NEVADA LEGISLATURE
LEGISLATIVE COMMITTEE ON SENIOR CITIZENS, VETERANS AND ADULTS WITH SPECIAL NEEDS

(*Nevada Revised Statutes* [NRS] 218E.750)

MINUTES

April 30, 2024

The third meeting of the Legislative Committee on Senior Citizens, Veterans and Adults With Special Needs for the 2023–2024 Interim was held on Tuesday, April 30, 2024, at 9:30 a.m. in Room 4401, Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. The meeting was videoconferenced to Room 3138, Legislative Building, 401 South Carson Street, Carson City, Nevada.

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

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:

Senator Pat Spearman, Chair
Assemblywoman Tracy Brown-May, Vice Chair
Senator Marilyn Dondero Loop
Assemblyman Reuben D'Silva

COMMITTEE MEMBER PRESENT IN CARSON CITY:

Senator Lisa Krasner

COMMITTEE MEMBER ATTENDING REMOTELY:

Assemblyman Ken Gray

LEGISLATIVE COUNSEL BUREAU STAFF PRESENT:

Destini Cooper, Senior Policy Analyst, Research Division
Jennifer Ruedy, Research Director, Research Division
Christina Harper, Manager of Research Policy Assistants, Research Division
Terese Martinez, Research Policy Assistant, Research Division
David Nauss, Senior Deputy Legislative Counsel, Legal Division
Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division

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

AGENDA ITEM I—OPENING REMARKS

Chair Spearman:

Good morning, everyone, and welcome to this edition of the Legislative Committee on Senior Citizens, Veterans and Adults With Special Needs. I would like to announce to everyone who is here and those watching us, we have American Sign Language (ASL) interpreters here, and that is wonderful. We have several here, so they will not get tired during the meeting.

Secretary, please call the roll.

[Roll call reflected in Committee Members present.]

[Chair Spearman reviewed meeting and testimony guidelines.]

AGENDA ITEM II—PUBLIC COMMENT

Chair Spearman:

Let us go to public comment. Do we have anyone here in Las Vegas? Anyone up north? Begin when you are ready.

Larry Dailey, Nevada Resident:

A study in the American Journal of Public Health shows that people with autism have an average lifespan of 36 years. A lot of them die because they do not get the help they need. I told a Nevada Department of Health and Human Services (DHHS) official that a family member is not getting the services she needs from the Aging and Disability Services Division (ADSD). He acknowledged the State was probably in violation of the law and said the ADSD would probably take ten years to fix its management problems. My family member is 26 years old. Her statistical life will be over before the ADSD—according to that official—fixes its management problems; she could die in ten years. She has not ever received all of her services and certainly not all of them in the last year. The State knows this. It could be perhaps inadvertently killing her and others.

There is already a statute, NRS 435.430 that says the ADSD should ensure continuity in the care and treatment of persons with intellectual disabilities in this State. But there is no enforcement mechanism for that law. There are no consequences for failing to provide continuity of care for people like my family member, and NRS 435.430 seems to be an underfunded mandate. It requires continuity of services but does not ensure there will be sufficient funding for those services.

My family member does not want to be a charity case, and she does not want to die. She has a college degree. She can contribute to the economy. She is wonderful, and she needs help; and I need her to live. Please act to keep people like her alive and productive. Please pass legislation that puts oversight and funding into the laws. Nobody should ever hear from a State official that their family member with autism might take ten years to get the services she needs, and therefore, might die before the management and funding problems are fixed. Coming into this meeting, I see you are going to hear later on the people with intellectual and developmental disabilities, about more than 500 of them are on a waitlist for services. Now, this is the Department's reporting; this is from the people who do not want you to hear the bad news. I am guessing, if you looked at all the services that are supposed to be delivered, that number might be tripled. Thank you. Please address this issue.

Chair Spearman:

Anyone else? Broadcast and Production Services (BPS), is there anyone on the phones?

BPS:

The public line is open and working; however, there are no callers at this time.

Chair Spearman:

Let us give it a few more minutes.

BPS:

Chair, there are still no callers at this time.

Chair Spearman:

Thank you.

AGENDA ITEM III—APPROVAL OF THE MINUTES FOR THE MEETING ON MARCH 26, 2024

We will move now to the approval of the minutes for the meeting on March 26, 2024. Members of the Committee, are there any questions regarding the minutes? Up north? [There were no questions regarding the minutes.] I will entertain a motion to approve the minutes for the Committee meeting on March 26, 2024.

> SENATOR DONDERO LOOP MOVED TO APPROVE THE MINUTES OF THE MEETING HELD ON MARCH 26, 2024.
>
> VICE CHAIR BROWN-MAY SECONDED THE MOTION.
>
> THE MOTION PASSED UNANIMOUSLY.

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AGENDA ITEM IV—PRESENTATION ON THE QUALITY OF LIFE FOR INDIVIDUALS, WORKPLACE EQUALITY, AND OTHER EQUAL RIGHTS FOR LGBTQ+ ADULTS WITH SPECIAL NEEDS

Chair Spearman:

Agenda Item IV, presentation on the quality of life of individuals and workplace equality and other equal rights for the LGBTQ+ adults with special needs. We have Mr. André Wade, State Director for Silver State Equality, with us. Welcome, Mr. Wade. Begin when you are ready.

André C. Wade, State Director, Silver State Equality:

Good morning, Chair, Vice Chair, and Members of the Committee. Thanks for having me here today. We are a statewide LGBTQ+ civil rights organization here in Nevada. Our mission is to bring the voices of LGBTQ+ people and our allies to the institutions of power to create a world that is healthy, just, and fully equal. We do that by trying to pass pro-equality laws here in Nevada and Washington, D.C., advancing civil rights and social justice issues for the LGBTQ+ community, and then working on public education and advocacy on a myriad of issues. (Agenda Item IV)

To give you a brief snapshot of the work we do in general, that is intersectional and looking at a lot of different life domains of the LGBTQ+ community. We focus on youth; we have a youth in out-of-home placement work group that focuses on children in foster care, juvenile justice, and experiencing homelessness. We tackle looking at Assembly Bills 99 and 180 that were passed in 2017, to ensure the implementation of those laws. Most recently, we were able to secure $200,000 for a statewide study on youth homelessness, including LGBTQ+ youth, to better have a sense of the prevalence of the issues. We can solve the issue of homelessness with housing and other interventions.

We also have a student advisory council that most recently did a statewide survey to find out the challenges of students—LGBTQ+ people and students—particularly in high school. The report, as you can imagine, found that many young people are still experiencing a lot of bullying; they do not feel like they have support of school counselors and administrators and want more training of staff and administrators. There might be trainings in place, but they might not be that long or well done. At the end of the day, we have these young people that are being impacted.

We have also done work on public health around the Coronavirus Disease of 2019 (COVID-19), monkeypox (MPOX), and human immunodeficiency virus (HIV); making sure this particular community across the State has the education about the various diseases, that interventions are flown to them, that they are getting the information in a way that is applicable to them through community centers—through trusted messengers. With HIV being a communicable disease that impacts everyone, regardless of orientation or gender identity, we try to ensure people have the tools available to get the resources they need. However, when it comes to HIV—and I will talk about this a little later when it comes to older adults—there is very little information that helps support people who are looking to solve the issue and provide supports for older adults with HIV. You can even say that for people with special needs.

We have done a lot of work around transgender issues, implementing nondiscrimination protections—and the health care and the justice side, as well—through different laws. Lastly, we do advocacy around seniors and people who are differently abled—and that is on a statewide policy and federal level.

Today, I will mention "intersectionality" a few times. Intersectionality is a term to describe how things like your gender, race, class, and other characteristics like your romantic orientation, veteran status, and abilities intersect and overlap, creating unique situations, opportunities, and barriers for people at certain times, instances, and moments in their lives. If you think about someone's abilities, veteran status, sexual orientation, and gender identity, all of these create unique experiences for people. Some people might be, on their face, similar by race, but if you look at other intersectional characteristics of folks, that is where the differences lie.

When we talk about inclusion of LGBTQ+ people, the goal is to have preexisting or new policies, programs, and outreach efforts to include LGBTQ+ people. It is not necessarily about creating things that are terribly new, and it is not about us having special or more rights than others. It is about having equality and being equally thought about when programs are being created, outreach is being done, and policies are being developed. We want that to be throughout various life domains—in education, health and well-being overall, finance, et cetera.

I am going to speak about ways in which we could be more inclusive for the LGBTQ+ community. Largely, here in Nevada, we have great laws that are pretty innovative compared to other states across the nation; we even do pretty well when it comes to organizations and nonprofits being mindful of LGBTQ+ people. But we are also struggling with making sure the great laws we have and the practices on the ground are felt by people in real time, especially for those who are in rural and frontier communities, and particularly those who are transgender.

When it comes to being inclusive with legislation, policies, and regulations—it could be when we are talking about different demographics or classes of people—age, race, geography—to also include sexual orientation, gender identity, or LGBTQ+ people, or gender minorities, sexual minorities, as protected classes; or as being mindful of what a program is intended to include. We encourage the language to be explicit in including LGBTQ+ people and not just make assumptions.

Same for programs, practices, and outreach—often, programs are designed without considering LGBTQ+ people. If you think about LGBTQ+ people not being considered, you have to think about those who are considered, without there being consideration for any other characteristics they might have. We are missing these opportunities.

When we talk about health, we have a lot of people who are able to access medication and health insurance nowadays; but when they go to the doctor, they may feel discriminated against because their providers are not trained on LGBTQ+ competencies. If that happens, and people face discrimination while seeking health care, then they might be more likely to not seek health care in the future, until there is a big issue they are dealing with.

With professional development—often people feel they have been through enough trainings; that we do not want to mandate or require professionals to have more trainings that is particularly for LGBTQ+ people. But when you have the knowledge that the people you are interacting with could be or are from the LGBTQ+ community, and there are special considerations about the unique experiences of LGBTQ+ people, then when people are trained up, they can better care for people when they are accessing services and treatment.

As much advancement that we have made in the area of the equality movement, it is still transgender folks who are often excluded when it comes to policymaking or programmatic efforts—or even recognizing their existence in the first place. If we have about 5 percent of the adult population in Nevada as LGBTQ and about 1 to 2 percent transgender, those are thousands of people who are not thought about when legislation is being created, programs are being created, and outreach is done. That can impact and improve their quality of life overall.

In the areas of the workplace, you can think about how people start a job and think about these areas where inclusion of LGBTQ+ people can be involved. When we talk about recruitment of people in the workforce—having information about the jobs being directed at community centers for LGBTQ+ people who are more likely to see that job description. The hiring practices—making sure there are LGBTQ+ people who are being hired, who can then provide information about how to solve these issues around being inclusive to clients and folks who are involved in different systems and programs. Creating a welcoming workplace is done by nondiscrimination policies, but also creating a sense of belonging for LGBTQ+ people so they feel they are not only in the workplace and supported, but also that they belong there; they want to stay there and be contributing to the overall organization. You want to have these promotions and retentions in place, because right now LGBTQ+ people are more likely to live in poverty. Studies show they are also more likely to work more overtime and more hours, but then also have the risk of losing a source of income over time compared to their non-LGBTQ+ peers. When it comes to the workplace, there are ways to get people involved in working, and there is a way to get them involved in staying on the job—also paying a livable wage, so they are moving from not only earning 90 percent of the median income, but actually the full 100 percent of the median income for a particular area.

One way to include LGBTQ+ people in things that are already existing is to look at the plans that already exist. Instead of reinventing a special program for LGBTQ+ people, you can take what is either already in place and see where there are gaps—where LGBTQ+ people do not exist in those plans—or in the beginning, make sure that LGBTQ+ people are already included.

There was a bulletin from this Committee back in 2022, that talked about these different items on the screen [Programs to Assist Seniors with Dementia and Their Caregivers; Support of Services for Veterans and Military Spouses; Proposals to Assist Vulnerable Adults; Proposals to Update Guardianship Laws; and Homelessness of Vulnerable Adults], and there is no mention of LGBTQ+ people in the thinking behind "what is needed for these particular programs?" Now there is a program called Research Inclusion Supports Equity (RISE) out of University of Nevada, Las Vegas (UNLV), with Dr. Jason Flatt—in collaboration with Emory University and University of Tennessee, Knoxville—that specifically addresses LGBTQ+ dementia and caregivers of LGBTQ+ people. That is something that can be looked at to help better inform the plans and information that are being developed at the State level.

When we look at support for services for vets and military spouses, there are about 1 million people that identify as LGBTQ+ who are Veterans and who have military spouses. There are opportunities to ensure this population is receiving the services they deserve. You have the removal of LGBTQ+ Veterans from the military, and then them not getting the resources available to them because they have dishonorable discharges. We are working to make sure folks who left the military because of a dishonorable discharge because of their identity can have those benefits available to them—because, again, these are potentially half-a-million people who fall into that category.

When we look at proposals to assist vulnerable adults, there is no mention of LGBTQ+ people. When we talk about guardianship laws, the laws that are in place almost assume there are no LGBTQ+ considerations. Those are things we are looking to solve when people are looking into creating programs and outreach efforts.

For homelessness, a couple of years ago we looked at the Strategic Plan of the United States Interagency Council on Homelessness (USICH), and there was only one mention of LGBTQ+ people in the entire Plan. If you think about the estimates of youth, which is 20 to 40 percent of the population are LGBTQ+ and a certain other percent for adults, then we are looking at an entire strategy to solve homelessness overall that does not include LGBTQ+ people. With the help of the USICH, we were able to add a lot more information in the Strategic Plan; so there could be a road map to better ensure that when people are looking at a strategic plan and how they want to solve an issue, there are resources, interventions, and thought behind how to solve the issue for the LGBTQ+ community.

Same thing for the Nevada State Plan for Aging Services; there is probably one mention of LGBTQ+ people in the 2018 to 2024 Plan. When the new Plan is being developed, there is an opportunity to be inclusive. I met with the ADSD—I think it was in December or January of [2024]—with the national organization called Services & Advocacy for GLBT Elders (SAGE). They recognize that they—the ADSD—has not included LGBTQ+ people in the Plan in and of itself and in its outreach efforts. They hope to be able to solve for that, because if they do not, then there are going to be a lot of missed opportunities for this particular population.

[It is] kind of the same thing for the different State plans on HIV. You will see the mention of LGBTQ+ people as it relates to HIV, especially men who have sex with men. But when you talk about older populations, there is a missed opportunity to think about people who are older and living with HIV—because now that HIV is not the "death sentence" that it was from the '80s and '90s, people are living longer. We have to think about interventions and resources that are available to people who are older—people living with HIV.
One department that has done a good job of being more inclusive is the Nevada Office of Minority Health and Equity (NOMHE). I think their first Plan in 2022, and then this current Plan in 2023, *Minority Health Report for the State of Nevada*, is very explicit in including LGBTQ+ information—and even around diseases like heart disease and cancer. It shows a breakdown of the prevalence of these diseases as it relates to someone's sexual orientation and gender identity, which is huge. That is something that is innovative and progressive for a State report from a particular department.

Overall, we do well with our laws here in Nevada, but when you look at State plans and efforts, the mention of LGBTQ+ people is not there. We have about 5 percent of adults who identify as LGBTQ+ in the State of Nevada; there is a huge population out there that is being missed.

A national transgender organization recently did a national study of transgender folks. They surveyed about 92,000 people and asked them about their health and income. In 2015, they had some Nevada-specific information. I am sure, in a few years, we will get the data to have Nevada-specific information for 2022. It shows how much people who are transgender are going to the doctor, how often they have health insurance, what their mental health is like. If we can take this information and flow it into the different departments at the State and community levels, then there is a way for us to continue to solve the issues of including LGBTQ+ people—to address quality of life—that is not necessarily at the legislative level.

I will end there to see if there are any specific questions or reflections you might have for me.

Chair Spearman:

Thank you. Committee Members, questions? Questions up north?

Assemblyman Gray:

Madam Chair, I do have a quick question. Sir, I would like to question your characterization of discharges. It is a bad situation. However, I do not want to make it seem worse than it is. As some of the Committee Members know, you can only get a dishonorable discharge via a court martial. I would like to know what those discharges were. Were they general, under "other than honorable"? Which is a characterization, it is not actually a bad conduct discharge or a dishonorable [discharge]. Also, the numbers you gave of 1 million—how many of those are actually in Nevada? This is something I am passionate about and want to get fixed. We discussed this last meeting about how a lot of these folks could go back and get their discharges upgraded to an actual honorable [discharge], especially given the new way in which we are viewing these situations. I had very good friends who were put out, and it broke my heart. But I want to make sure when we are presenting facts, that they are facts. So I would like—[the Zoom call disconnected.]

Chair Spearman:

Did we lose him? It looks like the feed might have stopped. Mr. Wade?

Mr. Wade:

I can find out as much as I can—what the Nevada-specific data is for that population. Nationally, the estimates are that there are 1 million vets who identify as LGBTQ+ and then a portion of those who have been dishonorably discharged.

Chair Spearman:

Nevada Revised Statutes 417.121 is the legislation that was passed; it requires Nevada's Department of Veterans Services (NDVS) Director to do outreach to LGBTQ and Veterans. The difficulty in trying to make sure we have captured those who have been affected by that is many of them have gone along their way. A lot of Veterans do not think they are a Veteran unless they retire. I am going to ask you—and I did talk with the new Director, Director Devine—but I asked her to work with as many agencies as possible to make sure we are capturing them. That would also include whenever you have an event, making sure somebody from NDVS is there—set up a table to do whatever you need to do, but to work very closely. To Assemblyman Gray's point, dishonorable would come with a court martial. In the very early days, before "Don't Ask, Don't Tell" (DADT), like in the '80s or the '70s, they were just kicked out; they were asked and whether they said yes or not, they were just kicked out. Usually this discharge was characterized as dishonorable. If you work very closely with NDVS, we might be able to find out who that person or those persons are.

Assemblyman Gray, we are glad to see you back. Did you have additional questions?

Assemblyman Gray:

No, ma'am. You hit the nail on the head, and I appreciate that. This is something we need to all work together on to get fixed. Thank you.

Chair Spearman:

Thank you. I think the connection between you and NDVS is going to be critical. Not just NDVS here, but because the Silver State is very close to California, working with them; because we noticed populations now are very mobile between California and Nevada and Nevada and California.

Any other questions, Committee Members?

I have a couple. We have got Veterans who are homeless, and some who are near homeless. Have you talked with anyone from the Nevada State Veterans Home, either

Northern or Southern, to see what, if any, spaces they might have available, or at least find out what the requirements would be for someone to be eligible to go there?

Mr. Wade:

I have not; we have been focusing on youth, but I will make a note to do so.

Chair Spearman:

In 2017 or 2019, we did a bill that required DHHS to develop cultural competency courses for everyone. It started with the medical facilities. Do you have a handle on how well that is or is not going? Are there things we need to do to make sure those classes are happening? Do we have any way to follow up? That was part of what they were supposed to do—follow up and see how that was going.

Mr. Wade:

That is a good question; and a point of contention in that it is been hard to find out which departments are implementing cultural competencies on a regular basis and consistently. As an example—a little bit different from your question—but with AB 99 that is focused on child welfare, we had to speak to a lot of people on the child welfare and juvenile justice side to find out what trainings were being offered and how and by when, as relates to the law. I recently saw—and I have to find out where it came from exactly—but the requirement for foster parents to have training was going to be from once every year—and through regulation. I think there is a recommendation to move it to just at their intake—the orientation.

To your particular question in the health care space, I have not been in those conversations in about a year or so, but there were challenges to find out how well those trainings were being implemented. We will have to do research to find out where we are at with things, but that has been a lack of accountability. To the caller's point about his daughter, you have these laws in place, but if there is no accountability, people can say, "Yeah, I am not going to do that." Then the trainings do not happen. You have advocates who are constantly trying to figure out where we are with things, and it becomes a little challenging.

Chair Spearman:

I am not sure what the breakdown is, but perhaps [our Legal Counsel] will need to look and see if there are any loopholes, to make sure that is happening; because it is not just LGBTQ+ individuals, but it is people with disabilities, anyone who is in a marginalized space, making sure they are getting the type of treatment they need. If you work with DHHS, we will take a look and see what needs to happen. If we need to do a bill next session that tightens that up, then we will do that.

I had one more question. You had things on one of the slides, where you talked about dementia, Alzheimer's, and that sort of thing. Are you familiar with Dr. [Dylan] Wint over at the Cleveland Clinic Lou Ruvo Center for Brain Health?

Mr. Wade:

I am not. I [will] float that to Dr. Jason Flatt, who has been leading this area. What was their name again?

Chair Spearman:

Dr. Wint—he gave us a presentation. Lou Ruvo is associated with the Cleveland Clinic, as well. That might be a very good resource when you are talking about people who have Alzheimer's, dementia, and that sort of thing. I would encourage you to do that.

There are statistics that are pretty alarming with respect to suicide—especially LGBTQ+ who are over [the age of] 50—many who have diseases or disabilities that keep them isolated. There are times of the year when it is more prevalent than not, like between Thanksgiving and New Year's. Are you partnering with anybody to develop a social program or some type of event they could come to? I am not saying something that would cost a lot. In California last September, Doretha Williams-Flournoy had a meeting and invited seniors in the LGBTQ community to come, and they spent a day—workshop, games, or whatever else—and that helped to connect them. Are you doing anything like that? Because sometimes they can fall off the radar because they are already isolated.

Mr. Wade:

That is not part of our work. But I think the LGBTQ+ Center in Southern Nevada and in Reno—Our Center—I think they would be poised to solve that issue by creating programming for those folks. We can definitely partner with them on that.

Chair Spearman:

I would appreciate that; because it would be good if all three of you could come together to answer these questions I am asking, and then have one robust plan in place so we could address this.

Mr. Wade:

Those are very good ideas and things we can implement. The hope is that these one-off efforts do not end there; because what we are trying to do is create an ecosystem of treatment, care, and support. Once folks go to an event or a center and they feel supported—but as they navigate their everyday lives, if they are going to institutions that are not supportive or other mainstream organizations, then [there is the] rub. When we have these larger State plans, let us say, around dementia, keeping it there—if there can be a lot more explicit information related to the LGBTQ+ community and suicidality and dementia—all these other things—then when people are looking to solve an issue, they can go to a document, which—these reports are in place to be a resource. But if the information is not there, then it is like, "Where do I start?" You start from scratch. We can do the one-off events and efforts, but we are trying to find ways to create ecosystems that are supported by policy, practice, and outreach at different levels. We will need support from our Legislators and department heads to help make that happen.

Chair Spearman:

Thank you. Committee Members, questions? No questions? Why do you have me ask all the questions? They send the questions to me and tell me to ask. I am joking. Any questions up north? [There were no additional questions.]

Mr. Wade:

Yes—I would like to add quickly—because I did not really touch on it. When we have young people and adults with special needs—however we want to frame them—we do have to recognize their sexuality—heterosexuality, bisexual, homosexual, whatever it might be. Often, when it comes to these populations, that is a missed opportunity so they can get sexual health care. Those are things I know the LGBTQ+ Center of Southern Nevada has tried to tackle from time to time, but I want to emphasize that is a need, and I believe the Senator thinks so, as well. I am putting that out there on the record, and we will do work with RISE, with UNLV, and Lou Ruvo Center to see if we can make those connections and address the Veterans issues you mentioned.

Chair Spearman:

Thank you. While you are looking at intersections, it would be great if all the people in that ecosystem would look at integration of all the activities, programs, resources, et cetera. It would be great if they could put one word in—or "no wrong door"; wherever they land somebody there would know what else is available.

Mr. Wade:

I agree. I do not know if my presentation got at that, but that is what I was trying to speak to. I agree with you 100 percent.

AGENDA ITEM V—PRESENTATION ON THE IMPLEMENTATION OF ASSEMBLY BILL 252 (2023) AND POLICY RECOMMENDATIONS ON HOW TO IMPROVE THE ACCESSIBILITY OF THE MUSEUMS AND HISTORICAL SOCIETIES ESTABLISHED AS INSTITUTIONS OF THE DIVISION OF MUSEUMS AND HISTORY, DEPARTMENT OF TOURISM AND CULTURAL AFFAIRS

Chair Spearman:

We will move now to Item V, presentation on the implementation of AB 252 and policy recommendations on how to improve the accessibility of the museums and historical societies established by institutions of the Division of Museums and History, Department of Tourism and Cultural Affairs (DTCA).

I am going to turn the gavel over to our Vice Chair for about five minutes, and I will be right back. Are we presenting up north? Begin when you are ready.

Dan Thielen, Administrator, Nevada's Division of Museums and History, DTCA:

Madam Chair, Madam Vice Chair, and Committee Members, thank you for having us here today. We have a Board of Museums and History that supports us. With me today is Dora Martinez, Board Member, for us in Carson City. Today, we want to talk about AB 252, and what we have done to comply, embrace, and enhance—and try to make this an exceptional place for people to come visit and spend time.

I am a Veteran. I am a parent of a disabled daughter. I am invested deeply in this, and I understand some of the challenges we face in our museums and in Nevada, as well. Part of our funding comes through the General Fund. There are admissions and train ride fees that go into the General Fund, and we obligate, budget, and program them into the yearly operations of the museums. Our other funding comes through room tax, through DTCA. We have what we feel is a dual responsibility to both support Nevadans in exploring the treasures that belong to them; but also inviting people from all over the world to enjoy those artifacts and treasures. Museums have a unique opportunity to connect and [offer], in some ways, object-based learning. Meaning—I can tell you about this water bottle that is here, but until you pick it up, open it up, and taste what is inside, you do not really know what I am talking about. Sometimes in a museum, we can bring out an artifact, and we connect with people in a way that may not happen in any other way. I want to share one example.

Dora Martinez, Board Member, Board of Museums and History, DTCA:

Good morning, Madam Chair and the rest of the Committee, my son to you says, "Hooyah." For all of you who may not know—I am totally blind. I am a very proud mother, a military mom, and a grandma. I am really interested in bringing my grandkids to the museum, and we just want to be included. Right now, it is difficult. As I said, I am blind, and it is not accessible to me, and that is an education we can offer to our new generation.

I am very proud and very happy; I have a very happy dance in my heart that Assemblywoman Cohen sponsored this bill. I am so thankful for our Director—who has a bottle with a question inside, "What is in it?"—that he is so willing to have a universal design with our museum from the very beginning. It is always good and economically sound when we start a project accessible to all from the very beginning, so we do not go back and try to do right. As you said in your prior statement, I understand you guys want to do right. It is a relief to hear that from you and all of the Legislators that want to do right. Because whether we like it or not, as we age, we are all going to get there. Disability does not discriminate. You could be the richest person on earth, but your hearing might go away, your eyesight might diminish, you might need assistance in walking. If we do this right from the very beginning, I think it saves the State money. We could also be the role model in the United States, like we are with some of our past bills—the accessibility voting bill—which I will not go into because you guys understand that. Thank you.

Mr. Thielen:

In addition to AB 252, I want to share one story that has thunderstruck me in its impact. We had an event, a rail fair in Carson City; we called it the Great Western Steam Up. It was post-COVID. It turned out to be the number one ticketed event in Carson City's history. It brought people from all over the planet to Nevada, and my wife and daughter were helping out with the things that were going on. Apparently, right after we put this on the Internet, somebody in Iowa saw it—a kid with autism. He told his mom and dad that is where they were going that summer, and they said, "Oh, okay. That is where we are going." Over the four-day event they stayed in Nevada visiting at the railroad museum. We brought in a tremendous amount of equipment, and there is something about when a locomotive starts up. If in any other museum setting, we could do the same thing we can do with the locomotive—if we could animate the mastodons that are in the museums and bring them to life. When the mastodon would take that first step off the plinth and make that thump in front of a kid, they would know more about a mastodon than has been written about them. Our locomotives somehow connect in that same fashion.

This family got close to my wife and my daughter; they migrated there and hung out with my wife, and they said, on day two, "We would love it if my son could ride in a locomotive," because he had not done that. So my wife says, "Oh, I know a guy." They eventually connected us, and I could not get him there. I was so busy. I was so wrapped up with everything that was going on with this event, and I could not get him in there. Finally I knew the day was running out, and it was going to be the last opportunity. I looked at this kid, I did not know where his dad was—he was like 21. I said, "Look, we have got to run; because if we do not run, we are going to get bumped into, and we are going to get stopped," so we took off. The locomotive that was in the station—the people that are there are terrific and adaptable. I said, "Hey, can you make room?" They did, and they got this young man on the train. I went off, and I am going in the chaos of the day when this man shows up next to me; he starts hovering, and he gets closer and closer, and I am talking to other people. Then finally when I can turn to him, his mouth starts moving, but he cannot say a word. Then a giant tear came down his face like this, because we made a connection—and museums can do that.

That is our goal with AB 252. We are grateful for this law; oddly, we are grateful for a law. We are grateful for the money that has been put into it. We are grateful to have Ms. Martinez on our Board of Museums and History. Those are some of the requirements of that. We have submitted our Americans with Disabilities Act (ADA) package through the *Executive Budget* in the Client Assistance Program (CAP) process. I put it in our top ten list because I think it is so important that we get our museums to where they are accessible to everyone. These are Nevada's treasures. They belong to the people of Nevada—and they belong to all of the people of Nevada; that is our goal is to get them into their hands.

One of the provisions of AB 252 is that the Legislative Committee on Senior Citizens, Veterans and Adults With Special Needs needs to study, during the interim, any issues that exist that limit the ability of persons with disabilities [to] access the institutions of the Division. I invite you to come to the museums—all seven of them—and let us walk through there, and let us look through somebody else's eyes—and help us develop the plan that makes them completely accessible. There is no question in my mind that if we all live long enough, 100 percent of us will fall into the seniors—well, senior citizens, of course—but we will all have special needs. We will all deteriorate, and we will all wish there was a ramp instead of stairs, an elevator instead of a ramp, and all the things that make our museums accessible. We will be incorporating universal design in everything going forward and make every effort to retrograde our exhibits and the activities of the museum. But going forward, everything we put down is going to be in place. In the DTCA, we have hired a firm that will help us make our website completely accessible, and we are in the process of that. We are in progress on a lot of these things. What I would like to do as a Division is—there is a baseline of compliance with the law; and I think that is very good. But what I would love in our Division is that it is exceptional. That the people who come in feel included. That they have a life-changing experience in the museum that enhances some part of the brain that fires off in a way that gives them meaning; and that we can be part of that. That is my presentation. I can entertain your questions.

Vice Chair Brown-May:

Thank you, Administrator, for the presentation. Anyone have questions?

Assemblyman Gray:

Madam Vice Chair, I would like to mention to Mr. Thielen and Ms. Martinez what a great job they do. I think I am going to take you up on your offer this summer and visit each one of your facilities, bring the kids along, and go take a tour. So, be ready for that.

Vice Chair Brown-May:

Thank you, Assemblyman Gray. I do have a couple of questions, Administrator.

First, Ms. Martinez, it is beautiful to see you here. I appreciate your participation as a Board Member and your good work to support folks with disabilities in our community.

Administrator, one of the parts of this bill authorized the Division to be able to apply for grants or donations to specifically address accessibility issues. Do you have information regarding any grant application that has been submitted as a way to fund our improvements?

Mr. Thielen:

At this time, we have not applied for grants. We are in our budget-building cycle, and our staffing is stretched; and that is a terrible excuse. We are on the lookout. It is tough to pin the tail on the donkey on this one.

Vice Chair Brown-May:

Thank you for that, Administrator. I appreciate your candor relative to the barriers you are facing. I am curious to know, do you have an action plan or priority steps regarding what the number one step will be to improve accessibility? Given that we have a number of different communities who are experiencing different types of disabilities. We have a number of folks here who are part of the deaf and hard-of-hearing community. We have a number of folks here who are part of the blind or low-vision community. We have folks with intellectual and developmental disabilities. We have people who are on the autism spectrum. Knowing that we have this broad ranging community who all want to access our museums—this being the very first step for us. How do we help people who have a visual disability to be able to access our presentations? Do you have a priority of how we will go about making sure our museums are more accessible?

Mr. Thielen:

My priority, at this time, is to make all of our websites accessible for people with visual disabilities. Then going forward, every exhibit that goes in, we will have to make it universally designed so it is accessible across the spectrum; so that, going forward, new exhibits get put in, in that fashion. Of course, the ongoing addressing of ADA access throughout the museum for both staff and visitors is a critical criteria. It is expensive to do and requires a substantial maintenance tail to ensure that is happening. We are asking for that in our *Executive Budget* request—to address these things. It is low-hanging fruit, and we absolutely have to address those things; there is no question about it. Then going forward, we will develop curriculum that focuses on each of these areas that help all of Nevada access their collections. We know we have a unique opportunity in these areas to turn on excitement and that part of discovery people absolutely are attracted to. It is an exciting opportunity and an exciting time to do that.

Ms. Martinez:

Hi, Vice Chair Brown-May. With the technology nowadays with artificial intelligence (AI), they are already working on a variety of disabilities in the museums. I am part, and Dr. Joe Schneider—who presented with the Assemblywoman and I last year—is the Executive Director for an audio description program for the American Council of the Blind. He knows a lot about audio description for low-vision and blind folks, and he is connected with other disabled communities. Artificial intelligence is coming quickly, and we could always use their ideas. It is not like we are reinventing the wheel from the bottom up. It is already there to borrow and adjust to our State. Thank you.

Vice Chair Brown-May:

Thank you, Ms. Martinez. I appreciate the clarification relative to that and the audio descriptors, which I know we worked really hard on during this session. I appreciate you are here and that you are able to help guide our [Legislature] going forward.

Chair Spearman:

Thank you. Additional comments? I understand they asked all the questions while I was gone.

Senator Krasner:

Chair Spearman, may I ask a question or make a comment?

Chair Spearman:

Yes, thank you.

Senator Krasner:

I wanted to say thank you, [Administrator] Thielen, for being here today. Thank you, Ms. Martinez; you have always been so active, and we appreciate it here at the Legislature. Your presence is so important. Our State of Nevada museums are wonderful. They are the gems of our State because they are for everybody—every person in this State. It is our duty as the Legislature to care for them, keep them intact, and grow them.

I had some questions. Are we currently doing anything, or do any of the museums have anything like audio presentations for persons that are blind? Or visual and braille descriptions for persons that are needing that—maybe they are deaf. Or are those things currently not in our museums but something that is on the list, and you are asking for funding in the Governor's budget? Where are we?

Mr. Thielen:

We have audio at several of our museums, but not all of them. That is a challenge. We have some at the Nevada Historical Society in Reno, and at the Las Vegas Museum; we have developed good audio content. It is never enough, quite frankly—because once you start getting into it, you thirst for more, and it takes a tremendous amount of staff time to develop that. But that is the part of going forward with our exhibitory. When we have a component that includes braille, when we have a component that includes an audio tour—we are living in a time that is amazing because almost everybody walking in the front door carries a supercomputer in their pocket, and we plan to leverage that. We have a challenge throughout our museums in that they are Wi-Fi caves, because it is tough to get Wi-Fi in State buildings. We are moving forward on that in order to make the content available that is additional for the other ability groups that we want to reach. It is a high priority. We are currently using a program called OnCell, and that is our front-facing audio software.

Senator Krasner:

Thank you.

AGENDA ITEM VI—OVERVIEW OF HOME- AND COMMUNITY-BASED WAIVERS AND RESOURCES

Chair Spearman:

We will move to Item VI, overview of home- and community-based waivers and resources. Looks like everybody is up in Carson City. Ms. Wickland—and you have somebody with you–begin when you are ready.

Crystal Wren, Chief, Operations and Quality Assurance, ADSD, DHHS:

Good morning, Chair, Vice Chair, and Members of the Committee. Today I am joined by Megan Wickland. She is my counterpart over the [Home- and Community-Based Services (HCBS)] Waiver for Individuals with Intellectual Disabilities and Related Conditions. We are going to be talking about: what is a waiver; introduction to our HCBS Waivers; our involvement with the Centers for Medicare and Medicaid Services (CMS); the Waiver eligibility and approval process; we are going to talk about each waiver, give an overview of services and eligibility components; and then we will open it up for questions. (Agenda Item VI)

What are HCBS? Home- and Community-Based Services provide opportunities for individuals to receive services in their own home or a community setting, rather than an institution or another isolated setting. Programs serve a variety of targeted populations, such as people with intellectual disabilities, physical disabilities, or the frail elderly. Generally, HCBS services are nonmedical. They are more social in the services that are provided. They are also tailored to meet that individual's needs and are driven by the individual's choice.

Home- and Community-Based Services waivers began in 1981. They were intended to overcome the bias that was set for those who are in an institutional setting or other kind of long-term care setting, which can really be supported in the community. There was a passage that expanded HCBS services by the ADA, as well as the *Olmstead* decision, that allowed for the Social Security [Act] Section 1915(c) to be enacted to allow the states to introduce waivers as we see fit for our targeted populations. What it did was it waived existing Medicaid regulations, allowing us flexibility to introduce an additional program that went above and beyond the normal scope of Medicaid. It allowed us to use Medicaid money for services that are not generally provided through Medicaid and put these in the flexibilities of our HCBS waivers.

With the populations that are targeted, the HCBS waivers intended to give us that flexibility to determine what the need was in each state. Across the states, there are roughly 260 1915(c) waivers, and Nevada has 3, in which we targeted certain populations. Some caveats to a waiver is—they cannot pay for the same services that Medicaid authorizes. Those who are on a waiver will have the full flexibility of full fee-for-service or full Medicaid, so they will be entitled to that service. But a waiver cannot duplicate what Medicaid funds for fee-for-service programs. It is intended to be a supplemental program. It is above and beyond the normal scope of Medicaid; it can enhance the service, but it cannot duplicate that. It also cannot pay for duplicative services provided by Individuals with Disabilities Education Act (IDEA) or for [Title] IV(e) [of the Social Security Act]. It also cannot support individuals who are in an institution or another long-term care setting such as a hospital, jail, or an intermediate care facility.

Waivers must be cost neutral; we have to demonstrate as a State that we have cost neutrality. What this means is that our partners at the Division of Health Care Financing and Policy (DHCFP) [of DHHS] do annual reports to CMS that demonstrate the cost to support folks in their own home and keep them on an HCBS waiver is lower than it would be if we had these folks in an institutional setting.

The home- and community-based settings must be integrated into the community. Any work settings must have full access to the community. Any residential settings must also share that access. These settings ensure the rights to privacy, dignity, respect, and freedom from coercion and restraint. They optimize an individual's initiative, autonomy, and independence in making life choices. They facilitate individual choice regarding their services and supports and who provides them. They ensure they have access to the same degree as a non-Medicaid person living in the community. Any lease agreements that are set up have protections, and it includes their rights and their freedoms—just like a normal person, not on Medicaid—who is renting or has a lease agreement set up. It is putting individual choice into that person's plan and decisions. It is allowing them to make the decisions of what they want and giving them that flexibility to have the same expectations that people who are not on Medicaid programs have.

Our intake and approval process—I call this the "circle of waiver life." We have three agencies that are involved in our eligibility components for a waiver. We have the ADSD—which is where we are at—and that is the start of a waiver. That is going to be your intake, initial application process, and your assessments. Our partners at the Division of Welfare and Supportive Services (DWSS) [of DHHS] are in charge of our financial component. They will do the financial determination to make sure this person meets that criteria; then our partners at DHCFP will do the final approval. They ensure everybody has done what we needed according to their obligation with CMS, and then they will issue our final approval.

A little more about our financial requirements and our partners at DWSS—individuals applying for the waiver have to be at or below 300 percent of the Social Security income level, have resources that do not exceed $2,000, be a resident of Nevada, and a U.S. citizen or a lawful permanent resident. As I said earlier, where we can target populations for 1915(c) waivers—currently, Nevada has three waivers. We target folks that are over the age of 65, have a physical disability determined by a medical professional, and have an intellectual or a developmental disability determined by a medical professional. All three of these waivers must meet an institutional or an intermediate care facility level of care, and they all must be within the income requirements I explained earlier from DWSS.

I am going to talk about the frail elderly and the waiver for those with a physical disability. The intake process is handled at our ADSD offices. We have intake specialists who are positioned in each of our offices; we are located in Carson City, Elko, Reno, and Las Vegas. When an individual applies at a local office, they are going to be screened by an intake specialist to determine if they meet the presumptive eligibility for a waiver. They are going to conduct a level of care, ask about needs, look at community and natural supports, and get a snapshot of this individual to determine next steps.

Once they are approved for the waiver from the intake specialist, they may go on a waitlist; or if we have a waiver slot available, we will put them on to the waiver and send them to DWSS for financial eligibility. If they are on a waitlist, they are supported by an intake specialist while waiting for a slot to open. That intake specialist does routine check-ins to make sure they are safe and secure in their home. They also do referrals to our community partners to make sure they are receiving services they may qualify for outside of the waiver—maintaining that contact for their safety.

Once they are approved, they are assigned to a case manager. In southern Nevada—in Las Vegas and Henderson—we have two options; we have a private and a public case management provider. In the northern Nevada offices, we have the public ADSD case management group. Their case manager—once they are approved—will conduct a social health assessment. They go in further than our intake specialist did; they do a deep dive, and they thoroughly look at the level of care and services that are needed to support them in their home to keep them independent—health and safety being a number one priority—and also take into account their natural supports and their selections of providers and service types they want. Once it is determined which services they need, a list of Medicaid-enrolled providers is provided to that individual, and the case manager will assist as requested. If the individual wants to select a provider agency by themselves, then we will let them do that. If they need assistance, we will help carry them through that. Once they determine a provider, the case manager will reach out to ensure there is availability. Once that is confirmed, the case manager will set up a prior authorization with our partners at DHCFP to allow that service to begin.

Here [on the presentation slide] are services that are provided under both of these waivers. Most of these services cross over each other on the frail elderly side, until you get to adult day care. That is where it stops. The frail elderly waiver has three additional services that are provided—and the same on the physically disabled [waiver] side [of the presentation slide]. We do have additional services provided, which is the "home delivered meals" down through the "environment accessibility adaptation." I am going to go over each of these services.

Everybody on a waiver will receive a case management service. They will have an assigned case manager; that person is assigned to this individual to support the social health assessment. But they are also going to develop that plan of care, and they are going to remain in routine contact with this individual to make sure their risks are being mitigated, their health and safety are assured, and their goals are being met. That is a big thing we look at too—we look at short-term and long-term goals for individuals. We set up services, and we help them to reach these goals. They are also going to connect them with community partners. They are going to look at other resources available as needed; and make sure these people feel supported.

Chore service is offered under both waivers, and this service is an intermittent service. It is generally one time. It can be used as like a deep clean. We do have instances where we might need a carpet cleaning, or maybe there is a hoarding situation, and we need someone to come in and help relieve the house of those items to allow for accessibility; things like that. It is tailored as more of a one-time deal or as needed.

Homemaker [service] is assistance with your instrumental activities of daily living (IADL), which is going to cover your homemaking tasks—housekeeping, cleaning, shopping, laundry, meal preparation; things like that.

Adult companion [service] is intended to provide nonmedical care, supervision—social connection with an individual. Adult companions can perform tasks of personal care assistance, but it is intended to be an additional service of support for these individuals. A lot of times, it is used as respite for your primary caregiver, because it does have that social connection.

We have respite [care], as well, which is a standalone service, and that is a short-term solution to relieving the primary caregiver. But unlike [the] adult companion [service], it is intended to support the services. Adult companion steps in for the social aspect; respite is going to come in and help with your IADLs. Your activities of daily living (ADLs) are going to be your bathing, grooming, toileting, mobility, transferring—things [related to] the functionality of your body.

We also have our personal emergency response system (PERS). This is the "I have fallen" button, and they can hit it for an emergency. There are bracelet aspects; there are a lot of different kinds now. We are very happy to see that providers are getting creative with ways these options are being offered. This is afforded to folks that are alone for the majority of the day or a health risk—like a fall risk. Maybe there is a safety component there, and that is something we offer. A lot of our PERS providers are getting more creative with things they offer. We have ones that offer our medical alert boxes for medication now. We have got some that are starting to do the electronic pets; I do not know if anyone has seen those, but it is usually a cat or a dog. They also have a parrot that can sit on your walker. They are really for that social connection. It mimics an animal; it gives people that support without having the actual animal to take care of.

Continuing on, we have specific waivers under our physically disabled waiver, and one of those is attendant care. The attendant care service is an extension of our State Plan Personal Care Services. As I said earlier, the waiver services cannot duplicate, but they can enhance—they can be an addition. Our State Plan Personal Care Services max out at 30 or 32—I would have to defer to DHCFP. Once they max out with either that number or the maximum as determined for them by the Medicaid professional, then we can authorize attendant care. It provides additional hours determined by the case manager, and these will cover your ADL and IADL needs.

The home delivered meals are a permanent service under our physically disabled waiver, and it covers up to two meals per day. There is an option depending on where folks live; they can either get the meals delivered from one of our congregate sites, or they can get frozen delivered meals from a larger provider. It depends on the availability in their region. Currently, home delivered meals are also on our frail elderly waiver, but it is only funded through the [2023–2025] Biennium. So, DHCFP has been looking into making this a permanent service under the frail elderly option.

The specialized medical equipment [service] is intended to support equipment that is not covered by Medicaid; or if they exhaust the Medicaid option, then we can step in and authorize that. Quite commonly, we will see briefs, bed sheets, gloves, things like that being covered—where Medicaid will have a maximum amount allowed. We can authorize this under the specialized medical equipment [service option].

Last, we have the environment accessibility adaptation service. This is intended to support a person's residence. We may come in and widen a doorway. We may install grab bars—in a bathroom, for example. There may be a ramp put in, the threshold may need to be even for wheelchair access, things like that. It is intended to help a person remain in their home and allow us to do that adaptation.

Our frail elderly waiver has one service that is only covered under that waiver. The adult day care [service] is only under our frail elderly waiver; it is intended to support folks during the day. Generally, it is used as a form of respite for a primary caregiver, as well, and it gives individuals that social factor; and it also supports them with their meals and their oversight. You may have heard about "adult day health care," which is a different service from this; that is offered to folks on Medicaid. This is not intended to provide that medical component. It is similar to adult day health care without that medical piece; it is more of a social aspect.

Both the frail elderly and the physically disabled waivers have a residential option. Under the frail elderly waiver, it is referred to as "augmented personal care," which is provided in a group home or in assisted living. It is intended to be 24-hour support for an individual who needs that oversight—who needs assistance with their ADL and IADL—but it does not support medical. It is that in-between—when an individual perhaps is no longer safe in their home, but they do not have that need for an institutional or nursing facility level; then we will look at the augmented personal care service and work with the family and the individual to find a placement that suits their needs.

Assisted living is the same service I mentioned earlier; it is labeled under the physically disabled waiver. It is that 24-hour setting. Currently, we do not have any in the North. I believe we have two in the South for the physically disabled waiver. We are looking at soliciting expansion for these options.

I want to introduce—these are our numbers as of February 2024. For our frail elderly waiver, we currently have 2,539 individuals enrolled on the waiver. We have 1,150 individuals on our waitlist. For our physically disabled waiver, we have 1,155 individuals enrolled and 227 individuals on our waitlist.

With that, I am going to turn it over to Ms. Wickland, who is going to introduce the intellectual/developmental disability waiver.

Megan Wickland, Health Program Manager III and Quality Assurance Manager, Developmental Services, ADSD, DHHS:

Hello. I am going to review our waiver for individuals with intellectual and developmental disabilities. Nevada Developmental Services provide services and supports to people of all ages across the lifespan that have either an intellectual or developmental disability. We have three regional centers across the State: Desert Regional Center (DRC) serves Clark County; Sierra Regional Center (SRC) serves Washoe County; and Rural Regional Center (RRC) serves all of our rural counties with offices located throughout.

Individuals need to apply at the regional center based on the area in which they live. AN intake specialist will then work with them to gather all the supporting information and documentation needed to determine if the person meets eligibility criteria. To be eligible for developmental services, a person either has to have a developmental delay—that is for a child under the age of 6, and then at 6 [years of age] they have to be reevaluated—or have a diagnosis of an intellectual disability or developmental disability with an onset before the age of 22. Once the information is gathered, it is then reviewed by an Eligibility Review Committee; that includes a licensed psychologist. If needed, psychological testing and assessment can be done by the regional center to help inform eligibility. If a person is found eligible, the case is opened and is assigned to a service coordinator, who provides targeted case management services.

We have 11 distinct waiver services on our waiver, and I will go through each one. Of note, we were able to add two new waiver services in our latest renewal in October of 2023. That includes dental services and individual directed goods and services.

Our jobs and day training services are provided through contracted certified community providers. We have four programs available to individuals in developing vocational skills, finding employment, or engaging in other meaningful activities during their day. The first is day habilitation; these services are not vocational in nature. They are regularly scheduled activities that occur in a nonresidential setting with the intent to help a person to acquire, retain, or improve their self-help, socialization, or adaptive skills. This can also include retirement activities.

We have prevocational services. These services are intended to help develop and teach general skills that will lead to competitive integrated employment—as well as provide for training, work opportunities, and experience—including volunteer work.

We have two types of supported employment services. We have individual supported employment, which is provided to people who need support to either obtain or maintain a competitive job in the community. Then we have group supported employment that provides services to small groups of two to eight people who are working in a regular business, industry, or other community setting. That could be like doing landscaping or janitorial work in the community.

Our last jobs and day training service is career planning. This is a time-limited service that helps a person with job exploration—identifying a career direction they would like to do out in the community and developing a plan to support that process.

Residential support services and residential support management are our next two waiver services that are also provided by contracted certified residential provider agencies through our supported living arrangement program. The services are individually planned and provided on a continuum of service delivery, ranging from either intermittent to 24-hour support. Services can be provided in the individual's home or in their family home where they receive services intermittently for a designated number of hours per week. A provider will come in and work with them on specific goals, such as budgeting, grocery shopping, cooking, home management, socialization skills; those types of things. [Services can also be provided] in a shared living home, where a person will live with another family or another adult. That service also incorporates natural supports into their day-to-day routine. Our 24-hour homes serve up to four individuals in a home in the community where they each have their own bedroom, and there is 24-hour shift staff providing supports throughout the day.

Direct services and protective oversight is provided to the individual to help the person to acquire, improve, retain, or maintain skills necessary for the person to be successful and live in their community. Residential support managers perform a variety of tasks to support the health and welfare of the individual; that would include things such as developing the person's habilitation plan, training the residential support staff, scheduling medical appointments, following up with health and welfare concerns, and assisting with applying for and obtaining community resources and benefits—those types of things.

Our next waiver service is behavioral consultation, training, and intervention. These are services provided by professionals in psychology, behavior analysis, or related fields. It requires expertise working with our population and conducting functional assessments and providing positive behavior supports. The service provides behaviorally based assessment and intervention for people, as well as support, training, and consultation to family members, caregivers, and the provider staff. It includes conducting a functional behavior assessment, developing a behavior support plan, training the team on that behavior support plan and data collection, as well as monitoring the plan to ensure progress is being made.

Our next service is our counseling services; these services are provided based on the person's need to assure their health and welfare in the community. It is provided by professionals who have a master's degree and licensure in psychology, social work, marriage and family therapy, or clinical professional counselors. They also need to have experience working with our population. The services include assessment and evaluation, individual and group counseling, therapeutic intervention strategies, risk assessment, skill development, and psycho-educational activities.

We also offer nursing services, including three areas of service. Medical management can be provided by either a registered nurse or a licensed practical nurse; these services relate directly to the medical needs of the person. We can also provide a nursing assessment, which is only conducted by a registered nurse; it identifies the needs, preferences, and abilities of the person. Last, there are direct services that can be provided by either a registered nurse or a licensed practical nurse for routine medical and health care services. These services are not covered by Medicaid State Plan; this would be over and above what Medicaid covers.

We have nonmedical transportation, as well; this service allows people to gain access into the community so they can participate in normal day-to-day activities, such as grocery shopping, recreation activities, participating in social events, civic duties, and attending worship service—those types of things.

We have nutritional counseling performed by a registered dietician, including an assessment of a person's nutritional needs, developing a nutritional plan, as well as training and education to the person and those who are supporting them. It does not include the cost of meals or food items, and this also was not covered by Medicaid State Plan.

One of our new services we added, in October of 2023, is our dental services; this is available to adult recipients who are 21 years or older. The scope of nature differs from the State Plan Dental Service for Adults that only covers emergency extractions, palliative care, and removable prosthesis with prior approval. Our dental services have a maximum of $2,500 per rolling year. It starts the month the dental service is approved, and no prior authorization is needed for our waiver dental services. The services and treatments include diagnostic procedures, preventative services, X-rays, restorative, periodontal, endodontic, and the other items listed [which are dentures/partials, oral surgery, adjunctive general service, and occlusal guard and adjustment].

Our last waiver service we were able to add is our individual directed goods and services. These are services, equipment, or supplies that address a specific need or outcome for a person that has to improve or maintain a person's opportunities to be fully included within the community, ensuring their health, safety, and welfare. It has a maximum of $3,000 per year and includes the following areas: memberships and fees—this could include costs for community recreation classes, athletic activities such as Special Olympics, a health membership to a gym or an online fitness program; bedbug extermination—in a person's residence only, their family home or their own home; equipment and supplies—this includes assistive technology, devices, controls, appliances, or other items that support a person to increase their ability to perform activities of daily living. It also includes accessories essential to prolong the life of the assistive technology device, such as screen protectors, batteries, or protective cases. We also offer home adaptations under our goods and services—this would include physical adaptations to a person's residence to improve their independence, which could include ramps, grab bars, widening of doorways, or bathroom modifications. These services cannot be covered under Medicaid State Plan or any other private or publicly funded resource.

As of February 2024, we are currently serving 2,711 individuals on our waiver [for individuals with intellectual and developmental disabilities], and we have a waitlist of 548 people. Any questions?

Chair Spearman:

Committee, questions? Vice Chair Brown-May; then Assemblyman D'Silva.

Vice Chair Brown-May:

Thank you for this great presentation. Very happy to have you both here and to have walked us, as a Committee, through the very detailed waivers we have here in Nevada. First, I want to congratulate you on your really good work and adding new waiver services, so we can continue to improve the quality of life of the folks seeking this service.

My first question is regarding lease agreements. When you said we have protections in place for the folks who are seeking services to live independently; and the lease protections. It is my understanding that is about self-directing their services. Earlier this morning, we heard from a provider who was talking about difficulty acquiring leases from landlords as a way to be able to provide a residence for a person who would be on a waiver service. Have you heard about that? Is this anecdotal? Are we experiencing that shortage in this way? Could you provide additional information there?

Ms. Wickland:

Yes, we are hearing more and more from providers statewide who are having issues obtaining lease agreements for individuals—for homes within the community.

Vice Chair Brown-May:

Thank you, Ms. Wickland. Do you believe that might be contributing to the waitlist, or is there an ample supply, at this point? Is that causing us to back up services for this population?

Ms. Wickland:

I do not know if that is correlated; we can look into that. Typically, these are individuals who are already receiving a service who—maybe they are trying to move or find a place. So, we would have to get that information and look into that for you.

Vice Chair Brown-May:

Thank you, I appreciate that. Given that it is a new trend—and maybe it is one of the new pieces of data we can continue to track to see if there is an indication as to creating a shortage of housing for this population or the provider network. Secondarily, we talked about $2,000 in resources as being part of the qualifiers for waiver support services. Is that inclusive of Achieving a Better Life Experience (ABLE) accounts, or do ABLE accounts come into play at all when we look at a person's resources for qualifying for waiver services?

Ms. Wren:

I would defer to my partners at DWSS; they are the experts on the financials. I am happy to get that information. I would hate to misspeak.

Chair Spearman:

They are coming up now.

Kelly Cantrelle, Deputy Administrator, DWSS, DHHS:

Good morning. With me today are two of our waiver experts. I am going to go ahead and defer your question to Supervisor, Ms. Cynthia James.

Cynthia James, Family Services Supervisor 1, DWSS, DHHS:

Good morning. The ABLE accounts are vetted through another process we have. Portions of them could be countable towards the $2,000, and some of them cannot; that goes through the Deputy District Attorney that helps us out with those kinds of accounts for those cases.

Chair Spearman:

So, it is federal.

Ms. James:

Yes, ma'am; those are federal.

Chair Spearman:

We need our federal delegation to step in, because $2,000 is not a whole lot. You have to be living under the bridge on Washington Street to qualify, if that is the standard. Can you do me a favor? Can you get me the information on what the federal statute is—and if there has been any movement towards updating that? Because, in Las Vegas, I do not even know who could live off of $2,000.

Ms. Cantrelle:

We will get that information for you.

Chair Spearman:

Thank you, and I will make sure this is disseminated to the Committee.
Assemblyman D'Silva.

Assemblyman D'Silva:

I had a two-part question. My first question was also relating to the $2,000 in resources, but I think we will be receiving more information. I thank you for that.

My second question is—looking at these numbers with the individuals who are being served and who are participating in the program. They look kind of low. I was wondering why these numbers are where they are at. Is it a staffing issue? Funding? Maybe the ability or lack of ability of acquiring providers? I am asking why we do not have more people participating in these programs.

Ms. Wren:

That is an excellent question and observation. As of February 2024, for our physically disabled waiver, we have a little over 200 folks that were waiting. Our frail elderly waiver has over 1,000 people waiting. It is exactly what you stated. We do have staffing issues with the State and with our private case management company who has come on board in Las Vegas. We are having some hurdles at hiring licensed individuals to perform this case management activity. With our vacancies, we are unable to fill all of the slots that are available for the frail elderly and physically disabled waivers. I will say that the State—our Division, as well as the DHCFP—are researching other states to see what their case management requirements are. We have found that it is pretty split. There are a lot of states that still require licensure, but then we have other states that are omitting the licensure requirement and looking at education and experience—to have folks do the case management activities. We are pursuing that in hopes that will help relieve our vacancy rate. We are working with our partners at DHCFP to include this into one of the next waiver amendments—to allow that removal of licensure in hopes that we will have a higher staffing ratio.

Chair Spearman:

Along with the staffing, I heard you say you are looking at what other states are doing. I think we did something with compacts. Can you speak about that? In the last six or seven years, we have done a lot with compacts. Is that something we have already done that you could take advantage of? Or is it something we should look at?

Ms. Wren:

I apologize; I am not familiar with that study. I would be happy to look at that and get that from my Division.

Chair Spearman:

It is not a study. The compact is the licensure piece that allows people from one state to come into Nevada, if all things are equal, and to get licensed without having to go through 900 hoops.

Jennifer Frischmann, Manager of Quality Assurance, ADSD, DHHS:

Good morning. [Chair] Spearman, I appreciate the fact—looking into the compacts and that is through the licensing board. As Ms. Wren indicated, right now we require a licensed social worker or other licensed health care professional. What we are finding is that, for case management, if you have the right experience, you do not necessarily need that licensure. So, we are looking at removing that component and going off of education and experience, rather than the licensure.

Chair Spearman:

I am going to try to find out because it seems like we did something with social workers. I know we did something with the marriage and family therapists (MFTs) back in 2017. With the compacts in mind, and if you are going to do away with that requirement, have you looked at anything where there might be some type of a partnership with Nellis Air Force Base—with military? I am sorry; I will qualify. I am thinking because we have military members who come in, and they have spouses that have various professional degrees—so is it possible to look at—if that is happening, if you have someone who is coming in, and they have those qualifications; that might help with the staffing shortage, along with once I have figured out what we have done with compacts.

Ms. Frischmann:

We have not reached out directly to Nellis or any of our other military installments here in Nevada, but we can certainly do that and do targeted recruiting when we post these positions. That is something we can absolutely look into.

Chair Spearman:

You might look at NDVS as part of that and maybe even the Nevada National Guard, because sometimes you have people who leave active duty, and they transfer directly into the Guard—and that might be an opportunity either for them or for their spouses. We talked also about caseload. What is the average caseload?

Ms. Wren:

Our targeted caseload is 1 to 50 for the frail elderly and physically disabled waivers. We are currently at 1 to 55 to 57 statewide, due to vacancies and folks taking time off—maternity leave, whatever it may be. We average 1 to 50 to help ensure our quality.

Chair Spearman:

Thank you. Committee, any questions? Vice Chair? Somebody up north? Senator Krasner.

Senator Krasner:

Yes, Chair; I have some questions, please. Thank you for your very informative presentation. I learned new things, and I appreciate you being here.

First of all, you said the waiver cannot be used if it is something that [Medicaid] already covers. That is interesting to know; I did not know that. We had somebody here in the audience earlier during public comment; I do not know if you were in the audience. He spoke about a loved one with autism who was not getting the needed services. Would that waiver you are talking about cover somebody like his loved one who needs additional services that are not being provided by Medicaid? That is my first question.

Ms. Wickland:

In Developmental Services, we also provide services or waiver services to people who may not even be on the waiver. These services are available to anyone who qualifies for our services. Yes, to answer your question; these services would be available to that gentleman's daughter, regardless of whether or not she qualified for the waiver.

Senator Krasner:

Excellent, thank you very much. Next question; you talk about going to select somebody. The individual has to select a provider from multiple options, but I am on the ADSD website right now; and I looked at providers. When I go there, there is no list of approved providers. It says providers—it gives some information about providers—but there is no list of providers. Trying to let people help themselves instead of constantly calling you guys; you are already overwhelmed, it sounds like, and doing a great job. But in order to help people in the community to help themselves, is it possible to put a list of approved providers for services on your website? So people can go and say, "Oh, here are my choices—this center in Las Vegas, this center in Reno, this center in the rurals." Is that possible? I had someone complain to me and asked me to bring a bill regarding that very issue, but maybe I do not need to bring a bill. Maybe it is something you guys can say, "We never thought of that; we can put those approved providers right here on the website." I do not know. What are your thoughts?

Ms. Wickland:

Yes, we can certainly get our providers added for each program. In Developmental Services, we do a vendor referral process. When a service is available to a recipient, then a vendor referral goes out to all of those approved providers of that service type they may be interested in. If it is a supported living arrangement or a jobs and day training program, it will go out to all of those providers, and then providers that have the capacity to serve that person will respond. Then that person has the opportunity to interview those providers and tour sites—those types of things—based on how their interviews go. So, they do have a choice, but we can certainly look at adding providers to our website.

Senator Krasner:

That would be great. If you could add the approved providers to your website for the specific categories, it sounds like it would save a couple of steps. Because you said when somebody is approved and a list goes out to the approved providers, they have to contact the people, then the people have to go back to them and interview them. If the person could look on the website and say, "These are the approved providers, so I can call these five different ones and talk to them, or make an appointment to go." It would save several steps. It would save you extra work too. I would sure appreciate if you could work on that. Would you mind getting back to the Committee and letting us know if, yes, that is something you can do; put the approved provider list—maybe their name, phone number, and their location—on the website? Or if not, like, "Senator Krasner, we need to hire a person to do that because that is going to take a whole week of computer input." Would you let the Committee know? If you need that help, then we can provide it. Or if you guys got it covered, then I do not need to bring a bill next session. Thank you.

Ms. Frischmann:

That is truly the job of the case manager or the service coordinator under Developmental Services. They work as that conduit to connect the providers with the individual served. We can absolutely put a list out there; but we do not just put that on the individual being served, because that is tedious. That would be like looking through a phone book for a doctor. We try to pair up the provider with the individual, and then we do have to authorize those services. The State is already involved a little bit with the case management component; it is something we are already doing. But I see your point to allow people to see who we have enrolled and what the potential options are, and then they can go back to their case manager and say, "Can we check out A, B, C provider?" We can absolutely look at putting something public facing for you.

Senator Krasner:

Thank you. I appreciate that so much, because I got a complaint, "Can you bring a bill to force them to put up the approved providers, so we know who the approved providers are, and we can look and pick?" Then, of course, interact with you, but they want that option to know who the approved providers are for that particular area.

My next question; why are some people on the waitlist? You talked about persons with disabilities and then, additionally, persons with intellectual disabilities. Then you said this many people are on the waitlist. Why are some people on the waitlist?

Ms. Wickland:

It could be that they are waiting for the provider to provide those supports. Oftentimes, as we have heard from Nate Boyack, and our State of Nevada Association of Providers speaking about the provider capacity. We are certainly hoping with the rate increase that went into effect April 1 [of 2024], we will see more stability within our provider network. So we can have more providers to deliver those services. We are certainly looking at recruiting providers from out of state, as well to help support our individuals here in Nevada, so we can get the waitlist down.

Senator Krasner:

Great, thank you. I appreciate you being here today, not just giving us this informative and important presentation, but letting us know what you need. We cannot read your minds, and this is so important. Whatever you need, you have to let us know, you have to come to us and ask us, and we appreciate you being here. Anyway, thank you so much.

Chair Spearman:

Committee, additional questions? Vice Chair.

Vice Chair Brown-May:

I have one final question. During the presentation, it was noted that the frail elderly meals are only funded through this [2023–2024] Biennium. Could we speak to that with a little more detail? Is there a plan for us to add it into the next biennium? Is this a waiver service? What is the solution?

Ms. Wren:

Yes, the meals on the frail elderly waiver were put in during the COVID-19 pandemic as part of an Appendix K option. Appendix K allowed states to put in flexibilities to assist during a national pandemic. Once Appendix K expired, the State was able to use American Rescue Plan Act (ARPA) funding to continue the meals for an extended period of time. Then the DHCFP has been able to fund those meals through the biennium. So, all of the funding for the frail elderly and the physically disabled waivers is through the DHCFP’s budget. I know from discussions with that agency, they are looking into putting this into their budget plan—into their ask—and then making that a permanent solution for the frail elderly waiver.

Vice Chair Brown-May:

Thank you for that. According to the presentation, there are 2,539 individual participants on the frail elderly waiver. Do you know how many of them would utilize this meal service?

Ms. Wren:

I would want to get back to you with exact numbers, but the last time we ran it, we were between 300 and 500.

Chair Spearman:

I have a couple of questions before we break for lunch. Demographics—do you all have any of this information categorized in terms of demographics? The reason I say that is because, in some cultures, all of this is different. There may be cultures where certain types of food are not acceptable. There may be cultures where it may not be feasible to have a male as a helper—or a social worker—for a female. I want to know if we are looking at demographics. That ties into the question I had with Silver State Equality earlier—the cultural competency piece. It is not just those who are in the program, but there are also some of their family members that might be in and out with them in the program. Does that make sense to you?

Ms. Wren:

With ADSD, we do have cultural competency training that has been put out. Our Human Resources Division is working with the Department of Education—I believe, the Department of Administration to put out cultural competencies. Our staff are going through this training, which include our case managers. That is something we are pushing and making sure all folks take advantage of—I believe it is through the end of this year. I can get details back to the Committee.

I will say, for folks who are on the waivers, that is a big part of the social health assessment that is done by the case managers—is investigating the needs and the wants of the individual. There are questions that are geared towards developing what services are appropriate for the person, as well as what types of wants or needs they have. If there is a dietary restriction for whatever reason, that needs to be noted. Then we will work with our partners with either home-delivered meals or with our personal care agencies that are doing preparation in the home to make sure that is recognized. We also take note of their preferences; it could be something as you indicated, maybe they prefer a female or a male as a caregiver. They may prefer that they bathe in the morning instead of the evening. There is a lot of complexity that goes into it, making sure that individual has a voice and that their needs are reflected in their plan. This was brought down from CMS in 2014 with the [HCBS] Settings Rule. That integrated person-centered choice into our plans of care and forced the states to make sure individuals have a voice. We are grateful for that and that hard work, but it is being reflected; and the case managers are doing a good job with their health assessments at investigating the needs and wants of the individuals.

Chair Spearman:

You do not have to answer this now, but if you could get back to me on it. Mr. Wade also mentioned the fact that there are elderly people in the LGBTQ+ community who need additional services, and I do not know if he was familiar with what ADSD does; but if you can coordinate with Silver State Equality to make sure we are covering all the bases.

Ms. Wren:

Yes.

Chair Spearman:

Committee, any additional questions? Anybody up north?

Senator Krasner:

Chair, one more thing—I forgot to say thank you all for the work you do.

Chair Spearman:

Thank you for your presentation. It is four minutes after 12 p.m. Committee Members, let us take a lunch break and try to get back in here by 12:30 p.m. With that, we are in recess.

AGENDA ITEM VII—OVERVIEW OF RESOURCES, GAPS IN SERVICES, TRENDS, AND POLICY RECOMMENDATIONS FOR ADULTS WITH DISABILITIES

Let us start with Item VII, overview of resources, gaps in services, trends, and policy recommendations for adults with disabilities. Rebecca Jayakumar, begin when you are ready.

Rebecca Jayakumar, PharmD, Legislative Director and President, Southern Nevada Chapter, National Federation of the Blind (NFB):

I am also on the Board of Blindconnect, but I am not representing them today in this topic; however, this would also benefit their members as well. (Agenda Item VII A)

The National Federation of the Blind has both the national and then our local and State chapters. I will give a quick overview of what our services are and the things we do for our community. Then what I am requesting today, is looking at *Newsline* and looking at equal access. We have heard a lot today that access is that equalizer between individuals with disabilities, as well as—it is the foundation to be integrated into the community. This is one of those opportunities to be able to learn more about the community and be involved within it, and what that funding would look like if this was something to move forward.

The National Federation of the Blind is actually the oldest membership and advocacy organization of the blind across the world—not only in the United States but across the world, as well. A lot of our activities, particularly at the national level, are on advocacy. We are looking at passing bills that will help those with blindness, low vision, and different disabilities across the board.

Some of the services we have that I think are very beneficial—we have a Free White Cane Program. I have mine with me today; but it is light out, so I do not need to have it. I am speaking as somebody who is blind/multi-disabled; I also have some deafness. Thank you for your advocacy. I do not use sign language though, because I would not be able to see that. Our White Cane Program allows people who are not members of our organization—that could benefit from having a white cane to navigate the world—to get a free cane every six months. Any individual who has blindness or low vision would be able to do that.

Additionally, we have an Independence Market that has a number of different nonvisually accessible contraptions. It could be anything from kitchen items, to things they are using in daily life, to watches, to even recreation—we even have soccer balls that are fully accessible, so you could hear it beeping and be able to find it.

We also have an excellent Nonvisual Accessibility Center, and this helps other organizations "up" their nonvisible accessibility. We heard from the museums earlier, and they are using audio description and trying to upgrade those things. This is a resource for them and anybody throughout the United States.

For training and education—we do things with teachers of the blind and have them do scholarships and get integrated into the community to understand the needs of the students they are providing services to; to education of different organizations outside of ours.

Advocacy—we have a premier advocacy event every year called Washington Seminar. We go to Capitol Hill [in Washington, D.C.] and speak to our Nevada representatives, as well as every other state that is there at the same time. If you happen to be there, you will see guide dogs and canes everywhere throughout the day.

We have a number of scholarships and awards. Some of these go to sighted individuals—i.e., awards for teachers of the blind who are contributing, as well, to our community. But the majority of the scholarships are for the blind individuals who are going to college. They usually give out—I believe it is $250,000 a year to help individuals get that education which may not be feasible otherwise.

And then legal support—we have a legal team at the national headquarters that will either give advice depending on the situation or take on cases of discrimination in different states.

Part of our mission is to build community. I am relatively new to blindness; it has been less than five years, at this point in time. When you are losing your sight, it is devastating. You feel like you lose your sighted friends, at some point, because you need more things. The only person I knew who was blind was my grandmother. That is common within our community, that we do not know people [who are blind]; and we do not have the resources to necessarily connect with them. That is a brief overview of the things that our national [organization] offers.

Our Nevada affiliate is a component of our national [organization]. We are a nonprofit, and we are fully volunteer run. Not a single individual is paid through this. And our entire Board is blind or low vision—they are within the spectrum of blindness. [The organization] is called the National Federation of the Blind, rather than for the blind; i.e., we are driving what we think our community needs, and we have a lot of intersections that were mentioned today. I happen to be a Veteran, and a number of our members are also Veterans and highly involved in the Veteran community; to LGBTQ, to deafness. We have a large intersection of different components of this.

We are looking for full integration and participation in our communities. So often, people who are blind do not feel part of the community for a number of different reasons. A lot of it is the barriers we have already heard about today—whether that be legal, economic, or social. The $2,000 [income limit] you heard about in that last presentation has not been increased since 1987; that is a problem. We know there has been inflation over the last 40 years. We definitely have a lot of barriers, and it is probably across the board for all the people speaking today, in regards to what is there.

Assisting those to acquire skills of independence—I think the majority of people either born blind or who go blind later in life want to be independent and live their life the way they want to live it. Although we are not giving services, we are advocating for services, as well as collaborating with those who are giving services. One of those happens to be Blindconnect; it is one of our only services here in Nevada. The NFB national [organization] has two training centers—one in Colorado and one in Louisiana—where people can get sent there to get blindness skills; because that transition needs to happen. We joke that you have to learn how to become blind, because now the world—for lack of a better term—"looks" different than what we see normally.

Promoting civil rights through education and legislative action—particularly for those who go blind later in life, they do not always know what their civil rights are. Often in our meetings, it comes up—things that somebody is [being challenged] with in the recent time. For example, last month we had a member who went to Target and asked for customer assistance to help find the products they were looking for. They go to this particular Target at least every couple of weeks and ask for these same services. There happened to be a manager on duty who said, “We do not do that.” Through the ADA, it is a requirement to have that [assistance] available. That does not mean it happens immediately when they arrive, but with some wait time—getting a service member to come; they will walk them through [the store] and do those things.

Additionally, we had a student in northern Nevada who is 16 years old. She wants to start working this summer. She has some usable vision, and she was having challenges with people understanding what she could and could not do. We gave her the information about transition services for teenagers who are going towards [gaining employment]—something she was not aware of—through vocational rehabilitation. We are giving information relatively frequently to our members to try to help them understand what they do and do not get access to and how to find those services that are not readily available.

We have three chapters in Nevada. We have our Northern Nevada Chapter, which primarily [serves] Reno and Sparks; however, we have a few [people] in Carson City that go there, as well. We have our Southern Nevada Chapter, which primarily [serves] Las Vegas, Henderson, and North Las Vegas. Then we have our Southern Nye Chapter, which is only two years old, but we have the most members in the Southern Nye Chapter, of all components. It is very interesting that in two years, they were able to grow much more than [the other chapters]—or our other communities that have in the past.

Currently, we only have one division and that is our Association of Blind Students. We are probably a little bit low on our number of blind students who are involved—somewhere we are looking to expand in the future.

Blindness in Nevada—I am a professor, so sometimes it bothers me when I see statistics that are different; so I will note this is from the Centers for Disease Control and Prevention (CDC), that there are 87,000 Nevadans reporting blindness or severe sight loss. Severe sight loss would be that it is uncorrectable; with glasses, they are not able to correct whatever that visual defect is. You will see different ranges of [these numbers] because they are all estimates based off of population estimates. Depending on the county, this ranges from 2 to 11 percent. Southern Nye County happens to be closer to 11 percent, which perhaps is why [that Chapter] has grown the fastest overall. A lot of our rural communities have seniors there, and they are the ones who have the higher percentages [of blindness] a majority of the time.

When we are thinking about accessible content, accessibility helps everybody. Sometimes we get annoyed that our phone talks to us, but Siri was developed for blind individuals—or if you have Alexa, or whatever you have. You talk to it, and it tells you something. When we build these things, accessibility helps people that are outside of our intended audience. Content that may be accessible to somebody who is blind may also help somebody with a physical disability; they may not be able to hold the book, turn the pages, or things of that nature. Perceptual [disabilities]—where they are unable to focus on something or they are unable to perceive what is happening from a written text. Intellectual and developmental disabilities may have issues with text, as well. Sometimes cognitive disabilities will fall within that, where they may hear the auditory and will not be able to [understand] written [text]. We think, a lot of times with developmental [disabilities]—things like dyslexia—it can fall within that. Then, of course, our visual disabilities, which is what our organization primarily supports, but recognizing this could be a much larger swath of individuals that accessibility can help.

The *NFB-Newsline*—which I will get into a little bit more—it utilizes the same standards as the Library of Congress as to who would be able to register for the program. The Library of

Congress has Talking Books here in Nevada. They also have the Braille and Audio Reading Download (BARD) service, which is a number of different textbooks that are all audio described. With that, if there is any physical or print disability, they would be able to register for *NFB-Newsline*; it is not just blind individuals.

I included this [photograph of two blind individuals in front of the "Welcome to Fabulous Las Vegas" sign, with the text "LIVE THE LIFE YOU WANT" added onto the presentation slide] because this is our previous NFB State President, as well as our National President. In 2019, we held the State convention, and our slogan for the NFB is, "Live the life you want"; being able to have that independence and do the things you would like to be able to do.

Why I am here is NFB has what is called the *Newsline*. This is an already developed program. While the national [organization] runs the program, it is state-sponsored from a funding aspect. We currently have it in 47 states and the District of Columbia; the 3 states that do not have it currently are Alaska, North Dakota, and Wyoming. There are efforts—at least in Alaska right now—to move that forward. Currently, we have it available in Nevada, and our nonprofit is currently funding it. However, we have a $7 membership fee, and that does not cover [the program], as you will see in a moment. We know a number of blind individuals are on fixed incomes, and we try to keep the membership as low as possible to get them the resources they need.

[*Newsline*] is fully operated by the NFB—our national [organization]—and it provides both audio and braille information access. Most people use the audio, but we have a number of individuals who take it to a converter that makes it into braille, as well. Of note, about 7 percent of blind individuals currently read braille; so that is probably an under-used service, at this point in time. Audio tends to be more prevalent. It is free to the user; they do not need to be a National Federation of the Blind member. However, the majority of our outreach ends up being that group, but we correlate with the independent living centers and BARD to try to get more people registered. I feel like this has been spoken about multiple times today—equal access is the greatest barrier. Without accessibility and having access to things, we cannot be fully integrated into the community. Visual context—if you think about our perception, it is 80 percent visual. When you lose that ability, you now have lost a huge portion of the world around you. This is a equalizing component to be able to give them more information.

What is *NFB-Newsline*? I mentioned it a few times. It is an accessible news publication. Right now, they have 500 print publications; that includes state, national, and international news. For State of Nevada news, we have the *Associated Press Nevada*, *Las Vegas Review-Journal*, and the *Reno Gazette-Journal*. If this was to be funded, we would be expanding that with two additional journals. There are also some magazines. Having current news is a huge component.

When the tragic UNLV shooting happened, we had a member who was supposed to be on campus in the building where it happened. The majority of our members do not get current news because of accessibility components. When I sent out the email saying we were so happy to hear that so-and-so was safe, people had no idea what I was talking about. They typically do not have a lot of access to what is currently happening in their community, let alone what is happening outside of their community. Braille and Audio Reading Download service is wonderful. It is great access, but it is primarily print books that are fiction, nonfiction, and everything in between—not necessarily current news.

The other big thing that [*Newsline*] has is emergency weather alerts with AccuWeather; it is a collaboration with them to make it accessible. If you have ever heard those loud beeping noises when there is an emergency alert, then this little, tiny text goes across to tell you what is happening; that is not extremely accessible to somebody who is blind. This would give them alerts directly on their phone that there is something happening and give them all the information so they can more directly prepare for it. That sometimes can be a little bit challenging. In Nevada, we may not have hurricanes and tornados and things of that nature where you have to go somewhere right away, but we certainly have high winds all the time and considerations of that component.

I think one of the biggest things—only 30 percent of blind and low-vision individuals are employed. Many blind and low-vision individuals want to be employed, but there are a number of barriers to that. *Newsline* has over 100,000 job listings. It is both local and national, and I think that is a huge component to be able to get back into the workforce and can be a collaboration between the Department of Employment, Training and Rehabilitation (DETR) and NFB to be able to provide what is out there. Plus, them getting the skills to be able to go into whatever they would be moving into. Another component of that is, while you can search geographic area, a lot of blind individuals work remotely because of transportation issues. They could potentially get jobs that are outside of this area and be able to do whatever it might be. Technology has advanced incredibly far—if you have to become blind, this is the time to do it. Now you can use—there are so many screen readers and things of that nature to be able to do all sorts of different activities. Most people are shocked that I work at a college of medicine, and I happen to be blind. I have some usable vision, but I rely on a lot of these services, as well. They can make [job] alerts in there; if they are looking for something specific, they can set a job alert [to be sent] directly to their email. They know about it as soon as it is posted—to be one of those early people to apply for it.

We are all living in this world right now where everything has gone up in price; we know inflation is real. Food prices had—I think the statistic was—26 percent increases since the pandemic. We know many people that are disabled, including those who are blind, have fixed incomes. Being able to know where there are sales in regards to what they are trying to look for—particularly our grocery stores and things like Target and Walmart—can be extremely helpful. This gives them an accessible version of retail flyers that [other] people would possibly get by looking online.

Not something I personally care about that much, but interactive TV listings—they talked about audio description previously. A lot of shows now have audio description to tell exactly what is happening on the screen, and [people] are able to engage with that. Furthermore, it has customizable information. The State of Nevada could add things in there, whether it is disability or blindness related events that are happening. We almost always are involved in the Independent Living Center and disability awareness events, things like scholarships. There is one centralized location where people could find this information—lots of potential benefits.

I want to add to that—with print journals or newspapers, a lot of times there are paywalls first, and even if you pay for it, it is not always accessible. Visually, we know those ads are annoying; they pop up, and sometimes you cannot find it. For blind individuals, they have to tap to find the X throughout their entire phone. Secondarily, wherever you are in the message, it will start to read, "Now the ad"; so you could be midsentence, and now you are talking about something else completely, and then you go back to the sentence. Whereas, visually, you may be able to ignore that ad and page down; with screen readers, they are going to be reading that. The NFB takes out all the ads and distractors, so it is just the news component of it, and that is what makes it accessible.

Furthermore, accessibility—we have different avenues to get into *Newsline*; something that will work for everybody. You can use a touch-tone telephone to call into it. A lot of our Southern Nye [Chapter] individuals who are not extremely phone or Internet savvy utilize this, as well as a few of our Northern Nevada [Chapter individuals]. They can call in and get the same information, and it is very easy to direct exactly where you want to go. The Internet is always an option to use; you can pick the areas you want to be sent to your email, or you can scroll through it and have the screen reader read it. All new computers have a screen reader built in, but for some of the older ones, you may have to have an additional screen reader to be able to read that. The Internet is super helpful for those with Android phones because, currently, there is not a mobile app for Android. There is a mobile app for Apple—not to promote them in any way—they have the most accessibility, and a lot of blind individuals do use Apple, but there are certainly people who do not; it has a built-in screen reader. If you use Siri, that is your screen reader. For Amazon Alexa—you can literally tell it, "Alexa, open National Federation," and it will pull up the *NFB-Newsline*; and you can tell it exactly where you want to go—"I want to read the *Las Vegas Review-Journal* article so-and-so," and it will take you directly there.

For those who are braille readers, you can also have it changed into a refreshable braille screen where you see about 70 lines at a time. This is particularly helpful for our deaf-blind community because the audio may not be effective for them. Talking Book players—it is what is given from Talking Books, to be able to play books if you do not use the app. It looks like a cassette player from the 1980s, but it works for this; and it connects to the *NFB-Newsline*, and you are able to see all the news there.

[Dr. Jayakumar played an example of a screen reader reading an article about the weather forecast.] That may seem really fast; I have it at 1.5 [times the normal] speed. I currently listen to it 2 to 3 [times the normal] speed, so I did slow it down for you. I picked the most benign news article I could find that everybody could relate to in the last month. We tend to listen to things quicker because that is our primary perception. My husband will not share any audio with me because he cannot deal with this. I did slow it down a little bit, but I wanted to give you a feeling of how we would listen to it; so I did keep it faster than I would otherwise. That is an example where there are no ads; it is just the text. You technically could read on your phone if you have large enough print on there. Also, if you turn on your audio, you would be able to listen to it. Unfortunately, when I presented this to Assemblywoman Tracy Brown-May previously, I did not have my audio on because I had my phone on silent, and I realized I could not actually show her how it worked.

What does *Newsline* include? From a national standpoint and why they take care of all of the major components of it. They do all the legal contracts with the publisher—that does not come out of the State; they manage all that component, which is huge. I do not think we can manage it otherwise. They do all the servers, software, technical maintenance, and upkeep to make sure it is fully functional. I have been using it for four years, and I have yet to have a time when it was down. I am not going to say it is not going to ever happen, but it is available 24/7. If it is the middle of the night and you cannot sleep, you could turn it on and listen to it. They have technicians you can call if there are any issues. Or if you are having trouble figuring out how to navigate it, they are able to help with that, as well. It is a reliable format, regular delivery; as soon as that newspaper is coming out, they have updated their stuff. If I look at it Saturday afternoon, I can see Saturday's morning news. It is very reliable in that sense. You may not be able to get it the instant it comes out, but shortly thereafter. They have a help desk. Our Vice President just did this because she could not remember her password. It was not a password issue; they had entered her email incorrectly. They were able to fix it, and she was able to have access. We have an Outreach Division that has outreach materials. They have webinars and workshops, but it is primarily at our convention, to get more people to utilize it. Moving forward, if this was something to be appropriated in the future, we would have somebody here in Nevada to do outreach to be able to get more individuals involved in it.

There is a registration database and records to know approximately how many people are using [*Newsline*]. Currently, we have about 800 in Nevada—that is just 1 percent of the 87,000 people that are blind or low vision. We do not have anybody dedicated to do outreach in Nevada; therefore, it is just those we come across in our community. Furthermore, those that are print disabled—I do not have good statistics on that, unfortunately—but there are more individuals within that [demographic] who could also benefit from this. Currently, nationally, they employ six staff members—so, being able to reach them and get any issues fixed and taken care of in a timely manner.

What we would love to see happen—and perhaps is our proposal—is having this appropriated to the Nevada State Library Talking Books. They are already giving print books in an accessible format to those that are either print disabled or blind/low vision, and they are already doing outreach programs. I first got connected with them at Blindconnect when I was getting services. They do a number of different outreach [activities] already. This is similar to what more than 20 states have done already. A few states go through things like DETR or their equivalent to DETR. We do not think that is necessarily the best, because not all blind individuals are looking for jobs. We have a number of seniors. We have a number of people that may have [multiple] disabilities and may not be looking to [get a job], so that would be a smaller population; whereas the Nevada State Library Talking Books is more expansive on who may benefit from it.

If it was to be funded, it would include marketing and outreach. Within two weeks of somebody signing up, they would be contacted and given more information about it, how to utilize it—all the different ways they can utilize it—and make sure they have the contact number. If somebody is not using it that much, they would reach out to them and ask where the barriers were; because we know the services are great, but if they are not being utilized, there is no benefit at that point in time.

Managing the local channel—currently, there are three in Nevada that are newspapers, as well as adding on two more. They would have a web page dedicated to this. Currently, we have a very brief web page that says this service is available, but it would be dedicated to it and getting signed up for it. Then that outreach of going to the community and telling people about it to make sure that we are getting everybody who could benefit involved in the program.

I already mentioned the two State publications would be added to that. It would be member- and State-determined on what they would want from that. It would cover all eligible Nevada residents. One of the great things about this is, as the program expands, whether we have 1 or 10,000 people, the price is the same. It is an [activation] fee. The cost remains the same because a lot of the cost is due to those legal contracts with the publishers. We have 800 people now, but we would love to see all 87,000 people that are blind or low vision get involved in it.

What is the cost of it? We know about budgets, and we want it to go as far as possible. We want to make sure we are appropriating funds to services that will be utilized. For *NFB-Newsline*, to turn it on would cost $30,500 per year. We have had it in Nevada for almost 15 years. We had a grant initially funding this, and currently, our nonprofit has been funding it. However, we are at a point, with our $7 membership—that is not feasible, because we did not have enough members to even cover this one service; let alone everything else we are doing. The marketing and outreach—which would be the additional two publications and making sure more people can get enrolled and having one person dedicated to this program—would be $24,000 a year. The additional publications is $15,000, which is a total of $70,000 [per year]. If it was a two-year appropriation, it would be $140,000 per budget cycle. I want to be very transparent with the cost because I understand that may not always be feasible; we have limited budgets everywhere. Any questions? Thank you for listening.

Chair Spearman:

Thank you, and thank you for your service. Which branch?

Dr. Jayakumar:

I was in the Army.

Chair Spearman:

Where in the Army?

Dr. Jayakumar:

I was in Missouri, Fort Lost in the Woods—if you know anything about that.

Chair Spearman:

I do. We have a Marine on the dais. So that is why I need it, but it is all good. Everyone else came from the Army. We were first.

Assemblyman Gray:

Let us not forget about the Air Force.

Chair Spearman:

They started off as the Army Air Corps.

First of all, Committee, any questions? Assemblyman D'Silva, the Marine.

Assemblyman D'Silva:

Thank you, Dr. Jayakumar, for your excellent presentation. Even though I am a Marine, I did serve at Fort Leonard Wood. The Marines Motor T School is out there in Fort Lost in the Woods. So I know the base/the installation very well.

My question is this—has there been any sort of outreach or relationship between the organization and our local schools? I think there is an ample opportunity to gain volunteers and to also gain attention to these issues through working with our school system. I was wondering if that is something that is ongoing, or if it is something you are thinking about.

Dr. Jayakumar:

We are in the early stages of reaching out to the schools. We currently have an individual who recently joined the technology group at Clark County School District (CCSD). They are working towards anything we have—programming—to be able to share it with the students who may be blind, because Family Educational Rights and Privacy Act (FERPA) always has challenges there. Additionally, this summer, we have a Science, Technology, Engineering, and Math (STEM) program we are running through Roseman University and their lab space, to be able to learn about astronomy and how to make it accessible. We are in early stages of reaching out to the school district, as well as working with the Blind Children's Foundation here in town. Northern Nevada probably is further along, but their Chapter has been around a little bit longer.

Assemblyman D'Silva:

Thank you, Professor. Any way that I can help, please let me know.

Dr. Jayakumar:

Thank you, I appreciate that.

Chair Spearman:

Vice Chair.

Vice Chair Brown-May:

Thank you, Dr. Jayakumar. It is great to see you. Thank you for coming and giving us this presentation today. As you and I discussed briefly, we are talking about finances. While this is not a money committee—we are a policy committee—and investing in people with disabilities is what the Committee is here to address. Can you talk to me about the national organization versus the State chapter? We look at national organizations that are nonprofits, and we think they have a lot of money. You do not have any paid staff here. What can you tell me about the financial sustainability of our Nevada chapters, and why it would help us as a Legislature to fund this activity?

Dr. Jayakumar:

We are fully membership or donation based for our funding. We have been able to manage paying for this—I believe—since 2018. However, much of our stuff has been in money markets; we were able to move it around to gain interest on it.

From an advocacy standpoint and serving the individuals who are blind and low vision—because we are run by the individuals who identify as that, we are able to determine what our community needs and are able to have their best interests in mind as we are supporting or opposing things that are going through legislation. Again, I am relatively new to this, so I cannot talk through the whole history, but I know our legislative—moving forward is our focus. We are an advocacy group but became more social over time; so, financially, we have been able to sustain. Right now, if we continue to do this, we will have issues being able to sustain moving forward and to be able to serve our community. However, our chapters—we raise our own [money] through all sorts of different types of donations, fundraisers, and things of that nature outside of our memberships. Outside of this, our costs are low because we are volunteer-run.

Vice Chair Brown-May:

Thank you, I appreciate that. In your presentation, it looks like libraries would potentially be the best place to reach the broadest constituency for this program. Is that right? Is that the recommendation?

Dr. Jayakumar:

That would be our recommendation, because while we have a Blind Commission, it primarily is vocational; [DETR]—those are primarily people going to look for work. Not all of our members would necessarily be doing that, nor are all blind individuals, particularly. The incidence of blindness goes up as you age, so a lot of people are retired, and they may not be able to reach those services and get connected with it. Whereas, the BARD and library services have outreach already to the blind community through Talking Books. They are able to reach a much larger portion of population that could benefit from this; outside of even blindness. We do not have those connections, necessarily.

Chair Spearman:

Senator Dondero Loop.

Senator Dondero Loop:

I am wondering if you have outreach in medical offices. People get their teeth cleaned, people go to the doctor; they may even go to an eye doctor if they are not totally blind or need that type of follow-up. It seems to me the medical field would be a place—if they had papers, flyers, whatever it may be, people could share that information with them. That is a place everyone goes. Have you done that?

Dr. Jayakumar:

We have not, at this point in time. We are looking at getting [our information to] eye doctors; because even if individuals are fully blind, typically to receive services, they still need a yearly checkup. For CMS, we have a woman who does not have eyes, and she still has to go to an eye appointment. [Her eyes] have been removed. She is never going to see again, but she has to prove, frequently, that she is blind. That is our first step of reaching out for these programs—is through the eye doctor, because they might be able to recognize those who would most benefit from it. I think, outside of that, the medical offices would be ideal, as well. Having a dedicated person to this would also help us significantly.

Senator Dondero Loop:

I would suggest that on a doctor's, optometrist’s, or ophthalmologist's website, they have a link. It might be great to work with their professional group to see if there is a way to put a link on the websites, so someone who is helping them could go on; when they go to make the appointment, or they call to make the appointment, even the girl at the front desk could say, “We have a link on our website—make sure you have somebody help you look at that or receive that information.” Just a thought.

Dr. Jayakumar:

I appreciate that. We have not done that previously, but I think that would be helpful. I know other states have added it to the library web page, for example. I think that would be very beneficial.

Chair Spearman:

Anyone up north? [There were no additional questions.]

I have a couple of questions, and you might have answered them already; but I did not hear it well. For pediatric care, parents have a newborn, and before they leave the hospital, the doctor says the baby is probably not going to be sighted. What do they do?

Dr. Jayakumar:

At this point in time, we do not have a parents of blind children division. However, we have a few people who are very dedicated to that; we have blind individuals with blind children, and those services are things they are super interested in. Having the ability to contact different services—because a lot of it is learning how to navigate the world differently than we generally consider it; it is still fully feasible and having that support system.

We do not currently run a support group, but we do connect. There is a Northern Nevada Center for Independent Living peer support group that is virtual, as well as—Blindconnect has an in-person one; and connecting them to those services. Parents never want anything to be wrong with their child—abnormal, I should say—that is not their stereotypical thing, but there are so many things that can be done early on. Can I say we have been that resource in the past? No, I cannot say that. But we would always connect them to the Blind Children Foundation, as well as other services outside that, and support for the parents.

Chair Spearman:

Thank you. This may be redundant. Your connection with the military, is that a strong partnership? I am thinking now of our military members who may come back and have been wounded, and part of their recovery means they will either have lost their sight or are losing their sight.

Dr. Jayakumar:

We have, in our Southern Nye [Chapter]—I believe she is the Secretary, as well as an affiliate Board Member—she is highly active with the Veterans. She just was speaking. She worked for multiple governors here in the State and is very interested in making sure our Veterans have the services they need, and she talks through blindness with it. She is our biggest advocate for that. We have a number, including myself, that support a handful in each of the different [chapters]. Our President in the Northern Nevada [Chapter] is a Veteran, as well. Surprisingly, we have three presidents that are Veterans. It seems to be a theme. She is probably our biggest coordinator of that. She does talks around the United States, as well as locally. As Veterans get older, blindness is a component. We have not connected as much with the U.S. Department of Veterans Affairs (VA) as we probably should have in regard to services.

Chair Spearman:

Thank you. Any other questions? [There were no additional questions.] Thank you for the presentation. Appreciate it; and very enlightening. Pronounce your name again for me.

Dr. Jayakumar:

Jay-koo-mar; just pretend the middle letters are not there.

Chair Spearman:

For the record, I understand there were copyright issues with putting the full presentation of VII A online. If you were looking for it like I was, that is why it was not there.

With that, we will go to Item VII B.

Eric Wilcox, Chair, Nevada Commission for Persons Who Are Deaf and Hard of Hearing, ADSD, DHHS:

Good afternoon, I am a parent of a deaf child. I have two colleagues down in Las Vegas that are going to join me in making a joint presentation here, but I want to make sure they are situated with the interpreters and that we have accessibility.

Obioma Officer, Executive Director, Nevada Commission of Persons Who Are Deaf and Hard of Hearing, ADSD, DHHS:

Hello, this is Obioma Officer. We are honored to be here today with you.

Shelly Fried, Secretary, Las Vegas Deaf Seniors:

My name is Shelly Fried.

Mr. Wilcox:

Here is the agenda for our presentation. Obioma, did you want to introduce our presentation for us? (Agenda Item VII B)

Ms. Officer:

I am going to go ahead with the agenda. Our agenda items will start with our introductions, which we have already done. Then we will go into a little bit more about who we are and what it is that we do. We are going to talk about the deaf and hard of hearing community in general, and the community feedback we have received from our qualitative data analysis from our town halls and from all of our travels within the community—and the proposals we have for 2024 and the priority recommendations we have for the community. We will also be able to share with you the different people we have collaborated with, the nonprofits in the community, and others who have supported the needs of the deaf and hard of hearing, as well. We can close with our continued efforts to connect within the community and, hopefully, the work we can do together—ways to stay informed and for all of you to stay connected with us. Eric?

Mr. Wilcox:

Thank you, Obioma. To continue on about the Commission, the Commission was established in 2017. It was created within the Office of the Governor of Nevada and consists of 11 members who are appointed by the Governor. In a moment, we will go into more detail about the membership. But before we do that—what we do, essentially, is compile information we collect from our experiences and from our interactions with the community and try to arrive at a set of recommendations and communicate those to the Governor and to the Legislature, as we are today. We compile these in a strategic State Plan for the deaf and hard of hearing, which we maintain and is available on our website. This primarily addresses aspects of: access for the deaf and hard of hearing and services in the State; engagement—engaging the deaf and hard of hearing community with the legislative process; and advocacy—that is, we try to listen to the community, hear their complaints and concerns, and help bring those to you here, and distill those into specific recommendations.

Ms. Officer:

Next, we will address membership. We have a total of 12 seats on the Commission, and all are appointed by the Governor. The first seat we have [seat (a)] is one that focuses on employment. People who are deaf and hard of hearing—somebody who works in that profession is able to support the community in the needs of access to employment. This is representation on our Commission because those are needs that are highly important for the deaf and hard of hearing community. We see gaps in services where people are not able to find enough work—or they are not hired, and the reason for not being hired is because they are deaf; they need a sign language interpreter and accommodations. There is an additional cost to hiring said individual; therefore, they do not get hired.

[In the meeting materials submitted by the presenters, seat (a) is: "One nonvoting member who is employed by the State and who participates in the administration of the programs of this State that provide services to persons who are deaf, hard of hearing or speech impaired."]

Seat (b) is a member of the Nevada Association of the Deaf (NVAD). That organization focuses on the politics of advocating for the deaf and hard of hearing—the policies and the laws. We have a chapter in Nevada at this time that has continued to focus on the needs and gives its support to the community. If you have a chance to reach out and collaborate with them, that would be great.

Seat (c) is a member that is experienced and has knowledge of services for those who are in the deaf and hard of hearing community. That would be anyone who has experience with deaf and hard of hearing services, providing them services directly, advocacy—whether it be nonprofit or an agency that provides support to anybody within the community. That individual works with the community and provides direct services—has in the past or continues to do so and will into the future.

Seat (d) is an individual who is a nonvoting member. It is the Executive Director for the Nevada Telecommunications Association (NTA). They were part of the development of the Commission—so they continue to have an ongoing representative seat on the Commission.

Seat (e) is a member who uses telecommunications relay services. It can be, for example—relay services can be a Communication Access Realtime Translation (CART) provider. It can be relay services where we use ASL to access communications; anyone who is using that technology to get access to communication when it comes to their phone line or through video relay service (VRS). Again, that means a video screen where there is an interpreter there who is present and ready to process calls—relay a call for a person who is deaf and hard of hearing.

Seat (f) is a member that is a parent of a child who is deaf and hard of hearing or speech impaired. It would be a parent who has a child that may have been born deaf, or with the hearing loss was not able to pass the auditory exam they were given, or later in life had a hearing loss. We recognize that as a parent, they have needs also, just like a deaf person. They are making decisions for another person, and they have to take that into consideration—in understanding how it aligns with the family as a whole, what their needs are.

Seat (g) is a member who represents the educational field in the State of Nevada and has knowledge concerning the provision of communication services with those who are deaf and hard of hearing or speech impaired in K–12 and postsecondary schools. So, they have the focus of a professional perspective when it comes to an educational setting for the deaf and hard of hearing.

Seat (h) is one member who represents an advocacy organization. Currently, that person is a member of the Las Vegas Deaf Seniors (LVDS). We consider our senior citizens when we have concerns and needs in our community, as well.

Seat (i) is a member who is deaf or hard of hearing. You are represented if you have a hearing loss, whether you recognize yourself as deaf or hard of hearing; or you are oral—you do not use ASL as your mode of communication. We have a seat for someone to represent those members of the community on the Commission, as well.

Seat (j) is a member who specializes in issues related to employment of persons with disabilities. It is somebody who works with individuals who are seeking employment or need help with employment placement. Let me double check my slides, because I think I have already mentioned that member. I apologize if I am repeating myself. I am incredibly nervous.

Seat (k) is a member who is a parent or a guardian of a child who is under the age of six years old that is deaf or hard of hearing. The reason why we have two seats for parents to represent the community is that it is very important to realize that our individualized education program (IEP) age can be as early as 6, and it ranges all the way to 21—actually 22; we just had a law that changed that. You can have an IEP from as young as 6 years old and all the way up until you are 22. It means our [ages] zero to five do not necessarily get the support/representation needed. If the students are not provided with access to language between ages zero to five, it can impact their education; and there is a correlation with their development.

The last seat we have [seat (l)]—we are very proud of this one—we had it added recently by the Legislature. This seat is a representative that is a sign language interpreter in the State of Nevada and is registered [with the Division pursuant to NRS 656A.100] to work as a sign language interpreter in the State of Nevada. The seat is very important because two years ago we compiled data from the community, and the outcry from the community was the concern that we do not have enough access to sign language interpreters. We do not have the ability to grow the skills of that profession in our State. Of all the seats of the members we had, we did not have one for the interpreting field itself; we did not have an interpreter. We did not have an expert on our Commission who could speak to that need or those issues. Now we have that seat available, and it can be filled by an interpreter. We thank the leadership within the Legislature for working with us so we could add that seat to our Commission.

Mr. Wilcox:

I want to talk briefly about the vision and the mission of the Deaf Commission. I am going to start with the vision. We have a vision of a Nevada where all residents who are deaf, hard of hearing, or persons with speech disabilities, along with their families and professionals who support them, have timely access to information, effective communication, education, and services that promote choice and independence.

To that goal, it is our mission to advocate for and support the goal—that all Nevada citizens have equal and full access to resources, services, and opportunities in all aspects of community life. It is sort of encompassing, in that we hear a variety of complaints that address a very broad range of life experiences and challenges faced by deaf, hard of hearing, and speech impaired within the State. We try to collect all of that information and promote a vision where all aspects of life for deaf and hard of hearing and speech impaired in the State are served.

I am going to move on and talk briefly about hearing loss itself, by way of providing additional background. You will see a variety of descriptions here for types of hearing loss or severity of hearing loss. I can say, from doing this work for a number of years, that we have individuals in the State that represent all of these types and degrees of hearing loss. Hearing loss is defined very broadly in our context; basically, when any part of the ear or auditory hearing system is not working in the usual way. This could involve—as I will explain in a minute—the outer, the middle, or the inner ear, or even the deep parts of the inner ear where speech processing occurs.

On the left side [of the presentation slide] are the four types of hearing loss. On the outer parts of the ear—this would be a difficulty receiving, in the ear structure, the vibrations of air that make up sound waves; that would be a conductive hearing loss. Sensorineural hearing loss—which is what my daughter has—is a little bit deeper in the ear. That is a condition where there is a difficulty in translating those vibrations of sound waves in the air; translating that into the electrical impulses that later get processed by the brain. Some folks have mixed hearing loss; that is a combination of those two. Then there are conditions that occur deeper in the system—auditory neuropathy spectrum disorders. This would be deeper, where the auditory nerve is not properly transmitting the electrical signal to the brain, or there are conditions in the auditory processing in the brain itself.

There is a wide variety of degrees of hearing loss, from mild to profound—as I am sure many of us have experienced. On the right side [of the presentation slide], there are some other descriptors of hearing loss. It can be both unilateral or bilateral. We see a lot of kids, for example, that show up in our educational system with unilateral hearing loss, as well as bilateral hearing loss. Pre-lingual versus post-lingual [hearing loss] is very important for the language development. A hearing loss that develops before a child is lingual compared to somebody who is older and has a hearing loss develop after they have developed a language has a profound effect on language acquisition and major implications for how to approach teaching language acquisition. As I'm sure many of us have experiences, hearing loss can be progressive—like an age-onset hearing loss that starts very mild and, as you get older, progresses—or it can be very sudden due to a trauma or a sudden sickness. It can fluctuate; we have known folks whose level of hearing loss is not stable. Sometimes they feel like they hear better than at other times. It can be either congenital or acquired.

I am going to move on and hand it off to Shelly with important information about deaf culture and communication.

Ms. Officer:

If I could interrupt quickly; I found where my error was previously for seat (a). It is actually regarding a State worker who represents a program within the State for the deaf and hard of hearing. That was how we could differentiate the two; somebody who works, but also somebody who is part of, a State program, early intervention, that kind of thing. A State worker—so I want to apologize for the confusion of saying two seats had the same responsibility, when they were different. Now Shelly if you could go right ahead.

Ms. Fried:

Hello, Chair, Vice Chair, and Members of the Committee. Thank you for having me. I wanted to explain what deaf culture is as quickly as I could. I am a deaf individual, and I do have my own culture. I have my own language. I have values and norms that I adhere to because of that. But often what occurs is—and I am going to refer to a child who is living in a family where no one else uses sign language; they have hearing family members. The child will absorb the language and cultural norms of the family they live with, which means they will identify with those family members. But as they grow older, that will change. They will have different experiences as they grow older and they are with their family members during cultural events, like celebrating holidays. You will have a member of the family who is deaf—and they are the only one in that family who is deaf—and because they are with all hearing people, they are isolated; they do not have the ability to communicate with their family members, which is heartbreaking.

I used to work as a principal in a school for the deaf in another state. I would often try to explain the concept of having two families. You want to make sure the deaf children you have in your families have deaf friends they can be with—so they have someone to play with, someone to communicate with, someone who has the same cultural norms as them. That is a gap in this State. In Nevada, we do not have access to having deaf children have other friends—because of those limitations—that are also deaf like them.

In addition, I wanted to emphasize specifically about sign language—because it is a visual language, as you can see—it does not have a written language. We do not have a way to write down American Sign Language. Whereas the hearing community sees sign language, and they think everyone can read and write English; that is not the case. English would be our second language, if we were even fluent in our second language. So, the Language Access Plan for the State of Nevada needs to be adjusted in order to provide video access to language. Having ASL on video on government websites and on different programs that are offered within the State so deaf people can watch it and see it in their own language—they can see it in sign language.

In the State of Nevada, the third language used the most is ASL. The first is English; the second is Spanish—and you provide Spanish translation. But for the deaf who live in the State who use ASL and need access to that visual language, we do not have it. We may have captioning, which means we would have to be reading in English, but those who are not fluent in English would not have the ability to follow that closed captioning to the extent of somebody with the fluency. In the State of Nevada, the average reading grade level for a deaf person is only the fourth grade, and most captioning and most language on posters is at a sixth grade reading level, which puts them at a loss. Now we have a delay; we are not able to access things, and the deaf and hard of hearing in the community do not have the language they need to understand.

In the U.S. Census we had for the State of Nevada, it shows the statistics for Nevada—from the ages 18 to 64, we have 688,000 [people with a hearing loss]; of those who are 65 and older with a hearing loss as 533,000. The remaining would be the 0 to 17 [age range] who have that hearing loss. If you look at those numbers from 18 to 64—it is an incredible number. I would like to propose that this should be seen as a form of injustice to not give access to this amount of people living in the State of Nevada. Such a large number of those with a hearing loss—deaf people who live in the State of Nevada—are not given access to services or to communication.

[The statistics from the U.S. Census that are given above are actually from the *Total* Population Estimates in Nevada. According to the 2022 U.S. Census, the population aged 18 to 64 years old with a hearing difficulty is 44,754. The population aged 65 and older with a hearing difficulty is 78,162. The population under age 18 with a hearing difficulty is 5,706. The total percentage of the population of Nevada with a hearing difficulty is 4.1 percent.]

I wanted to take a moment to explain the identity that comes with the cultural norms and the language we have. Deaf and hard of hearing members of the community have the ability to identify themselves as "Deaf"; we use a capital D. It means we went to a school for the deaf. It means we are working in a profession where we serve the deaf. It means we identify as a deaf person. The language used is ASL. We recognize that as our culture. That identity is "Deaf" with a capital D—and that identity is what I identify as—but it is a cultural view, and so we do not have the view that we are disabled. You will come across that difference.

We have also within the community the identity of "hearing." This happens a lot in the State of Nevada. We have deaf people who are passive in that they have identified as the hearing culture around them has labeled them, and they view themselves as being disabled.

We also have the marginal identity, which means they can function in both hearing and deaf communities. They can go back and forth and have the ability to deal with members of both communities. Often, they identify as being hard of hearing. They can use communication with hearing people, they can speak or write back and forth, but they can also sign.

The last one would be a bicultural identity, which means you can identify yourself as deaf but also have a bicultural identity. I have children myself who are hearing, I work with people who are hearing, and I identify with both cultures. I understand you, as a member of this legislative Committee; I am working with you, and I am trying to adapt to the appropriate norms in working with each and every one of you. I can go back and forth between [both deaf and hearing individuals]. I can identify my cultural norms and your cultural norms, and I can adapt to either. I can understand how to work with both groups. I can be with deaf people, and I can be with hearing people.

We wanted to bring forth terms that could be misunderstood or misspoken—maybe not intentionally, but labels used inappropriately. We have "D/deaf and Hard of Hearing." A lot of people will say, "I am big 'D' Deaf/little 'd' deaf," to identify their culture and the community they identify with. It could be the norms you choose to live by. For an example, I once was a member of the Commission; I am currently not a member of the Commission, and there is a reason for that choice. The main reason was because when I was part of that Commission, I was told by ADSD that I could not speak out. I felt that was not appropriate. But if I was not a member of the Commission, I could speak out; I could come here and speak directly to you as a Committee, because I care and I want to be able to share.

Deafblind [individuals]—that is really heartbreaking. There are many deaf and blind individuals who live in the State of Nevada. I do not have the statistics. I do not have a report about any of those individuals, but they are not receiving the services they need.

We also have "Deaf and Hard of Hearing Plus" [individuals], which means they have a dual diagnosis. This often comes with the educational system and the special needs they are provided in an educational setting—and the different situations that they would be in—and how they develop an IEP or their 504 Plan. This would be a diagnosis used for that.

“Hearing Impaired” is not used as often anymore. That is because hearing impaired—“impaired” makes it sound like it cannot be fixed or something is broken. But a lot of people use technology, the [cochlear] implant, hearing aids, and they can hear to some degree.

The last one we have is “Deaf Mute,” which is considered highly offensive. It is not even a term we would use.

Mr. Wilcox:

Thank you very much, Shelly. Next, we have background about the Commission and the community we serve, and I want to get into the meat of the feedback we have gotten from the community. One of the things we do on the Commission is we have a regular schedule of town hall meetings. We are now doing this twice a year. That is two town halls each year in Reno, two each year in Las Vegas, and twice a year, we will go to a rural community and hold a town hall in a rural community, as well. Recently, we were in Ely; some months ago, we were in Pahrump; and in the last few years, we have—twice, I believe—gone to Elko.

What is distilled in these next two slides is an analysis that Obioma, our Executive Director, has done to try to take the notes we collect from all of the stories and all of the feedback we get from the community and try to distill this down into themes, and then further distill that down into recommendations. This is a work in progress. A lot of this is based on feedback we have gotten at our more recent town halls. We are still in the process of trying to translate this into a more concrete legislative agenda, looking towards the 2025 Legislative Session.

A lot of the feedback has been organized into three overarching headings: inclusion of the deaf and hard of hearing community; language development in that community; and health care access. What I would like to do before we get to that slide is talk about the five themes that are listed here. In each of these three areas, Obioma has listed these five themes from feedback we received related to the overarching need. I want to give a flavor of some of the comments we have received related to these five themes.

Theme number one is ASL access. This has been a persistent complaint we have received over the several years that I have been on the Commission. There are not enough interpreters in Nevada, and the interpreters as a whole are not sufficiently skillful. We have a lot of situations where, if there is an interpreter available, the individual feels like they are struggling to communicate because of the quality of interpreting. We also get a lot of complaints about the quality of the interpreting in schools. Hospitals and doctors’ offices are two of the places we hear the most about [the lack of ASL access]. Either somebody goes to the hospital or makes an appointment for the doctor, says they need an interpreter, tells them in advance, and they are either told, “We do not do that; you can find your own interpreter,” or they are told an interpreter was arranged, but then when they show up for their appointment, there is no interpreter there—so somehow the ball got dropped.

We have also heard complaints about this in employment. Recently, an individual who was hired to work in the logistics field showed up for training, and there was no interpreter. They came back some weeks later for the rescheduled training—still no interpreter there. That person remained unemployed for months—if not years—after that simply because each time they showed up for training, there was no interpreter there. Even State offices—recently, we heard of somebody who showed up at the Department of Motor Vehicles (DMV) to take a driving test, told them in advance they needed an interpreter, and they were told, “Well, we do not provide that.”

We also hear often about the use of virtual remote interpreting; that is using a piece of technology—an iPad—with a remote interpreter. Often that does not work effectively. It is used in a situation where it is not appropriate, like somebody is hurt in the hospital, or the staff who are providing that do not know how to use it—so nobody can make it work. Or the place where they are trying to use it does not have stable enough Internet to have a video connection to an interpreter.

The next theme is ADA compliance. We hear of many businesses and public offices that are routinely violating the Americans with Disabilities Act. We hear many stories of students in schools that are routinely violating the Individuals with Disabilities Education Act (IDEA). For example, as I noted before, when the DMV says, "Well, we do not provide an ASL interpreter," my understanding is that is a violation of the federal law. In many cases, it is ignorance. I will get to outreach a little bit later, but what we really need in Nevada is a comprehensive, continuous process for outreach and training, which the Commission is not prepared or funded to be able to provide. That needs to be coupled with enforcement, for example, through an ADA compliance officer. Because right now the sense is that places of business, or even State agencies, can simply ignore the ADA; and there is really no recourse for the community.

The third theme is education, services, and advocacy for the deaf and hard of hearing. On education, there are many stories about poor educational outcomes. We have limited statistics on this—so there is actually a need to better document the educational outcomes for deaf and hard of hearing [individuals]. We have limited expertise in the schools for deaf education. I know from my personal experience, there are teachers of the deaf, speech pathologists, and classroom aides who are very knowledgeable and highly competent, but there are very few people in management positions. We see a lot of teachers leaving because they do not feel like they can exercise their expertise, because they are managed by people who do not understand their expertise. I believe we are on the agenda for that Committee a little later this month.

Regarding services, there is a provision in the NRS for the ADSD to provide a Deaf Center—a physical office with staff that are culturally competent in communicating with the deaf, to provide deaf individuals with support and advocacy to gain proper access to the services they deserve. This is funded under the universal access [Communication Access Program] surcharge on your phone bill—so the funding for that does not come out of the General Fund of Nevada. This Center was operated for several years statewide and included Deaf Center offices both in Reno and Las Vegas. But recently, those offices closed mainly due—in my view—to bureaucratic obstacles imposed on them by the State. The service model that was put in its place has not been responsive to the needs of the deaf community. Many complaints are coming to us about individuals trying to access help from the State to gain access to the services they deserve, and not being able to make use of the service delivery model that is currently in place. In spite of the fact that we have tried to help the ADSD, the current service model does not demonstrate any of the communication or cultural competency required, which was something that the Deaf Centers of Nevada did provide very well. In fact, the Deaf Centers of Nevada employed a significant number of deaf individuals who were part of the community, as well as trained and competent in delivering those services. Since the Deaf Centers closed, a lot of those people have left the State. We have even lost some of the ability and competency to provide these services in the State. There is a need for the State to correct that model—the model that hobbled the Deaf Centers of Nevada—and work constructively to restore the Deaf Centers. This has been a clear message we have received in our town halls recently.

On the advocacy side, the Commission takes a lot of complaints, but we are all volunteers. We have one to maybe one-and-a-half full-time equivalent (FTE) of administrative support, and we have a budget of $25,000 from the State; and that is not even enough to meet our requirements to have interpreters and communication access at our meetings. As you will see in this meeting today, there are several interpreters involved in providing accessibility to deaf individuals who are participating in this meeting right now. Every single meeting we hold, we have to have this level of support. In fact, we have live captioning involved at all of our meetings, as well; and that all costs money because they are professionals. What I am trying to say is we do not have the resources to properly provide comprehensive and professional advocacy in response to all of the complaints we receive. We are doing what we can to build advocacy capacity, but there is still a great deal of work to be done in that area.

Deaf and hard of hearing equipment—I mentioned this briefly, so I will not reiterate—but a lot of places are using video remote interpreting, and that is not working for a lot of people. We hear lots of complaints about this. The other thing we hear lots of complaints about is a lack of captioning in public places. Some states have advanced laws obligating public spaces—even private businesses that operate as public spaces, like bars and restaurants—to require them to have captioning if they are going to have television screens on in the public spaces; we hear many complaints about that.

The last of these five themes is deaf and hard of hearing cultural competency and sensitivity training. This goes back to the issue of ADA compliance I mentioned earlier. We have, in the past, done outreach to first responders, the Governor's Office, the LCB, and the TV broadcasters in Nevada. We have even done outreach to the National Weather Service. But staff changes. The Governor's Office changes; it is a whole new staff who did not hear any of the information we provided before. I am sure there is staff turnover in the LCB. First responders—with all the first responders throughout the State, there are constant new hires happening. There needs to be some mechanism to provide continuous competency and training, if the systems of public service in the State are going to provide adequate accessibility to the deaf and hard of hearing in the State.

Next are the recommendations, and I believe I am handing this off to Obioma or Shelly.

Ms. Officer:

Thank you all for your patience and taking in all of this information. I know it is a lot, and I know it has content that may be hard to follow, but I am appreciative of the fact that you are wanting to pay attention to the needs of our community. As the Executive Director of the Commission, these are the recommendations, based on the data that has been collected from the community—going to the town halls, getting feedback, and listening to them at our meetings. This is in line with what Eric has shared with you and the needs of our community. We will continue to do that to make sure they feel heard, because we do not take these things lightly. We have been on a journey with them, making sure we have gone all over the State. This month we had more town halls; we were able to have more members of the community come out, and my heart is heavy for our community. It does take its toll, to see what they have to go through. These are the recommendations from the documented data we received; and from me, as the Executive Director, asking that you please join us in the fight to give the community what it needs.

Recommendation number one—this is a part of our State Plan. For us, we will continue to engage with the community. We will have town halls, round table discussions; and make sure we have general events to bring awareness of deafness to the community. We are the only State I know of on the West Coast that does not recognize the deaf and hard of hearing at a national level. We do not have Deaf Awareness Day in the State; we do not celebrate that or recognize it. I do not know why that is—good question—something to think about; it should happen, for sure.

We would like to increase our focus on the legislative advocacy that is needed within the community—and be prepared to address the needs for the deaf and hard of hearing with a direct service model like what we see in other states when it comes to cultural competency [found in] a deaf school, having a deaf center, and an office for deaf services. The deaf services that are provided nationwide should also be available to residents of the State of Nevada.

Recommendation number five—in regards to health care, we would like to increase ADA compliance, which is mandatory. These are mandates and keep organizations accountable. We want to see an increased amount of health care services, engagement, communication, and access for the deaf and hard of hearing because health care is incredibly imperative. Networking needs to expand within our community. Our hospitals—from what we understand from the community members at our town hall—the deaf and hard of hearing are repeatedly being told they cannot receive services; "You can bring a family member to interpret for you."

We have children—I am not talking about 16- and 17-year-olds—we have had two occurrences within our community in the last six months of an 8-year-old expected to interpret for their parent in a situation that would be considered horrific when it came to medical terms. In the second situation, for a government need. An eight-year-old? I do not think that would be appropriate—to talk about cancer, to talk about diabetes—to relay that type of information. Even the vocabulary that would apply to these situations would be incredibly outside the range of language any eight-year-old would have, and to see them try to process that for their parent—what it might feel like. That is definitely something we want to see stop. We want to network, we want to make sure our hospitals—we want to do outreach. We want to make sure that, as professionals, they understand that is their responsibility under federal law. They are supposed to adhere to the ADA. These are not suggestions that the federal government made, but rather mandates.

Recommendation number six relates to the State Plan—language development. Immediate intervention needs to happen for those who are deaf and hard of hearing. Post K–12 and for student services, we need early intervention, as well. We need advocacy for language development. We need our school districts to have expert professionals; those who are working in the field of education with these skill sets. We need to have a language acquisition plan and make sure it is implemented and being followed, not just something that is conceptualized and then we never see brought to the fore. We need to have people who are qualified to check on the Learning Assistance Program (LAP), to make sure those students are getting the access, to make sure we are not depriving our students. Because, repeatedly, that is what we are seeing; they are being deprived of services, and we need to see that change immediately. Our children are the ones who are suffering, and they are the future we have in this community; and we want to focus on what their needs are.

Adhering to the IEPs—these are not suggestions; these are legal documents. These are supposed to be mandated. An IEP is a legal document that should be followed in its entirety. We need to continue to make people accountable—having more education, knowledge, and cultural competency, and having the ability to comply with the law we currently have in place. We have an NRS. We have all the supports that are available. They have what they need. The problem is not that we do not have them, but rather the problem is that the people do not want to adhere to what has already been put into place. They have the laws;

they just do not want to follow them. So how do we go about giving those laws the teeth they deserve? Now I am going to pass it over to Shelly Fried.

Ms. Fried:

I wanted to address the Committee as the Secretary of the Las Vegas Deaf Seniors. I happen to be formally educated. I like to collaborate with outside agencies and different organizations, and I invite them to come to our Las Vegas Deaf Seniors meetings, so that the members of our organization can get what they need—because we no longer have a Deaf Center. They need access. But I am also retired, and I want to take time for myself. But here in this community, there is a huge need. Being that my passion is to serve, I am using my own time to volunteer to organize these things and collaborate with different organizations to provide for members of the community I am a part of. We have community events, like there was a deaf collaboration with Metro Police. We had a deaf event where we had a cookout for the community to be able to all come together to socialize and spend time together.

But I also wanted to share that currently, we have issues in regards with the Nevada Care Connection (NVCC) and with Jewish Family Services. I had someone who was 88 years old and very frail and weak; she is a size zero. She is tiny and frail—to give you an idea of who she is and what she might look like. She was evicted. She came to the Deaf Seniors for help. We do not have a Deaf Center that could assist her, so I was contacted in order to assist her. I reached out to NVCC, and I said, "This is an emergency; we need help." They said, "Okay, no problem. We will refer you to Jewish Family Services." I thought, "Okay, we have got three days to get this taken care of. This is an emergency situation." Of course, we got nowhere. We ended up, as an organization, finding a way to network with the members of our organization to get a bunch of friends to help her out. We were able to get a truck to pack her up; then I ended up giving up two weeks of my own time to find the information needed in order to navigate the system within the State of Nevada to get her the help she needed. But the housing is difficult and I am deaf, and I could not get the help. I could not reach out to get the help she needed, and I had to find an apartment for her. We were able to move her into—not the best situation, but it was something that could cover her needs immediately.

Jewish Family Services contacted me 47 days later to address this issue—47 days. That said, I am trying to think, as an advocate; I am trying to have compassion and understand. I contacted the Office of Community Living, and I said, "Is there any way I can have NVCC and Jewish Family Services come to us? Can you please come to the community center where the Deaf Seniors have our club meetings and reach out and help them?" We had 70 people show up that day for that event. And I said, "Please make sure you bring four interpreters"; and they did. They did bring four interpreters with them. Then their eyes were opened beyond belief about the needs of services for the members of this community. I was not able to count, but I think there were at least 16 intakes done that day in two hours. In that amount of time, 16 people had intakes. They told us that day—it [would be] five to seven business days [to process]. I held that event on March 26 [of 2024], and we have had one response; one out of those 16 intakes. I think that is, quite frankly, unacceptable. If we had a center that served the deaf community, it would be taken care of instantly; we would not have these issues. Even though we try to collaborate and work with the different agencies.

I want to recognize those we have collaborated with—organizations on this slide [of the presentation] have fully supported the deaf and hard of hearing community, which is my community. They have served us; they have collaborated with us. These are all of the organizations we have worked with on a regular basis. It is amazing the compassion they have, and I understand they are walking in step with us to make things better.

Ms. Officer:

I wanted to make sure you knew ways you could continue to connect with us, walk, and engage with us. We want you to be aware of what our Commission is doing within the community. We hope this will help you to be able to do that. We have a website. We have our meetings scheduled on a regular basis. Our next meeting is Wednesday, May 8, 2024, from 9 a.m. to 12 noon, and it is open to the public. Any member of any community can attend, and they can see what is going on within the deaf and hard of hearing community. This weekend, on May 4, 2024, we will have "May the Fourth be With You Cook Out." We will be able to celebrate Star Wars within our community; and we will be able to talk about the needs and how we can set up a Deaf Center.

Know that we are actively trying to support each other. We are trying to do the work that is needed in order to build the community. In addition to that, all community events that happen, you are more than welcome to attend. We want to see better unity across the State of Nevada when it comes to working within communities.

We have our State Plan, which you can review and read at any time. We also have our annual report, which we did for last year. We have our *2023 Annual Report*; you can see all of the data there. You can also take a closer look to see what some of our successes are, what some of our needs are, and how we are trying to improve in those areas. If you want a real close look at what we are doing, add your name to the Listserv, and you will get repeated reminders of everything that is going on.

At this time, I would like to go ahead and welcome any questions you have for us, as the Committee.

Chair Spearman:

Thank you. Assemblyman D'Silva?

Assemblyman D'Silva:

Thank you again, members of the Commission, for being here with us today and giving us an excellent and very informative presentation. My question is similar to one I asked Dr. Jayakumar. I do have experience with this. I am a teacher; I teach at Rancho High School, and we have been having a program at my school for DHH students. I myself have had a DHH student in my classroom every single year now, going back to at least 2018. It was my understanding that there was an effort being made by the school district—CCSD—to make sure our students were being taken care of and that there were resources being delved [into]. But I heard today there were significant issues and this was not the case. You being the experts on this issue in our State, I was wondering if I could draw you out a little bit more on that specific need here in our local school district, the Clark County School District—if you can educate us more about some of those needs that need to be met for our children. Thank you.

Ms. Fried:

Absolutely. From what I know, prior to this school year we had four high schools that had programs where deaf students were allowed to go. Unfortunately, two were closed. So now you only have two options. You can attend Rancho, and you can attend Liberty; one high school in Henderson and one in the middle of the city. The difficulties the deaf students face—you know what? Let me start with you. You are a teacher, and you identify with your students. You teach them, and then when you have an interpreter, a tutor, or a signing aid in your room, you always had somebody in the room who could help you communicate with the student that had the hearing loss. Correct?

Assemblyman D'Silva:

That is correct.

Ms. Fried:

Sometimes they would use a tutor or a signing aid as an interpreter; that is a problem. These children are not being provided sign language interpreters to facilitate communication. They use tutors, signing aids, or whoever they have available. This is not your fault; this is not any teacher's fault. Any teacher assumes another adult in the room is qualified and is supposed to be there for that student. Some things are a violation of the IEP plan. The IEP may have support services—it says a tutor, it might say a signing aid or a sign language interpreter; but all of those professionals provide different roles. Clark County School District will conveniently put them all into one role, and you might not have somebody who is skillfully relaying communication to the student in your classroom. Within an IEP meeting—you may have been asked to go into one and asked how the student is doing, and you, as a teacher, might have to say, "Well, let us ask the interpreter; they are the ones who know." You can see how a teacher would not even be responsible for their education; they are giving it to the other professional in the room. That may be an example of some of the things the deaf students are facing.

That is an example of 1 of 100 issues, but CCSD has already violated multiple IEPs and Individuals with Disabilities Education Act (IDEA). They want to put students in a 504 plan instead of an IEP to avoid all the mandates that would be in an IEP. The second thing I would add to that is there is not enough qualified educational interpreters. Interpreters have to be registered with the State of Nevada. We have a small pool of interpreters that are qualified to interpret. That registry does have a list of them, but it is very limited. For example, there is one class that does not have an interpreter. There are four students in the class, and each student has an iPad with a Video Remote Interpreting (VRI) interpreter who comes on there when the classroom and the four students are supposed to—so four students, four ipads, and they are staring at an iPad all day. It is like they are forever trapped in what would be pandemic-type situations. We are using an access on a Zoom or an iPad for a child that is deaf. They are not giving the equivalent services of the hearing students in your classroom. It is not the same.

Mr. Wilcox:

I was going to ask the Chair if I could address the Assemblyman's question, as well. My daughter is a student in Washoe County schools, not in Clark County, so my experience is more here, but I did want to make the point that a lot of what Shelly is describing is really describing the situation statewide. One overarching point is there is only one option for education for a deaf child; there is just mainstream. The only option is to put the kid in their mainstream school. In Washoe County schools, there is a deaf education program. So, you do not necessarily go to your neighborhood school; you go to the school that has the deaf education program in it. But, it is still what we call a "mainstream" educational experience. There is no option for a deaf school or a deaf school-like experience in the State of Nevada.

Then the lack of expertise that I mentioned before—in the elementary and middle schools in Washoe County, for example, there are teachers of the deaf who are quite knowledgeable. There are a handful of itinerant teachers of the deaf who float around the district, visiting kids that are in neighborhood schools. But at the high school, for example, there is not a competent teacher of the deaf. There used to be, but she left, and they did not replace her with somebody who is competent. In the rural areas, we find some of the school districts have literally no expertise at all. They have interpreters that are not up to the standard expected of an educational interpreter. They do not have a teacher of the deaf; or if they even do have a teacher of the deaf, it is somebody who is not terribly experienced. They have speech and language pathologists who have no experience serving kids who are deaf. These problems are essentially statewide.

Ms. Officer:

As a State worker, I appreciate all of the feedback as to what is happening in the community. I know the more we have people come to our town halls, there are experiences shared by individuals with names of the schools where this is happening, and the professionals they are dealing with. It is targeted information. Please know you are welcome to come to any of those town halls to work with the community, get more information, and have an in-depth discussion.

We will have an engagement conference—December 13 and 14 [of 2024]. The dates may change slightly, but we will have a conference towards the end of the year to have an in-depth conversation regarding the concerns about what is going on in our State and how we can make those changes; so when we have Deaf Day again at the Legislature in 2025, we will have more information to bring to the table.

Again, these are not isolated incidents; these are not just, "Oh, one person had an experience." It is a collection of experiences within a community concerning lack of services within the State of Nevada, for constituents who are here in Nevada.

Senator Dondero Loop:

I, too, am a teacher. I retired after 30 years of teaching elementary school and also being a librarian. My question to you is—we have identified a lot of problems. I taught at a couple of schools—well, several schools—that had a sundry of programs, if you will. We had an autistic classroom, a deaf classroom, and several different classrooms at some of the schools I was at. We have identified some of the problems. As a Legislator, I would like to know what the solution is. In other words, what legislation do we need to pass? We do not run the school district, although it is a thought. What can we do to pass legislation that will help these children? Not that I am not concerned about the older kids, but we all know the sooner we catch these kids, the better the outcome is. What can we do to help you legislatively? Is there a policy that needs to be passed?

Mr. Wilcox:

That is a great question, and the short answer is we are still in the process of trying to figure out how to distill what we are hearing into specific legislative asks. That is a challenge for us, because none of us are professionals in public policy.

Something I mentioned before, but I wanted to reiterate, which I think is relevant to this, is that there is no expertise at the top. There is nobody in Nevada's Department of Education (NDE) that has, to my knowledge, any understanding or knowledge about language acquisition for deaf kids or education of deaf kids. So, I think—and I have heard this from many people—until there is some recognition and expertise at the top, we may never see real improvement. This extends down to the school districts, as well. As I mentioned, there are knowledgeable people at the ground level working in classrooms with kids, but there are not enough of them. The teacher shortage we hear about nationwide is a contributing factor to that. Difficulty finding teachers who are competent to hire and bring into Nevada is a problem. Although we have also heard complaints about, for example, districts not advertising to hire a live interpreter when they are using a video interpreter. The implication being that it is cheaper and easier for them to buy an iPad than to make the effort to hire a live person.

Beyond the classroom—as far as I know—I have not yet met an administrator at one of the school districts who has any knowledge or competence in this topic area. It is not just NDE, it is at the school district level, as well. As I alluded to earlier, the teachers in the classroom who do have experience, do not really feel empowered to use it. They feel like they are told how to do their job by people who do not understand how to do the job. I wish I had a better answer for you—and maybe my colleagues have other things to say—but I would say we need help in understanding how we can affect real change with regard to education in the State. Thank you.

Ms. Fried:

I worked for the State of California; I worked at the Residential School for the Deaf in Riverside, California. I see a few differences in the approach of education here in the State of Nevada. I talked with two Senators last year, and I will share with you what I shared with them. I think there should be regionalization of schools; a Las Vegas day school in Nevada, where we have an elementary, middle, and high school—or in different parts of the State—that also provides services within that school for [ages] zero to five, when it comes to deaf and hard of hearing for language; different role models that are working within that school that are deaf adults. You would need less school staff if you were to put them all together, instead of separate programs, or putting them all over the State—but rather having these day schools in different locations. Having high school students work with our elementary school students—you would call it a big community in a small town. You have got a day school that has all grade levels. Maybe Las Vegas and Reno could each have one—something along those lines.

Transportation is another challenge our deaf kids face. I know that, financially speaking, it is smarter if we do regional schools. A residential school would be—you are talking about a big chunk of funds to do something like a residential school. But if you have schools based on the region, and all of the deaf students come together, you would in essence save funds as opposed to keeping them in separate programs all over the State, with substandard services.

Senator Dondero Loop:

Thank you. I understand what you are saying, because I have been around long enough that I remember when we started putting kids in separate schools along the way. Part of that was because we had parents who did not want their children going across town; because, in Las Vegas, we happened to have a huge geographic area. In fact, the other day I was talking to a father who had a very disabled, nonverbal son. He was upset because his son was being bussed to a program not close to their house, and he was struggling with why he could not go to the school right next to him. Sometimes, while I understand that—even as a parent of children who do not have these disabilities—it unfortunately becomes a cost issue or sometimes an isolation issue; you would not want one child at a school. You want those children to have support services. I say that not only as a mother, but as a long-time teacher who worked with a lot of different children.

I will have to do some research. I will have to find out from the Superintendent [of Public Instruction] what we have there. I will have to find out from the school districts what we have there, and start to marry some of the expertise. I know we have interpreters at all the public meetings, for example, but do those transfer down to the schools? I agree with you that we do not have enough professionals. We do not have enough teachers; on top of that, we do not have enough teachers for the deaf, blind, autistic students, et cetera. We have tried to help with the licensing, so people who want to move here do not have so many barriers. We have developed a compact so, if you are in the military and your husband, wife, or significant other is transferred here, your licensing "adventure" is not as hard, and we can slip you into a classroom. We are working on things, but I welcome you to reach out to me so we can work on this together. We cannot just produce people, but maybe we can find better solutions around our State or better policy pieces to help remedy the situation a little bit. Thank you for being here, and thank you for all you have done.

Ms. Officer:

Thank you. I have heard from different people within the community and from different members of this Committee today who talked about cultural competency. Over and over again we have heard we do not have enough people that have the knowledge or experience to know what is happening within the life of each of the individuals we are serving to provide them that service. As a person with a hearing loss providing a service, it makes sense what you are saying. We need to have engagement and cultural competency; we need to understand who we are serving, but most of our service providers do not have that background. We hear that often as a Commission, that those who are serving the deaf community are not themselves culturally competent. Members of the deaf community are not getting hired to fill the positions to serve the deaf community. Preference is usually given to those who sign and speak—so they are hearing, they can speak on their own—and they will be hired before a deaf person who would have the cultural competence, the knowledge, and the linguistic ability. Our students in our community would benefit if that were the case. But when it is not, they are not being exposed to the language and the culture they need in order to get the services in an appropriate way. That being said, finding the experts—not only is that a challenge—but convincing those in the positions of authority to then hire those experts.

Are there any more questions?

Senator Spearman:

Anyone up north have any questions? I do not see any hands raised. I have a couple questions. In 2017, when I was Chair of Health and Human Services, we sponsored the bill to establish the Commission of the Deaf, because prior to that it was a Committee. I am so glad to see it is still alive and functioning well. We also had a bill, SB 203, that I sponsored that would have created a school for deaf, hard of hearing, blind, and vision-impaired children. It got enrolled in Chapter 601 [of NRS]. I am trying to figure out what happened to it, because I know part of the issue was what Senator Dondero Loop said. Parents in the North did not want their kids to come south; the parents in the South did not want their kids to go north—and we did not have the funding to create two schools. I had a recommendation that we would start with one and move to two. The issue throughout that session in 2019, was how do we pay for it?

We also had a bill—in I think it was 2017—for insurance companies to provide hearing aids for children up to grade 6, I think it was. When they would have an opportunity to learn spoken language and also ASL, and we could not get that across the finish line either. What you are saying is déja vu for me, but I would not give up because I know one of the things we always grapple with; and that is funding. Unfortunately, we only meet every other year. That is draconian; the Legislature ought to meet every year. What happens is when something passes, is in limbo, or does not pass, you have to wait 18 months to bring it back. Memory gets short, and there are other bills you try to carry. That is the first thing I would say. As soon as Ms. Cooper finds it, I will read it.

But in the meantime—and this is also for Dr. Jayakumar, if you can come to the table. One of the things I brought up in the [32nd] Special Session of 2020—when we were talking about mail-in ballots, and there were some of my colleagues who were adamantly against it. But I saw that and see that still as a way for people who are blind, visually impaired, deaf, or hard of hearing to participate in the process. Can someone tell me how that happens now? Is that process something that goes throughout—I mean the ability to vote, and I am not just talking about presidential. The ability to vote is a basic right of citizens, unless there is something that has happened and that right has been taken away. Anybody tell me—how do you do that? Do you do that? Can you do that? If so, how?

Ms. Officer:

We just met about the voting polls with another organization, the Nevada Governor's Council on Developmental Disabilities (NGCDD), in order to talk about that specific issue. Voting polls are not accessible for the deaf and hard of hearing because of all of the English verbiage that is used. We are trying to create, work with, and collaborate in order to create a way for voting polls to be accessible. I understand the blind community has similar concerns; and those who have developmental delays need to have somebody with them in order to provide support—but having that concept of making voting accessible. Having a person in the box with you—maybe interpreting—or having someone to help you is illegal. You cannot do that. We are not able to provide that type of a service, but we are working to figure out how to give people access when it comes to the voting polls, so everyone has the right to vote. People in the deaf and hard of hearing community do vote—yes, absolutely. However, with barriers; it can be difficult.

Ms. Fried:

You will have more voters come from the deaf and hard of hearing community, if we have videos that signed things in ASL. Having the video, maybe like a Picture-in-Picture (PiP); you have an interpreter in a square or a bubble—and you click "yes" or "no," and you have that interpreter signing. A deaf person can go right into the booth and have an interpreter, not necessarily present with them, but rather, providing that access on the screen.

Ms. Officer:

That is exactly what we talked about with the "DD Council" [that is, NGCDD]. How do we navigate the current legalities of confidentiality, not having someone influence someone else when it comes to their vote? We have been talking about partnering with different organizations, companies that would provide automatic on-demand interpreters that would be able to sign for them, and they could see the wording or the phrasing—whatever verbiage was provided; the interpreter would sign the exact verbiage, and then they would have the options to click on. That was all discussed with that meeting with the DD Council, but there was not a conclusion at that time.

Dr. Jayakumar:

For the blind community, every voting site does have to have one accessible—nonvisually accessible [voting system]. However, the barrier is the workers at the poll station are not always trained on how to utilize that. Often, they are recommending having somebody come in [to assist]. Of course, as a blind individual, depending on how much sight is remaining, the person assisting could put whatever they want in there, which, again, is not legal. So, that is not necessarily the best solution.

They did incorporate an online voting option, which is more accessible because you can use your own personal screen reader to do that. However, there has been a lot of opposition towards that, because people are worried about voter fraud. But for the blind community, [online voting] is a big advancement, since the polls are not always trained on how to use accessible machines.

Chair Spearman:

Which is why I heard from someone in the deaf community about the vote by mail because it comes to your home; it is private. As a voter, as an adult, most people who are hard of hearing, deaf, hearing impaired, blind, or visually impaired—most already know how to read the language; and they can do that in the privacy of their home. If they have a question, they could ask someone who they know will not lead them wrong—will not just tell them anything. That—and then the sample ballots go out first. So, when the sample ballots come to your home, you have an opportunity to look them over and decide, on the sample ballots, how you will vote and who you will vote for. The information there, once you see who you want to vote for—for President, Senate, Congress, State—everybody down the line. Once you do that, then when you go into the voting booth, you know what you want to do. The whole idea, at least for me—why I supported it strongly—is that it helps people who do not have access to someone who can interpret for them, or someone who should help those who are sight impaired. It does not do that.

For our senior citizens, who are mobility challenged, [voting] at home allows them to participate in the process. So, I am deeply disturbed if we are not taking advantage of those options, so you all can participate in this civic action. Does that make sense to you? Somebody, please comment.

Ms. Fried:

Yes. To give you an example, yesterday I was summoned for jury duty. Now, two months ahead of the date it was scheduled, I asked for an interpreter—two months in advance. I arrived yesterday to be a proud citizen, to do my duty to be on a jury. No interpreter. In addition to that, I emailed and said, "Why? I am disappointed; I asked for this in advance. I wanted to be there; I would be happy to be on a jury, but I did not get equal access to have the opportunity to be put on that jury." There was a Spanish interpreter there but not a sign language interpreter when I showed up yesterday for my summons.

Ms. Officer:

Your suggestion of ballot usage is a fantastic idea. Having equal access is incredible. But also, setting up a way to be able to go into the poll—to have that experience too. You go in; you have that independence. As a child you look forward to the time when it is your turn to vote. You are old enough, then you get to a [polling] place, and nobody knows how to use [the machine]. I cannot access it. The things we have—ballots at home is great. But having that experience of going into the polls or going into jury duty—maybe even getting called to be on a jury. It is that continual lack of compliance with ADA; these are federal laws. Why does that happen? Why is that even an issue that there is not an interpreter present for jury duty?

Ms. Fried:

Yesterday, the woman I spoke with said, "Do not worry, you are excused." And I said, "No, you do not understand; I do not want to be excused. Maybe you are used to excusing people—or people want to be excused—but I do not want to be excused." What are you trying to say to me? Am I less than? I cannot serve on a jury because I am deaf, so I am excused? I felt like everyone else gets to go to jury duty. Everyone else who is hearing, they have the opportunity to serve.

Ms. Officer:

The standard practice is the problem. The standard practice in the State of Nevada is they do not have to adhere to the ADA. That is what needs to change.

Senator Spearman:

Thank you. I want to say, in the absence of the perfect system, I would encourage you when your sample ballots come in to look at that and mark it. I believe you can take that in the booth with you. Am I correct? I believe you can take that sample ballot into the booth with you. You have what you want to do on the sample ballot, and you can do what you need to do—if you go into a polling place. The other option would be, if there is no one available or you cannot get to a polling place, then when the real ballot comes in, all you have to do is fill that out according to what you have already put on the sample ballot. Does that make sense to you? That is not perfect, but as I said before, I advocate for vote by mail because it eliminates some of the barriers. And interpreters—we do not have enough in Nevada, and we do not pay enough either. So, until we get to that point—the thing about voting is when you vote, your voice is heard. When you vote for someone, and they advocate for what you advocate, or do not, or they are neutral—you have a say in who gets there. So, I would encourage you all to use those provisions the State has afforded you, until we get to a place where someone can meet you at the polling place.

First, you will receive your sample ballot; and that is also available online. If you cannot access it online, then use the paper ballot. You can sit there and discuss with whomever you have your political conversations with to figure out who you want to vote for, and mark that sample ballot; and when your official mail in ballot comes, you can fill that out. If you elect not to fill out the official mail-in ballot, then what you have to do is take that with you to the polling place, so it can be destroyed. You cannot do both. If you decide to go to the polling place, you can take your sample ballot—the sample ballot only. You can return the mail-in ballot or take it to the polling place, and drop it [off]. You can do that; you can have that experience of going into the polls, and I would encourage you to please do that. One of the reasons why we did that was to make sure communities that were challenged with mobility, sight, hearing, or other challenges—to make sure there was a way for them to vote.

Mr. Wilcox:

Can I respond? I wanted to have Catherine Nielsen here from the Governor's Council of Developmental Disabilities to come and address one aspect of what you are talking about, because she was working with us on this exact issue of voting. I think she wanted to respond to one aspect of what you just were talking about.

Chair Spearman:

We have them on Agenda Item X.

Catherine Nielsen, Executive Director, Nevada Governor's Council on Developmental Disabilities, Department of Health and Human Services:

I am also a Commissioner, if that makes a difference—whatever works for you. I was going to say, I am also a Commissioner for the Nevada Commission for Persons Who Are Deaf and Hard of Hearing. I wanted to make note that there are two parts of the online voting system. Yes, you can mail it in, and yes, you can take it with you, but there is also the opportunity to cast your vote online as well. That is another opportunity. But the biggest [issue] we have is the mail in ballots that come are in English; and therefore, a lot of individuals who utilize ASL as their primary language do not or cannot understand the ballot. Ms. Officer was mentioning some of the projects we are working on, and we are working with Mark Wlaschin, from the Nevada Secretary of State's office, to produce more videos. We currently have several that talk about the election cycle, and on those videos, we have an individual who is utilizing ASL to help communicate some of that. We understand some of those issues revolve around not knowing who to vote for, as far as who is a candidate. What does the Governor do? What do our Senators, Assemblywomen, or Assemblymen do? We want to try to educate the community, as you said, so they can be as involved as possible with their voting and being a part of the election cycle.

Chair Spearman:

Thank you. We have until November. I think one election will take place in June, but then you have another one in November. However you can schedule that so you get maximum participation with the tools we already have in place, I would encourage you to do that. I think our Legal [Counsel] has a comment.

David Nauss, Deputy Legal Counsel, Legal Division, Legislative Counsel Bureau:

Just a clarification on SB 203. The original bill provided for a study on the feasibility of establishing a public school for pupils who are blind, visually impaired, deaf, or hard of hearing. That study was amended out before the bill was enrolled.

Chair Spearman:

Voting matters. Any other comments or questions? [There were no additional questions.] Thank you all. I appreciate your indulgence. I am sure the enlightenment will not be in vain.

AGENDA ITEM VIII—OVERVIEW OF STATE AND NEVADA ASSOCIATION OF PROVIDERS (SNAP) AND BARRIERS THAT PREVENT ACCESSIBILITY FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

[This agenda item was taken out of order.]

Chair Spearman:

We will go to Item VIII, overview of State of Nevada Association of Providers (SNAP) and barriers that prevent accessibility for persons with developmental disabilities. Mr. Boyack, please begin when you are ready.

Nate Boyack, Executive Committee Member, State of Nevada Association of Providers (SNAP); and Executive Director, Bringing About Independence (BAI):

I am on the Executive Committee of SNAP; and the Executive Director of BAI, which is a residential services provider in Las Vegas.

Madam Chair, Vice Chair, and Members of the Committee, I appreciate the opportunity to speak to you today about people with developmental disabilities, both in the residential and in the jobs and day training setting. I would like to start off the presentation today with a short video that gives a little bit of background about the services we provide as agencies and organizations. (Agenda Item VIII)

[Mr. Boyack played a video for the Committee; transcribed as follows.]

TROY FRIDEN, CHIEF EXECUTIVE OFFICER, NEVADA PROVIDER:

The day to day of a person's life at home includes meals, laundry, chores, activities, laughing, and learning. The objective of the caregivers is to keep the individuals safe and progressing towards their goals of becoming independent. Having staff who are rested and who have the energy and enthusiasm to carry out activities, to run plans, to work through difficult days, and to still stay positive is key. Individuals who are given consistent care flourish.

Meet Cassie and Cece; twin sisters who are working on their goals of independence.

CASSIE:

We get up at 5 a.m. counting out the calories for breakfast.

CECE:

The eggs are 70 calories, [lemons] are 45 calories, and the yogurt is 80 calories. These are 50 calories.

CASSIE:

Since the pandemic of March, we have been doing this healthy lifestyle—1,500 calories.

CECE:

I was 303, and she was 304.

CASSIE:

Yeah, I was 304.

CECE:

And we lost over 100 pounds. I like how this—that they help us with our diet. They come a long way with our diet. They helped us.

MISHA, HOUSE MANAGER:

They do love to cook. So it is constantly teaching them—bacteria, after you cook with chicken. Make sure, while you are cooking, use gloves with the chicken—washing your hands. If you touch your phone while you are cooking, put the phone to the side. I have one, she constantly needs assistance because she does not even know how to boil water. So, we are here to teach her.

CECE:

Well, I just like living here. I love my staff. I love my House Manager. They help us get to learn new things; how to be a better person.

MISHA:

Currently, in our program, the four ladies that we serve, one of them out of the four could possibly live on her own, but also with assistance—probably check-ins maybe throughout the week. But the three other ladies would definitely need ongoing services.

CASSIE:

Well, there was an agency for people with special needs, and I was curious. They say you give money, but I did not know. They said if you get that money, you have to give them money. At first, I was curious, but I told staff because I felt guilty that I did something wrong. And then they told me that’s a scammer. I have to be careful not to give personal information out to strangers or people I do not know.

MISHA:

So, the two ladies that we serve are very high functioning. They are too trusting; and no matter what situation they are in, it is our job to make sure that they cannot trust everybody, and it is a constant battle. This is a very active house; these ladies love to go, go, go. Some of them, cleaning is not important to them. They are more excited about what outing, what dance, their phones, letting them know there are other things besides your phones. You have doctor's appointments, you have appointments, family.

ANOTHER STAFF MEMBER:

Okay. You did a great job.

MISHA:

This field is very rewarding; we are serving individuals. They are here for a reason. [Video intermittently cuts away to footage of a staff person helping Cassie and Cece.] If it was not for the staff—we are constantly learning through them. But at the same time, they are constantly learning through us. So, if it was not for a healthy team—a healthy house—you would not have a productive house running. These ladies would not be able to function in a normal [daily] life, if there was not people to help support them.

[Video transcript ends.]

Mr. Boyack:

I appreciate the opportunity to show you that video. I apologize that we did not have subtitles available; we will add that for future presentations.

I would like to discuss our services and the challenges we still face moving forward going into the next legislative session. I would also like to recognize that the Executive Director of our organization SNAP, Mary Pierzynski, is in attendance in Carson City. We appreciate her and her availability today.

We have two recommendations we would like to make to the Committee. The first being related to funding, and we really appreciate—you saw the services we are able to provide to the people with intellectual disabilities in the community through different jobs and day training. The last legislative session—thanks to the Legislature, the Governor, and the Governor's budget—provided for a significantly large rate increase for our direct care employees, which is fantastic; we are excited to see that implemented starting this month. There were a number of hurdles we had to move through with Medicaid and payments; and ADSD has been fantastic working with all the providers and different agencies involved to make that rate increase a reality. So, thank you very much; it is greatly appreciated, and it will help tremendously moving services forward. Related to rates and services, the Nevada Legislature in 2022 generously gave agencies a rate increase to pay their direct support workers more to help with the turnover and vacancy crisis that plagues the industry.

We recommend putting in place a cost of living adjustment (COLA) each budget cycle that takes into consideration inflation and the Consumer Price Index (CPI), so Nevada's disability services do not get behind pay scales again. Maintaining sufficient staff is crucial to ensuring the safety and well-being of the intellectually disabled—cared for by the providers represented by SNAP. Maintaining a livable wage for caregivers is imperative to keeping them in the profession. This most recent rate increase will allow our providers to pay our staff an average wage of $18 an hour, which is fantastic. We want to ensure moving forward—we have been working with the Legislature and the Governor's Office for years to get our direct care employees or direct support professionals to a wage that would be a livable wage. We want to ensure moving forward that we are able to continue that with the help of the State of Nevada.

There is one note related to the COLA request, and we want to make sure the Committee and everybody involved is aware that our services are funded by Medicaid. The State administers the service, but the majority of the funding actually comes from the federal government, through the Federal Medical Assistance Percentage (FMAP) match. That percentage ranges anywhere from typically 65 even up to 80 percent. It moves based on federal regulations and different funding levels available for the State. But in essence, the federal government picks up two-thirds of the cost of all the services. For every dollar that is spent by the State of Nevada, the federal government reimburses anywhere from 65 to 75 percent—typically—for those services. That is definitely something to keep in mind. The State of Nevada gets great value for every dollar it spends on services for people with developmental disabilities. I will pause there. Does the Committee have any questions related to funding, direct support staff, or the services we provide? I have one other issue I would like to bring up, but I would like to see if there is anything before we move on.

Chair Spearman:

Thank you. Committee Members?

Vice Chair Brown-May:

Thank you, Mr. Boyack, for being here to present. I know you know this is a personal issue for me and my employer, and I have spent many years supporting this population of folks with special needs. I appreciate the information you have brought. I have relative questions about the direct support professionals you are talking about. You noted that the rate increase will help with turnover. Can you talk to us about that? What is the current turnover rate of direct support professionals, or vacancy rates providers might be experiencing?

Mr. Boyack:

During the pandemic and shortly after, we were seeing turnover rates of up to 140 percent of employees; that has since come down. We were able to see a bit of a rate increase this past July [of 2023]; that brought our turnover rate down to just under 100. I think we are between 90 and 100, and this is across all agencies that are members of our provider group. We have over 20 agencies throughout the State that provide services. I say under 100—we are happy it is moving down, but 100 percent turnover is still not good. We anticipate with the rate increase that recently went into effect, we would see that number come significantly down even more. Honestly, there is always going to be turnover in the profession we work in. Probably a healthy turnover rate would be about 50 percent; we still have a ways to go before we hit that. Our vacancy rate varies based on the provider. Some providers serve people with more behavioral or medical challenges. Their turnover or vacancy rate for employees tends to be higher than other providers that do not serve those people who have significant issues and challenges.

Vice Chair Brown-May:

Thank you for that. Earlier this morning, we heard public comment from a person who has a family member diagnosed with autism. What is the need? That is the question. Do you know how many people would need this service? Would that person who was described this morning fit into this type of service you provide?

Mr. Boyack:

The current waitlist—and that type of information—we would need to obtain from ADSD. They have been very forthcoming with our organization as far as where the needs are and where providers would be able to help. The gentleman who testified with the family member who is diagnosed with autism is dealing with significant challenges and barriers to getting services. I would definitely have them continue to work with the State and the Legislature to make sure those services and the providers are available to be able to provide the care necessary—to see the success we all want to see for everybody with special needs and those types of diagnoses.

Chair Spearman:

Additional questions? Up north? Assemblyman Gray, did you have a question?

[There were no additional questions.]

I do not have a question, just a comment. I thank everyone who is in that space helping those have a better quality of life. I know every session we wrangle and wrench our hands trying to make sure we are stretching every penny of the budget. Let us keep hoping, and rest assured that we are working to make sure we make things right and comfortable for folks. Sometimes we do not get all the way to 100; we might have to get to where you want to go incrementally, but we will work hard on that.

Mr. Boyack:

Madam Chair, we appreciate it; thank you very much. The last recommendation I have kind of ties in with housing and some of the issues we saw in that video. The two twin sisters lived together for many years, but one of them had wanted to move to her own apartment for a number of years. We were actually able to make that happen for her about six months ago; she was able to move out into the community into an apartment with another friend of hers. That has been a really exciting and challenging situation for her, but it has been great.

One of the main challenges the providers are running into now is the availability of housing—and the opportunity we are able to have for landlords, investors, and these large-scale companies to come in and keep agencies like ours from supporting people with developmental disabilities in the community. State of Nevada Association of Providers recommends State legislation to prevent companies and landlords from discriminating against people with developmental disabilities when searching for community housing. State of Nevada Association of Providers agencies contract with ADSD to provide services for intellectually disabled individuals throughout the State of Nevada. Recently, increased housing costs and the scarcity of rental properties has made it difficult for individuals with disabilities to obtain appropriate housing. Many property management companies will not consider applications from the individuals we support, nor from the companies that assist them. Recently, one of our provider agencies was forced to move from a home they had been in for over nine years, as the owning entity refused to continue the lease.

As a SNAP organization and as the Executive Director of a residential service provider, we found this appalling that there was a company that refused to renew the lease. There were corporate structure and liability reasons for the requirement to change the name on the lease to a business name, to support four individuals to continue to live in the community—who lived in this home for over nine years. The rent was paid on time. Utilities were paid on time. They kept the house up very well, as you can see in the video; the types of homes that our individuals live in are very well kept. We have direct support professionals there all the time, and the company came back and said they were unwilling to renew the lease. The individuals that are supported in that home do not qualify financially based on the requirements of the management company. When asked if the company could cosign for those individuals, we were told "no"—the company was not allowed to cosign and there was a notice to vacate that was issued to the organization. Basically, right before the holidays, these individuals through this company were told they were going to have to move within 60 days. That is one of the challenges we run into. We would like to address that with the Committee. We feel there are federal and State laws and legislation in place already to protect people with developmental disabilities in this situation. But we feel they may not go far enough, or there may need to be other legislation put in place in order to protect people to continue to live in their homes in the communities.

Chair Spearman:

The federal legislation you talked about—if you could get that to us, so we could take a look at it. Everybody is having a problem with rentals, because I think it is something like 60 percent of the houses—at least in North Las Vegas—are owned by corporations. There are very few "mom and pop" [rentals], but let us see what we can do. I think we have an obligation to do all we can do.

Mr. Boyack:

Thank you, Chair. We appreciate the Committee's help and willingness to look into this. We can get you the information for the Federal Fair Housing Act. I think [Chapter 118 of NRS] addresses discrimination, as well. We are not necessarily talking about just the financial aspect; ADSD in the State is very generous with helping to find people with developmental disabilities housing and helping supplement the costs for that. But it is the actual fact that when we go to apply for the housing, we are being told "no"; they will not even consider our application because of the situation we are in. They say they will not rent to corporations, and they will not rent to people with developmental disabilities if they do not qualify financially. My agency personally had reached out to a number of organizations. The agency I described was actually the agency I am the Executive Director for; when trying to find another home for these four individuals, I reached out to a number of property management companies. We are looking for a four-bedroom, single-story home; and they are available for rent. If you look on the market, they are available. We would reach out, fill out the online application, go into the discussions a little bit further, and they say, "No, we are not going to even consider your application; we are not going to rent to you." That is where it stopped. We are trying to find legislative backing and some additional force that can be put in place—at least, for these companies to be mandated to see and recognize our applications for these people. They cannot fill out the applications on their own. Financially, they are on Social Security. They make minimum wage, typically, so they do not qualify; and we understand the financial qualification aspect of it. That is where our companies come in and are willing to cosign the leases. We are able to guarantee the payments to these organizations, but they are still telling us "no"; they will not even consider it. So, Chair, I would be happy to get you any information the Committee would desire related to this issue.

Chair Spearman:

Thank you so much, and we will do what we can do.

Mr. Boyack:

Thank you. Any other questions? [There were no more questions.] Madam Chair and Committee, thank you again, and thank you for the opportunity to move it up a little bit in the presentation. I appreciate it.

Chair Spearman:

Not a problem.

AGENDA ITEM IX—PRESENTATION ON ACCESSIBILITY IN THE LEGISLATURE FOR ADULTS WITH DISABILITIES

[This agenda item was taken out of order.]

Chair Spearman:

We will now move to Item IX, presentation on accessibility in the Legislature for adults with disabilities.

Lance Ledet, President, Hearing Loss Association of America Southern Nevada Chapter (HLAASNC):

Thank you, Madam Chair. I am going to share my screen (Agenda Item IX). Before I begin, I want to let everyone know I was appointed to the Deaf Commission at the end of February, and I have not been able to have a meeting with the Deaf Commission to go over the recommendations you requested in the email. I do not feel comfortable giving recommendations from the HLAASNC until I at least speak with the Deaf Commission in a meeting next month on [May 8, 2024]. But I will give a few recommendations the HLAA had prior to my being appointed to the Deaf Commission. Joining me is Deanna Gay, the Vice President [of the HLAASNC]. Deanna joined with me a little over a year ago.

In 2018, I started this Chapter; it is part of the National Chapter. A little bit about HLAA—the mission of the HLAASNC is to open the world of communication to people with hearing loss by providing information, education, support, and advocacy.

While we are on this topic, I loved the presentation Eric gave earlier when he mentioned cultural competency, and one of your replies was, “What can the Legislature do?” To give you a quick example, something that has been going on for about two years now—I am also the Chairman of the Assistive Technology (AT) Council here in Nevada. The last legislative session, several individuals complained of not having closed captions during the legislative session. That seemed to be a big issue during that time.

We have a support group every other month; and we provide information, education, support, and advocacy as often as we can. Our primary purpose is to educate ourselves, families, friends, and coworkers. We keep up on the latest in assistive technology. We provide technology and medical advances to all individuals with hearing loss. We are primarily oral; the support group is more set up to help individuals with hearing loss. Some chapters across the nation of only about 5 to 7 percent do support ASL, but they are very large. Right now, the HLAASNC is trying to build themselves back up; the COVID-19 pandemic really hurt us. We are down to 178 chapters nationwide; before COVID-19, we had over 460 chapters, I believe. We are doing a lot of outreach and trying to get the HLAASNC back up to where it was prior to COVID-19.

Another problem—the original presentation I sent, I have to apologize, there were modifications made that I did not notice. I am not sure how they were made, but I can understand if there was an issue.

I do want to talk about cultural competency. Deanna and I both wear bilateral hearing aids. Neither one of us requested CART in this meeting. To give you a small example why closed captions are so critical. Right now, at the bottom of your Zoom screen you can see the “more” option—you may have to move your mouse. In most cases, anyone who holds a Zoom or a Teams meeting, they will have the closed caption radio button engaged for an individual who may have hearing loss, who may not need CART. If I would have requested CART, you would probably have had to pay a couple hundred dollars or more to have CART present to do captions. Whereas, if you had the radio button turned on, I could have clicked closed caption and turned the closed caption on without any problem, without anyone even knowing. I think that is very important. I think all councils and commissions, if they do not have CART or if no one has requested CART, I think it would be a great idea to always have the closed caption activated. The closed caption I am talking about is the free closed caption that comes with Zoom or Teams. You turn it on; that is all you do, but you have to do it prior to the meeting starting.

I am not going to keep everyone; I know you are tired. Regarding support and advocacy, we support everyone who emails us and requests anything. We go out of our way to help everyone. We have an annual convention each year; this year it is in Phoenix, [Arizona,] and I will be attending. These meetings are a great wealth of resources about assistive technology. I cannot stress enough, anyone who wants to learn more about hearing loss should definitely attend these meetings each year at the convention.

Membership—they changed since COVID-19. You can pay as little as $5 to become a member. If you want to be a true member, it is $45 a year. You get the *Hearing Life* magazine seasonally. That is something you get becoming a member.

You can see there are not many chapters left since COVID-19. We are the only one in Nevada, but we are trying to get up to at least three. We hold our virtual meetings bimonthly on the same day; the second Thursday each month.

Key activities—Walk4Hearing is the largest event of its kind for people with hearing loss. It is held in cities across the country. I have been trying to get it here in Las Vegas for a while, but they are wanting to build it up a bit larger before we are able to do it. Hopefully, we are wanting to do it in 2025 to 2026. Hearingloss.org is our main website. "Get in the Hearing Loop" talks about hearing loops you can use in government buildings, which is something I would like to talk to the Deaf Commission about next month.

Hearing help—this [slide of the presentation] talks about basic hearing symptoms. All of the links work on this website. If anyone would like a copy of it, I will be more than happy to share it with you.

If you think you have hearing loss—Eric went over all of the symptoms about hearing loss in his presentation. Basically, they covered a lot of the things I was going to say. I left all of the links here in [the slide titled] "Technology." The one thing I did want to mention, when it comes to assistive technology—I am not sure if it is possible with the upcoming legislation. I know, recently, if you have Medicaid and you have hearing loss, you can get a pair of hearing aids. I would strongly urge the Legislature to please consider the possibility of allowing an individual with hearing loss to have a choice between either purchasing a pair of hearing aids or purchasing a pair of the new closed caption glasses. They are called "XanderGlasses." There are no wires. It is literally a pair of glasses you put on—you charge it overnight—and when people you are looking at talk, you actually are reading the captions going across the screen on the glasses. Many of the people I have helped, who have emailed me—I help if they are looking to purchase hearing aids, or looking for a better way to hear due to the type of hearing loss they have. A lot of them are beginning to opt to get the glasses rather than getting the hearing aids. The main reason is the glasses are not as affected by humidity as much as the hearing aids are. My hearing aids I wear—I have to replace them every four years regardless of which state I am in. These glasses are very expensive, but they seem to last at least ten years or more.

I have some videos in here; I am not going to play them—I know everyone is tired. But they are great videos. Eric went over the different types of hearing aids earlier. There are cochlear implants, inner ear implantable, and osseointegrated devices, which are surgically embedded in the outside of the person's skull. It is a type of cochlear implant that has a processor, which helps someone know which way the sound is coming from.

Anyone needing more information, feel free to contact Deanna Gay or myself. A few more things I would like to mention—I strongly think closed captions, like I said earlier, should be on at all times, even if CART is or is not being provided. Some people can get by using the closed captions. Like now, I know Deanna and I were texting, and if we would have had closed captions here—I think Deanna used up the 603 minutes she had on Otter, and I used up the free minutes for the month on Ava. We were chatting about it all. It is simply turning on. The closed caption glasses technology was released last year; I had a chance to try that in 2021 when it was a prototype. It is truly amazing. They even have additional features with some additional companies making them. If Medicaid could have a way to give someone a choice or the options to go either way, it would benefit a lot of people, especially those with sensorineural hearing loss.

The only other thing I want to bring up—until I meet with the Deaf Commission next month—is in the 2023 Legislative Session, we had several people who were members of the AT Council. They did not have hearing loss, but they needed close captions due to their disability. They were struggling. They wrote many letters to several people in the Legislature trying to get something passed. I am not sure if that is something you can do for everyone or for every single video. That is feedback you had asked for that I feel comfortable sharing at this time. Any questions? I am going to end for now.

Chair Spearman:

Vice Chair.

Vice Chair Brown-May:

Thank you, Mr. Ledet. We are happy you are here. We are sorry it took us so long to get to you this afternoon, but we appreciate your patience. You and I have had an opportunity to work pretty closely together with regard to some of your recommendations. We have here a device—I am sure you can see on video—that is the current adaptive technology available to us as Legislators and the general public, which is that amplified hearing device I shared with you some time ago. Do you have a recommendation for a different type of device to help us become more accessible for people who are hard of hearing?

Mr. Ledet:

Does the device you are holding in your hand work with a hearing aid or without a hearing aid?

Vice Chair Brown-May:

This device works without a hearing aid. Actually, Senator, do you wear a hearing aid and this device?

Chair Spearman:

No.

Vice Chair Brown-May:

Without.

Mr. Ledet:

Just making sure, because I saw the device you sent me, and one picture I saw said it was a telecoil (T-Coil); that confused me because that needs a hearing aid. What you showed me is similar to what they call a “pocket talker” [a portable personal amplifier]. Depending on the decibels (dB)—they do make a Pocketalker 2.0 that I have tried. It works very well. It is probably the loudest out of all of them, and it is completely adjustable. That device works without hearing aids, as well as with hearing aids. When it comes to someone who has hearing aids who wants to hear in a government building better, whether they have Bluetooth or a T-Coil, that is a whole other story. You need a completely different device depending on the hearing aid or cochlear implant type. But the Pocketalker 2.0 would be a good device. It is much better than the one you just showed me, because it has two speakers—one on each ear.

Vice Chair Brown-May:

Thank you for that. I am curious to know—we did a bit of research—we do have adaptive technology available, in the legislative buildings in particular. Is it that we do not, as a general public, know we have adaptive technology available? Maybe a sign at the front desk; would that help us to direct people? Do you think that could be a viable solution as we continue to explore technology?

Mr. Ledet:

That is a great question; I am going to give you more than one answer to that. Number one, a lot of audiologists forget to educate their clients on what comes with their hearing aid and what their choices are. Their choices are either to get a T-Coil, Bluetooth, or both. I decided to get both of them. If they do not educate them and tell them what the T-Coil does and actually show them—90 percent of the audiologists in the State do not have a way to demonstrate a T-Coil at their office, believe it or not.

Having a sign would be very helpful. You would also probably want to have a brochure next to it, maybe in plexiglass, saying, "If you are wearing hearing aids or cochlear implants, simply engage your T-Coil." You may still have someone ask, "What is a T-Coil?" because [T-Coils] were not explained by their audiologist—if that actually works with their hearing aids—due to the fact that the audiologist does not have a way to demonstrate it when they sell the hearing aids. That is a big problem here in Nevada; the audiologists do not demonstrate the external devices you can use with your hearing aid. You have many different types of neck loops for Bluetooth, for T-Coils; you have different devices such as little pin speakers, the conference table, transmitters, and receivers. They do not tell the individual any of this. Those extra devices, even though they cost $200 or $300, they make so much of a difference in helping someone hear. It is a shame the audiologists do not go deeper into what can connect to the hearing aids they sell.

Chair Spearman:

Thank you. Additional questions? Any questions in Carson City? I do not see any. The adaptive device the Vice Chair held up was something I used to use. One of the things that occurred to me—and I was told by someone who tries to follow us online about three or four years ago—when people who came to the table and some of us on the dais did not speak loud enough, it was difficult for them to hear. I always try to announce that at the beginning of the meeting, so people are aware that there are folks who are listening to us online. If they are listening to us online, they do not have the adaptive device. If people do not speak clearly and into the mic, that might be a problem. Thank you so much, sir.

Mr. Ledet:

You are very welcome; thank you.

AGENDA ITEM X—OVERVIEW OF NEVADA GOVERNOR'S COUNCIL ON DEVELOPMENTAL DISABILITIES (NGCDD) WITH EMPHASIS ON THE FIVE YEAR STATE PLAN

[This agenda item was taken out of order.]

Chair Spearman:

Let us jump to Item X, overview of Nevada Governor's Council on Developmental Disabilities, emphasis on the Five-Year State Plan.

Catherine Nielsen, previously identified:

Good afternoon, [Chair] Spearman, and other Members of this Committee. I have with me today—

Alysa Marquez, Intern, Nevada Governor's Council on Developmental Disabilities, Department of Health and Human Services:

I am presenting with her, and I am the intern for the Council.

Ms. Nielsen:

Alysa is going to help me run my PowerPoint today; she is our main intern for the office, and she absolutely loves doing that work for us (Agenda Item X). I am first going to provide you with a few statistics. I know you all heard a lot today, so I am going to do my best to try and keep them short, sweet, and to the point. A lot of the statistics are from the CDC's most recent data they put out in 2021. In our State, for adults with disabilities, we have: 29.9 percent have any disability; 13.9 percent have a cognitive disability; 6.8 percent have a hearing disability; 13.8 percent have a mobility or physical disability; 6.3 percent have a vision disability; 4.7 percent have a self-care disability; 8.3 percent have an independent living disability; and 70.1 percent have no disability at all. I also provided you with hard numbers [on the presentation slide], so you can see exactly how many individuals you are representing when making these decisions. I also provided you with data. The printout you have does not have this data because the day we turned this information into Ms. Cooper, the Residential Information Systems Project (RISP) *State Profiles* data were released, as well. I wanted to add this, and you can also look this up on the RISP *State Profiles* data for Nevada that was released last week.

As of 2020, a majority of the individuals with disabilities are living in their family homes, some own their own homes, a few live with host or foster families, and a small number live in group or residential care facilities.

The goal of long-term services and supports (LTSS), which is a unit of Nevada Medicaid, is to support those individuals who need ongoing care due to age, physical or intellectual disabilities, or chronic illnesses. It is a comprehensive service that delivers in-home and community-based settings, or long-term care facilities, depending on the needs or preferences of the individual—as you heard a lot today about home and community-based services.

The other piece is also from the RISP data, and this is the status of Nevada's Medicaid recipients, as reported by ADSD. The second chart shows you, over time, the number of people that are served by our State Intellectual or Developmental Disability (IDD) agencies—the number of people receiving one or more long-term support services. This is in addition to those who receive case management and the number of people with IDD that are currently waiting for Medicaid waiver funded services while living with a family member in their own home. This information was reported directly from Medicaid, so I will not speak on their behalf, but this is something you can look up, available on the RISP State profiles.

There is an average amount spent per person by age and by setting that is reported by Medicaid, as well. Currently, in the State of Nevada, we have one State-run Intermediate Care Facility (ICF), which is located in Southern Nevada; that is the Desert Regional Center. An ICF/IDD can also mean a smaller setting, but essentially, an institutional-like setting. We currently spend, on all ages, $224,571 per year per person. If we serve these individuals with a waiver, we are only spending about $57,720; that is for home and community-based services for all ages. There is not much of a difference for those that are considered [age] 22 and up, because below the age of 22, they are typically served within the school district setting. We also provided information on those who do not live in a family home; it is slightly more expensive for us to provide them with services. But for those that are living in their family home over the age of 22—mainly host home providers and family home providers—we are only spending roughly $14,724 to serve them. As of right now, there are a lot of agencies that do not pay family home providers; but the few that do are obviously [offering] a dramatic savings, financially, by ensuring the families or those that support these individuals are reimbursed for their services to these individuals; rather than paying somebody from outside the home to come in and provide those services.

You asked us to talk to you about our key Council activities. I have presented here a lot in front of the Legislature, so I am sure you know who the Nevada Governor's Council on Developmental Disabilities (DD Council) is. We are authorized by the Developmental Disabilities Assistance and Bill of Rights Act (DD Act), but our purpose is to independently educate the Governor and the Legislature on public policy issues. Any time we testify, we try to make sure it is education and advocacy based, in the sense that we voice the community's concerns if they bring them to us.

We also engage in community advocacy, systemic change, and capacity building activities. We do so through a lot of different community events—trainings like our Partners in Policymaking, et cetera—where we educate individuals with intellectual and developmental disabilities or their family members on how to be active in policymaking. The other focus is on individuals with intellectual and developmental disabilities and their families, as well as the community that supports them. Sixty percent of our Council is made up of IDD individuals and their family members, so they always have the voice representing what is being changed for them.

We gather input from the community on services available, any barriers they faced, and we create a Five-Year State Plan to address the most pressing issues that are identified. I will talk to you about how we do that, when I identify what the top barriers are that have been identified as of this year. These are all outlined in the Developmental Disabilities and Bill of Rights Act—we cannot randomly pull up these topic areas; they are those that are identified federally.

People with long-term intellectual and developmental disabilities and their family members will be full and equal participants in decisions that affect their lives. I am sure you have heard the term "nothing about us without us." Essentially, we promote the term "nothing without us," because every part of human life encompasses individuals with disabilities. So, you should be having no discussions, plans, events, without ensuring that you are including the disability community.

What are the top areas gathered for our current Plan? The last Five-Year State Plan that started in 2021 and ends in 2026—the top areas we have identified are employment, health, education, quality assurance, transportation, and housing; and those were identified by the community themselves.

We were asked to identify what the top barriers are to accessing these areas of emphasis. Number one is always long waitlists for services. That is the biggest piece we hear all the time—long waitlists, everywhere we go; whether or not they are approved, or whether they are approved yet waiting for a service.

We also hear that not knowing what services are available [is a barrier]. It was mentioned earlier about not knowing where they [should] go or who handles what. We know that is a barrier, and we are currently working with ADSD and other State agencies to streamline that process; so, when somebody applies for a service, they apply for one service and, therefore, they get to know what all the other services are that they qualify for with a one-stop shop.

[Another barrier is] not enough services or supports for residential, assisted living, or other housing options. We understand that, as well. We are working with the Guinn Center to produce a report that talks about the landscape of housing, currently—hopefully, that will be released in June. It talks about all of the different housing options, barriers to accessing housing, and what is currently the landscape for anybody who lives in the State of Nevada to access housing, as well.

There is not enough accessible or affordable transportation options. I am sure this is something you hear a lot. We are a primarily rural State; and we do not have any sort of coordinated transportation systems; especially something that leads from the South to the North. You could drive from Las Vegas to the Fallon area and pass less than a dozen people, especially if you are driving in the middle of the night. It is very hard to reach between the South and the North, and a lot of people end up leaving the State in order to get services; because it is simply quicker to head over to Utah, Arizona, or California from the various areas than it is to go to the other half of our State.

There is not enough—and people cannot access—coordinated health, dental, mental health, and any other human and social services. As you heard from ADSD earlier, we are working extremely hard to expand services and, especially, waiver options for those in Nevada. They have added things to dental health to expand those services, but we are working with the other areas, especially areas of mental health to ensure those with IDD are addressed. As you heard from the gentleman prior—dementia being a very large topic here. Right now, a lot of individuals with intellectual and developmental disabilities—and primarily those with diagnoses such as Down syndrome—do go on to develop dementia. It is a project of our office to make sure we offer, not only screening tools, but training for support providers and service providers in the industry.

We do not have enough transition services from school into adulthood. Currently, a lot of individuals, especially those who are deaf and hard of hearing—or for those who have a lack of family support—are not getting information on transition, especially their transition options. If they do get information on transition, it is very limited, and it is usually coming directly from the teacher. The school districts are not held responsible to make sure transition services are provided. Nevada Vocational Rehabilitation is working on the Pre-Employment Training Services (Pre-ETS) for transition, but this fails to address any of the students who maybe are not considering employment directly after high school. We want to make sure you know we are working on educating as many of the students and families on their transition options, and also the professionals who work alongside of them, so they can help encourage that, as well.

One of our key projects under that is our Youth Empowering Students (YES) program, where we have young adults who go into the schools and teach them for us—because I am sure they are tired of hearing from mom and dad and all the rest of the professionals in front of them. But they listen a lot better to their friends and their peers; so we have peers going into the schools to teach about that.

We do not have enough services or supports for getting or keeping a paying job. That also leads into the supports that Nevada Vocational Rehabilitation is expanding right now. We are working with them to help ensure there is access to employment across the spectrum. As of right now, a lot of employers hesitate to hire people with disabilities, and it is usually for a lack of—not knowing the information out there, statistics; the general understanding of how to hire and keep somebody employed with a disability.

We are working on the Employment First coalition. I have been working with a couple of your past Legislators, as well as Governor Lombardo's office, to see if there is a possibility of us moving forward with the Employment First initiative in the State. Governor Sandoval did sign an Employment First initiative several years ago that was not carried through Governor Sisolak's time in office. We are hopeful that Governor Lombardo, as supportive as he is on employing the State of Nevada, will continue to support that effort, as well.

Obviously, we have a lot of Hispanic and rural communities—and I should have added to this that the tribal communities are also lacking in a lot of the areas of emphasis. We are working to ensure we reduce a lot of those barriers. We provide all of our information in as many languages as possible, including ASL and braille printing. We also try to do coordinated outreach to the rural communities, where we go in person and see them.

We have started our Five-Year State Plan initiatives for the next Five-Year State Plan, where we are gathering input from the community right now on the different areas they are currently lacking in, in the State of Nevada. A lot of the comments we get are [concerns] related to other State agencies, not necessarily ours. We have been working to share that information with the other State agencies, about any comments that maybe impact their service delivery. As of this morning, we have more than 400 responses to our survey.

We have some key activities. I am missing a slide here, but the top areas of emphasis gathered for our current State Plan roll into what we are gathering for our next State Plan, as well. Some of our key projects—obviously, work on policymaking education. We try to come here as much as possible. Any time there is a bill that impacts the disability community, our Council, or any State employees; we try to be here to provide policymaking education. But we also try to not take the voice from people with disabilities. So, if they would like to come here themselves; they may ask for financial assistance for transportation to be here. We try to make sure that is coordinated for them, so finance is never a reason not to make sure their voice is heard. We do our Partners in Policymaking education, as well.

We have Council and Committee participation. Our Council is fully committed to ensuring the lives of people with intellectual and developmental disabilities are addressed in all areas of the State and the State's work, as well as our Committee members. We have individuals on our Council that represent most of the State agencies like ADSD; DWSS; Maternal, Child & Adolescent Health (MCAH); et cetera.

We also try to reduce barriers to accessing information. You heard a lot from the deaf and hard of hearing community and those who are blind and visually impaired. They have an extremely difficult time accessing information; much more difficult than it should be. We have worked a long time with a couple of your Legislators who are actively pushing for language access, especially last year. A lot of the bills were talking about ensuring that we had access to the top 12 common languages in the State of Nevada but failed to address ASL as being a language. I cannot off the top of my head remember which one of your Legislators sponsored the bill—but there was a Language Access Plan that actually did—and was amended to include visual languages, as well as written and verbal.

We also work on community education activities; we try to educate the community as much as possible in different, various aspects of the disability community. We do a leadership training; we try to train the leaders in our community to be more involved in their policymaking with the youth in our YES program. We also have our Partners in Policymaking, which is for any adult over the age of 18 to participate in policymaking activities. We hold Lunch and Learn webinars, which we have throughout the year that are held from 12 [p.m.] to 1 p.m., multiple times a month on various topics. We have had a lot of federal representatives come and present to our State during those Lunch and Learns. We hold our Silver State Self-Advocacy Conference; this year it is being held August 6 and 7, [2024,] in Reno. If you are available and would like to learn more about the disability community, this event is planned by and for individuals with intellectual and developmental disabilities. We invite you to come learn alongside the individuals you are making decisions on behalf of. On August 5, [2024,] we will have a Self-Advocacy Networking Night, which will offer the opportunity for self-advocates to come together.

Some of the key activities and projects include emerging needs, as well. We have been working with the Division of Emergency Management [of the Department of Public Safety] on emergency preparedness. We have been working on ensuring the access and functional needs population is included in all aspects of emergency planning. As of right now, the Federal Emergency Management Agency (FEMA) has eliminated the need for the G197 [Integrating Access and Functional Needs in Emergency Management] course in all states and has left it to the states to do that work. Essentially, the access and functional needs planning is left up to the states to determine if it is a high enough need or not. It is such a high need in Nevada that the last time we had a mass shooting at the end of [2023], there was a student that had disabilities who was unintentionally left in the building. We are working with UNLV to make sure that never happens again.

Self-advocacy organization support—there are a couple of self-advocacy organizations across the State of Nevada; we try to support them as much as possible. For instance, the Kiwanis Aktion Club of Carson Valley, out of Gardnerville—we have sent them to a couple of conferences to expand their knowledge. The Arc of (Southern) Nevada—we helped pay for their brochures and a couple of tablecloths, so they could reach out to the community and ensure they were networking with their community and building the new organization they have. We try to make sure self-advocates are at the top of everything here.

We work in cross-disability and cultural diversity. You heard a lot from the Nevada Commission for Persons Who Are Deaf and Hard of Hearing earlier today. We also work with those who are blind and visually impaired. We have also added a land acknowledgment to all of our agendas to ensure those who are in tribal communities have a lot of access to information and feel included everywhere we go.

We have other community projects and grants, as well. As of right now, we are working to reduce barriers to accessing transportation, which is the iCanBike Camp that we have put on. This would be the third camp we completed in Las Vegas. We have another one coming in Reno, where we teach individuals with disabilities, who are eight years [of age] and older—all the way up into their aging years—how to ride a bike. It is something a lot of people take advantage of, if they do not necessarily have that skill, or if they do have that skill and never use it. Talking about the lack of transportation we talked about earlier being a barrier, a lot of areas in our State, transportation shuts down at 5 o'clock. From 5 o'clock on, how do the individuals with disabilities get to a grocery store, go visit their friends, see a movie, go to dinner, get their meds from a store—anything of that nature? It is really hard. By providing another opportunity for transportation, like teaching them how to ride a bike, we have expanded those opportunities.

We have employment as one of our goals. In the past, we have provided training to employers to make sure they are inclusive in their hiring practices and that they have a diverse workforce. We are continuing to work on employment through our transition goal, as well as through some of our other grant opportunities.

We also would like to improve access to housing options. As we talked about, we will be utilizing the *Guinn Center Report* that is going to be available in about two months, which will talk about an in-depth analysis of the landscape of housing options here in Nevada. We have a long-term goal to increase access to housing options and to ensure that housing options are fully accessible to those with disabilities—as well as the rest of the community—and that they are integrated in the community.

We also want to increase access to quality services for individuals transitioning into adulthood. As we mentioned, our YES program is helping us do that, and we will continue doing that.

We have already started gathering input from the disability community. As I mentioned, we have over 400 responses as of this morning, and we released that survey in January [2024]. This has already been sent out by the whole State: Nevada Center for Excellence and Disabilities; ADSD; the Nevada Disability Advocacy and Law Center; Nevada Vocational Rehabilitation; and MCAH. A lot of the State agencies that serve the disability community are the ones collecting this information, as well as sending them our way. The survey is going to close January 2025. At that point, there will be a report released, especially to you representatives, on what the disability community is stating are their biggest barriers and what are the barriers for them at being able to access that. In March of 2025, we will have a draft plan for everybody to review and provide any public comments on.

Our current surveys identified several areas of need, and six areas of greatest importance were—as of 9 a.m. this morning, I double-checked those statistics—employment, health, education, recreation, transportation, and housing. The only one that changed from last time was recreation. We are trying to expand opportunities for recreation because recreational activities are not just about going out and having fun; they build a sense of community, networking, and skills that cannot be taught in a lot of other settings.

Our current survey has identified barriers to getting those needs. The biggest barrier is long waitlists for services. As much as we take a look at the numbers ADSD presented to you this morning, even one person on a waitlist is long enough to say we need to work on this; and we need to make sure we are addressing the needs of those who have the greatest importance for supported services.

We do not have enough school services or supports. You heard from the Nevada Commission for Persons Who Are Deaf and Hard of Hearing that we do not have a Deaf School. That is specific for those who are deaf and hard of hearing, and we have a lot of children inside of the school districts who are experiencing a great injustice. I tried to file a complaint with the U.S. Department of Justice (DOJ), especially on the status of our education here in the State of Nevada. I gave them exact verbiage quotes from paraprofessionals, quotes from parents. But unless we are able to provide them names of parents and students, there is nothing the DOJ is willing to do to move forward with that complaint. We put that on you to ensure NDE is held responsible for their requirements; and that they are the ones who are ensuring the school districts are listening and following the rules. The unfortunate mentality of our school districts in the State of Nevada, especially for those who are deaf and hard of hearing is, "They can't hear us, so what does it matter to them anyway?" These exact words have come out of principals mouths, out of Washoe County School District, out of paraprofessionals—teachers who are trusted to educate our students are talking about our students this way.

We do not have enough and cannot access recreational activities. Like I said, recreational activities are much more than going out and having fun with our friends. They build skills, a sense of community, and a network. There is not enough and they cannot access coordinated health, dental, mental health, and other human and social services. It is not changing; over the last six or seven years now, we have been having the same exact goal on our Plan. We do not have enough coordinated health. We are getting there on dental, but our mental health and human and social services are still greatly lacking; and we would love to see you address those needs. We also do not have enough transition services from school into adulthood. As we mentioned, we are working with Nevada Vocational Rehabilitation to address those concerns, and we commend them on their efforts and their work moving forward.

Specific comments on identified needs—and these are comments directly from the surveys themselves. Their statements are such things as: people are leaving our State at alarming rates to receive services. People have to leave Nevada; they need to go somewhere other than here to get a service. It is your job to make sure those services are supported financially, as well as the fact that their networks are built with sturdiness.

We do not have services that provide support to anyone with no habilitative needs, such as [someone] under the age of 55 without employment goals, or those that are over the age of 55. If somebody under the age of 55 does not have an employment goal, they do not have a service in order for them to go and get services provided to them. Those that are over the age of 55 have a lack of services, as well. You heard from the Sanford Center on Aging that this is something we need to address.

I already told you that deaf students, both children and adults, have a lack of services across the board, and even our own State is lacking in providing those same services. We have an interpretation team for the State of Nevada, but many individuals with disabilities, as well as other State services, do not even know they exist or that they could provide them with interpretation services.

Support to the teachers of those who have intellectual and/or developmental disabilities, especially those in the rural or frontier areas of Nevada, and those who provide the services to those who are deaf, hard of hearing are virtually nonexistent. There are no supports for our teachers, especially the teachers who want to do the work; especially the teachers who have their hands tied. If they say anything, they are going to lose their job. That is the problem we are left with now; every single story we hear from paraprofessionals and teachers is that they are afraid they are going to lose their job if they speak up, and that is not right.

We know affordable housing is scarce. It is scarce for everyone—every population, every person is having trouble accessing housing. With the Guinn Center's support and your support, we are hopeful we can make an impact on housing for everyone, especially those with disabilities in Nevada.

Transportation beyond Reno and Las Vegas is virtually nonexistent. This was a comment that was echoed at least 30 times in various different comments. We do not have anything outside of Reno or Las Vegas. We have no way to get from Reno to Las Vegas unless you fly, drive, or hitchhike through where they have the Clown Motel [in Tonopah]. We want to make sure we get some sort of work in transportation. If there is a way we can help support the Regional Transportation Commissions, they are doing great work to coordinate transportation.

Mental health is greatly lacking in every area for every person, whether it be in the prison systems or out in the community. Mental health is scarce everywhere. I know telemedicine is not ideal, but it is something that is helping bridge the gap here in the State, currently. More access to telemedicine services, especially mental health care, is something that has been identified as a way to bridge that gap.

We also have a lack of staff or quality staff. I have heard it a million different times that Nevada Vocational Rehabilitation really struggles to get or keep their rehabilitation counselors. That is not any different from other agencies. It seems that State employees—some of us realize we can make a lot more money working outside of the State or that the federal government typically pays a lot more to do the same job. We would like to see an increase for those that are State employees. The reason we do not have any staff is because you do not pay us enough to do this job. I have been in this room since 9 a.m. this morning, and it is almost 4 o’clock; and I guarantee a lot of people do not have that same desire to continue to fight and get paid hardly anything to do it. That is why we currently have a lack of staff. We also do not have a lot of quality staff. Our interpreters in the State of Nevada—the few of them that are quality—they really work hard, and they have to make up for the other ones that are not. A lot of our students in schools are the ones who get that biggest impact and biggest lack of quality in staff.

We have position statements—I am not going to read all of their topics, but you can visit them online. We have 19 total; and these are position statements that have been vetted—discussed thoroughly. They go through the history of the different topics, tell you where we are at with the State of Nevada, and then they make any policy recommendations on behalf of the intellectual developmental disability community. I am not going to read any of the names off for you, but they are all the various topics that impact everyone in this community. We are also adding emergency preparedness, community events, and disability policymaking as a position statement, as well.

The last thing two things I will talk to you about are suggestions to include the disability community in the Legislature. One thing they had asked for me to talk about today was how do we ensure we have more people with disabilities that are involved in the Legislature? The first thing you can do is change our *Constitution*; the language is disrespectful and demeaning. If we are calling people “deaf and dumb,” do you think they want to come and sit here in front of you? I know we are working hard to change our *Constitution*; so, I echo and I encourage you to continue to work hard to do that.

We ask you to also increase accessibility. I see for the very first time today, a sign language interpreter on the screen staying on the screen the entire time. There have been many times we have had people who are deaf and hard of hearing come to the Legislature, request an interpreter—even on our Deaf Day at the Legislature—and they remove the interpreter from the screen at various parts of hearings. Especially when it comes to your votes on the floor, there is no interpreter on the screen. So we want, urge, and beg you to please increase accessibility; provide interpreters, and provide them all the time. The fact that I have seen interpreters on this screen the entire day, I understand was probably a financial hit for you. But imagine what it feels like to come to this room, sit here in silence, and not have any idea what you are talking about.

Also, double check your links. Double check them on the agenda; sometimes they are broken. It happens to the best of us. Making sure you have somebody to double check those links—it happened at least a dozen times last legislative session [in 2023]. We are hopeful that with as many opportunities to provide our input, that those get checked.

Provide multiple options to participate. Just calling in on the phone to provide your comment is difficult for some people, but I love that you are also increasing access by allowing them to submit things prior, allowing people to come in person, Zoom, et cetera. That is really awesome.

Increase your building accessibility, as well. I love that you are doing a lot of work to improve the design. As you are including any sort of design builds or changes, make sure you are ensuring accessibility when you do that.

Increase opportunities. I would love to see you have interns here with disabilities. We brought our intern today, Ms. Alysa, because she very much enjoys being an intern with us and coming to the Legislature. She told me I could not run the PowerPoint today because that was her job. Last year, Assemblywoman Tracy Brown-May brought her in as intern, as well. I encourage you to offer that opportunity to your constituents. Ms. Krasner is our Senator up here; so we are going to see if we can get our intern into her office this year.

I talked about "nothing without us." If you are planning something, please make sure you are planning for the disability community. Universal design works for everyone. "Nothing about us without us" has now transitioned to "Nothing without us." Disability is a natural part of the human experience. It does not discriminate. It happens in utero. We still have to deal with disabilities when it comes to how we deal with somebody's human remains after their life, as well. From before birth until after death, it impacts everyone, and universal design can work for everyone.

Some of those key takeaways—and I am going to try and talk quickly, so I can get through this for you—is that the barriers are not changing.

Chair Spearman:

You said you had to leave, but we have got some questions. We can read the takeaways; they are on the screen now. First of all, let me say this, because I do not want anybody to go away with the wrong interpretation. The Legislature does not do the budget. The budget is done with the Legislature and the Executive Branch, and both have input in that. With regard to changing the *Nevada Constitution* that call people "deaf and dumb," I would encourage whoever said that to go to the new portion of the *Constitution* that was passed by the people in 2020. We got it in 2017, and we brought it again in 2019; it passed, and so then the people voted on it in 2020. It is the most expansive Equal Rights Amendment in the country. That is not my saying; that is other people saying so. So, there are a couple of inaccuracies that were made there. I would encourage whoever said that to go to that, because I believe we have we have done it.

[Assembly Joint Resolution 1 (2021) has been approved in identical form by the Legislature in two consecutive sessions; it will revise the terms relating to persons with certain conditions in the *Nevada Constitution* if approved by the voters at the General Election in November 2024. Senate Joint Resolution 8 (2019) amended the *Nevada Constitution* in 2022, guaranteeing that equality of rights shall not be denied or abridged by this State.]

The Executive and the Legislative Branches come together and put the budget in, and sometimes it is very contentious. People might want to come around the last two weeks of session because that is when we have to get right down to the nitty gritty; and some bills we think are important—some of those bills get vetoed. I see my colleague, Senator Dondero Loop has a question.

Senator Dondero Loop:

Thank you very much, Madam Chair; I appreciate you allowing me to have some questions here. Ms. Nielson, thank you for your overview and your critique of how we operate. I appreciate you bringing up the iCanBike program because I followed that, and Diana Rovetti did a wonderful job with that. Can you tell me how your department is actually funded? Is it funded through the federal government, or is it funded through the State? How is it actually funded?

Ms. Nielsen:

Absolutely. We are 75 percent federally funded through the Developmental Disabilities Assistance and Bill of Rights Act of 2000, Administration on Community Living's DD Council programs; and then 25 percent of our funds come from State General Fund [appropriations].

Senator Dondero Loop:

Great. If your funding comes through the federal government and you do grants, et cetera, can you fund the blind program that was brought up earlier by NIB?

Ms. Nielsen:

It would depend on how that was written and what that was written about. Our budget is quite small in comparison to others, but we do have some flexibility as far as what we can pay for. Is it reducing barriers to accessing information? So, in a sense, yes. Those are things that we can pay for.

Senator Dondero Loop:

Great. I would encourage you to look at funding that for us. Since you are asking us to fund things, I would suggest you look at that first. Also, how big is your department? How many people are in your department? Is it just you? Is it five people? Is it 25 people?

Ms. Nielsen:

We are located within the Director's Office of the Department of Health and Human Services. Our actual staff for the Council—we have six staff members; five paid and then one internship through Vocational Rehabilitation.

Senator Dondero Loop:

If you have those people, and you are writing grants, I am assuming you can also help with some of the disability acts you are saying we need to cover. I would suggest, for example, that possibly you could help find some of our interpreters we may need. Certainly, for example, with me, I would not have that expertise, unfortunately. I would love to have it, but I do not have it, and your department does have it. Perhaps you can—instead of criticizing—reach out and say, "I know you are going to have a finance meeting. Do you have an interpreter?" Then I maybe say, "No, I do not. Do you have one available?" Because we have no staff. I do not have a secretary, except when I am at the building, which is every other year in the odd years. I am sure we could use all the help we can get, and I am sure we are working as fast as we can in the State of Nevada. Due to the fact that you have federal funding, I am hoping maybe you can help out with that. I heard a whole lot of criticisms and not a lot of solutions.

Ms. Nielsen:

Two things here. Absolutely, we can help you with interpreters or any questions you may have regarding that. We have a [CART] team here with ADSD, as well. They are, in simpler terms, kind of our gurus when it comes to interpretation; so they also can assist with that. But we would be happy to help with that.

On the other path of it, as much as they may seem like criticisms, they are not our voices. This is the community that has brought these concerns to us. We are the people that, unfortunately, have to sometimes deliver that bad news. Sometimes we have to say, "This is what your community is saying." We are allies, and we are working alongside of the various different State service providing agencies to make sure we are addressing as many as we can. Unfortunately, what was asked of me today was to report on our Five-Year State Plan, and that is how we build our Five-Year State Plan—is identifying any of those barriers in the community and how we can address them. I do not know if maybe you are able to clarify on anything that may have been construed as criticism, but that is certainly not what the community wants you to hear. They have concerns; it is not criticism. It is passion; it is their families.

Senator Dondero Loop:

Probably the last 20 minutes. I would say, if you come with solutions, it helps. I get the criticism you want to air, but the solutions are helpful because you seem to be the expert, and not me. I am asking you for solutions, and I will reach out to Mr. Whitley as well, but the fact that your department is funded 75 percent federal, I am not sure who—that is why I am trying to figure out who oversees you that I could reach out to and say, "Hey, can you assist—." I do not know who that person is.

Ms. Nielsen:

I would be happy to help connect you with the [CART] team; there are State interpreters, as well—that is Jen Montoya over at ADSD. She oversees all of the interpreter piece. But like you said, accessibility can be totally different for every different person. We would be happy to help give you any of those resources you may need. We were trying to compliment the fact that the interpreters were provided and provided the whole day; that was very beneficial to those with disabilities. Thank you.

Senator Dondero Loop:

Thank you very much. I hope you will look into funding the blind program that was requested, and I will reach out to a couple of people. Thank you.

Chair Spearman:

Thank you. Vice Chair.

Vice Chair Brown-May:

Thank you, Ms. Nielsen, for the presentation. I have one clarifying question. I thought I heard you say you attempted to file a complaint against the State of Nevada with the Department of Justice—federally. I am curious to know, did I actually hear that? Did you attempt to reach out to the Protection and Advocacy organization locally for assistance?

Ms. Nielsen:

First things first, I am the President of the Board for the Nevada Disability Advocacy and Law Center (NDALC); so we have had thorough conversations with them. This was last year; we had reached out to them because we had tried to rectify things with the Department of Education. There were some serious concerns coming out of Washoe County School District and the current status of those who are deaf and hard of hearing in the State of Nevada. Unfortunately, NDE does have their hands tied in some aspects of it. Our only option was to go and reach out to the U.S. Department of Justice because they are the next step. We are federally identified through the Developmental Disabilities and Bill of Rights Act to identify the most pressing needs of those with IDD in the State of Nevada. Unfortunately, sometimes it does not agree with State agencies; and that is the autonomy that was built into this federal Act is that we are able to listen to the voices and bring them forward or bring them with us in the cases where they are willing to do so. So yes, you did hear that correctly. And yes, we did speak with the Department of Education. We did speak with the Protection and Advocacy system here in the State of Nevada, but they are going through some significant changes—employment changes. So, unfortunately, our only option was to reach out for support federally.

Vice Chair Brown-May:

Thank you for that clarification. Now I understand that you are the President of the Protection and Advocacy Organizations Board, while serving as the Executive Director for the DD Council. Is not the original Act intended to have three separate divisions—the DD Council, the Protection and Advocacy Organization, and the University Center for Excellence and Disabilities, that are all created by the same Developmental Disabilities Act? Is it not intended for there to be separation there? I do not understand how you are leading both boards simultaneously.

Ms. Nielsen:

I only lead the systemic part—I am only the Executive Director of the Council, so I am not the Chair of our Council; therefore, no, I definitely do not lead our Council in that aspect of it. But the same aspect of that, I am the President of the Board of Directors for the

Disability Advocacy and Law Center, and we did reach out to the Administration for Community Living to make sure there were no concerns with that; and there were not.

Chair Spearman:

Additional questions? Comments? Anyone up north? [There were no additional questions.] Thank you, Ms. Nielsen, for your presentation. I would say the Equal Rights Amendment in Nevada covers all of those areas you said were discriminatory or offensive, because it does include disabilities, and it does include race, gender, creed, religion, all of those things; and it is been termed to be the most expansive in the country. So perhaps your organization can look at that and see how you might be able to use that as a way to leverage the money you get from the federal government. That is all I have. Thanks a lot.

AGENDA ITEM XI—PRESENTATION ON THE AGING OF THE POPULATION IN NEVADA

[This agenda item was taken out of order.]

I think we have someone who has to leave before 3:30 p.m., so let me pull him in; Agenda Item XI, presentation on the aging of the population in Nevada. In Carson City, Mr. Reed, proceed when you are ready.

Peter Reed, Ph.D., MPH; Director, Sanford Center for Aging, School of Medicine; and Professor of Public Health, University of Nevada, Reno:

Thank you very much, Chair Spearman, and Members of the Committee, for the invitation to speak to you today about aging in Nevada and supporting quality of life. It is a topic my team and I are really passionate about; and there is a large network of aging service providers around the State that are doing everything they can to support the quality of life and well-being of elder Nevadans. The dialogue you all have as a Committee is really critical to that process. (Agenda Item XI-1)

I wanted to start with an aspirational goal I have set for myself and my work in Nevada, which is that 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. As I go through my presentation today, I hope you will keep this aspiration in mind. This is not the current state of affairs as it relates to elders who are living with physical and cognitive changes. As I present on the prevalence of chronic disease, the aging of the population, how common Alzheimer's disease and dementia are among the population, and the limitations in activities of daily living those changes create, I hope you will think back to this and recognize that despite those changes, if we as a community, we as a State, you as Legislators, support the development and delivery of community-based supports and services and the health care resources people need that are individualized and tailored to their level of need and that leverage and maximize their retained abilities, people can and will live well. That ultimately is the goal here.

When I say "quality of life," what am I discussing? First off, that is a concept, and certainly in the academic literature, it is often described as something that is subjective. Each of us defines our own quality of life for ourselves. For me, my quality of life would be diminished if I did not have music in my life. I am sure each of you have your own interests and preferences and things you engage with that help to bring quality into your life. But from a health care perspective, when we are thinking about health-related quality of life, and particularly among the older population, we think about that across these different domains. We are thinking about physical health, mental and emotional health, cognitive health, social health, spiritual health, environmental health, and financial health. All of those dimensions are needed for people to live well and maintain their health and well-being in the community. When you think about these health-related domains of quality of life, these are elements that can be diminished when people develop physical and cognitive changes. If someone is living with a chronic disease that limits their independence and their activities of daily living, that can directly impact their financial and social health. Obviously, it is already impacting their physical and cognitive health and their emotional well-being as well. That is why I draw a distinction between quality of life and well-being.

This is a framework of well-being that was developed by an organization called the Eden Alternative that really resonates with me. If you think about well-being as being a concept or a state of being that transcends quality of life, it is a path to a life worth living. We are thinking about concepts such as: identity or being known to the people around you, having personhood and individuality, leveraging your history; growth, or the opportunities for development and enrichment, learning and connecting; autonomy or self-determination and liberty; security—that is not just physical safety, but it is really freedom from doubt, anxiety, or fear—and privacy; connectedness or belonging and social connections with others; meaning—what is important and significant to a person, what is their purpose—and joy, thinking about happiness and pleasure and what brings them those things. These domains of well-being—identity, growth, autonomy, security, connectedness, meaning, and joy—these are things I would argue do not need to be diminished, if somebody develops physical or cognitive changes. Somebody who may be living with multiple chronic conditions—living with dementia—can still experience all of these domains to a very high level. They may just need accommodations to help to support them in achieving that level of well-being.

I like to think about both quality of life and well-being together, because they are so important, and they give us opportunities to consider how, from a policy perspective or perhaps from a programmatic perspective, we can put the resources and supports in place to enable people to live well despite physical and cognitive changes.

Given those aspirational goals and the definitions of quality of life and well-being, we know there are massive changes taking place across Nevada. These data [on the presentation slide] are the national data I received from the National Center on Aging, and you can see—essentially, this is what in the field we call a "demographic transition." And this may be redundant—some things you have already heard—so I am not going to spend a lot of time on this. You can see that chart on the left demonstrates a massive shift where there is a trend towards having a much younger population, to having a more even distribution of the population across various age groups. That chart to your right demonstrates that, over time—as you can see, there actually is a crossover that is going to be happening over the next few years in which the United States is going to, for the first time, have a higher number of people over the age of 65 than they do children under the age of 18. This is a massive demographic shift that is taking place across the population. What we have to consider are what the implications of that will be. What does it mean if the population of Nevada is going to go from 14 or 15 percent of people over the age of 65, to 20 percent of the population being over the age of 65, in the next five years. This shift is happening very rapidly, and it is happening right now. In fact, in the United States, with the aging of the baby boom generation, there are 10,000 baby boomers turning 65 every single day, and that is going to continue for the next decade.

Why do elders need support? It comes back to a lot of the things I am sure you consider as a Committee in terms of the lifelong resources that are available to help to support people in living well. Ultimately, in my view, as a public health gerontologist, it is the accumulation of risk that occurs over the entire life course. There are social determinants of health and the conditions in which people are born, live, work, play, and age that affect their access to certain resources that are health promoting. There are behavioral and lifestyle issues that contribute. When we think about physical activity, healthy diet, tobacco use, alcohol use—these are driving chronic disease. But it is over the course of decades these conditions develop; and therefore, they are much more prevalent among older adults.

When we think about the common geriatric syndromes, we look at frailty and falls; Alzheimer's disease and dementia; polypharmacy, which is people who are taking too many medications—whether they are prescription or over the counter medications—and the interactions between those medications; and we look at multiple chronic conditions—people are not living with just one chronic condition, but they may have multiple conditions.

In a health care context, one of the frameworks that has been developed that we teach to health care professionals from the Sanford Center for Aging is called the four "M"s of an age-friendly health system. Essentially what we are saying is that in any health care interaction with an older adult, the health care provider team—not just the physicians, but all members of that team—should be assessing what matters most to the patient. What are their preferences and interests for their care? Because if you are telling someone what they should do, and then blaming them when they do not follow through—calling them noncompliant—you are not taking the time as a provider to get to know what is possible for them, given their personal preferences and priorities. So, that is the first thing—what matters.

We also look at medications. There, we are really looking at whether or not the medications they are taking—both prescribed and unprescribed—are needed for the conditions they may have, or whether or not there are interactions between those medications that could be creating challenges.

We also look at what we call "mentation." A lot of folks have started to rename that and call it "mind," because mentation is a funny word. What we are capturing there is dementia, but also depression and delirium as common conditions.

Finally, mobility—looking at frailty and falls as a potential risk. In any health care visit, we try to look at those four "M"s to understand what is happening with the whole person and where they may need both clinical or community-based supports to enable them to live well.

I want to show this slide from the National Council on Aging; it demonstrates how common these conditions are. I really want to hit this home. You can see on this chart where it says 80 percent—that is four out of five people over the age of 65 are living with at least one chronic condition. You can see that over two-thirds of people over the age of 65 are living with two or more chronic conditions. These conditions are very present in the lives of elders. I am a public health professional, and I would love to tell you if you pour all your money into public health primary prevention strategies, we can prevent this. But when you are talking about 80 percent and 68 percent as prevalence for chronic disease, I am not sure that is a viable solution. I think, while we support investments in public health prevention and move upstream to try to reduce the prevalence of these, we also must have ways to support people in living well despite these conditions. These are national data, looking at the top ten chronic conditions; I would encourage you to take a closer look at those data, as well.

The impact of these conditions is that they limit people's independence. Nevada is a state that is very committed to independence, and the individuals who live within this State embrace that as a core value. When they start to experience limitations in their activities of daily living, when people are struggling with daily hygiene, with getting themselves dressed, with successfully eating meals or going to the restroom, with getting up and down from a chair, from their bed, with mobility and walking—these limitations then require support. There is a wide range across a continuum of long-term supports and services that are available to help people find the support they need; though I think a lot of that falls to families to provide support in the community, and a lot of families maybe do not have the knowledge, skills, resources, or the ability to support their loved ones. It is important that we have a network of services that are capable of meeting those needs.

What is needed for addressing quality of life and well-being? I have mentioned this multiple times—community-based supports and services. When you are looking at opportunities from a policy perspective to invest in providing support for community-based supports and services, certainly the Nevada ADSD comes to mind. They are the vehicle by which Older Americans Act (OAA) dollars from the federal government comes into the State and then gets distributed to community-based aging service providers. Those OAA dollars are necessary, but not sufficient. There is also a need for the State to invest in these resources to help ADSD provide the community-based supports that are going to help to support quality of life and well-being.

We also have a great need for access to quality geriatrics health care. I am going to share a bit more about that here in Nevada—these are needs nationwide; these are just needs of elders. I am going to get into the Nevada data here in a second, but thinking about the availability of geriatrics, neurology, and geriatrics-capable primary care is a really important need.

There is also a need for access to respectful and supportive long-term care; I am talking about skilled nursing and assisted living. Most elders do not live in residential care communities; they live in their homes, in the community. But when their needs exceed the ability to have them met within their home, these are resources that are available to help to get them the supports they need.

There is also a need to respect human and legal rights. We live in a society—and I will say it—that is very ageist. We tend to be a very youth-oriented society. We are also very ablest; we tend to be a society that prizes function. As people age and their abilities change, they are kind of hit with a double whammy of ageism and ableism. A lot of times—particularly if they are diagnosed with a condition such as Alzheimer's disease—that label of having that disease or diagnosis can result in people starting to make decisions for them, instead of finding ways to support them in making decisions for themselves. Preserving the human and legal rights of elders is a really critical need.

Social engagement is also an incredibly important aspect of supporting the quality of life and well-being of elders. In our communities, we need to have social resources available to make meaningful and important connections to others and to remain engaged.

What does this look like in Nevada? Currently, 17 percent of Nevada is age 65 or older. As I mentioned, that is going to get to 20 percent by 2030. Stunningly, we are only five-and-a-half years away from 2030; that is coming very quickly. With 20 percent of the population being over the age of 65 and continuing to grow in the 2030s, I think it is really important—where we have a health care system today that struggles to care for elders, and a community-based aging services system that struggles to care for elders; and that demand is only increasing. This is, in some ways, an issue around the country, but it is more pronounced here in Nevada. Nevada is one of only three states with a higher than 57 percent increase in the percent of people over 65 between 2008 and 2018. We are the third fastest aging state in the country [tied with Colorado].

Nevada also has a highly diverse population of elders; just as we have a highly diverse population—period. We have elders living in urban, rural, frontier, and tribal settings; we have a significant racial and ethnic diversity, as well as economic diversity. If I could leave you with one point to take home with you, it is that we tend to think of elders as being very homogeneous—because we have these generational myths. We can all talk about the stereotypes that exist for millennials; or I am Gen X, so you can tell me what you think that says about me. But there are a lot of stereotypes about boomers, the Greatest Generation, and elders; and people tend to think of them as being very similar. But the elder population represents all aspects of the diversity of our larger population. There are people with significant means and economic resources, and there are people with very few economic resources. Any aspect of the diversity of the population you can consider, that is reflected within the population of elders. It is a very heterogeneous population.

In terms of health in Nevada, recent data shows: about 25 percent of Nevada's elders are living with diabetes; 43 percent living with obesity; 10 percent living with dementia; and 29 percent living with subjective cognitive decline—that is the highest in the United States. Those are data that come from a population-based survey that was asking people to report on whether or not they feel their cognition has changed. It is subjective; it is a person saying, "Yes, I believe I have changes in my cognition, such that it is declining." But 29 percent of elders in our State are reporting that, and that is the highest.

I realize [the text is] very small—I encourage you to take a closer look at the slides, but these are data from the Sanford Center, Geriatric Specialty Care Center. At the Sanford Center for Aging, we have an interdisciplinary, comprehensive Geriatric Assessment Clinic, in which we see complex cases that are referred by primary care providers for a specialty consult. Among the patients we see in our clinic—and these are data of over almost 750 patients we have seen—we see an average of three chronic conditions, with high blood pressure, high cholesterol, arthritis, depression, gastro-intestinal (GI) disorders, diabetes, cancer, and dementia being the most common. We have seen 38 percent of our patients who have experienced a fall in the prior six months. Interestingly, that is aligned with national data. Up to one-third of people ages 65 and older fall every year; so that is a really serious concern. You can see all of those issues I was describing in terms of chronic diseases, frailty and falls, cognitive impairment—all of these things are present or perhaps, in some cases, even more pronounced among the population of elders here in Nevada. The question becomes—what do we do to address this?

One critical issue—one critical need is Nevada's geriatrics workforce. In 2021, there were 57 geriatricians in Nevada; that is 1 for every almost 12,000 people over the age of 60. There is only one geriatrician practicing in a rural community. Only 13 percent of Nevada's advanced practice nurses specialize in adult gerontology. You can see on the geriatric specialty side, there are limited resources available for caring for elders. There is a key point here, which is that it is unlikely—no matter what efforts we put in place—that we are going to be able to recruit and train enough geriatric specialists to meet the needs of our rapidly aging population. That speaks to a shift in focus needing to happen, such that we are enabling all health care providers—not just geriatric specialists—to have a basic level of geriatrics and neurology competency in serving their older patients. If we can build that capacity among the primary care provider network, then that will give us an opportunity to use our limited geriatric specialists for the most complicated cases, and as consultants to the primary care providers who are capable of caring for elders in their own right.

When I think about key recommendations at the general level, certainly we need to consider how to put more investments into our community-based aging supports and services to build our infrastructure and our capacity. When I'm thinking of these services—you can think of it as a pyramid, a hierarchy of needs—it starts at the basic level. We are talking about things like transportation, affordable housing, and food security. Then it moves up into access to effective geriatrics, competent primary care, effective geriatric specialty care, and neurology. It moves up into social and civic engagement opportunities in the community. Thinking about all the different dimensions of a person's life and how, when someone is developing limitations in their activities of daily living, they need accommodations and support to help to meet and fulfill those needs.

That means also there is a need for training, education, and workforce development. We are blessed here in the State of Nevada. Currently, we have two federal awards from the Health Resources and Services Administration (HRSA); it is called the Geriatrics Workforce Enhancement Program. There is a grant at the University of Nevada, Reno (UNR), and a grant at the University of Nevada, Las Vegas. We work together very closely to develop and deliver training for primary care providers on geriatrics. As you are aware, grants have end dates and the end date for those grants is June 30 [of 2024]. We are both still waiting to hear on our proposals. If we are fortunate to both be funded again, that would be a $10 million investment by the federal government in geriatrics education in our State. But these are competitive proposals, so our fingers are crossed; we are hopeful that will come through. Either way there is a need to increase investments in graduate medical education, so that we are training residents and fellows in caring for elders. There is a need for geriatrics and neurology basics for all trainees in medicine, nursing, social work, physician assistants, public health, psychology, and all other health professions. It is incumbent upon us to build the health care workforce that is going to be needed to care for the population of elders we are experiencing here in this State, because of all of those needs I just mentioned.

I want to take a step [back] and focus specifically on Alzheimer's disease and dementia. I did provide to you as a handout today the Nevada State Plan to address Alzheimer's disease and other dementias (Agenda Item XI-2). I serve as a member of Nevada's Task Force on Alzheimer's Disease; so I had the opportunity to help develop the State Plan along with a wonderful group of colleagues who serve on that Task Force. We release the State Plan of recommendations every two years; the most recent is for 2023–2024.

I want to—particularly from a policy perspective—draw your attention to three specific recommendations. The first two: recommendation number four—outreach to primary care providers; and recommendation number five—dementia care specialist programs. Both of these were brought forward in the last legislative session as bills. Unfortunately, neither of them made it through the entire process. In fact, I believe the bill that came out from our recommendation on outreach to primary care providers, which was to establish the Nevada Memory Net—or a network of dementia assessment clinics around the State—using a hub-and-spoke model to serve rural communities in addition to our urban communities. I believe that was a bill that came out of this Committee; so I want to thank you all for your support of those efforts. I would encourage you to take another look at that recommendation and consider what opportunities there would be to move forward the establishment of a Nevada Memory Network. I could go on a whole other talk about the importance of early detection and accurate diagnosis for Alzheimer's disease and dementia. Right now, in Nevada, we live in a neurology desert. Investing resources where they are needed to help to build that capacity to identify people who are living with dementia would be an enormous step forward in being able to connect them then with the community-based supports and services they have. I will say the model which was proposed in that bill was replicated from a model that exists within the State of Georgia. It is in the Georgia State Budget as a line item specifically for their memory assessment clinics; I believe it is $7 million a year. We were not asking for anywhere near that amount to be able to start this up here in Nevada. But I encourage you to take another look at that; that was SB 297 in the [2023] Session.

Similarly, the dementia care specialists program is a program that would work with the senior centers in every county in Nevada to embed a dementia care specialist who could help to provide supports to people living with dementia in those communities—to connect them with the needed resources available within their communities. That is based on a model developed in Wisconsin, where that is a thriving program. Fortunately, that initiative with the dementia care specialists has taken root in the form of a pilot. Our colleagues at the ADSD were able to get a federal grant from the Administration for Community Living; that is a three-year federal grant. They are going to be launching a dementia care specialist program with a handful of specialists in a handful of counties. But the opportunity exists to leverage the good results from that pilot through the legislative session; then ensure that is an available resource to elders across the State in every community.

Finally, I want to draw your attention to recommendation number 17, which is called Choice in Care and Care Settings. You will remember back in my introduction, when I was talking about the need to help to preserve human and legal rights—to preserve self-determination and autonomy. If you review recommendation number 17 in our State Plan, you will see there are challenges—not only in Nevada, but around the country—in terms of the use of segregated and locked residential care units for people living with dementia. The research that was done to inform that recommendation was completed by Dr. Jennifer Carson, who is a colleague of mine at the University of Nevada, Reno, and also serves on the Task Force for Alzheimer's Disease. She was able to do a really good job describing the legal basis for that recommendation, drawing upon the 1999 Supreme Court *Olmstead* decision, as well as the ADA. I realize this is contrary to frequent practice—I think that is because of a lack of awareness—but legally, there are only two people who can place a person in a locked memory care unit, even if that person is living with dementia; and those two people are the person [themselves] choosing to live within a special care unit or a memory care unit, or a legal guardian. That person would have had to go through the guardianship process within the courts and have that guardian assigned and then that person could make that decision. But it is common practice for family members or a physician to make the recommendation, or for the marketing person at a residential care community to sell someone on the idea of a memory care unit. I am not criticizing memory care units; they provide a really valuable resource. What I am doing is reminding us that, legally, even when someone has a diagnosis of dementia, they have the right to determine their own living situation and their own living environment. I would encourage you to take a look at that recommendation, and consider if there are any potential policy directions that could help to, at a minimum, raise awareness of this fact and help to restore that right to people living with dementia. I might even recommend you invite Dr. Jennifer Carson to come and speak in depth on this recommendation, because she has significant expertise and has done a lot of research on this topic to understand the law and to identify ways to help to raise awareness of the law.

I did provide my references here in going through the presentation. I would be happy to answer any questions you may have. I do have time for questions.

Chair Spearman:

Thank you. Committee Members, any questions? Assemblyman D'Silva.

Assemblyman D'Silva:

Thank you, Chair; and good to see you again, Professor Reed. I believe I met you when I toured UNR's Sanford Center earlier this year. I have a question about a growing topic in the communities I am with—at senior centers, when I am knocking on doors. As elected officials, we know the majority of voters tend to be above the age of 55. In my district, it is almost more than two-thirds, like almost 70 percent of the voters are. I get to have a tremendous number of conversations as a younger person with seniors here in our State. One thing that has come up has been the sense of—and I think you mentioned it here—connectedness. There has been an anxiety building up within—not just seniors. I think this is a prevailing issue throughout all age groups—about the lack of interconnectedness. I know we focus on the physical ailments that are of concern here, but I was wondering if you could speak a little bit more about social connectivity and some of those issues that also are of concern to us. Thank you.

Dr. Reed:

Yes. You are absolutely right; social isolation and loneliness are historically very significant problems among the older population. I will start with that historical element for a minute. That is because as people age, they experience loss. They may experience a loss of a spouse. If they have children, those children become adults; they perhaps are moving away. When they retire—there is a lot of socialization that takes place in the workplace. Finding ways to offer opportunities for people to stay meaningfully engaged in civic events and opportunities in the community; finding ways to help alleviate that social isolation—that has been a problem for decades—is critical.

The pandemic did not do us any favors in terms of social isolation; it also gave us all a sense of what it means to be home bound and to be isolated from face-to-face interactions with folks. Finding ways to address social isolation among the elder community was something that was a big focus during the pandemic; because if it was a problem before, it was a crisis during the pandemic. There were a lot of resources developed leveraging telehealth technology, but also thinking about ways to bring people together to foster and support social connections and social connectedness; and those resources are very important.

We have a program at the Sanford Center for Aging that is funded by Nevada's ADSD called Senior Outreach Services, in which we recruit volunteers to go into the homes of isolated home bound elders and provide them with companionship. A lot of folks may say, "Why are we using funding to provide a program to offer companionship?" It is because of the plague of loneliness and isolation among elders. It is a critically important component. I will say that even in our clinical context, it is something we focus on. Our interdisciplinary comprehensive assessment is not just a medical assessment; we have a team of providers that meets with each patient, as well as with their families at the same time. The team includes: a medical provider; a geriatric pharmacist to look at polypharmacy issues; and clinical social workers who are looking at their living environment, their psychosocial needs, and thinking about what types of social resources would be needed to help to maintain quality of life and well-being. It is not something that I included in the prevalence data; so I appreciate you bringing that up because it is very much an important need to address, as well. Thank you.

Chair Spearman:

Additional questions? Carson City? Questions? I do not see any.

I have a couple of things. Our first presentation today was with Silver State Equality, and we talked about, to a certain extent, what that looks like for seniors in that community. With the information you have and the studies that have been done, have there been any that looked specifically at those individuals?

Dr. Reed:

When you say those individuals, are you—in the context of equality, are you referring to income inequality or racial diversity?

Chair Spearman:

No; seniors in the LGBTQ+ community.

Dr. Reed:

Yes, absolutely. There are many LGBT elders, as you are aware. That certainly is a population we want to be able to serve effectively with the resources we are offering. I think the work we do at the Sanford Center for Aging—and that I am aware of with other aging service providers, as well—we approach it with a spirit of cultural humility. We do not believe we are ever capable of being culturally competent in the backgrounds of all the people who might come to us for supports and services. Whether it is a member of the LGBTQ community or a member of any other potentially vulnerable group, we approach it with the desire to get to know who they are as a person—not as a group of people, but who they are as an individual—and what their preferences are and how those preferences align with their needs, as well as their strengths and retained abilities. We think about that in the context of care as being a person-centered approach or a patient-centered approach—which are buzzwords but mean a lot in terms of our opportunities to individualize the support people receive.

We welcome people from the LGBT community to leverage and take advantage of the resources. I will say that, at least in our portfolio, we do not have anything specific for that community, but there certainly is research on the needs of the LGBTQ elder community. Through our embracing the value of cultural humility and patient-centered approaches to care, we certainly can support them with any of the programs or clinical services we offer.

Chair Spearman:

Thank you. The next thing is a comment on recommendation 17, Choice and Care in Settings. You said there are only two people that could legally confine someone with dementia to a locked facility. Yes?

Dr. Reed:

Correct; that is the person living with dementia and a legal guardian.

Chair Spearman:

I want to say it was 2017—Southern Nevada Legal [or the Legal Aid Center of Southern Nevada] brought a bill, and I believe we might have strengthened that. So if that is happening, we can make sure we take care of it according to statute.

Dr. Reed:

Thank you.

Chair Spearman:

Last thing is—and this is more of a comment, as well. It looks like what our population is doing is inverting. We have got here at the top people under [the age of] 50, and then you have people over 50. But now what we are looking at is shifting. Is there anything you all have thought of or that you could think of? Take some time on your way back to Reno [to think] about doing intergenerational things; because I find those are the things that would mean the most—especially to seniors whose children have moved away, and they have limited contact with their grandchildren.

In Texas, we had a program—Rearing Our Own To Succeed (ROOTS). It was the seniors in the community that came to the after-school program to read to mostly elementary school children, and it was the seniors in the community that fixed dinner for them—because for many of them lunch would be the last meal they would have until breakfast the next day. Just a thought.

Dr. Reed:

Yes, thank you very much for that thought, Chair Spearman. I think you are absolutely right; anything we can do to foster intergenerational connectedness is positive both for the elders and for the youth and everyone in between. We certainly try to develop opportunities to support that in the work we do at the Stanford Center for Aging. In fact, one thing I did not mention is we have an academic program that focuses on teaching gerontology to undergraduate students at the University. There are many service-learning opportunities within that program to give them the chance specifically to engage in intergenerational service; but also social engagement with elders. That is one small example, but I take your point. And that is absolutely something that should be cultivated and fostered over time; because the more young people know about the experiences of elders, not only the greater empathy will they have for investing in the services that are required—or perhaps going into the field of gerontology and geriatrics—but it also helps them to see their own future, which is a really important thing. Back to the original question from the Assemblyman—it also increases social engagement opportunities for elders, as well, as a way to reduce isolation. Thank you.

Chair Spearman:

Thank you. As you grab your keys and get ready to walk out the door—I have a theory that has not been disproven; and that is, if you do not die young, you are going to get old.

Dr. Reed:

There is only one alternative to aging, and you just hit the nail on the head with that one.

Chair Spearman:

And nobody is rushing to that one. Thank you, Mr. Reed.

AGENDA ITEM XII—DISCUSSION OF SOLICITATION OF RECOMMENDATIONS

Chair Spearman:

We will go to Item XII, discussion of solicitation of recommendations. We are going to extend that deadline to August 1, 2024. We heard pertinent recommendations, especially dealing with dementia and our senior population. I would ask the Committee Members to consider those as a way to move forward in terms of making sure we are ready for the inversion of the population when it gets here. Because there will be an increase—I think it is going to be an increase of 20 percent in adults over [the age of] 65—we might also want to look at what the peripheral needs might be. For example, if someone is 65, and they have a son or daughter who is 40, 30, or 35, they may be in that sandwich generation; they may have responsibility for their child and have now assumed responsibility for their parents. I am not quite sure what that would look like, but let us look at how those peripheral elements might influence what we do.

Comments, Committee Members? I do not see any.

AGENDA ITEM XIII—PUBLIC COMMENT

Chair Spearman:

Let us go to Item XIII, public comment. Anybody in Carson City? Remember public comment is limited to two minutes, and we do not comment at all on what you say—we just listen. I do not see anybody here in Las Vegas. Broadcast, anybody on the phones?

BPS:

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

Dora Martinez, previously identified:

Good evening, Chair and Members of the Committee. Thank you for all your patience and your beautiful smiles there today. I was honored to come and present on AB 252. We hope you will consider our ask. I want to thank all of you, and especially much gratitude to Senator Krasner. I wish I had known you were there, I would have come and gave you a hug. That is what happens when you are blind, you kind of miss things. Just know that I really appreciate you and all that you do.

I want to thank the amazing Catherine Nielsen for being there and putting a face of disabled community and population of Nevada moving forward. Because of her expertise, knowledge, patience, and understanding, we are in good hands, and we are moving forward together. Her office is an office of six staff who are Wonder Women. They do everything; and if they do not know the answer, they will find it. We appreciate everything she does and her awesome staff who are very accommodating and have accessible agenda, which I hope LCB will follow. Thank you so much, and make it a great night. Drive safe.

Chair Spearman:

Thank you. BPS, anyone else on the phone?

BPS:

Yes, Chair. Please standby.

D. J. Coquilla:

Good afternoon. Thank you, [Chair] Spearman, and other Members of the Committee. I am here as an advocate for my 87-year-old father. He is a Veteran and is disabled with Alzheimer's. You might have heard—the Alzheimer's Association, as of 2023, reports that 49,000 people suffer from Alzheimer's disease in the State of Nevada. The elderly and the disabled, they need our protection—also financially, because they are targets.

I will just share two brief true stories. Recently, in March 2023, I contacted one of our homeowners associations (HOAs), Taylor Association Management, for a detailed account of all the fees associated with the HOA. I mentioned to them that my father has Alzheimer's. I was telling everyone who would listen. He was current on his dues. But on January 31st, we were surprisingly informed of a $9,900 penalty we received for not painting his house—which was shocking. He never received any notice. After painting the house within two weeks and sending the photographs to the HOA, he received a letter demanding the $9,900 fee was due and payable immediately upon receipt of the letter. There was no—they refused to waive or reduce the fines or discuss a payment plan.

In another situation, with a different HOA, my father was calling, sending letters and checks, and trying to communicate with the HOA. He wanted clarification because there was a fee, and he thought he already paid it. They never responded to him, which led him to believe his financial obligations had been met. All this, it just leads up to—and the elderly can, I have seen many times, they can be targets. Thirty-six hundred dollars for removing pigeons or twenty thousand dollar heating, ventilation, and air conditioning (HVACs) that someone wants my father to sign in 20 minutes. They are targets. Many times the family members are not living in the State; so, many people may not even have family members around. I think they need protection, especially financial protection. I would like to maybe draft a bill to amend [Chapter 116 of NRS], governing the HOAs; because they are separate private companies. They need to be able to be mandated to respond to homeowner questions, especially with financial matters; because we are in a nonjudicial lien State. The HOA management companies—who are, many times, owned by the investment companies and the collection companies—they operate in those nonjudicial lien states because you could just pop a note in the mail. For people that are cognitively impaired, like my dad—and my dad was paying the mortgage even nine months after the transfer. Their brains are not—they just really need protection, especially with the HOAs. They need to be able to be mandated to respond to the homeowners in a timely fashion, especially with financial matters. Thank you so much.

Chair Spearman:

Thank you. BPS, anyone else on the lines?

BPS:

Yes, Chair. Caller with the last three digits 4-1-9, you are unmuted and may begin.

Benjamin Challinor, Director of Public Policy, Alzheimer’s Association:

Hello, Chair Spearman and Members of the Committee. I would like to thank our colleague who we work really closely with, Dr. Peter Reed, for presenting his recommendations on behalf of the Sanford Center. One of those being the Nevada Memory Net that we submitted for recommendation to the Committee. It is good to see our fellow stakeholders are presenting this as a recommendation to the Committee, as well; it shows we need to make sure we are able to proceed with the Nevada Memory Net, so we could address the needs of Nevadans who are living with Alzheimer's and their families and caregivers. I submitted the recommendation to Committee staff earlier this month. I am looking forward to working with the Committee moving forward to make sure we are able to get this introduced next legislative session, as well as passed and implemented. Thank you.

BPS:

If you recently joined the call and would like to participate in public comment, please press *9 on your phone to take your place in the queue. Chair, the public line is open and working; however, there are no more callers at this time.

Chair Spearman:

Thank you very much. I would like to thank the Committee Members, as well as those who stuck it out with us. This was a rather long meeting, but I think we were able to gather good information. Our next meeting will be August 20, 2024 [The meeting was rescheduled for August 26, 2024.]. With that, we are adjourned.

AGENDA ITEM XIV—ADJOURNMENT

There being no further business to come before the Committee, the meeting was adjourned at 4:52 p.m.

Respectfully submitted,

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Terese Martinez
Research Policy Assistant

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Destini Cooper
Senior Policy Analyst

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Jennifer Ruedy
Deputy Research Director

APPROVED BY:

____

Senator Pat Spearman, Chair

Date: ___________________________________

MEETING MATERIALS

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
Agenda Item IV	André C. Wade, State Director, Silver State Equality	Pdf
Agenda Item VI	Crystal Wren, Chief, Operations and Quality Assurance, Aging and Disability Services Division (ADSD), Department of Health and Human Services (DHHS) Megan Wickland, Health Program Manager III and Quality Assurance Manager, Developmental Services, ADSD, DHHS	PowerPoint Presentation
Agenda Item VII A	Rebecca Jayakumar, PharmD, Legislative Director and President, Southern Nevada Chapter, National Federation of the Blind of Nevada	PowerPoint Presentation (available in the Library due to copyright issues)
Agenda Item VII B	Eric Wilcox, Chair, Nevada Commission for Persons Who Are Deaf and Hard of Hearing, DHHS Obioma Officer, Executive Director, Nevada Commission for Persons Who Are Deaf and Hard of Hearing, DHHS	PowerPoint Presentation
Agenda Item VIII	Nate Boyack, Executive Committee Member, State of Nevada Association of Providers (SNAP); and Executive Director, Bringing About Independence (BAI)	Video
Agenda Item IX	Lance Ledet, President, Hearing Loss Association of America, Southern Nevada Chapter	Pdf

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
Agenda Item X	Catherine Nielsen, Executive Director, Nevada Governor's Council on Developmental Disabilities, DHHS	PowerPoint Presentation
Agenda Item XI-1	Peter Reed, Ph.D., MPH; Director, Sanford Center for Aging, School of Medicine; and Professor of Public Health, University of Nevada, Reno (UNR)	PowerPoint Presentation (available in the Library due to copyright issues)
Agenda Item XI-2	Peter Reed, Ph.D., MPH; Director, Sanford Center for Aging, School of Medicine; and Professor of Public Health, University of Nevada, Reno (UNR)	Pdf

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