State of Nevada
Aging and Disability Services

Olmstead Plan

2023-2028

Acknowledgements

This Olmstead Plan was made possible through the combined efforts of countless individuals, organizations, and state agencies.

It represents the *voices* of hundreds of Nevadans that are living with and/or caring for someone with a disability or functional limitation who participated in a consumer survey or a community workshop.

It includes the *perspective* of providers working in community-based organizations and government programs that participated in key person interviews.

It was supported with *leadership* offered by a Steering Committee made up of 14 individuals, of whom four are people who have a disability themselves, and of whom five are family members of individuals who have a disability.

The combined commitment of time and ideas from everyone who participated is sincerely acknowledged and appreciated by the State of Nevada, Department of Health and Human Services, Aging and Disability Services Division.

Table of Contents

Executive Summary

The State of Nevada Aging and Disability Services Division (ADSD) serves Nevada's elders, children, and adults with disabilities or special health care needs. The mission of ADSD is to ensure the provision of effective supports and services to meet the needs of individuals and families, helping them lead independent, meaningful, and dignified lives. One element of achieving this mission is through implementation of an Olmstead Plan which sets forth a strategy to ensure that older adults and persons with disabilities have the opportunity to achieve optimal quality of life in the community of their choice.

In November 2022, the Aging and Disability Services Division (ADSD) within the Nevada State Department of Health and Human Services (DHHS), embarked upon a process to develop a division specific Olmstead Plan. To do so, ADSD established an Olmstead Planning Steering Committee made up of individuals who are disabled, individuals who represent specific populations served by ADSD, and ADSD staff. This group met over a one-year period of time to accomplish three objectives which included; 1) understanding the current system of providing community-based services and supports to people with disabilities, 2) identifying the strengths and weaknesses within said system, and 3) developing a plan of action to ensure that older adults and persons with disabilities have the opportunity to achieve optimal quality of life in the community of their choice.

Current System of Supports

ADSD is one of many systems that is charged with ensuring individuals with disabilities have access to services and supports that help ensure people can live, work, and play in the community of their choice. Beyond ADSD, the other systems that impact community integration include those that provide behavioral health, housing, transportation, job training, education, and healthcare. A review of the current system of support was limited to ADSD for the purpose of this plan.

Of the population living in Nevada with a disability, a smaller portion than the whole is served by ADSD programs. ADSD offers a variety of services, some of which are specifically geared to home and community based care options and are provided with the express intent of supporting community integration. These services are often referred to as Home and Community-Based Services (HCBS) or "Waiver" services. ADSD offers other support services that are often essential so that home and community-based care can be an option. Funding for all services comes from numerous sources including federal Medicaid dollars, state general funds, federal grants, and other funding mechanisms.

The Steering Committee reviewed the programs and corresponding services offered by ADSD as well as the number of people historically served. In addition, the number of people on various waitlists and the average time spent on waitlists was assessed, as was the number of individuals served in HCBS Waiver programming versus those served in Medicaid-funded intermediate care facilities or nursing homes. This information was combined with a variety of inputs provided by service recipients, providers and ADSD staff to identify the strengths and weaknesses of the ADSD system and to identify issues requiring action.

Issues Requiring Action

The following issues were identified as requiring action to improve community integration opportunities.

Fractured and complex system: The system for providing community integration opportunities was described as siloed and difficult to navigate, lacking a continuum of care and ease of access.

Lack of sufficient and flexible funding: Insufficient as well as a lack of flexibility in funding services that promote community integration was noted as a primary barrier to providing person-centered care. Additionally, eligibility requirements sometimes leave individuals without the assistance needed to remain in a community-based setting.

Workforce shortages and sufficiency: Challenges in filling positions and ensuring knowledgeable and appropriately trained individuals within the system were repeatedly identified.

Inadequate data collection, tracking, and sharing across programs: Data systems utilized by ADSD don't share information across programs and/or funding streams, leaving people to complete multiple applications for various services. Data systems also fail to produce the metrics necessary for comprehensive and longitudinal data tracking needed to support data-driven decision making. Specifically, data is not available to inform how resources that are allocated are used, and about the impact of those services on people's lives.

Limited knowledge of service availability: People with lived experience and their family members/support system lack awareness of ADSD services for community integration. Additionally, service providers are not always aware of the array of services available that support community integration. Peer-to-peer information sharing, self-directed internet research, and service providers were identified as primary sources of information.

Lack of understanding of the Olmstead Decision: People with lived experience and their family members/support system have limited understanding of the Olmstead Decision, if at all. There are differing levels of awareness among populations, with the aging population and individuals with dementia or Alzheimer's being less aware. Providers also often indicated low awareness.

Gaps in services for people with disabilities: Affordable housing, transportation, supported living arrangements, personal assistance support, and employment with a living wage were among the services identified as needed but not always accessible by both persons with lived experience (PLEs) and the professionals that serve them.

These issues were the primary drivers in the development of a plan to improve the ADSD system in support of community integration opportunities for people with disabilities.

The Steering Committee identified the following goals and objectives to address the issues identified for action.

Goal #1: Improve knowledge about ADSD services and other resources.

Objective 1.1: Promote accurate, comprehensive, and accessible information about what supports are available through ADSD and how to navigate the system.

Objective 1.2: Ensure providers, parents, and consumers know about the full spectrum of support available to individuals with disabilities.

Objective 1.3: Educate parents and caregivers of transition aged youth (TAY) about resources available through ADSD and the intersection of its work with that of local school districts and workforce development/job training providers.

Goal #2: Expand workforce capacity to serve people in community-based settings.

Objective 2.1: Improve ADSD workforce recruitment and retention efforts.

Objective 2.2: Prioritize provider recruitment efforts for services that are most needed and least available, with an emphasis on services in the rural areas of the state.

Objective 2.3: Support free/low-cost and ongoing professional development offerings to workforce (internal and external to ADSD) serving individuals with disabilities.

Goal #3: Increase accountability within ADSD for the implementation of timely, high quality, community-based services for individuals with disabilities.

Objective 3.1: Establish reliable, timely, and consistent data collection efforts across ADSD programming.

Objective 3.2: Develop division-wide quality assurance practices.

Objective 3.3: Implement best practices and regulatory requirements associated with community integration efforts.

Goal #4: Embed a person-centered culture among all ADSD staff and within Division operations.

Objective 4.1: Simplify the process for accessing ADSD services.

Objective 4.2: Require the use of person-centered care among all ADSD staff.

Goal #5: Develop a systems-wide approach to addressing the comprehensive needs of individuals with disabilities from a person-centered framework.

Objective 5.1: Establish more formal connections with other state, county, city, and community-based services providers.

Objective 5.2: Establish advocacy efforts aimed at improving support for individuals with disabilities in areas that either fall outside the authority of ADSD to implement or that require legislative support.

ADSD will utilize this plan as a management tool to direct activities, with monitoring of activities conducted quarterly, status reports completed semi-annually, and updates established annually.

Setting the Stage

Background

The State of Nevada Aging and Disability Services Division (ADSD) serves Nevada's elders, children, and adults with disabilities or special health care needs. The mission of ADSD is to ensure the provision of effective supports and services to meet the needs of individuals and families, helping them lead independent, meaningful, and dignified lives. One element of achieving this mission is through implementation of an Olmstead Plan which sets forth a strategy to ensure that older adults and persons with disabilities have the opportunity to achieve optimal quality of life in the community of their choice.

Purpose of the Plan

Title II of the Americans with Disabilities Act (ADA) of 1990 established a mandate that public entities ensure people with disabilities are offered the opportunity to live in the most integrated settings possible. In the landmark *Olmstead v. L.C. decision (1999)*, the U.S. Supreme Court reaffirmed this obligation and encouraged the development of 'Olmstead plans' to establish actionable strategies that would support community integration efforts.

According to the U.S. Department of Justice (DOJ) Civil Rights Division, a comprehensive, effectively working plan must:

> *"…do more than provide vague assurances of future integrated options or describe the entity's general history of increased funding for community services and decreased institutional populations. Instead, it must reflect an analysis of the extent to which the public entity is providing services in the most integrated setting and must contain concrete and reliable commitments to expand integrated opportunities. The plan must have specific and reasonable timeframes and measurable goals for which the public entity may be held accountable, and there must be funding to support the plan."*

The required components of an Olmstead plan include:

1. **State System Description:** It must include a description of the state's current system of providing community-based services and supports to people with disabilities.

2. **Asset & Gaps Analysis:** Data must be gathered that helps to inform an assessment of the strengths and weaknesses of that system.

3. **Plan of Action:** A plan of action must be developed to address how the state intends to expand opportunities for community-based services. The plan must have measurable goals and timeframes and there must be funding to support implementation.

This plan addresses each of these areas and will guide ADSD in ensuring an accessible person/family centered State system that provides services where and when they are needed. That said, ADSD understands that achieving sustainable change for all of Nevada's residents who have a disability and seek opportunities within communities of their choice will require partnerships and efforts that are beyond the scope of the State service system. Because of that, **this plan will explore the variety of supports needed by Nevadans with a disability but will focus its action on what ADSD has the authority to implement.**

Methods and Approach

To develop this plan, a three-phased approach was used: Phase I – Project Organization and Data Collection; Phase II – Assessment of Current System and Needs; and Phase III – Establishment of the Olmstead Plan for Community Integration. Activities related to the three phases took place between November 2022 and November 2023.

Phase I – Project Organization and Data Collection

The planning process began with the establishment of the Olmstead Planning Steering Committee (herein referred to as the Steering Committee) that would guide and support all planning efforts. This Steering Committee was made up of ADSD staff as well as representatives from the various communities that are impacted by the Olmstead plan. A full list of Steering Committee Members is provided below.

Name	Organizational/Community Representation
Jessica Adams	Nevada DHHS, Aging and Disability Services Deputy Administrator
Steven Cohen *(served 3/2023-8/2023)*	Assistive Technology Council (AT Council)
Chuck Duarte *(served 11/2022-2/2023)*	Task Force on Alzheimer's Disease (TFAD)
Dorothy Edwards	Commission on Aging (COA)
Jennifer Frischmann	Nevada DHHS, Aging and Disability Services Manager of Quality Assurance
Deidre Manley	Nevada Lifespan Respite Care Coalition
Kimberly Palma-Ortega	Nevada Governor's Council on Developmental Disabilities
Cheyenne Pasquale	Nevada DHHS, Aging and Disability Services Chief I, Planning
Ashley Price *(served 8/2023-11/2023)*	Assistive Technology Council (AT Council)
Jennifer Richards	Nevada DHHS, Aging and Disability Services Chief Elder and Disability Rights Attorney
Eli Schwartz	Nevada Commission for Persons Who are Deaf, Hard of Hearing, or Speech Impaired
Cindi Swanson	Commission on Services for Persons with Disabilities (CSPD)
Diane Thorkildson	Nevada Center for Excellence in Disabilities (NCED)
Korri Ward	Commission on Autism Spectrum Disorders (ASD Commission)
Julie Weismann-Steinbaugh	Statewide Independent Living Council (SILC)
Megan Wickland	Nevada DHHS, Aging and Disability Services Health Program Manager III

During the first two meetings of the Steering Committee, held in November 2022 and January 2023, the planning approach for development of the Olmstead plan was reviewed and finalized as was the method for data collection. Data collection efforts informed Phase II of the planning process and is described below.

Phase II – Assessment of Current System and Needs

There were multiple methods of data collection conducted to support an assessment of the current system strengths and weaknesses, each of which are described more fully below.

Public Data

The number of individuals in Nevada with a disability was taken from the U.S. Census Bureau, 2021 American Community Survey 1-Year Estimates. The 2021 American Community Survey (ACS) data generally reflect the March 2020 Office of Management and Budget (OMB) delineations of metropolitan and micropolitan statistical areas. In certain instances, the names, codes, and boundaries of the principal cities shown in ACS tables may differ from the OMB delineations due to differences in the effective dates of the geographic entities. Additionally, it is important to note that data related to children under 5 with cognitive difficulty, ambulatory difficulty, and self-care difficulty are not included in these measures.

State System Descriptions and Data on Numbers Served

ADSD staff members provided information about the various services offered through ADSD that support community integration as well as year over year data regarding the number of individuals served, number of people on waitlists, and the average time spent on waitlists. This data is cited as "ADSD Caseload Statistics SFY 16-22" and was extracted from the various data systems used by the Division and provided directly to the authors of this report by ADSD.

Consumer Survey

The Nevada Center for Excellence in Disabilities (NCED) conducted a statewide survey in the summer of 2022 regarding Nevada's Aging and Disability Services Division's Olmstead Plan and its programs and services. 300 respondents completed the survey, comprising 170 people with lived experience (people with disabilities, older adults, and their family members) and 130 professionals.

Community Workshops

A total of nine community workshops were conducted in the Months of February and March 2023. These workshops were held to gather feedback directly from 128 consumers, family members, care providers, and advocates about what was needed to improve community-based services and supports to people with disabilities across the lifespan. The locations, dates, and the total number of individuals that participated are provided in the summary report provided in the appendix of this document.

The workshop discussions were structured around 11 questions developed to assess the extent that people knew about the Olmstead decision as well as the services available to support community integration. The bulk of each workshop focused on what services were needed for community integration purposes and how well the existing service systems met such needs.

The structure of the workshops was consistent across all seven in-person gatherings. To ensure sufficient time for all participants in the two virtual settings, the structure for input was slightly modified. Input received from the in-person gatherings was summarized and then presented to participants in the virtual settings. Participants in the virtual settings were asked to indicate, through polling, the extent to which they agreed with what had already been identified. Following polling, participants were offered the opportunity to add

any additional thoughts they had on the subject either verbally or through use of the chat function within the Zoom platform.

Key Person Interviews

Interviews were conducted with individuals identified by ADSD and the Steering Committee as having specialized knowledge about the systems that provide community-based services and supports for ADSD service populations. The purpose of these interviews was to understand the strengths and weaknesses of the existing system as well as to solicit ideas about how the system can and/or should be improved.

A total of 21 individuals from 18 organizations participated in the interviews. The sector and organizations represented by the interviewees are included in the table below.[1]

Nevada State & County Agencies	Community-Based Service Providers	Advocacy Organizations & Associations
• Clark County Department of Family Services • Washoe County Social Services • Department of Education, Office of Inclusive Education • Department of Employment, Training, and Rehabilitation Bureau of Vocational Rehabilitation • Division of Health Care Financing and Policy • Division of Public and Behavioral Health	• Advanced Personal Care Solutions • Blind Connect • Collaboration Center Foundation • Nevada PEP • Northern Nevada Center for Independent Living • Opportunity Village • Southern Nevada Center for Independent Living • United Cerebral Palsy of Nevada	• Group Home Association • Legal Aid Center of Southern Nevada • Personal Care Association of Nevada

Input received through all data collection efforts was analyzed to identify system assets and gaps as well as the most critical issues for action. The Steering Committee held three meetings March through June 2023, to review data collected and to finalize the current system assessment.

Phase III – Establishing the Olmstead Plan

The Steering Committee held working meetings from July through November 2023, to complete the Olmstead plan, building specific goals, objectives, and actions to be taken over the next five years. Public input was received on the draft plan and then finalized at the last Steering Committee meeting held in November 2023.

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[1] Note that some individuals represented multiple interests, such as working for a provider or advocacy organization and being a person with lived experience (PLE).

Having a Strategic Orientation

The Olmstead plan will be implemented within the unified framework of the Nevada State Department of Health and Human Services. This framework includes the following vision, mission, and guiding principles.

Vision for Nevadans

Nevadans, regardless of age or ability, will enjoy a meaningful life led with dignity and self-determination.

Mission

Nevadans have the opportunity to achieve optimal quality of life in the community of their choice.

Guiding Principles

Guiding principles are the values or mutually held beliefs that are used for all decision making. The Steering Committee confirmed the following guiding principles in the process of establishing the plan contained herein.

- **Independence:** People should have options and the ability to select the manner in which they live.
- **Access:** People's needs are identified and met quickly.
- **Dignity:** People are viewed and respected as human beings.
- **Integration:** People can live, work and play as a part of their community.
- **Quality:** Services and supports achieve desired person-centered outcomes.
- **Sustainability:** Services and supports can be delivered over the long term so individuals can be self-sufficient.
- **Equity:** Systems and services will center the priorities of people with diverse backgrounds and identifies and include marginalized and under-represented groups in planning, strategies, and resource allocation toward equitable outcomes.

In addition to this framework, the Steering Committee added contextual considerations to their work in creating this plan which acknowledges the following:

- **Cross Coordination:** Cross coordination between state, county and local government systems, as well community service providers, are necessary for community inclusion to become a reality.
- **Directed Funding:** Funding should be directed to efforts that expand the opportunity for community inclusion as opposed to simply sustaining existing services and support.

In addition to these two contextual considerations, the Steering Committee emphasized the need to align efforts within the Center for Medicaid Services (CMS) Home and Community Based Services (HCBS) Settings Rule, which simply stated helps support the outcome that "people with disabilities deserve the same rights to make choices, access the broader community and interact with the broader world as anyone else."[2]. Additionally, efforts to support Nevada's No Wrong Door system should also be considered in the implementation of this plan. For more information on the HCBS Settings Rule and the No Wrong Door framework, please see Appendix G. Relevant Definitions.

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[2] Retrieved on January 27, 2023 from: https://www.aclu.org/sites/default/files/field_document/aclu_faq_-_hcbs_settings_rule-final-_1-10-18.pdf

Understanding the Current Reality
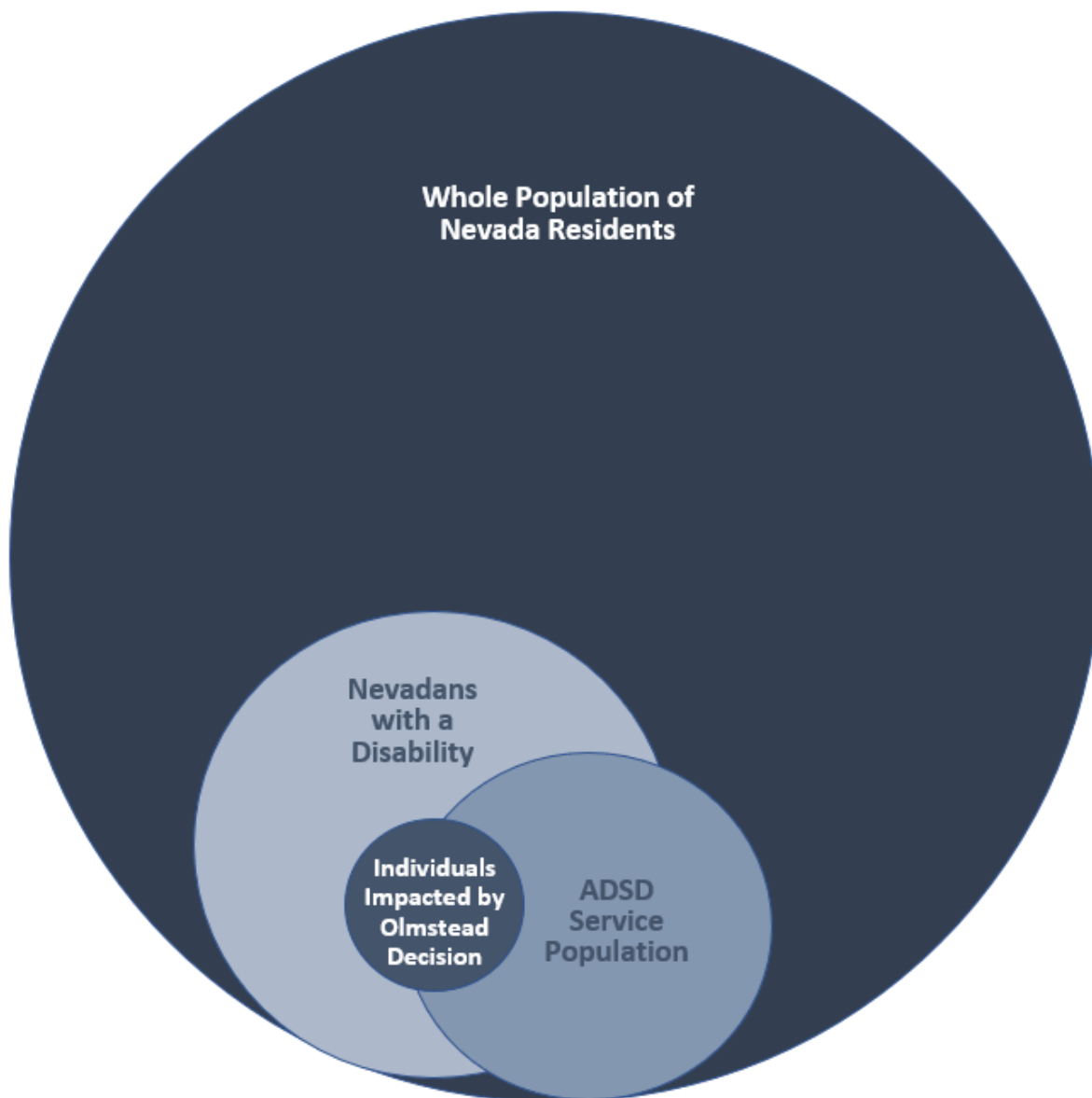
As an initial step in developing a plan to best support community integration for Nevadans with disabilities, a review of the impacted population as well as the State system that serves this population was conducted. The graphic above depicts the specific population that this plan was developed for within the larger context of those served by ADSD, those who live in Nevada with a disability, and finally within the context of the entire Nevada State population.

Individuals impacted by the Olmstead decision include individuals with disabilities who are unnecessarily institutionalized, or who are at risk of unnecessary institutionalization, and who could live in a more integrated setting[3] with appropriate supports and services.

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[3] For the purpose of this plan, integrated settings are defined as "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible." *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 605–06 (1999); 28 C.F.R. pt. 35 app. A (2010).
Olmstead Plan I **2023**

Landscape of Individuals in Nevada with a Disability

According to the US Census Bureau's American Community Survey (ACS) 1-year population estimates, there are approximately 375,254 Nevadans with a disability. The total number of individuals with a disability by county is provided in the graphic and corresponding table below.

Number of Individuals with a Disability by County[4]
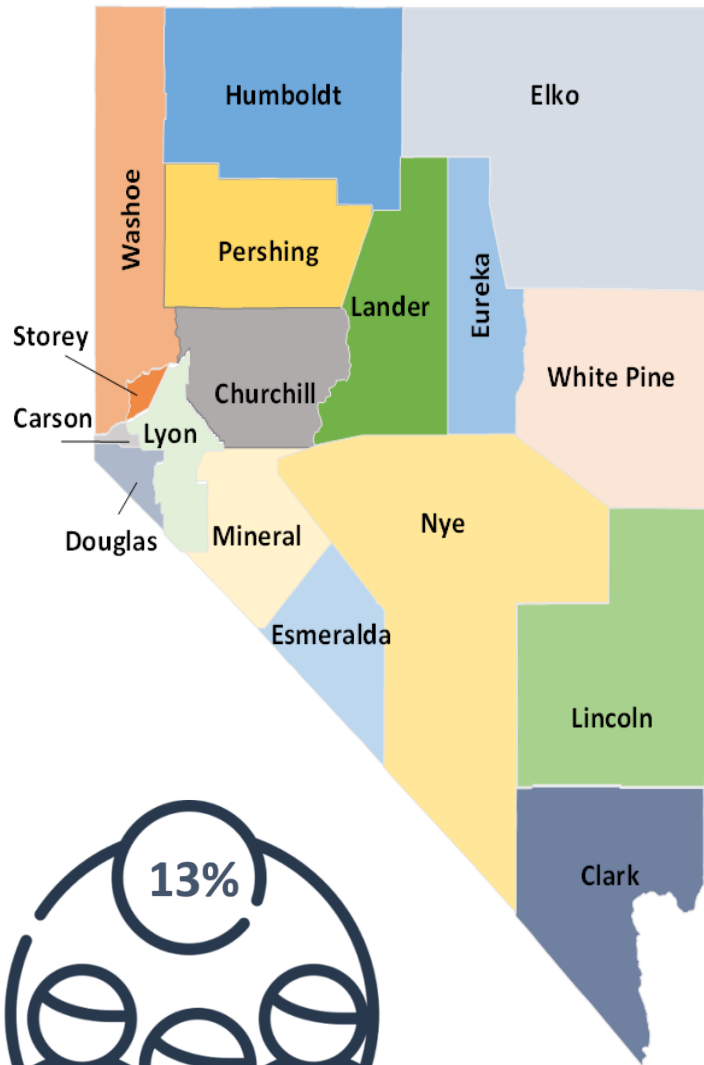
County	Total Population	Number of People with a Disability	Percent of People with a Disability
Carson	53,077	8,739	16%
Churchill	23,367	3,592	15%
Clark	2,204,659	267,031	12%
Douglas	48,245	6,926	14%
Elko	51,827	5,775	11%
Esmeralda	1,024	217	21%
Eureka	1,834	272	15%
Humboldt	16,623	2,104	13%
Lander	5,518	789	14%
Lincoln	4,542	910	20%
Lyon	55,395	9,190	17%
Mineral	4,418	636	14%
Nye	45,054	10,825	24%
Pershing	4,715	592	13%
Storey	4,030	859	21%
Washoe	461,256	55,580	12%
White Pine	8,048	1,217	15%
Nevada	**2,993,632**	**375,254**	**13%**

[4] Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates. Retrieved on November 18, 2022 from: https://data.census.gov/cedsci/table?q=nevadans%20with%20a%20disbility&g=0400000US32,32%240500000&tid=ACSST5Y2020.S1810

Olmstead Plan I **2023**

Adults with Disabilities[5]

The number of adults with any disabilities in Nevada totals 347,478 or approximately 15.06% of the total adult population. A breakdown of the number and percent of adults with a disability by type is provided below.

Percentage of Adults in Nevada With a Disability by Type

8.31%	5.35%	4.81%	4.80%	3.13%	2.86%
Ambulatory Difficulty	Independent Living Difficulty	Cognitive Difficulty	Hearing Difficulty	Vision Difficulty	Self-Care Difficulty
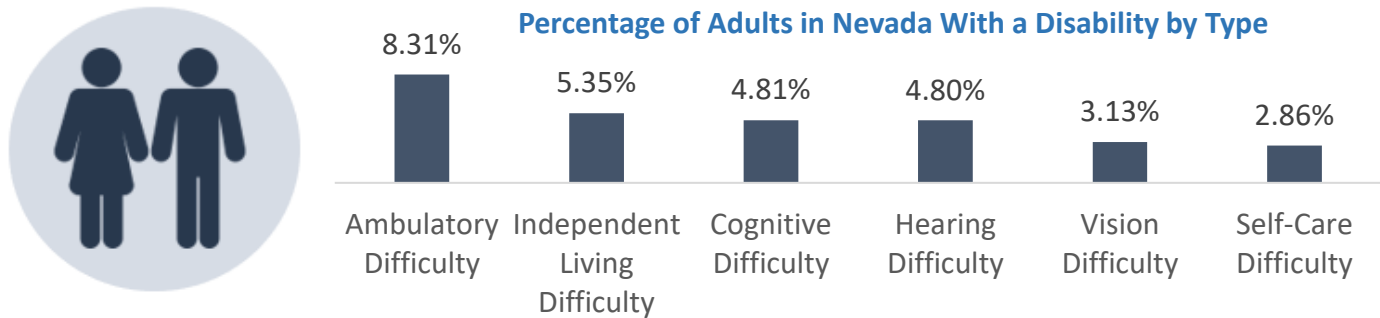
Among adults with a disability in Nevada, the most prevalent type experienced is ambulatory difficulties. It is estimated that 8.31% of the adult population in Nevada have some difficulty walking or climbing stairs. The chart below provides estimates of the number of adults living with various disabilities by county. It should be noted that while the total number of adults with a disability is unduplicated, individuals may experience more than one type of disability and therefore could be represented in more than one subcategory in the table below.

County	Total Number of Adults with a Disability	Total Number with Hearing Difficulty	Total Number with Vision Difficulty	Total Number with Cognitive Difficulty	Total Number with Ambulatory Difficulty	Total Number with Self-Care Difficulty	Total Number with Independent Living Difficulty
Carson	8,043	3,427	1,887	2,767	4,279	1,657	2,695
Churchill	3,388	1,478	822	859	1,700	458	1,071
Clark	246,993	72,517	50,524	79,877	137,883	47,176	89,199
Douglas	6,697	2,917	1,278	1,905	3,515	1,031	1,844
Elko	5,464	2,532	1,063	1,413	2,394	825	1,686
Esmeralda	209	109	35	62	144	31	86
Eureka	206	115	48	32	73	12	85
Humboldt	1,888	807	329	313	1,034	184	504
Lander	772	294	160	141	400	88	179
Lincoln	871	195	76	194	669	161	364
Lyon	8,499	2,926	1,593	2,713	4,857	2,067	3,295
Mineral	636	274	118	284	363	81	117
Nye	10,349	3,802	2,348	2,991	5,385	1,465	3,096
Pershing	566	246	75	125	315	109	209
Storey	859	364	242	396	561	283	309
Washoe	50,904	18,234	11,159	16,628	27,661	10,188	18,276
White Pine	1,134	454	421	259	532	150	359
Nevada	**347,478**	**110,691**	**72,178**	**110,959**	**191,765**	**65,966**	**123,374**

[5]Ibid
Olmstead Plan I **2023**

Children with Disabilities[6]

Percentage of Children in Nevada With a Disability by Type

2.69%	1.13%	0.73%	0.64%	0.55%
Cognitive Difficulty	Vision Difficulty	Self-Care Difficulty	Hearing Difficulty	Ambulatory Difficulty

The number of children with disabilities in Nevada totals 27,776 or approximately 4.05% of the total child population. A breakdown of the number and percent of children with a disability by type is provided below.
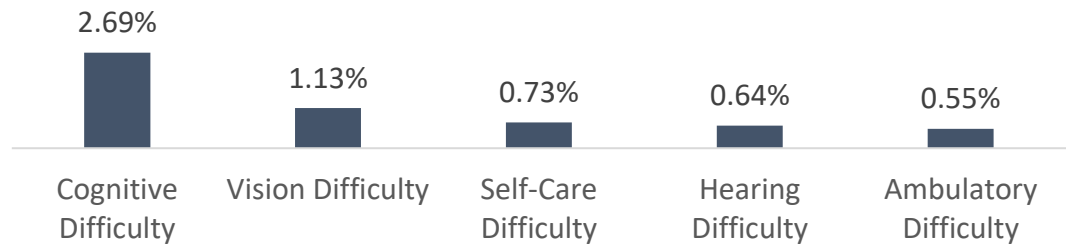
Of children with a disability in Nevada, the most prevalent type experienced is cognitive difficulties. 2.69% of the child population in Nevada have some difficulty concentrating, remembering, or making decisions. The chart below provides estimates of the number of children living with various disabilities by county. As noted within the adult table, while the total number of children with a disability is unduplicated, individuals may experience more than one type of disability and therefore could be represented in more than one subcategory in the table below.

County	Total Number of Children with a Disability	Total Number with Hearing Difficulty	Total Number with Vision Difficulty	Total Number with Cognitive Difficulty	Total Number with Ambulatory Difficulty	Total Number with Self-Care Difficulty
Carson	696	292	447	386	213	191
Churchill	204	58	31	128	30	55
Clark	20,038	2,288	4,823	13,320	2,440	3,442
Douglas	229	6	18	184	0	111
Elko	311	49	44	232	27	21
Esmeralda	8	0	6	0	2	2
Eureka	66	0	38	28	0	0
Humboldt	216	28	66	122	0	6
Lander	17	0	0	17	0	0
Lincoln	39	0	0	39	0	0
Lyon	691	144	196	641	205	249
Mineral	0	0	0	0	0	0
Nye	476	0	122	425	0	0
Pershing	26	0	0	26	0	0
Storey	0	0	0	0	0	0
Washoe	4,676	1,507	1,966	2,818	852	924
White Pine	83	0	1	82	0	0
Nevada	**27,776**	**4,372**	**7,758**	**18,448**	**3,769**	**5,001**

[6] Ibid
Olmstead Plan I **2023**

ADSD Systems Description

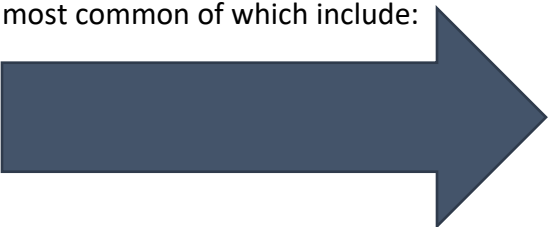> ### Complexity of Ensuring Systems Support Community Integration
>
> ADSD is one of many systems that is charged with ensuring individuals with disabilities have access to services and supports that help ensure people can shelter, work, and live in the community of their choice. Beyond ADSD, the other systems that impact community integration include those that provide behavioral health, housing, transportation, and healthcare.
>
> The coordination between these systems is but one condition that must be acknowledged to understand the complexity of ensuring individuals with disabilities have access to the supports they require. The various systems' funding streams, with their specific eligibility requirements and sometimes overlapping regulations, also contribute to the complex nature of addressing community integration opportunities.
>
> Because this is an ADSD specific plan, the systems description provided within this section is a snapshot of the services and supports provided by ADSD alone, at the time of plan development (April 2023).

Of the population living in Nevada with a disability, a smaller portion than the whole is served by ADSD programs. ADSD offers a variety of services, some of which are specifically geared to home and community based care options and are provided with the express intent of supporting community integration. These services are often referred to as Home and Community-Based Services (HCBS) or "Waiver" services. ADSD offers other support services that are often essential so that home and community-based care can be an option. Funding for all services comes from numerous sources including federal Medicaid dollars, state general funds, federal grants, and other funding mechanisms.

For the purpose of this plan, the following section provides a list of the programs and corresponding services offered by ADSD as well as the number of people historically served. In addition, the number of people on various waitlists and the average time spent on waitlists is offered where available. ADSD has a self-imposed goal that people will not be on waitlists for any more than 90 days, although as the data demonstrates, that goal is not always met. It is important to note that a person can be on a waitlist for a variety of reasons, the most common of which include:

- Insufficient funding to support service delivery
- Insufficient staffing to case manage services and supports
- Lack of providers available to offer services
- Service recipient rejection based on provider(s) available

The information in the following section is bundled by specific ADSD service populations which include 1) individuals with intellectual or developmental disabilities, 2) individuals who have a physical disability, and 3) older adults. For more detailed information on service definitions, please refer to Appendix A.
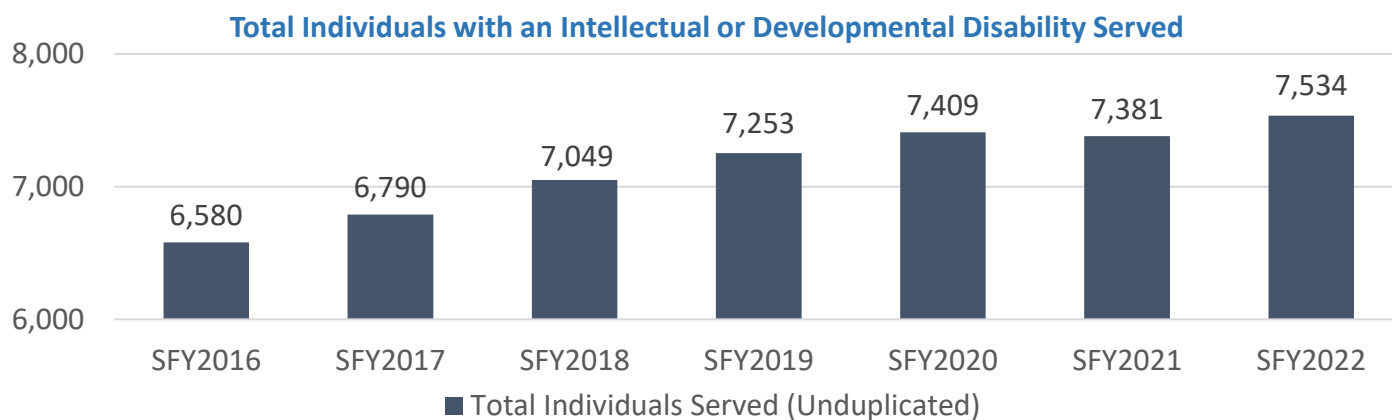
ADSD Service Systems Description for Individuals with Intellectual or Developmental Disabilities

ADSD provides programming to individuals diagnosed with intellectual or developmental disabilities (I/DD) who meet substantial functional limitation requirements. Developmental Services (which is the overarching name of the program within ADSD that supports individuals with intellectual or developmental disabilities) offers an array of services to meet individual needs through the person-centered planning process. These services are provided through four sub-programs: Residential Services Program, Jobs and Day Training Program, Family Support Program, and Family Preservation Program. Individuals may participate in and receive services from multiple programs simultaneously. Upon eligibility determination, service coordination and development of a person-centered plan are immediately provided to establish services needed. In addition to service coordination, services that may be available to individuals with intellectual or developmental disabilities comprise:

✓ Behavioral Consultation, Training, and Intervention	✓ Nursing Services	✓ Residential Support Services
✓ Career Planning	✓ Nutritional Counseling	✓ Respite
✓ Counseling (Individual and Group)	✓ Prevocational Services	✓ Self-Directed Family Support Services
✓ Day Habilitation	✓ Purchase of Service	✓ Service Coordination
✓ Family Preservation Program	✓ Regional Center Clinical Services	✓ Supported Employment
✓ Non-Medical Transportation	✓ Residential Support Management	

Number of Individuals Served

The figure below illustrates the total number of unduplicated people with intellectual or developmental disabilities who received support from ADSD between 2016 and 2022. People included in the total number served may have received only service coordination or one or more of the additional services described above.

Total Individuals with an Intellectual or Developmental Disability Served

SFY2016	SFY2017	SFY2018	SFY2019	SFY2020	SFY2021	SFY2022
6,580	6,790	7,049	7,253	7,409	7,381	7,534

■ Total Individuals Served (Unduplicated)

As is demonstrated in the figure, the total number served has increased from 6,580 in SFY2016 to 7,534 in SFY2022.[7]

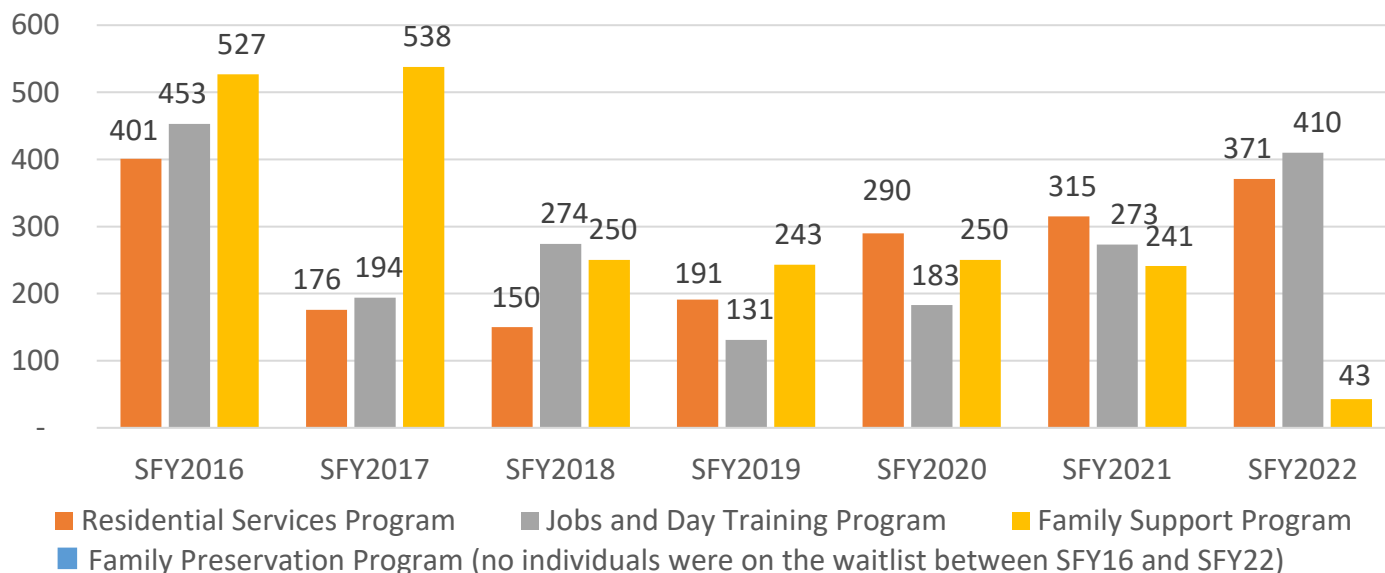[7] ADSD Caseload Statistics SFY 16-22

Number of Individuals on Program Waitlists

As noted earlier in this section, upon eligibility approval, service coordination and a person-centered plan are immediately provided to determine additional services needed. The figure below shows how many people were on the waitlist for services offered under specific programming for each of the past seven years. Note that because individuals can be on the waitlist for multiple programs at a given time, the waitlist counts are provided by the type of program sought rather than by a count of unduplicated individuals.

In SFY2022 there were 371 people on the waitlist for residential services programming, 410 people on the waitlist for jobs and day training programming, and 43 people on the waitlist for family support programming.[8]

Individuals on Waitlists for Intellectual or Developmental Disability Programs

	SFY2016	SFY2017	SFY2018	SFY2019	SFY2020	SFY2021	SFY2022
Residential Services Program	401	176	150	191	290	315	371
Jobs and Day Training Program	453	194	274	131	183	273	410
Family Support Program	527	538	250	243	250	241	43

■ Residential Services Program ■ Jobs and Day Training Program ■ Family Support Program
■ Family Preservation Program (no individuals were on the waitlist between SFY16 and SFY22)

Average Time Spent on Waitlist

As stated earlier in this section, services for individuals with intellectual or developmental disabilities are funded by a variety of sources. The average time spent on waitlists is only available for those receiving support under the Home and Community Based Services Waiver for Individuals with Intellectual or Developmental Disabilities (HCBS-IDD).

Average Number of Days on Waitlist for HCBS-IDD Programming

SFY2016	SFY2017	SFY2018	SFY2019	SFY2020	SFY2021	SFY2022
494	627	686	612	477	184	315

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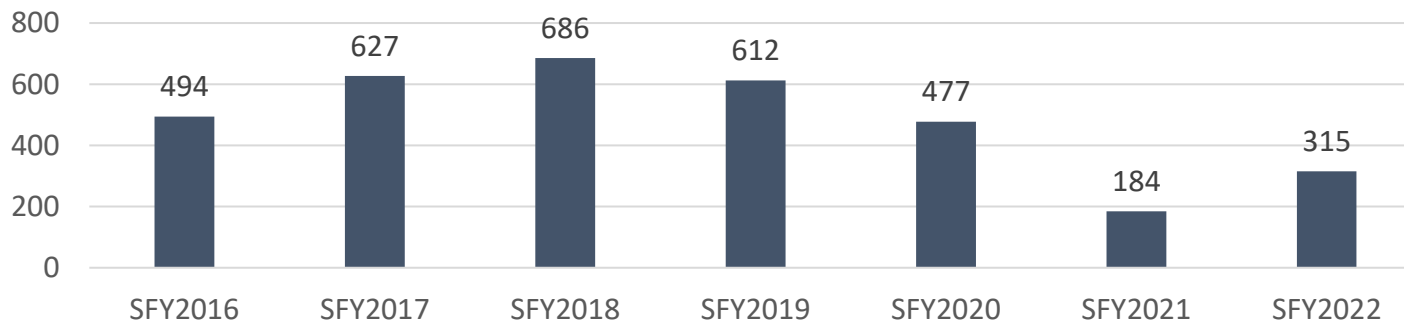
[8] ADSD Caseload Statistics SFY 16-22

Contextual Considerations

Various conditions have impacted ADSD as it serves people with intellectual and/or developmental disabilities. Each circumstance is being offered for contextual understanding when looking at the data particular to this service population.

ADSD identified the COVID-19 pandemic as the primary factor in the decreased number of people served in SFY 2021. This was due in large part to a decrease in the number of referrals received f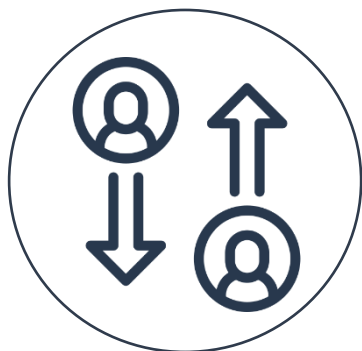or Developmental Services by other service systems (such as schools) and people's hesitation in leaving their homes to access care.

Despite the dip in numbers served in SFY 2021, the pandemic is an assumed factor for the increase in numbers served in SFY 2022. The mental health issues that individuals struggled with during the pandemic are believed to have brought more children into the service system. Parents who may have delayed accessing supports for their children who have an intellectual or developmental disability have sought out assistance with the mental health concerns considered to be impacted by COVID-19.

Workforce issues have been the primary barrier for individuals getting the support needed within Residential Services and Jobs and Day Training programming offered through Developmental Services. Providers do not have enough staff to support residential and job and day training need within Nevada. The result can be seen in the increased number of people on waitlists for these two programming areas.

According to ADSD, "currently there are less people receiving residential services and jobs and day training services than prior to COVID." To address the issue, funding for these services was shifted in SFY 2021 and SFY 2022 to Family Support programming so that families were able to get some assistance.

Traditionally, Developmental Services has served more people with intellectual disabilities than those with developmental disabilities, however this is changing. ADSD is seeing more and more people with developmental disabilities seeking support. It is estimated that between 65-70% of the new cases opened within Developmental Services in FY 22-23 was made up of individuals with developmental disabilities.

Developmental Services is also experiencing an increase in the number of people with a dual diagnosis (people who have a developmental disability and a mental health issue, in particular). This shift has implications for the service system as many providers feel ill-equipped to meet the needs of this service population, leaving many without the support required.

ADSD Service Systems Description for Individuals with Physical Disabilities

ADSD provides programming to individuals with physical disabilities. These services are provided through three programs that represent unique funding sources: Home and Community Based Services Waiver for the Physically Disabled (HCBS-PD), Assistive Technology for Independent Living Program (AT/IL), and Personal Assistance Services (PAS) Program. Individuals may participate in either HCBS-PD or PAS programing in addition to AT/IL. Individuals cannot participate in HCBS-PD and PAS at the same time.

Upon service approval, coordination and a person-centered plan is immediately provided to determine additional services needed. Services that may be available to individuals with physical disabilities through the three programs above include:
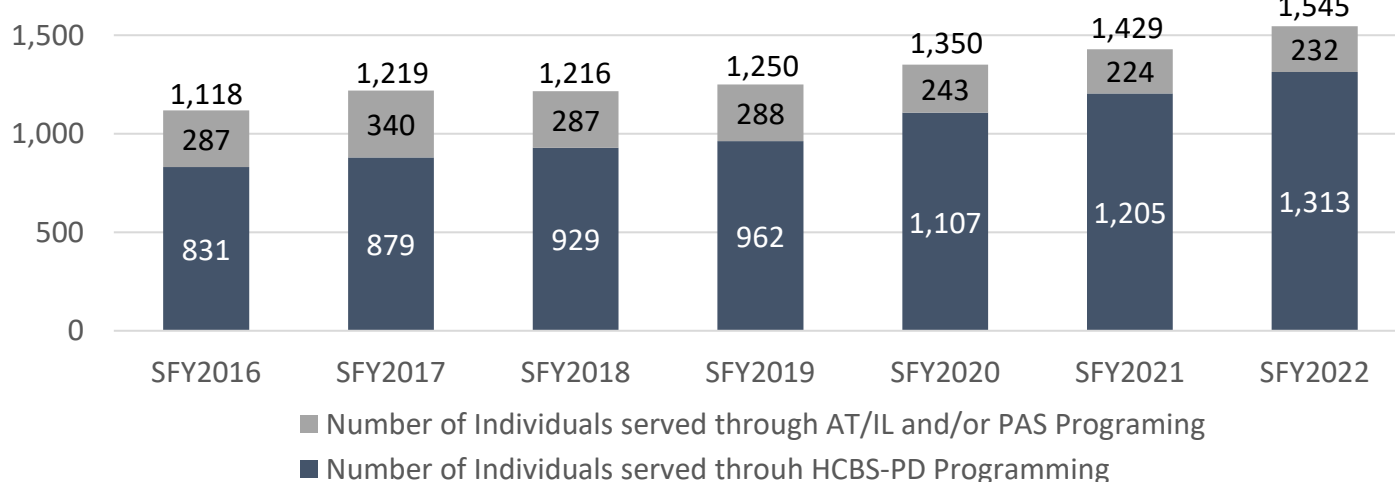
✓ Assisted Living	✓ Home Delivered Meals	✓ Personal Emergency Response System (PERS)
✓ Attendant Care	✓ Homemaker Assistance	✓ Respite
✓ Case Management	✓ Home Modifications	✓ Specialized Medical Equipment and Supplies
✓ Chore Services		

Number of Individuals Served

The figure below illustrates an estimated total number of people with physical disabilities who received support from ADSD over the past seven years. People included in the total number served may have received one or more of the services described above. Due to the data management systems used, an unduplicated count is not available for this service population. As such, the figure below illustrates the minimum and maximum number of individuals served in each year.[9]

As is demonstrated in the figure, the total number served has increased from a minimum of 831 in SFY2016 to a minimum of 1,313 in SFY2022.[10]

Total Number of Individuals with a Physical Disability Served

	SFY2016	SFY2017	SFY2018	SFY2019	SFY2020	SFY2021	SFY2022
Total	1,118	1,219	1,216	1,250	1,350	1,429	1,545
AT/IL and/or PAS	287	340	287	288	243	224	232
HCBS-PD	831	879	929	962	1,107	1,205	1,313

■ Number of Individuals served through AT/IL and/or PAS Programing
■ Number of Individuals served throuh HCBS-PD Programming

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[9] The HCBS-PD number is identified as the minimum number of people served as this program served the most unduplicated individuals. The people served by AT/IL and/or PAS programming may or may not have also accessed the HCBS-PD programming making an unduplicated total count impossible.
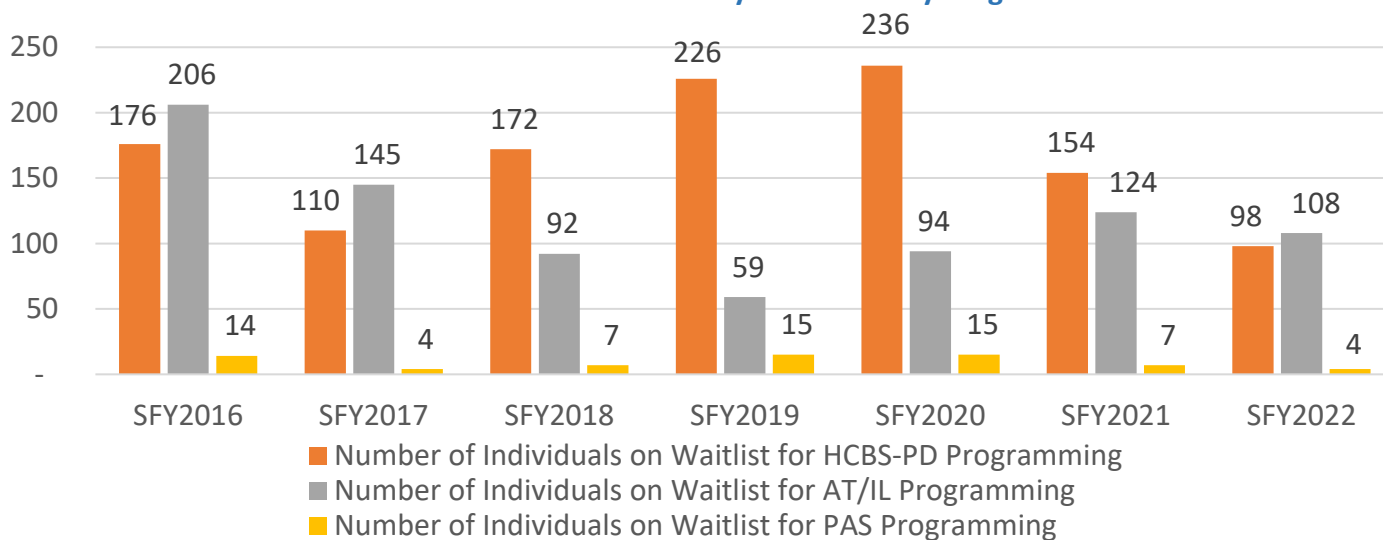
[10] ADSD Caseload Statistics SFY 16-22

Olmstead Plan I **2023**

Number of Individuals on Program Waitlists

The figure below shows the total number of unduplicated people who were on a waitlist for programming for individuals with physical disabilities in each of the past seven years. Note that because individuals can be on the waitlist for multiple programs at a given time, the waitlist counts are provided by the program rather than by a count of unduplicated individuals.

In SFY2022 there were 98 people on the waitlist for Home and Community Based Services Waiver for Physically Disabled (HCBS-PD) programming, 108 people on the waitlist for Assistive Technology for Independent Living (AT/IL) programming, and 4 people on the waitlist for Personal Assistance Services (PAS) programming.[11]

Individuals on Waitlists for Physical Disability Programs

- Number of Individuals on Waitlist for HCBS-PD Programming
- Number of Individuals on Waitlist for AT/IL Programming
- Number of Individuals on Waitlist for PAS Programming

Average Time Spent on Waitlist

As stated earlier in this section, services for individuals with physical disabilities are funded by a variety of sources. The average time spent on waitlists for each of these programs is provided below. [12]

Average Number of Days on Waitlists for Physical Disability Programs

- Average Number of Days on Waitlist for HCBS-PD Programming
- Average Number of Days on Waitlist for AT/IL Programming
- Average Number of Days on Waitlist for PAS Programming

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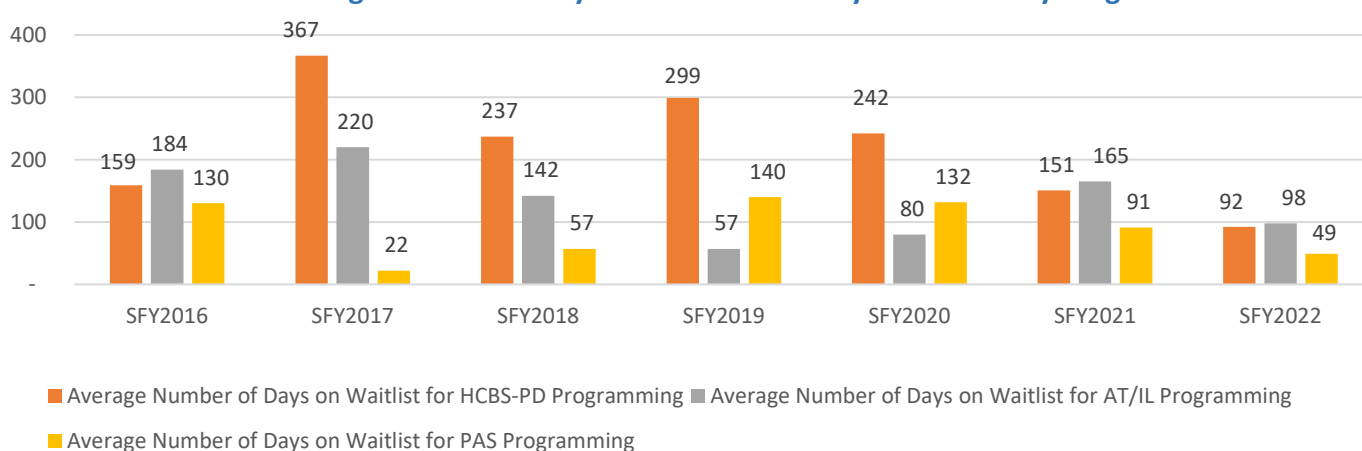
[11] Ibid
[12] Ibid

ADSD Service Systems Description for Older Adults

As some individuals age, they begin to experience a decreased ability to live independently, either due to cognitive or physical decline. ADSD provides services to support older adults with such disabilities based on cognitive or physical decline through three programs that represent unique funding sources: Home and Community Based Services Waiver for the Frail Elderly (HCBS-FE), Older Americans Act (OAA), and Community Options Program for the Elderly (COPE). Individuals may participate in either HCB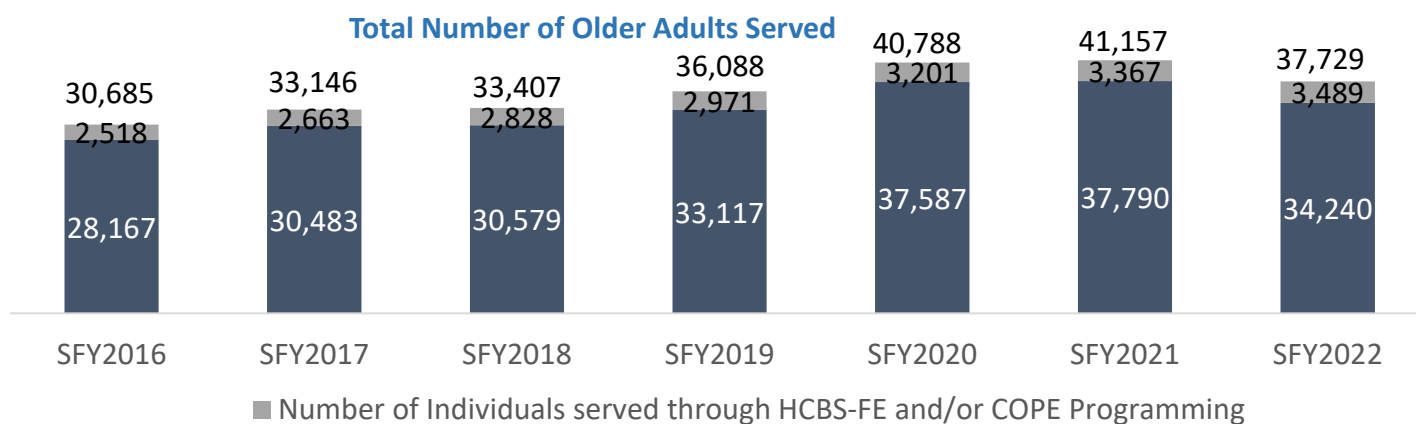S-FE or COPE programing in addition to OAA programming. Individuals cannot participate in HCBS-FE and COPE at the same time. Upon service approval, coordination and a person-centered plan is provided to determine additional services needed. Services that may be available to older adults through the three programs above include:

✓ Adult Companion	✓ Home Delivered Meals	✓ Personal Emergency Response System (PERS)
✓ Augmented Personal Care in Residential Care Settings	✓ Homemaker Assistance	✓ Respite
✓ Case Management	✓ Home Modification and Repairs	✓ Social Adult Daycare
✓ Chore Services	✓ Personal Care Services	✓ Transportation

Number of Individuals Served

The figure below illustrates an estimated total number of older adults who received support from ADSD over the past seven years. People included in the total number served may have received one or more of the services described above. Due to the data management systems used, an unduplicated count is not available for this service population. As such, the figure below illustrates the minimum and maximum number of individuals served in each year. The blue bar represents the number of people served specifically through OAA programming while the grey bar represents people served through HCBS-FE and/or COPE programming. The blue bar represents the minimum number of people served while the combined total of the blue and grey represents the maximum number of people served.[13]

As demonstrated in the figure, the total number of individuals served increased between SFY2016 and SFY2021, reaching its highest minimum count of 37,790 in SFY2021 before decreasing to 34,240 in SFY2022.[14]

Total Number of Older Adults Served

	SFY2016	SFY2017	SFY2018	SFY2019	SFY2020	SFY2021	SFY2022
Total	30,685	33,146	33,407	36,088	40,788	41,157	37,729
HCBS-FE/COPE	2,518	2,663	2,828	2,971	3,201	3,367	3,489
OAA	28,167	30,483	30,579	33,117	37,587	37,790	34,240

■ Number of Individuals served through HCBS-FE and/or COPE Programming

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[13] The OAA number is identified as the minimum number of people served as this program served the most unduplicated individuals. The people served by HCBS-FE and/or COPE programming may or may not have also accessed the OAA programming making an unduplicated total count impossible.
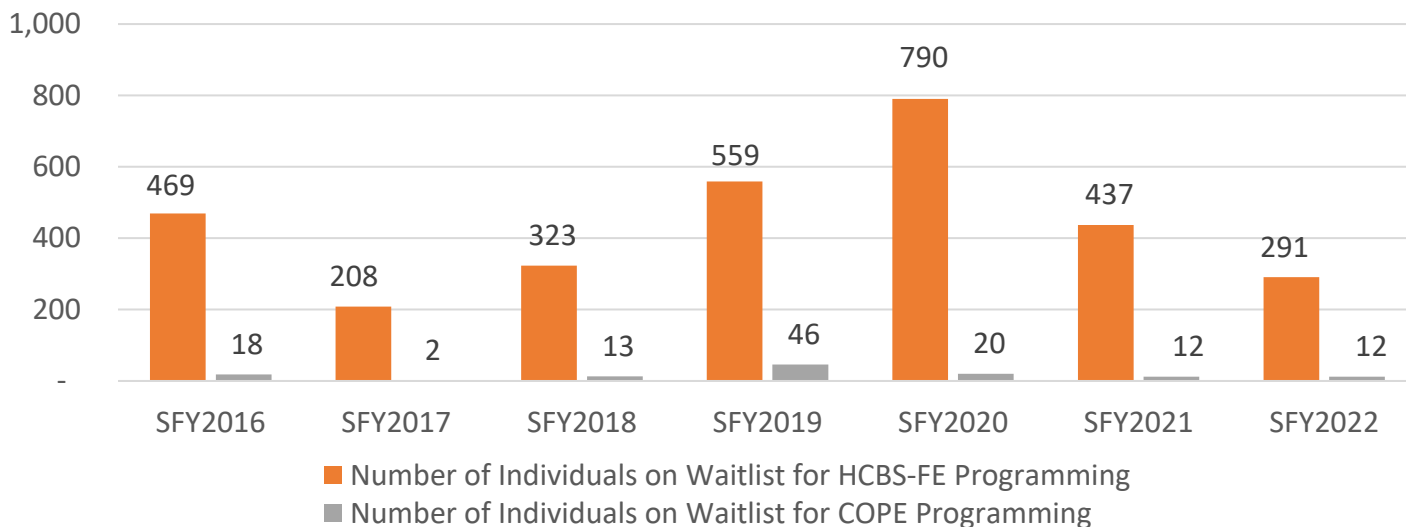
[14] Ibid

Olmstead Plan I **2023**

Number of Individuals on Program Waitlists

The figure below shows the total number of unduplicated people who were on a waitlist for programming for older adults with disabilities in each of the past seven years. Note that because individuals can be on the waitlist for multiple programs at a given time, the waitlist counts are provided by the program rather than by a count of unduplicated individuals. Additionally, waitlist data is only available for HCBS-FE and COPE programming. Waitlist data is not available for OAA programming.

In SFY2022 there were 291 people on the waitlist for HCBS-FE programming and 12 people on the waitlist for COPE programming.[15]
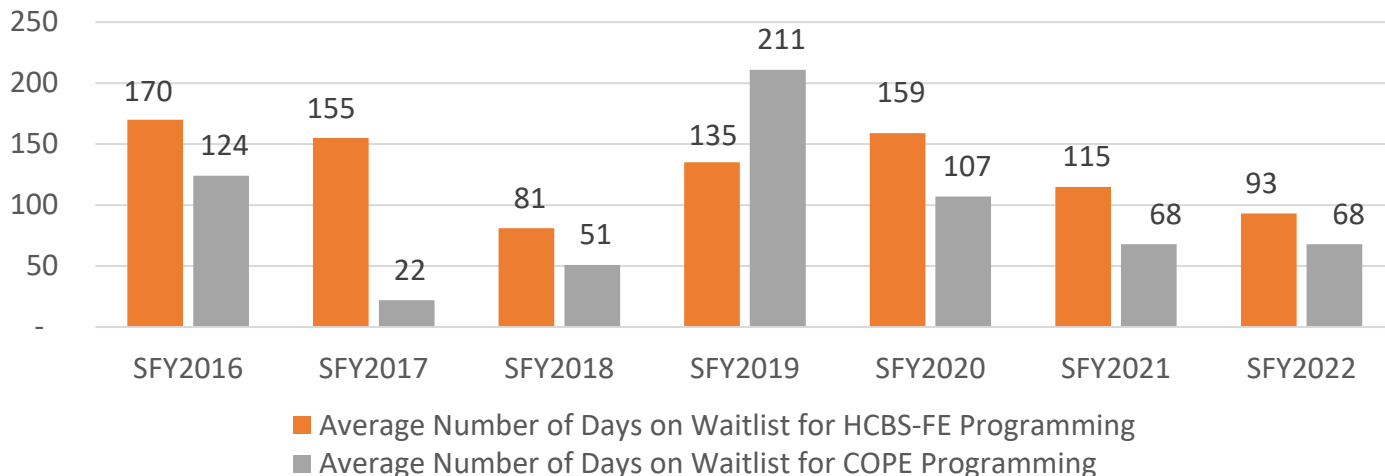
Individuals on Waitlists for Programs for Older Adults

Bar chart "Individuals on Waitlists for Programs for Older Adults". Orange bars = Number of Individuals on Waitlist for HCBS-FE Programming; Gray bars = Number of Individuals on Waitlist for COPE Programming.

	SFY2016	SFY2017	SFY2018	SFY2019	SFY2020	SFY2021	SFY2022
HCBS-FE	469	208	323	559	790	437	291
COPE	18	2	13	46	20	12	12

Average Time Spent on Waitlist

As stated earlier in this section, services for older adults with disabilities are funded by a variety of sources. The average time spent on waitlists is only available for those receiving support under the HCBS-FE and COPE programming.[16]

Average Number of Days Spent on Waitlists for Older Adults Programs

Bar chart "Average Number of Days Spent on Waitlists for Older Adults Programs". Orange bars = Average Number of Days on Waitlist for HCBS-FE Programming; Gray bars = Average Number of Days on Waitlist for COPE Programming.

	SFY2016	SFY2017	SFY2018	SFY2019	SFY2020	SFY2021	SFY2022
HCBS-FE	170	155	81	135	159	115	93
COPE	124	22	51	211	107	68	68

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[15] Ibid
[16] Ibid
Olmstead Plan I **2023**

Contextual Considerations

Various conditions have impacted ADSD as it serves older adults with some sort of functional limitation. Each circumstance is being offered for contextual understanding when looking at the data particular to this service population.

The COVID-19 pandemic was the primary factor in the increased number of people served in SFY 2021 and SFY 2022. This was due in large part to older individuals needing increased assistance because of the restrictions that the pandemic placed on everyday life. Many of the home-delivered services such as home-delivered meals as well as adult companion services saw a significant increase in utilization.

As society continues to return to pre-pandemic behavior, the number of older adults needing services is expected to decrease back to pre-pandemic levels of care.

Waitlist data for older adults accessing ADSD services due to a functional limitation is not universally available. While most older adults accessing support through ADSD do so under the OAA programming, waitlist information is not collected for this population. Additionally, while those individuals on waitlists to access HCBS-FE programming is collected, the average time spent on waitlists is not tracked.

The various data systems used throughout ADSD is a systems level issue that has been recognized as a barrier and continues to impact the ability of ADSD to use metrics to drive programming and continuous quality improvement.

Comparison of Individuals Served by ADSD in Community Versus Institutional Settings

Beyond understanding the types of programs and services provided to ADSD clients that support community integration, the Steering Committee also reviewed the number of individuals served in Medicaid funded community based programs (HCBS-IDD, HCBS-PD, and HCBS-FE Waiver programming) versus the number of individuals served within Medicaid funded institutional settings (Intermediate Care Facilities and Nursing Homes).

This comparison was relevant to Olmstead Plan development as anyone who qualifies for HCBS Waiver services has a significant enough level of need that they are either already in an institutional setting or at imminent risk for placement within an institutional setting.[17] As such, the comparison provided on the next page demonstrates the number of people who were served through HCBS Waiver programming versus those served in either an Intermediate Care Facility or a Nursing Home.

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[17] To qualify for HCBS-PD or HCBS-FE programming, an individual must meet a level of care for a nursing facility (NF), while those on HCBS-IDD must qualify for an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IDD).

Olmstead Plan I **2023**

**Total Number of Individuals Served in HCBS Waiver Programming
Versus those Served In Medicaid-Funded Intermediate Care Facilities or Nursing Homes**

- ■ Number of People Served in HCBS Waiver Programs
- ■ Number of People Served in Intermediate Care Facilities or Nursing Homes
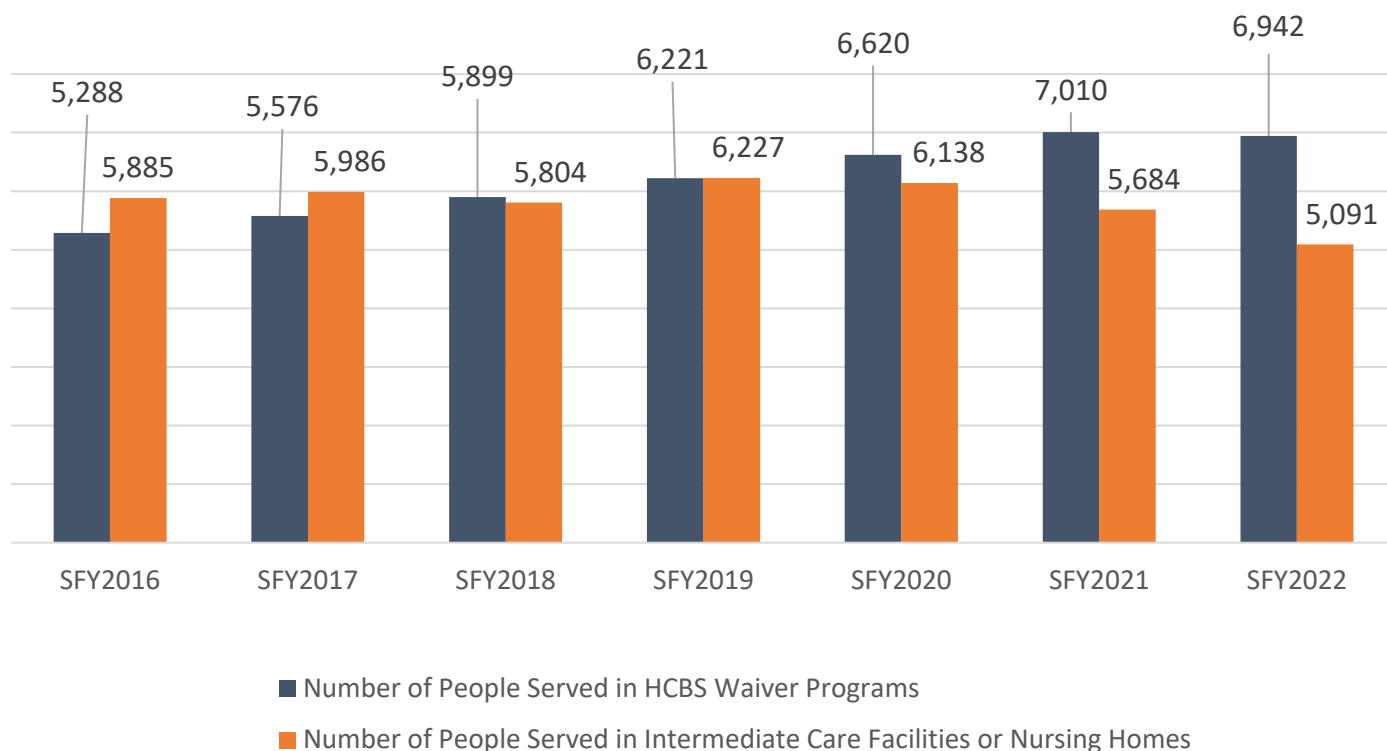
As the table above demonstrates, the number of people being served within institutional settings is decreasing over time while the number of people being served in community-based settings is increasing over time.

Support for Care Transitions

For individuals who are being served within Intermediate Care Facilities and Nursing Homes, efforts are made to continually assess whether home and community-based care is an option. Various approaches are taken to conduct such assessments based on the institutional setting. Regardless of the approach, assessments are conducted on a quarterly basis. If it is determined that an individual CAN be served in a community-based setting and that they WANT to be served in such manner, they are often referred to programs that support their transition efforts. These programs include the following:

Facility Outreach and Community Integration Services (FOCIS): FOCIS Is a program that offers Medicaid recipients who are either in an institutional setting or at imminent risk of placement within such a setting the support of a Health Care Coordinator. The Health Care Coordinators advocate for program participants and assist them in navigating the system of support needed to live outside of an institutional setting.

No Wrong Door (NWD): No Wrong Door is the framework for implementing Nevada Care Connection Resource Centers. This programming can support individuals in exploring options and services for transitioning. Current areas of focus are on assisting individuals transitioning from acute care hospital settings to community-based settings. Future efforts will expand diversion and transition activities from other settings such as skilled nursing facilities.

Additional information about NWD is included in the Appendix of the document.
Olmstead Plan I **2023**

Assets and Gaps in Care

To understand both the assets as well as gaps in the systems that support community integration, an analysis was conducted which included a review of the state system and the number of people served, as well as information gathered through the UNR survey, key person interviews, and consumer workshops.

Assets to Leverage

A variety of assets were identified while assessing the current systems of support available to individuals with disabilities. These assets should be leveraged and built upon to enhance progress towards community integration.

Focus on community-integration: ADSD leadership and community providers described a focus on enhancing opportunities for people with disabilities to live, work, and play in communities of their choice. Many providers described community integration as their "default setting" in provision of care and often referred to a person-centered approach to service delivery. Furthermore, the data provided on page 22 indicates a progressive shift in ADSD's service delivery, with an increasing number of individuals being served in community-based settings and a decreasing reliance on congregate-care settings over the years.

Further indication of support for individuals with disabilities and their rights as it pertains to home and community-based supports can be seen in SB 315 as adopted in the 2023 Nevada state legislative session.

> **Bill of Rights for Persons with Intellectual, Developmental or Physical Disabilities or who are Aged**
>
> Senate Bill 315, as taken up in the 2023 Nevada State Legislative session, prescribes certain rights for individuals who are aged or disabled and who are receiving home and community-based waiver services. Further, this bill sets forth certain rights for students with disabilities who are enrolled in public school or who are receiving certain services from a special education provider and transition services through an individualized education program.

Partnerships with providers: Some providers that took part in community workshops and key person interviews referenced a strong working relationship with ADSD while others noted a reliance on other service partnerships as an integral component of meeting people's diverse range of needs. These collaborations will play a pivotal role in achieving community integration at a statewide level since no single agency, program, or practice can accomplish it independently.

Engaging people with lived experience: ADSD has engaged a number of people with lived experience (PLEs) into their system. PLEs sit on several boards and commissions, advising the Division on a variety of issues. ADSD has also relied upon PLEs as a component of this process by way of; 1) requesting individuals to serve on the Steering Committee who have a lived experience, and 2) soliciting PLE input using community workshops and public comments received on the ADSD Olmstead Planning webpage.

Co-location of services: Community workshop participants in at least two locations as well as one key person interviewed identified the ease of accessing services when different programs and supports are located in the same place. The co-location of services increases access by making it more convenient, coordinated, and comprehensive for individuals seeking support. It helps overcome barriers and ensures that people can easily access the services they require in a more efficient and effective manner.

Legislative support: ADSD reports a consistent trend where the number of individuals on waiting lists decreases after each bi-annual legislative session. This reduction can be attributed to the allocation of funding specifically designated to address these waitlists. However, it is important to note that the bi-annual nature of budget adoptions results in waitlist concerns being addressed only once every other year.

Pending rate increases: The 2023 Nevada legislative session passed the largest single rate increase to Developmental Services-contracted providers in the history of Developmental Services. Burns & Associates completed a rate study for Developmental Services in 2021, which was the first rate study since 2002. This study outlined a change in service authorization methodology to more closely align with how individuals are requesting to receive services and how services are currently provided. These changes are expected to ease difficulty in provider billing, are aligned with federal Home and Community Based Settings Rules expectations and authorizes services in a way that allows for personal choice and creating a meaningful day for individuals served. Details on this as well as additional action taken by the 2023 Legislature impacting Developmental Services can be found in Appendix F.

Gaps to Address

The following gaps are being provided individually, however many of them are interdependent and should be addressed as such**.**

Fractured and complex system: While some individuals noted the ease of accessing services, others indicated that the system for providing community integration opportunities is siloed and difficult to navigate, lacking a continuum of care and ease of access. The system needs to apply person-centered practices throughout, establish continuity between children/youth and adult programs, develop a fair and transparent grievance system, and disseminate reliable information on programs and services in an easily accessible manner. Engaging people with lived experience and partnering more closely with county entities and community service organizations were also identified as ways to improve the system.

Lack of sufficient and flexible funding: Insufficient as well as a lack of flexibility in funding services that promote community integration was noted as a primary barrier to providing person-centered care. Additionally, eligibility requirements sometimes leave individuals without the assistance needed to remain in a community-based setting. Advocating for more funding, revising rates and how services are paid for, expanding waiver services, and establishing more flexible funding options for service delivery are suggested actions to address this issue.

Workforce shortages and sufficiency: Challenges in filling positions and ensuring knowledgeable and appropriately trained individuals within the system were repeatedly identified. Adjusting Medicaid reimbursement rates, incentivizing employment/service provision, providing Olmstead and person-centered training to staff, and implementing innovative recruitment and training practices can help address this issue.

Inadequate data collection, tracking, and sharing across programs: Data systems utilized by ADSD do not share information across programs and/or funding streams, leaving people to complete multiple applications for various services. Data systems also fail to produce the metrics necessary for the types of comprehensive and longitudinal data tracking needed to support data-driven decision making. Specifically, data is not available to inform how resources allocated to serve individuals with disabilities are used, and about the impact of those services on people's lives. This circumstance was highlighted as ADSD set forth to describe and assess the current system as a component of plan development. Establishing a data collection system

that includes comprehensive data across programs and services could support not only better insights by ADSD but could also promote easier access for the people being served.

Limited knowledge of service availability: People with lived experience and their family members/support system lack awareness of ADSD services for community integration. Additionally, service providers are also not aware of the array of services available that support community integration. Peer-to-peer information sharing, self-directed internet research, and service providers were identified as primary sources of information. Improving the ADSD website, targeted messaging, staff training, provider outreach, and enhancing collaboration with other agencies can increase awareness and increase access and utilization of services.

Lack of understanding of the Olmstead Decision: People with lived experience and their family members/support system have limited understanding of the Olmstead Decision, if at all. There are differing levels of awareness among populations, with the aging population and individuals with dementia or Alzheimer's being less informed. Providers also often indicated low awareness. Public education about the decision and its implications, especially regarding the community integration mandate, can improve understanding and support system design modifications.

Gaps in services for people with disabilities: Affordable housing, transportation, supported living arrangements, personal assistance support, and employment with a living wage were among the services identified as needed but not always accessible by both PLEs and the professionals that serve them. While some of these services fall outside of the authority of ADSD, it will be important to partner and advocate with other state departments and divisions, as well as counties, community-based providers, and advocacy groups to support true inclusion of individuals with disabilities into the fabric of Nevada's society.

Additionally, long waitlists leave some people without timely access to care. Transparent communication with individuals on the waitlist, providing updates and information about status can help manage expectations and reduce frustration.

Critical Issues for Action

While all gaps are important, the following have been identified as critical and needing action within this plan.

Improve Knowledge Sharing: Establish a clear, complete, and accessible method of information sharing about services available, eligibility requirements, the application process, and grievance procedures that are associated with services and service providers. Additionally, make information about community service providers publicly available. Information such as what providers are available, what their service capacity is, the quality of their service provision, the grievance process they use, and their waitlists should be accessible.

Prioritize ADSD Workforce Supports: Assess the ADSD workforce, identifying barriers to employment and addressing such barriers to encourage a full and sustainable workforce to implement ADSD services and supports. Provide all ADSD staff with training on Olmstead, person-centered planning, and the promotion of community integration over institutionalization and segregated settings. Also establish an expectation that care coordinators and other direct service staff work from a preventive position to identify any and all strategies to support an individual's needs that could prevent future placement in a segregated setting (in school, work, or home-based settings).

Make Inclusion and Accountability an Imperative. Integrate the disability community into every aspect of the ADSD service system. Piloting a culture of inclusion within ADSD that brings people with disabilities into the service system as subject matter experts, policy makers, and service providers would promote inclusion.

Focus on Data Collection and Continuous Quality Improvement: Establish standard data collection efforts across all ADSD programs and services. Additionally establish systems that would enable the Division to:

- Pro-actively monitor individuals who are placed on a waitlist, ensuring they are not on a waitlist for more than 90 days.
- Assess quality of care provided by ADSD as well as community service providers, identifying plans to address any issues identified including placement of programs and providers on systems improvement plans.
- Develop a consumer grievances process that outlines how a grievance can be submitted, what the due process will look like, and how qualified grievances will be managed.

Develop a Statewide Solution: ADSD should advocate, coordinate, and facilitate, if necessary, a multidisciplinary planning group to address the needs of individuals with disabilities in a manner that places the burden to serve on the systems as opposed to the people it impacts. Person-centered planning should not be implemented strictly at the program level but rather should be executed at the systems level.

A Plan for the Future

The following section describes how ADSD intends to expand opportunities for community-based services. The plan accounts for limited staff resources and guides resources strategically, establishing a realistic approach to assist ADSD in implementing and measuring progress towards meeting its goals and holding itself accountable in the work that it does.

Action, Timing, and Benchmarks for Success

Goal #1: Improve knowledge about ADSD services and other resources.

Objective 1.1: Promote accurate, comprehensive, and accessible information about what supports are available through ADSD and how to navigate the system.

Strategies	ADSD Lead	Timeframe for Completion	Benchmarks for Measuring Success
Strategy 1.1a: Overhaul the ADSD website to ensure it has accurate, comprehensive, and accessible information about what resources are available through ADSD and how to navigate the system.	Public Information Officer	December 2024	• *Launch of revised website* • *Summary report of testing for usefulness and accessibility by end users* • *Website utilization data tracked over time*
Strategy 1.1b: Develop and implement a communications plan which includes strategies for each specific population served by ADSD (according to disability, age, marginalized communities, and geographical location).	Public Information Officer	December 2024	• *Establishment of communications plan and corresponding outreach collateral* • *Number of communication strategies implemented according to communications plan tracked and reported over time*
Strategy 1.1c: Establish a mechanism (such as listservs) to provide ongoing updates to the public about ADSD programs and services.	Public Information Officer	December 2024	• *Regular and ongoing updates to master listserv for distribution of updates regarding ADSD programs/services* • *Number of posts measured through mechanism (listserv, social media, etc.)* • *Number of individuals on listserv for ADSD updates tracked over time*

The following considerations should be taken into account when implementing Strategy 1.1a:

- Include the following kinds of information on the ADSD website: types of services available, the different pathways to accessing services, and the community-based providers that are available to support individuals with disabilities.
- Test the newly developed website with consumers and families to ensure that it is accessible and easy to navigate.
- Ensure there is a mechanism embedded within the website to collect input from the public about the usefulness and/or difficulty in accessing information on the website.
- Conduct a comprehensive annual review of the ADSD website, updating the structure and/or information, as needed.

Objective 1.2: Ensure providers, parents, and consumers know about the full spectrum of support available to individuals with disabilities.

Strategies	ADSD Lead	Timeframe for Completion	Benchmarks for Measuring Success
Strategy 1.2a: Implement division-wide benefits counseling for individuals with disabilities regardless of program participation or payee of services.	Community Engagement Manager	December 2025	• *Implementation of benefits counseling service option for all ADSD service recipients* • *Number of people (by population) who have received benefits counseling*
Strategy 1.2b: Facilitate twice per year fairs highlighting ADSD and community-based resources available for individuals with disabilities.	Community Engagement Manager	July 2025	• *Number of resource fairs hosted by ADSD* • *Number of people attending resource fairs*
Strategy 1.2c: Train ADSD staff on services available beyond ADSD to assist them in connecting individuals to the full range of care needed.	HR Manager	July 2026	• *Number of staff trained on community based services per year* • *Number of trainings offered on community based services per year* • *% of ADSD workforce that reports having proficiency in knowledge of community based resources*

Objective 1.3: Educate parents and caregivers of transition aged youth[18] (TAY) about resources available through ADSD and the intersection of its work with that of local school districts and workforce development/job training providers.

Strategies	ADSD Lead	Timeframe for Completion	Benchmarks for Measuring Success
Strategy 1.3a: Establish outreach materials targeting transition aged youth (TAY) and their families, customizing the materials as well as the distribution strategy to each region throughout Nevada.	Public Information officer	December 2024	• *Number of outreach materials published* • *Number of TAY ADSD service recipients that are supported with IEP transition services*
Strategy 1.3b: Establish and deploy in-service training with educational institutions and job training providers in Nevada.	NWD Training Coordinator	July 2025	• *Number of in-service trainings provided to educational institutions and JTO providers* • *Number of TAY and their families receiving referrals for Resource & Service Navigation each year*

Goal #2: Expand workforce capacity to serve people in community-based settings.

Objective 2.1: Improve ADSD workforce recruitment and retention efforts.

Strategies	ADSD Lead	Timeframe for Completion	Benchmarks for Measuring Success
Strategy 2.1a: Research, document, and advocate (if needed) regarding the impact of ADSD staff shortages on consumer access to needed services and business operations.	ADSD Human Resources Manager	July 2024	• *Quarterly vacancy reports to demonstrate staff vacancies* • *Annual Report demonstrating impact of staff vacancies on consumer access*

[18] Transition aged youth (TAY) for the purpose of this report are defined as youth aged 14 through 22 years of age.

Strategies	ADSD Lead	Timeframe for Completion	Benchmarks for Measuring Success
Strategy 2.1b: Identify primary barriers to ADSD staff recruitment, and quality and retention efforts and advocate for necessary changes.	ADSD Human Resources Manager	July 2025	• *Recruitment barriers as identified from ADSD-DEI Advisory Group* • *Quality and retention discoveries as identified through exit interviews with ADSD staff leaving the Division* • *Annual Report summarizing barriers identified in each area of workforce development*
Strategy 2.1c: Explore opportunities for how more individuals with disabilities can become employed by ADSD (beyond the work of the 700 hours program).	ADSD Human Resources Manager	July 2025	• *Summary documentation of efforts made to recruit, retain, and elevate ADSD staff with identified disability* • *Number/percent of ADSD staff with an identified disability*

The following considerations should be taken into account when implementing Strategy 2.1a:

- Staff shortage reviews should include an analysis of caseload sizes and advocacy efforts should include best practice strategies.

Objective 2.2: Prioritize provider recruitment efforts for services that are most needed and least available, with an emphasis on services in the rural areas of the state.

Strategies	ADSD Lead	Timeframe for Completion	Benchmarks for Measuring Success
Strategy 2.2a: Establish a shared understanding between ADSD and consumer advocacy groups, boards, and commissions regarding workforce shortage areas.	ADSD Planning Chief	July 2024	• *Publication of Direct Care Workforce Report (which will include a plan to address workforce shortages)*
Strategy 2.2b: Deploy ADSD staff to outreach and engage potential providers that fill workforce shortage areas.	Community Engagement Manager	July 2025	• *Number of outreach events (individual and group) held each year* • *Number of direct support professionals recruited to registry*

Objective 2.3: Support free/low-cost and ongoing professional development offerings to workforce (internal and external to ADSD) serving individuals with-disabilities.

Strategies	ADSD Lead	Timeframe for Completion	Benchmarks for Measuring Success
Strategy 2.3a: Develop a learning platform that will be accessible online for staff and for family/community members around issues of importance to individuals with disabilities.	ADSD Planning Chief	December 2024	• *Launch of online learning platform on ADSD website* • *Number of online trainings added each year* • *Online analytics that demonstrate the number of individuals that utilize online learning platform* • *Number/percent of staff and others reporting high levels of satisfaction with learning platform*
Strategy 2.3b: Continue offering training focused on person-centered practices, self-determination, resources/services available, and other issues of critical importance for community integration efforts.	Quality Assurance Manager	March 2025	• *Number of trainings provided by topic area* • *Number of people completing trainings*

Goal #3: Increase accountability within ADSD for the implementation of timely, high quality, community-based services for individuals with disabilities.

Objective 3.1: Establish reliable, timely, and consistent data collection efforts across ADSD programming.

Strategies	ADSD Lead	Timeframe for Completion	Benchmarks for Measuring Success
Strategy 3.1a: Assess ADSD data system's capacity and limitations for identifying individuals funded to receive community-based services and projecting unmet needs.	ADSD Project Manager	December 2024	• *Final project report from case management system vendor that demonstrates data system capacity*
Strategy 3.1b: Generate regular reports across all programs on the numbers and demographics of individuals served, services provided, and service settings.	Quality Assurance Manager Analyst III	July 2025	• *ADSD Dashboard with the information described, published monthly*

Strategies	ADSD Lead	Timeframe for Completion	Benchmarks for Measuring Success
Strategy 3.1c: Establish a methodology for intra-agency data sharing capabilities to identify individuals and families receiving services provided, the cost of care, and gaps in care.	NWD Coordinator	January 2027	• *NWD implementation plan will outline methodology for data sharing* • *Approved budget authority to implement systems change efforts associated with data sharing activities/tools*

Objective 3.2: Develop division-wide quality assurance practices.

Strategies	ADSD Lead	Timeframe for Completion	Benchmarks for Measuring Success
Strategy 3.2a: Review existing practices around consumer satisfaction assessments and grievance policies throughout the division, identifying components that should be expanded and those that should be discontinued or modified.	Money Follows the Person (MFP) Quality Analyst	December 2024	• *Summary report on assessment and recommendations regarding division wide satisfaction and grievance practices*
Strategy 3.2b: Ensure individuals understand and have access to grievance practices and retaliation mitigation efforts within and throughout ADSD.	ADSD Chief Rights Attorney	July 2025	• *Number/percent of ADSD service recipients indicating knowledge about grievance policies and retaliation options*
Strategy 3.2c: Collect consumer surveys for information about satisfaction with services, barriers to access, and other supports needed but not received for all ADSD service recipients on at least an annual basis, identifying opportunities for operational improvements.	Quality Assurance Manager	December 2025	• *Annual distribution of division-wide consumer satisfaction survey and corresponding report of results*

Objective 3.3: Implement best practices and regulatory requirements associated with community integration efforts.

Strategies	ADSD Lead	Timeframe for Completion	Benchmarks for Measuring Success
Strategy 3.3a: Create a mechanism to implement ADSD Olmstead Plan, monitor activities, and measure efforts on a regular basis.	ADSD Planning Chief	December 2024	• *Quarterly internal meetings to discuss progress on ADSD Olmstead Plan* • *Semi-Annual Status Reports on ADSD Olmstead Plan to CSPD* • *Annual Evaluation Report on ADSD Olmstead Plan to CSPD*
Strategy 3.3b: Track implementation efforts of No Wrong Door (NWD) governance project and Nevada adherence to National Key Elements.	ADSD Planning Chief	September 2025	• *Annual Report on NWD Efforts*
Strategy 3.3c: Monitor implementation of 2023 Home and Community Based Services (HCBS) Final Settings Rule, reporting every other year on the Quality Measure Set for HCBS programs.	Money Follows the Person (MFP) Quality Analyst	December 2025	• *Bi-annual Report on HCBS Quality Measures*

Goal #4: Embed a person-centered culture among all ADSD staff and within Division operations.

Objective 4.1: Simplify the process for accessing ADSD services.

Strategies	ADSD Lead	Timeframe for Completion	Benchmarks for Measuring Success
Strategy 4.1a: Determine the feasibility of implementing a single point of entry/application process for ADSD services.	ADSD Executive Team	July 2025	• *Final project report from the Business Process Re-Engineering project regarding establishment of single point of entry*

Strategies	ADSD Lead	Timeframe for Completion	Benchmarks for Measuring Success
Strategy 4.1b: Establish and widely distribute an accessible video which demonstrates the step-by-step process involved in applying for ADSD services.	Community Engagement Manager	January 2026	• *Video developed and posted on ADSD website in multiple formats and various languages to ensure accessibility* • *Analytics report on number of people who have viewed video*
Strategy 4.1c: Expand the capacity of ADSD's NWD navigator system, in which a single provider/program is available to support families in accessing services throughout their lifespan and within the variety of systems that offer services.	Planning Chief I	September 2024	• *NWD Implementation Plan which details a plan for navigator expansion* • *Increase in number of navigators statewide*

The following considerations should be taken into account when implementing Strategy 4.1c:
- The existing 888 number hosted by ADSD should be widely promoted and calls to the number should be responded to within 24-hours whenever possible.

Objective 4.2: Require the use of person-centered care among all ADSD staff.

Strategies	ADSD Lead	Timeframe for Completion	Benchmarks for Measuring Success
Strategy 4.2a: Develop and utilize a universal definition of "person-centered care" among ADSD staff, community providers, people with lived experiences, and their family members/support system.	Quality Assurance Manager	October 2024	• *Final Health Management Associates (HMA) Report with recommendations on how to embed person-centeredness within ADSD culture* • *Shared definition established and widely distributed throughout ADSD and via ADSD communications with providers and people with lived experiences*

Strategies	ADSD Lead	Timeframe for Completion	Benchmarks for Measuring Success
Strategy 4.2b: Expand the understanding of individual potential and the exploration of all possibilities for individuals with disabilities, their family members/support system, and providers who serve them.	Quality Assurance Manager	July 2025	• *Training is deployed to ADSD staff in which "individual potential and exploration of all possibilities" is a topic* • *Case review audits include a mechanism to rate how well this concept is incorporated into plans* • *Consumer Assessment of Healthcare Providers and Systems Survey Results reviewed regularly[19]*
Strategy 4.2c: Integrate the requirement of person-centered care with a focus on community integration into both ADSD personnel employment standards and ADSD-supported provider performance standards	Quality Assurance Manager ADSD Human Resources Manager	July 2026 (will occur on a rolling basis) July 2027	• *Updates to provider performance and quality assurance standards* • *Updates to personnel employment standards*
Strategy 4.2d: Require the use of person-centered care among all ADSD staff.	Quality Assurance Manager	July 2025	• *Improved ratings over time within the category of person-centered culture/operations as demonstrated in the annual climate survey*

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[19] Consumer Assessment of Healthcare Providers and Systems Survey: https://www.ahrq.gov/cahps/surveys-guidance/hcbs/index.html
Olmstead Plan I **2023**

Goal #5: Develop a systems-wide approach to addressing the comprehensive needs of individuals with disabilities from a person-centered framework.

Objective 5: Establish more formal connections with other state, county, city, and community-based services providers.

Strategies	ADSD Lead	Timeframe for Completion	Benchmarks for Measuring Success
Strategy 5.1a: Establish more collaborative partnerships with other state, county, city, and community-based services providers.	QA and Regional Coordinators	February 2026	• *Number of MOU/other Partnership Agreements in place* • *Increased number of providers working in partnership with ADSD* • *Demonstration of partnerships (through meeting attendance, joint program implementation, etc.) with other entities required to implement the Olmstead Decision*
Strategy 5.1b: Host gatherings focused on community integration which brings together various state, county, city and community-based service providers to identify strengths and challenges and establishes plans for more integrated service deployment.	Regional Coordinators	July 2025	• *# of events hosted* • *# of attendees* • *# of outreach events attended*
Strategy 5.1c: Research, assess, and recommend to the Directors office and/or the Legislature, a statewide approach to implementing Olmstead.	Chief Rights Attorney in conjunction with the Regional Coordinators	July 2024	• *Research and present to advisory bodies the approach to Olmstead in Nevada and other states* • *Statement of Support from a unified state approach to Olmstead implementation from ADSD, ADSD advisory bodies, and other invested partners* • *ADSD Division Administrator to solicit support for and submit recommendation(s) for a unified state plan to the Directors' office*

Objective 5.2: Establish advocacy efforts aimed at improving support for individuals with disabilities in areas that either fall outside the authority of ADSD to implement or that require legislative support.

Strategies	ADSD Lead	Timeframe for Completion	Benchmarks for Measuring Success
Strategy 5.2a: Build a unified advocacy agenda focusing on the issues most important to ensuring community integration is available to individuals with disabilities.	Chief Rights Attorney	July 2025	• *# of legislative recommendations submitted* • *# of legislative initiatives passed*
Strategy 5.2b: Actively promote ADSD Olmstead Plan to support change efforts among other providers and partner agencies.	Community Engagement Manager	June 2024 and ongoing	• *Website analytics regarding Olmstead Plan regarding views and engagement (downloads, clicks, reactions)* • *Number of presentations (with custom call to action) to the community and complimentary service providers regarding ADSD Olmstead Plan*
Strategy 5.2c: Support ADSD Boards and Commissions (as described in Appendix H) to effectively advocate for systems change.	Community Engagement Manager	June 2024	• *# of Trainings provided (Annual ADSD advisory boards and commissions training)* • *# of Contacts with Chief Rights Attorney*

The following considerations should be taken into account when implementing Strategy 5.2a:

- Advocacy agenda should include the tracking and monitoring of rate studies (to be conducted by Division of Health Care Financing and Policy) to ensure they are occurring according to schedule, and that the information is used to advocate for increased funding when necessary.
- Advocacy efforts should address the gaps in services for individuals with disabilities to include housing, transportation, and supported living arrangements.

Case Study

A Tale of Two Systems

Douglas is a 30-year-old man who was born in Las Vegas and moved to rural Nevada at the age of 10 where he continues to reside in a self-contained apartment within his parent's house. He is diagnosed with autism, cerebral palsy, generalized seizure disorder, and cognitive delay. He is also nonverbal. Based on his conditions, Douglas cannot be left home alone and requires support to accomplish his daily living routine safely, successfully and enjoyably. Many of the supports he currently receives are provided by the State of Nevada Aging and Disability Services Division (ADSD) within the Department of Health and Human Services. ADSD provides these services through its Rural Regional Center and its contracted service partners.

The challenge facing Douglas, his family, and many other families living with autism and other disabilities, is that the system that is meant to provide support so that he can live his *best quality of life* in the **community of his choosing** is failing to provide timely and sufficient care based on policy and practical barriers. This case study is meant to describe systemic issues that are impacting Douglas specifically and illustrate experiences likely felt by other Nevadans in similar circumstances. Moreover, it is meant to demonstrate how the changes outlined in this Olmstead Plan, if successfully implemented, can improve the system and ultimately the livelihood of Nevadans living with disabilities.

Systems Issue #1: Centering the Needs of People with Disabilities throughout the Service Cycle

- Douglas's Situation: Douglas needs Applied Behavior Analysis (ABA) therapy services. He was able to access these services from the time he was 14 years of age until he turned 22 years old and "aged out" of eligibility for that type of support. The ABA support provided to Douglas during that time included assistive technology, visual supports and self-determination. It also helped Douglas moderate his behavior by directing his attention to social cues and the understanding of appropriate behavior based on contextual cues. Since turning 22, and with the absence of ABA therapy services, Douglas has regressed in his independence. His regression is reflected in his parents acting as an ABA provider, leading efforts to infuse these support strategies into care provided by ADSD staff and their contracted service partners. The current system continues to rely upon families and support networks to provide direction and oversight in the appropriate care of their loved one living with autism. For those without a support mechanism, the likelihood of institutionalization increases significantly, as does the cost to the state.

- Current System Response: Up until the 2023 legislative session, individuals with autism were only eligible for ABA support until their 22nd birthday. In 2023, Senator Heidi Seevers Gansert (R-Reno) supported legislation that unanimously passed and was signed into law to expand ABA services for people with autism from 21 to 27 for those receiving Medicaid, a government-funded health insurance for low-income people and those with disabilities.

- Person-Centered System Response: The ideal system would ensure that all individuals with autism have access to ABA services throughout their lifespan, regardless of age or payor type. While the expansion of benefits achieved in the 2023 Legislative session for individuals receiving Medicaid is progress, it stops short of offering this consistent lifeline of care to Nevadans with autism. On the pathway to this person-centered system response, there is an opportunity to train ADSD and their contracted service providers on how to incorporate elements of ABA therapy into their service approach to individuals over 27 years of age. In doing so, the system would be centering the needs of people with disabilities throughout their lifespan as opposed to expecting Nevadans with disabilities to acclimate to a system's constraints.

System Issue #2: Availability of a Sufficient and Well-Trained Workforce to Deliver Services

- Douglas's Situation: Douglas lives in rural Nevada. Elko is the closest city to his home. Living in such a remote area limits the availability of providers that Douglas has access to. His parents regularly supplement his care needs when they are able, but that leaves Douglas dependent on a support system that may not always be available to him.

  On May 26, 2023, Douglas had a hard day. Three days earlier his service dog died, and he was struggling with the grief. Beyond the mental distress, Douglas was also not feeling well physically. That morning, he ran out of his kitchen biting a book in the presence of his experienced personal care assistant (PCA). Noting his disposition, the experienced PCA instructed a new PCA team member (who was in training) that it was best to be particularly gentle in their care for Douglas on this day, and that they should give him lots of breaks. With that, the three of them began to follow the schedule of activities that had been predetermined. In the middle of their scheduled activities, the experienced PCA had an emergency and had to leave the new PCA to support Douglas on her own. Subsequently, the new PCA did not follow the schedule and instead took Douglas to the gym where it was loud and crowded. The new PCA decided they would stay at the gym despite the previously mentioned circumstances. Douglas became aggressive while at the gym and ended up biting his personal care assistant. The personal care assistant terminated services with Douglas. As a resulted of this and an insufficient workforce in rural Nevada, Douglas was dependent upon his parents for 50% of his contracted service hours.

- Current System Response: The current system relies upon private providers to offer a variety of direct services funded by ADSD. When there is an insufficient number of providers to meet the needs of people with disabilities the results can include; 1) a delay in accessing services, 2) care choices being limited to providers who may not be best suited for an individual, and/or 3) families being forced to consider relocation to a community where providers are available (but where they likely lack a support system). Low wages, travel requirements and nontraditional working hours are all impediments to securing a high-quality and sustainable workforce. In Douglas's case, he doesn't have many options when it comes to finding providers that can help him live, work and play in the community as independently as possible. With Douglas, his support professionals usually last between four and eight months at a time.

Every time there is a change in staffing, Douglas' routine is disrupted, resulting in more behaviors and additional dependence upon his parents. Additionally, the training that his direct care staff receive has often been inadequate to meet Douglas's particular needs. His parents have therefore served as the "trainer of last resort", ensuring that the providers assisting Douglas are trained sufficiently to meet his basic needs. Every time there is staff turn-over, Douglas' parents are forced to make difficult decisions such as taking days off of work, cancelling vacations or calling on friends and family members to "pitch in." With every change in staff, the parents prepare to train the new, but likely temporary staff person providing critical services and support to Douglas.

- Person-Centered System Response: The ideal system would ensure that high quality care and services are available to promote a person's greatest level of independence regardless of their location, age, or payor type. It is a system that proactively identifies where provider and staff shortages exist and targets outreach, recruitment and retention efforts that are effective in making services to vulnerable populations a viable business option and one in which no gaps in care occur.

System Issue #3: Timely Resolution to Systems Issues

- Douglas's Situation: Following the incident described above, a meeting was requested by Douglas's mother to discuss the possibility of securing a Functional Behavioral Assessment (FBA) by a Board-Certified Behavioral Analyst (BCBA). Additionally, she requested that the BCBA be authorized to train the direct care staff assigned to Douglas moving forward. Douglas's mother did the foundational work to identify a BCBA who could provide this kind of support and connected that individual with ADSD to complete the necessary paperwork to secure services needed.

- Current System Response: Four months passed and Douglas's PCA had not been replaced, the FBA had not been completed and staff did not receive any behavioral training or support. Furthermore, the BCBA that Douglas's mother identified has not yet received approval through the Rural Regional Center to serve Douglas despite being a contracted provider through the ADSD Autism Treatment Assistance Program (ATAP) as well as other state agencies to include Medicaid. The application process for providers is slow and the reimbursement rates vary from program to program, with ADSD paying less for BCBA services than Medicaid.

- Person-Centered System Response: The ideal system would establish a mechanism to ensure that Nevadans with disabilities are not left without services for extended periods of time due to regulatory hurdles. Utilizing a preventative model, it would prioritize addressing situations before individuals are forced into institutional settings because their needs cannot be met within the community. Douglas is fortunate to have a family that can fill in the gaps but that is not true for all Nevadans in similar circumstances. What will become of Douglas when his parents are no longer available to be his care giver, advocate and "trainer of last resort"?
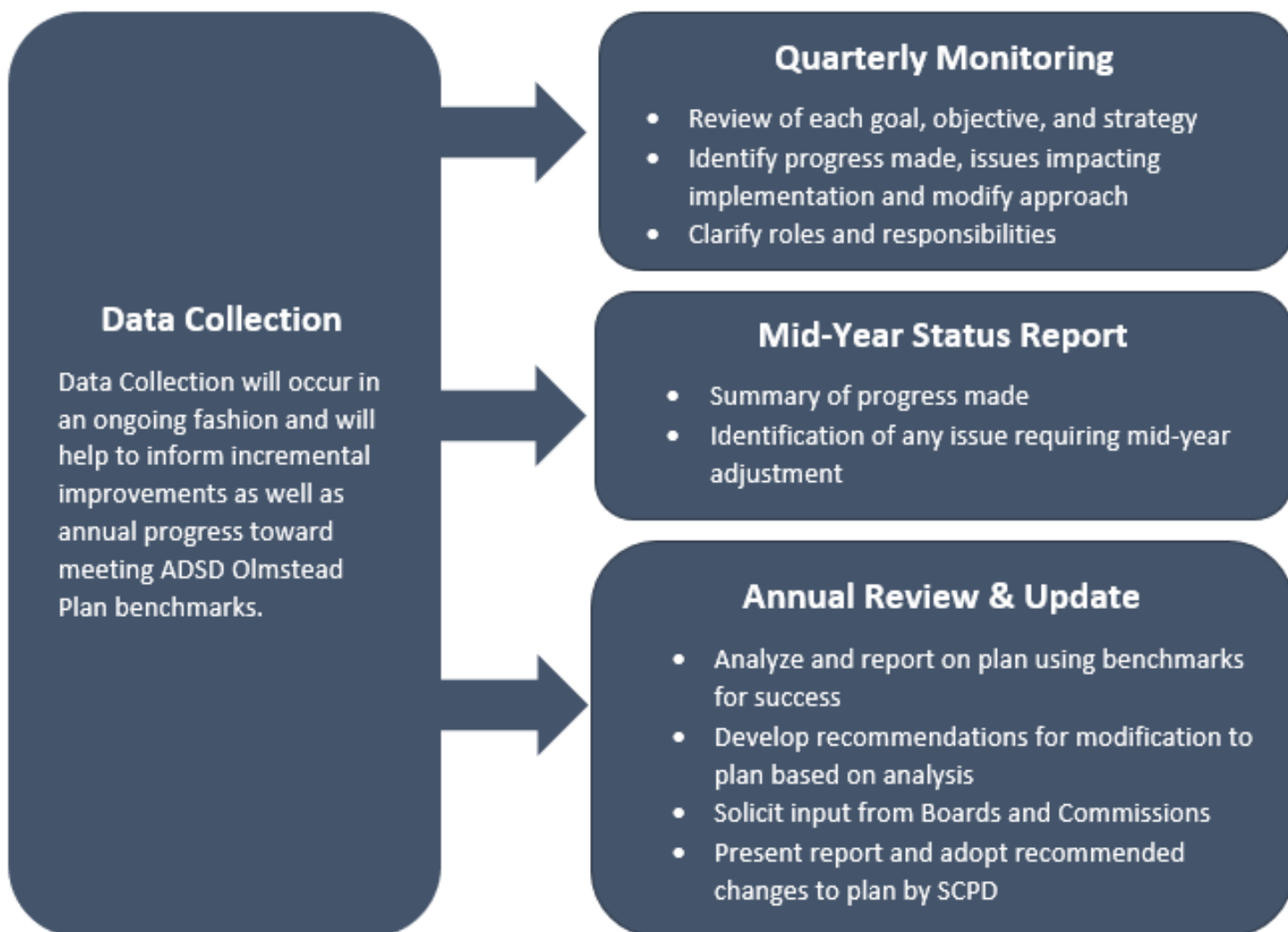
  It is something that plagues his mother Korri…
  "I worry about when I die. What's that going to look like? My son's routine is going to change. How's that going to be taught to him?"

Being Accountable for Change

This plan will be used as a management tool to expand community integration efforts with clarity throughout ADSD and in a manner that ensures partnership and transparency in the process. To accomplish this, all activities will be monitored on a quarterly basis within ADSD. ADSD will use this quarterly practice to share progress made, identify issues impacting implementation, and modify activities as needed. This quarterly review will be summarized and presented to the Commission on Services for Persons with Disabilities (CSPD) as a standing agenda item. Additionally, a mid-year status report will be developed and provided to the (CSPD) as the recognized oversight entity for Olmstead efforts. Lastly, an annual report on ADSD Olmstead Plan progress will be completed. This annual report will include an internal assessment of all efforts and identified recommendations for modifications to the plan. The annual report will be shared with the various boards and commissions that serve ADSD and input will be solicited regarding recommendations and/or other emergent issues that should be addressed to support expanded community integration opportunities. The input received from such boards will then be integrated into the Annual Report which will be presented and adopted by the CSPD.

A graphic of this process is provided below.

Data Collection

Data Collection will occur in an ongoing fashion and will help to inform incremental improvements as well as annual progress toward meeting ADSD Olmstead Plan benchmarks.

Quarterly Monitoring

- Review of each goal, objective, and strategy
- Identify progress made, issues impacting implementation and modify approach
- Clarify roles and responsibilities

Mid-Year Status Report

- Summary of progress made
- Identification of any issue requiring mid-year adjustment

Annual Review & Update

- Analyze and report on plan using benchmarks for success
- Develop recommendations for modification to plan based on analysis
- Solicit input from Boards and Commissions
- Present report and adopt recommended changes to plan by SCPD

Appendix

A brief description of each of the documents contained within the appendix is offered below.

Appendix A

ADSD Service Descriptions: Service descriptions are provided and bundled by specific ADSD service populations which include 1) individuals with intellectual or developmental disabilities, 2) individuals who have a physical disability, and 3) older adults.

Appendix B

2022 Nevada Olmstead Survey Results: Nevada Center for Excellence in Disabilities (NCED) survey results regarding Nevada's Aging and Disability Services Division Olmstead Plan and its programs and services.

Appendix C

ADSD Olmstead Community Workshop Summary Report: Summary Report of community workshops held to gather feedback directly from people with lived experience (PLEs) to include ADSD service recipients, family members, care providers, and advocates about what is needed to improve community-based services and supports to people with disabilities across the lifespan.

Appendix D

ADSD Olmstead Key Person Interviews Summary Report: Summary Report of key person interviews conducted to understand the strengths and weaknesses of the existing system as well as solicit ideas about how the system should be improved.

Appendix E

Complimentary Efforts to Improve ADSD Service System: Provides a summary of current or planned efforts to improve the ADSD service system that were taken into consideration in the development of this plan.

Appendix F

Developmental Services Approved Budget for State Fiscal Years 24/25: Memo distributed to ADSD staff and providers by Jessica Adams, Deputy Administrator for Developmental Services, on 5/12/23, describing initiatives which were approved by the Nevada State Legislature.

Appendix G

Relevant Definitions: Definitions of terms utilized throughout the document.

Appendix H

ADSD Boards and Commissions: A description of the boards and commissions that support ADSD operation and offer PLEs the opportunity to provide input and oversight to operations.

Appendix I

2016 Olmstead Plan Discussion: A brief overview of efforts taken since 2016 plan development and challenges encountered in implementation.

Appendix A. ADSD Service Descriptions

Home and Community Based Care Service Descriptions for Individuals with Intellectual or Developmental Disabilities

The following home and community-based care services are available to individuals diagnosed with intellectual or developmental disabilities who meet substantial limitation requirements. Individuals may be eligible for the services described below based on the eligibility requirements of the various funding streams that support such services.

✓ Behavioral Consultation, Training, and Intervention	✓ Nursing Services	✓ Residential Support Services
✓ Career Planning	✓ Nutritional Counseling	✓ Respite
✓ Counseling (Individual and Group)	✓ Prevocational Services	✓ Self-Directed Family Support Services
✓ Day Habilitation	✓ Purchase of Service	✓ Service Coordination
✓ Family Preservation Program	✓ Regional Center Clinical Services	✓ Supported Employment
✓ Non-Medical Transportation	✓ Residential Support Management	

The following descriptions are offered to provide contextual understanding of each service option.

BEHAVIORAL CONSULTATION, TRAINING, AND INTERVENTION

Behavioral consultation, training and intervention services provide behaviorally based assessment and intervention for recipients, as well as support, training, and consultation to family members, caregivers, paid residential support staff, or jobs and day training staff. This service also includes participation in the development and implementation of Person-Centered Plan and/or positive behavior support plan, necessary to improve a recipient's independence and inclusion in their community, increase positive alternative behaviors, and/or address challenging behavior. Services may be provided in the recipient's home, school, workplace, or in the community. This service is provided by a professional holding either a Bachelor's level licensure, Master's, or Doctoral level licensure with a degree in psychology, special education or closely allied field with expertise in functional assessment and the provision of positive behavioral supports with experience serving individuals with intellectual and developmental disabilities.

CAREEER PLANNING

This is a person-centered, comprehensive employment planning and support service that provides recipients with assistance to obtain, maintain or advance in competitive employment or self-employment. It is time-limited and focuses on engaging a recipient in identifying a career direction and developing a plan for achieving competitive integrated employment with pay at or above minimum wage. Career planning includes

activities that are primarily directed at assisting an individual with identification of an employment goal and a plan to achieve the goal (e.g., job exploration, job shadowing, assessment of interests) that are associated with performing competitive work in the community integrated employment. Services are contracted by a certified provider of Jobs and Day Training with Developmental Services.

COUNSELING SERVICES (INDIVIDUAL AND GROUP)

Counseling Services provide assessment/evaluation, individual and group counseling services, consultation, therapeutic interventions strategies, risk assessment, skill development, psycho-educational activities, support, and guidance for waiver recipients and/or family members, caregivers, and team members not covered by Medicaid State Plan, and which improve the individual's personal adaptation and inclusion in the community. This service provides problem identification and resolution in the areas of interpersonal relationships, community participation, independence, and attaining personal outcomes. Services are provided by professionals in psychology, counseling, and related fields and who have expertise in intellectual/developmental disabilities.

DAY HABILITATION

Day Habilitation services are regularly scheduled activities in a non-residential setting that assist with the acquisition, retention, or improvement in self-help, socialization and adaptive skills including performing activities of daily living and community living. Activities and environments are designed to foster the acquisition of skills; build positive social behavior and interpersonal competence; greater independence and personal choice. Services focus on enabling participants to attain or maintain their maximum potential. Services are not vocational in nature and can include retirement services. Services are contracted by a certified provider of Jobs and Day Training with Developmental Services.

FAMILY PRESERVATION PROGRAM

The Family Preservation Program (FPP) offers financial assistance to qualified families with individuals living at home who are diagnosed with a severe to profound intellectual and developmental disability. Families receive a monthly allotment to be used at their discretion to support the family unit and sustain natural support networks.

NON-MEDICAL TRANSPORTATION

Non-Medical Transportation services are offered in order to enable waiver recipients to gain access to community services, activities, and resources. Non-Medical Transportation services allow individuals to engage in normal day-to-day, non-medical activities, such as going to the grocery store or bank, participating in social events and other civic activities, or attending a worship service. This service is contracted by a certified provider of Developmental Services.

NURSING SERVICES

Nursing Services includes three components: Medical Management; Nursing Assessment and Direct Services. These services may be delivered in a person's home, day program or other community setting based on the individualized need of the recipient and identified in the Person-Centered Plan. Nursing Services are provided by a licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) who is under the supervision of a

licensed RN. Nursing services under the waiver differ in nature, scope, supervision arrangements, or provider type from skilled nursing services in the Medicaid State Plan.

MEDICAL MANAGEMENT

This performed by either a RN or LPN to develop health service support plans; conduct professional observation and assessment; individualized program design and implementation; training of direct support staff or family members to carry out treatment; monitoring of staff knowledge and competence to improve health outcomes; assistance with revision of health support plans in response to new or revised treatment orders or lack of positive outcomes of current supports by staff; monitoring/assessment of the individual's condition in response to current health supports provided; and as needed assistance with referrals to other medical providers.

NURSING ASSESSMENT

This is performed by a RN only to identify the needs, preferences, and abilities of the individual. This assessment includes an interview with the recipient and/or their designated or legal representative, an observation by the nurse, and considers the symptoms and signs of condition, verbal and nonverbal communications, medical and social history, medication, and any other information available. Assessments provide the basis for recommendations for medical and mental health care and follow-up.

DIRECT SERVICES

This is performed by either a RN or LPN and includes the provision of routine medical and health care services that are integral to meeting the daily needs of recipients who are ill and or have ongoing medical needs.

NUTRITIONAL COUNSELING

Nutritional Counseling services include assessment of an individual's nutritional needs, development, and/or revision of a recipient's nutritional plan, counseling and nutritional intervention, and observation and technical assistance related to the successful implementation of the nutritional plan. These services include training, education and consultation for recipients, family members, or support staff involved in the day-to-day support of the recipient; comprehensive assessment of nutritional needs; development, implementation and monitoring of the nutritional plan incorporated into the individual's Person-Centered Plan, including updating and making changes to the plan as needed; aid in menu planning and making healthy options; nutritional education and consultation; and developing quarterly summaries of progress on the nutritional plan. Nutritional counseling services under the waiver differ in nature, scope, supervision arrangements, or provider type (including providing training and qualifications) from nutritional counseling services in the Medicaid State plan. This service is provided by a registered Dietician by the American Dietetic Association.

PREVOCATIONAL SERVICES

Prevocational Services provides for learning and work experience, including volunteer work, where a person can develop general, non-job or task-specific strengths and skills that contribute to employability in paid employment within integrated settings. Services are intended to develop and teach general skills that will optimally lead to integrated community employment at or above minimum wage. Recipients may be paid at special minimum wages (less than minimum wage) while receiving prevocational services if the provider has

been certified by the U.S. Department of Labor to pay special minimum wages. Services are contracted by a certified provider of Jobs and Day Training with Developmental Services.

PURCHASE OF SERVICE

Purchase of Service (POS) offers a small supplement to assist a family in critical need or during a crisis. All funding sources and existing resources must be used by the family before POS can be accessed. Examples of critical need include utility payment to avoid loss of utility services, groceries, medical/dental expenses not covered by Medicaid.

REGIONAL CENTER CLINICAL SERVICES

The Regional Centers employ Psychological Services teams of Licensed Psychologists and Mental Health Counselors, as well as Registered Nurses. Psychological Services staff perform intake functions, complete assessments, group counseling, individual counseling, and provide technical assistance to support teams. Nursing staff perform nursing assessments, assist with hospital discharges, and provide technical assistance to support teams.

RESIDENTIAL SUPPORT MANAGEMENT

Residential Support Management is designed to ensure the health and welfare of individuals receiving Residential Support Services from certified agencies to in order to assure those services are planned, scheduled, implemented, and monitored as the recipient prefers, and as needed, depending on the frequency and duration of approved services. Residential support managers assist the individual with managing their residential supports and are responsible to develop, implement, and monitor the specific residential habilitation plan related to the Residential Support Services. Services are contracted by a certified provider of Residential Support Services with Developmental Services.

RESIDENTIAL SUPPORT SERVICES

Residential Support Services are direct services and protective oversight provided to the person to assist in the acquisition, improvement, retention, and maintenance of the skills necessary for the person to reside in their home and community successfully, safely and responsibly. Services are individually planned and provided on a continuum of service delivery ranging from intermittent support to twenty-four (24) supported living arrangements. Services are contracted by a certified provider of Residential Support Services with Developmental Services.

RESPITE

Respite services are available to individuals who reside in their family home. Respite provides families temporary relief from the responsibilities of caring for their loved ones and to support individuals in their most natural family environment. Families receive a monthly allotment and select their own respite provider.

SELF-DIRECTED FAMILY SUPPORT SERVICES

Families with eligible children under the age of 18 living in the family home can receive monthly funding to purchase specialized treatment, skill building and/or organized programming to assist the child/family in successful integration into their community. Services are self-directed by the family.

Olmstead Plan I **2023**

SERVICE COORDINATION

All individuals who are found eligible for Developmental Services are assigned a Service Coordinator who provides Targeted Case Management services. The role of the Service Coordinator is to identify and assist the person or family in accessing needed support services; link the person or family to community resources, information and services; assist the person in developing a Person-Centered Plan (PCP) and provide monitoring and follow-up activities of the goals and services outlined in the PCP.

SUPPORTED EMPLOYMENT

There are two types of Supported Employment services: Individual and Small Group. Supported Employment services are contracted by a certified provider of Jobs and Day Training services with Developmental Services.

INDIVIDUAL SUPPORTED EMPLOYMENT

Individual Supported Employment is provided to individuals that need intensive, ongoing supports to obtain (job development) and maintain (job coaching) a job in a competitive integrated community work setting for which the individual is compensated at or above minimum wage. Customized employment is one way to provide individual supported employment in which the provider focuses on the strengths of the individual and works with potential employers to customize a job that will benefit both the employer and the employee. The outcome is for individuals to have sustained employment, paid at or above minimum wage, in an integrated community setting.

SMALL GROUP SUPPORTED EMPLOYMENT

Small Group Supported Employment provides services and training to two (2) to eight (8) individuals who are working in a regular business, industry, or other community setting. This support must be provided in a manner that promotes integration in the workplace and interaction between participants and people without disabilities within those workplaces. The outcome is for individuals to have sustained employment, paid at or above minimum wage, in an integrated community setting.

Home and Community Based Care Service Descriptions for Individuals with Physical Disabilities

The following home and community-based care services are available to individuals with physical disabilities. Individuals may be eligible for some, if not all services, described below based on the eligibility requirements of the various funding streams that support such services.

✓ Assisted Living	✓ Home Delivered Meals	✓ Personal Emergency Response System (PERS)
✓ Attendant Care	✓ Homemaker Assistance	✓ Respite
✓ Case Management	✓ Home Modifications	✓ Specialized Medical Equipment and Supplies
✓ Chore Services		

The following descriptions are offered to provide contextual understanding of each service option.

ASSISTED LIVING

Services are all-inclusive services furnished by an assisted living services provider. Assisted living services are intended to provide all support services needed in the community and may include personal care, homemaker, chore, attendant care, meal preparation, companion, medication oversight (to the extent permitted under state law), transportation, diet and nutrition, orientation and mobility, community mobility/transportation training, advocacy for related social services, health maintenance, active supervision, home and community safety training, provided in a home-like environment in a licensed (where applicable) community care facility.

ATTENDANT CARE

Services are described as personal care services that support activities of daily living including but not limited to bathing, toileting, transferring, dressing, and eating.

CASE MANAGEMENT

Support to assist individuals gaining access to needed waiver and other state plan services, as well as medical, social, educational and other services. Ongoing monitoring of the provision of services in line with an individual plan of care.

CHORE SERVICES

This service includes heavy household chores such as cleaning windows and walls, shampooing carpets, taking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress, minor home repairs and removing trash and debris from the yard.

HOME DELIVERED MEALS

The provision of meals to persons at risk of institutional care due to inadequate nutrition. Home delivered meals include the planning, purchase, preparation and delivery or transportation costs of meals to a person's home.

HOMEMAKER ASSISTANCE

Support services to help individuals with instrumental activities of daily living, including meal preparation, light housekeeping, laundry, and shopping.

HOME MODIFICATIONS

Physical adaptations to the residence of the recipient or the recipient's family, identified in the individual's plan of care, that are necessary to ensure the health, welfare and safety of the recipient or that enable the recipient to function with greater independence in the home. (Formally called 'Environmental Accessibility Adaptions' in the Medicaid manual). Within the Assistive Technology for Independent Living program, this service could also include the provision of assistive technology and/or vehicle modifications to support an individual's independent living goals.

PERSONAL EMERGENCY RESPONSE SYSTEM

PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The Individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated.

RESPITE

Services provided to unpaid caregivers of individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES

Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the Medicaid State Plan and shall exclude those items that are not of direct medical or remedial benefit to the individual.

Home and Community Based Care Service Descriptions for Older Adults

The following home and community-based care services are available to older adults who require support to help them remain in their homes for as long as possible. Individuals may be eligible for some, if not all services, described below based on the eligibility requirements of the various funding streams that support such services.

✓ Adult Companion	✓ Home Delivered Meals	✓ Personal Emergency Response System (PERS)
✓ Augmented Personal Care in Residential Care Settings	✓ Homemaker Assistance	✓ Respite
✓ Case Management	✓ Home Modification and Repairs	✓ Social Adult Daycare
✓ Chore Services	✓ Personal Care Services	✓ Transportation

The following descriptions are offered to provide contextual understanding of each service option.

ADULT COMPANION

Provides non-medical care, supervision, and socialization to a functionally impaired person in his or her home or place of residence, which may provide temporary relief for the primary caregiver.

AUGMENTED PERSONAL CARE IN RESIDENTIAL CARE SETTINGS

Augmented personal care provided in a licensed residential facility for groups or assisted living facilities is a 24-hour in home service that provides supervision and assistance for functionally impaired elderly individuals with basic self-care and activities of daily living. This care is over and above the mandatory service provision required by regulation for residential facility for groups.

CASE MANAGEMENT

Support to assist individuals gaining access to needed waiver and other state plan services, as well as medical, social, educational and other services. Ongoing monitoring of the provision of services in line with an individual plan of care.

CHORE SERVICES

This service includes heavy household chores such as cleaning windows and walls, shampooing carpets, taking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress, minor home repairs and removing trash and debris from the yard.

HOME DELIVERED MEALS

The provision of meals to persons at risk of institutional care due to inadequate nutrition. Home delivered meals include the planning, purchase, preparation and delivery or transportation costs of meals to a person's home.

HOMEMAKER ASSISTANCE

Support services to help individuals with instrumental activities of daily living, including meal preparation, light housekeeping, laundry, and shopping.

HOME MODIFICATIONS AND REPAIRS

Physical adaptations to the residence of the person or the person's family, that are necessary to ensure the health, welfare, and safety of the individual or that enable the individual to function with greater independence in the home. Services may also include minor repairs for older adults.

PERSONAL CARE SERVICES

Services are described as personal care services that support activities of daily living including but not limited to bathing, toileting, transferring, dressing, and eating.

PERSONAL EMERGENCY RESPONSE SYSTEM

PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The Individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated.

RESPITE

Services provided to unpaid caregivers of individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

SOCIAL ADULT DAYCARE

Provision of supervision and activities in an Adult Day Care center for 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting.

TRANSPORTATION

Provides safe transportation for access to services such as: nutrition, medical services, social services, adult day care, shopping, and socialization. Includes Transportation Vouchers, provision of escorted or independent transportation by trained subrecipient staff or volunteers.

2022 Nevada Olmstead Survey: Results

Submitted by:

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Nevada Center for Excellence in Disabilities

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Executive Summary

In the summer of 2022, the Nevada Center for Excellence in Disabilities (NCED) conducted a survey regarding Nevada's Aging and Disability Services Division's Olmstead Plan and its programs and services. 300 respondents completed the survey. 170 people with lived experience (people with disabilities, older adults, and their family members) and 130 professionals. The results of that survey are presented in this report. Throughout the report, comparisons of data from people with lived experience with data from professionals are presented, where possible. NCED recommendations are interspersed throughout the document. The recommendations are listed below, and they highlight the major finding from this survey:

➢ Recommendation 1: With nearly one in four people feeling that they are not living in an appropriate setting, Nevada should invest additional resources into gaining greater understanding of the barriers which are preventing people with lived experience from accessing appropriate housing. Once the barriers are identified, additional policies need to be enacted to ensure that people with disabilities can choose to live in appropriate community-based settings.

➢ Recommendation 2: Given the low levels of awareness of Nevada's Olmstead Plan, it is important that ADSD plan to engage in a public awareness campaign when the new plan is initiated. A simple strategy may be sharing information routinely with stakeholders on ADSD listservs. Public awareness of the plan is essential for stakeholders so that they can provide appropriate feedback in a timely fashion.

➢ Recommendation 3: Data indicates that there is a high degree of agreement that the existing Olmstead goals represent the preferences of people with lived experience, a low awareness of the Olmstead Plan, and a low perception that the state is achieving the goals. As a result, additional resources need to be put into the actual activities that support goal achievement rather than directing efforts toward developing new goals. Although the data collected in this report makes it difficult to suggest that the answer is more resources, perhaps the answer is a better utilization of existing resources and establishing higher expectations for the providers of services.

➢ Recommendation 4: ADSD should consider conducting qualitative interviews or focus groups with people with disabilities to better understand the services that are most important to them. This will provide insight into differences in the perceptions of what services are the most important for people with disabilities and older adults in Nevada.

➢ Recommendation 5: As mentioned in the first recommendation, additional qualitative data needs to be collected regarding the barriers to service experienced by people with disabilities. The data collected in this report highlights a stark contrast between the service barriers perceived by professionals and the actual barriers experienced by people with lived experience. Addressing this contrast requires that ADSD increase efforts to incorporate people who personally experience those barriers into any planning efforts.

➢ Recommendation 6: With the exception of programs for older adults, survey respondents were less than satisfied with the other programs and services offered in Nevada. This suggests that more data needs to be collected about those programs and services and how they can be more effective. Simply stated, Olmstead goals are not achievable if the necessary services, resources, and supports are unavailable.

➢ Recommendation 7: The qualitative comments about the lack of consumer understanding of available services are supported by the quantitative data/assessments of programs and services. Data indicates a lack of knowledge about what services are available in Nevada. ADSD should develop mechanisms to ensure that eligible individuals (and family members) are aware of the programming available in Nevada, and how to access those programs and services.

Background

In 1999, the United States' Supreme Court ruled in favor of the plaintiffs in Olmstead v L.C., a case based on the Americans with Disabilities (ADA). The Court determined that people with disabilities have the right to state-funded services and supports in the community provided that: (1) professionals determined that community-based settings would be appropriate, (2) the person with a disability does not oppose a community-based setting, and (3) providing services in the community constitutes a "reasonable accommodation" in comparison with other people with disabilities.[20] Individual states develop Olmstead Plans to help the state adhere to this ADA decision, and states regularly revisit these plans to ensure that the plan is working and to determine how it needs to be modified.

In the summer of 2022, Nevada's Aging and Disability Services Division (ADSD) contracted with the Nevada Center for the Disabilities (NCED) to gather stakeholder feedback on the Olmstead plan and ADSD services to determine how people with lived experiences and professionals who provide services to this population felt about the Olmstead Plan and ADSD services. As part of the contract, older adults were also included alongside people with disabilities as ADSD also includes them within their Olmstead Plan. It should be noted that multiple Olmstead Plans exist within different divisions within the state of Nevada service system. The information contained in this report is specific to the ADSD Olmstead Plan and ADSD services.

ADSD's latest Olmstead Plan[21] was developed for 2016-21. it includes the following goals:

- Goal #1: Strong, Supportive Systems: Fund and implement an integrated, high quality, person- centered service delivery system.
- Goal #2: Access and Engagement: Facilitate timely, responsive services to achieve person-directed goals.
- Goal #3: Meaningful Community Integration: Increase opportunities and supports that promote social connection and enhance self-determination and personal dignity.
- Goal #4: Strengthening Other Systems to Address Barriers: Expand systems and supports to ensure that older adults and persons with disabilities have the opportunity to achieve optimal quality of life in the community of their choice.
- Goal #5: Accountability: Establish and report on Nevada's progress to implement an integrated, high quality, person-centered service delivery culture across systems throughout the state with measurable indicators and outcomes that address the unmet need for services. Use data to drive quality improvement and decision making regarding resource allocation and policy within the state to meet the needs of Nevadans while upholding guiding principles and ensuring accountability for the implementation of the plan.

Methodology

Data for this report was gathered through an online survey developed by the NCED and the Nevada Center for Program Evaluation, both located at the University of Nevada, Reno, with input from ADSD staff. The survey includes both closed-ended and qualitative questions. The Center for Program Evaluation managed the survey development and data collection, while the NCED is responsible for this report. The questions used in the

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[20] For more information on the Olmstead decision, please see https://www.olmsteadrights.org/about-olmstead/.

[21] Available at https://adsd.nv.gov/uploadedFiles/adsdnvgov/content/Boards/COA/DHHS%20Olmstead%20Plan%20ADSD%20Strategic%20Plan%202016%20Final.pdf

Olmstead Plan I **2023**

survey are based on questions used in other state Olmstead surveys, although the questions themselves were modified to the Nevada context.

The survey was distributed electronically via various email listservs, including listservs managed by ADSD, the NCED, and individual NCED projects. The email included an attachment/flyer for organizations to post in their offices. The flyer included a QR code that links to the survey for people to have easy access to the survey. Thus, this should be considered a snowball/opportunistic sample, rather than a random sample. As a result, the data may not be representative of the everyone with lived experience or providers in Nevada.

Respondents

A total of 300 respondents completed the survey. We compared two groups throughout this report: (1) people with lived experience (170), which includes people with disabilities, older adults, or family members, and (2) professionals (130), which includes state or county employees, policymakers or legislators, service providers, and educators or school district representatives. The breakdown of the composition of each group can be found in Table 1: Group Composition.

Table 1: Group Composition

How are you connected to the disability or older adult community?	Frequency	Percent
Lived Experience	**170**	**56.7**
Person with disabilities	37	12.3
Parents / Family / Guardian of a person with disability	122	40.7
Older adult	5	1.7
Family member of older adult	6	2.0
Professionals	**130**	**43.3**
State or county employee	61	20.3
Policymaker or legislator	1	0.3
Service provider/agency	58	19.3
Educator or school district representative	10	3.0

It should be noted that most (122 of 170) respondents in the lived experience group are family members of people with disabilities, thus, the results tend to skew towards family experiences.

We asked about the demographic characteristics of people with lived experience, but not professionals. The results are shown in Table 2: Demographics. Please note that for most of these questions people could select more than one answer or refuse to respond, so the percentages do not always add to 100.

Table 2: Demographics of People with Lived Experience

Demographic	Frequency	Percent
Autism	46	27.1
Deaf blindness	7	4.1
Deafness	9	5.3
Developmental delay	32	18.8
Emotional disturbance	8	4.7
Hearing Impairment	10	5.9
Intellectual Disability	45	26.5

Demographic	Frequency	Percent
Multiple Disabilities	21	12.4
Orthopedic Impairment	15	8.8
Other Health Impairment	18	10.6
Specific learning disability	7	4.1
Speech or language impairment	24	14.1
Traumatic brain injury	7	4.1
Visual impairment	5	2.9
Other disability	24	14.1
Male	18	16.5
Female	83	76.1
Non-binary/third gender	2	1.8
Prefer not to say	6	5.5
American Indian or Alaskan Native	8	4.7
Asian or Asian American7	5	2.9
Black or African American	8	4.7
Native Hawaiian or other Pacific Islander	4	2.4
Hispanic	19	11.2
White or Caucasian	76	44.7

How old are you? (Years)	N=23, Range=21-88, Mean=51.1
How old is your family member? (Years)	N=73, Range=2-82, Mean=21.8

Results

Appropriate Setting in the Community

At its core, the Olmstead decision is about ensuring that people with disabilities are able to live in an appropriately supported community-based setting of their choosing. People with disabilities who responded to the survey were asked if they were living in such a community setting. 35 of the 37 people with disabilities completed this question, and almost three-quarters of the respondents (26 of 35) felt that they were living in an appropriate setting, while a quarter disagreed with that statement.

> ➢ *Recommendation 1: With nearly one in four people feeling that they are not living in an appropriate setting, Nevada should invest additional resources into gaining greater understanding of the barriers which are preventing people with lived experience from accessing appropriate housing. Once the barriers are identified, additional policies need to be enacted to ensure that people with disabilities can choose to live in appropriate community-based settings.*

Table 3: Living in Appropriate, Community-Based Settings

Do you feel that you are living in an appropriate community-based setting of your choice with the supports you need?	Frequency	Percent
Yes	26	74.3
No	9	25.7

Knowledge of Olmstead and the Rights of People with Disabilities and Older Adults

Both people with lived experience and professionals were asked about their understanding of the rights of people with disabilities or older adults. Each group was very familiar with rights; only 18.4% of people with lived experience and 12.1% of professionals reported that they only understood "a little bit" or "nothing" about the rights of these populations. The rest of the respondents reported that they understood "a moderate amount", "quite a bit," or "a great deal" about those rights (Table 4: Understanding of Rights of People with Disabilities and Older Adults).

Table 4: Understanding of Rights of People with Disabilities and Older Adults

How much do you understand about the rights of people with disabilities or older adults?	Lived experience	Professional
	Frequency (Percent)	Frequency (Percent)
Nothing	5(4%)	2 (1.7%)
A little	18(14.4%)	12 (10.4%)
A moderate amount	44(35.2%)	40 (34.8%)
Quite a bit	34(27.2%)	33 (28.7%)
A great deal	24(19.2%)	28 (24.3%)

Despite both groups having a solid understanding of rights for these populations, no other group was very aware of Nevada's Olmstead Plan (see Table 5: Awareness of Nevada's Olmstead Plan). Only about 21% of each group said that they were familiar with the plan, and over half of the people with lived experience and over 44% of professionals said that they had never heard of it.

➢ *Recommendation 2: Given the low levels of awareness of Nevada's Olmstead Plan, it is important that ADSD plan to engage in a public awareness campaign when the new plan is initiated. A simple strategy may be sharing information routinely with stakeholders on ADSD listservs. Public awareness of the plan is essential for stakeholders so that they can provide appropriate feedback in a timely fashion.*

Table 5: Awareness of Nevada's Olmstead Plan

Are you aware of Nevada's Olmstead plan?	Lived experience	Professional
	Frequency (Percent)	Frequency (Percent)
Yes, I am familiar with it.	27 (21.6%)	24 (20.9%)
Yes, I have only heard of it (before receiving this survey) but have not read the plan.	35 (28%)	40 (34.8%)
No, I have never heard of it.	63 (50.4%)	51 (44.3%)

The survey also asked "What should be done to make information like this plan more accessible to people with disabilities or older adults?"

People with Lived Experience

People with lived experiences provided several ideas about how to make this plan more accessible to people with disabilities or older adults. Ideas included:

- Using advertisements like pamphlets, flyers, e-mails, newsletters, information sessions, and billboards to make information more accessible to persons with impairments or older adults.
- Making sure all publications are written in plain language.
- Involving those in the community who are impacted by disabilities.
- Working with the school districts to educate students with disabilities and their parents.
- Establishing information centers with information available in many formats.

Ensuring that service providers like regional centers, Vocational Rehabilitation, etc. talk about the Olmstead plan during yearly meetings.

Professionals

Suggestions from professionals also focused on the use of plain language in advertising across a variety of media, constant interaction with the public and their family members and caregivers, and training of informers. Additional suggestions included webinars, social media posts, advertising with medical providers, and ensuring that ADSD leadership increase communication with ADSD personnel about the Olmstead plan. Finally, professionals noted that the utilization of both Spanish and English is crucial.

Olmstead Goals and Progress

The survey further shared Nevada's (ADSD) Olmstead Plan with respondents and asked for their opinion on whether or not the goals represent what they think is important in Nevada. The vast majority (94.9% of people with lived experience and 98.1% of professionals) indicated that the goals represented what they felt was important (see Table 6: Agreement with Olmstead Goals).

Table 6: Agreement with Olmstead Goals

Do these goals represent what you think is important for people with disabilities and older adults to live where they want in the community with the services and supports, they need in Nevada?	Lived experience	Professional
	Frequency (Percent)	Frequency (Percent)
Yes	112 (94.9%)	105 (98.1%)
No	6 (5.1%)	2 (1.5%)

As a follow-up, the survey also asked how well respondents felt that Nevada had implemented services to promote each of the goals. Table 7: Nevada Implementation of Olmstead Goals contains results for each of the themes. Respondents were able to choose a value from 1-4 (1-very poorly, 2-poorly, 3-somewhat well, 4-very well), and this table displays the mean response.

Table 7: Nevada Implementation of Olmstead Goals (mean response)

How well has Nevada…	Lived experience	Professional
Implemented an integrated, high-quality, person-centered service delivery system?	2.11	2.44
Facilitated timely, responsive services to achieve person-directed goals?	2.06	2.35
Increased opportunities and supports that promote social connection and enhance self-determination and personal dignity?	2.19	2.39

How well has Nevada…	Lived experience	Professional
Expanded systems and supports to ensure that older adults and persons with disabilities have the opportunity to achieve optimal quality of life in the community of their choice?	2.14	2.31
Reported on the state's progress to implement an integrated, high-quality, person-centered service delivery culture across systems throughout the state?	2.04	2.26
Used data to drive quality improve improvement and decision-making regarding resource allocation and policy within the state to meet the needs of Nevadans?	2.13	2.28

People with lived experience and professionals rated progress/activities related to each goal less than a mean of 2.5; this means that respondents were more likely to respond "poorly" than "somewhat well" to each question. Although each of the questions was rated poorly, the lowest scoring aspect for both groups was how well the state has reported on progress to implement an integrated, high-quality, person-centered service delivery culture across systems throughout the state.

> ➤ *Recommendation 3: Data indicates that there is a high degree of agreement that the existing Olmstead goals represent the preferences of people with lived experience, a low awareness of the Olmstead Plan, and a low perception that the state is achieving the goals. As a result, additional resources need to be put into the actual activities that support goal achievement rather than directing efforts toward developing new goals. Although the data collected in this report makes it difficult to suggest that the answer is more resources, perhaps the answer is a better utilization of existing resources and establishing higher expectations for the providers of services*

Feedback on Existing Olmstead Goals

The survey also provided respondents with an opportunity to provide qualitative feedback related to the Olmstead Plan and goals.

People with Lived Experience

People with lived experience who provided qualitative feedback highlighted problems with the goal setting process rather than problems with the actual goals. People with lived experience repeatedly referenced the need to more actively include people with lived experience in the goal development process. As one respondent noted, "the plan that is referenced followed the same state processes that are always used," which don't always account for the people who use the services being talked about. The respondent continued that many people who are intended to be served by these programs and services "cannot even get to the events and most are so used to not be heard they don't even try." Additionally, the respondent stated that community meetings are not always effective because those meetings are dominated by "the same programmatic people showing out and getting their priorities heard."

Another respondent was concerned that the goals were too generic. As the respondent explained, the goals "sound like 'words' not actions, which can just be interpreted to do whatever – [they] need action-based wording and goals that have actual numbers you plan on achieving - that's real accountability & knowing & proving you actually did anything you said you would."

Professionals

Only one professional responded to the qualitative question. That response is presented verbatim below:

"These goals seem to be centered on the services provided by a state system (and I understand that this is a state act and that is where legislation can be implemented) but a large amount of barriers impacting individuals with disabilities in NV are related to the lack of medical and educational resources and overburdened medical professionals that are in the state. Accessing quality medical care is a real struggle in NV."

ADSD Programs and Services and Barriers

In addition to questions about Nevada's Olmstead Plan, the survey also contained questions that assessed programs and services provided by ADSD. The first two questions asked people with lived experience and professionals what services they felt were most important in Nevada and what they felt were the barriers to services.

Most Important Services

People who responded the survey were asked what they thought the most important five services were in the state of Nevada. They were shown the list of services contained in Table 8: Most Important Services for People with Disabilities and Older Adults and only allowed to select five of them. The result shows that there were significant differences (indicated with a *) between professionals and people with lived experiences.144 people with lived experience reported what they thought were the most important services. However, they did not always select five; they averaged only 4.18 (1-5) most important services per person. Similarly, 123 professionals also reported their most important services; on average, they reported more services that they found most important than people with lived experience. Professionals averaged more services per respondent (4.72 (1-5)).

The differences between people with lived experience and professionals are interesting, but also difficult to explain because professionals typically marked more services as important than people with lived experience. One explanation may be that people with lived experience only selected a couple of services that were the most important to them. Professionals tended to select more services. It's possible that if both groups were required to select exactly the same number of services, the percentages for professionals would not be higher and there might not be as many significant differences between the groups. The survey was not designed to understand "the why" of how people responded. It's important to continue to collect data to help understand differences in understandings of what services are the most important.

> ➢ *Recommendation 4: ADSD should consider conducting qualitative interviews or focus groups with people with disabilities to better understand the services that are most important to them. This will provide insight into differences in the perceptions of what services are the most important for people with disabilities and older adults in Nevada.*

Table 8: Most Important Services for People with Disabilities and Older Adults

Services	Lived experience (144)	Professional (123)
	Frequency (Percentage)	Frequency (Percentage)
*Accessible, affordable housing options ($\chi^2 = 18.8$, df=1, p< 0.001)	66 (45.8%)	87 (70.7%)
Personal care assistance ($\chi^2 = 0.0221$, df=1, p= 0.89)	34 (23.6%)	30 (24.4%)

Services	Lived experience (144)	Professional (123)
*Supported living (χ^2 = 12.367, df=1, p< 0.001)	51 (35.4%)	70 (56.9%)
*Independent living skills training (χ^2 =2.179, df=1, p=0.1399)	52 (36.1%)	34 (27.6%)
Advocacy or direct legal support (χ^2 =0.4097, df=1, p=0.522147)	29 (20.1%)	21 (17.1%)
*Affordable, accessible transportation options (χ^2 =11.2841, df=1, p<0.001)	49 (34%)	67 (54.5%)
After hours/weekend accessible transportation (χ^2 =0.0072, df=1, p= 0.93246)	9 (6.3%)	8 (6.5%)
Affordable, accessible transportation for appointments and activities located outside the county in which I live (χ^2 =0.3548, df=1, p=0.5514)	9 (6.3%)	10 (8.1%)
Affordable food (χ^2 =2.0346, df=1, p=0.15375)	27 (18.8%)	32 (26%)
*Employment with a living wage (χ^2 =9.3081, df=1, p=0.002281)	71 (49.3%)	38 (30.9%)
Accessible laundry facilities ($\chi2$ =0.0125, df=1, p=0.9108)	1 (0.7%)	1 (0.8%)
*Bilingual services and supports ($\chi2$ =4.984, df=1, p=0.02558)	6 (4.2%)	14 (11.4%)
Services and supports that respect my culture ($\chi2$ = 0.6079, df=1, p=0.43558)	6 (4.2%)	3 (2.4%)
Day programs ($\chi2$ =2.779, df=1, p=0.09551)	34 (23.6%)	19 (15.4%)
*Respite care ($\chi2$ =9.448, df=1, p=0.002114)	41 (28.5%)	16 (13%)
Support groups that meet my needs ($\chi2$ =0.7007, df=1, p=0.40255)	12 (8.3%)	7 (5.7%)
LGBTQIA+ specific provider ($\chi2$ =0.3981, df=1, p = 0.528069)	2 (1.4%)	3 (2.4%)
Computer classes ($\chi2$ =0.0298, df=1, p = 0.862904)	4 (2.8%)	3 (2.4%)
Assistance to obtain a driver's license ($\chi2$ =0.0099, df=1, p=0.920844)	5 (3.5%)	4 (3.3%)
Veteran's assistance for individual and/or families ($\chi2$ =0.8963, df=1, p= 0.343768)	3 (2.1%)	5 (4.1%)
*Assistive technology and related services ($\chi2$ =10.8254, df=1, p=0.0010001)	3 (2.1%)	16 (13%)
Resources specific to my disability or status as an older adult and the unique barriers I face ($\chi2$ =0.4999, df=1, p=0.4796)	19 (13.2%)	20 (16.3%)

Services	Lived experience (144)	Professional (123)
*Accessible and affordable mental health and/or behavioral health services ($\chi2 =5.462$, df=1, p=0.01944)	38 (26.4%)	49 (39.8%)
Accessible andd affordable testing and diagnostic services ($\chi2 = 0.2929$, df=1, p=0.5884)	20 (13.9%)	20 (16.3%)
Advocacy organizations ($\chi2 =2.4077$, df=1, p= 0.1207)	11 (7.6%)	4 (3.3%)

According to the qualitative responses to this question, respondents believed there to be important services not included in the survey's list. Such services included home therapy and simplified access to programs. In addition to affordable housing and transportation choices, a few respondents believed that affordable assisted living facilities for all types of people with disabilities are equally vital. Training and awareness campaigns must then be held for state employees and human resource personnel who work with people with disabilities. Programs for education and awareness are crucial for the family's understanding of programming and policy. A few respondents also agreed that individuals with disabilities should have access to adequate jobs that pay enough for them to support themselves daily. Finally, the respondents listed some of the crucial services as technical assistance, case management assistance, and additional human resources in the facilities that are available.

Barriers

A similar question asked respondents what they thought were the barriers that kept people from getting the services and support they need in the State of Nevada. They were shown the list of services contained in Table 9: Barriers to Services. This question is slightly different from the question about the most important services, because there was no limit to the number of barriers that respondents could select. However, professionals still selected more barriers than people with lived experience. 132 people with lived experience reported barriers that kept them from getting services and support. They averaged 4.06 barriers (1-13). Also, 118 professionals reported barriers and they averaged 6.66 barriers (1-14). Because professionals reported more barriers on average, their percentage tends to be higher. The result shows that there were significant differences (indicated with a *) between professionals and people with lived experiences.

Table 9: Barriers to Services

Barrier	Lived experience (132)	Professional (118)
	Frequency (Percentage)	Frequency (Percentage)
*Long wait times for services ($\chi^2 = 8.2525$, df=1, p= 0.00407)	67 (50.8%)	81 (68.6%)
Services are not available at convenient times ($\chi^2 = 0.2408$, df=1, p=0.6236)	42 (31.8%)	41 (34.7%)
*I don't know what services are available to me ($\chi^2 = 16.9842$, df=1, p<0.001)	70 (53%)	92 (78%)
*I don't have enough money to pay for services ($\chi^2 = 15.37$, df=1, p < 0.001)	50 (37.9%)	74 (62.7%)

Barrier	Lived experience (132)	Professional (118)
Some providers do not take Medicaid (χ^2 cannot be calculated)	52 (39.4%)	- (0%)
*I have a hard time getting accessible transportation ($\chi^2 = 75.2909$, df=1, p < 0.001)	16 (12.1%)	77 (65.3%)
*Services I want are not available in the area ($\chi^2 = 8.298$, df=1, p = 0.00397)	52 (39.4%)	68 (57.6%)
*Services are not available in my preferred language ($\chi^2 = 19.52$, df=1, p<0.001)	6 (4.5%)	28 (23.7%)
*Service providers are not respectful of my culture ($\chi^2 = 4.037$, df=1, p=0.04452)	8 (6.1%)	16 (13.6%)
*I can't get the technology I need ($\chi^2 = 41.4055$, df=1, p<0.001)	8 (6.1%)	47 (39.8%)
*I don't have people around to help me ($\chi^2 = 26.544$, df=1, p<0.001)	28 (21.2%)	62 (52.5%)
I don't qualify for some programs or services ($\chi^2 = 0.0188$, df=1, p=0.89084)	47 (35.6%)	43 (36.4%)
*It's hard to apply for some programs or services ($\chi^2 =11.988$, df=1, p<0.001)	44 (33.3%)	65 (55.1%)
My immigration status (χ^2 cannot be calculated)	0 (0%)	22 (18.6%)
*Medicaid reimbursement rates are too low to maintain appropriate support ($\chi^2 =7.578$, df=1, p=0.005909)	45 (34.1%)	70 (59.3%)

> ➢ *Recommendation 5: As mentioned in the first recommendation, additional qualitative data needs to be collected regarding the barriers to service experienced by people with disabilities. The data collected in this report highlights a stark contrast between the service barriers perceived by professionals and the actual barriers experienced by people with lived experience. Addressing this contrast requires that ADSD increase efforts to incorporate people who personally experience those barriers into any planning efforts.*

Again, the survey also included the opportunity for respondents to provide qualitative information about barriers. Unlike other sections of the survey, feedback about barriers from both the people with lived experience and the professionals was very similar. Respondents identified the overall lack of services and significant personnel shortages as the major obstacles to people receiving services. Additionally, respondents indicated that a lack of understanding about available services, as well as inflexible and complicated application processes, also prevent people for accessing services. Finally, other difficulties mentioned by respondents included stigma, a lack of adequately financed programs, insufficient compensation for the workforce, and a lack of insurance coverage.

Assessments of Programs and Services

The remainder of the survey allowed people who received or were eligible to receive certain services to rate their satisfaction with those services. The data are reported by category services and the mean score on a scale from 1-4 (1-very dissatisfied, 2-dissatisfied, 3-satisfied, 4-very satisfied) is included in the table, along with the number of people who were unaware of the program/service.

Programs for the Elderly

Assessments of Programs for the Elderly are contained in Table 10: Assessment of Programs for the Elderly. Because of the low number of respondents that were eligible to answer this question, assumptions about the data's meaning should be made with caution; however, for the most part, respondents were satisfied, with each mean somewhere between satisfied (3) and very satisfied (4).

Table 10: Assessment of Programs for the Elderly

Rate of satisfaction with each of the services provided by State of Nevada to Elderly people.	Mean	I am not aware of this service
Case Management	3.00 (n=8)	1
Personal Care	3.50 (n=8)	2
Homemaker	3.57 (n=7)	2
Adult Day Care	3.83 (n=6)	1
Adult Companion	3.40 (n=5)	2
Personal Emergency Response System	3.86 (n=7)	2
Chore service	3.75 (n=8)	2
Respite	3.00 (n=3)	4

Waiver Services for People with Physical Disabilities

Table 11: Waiver Services for People with Physical Disabilities contains the assessments of people eligible for those services and people whose family members are eligible for the services. For each service, the mean score is less than 3, implying that respondents are less than satisfied on average with each service. A significant number of people said that they were not familiar with most of the services.

Table 11: Waiver Services for People with Physical Disabilities

Rate of satisfaction with Waiver Services for People with Physical Disabilities	Mean	I am not aware of this service
Chore	2.76 (n=17)	74
Homemaker	2.47 (n= 19)	72
Respite	2.46 (n=71)	23
Personal Emergency Response System	2.71 (n= 21)	64
Attendant Care	2.29 (n= 31)	47
Home Delivered Meals	2.92 (n= 24)	38
Specialized Medical Equipment	2.57 (n= 23)	30
Home modification	2.39 (n=23)	34

Rate of satisfaction with Waiver Services for People with Physical Disabilities	Mean	I am not aware of this service
Assisted Living	2.37 (n= 27)	24
Case Management	2.65 (n= 66)	26

Waiver Services for People with Intellectual and Developmental Disabilities

Table 12: Waiver Services for People with Intellectual and Developmental Disabilities contains assessments of waiver services for people with intellectual and developmental disabilities. Data includes responses from people IDD, as well as the family members. Similar to the table for waiver for physical disability, the mean response for each service is less than 3, indicating that people are not satisfied on average. A large number of respondents were not aware of particular services.

Table 12: Waiver Services for People with Intellectual and Developmental Disabilities

How satisfied are you with the State of Nevada waiver services for People with Intellectual and Developmental Disabilities?	Mean	I am not aware of this service.
Supported Living Arrangement Services	2.48 (n= 33)	34
Jobs and Day Training Services	2.34 (n= 53)	24
Behavioral Consultation, Training and Intervention	2.51 (n= 37)	37
Counseling Services	2.44 (n= 43)	39
Nursing Services	2.78 (n= 27)	24
Nutritional Counseling Services	2.60 (n=25)	47
Non-Medical Transportation	2.33 (n= 39)	41

Other Nevada Programs and Services

People with disabilities and their family members were also asked about other Nevada programs and services. The following tables contain assessments of different categories of programs and services in Nevada. As with the previous tables, the average score was less than 3 for these programs and services, indicating that people with lived experience were less than satisfied with them. The first of these tables contains assessments of ADSD programs and the table that follows contains other programs and services available in Nevada.

Table 13: Assessments of ADSD Programs

Satisfaction with ADSD Programs	Mean	I am not aware of this service
Adult Protective Services	2.60 (n= 47)	21
NV Care Connection – Resource Centers	2.63 (n= 41)	65
Nevada	2.46 (n= 56)	49
Community Advocates	3.09 (n= 65)	47
Office of Consumer Health Assistance	2.42 (n= 33)	74
Medicare Assistance Program	2.57 (n= 63)	26
Senior/Disability Rx Program	2.49 (n=37)	37
NV Autism Treatment Assistance Program	2.62 (n= 50)	26

Satisfaction with ADSD Programs	Mean	I am not aware of this service
NV Early Intervention Services	2.99 (n= 75)	6
Personal Assistance Services Program	2.46 (n= 41)	58
NV Assistive Technology Collaborative	2.79 (n= 33)	64
Long Term Care Ombudsman	2.73 (n= 30)	48
Assistive Technology for Independent Living Program	2.69 (n= 35)	54
Deaf and Hard of Hearing Services	2.76 (n= 29)	23
Taxi Assistance Program	2.67 (n= 24)	71

Table 14: Assessments of other Nevada Programs and Services

Satisfaction with Other Nevada Programs and Services	Mean	I am not aware of this service
Family Preservation program	2.75 (n=16)	57
Respite	2.51 (n= 67)	21
Purchase of Service	2.24 (n= 17)	68
Self-Directed Services	2.29 (n= 31)	60
Home Repair and Modification	2.57 (n= 21)	44
Health Promotion	2.74 (n= 23)	56
Transportation	2.43 (n= 60)	28
Caregiver Support Services	2.47 (n= 38)	53
Legal Assistance	2.36 (n= 45)	42
Food Assistance	3.10 (n= 52)	30
Homemaker	2.82 (n= 22)	57

> ➢ *Recommendation 6: With the exception of programs for older adults, survey respondents were less than satisfied with the other programs and services offered in Nevada. This suggests that more data needs to be collected about those programs and services and how they can be more effective. Simply stated, Olmstead goals are not achievable if the necessary services, resources, and supports are unavailable.*

Policy Suggestions

The survey asked respondents about suggestions they had for policies to improve the lives of and opportunities for people with disabilities or older adults in Nevada.

People with Lived Experience

People with lived experience proposed a variety of ideas relating to enhancing the opportunities and lives of those with disabilities in Nevada. The majority of responders reported a lack of knowledge and understanding about available services as a significant barrier to success. Respondents noted that developing a single organization responsible for assisting people with service access might help to reducing the confusion about services and eligibility. Respondents also recommended increasing salary and investing in training as means through which to reduce staffing shortage and improve overall consumer satisfaction. Additionally, respondents

suggested that reducing bureaucratic requirements and improving inflexible eligibility requirements would serve to reduce waiting lists and prevent people from being turned away for trivial reasons. Additional recommendations included more affordable housing, a stronger Medicaid program, improved transportation and road safety, and more employment opportunities.

Professionals

Professionals proposed a variety of strategies to enhance the opportunities and lives of those with disabilities. The majority of respondents believed that there should be more services that target particular groups and purposes, such as companionship, advocacy to lessen stigma, programs for youth and older people, and greater awareness of mental illness. Respondents agreed that more money is needed and that rules should be improved to guarantee access to affordable housing, assisted living, and transportation. Professionals also advocated for increased wages and a re-evaluation of eligibility criteria. Other recommendations included reviewing current services, updating policies, improving plan execution, raising awareness of current services through advertising, and streamlining the system.

> ➢ *Recommendation 7: The qualitative comments about the lack of consumer understanding of available services are supported by the quantitative data/assessments of programs and services. Data indicates a lack of knowledge about what services are available in Nevada. ADSD should develop mechanisms to ensure that eligible individuals (and family members) are aware of the programming available in Nevada, and how to access those programs and services.*

Educating Stakeholders on Services and Resources

The survey also asked, "What should be done to better educate individuals of the services and resources available?"

People with Lived Experience

People with lived experience identified the most crucial strategy in educating people about services and resources as a multifaceted public education and awareness campaign designed to incorporate the use of print media, social media, public service announcements, email messages, and webinars. Respondents also indicated a need for increased funding and an increase in ADSD personnel's understanding about available services. Respondents encouraged ADSD leadership to engage with other community-based leaders, such a healthcare practitioners and educators, in the distribution of information about available services.

Professionals

Professional respondents identified strategies for improving consumer education. Such strategies included:

- Developing a robust collaboration between ADSD and school districts to provide information to students with disabilities and their parents;
- Involving people with disabilities in all aspects of service planning, implementation, and evaluation;
- Re-imagining the processes through which the regional centers deliver services., including the development of resources hubs in each county;
- Engaging in a multi-faceted public education campaign.

ADSD Community Workshops
Summary Report

Methods

Community Workshops were held with consumers, caregivers, family members, and advocates at multiple locations in the north, south, and rural areas of Nevada. The purpose of the Community Workshops was to gather feedback directly from people with lived experience (PLEs) to include ADSD service recipients, family members, care providers, and advocates about what is needed to improve community-based services and supports to people with disabilities across the lifespan.

Workshops lasted approximately 90 minutes at each site. Each workshop began with a description of the Olmstead decision, the ADSD Olmstead planning process, and an explanation of how the workshop information was relevant to planning efforts.

Workshop Logistics and Number of Participants

There were a total of nine workshops conducted that hosted a combined total of 128 participants. The location, date, and number of participants for each of the nine Community Workshops are provided below.

- The Reno workshop occurred on February 21, 2023, and had a total of 10 participants.
- The Fallon workshop occurred on February 21, 2023, and had a total of 12 participants.
- The Winnemucca workshop occurred on February 22, 2023, and had a total of 1 participant.
- The Elko workshop occurred on February 23, 2023, and had a total of 19 participants.
- The Mesquite workshop occurred on February 27, 2023, and had a total of 5 participants.
- The Pahrump workshop occurred on February 28, 2023, and had a total of 6 participants.
- The Las Vegas workshop occurred on March 1, 2023, and had a total of 21 participants.
- A virtual workshop occurred on March 6, 2023, and had a total of 35 participants.
- A virtual workshop occurred on March 10, 2023, and had a total of 19 participants.

Summary of Workshop Discussions

The workshop discussions were structured around 11 questions that were developed to assess the extent that people knew about the Olmstead decision as well as the services available to support community integration. The bulk of each workshop focused on what services were needed for community integration purposes and how well the existing service systems met such needs.

The structure of the workshops was consistent across all in-person gatherings. To ensure sufficient time for all participants in the virtual settings, the structure for input was slightly modified. Input received from the in-person gatherings was summarized and then presented to participants in the virtual settings. Participants in the virtual settings were then asked to indicate, through polling, the extent to which they agreed with what had already been identified. Following polling, participants were offered the opportunity to add any additional thoughts they had on the subject either verbally or through use of the chat function within Zoom.

The summary of input received across all workshops is provided on the following pages.

Olmstead Plan I **2023**

Understanding of the Olmstead Decision

Participants were asked to describe to what extent people with lived experience and their family members understand the Olmstead decision.

People have a limited to non-existent understanding of the Olmstead Decision. While a handful of workshop participants indicated a moderate to deep understanding of the Olmstead decision, the vast majority indicated a limited to non-existent awareness. There was recognition that while individuals may not know about the term "Olmstead" specifically, there was some understanding of "waiver" services and the availability of supports to assist with independent and integrated living options.

> "People don't understand the far-reaching things that Olmstead impacts - things like transportation and access. Furthermore, service providers don't know the 10 waiver services, placing people [with lived experience] in the position of having to ask for them."
>
> ~Workshop participant, and service provider~

During the two virtual workshops, polling was offered that asked people to rate their level of understanding of Olmstead on a scale between one and five. Of the 44 people who participated in the poll, the results were as follows:

- 32% (14/44) rated themselves as a "1" indicating they know nothing about Olmstead.
- 59% (26/44) rated themselves as a "2" indicating they know a little, but not much.
- 7% (3/44) rated themselves as a "3" indicating they knew a reasonable amount.
- 2% (1/44) rated themselves as a "4" indicating they know a good amount.
- Not a single participant that responded to the poll rated themselves as a "5" indicating they knew a lot.

Some contextual themes came up throughout the discussion on this topic and are summarized below.

- There are differing understandings of Olmstead between those with developmental delays (and the individuals that care for them) and those from populations of individuals that are aging, and/or that are experiencing Alzheimer's and/or dementia. Workshop participants indicated that the aging population as well as those individuals with dementia or Alzheimer's may be less informed than the other populations impacted by the Olmstead decision. Reasons offered for this included the belief that the aging population did not grow up with the benefits offered by the ADA or the Olmstead decision.

- While service provider workshop participants indicated a greater knowledge than people with lived experiences, they still indicated a low level of awareness about the decision or its implications to service delivery. Furthermore, there were comments made at two of the workshops proposing that with a higher level of awareness about Olmstead, providers, specifically those conducting functional assessments, may conduct their business in a manner that provides greater access to Olmstead driven supports.

- Some participants indicated a greater knowledge of the Olmstead decision in other states and associated this to lawsuits that have been levied against those states, bringing the issue to the forefront of the service delivery system.

> "This is the first time I am ever hearing about anything called the Olmstead Decision."
>
> ~Workshop participant, and father of a child with severe functional disabilities~

Knowledge of ADSD Services Availability & Identifying Where People Get Information

Participants were asked to identify where they got information the first time they accessed support through ADSD or other state divisions.

Peer-to-peer information sharing, self-directed internet research, and service providers were most often the sources that people identified as having provided information about available services and supports. Other sources of first-time information included schools, hospitals, and regional centers. Specific service providers referenced at least once but no more than twice during workshops included the Autism Network, Care Chest, the Douglas County Public Guardian, Nevada Early Intervention Services, the Nevada Care Connection, Nevada Pep, and 211.

> "I am one of those parents who is tired. It takes so much energy to get information, and I need that energy to care for my 38-year old son."
>
> ~Workshop participant, and parent of an adult child with severe functional disabilities~

During the two virtual workshops, polling was offered to assess the degree to which people agreed with the sources of first-time information that had already been identified. While a total of 38 people participated in the poll, respondents were offered the option to agree with as many of the locations as they saw fit. The results demonstrate the percentage of those that participated in the poll's agreement with the locations where people most often get their information from when accessing ADSD or other state sponsored supports for the first time.

- 26% (10/38) agreed that peers were their first source of information about support options.
- 26% (10/38) agreed that self-directed research efforts were what led to accessing first time supports.
- 26% (10/38) agreed that service providers were their first source of information about support options.
- 16% (6/38) agreed that schools were their first source of information about support options.
- 8% (3/38) agreed that hospitals were their first source of information about support options.
- 8% (3/38) agreed that regional centers were their first source of information about support options.

Some contextual themes came up throughout the discussion on this topic and are summarized below.
- Peer-to-peer information sharing is where many people receive information about ADSD.
- Hospitals will provide information to parents if they have a child born with a disability or if a person has shown up at the hospital and is being discharged with a functional limitation.
- Schools were noted as a place where people often first encountered ADSD services, however they noted that the information shared was not universally distributed.
- Sometimes service providers will offer referrals to ADSD services, but that is very dependent on the individual as there is no systems wide approach to service connection.

- Many folks stated they first learned about ADSD services through their own internet research but stressed that the information was hard to find or understand.

> "I called every state number I could find online... I continued to call until I got directed to call Sierra Regional Center, which is how the ball got rolling for my daughter. The process took eight months."
>
> ~Workshop participant, and parent of a child with a disability~

Participants were asked to share their perspective about the extent that people with lived experience (and their family members) know about services that provide community integration supports?

People with lived experience, as well as their family members do not know much about what services are available to support community integration. There was a variety of perceived reasons offered to explain this circumstance which included high turn-over rates of ADSD staffing, intentional withholding of information by service providers, and a constant churning of available services/service providers. These reasonings and more are more fully summarized below.

> "I work for the NCED Family Navigation Network and find that families who contact us have heard that there are some kind of support/services out there, but they don't know what they are let alone how to access them."
>
> ~Workshop participant, and service provider~

- People get information in bits and pieces, and usually from other service providers. The amount of information you get and the quality of that information is largely dependent on the individual service provider.
- Because of the high turn-over at ADSD, it is not common to find an employee that has a deep understanding about the variety of services available through ADSD. This leaves PLEs with the responsibility of knowing the key terms or the right things to ask for, to get the help they need.
- Sometimes providers intentionally do not share information with PLEs about what services are available either because they are competing against other organizations to provide such services, or it is not in their organization's best interest to share such information.
- Because people are on long waiting lists, sometimes they just give up on trying to understand what services are available. They feel hopeless about getting their needs met.
- Because things change (due to legislation or provider turn-over), many people do not know the full range of services available or who can provide services to them.

Participants were asked to share their perspective about where people with lived experience (and their family members) get information?

Peer-to-Peer information sharing, self-directed internet research and service providers were identified most often as the places where PLEs get information about available services and supports. Advocacy organizations and doctor's offices were also identified. Other sources with greater specificity included:

- Tv news segments and newspapers: Older people were identified as accessing information through more traditional mediums.

Olmstead Plan I **2023**

- Referrals and transfers from other states: People who move to Nevada from another state will often seek out similar services as a component of their move.

> "The NCED Family Navigation Network helps in connecting families with resources. They have been very helpful for me in getting resources and information for my daughter. They got me help with medical connections, community resources and assistance for things for her to participate to the fullest extent possible in school"
>
> ~Workshop participant, and mother to a child with a disability~

Lastly, participants were asked what they would recommend to help ensure that information is readily available about the services that are available through ADSD.

Workshop participants made several suggestions regarding how ADSD could increase knowledge and awareness of its service options. Suggestions identified in at least two of the nine workshops conducted are described below.

- **ADSD Website Improvements:** Improvements to the ADSD website were almost universally requested in the community workshops conducted. Suggestions such as the use of simple language, comprehensive service listings and descriptions, and navigational ease were identified as needed improvements.
- **Targeted Messaging:** It was recommended numerous times that ADSD develop targeted messaging to each of its service populations. Specific recommendations included:
  - Utilizing tv ads, billboards, and direct mail for seniors. Sending information within utilities billing was also identified as a potential strategy to spread information to seniors.
  - Utilizing specific social media platforms for targeted age ranges and demographic profiles.
- **ADSD Staff Trainings:** Regular and ongoing training for ADSD staff to ensure they understand the full range of services available throughout the agency, regardless of population being served, and can act as a "no wrong door" portal to all available assistance was recommended in most workshops conducted.
- **Provider Outreach and Education:** There was a wide consensus that ADSD should conduct regular outreach and education efforts with partners that most intersect with the work they do. Hospitals, schools, contractors, first responders, public health nurses, and other social service entities should receive regular (one person suggested quarterly) updates about service offerings.
- **Promotion of 211:** Workshop participants were of mixed opinions about the value of 211. While some participants considered the state resource outdated and limited in its helpfulness, others felt like it had existing value or at least the potential of usefulness but only after the successful deployment of necessary improvements.
- **Pro-active Client Communications:** A variety of suggestions were offered regarding pro-active client communications, each of which are provided below.
  - Assigning transition coordinators to families that are leaving one system and entering another to ensure they have the information needed to successfully access all available services within the new system.

- Each ADSD caseworker should, when working with a family, go through a checklist of other services that they may also benefit from.
- Upon initial eligibility determination, send families information about other service options available and their contact information.
- Centralize information about community service provider options, capacity, and quality of care.

> "We have been hearing about No Wrong Door for years, and there is still no progress. I was just in a meeting before this about No Wrong Door, but nobody can get the right information from ANY Door. Things are not getting done."
>
> ~Workshop participant, and service provider~

Needs to Keep (or Support) Individuals Living within Integrated Settings

Service Enhancements: Participants were asked to describe what services are most needed to ensure community integration opportunities.

Housing, transportation, in-home care, personal care attendants, and respite care were the services most referenced as needed to support and sustain community integration options for individuals with disabilities.

Expansion of the following services was described in many of the community workshops held:

- ✓ Affordable Housing Options & Modification
- ✓ Crisis Supports
- ✓ Day Care Services
- ✓ Durable Medical Equipment
- ✓ Home-based Therapies
- ✓ Job Training Programs and Providers
- ✓ Life Skills Training and Financial Counseling
- ✓ Mobile Crisis Services
- ✓ Peer Support Network
- ✓ Personal Care Attendants
- ✓ Personal Support Assistance
- ✓ Primary Care (In-Home and Community)
- ✓ Respite for Families
- ✓ Social and Recreational Opportunities
- ✓ Supported Living Arrangements
- ✓ Transportation Options

> "The number one issue we always hear about is housing and supported living arrangements. There is a homelessness problem. People are stuck in institutions. Real estate has skyrocketed. There are advocates with money to move folks out of institutions, but no money for housing after that."
>
> ~Workshop participant, and service provider~

Other suggestions made at least once during workshops included:

- ✓ Behavioral Health Care
- ✓ Community Inclusion Training for Employers and Providers Servicing Individuals with Disabilities
- ✓ Competitive Employment/Job Placement
- ✓ Expanded Resource Navigation
- ✓ Gambling Support
- ✓ Host Home Program
- ✓ Life Skills Training
- ✓ Mental Stimulation Activities
- ✓ Self-Advocacy Training
- ✓ Social Security Advocates
- ✓ Special Dental Clinics
- ✓ Supported Decision Making
- ✓ Supported Employment Options
- ✓ Volunteer Opportunities

Olmstead Plan I **2023**

Geographic Specific-Enhancements: Additionally, participants were asked if there were any geographical considerations that should be considered as a component of the planning process.

- **Incentives for Services to Rural Populations:** Workshop participants expressed a significant need to incentivize providers to service rural areas. Without an incentive, providers are not able to sustain the cost of service provision, contributing to high turn-over and low quality of care.

- **Weather-based accommodations:** Multiple providers identified the implications for service populations living in Las Vegas and some of the adjacent communities that experience high temperatures in the summertime. Activities requiring outdoor participation are not always an option as high temperatures are known to be a seizure trigger for some developmental conditions. Additionally, the high cost of air conditioning during these months to host additional indoor activities should be accounted for.

System Enhancements: Participants were asked to identify the one thing they would change about the current service system particular to ADSD.

Several suggestions were made regarding the changes needed within the ADSD service system, all of which are summarized below.

- Assign a universal navigator to families that stays with them throughout their lifespan.
- Center the person in service delivery instead of the division, program, or funding stream.
- Decrease bureaucracy for family members caring for their loved ones.
- Decrease staff to client caseloads so more person-centered and pro-active service delivery can occur.
- Establish more public/private/family partnerships to ensure long-term sustainable service system.
- Improve ADSD staff knowledge of full-service spectrum and require person-centered care practices.
- Increase flexibility in service offerings and eligibility requirements.
- Streamline application process and information sharing across State departments and divisions.

Participants were asked if there was any other information that they felt critical for the planning group to understand.

- Workforce Compensation: Participants described a reality in which provider rates and reimbursements are so low that the field cannot sustain a sufficient workforce in quantity, quality, or longevity.

Barriers to Accessing Supports

Participants were asked to share the primary barriers to accessing community-based supports through ADSD.

The primary barriers to accessing community-based services through ADSD include 1) the system being difficult to navigate, 2) long wait lists, 3) inflexible eligibility requirements, and 4) an insufficient workforce within ADSD and throughout industries that provide community-based supports.

Other barriers noted during workshops included:

- A lack of knowledge about what services are available or what exactly to ask for serves as a barrier for PLEs.
- Stigma and fear of PLE's personal autonomy being taken away from them.
- Distrust of state system. People get frustrated with the system and just give up.
- Sometimes the lack of culturally appropriate care or language barriers prevent people from getting the help they need.
- It is hard to get a diagnosis that makes people eligible for support.

Beyond the barriers to accessing supports through ADSD, multiple workshop participants referenced the difficulty in accessing supports as an individual who does not qualify for Medicaid. There was also a note made of individuals who are outside the geographical boundaries of the major population hubs being unable to access services only because of the regional center that was servicing them.

> "People don't know that there are advocates out there to speak up for their needs…there are people you can call on when your case worker is not listening to you. Agencies don't want you to have an advocate because it means it keeps them on their toes."
>
> ~Workshop participant, and individual with a disability~

Participants were finally asked whether it was easy or difficult to navigate the ADSD service system.

Participants noted that there were both assets and gaps experienced when navigating the ADSD service system. While the gaps were more often referenced, several participants in multiple workshops shared that they appreciated ADSD for a variety of reasons. The list of both assets and gaps have been summarized below.

Strengths of Navigating the ADSD Service System include:

- Some service providers noted having an open line of communication with individuals at ADSD who are responsive.
- Some ADSD state staff are knowledgeable and care about people.

> "ADSD is the best of the state divisions. They just need to make information more accessible and the process a little bit easier"
>
> ~Workshop participant, and service provider~

Gaps in Navigating the ADSD Service System include:

- Service providers are always changing, making it hard to get services and nearly impossible to build community knowledge of who to contact for support.
- The application process is cumbersome and time consuming. The requirement to go through "due process" for everything was also noted as a difficulty.
- The systems in the various parts of the state are different, making it hard for people to know what to do when they move.
- Staffing levels are low resulting in people being served at a slower pace than what would be considered reasonable and the division lacks an overall depth of knowledge to do the job effectively. Both of these leave PLE independently responsible for their own care or reliant on the grace of a loved one to make sure they are okay.

- The lack of cell service in the rural areas of the state can make it difficult to access the care you need if it is dependent on telecommunications.
- There are few transitional supports offered for people as they age into or qualify for other services. This is especially true for those young adults with disabilities that are transitioning out of school-based supports.
- Participants raised the issue of not knowing which community-based providers to choose from and not having access to quality assurance information makes it difficult to determine best options.
- COVID-19 and the transition to virtual therapies was identified as a concern regarding the diminished value of that needed service.

"I work in the system and it is hard for ME. You have to know who the correct staff and departments are. The names of the department don't always align with what they provide. People get bumped from place to place because none of us know what the other people do. You keep hitting barriers."

~Workshop participant, and service provider~

ADSD Olmstead Key Person Interview
Summary Report

Methods

To support development of the ADSD Olmstead Plan, interviews were conducted with individuals identified by the ADSD Core Team and ADSD Olmstead Planning Steering Committee as having specialized knowledge about the systems that provide community-based services and supports for ADSD service populations. The purpose of these interviews was to understand the strengths and weaknesses of the existing system as well as solicit ideas about how the system can and/or should be improved.

Prior to conducting these interviews, SEI drafted seven questions to solicit the information being sought. These questions were provided to the Steering Committee for approval before being used. The question list, along with a factsheet summarizing the ADSD Olmstead project, were distributed to participants in advance of their interviews. All interviews were conducted in March and April of 2023 and occurred either virtually via Zoom technology or over a phone call.

Interviews were semi-structured and additional, or follow-up questions were added by the interviewer as appropriate to meet interview objectives and seek clarity on responses. To facilitate a more readable summary, if a response to one question aligned more with the intent of another question, it is included in the latter throughout this document. One interview was conducted with an individual that did not follow the structure used in the other interviews. When possible, information provided by that individual is included in the section which is most applicable.

All interviews were conducted by one of two members of the SEI team (only two members of the SEI team served as interviewers to support consistency in approach and documentation). This summary was drafted by the individuals who conducted most interviews and is based on a review of the notes summarizing each call. Finally, a confirmation of themes was conducted by a third team member who did not participate in the interviews through a review of all of the interview notes.

Participants

Individuals from 22 organizations were recommended for inclusion in the interview process by either the ADSD Core Team and/or the ADSD Olmstead Planning Steering Committee. Not all individuals identified responded to SEI's requests for interview participation. A total of 21 individuals from 18 organizations participated in interviews. The sector and organizations represented by the interviewees are included in the table on the following page.[22]

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[22] Note that some individuals represent multiple interests, such as working for a provider or advocacy organization and also being a person with lived experience (PLE). Also, there were at least three interviewees who self-identified as PLEs. Two interviewees are person(s) with a disability, and one is a family member/caretaker of someone with a disability.

Nevada State & County Agencies	Community-Based Service Providers	Advocacy Organizations & Associations
• Clark County Department of Family Services • Washoe County Social Services • Department of Education Office of Inclusive Education • Department of Employment, Training, and Rehabilitation Bureau of Vocational Rehabilitation • Division of Health Care Financing and Policy • Division of Public and Behavioral Health	• Advanced Personal Care Solutions • Blind Connect • Collaboration Center Foundation • Nevada PEP • Northern Nevada Center for Independent Living • Opportunity Village • Southern Nevada Center for Independent Living • United Cerebral Palsy of Nevada	• Group Home Association • Legal Aid Center of Southern Nevada • Personal Care Association of Nevada

Summary of Key Person Interviews

Input received across interviews is summarized on the following pages, with a focus on key themes seen in multiple interviews; these key themes are indicated in **bold blue font** and are followed by additional responses that were shared by fewer participants. The areas of inquiry covered by the initial seven questions are indicated by grey bars.

To what extent do you (and your team members) understand the Olmstead decision and how is that information used within your organization?

Awareness and use of the Olmstead decision varied across and within organizations, with many interviewees indicating that while their organization's work is aligned with the Olmstead decision, awareness of that alignment within their organization is limited.

> "We don't realize that when we advocate for our clients to be in a more independent environment that we are using Olmstead."
>
> ~Interview Participant~

Olmstead Awareness

- **Over half of the interviewees indicated that awareness is higher at some levels of the organization (e.g., at the administrative or advocacy level or within positions that serve high-need clients) but that not all staff are aware of Olmstead and/or do not understand that; 1) it is a driver for organizational policies or, 2) that it guides the work they do on a daily basis.**

- Fewer interviewees indicated that awareness of the Olmstead decision is high or pervasive throughout all levels of their organization, and one individual indicated they were unaware of the Olmstead decision prior to the interview.

Olmstead Use

- **During approximately half of the interviews, it was noted that the work their organization conducts is aligned with the Olmstead decision, but that Olmstead is not regularly cited as a driver for the work.**

- During some interviews it was indicated that content related to the Olmstead decision is included in staff training.

What programs, policies, and procedures are in place or being proposed within your organization that promote and facilitate services in the most integrated settings?

Interview participants that were representing an organization indicated the following programs, policies, and procedures either in place or being proposed within their organization to promote or facilitate service provision in integrated settings.

Programs

- **Many interviewees that offer direct service delivery indicated that their approach to care is rooted in an individual's ability to shelter, work, and live in an integrated setting. Specific services cited include personal care assistance, life skills training, and prioritizing placement of welfare-system involved adults and children in settings that are not segregated.**

- **Providing referrals to or information about other community-based organizations that provide community integration opportunities were also cited often as a mechanism to support community integration for families being served.**

- Some interviewees described offering services that support an individual's ability to work in an integrated setting (through training, placement, or provision of an integrated workplace).

- A few interviewees described facilitating access to funding that can be used to pay for services that can help individuals avoid unnecessary institutionalization.

Policies and Procedures

- **Some interviewees identified co-creating independent living plans (ILPs) or other individual plans with clients. These plans serve to identify individual and custom goals as well as resources needed and available to support their own or their child(ren)'s ability to shelter, work and/or live in an integrated setting.**

- **Some interviewees also described conducting advocacy efforts to enhance community integration opportunities for the clients they serve.**

- A few interviewees described developing or sustaining internal policies that prioritize community integration in activity and service provision within their organization.

What is being done within your organization to ensure services that support community integration are person-centered and high quality?

The following examples were provided as ways in which the organizations represented during the interviews are ensuring services that support community integration are person-centered and high-quality.

Person-centered

- **Many interviewees described a general use of a person-centered approach and/or meeting people where they are at as a typical approach to service delivery.**

- **Interviewees also described providing information to clients about their rights and their ability to advocate for themselves. Additionally, interviewees described an approach to service delivery that prioritizes the desires of clients over a provider's assessment of what is best for said client.**

Individual interviewees also described the following ways in which they support person-centered service delivery:

- Adjusting feedback mechanisms to align with the abilities of the people being served. For example, one provider noted that they will document how non-verbal individuals they work with react to different opportunities to help inform what they liked or were uninterested in.

- Conducting an annual service plan review as a component of service delivery in an effort to support person-centered care.

- Creative problem solving to meet the needs of the client. An example offered by one interviewee was paying for all beds within a foster home despite only placing one child (who has significant special needs) within the home.

- Providing culturally competent and linguistically accessible services as a way in which they offer customized and appropriate care to clients.

- Supporting individuals in learning skills that empower them to do things on their own (self-directed care) was also described in a few of the interviews conducted.

During some interviews, participants noted challenges to the application of a person-centered approach in service delivery. Barriers identified included the perception that the system is not designed to serve people in an individualized fashion and/or that funding limitations and a lack of a sufficient provider base prevents flexible service delivery and person-centered care.

> "We train our staff to be person-centered, to think about the person first, and to help the person make the most informed choice."
>
> ~Interview Participant~

High-quality

- **Many interviewees described the use of client satisfaction surveys as a mechanism to track and address the quality of their service provision.**

- **Some interviewees described a system of conducting follow-up with people after they have been served or participated in a program.**

- **Some monitor and adhere to funder-mandated reporting requirements, and/or utilize dedicated quality assurance teams.**

Individual interviewees also described the following ways in which they ensure high-quality service delivery:

- Application of best practices from national sources as a way to ensure high quality service delivery,

- Ensuring PLEs have a voice in the organization. An example of this that was shared was the requirement that over half of the staff or board of the organization are required to be PLEs.

- Other activities that were offered as mechanisms to support high quality service delivery included informal observations, use of staff surveys, and use of technology to monitor care provider status and to communicate with clients.

To what extent are state systems, counties and community providers working together to support community integration efforts? Where are the pain points and what is working well?

Interviewees were asked to share their perceptions about how well state systems, counties, and community providers work together to support community integration. Additionally, individuals were asked to identify specific pain points and examples of what is working well.

Many interviewees focused on the second half of the question regarding pain points and successes. Of those participants who did offer a general assessment of how well systems work together, primary responses included:

> "We are a small piece of the whole system. For the system to work, we all need to be working together."
>
> ~Interview Participant~

- **During many interviews it was noted that the system is not working well or could be working better to support community integration. Several participants noted that the system does not seem to be designed to support collaboration, as detailed under the pain points section below.**

- A few interviewees indicated that the strength of collaboration varies across sectors and locations.

- During one interview, a participant indicated that they were unsure how organizations are working together or how well they are working together to support community integration.

Pain Points

- **Many interviews highlighted silos as the current reality, exacerbated by a lack of information sharing between agencies. Additionally, many depicted a system that is structured to find fault rather than operate collaboratively.** Several participants indicated that creating a plan specifically for ADSD will reinforce silos and continue to limit the number of individuals covered by the plan. These individuals suggested an interagency approach to plan development and service delivery as a more appropriate approach to truly supporting community integration. Standing, interagency meetings were

recommended by a few participants as an option for helping to facilitate information sharing and eliminate silos that negatively impact community integration collaboration efforts. One participant noted that the system should be structured to facilitate information sharing between organizations in order to provide a more seamless continuum of care for individuals. A few participants indicated that they felt the current system focuses on assigning blame when an issue arises rather than collaboratively finding a solution.

- **Some participants described a service system that does not serve all populations that require support to shelter, work, and live in an integrated setting.** A lack of services to support individuals with behavioral health issues, as well as individuals that do not meet specific eligibility requirements but who still need supports to live in a non-segregated setting, was specifically raised as populations not covered by the current system. One interviewee noted that state agencies are selectively using eligibility assessments that deny access to services, which leaves gaps in services and resource availability for individuals that fall between the eligibility requirements of different agencies.

- **Some interviewees stated that many supportive services needed for community integration are lacking.** Housing and transportation were specifically noted as barriers to developing a comprehensive system that supports community integration.

- **Transitions, specifically between the children/youth and adult system, were described by some as extremely challenging,** with interviewees noting that systems serving different age populations do not work together. They also noted that the education system serves children and youth from an entitlement framework, wherein the school is responsible for the majority of service provision once standard eligibility is determined; this is radically different from the adult system, which requires individuals to advocate for themselves and apply for services separately, often through multiple organizations. This transition and difference in how services are accessed result in people becoming frustrated and not accessing adult-level services and supports leaving these individuals at risk of ending up in institutions.

- **Public awareness of service availability and how to apply for services is limited.** Some interviewees noted that many people do not know what services are available, what they may be eligible for, how to apply for services, and what the overall process will entail. The engagement of people with lived experience serving as peer support was provided as an option for helping individuals navigate the system in an informed way.

Working Well

- **Collaboration and relationships were noted by some as things that were working well within the service system.** In contrast to the primary pain point of the siloed nature of the system, several participants noted that collaboration and relationships are two areas that are working well in the system. That said, many of these relationships and collaborations seem to be location-specific, individual, or personality-generated, rather than system or organization wide.

- **Co-location of services was noted by a few interviewees as a strength of the existing system.** Interviewees offered that sharing space with other organizations, including state agencies, has been helpful in providing comprehensive supports for community integration.

- **Nurturing a shared understanding of the system was noted by a few interviewees as a helpful effort in working together to support community integration.** Participants noted that their participation and/or facilitation of intra- and inter-agency committees and groups, as well as use of MOUs between organizations, has helped contribute to a system that supports community integration.

During some interviews a follow-up question was asked to determine how organizations work with ADSD specifically. Responses included:

- **Limited or no interaction with ADSD** was noted by some individuals who were interviewed. These individuals describe a struggle to identify the correct people at ADSD to connect or work with, and that ADSD provided funding is avoided because it comes with prohibitively high requirements.

- **A recent uptick in actual or planned collaboration with ADSD** was noted by a few interviewees. Interviewees described ADSD providing on-site assessments for clients, planned meetings, and a desire to execute MOUs or formalize processes with ADSD as examples of improved collaborations. One individual noted that when they talk to someone from ADSD they feel like they are talking to someone who wants to be helpful.

- **A few individuals noted that working directly with regional centers** has been a positive experience.

In a recent study conducted by UNR, it was found that there is a "stark contrast between the service barriers perceived by professionals and PLEs." What do you ascribe this contrast to?

Due to time, this question was not explored during all interviews. The following possibilities were provided by respondents as reasons why the NCED survey showed stark contrasts between the service barriers perceived by professionals and those perceived by PLEs.

- **During some interviews it was speculated that the difference between barriers perceived by professionals and PLEs may be due to survey respondents looking at the question from different perspectives.** Interviewees indicated that PLEs are reporting barriers they have personally experienced, whereas providers are navigating the system on behalf of multiple clients and reporting what they have experienced through that lens. One interviewee noted that providers might not have referenced barriers that are related to the life circumstances of the people they serve.

- A few interviewees speculated that the difference might have to do with past experiences and expectation management. Interviewees noted that professionals have a higher expectation of what should be possible and available, while people with lived experience who are navigating the system are used to services and supports not being accessible or available and have developed an acceptance of that.

"There is an engrained expectation that [PLEs] should be grateful for what they have, which explains the underreporting of barriers [by PLEs]. PLEs aren't trained to advocate for themselves, but to be more understanding and accept what is available rather than demand what they need."

~Interview Participant~

If you could identify the most critical systems issue that needs to be addressed to better support community integration, what would it be? How would you suggest solving that issue?

While interviewees were asked to identify the <u>single</u> most critical issue that should be addressed, as well as recommendations for solving the issue, many provided information on multiple issues. All responses are included in the summary below. Being that many of these issues are interrelated, it may be of most benefit to consider them together to identify which solutions will have the greatest impact on critical issues resolution.

Critical Issue	Suggested Action
A fractured, complex system without a continuum of care or ease of access. During one interview it was noted that compared to the children's system where the education system serves as a primary convener and source of information, the adult system is siloed and difficult to navigate. Another participant indicated that ADSD needs to shift how they provide services and supports to families and make the process shorter and more streamlined.	o Apply person-centered practices throughout the system o Provide resources for individuals that do not meet eligibility requirements o Develop a fair and transparent grievance system o Disseminate reliable information on programs and services in an easily accessible manner o Engage people with lived experience in a meaningful way, such as through the inclusion of peer supports o Institute quality control activities both internally and for state subcontractors o Improve the application process, such as by simplifying forms and processes o Increase the number of services available o Integrates support services that can help avoid institutionalization, such as mobile crisis team through regional centers Partner with community service organizations for service provision and information dissemination
Lack of sufficient and flexible funding. The sub-issues identified as being caused by a lack of funding included the following, several of which were noted as critical issues themselves by other interviewees: • Not enough integrated or supportive housing options and transportation supports	o Advocate for more funding from the State legislature o Partner with DHCFP to revise the existing rate structure o Revise existing waiver services o Establish more waiver services (a children's waiver was specifically called for)

Olmstead Plan I **2023**

Critical Issue	Suggested Action
• Lack of alternatives to incarceration for individuals with mental health issues • Insufficient number of integrated or community-based facilities, such as housing, for adults and children • Shortage of staff and community service providers needed to support community integration efforts • Inability to customize services and supports to align with people's unique needs • Unreasonably long waitlists for people with critical needs	○ Resolve workforce shortages to address waitlist issues ○ Reinstate access to on-demand buses that have been repurposed for school transportation In addition to these specific recommendations, interviewees noted that public education about what Medicaid can and cannot cover would improve understanding and help manage expectations. It was also proposed that this was a necessary step to help providers and system participants design a system that includes necessary, supplementary funding.
Workforce shortages and sufficiency, with interviewees noting challenges in filling positions in general and also ensuring that individuals working within the system are knowledgeable and appropriately trained. One participant indicated that it is critical to ensure that people who understand and support community integration are employed throughout the system.	○ Adjust Medicaid reimbursement rates or making other changes so that providers can increase staff wages and invest in appropriate recruitment, training, and retention strategies ○ Encouraging people (with a focus on PLEs) to work for the state, and adjusting hiring processes to make it easier to fill vacancies ○ Provide training on Olmstead to staff throughout the system and embed tenets of Olmstead throughout work performance standards ○ Incentivize employment/service provision in rural areas and participate in innovative recruitment and training practices (to include virtual recruitment, hybrid work options, etc.)
Negative community perception of people with disabilities.	○ Increase the presence of individuals with disabilities in public spaces

Are there specific geographic considerations that need to be taken into account when providing services that promote community integration?

Due to time, this question was not explored during all interviews. The following geographic considerations that should be considered when providing services that promote community integration.

General Considerations

• A few participants noted that tele-health, virtual supports, and traveling clinicians could be utilized to fill gaps in workforce availability throughout the state

Olmstead Plan I **2023**

Other consideration offered by individual interviewees included:

- The cost to employ staff varies in different places across the state while the reimbursement amounts through Medicaid do not

- Transportation can cause challenges as it can take a very long time to get from one place to another in Nevada

- Some areas of the state are so hot in the summer that families do not want loved ones to participate in services for fear of a heat-related medical issue

Metropolitan/Suburban/Urban Areas

- A few participants noted that the large population in Las Vegas cannot be served by the existing service spectrum

- One participant shared that sufficient housing and transportation are not available in the northern part of the state

Rural Areas

- A few participants noted that there is a limited workforce and/or limited services available in the rural areas, and creative solutions are often required to support families in these areas

- One participant noted that there are fewer opportunities for integration in rural areas compared to the bigger cities

> "Even though the rural [areas] are more inclusive, with a better sense of community and where everybody helps everybody else, they are very limited in services."
>
> ~Interview Participant~

Other Comments and Interviewer Observations

As time allowed, participants were asked to provide any other information they would like the ADSD Olmstead Plan Steering Committee to consider. Responses included:

- Some interviewees felt that Olmstead should be at the forefront of service delivery. One participant noted that the regional center system needs to move away from offering segregated settings as the only option available for people to live and work, and another noted that the culture among service providers that people need to "earn" their choices is a problem.

- Some participants reiterated the gaps in the current system of care noting housing, transportation, and the availability of non-congregate settings. One interview revealed the impression that community-based providers actually prefer to offer congregate based care due to the ease of this service delivery strategy. Additionally, one participant noted that the need for expanded group and foster care homes is increasing while the supply is decreasing.

Olmstead Plan I **2023**

- Advocating for service providers to go outside their existing framework for problem solving and service provision was mentioned by a few participants. Suggestions for how to make this happen included the directive to have conversations with PLEs, asking them directly what they want, what their hopes and dreams are, and then follow through on the responses provided. It was noted that it is a problem when people are asked what they want and then nothing happens. Similarly, another participant indicated that when they worked in another state, consumer and consumer advocates were included in the process of developing and implementing the plan.

- One interviewee shared that it was their hope that the ADSD Olmstead plan was not being revised just stay in compliance, but rather to spur actual change.

- A few participants indicated a positive shift occurring in mindset among some ADSD staff (service coordinators were mentioned specifically). At least one person expressed hope that person-centered plans will work better/be used more in the future.

- One interviewee indicated that a person who is living in a congregate setting is more vulnerable in regard to their personal health and safety, stating that "it scares me as an older person to see this system [and think I might be needing to use it soon]".

During this, and other sections of the interviews, some participants noted that they did not feel like their organization represented individuals covered by the Olmstead decision or that the work they do does not directly impact community integration. This may indicate that there is room to develop a more robust shared understanding of how different elements contribute to a system that supports community integration for individuals who are aging and/or those that have a disability.

Appendix E. Complimentary Efforts to Improve the ADSD Service System

- **FOCIS/MFP Transition**
  - During the 82nd legislative session ADSD was approved to move the Money Follows the Person (MFP) and the Facility Outreach and Community Integration Services (FOCIS) program from the Division of Health Care Financing and Policy (DHCFP).
    - Money Follows the Person (MFP) program provides states with enhanced federal matching funds for services and supports to help seniors and people with disabilities move from institutions to the community.
    - The Facility Outreach and Community Integration Services program (FOCIS) program is intended to provide Medicaid recipients with a choice to seek an alternative to institutional placement. This program typically targets individuals who are currently in a skilled nursing facility, but can also work with hospitals to help divert individuals from institutional placement.
  - As ADSD is actively engaged with the populations that are served by MFP and FOCIS, the state can expect additional transitions from institutional care to a home and community-based setting.

- **NWD Governance Project**
  - In September 2022, ADSD was awarded federal funding to enhance our state's efforts related to a no wrong door system (NWD) for long term care needs of residents. ADSD has been leading these efforts since 2005 under the Nevada Care Connection brand. Our primary efforts have focused on establishing local aging and disability resource centers to help individuals navigate the long-term services and supports system. The new grant will fund an effort to identify system enhancement recommendations using a national framework of best practices. It will also identify a governance structure for continuous improvement efforts.

- **Business Process Re-Engineering Project**
  - ADSD has contracted with Change & Innovation Agency to complete a high-level review of current processes across various programs and services to identify opportunities for improvement to ADSD. Improvement recommendations will target ways to increase capacity, and better meet the policy and practice objective of the Division and its various programs. Through this process, ADSD will evaluate opportunities to:
    - Streamline intake, and case management business processes and systems.
    - Adapt to change in a post-pandemic new normal, including person-centered planning to ensure the needs of the individuals are met.
    - Create efficiency in operations and workflows, moving to automation and away from human intervention.
    - Adjust staffing needs/workflows based on the changing needs of the population served.
    - Improve the quality of and access to services.
    - Identify touchpoints and duplication to create efficiencies and remove access barriers.
    - Find opportunities for centralization and statewide standardization.

    It is expected that the recommendations that come out of this process will likely coincide with issues identified throughout the ADSD Olmstead Planning process.

- **Developmental Services Intensive Support Services**
  - o To provide more comprehensive services to individuals dually diagnosed with an intellectual/developmental disability (IDD) and a behavioral health disorder, Developmental Services is expanding support efforts statewide targeted to this population.
    - ▪ ADSD received budget approval in the 82nd Legislative session to expand the Youth Intensive Support Services (YISS) program statewide in Fiscal Year 2024. The YISS program has been operating at Desert Regional Center in Las Vegas for several years and it focuses on youth up to the age of 22 who need intensive support due to dual diagnosis. Service Coordinators working in YISS carry a lower caseload of 1:15 so they can successfully coordinate all specialized services needed for the youth to successfully gain needed skills, reduce difficult behaviors, and remain living in the family home or an appropriate community-based residential setting. With the approved Developmental Services budgets, there will soon be YISS Service Coordinators serving all areas of Nevada, as well as a statewide Program Manager responsible for YISS program planning and development, as well as needed collaboration with child welfare agencies and numerous other stakeholders.
    - ▪ Developmental Services received ARPA funding to establish Intensive Behavioral Support Homes in Nevada. This will be a new type of community-based residential service designed to support intensive needs with specially trained direct support staff and needed professional services to avoid institutionalization. ADSD is working with a national consultant with expertise in this area to help develop a Request for Proposals to ensure a provider with the needed skills and service model for this population is obtained.

- **HCBS Rule Implementation Analysis**
  - o ADSD has contracted with a national consultant with expertise in the Medicaid HCBS Rule to assess existing efforts to comply with the HCBS Final Rule, specific to person-centered practices within the operational activities of the waivers under ADSD. These efforts will include research and analysis, stakeholder engagement, technical assistance and program design. The HCBS Final Rule is a complex federal regulation that aims to improve the quality and community integration of home and community-based services under Medicaid programs.

- **Community Engagement Team**
  - o ADSD has utilized federal funding to develop a Community Engagement Team within our agency. This team will be responsible for coordinating outreach efforts, bringing forth policy recommendations from regions throughout the state, and increasing stakeholder engagement efforts throughout ADSD programs. This team will help support cross-coordination efforts among community partners, as well as among various advocacy bodies to improve planning and access to services. This team was approved for state general funding in the Legislative session, making them permanent positions within the agency.

- **Public Health Literacy Project**
  - o ADSD has received ARPA funding to support efforts to modernize the agency's website, enhancing the content and organization of the website while also ensuring access by the

general public. This project will also provide an opportunity for ADSD to increase awareness of programs and services through re-branding and enhancement of existing outreach materials. Finally, funding under this project will be used to support expanded outreach opportunities that have not historically been available to the agency due to resource limitations as well as a plan for continuing efforts. These efforts will help bring greater awareness of the existing services offered by the agency. The project will take place starting August 1, 2023 and will end on December 31, 2024.

- **Lifespan Respite Projects**
  - ADSD has three federal grants under the Lifespan Respite Care Act to expand access to respite services for Nevada's family caregivers. Existing efforts are focused on standardized data collection specifically related to family caregivers, increased recruitment of respite workers, expanding respite opportunities, and promoting respite as a service for family caregivers.

    The most recent grant is a partnership between DCFS and ADSD to build respite models specifically for families of children with disabilities, in particular children who have a dual-diagnosis of intellectual/developmental disability and behavioral health needs.

    These grants will also support implementation of AB100 passed during the 82nd legislative session enabling ADSD to develop and administer evidence based and culturally sensitive caregiver assessments to help assess family caregiver support needs. It also will include the development of an annual progress report. Supporting family caregivers is critical to ensuring individuals are able to continue to live in their own homes.

- **Technology Enhancements**
  - ADSD is partnering with the Division of Welfare and Supportive Services and the Division of Healthcare Financing and Policy on two technology projects to help facilitate access to the state's long term services and supports.
    - The first project is focused on the utilization of technology to streamline the eligibility determination process for the state's three HCBS waivers. This project is expected to shorten the amount of time that it takes to determine someone eligible for an HCBS waiver.
    - The second project is a technology solution under our state's existing No Wrong Door efforts that will help individuals who are applying for public programs connect with multiple programs that they may be eligible for, while reducing the duplication of information that must be provided each time. This project will establish a referral mechanism to other programs individuals may benefit from.

- **Autism Treatment Assistance Program (ATAP)**
  - A Psychological Development Counselor position was added to this team to increase access to services. This position will be responsible for supporting families in obtaining a diagnosis and verifying eligibility for the program. If a person does not qualify for ATAP services based on their diagnosis but needs services, this position will help us determine those gaps for future planning.

- **Community Based Care Capacity Project**

- o ADSD received approval of ARPA funding for expansion of community-based care beds in residential facilities for groups. These one-time funds will be granted to community providers to pay for upgrades needed to meet licensure requirements or to expand the number of beds in a current home. Residential facilities for groups are residential settings that are a less restrictive option for individuals who need support in activities of daily living.

- **Personal Care Workforce Impact Project**
  - o ADSD was approved to use one time ARPA funding to create a consensus curriculum to train professional caregivers. This project is targeting underemployed or unemployed individuals including disproportionately underserved individuals with the goal of expanding the personal care workforce. This project is focused on the personal care workforce due to the high demand for these services to support community integration.

- **Supportive Services for People with Disabilities**
  - o In state fiscal year 2024 ADSD applied for Title XX grant funds for services to individuals with physical disabilities. This is a transition from previous use of these funds and addresses funding gaps for services for this population.

- **Senior Rx/Disability Rx Program**
  - o Legislative approval (SB4 - 2023) was received to make changes to this program which will allow ADSD greater flexibility to address the out-of-pocket prescription medication expenses of the populations served by our agency. The agency now can adapt to federal and state policy changes and more effectively address the needs of a broader population of Nevadans, while increasing equity in access to prescription medications for those Nevadans most in need.

- **Addressing Fetal Alcohol Spectrum Disorders**
  - o AB422 passed during the 82nd legislative session, directing ADSD staff to identify available funding to create a pilot program that will provide training in evidence-based models of treatment for fetal alcohol spectrum disorders. By increasing provider capacity to support individuals with fetal alcohol spectrum disorder within the community, individuals may be able to avoid institutionalization or unnecessary hospitalization.

- **Medicaid Rate Study**
  - o The Division of Health Care Financing and Policy (Medicaid) has contracted a vendor to conduct a comprehensive rate study of the Frail Elderly and Physically Disabled Waiver as well as 1915(I) home and community-based state plan services. The results of this rate study could support ADSD efforts to increase provider capacity and incentivize providers to serve additional Medicaid recipients.

- **Additional Legislation from the 82nd Session to Note**
  - o AB78 was signed into law which exempts certain providers of jobs and day training services from licensure as nurses. This allows jobs and day training (JDT) providers for Developmental Services to perform limited nursing functions, such as medication administration with the required training. This accommodation will offer people in need of this type of medical support

during the day to participate in JDT services. This exemption will allow more individuals to participate in these services.

o AB208 was signed into law and establishes a new Medicaid waiver program to provide structured family caregiving support to waiver recipients with a dementia diagnosis. Services are intended to support individuals with dementia and their caregivers in maintaining community living.

o AB 259 was signed into law and will end the subminimum wage program for persons with disabilities in Nevada.   The payment of subminimum wages to people with disabilities in Nevada under federal 14(c) certificates will be illegal in Nevada as of January 1, 2028, and no new individuals may begin to be paid subminimum wages as of January 1, 2025. Additionally, the HCBS-IDD Waiver must add benefits counseling as a service as of January 1, 2025, which will educate individuals served and their families on how employment wages can impact their federal and state benefits such as social security, Medicare, Medicaid, housing assistance, and the Supplemental Nutrition Assistance Program (SNAP). Individuals will be able to make more informed choices when pursuing employment goals.

o AB 130 was signed into law. It prioritizes funding from the Funds for Healthy Nevada for grants available that support assisted living facilities. This funding can be used for the expansion of an assisted living facility, the operation of an assisted living facility, and prioritizes those assisted living facilities that provide services to low income individuals. Assisted living facilities are less restrictive residential settings for individuals who need support.

o SB 298 was signed into law, Increasing the requirement to provide residents with information regarding their rights related to residing in a residential facility for groups. This bill specifically establishes a baseline for contractual agreements at these types of facilities, bringing Nevada into compliance with the HCBS Final Settings rule and establishing eviction protections for residents.

o AJR1 – The resolution proposed to amend the Nevada Constitution to revise terms relating to persons with mental illness and disabilities. Removing stigmatizing and discriminatory language from Nevada's constitution acknowledges individuals with mental illness and disabilities as valuable members of our society. This resolution was passed for the second time through Nevada's legislature and will now go to the voters at the next general election.

Appendix F. Developmental Services Approved Budget for State Fiscal Years 24/25

As referenced in a memo distributed to ADSD staff and providers by Jessica Adams, Deputy Administrator for Developmental Services, on 5/12/23, the following initiatives related to community-based Developmental Services were approved by the Nevada State Legislature.

Caseload & Waitlist Funding

Every budget received the funding and positions needed to maintain staffing levels for projected caseload growth at each Regional Center. In addition, monies needed to fund additional family support, Supported Living, and Jobs & Day Training services were received to both eliminate waitlists and serve the new projected caseload for each of these services.

Family Preservation Program

The Family Preservation Program (FPP) provides financial assistance on a monthly basis to families residing in Nevada who are providing care in their home for family members with severe or profound intellectual or developmental disability. This financial assistance is meant to help off-set expenses necessary to meet the special needs of the person with an intellectual or developmental disability and to help strengthen and support families, thereby keeping families intact and reducing the need for out-of- home care. The family must have a gross household income at or below 300% of the Federal Poverty Level.

The approved monthly allotment for FPP will increase from the current $374/month to $486/month for the upcoming biennium starting on 7/1/23.

Self-Directed Family Support Services

The Self-Directed Family Support Services program (aka Fiscal Intermediary program) allows families with children under the age of 18 to purchase specialized treatment, skill building and organized programming to assist the individual/family in successful integration into their community. Examples of services that may be purchased include behavior training/management; specialized day and after-school care and recreation programs; daily living skills training; and specialized therapeutic services not covered by insurance. The family must have a gross household income at or below 300% of the Federal Poverty Level and the child cannot concurrently receive Supported Living or Jobs and Day Training services.

The approved monthly allotment for this service will increase from the current $450/ month to $679/month for the upcoming biennium starting on 7/1/23. The approved amount is more than the $650/month that had been proposed so the rate was fully increased for the annual average Consumer Price Index (CPI) since 2006 when the rate of $450/month was developed.

Youth Intensive Support Services

All Regional Centers have proposed expansions to the Youth Intensive Support Services (YISS) program that currently operates only at Desert Regional Center. The YISS program focuses on youth up to age 22 who need intensive support due to dual diagnosis (intellectual/developmental disability and mental illness) and/or intensive behavioral challenges. The goal of YISS is to coordinate all specialized services needed for the youth to successfully gain needed skills, reduce difficult behaviors, and remain living in the family home or an appropriate community-based residential setting. As many are already aware, Nevada has experienced an increase in youth with high levels of support needs over the last two years. The approved budgets expand the

YISS program to all Regional Centers, adding eight (8) YISS Service Coordinators that will carry a caseload of 1:15 versus the typical 1:45. Additionally, a new Health Program Manager III to oversee YISS statewide was approved.

Board Certified Behavior Analysts

Rural and Sierra Regional Centers received monies to contract with a full-time Board Certified Behavior Analyst (BCBA) at each Regional Center. These positions will be members of the Psychological Services team supporting the caseloads of the Regional Centers as a whole, as opposed to those currently supporting individual people through the Behavioral Consultation, Training & Intervention service. Desert Regional Center already has funding for these contractors in their budget, so no additional funding for Desert Regional Center was requested or received.

Continuation of Dental Services in the Waiver for Individuals with Intellectual or Developmental Disabilities (Division of Health Care Financing & Policy budget)

The Division of Health Care Financing and Policy (DHCFP), otherwise known as Nevada Medicaid, received monies in their budgets to continue the new dental service that launched in our Waiver a few months ago through the use of ARPA funds. By having the state general fund match in the DHCFP budget for this waiver service, dentists will continue to authorize service, claim for services, and be paid for services through Medicaid's MMIS billing system as opposed to moving this service into WellSky and needing dentists to enroll with ADSD as a provider.

Provider Rate Increases & Changes to Service Authorization

The largest single rate increase to DS-contracted providers in the history of Developmental Services was approved. These rate increases will occur in two phases so there is time for Developmental Services staff, people served, and providers to prepare for the service authorization methodology change that will occur in the second phase on 4/1/2024. Along with the budget approval, the Legislature approved for a letter of intent to be issued to Developmental Services requiring us to report to the Interim Finance Committee (IFC) on a semi-annual basis during the 2023-25 biennium on the status of the provider rate increases and associated provider capacity and waitlists for services, including:

- ✓ Number of individuals receiving services
- ✓ Number of individuals waiting for services
- ✓ Average wait time
- ✓ Discussion of the effect of the rate increase on provider capacity and the ability to need service needs
- ✓ Associated concerns or challenges

Appendix G. Relevant Definitions

Olmstead Decision[23]

On June 22, 1999, the United States Supreme Court held in Olmstead v. L.C. that unjustified segregation of persons with disabilities constitutes discrimination in violation of title II of the Americans with Disabilities Act. The Court held that public entities must provide community-based services to persons with disabilities when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity.

The Supreme Court explained that its holding "reflects two evident judgments." First, "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable of or unworthy of participating in community life." Second, "confinement in an institution[24] severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."

Older Nevadan and Persons with Disabilities

An older person is defined in Nevada law as a person who is 60 years of age or older.

Persons with disabilities: Federal laws define a person with a disability as "Any person who has a physical or mental impairment that substantially limits one or more major life activities; has a record of such impairment; or is regarded as having such an impairment."

Types of Disabilities

NRS 426.068 "Disability" defined.

"Disability" means, with respect to a person:
1. A physical or mental impairment that substantially limits one or more of the major life activities of the person;
2. A record of such an impairment; or
3. Being regarded as having such an impairment.

     (Added to NRS by 2003, 2973)

NRS 426.082 "Person who is blind" defined.

"Person who is blind" means any person whose visual acuity with correcting lenses does not exceed 20/200 in the better eye, or whose vision in the better eye is restricted to a field which subtends an angle of not greater than 20°.

(Added to NRS by 1981, 1916)—(Substituted in revision for NRS 426.041)

NRS 426.520 "Person who is blind" further defined.

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[23] Retrieved on September 19, 2016 from: https://www.ada.gov/olmstead/olmstead_about.htm
[24] Note that for the purposes of this plan, institutions are defined to include schools, jails, prisons, hospitals, nursing homes, sheltered workshops and other settings that are not based or integrated in the community.

"Person who is blind" means a person described in NRS 426.082 and any person who by reason of loss or impairment of eyesight is unable to provide himself or herself with the necessities of life, and who has not sufficient income of his or her own to maintain himself or herself.

(Added to NRS by 1957, 781; A 1959, 148; 1963, 920; 1965, 771; 1967, 1162; 1973, 1388; 1981, 1917; 2005, 114)

NRS 426.084 "Person who is deaf" defined.
"Person who is deaf" means any person who, by reason of the loss or impairment of hearing, has an aural disability which limits, contributes to limiting or which, if not corrected, will probably result in limiting the activities or functions of the person.

(Added to NRS by 1981, 1916; A 2003, 2630)—(Substituted in revision for NRS 426.055)

NRS 426.431 "Person with a permanent disability" defined.
"Person with a permanent disability" means a person:
1. With a disability which limits or impairs the ability to walk, as defined in NRS 482.3835; and
2. Whose disability has been certified by a licensed physician as irreversible.

(Added to NRS by 1999, 1158)

NRS 427A.029 "Frail elderly person" defined.
"Frail elderly person" means a natural person 65 years of age or older who:
1. Has a physical or mental limitation that restricts the ability of the person to live independently and carry out activities of normal daily living; and
2. Has been or is at risk of being placed in a facility for long-term care.

(Added to NRS by 1987, 973)

NRS 427A.122 "Elderly person" defined.
As used in NRS 427A.122 to 427A.1236, inclusive, unless the context otherwise requires, "elderly person" means a person who is 60 years of age or older.

(Added to NRS by 1999, 126)

NRS 427A.791 "Person with a physical disability" defined.
As used in NRS 427A.791, 427A.793 and 427A.795, unless the context otherwise requires, "person with a physical disability" means a person with a physical disability that substantially limits the person's ability to participate and contribute independently in the community in which he or she lives.

(Added to NRS by 2009, 2384)

NRS 427A.7951 "Person with a disability who needs independent living services" defined.
As used in NRS 427A.7951 to 427A.7957, inclusive, unless the context otherwise requires, "person with a disability who needs independent living services" means a person with a physical disability, as that term is defined in NRS 427A.791, including, without limitation, a person who is blind, as that term is defined in NRS 426.082, who is in need of independent living services and who does not have a vocational goal.

Olmstead Plan I **2023**

(Added to NRS by 2015, 1432)

NRS 427A.800 "Traumatic brain injury" defined.
As used in this section and NRS 427A.850 and 427A.860, "traumatic brain injury" means a sudden shock or damage to the brain or its coverings which is not of a degenerative nature and produces an altered state of consciousness or temporarily or permanently impairs the mental, cognitive, behavioral or physical functioning of the brain. The term does not include:
1. A cerebral vascular accident;
2. An aneurism; or
3. A congenital defect.

(Added to NRS by 2009, 2393; A 2013, 216)

NRS 427A.865 "Missing endangered older person" defined.
"Missing endangered older person" means a person who is 60 years of age or older whose whereabouts are unknown and who:
1. Has been diagnosed with a medical or mental health condition that places the person in danger of serious physical harm or death; or
2. Is missing under suspicious or unexplained circumstances that place the person in danger of serious physical harm or death.

(Added to NRS by 2011, 829)

NRS 433.099 "Intellectual disability" defined.
"Intellectual disability" means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

(Added to NRS by 1975, 1591; A 2013, 662) — (Substituted in revision for NRS 433.174)

NRS 433.164 "Mental illness" defined.
"Mental illness" (as currently defined in NRS) means a clinically significant disorder of thought, mood, perception, orientation, memory or behavior which:
1. Is listed in the most recent edition of the clinical manual of the International Classification of Diseases, ICD-9-CM, code range 295 to 302.9, inclusive, 306 to 309.9, inclusive, or 311 to 316, inclusive, or the corresponding code in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, Axis I; and
2. Seriously limits the capacity of a person to function in the primary aspects of daily living, including, without limitation, personal relations, living arrangements, employment and recreation.

(Added to NRS by 1975, 1591; A 2003, 1941)

NRS 435.007 Definitions. As used, unless the context otherwise requires:
1. "Administrative officer" means a person with overall executive and administrative responsibility for those state or nonstate intellectual disability centers designated by the Administrator.
2. "Administrator" means the Administrator of the Division.

3. "Child" means any person under the age of 18 years who may be eligible for intellectual disability services or services for a related condition.

4. "Department" means the Department of Health and Human Services.

5. "Director of the Department" means the administrative head of the Department.

6. "Division" means the Aging and Disability Services Division of the Department.

7. "Division facility" means any unit or subunit operated by the Division for the care, treatment and training of consumers.

8. "Intellectual disability" means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

9. "Intellectual disability center" means an organized program for providing appropriate services and treatment to persons with intellectual disabilities and persons with related conditions. An intellectual disability center may include facilities for residential treatment and training.

10. "Medical director" means the chief medical officer of any program of the Division for persons with intellectual disabilities and persons with other related conditions.

11. "Mental illness" has the meaning ascribed to it in NRS 433.164.

12. "Parent" means the parent of a child. The term does not include the parent of a person who has attained the age of 18 years.

13. "Person" includes a child and any other consumer with an intellectual disability or a related condition who has attained the age of 18 years.

14. "Person professionally qualified in the field of psychiatric mental health" has the meaning ascribed to it in NRS 433.209.

15. "Persons with related conditions" means persons who have a severe, chronic disability which:

    (a) Is attributable to:

        (1) Cerebral palsy or epilepsy; or

        (2) Any other condition, other than mental illness, found to be closely related to an intellectual disability because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual disability and requires treatment or services similar to those required by a person with an intellectual disability;

    (b) Is manifested before the person affected attains the age of 22 years;

    (c) Is likely to continue indefinitely; and

    (d) Results in substantial functional limitations in three or more of the following areas of major life activity:

        (1) Taking care of oneself;

        (2) Understanding and use of language;

        (3) Learning;

        (4) Mobility;

        (5) Self-direction; and

        (6) Capacity for independent living.

16. "Residential facility for groups" means a structure similar to a private residence which will house a small number of persons in a homelike atmosphere.

17. "Training" means a program of services directed primarily toward enhancing the health, welfare and development of persons with intellectual disabilities and persons with related conditions through the process of providing those experiences that will enable the person to:

    (a) Develop his or her physical, intellectual, social and emotional capacities to the fullest extent;

    (b) Live in an environment that is conducive to personal dignity; and

    (c) Continue development of those skills, habits and attitudes essential to adaptation in contemporary society.

18. "Treatment" means any combination of procedures or activities, of whatever level of intensity and whatever duration, ranging from occasional counseling sessions to full-time admission to a residential facility.

(Added to NRS by 1975, 1617; A 1979, 1325; 1981, 1579; 1985, 1761; 1999, 2594; 2011, 435; 2013, 669, 3032)

Types of Residential Services/Supported Living Arrangements

Residential support services assist individuals in the acquisition, improvement, retention and maintenance of skills needed so that they can safely and responsibly reside in their home and community of choice. Services provided encompass support needed throughout the course of normal daily living and are individually planned and coordinated. These services exist on a continuum ranging from intermittent to 24-hour supported living arrangements (SLA).

The types of supported living arrangements include:

- **Intermittent Supported Living Arrangement (SLA):** person lives in a home or apartment by themselves, with a roommate or family and receives intermittent supports
- **Intensive Supported Living Arrangement (ISLA):** person requires higher level of support; resides in a community neighborhood with roommates that share support services delivered by provider
- **24-Hour Intensive Supported Living Arrangement (24-hr ISLA):** person needs maximum support services, staff present at night; resides in a community neighborhood with roommates, share support services
- **Shared Living:** people live in a family living situation, receive services from a Shared Living Provider who includes person in family life and activities as a natural support

Additional Types of residential settings include:

- **Assisted Living Facilities:** These are licensed residential settings where individuals live in their own apartments or rooms and share common areas. These settings provide assistance with daily care, but not as much as what is provided in a skilled nursing facility.
- **Group Homes:** These are smaller licensed residential settings, similar to an Assisted Living facility that helps with daily care.
- **Homes for Individual Care (HIRC):** These unlicensed homes are the smallest of residential settings, limited to 2 beds, allowing for more flexibility and personal attention to meet the personal care needs of residents.

Types of Institutional Facilities

NRS 449.0039 "Facility for skilled nursing" defined.
1. "Facility for skilled nursing" means an establishment which provides continuous skilled nursing and related care as prescribed by a physician to a patient in the facility who is not in an acute episode of illness and whose primary need is the availability of such care on a continuous basis.
2. "Facility for skilled nursing" does not include a facility which meets the requirements of a general or any other special hospital.

NRS 449.0038 "Facility for intermediate care" defined.

"Facility for intermediate care" means an establishment operated and maintained to provide 24-hour personal and medical supervision, for a person who does not have illness, disease, injury or other condition that would require the degree of care and treatment which a hospital or facility for skilled nursing is designed to provide.

Home and Community Based Services (HCBS) Settings Rule

As taken from the Administration for Community Living, "The Home and Community Based Services (HCBS) Settings Rule ensures that people who receive services and supports through Medicaid's HCBS programs have full access to the benefits of community living and are able to receive services in the most integrated setting. It protects individuals' autonomy to make choices and to control the decisions in their lives, a right most people take for granted. This includes controlling personal resources; being treated with privacy, dignity, respect, and freedom from coercion and restraint; deciding what and when to eat; having visitors; being able to lock doors; and having the protections of a lease or other legally enforceable agreement. The rule requires a person-centered process for planning HCBS, which means that the individuals receiving services direct the planning process and the plan reflects their own preferences and goals they have set for themselves. The rule is critical to CMS' broader efforts to expand availability and improve the quality of Medicaid-funded HCBS.

Under the rule, a setting that is truly home and community based is one that:

- Is integrated in and supports access to the greater community
- Provides opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources
- Ensures the individual receives services in the community to the same degree of access as individuals not receiving Medicaid home and community-based services
- Is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting
  - Person-centered service plans document the options based on the individual's needs, preferences; and for residential settings, the individual's resources
- Ensures an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint
- Optimizes individual initiative, autonomy, and independence in making life choices
- Facilitates individual choice regarding services and supports, and who provides them

Provider owned or controlled settings also have additional requirements they are expected to meet. States are currently at different stages in working on their state transition plans (STPs) and completing heightened

scrutiny reviews for settings that are identified as "presumptively institutional." Presumptively institutional settings are:

- Settings in a publicly or privately-owned facility providing inpatient treatment
- Settings on grounds of, or adjacent to, a public institution
- Settings with the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS

The transition period for implementing the HCBS Settings Rule ended on March 17, 2023. States must now be fully compliant with the requirements of the rule that have not been impacted by the COVID-19 pandemic to continue receiving Medicaid funding. For those requirements that have been impacted by the pandemic, states can submit corrective action plans (CAPs) to allow settings more time to meet those requirements."[25]

Person-centered Planning
Person-centered planning is a process-oriented approach to empowering people with disability labels. It focuses on the people and their needs by putting them in charge of defining the direction for their lives, not on the systems that may or may not be available to serve them. This ultimately leads to greater inclusion as valued members of both community and society.

The term "person-centered plan" is used in many fields (e.g., health care, nursing care, aging, mental health, employment, education). Although the details of person-centered planning are expressed differently in these contexts, all of these approaches aid practitioners and communities in developing whole life, person-driven approaches to supporting people who experience barriers to full engagement in community living. The fundamental principle is that government and service providers begin by listening to individuals about what is important to them in creating or maintaining a personally valued, community life. Planning of supports and services is not driven or limited by professional opinion or available service options but focused on the person's preferences and whole life context. Effective support and services are identified to help people live, learn, work, and participate in their preferred communities and on their own terms. Many state and federal policies now mandate person-centered delivery of long-term services and supports. In January 2014, the Centers for Medicare and Medicaid Services (CMS) issued a rule that applies to all Home and Community-Based Services; this rule provides a description of a person-centered service plan.

No Wrong Door
No Wrong Door **(NWD) is a philosophical approach to services.** It supports streamlined access to long-term services and supports (LTSS) for older adults and individuals with disabilities. According to the Administration for Community Living, NWD systems are *"designed to serve as highly visible and trusted places where people of all ages, incomes and disabilities get information and one-on-one person-centered counseling on the full range of LTSS options."* To effectively implement a NWD approach to services, the following key functions must be operational; 1. State Governance and Administration; 2. Public Outreach and Coordination with Key Referral Sources; 3. Person-Centered Counseling (PCC); and 4. Streamlined Eligibility for Public Programs.

The graphic on the following page is a depiction of how each of these functions work within the system.

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[25] Retrieved on August 21, 2023 from: https://acl.gov/programs/hcbs-settings-rule#:~:text=The%20transition%20period%20for%20implementing,to%20continue%20receiving%20Medicaid%20funding.

No Wrong Door System Functions

Public Outreach and Links to Key Referral Sources

Schools | Family Members & Friends | Individuals | Local Non-Profits | LTSS Providers

1-800 #'s/211 | Acute Care Systems | VA Medical Center | Nursing Homes

Local I&R Programs | Hospitals | Veteran Directed HCBS | MFP/ Section Q

Person Centered Counseling

Confirming Need For/Interest in Person Centered Counseling

Support Any Immediate LTSS Needs, Conducts Personal Interview and Identifies Goals, Strengths and Preferences

Comprehensive review of private resources and informal supports

Facilitates the development and implementation of the Person Centered Plan

Linking Individuals to Private Pay Resources
Helps individuals connect to services that will be covered out of pocket or through other community resources

Streamlined Access to Public Programs

Preliminary Functional Eligibility Assessment for Public Programs: Collects any additional functional data needed for public programs including, if appropriate, Medicaid

Preliminary Financial Eligibility Assessment for Public Programs: Supports the individual in submitting applications for public programs including, if appropriate, Medicaid

Final Determination of Functional Eligibility for Public Programs: Completes the process that officially determines that individuals are eligible for public programs

Final Determination of Financial Eligibility for Public Programs: Completes the process that officially determines that individuals are eligible for public programs

Follow-up
Ensures the plan's services are initiated, meets the needs of the individual and is adjusted as needed.

Governance and Administration of the NWD System

State Oversight, Management and Financing of the NWD System
Must include State Medicaid Agency, State Agencies Administering programs for Aging, Intellectual and Developmental Disabilities, Physical Disabilities and Mental/Behavioral Health needs.

Administration includes input from external stakeholders, including consumers and their advocates, on the design, implementation and on-going operations of the system

MIS tracks clients, services, outcomes, expenditures and organizational performance, enables information to flow with client from initial person centered plan through follow-up, and supports on-going evaluation and continuous quality improvement

The Administration for Community Living has established best practices around a set of elements that are essential to each of the four functions within a NWD system. For more information about these elements, please explore the NWD System of Access to LTSS for all Populations and Payers.

Olmstead Plan I **2023**

Appendix H. ADSD Boards and Commissions

The following is a list of the public advisory bodies that are supported by the Aging and Disability Services Division. These councils and commissions provide advocacy and education on behalf of the populations they serve, including advocating for policy and programs to support the individuals they represent. The membership of these public bodies varies based on a variety of factors, but all include seats for people with lived experience.   All meetings are open to the public.

More information about each public body including their meeting information and how to apply is available on the ADSD website at: Boards and Commissions (nv.gov)

ADSD Boards and Commissions
Assistive Technology Council – provides consumer-responsive, consumer -driven advice for the planning, implementation, and evaluation of assistive technology programs.
Commission on Aging – facilitate and enhance the quality of life and services for all Nevada seniors through partnership with the Aging and Disability Services Division and other entities.
Commission on Autism Spectrum Disorders – provides leadership, oversight, and legislative advocacy in support of Nevadans living with autism spectrum disorders.
Commission on Services for Persons with Disabilities (CSPD) – facilitate and enhance the quality of life and services for children and adults with disabilities in Nevada.
Task Force on Alzheimer's Disease (TFAD) – responsible for carrying out the State Plan to Address Alzheimer's Disease which serves as a blueprint of identifying specific actions to support individuals living with dementia.
Nevada Commission for Persons who are Deaf and Hard of Hearing – advocates for and supports goals that all Nevada citizens have equal and full access to resources, services, and opportunities in all aspects of community life.
Nevada Lifespan Respite Coalition – support and advocate for family caregivers in our community by promoting awareness and access to, as well as coordination and advocacy for, respite services in Nevada.
State Independent Living Council – advocates for the development of a network of programs, services and options designed to empower Nevadans with disabilities to live independent

Appendix I: 2016 Olmstead Plan Discussion

The 2016 Nevada State Department of Health and Human Services (DHHS) Olmstead Plan set forth a bold agenda to change the culture of service provision in Nevada for older Nevadans and those living with intellectual, developmental and/or physical disabilities. It was designed to be inclusive rather than focusing on exclusive subpopulations and was intended to solve gaps that were, in part, due to the state structure. Unfortunately, the plan encountered critical barriers that impeded implementation efforts. The most significant barrier in plan deployment was the identification of goals and strategies that crossed multiple divisions within DHHS without clear authority given to the Aging and Disability Services Division (ADSD) to allocate resource or hold other divisions accountable for implementation activities. Because of this, ADSD developed the 2023 plan contained herein with a focus on activities that were strictly within their control. That said, progress in expanding community integration opportunities still occurred and are summarized below.

Building a Person-Centered System of Care: ADSD has made efforts to establish a more person-centered system of care. Activities included:

- Investment in a "No Wrong Door" (NWD) System: ADSD has been working to build a "No Wrong Door" (NWD) system of care throughout its operations. Since 2016 ADSD was awarded a NWD governance grant which established a steering committee to help Nevada advance efforts under the Nevada Care Connection umbrella of services and supports.
- Person-Centered Care Activities: ADSD heavily invested in person-centered care efforts. Many ADSD programs utilized person-centered planning as an approach to best support individuals and their desires. Additionally, Person-Centered Thinking training was provided to all team members throughout ADSD.
- Establishment of Language Access Plan: In 2022 ADSD produced a Language Access Plan (LAP) to ensure that supports were offered to individuals with limited English proficiency and that they have meaningful and timely access to ADSD services in their preferred language. In addition to this rate increase, the Legislature is now requiring Developmental Services report to the Interim Finance Committee (IFC) on a semi-annual basis during the 2023-25 biennium on the status of the provider rate increases and associated provider capacity and waitlists for services.

Supporting Transitions from Institutional Care to Community Care: ADSD has worked closely with DHCFP to implement the "Money Follows the Person" program which provides enhanced support for transitions from facility-based care to community-based care. Most recently, the program moved from DHCFP to ADSD with the goal of being able to provide these supports more directly, requiring less negotiation on the part of the service participant. Two other programs have been supported by ADSD that assist with transitional activities. The FOCIS program offers Medicaid recipients who are either in an institutional setting or at imminent risk of placement within such a setting with the support of a Health Care Coordinator. The Health Care Coordinators advocate for program participants and assist them in navigating the system of support needed to live outside of an institutional setting. The Balancing Incentives Program (BIP) is intended to rebalance spending on community-based services over institutional spending. ADSD has partnered with DHCFP on both of these services.

Partnered on Workforce Issues Impacting Community Integration Opportunities: ADSD partnered with other state divisions to support workforce issues that impact community integration opportunities. Activities included:

- Respite Workforce: ADSD secured three grants focused on supporting workforce development efforts geared to respite providers. These grants supported recruitment activities for respite providers, training for potential respite providers, and developing a list of trained respite providers. Additionally, ADSD coordinated with the DHHS Grants Management Unit to ensure that duplication of efforts was not occurring and to ensure that respite is available to people across their lifespan. Lastly, ADSD partnered with the Nevada Lifespan Respite Care Coalition to increase outreach and awareness of respite to Nevada's Caregivers.
- Family Caregivers: ADSD incorporated Caregiver Support and Consultation within the Nevada Care Connection framework and sought to enhance certification options for Navigators who specifically support family caregivers.
- Nevada Caregiving Report: In 2022 ADSD produced the Caregiving in Nevada 2022 Report, which documented the system efforts, data collection, and actions taken to advance caregiver services and supports in Nevada.
- Rate Increases: In the 2023 Legislative Session, the largest single rate increase to Developmental Services contracted providers in the history of Developmental Services was approved.

Support for Individuals with Disabilities during the COVID-19 Pandemic: ADSD in partnership with the Commission on Services to Persons with Disabilities (CSPD) and the Statewide Independent Living Council (SILC) worked to ensure services were accessible for individuals reaching out to Nevada 211 and the Nevada CAN program, a state program designed specifically to assist Nevada's most vulnerable populations for the duration of the pandemic.

Invested in New Programs and Expanded Partnerships: ADSD piloted new programming and partnered with other state agencies and service providers in new and meaningful ways that support expanded community integration efforts. These included:

- Lifespan Respite Demonstration Project: The Respite Rx pilot program was a self-directed program designed to empower caregivers to have autonomy over their own respite services. The caregivers on the Respite Rx program were given a full year to utilize it. They were provided with a monthly budget of $308 or $3,696 for the year. After determining a maximum amount of respite funding, Nevada committed to serve 60 families through the self-directed program on a "first-come, first served" basis. As barriers were found throughout the program's life cycle, several refinements to the model were made to ensure caregivers were given the opportunity to utilize the program to their advantage.
- Collaborative Workgroup to Address Transportation Barriers: In 2021 DHHS agencies (Including ADSD) and the Nevada Department of Transportation started a collaborative workgroup to share information about funding opportunities and transportation services to improve collaborations.
- Partnership to Address Housing Gaps: ADSD has engaged in conversations with the Housing Division's Housing Advocate and the Silver State Housing Registry to address the housing issues that impact the opportunity for people with disabilities to have adequate housing resources. This is an area that continues to require discussion but is largely outside of ADSD authority to make substantive improvement.