers to return to certain professions without losing their pension benefits. This is often more commonly seen in jobs that have critical workforce shortages and even still is typically for a predetermined and limited amount of time or has specific earning caps. Additionally, some employers may not have to make pension withholdings for retiree workers. This could enable them to pay into their unfunded liabilities, for example, instead of making those withholdings. However, one caveat would be there is limited oversight when it comes to double dipping and the penalties associated with it. The enforcement of those penalties is usually reactive. This is yet another reason why the fiscal impacts on retirement are difficult to determine.

Moving on to the individual and workforce impacts of unretirement. In some plans, reentering the workforce may result in pension benefits being frozen or interrupted. Typically, this is to avoid double dipping. There are a lot of exceptions that exist, but this varies greatly by retirement plan and profession. There have been critical workforce shortages in nearly every state and particularly in a lot of sectors. We have seen this predominantly in teaching professions, public safety such as firefighting and law enforcement, as well as service industry and retail. This has resulted in a lot of states and plans making temporary changes that allow retirees to return to work without interruption to their benefits. This has been common in teaching professions and public safety. When it comes to Social Security, an individual may be able to work after their full retirement age without their Social Security benefits being penalized. At the same time, those extra earnings may push a retiree into a higher tax bracket. There is also a possibility they may have to pay back received benefits depending on the time frame, though this is generally only true if you return to work within a year or less of applying for your Social Security benefits.

The mental stimulation and emotional fulfillment of individuals returning to work can result in better health outcomes later in life. More physically demanding jobs, though there are less and less of those, could have a negative impact on health for retirees. The increase of job options that are non-physical or less physically strenuous has enabled retirees

reentering the workforce to avoid that. Additionally, retiree workers can help address critical workforce shortages as well as skills shortages. Most states and workforces are facing both workforce shortages and skills shortages. This is increasing as more and more people are retiring. We are losing more of that institutional knowledge. There have also been significant issues with recruitment and retention in certain sectors. Particularly in education, service industry, retail, and public safety. Allowing retirees to return to work can help address those workforce shortages, even if temporarily, and help fill important skills gaps. There has also been research from the Organization for Economic Cooperation and Development that has shown a more age-diverse workforce has lower turnover and is generally much higher in productivity. This is due to diverse skills, collaboration, and shared knowledge. There are a lot of benefits to retirees returning to work as well.

Lastly, when we are looking at reemployment after retirement legislation, NCSL has a pension database that tracks a wide variety of introduced and enacted legislation on pension-related topics. This includes unretirement, or as we track it at NCSL, reemployment after retirement. In 2023 we saw more than 175 bills introduced related to reemployment after retirement, but only around 60 of those were enacted. To date, we have seen between 81 and 85 bills introduced in 2024, with about 20 being enacted. Most of these bills are making changes to existing provisions. This includes caps on annual hours, earning limitations, making changes to the time required between retirement and reemployment, eligibility, and permitting employment of certain workers [such as] teachers, law enforcement officers, et cetera, to reenter the workforce without the suspension of their pension benefits. We have also seen a handful of bills related to penalties for exceeding reemployment after retirement restrictions. Similar to most of the pension and retirement-related legislation we see at NCSL, we expect there will continue to be a far greater number of bills related to unretirement that will be introduced as opposed to enacted. We also anticipate the continuation of legislation addressing unretirement, especially in coming years as the unretirement trend continues to grow and becomes a more permanent feature of our workforce. With that, I will wrap up and say thank you again for allowing me to share this information. I will open it up to questions.

***Vice President Jordan:***

We appreciate you joining us this morning. We had an informational meeting as it relates to age discrimination. Forum Members, do we have questions?

***Mr. Troth:***

We talked about insufficient retirement savings, and you addressed some of that. Does your group look at reasons? You mentioned why some people are not saving and you enumerated several of those. Is there a problem in our culture of training, education, and understanding of you need to save and prepare for the retirement years, whenever that starts? Is that an issue your group has identified? You did not enumerate that specifically, but is that something that needs to be looked at more?

***Ms. Rowe:***

One of the things we have seen at NCSL is there are a lot of younger workers that do not have the access to or maybe are not as interested in or seeking out financial literacy education. I think with the changes we have seen pivoting away from the more traditional pension-type of system to 401(k)s, hybrid plans, cash balance plans—another thing is there is a lot of information out there, and what we have heard is it can feel hard for younger folks to navigate those systems. I do think the financial literacy, awareness, and the

education around the need to save for retirement is a piece of it. I will also add that the research we worked with Pew and EConsult Solutions as well, which I am happy to share the link to after the presentation, one of the things the research indicated was there are a lot of people that do not have the extra income with inflation, cost of living, and lack of affordable housing. Folks just do not have the extra income to put into their retirement plans, if they even have them.

I think with the evolving nature of work and more people shifting to remote work, we have seen a huge uptick in gig workers, independent contractors, and private sector workers that are leaving the public sector to go into the private sector—maybe because the wages are higher, the salaries are better, or a variety of reasons—that might not have access to an employer-sponsored retirement plan. There have been a lot of states that have taken different creative approaches to address this, like automatic individual retirement arrangements (IRAs) or other similar state-sponsored savings programs that have been introduced to address that. I think financial literacy is a piece of it, but what we have seen and what the research has indicated is folks are not saving enough because they either do not have enough or they do not understand the nature of their retirement plan and the best way to make the most out of the money they do have.

***Mr. Troth:***

On the double dipping situation, what has your group looked at, or is there an understanding of how big of an issue unreported income is for seniors in these situations that do things off the books that are not taxed? Basically, "I can go do something to make money and not report it." Is that an issue?

***Ms. Rowe:***

We have not tracked this extraordinarily closely. We track legislation related to violations or penalties for violating the postretirement restrictions. What we have seen is double dipping in the past, in the early 2000s, was a bit more of an issue simply because retirement plans had not enforced or enacted penalties or did not specifically differentiate what the limitations or restrictions were. It has become less of an issue mainly because most retirement plans we have seen have specific restrictions. That could be a cap on hours annually or earning limitations if you make above "x" amount of money per year, your retirement benefits will be frozen. More commonly though, what we have seen is that it has become less of an issue because we have a lot of states and retirement plans that have made changes that allow retirees to in fact reenter the workforce without interruption of their benefits. If you look at the definition of "double dipping," you could say it technically is, but these are positions that are critical workforce shortages. [They are] skill shortages where we need people to fill those roles. Even with those changes, they are generally temporary, so it must be in a school district with a critical workforce shortage or in an industry with a critical workforce shortage, and it can only be for a limited period of time. We have seen a lot of changes with how to address or prevent double dipping. The caveat here is that because there is no single agency that tracks postretirement earnings, we have seen it is largely up to the retiree to calculate those earnings and determine what their earnings cap is. That can often be complicated. They vary widely by individual, and there is not a particular entity where there is oversight, and enforcement is reactive. I think it is less of an issue, but I also think it is difficult to know what exactly is happening because we do not have one entity effectively or consistently tracking those earnings.

***Mr. Troth:***

In your group's research and study, is there more of an issue with the double dipping from government entities versus private sector entities?

***Ms. Rowe:***

I will not say we have identified that as being an issue. One of the things I have seen in my research around reemployment after retirement policies is there are a lot of plans that may have specific restrictions around retirees reentering the workforce, but those restrictions do not apply if you go from working for the public sector to working for the private sector or if you go from working for the public sector under a particular plan, maybe you are drawing benefits from this particular plan, but then you reenter the workforce in the public sector under a different plan. You have different coverage. Transitioning from public sector to private sector is typically less of an issue because plans allow that. Generally speaking, they have regulations that do not apply if you go from public sector to private sector. That is largely because of the framework and structures that exist within public versus private in terms of retirement plan access.

***Ms. Bongiorno:***

In the private sector, if a company files bankruptcy, how does that affect the pension plan for any individual, a senior in particular?

***Ms. Rowe:***

I would have to dig more into the specifics of this. Typically, even if you file bankruptcy, any benefits you are currently beholden to, you have to find a way to meet those benefits. I have not seen specific scenarios where an entity has filed bankruptcy and has not been able to meet those benefits or where there has been legal action. I would have to look more into that. I think with the private sector, it also looks different because a lot of private sector jobs do not offer access to retirement plans. This is where we are seeing more state-sponsored retirement programs coming into play. My understanding is they are typically still beholden to make those benefits and to make those retirees whole. I think there is a variety of mechanisms to ensure that happens. Whether or not it does or if there have been incidents where legal action has followed, I am not sure. I would have to dig more into that and get back to you with my findings.

***Ms. Bongiorno:***

I wish you would. The reason I am asking, I had a particular client that worked for an escrow company. They filed bankruptcy, and she lost all her pension. At that age it was difficult for the woman to succeed in anything else. I would like to know that though.

***Ms. Rowe:***

I know with the public pension plans there are mechanisms in place. The Pension Benefit Guaranty Corporation will, if an employer cannot make their retirement responsibilities or cannot meet those benefits, they are then required to do that. I do not believe there is an entity that exists like that for the private sector. I am happy to do some digging into that and see what I can find.

***Mr. Slaughter:***

This might not be a fair question. In the future, are we facing a tsunami when it comes to people that are underfunded for postretirement with the gig workers and side hustlers?

***Ms. Rowe:***

All research indicates, and we have recently put out some publications on this, including a podcast about the lack of sufficient retirement savings—I think some entities, researchers, and labor economists are saying the lack of retirement savings is already a crisis. In the long run, it is going to cost state and federal governments quite a bit of money if we do not make up that savings gap. A big part of it is we have a lot of people that do not have access to—and I would have to look at the numbers because they are constantly changing. I believe the last I looked was around 50 percent or higher of private sector workers do not have access to an employer-sponsored retirement plan at all. That is a big part of it. You have gig workers, independent contractors, and private sector workers that do not have access to any type of retirement plan. Generally speaking, research has indicated if they are not given a plan or if they do not have access to a plan—it could be optional; it does not have to be mandatory—they are far less likely to seek out a plan on their own and make allocations to that plan. We have seen a lot of states transitioning to state-sponsored retirement plans and portable benefits for gig workers. I would say it is a crisis, and if we do not address that savings gap, it is going to end up costing state and federal governments a lot of money in the long run for this lack of sufficient retirement savings.

***Mr. Slaughter:***

If we do not have sufficient funds for future retirees, then it is going to come from the federal government. We are talking about raising the national debt, which can be catastrophic.

***Ms. Rowe:***

Absolutely. I will be sure to share the research and synopsis that NCSL worked on last year that gives some creative ways we have seen states addressing this insufficient retirement savings. It also has some great data on how much it is estimated this insufficient retirement savings is going to cost state and federal governments. It is a lot of money. There are some hard numbers, but there are also some quite simple and straightforward ways to close that gap. I will be sure to share that with you. But you are right, it is going to cost a lot of money and will raise the debt for sure.

***Vice President Jordan:***

I have a question based on Mr. Troth's question. I have a different point of view. I looked at ten different school districts around the nation who have retired teachers and are seeking their retired teachers to come back because there is a shortage of teachers in the schools. That is a whole different focus. Many folks, and particularly teachers, that get out of college and start working when they are 22 up to 25 are ready for retirement at 55, but they are still full of energy and interested in working. Many of them are going back doing part-time work in the schools because there is a lack of educational personnel, and the pedagogy requires licensed teachers. That is another focus. There are a lot of school districts recruiting seniors to come back and do that work. What is your feeling about that?

***Ms. Rowe:***

That is absolutely right. What we have seen as well in our legislative tracking and research is there are a lot of school districts facing severe workforce shortages, not just with teachers, but with education personnel in general. As a result, we have seen significant efforts to recruit or incentivize retirees to reenter the workforce. We have even seen legislation that is not targeting retired teachers specifically. If you are law enforcement or you have worked in the public sector, recruiting them to work as substitute teachers or to work simply in some kind of education personnel capacity. We have seen a big uptick in that. I would say the vast majority of the legislation we have seen and the vast majority of the plans I am aware of have specific provisions for rehiring retirees to come back into teaching professions because there is such a workforce shortage. I think your observation is dead on. I think that is a trend we will continue to see. We have also seen in rural districts this is a particular problem. Where there is understaffing in certain urban areas, where there are schools with high turnover rates, we have seen a lot of teachers reentering the workforce to work part-time and still being able to collect those pension benefits because of that critical workforce shortage and those skills shortages. I think this is something that is common, and I think we will see this trend continue in the coming years.

***Vice President Jordan:***

Forum Members, do we have any other questions? If not, we thank you for your presentation. We would appreciate anything you want to send us for additional information.

***Ms. Rowe:***

I will definitely share. I will send it to Ms. Kalina and make sure it is distributed to all the Members of the Forum.

## AGENDA ITEM VI—OVERVIEW OF THE NEVADA EQUAL RIGHTS COMMISSION AND AGEISM IN THE STATE'S WORKFORCE

[This agenda item was taken out of order.]

***Vice President Jordan:***

We will move on to an overview of the Nevada Equal Rights Commission (NERC) and ageism in the State's workforce.

***Kara Jenkins, Administrator, NERC:***

It is my honor to go over State laws that protect older workers. I have some interesting updates I think your Forum should be aware of about older workers as it pertains to workplace discrimination. Before I get started, I want to introduce myself and say I have been with NERC for over 12 years. I was originally appointed by Governor Brian Sandoval. I have maintained through other governors. I am currently under Governor Joe Lombardo. It is my honor to serve Nevada.

Nevada Equal Rights Commission is a statewide commission created in 1961. It was meant to investigate, fully resolve, and settle discrimination in employment, housing, and public spaces. Today, we will focus on employment because that was the request of the Forum to report to you all on what we are seeing in terms of data and challenges for older workers under what is called ADEA, the Age Discrimination in Employment Act. Nevada also has a State law counterpart to protect workers who are 40 and over.

We are a statewide agency. We have an office in Reno at the Corporate Boulevard location, and we have an office in Las Vegas. I am in Las Vegas. I want to give an overview about where we are, how we got to a place of protecting older workers, and the challenges we are seeing. I hate to be a wet blanket, but it is bleak. We are not seeing a lot of legislation in favor of protecting older workers because the threshold in order to proceed on a litigation or claim of discrimination is so hard. We have the Supreme Court to thank for that. Before I go there, I want to talk about the law as it relates to older workers and in general protecting the people. I will go over this, and we will have more of a dialogue on my presentation, especially about the Supreme Court case that makes it challenging for workers who are filing complaints of discrimination.

Nevada Equal Rights Commission is the State's equal opportunity agency. The federal government has an organization called the Equal Employment Opportunity Commission (EEOC). Nevada has the NERC. We are partners with the EEOC. What does that mean? It means cases of discrimination that are filed in Nevada can either be filed with NERC or the EEOC. You can pick. There is a local office in Las Vegas. We work hand in hand with them, and we share cases. We have shared software and data for the purpose of identifying whoever files with us first, we will investigate that case. We make sure we are not double dipping, so if someone files a complaint of workplace or age discrimination with the EEOC in Nevada, if they file with us, we have to have hands off because it is already with our federal counterpart. Likewise, if someone files a complaint of workplace discrimination because they were demoted or not promoted because of what they felt was their age, EEOC cannot take the case. We will be doing the investigation. We share work case responsibilities because, on average, we get over 1,600 cases a year, but it is low when we talk about age discrimination. It is difficult to prove that case, and a lot of older workers do not file.

The Age Discrimination in Employment Act (ADEA) of 1967 was huge legislation. That legislation was passed right after the Civil Rights Act of 1964. We are going to hop in the time machine, and I am going to take you on a history lesson because a lot of us were around when this happened. When we had the Civil Rights Act of 1964, we were in an interesting time in our country, similar to how you might see our country now. There were a lot of social movements and efforts to try to get folks equal access and equal opportunities on the job regardless of their race, sex, national origin, or religion. That was huge. The Civil Rights Act was penned into legislation. It had been a movement. It had been lobbied. In fact, it was the longest legislated lobbied bill ever in the history of the United States of America. In order for it to pass, the Voting Rights Act portion had to be taken off. We did not get the Voting Rights Act passed until 1965, but finally it happened. [President] Lyndon Johnson was the one who signed the Civil Rights Act of 1964, which was the first ever in history federal protection for workers based on what we now call "protected status," meaning that just by virtue of you being who you are, because of the history of discrimination you or people like you have faced, you are now in what is considered a "protected class" or "protected status." It does not mean you get anything. It just means that if you do face discrimination moving forward, you have a right of claim. You can now sue, or you can go to a state agency, and they can help you either settle it, prepare you, or give you a right to sue your employer for discrimination based on what we call *mutable characteristics* that you cannot change. We cannot change how we are born. We cannot change the color of our skin. We cannot even help or slow down the aging process. It is an aspect of humanity. We are just humans. There are some that face discrimination more frequently, based on data and based on what we know, than others. These people became protected under the Civil Rights Act of 1964.

[President] Lyndon Johnson was not done with race, sex, national origin, or those protections. Three years later, in 1967 ADEA was signed by him. Now, this was specific

legislation. None of its kind had ever been passed. What that legislation said was that if you are 40 and over, and I believe a lot of us can raise our hands to that, you are going to face—and we have seen it—more discrimination in the workplace than people who are 39 and under. Why is that? Why do we see more discrimination for folks 40 and over? We can all give opinions on it, but we actually have data to show that for some odd reason, they think once you hit 40 you are like day-old bread. That is just not the case. I recall after graduating law school in my twenties and having multiple jobs. I worked for two lawyers part time. I worked at Bath and Body Works selling hand creams and lotions. My parents were quite concerned about my path in life. They did not know what I was going to do if I was going to land with one job, but I was trying to get my sea legs. I was trying to figure out who I wanted to be in the world and what job was a good fit for me. It was not until later in life, 35, 38, 40 [years old] that I began to feel comfortable in knowing where I could be an asset, where I could lend my skills, and contribute to an organization or an agency. For me, it was government and public service. That is what is interesting about how people who are over 40 seem to get put in this category that they are no longer viable. When in fact, data shows that if you are 40 and over, you are much more likely to stay, you have a mortgage, you are a reliable worker, you have bills to pay, and you have kids to send to school. Data shows the more mature workers are the ones that are more stable.

When we look at older workers moving up the age range, you get closer to retirement. There are benefits at 60 to 65. You have access to Social Security benefits. There are so many things that incentivize someone to stay. Plus, you have institutional knowledge. If you have been with a company for more than 10 years, more than 20 years, or 30 years of your life, you have now invested yourself into an organization where you basically are a brand ambassador for that organization, and no one can tell you about your organization but you. You are the best person with the inside knowledge and history of that organization or your employer. Yet here we are, and here I am talking to you about what we see in a lot of workers who are approaching 40, 50, or even 60 years old being demoted or fired. These are called adverse employment actions.

When I looked at the data with NERC, I looked at how many cases we got alleging discrimination based on age for those reasons. The main reasons are: "I feel like I did not get this promotion even though I was the most qualified. I had the longest experience. I even trained the person that got the job over me, but I did not get the job." We looked into it. My management analyst and I looked at the numbers, and it was discouraging. It was discouraging to see that even after almost a year of settling cases on behalf of Nevadans for discrimination, age discrimination claims were among the lowest settled. Less than 1 percent of cases that we got settled. Let me tell you why and what that means in raw data. We had eight cases this last year that were based on age. Do we think that Nevada is perfect, and we do not see age discrimination? No. We know filings are low for people to bring their cases to NERC for a potential settlement or a right to sue; they are not filing at all, or it is a tough burden to meet.

When we talk about filing a case or a claim of discrimination based on age, I will use myself as an example. If you are following a case of discrimination, you file online with us and you talk about what you feel the discrimination was. What was the discriminatory act? For purposes of this opportunity to speak in this session, it would be age, so we would select age meaning we are 40 and over, and we feel like we were denied an employment opportunity because we think our employer has a bias against people who are over 40. I am 46, so let us use my age. My proof is the person that did get the job was less qualified and significantly younger than me, ten years younger, which is great evidence to show. Perhaps they were less experienced or was an individual I trained. There is my evidence that I filed a complaint. The Nevada Equal Rights Commission takes the complaint and looks into it. We

investigate it, and it all looks good. However, we have *Gross v. FBL Financial Services Inc.*, a Supreme Court case in 2009 that says in order to prevail on an age discrimination complaint, age has to be the "but for" factor for the discrimination. This is unlike any standard of proof or burden that any other complainant has to endure if they are filing a race complaint or a complaint based on sex. For those types of complaints under Title VII—when we talked about the Civil Rights Act of 1964—for those allegations of discrimination, the only burden for the plaintiff or the charging party or the complainant is that your type of discrimination had to be the motivating factor for the discrimination, not the only sole but for cause.

Let me break that down even more. It means that if I feel like I am facing age discrimination, as the alleger, the plaintiff, the complainant, I have to show and I have to show it to NERC or even EEOC that there was no other reason for the employer to not promote me but my age. That is very limiting. That is like walking a tight rope over the Grand Canyon with no safety net because there are so many reasons the employer can say they did not promote you other than age. They can say, "You were tardy a lot, or we were worried about attendance, or we had to accommodate you a lot," which could also lead into disability discrimination because we know with age comes other protected classes or other conditions that you should be given accommodation for. We can talk about that at another time. I am happy to train on that and discuss those issues. With age, a lot of folks are being barred from moving forward on their age discrimination complaints because they cannot get past this hurdle, this burden of proof that says you have to show that the only reason you did not get the promotion was because of your age. That is so hard to show where in other cases of discrimination, race or sex or national origin discrimination, it just has to be the motivating factor, meaning there can be other reasons that maybe the employer did not promote you, but you can show that for the most part they did not like me because of my race or my sex. There might have been other things they can say they are defending on that. Maybe my attendance was not good, or I was an average worker, so that is why I did not get the promotion, but even still you can prevail on a claim if you can show that they still do not like you because of your race, sex, or those other particular categories, unlike age. For age claims, you have to show the only reason you did not get promoted and the younger worker did, who you trained, was because your age. That is so hard to prove.

There have been articles written about this. There has been a lot of criticism about the Supreme Court case. Moving forward, in the State of Nevada, you all have an opportunity to create bills that can make it easier for people in the State to prevail on claims of age discrimination. We do not think it does not happen. When COVID-19 happened in 2020, we saw a huge number of folks filing complaints because they were excessed because a lot of employers were afraid of preexisting conditions, and they still wanted folks to work. However, if you were at risk of exacerbating your preexisting condition that was age related with a potential COVID-19 exposure, it meant the employers did not want to take a risk of getting you sick or having to support you in that. There is a lot of work to do in this space. I am grateful for the opportunity to speak on age discrimination, tell you where we are at in Nevada, and highlight we are less than 1 percent of claims that are filed with us. Even less are settled because we have a Supreme Court case and this burden of proof that is so hard to show age discrimination, unlike any other type of discrimination we see in the State.

My call of action would be to look at this and see if there is anything you can do to mobilize and perhaps make it easier for our 40-and-older working population to have access to moving forward with charges of discrimination and to stop employers from abusing the fact that it is hard to win or prevail on an age discrimination claim. We want to encourage employers to hire mature workers so that people can have a QOL. I will speak personally and then I will step down. Until my dad passed away last year, he was working. There was

no way we were going to get that man to retire. He had a corporate job he retired from, but then he went and worked at a smaller office because he liked to work. It gives meaning and it keeps people out there. Employment is not only beneficial in that you get paid; you make connections, you are social, it keeps you going. We do not throw people away because they get older because guess what? We are all going to get older. We need to make sure we support agencies like NERC to protect workers and investigate the discriminatory practices. We also need to look at the laws that make it so hard to do. With that, I will yield my time. I want to thank the Members of this Forum today for having me. I am at your disposal and at your pleasure anytime to talk more about trends or data or how I can lend my services to you all. If there are any questions, I am happy to answer them at this time.

***Vice President Jordan:***

Thank you for your wonderful presentation on ageism in Nevada's workforce. We look forward to you sending in the information so we can review and discuss exactly what you are talking about because it has a lot of merit as it relates to seniors. Forum Members, do you have any questions?

***Ms. Adin:***

I know at one time there was discrimination because of hairstyles. Is that still going on?

***Ms. Jenkins:***

Yes. We still see that. However, we were encouraged with the passing and the signing of the Creating a Respectful and Open World for Natural Hair (CROWN) Act. What a lot of folks do not know is that for many people of color, we would have to conform our hair in order to see promotions because there was data that showed that if you had certain hairstyles, you could either not even get the job or promote. There was a lot of talk about this. Creating a Respectful and Open World for Natural Hair Act legislation at the federal level has not passed yet, but in Nevada, we do have protection. It is also for our kids in schools. If you wear your hair as it grows naturally out of your head, which might be curlier or textured hair, a condition of employment should not be to straighten it. It is just to be well groomed in any work environment, but let your hair be your hair. If you feel you are being discriminated against or not given a job opportunity or promotion or a lot of cases we saw were in schools where kids, young girls, would have braids for instance. For those who [may not know] it is hair that is braided down. They would be told they could not come back to class until they undid their braids and/or changed their hair according to what we would call grooming codes that were pretextual in nature, meaning they wanted you to conform. We would get complaints where people would say, "My kid's hair is naturally curly. She is mixed race, or she is African American. There are complaints about people not being able to see around her hair or having to do something different with her hair." Those issues have not traditionally been tied to race, but you cannot change how your hair grows out of your head. It is very much tied to race.

Governor Sisolak signed the CROWN Act. That is also legislation NERC enforces. You should not have to, as a condition of employment, change how your hair grows out of your head to conform. Rather, you should be able to get the job based on your merit, your work ethic, and how you present in other ways that are related to the job. We saw it impacted women more so, and it also lent itself to men with beards, folks who had alopecia or hair conditions they could not help, which meant they would have to wear wigs, but some people do not want to wear wigs. To your question, yes. We do see hair come up as an issue. We now have jurisdiction to investigate, settle those complaints, and let employers know you cannot

make a condition of employment out of hair. You have to look at their qualifications, if they can meet their job duties, and rate them on that. If they are being demoted or being asked, even in public accommodation or school settings or public places, to change or conform themselves in order to participate or equally enjoy the premises, that is illegal.

***Mr. Troth:***

Are there any other legislative actions or proposals concerning seniors that are being discussed with other forums this group might need to be aware of that we could support or learn more about for the next legislative session?

***Ms. Jenkins:***

Yes. 2025 is going to be interesting. I would like to stay in touch with the Forum to let you know what I am hearing. At the Executive level, because we are under the Governor's Office, we lend ourselves to Legislators who may want to talk to us about how we would implement their legislative initiatives or their bills they hope the Governor will sign. I am not aware of any other services. However, I do know transportation is a huge issue for our seniors. Disability discrimination comes to NERC on folks not giving a reasonable accommodation so people can do their jobs who are otherwise qualified. Also, looking at these age claims, I was interviewed in 2019 by a great journalist, and we talked about how this Supreme Court case has made it so difficult for folks facing age discrimination to even prevail on a claim of age discrimination because the burden is so tough. It is unlike any other burden for any other protected status. You have to essentially show the only reason you were demoted or did not get the promotion was because of your age. When in other cases, it is a lesser standard. It is a lesser threshold. It just has to be a motivating factor. The motivation for not promoting you was because of your race or because you are a woman or another [protected] category, but for age, it is so hard. You also have seniors who want to live well. That includes folks in my family too. To go through the process of filing a charge—if you think riding a bus is complicated, to have to get into litigation about this is super intimidating.

We will do our best at NERC to facilitate the process of filing your complaint up to the point of maybe getting your right to sue or settlement, but because the standards are so difficult to get a positive finding from my Agency to help you with that, I think that is where we are going to need to start. My opinion is mine, and they do not reflect that of NERC. We are an Executive agency. Sorry about that legal disclaimer. I would like to see support in this area to allow seniors the ability to have more leverage, just like any other protected class, to get their charges pushed through, so we can give them relief and settle cases because that is what we do. Our goal is to try to encourage private settlement, not court. Court takes a long time. If we can privately settle cases and make people whole, it is incentivizing to the employer. They are not outed, so to speak. Usually, the individuals just want their form of justice, which is they want their promotion or if they were denied the promotion because of their age, they are rectified and made whole through a settlement. Then we move on. We allow people to move on with their lives. Then we train and prevent discrimination like that. Support of our Agency is greatly helpful to make sure we have qualified investigators, we have a robust outreach program, and we are funded well. That is what I could say for right now, but I want to have more conversations about how I can assist your Forum to make sure seniors are seen.

***Ms. Bongiorno:***

I have been here 15 years. I thoroughly enjoyed your presentation. I still run a business, but my applications are not such that I see what many people have to go through. In essence, they have to file them online. Is that true?

***Ms. Jenkins:***

Yes.

***Ms. Bongiorno:***

Then online when you have an application, does it necessarily have to have your age, or do they ask your birthday or something of that effect?

***Ms. Jenkins:***

They should not be asking. They usually do a work around where they ask your birthday. Feel free to leave that blank. I say this in my general life, people can ask questions that I can choose to answer or not. When we talk about applications for employment, we even talked about this with some of our reentered citizens in Nevada who served their time and paid their debt to society, and they had the question, "Have you been convicted of a felony?" There are some exceptions where they do not have to check it until after they have had an interview and right around the time a conditional offer of employment is made where you can tell your interviewers or your potential employer "Yes, I did have a felony, and it is not related to this job." It allows people to get to know you and not see your application, whether it is your age or what have you, and say, "Too old." Yes, it should not necessarily be where you feel forced to fill out what your age is. They want to know when your birthday is. I am a lawyer. My investigators will look at that and see if that is on the application. If you feel like as soon as you put you were born on February 25, 1951, for example, and then she does not get a call back, that is indicative. Then here we have this burden where we have to show it was because of her age they did not give her an interview. That is so narrow.

***Ms. Bongiorno:***

I would definitely support legislation that would eliminate that question because I think you are entirely right where that is concerned. I know in many cases they ask me, but I am not frightened of it. I tell them, I am proud of the fact that I could sit on a Forum like this, and that I run a business. Yet, to this day, I have people constantly coming to me for advice. We hope during the process of our life's journey we acquire knowledge. When we reach a certain age, we have that knowledge. We have wisdom and dispense it.

***Vice President Jordan:***

Are there any other questions from the Forum? [There were none.] We thank Ms. Jenkins for a wonderful and passionate presentation this morning. I look forward to you sending us the information.

## AGENDA ITEM VII—OVERVIEW OF NEVADA DATA RELATED TO INDIVIDUALS 65 YEARS OF AGE AND OLDER RETURNING TO THE WORKFORCE

***Vice President Jordan:***

Unfortunately, Mr. Schmidt is not going to be able to present an overview of Nevada data related to individuals 65 years of age and older returning to the workforce. We are going to move on.

[David Schmidt, Chief Economist, Research and Analysis Bureau, Department of Employment, Training and Rehabilitation, submitted a PowerPoint presentation for the record (Agenda Item VII).]

## AGENDA ITEM VIII—OVERVIEW OF HEALTH CARE CONCERNS AND ACCESS TO HEALTH CARE FOR SENIORS IN NEVADA

***Vice President Jordan:***

Our next presentation is an overview of health care concerns and access to health care for senior citizens in Nevada. Our presenter is reporting from Carson City. Welcome, we are glad to have you. You may commence.

***Peter Reed, Ph.D., M.P.H., Director, Sanford Center for Aging, University of Nevada, Reno (UNR) School of Medicine:***

Thank you for inviting me to speak to you today about aging, QOL, and health care in Nevada. I also serve as a professor of public health in the School of Public Health. Today, I am going to be talking about elders, aging, the landscape of aging and health care access, and needs across the State of Nevada. (Agenda Item VIII A-1) [Due to copyright issues, the presentation is on file in the Research Library of the LCB, Carson City, Nevada. For copies, contact the Library at (775) 684-6827 or https://www.leg.state.nv.us/Division/Research/About/Contact.]

I would like to start with what I consider to be an aspirational goal. This is, if you will, my vision for what the future can hold. I put this statement up front because I think it is a good way to ground ourselves in some common, shared goals. I believe Nevada's elders will live well, despite physical and cognitive changes, when they receive appropriate support that matches their needs and retained abilities and preserves their autonomy and personhood. What do I mean by that? There is a high burden of chronic disease among older adults everywhere, not just here in Nevada. Whether those chronic diseases are related to physical or potentially cognitive limitations, that can create challenges for people in their independence in everyday life. However, those challenges can be overcome if we have the right network of community-based supports and services, the proper access to health care, and if we can diminish ageism in our society in a way that respects and promotes the independence, well-being, and personhood of all older adults. That is why I say, "despite physical and cognitive changes that may come along with the aging process, with the right supports in place, we can achieve positive outcomes for all people."

When I talk about QOL, I want to touch on what I mean by that. Certainly, this could be considered to be a subjective concept. QOL is different for each one of us. You can think of it on a variety of different dimensions. For example, if you ask me, "What contributes to me fulfilling a high QOL?" I would probably start to talk about music, being able to listen to

music, play music, and go see live music. All these things are important to me. It is important to recognize that while there is a subjective component to QOL, it does function across different dimensions. From my role as a public health gerontologist at the University, I think about health-related QOL. These are not the things I may enjoy that bring meaning and purpose into my everyday life. These are the elements of my health that also can contribute to QOL. There are a variety of facets to health-related QOL I think are relevant. I think about being able to promote physical health, mental and emotional health, cognitive health, social health, spiritual health, environmental health, and financial health. All those different dimensions of QOL play a role in someone's lived experience every day and the extent to which they can live the life they choose every day until the end of their life. What is interesting about these is that these dimensions of health-related QOL can be diminished. If someone develops chronic conditions such as diabetes, hypertension, high cholesterol, or arthritis, it can have an impact on their functioning and their independence. As people develop certain conditions, these elements of health-related QOL can decline. I like to say while these are declining because of those conditions, if we give people the right access to the right support services and health care, then we can minimize that decline and minimize that impact.

On the flip side, you will also hear me talk frequently about well-being. I think of well-being as being a bit more of a global concept. I think of well-being as the path to a life worth living. This is a framework or a definition that was developed by an organization I work with called The Eden Alternative International. They talk about well-being as a path to the life worth living. What is interesting about these dimensions of well-being is these do not have to decline with physical or cognitive limitations related to chronic diseases. These are elements that transcend our health but contribute to our overall lived experience every day. Things such as: identity or being known to others; having personhood and individuality; growth or development, enrichment, expanding and evolving, learning new things; autonomy, self-determination and freedom; security or freedom from doubt or anxiety and fear; connectedness, which is a social connection, feeling a sense of belonging and being connected to others as well as time and place; having meaning in everyday life; and joy. When I think about the fundamentals of our independence, and I know in the U.S. and certainly Nevada, we are committed to being independent. We are an independent-minded State. What is interesting is we are all interdependent. We rely on others. We rely on the connections we have to help build our well-being, our meaning, our purpose, and our sense of identity. Even going back, when I think about that principle of promoting life, liberty, and the pursuit of happiness, I see that in these dimensions of well-being. I think life is about growth and development. I think liberty is about autonomy and self-determination. Happiness is about joy. When we think about those fundamental freedoms and fundamental rights that all people should enjoy, these dimensions of well-being give us some insight into how to define that and then give us opportunities to try to develop the services and supports necessary to help promote it despite the chronic conditions someone may be experiencing.

This would not be a presentation on aging if I did not talk a about the demographics of the aging of the population. Given this is the Silver Haired Legislative Forum, I suspect you see these data a lot. Maybe not these exact graphs, but I am certain you are familiar. We live in a rapidly aging country, and a rapidly aging State. It looks like within the next ten years, by 2034, we are going to see that crossover where for the first time in history, we have a higher percent of people over the age of 65 than we do children under the age of 18. I call this a demographic transition that we are experiencing as we start to see a higher percentage of our population be older adults relative to the rest of the population.

If you think back to my aspiration, this idea that all elders can live well despite physical or cognitive conditions, it is important to understand why there is a need for support and that interdependence I talked about to help promote QOL and well-being. I want to talk a bit about some of the conditions that are common. There is a phrase we use in clinical geriatrics called geriatric syndromes. Geriatric syndromes are things that are complex. They often are referring to multiple different factors playing a role in someone's health. They require a variety of different disciplines to be able to understand and support people who are experiencing these. Some of the key syndromes I am most familiar with in the work I do the Sanford Center for Aging are frailty and falls. As people age, they may start to experience bone loss or osteoporosis or perhaps muscle loss or sarcopenia. This might result in them being more frail and more brittle. It might also affect their mobility and their ability to ambulate safely and therefore increase their risk of falls. This is something we want to be able to pay attention to.

Also, cognitive health or dementia. Dementia is an umbrella term for any of the symptoms related to memory loss and personality changes that may come along with a variety of different causes such as Alzheimer's disease, frontotemporal dementia, or vascular dementia. It is essentially impacting people's cognition.

Polypharmacy is a real challenge where people are taking too many medications. We offer a program at the Sanford Center for Aging called Medication Therapy Management (MTM) where we review the medications someone is taking relative to their health conditions and then provide guidance and recommendations to the person as well as their primary care provider on what they can do to find that optimal mix. We had a client one time in our MTM program that was on 42 different prescription drugs prescribed by seven different physicians. To think about how you would manage that is like, take this one in the morning and this one at night and this one with food and this one on an empty stomach and this one after you light a candle. It gets extremely complicated. The goal in our program is to reduce the number of medications people are taking because there can be a lot of negative consequences from the interactions between those.

The other geriatric syndrome we look at is multiple chronic conditions or multiple comorbidities, as we refer to them. I mentioned these chronic conditions previously, but it is common for people to be experiencing numerous conditions at the same time. Someone may be experiencing obesity, diabetes, hypertension, and arthritis at the same time. It is the intersection of those conditions and understanding how—back to that concept of polypharmacy. If I prescribe one drug for this condition, it may have an impact on another condition or it may result in the need for a drug for that other condition that interacts with the drug from the first condition. It gets really complex. That is where geriatrics specialty care and health care providers who are trained to understand older adults and the complexities of these geriatric syndromes become important.

We promote through training programs. We do this at UNR and also our colleagues at the University of Nevada, Las Vegas (UNLV), we have training programs for primary care providers to help them understand how to best support older adults. We teach them a framework called the four Ms of an age-friendly health system, which essentially means in any interaction with an older adult, any health care provider should be first considering what matters most to the person. What are their preferences? What are they interested in? You see it all the time where a provider gives someone instruction on something they need to do for their condition or for their health, and that person does not follow through with it, and the provider calls them non-compliant. I may be a little radical, but I do not believe there are any non-compliant patients. I think there are providers who did not get to understand that patient's preferences and develop a plan that person is likely to follow through on. It

becomes about delivering patient-centered or person-centered care that is reflective of the priorities of the individual. Second, we ask them to be sure they are looking at medications. I already talked about polypharmacy. This is an important area to assess for any individual. Mentation relates to the mind, so looking at dementia, delirium, and depression. What are the things happening there? Finally, mobility. It is taking those geriatric syndromes from the top and then putting it into a framework we can use to educate providers to say you need to be thinking about these four Ms: what matters most; medications; mentation; and mobility in any interaction with an older patient.

Coming back to this idea of chronic disease, I want to share these data that are available. This is information from the National Council on Aging. What is interesting to note is you can look at the specific conditions. These are the top ten chronic conditions among adults aged 65 and older. What is fascinating to me is the cumulative impact of those. According to this estimate, 80 percent of people over the age of 65 are living with at least one chronic condition. Over two-thirds, or 68 percent, are living with two or more chronic conditions. It is common for people to have multiple chronic conditions. The impact of these conditions is on activities of daily living. Being the Silver Haired Legislative Forum, you all are probably familiar with the term of ADLs or activities of daily living. This is essentially people's independence. That independence can be compromised when they are living with multiple chronic conditions. The ability for them to take care of themselves in everyday life is diminished, and therefore they need support. They need the right kinds of family support, the right kinds of community aging services, as well as health care services to help minimize the decline in activities of daily living and promote their independence.

From your perspective, as policy makers, what is needed to help promote QOL and well-being for Nevada's elders? I believe we need a significant infusion of resources into the availability of community-based supports and services. When I am talking about community-based supports and services, what am I referring to? I am thinking about our senior centers. I am thinking about all the nonprofit community organizations that are often funded by the Nevada Aging and Disability Services Division (ADSD) or perhaps the Nevada Division of Public and Behavioral Health (DPBH) that are giving them funding from some Older Americans Act dollars, but also from the State to be able to provide services in our communities that help to promote independence of elders. Things such as transportation programs, companionship programs, caregiver resources, and adult day resources. These are necessary to help give people that boost I talked about earlier, to give people the support they need to live well despite the conditions they may be experiencing.

Similarly, we need increased access to quality geriatrics capable health care. We live in a State that has a low number of geriatricians. We are often referred to as a neurology desert. When it comes to getting an accurate diagnosis of a cognitive impairment, that can be extremely challenging. We also have a low ratio of primary care providers relative to the larger population. Increasing the health care resources that are available is important. I would argue also ensuring the health care providers who are in the State have the right education and training to be able to best support older adults is an important component as well. People also need access to respectful and supportive long-term care. I am talking about both skilled nursing and assisted living communities as well as independent living or perhaps adult day communities. Ensuring those are widely available and the model of care being delivered within those is developed around the best principles for supporting the individuals in retaining the freedoms and rights they have come to expect as human beings in our society is important. Moving into a long-term care community should not mean you are having your autonomy taken away. It should not mean you are having your self-determination or your opportunity to engage in the activities you enjoy taken away. People should retain those freedoms. It comes back to that idea of promoting a patient- or

person-centered care. Respecting human and legal rights, particularly around autonomy and self-determination, I think is something that is often compromised in our society because of how agist our culture is. We live in a youth-oriented society. I am apt to say youth and beauty are the things our culture puts forward as the standards we should all strive for. In my experience, I would say not all young people are beautiful. It should be much more about enabling all people to live well despite their age and diminishing any potential discrimination that may come as a result of the group someone is a part of.

Finally, I want to touch on the need for continued social engagement, meaning, and purpose. When you wrap all these things together, people need to be connected to others because that is an opportunity to receive and give support and continue making meaningful contributions. People need to have the ability to make decisions for themselves in their everyday life. If they have compromised cognitive function, there are ways to support them in still being engaged in decisions that affect their own life. People need access to long-term care, health care, and community-based supports and services available to help them live well.

Let us talk a bit about the data in Nevada. I know you are probably familiar with this. The most recent data I have seen comes from the *Elders Count Nevada* that was put out by the ADSD in 2021. About 17 percent of our population is over the age of 65. We expect that to increase to 20 percent within the next five years. Interestingly, between 2008 and 2018, Nevada was the second or third-fastest aging State in the country. We are one of only three states with an increase of over 57 percent in the population of people ages 65 and older during that time frame. Yes, the country is aging, but Nevada is aging much more rapidly. That speaks to the importance of us developing those resources I mentioned. The other thing I want to mention is we have a highly diverse population of elders. Because of that ageism I mentioned earlier, there is this tendency to homogenize older adults. That is a fallacy. Every dimension of the human experience you can conceive of is reflected in the population of people over the age of 65. If you want to talk about racial diversity, diversity economically, and diversity in terms of sexual orientation or sexual preferences, all these facets are reflected among elders. You have some elders who can pay out of pocket for everything they need because they are perfectly capable and have very high means. Then you have a larger group of elders who do not have the financial resources in today's extremely expensive environment to be able to meet their own needs independently. It is important to always recognize that heterogeneity of the diverse elders across our State.

I showed you the national data on chronic conditions, and I want to share a little from Nevada as well. You can see here obesity is over 40 percent, diabetes is 25 percent, we have about a 10 percent dementia. In terms of subjective cognitive decline, which is people who say they themselves are experiencing memory challenges, we are at 29 percent, which is the highest in the U.S., which is interesting. These are data from the Sanford Center for Aging. We offer a geriatric specialty care center in partnership with Renown Health where we see patients and do a comprehensive interdisciplinary geriatric specialty assessment. Among almost 750 patients that we saw there, we had an average of three chronic conditions, the highest of those being high blood pressure, high cholesterol, arthritis, depression, gastrointestinal (GI) disorders, diabetes, cancer, and dementia. [There were] 38 percent of people falling in the six months prior. You can see these chronic conditions I talked about earlier that have a direct impact on people's activities of daily living are highly prevalent in the State of Nevada.

What is the workforce available to meet those needs? We have about 57 geriatricians in the State, which is 1 for every almost 12,000 people over the age of 60. It is woefully inadequate. There is only one geriatrician I am aware of practicing in Nevada's rural

counties. That goes back to heterogeneity I talked about and that rural/urban divide in terms of access. One key point here is while we do have limited geriatric specialty providers, both on the physician and the advanced practice registered nurse (APRN) side, I do not think we can ever overcome that barrier. I do not think we are suddenly going to start training a bunch of geriatric specialists and get to a point where all elders have access to specialty care. What I think is important is we acknowledge that and put energy into ensuring all health care providers no matter their discipline, particularly all primary care providers, have expertise in supporting elders to a certain level of competence and then understand their own limits and when to refer people to the geriatric specialists that are available. The bottom line is all health care providers need geriatrics training to achieve that basic level of competence, and it is limited right now.

Circling back to my key recommendations, I suggest increasing investments in community-based aging supports and services both in terms of infrastructure and capacity. The more resources we have in our communities available to help support people's QOL, well-being, and promote their independence, the better the opportunity will be for elders to live well. We also need support for training, education, and workforce development. This is looking at graduate medical education and ensuring we have advanced providers in specific disciplines ensuring that all health care students and all emerging health care professionals have some basics in geriatrics and neurology. I am talking about students in medicine, nursing, social work, public health, psychology, as well as other health professions—physician assistants for example. All these providers are coming out of the health profession schools in our State need to have some element of geriatrics and neurology included in their curriculum so they can have that basic level of competence. Also thinking about how to develop the geriatrics workforce by ensuring all providers are receiving training on those four Ms of an age-friendly health system I mentioned previously.

I want to provide a couple of points specifically related to dementia. In full disclosure, I am the past Chair of the Nevada Task Force on Alzheimer's Disease. In my term as Chair, which was the recent term, we released the *2023–2024 State Plan on Alzheimer's Disease* (Agenda Item VIII A-2). There are four recommendations I want to highlight because these are things that directly relate to potential policy change. The first was Senate Bill 297 in the 2023 session. The recommendation is called outreach to primary care providers. The focus on that one, and the bill that came out of it, was to launch an initiative called Nevada Memory Net. This is modeled after a program in the State of Georgia where their state provides $8 million per year in as a line item in their state budget to ensure all elders have access to comprehensive dementia assessments. We developed a plan to be able to do something on a much smaller scale—not asking for $8 million a year—to ensure there is education and training giving primary care providers the tools to make an effective cognitive screen. If that is positive, then they refer them to a comprehensive diagnostic workup so an accurate diagnosis can be made.

The second element is called Dementia Care Specialists Program. This was a bill in the last legislative session, Assembly Bill 167. I should have mentioned neither of these bills passed by the way. These are all things that could potentially come forward again. With the Dementia Care Specialist Program, the idea is to embed a care manager essentially with expertise in dementia in each county. When someone comes forward who is experiencing dementia, this person can help them navigate the system of community-based supports and services that are available to them and ensure they get connected. Fortunately, while the bill did not pass, ADSD was the recipient of a three-year federal grant to launch a pilot of this Program. There is work already happening to test this model of embedding dementia specialists within the county to help with care navigation.

The final recommendation from the *Nevada State Plan on Alzheimer's Disease* I will draw your attention to is recommendation 17, Choice in Care and Care Settings. I provided the *State Plan* as a handout for you today. I recommend you read particularly this recommendation because it does an outstanding job of laying out the federal law that relates to people having the opportunity to live in the least restrictive environment and having the right to decide for themselves where they are going to live. This has particular relevance for people living with dementia who are in locked segregated memory care units. There are a lot of people in segregated memory care units today who did not choose to be there themselves. If you look at the law as it is outlined in recommendation 17, you will see essentially there are only two people that can decide to enter a locked memory care unit, and that is the person themselves living with dementia or a court-appointed guardian. If the person has not gone through a full guardianship process, no one else—not their power of attorney, their family member, or even their physician—can order them to be locked into a memory care unit against their will. This is common practice nationwide, and it is problematic. In that recommendation, we are trying to work with the State Ombudsman's office as well as the State Bureau of Health Care Quality and Compliance (HCQC) and helping them look at what can be done to ensure due process. If someone is choosing to live there, that is great, but if someone prefers not to live in a segregated locked unit, then they do not do so. Those are three areas specifically focused on dementia that I encourage you to take a look at in that *State Plan on Alzheimer's Disease*.

With that, I will share my references with you so you can see where I sourced the data I have presented to you today. I would be happy to answer any questions or have any discussion you would like to have.

***Vice President Jordan:***

Forum Members, do you have any questions? Mr. Slaughter.

***Mr. Slaughter:***

For the past seven years, I have been volunteering and working with folks with Parkinson's disease as a trainer. I was a boxer, and I also used to be a coach of UNLV boxing years ago. One thing I am trying to introduce is the fact that there are a lot of people that come to these programs that have disposable income. Do not get me wrong, I love these people to death, but I noticed I have not had any African Americans or Hispanics coming there. One of the reasons why is because it is north of $100 a month to go to these programs. I do it because the love of labor. I do it for free, and I have been there every week for the past seven years. I am trying to introduce a bill draft request (BDR) that targets underserved people in the State of Nevada with neurological degenerative diseases. I noticed SB 390 was passed last session which dealt with the registration of people with neurological diseases in the State of Nevada. I would like to augment that with how we fund people that cannot go to these programs because we know they work. Movement works when you have a neurological degenerative disease. Like you were saying, you have to have people with expertise in those areas in order to implement that. What is the State doing to—we identify with a registration—find programs? Not just my program, there are other programs that deal with people with these afflictions, like Dancing with Parkinson's, and they have other programs. I think board games or chess games deal with movement. If there is anything else in the State and the funding, how do we get this implemented?

***Dr. Reed:***

Thank you for that question and sharing your experience with the program you referenced. I think there are two levels to your question. The first is about how do we connect people with programs? The second is about access, particularly where there is a cost associated with those programs. On the first element of connecting people, I think there are several different things we need to invest in. One is the marketing outreach and resources specifically intended to help raise awareness of the availability of programs. I have been involved in the field of aging services my entire adult life. I hear often, "There are no programs or services available for us," and it always triggers something for me because I think to myself, well there actually are a lot of programs available, but folks do not know about them. Raising awareness of the availability of these resources is critical. Also, in terms of connecting people with programs, the kinds of things I mentioned earlier like that dementia care specialist position embedded within counties to help identify resources somebody needs and then do a warm handoff to connect them with those resources. I think that is an important step. There are other programs that exist right now such as Nevada Care Connection and Nevada 2-1-1 where they have specialists with access to a database of all the different community programs and resources. Again, people have to know that is available to them in order to reach out and to seek those kinds of services. I think it is raising awareness and also having specialists who are informed about everything that is available within a given community prepared to help individuals who are in need navigate those services.

In terms of the access and cost component, that is challenging. Maybe I am an idealist, but in my mind, these programs should be available for free. People who do have means who would have otherwise been able to pay out of pocket could be asked to donate to help support those programs. If there is a fee associated with it, that immediately gets us into a potential inequity in terms of access. I think that is not something we want to see. For example, at the Sanford Center for Aging, all the programs and services we offer, with one exception, are funded by grants that we receive either from the State through ADSD, DPBH, or from federal grant sources. Because we receive grant dollars to deliver these programs, we are able to make those programs free to anyone who would like to participate. The one exception is our program the Osher Lifelong Learning Institute (OLLI). There is an annual membership fee for participating in that program, but for folks who cannot afford that fee, we have been able to receive donations from those who are able to provide scholarships. I think if you follow that same approach and model, it requires investments by the State in ADSD and DPBH for them to increase the flow of funding into local community-based organizations that are delivering these services and doing so in a way that enables them to deliver those services for free to anyone who is in need. Am I an idealist? Perhaps. This seems like—at least from my perspective as a public health gerontologist—an essential way to build the necessary infrastructure to ensure equitable access for all elders given the heterogeneity of the population. It requires a decision to make that investment.

***Mr. Slaughter:***

Since I have been working with this program for the last several years, I have noticed there were two areas in Las Vegas that offered this particular program. One was in Henderson, and the other is in North Las Vegas, I think. The other thing is to find these places in areas where they may live, like maybe on the west side of town or the east side of town where people retire, and they were housekeepers or food service workers, and they might not have the transportation or the money. This is my goal. Being idealistic like you, I think we can make this happen. I think we can spread the wealth amongst the State of Nevada to

get underserved people in these programs because I know they work. I see they work. There is community, there is joy, there is everything involved as far as managing your affliction in these programs. When people come together, they talk about their different medications and different doctors. They feel like they are not alone.

***Ms. Daniels:***

I have a comment about not being put in a facility if you do not want to. My husband is 62 with severe Alzheimer's. I could no longer take care of him because I am 72. He did not fight me on going. I did not let him know in advance that he was going, but he has been happy. I am glad I did not have to have his permission.

***Dr. Marchant:***

A point of personal privilege, being one of the elder population in the State, I prefer to be called among the long-living rather than the other things. If you could work that into your rap, I would appreciate that.

***Dr. Reed:***

I will certainly do my best. Language is important. That is something I know very well.

***Vice President Jordan:***

Dr. Reed, I looked at the Alzheimer's report, and I did an intense review of your material. I was concerned about an issue. While there has been considerable and welcome attention in the area of dementia over recent years, the mental health of people in later life, specifically the complex relationship between dementia and mental health problems, is a neglected area in public discourse, policy, and service provisions. For older adults who experience intellectual decline, it is sometimes difficult to tell whether the cause is dementia or depression. Both disorders are common in later years, and each can lead to the other. Why does your extremely comprehensive report never mention or address anything that has to do with mental health?

***Dr. Reed:***

I would answer that in a couple ways. First of all, I agree with you that mental health and aging is an incredibly important area that deserves specific attention and specific resources. Mental health conditions do intersect with cognitive health conditions and dementia in a variety of different ways. From a health care perspective, when I think about how we might address the intersection between these, it reinforces the importance of ensuring a comprehensive and accurate diagnosis. Frankly, that cannot be done in a 15-minute primary care visit with a cognitive screening tool. There needs to be a referral to a neurologist, a neuropsychologist, geriatrician, or geriatric psychiatrist who can do the full comprehensive workup necessary to determine if it is depression that may be manifesting itself in terms of cognitive issues, or is this Alzheimer's disease? There may be someone who is experiencing depression as a result of their memory changes. It is a bidirectional relationship that requires deep sophisticated assessment to be able to determine.

Why is mental health not specifically called out in the *State Plan on Alzheimer's Disease*? I think that is largely because the Task Force on Alzheimer's Disease is specifically charged with looking at issues related to cognitive health and dementia. There has been a longstanding misunderstanding and confusion about the differences between mental health and cognitive health. Similar to the way you all are convened and how you determine the

topics you are going to tackle as a group, the Task Force on Alzheimer's Disease has members who are appointed by the Director of Health and Human Services. They bring their own ideas and priorities forward to focus on. I am no longer the Chair, but I am still on the Task Force. We are currently working on drafting our new two-year State Plan. This is a topic I will certainly raise with the Task Force to be sure we are looking at that intersection between cognitive and mental health and not neglecting that as an important interrelated area.

***Vice President Jordan:***

My question was one that I well thought out simply because we have a lot of people suffering from depression, but they are diagnosed with dementia. I think we need to look carefully at depression because that is something we can fix. There are cures for that. If we are going to dementia and moving to Alzheimer's, that is not something we can immediately fix or that we have a cure for. I do not want seniors who are in facilities to think the only answer is that they have dementia because they are forgetful and missing out on things. We are not giving them the services they are entitled to. I appreciate your presentation.

***Dr. Reed:***

Thank you for the opportunity to present today. If there is any further follow-up, please let me know.

***Vice President Jordan:***

We have one more question for you. Ms. Bongiorno.

***Ms. Bongiorno:***

Can you tell me what the difference is in what we call independent living and what we call assisted living, and the cost between those two facilities?

***Dr. Reed:***

I am not sure I have up-to-date information on the average cost of independent living versus assisted living. I think there are a variety of factors that determine that. In general, independent living should be less expensive on a monthly basis than assisted living. The difference being in independent living, there is an expectation that someone is able to largely fulfill their own activities of daily living. They are receiving assistance perhaps with meals in a common area with other residents, perhaps transportation services, or housekeeping services that are available, but they are largely living independently versus in assisted living where someone is experiencing limitations in their activities of daily living, like their ability to dress themselves or take care of their own personal hygiene. Therefore, there are staff within those communities to provide them with day-to-day support for fulfilling those activities of daily living. I will take your question one level further, which is to draw a distinction between an assisted living community that is enabling or supporting people with their activities of daily living to a skilled nursing home where there are skilled nursing services available helping to provide treatment for certain medical conditions on an ongoing basis in addition to providing support for activities of daily living.

***Ms. Bongiorno:***

In some of these facilities, as far as having attendants or caregivers on premises, I have heard that you can have as many as 200 patients and in the evenings maybe only two attendees for that amount of people. Is that true?

***Dr. Reed:***

I am not exactly sure what the regulations state in terms of the ratios of staff to residents at the different levels of care. There are specifically trained staff within each of those different types of long-term care. For example, in an assisted living community, you would have a direct care worker or a personal care attendant, which is someone who is assisting with activities of daily living. Whereas, in a nursing home, you would have a certified nursing assistant who is supporting the medical treatment the person is receiving within that community under the guidance of a registered nurse or a director of nursing. There are a variety of different disciplines that provide care within these contexts. I would have to get back to you and look at specifically what Nevada's regulations are related to the staff-to-resident ratio in those different types of care.

***Ms. Bongiorno:***

Let us say someone goes to a doctor because they are forgetting. Is it not true that doctor is required to report to the State that individual's condition? Then they send out a so-called social worker or case worker that evaluates that person in their home, and then they go back and report it. Is that correct, they are required to do that?

***Dr. Reed:***

If there is required reporting of diagnoses that triggers a case manager being assigned to assess the individual's living situation, that is news to me. I would have to look into that. That is something I would have a hard time believing, but certainly, I am not going to say it is not true.

***Vice President Jordan:***

Dr. Reed, we have enjoyed your presentation, and we look forward to hearing from you in the future. If there are no other questions, we will move on.

## AGENDA ITEM IX—OVERVIEW OF GERIATRIC HEALTH CARE WORKFORCE TRENDS AND POLICY INITIATIVES IN NEVADA

***Vice President Jordan:***

Next is an overview of the geriatric health care workforce trends and policy initiatives. You may begin.

***John Packham, Ph.D., Associate Dean, Office of Statewide Initiatives, UNR School of Medicine:***

Thank you for the opportunity to join you. I am also Co-Director of the Nevada Health Workforce Research Center. A lot of what I am going to present is going to build on and complement what Peter and some of the previous speakers have touched on, but I will largely be focusing on the health care workforce and the implications that has for geriatric care in Nevada. Some of the information I am presenting will come from resources you can

find online. I am hoping Forum staff shared with you hard copies of a couple of reports from our Office, including our biennial *Nevada Rural and Frontier Health Data Book*, as well as *Health Care Careers in Nevada* manual. The career manual is now in its seventh edition. It has been shared with students, principals, guidance counselors, and so forth in all 17 of Nevada's counties to highlight the range, variety, and number of good paying jobs in health care and where to go for the training for those jobs. I hope you will have an opportunity to peruse both of those at your leisure. (Agenda Item IX) [Due to copyright issues, the presentation is on file in the Research Library of the LCB, Carson City, Nevada. For copies, contact the Library at (775) 684-6827 or https://www.leg.state.nv.us/Division/Research/About/Contact.]

I wanted to begin with access to care and the role health workforce and health workforce development plays in either enhancing access to care or impeding it. There are both good and bad stories along those fronts. When I teach health policy at UNR, and I am talking about access to care, I like to begin by simply saying that access to care is not complicated. It essentially means receiving health care services or products such as a pharmaceutical product or a medical device when they are needed. When we think about what policy measures we can take as a State, or a nation for that matter, they typically fall into two categories. One is addressing financial barriers, and the other is a broader range of what I consider nonfinancial barriers to care. At the top of the list is health insurance coverage. It is hard to underestimate the absolute importance of insurance coverage in improving access to care. I would qualify that by saying all of us, including seniors, face substantial financial barriers in the form of rising out-of-pocket expenses, cost-sharing requirements, whether you are on Medicare or a private plan such as myself, and the overall affordability of medical services. Nonfinancial barriers, particularly for those living and working in rural areas of the State, include transportation, specialists that Dr. Reed alluded to that are necessary for optimum care for the older population in the State, which is a formidable challenge when it requires a 180-mile drive from Winnemucca to Reno or farther to Las Vegas. There is a lot that goes into that.

I will illustrate with a couple of examples, but one of my big concerns is when we think about access barriers for seniors, I would like to point out Medicare, of course, has been a game changer for the past 50 years. There is inadequate insurance coverage for a lot of what seniors need. Medicare typically does not cover oral health care, vision, and hearing services. There is also the problem of rising out-of-pocket expenses. I am working on a report with the Kaiser Family Foundation in Washington D.C. on the problem I am seeing, not just with the senior population, but with Nevadans of all income levels. If you have a cost-sharing requirement on an inpatient stay, an outpatient procedure, or even an emergency department visit, that is often competing with housing costs, food costs, transportation needs, and so forth. That puts a real pinch on an individual's ability to access care even if they are insured, as is the case with the Medicare population.

For the conversation today, I am going to highlight what workforce shortages mean for access to care. I think we have made important strides in the State over the past decade. Through the Affordable Care Act, we have cut our uninsured population in half. There is still a lot of unfinished business and work to do in that regard, but given that positive trend, we still face some formidable workforce barriers. This is summarizing what I consider the big drivers of demand for health care services. At the top of the list are some demographic factors. I would like to highlight population growth because what we are seeing in Nevada in the post-pandemic period is population growth starting to drive additional demand for health care in our State. In Clark County alone, you are seeing 3,000 to 4,000 new residents enter your County looking for housing and coming here largely for employment opportunities. That is putting a significant demand on health care. My concern is when you

see population growth increasing, we are not seeing the workforce grow quite as fast. In some respects, we are treading water against that demographic trend. Other factors I have listed include economic growth and diversification which is playing a role as is continued gains in health insurance coverage.

The bottom line is there is steady growth and demand for health care, and that is putting strains on a workforce that is already characterized by shortages in many important areas. The good news is what we have seen across most health professions, including medicine, nursing, and behavioral health, is a steady growth in licensees. However, qualifying that when we adjust for population growth in those areas, we are seeing a treading of water in terms of the State's workforce. I will highlight some important workforce shortages we face. We have an aging health workforce serving an aging population. The average age of a physician in the State is pushing the age of 55; ditto with nursing. One of my concerns is that every time we see the economy improve, we see an exodus of individuals from the workforce. That includes the health workforce as retirement portfolios improve and people are in a position to retire.

I am also going to highlight what I refer to as the geographic maldistribution of the workforce. Some folks would argue, and I disagree with them, that we have plenty of physicians, plenty of nurses, and the problem is there needs to be a redistribution or movement of providers from areas facing shortages to those without shortages. In this chart, these are federally designated primary care shortage areas. That is areas of the State that lack primary care physicians, be they internist or generalist, as well as family medicine doctors and geriatricians. The darker the shade, the more severe the shortage area. A couple of things stand out, and that is there are few parts of Nevada that are untouched by primary care shortages. While the problems may be acute in rural areas of the State, Washoe County and Clark County, the big urban centers of the State continue to face shortage areas. By my office's estimate, a little over two-thirds of the State's population reside in a primary care shortage area. It is a similar story with oral health. Again, the darker the shade, the more severe the shortage area. Essentially, three in five Nevadans live in a dental shortage area. At the top of the list of concerns for most policymakers in the State is the severity of our mental health shortage area. All 14 rural and frontier counties in the State are mental health professional shortage areas. I would point out urban areas are severely impacted by psychiatry and clinical psychology shortages as well.

The last thing I will highlight with respect to workforce shortages is my concern that the State continues to face a shortage of registered nurses, whether they are at the bedside or in outpatient clinic settings such as nursing homes. It is hard to translate what being 49$^{th}$ or 50$^{th}$ in the country with respect to the number of nurses per capita. We have devised a way of reframing that. If you take the number of registered nurses (RNs) per capita in Nevada and compare that with the national per capita average, how many additional nurses or health professionals would it take to bring Nevada up to that? The numbers I have listed here are staggering. To reach that national per capita average, that is to move Nevada from 48$^{th}$ or 49$^{th}$ to the middle of the pack, we need 3,100 additional RNs. We need almost as many more licensed practical nurses. Certified nursing assistants are an integral part of nursing home care in this State; we need over 5,000. It is a way of saying when we think about access, being that low on those per capita averages means regardless of insurance coverage, folks are going to face barriers accessing care if there are simply not enough providers available.

What do we do about these shortages and workforce issues? For the sake of simplicity, I like to say we have three general sets of solutions. First and foremost, the way we keep and retain physicians, nurses, and other health professionals in State is simply to increase the

number and diversity of health program graduates. Historically, we have been late to the game. It was early 2000s when we built our first dental school. Las Vegas did not have its own allopathic school of medicine until five or six years ago. Ditto with most areas. I would argue it is never too late to begin addressing those shortages because we pay for it anyway. If we are recruiting physicians or paying traveling nurses from out of the State to come practice here, that comes with a heavy price tag. There is no substitute for growing your own. There is a wonderful Chinese proverb I like to use in this context, "The best time to plant a tree was 20 years ago. The second-best time is right now." It is never too late to address that. I am going to highlight and illustrate some examples of stretching the workforce and provide a few examples of that third category, which is not going to move the needle on workforce.

Growing our own will be at the top of the list. I am not going to explain everything on this list, but I am happy to address any questions you might have. Each of the bullets refer to expanding the capacity of the State's higher education system and program partners to increase the number of physicians, nurses, lab techs, radiology techs, and so forth. I have also included on this list a couple of ways we ensure those we grow remain in Nevada. I will highlight loan repayment and forgiveness programs. The State Treasurer introduced and the Governor signed an important bill in the last session that expanded the number of dollars into the millions available to health professionals who agree to practice in Nevada and serve in a medically underserved area with loan forgiveness up to $120,000 per provider in some instances. We know what works in growing our workforce. We also have some additional weapons in our arsenal to keep them here. Loan forgiveness is at the top of the list.

The second category, which is equally important in many ways, are efforts we can stretch the existing workforce or make the most or improve the efficiency and effectiveness of the workforce that is already here. Dr. Reed mentioned a great one: expanding geriatric training for those physicians, nurses, and other health professionals that already work here. It is not necessarily creating a new health professional. It is expanding their ability to practice at the top of their scope and address specific population needs.

The final category is a number of measures. We saw a lot of these put into place during the pandemic. When we were short, like many parts of the country, we saw an explosion of use in traveling or contract nurses from other states. That severely raised the price tag of health care in this State and elsewhere. Most of the items on this list as I noted earlier are not going to move the needle on that workforce.

I wanted to mention a couple of strategies that stretch the workforce category. Full disclosure, Project Extension for Community Health Outcomes (ECHO) Nevada has been around for about ten years. It is overseen by my office in Reno. Project ECHO is not a traditional telemedicine consultation. I think most of you are familiar with the type of consultation that takes place with a provider on one end of a telemedicine or telehealth consult with a patient on the other end. That is typically a one-on-one way of treating or managing a disease or illness. What we are doing with ECHO is a little different. We are using a specialist based in Reno or Las Vegas to provide didactic training and case reviews for primary care providers across the State. We cannot have rheumatology, cardiologists, hepatologists, and other specialists in particularly the small, rural communities, but what we can do is improve the capacity of those primary care doctors, nurse practitioners, and physician assistants (PAs), to treat, manage, and keep those patients local. That is a stretch of the existing workforce we already have. I have included some information on Project ECHO Nevada and those specialty sessions or clinics we offer through the ECHO Program.

Another mechanism for stretching the workforce is granting providers added ability to treat and manage conditions they heretofore have not been able to do. I am highlighting AB 170, which was passed in the 2013 Legislative Session. It allowed nurse practitioners in the State of Nevada to practice independently of the supervision of physicians. Prior to this, a nurse practitioner had to have a physician sign off, for example, on prescriptions for their patients and meet certain supervisory requirements. When our Legislature passed that bill a decade ago, what we saw in the wake of that is a dramatic growth in the number of nurse practitioners that moved to Nevada, gained licensure in our State, and are now addressing the primary care workforce needs of this State. In that figure, the blue line is adjusted for population growth. I am unaware of another facet of the workforce in which we have seen dramatic growth faster than population growth as we have seen with nurse practitioners. There are things we can do other than expand nursing programs.

The final example I will give in the category of stretching the workforce would be team-based models of care. We have slowly seen an evolution of the health system that has gone from a physician-centric model of provider to patient care, to ones incorporating a diverse health care team. There is still a critical role for physicians and clinicians in this, but when we see team-based models of care, what we are seeing is a more effective utilization of the existing workforce. Community health centers, if you have been to the Northern Nevada HOPES Clinic or the Nevada Health Centers in the south, you see team-based models of care that have been in existence for couple of decades. I think the system will continue to evolve in that direction.

I am going to close this discussion by talking about policy measures the State has taken or considered to increase the health workforce in Nevada and address those shortages I keep alluding to. I should note when Packham refers to a win, I am trying to say these are measures that have increased the supply of physicians, nurses, and other health professionals or stand to given what we know. They include an important expansion of nursing grants statewide to all the public nursing programs and additional dollars put into loan repayment. Finally, addressing behavioral health workforce pipeline and kindergarten (K) through 12 education—some of the other items listed here, including important dollars for that UNLV medical school class expansion.

What we did not see during the 2023 Session was action on the items listed on this slide. They are measures we know will have an important impact on increasing the supply of nurses in particular in this State. I think these will be revisited in 2025. The last item on that list is one I think we will be assessing the impact for at least another decade. During the 2023 Session, the medical malpractice caps on physicians and other providers that carry liability insurance was increased. When we have seen that increase in other states, we have also seen the number of medical malpractice lawsuits increase. I think the jury is still out on what impact that will have on the workforce. My Office and others will be monitoring that closely because what we do not want to see is that associated with physicians and other practitioners leaving the State because they cannot afford malpractice premiums and the ability to practice in the State.

I am closing by reiterating some of those. I think these will need to be addressed next spring in the 2025 Session. Every item on here is worthy of the Legislature's consideration because again, it is never too late to begin addressing what we know works in expanding the State's health workforce and addressing those particular shortages.

The final thing in my presentation are recent and upcoming reports from my Office. Please do not hesitate to reach out to me if this Forum or any individual participating in this

meeting would like more information. With that, I am happy to address any questions you might have.

***Mr. Troth:***

Can I revisit your terminology on loan forgiveness? Who is going to pay for that if it is loan forgiveness?

***Dr. Packham:***

I will give you a simple case study. For the past 34 years, my Office has overseen a loan repayment program. What we have done successfully over those three decades is received a federal grant for $500,000. That has been matched with State dollars, typically a General Fund appropriation. This year, it was dollars from the Treasurer's Office. What we typically have in the course of a biennium is a million dollars that we make available to physicians, nurses, pharmacists, and other providers up to $25,000 a year for a two-year stint to forgive outstanding student loans. Typically, in the case of physicians, it is their undergraduate medical education, and as long as they meet the requirement of practicing in a medically underserved area, we will use those dollars to forgive up to $25,000 a year. The Treasurer's program is a little bit different. It is not a General Fund appropriation. Rather, it is the use of dollars the Treasurer has invested from the Unclaimed Property Fund. That is an innovative and good use of those dollars with the sole aim of keeping providers who have been trained and educated in the State from moving to another state because they got an opportunity to pay off those loans and start a career elsewhere that might be more lucrative. I think that is going to be a game changer in Nevada.

***Mr. Troth:***

I totally get you. Every dollar is going to be some kind of government tax dollar, either federal or state. That is what I was looking for. You are not getting those from anybody outside in the private sector or anybody donating money.

***Dr. Packham:***

Thank you for that reminder. There is a loan forgiveness program managed through the Governor's Office of Science, Innovation and Technology. Those dollars are provided by the Pennington Family Foundation. There are some private, philanthropic dollars out there. I would make a plug if that is a direction that foundations and philanthropic organizations want to pursue, there cannot be enough dollars in that space.

***Mr. Troth:***

I totally agree. I am glad to hear that. What are obstacles to expanding the team-based model of care? I think that is a great thing. I have seen some of that go before. What are some of the things that keep that from expanding? I ran the numbers. We are short about 12,000 health care workers of assorted types. This looks like a good utilization of some of that. Are there things that keep that from expanding?

***Dr. Packham:***

Absolutely. I will give you a recent example that I think is important. You may have heard of a relatively new type of health professional called a community health worker. What a community health worker does, particularly in an outpatient clinic setting, is improve the ability of that overall office to make sure individuals are on time for appointments,

coordinate with specialists if they require a specialty referral, if they have a prescription to be filled, if they need transportation to make that clinic visit, and so forth. It is the type of worker who is not a clinician or has clinical training so much as they improve the effectiveness of the overall organization. Through most of our State's history, there was no form of reimbursement for the utilization of community health workers. A couple of legislative sessions ago, a small but mighty measure was taken by State lawmakers to allow Medicaid to reimburse clinics for the use of those community health workers. Once they become a part of the ability of the clinic or health care enterprise to capture reimbursement and make sure those community health workers are paid for, that is one mechanism we can utilize to move us towards team-based care. I would argue if you look at federally qualified community health centers, community health centers, clinics, rural health clinics, and rural counties of the State, they have already been moving in that direction because it works. It helps keep costs down. The best operating team-based model improves the ability of a physician or nurse practitioner to do what they were trained to do: treat and manage disease and leave the administrative tasks and all that care and coordination to workers like community health workers, medical assistants, and so forth.

***Mr. Linden:***

I have feedback because my background was 30 years in health care management on the provider side. Subsequent to that, I owned a business here in town. I am now fully retired. The issues and the acute shortage of providers have been here the 25 years I have lived in Las Vegas. It is great to see them on a slide, people recognizing them on a broader level, and better yet making progress, it appears. I find that encouraging.

***Dr. Packham:***

I would agree, when I was making this presentation 15 or 20 years ago, it was a lot more dire than it is now. You have added a medical school in Las Vegas. We have tripled the size of our residency and fellowship programs. There is still a lot of work to be done, but we have made progress.

***Vice President Jordan:***

Dr. Packham, we enjoyed your presentation this morning. Are there any other questions? Seeing none, we will move on.

## AGENDA ITEM X—FACILITATOR REPORTS ON ISSUES OF IMPORTANCE TO SENIORS

***Vice President Jordan:***

Next, the facilitator reports on issues of importance to seniors. We are going to ask our Northern Facilitator to discuss any issues of importance for seniors in Northern Nevada.

***Ms. Adin:***

Most of the issues I had today were also discussed in the last presentation about nursing homes. I have noticed the shortage of nurses. I brought up the issue of more traveling nurses, maybe for nursing homes. I think the pay scale makes a big difference. The increase in patients—we are having more patients now than we have before in nursing homes. There are patients calling out for help, and the nurse is not available to help them. I have helped some when I visited there. We have a big issue in most of the nursing homes.

That issue was brought up in the last presentation with ways we can solve some of the problems. That is all I have for this presentation.

***Vice President Jordan:***

Ms. Adin, it is good to see you are feeling better and looking great. Ms. Tyler, who was our Southern Facilitator, is no longer able to serve with the Forum. We will miss her, and we wish her well.

## AGENDA ITEM XI—DISCUSSION OF SOLICITATION OF RECOMMENDATIONS

***Vice President Jordan:***

We will now look at the discussion of solicitation of recommendations. I would like to mention the solicitation of recommendations memorandum and related information has been uploaded to the Forum's web page. This memo asks all interested parties to submit recommendations to us for potential legislation. As a reminder, the Forum may request one BDR. I encourage all Members of the Forum as well as individuals and organizations to bring forward recommendations on possible legislation. Are there any comments or questions from the Forum regarding the discussion of solicitation of recommendations at this time? Seeing none, we will move to our final public comment period.

## AGENDA ITEM XII—PUBLIC COMMENT

[Vice President Jordan called for public comment; however, no testimony was presented.]

***Vice President Jordan:***

We want to thank all our Forum Members for their outstanding service today. We wish President Almaraz a speedy recovery. Our next meeting will not be held in this building. We will notify you as to the new address and location for the meeting in August. This concludes our meeting for today. Our next meeting will be the work session held on Wednesday, August 7, starting at 10 a.m.

## AGENDA ITEM XIII—ADJOURNMENT

There being no further business to come before the Forum, the meeting was adjourned at 2:17 p.m.

Respectfully submitted,

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Julianne King
Assistant Manager of Research Policy Assistants

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Ashlee Kalina
Constituent Services Analyst/Program Facilitator

APPROVED BY:

_____

Fran Almaraz, President

Date: _____

# MEETING MATERIAL

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| Agenda Item IV A | Terri Reed, Administrator of Paratransit and Special Services, Regional Transportation Commission (RTC) of Southern Nevada | PowerPoint Presentation<br><br>This is on file in the Research Library of the Legislative Counsel Bureau (LCB), Carson City, Nevada. For copies, contact the Library at (775) 684-6825. |
| Agenda Item IV B | Paul Nelson, Government Affairs Officer, RTC of Washoe County<br><br>Jim Gee, Director of Public Transit, RTC of Washoe County | PowerPoint Presentation |
| Agenda Item V | Angela Rowe, Policy Specialist, Employment, Labor and Retirement Program, National Conference of State Legislatures | PowerPoint Presentation |
| Agenda Item VII | David Schmidt, Chief Economist, Research and Analysis Bureau, Department of Employment, Training and Rehabilitation | PowerPoint Presentation |
| Agenda Item VIII A-1 | Peter Reed, Ph.D., M.P.H., Director, Sanford Center for Aging, University of Nevada, Reno (UNR) School of Medicine | PowerPoint Presentation<br><br>This is on file in the Research Library of the Legislative Counsel Bureau (LCB), Carson City, Nevada. For copies, contact the Library at (775) 684-6825. |
| Agenda Item VIII A-2 | Peter Reed, Ph.D., M.P.H., Director, Sanford Center for Aging, UNR School of Medicine | Handout |
| Agenda Item IX | John Packham, Ph.D., Associate Dean, Office of Statewide Initiatives, UNR School of Medicine | PowerPoint Presentation |

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