NEVADA LEGISLATURE
JOINT INTERIM STANDING COMMITTEE ON HEALTH AND HUMAN SERVICES

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

MINUTES

May 19, 2022

The fifth meeting of the Joint Interim Standing Committee on Health and Human Services for the 2021–2022 Interim was held on Thursday, May 19, 2022, at 9 a.m. in Room 4100, Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401, Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada.

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

COMMITTEE MEMBERS PRESENT IN CARSON CITY:

Assemblywoman Sarah Peters, Chair
Assemblywoman Robin L. Titus, M.D.

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:

Assemblywoman Michelle Gorelow
Assemblyman Gregory T. Hafen II

COMMITTEE MEMBERS ATTENDING VIA REMOTELY:

Senator Fabian Doñate, Vice Chair
Senator Joseph (Joe) P. Hardy, M.D.
Senator Dallas Harris
Assemblyman David Orentlicher, M.D.

LEGISLATIVE COUNSEL BUREAU STAFF PRESENT:

Patrick B. Ashton, Senior Policy Analyst, Research Division
Kristi Robusto, Senior Policy Analyst, Research Division
Julianne King, Assistant Manager of Research Policy Assistants, Research Division
Crystal Rowe, Research Policy Assistant, Research Division
Eric Robbins, Principal Deputy Legislative Counsel, Legal Division
John Kucera, Principal Program Analyst, Fiscal Analysis Division

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

AGENDA ITEM I—CALL TO ORDER

Chair Peters:

Good morning, everyone. I would like to call this meeting to order. Welcome to the fifth meeting of the Joint Interim Standing Committee on Health and Human Services.

I have a couple of personal remarks about today and the subject matter we will be talking about. I think it is common for us to say "women" when we are discussing maternal health issues. I want to be clear that the intent of this meeting is to be inclusive of all people who give birth and people seeking care for pregnancy and for children. Maternal health and newborn to early childhood services and care are part of a broader system. They are impacted by systemic bias and disparities that particularly impact our Black, Indigenous, and People of Color (BIPOC) community. I am looking forward to this discussion and want to thank all the folks who are presenting today.

[Chair Peters reviewed meeting protocol and information related to providing public comment.]

AGENDA ITEM II—PUBLIC COMMENT

Chair Peters:

We will start with public comment from those in the physical locations and then move to public comment from anyone who has called in.

Is there anyone in Carson City who would like to provide public comment today? I am not seeing anybody come up to the table.

Is there anyone in Las Vegas who would like to provide public comment at this time? I do not see anybody moving to the front of the room in Las Vegas.

Broadcast and Production Services (BPS), will you please add the first caller for public comment to the meeting?

BPS:

To give public comment, please press "*9" on your phone to take your place in the queue.

Chair Peters:

We will give it a minute or so for people to call in because we know there is a delay online.

BPS:

Caller you are unmuted and may begin.

Leann McAllister, Executive Director, Nevada Chapter of the American Academy of Pediatrics (Nevada AAP):

The Nevada AAP currently has 283 members, most of whom are board-certified pediatricians, both primary and specialty care; members also include pediatric nurse practitioners, physician assistants, pediatric residents, and medical students, all of whom live and work in Nevada and have dedicated their professional lives to the health of all children (Agenda Item II).

My members care a great deal about all the topics on today's agenda, and I thank you as you consider creating legislation and funding programs to improve the health of pregnant patients, their newborns, and toddlers.

Although our colleagues in obstetrics/gynecology (OB/GYN) are the experts in caring for pregnant patients, pediatricians play an integral role in partnering with families caring for newborns. Threats to family preservation come in many forms including inadequate access to safe housing, food insecurity, gun violence, and lack of access to opioid treatment. In the pediatric medical home, doctors create safe spaces for families to ensure all of Nevada's children have the resources they need to thrive. Nevada legislators must also help by extending the postpartum coverage period for individuals who were enrolled in Medicaid while pregnant to a full year after the end of pregnancy and by supporting robust paid family leave in our state.

Given the link between nutrition and health, the AAP is a leading voice in support of strong, science-based nutrition programs to help promote children's lifelong health and combat food insecurity. Nevada legislators must follow the successful lead of others and impose taxes to decrease the consumption of sugary drinks by children. We also ask for legislation that limits childcare centers and schools from serving toddlers anything except plain milk and water as even 100 percent fruit juice can harm a child's teeth and add unneeded calories to the diet.

Here in Nevada, we are fortunate to have Dr. Steven Shane who is board-certified in both pediatrics and obesity medicine. Under Dr. Shane's leadership, the Nevada AAP is asking the Nevada Legislature to fund a statewide proven public health program called 5-2-1-0 to promote that all Nevadans: consume five fruits and vegetables a day; limit recreational screen time to two hours or less per day; engage in at least one hour of active play; and drink zero sugar-sweetened beverages. Thank you.

BPS:

Once again, if you would like to give public comment, please press "*9" on your phone to take your place in the queue. Caller, you are unmuted and may begin.

Dora Martinez, Nevada Disability Peer Action Coalition:

Good morning, Assemblywoman Peters, and the rest of the Committee. I want to ditto the first caller and to encourage the school district to not have vending machines in schools. They have a lot of sweet drinks and candy bars in them, and it is not appropriate. Thank you; have a good morning.

BPS:

Chair, the public line is open and working, however, there are no more callers at this time.

Chair Peters:

We will close public comment and move on to our next agenda item.

AGENDA ITEM III—CONSIDERATION OF REGULATIONS PROPOSED OR ADOPTED BY CERTAIN LICENSING BOARDS PURSUANT TO *NEVADA REVISED STATUTES* 439B.225

Chair Peters:

Agenda Item III is our consideration of regulations proposed or adopted by certain licensing boards, pursuant to NRS 439B.225. I want to remind the Committee this is informational only; staff informed you of the status of the regulatory process of the regulations we are considering. If you have a greater interest in participating in the development of these regulations, the process can be found on the LCB website, or you can reach out to our staff for additional assistance.

Committee review is an important process to follow up on bills that have passed in the last couple of sessions, but we will not be taking any action on these items today. I will ask staff to introduce these. We have representatives from the boards that are proposing these regulatory changes, and we will take questions on these regulations for each board individually. We will be taking Items A, E, and F together, and Items B, C, D, and G together.

A. LCB FILE R175-20 OF THE BOARD OF PSYCHOLOGICAL EXAMINERS

(Agenda Item III A)

B. LCB FILE R013-21 OF THE STATE BOARD OF PHARMACY

(Agenda Item III B)

C. LCB FILE R041-21 OF THE STATE BOARD OF PHARMACY

(Agenda Item III C)

D. LCB FILE R120-21 OF THE STATE BOARD OF PHARMACY

(Agenda Item III D)

E. LCB FILE R121-21 OF THE BOARD OF PSYCHOLOGICAL EXAMINERS

(Agenda Item III E)

F. LCB FILE R127-21 OF THE BOARD OF PSYCHOLOGICAL EXAMINERS

(Agenda Item III F)

G. LCB FILE R051-22 OF THE STATE BOARD OF PHARMACY

(Agenda Item III G)

Eric Robbins, Principal Deputy Legislative Counsel, Legal Division, LCB:

We have seven regulations for the consideration of the Committee today. Four are from the Board of Pharmacy, and three are from the Board of Psychological Examiners. As a further note, R013-21 from the Board of Pharmacy has been adopted and approved by the Legislative Commission; any further changes would have to be through a new regulation or through legislation.

We do have representatives from the agencies, although, I know we had some issues with getting Lisa Scurry from the Board of Psychological Examiners; I am not sure if those have been resolved yet. We should start with the Board of Pharmacy regulations if anyone has any questions.

Chair Peters:

Thank you, Mr. Robbins. Are there any questions from the Committee on the regulations presented today for the State Board of Pharmacy? Dr. Titus, go ahead.

Assemblywoman Titus:

For clarification, R013-21 has already been adopted by the Legislative Commission?

Mr. Robbins:

Yes, R013-21 has been adopted.

Assemblywoman Titus:

I did have some questions on that regulation, but it has already been adopted, so I am going to reach out to the Board of Pharmacy.

Chair Peters:

Are there any other questions from the Committee on the regulations presented today? Seeing none, we will go ahead and close this agenda item.

(The following section of this item was taken out of order.)

We will go ahead and reopen Agenda Item III for a correction.

Mr. Robbins:

I wanted to correct something I said about Regulation 013-21. The regulation has indeed been adopted by the Board of Pharmacy. However, I thought it had been heard by the Legislative Commission and approved; it has not. It will be on the next agenda for the Legislative Commission, which is on June 10, 2022, when they are scheduled to meet. The regulation is not currently effective and has not been approved by the Legislative Commission.

Chair Peters:

While we are under this agenda item, I know Dr. Titus had a question about this regulation. Please go ahead with your question.

Assemblywoman Titus:

I will reach out to the Board of Pharmacy after this meeting. Mr. Robbins, for my understanding, if the regulation has been adopted, they cannot enforce it—or it is not an official regulation—until the Legislative Commission approves it. Is that correct?

Mr. Robbins:

Yes, that is correct. The regulation does not become effective until it is approved by the Legislative Commission. The Legislative Commission does sometimes send regulations back to the agency for further changes.

Assemblywoman Titus:

I will reach out to my Legislative Commission members and the Board of Pharmacy on my concerns over this regulation. We will not need to deal with that today. Thank you for that clarification. There is still hope.

Chair Peters:

Unless there are other questions, we are going to close this agenda item and move on to Agenda Item VI.

AGENDA ITEM IV—OVERVIEW OF MATERNAL MORBIDITY AND MORTALITY IN NEVADA

Chair Peters:

Our next agenda item, which is Agenda Item IV, is an overview of maternal morbidity and mortality in Nevada. We will start with the data at hand, followed by a baseline of where we stand today on this particular issue, and then move into topic specific presentations from the experienced folks across our state. Ms. Kyra Morgan is here to present. Please go ahead, Ms. Morgan, when you are ready.

Kyra Morgan, Chief Biostatistician, Office of Analytics, Department of Health and Human Services (DHHS):

Good morning. I am going to go over quickly some data related to maternal mortality and severe maternal morbidity. I am going to start with some background and definitions. We are going to focus in this conversation on pregnancy-associated deaths, which really is the widest net we can cast related to maternal mortality (Agenda Item IV).

Maternal mortality, or *pregnancy-associated death*, is defined as "death while pregnant or within one year of the termination of pregnancy, regardless of the cause." There are also definitions for *pregnancy-related deaths*, which are a subset of pregnancy-associated deaths and maternal deaths. Since our counts are so small in Nevada, it is really hard for us to draw conclusions or present information by any kind of demographic subgroup. We are going to focus, again, on pregnancy-associated deaths.

The information I am presenting today is part of a *Maternal Mortality and Severe Maternal Morbidity Nevada, 2021* report that is available on our website. The data in the report is a little bit older. We updated it for this presentation, so the 2021 data throughout my presentation is preliminary, subject to changes, and not yet available online.

I also wanted to give you some background definitions on *maternal morbidity*. It is "a continuum from mild, adverse effects to life-threatening events or maternal death." We are going to focus here on *severe maternal morbidity*, which is the second tier of that pyramid. It "refers to conditions and diagnoses that indicate potentially life-threatening maternal complications, including unexpected outcomes of labor and delivery resulting in significant short- or long-term consequences to health."

We are going to start with pregnancy-associated deaths. There were 36 in Nevada in 2021, which is why we focus on this larger category. As you can imagine, if we drill down much further than that, we get a little bit too specific. The rate of pregnancy-associated deaths is about 108 per 100,000 live births. It is fairly rare, and 78 percent of pregnancy-associated deaths typically occur in Clark County. The most noteworthy trend over time, is the significant increase we saw between 2019 and 2020. We went from 21—or a rate of 60 per 100,000—to 40 cases in 2020—with a rate of 119 per 100,000.

When we look at pregnancy-associated deaths by race/ethnicity, we see that the Black non-Hispanics had the highest pregnancy-associated death ratio. They accounted for 25 percent of pregnancy-associated deaths, but only 15 percent of pregnancies. You can see the disproportionate effect on that population. Hispanics had the lowest pregnancy-associated death ratio at 66 per 100,000 live births. They accounted for 22 percent of pregnancy-associated deaths, compared to 36 percent of pregnancies.

You will notice throughout my presentation that we are suppressing data for populations with too small of counts to have any kind of statistical reliability. That is our American Indian/Alaskan Native population and anyone who is recorded with an unknown or other race/ethnicity.

When we look at pregnancy-associated deaths by age, you can see hugely disproportionate ratios in our individuals aged 40 and older. The rate for that group is nearly 405 per 100,000 live births, followed by 35- to 39-year-olds. We tend to sometimes combine 35 to 39 and 40-plus because we know the risk factors associated with that age breakout. When we consider those in aggregate, we see that 33 percent of pregnancy-associated deaths are to individuals aged 35 and older, compared to 19 percent of pregnancies taking place in that age group.

We can also look at the underlying cause of death in these instances. Interestingly, in 2021, we saw the most common cause of death was nontransport accidents. When we dug a little bit deeper into that, we identified that all of those nontransport accidents were due to unintentional drug overdose. The second most common cause of death was related to pregnancy and childbirth.

Now I am going to transition over to severe maternal morbidity. Again, these are conditions and diagnoses that indicate potentially life-threatening maternal complication, including unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to health.

I included some national comparisons because I think it is always good to have a benchmark. The Centers for Disease Control and Prevention (CDC) is a little behind in its available national data; the most recent data on this slide is 2014, which is pretty old, but I included it because it shows a significant increase in the ten years nationally that were shown in the magnitude of 200 percent. The biggest takeaway here is that blood transfusions play a huge role in that. If we exclude blood transfusions, severe blood loss, or hemorrhaging from severe maternal morbidity, we would only have observed a 20 percent increase over that ten-year period nationally. It is largely driven by individuals needing

blood transfusions. Then, although this is dated back in 2014, the national rate for severe maternal morbidity was 144 for 10,000 deliveries.

In Nevada, we are only trending six years back. If you compare to 2016, which is the most relevant compared to the national data, Nevada had a lower rate, which is 126.5. However, it has increased a little bit over time with 440 cases in 2021. If we excluded blood transfusions, similarly to national metrics, we would see that rate drop to about 80 for 10,000 deliveries. In Nevada, this is also largely driven by individuals requiring blood transfusions.

When we break this down by maternal race/ethnicity, we find similar disparities in the Black non-Hispanic group and our Asian or Pacific Islander subgroup—those rates are 279.5 per 10,000 deliveries and 286.7 for 10,000 deliveries, respectively. Again, we are suppressing our American Indian/Alaskan Native and other unknown race individuals because we did not have statistically reliable information.

Here we are looking at maternal morbidity by age. You can see there is a similar effect in our older populations, age 35 and older. For this indicator, we also see increased rates of severe maternal morbidity in our younger population under the age of 20.

There are a total of 21 indicators we use to identify severe maternal morbidity. Eighty-one percent of the cases represented in 2021 had just one indicator present, 11 percent had two indicators present, and 8 percent had three or more indicators present.

We can look at indicators in different ways. This is looking at the leading diagnosis-based indicators and that is adult respiratory distress syndrome. Interestingly, when we dug a little bit deeper into this, we found that 59 percent of those were confirmed Coronavirus Disease of 2019 (COVID-19) cases in 2021, followed by sepsis, disseminated intervascular coagulation, shock, and then you see the rest on the graph.

We can also look at procedure-based indicators. Again, blood transfusion being the leading indicator there, followed by hysterectomy and then some require ventilation.

Here, we are trying to identify specific maternal demographic characteristics and prenatal and delivery characteristics that were found to be significantly associated with severe maternal morbidity. We found maternal age, maternal race/ethnicity, health insurance status, adequacy of prenatal care, parity, method of delivery, plurality or twins or multiples, and maternal chronic disease status all having a significant impact on severe maternal morbidity.

This is the end of my data presentation. I am happy to take questions now or at the leisure of the Committee.

Chair Peters:

Are there any questions from the Committee on the data, specifically? As a reminder, we do have experts in this area presenting later today and they may be able to answer these questions, either through their presentations or in the question-and-answer period. I do not see any questions.

Thank you, Ms. Morgan. We appreciate you presenting this data today and look forward to diving into more of the specifics on it. We are going to go ahead and close this agenda item.

AGENDA ITEM V—UPDATE FROM THE MATERNAL MORTALITY REVIEW COMMITTEE

Chair Peters:

We will move on to the next presentation, which is Agenda Item V, an update from the Maternal Mortality Review Committee (MMRC).

In the last couple of sessions, we stood up a maternal mortality committee to look at the causes of death for birthing people in the State of Nevada and the statistics associated with those, and then we came up with some solutions for us. I am looking forward to this presentation and seeing what we have come up with over the last couple of years since that was established. We have with us today, Tami Conn. Please go ahead with your presentation when you are ready.

Tami Conn, Maternal, Child and Adolescent Health Section Manager, Bureau of Child, Family and Community Wellness, Division of Public and Behavioral Health (DPBH), DHHS:

Thank you for having me here today. I will be providing an overview and update for Nevada's Maternal Mortality Review Committee (Agenda Item V A-1).

As Ms. Morgan previously mentioned, within maternal mortality there are three definitions of maternal deaths comprised in that. *Pregnancy-associated deaths* are the "death of a person while pregnant or within one year of the termination of pregnancy, regardless of the cause." *Pregnancy-related deaths* are the "death of a person while pregnant or within one year from the end of the pregnancy caused from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition from the physiologic effects of pregnancy." Then drilled down even further, is *maternal death*, which is the "death of a person while pregnant or within 42 days of the termination of the pregnancy, regardless of the duration and site of pregnancy, from any cause related to, or aggravated by, the pregnancy or its management." This does not include accidental or incidental causes.

Maternal Mortality Review Committees across the country review deaths within one year of pregnancy. They use multiple data sources to obtain the data, with the goal of using that data to drive recommendations and actions to eliminate preventable maternal mortality and to address disparities. The MMRCs in the United States support standardized, nationwide data sharing on maternal deaths. Most MMRCs in the United States have shifted to using the same data collection system so that data is standardized. The MMRCs look on a case-by-case basis and then address the question, "If they had not been pregnant, would they have died?" Per the CDC, 63 percent of pregnancy-related deaths are preventable.

The MMRCs are multidisciplinary committees. They are typically in states, but they are also found throughout cities or counties. They perform comprehensive reviews of death among pregnant people or people within a year of the end of pregnancy. The CDC does work with MMRCs nationwide to improve the review processes that inform recommendations for preventing future deaths. As I said, most states are moving to a standardized data collection system called the Maternal Mortality Review Information Application. It is a data system designed to facilitate MMRCs through collection of data. It documents committee deliberations and standardizes the data indicators.

Nevada's MMRC reviews the deaths of all people who died during pregnancy or within 365 days from the end of pregnancy. We review them regardless of the cause of death. Our

committee is required to have a minimum of 6 members, but no more than 12 members. Those members are required to be providers of health care, representatives of nonprofit organizations whose work is related to health care pregnancy issues, representatives of agencies involved in vital statistics, law enforcement, public health, or other persons interested in maternal health and welfare. The Committee should represent a racial, ethnic, linguistic, and geographic diversity of the state. The current Committee members for the Nevada MMRC are:

- Sandra Koch, M.D., F.A.C.O.G., Chair;
- David Jackson, M.D., M.F.M.;
- Ericka F. Washington, Executive Director, Make It Work Nevada;
- James M. Alexander, M.D., M.F.M.;
- Jennifer Vanderlaan, Ph.D., M.P.H., A.P.R.N., C.N.M., F.N.P.;
- Jollina Simpson, I.B.C.L.C., C.H.W., President, Kijiji Sisterhood;
- Joseph Adashek, M.D., F.A.C.O.G.;
- Laura D. Knight, M.D., Chief Medical Examiner and Coroner, Regional Medical Examiner's Office, Washoe County;
- Melanie Rhee, L.C.S.W.;
- Melinda Hoskins, M.S., A.P.R.N., C.N.M., I.B.C.L.C.; and
- Natalie Nicholson, D.N.P., M.B.A., R.N., C.E.N.P.

The reporting required of Nevada's MMRC includes an annual report due by April 1 on maternal mortality and severe maternal morbidity and is published online through DHHS. It is the report that Ms. Morgan mentioned in her presentation. There is an additional report, *Maternal Mortality Nevada, December 2018–2020*, required from the MMRC biannually, in even-numbered years, due to the director of the LCB. It contains incidents of maternal mortality and severe maternal morbidity during the immediately preceding 24 months and should also contain any recommendations for legislation or policy changes. This is the report that truly captures the recommendations from the MMRC itself. The Committee was established in 2020, so we have only had one report, which was in 2020. We will have an upcoming report due at the end of 2022.

I want to go through the recommendations from the 2020 report. The Committee identified substance use and pregnancy and wanted to provide adequate substance use treatment options to pregnant people. The MMRC recommended educating providers on the Nevada substance use disorder treatment options that already exist for pregnant people and then removing any barriers to care. The MMRC wanted to address social determinants of health contributing to maternal mortality and recommended providers consider administering a prenatal suicide screen, in addition to the antepartum and postpartum depression screenings. Additionally, they wanted outreach promoting the importance of prenatal care and preventing any delays in obtaining that prenatal care.

Two more recommendations were to improve the functionality of the MMRCs. One of which was addressed in Assembly Bill 287 (2021). It addressed the barrier of the MMRC being able to access the Nevada Central Cancer Registry data for case abstraction. It was already resolved in AB 287, and we appreciate that. The MMRC also identified the lack of family interviews and data regarding social determinants of health and that created a barrier to making recommendations. They supported securing dedicated funding to ensure that qualitative data collection occurs. Informant interviews for MMRCs is a newer process for states nationwide, and I will talk about how we are working on that later in my presentation.

Regarding other changes that have occurred for the MMRC, AB 119 (2021) strengthened language on identifying disparities in maternal mortality and severe maternal morbidity. It

added language for reviewing and identifying disparities and maternal mortality incidence; analyzing race, ethnicity, age, geographic region, or any other variable identified by the Committee; and provided language to collaborate on the biannual report recommendations with the Advisory Committee on Minority Health and Equity, Office of Minority Health and Equity, DHHS. I presented to the Advisory Committee last year. We have met in 2022 and are ready to collaborate on the upcoming 2022 report.

Regarding future opportunities for change, AB 287 (2021) also made changes to Chapter 442 of NRS to include gender-neutral language. It also clarified the access to the cancer registry, like I previously mentioned. The gender-neutral language changes did not include pregnancy throughout NRS 442.761 and 442.774, those changes only included those giving birth or those who gave birth. It would be important to add in the pregnancy language into the NRS so it could read "persons who are pregnant, are giving birth, or who have given birth," as used elsewhere in AB 287. The addition of including the pregnant term would just retain the MMRCs authority to request records relating to pregnancy.

I wanted to provide a funding update. As many of you know, we applied for funding dedicated to our MMRC. In 2019, we applied for the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) grants. In 2019, our grant application was approved; however, it was not funded at the time. We began our MMRC for the first couple of years without any dedicated fund. In July 2021, we were notified the original application—that was approved, but not funded—was being funded, which was great news. The funding began late September 2021 and allows us to hire a full-time registered nurse abstractor. Currently, our MMRC has one part-time nurse abstractor, which sometimes causes issues with the time it takes to review cases. One case can take up to 20 hours to enter the data into the application. It is a timely process, and we want to make sure we are capturing every aspect of that case to honor that person. The funding allows for hiring of a full-time registered nurse; then, we are also partially funding a data evaluator.

Other funding opportunities that have come up, the Chronic Disease Prevention and Health Promotion Section within DPBH, DHHS, has provided us with health disparity focused funding. This funding runs from the beginning of this year through May 2023 and allows for the hiring of two MMRC master of social work positions. These two positions will be conducting informal interviews. As I previously mentioned, the Committee wanted that social determinant of health qualitative data to be collected. These informant interviews will provide such rich information on social determinants of health and other contributing factors. They will be able to gather anything that we do not see throughout medical records. We have been able to hire both positions, which I am grateful for. One started last month and the other person will be starting next week. We have to create protocols before they can begin the informant interviews, but we will get there soon.

Other related efforts to the MMRC include a perinatal quality collaborative (PQC). Currently, Nevada does not have a PQC, and it could benefit greatly from having one. It could be another implementing body for MMRC recommendations, serve as a hub for our other program, Alliance for Innovation on Maternal Health (AIM), and could work on other perinatal efforts and improving birth outcomes. In addition, our Nevada AIM program is a national data-driven maternal safety and quality improvement initiative. We are a newer AIM state, and we are working towards the fall of 2022 to launch the first bundle, which is on severe hypertension. We also have other perinatal health initiative efforts to address key contributors to maternal mortality, such as perinatal behavioral health.

Here are some resource links if you want more information. I will be happy to take any questions.

Chair Peters:

Thank you, Ms. Conn. Are there any questions from the Committee? I have a couple of clarifying questions, then we will go to Assemblywoman Gorelow and Dr. Titus for questions.

First of all, congratulations on the new hire, that is good to hear that we are filling state positions. My question is about the partially funded data evaluator. Can you talk about how you are partially funding? Are you leveraging with another entity that is funding the other part of that data evaluator?

Ms. Conn:

It will be a contracted position. Due to the amount of funding we received, we were able to pay 50 percent of that position. The other 50 percent will be paid through money from our Alliance for Innovation on Maternal Health initiative. Both parts of the funding work towards material mortality and severe maternal morbidity, but it will be a 50/50 split between the two.

Chair Peters:

Thank you. Assemblywoman Gorelow, please proceed with your question.

Assemblywoman Gorelow:

I believe the fetal infant mortality reviews only certain counties in the state. I want to verify the MMRC covers all counties in Nevada.

Ms. Conn:

Yes, you are correct. The fetal infant mortality review only goes over one county, but the MMRC reviews deaths in the entire state. We have representation on the MMRC from both the north and south parts of the state to make sure the geographic diversity is representative.

Chair Peters:

Dr. Titus, please go ahead.

Assemblywoman Titus:

My question is along the same lines about the data evaluator. Looking at this presentation and the one prior, we are given a static set of information and percentages. In the previous report for Clark County, there were 36 deaths in 2021 from pregnancy-related deaths. Then, several slides later, there was some information that said 30 percent of deaths from pregnancy were drug-related or overdose-related. Is that to assume then, that 10 out of the 36 people who died during pregnancy in Clark County had drug overdoses? Could we tease out some of that data? There are many different reasons woman die; pregnancy can be one of them. For that age group, is that an extraordinary number of women dying pregnant versus women who are not pregnant dying from auto accidents, accidents in the home, or from overdose? I would like to see the spectrum of deaths for women in that age group and the cause of their deaths. I am not sure that is an extraordinary number of deaths based on how many people live in Clark County in that age group. Hopefully, your data evaluator can get more of a picture about the overall death rate for women in that age group.

Ms. Morgan:

We can surely get you that information on total deaths and then break it down by cause so you can see the umbrella that it falls under. We can provide that to the Committee as a follow-up.

Assemblywoman Titus:

I really think that is the key. In Nevada, do we have more women dying during pregnancy compared to the national statistics? Maybe that is a low number. We do not want to see any woman die due to complications of pregnancy, but are we doing good or are we not doing good? The statistic of 36 women who died last year in Clark County from complications of pregnancy is one point in time. How does that fall in the spectrum? It is one of the purposes of the regulations we passed in the NRS and doing these studies, but it only works if we put it in perspective compared to other areas.

Ms. Morgan:

I want to clarify that the number is statewide. The 36 pregnancy-associated deaths were statewide, not specific to Clark County, and 78 percent of those pregnancy-associated deaths were in Clark County.

Chair Peters:

I also asked staff to make sure we had access to the report Ms. Morgan mentioned in her presentation. If you have problems with it, or have not received it from staff, please let us know and we will ensure you get that *Maternal Mortality and Severe Maternal Morbidity Nevada, 2021* report.

Are there any other questions from the Committee on this presentation? Go ahead Vice Chair Doñate.

Vice Chair Doñate:

My question is in regard to the policy recommendations you proposed. It is my understanding that other states have moved towards creating an implicit bias and cultural competency training for health care professionals that work in the perinatal space. Is that something that is required now? If I am a health care professional who works in this space, do I have the ability to get certified by a state program, or are there any requirements for me to get training in this? I would love the chance to hear your feedback on these conversations that have taken place, or where we stand.

Ms. Conn:

I would not be able to answer your question in regard to what is required for Nevada licensing, but I could get back with an answer on that. In terms of our Committee trainings, we are planning to provide implicit bias trainings and health equity, diversity, and inclusion training. However, we do not have any requirements for the Committee.

Chair Peters:

I believe we have been working on some of that with DPBH and their licensing division. I am going to ask staff if we have anybody who is coming up to present later today, and if they might be able to answer that question. I do believe there are existing requirements for cultural competency training for certain environments, but I am not sure how broad or how

specific it is to the perinatal space. We will look into that and see if we can get an answer today.

Are there any other questions from the Committee on this particular topic? Thank you, Ms. Conn for presenting on this issue; we look forward to seeing your bill recommendations.

On a side note, we are looking to work session potential bill draft requests (BDRs) through this Committee in July and August. If you have ideas that you would like to ensure get on our consideration list, please send those in earlier rather than later. You can send those to our Committee's email address, or reach out to staff, or myself, and we will make sure those get on the list.

Before we move on to the next agenda item, I would like to go back to Agenda Item III for a correction from our legal staff, Mr. Robbins.

(The following section of testimony was taken out of order.)

Chair Peters:

We are going to reopen Agenda Item V and address Vice Chair Doñate's question about cultural competency training for medical providers. Our legal staff, Mr. Robbins, has a response to where some of the regulations are regarding that issue.

Mr. Robbins:

There are two sets of requirements I want to talk about. The first is NRS 449.103, which requires cultural competency training for employees of any facility licensed pursuant to Chapter 449 of NRS, which are your medical facilities and facilities for the dependent. The requirement was enacted by Senate Bill 364 (2019) and SB 470 (2019). Pursuant to that, DHHS adopted LCB File R016-20. Sections 14 through 18 of that regulation prescribed the cultural competency requirements. It basically requires new hires to receive training approved by the Department in cultural competency, prescribes the required topics for that training, and the process for getting the training approved. The hires have to receive the training annually thereafter.

The other requirement was from AB 327 (2021), which requires mental health providers and nurses to receive cultural competency training. Specifically, psychiatrists, physician assistants serving under a psychiatrist, nurses, psychologists, social workers, marriage and family therapists, clinical professional counselors, and behavioral analysts must receive cultural competency training as part of the continuing education for renewing their license; that is the other requirement that currently exists in the law.

Chair Peters:

I believe the standards and curriculum for those training programs have been developed, or are in the development process, and are being negotiated with the higher education institutions who would train in those areas.

Vice Chair Doñate, do you have any follow-up questions?

Assemblyman Hafen, please go ahead with your question.

Assemblyman Hafen:

I have a follow-up. I heard some concerns from the rural communities about the accessibility of the training. You stated the higher education institutions would be involved. I want to make sure that we are not adding an additional burden of days of travel. We are already understaffed in the rural areas, and I want to make sure there is going to be some accessibility to the rural communities for this training.

Chair Peters:

Thank you for bringing up that point and I do believe that is being considered. I am not in the position of promulgating those regulations and developing those curriculums and process. I can connect you, or have staff connect you, with DPBH who are working on those regulations. I believe options for virtual meetings are available.

Dr. Titus, do you have any experience you would like to share?

Assemblywoman Titus:

I have asked that question many times, making sure through health care that it is online. When we met last time, I was concerned about some of these regulations—such as the speech and pathology regulation—and access. I think much of this can be online and it is really up to the boards requiring this to be online.

Chair Peters:

We have a member in the audience, Mr. Cafferata, who has a comment on this.

Mr. Cafferata, if you would like to come up and respond? I know you have been working with a broad group on the topic area.

Senator Hardy:

Madam Chair.

Chair Peters:

Senator Hardy, can I come back to you after Mr. Cafferata's response, or do you have a comment that may integrate with this issue?

Senator Hardy:

It may integrate. I wanted to clarify—it is in the law, but until the regulations take place, are they not responsible for abiding by the regulation and therefore the law?

Chair Peters:

I am going to let our legal staff answer that question. Mr. Robbins, please go ahead.

Mr. Robbins:

With regard to the requirements for the cultural competency training of people in medical facilities, those requirements are in law, but they are in a regulation that has been adopted and is effective. They do have to comply with those requirements.

Senator Hardy:

I am looking at the people in the rurals, for instance. Is everybody required, or are we still waiting for regulations that have to be instituted in order for everybody who is affected by this law?

Mr. Robbins:

The regulations have been adopted, so the requirements would apply to everyone, including rural areas.

Chair Peters:

Mr. Cafferata, do you have a have comments on this?

Jay Cafferata, Public Health Diversity Advisor, Nevada Public Health Training Center, School of Public Health, University of Nevada, Reno (UNR):

Good morning, thank you for taking this exception. I am currently a person who provides third party training for NRS 449.103. The regulations were adopted and passed by the State Board of Health in 2020 and the training has been going on since that time. There are currently four providers available to anyone in the state to take that training and can be found on the DHHS's Bureau of Health Care Quality and Compliance (HCQC) website including, as legal said, the ability and the avenue to apply for additional trainings to be approved.

Under AB 327, those regulations are still being developed and that has not been completed at this time. However, the state licensing boards are the enforcement action of that and not the state, so each licensing board has to approve their own set of regulations about how and what they will accept as meeting the terms of that law.

For NRS 449.103, that has been done and is already done. There are two providers for an online version of the cultural competency that meets NRS 449.013, and UNR and myself are the trainers. It has been available online since August 2021 and it is available to anyone at any time 24/7. There is also a provider in Las Vegas that has an online class.

Currently, as part of our contract with the state, this training is provided to any state employee at no cost to them. Anyone from the state can take the training that meets the requirements of NRS 449.103, as well as AB 327, because in the law about AB 327, it says NRS 449.103 will cover and meet the requirements for that.

The regulations proposed for the Board of Psychological Examiners also include training approved for NRS 449.103, which will also meet their requirements. All of these avenues have been covered already and training is available and online.

Chair Peters:

Thank you. Please go ahead, Senator Hardy.

Senator Hardy:

I get a mixed message here. I hear the words "things are covered," but are they required by everybody—whether or not they are in a hospital setting—*before* the regulation or is the regulation still pending in some instances and therefore, they are not responsible for it *until* the regulation passes, everywhere to everybody?

Mr. Robbins:

The regulation for medical facilities and facilities for the dependent under NRS 449.103 has been adopted and approved. The requirements are effective; they apply to everyone. Everyone who works in a medical facility or a facility for the dependent, currently has to take this cultural competency training. The AB 327 requirements, as Mr. Cafferata said, are still being adopted by the various licensing boards. Those are our requirements for mental health providers to take cultural competency as part of their continuing education. Those are not effective yet, so those people do not currently have to comply with them.

Senator Hardy:

Thank you.

Mr. Cafferata:

Can I add one thing? Some licensing boards, like the State Board of Nursing, have already approved the regulations. They went into effect on January 1, 2022.

Chair Peters:

Dr. Titus has another question or comment.

Assemblywoman Titus:

Thank you for some clarification. You mentioned it is free to any state employee; however, what about the rest of us who are not state employees and are mandated to do this? Is there a waiting period? Hopefully those in the rurals can sign up online. What would be the cost to the average person?

Mr. Cafferata:

Currently, the training is nine hours long, it is available asynchronously, that is for anyone. The cost is $100, which is about $11 an hour for a continuing education unit.

Assemblywoman Titus:

I thought the law says there has to be two hours of training in some of the regulations.

Mr. Cafferata:

The other piece of that is under NRS 449.103, the facility must provide the cultural competency training, and not the individual, because that is under the licensing statute and it has to do with the licensing of the facility. When you look at AB 327, those requirements are by each board, depending on whatever they decide is going to be required. Assembly Bill 327 says a minimum of two hours. It does not add any length of time, but it does have a set of topics that must be covered. Assembly Bill 327 adds two additional groups of people over the number of people required under NRS 449.103—those are veterans and people with mental illness.

Assemblywoman Titus:

You offer a nine-hour program; do you have the cliff version of that, a two-hour program?

Mr. Cafferata:

Absolutely not; it cannot be reduced in any way I have found. None of the other providers provide this in anything less than nine hours because of the level of rigor and depth the law requires. There are certain criteria in the regulations that must be met in order to become an approved course. It is not intended to be a check the box, it is intended to change behavior. When we look at adult learning principles, we understand you cannot be led to change your behavior in a two-hour period and cover all of these topics. You cannot even read the law in two hours and cover all the things under NRS 449.103.

Chair Peters:

I appreciate the interest in this topic area. It is a bit of a tangent for today, but very important, especially in this area where we are understanding the dynamic relationship the health care industry has with our culturally and societally encouraged biases and how we break those down. I appreciate the work you have been doing, and I appreciate the interest from our providers who are responsible for taking this training.

As a side note, I do not work in the health care industry. I work with potentially hazardous materials and must take a 40-hour initial training for hazardous material handling and an 8-hour training annually after that. I do not think this is too much for professional expectation for education, but I appreciate the interest. If you would like to continue this offline, I would encourage that.

Senator Hardy:

I have major issues with the Legislature saying two hours and then we have a de facto "you have to take nine hours." The things you are talking about are for people who are already in the field. If we are requiring nine hours to get a certificate, instead of what the Legislature has said to take two hours, then the person can go "out of state" to get training. I have a major problem when we start saying we are going to make something more than what the Legislature said. I think that is irresponsible for what we are trying to say to our people when we require something and then, lo and behold, it is multiplied. I have problems with that.

Chair Peters:

Thank you for the comment. For the record, we did say at a minimum of two hours in the legislation. It does not exceed that to the extent of not being what our intention was. I am going to move on from this particular item. If you have additional questions or comments, please feel free to reach out to HCQC and discuss with them the expectations for that training. As we start to integrate more of the understanding of cultural competency societally, we may need less training as people inherently understand the needs of a diverse body of people such as we have in the State of Nevada.

[Subsequent to the meeting, Ms. Morgan provided a follow-up memorandum regarding pregnancy-associated deaths in Nevada, NAS adverse birth outcomes, and education initiatives available for parents.] (Agenda Item V A-2)

AGENDA ITEM VI—ACCESS TO MATERNAL CARE AND RELATED EXPANSION OF MEDICAID COVERAGE FOR WOMEN

Chair Peters:

Moving on to Agenda Item VI. This is a presentation on the access to maternal care and related expansion of Medicaid coverage for women. We have representatives from state Medicaid to present. Please go ahead when you are ready.

Antonina C. Capurro, D.M.D., M.P.H., M.B.A., Deputy Administrator, Division of Health Care Financing and Policy (DHCFP), DHHS:

Good morning, Chair Peters, members of the Committee, and staff. We have a small change in our presenters this morning. Ms. Erin Lynch is unable to join us due to an illness, we send her our thoughts for a speedy recovery. In her place, I am joined by Ms. Briza Virgen.

I would like to thank you for the opportunity to present information on Medicaid coverage related to maternal health (Agenda Item VI). We have a brief presentation this morning. We will be discussing statistics and covered services; then we will move into the implementation of bills from the 81st Legislative Session that center on maternal, child, and adolescent health; and then provide policy recommendations for future consideration.

The Committee may recall, we had a presentation in January where we presented some of these data points. Currently, one in four Nevadans are covered by Medicaid. At our January presentation, we indicated our recipient growth—since the start of the public health emergency of February 2020—was 33.5 percent, it is now 37.2 percent growth. We also have nearly 30 percent of the state's expenditures, and we cover 55 percent of the births in Nevada. We also have 76 percent of our recipients who are covered through a managed care organization. Forty-two percent of our enrollees are children 0 to 18 years of age; of that, 7 percent are 0 to 3 years old. We also have the highest increase in our per member, per month (PMPM) spent in our infant population, where our spend has increased 26 percent from 2016 to 2019.

The Families First Coronavirus Response Act (H.R.6201 of the 116th Congress) established a continuous Medicaid enrollment safeguard beginning in March 2020. It will end when the federal government declares the public health emergency has ended. We have had a steady increase in our enrollment over time. Before the beginning of the public health emergency, we were consistent at around 645,000 enrollees, but month over month, we are increasing.

As I mentioned, Medicaid funds 55 percent of the births in the state. We are higher than the national average. Nationally, Medicaid covers 42 percent of the births in the nation. We have variations in region for that coverage. Over time, we have had a slight decrease in our percentage of Medicaid-covered births. Clark County had a slight decrease. Then looking at Washoe County and the rural areas, again a slight decrease. It is interesting to note, the rural areas have a higher percentage of births paid by Medicaid versus Washoe County, and they are nearly identical to Clark County. This is some of the data we take into consideration when we are making policy decisions and when we are working to improve maternal and child health.

I will now turn the presentation over to Ms. Virgen, who will provide information on Medicaid's maternity care services and the implementation activities for our maternal child health bills from the previous legislative session.

Briza Virgen, Social Services Chief I, Medical Programs, DHCFP, DHHS:

Thank you, Dr. Capurro. Nevada Medicaid covers medically necessary services that are within the state plan. Some maternity care services are listed here, but the list is not all inclusive. Maternity care services may be provided by a physician, physician assistant, nurse midwife, or advanced practice registered nurse. These services may include: prenatal visits; lab work; imaging; postpartum visits—pregnant women with Medicaid maintain eligibility until 60 days after the pregnancy ends—and labor and delivery in multiple settings—hospitals, home births, and freestanding birthing centers. A freestanding birthing center is a facility that is not part of the hospital, and it provides services for normal, uncomplicated births. Both home and freestanding birthing center births are appropriate for recipients with low-risk pregnancies, intended vaginal deliveries, and no reasonably foreseeable expectation of any complications. Anesthesia services are also included.

The Welcome to Nevada Medicaid recipient booklet is a booklet we share with the recipients in the community. We are currently working on updating the booklet to include the new services covered by Nevada Medicaid.

Additionally, one of our newest covered services is doula services. This was passed in the 81st Legislative Session with AB 256 and this new provider of doula and doula services became effective April 1, 2022, with Nevada Medicaid. A doula is a nonmedical trained professional who provides education and emotional and physical support during pregnancy, labor delivery, and postpartum period.

We are currently exploring the creation of an incentive to connect women to a dental cleaning and prenatal exam, but it will be dependent on funding available.

Community health worker services—this policy was recently implemented as of February 1, 2022. This is a new provider type that Nevada Medicaid created as a result of AB 191, which was passed during the 81st Legislative Session. Community health workers are trained public health educators improving healthcare delivery, requiring integrated and coordinated services across the continuum of health. Community health workers provide recipients culturally and linguistically appropriate health education related to disease prevention and chronic disease management to better understand their condition, responsibilities, and health care options.

Additionally, we cover dental services during the prenatal period; these can include cleanings, preventive care, and restorative care. We also cover behavioral health services including substance use during pregnancy, nonemergency medical transportation to Medicaid covered services, and emergency transportation. Again, this list of covered services is not all inclusive.

Next, I will review the bills passed during the 81st Legislative Session related to maternal child health. Assembly Bill 189 becomes effective July 1, 2022, and contains two components. The first one is Medicaid presumptive eligibility for pregnant women as determined by a qualified provider. Presumptive eligibility is valid until the last day of the month, immediately following the month of enrollment, without submitting a Medicaid application. The second component of the bill is the residency in the United States for Medicaid eligibility. It allows us to remove the limitation of a pregnant woman residing in the United States for a prescribed period of time, in order to be able to enroll into Medicaid. This bill is requiring a state plan amendment, so both DHCFP and DWSS are working together to create that state plan amendment and to submit it to the Centers for Medicare and Medicaid Services (CMS) for review and approval.

Assembly Bill 191 (2021) is the bill that allowed Nevada Medicaid to create a new provider type, which is Provider Type (PT) 89, for community health workers and their services. This policy became effective as of February 1, 2022, under Chapter 600 - Physician Services of the *Medicaid Services Manual*. Additionally, Nevada Medicaid issued a web announcement in February, which offered providers some information and guidance on how to enroll with Nevada Medicaid, as well as trainings and billing guidelines. We are currently working with CMS on the state plan amendment and continue to work with them.

Some of the covered services that community health workers offer is guidance in attaining health care services, identifying recipient needs, providing education from preventive health services to chronic disease self-management, providing information on health and community resources, connecting recipients to preventive health services or community services to improve health outcomes, and promoting health literacy.

Again, AB 256 allowed Nevada Medicaid to create another new provider type, which is PT 90 for doulas. This policy also resides under Chapter 600 - Physician Services of the *Medicaid Services Manual* and became effective April 1, 2022. Again, there was a web announcement issued in April that provides billing and enrollment guidance, and we continue to work with CMS on that approval and state plan amendment.

As part of this, DHCFP partnered with the Nevada Certification Board, and they agreed to become Nevada's doula certification body. The Board created a doula certification page on their website. They also put out a request for professional doulas to submit applications, and from those applications, they selected a group of professional doulas to be the advisory group. This advisory group started meeting in January 2022. They have been meeting frequently and began developing what the board would require, such as the skills and training the doulas must have in order for the Board to certify them in Nevada. They began accepting applications as of April 1, 2022, which aligned perfectly with when our policy effective date began. Doulas provide emotional support. They provide physical comfort measures during labor and delivery. They facilitate access to resources to improve health- and birth-related outcomes. Doulas provide evidence-based education and guidance, such as general health practices, newborn health and behavior, and a multitude of other things.

Senate Bill 420 (2021) contained several components. The bill allowed Nevada Medicaid to include in the state plan these maternal child health services, but only to the extent funding is available, which is the language in the bill. The first one is Medicaid expansion for pregnant women by increasing the federal poverty limit from 160 percent to 200 percent for this target group. This would support the continuity of coverage and care for pregnant women and their infants. Women with Medicaid are more likely to receive the adequate prenatal care when compared to uninsured women.

Secondly, the bill provides for increasing the reimbursement rates for advanced practice registered nurses, which are PT 24, and certified nurse midwives, which are PT 74, to be equal in pay to physicians, which are PT 20. This would allow equal pay for equal work and improves access to care. Advanced practice registered nurses can fill the gap, as there are not enough providers or specialists who are able to take Medicaid at the time.

The third component creates a new provider type for international board-certified lactation consultants, who are nonphysician health care professionals. It also adds coverage for breast pumps and supplies. Breast milk provides a baby with the ideal nutrition and supports growth and development. Breastfeeding can also help protect baby and mom against certain illnesses and diseases.

The fourth component adds noninvasive prenatal screens (NIPS) as a covered service. Noninvasive prenatal screens are a cell-free noninvasive fetal DNA screening test, or a chromosomal screening, for abnormalities. Nevada Medicaid currently covers the first and second trimester screenings, which include trisomy 18—which is Edwards syndrome—and trisomy 21—which is Down syndrome. Whereas, NIPS covers these, in addition to trisomy 13—which is the Patau syndrome—along with sex chromosomal abnormalities. These screens are recommended by the American College of Obstetricians and Gynecologists (ACOG) as one of the options for prenatal screenings as well.

I will pass the presentation back to Dr. Capurro.

Dr. Capurro:

I would like to now review three maternal child health policy recommendations. The first, as we discussed during the 81st Legislative Session, SB 420 allowed Medicaid to include in the state plan several maternal and child health services, as we just reviewed. These services were authorized to the extent funding is available. We have included this in the policy recommendation section as the Division recognizes the value and importance in implementing these services, should budgetary authority be available in the next legislative session. This is a mere image of those items we discussed previously.

I will now introduce a policy concept that is currently being utilized by 24 states to connect health care to school readiness through a health examination before school entrance policy. This policy is centered on the ideal that all Nevada children have the right to access health care before they enter school to improve attendance and engagement in learning. It would include a medical, dental, and mental health screening at specific age levels. Currently, Nevada schools, in counties with a population of 100,000 or more, are required by law to provide a vision, scoliosis, and hearing screening at set intervals. Following the model of health assessments before school entrance policies in other states, this requirement could be incorporated into a broader policy that includes the completion of a medical, mental health, and dental screening before school entrance by a medical or dental personnel outside of the school. Some of the benefits of this policy concept may include increased access to health care for students that may result in better attendance and more engagement and learning; a possible cost savings measure for school districts by allowing the nursing staff to be redistributed as a result of completing the current health screenings by community providers; and establishing medical, dental, and mental health homes for students.

Our last policy recommendation is a 12-month continuous coverage policy. The American Rescue Plan Act of 2021 (H.R.1319 of the 117th Congress) (ARPA) has established a new state option that extends Medicaid and Children's Health Insurance Program (CHIP) health insurance program coverage for pregnant women for one year following a baby's birth. Under current law, Medicaid and CHIP, pregnant women's coverage only extends until 60 days postpartum. This went into effect April 1, 2022, and extends to March 31, 2027, when the current statutory authority for this extended postpartum coverage option would expire.

Our CMS strategies has indicated they will work with states to identify other options to maintain this extended postpartum coverage if the statutory authority to extend the coverage is not reauthorized. Extended postpartum coverage would offer Nevadans an opportunity to provide care that can reduce pregnancy-related deaths and severe maternal morbidity; it would also improve continuity of care for chronic conditions such as diabetes, hypertension, cardiac conditions, substance use disorder, and depression. The CMS has approved this new state plan option through ARPA for seven states currently, and they are

working with nine additional states to complete their state plan amendments. The State Official Letter outlines this authority. It should be noted, though, that funding would be needed for Nevada to apply for this opportunity.

We now stand ready for any questions you might have.

Chair Peters:

Are there any questions from the Committee on this presentation? I appreciate you coming with policy recommendations, and I look forward to continuing the conversations around the funding mechanism. We are not limited to policy bills in this Committee, but vetting fiscal requests are difficult to do under a policy lens. I think we could consider some of those, but we also need to digest and look at the fiscal implications and where those would come from. We have the capacity to look into those over the next month or so before we work session our BDR options.

Dr. Titus, did you have a question?

Assemblywoman Titus:

I have a follow-up comment. Both of us have sat on this Committee a number of times, and it is not against our purview to put through a policy and then see whether it gets a fiscal note.

Chair Peters:

That is correct. With Medicaid, some of these are extensions of programs that you were asked to implement without funding last cycle, it would be interesting to see if you are able to build those into budgets, or not, and where we need to look for the state match or what other funding mechanisms may look like. We look forward to continuing those conversations.

Are there any other questions on this particular presentation? I have others related to the work being done around evidence-based services and care and continuity of care, but I am going to take those offline with you all and see where we are at with some of those discussions. Thank you, we appreciate you being here and presenting on this topic area.

We are going to close this agenda item and go back to Agenda Item V.

AGENDA ITEM VII—RATES OF CANNABIS AND ILLICIT SUBSTANCE USE DURING PREGNANCY AND NEONATAL ABSTINENCE SYNDROME, AND THE IMPLICATIONS ON CHILD WELFARE

Chair Peters:

We are on Agenda Item VII, rates of cannabis and illicit substance use during pregnancy and neonatal abstinence syndrome and the implications on child welfare. We have representatives from the state and health care facilities here to talk about this particular issue. Please introduce yourself and begin when you are ready.

Alexia Benshoof, Health Bureau Chief, Office of Analytics, DHHS:

Today I am going to be presenting on prenatal substance and marijuana/cannabis use, neonatal abstinence syndrome, and child welfare impacts (Agenda Item VII A).

To begin, I would like to provide some background data on self-reported substance use in the general population. The National Survey on Drug Use and Health collects self-reported substance use from Americans age 12 and older. For a question asking respondents if they used any substances within the last 30 days, in 2020, 13.5 percent of national respondents reported using illegal drugs, 11.8 percent reported using marijuana, and 1.9 percent reported misusing prescription drugs.

In Nevada, the Behavioral Risk Factor Surveillance System (BRFSS) collects self-reported substance use for citizens aged 18 and older. It asks a similar question to find out if respondents have used any substances within the last 30 days to feel good or get high. In 2020 in Nevada, according to the BRFSS, 2.9 percent of respondents reported using illegal drugs, which is lower than similar national data; 19.4 percent of respondents reported using marijuana, which is higher than similar national data; and 0.8 percent reported misusing prescription drugs. Rates of self-reported marijuana use in the general population in Nevada, via the BRFSS, have increased since legalization in 2017.

Data related to self-reported substance use during pregnancy is available from the Nevada electronic birth registry system. Self-reported data from the birth record, may be under reported because of stigma and legal implications. For context, out of 33,139 births in 2021, 3 percent of mothers reported substance use.

Before we get into the data, there are a few definitions I would like you to be aware of. *Select substances* includes alcohol, heroin, marijuana/cannabis, methamphetamines, opioids excluding heroin, and polysubstance use. Whereas, *illicit substances* include cocaine, heroin, methamphetamines, opioids, polysubstance use, and other unknown illicit drug use. In this category, marijuana/cannabis is not included.

Some prenatal substance use data are broken down by geographical region. These regions match those of the Nevada Regional Behavioral Health Policy Boards, which are Washoe, northern, rural, southern, and Clark; specific counties are included in various regions. I want to point out the southern region does not include Clark County.

Overall rates of self-reported prenatal substance use remained relatively stable over the last ten years, except for marijuana/cannabis. From 2017 to 2021, self-reported prenatal marijuana use increased by 212 percent.

Now, in looking at illicit substance use by region, for most of the last ten years, Washoe County had the highest rate of self-reported illicit use. Most recently, in 2021, they had a rate of 12.0 per 1,000 live births, and in 2021, Clark County had the lowest rate of 6.7 per 1,000 live births. Just a reminder, illicit substance use does not include self-reported marijuana/cannabis use.

When looking at prenatal illicit substance use by race and ethnicity, we can see in most years that American Indian/Alaskan Native non-Hispanic; White non-Hispanic; and Black non-Hispanic people have the highest rates of self-reported illicit prenatal substance use.

Moving over to prenatal marijuana use, rates of self-reported prenatal marijuana use have grown statewide since legalization. In 2021, the regions of Washoe, southern, and northern had higher rates of self-reported use, and Clark County had the lowest rate of self-reported use, but growth is seen across all regions in Nevada. Additionally, prenatal self-reported marijuana use is increasing across all age groups, especially since legalization. Rates continue to be highest among Nevadans aged 15 to 24. Prenatal self-reported marijuana use is also increasing across all race/ethnicity groups since 2017, and most notably among

American Indian/Alaskan Native non-Hispanics and Black non-Hispanic Nevadans. In 2021, these groups have the highest rates of self-reported marijuana/cannabis use.

Prenatal substance use can result in neonatal abstinence syndrome (NAS). Neonatal abstinence syndrome is a group of issues that occur in newborns who were exposed to addictive, illegal, or prescription drugs while in the womb, and withdrawal or abstinence symptoms develop shortly after birth. The CDC reports the number of babies born with NAS is increasing nationally. Between 2010 and 2017, nationally, it increased by 82 percent. Increases were seen for nearly all states and demographic groups. Comparatively, in Nevada, the number of babies born with NAS increased by 152 percent in that same time range.

I would like to briefly touch on the methodology we use in Nevada for identifying infants with NAS. We look at inpatient hospital billing data. Infants must be Nevada residents who are hospitalized within one year of birth and associated with the International Classification of Diseases (ICD) 10 codes of P96.1 and P96.2, which relate to withdrawal symptoms in newborns. Our methodology is similar to that of the national data shared by the CDC previously.

As noted, neonatal abstinence syndrome has increased in Nevada since 2010 and peaked in 2016. From 2016 to 2021, inpatient admissions for NAS decreased by 42 percent before increasing again recently in 2021.

When looking at NAS by race and ethnicity, historically, we can see that White non-Hispanics have had higher rates of NAS compared to other ethnicities. Although, in 2021, American Indian/Alaska Native non-Hispanics had the highest rate at 10.9 per 1,000 live births and White non-Hispanics had the second highest rate at 10.6 per 1,000 live births.

Prenatal substance use and parental substance use, in general, do have an impact on child welfare. Substance use is a risk factor for child maltreatment as it can affect a parent's ability to function as a caregiver and provide for their child's basic needs. In Nevada, health care providers involved in the delivery or care of substance-exposed infants must notify child protective services (CPS) agencies so the need for intervention with the child and family can be assessed and a plan of care can be developed to ensure the safety and well-being of substance-exposed infants.

In Nevada, *substance-exposed infants* are defined as "children under age 12 months identified as being affected by substance abuse, who have withdrawal symptoms from prenatal exposure or whose mother is receiving treatment for substance use disorder." Practices related to substance exposed infants are guided by federal Comprehensive Addiction and Recovery Act of 2016 (CARA) (S.524 of the 114th Congress) regulations. It required states, through Child Abuse Prevention and Treatment Act (CAPTA) (S.1191 of the 93rd Congress) regulations, to focus on the effects of substances on infants, children, and families. A CARA Plan of Care is something that must be developed when an infant has been identified by a health care provider as being a substance-exposed infant. The purpose of this plan is to identify needs and services for the infant and family.

The number of substance exposed infants reported to CPS agencies in Nevada has increased from 2016 to 2021 by 80 percent. Although, the number of infants screened in for further CPS involvement, decreased from 2018 to 2021. This is likely due to changes in screening practices after CARA Plan of Care regulations were implemented in Nevada.

Most infants screened in for a CPS investigation were determined to be safe with their family of origin. This is an average of 72 percent of infants between 2016 and 2021. This means the CPS case can close and further child welfare agency involvement is not necessary. We did see some changes after CARA regulations were implemented in Nevada. We saw some changes in the proportion of infants determined to be unsafe out of all infants screened into CPS; this is likely due to those screening practice changes mentioned earlier.

For the substance-exposed infants found to be unsafe during a CPS investigation, most had an out-of-home safety plan put in place while child welfare services continued with the family. An out-of-home safety plan means the infant is put in foster care. Foster care can be provided by relatives, fictive kin, or by nonrelative providers. Of the unsafe infants with an out-of-home safety plan, the majority were placed in nonrelative foster care between 2016 and 2021. Although the proportion of infants placed with relatives or fictive kin over the years has been increasing.

This concludes my presentation. I thank you for the opportunity to present and I am happy to take any questions you may have.

Chair Peters:

Are there any questions from the Committee? Assemblywoman Gorelow, please go ahead.

Assemblywoman Gorelow:

Besides the NAS, do we have any other information on adverse birth outcomes, such as preterm birth?

Ms. Benshoof:

We certainly can take a look and see what else we can provide on this topic for you.

Chair Peters:

If you could provide that to staff, they can disseminate that throughout the Committee.

Are there any other questions on this presentation? We have a presentation from a provider coming up next who may be able to answer questions as well.

Assemblyman Hafen, please go ahead.

Assemblyman Hafen:

Thank you, Madam Chair, I might have a couple of questions if you will indulge me. Are we trying to do any education for upcoming mothers on the effects of marijuana use during pregnancy, mainly for preventative measures?

Ms. Benshoof:

Again, this is something we can consult with program staff and others in DHHS and get back to you.

Assemblyman Hafen:

In that regard, are there any warning labels on the marijuana products, similar to tobacco and alcohol, to warn people of the potential side effects of use during pregnancy?

Chair Peters:

I am asking our legal staff to look at what we put in the law for recreational marijuana use and what has to be included on those labels because we may have included that. Our provider may also be interested in answering these questions as they would be more face forward with patients potentially. If you want to hold onto those questions for our next presentation, they may be able to help you with those questions.

Assemblyman Hafen:

Absolutely. I want to thank you for the information and bringing this to our attention; it is startling to see that 200 percent increase in self-reported prenatal marijuana use.

Chair Peters:

Next, we have Dr. Nagar from Saint Rose Dominican to present as the provider under this topic. Please introduce yourself and proceed when you are ready.

[Subsequent to the meeting, Ms. Morgan provided a follow-up memorandum regarding pregnancy-associated deaths in Nevada, NAS adverse birth outcomes, and education initiatives available for parents.] (Agenda Item V A-2)

Deepa Nagar, M.D., M.B.A., F.A.A.P., Newborn Intensive Care Unit (NICU) Medical Director and Chair, Department of Pediatrics, Siena Campus, Dignity Health-Saint Rose Dominican:

I am thankful for having this opportunity to talk about something that is becoming a huge challenge in our community. I have been asked to talk about breastfeeding and cannabis use in the NICU (Agenda Item VII B). I would be happy to also talk about the NAS because that is a significant component of some of these challenges.

In addition to working for Saint Rose Dominican, I am also a corporate director for Pediatrix Medical Group, which provides services for the NICU care in every hospital in the state except for the University Medical Center of Southern Nevada (UMC). Within our own group, we recently started a neonatal collaborative group to look at how we can do a cohesive presentation of care across the state, and I am the chair for that committee.

Before presenting some of our data, I wanted to talk about the recommendations for the different committees out there and the different recommendations across the country. From a CDC point of view, use of marijuana in any form—edibles, oils, et cetera—while breastfeeding can allow harmful chemicals to pass from the mother to the infant through breast milk or secondhand smoke exposure. To limit the potential risk to the infant, breastfeeding mothers should be advised not to use marijuana or products containing cannabidiol (CBD) in any form. These chemicals have the potential to affect a variety of neurodevelopmental processes in the infant. Tetrahydrocannabinol (THC), which is the main component of marijuana, is stored in body fat. Unfortunately, breast milk has such a component of fat in it there is a significant attachment of THC to the breast milk and is slowly released over an unknown period of time through the breast milk to the baby. Cannabidiol contains contaminants potentially—like pesticides, heavy chemicals, heavy metals, bacteria, and fungus—and can be dangerous both to the mom and the infant. Data on the effects of marijuana and CBD exposure to the infant through breastfeeding are limited and, unfortunately, conflicting. It has been one of our major challenges. Marijuana use may also impair a mother's or caregiver’s judgment and ability to care for the infant.

The United States Food and Drug Administration (FDA) also has similar recommendations, but it really uses stronger words. The FDA "strongly advises" that during pregnancy and while breastfeeding, mothers should avoid using CBD, THC, or marijuana in any of these forms. The Office of the Surgeon General, U.S. Department of Health and Human Services, says marijuana use during pregnancy may affect the fetal brain—THC can enter the fetal brain through the mother's bloodstream during pregnancy; may increase the risk of a newborn with low birth weight; and may increase risk of premature birth and potential stillbirths. Breast milk can contain THC up to six days; that is recorded by the FDA, but other data says it can be present in breast milk up to six weeks. The newborn's brain development can be severely affected such as hyperactivity, poor cognitive function, and other long-term consequences. Again, due to the inconsistent literature, this is one of the challenges we are presented with the information. Other than the one approved prescription drug, CBD products have not been evaluated or approved by the FDA for use as drug products. The FDA states: they do not know if they are safe and effective to treat a particular disease; what, if any, dosage may be considered safe; how they could interact with other drugs or foods; or whether they can be dangerous and have side effects that can have safety concerns.

As a result of those statements from the CDC and FDA, ACOG has similar concerns. They recommend that OB/GYNs should counsel women against using marijuana while they are trying to get pregnant, during pregnancy, and while they are trying to breastfeed.

The AAP also has similar concerns about avoiding marijuana use and says no amount of marijuana has been proven safe to use during pregnancy or while breastfeeding. When we antidotally ask, a lot of moms said they are using it for morning sickness during pregnancy. This has never been studied or determined to be safe; it is not safer than tobacco use. When smoked, the carbon monoxide in the blood concentration of these women is five times higher than when tobacco is used. This provides less oxygen to the baby and may be one of the reasons for the smaller children and potentially preterm labor, but again, not clearly defined. From a brain development side of the concerns, we have problem-solving skills, memory, visual perception, behavior, attention, executive function, and impulse control especially as they are becoming teenagers. Another concern is the THC concentrations in marijuana have quadrupled since the 1980s when the studies were initially conducted. These concentrations may be much higher, but we just do not have the studies.

Other studies have also shown some very significant concerns. In the women of childbearing age, marijuana use ranges between 15 to 28 percent, this is self-reporting. Unfortunately, in the United Kingdom, a longitudinal development and infancy study was performed across the country and found that most pregnant women who used cocaine, ecstasy, methamphetamines, and other stimulants and illicit drugs usually stopped using by the second trimester. However, due to the potential lack of information and/or beliefs, 48 percent of previous marijuana users continued to use marijuana as well as alcohol, which is 64 percent, and tobacco, which is 46 percent, throughout the entire pregnancy. They have a very strong belief marijuana is less concerning than alcohol or even tobacco. Trying to change that belief has been a big challenge.

At the Siena Campus of the Saint Rose Dominican Hospital, we have looked at breastfeeding rates at the time of discharge. One of the concerns we have been working towards is trying to increase breastfeeding rates; however, we are noticing a significant drop. In 2020, maternal breastfeeding at the time of discharge was approximately 55 percent. In 2021, it was a little higher at 58 percent. However, of those who are not providing breast milk when we are able to stratify the different patients, we see approximately 23 percent of the babies who are not given breast milk is due to the mother's use of drugs during pregnancy and in the breast milk, which is significantly higher than the 14 percent we had in 2020. Of that,

60 percent have either just a marijuana exposure or a concomitant use of marijuana with the other substances, so the infant is exposed during the pregnancy with polysubstance use. I do not have the 2020 numbers for THC use; however, we know it is higher than the 60 percent in 2021.

As a provider, I was asked to talk about some cases. As we know, breast milk is one of the best nutrition for babies. However, in preemies and micropreemies, we know breast milk has some protective effects to the gastrointestinal (GI) tract and other organ systems. From the literature, we have decided to provide an exclusive breast milk diet to babies less than 34 weeks. This means the hospital—at their own expense—pays for donor breast milk, supplementation like Prolacta, and other calorie-increasing options, which are all breast milk related, so these babies—less than 34 weeks—are getting an exclusive breast milk diet until they are 34 weeks of gestation. We had several babies who were born around 33 and almost 34 weeks of gestation. We were struggling to decide if we should start the donor breast milk when we would have to switch over to formula in the next couple of days.

We had one baby who was 37 weeks and the mom had a history of marijuana use. She was adamant she wanted a breast milk diet for her child. When we presented her the information about the AAP and federal recommendations, she still felt the breast milk diet would be best for her baby. We made a compromise with her that she would pump and dump her breast milk for one week. Then, we would check her breast milk to make sure there was no THC, and once it was safe, we would provide that for her baby. Unfortunately, when the time came for her to be tested, she told us she had not changed her use. Her marijuana use was for hyperemesis gravidarum, which is basically an increased emesis during pregnancy. Even though she had the baby, and this condition was no longer a concern, she was not comfortable stopping her marijuana use. This created tension between the medical staff and family because she was so adamant about wanting breast milk. We were able to convince her that we needed to use formula in this infant and we proceeded to care for this infant, who went home healthy by approximately 35 weeks. However, she mentioned that once the baby went home, she was going to breastfeed again.

Another infant was a term infant who unfortunately, for other medical reasons, had perinatal stress and came out with no heart rate and no respiratory effort. We had to code this baby; chest compressions were done and epinephrine was given. We were able to save this baby's life. Subsequently, we placed the baby on hypothermia, which is a medically induced coma where we cool them down to 33 degrees to protect their brain and organs for approximately 72 hours to decrease the chemical releases in the brain. This baby had a wonderful outcome. The tests showed there was no effect from the initial perinatal stress and even though this baby was born essentially dead, we were able to have a wonderful outcome. However, when it came time to start food, this mom also had a history of habitual marijuana use and was adamant she wanted her breast milk given to the baby. Despite all of the education, including a neurology consultation and education on the potential neurological developmental effects from exposure from THC, cannabis, and other contaminants in marijuana, she was adamant about wanting breast milk to be used. She called me and my staff four-letter words. They told us this was legal and it should be used. We tried to explain that alcohol is legal, but it does not mean it is appropriate for a baby and the studies are concerning. She told us it was an organic product. Again, this mom agreed to use formula in the hospital, but said once the baby comes home she will be breastfeeding.

I mentioned earlier there are significant components in breast milk that protect a very premature baby and help with their development, but also for their GI tract, which can become very ill where parts or the whole GI tract can die. This can lead to a premature baby having multiple surgeries, a prolonged hospital stay, and some babies may not

survive. On the other hand, some of these babies end up going home on home total parenteral nutrition and need care for years because of a short-gut syndrome. We had a 24-week baby whose mom had a history of marijuana use. We showed her the significant impact of breast milk for these babies and how important her breast milk was. She decided not to provide breast milk because she could not stop using marijuana for her anxiety. The marijuana was not a prescribed medication; it was off the streets, and she felt it was more important than the numerous things that have been shown to benefit babies this premature.

This is the end of my presentation; I am happy to answer any questions.

Chair Peters:

Thank you for the presentation; those are intense examples. I have a couple of questions, but I am going to start with Dr. Titus. Please go ahead with your question.

Assemblywoman Titus:

Thank you for the lives you have saved and the continual engagement to help this very vulnerable population. My question revolves around formula and the donor breast milk programs. How accessible is that to your infants; what does your supply look like; how well does that serve you; and what other options are there throughout the state? The next question is, what does your supply of formula look like in southern Nevada right now? We are seeing continual articles where there are empty shelves of formula in stores, and I am wondering about your situation in Clark County.

Dr. Nagar:

It is an excellent question. I will start with the breast milk diet component. An exclusive breast milk diet definitely has an impact on the outcomes of these infants in multiple organs, but especially the neurodevelopmental and the GI tract, which is known to be a component of our immune system and has a broad connection between the gut and brain health. We strongly believe in the improvement of outcomes due to breast milk and because of that, for over a decade, Dignity Health has been providing—at our own cost—breast milk from a California breast milk bank. Then, for the extra calories we are providing Prolacta, which is ten times more costly than formula—again, at our own cost. Not every hospital in the state provides an exclusive breast milk diet because of the increased cost. We know the [inaudible] has the use of donor breast milk and they are going to be providing Prolacta soon. The valley systems do not have donor breast milk, but the Reno system does. All of that is provided by the hospital and their cost.

There are some challenges to donor breast milk from different state entities and limitations are there because of this higher use of marijuana and the risk of virus transmission. The testing process for breast milk is more impressive than blood products. We are very careful about the products we receive.

From a formula point of view, we are seeing challenges in the supply chain. We are able to make substitutions between the different formula companies and have the support of that. I was told today that Similac was approved to open their facility again, but there will probably be a two-week delay before that warehouse is producing more formula. We have tried to educate parents that the formulas from different stores are as good as name brands. We know parents are ordering supplies from Canada and other countries, which is a concern. Unfortunately, there are also some situations where they are sharing breast milk from strangers, which is risky because of the transmission of viruses, drugs, and potential dilution of the breast milk, which can cause seizures and other complications in babies. We

are recommending to parents not to share. We are trying to help support this lactation process without making the parents feel inadequate if they are not able to provide breast milk.

Assemblywoman Titus:

Is Dignity Health, Clark County, or the state doing any public service announcements regarding the formula concerns and the risks of sharing breast milk?

Dr. Nagar:

I have not seen anything from the state itself. I have been asked personally to talk with several of the news outlets about some of these concerns. It would be helpful if we had a cohesive message. One thing I want to emphasize is that because of these concerns and marijuana becoming so ubiquitous in its use across the country, more physicians are leaning towards the benefits of breast milk outweighing the potential risks that are not well-studied, and using breast milk in their units and with the babies. The formula concern is there and is becoming more of a concern in the hospitals, despite CDC, FDA, and ACOG all having statements like this. There are more units across the country and even in our own state, where physicians, because of a multitude of reasons, are saying if we do not have formula or if mom is focused on providing breast milk as long as she is educated on the risks, they are providing the breast milk.

Assemblywoman Titus:

I am certainly concerned. This issue with formula and breast milk is something that we should not take lightly and an issue we have seen statewide. I am thankful you are willing, and the news media has reached out to you for information, but I think this is something our state should get on board with sooner rather than later. It is a true crisis that is not being acknowledged.

Chair Peters:

Assemblyman Hafen, I would like to come back around to your question regarding labelling. I asked our legal counsel to look at the regulations regarding labelling and he has an update for you.

Mr. Robbins:

The labelling requirements are spelled out in NRS 678B.520. Currently, cannabis products do have to have a label that says, "Keep out of reach of children." In addition, a cannabis facility is required to convey to each purchaser of a cannabis product in the manner prescribed by the Cannabis Compliance Board that: cannabis should be kept out of reach of children; cannabis products can cause severe illness in children; allowing children to ingest cannabis or cannabis products or storing cannabis or cannabis products in a location accessible to children may result in an investigation by a child welfare agency; and also that pregnant women should consult with a physician before ingesting cannabis or cannabis products. This was changed last session with SB 168 (2021). Before SB 168, the cannabis facility was required to include a written notification of these things with each sale. Now, they have to convey this information to each purchaser in the manner prescribed by the Cannabis Compliance Board. I have not been able to locate any regulations proposed or adopted by the Cannabis Compliance Board to carry out the requirements. The regulations do not yet prescribe the manner in which this information must be provided by the cannabis sales facility. If you have additional questions, I recommend contacting the Cannabis Compliance Board.

Dr. Nagar:

May I add to that? When we anecdotally ask moms about cannabis use, a majority of them state they do not go to any of these dispensaries because they are too expensive; therefore, they have not been educated on it. We also did a quality improvement study where we asked moms if anybody had educated them during their pregnancy, including their OB/GYNs, regarding the risk of marijuana use. More than 75 percent of them said they had never been educated, asked, or even told about the challenges of cannabis use.

Chair Peters:

Assemblyman Hafen, did you have a follow-up?

Assemblyman Hafen:

I do. Thank you for that information; I wish we could find a way to get that information out better, as Dr. Titus stated. One of the things you mentioned in your presentation is marijuana should not be used when trying to get pregnant or breastfeeding and that was specifically towards women. Are there any consequences or recommendations on the male side of this?

Dr. Nagar:

Unfortunately, I would not be an expert on that information since I focus on the babies, but I am happy to research it and provide you information if I can.

Chair Peters:

I had a follow-up question regarding research. What studies are occurring around the use of marijuana during conception and pregnancy and the implications of marijuana in breast milk. I know it is difficult to conduct studies on pregnant people because you never want to put the potential child at risk. Are there studies being done?

Dr. Nagar:

Unfortunately, studies are limited because of the ethical implications, as you mentioned. We are looking at the infants in the NICUs. As I mentioned, Pediatrix covers a majority of the units in the state; we are also providers for over 30 percent of the private NICUs across the country, separate from the academic. We have a very robust database of over 30 million patient days and we have been following the increase in marijuana use and exposure to the infants. It is still being evaluated and we are hoping to present that as a study. I want to emphasize, by the time they come to us, those babies have already been exposed and we can only see the potential implications in the NICU and may not be able to do the developmental process because once the babies leave us, they may not be part of our system anymore. Those challenges are very concerning because there is limited focus on these kinds of studies right now.

Chair Peters:

Are there any other questions from the Committee? I have additional questions but I will ask them offline because we do have quite the agenda to get through. I am not seeing any other questions. Thank you, Dr. Nagar, we appreciate you being here today. We will close this agenda item.

AGENDA ITEM VIII—OVERVIEW OF PROGRAMS TO TREAT SUBSTANCE USE DURING AND AFTER PREGNANCY

Chair Peters:

We are going to move on to Agenda Item VIII. This is an overview of programs to treat substance use during and after pregnancy. Dr. Peterson with EMPOWERED is here to present; please introduce yourself and begin when you are ready.

Andria Peterson, PharmD, Executive Director, EMPOWERED, College of Medicine, Roseman University of Health Sciences:

Thank you for having me here today to present an update on the EMPOWERED program (Agenda Item VIII). I am grateful to be able to follow Dr. Nagar. I had the privilege of working with her for 12 years in the NICU and we were great colleagues. She is also the cofounder of the EMPOWERED program; I would like to acknowledge that as well.

For those of you that are not familiar with the Roseman University of Health Sciences, I want to provide some brief information. We were founded in 1999 in Henderson, Nevada. It is a nonprofit, private institution of higher learning that is focused on the health professions. We have a College of Medicine, College of Dental Medicine, College of Pharmacy, College of Nursing, and College of Graduate Studies. We have campuses in Henderson, the Summerland area of Las Vegas, and also South Jordan, Utah. We are regionally accredited by the Northwest Commission on Colleges and Universities. I am a product of Roseman; I attended pharmacy school there and graduated in 2008.

At Roseman, when we are in the classroom, we do something called active learning. I want to do something with you today that is active learning. I want you to look at these pictures and what do you think these moms and babies have in common? I want you to really look at the faces of these moms and these adorable babies. This one is focused more on the babies and here are some group pictures. As you look at these women, you are going to see women that might look like your sister, your friend, or a coworker. When you go to the grocery store today, you might see one of these faces. What they have in common is they are all program participants of the EMPOWERED program. The EMPOWERED program supports pregnant and postpartum women with substance use disorder. All of these women are in various stages of recovery. Some are still currently experiencing substance use disorder and navigating that. All these infants you have seen today were at risk for NAS when they were born. It is really important to put faces to the information we are talking about today when we talk about substance use disorder and pregnancy and NAS and what it looks like. It looks like these women and substance use disorder does not have a face.

I wanted to touch briefly on some Nevada trends, and we have had some great data today. This data came from the Overdose Data to Action Program, administered by DPBH, and is the suspected drug overdose-related emergency department (ED) visits from January 2018 to November 2021. I wanted to point this out because everybody is always curious about what COVID-19 did. We know COVID-19 impacted mental health and we know it impacted substance use disorder. The data is specific to Nevada and women of childbearing age, defined as ages 15 to 49. A lot of times people think women of childbearing age are women in their twenties, but it is 15 to 49. This is a large percentage of our population. In March 2020, there is a spike due to COVID-19 and it has remained elevated.

Moving on to another Nevada trend, the annual rate of suspected all drug-related overdose ED visits, again from January 2018 to November 2021, specific for women of that

childbearing age. There is a negative 4.6 percent change from 2018 to 2019. Then, from 2019 to 2020, it jumped 9.5 percent. Again, you can see the impact on the specific population with overdoses.

There was some data released by this team last week. If you have not read that report, I encourage you to look at it. They found there was a 20 percent increase in the rate of accidental drug overdose deaths among Nevadans from January 2020 to June 2021. Other interesting things they noted were: 65 percent involved an opioid; 58 percent involved a stimulant, such as methamphetamine; one in three involved an opioid and a stimulant, or what we will refer to as poly substance use, more than one substance; three in four overdoses occurred in the home; and one in three had a mental health diagnosis.

Everybody has done a great job today talking about this, but the problem is drug-induced deaths are the leading cause of death for reproductive age women in the United States. It is higher than motor vehicle accidents, gun violence, and homicide. We know this plays a huge role nationally, as well as locally in Nevada. Infants who are born to these mothers are going to be at risk for NAS or withdrawal symptoms seen in infants born to mothers who have used drugs during pregnancy. A large percentage of these births are funded by Medicaid; it was reported to be 82 percent. When we looked at the EMPOWERED program, we found 90 percent of our moms have Medicaid.

How do we identify someone with a substance use disorder? We saw the pictures of those moms. I do not think any of us would look at them in line at the grocery store and identify they have a substance use disorder. The process—screening, brief intervention, and referral to treatment (SBIRT)—is an evidence-based process that identifies individuals with a substance use disorder and those who are at risk for a substance use disorder. I want to take a minute to thank this Committee. I had the opportunity to work with the Committee to pass AB 442 (2021), which requires all providers in Nevada to obtain two hours of continuing education credit in SBIRT, one time. I am grateful and excited we can promote this evidence-based practice throughout all our providers in Nevada and make sure they are practicing it appropriately. Just to let you know, SBIRT is a billable process.

What do we do once we have identified someone with a substance use disorder? I want to talk specifically about the EMPOWERED program, which is a referral source specific to pregnant and postpartum women in southern Nevada. The program originated in Dignity Health and was there from June 2018 to July 2021. Essentially, we created a care coordination program that linked pregnant and postpartum women to services within the community because we found that services are available, but it is difficult and overwhelming for women to navigate these services. We helped provide linkage to care for prenatal care, medication-assisted treatment, housing, employment, and support services like baby basics, maternity items, baby parenting classes, et cetera.

We had a lot of success. We had 275 patient encounters during that time. I will not go through each of these statistics, but 42 percent received referrals for medication-assisted treatment and 44 percent for prenatal care. We assisted with transportation of 84 percent. We found when we assisted with transportation, we have high rates of recovering, women do well. Twenty-six percent needed assistance with housing.

We also learned a lot through that process and made some observations. With regards to overdose deaths, women of childbearing age continue to be at a very high risk of developing substance use disorder. Screening by all health care providers is imperative. I want to highlight that this is not just women or individuals of childbearing age—this should be everyone. Everyone who has seen a provider should be screened for substance use

disorder. We also noted that patients with substance use disorder need strong support networks. They need strong home visiting programs. They need wraparound services for the entire family to fully support mom and baby. I want to remind you, back to that data, three in four overdoses in Nevadans occurred in the home. The family unit in that home is very important.

Our solution was the EMPOWERED program at Roseman University of Health Sciences. We were able to work with Dignity Health to move the program to Roseman and we have been able to expand services. We can support moms during pregnancy and the postpartum period. We support them with peer recovery and advocacy and specific treatment and resource provisions designed around their need, which is patient-centered and person-centered, because none of us have the same needs. When we meet with them, we identify their most urgent need for their recovery. We help with community support, and then we facilitate a referral to Genesis, Roseman University of Health Sciences. Genesis is a household-centered home visitation program that is focused on the social determinants of health. It involves a team going into the household, serving the social determinants of health that are impacting recovery, and helping that family navigate those.

Our mission statement is we develop and unleash the power of expectant and recent mothers with opioid and stimulant use disorders to be active in managing their health and partnering in their care from recovery through stabilization to resilience. We want to promote that resilience piece. I am excited to share we have women who are getting jobs and we have somebody graduating high school this week. We are having such great outcomes because we do not want to just have them survive, we want them to be able to thrive. Again, this is accomplished through iterative assessments; personalized patient-centered care plans; counseling services, including individual and group therapy when needed; health education; the facilitation of those referrals; and care coordination.

Once we have enrollment, we do a comprehensive assessment. Many of our program participants do present in crisis; they may have just delivered or sometimes the Division of Child and Family Services (DCFS), DHHS, has separated them from the child and they are worried about that. We help support and stabilize them through the crisis and then develop their individualized patient-centered treatment plan. We manage those interventions, provide case management, and continue to follow them through the pregnancy and postpartum period.

Our goal is to leverage the capacity and strategic processes of Roseman to deliver enhanced services. Again, we are now able to offer individual therapy and household-centered home visitation program. We provide access to care, support, and advocacy for participants. We have educational counselling services with individual and group therapy. We manage the social determinants of health of program participants and their families, and we support them from the recovery through stabilization to resilience.

Here is an example of a patient who has been involved in our program. She has lived in Nevada for more than a year; she is separated from her child; and she has no identification (ID). To be able to engage in a lot of services, you must have a government-issued ID, and we have been helping her with that process. This week, we were able to provide her with transportation. We paid the fee for her ID. She was able to go to the Department of Motor Vehicles (DMV) with our peer and left the DMV with her government-issued ID. She called our care manager afterwards and said it was life-changing for her. It is so humbling to think everyone is in various stages of recovery; everybody has different things that are impacting them to be able to make a successful recovery. Sometimes it is as simple as an ID, that we were able to help provide.

I want to touch on some barriers to treating substance use disorder in Nevada. One being that collaborative care codes are not covered by Medicaid. The second is that behavioral health is not included as a chronic health condition addressed by community health workers. Earlier today there was a presentation on that, and it is wonderful that we are now able to have community health workers as a reimbursable program in Nevada, but behavioral health is not included. Peer support services are also not reimbursed in health care settings. I want to emphasize the importance of those community health workers and peer support in treating substance use disorder.

The last thing I want to point out is access to buprenorphine. For those of you who are not familiar with the medications available to treat opioid use disorder, there is methadone, which a lot of people are familiar with, and there is also buprenorphine, among others. Buprenorphine is a lifesaving medication that is used in medication-assisted treatment. Specifically, I want to point out that neonates who are exposed to buprenorphine in utero have significantly lower rates of NAS and shorter NICU stays compared to methadone. For the most part, infants who were admitted to our NICU who were exposed to buprenorphine in utero did not experience NAS; they did not experience withdrawal. Health and Human Services recognized the importance of this medication, and they recently expanded access to buprenorphine. They revised their practice guidelines to allow practitioners to treat up to 30 patients without having to obtain certain training-related certifications.

One of the barriers we are seeing is with *Nevada Administrative Code* 639.748, where it requires a current and valid form of identification issued by a federal, state, or local government agency that contains a photograph. Again, many of our program participants are lacking this government-issued ID and it takes time to get that ID. When somebody wants to engage in treatment and wants to make a change, it is important to support them in the moment and not have it bogged down by that ID. With them lacking an ID, oftentimes when they get a prescription for buprenorphine, they are not able to pick up their medication from a pharmacy. I wanted to bring awareness to this issue. Some of you may be familiar with the Clarity Card, which is a homeless ID. It is not recognized at this time as a government-issued ID. It is very easy to get that homeless identification, or Clarity Card, but very difficult to get a government-issued ID.

I will open it up for questions.

Chair Peters:

Are there questions from the Committee on this presentation? I am not seeing any questions from members.

I have a question about the stigmas that exist for birthing people who use drugs. How are they offered care and treatment? You discussed some of that, but can you talk about some of the efforts to reduce bias and stigma within the treated populations and the treatment system.

Dr. Peterson:

That is a great question. I am not familiar with specific efforts around stigma. I participate in a group at the state level called the Nevada Reproductive Health Network, and we have discussed this as something that is needed. I am more familiar with the SBIRT, which is going to be around screening. It is evidence-based and provides guidance around how to have those conversations.

Dr. Nagar:

The screening process for the SBIRT is universal, and that is one of the important things of not having biases with certain populations and only asking questions in those populations. The recommendation is to be universal in these questions and seeing what risks are present for the patients.

The second thing I want to emphasize is that after hearing these presentations, I hope you are seeing how support during pregnancy can impact the life of the mom and baby. Having a cohesive state plan that looks at the PQC is one of the key components to making sure the medical community and state are looking at the care in a continuum instead of having silos, realizing there are issues, but not having that continuity in place. We have absolutely seen an improvement in outcomes, as Dr. Peterson mentioned, about the decrease in opioid withdrawal in these infants with buprenorphine exposure. We have even seen it with moms getting treatment in the medical-assisted treatment facilities, they are no longer on poly substance use and therefore the baby is not exposed to multiple substances. Their process of withdrawal is significantly improved because moms have shown they are getting this care during pregnancy. We can now say the mom and baby are on a safe pathway instead of separating them. We can work on breastfeeding with them, which, again, improves not only the connection between the mom and baby, but we know these women are more likely to not fall off the wagon. They are more likely to continue being in sobriety. There are so many components that are essential if we can look at the continuum of care and work as a community from pregnancy to delivery and postpartum. The risk of overdose is highest after, I think, the first eight months, which is one of the reasons why having Medicaid coverage up to a year is critical.

Chair Peters:

Thank you. I appreciate your perspective and that point. I also want to take a moment to highlight the statistics around transportation and the increased success of treatment. When barriers are removed from accessing care, people are more likely to seek treatment and complete treatment. This is not only for behavioral health, but we also see it for physical health. Sometimes it is easier to dismiss or diminish the need for continuous mental and behavioral health care that those barriers are still so problematic. I appreciate the statistics and I look forward to talking more about what we can do as a state around public transportation to ensure that barrier is diminished for most people in our state. Are there any other questions?

Dr. Peterson:

I would say that is where the social determinants of health come in. It is essential to be able to identify the social determinants of health in those underserved and at-risk populations to identify their barriers to accessing care, because when you remove them, they do engage in care and treatment and have successful outcomes.

Chair Peters:

Thank you again for the presentation and for being here today. I do not see any other questions or comments from Committee. We are going to close this agenda item.

AGENDA ITEM IX—THE NEED FOR A NEVADA PERINATAL QUALITY COLLABORATIVE, A PROFESSIONAL NETWORK TO ENHANCE THE QUALITY OF CARE FOR MOTHERS AND BABIES, AND OTHER CONSIDERATIONS TO IMPROVE OBSTETRIC OUTCOMES

Chair Peters:

Our next agenda item is Agenda Item IX, the need for a Nevada PQC, a professional network to enhance the quality of care for mothers and babies, and other considerations to improve obstetric outcomes. As a mom to three kids, I would love to see more of the overlapping of care and services and making sure we are looking holistically at family health metrics and not isolated maternal and baby health metrics. I think we are moving towards that direction. I am looking forward to this update on where we are and what we can do to help. Please proceed and introduce yourself when you are ready.

Brian K. Iriye, M.D., President, Hera Women's Health, and Managing Physician, High Risk Pregnancy Center:

I would like to thank everybody for welcoming me back (Agenda Item IX). I was the former president of the Society for Maternal-Fetal Medicine (SMFM), which is the world's most recognized high-risk pregnancy organization. I am the current president of Hera Women's Health, which is the national integrated health care model of multiple specialties. I have led two national workshops put together by ACOG, SMFM, and the National Institute of Child Health and Human Development for quality measures and obstetrics and also implementation science. I have written over 25 research articles and currently serve as the primary investigator for the Prematurity Risk Assessment Combined With Clinical Interventions for Improving Neonatal outcoMEs (PRIME) Trial, which is the largest preterm birth study in the United States in the last two decades.

When I was here in January 2020, I presented on support for: a PQC; changing the poverty threshold for Medicaid coverage for pregnancy; providing one-year postpartum coverage, which we are still trying to get to; supporting different types of payments for behavioral health in offices; and supporting payment systems to screen for medication-assisted treatment. We were successful in some of these things but not on others, probably because after January 2020 we fell into the COVID-19 issues. I would like to bring forward a little bit of this data we talked about in the past and then why it is so important to move forward in the future as we are coming out of the COVID-19 pandemic.

In the United States, our maternal mortality ratio is one of the highest in the world—I think we are 57th or 58th now—and we are last in developed countries. The maternal mortality rate is the death of a pregnant woman within 48 days of the termination of pregnancy or six weeks postpartum. It is expressed over 100,000 people or 100,000 births. The United States had the highest rate at 17.4, other countries are much lower.

The issues are not just expressed overall, but many health conditions felt in a disparate fashion with Black populations having three times the maternal mortality rates in comparison to Hispanic populations and 2.9 times greater than that of Caucasian populations. The CDC thinks this is mainly due to variations in health care, preexisting underlying conditions that may be exacerbated from inability to gain access, and then also structural racism and implicit bias.

Within Nevada, we have seen an uptick in our maternal mortality rate. I think this is partially due to how they have been counted. With this rapid uptick, Nevada is shadowing what the rest of the country is doing right now. When you look at it, you actually see this

increase from 2016 to 2017. This is a different graph on pregnancy-related mortality rate, which is not six weeks postpartum but up to a year postpartum from any cause related to or aggravated by the pregnancy. We are stable from 2012 to 2016 but started seeing this dramatic uptick in 2017.

Again, the issues are highlighted further by the disparate nature of how this affects our populations. The Black non-Hispanic population's perinatal-related mortality rate is 63, Asian populations are 55.8, and White non-Hispanic is 18.4. In the states that take their data and show it by race, our Black non-Hispanic perinatal-related mortality rate is the highest in the country right now.

Although I have been focusing on maternal mortality rate, I think the unknown story is the severe maternal morbidity rate and not only the medical health, but the cost. Severe maternal morbidity is thought to be 60 times greater than that of mortality and there is dramatically increased costs from that. The care of a birth that has severe maternal mortality is about 40 percent more than the cost of the birth without severe maternal mortality.

Where do we go from this? One of the clear answers here is a PQC. The CDC thinks—and I think the data from maternal mortality review committees shows this as well—up to about 60 percent of all maternal deaths are preventable and would probably lead to as high as a 60-fold decrease as well in the maternal morbidity rates. We really need a collaborative to increase our quality, improve outcomes, and decrease cost. We cannot have multiple people reinventing the same wheel over and over again. We need a coordinated statewide team to be able to improve the quality of care for these pregnancies, use data-driven, research-funded processes to improve our care, and utilize these methods to make change. We are one of only six states in the whole country without a PQC beyond the development stage. The other 44 states already have a collaborative, and we are one of only two states in the country that does not even have a developmental stage PQC—us and Idaho at the present time. We are at a point right now, where waiting for a grant is probably not a tenable solution. We did that with the maternal mortality review committees and were not able to move forward until we received a grant. This put us behind and hurt our process for women in the state and we are trying to dig out of that right now.

Perinatal quality collaboratives really work. One of the initial examples of success for a PQC was the California collaborative. If you look at when the PQC for California went into place—I believe around 2007—you can see the dramatic decrease of the maternal mortality rate in California compared to the increasing maternal mortality rate in the country.

California did not just decrease the maternal mortality though, they decreased their maternal morbidity by 21 percent and decreased elective deliveries, which lead to increased NICU problems, by 55 percent. The Illinois PQC decreased the time to treatment for severe hypertension, which is recommended in the United States anywhere from between 30 and 60 minutes, that also decreases maternal death. They showed in their study it decreased severe maternal morbidity and has a major cost savings.

This is the best time to move forward with a PQC because the hospitals are now going to be watched more. The CMS has adopted two maternal morbidity structural measures that need to be reported: (1) does your hospital participate in statewide or national PQC; and (2) has your hospital implemented safety practices or bundles related to certain conditions during pregnancy? We are late to the game now with our formation because we are one of only two states that does not have one, and one of six overall. It is going to be a question asked by CMS and I think this is going to further drive hospital participation.

When I came here in 2020, we were 1 of only 14 states without a PQC; now, as I said, we are 1 of only 2 states and 1 of only 6 states either without one or in the process of forming one. We are really in that "do not have one at all" game right now.

What does it take to form a PQC? You need a director, website with video capability, data capability, meeting capability, travel, training, education, and marketing. How do you do this? You need some initial government funding, maybe grants, or user fees.

How much money do you need? The CDC recommends these different levels:

- Limited funding—$10,000 to $100,000;
- Moderate funding—$100,000 to $500,000; or
- Substantial funding—greater than $500,000.

These are numbers from 2016. I believe Nevada would need probably $250,000 to $300,000 per year for two years and then possibly run it based on user fees. If we did a smaller collaborative—about $100,000 or $200,000 a year—we could probably get by, but we would not get ourselves up to speed like the rest of the country. Also, you can later incentivize PQC work by linking pay for deliveries to hospitals, giving a plus 2 percent fee for delivery for participating in a collaborative. You could possibly disincentivize nonparticipating hospitals by decreasing pay by about 5 percent. You could require modules of participation for physicians. Physicians and all providers participate in this; they could get disincentives or minus payments when they do not participate in the collaborative. Or you could fund this later by fees to overall hospitals that are not related to payment systems.

I think this needs to be done and needs to be done now. As I said, 60 percent of the maternal mortality and morbidity cases are preventable. We have a dramatically high health care inequities issue, the highest in the country right now for our Black populations. Putting something like this into place saves money as well. If you decrease early deliveries, you decrease subsequent NICU care, and you also decrease the cost of severe maternal morbidity cases. We need to concentrate our efforts on improving care to prevent these catastrophes and reduce costs of neonatal care. I want to emphasize that spending on pregnancy care is probably the most preventative care you can do because you are taking care of two patients at once and you are altering the trajectory for a baby throughout its lifetime spectrum. Pregnancy is really the ultimate value-based care.

This ends where I want to go with the collaborative and hopefully that convinces you. We have some other issues I want you to look at. If you see the spending in pregnancy, maybe I will be able to put it together for you in a way that is more understandable.

Within the United States, about 42.6 percent of births are covered by Medicaid. Pregnancy itself is not in the 20 most expensive costs in the United States. Care of a newborn is the third most expensive condition treated in the United States. We need to spend on pregnancy to decrease the costs and care of a newborn.

Next, people think physician fees are problematic. Physician fees have only increased over the last 15 to 20 years maximally by cost-of-living adjustment (COLA) increases and many times not even by COLA increases alone. Almost all of the increases in costs now to the system are dominated by hospital increases in costs, almost doubling in hospital increases in costs overall.

Regarding U.S. spending on obstetrical health, if you look at it by the billions, hospital fees are about $52 billion a year. Obstetrician provider fees are about $18 billion per year. The

NICU fees, which only treat about 10 percent of the patients being treated or 10 percent of pregnancies, is also $18 billion. It is equal to the entire amount of obstetrician provider fees overall. Obstetric anesthesia, which takes care of a pregnancy for several hours during delivery, is $7 billion in comparison to the nine months and the delivery spent with obstetrical fees.

This is a big problem in Nevada. If you look at this study from last year, Las Vegas had the highest OB/GYN shortage in the whole country. This leads to people running to different hospitals and not being able to spend as much time on the care of patients as they need to because they are busy and understaffed. They cannot have the ability to deliver as high of quality care that we want them to. We need increases in payments to providers to decrease this undersupply; global payment increases are needed urgently. At the same time, physicians should be responsible for payments. If we are going to increase payments, we should make value-based payments based upon true quality care. We should encourage our payers to develop systems to decrease NICU stays. We should disincentivize providers that do not follow care standards by giving disincentive payments to them to offset their global payments. I do not like solely recommending changes in payment on outcomes. Doing that is penny-wise and pound-foolish in those instances. You will then get providers who will cherry pick patients who have less problems, which will probably exacerbate disparities, maternal morbidity, and mortality. One interesting payment system is being done in North Carolina. They are increasing payments for patient-centered pregnancy homes. This is the model we are starting to put together for Hera Women's Health throughout the United States to develop more collaborative-based care.

As Dr. Nagar and Dr. Peterson stated, we would like to ask for Medicaid coverage threshold payments and postpartum payments during pregnancy. In the last session, we increased from 138 percent of the poverty level to 165 percent, but the United States payment for Medicaid for pregnancy is 200 to 205 percent of the poverty level. Although we improved, these are the areas that hurt the people with disparities the most. Since we do have the highest level of Black non-Hispanic perinatal mortality rates, spending money in this area is well worth the cost and may even save money down the road.

As we also stated, I would fight for expanding the Medicaid coverage to one year postpartum. This has been recommended by ACOG and SMFM and allows for increased chances for follow-up. As much as 40 to 50 percent of people, because of the increased problems with transportation and stresses of a new baby, do not make their postpartum follow-up or if they do not do it in time, they have a disruption in their health care coverage. This affects our marginalized populations the most and hurts the treatment of postpartum depression, getting contraception space deliveries a little bit better, or opioid use disorders. As was discussed earlier, about 15 percent of all pregnancy-associated perinatal mortality is due to overdose and peaks around the seven- and nine-month period after delivery. These people lose their opioid use disorder treatment and have overdoses.

Treatment of these people for postpartum gives a two-generation advantage. Fifty-five percent of all children living below the poverty level have a mother with some sort of depression. Having treatment for them afterwards, for up to a year, would help alleviate problems with depression that hurts the mother-child bond, which has implications on early brain development. One in five women has depressive symptoms, regardless of income. Treatment also gives smoking cessation after pregnancy and time to put that into place, which would decrease the risk of sudden infant death syndrome (SIDS). If you could stop people from smoking, it would stop the next pregnancy from having problems with preterm birth and low birth weight. Also, one year of postpartum contraception gives time to ensure the child is doing well. It improves birth spacing. This is important because 50 percent of all

births in the United States are unplanned, and 80 percent of them are in people with substance use disorders.

Dr. Peterson talked about collaborative care models where you take services and place them into a regular medical care office. For example, you might have mental health treatment in a primary care office. Patients with publicly funded insurance have increased challenges. We just talked about that with transportation; patients may have decreased cellphone services. You want to have things in one area—a one-stop shopping for medical and mental health. This also decreases the stigmas of treatment for mental health and opioid use disorders.

Currently, 1 in 11 people below the poverty level have severe depression and only 30 percent of them seek help. If they are going to a medical visit, this allows an opening of that door for treatment for these people overall. Again, this is a money saver. The treatment of each mother with a perinatal mood disorder in the United States, from a recent article of health affairs, shows savings of about $32,000 over five years for the treatment of the mother and the child.

Regarding opioid use disorder, people get problems of overdoses after delivery. We need to have behavioral health for during and after delivery. The High Risk Pregnancy Center runs the Maternal Opioid Treatment Health Education Recovery (MOTHER) Project. We treat with buprenorphine and have only had a 5 percent NAS rate, where the national rate is 55 to 60 percent. We follow a behavioral health model, which is a collaborative care model, but we cannot bill for these services. We have been lucky enough to receive grants, but grants are only a temporary steppingstone. We need to be able to pay our care managers and recovery support counselors. Collaborative care models really integrate these services overall. They decrease the stigma, build on existing provider relationships, and decrease the social determinants of health by creating one-stop visits. We really need to have collaborative care paid for by Medicaid.

We have a very deregionalized system of care within Nevada. In Clark County, eight of our nine hospitals that do deliveries, have Level 3 NICUs or above. This is too many. When you have too many higher level of care hospitals, you decrease the experience of each hospital, especially when we have a health care worker shortage. It has been shown in the Vermont Oxford database, if you do less than 50 very low birth weight deliveries per year, there is an 11 percent increase in neonatal death. Another article showed as many as 1 in 30 babies delivered in a low-volume NICU dies unnecessarily from not having the higher levels of care from experienced people. Another research article showed a risk adjusted odds of adverse outcomes, such as severe breathing problems, bleeding into the brain, or blindness was 16 to 55 percent higher among infants at hospitals with lower than 50 very low birth weight deliveries per year. In the Reno area, we have a third hospital that just opened. The two other hospitals have Level 3 NICUs that do deliveries and the plan of the third hospital is also to have a Level 3 NICU. It would make 11 hospitals in the state with Level 3 NICUs, and there were only 436 very low birth weights in all of Nevada in 2020. This means a majority of them are doing less than 50 deliveries a year, which probably leads to worsening outcomes.

How do you solve this? Do you look at a volume indicator? Do you look at the very low birth weight mortality? It is hard to say. Hospitals in the highest 20 percent of mortality usually tend to stay there, and the hospitals in the lowest 20 percent usually tend to stay there. You might want to make judgments based upon that.

When you have this deregionalization, and we also have an obstetric and maternal fetal medicine provider shortage, then you spread these providers over different areas, which exacerbates the problems of maternal care overall.

My final ask is for funding for PQC urgently. We got sidetracked last time because of the COVID-19 outbreak. I urge you to help us move forward to help our patients within Nevada. We need changes in global pregnancy funding to help reverse our shortage of providers in Nevada. I ask for the Medicaid coverage threshold to be increased more towards the national average of 200 percent, which would assist our mothers with social determinants of health and other disparities. I ask for the expansion of Medicaid coverage to one year to help with birth spacing and help with the treatment of mental health and opioid use disorders. I ask for the implementation of policies for behavioral health services, OB/GYN offices, and maternal-fetal medicine offices. I ask you to mandate state Medicaid to pay for collaborative care services. Then, we have to look at this explosion of Level 3 and Level 4 NICUs in our state that have deregionalized care, helps to produce worsening outcomes, deludes healthcare experience at each center, and exacerbates position shortages.

Chair Peters:

Thank you, that was a lot of information and I appreciate the summary at the end with the requests. Are there any questions from the Committee? Dr. Titus, I will start with you.

Assemblywoman Titus:

Thank you for the presentation. It was unexpected information you presented regarding the excess facilities diluting care and possibly worsening outcomes. I have a question about that, but first I would like clarification on one of your statements. You said 50 percent of pregnancies were unplanned and 80 percent of those had substance abuse involved. Did I hear that correctly?

Dr. Iriye:

I stated that incorrectly. It is 50 percent of pregnancies in the United States are unplanned; in mothers who have an opioid use disorder, 80 percent of them are unplanned.

Assemblywoman Titus:

Thank you for that clarification. I want to go back to your closing statement regarding the number of facilities in Nevada. In the health care realm, we have something called the Certificate of Need when you are applying for licensure to prevent excessive applications. This would apply to CT scans, MRIs, care flights, et cetera, and even hospitals. I thought there was some limitation on who could get licensure based on this Certificate of Need. Can any hospital put in a NICU? How has this expanded? Is there no regulation on the numbers of the NICUs that we have?

Dr. Iriye:

Generally, a hospital would need a certain volume of deliveries to be able to apply for a NICU increase in level of care. But all you have to do is show that you have certain equipment and certain personnel to be able to open a NICU at a certain point in time. There is a lot of burden to do that, so I do not want to underestimate that. Overall, the Certificate of Need from a community standard is not the case, it does not hold and does not move forward. As you can tell from the very low birth weight babies alone, you can show the need is not there. I would say it is because of a profit incentive for the care of neonates. If you look at hospital-based systems, the most profitable areas in hospital systems usually are the cardiac catheterization lab, the orthopedics operating room, and the second or third is always the NICU. There is a financial incentive to open a NICU, but at the same time this is creating other sorts of problems along the way. I see Dr. Nagar wants to comment here because she got back on her camera.

Dr. Nagar:

I cannot agree more with Dr. Iriye about the importance of quality of care instead of quantity of care. Similar challenges happen when the Level 3 NICUs are in place because for Level 3 NICUs, the physicians stay in-house. The shortage also continues to be a challenge for the neonatal world to provide that in-house coverage 24/7. Then, we have this dilution of care because of the limited services not only in the hospital, but also subspecialty coverage across the board. Anywhere from GI surgery, neurosurgery, and neurology—every one of them are having to go to multiple hospitals and it does dilute care.

Assemblywoman Titus:

To be clear, these NICUs can only get licensed if they can staff those facilities, which means they would either have to bring doctors in or share doctors. Why would we want to limit accessibility to health care when we know across the board that we do not have enough doctors in Nevada?

My second question is, are these NICUs Medicaid reimbursed already or are they private facilities? Do you have a breakdown on that?

Dr. Iriye:

Some institutions only accept certain forms of Medicaid, but all of them accept one form or another of Medicaid and they accept all of the Medicaid HMO plans.

In regard to staffing, the staffing numbers just say you need a certain number of personnel. It does not tell you how experienced that personnel is, or how they keep their experience by dealing with more severe cases all the time. It does not tell you the nursing experience or quality. It just tells you the numbers. You can get by that by hiring and training personnel for those positions, but it does not mean you have already trained, experienced, high-level care at each institution.

Chair Peters:

Are there any other questions from the Committee? Assemblywoman Gorelow, please go ahead.

Assemblywoman Gorelow:

Some people might not realize that we already have some maternal-child health coalitions and advisory committees in the state. Could you talk about how this would be different from what they are already working on?

Dr. Iyrie:

Are you talking about the perinatal quality collaborative?

Assemblywoman Gorelow:

Yes. The difference on how the PQC would be from the Advisory Board on Maternal and Child Health, DPBH, DHHS, or any of the three coalitions already in place.

Dr. Iryie:

They would really be the organization that puts together and solidifies the marketing, education, the data-driven response, and the implementation from a research perspective.

As I have shown, a PQC has decreased morbidity and mortality when set up in this fashion, and you need a centralized structure to be able to do that. Those structures are usually assisted by an organization called the National Institute for Children's Health Quality (NICHQ) or the National Network of Perinatal Quality Care Collaboratives (NNPQC) in the United States. They are federally funded organizations that have put these programs together to make sure they run at a high level and they utilize educational and research perspectives that are best practices.

Chair Peters:

Does anyone else have questions for Dr. Iryie? I am not seeing any. Thank you for the presentation; we appreciate it and your time. We will close this agenda item.

AGENDA ITEM X—PRESENTATION ON FOOD SECURITY FOR CHILDREN IN NEVADA

Chair Peters:

Agenda Item X is a presentation on food security for children in Nevada. We have Sarah Rogers with the Office of Food Security with us to present. Please introduce yourself and go ahead when you are ready.

Sarah Rogers, Nutrition Unit Deputy Chief, Office of Food Security, DPBH, DHHS:

I am here to talk about food security for children in Nevada (Agenda Item X). *Food security* means "the ability of a person to access enough food for an active and healthy lifestyle." The Office of Food Security's mission is to effectively improve the quality of life and health of Nevadans by increasing food security throughout the state. The guiding principles of the Office of Food Security include:

- Incorporate economic development opportunities into food security solutions;
- Use a comprehensive, coordinated approach to ending hunger and promoting health and nutrition, rather than just providing emergency short-term assistance;
- Focus on strategic partnerships among all levels of government, communities, nonprofit organizations, including foundations, private industries, universities, and research institutions;
- Use available resources in a more effective and efficient way; and
- Implement research-based strategies to achieve measurable results.

The target population for the Office is food-insecure Nevadans with an emphasis on children and older Nevadans. In addition, the Office of Food Security staffs the Governor's Council on Food Security (GCFS), DHHS, and supports the implementation of its guiding plan, *Food Security in Nevada: Nevada's Plan for Action*.

I am going to briefly touch on the GCFS. The Council is hoping to provide a more in-depth presentation to this Committee at a later date and would love to discuss all of its work that it has been doing as a council and some of their COVID-19 lessons. Our GCFS was established by Executive Order in 2014. It meets four times per year, and its 21 cross-sector members are tasked with identifying priorities in food security and implementing the *Food Security in Nevada: Nevada's Plan for Action*.

Food insecurity rates have decreased from the high in 2013, which was 16.2 percent, to 12.9 percent in 2018. This was coming off of the Great Recession. There was a low food insecurity rate in 2016 at 12.1 percent, which is the only time Nevada had a food insecurity rate lower than the national average in this time.

From 2019 to 2020, food insecurity rates in households with children increased across all three measures. The measures being: (1) food insecurity in households with children; (2) food insecurity among children; and (3) very low food security among children.

Overall, households with children had a substantially higher rate of food insecurity at 14.8 percent than those without children, which is 8.8 percent. Among households with children, married couple families had the lowest rate of food insecurity at 9.5 percent. This is from 2020.

According to data from Feeding America, in all 50 states and Washington, D.C., the estimated rate of child food insecurity is higher than the rate of overall food insecurity. Child food insecurity rates range from 10 percent in North Dakota to 25 percent in Louisiana, with the national average being 17 percent. Nevada is at 19.5 percent for food-insecure children.

In April 2020, overall, there was an increase in Supplemental Nutrition Assistance Program (SNAP) applications across all ages and demographics in Nevada counties between February and May 2020. As of April 2020, there were 201,985 children ranging from ages 0 to 18 on SNAP benefits and that number has decreased. As of April 2022, 185,432 children are currently enrolled in SNAP from ages 0 to 18. The majority of those children are in the age range between 6 and 12, at 73,099.

The Pandemic Electronic Benefit Transfer (P-EBT) was developed as a response to the pandemic and is for children ages 4 to 22, in grades pre-K through 12. In School Year (SY) 2021–2022, more than $96 million in P-EBT benefits were issued to approximately 330,000 Nevada children, which is less than SY 2020–2021 where approximately $340 million in P-EBT benefits were issued to approximately 396,000 Nevada children. Summer P-EBT was also issued; $151.7 million P-EBT benefits have been issued to approximately 396,000 children since 2020. Summer P-EBT is approximately $375 per eligible child.

Between March and April 2020, the Women, Infants, and Children (WIC) program had the greatest increase among pregnant women and children participants. During the height of the pandemic, WIC saw an increase in participation, but an overall decrease in actual food redemption. September 2021 is when participation fell below prepandemic levels. There are various barriers for WIC participation that we attribute to this decrease. Improvements were made in SNAP shopping, such as online shopping capabilities, but no improvements were made in WIC shopping. The WIC clinics started opening back up, requiring them to come back in person for appointments. The WIC program requires more follow-up to maintain benefits. Also, WIC benefits are not monetary, they are prescription-style benefits. Participants get a specific benefit package and do not get to choose what is purchased with benefits. Less than half of the women and children who are eligible to participate in WIC actually participate. All of the children in the 0 to 5 age range who are participating in SNAP are objectively eligible to participate in WIC, and that was around 60,000 children ages 0 to 5 participating in SNAP. As of April 2022, 40,489 children ages 0 to 5 are participating in WIC. There is a disparity there.

In Nevada, 388,420 people are struggling with hunger, of which 134,350 are children. One in eight Nevadans are food insecure and one in five Nevada children are food insecure. The COVID-19 pandemic has led to an unprecedented increase in food security and need for

nutrition services statewide and nationally. According to Feeding America, Nevada is projected to rank eighth nationally regarding rates of projected food insecurity in 2020 versus 2018. Six Nevada counties experienced more than a 30 percent increase in food insecurity from 2018 to 2020. The counties being Douglas, Elko, Lyon, Storey, Washoe, and Clark. Clark County experienced the largest increase of food insecurity, from 12.8 percent to 20.1 percent in 2020.

There is a large, broad base of literature illustrating links between food insecurity and poor child health and behavioral outcomes at every age. Some implications of child food insecurity are birth complications or low birth weights; low birth weights among infants are more common in counties with higher food insecurity rates. Other implications include poor maternal outcomes and iron deficiencies, and there are also developmental implications such as stunted growth, anemia, asthma, oral health problems, mental health disorders, and lower cognitive level. Some other overall negative health outcomes include lower quality diets or nutrition insecurity, higher health care costs, and higher obesity rates. Overall, food security is just linked to poor quality of life, which may prevent children from fully engaging in day-to-day activities.

Amid the COVID-19 pandemic, statewide food security partners faced unprecedented new challenges as the pandemic implications reversed Nevada's improvements in addressing food insecurity. The economic shutdown led to a staggering increase in unemployment, resulting in an increased need for nutrition services. There were also widespread physical school closings, which meant millions of children lost their access to subsidized school meals. These meals often play a key role in helping families meet their children's basic food and nutrition needs.

We learned that the COVID-19 pandemic had a disproportionate impact on racial and ethnic minorities, senior citizens, households with children, and people with chronic diseases. Programs had to pivot very quickly and be enhanced to adjust to increased needs and social distancing guidelines resulting in innovative programs and collaborations, such as drive-through distributions and home delivery programs through the Regional Transportation Commission (RTC) of Southern Nevada, among other delivery programs. Overall, there was an increase in program utilization between March and May 2020, such as food bank donation distributions, SNAP, and State Department of Agriculture programming. Waivers for SNAP and WIC were required to continue to serve in-need participants throughout the pandemic. There are identified technology advancements that WIC needs to continue to work on to serve its population. The supply chain issues increased the need to expand the food options for WIC, and we need to establish better connections with Nevada’s Department of Transportation to better collaborate on food security needs for the state.

We are currently in the process of conducting our food security strategic plan. So far, we have conducted more than 1,000 community member surveys and 67 food security provider surveys. Right now, we are in the process of conducting focus groups with state community partners and community members. The strategic plan will advise the Office of Food Security on policy recommendations for state food security efforts. We have our first strategic planning meeting, which will be held in person, in Carson City on May 24, 2022, and is open to all food security stakeholders. The chronic disease section, in partnership with the Office of Food Security, has applied for and received the State Partnerships Improving Nutrition and Equity grant through the National Association of Chronic Disease Directors. This will help us to work more on nutrition and equity across the system.

I am available to answer any questions.

Chair Peters:

Are there any questions from the Committee on this presentation? I am not seeing any questions from members, but I have a question. Can you talk about the biggest differences between the WIC and SNAP programs?

Ms. Rogers:

I am more well-versed in WIC since it is part of our nutrition unit. The WIC program is open to pregnant parents, postpartum parents, breastfeeding parents up to a year or six months postpartum if they are not breastfeeding, and children 0 to 5 years old or up to their fifth birthday. The income eligibility for WIC is a little higher than SNAP, and the requirements to maintain benefits on WIC requires a little more. It requires at least quarterly nutrition education; they do individual targeted nutrition education. It provides breastfeeding support, such as breast pumps to moms in need. It is a prescription-style food package. On average, I believe, the actual cost of a WIC food package comes out to about $35 per individual. It is a lot higher if we are providing formula in the package. The SNAP program is monetary benefits. A person has more options and ability to purchase a wider variety of foods, where WIC foods are mainly eggs, low-fat dairy products, some cheeses, yogurts, hot cereal, and cold cereal.

Chair Peters:

You mentioned there was a disparity with who accesses WIC versus who accesses SNAP. Could we see what the difference is and what those disparities look like? How do people apply for WIC versus SNAP? Are they through the same application process or are they separate programs?

Ms. Rogers:

They are separate programs. We do get WIC referrals through DWSS. If someone is going to apply for SNAP and DWSS identifies that, she could also qualify for WIC. We have a relationship with SNAP where we get those referrals, but the participant would have to call her closest, local WIC agency and apply separately. It is a certification appointment; they are required to have their height and weight taken, depending on the type of participant. If the participants are a pregnant woman or a child, we require iron to be taken—that can be a little poke on the finger or a referral to a clinic to get their iron levels checked. Height and weight needs to be checked at least once a year or twice, depending on whether they are a higher risk. They are assigned nutrition risk codes to identify if they are a lower nutrition risk or a higher nutrition risk. Participants are required to go through individual counseling and get some anthropometrics taken to get fully certified on the program.

Chair Peters:

Thank you, Ms. Rogers for the presentation; we appreciate your work. We will close this agenda item and move on to the next presentation.

AGENDA ITEM XI—OVERVIEW OF CHILDHOOD OBESITY IN NEVADA

Chair Peters:

Our next agenda item is an overview of childhood obesity in Nevada. Ms. Rogers will also be presenting on this agenda item, please go ahead.

Sarah Rogers, Nutrition Unit Deputy Chief, Office of Food Security, DPBH, DHHS:

I will present a little bit on childhood obesity in Nevada (Agenda Item XI A-1). The Chronic Disease Prevention and Health Promotion, DPBH, DHHS, program's mission is to improve health outcomes and quality of life by promoting health and wellness to prevent chronic disease and reduce the burden of disease for those already living with chronic conditions.

In 2017, the Nevada Legislature defined the term *obesity* as a "chronic disease characterized by an abnormal and unhealthy accumulation of body fat which is statistically correlated with premature mortality, hypertension, heart disease, diabetes, cancer and other health conditions" within NRS 439.517. The clinical diagnosis of childhood obesity is falling at or above the 95th percentile, which is based off a calculation of the individual's height and weight.

From 2017 to 2018, 19.3 percent of children were considered obese. Obesity rates for children and adults has been at a steady increase. Childhood obesity rates are lower than those of adults, but they follow similar trends.

Obesity is the most prevalent chronic disease in Nevada at 28.7 percent. However, it is lower than the national average, which is 31.9 percent.

The percentage of youth whose body mass index (BMI) qualifies them as obese continues to increase over the long term. In 2019, youth obesity increased from 11.4 percent in 2013 to 12.3 percent in 2019, compared to the percentage of the national youth obesity in 2019, which was 15.5 percent. Nevada youth obesity trends show a significant gender disparity. The percent difference of obese male students is significantly higher than females, with 7.5 percent of females to 15.3 percent of males classified as obese in 2013 and 9.3 percent of females to 15 percent of males classified as obese in 2019.

According to the Nevada Kindergarten Health Survey, over the years, the percentage of kindergartners whose BMI qualifies them as obese has decreased from 21.4 percent in 2015 to 18.7 percent in 2020. The percentage of children classified as overweight has increased over time from 10.6 percent in 2015 to 13.2 percent in percent 2020.

Nevada childhood obesity trends among children aged 2 to 4 years who are enrolled in the WIC program showed a statistically significant decline in 2018 to 11.7 percent, down from 13.8 percent in 2008. Nevada childhood obesity trends by sex among WIC participants show statistically significant disparities. Again, the percentage difference of obese WIC participant boys 2 to 4 years old is higher than the percentage of obese girls, from 12.9 percent of girls to 14.6 percent of boys classified as obese in 2008 and 10.8 percent of girls to 12.6 percent of boys classified as obese in 2018.

In 2018, the highest percentage of unhealthy weight status was among American Indian/Alaskan Native children; 18.1 percent were overweight, 15.2 percent has a high weight for length, and 12.2 percent were obese. The second highest was among Hispanic children; 16.1 percent were overweight, 12.5 percent had a high weight for length, and 14.5 percent were obese.

To summarize, the highest rate of youth and childhood obesity by gender is among Nevada boys. Youth obesity increased from 11.4 percent to 12.3 percent from 2013 to 2019. Nevada WIC childhood obesity decreased from 13.8 percent in 2008 to 11.7 percent in 2018. In Nevada WIC, American Indian/Alaskan Native and Hispanic children had the highest rates of obesity compared to races and ethnicities.

Some challenges include funding for the state's Prevention and Wellness Program, which is currently unstable and limited. Also, the reporting of school height and weight in NRS tends to be inconsistent. It is not standardized; height and weight are being collected with various types of equipment, schools are utilizing various methods, and not all the schools have height and weight collection equipment. During COVID-19, school nurses were reassigned to COVID-19 specific tasks; they are currently understaffed, and they do not have the ability to collect all the height and weight data they need to. Absences and school closures have also reduced the ability to collect this information since the start of the pandemic.

In the Kindergarten Health Survey, evidence from the Behavioral Risk Factor Surveillance System and the Youth Risk Behavioral Surveillance System shows that self-reported or perceived BMI is significantly lower than when an individual's BMI is actually measured.

The WIC data is the most used and most reliable for obesity status of 0- to 4-year-olds. Nevada WIC serves approximately 12,000 1- to 5-year-olds, which is a small percentage of Nevada's entire 1- to 5-year-old population. The WIC program also provides individualized nutrition education and supplemental nutritious foods, which has shown to improve the BMI status of children participating in WIC versus those not participating in WIC. It is not a good measure to compare or represent the state as a whole.

Body mass index measure by itself should not be used to guide prevention and management efforts. Body mass index is only a perceived risk; many other measurements and environmental and genetic factors may need to be taken into account to fully address the obesity problem.

Our Chronic Disease Prevention and Health Promotion program is currently in the process of updating its strategic plan; the program is on a similar path as mentioned for the food security strategic plan. It is a little bit behind in the process because it started a little bit later, but so far, we have gotten some great responses and feedback. Again, the strategic plan will help to update the chronic disease priorities and identify efforts across the state.

Some potential opportunities to decrease childhood obesity are to increase the availability of measured data; standardize and fund school height and weight data collection efforts; provide culturally appropriate, inclusive, and destigmatized weight education; encourage participation in federal nutrition programs; and provide mandatory or have mandatory physical education and physical activity in schools.

More priorities could be to develop a robust surveillance system and wellness program. The cost for this would be estimated around $4 million a year, based on similar models in other states. The current disease-specific funds are restrictive and cannot be utilized for comprehensive surveillance or the development of a robust wellness program to address mental health, oral health, nutrition, and physical activity. These dollars could:

- Support a wellness manager, a wellness coordinator, and a wellness evaluator, which are needed to oversee program implementation efforts;
- Support the growth of a 5-2-1-0 Healthy Children program;
- Utilize peer community health worker models in schools for youth wellness;
- Increase dedicated personnel for an oral health program; and
- Support comprehensive programs that address risk factors and meet the needs of Nevadans.

Evidence indicates increased funding, resulting capacity, and resources would improve health outcomes related to chronic disease, as well as improve overall wellness and quality of life for Nevada's children.

Are there any questions?

Chair Peters:

Are there any questions from the Committee? I am not seeing members with questions. Thank you for the data. I appreciate you pointing out the BMI measure by itself should not be used to guide prevention and management efforts. I would be interested in what solutions, proposals, or programs you have in place to ensure that is not the case and that we are moving forward with holistic models of prevention and management because everybody is different. It is not something you have to answer today, but in the future, we would like to hear from you on that piece.

Ms. Rogers:

Yes, it is absolutely something we are thinking about.

Chair Peters:

If there is anything we can do to help, let us know. Thank you again for your presentations today, Ms. Rogers; we appreciate you being here.

[Subsequent to the meeting, Ms. Rogers provided a follow-up memorandum regarding the WIC certification process and eligibility requirements.] (Agenda Item XI A-2)

AGENDA ITEM XII—ACCESS TO CHILDCARE: SUCCESSES AND CHALLENGES

Chair Peters:

We will and move on to our next agenda item. Agenda Item XII is access to childcare: successes and challenges. We have Karissa Machado with the Child Care and Development Program. Please introduce yourself and proceed when you are ready.

Karissa Loper Machado, M.P.H., Agency Manager, Child Care and Development Program, DWSS, DHHS:

Thank you for inviting me to discuss Nevada's efforts to address the challenges in our childcare system (Agenda Item XII). The federal relief funds and further investments from Governor Steve Sisolak are allowing Nevada to make system changes and investments intended to create long-term improvements as well as immediate stabilization of the industry.

Nevada's Child Care and Development Program is the lead agency administering the Childcare and Development Block Grant and associated Childcare and Development Fund, which funds childcare subsidies for Nevadans as well as other programming. We provide high-quality programming to ensure a safe, stable, and healthy start for all Nevada children. We collaborate with diverse stakeholders, including DPBH for childcare licensing; the Office of Early Learning and Development in Nevada's Department of Education (NDE); and a multitude of community partners and local municipalities to foster successful and healthy communities. Finally, we use data to identify and invest in childcare expansion and improvement opportunities, which support families and Nevada's economy.

The future of our childcare system depends on better integration and alignment among all key stakeholders. In particular, we need to address four concurrent challenges: (1) affordability for parents and caregivers; (2) capacity of licensed and other childcare provider types; (3) accessibility of childcare to all Nevadans, particularly families living in childcare deserts, including the fostering of a diverse set of provider options; and (4) improving the quality of early childhood education and care delivery in close partnership with NDE's Office of Early Learning and Development.

The changes we have made to date include efforts to support Nevada's families as well as our childcare provider network. First, we have increased the income eligibility for a household to qualify for a childcare subsidy from 130 percent of the federal poverty level, to now, 85 percent of the state's median income. This, essentially, has doubled the amount a household can earn monthly and be eligible for a childcare subsidy. For example, $1,500 a month for a household of four is now $3,000 a month. This change increases access to the subsidy program and affordability for more Nevada families.

Another key policy change that improves access and affordability is the allowance of education and training without associated work as an accepted purpose of care for participation in the childcare subsidy program. Restrictive implementation of older policies, which were implemented when our budgets were much smaller even before normal federal increases in the block grant award, may be preventing Nevadans from being able to finish their education or attend a vocational training program if they also need access to childcare. The federal block grant rules allow us to define and include education and training as a purpose of care, and we have now, as of this month, expanded that ability back. We used to allow this in 2011, and we are now allowing it again to help more Nevadans achieve economic success.

The final subsidy program policy change intended to improve access and affordability for families, is to expand the amount of subsidy coverage to targeted subpopulations, which must be approved by the federal Administration for Children and Families, U.S. Department of Health and Human Services, which awards the block grant. We have been successful in receiving approval to add two additional targeted populations for whom we can cover 100 percent subsidy with no required co-pay. In Nevada, the subsidy program is administered on a sliding scale fee, as in many other states. Families are required to pay a co-pay based on their household income, which is a federal requirement of subsidy participation, as well, unless you have these approved subpopulations.

The currently approved subpopulations are listed, including our New Employees of Nevada (NEON) families that participate in the Temporary Assistance for Needy Families (TANF) program; children involved with child protective services or in the foster care system; and children who are experiencing homelessness. In Nevada, we know some populations are disproportionately impacted by the cost of childcare, to the point where it can prevent them from achieving economic success, and considerations need to be made to allow stability for children in other special circumstances.

The populations we are adding include public and civil servants essential to Nevada's economic recovery; for example, this would include school district employees and staff, State of Nevada employees, and other county employees who already meet the income eligibility level. We can now help them with a 100 percent subsidy coverage. We also added individuals who are attending a substance use disorder treatment or recovery program through DPBH and are actively meeting and partnering with our behavioral health partners, substance abuse prevention and treatment partners, and their care providers to receive childcare assistance when they need it.

We also know that expanding access is not effective if we are not also lifting up Nevada's childcare providers and the childcare workforce. This month we notified licensed providers the subsidy program has raised the rates it will pay providers to the 95th percentile of the 2018 Market Rate Survey based on the ages of children served and a licensed provider's quality rating through the Quality Rating and Improvement System (QRIS). Providers are seeing increases of $5 to $15 per day, per child in their subsidy rates from what they were prior to this month. For example, rates for seeing an infant have increased to about $7 per day based on the quality rating cycle. It is different for each child in an infant setting, a toddler setting, a prekindergarten setting, or a school-age child. There is a large range of providers and how their rates are calculated.

We are in the process of conducting the 2022 Market Rate Survey. You may have heard us say it is the 2018 Market Rate Survey, that is the last one we have. We are working actively with The Children's Cabinet to conduct the 2022 Market Rate Survey. We will have a much better look at today's costs of providing childcare for our childcare providers across the State of Nevada very soon. I expect by July.

We are doing a lot more with the ARPA dollars and the investments that have already been provided to us. The childcare stabilization grants are over $200 million in direct stipends that have been provided to childcare providers for up to six months, as budget would allow, for supporting their operations. They needed to use those funds to support keeping on a workforce—supporting their staff with either bonuses, training and development coverage, or other staff supports—as well as supporting families. We have also been working to help, not just centers or large providers, but individual staff through the Early Childhood Staff Stipend Incentive Program. The program provides financial incentives to childcare providers who are active members of the Nevada Registry, which is currently required for all staff who work in a licensed environment. They just need to be working in a qualified program at their time of application. So far, more than 4,000 applications have been received, of which more than half have been completely vetted through the Nevada Association for the Education of Young Children, who is working with us to make sure staff are aware of the program and are applying. We have paid $1,000 in staff stipends to over 800 staff so far, with more reimbursements in the works.

We are also supporting what is now titled the Nevada Strong Start Child Care Services Center, which was early on being dubbed as a shared services hub for childcare providers. Basically, this is a provider resource center, or one-stop shop, for childcare providers to access resources to help them run their business; improve their business; and access shared services operations, such as human resources support, payroll support, website development, et cetera. We have a variety of partners and services working with us.

Physical locations opened in Las Vegas in February 2022. The grand opening was televised, and Nevada's delegation and Governor Sisolak were there; it was a very exciting event. We expect to have a grand opening for the Reno location in late June. Currently, the building is being furnished.

There is also a virtual center that is live and bringing more than 2,000 resources—guidebooks, tool kits, policy suggestions, documents they can use in their own business, et cetera—to assist childcare providers in providing quality services and improving their services.

Our partners include Wonderschool, which is a private entity working with us to provide website development as well as assisting providers in achieving all the health safety and child development trainings they need to be successful in providing childcare. Candelen Kith and Kin is an important partner that is allowing us to reach better into the Spanish speaking

and Hispanic community in Nevada by developing the family, friend, and neighbor network. Although that network is not licensed, it is registered and can receive a subsidy by becoming registered in payment and receive the proper health and safety trainings that we expect in Nevada to allow children to be cared for in a safe environment. We have of course the Nevada QRIS, The Children's Cabinet, and the Las Vegas Urban League. We have the community health worker program, which is focusing on an early childhood education certification process. Those community health workers will be housed in both the North and South to help providers and families navigate their various social determinants of health from the childcare setting and provide that holistic type of service and care, as Chair Peters mentioned. Additionally, we have an Early Childhood Support Network, which helps our licensed providers get a substitute if they have a teacher call out for a day or two. It is a great network that helps the whole state be connected to educators who are ready and willing to come help.

We have childcare start-up and expansion grants available to family- and home-based childcare providers from $10,000 to $40,000, depending on the provider setting. It will allow them to improve the supplies they are using, including toys or other things that will help the children, or provider supports that are needed.

There is now the Child Care Expansion Grant from the Office of the Governor, which allowed $30 million of federal relief funding to come out and the Interim Finance Committee approved for us. Licensed childcare providers and other service providers in the early intervention (EI) space for children and youth with special health care needs are able to apply for an amount that has not been capped at this time. The preapplication phase is live right now and we have just started taking applications. We expect this $30 million to help a significant portion of childcare providers expand their capacity, renovate to expand capacity, et cetera. It is for construction costs only. Then, the other support programs I talked about are helping us round out the supports we can provide to the childcare system.

Infant/toddler slot expansion is another way to help stabilize providers and allow them to expand the slots available for infant and toddler care, which we know there is a dearth of compared to prekindergarten and other care.

We are working on background check fee assistance. This is sometimes a barrier to getting people into the workforce quickly. We can work with our licensing partners and partners at the Department of Public Safety to ensure the process is as streamlined as possible while still being accurate and comprehensive. We can help providers pay for their workforce to get those background checks because sometimes that is a barrier for the lower-wage workforce.

Business consultations are another provider support, which are also through the shared services hub. They help providers access loans, other improvements, or financial assistance that would help them to expand capacity or improve their childcare business otherwise.

A childcare provider action committee is bringing together all these state and resource support partners, along with the provider community and those providing care in our license centers, to have discussions so we can hear directly what providers need from us to provide and expand childcare services.

We also have a Nevada Youth First program. We are working with a variety of businesses, as well as other community partners, to steer young adults into the childcare workforce. We want to encourage people to enter the childcare and early education and development field to develop a robust workforce and a career pipeline for people who want to enter, knowing childcare has a huge need of impacting the economy overall.

We have family supports, along with the expanded subsidy eligibility and other subsidy program changes I already discussed. We are partnering with The Children's Cabinet to operate a statewide education outreach campaign to ensure everyone is informed about all of the system and policy improvements we are making to the childcare system to improve access, increase access, improve affordability, and lift up our provider systems.

We have parent leader engagement. While we are trying to ensure that we are doing better at communicating and hearing from our childcare providers, we want that from parents as well. We are working with a variety of partners—including DCFS and others on special needs consultation for infants and early childhood mental health—to ensure families are supported there. We also want to ensure that providers receive the training and support they need to help and provide care to all children.

This is the end of my presentation, and I am here for all your questions. Thank you.

Chair Peters:

Thank you for the presentation on where we stand and the great effort happening in your office. There is exciting work being done in this space. I want to remind the Committee, this information may not be typical for our Committee, but because of the way our Committee was formed, we have taken on childcare and child welfare issues. I wanted to expand on that because childcare is about family health and stability, and that is our charge. Are there any questions from the Committee? Dr. Hardy, please go ahead.

Senator Hardy:

Is there somewhere a family or provider can go to find all of these opportunities or do they just contact your office and they provide the information?

Ms. Machado:

Providers and parents can find assistance on Nevadachildcare.org as opposed to calling the state office. We like to send both providers and families there because it can help them navigate appropriately. We work with two childcare resource and referral centers. The Children's Cabinet serves northern and rural Nevada, and the Las Vegas Urban League serves Clark County and some of the rural southern Nevada areas. I can ensure the Committee receives that information. Also, if anyone was searching for subsidy assistance, no matter what website they end up on, they will be referred to the correct organization that helps them.

Chair Peters:

Along those lines, are providers able to suggest their parents or caregivers go through those channels to determine eligibility, or is that a burden on the parent and caregiver?

Ms. Machado:

Yes, when providers have new families come in and are helping them to understand their rates and budget, those providers who are already members of the subsidy network and are well connected between The Children's Cabinet or the Las Vegas Urban League know to refer the family over to one of the childcare resource and referral centers for help with applying for subsidy assistance.

Chair Peters:

Does DWSS offer these subsidies to eligible clients through other methods or is this something they have to research or request separately from the Division's initial process

Ms. Machado:

There is a direct referral link between our office at DWSS and the offices who do TANF, SNAP, and Medicaid. I believe they can say if the family also needs childcare assistance through the system. There is also a direct referral link from DWSS over to The Children's Cabinet and the Las Vegas Urban League. I recently asked those partners how that referral process works for them, and they said yes, they believe it is successful for the clients.

Chair Peters:

Are there any other questions from the Committee? Thank you again for the presentation; we really appreciate your time today. We are going to close this agenda item and move on to our next agenda item.

AGENDA ITEM XIII—OVERVIEW OF EARLY CHILDHOOD DEVELOPMENT, ADVERSE CHILDHOOD EXPERIENCES, AND IMPROVING HEALTH OUTCOMES FOR CHILDREN IN NEVADA

Chair Peters:

Agenda Item XIII is going to be two presentations on an overview of early childhood development, adverse childhood experiences, and improving health outcomes for children in Nevada. First, we will hear an overview of early childhood development and adverse childhood experiences from representatives of The Children's Cabinet, followed by ways to improve health outcomes for children in Nevada and policy considerations by representatives of the Children's Advocacy Alliance. We have The Children's Cabinet representative first, please introduce yourself and begin when you are ready.

Marty Elquist, Department Director, Early Education and Development, The Children's Cabinet:

Thank you, Chair Peters and members of the Committee, I really appreciate the invitation today. I am joined today by my colleague Denise Tanata. I am going to go over some basics on early childhood development, focusing on the early learning brain science, and then Denise is going to talk about system improvements and a grant we have with the Health Resources and Services Administration (HRSA) (Agenda Item XIII A).

There has been a ton of research done in brain science over the last 15 years; specifically, with young children. We know through imaging, that brains are built over time and skills build on skills. Our brain architecture is comprised of billions of neurons and connections between those neurons are what builds our brains and provides the foundation for us as human beings. The connections of both genes and experiences shape the developing brain. You have what you bring in from nature and then what is nurtured. The cognitive, emotional, and social capabilities are interrelated and intertwined throughout our lifetimes. We know that experiences are critical in the outcomes that we all have as humans. We know that if children are in toxic stress environments, it actually weakens the architecture of their developing brains, which can lead to lifelong problems in learning, behavior, and physical and mental health, and we all end up paying the price fivefold later on in life. Positive early childhood experiences are critical in supporting our children's development.

How we support our parents in supporting children through the services we provide is essential.

We are born with all of the neurons we are ever going to have. When we refer to brain growth, we are referring to the connections that are being made between these neurons. Those connections are called synapses, and they are stimulated by the type of early childhood experiences and interactions that children have. This is true for both positive and negative experiences, and that is important to remember. Scientists estimate we make a million synapses every second from birth to age three. When you think about those experiences you have with young children, knowing that brain development happens through interactions and relationships and you see the stress our parents are going through during that critical developmental period, it is essential we all understand this. We have to shift the culture and the thinking of how we raise our children and support our parents through this critical developmental time. As the brain makes all these connections, that is what builds the brain, and when we refer to brain growth, that is what we are referring to.

Synapses, the rapid period of growth—you use it, or you lose it; that is what is getting reinforced. Here is an image of a newborn and then one month, three months—you see the rapid connection happening, six months, one year, two years—look at how dense that is getting—four years and six years. All these passageways between these neurons are experiences formed over and over and over again, both positive and negative—that is important to remember. At about six years, what starts to happen is called "pruning" and it is a natural process. What happens is those connections, that are no longer being continually reinforced, start pruning away. The child's brain says, "I do not use that anymore, it is not my experience anymore and I am not going to build those connections in my brain." Again, it is important to remember this is for both positive and negative experiences.

Brain growth does not happen without relationships. Relationships are absolutely critical. We are born as social human beings; we are born with this desire to reach out and interact—to connect with eye contact, to coo, to be responded to, to cry, to be fed a bottle, to change a diaper—because we are social beings. These social cues are critical for communication in early childhood. Babies are born seeking that human connection and that response; understanding the communications of infants and toddlers is critical in how we respond and form those synapses, the positive ones. Children learn in and from relationships; learning does not happen absence of relationship. We say this over and over again, but the first teacher of a child is the mother, father, essential, or other caregiver. An infant must be in a nurturing and affectionate relationship with a caring adult in order for that positive development to occur in social realms—emotional, mental, physical, and then cognitive. It is well-rounded; you do not just teach to cognitive without other social, emotional growth happening at the same time. You cannot pick apart how we learn, it is all integrated.

Through that learning, stress is normal and positive stress response is normal. This is characterized by brief increases in heart rate, elevated hormone levels. Things like the first day of school or getting an immunization are normal things where we get an elevated stress response, but there is a loving caregiver there to buffer the response and the time of that stress period is generally short. These are called positive stress responses.

Then, there are tolerable stress responses. These are more prolonged or longer lasting difficulties, such as the loss of a loved one, a natural disaster, or a frightening injury, like being bit by a dog. If the activation of that stress response is time-limited and buffered by positive relationships and the child adapts, the brain and other organs recover from that stress. If children experience a couple of episodes of tolerable stress, as long as they are buffered by loving caring people in the child's life, they are easily overcome.

The third type is toxic stress response. A toxic stress response occurs when a child experiences strong, frequent, and prolonged adversity, such as physical or emotional abuse, chronic neglect, a caregiver's substance abuse, mental illness, exposure to violence, accumulated burdens of family economic hardship, or food insecurities. These experiences come without adequate adult support or an adult to buffer those negative experiences with positive interactions. This type of toxic stress has long-term impacts on children's brain architecture and the development of other organs; there is an increased risk for stress-related disease into the adult years, such as heart disease or diabetes. When we have multi generations experiencing poverty and toxic stress, it changes our DNA, and the science is clear on that.

Research indicates that supportive, responsive relationships with caring adults, as early in life as possible, can prevent or reverse these damages of heart disease and diabetes or substance abuse of the person experiencing the toxic stress themselves and depression. Just because somebody experiences toxic stress does not mean you cannot recover from it; it is just going to take a lot to support that person to overcome all those connections that have been made in the brain. These experiences are known as adverse childhood experiences (ACEs); I already mentioned emotional abuse, neglect, mental illness, household violence. The more ACEs a child experiences, the more likely he or she is to suffer from things like heart disease. Three plus ACEs are in that toxic stress zone. The *Early Childhood Two-Generation State Policy Profile* of the National Center for Children in Poverty, Bank Street Graduation School of Education, reported that in Nevada, 16 percent of our children under the age of six have three plus risk factors and 49 percent of our children have one to two. It is important to keep in mind how our children are being raised in our state.

Experiencing many ACEs, as well as things like racism and community violence without caring, supportive adults around them, exemplifies the toxic stress. It leaves our bodies in this elevated stress response and it creates wear and tear on our systems and health. It would be the same effect as revving the engine of your car for an entire week; think of the strain and stress it would have on an engine, giving it that much fuel going through the system. This is what is happening when we talk about toxic stress.

For those who have experienced multiple aces, there is a wide range of responses that can help including therapy, mediation, physical exercise, spending time in nature, and others. The best way to prevent, is to make sure our families with young children have access to the services they need, and the system supports their holistic development.

One of the programs The Children's Cabinet is involved with is improving our early childhood comprehensive system. The Children's Cabinet wrote a competitive grant for HRSA to address this comprehensive system that our children and families need for optimal development because through building a stronger system for our children and families, we can address toxic stress. We can ensure that 16 percent of our children do not experience three plus ACEs that can lead to toxic stress.

I will now turn it over to my colleague Denise Tanata.

Denise Tanata, Director, Early Childhood Comprehensive Systems, The Children's Cabinet:

As Ms. Elquist mentioned, last year HRSA, through their maternal and child health program, released the Early Childhood Comprehensive Systems: Health Integration Prenatal-to-Three Program (ECCS). In collaboration with numerous state agencies and private partners, The Children's Cabinet submitted an application. We were 1 of 20 states that were awarded this

grant. This is a five-year grant beginning in August 2021 for approximately $255,000 per year that focuses on strengthening early childhood systems.

The purpose of the HRSA grant is to build integrated maternal and early childhood systems of care that are equitable, sustainable, comprehensive, and inclusive of the health system; that promote early developmental health and family well-being; and increase family-centered access to care and engagement of the prenatal-to-three population. This initiative places a very strong emphasis on equity, particularly around ensuring that family leadership and engagement are therefore decision-making throughout the system.

The partner agencies and organizations listed provided a letter of support for the grant and participated in the development of the grant. The list includes multiple state agencies as well as private partners throughout the State of Nevada. As we have begun implementation of this initiative, we have continued to grow our list of partners. The project is looking at not only how we can better align and coordinate state agencies and departments within the early childhood system, but also how we can align, coordinate, and integrate initiatives and related work that is happening in the private sector. Strong public/private partnerships are essential to building a comprehensive, coordinated system that delivers equitable access to high-quality programs and services that meet the needs of all families in Nevada.

Next, I will go over the goals and objectives of the grant. The ECCS Health Integration Initiative includes five overarching goals. Goal 1 is to increase state-level infrastructure and capacity in Nevada to strengthen statewide maternal and early childhood systems of care. Our objectives under this goal are to create the early childhood comprehensive systems director position, which is the position I currently hold. Also, establishing the position of an early childhood comprehensive systems parent engagement coordinator. We have hired Ms. Ashley Dines who is doing that work statewide and the position is cofunded through the HRSA grant and DWSS with the ARPA funds. It is one of the collaborative initiatives that we have to do the parent engagement.

A long-term goal is to establish an office for early childhood in the Office of the Governor. Numerous states have already established similar offices to address the complex system of early childhood to align policies, procedures, and resources to better address the holistic needs of young children and their families. We are currently in the process of developing a concept document that researches how other states have aligned those offices and the coordinating cabinets in order to outline a potential structure for Nevada and to align that with our existing Nevada Early Childhood Advisory Council (ECAC).

Goal 2 is increasing coordination and alignment between maternal and child health and other statewide systems that impact young children and families to advance a common vision for early developmental health and family well-being in Nevada. We are currently working on a comprehensive system asset and gap analysis in collaboration with our HRSA technical assistance partners. The system asset and gap analysis will be complete later this year, and we would be happy to share that with you once it is done. We are also contracting with a national organization, the Children's Funding Project, to conduct a fiscal mapping analysis that will result in a dashboard that we can update on a regular basis. It will also include identification of our existing funding structures, opportunities for fiscal efficiency and the early childhood system, as well as gaps in resources and opportunities to fill those gaps. Additionally, we are coordinating the development of a unified prenatal-to-three strategic plan in alignment with our Nevada ECAC.

Goal 3 is to increase the capacity of health and early childhood systems in Nevada to deliver and effectively connect families to a continuum of services that promote early developmental health and family well-being beginning prenatally. One of our main projects,

as mentioned by Ms. Loper in the previous presentation, is we have developed the Early Childhood Community Health Worker Program, which actually started last month. We currently have five trained early childhood community health workers in southern Nevada; we are in the process of hiring for a coordinator in northern Nevada and hope to have those community health workers out in the field this summer with plans to expand those community health workers into the rural areas next fiscal year. I want to note that this program, as far as we can tell, is the first of its kind. It has the opportunity to serve as a model for other states and we are already beginning to receive inquiries through our national partnerships for how we are developing this program and how it is working and benefiting our families.

Goal 4 is to identify and implement policy and financing strategies that support the funding and sustainability of multigenerational preventive services and systems for the prenatal-to-three population in Nevada. As I previously mentioned, we are in the process of conducting a fiscal analysis. In that process we are also looking at policy priorities—what we need to do to change policies, practice alignment between different state agencies, systems, as well as private partners to streamline access to programs and services that meet the needs of children and families. We are also incorporating these strategies into that unified prenatal-to-three strategic plan, which will ultimately be a part of our Nevada ECAC strategic plan.

The last goal is to increase state-level capacity to advance equitable and improved access to services for underserved prenatal-to-three populations. With this, we are doing health equity data analysis. We are looking at how we can enhance both collection and utilization of cross-sector data, particularly looking at how we can make sure that we have disaggregated data, looking at race, ethnicity, geography across those systems. We have integrated a lot of these goals and objectives into our ECAC and have established subcommittees that align with each of these five goals. I also want to mention that under the equity piece, we have talked a lot about the emphasis on parent leadership and engagement in the decision-making process. We are in the process of establishing a family leadership council where those family members will receive training, coaching, and resources to support their engagement on a variety of boards, commissions, and task forces, starting with the integration of family leaders in decision-making roles beginning with the Nevada ECAC. Also, we will provide training and technical assistance, beginning with the Nevada ECAC, on strategies, policies, and procedures to support and encourage parent leadership opportunities.

We have recently restructured our Nevada ECAC to align with these goals and objectives, including those five subcommittees. Our goal is to align and coordinate systems as well as policy to better serve children and families, ultimately resulting in improved outcomes and reducing the need for more costly interventions past the early childhood years.

This concludes my presentation. We are open to answer any questions you may have.

Chair Peters:

Thank you for the presentations today. Are there questions from the Committee? Dr. Hardy and Dr. Titus have questions. Dr. Hardy, we will start with you.

Senator Hardy:

Director Elquist said something that intrigued me. She said, "Toxic stress changes the DNA." I hope she meant the effective DNA, because I do not think we change our DNA. Am I mistaken there?

Ms. Elquist:

Thank you for the question. I am not a medical doctor, so I do not know the difference between effective DNA. I just know the research as I read it, and I can get back to you. The Center on the Developing Child, Harvard University, is largely the source I go to on anything regarding toxic stress and brain development, as well as the Institute for Learning and Brain Sciences, University of Washington. Those two sources are the go-to sources. The Harvard Center on the Developing Child more so on the research behind toxic stress.

Senator Hardy:

I just wait for the DNA sample of a 21-year-old person who we had a DNA sample for when the person was six months old, and it is not the same person. I am curious if Harvard University has enough doctors who have figured that out.

Chair Peters:

Thank you for the question. We will go to Dr. Titus and her question.

Assemblywoman Titus:

Thank you, Dr. Hardy. I was also going to ask the question about what changes our DNA. I am curious about that resource and whether you could forward any document that you saw where the DNA was actually changed by behavior modification or intervention. I would be very curious to see that documentation.

I went to medical school a long time ago, and during my undergrad I did a lot of child psychology. I would just observe that we have certainly come a long way from the 1940s with B. F. Skinner and the Skinner Box on how we treat early childhood development. Thank you for your presentation.

Chair Peters:

I was admiring your presentation and the discussion about our neurons and synapses. It is, essentially, the presentation I give my children when they say they do not want to go to school, or eat healthy foods, or they want to give up on something that is hard, because that is how we learn, by building those synapses. Are there any other questions from the Committee?

We will move on to the next portion of this presentation on the health outcomes for children and policy considerations. We have representatives with the Children's Advocacy Alliance to talk about this particular issue. Please introduce yourself and begin when you are ready.

Annette Dawson Owens, School Readiness Policy Director, Children's Advocacy Alliance:

Good afternoon and thank you, Chair Peters, and Committee. We appreciate the opportunity to come and share with you today. Over the course of this interim, you have heard a number of startling statistics and outcomes for children and families in Nevada. As we think about all that has been shared, or will be shared, I am reminded of a quote by Marian Wright Edelman which states, "The question is not whether we can afford to invest in every child; it is whether we can afford not to." We want to underscore that we do not have time to not invest in our children.

I want to give you an overview about what you will hear today, particularly about the state of our children (Agenda Item XIII B). I will talk about the number of reports that we routinely develop and share as resources for you and others to make sound decisions about the things that will improve outcomes for children and families. We will also hear from Jamelle Nance who will share about a collective effort underway to transform conditions for children, particularly leveraging a number of investments whether it be home visiting, infant and early childhood mental health, leveraging community health workers, or improving maternal outcomes. There is something that can be done to change the trajectory for our children, and we implore you to do so.

The Children's Advocacy Alliance is a 23-year statewide independent, nonpartisan policy organization advocating to improve outcomes for our children and families in Nevada. We focus on four key areas: (1) education; (2) health; (3) safety; and (4) economic well-being. In keeping with this commitment, each year we publish a number of reports to aid others in conceptualizing and addressing the state of our children and families in Nevada.

Today, this presentation will have a message that will highlight the key findings related to health and other areas leveraging those resources. You will hear about a number of reports, including our 2021 KIDS COUNT Data Book, which will have another release in August of this year. You will hear about a recent pandemic report, which is a special report talking about the latent effects of the pandemic and highlight a few pain points for children and families during COVID-19. We will also share our routine, but insightful, Children's Report Card. The main takeaway is that we are in this together. We would love to partner with each of you in not only sharing these key resources, but also supporting your efforts to craft sound policy decisions for children. As part of that commitment, you will not only hear those startling data points but also a path forward, particularly as it relates to early investments and the Prenatal-to-3 State Policy Roadmap, which is an opportunity for you to change the trajectory through policy.

As we stated, we will talk about the 2021 KIDS COUNT Data Book, our Nevada Children's Mental Health Report Card, our pandemic report, and our Children's Report Card. All these resources can be found on our website in their entirety. We anticipate all the data in our reports, however, may actually be worse post-COVID-19.

We will start by highlighting the 2021 KIDS COUNT Data Book, noting that a new data book will be released in August, where Nevada is currently ranked 45th overall. We are 41st in economic well-being; 46th in education; 44th in family and community; and a little more positive, 34th in health. However, we failed or got worse in low birth weight and children and teens who are overweight or obese. We made gains with regard to children without mental health insurance, as well as children and teen deaths.

According to the Nevada Children's Mental Health Report Card, Nevada's overall grade in children's mental health was a D+. Nevada could benefit from the state investing in a comprehensive data management system so we can have real time information to understand the needs of children and families and act accordingly. Pain points seen through COVID-19 relate to only 13 percent of our families and children having access to help with insurance costs. Nevada has a 17 percent lack of consistent access to food, or food insecurity, while the national average was 14 percent. Nevada was ahead of the national average with 26 percent of individuals feeling the effects of depression compared to the national average of 21 percent. This shows the national effect of racial disparities across such areas as not having enough food, not being able to pay your mortgage on time, not having health insurance, and feeling depressed or hopeless. Again, we need to pay attention to the disparities that exist between different groups related to race.

We will now highlight the 2020 Nevada Children's Report Card. We earned a C+ in safety, an F in education, a D+ in economic well-being, and a D in health, which we will delve deeper in today. For health outcomes, our access to health care was rated as an F and stayed the same as in previous years. Prenatal and infant health went down and was rated as a D. Immunizations went up to a C-. Childhood obesity was a C-, as this grade dropped. Dental health was an F- and decreased. Mental health was a C and decreased. Sexual health increase to a C.

In the State of Nevada, the rate of uninsured children was 8 percent versus 6 percent in the United States, and we are rated 45th in the country. However, due to COVID-19, numbers have doubled and 8 million Americans lost employer-sponsored health insurance, with persons of color being disproportionately impacted. Again, we are in this together. Some of the data is startling, but there is a path forward that you will hear about relating to early investments, as well as the Prenatal-to-Three State Policy Roadmap, an opportunity to change the trajectory for Nevada's children through policy.

I will now turn the time over to my colleague Jamelle Nance.

Jamelle Nance, Strong Start Prenatal-to-Three Director, Children's Advocacy Alliance:

Thank you, Annette, and thank you to all the presenters who have given such great information today; hopefully, this will bring it around full circle. In Nevada, I am sure you have heard the term "strong start" in many different entities. Strong Start was coined as a campaign for community outreach that is aimed at mobilizing parents, educators, advocates, community, and business leaders to make quality early childhood experiences a priority in the state. The Children's Advocacy Alliance is the backbone organization that supports the Strong Start Nevada Campaign. The Prenatal-to-Three Initiative is supported by the Pritzker Early Children's Foundation. We have worked diligently together, with a plethora of community partners and business leaders, to move this initiative forward. The Campaign is broken down by the implementation of three workgroups to support the policy and resources that produce the best outcomes for young children and families. The three workgroups include the Strong Start prenatal-to-three maternal and child health work group, the community health workers and home visiting work group, and the early learning childcare work group and some of which are on this call today. We are excited to be able to speak to this initiative.

Some of our goals in the Strong Start Campaign include having an additional 2,215 infants and toddlers, that fall below the 200 percent federal poverty level, to utilize well child services under the 12-month continuous eligibility of Medicaid. This has come up as a reoccurring initiative that we want to support. We also hope to add an additional 8,500 pregnant people, below the 200 percent federal poverty level, on Medicaid that receive and utilize postpartum care services through the Medicaid expansion—again, looking at the 12-month continuous eligibility for those parents. In addition, we hope to add at least 450 infants and toddlers, below the 200 percent federal poverty level, having more access to quality childcare through the establishment of 450 contracted childcare subsidy slots of 3-, 4-, and 5-star centers, meaning they are of high-quality childcare providers. We talked about how childcare is giving us that holistic approach to health, not just to the child but to the family, to buffer some of those disparities we see in those early adverse childhood experiences.

If you participated in our winter Policy Summit, we had the opportunity to have Dr. Cynthia Osborne, Executive Director, Prenatal-to-Three Policy Impact Center, Peabody College of Education and Human Development, Vanderbilt University, present on the

Prenatal-to-Three State Policy Roadmap. We have been heavily utilizing the Policy Roadmap as a research-based model to discuss some of those policy goals that have the best outcomes for our children and families. There are eight policy goals, and we have highlighted three of those goals that we would like to continue to hone in on as we move forward.

One of the three goals we are highlighting today is access by way of:

- Necessary services for families through community health work and health care services;
- Reduced administrative burden—there has been some movement with the Medicaid eligibility requirements to recertify; and
- Identification of needs and connection to services through our community health workers and home visitors.

The next goal is the parent's ability to work. We talked about this a lot during the pandemic when families needed to return back to work. It also entails our childcare providers being sustainable and having the resources they need to continue to keep the doors open. This would include parents being able to find sustainable work in family-friendly work environments that allow them to take leave when children are born. Again, another opportunity for children to bond with their parents through paid leave is something we are interested in—being able to support our families both in the work environment and in the opportunity to return to work with a connection to childcare.

The third goal is having equitable health and birth opportunities, connecting families to the services we talked about today that produce the best outcomes for health.

I want to highlight a few points on the Policy Roadmap looking at where we rank in relation to other states. Although the data is not favorable, it is important to look at the specific areas where we moved forward and areas that need improvement. The percentage of low-income women who are uninsured is falling at 27.6 percent and ranking 40 amongst other states. For eligible families with children under 18 years of age not receiving SNAP, we look at those who may be eligible, but not yet receiving services. Our mission is to increase the utilization of services that we know is so important to our children and families.

We work with our partners to determine what policies impact children and families, not just research-based policies, but those community-based organizations and our state partners to refine our policy priorities. We talked about equity numerous times today. We want to highlight the importance of equity in all policies that families have access to such as vital services and resources, including home visiting and infant early childhood mental health services, as well as a parent's ability to work, ensuring a sustainable childcare workforce with livable wages, and ensuring health care access for children and families including 12-month continuous eligibility coverage for children as well as pregnant people.

Are there any questions?

Chair Peters:

Are there any questions from the Committee on this presentation? I am not seeing any. Thank you for the information and for being here today. We appreciate your policy summary and will be looking at those issues. We are going to close this agenda item and move on to our next agenda item.

AGENDA ITEM XIV—EARLY INTERVENTION SERVICES FOR CHILDREN BIRTH TO THREE YEARS OF AGE FROM THE PERCEPTION OF A PROVIDER

Chair Peters:

Agenda Item XIV is on EI services for children birth to three years of age from the perception of a provider. We have the Foundation for Positively Kids to present today on this topic. We also have Rob Burns of the Early Intervention Community Provider Association available for questions after the presentation. Please introduce yourself and proceed when you are ready.

Paula Hammack, Chief Strategy Officer, Foundation for Positively Kids:

Good afternoon, Madam Chair, and members of the Committee. We will give you a brief overview of the Foundation for Positively Kids (Agenda Item XIV). We are a local nonprofit located in Clark County. We were established in December 1999 by our Chief Executive Officer Fred Schultz. We provide several services to children that include EI services for children who are 0 to 3 years of age. We also provide two pediatric clinics in Clark County; one is on the Child Haven campus. We provide behavioral health services for youth 0 to 17 years of age. We also provide a social skills program for children 0 to 5 years of age who may be or are on the autism spectrum. We are currently working on becoming credentialed as an applied behavior analysis (ABA) program through Nevada Medicaid. We are also in the process of becoming accredited as a home health program with the Accreditation Commission for Health Care.

Some statistical information—we have been a community provider for EI since 2009. We are currently servicing 225 children, with 60 awaiting evaluations. Based on the children we serve, the most common service they need is speech. We average about 250 visits a month for speech therapy. Positively Kids (PK) has three full-time speech therapists and one part-time speech therapist. We also have one full-time occupational therapist and one part-time physical therapist. Then, we have developmental specialists, and they provide an average of about 300 visits a month for special instruction.

I always like to start with the challenges and then we can end on a positive note. Some of the challenges that we have in EI, which I am sure is not new information to you, is the current computer system that is utilized by EI is outdated and not user-friendly. It is a case management system that does not incorporate billing processes, thus requires the same information to be entered into two different systems making for duplicative work. Additionally, it does not have the capability to run reports that would assist in helping providers to track performance and outcomes.

Since the pandemic, it has become increasingly difficult to hire qualified staff who are willing to return to a home-based setting, which is not just something that PK is experiencing. This is a larger issue as we are now being forced to compete with other corporate employers who are seeking similar qualified applicants and have the financial means to offer bonuses or have higher hourly rates. For example, our speech pathologists are in high demand, as well as our occupational therapists and physical therapists. This also creates an issue with staff retention since employees are often seeking higher hourly rates.

Specific to the return of referrals generated from the PK clinic, since we have two pediatric clinics, sometimes children seen there are referred for EI services. The referral is sent to the state for assignment and there is no clear mechanism to ensure continuity of care for PK. We may not be the provider assigned to the family for EI services, possibly due to parent choice or because the case is randomly assigned to another EI community provider.

We have very limited audiology services in the State of Nevada, specific to each county. The services for audiology are limited to only one provider and at one location.

As stated earlier, EI services are provided to children between 0 and 3 years of age. Once they are 3 years old, they are transitioned over to providers that service 3- to 5-year-olds. Clark County School District is the primary service provider for those youth. We have heard that a lot of times children fall through the cracks, although that is anecdotal information. We do not have any way to track it because we are not the service provider. Something to consider in the future is if EI was extended to five years of age, children's needs may be better met before becoming school age. Again, you heard a presentation about brain development and how the 0 to 5 years of age are critical. For kids to be dropped off at the age of 3 to another transition, who may or may not be able to service them, it would behoove us to consider moving to 0 to 5 years of age for EI services.

Some of the successes—since we offer several types of services at Positivity Kids, we are able to provide a continuum of care for a number of the children we serve, especially those who are medically fragile or developmentally challenged.

We have developed our own internal EI audit process. We are also an active member of what we call the Positively Kids Quality Assurance Program Improvement Committee, which we are always looking to improve our processes.

One of the positives that came out of the pandemic was, since we were providing telehealth services, it assisted our staff in strengthening their parenting, coaching skills. The service was being done through telehealth and we were not necessarily in the home, we were really coaching up our parents to provide the service.

Positively Kids continues to maintain a strong relationship with the state EI representatives. We are committed to collaborating with the state and community partners to ensure that the children we serve are getting the best care possible. We are hopeful that over the next few years we will be able to expand the services we provide to the children we serve. Going forward, we are hoping to launch a pediatric skilled nursing facility, and we are considering looking into providing medical daycare for these kids that are medically fragile.

This concludes my presentation, and we are eager to take questions if warranted.

Chair Peters:

Thank you. I appreciate you bringing your challenges and then ending on a successful note, we always like to celebrate our successes in this state. Our job in the Legislature is to take on those challenges and find solutions to help enable our partners in both the state and private sectors to ensure we were providing services where they are needed. I appreciate your challenges slide especially so we can start to work on some of those solutions. Are there any questions from the Committee? Assemblywoman Gorelow has a question, please go ahead.

Assemblywoman Gorelow:

For transparency, I actually work at Positively Kids; however, I do not work directly with the EI program. Can you talk about the children who are being seen, what kind of delays you are seeing, and the children who are awaiting evaluation? Can you explain how a child qualifies for EI and the current wait list?

Jennifer Lagana, Vice President of Early Intervention, Foundation for Positively Kids:

Currently, children qualify for EI services under four different categories: (1) a 50 percent delay in one area of development; (2) a 25 percent delay in two or more areas of development; (3) a diagnosed medical condition, which falls under the category of auto eligible; or (4) an informed clinical opinion—there are times when children do not necessarily meet the other three criteria, but the team feels like this child would benefit from the services or the family would benefit from our support.

Most of the children we see come in with developmental delays, and that can be in any of the five areas of development. We assess cognitive, adaptive, self-help, communication, and physical domains.

We receive referrals primarily from pediatricians' offices, but we do occasionally get calls directly from parents who have noticed their children are not doing the same things other children their age are doing. All referrals go through the single point of contact, which is the Nevada Early Intervention Services (NEIS). Parents do have the right to choose which program they want, but if a parent does not have a preference, then they are assigned to the next available program in the rotation.

Chair Peters:

Mr. Burns, do you have anything to add from the perspective of the provider association on this topic area?

Rob Burns, President, Early Intervention Community Providers' Association:

Thank you, Madam Chair, and members of the Committee. I echo the presentation in terms of the trade associations. The trade association represents the community providers, with the exception of one, both in northern and southern Nevada. There are two critical points we could benefit from with the state's help: critical staff shortages, in terms of staff hiring, and retention, which is going to be a huge one. As my colleagues presented earlier, there are other entities in the health care system that can offer reimbursement rates, payment rates, or salaries that we are not able to do in the EI program. Then, the staff retention in our programs are compromised. Lastly, we would have to make sure that we are adequately funded so we can continue to service the children. After COVID-19, it is our opinion, our Child Find efforts will increase and we will see a greater need as we move forward into the post-COVID years. I appreciate the opportunity to address this body, thank you.

Chair Peters:

Thank you for being here today; I appreciate the perspective. Are there any other questions from the Committee from the provider perspective presentation? We will close this agenda item.

AGENDA ITEM XV—THE EARLY INTERVENTION SERVICES SYSTEM IN NEVADA: ASSISTING IN THE CHILDREN'S DEVELOPMENT BETWEEN BIRTH AND THREE YEARS OF AGE

Chair Peters:

We will move on to Agenda Item XV. This is the EI services system in Nevada assisting in the children's development between birth and three years of age. We have representative

from the Aging and Disability Services Division (ADSD), DHHS. Please introduce yourselves and begin when you are ready.

Fatima Taylor, M.Ed., C.P.M., Clinical Program Manager II, NEIS, ADSD, DHHS:

Good afternoon and thank you for the opportunity to present today. We will take you through our overview of EI services. This is a collaboration between the Individuals with Disabilities Education Act (IDEA) Part C Office and Early Intervention Services. The presentation will include a general overview of the EI system, successes and challenges in meeting child health outcomes, and critical employee shortages (Agenda Item XV).

We will start with the overview of the EI system. Early intervention is an array of services and supports for infants and toddlers from birth to age 3 with disabilities or developmental delays. These services help their development and help them to reach their full potential. These services are at no cost to families; our funding sources are the State General Fund, IDEA Part C funding, and insurance when families give us permission to bill.

Why is EI important? Early intervention is important because it has a lasting impact on a child's overall development, how they learn, and how they can regulate their emotions. In previous presentations, we heard about the critical time of the first three years of life for brain development. Early intervention, when presented timely, can improve the quality of life for children. I will pass it over to Dr. Malina-Lovell and she will present the next part of the presentation.

Lori Ann Malina-Lovell, DrPH, Part C Coordinator, IDEA Part C Office, DHHS:

Our target population is from birth to three years with delays or disabilities. During December 2021, our federally required point in time count was 3,136 children. Of this population, 65 percent are male with 35 percent female. Our system does not yet have sexual orientation gender identity (SOGI) data, but we are planning to develop processes to provide this required data within our new data system, which is expected to be implemented during 2023. Further representativeness by race, ethnicity during 2021 is reflected here for your reference. Our EI system is endeavoring to increase representativeness through a number of Child Find community outreach efforts and through advising from our EI equity subcommittee.

Stakeholders within our EI system includes the following entities. The Governor-appointed Interagency Coordinating Council (ICC) is a federally required advisory board for all states participating in IDEA Part C. The ICC is comprised of stakeholders across the field of EI, with subcommittees for Child Find, family participation, and equity. Next, we have the IDEA Part C Office, which is the lead agency providing general supervision and regulatory oversight of the comprehensive EI services system in Nevada. We received formula grant funding and federal oversight from the Office of Special Education Programs (OSEP), U.S. Department of Education. We have offices in Carson City and Las Vegas. We are pleased to collaborate statewide with ADSD, which provides the day-to-day operations of EI services throughout Nevada. The Division oversees and manages service delivery and service agreements. They are the system point of entry for all referrals to the system. They also managed base planning for services during the COVID-19 pandemic. The Division also manages the EI system budget made up of general funds, insurance billing, and IDEA funds. At this time, our presentation will continue with my colleague Sarah Horsman-Ploeger.

Sarah M. Horsman-Ploeger, M.Ed., Health Program Manager III, NEIS, ADSD, DHHS:

As Ms. Taylor mentioned, we have an array of EI services that we provide in the state. Some of those services are listed for you. We like to point out that services for children who are eligible are at no cost to families and are provided in a child's natural environment. We have direct contact information for anyone to refer a child through our system's point of entry.

As our colleagues at Positively Kids who presented before us, we have outlined the state regional offices, as well as our community partners and the regions they serve. Each program serves IDEA Part C-required services. Additionally, the state regional offices exclusively serve children or the most medically fragile infants and toddlers, as well as some non-Part C related programs and services, such as our CAPTA program, which was mentioned earlier, as well as a screening and monitoring program for children who may have been released from the NICU without significant medical needs, potential fetal alcohol syndrome suspicions, and potential NAS. If any of those children under our CAPTA or screening and monitoring program should show more significant concerns, a family has the right to refer to Part C for a full assessment and eligibility determination. I will now turn it back over to Dr. Malina-Lovell.

Dr. Malina-Lovell:

We are proud to share highlights of the successes occurring in our EI services system. During COVID-19, our system ensured the continuity of services to families with the use of alternative service methods, such as telehealth services allowed under OSEP and Medicaid. During federal Fiscal Year 2019–2020, our EI system met our State Systemic Improvement Plan's target for children exiting EI services who had made progress in their social, emotional development. The target was set at 68 percent and the actual achievement reflected that 74 percent of children exiting statewide had made progress in their social, emotional development and outcomes. This importantly ties into mental health for infants and toddlers. We attribute the success to the thoughtful, hard work from many among our EI and quality assurance programs, personnel, practitioners, families, and stakeholders promoting the social, emotional pyramid model efforts.

Another highlight is regarding our ARPA funds, which are being allocated with consideration of data-driven needs and stakeholder input within our EI System, including a new data system, which was addressed by our colleagues from Positively Kids; a systems study to further identify system needs and solutions; and training and professional development for the retention and career group of EI personnel.

Challenges experienced in our EI services system include that children under the age of 5 are not eligible for vaccination, 50 percent of families surveyed during Spring 2021 responded that services via telehealth methods were challenging, and many families experience challenges during the pertinent juncture of transition exit at age 3. A child leaves our EI services system at age 3 and may go on to receive services with the next program, such as an early childhood special education program or preschool. There is an excerpt of our Part C office's federal reporting to OSEP regarding families who found themselves waiting at the crossroads between EI and their next program, with delays and limitations that were attributable to the COVID-19 pandemic.

The Office of Special Education Programs provides guidance to states when services are impacted due to COVID-19, such as procedural safeguards and timely notifications to families. We will note that OSEP allows states to apply for additional flexibility to use IDEA

Part C funds to serve children beyond age 3 under IDEA, specifically with an extended option. This option extends services to a child who previously received EI services until the beginning of the school year following the child's third birthday with parental consent and according to IDEA regulations. The Office of Special Education Programs provides state incentive grants to these states that elect to offer Part C services beyond age 3 under IDEA. At this time, EI is legislated for the birth to age 3 population. We will conclude our presentation with Rique Robb.

Rique Robb, Deputy Administrator, Children's Services, ADSD, DHHS:

Based on the information shared by the community partners, the Nevada Early Intervention Community Partners Trade Association and state programs, it has been determined all EI programs are continuing to experience critical shortages in both direct and indirect staffing. As you have heard from our previous provider, it has definitely been an impact to EI services. The shortages directly impact Nevada's youngest and most vulnerable population and their families needing specialty services. The impact to Nevada's EI system is the risk to this vulnerable population waiting for critical and timely services with the goal to not negatively impact the child's development due to these challenges. It also could result in a corrective action from OSEP and potentially put us with a wait list, which we have not seen in many years. Our goal is to find a way to eliminate this critical shortage and be able to serve our populations appropriately. Due to the critical shortages for developmental specialists, there have been multiple requests to modify the current requirements of the EI educational endorsement. We are currently working with the IDEA Part C Office in the review of the potential options for licensure and retentions to ensure the special population reserves critical services timely and by appropriately educated staff.

We will be ending on a good note, which is something we have been waiting for quite some time. The ARPA funds through OSEP, afforded us to be able to work on two initiatives that we have been working towards for many years. One initiative is a system analysis, which started with an analysis of our rate study. As you remember from our last legislative session, we talked about rates and what that looked like for a comprehensive provider. The study has begun; we have the initial data that was presented last Friday, May 13, 2022, to the Trade Association and comprehensive community providers, and we are now in the phase of public comment. They are working towards that public comment, and it will close June 3, 2022. Burns & Associates, Inc., a Division of Health Management Associates, has been conducting the survey as a third party. We have been able to work with them to provide the information for the state providers, as well as the comprehensive community providers. So far, we do have an initial draft of that study and we look forward to that public comment period to ensure we have all of the information before the final analysis. The comments will be evaluated, and we will be able to have it finalized. We hope to give that information to all of you in a future meeting.

The analysis will also be reviewing the 50/50 requirement of the caseload split and the impact to services. It impacts service delivery when the system must enforce a rotation hold on parent choice. Parent choice is required by OSEP and federal law. It is also the right thing to do when we are allowing a family to choose which provider they would go to. In the past, we have found when we are not at that 50/50 caseload split, we must artificially stop that parent choice and take a program out of rotation, which is typically those community providers and are not supportive of that parent choice model. It is really important for us to share with you that is an impact to the service, the child, and the family if they are not able to have their choice of the community provider or state provider where they would like to have their child receive services. Ensuring we are within compliance with OSEP, we would like you to hear that request as we move forward and as we go into the next legislative session.

The great thing is we have learned many lessons already and we are only at the beginning stages of the analysis. We have learned how different our state is and Nevada is structured very differently from other states for EI services. One of those differences is how we are structured with the IDEA Part C Office, ADSD, our quality assurance, and NEIS as a whole. We are in different divisions and there are times when that division separates us in the alignment of our funding, compliance, and service delivery. Again, those are just items to keep in mind as we are moving forward with our analysis and when we move into the next phase through the Legislature.

The second initiative is building a NEIS comprehensive data reporting system. I have been with the program for almost five years, and we have been working on it since I came in. With the OSEP ARPA funding, we were able to work through the request for proposal (RFP) process with purchasing. We are excited to say that we have secured a vendor and are working towards the June Board of Examiners' meeting for that approval. We are here, five years later—at least for me—it has probably been almost ten years for us. You heard talk about the challenges of an outdated system. Our hope is that we will be able to stop some of the triplicates we have. Some programs require us to put things in three or four times, most are two at this point. Our track system will be eliminated and we will have a new system that ensures we have a comprehensive case management, billing, data, and federal reporting system that will be imperative for all our programs to be successful. It will help us ensure that we are working for those children and being able to have all their information in one place. No matter what program they are in, they are going to get the same system, the same processes, and the same supports they deserve.

I thank you Committee for taking the time with us. I know you have been here all day, so we appreciate your time and we are open to any questions you may have.

Chair Peters:

Thank you, this is very exciting. I am a huge fan of working smarter, not harder. The single input systems make life so much easier on the back end for quality control, in addition to the front end of putting in data that needs to be utilized later. Are there any questions for this presenter today? Assemblywoman Gorelow has a couple of questions, please go ahead.

Assemblywoman Gorelow:

I want to share that EI means a lot to me, not only because I, for transparency reasons, work for Positively Kids, but my own son was referred to EI when he was about 2 years old. I am excited to hear that you do not have a wait list because when he was referred, there was a wait list and he aged out before he was able to get any services. Even today, as he is almost 16 years old, I can still see some of his speech issues and I sometimes wonder if they would have been corrected if he had speech therapy early on. He is fine, but as a mom, you always wonder those things. When I looked at the auto eligibility, I noticed one of the criteria was a 27-week preterm; my son happened to be 36 weeks preterm. I thought at one point it was 32 weeks. Has that changed or am I remembering it incorrectly?

Ms. Taylor:

For auto eligible kids, long ago it was 27 weeks for preemies, if I am remembering correctly. For 32 weeks, if there were still concerns that did not come out, they would not have been auto eligible, but we could have done an informed clinical opinion to make the child eligible.

Assemblywoman Gorelow:

Since we are speaking of age, I liked your graphic about the race demographics for those who are being referred to EI. What age are children being referred to EI? As we know the earlier the better, but my son did not get referred to until he was 2 years old. Do we have an age breakout on when these children are being referred?

Ms. Robb:

Thank you for that question. We do not have that information with us today, but we would be happy to get back to the Committee.

Chair Peters:

If you would send that follow-up to staff and they will get it to the members. I have one more question for you on the workforce issue. You mentioned wanting to explore retention and recruitment strategies, but do you have any ideas at this point or partners you are working with on establishing what those strategies might be? We have a lot of movement in the Governor's Office on addressing this issue across the health care spectrum, but I have not heard from your providers about being brought into those processes. Can you talk about what that looks like?

Ms. Robb:

We are at a multilevel at this point. Some of them are state providers who are developmental specialists; obviously, we have master levels and some doctorate levels. They are also required to have an educational endorsement, which is specific to NEIS. This is one piece we are looking at because we get them and at about two years, they cannot make the three-year cut off. We are working with Dr. Malina-Lovell and her team with Part C to determine what that looks like and if there are modifications for that. We are in the process of that review for developmental specialist.

The other challenge is many of our speech and language therapists, occupational therapists, and physical therapists are contracted. They are all specialty therapists. Unfortunately, the state and our community providers are not able to compete based on what they are able to make either within a school district or the hospitals. Obviously, this would be a funding opportunity for us in regard to what that might look like. There are many things we could look at. We have found that therapies are not within the state range; they do not have a class spec. We would really look at what those ranges would be and how we might be able to meet that on a salary. Also, when it comes to developmental specialists, one of the challenges is if they do not meet the criteria when they come in, they have up to three years to meet that requirement. My colleagues may want to provide additional information.

Dr. Malina-Lovell:

Thank you for sharing those strategies about retention and recruitment. I would like to add that the IDEA Part C Office offers flexible licensing options for developmental specialists who must meet their three-year professional requirements. We provide an alternative licensure, or what we call an alternative certification, which is an equivalent of Nevada’s Department of Education’s (NDE) endorsement in early childhood developmentally delayed for ages birth to 7. This alternative certification provides savings for developmental specialists on licensing fees. Although, they are required to take the same coursework that NDE requires, there is additional flexibility, especially if needed for extensions on that timeframe when

developmental specialists can show they need extra time and have performed good faith efforts to meet the requirements.

Some other strategies that we are utilizing in our system to promote retention include providing professional development hours, at no cost to providers. Providers may use those hours towards licensure renewals with NDE or our IDEA Part C Office.

I would like to also add that we are incorporating as many strategies as we can to address what is prevalent in this field of public service regarding burnout and compassion fatigue. Throughout our state we are promoting self-care for our personnel, as well as diversity, equity, and inclusion efforts to support all personnel.

Chair Peters:

I have one more question related to the demographic's breakout. I just looked at the page Assemblywoman Gorelow mentioned. The percentage of Black children who are recommended for intervention services seems particularly low, population-wise, especially compared to our White and Hispanic populations. Can you talk about why that number may be so low?

Dr. Malina-Lovell:

Chair Peters is referring to the slide that depicts that 38 percent of children eligible for services are White, 37 percent Hispanic, 9 percent for Black children, and those lower percentages that you would see for two or more races—Asian, Hawaiian/Pacific Islander, Native American, and Alaskan Native.

I do not have that data with me at this time, but we can endeavor to locate that for you. Some of the information that has been brought to us is that these ethnicities and races are historically underrepresented. We are federally required by OSEP to increase that representativeness for those minorities in EI. Some of the efforts that we are using to increase this representativeness include engaging with our communities in various events. I can ask my ADSD colleagues to elaborate further on this because they are the ones involved at the direct level with the community and with families. We also have Child Find outreach efforts that we report on and are conducted throughout the state; we have fairs and parent council meetings. Then, as I had mentioned, we are endeavoring to address this through our ICC equity subcommittee.

Chair Peters:

I would also be interested if you have any demographic breakdowns of your providers with regard to race. One of the things that we have heard over and over again is the lack of representation of minority health care workers, particularly in the mental and behavioral health space. I was curious what those look like and how they compare to the representative demographics of those you serve. Thank you for the follow up if you have it.

Are there any other questions from the Committee? I do not see any. Thank you for being here and your presentation. We appreciate your time today and look forward to seeing some of these ideas come to fruition during session.

AGENDA ITEM XVI—UPDATE ON THE CORONAVIRUS DISEASE OF 2019 HEALTH CRISIS INTERIM STUDY PURSUANT TO SENATE BILL 209 (2021)

Chair Peters:

We are going to move on to our next agenda item. Agenda Item XVI is our final presentation for the day and is an update on the COVID-19 health crisis interim study pursuant to SB 209 (2021). Vice Chair Doñate will give us a brief summary of his findings so far, please proceed.

Fabian Doñate, Senate District 10:

Thank you, Chair Peters, and good afternoon to my colleagues. Today, I am presenting the second update on the COVID-19 health crisis interim study pursuant to SB 209. Before we begin, similar to last time, there is a handout available on the Committee's meeting page (Agenda Item XVI). As I stated before, Chair Peters has appointed me to lead the SB 209 interim study efforts during the January 20, 2022, Joint Interim Standing Committee on Health and Human Services meeting. As I summarized during our last meeting, I decided to hold various roundtable discussions with relevant stakeholders for each of the interim study requirements. I will try to provide as many updates as possible to the Committee over the coming months.

The last roundtable was held on April 25, 2022. I invited several stakeholders to their second virtual roundtable discussion, and this one focused on the requirements related to the COVID-19 pandemic on businesses, their employees, and the economy. Specifically, we looked at examining the benefits and challenges of implementing a task force between public and private representatives to support private businesses and the population areas of the state. We also tried to examine the economic impacts of the COVID-19 health crisis using an equitable perspective.

As with the first roundtable, stakeholders received a survey with different questions and we gave them the opportunity to give us policy proposals that we could look at for the next session. A list of the stakeholders who received the survey and who responded is provided in the handout. Most of the stakeholders were comprised of state and local associations and nonprofit entities, representing various business sectors and employees throughout Nevada.

The policy recommendations are probably the most important part of this handout. On page 2, there is a summary of the high-level discussion themes, along with the strengths and challenges encountered throughout the pandemic. Here are some highlights for you. First, the greatest strength identified was the resilience of workers and the entities serving their communities. Second, the greatest challenge identified was a critical labor shortage, which participants said is being impacted by both inflation and the high cost of childcare, transportation to work, and housing. Additionally, policy recommendations were summarized on page 2. One recommendation highlighted the need to update the state's process for moving the federal funds directly to those in need. I want to note, this was already brought up during the first roundtable discussion. While there were consistent themes identified during the roundtable discussion, we received many different policy recommendations from the survey respondents. Therefore, we decided to outline those specific recommendations provided in the addendum, which you can find on pages 3 and 4 of the handout.

Chair Peters, I look forward to sharing the final updates of the study. Our next roundtable is going to be on the discussion of our public health workforce, and the final roundtable is

going to be discussing health equity and special populations. This concludes my remarks, and I am available to answer any questions you may have.

Chair Peters:

Thank you, Vice Chair Doñate; we appreciate your effort and work in this space. I know from the folks who have an interest in this area, we appreciate the inclusion and discussions that are specific and pertinent to the issues at hand. Are there any questions from the Committee related to this update today? I am not seeing any. Thank you so much again. This report is great. I am going to look at your report, together with the last one, and I look forward to your final report in the coming months. We will close this agenda item today.

AGENDA ITEM XVII—PUBLIC COMMENT

Chair Peters:

Our final agenda item today is public comment. We will start public comment with those in the physical locations and then move to public comment from anyone who has called in.

There is no one in the room here in Carson City. Is there anybody in Las Vegas who would like to come to the podium for public comment? I am not seeing anybody coming up in Las Vegas either.

Broadcast and Production Services, please add the first caller for public comment to the meeting. We will give this a minute because I know there is a lag.

Is there anybody on the public comment line at this time?

BPS:

Yes, Chair. We have one caller. Caller, you are unmuted and may begin.

Katie Ryan, System Director of Government Relations, Dignity Health-Saint Rose Dominican:

Good afternoon, Chair Peters, and members of the Committee. Today you have heard from some of my colleagues about the need for additional Medicaid reimbursement for community health workers and peers when it comes to items like substance abuse, mental health, and violence prevention. Myself; Dr. Deborah Kuhls from University Medical Center and the University of Nevada, Las Vegas School of Medicine; along with The Health Alliance for Violence Intervention would love to present additional information to this Committee around other states that have done this work and allowed for additional reimbursement proprietors for violence prevention.

Our providers, particularly in our emergency departments and trauma centers, see these violence victims. Two-thirds of victims of gun violence are Medicaid patients and roughly one-third of them will be injured again without intervention. Hospital-based violence intervention programs consistently decrease the risk of being reinjured—generally from that one-third down to about only 4 or 5 percent—while increasing access to needed services such as primary care and mental health.

Intimate partner violence is also a huge issue. One in four women have dealt with this issue and consequences can range from physical injuries, chronic health conditions, mental health disorders, and even death. One in five homicide victims are killed by an intimate partner.

We have been in discussion with Medicaid and others at DHHS and there is an appetite to move forward. We would also love the opportunity to present to this Committee and get your support and funding for the health equity issue. Thank you, and I am available for any questions you may have.

Chair Peters:

Thank you so much for the public comment today; we will keep that in mind. Is there anyone else on the public comment line?

BPS:

Chair, there are no more callers at this time.

Chair Peters:

As a reminder, our next meeting will be held on June 16, 2022, at 9 a.m. It will be a joint meeting with the Joint Interim Standing Committee on Natural Resources to look at climate change and health risk indicators together. I will be attending in Las Vegas at Grant Sawyer, barring any public health crisis circumstances and lack of travel. I hope to see my colleagues in the building if you are able to make it.

AGENDA ITEM XVIII—ADJOURNMENT

There being no further business to come before the Committee, the meeting was adjourned at 3:26 p.m.

Respectfully submitted,

_____

Crystal Rowe
Research Policy Assistant

_____

Patrick B. Ashton
Senior Policy Analyst

APPROVED BY:

_____

Assemblywoman Sarah Peters, Chair

Date: _____

MEETING MATERIALS

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
Agenda Item II	Leann McAllister, Executive Director, Nevada Chapter of the American Academy of Pediatrics	Written Remarks
Agenda Item III A	Eric Robbins, Principal Deputy Legislative Counsel, Legal Division, Legislative Counsel Bureau (LCB)	LCB File R175-20 of the Board of Psychological Examiners
Agenda Item III B	Eric Robbins, Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R013-21 of the State Board of Pharmacy
Agenda Item III C	Eric Robbins, Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R041-21 of the State Board of Pharmacy
Agenda Item III D	Eric Robbins, Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R120-21 of the State Board of Pharmacy
Agenda Item III E	Eric Robbins, Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R121-21 of the Board of Psychological Examiners
Agenda Item III F	Eric Robbins, Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R127-21 of the Board of Psychological Examiners
Agenda Item III G	Eric Robbins, Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R051-22 of the State Board of Pharmacy
Agenda Item IV	Kyra Morgan, Chief Biostatistician, Office of Analytics, Department of Health and Human Services (DHHS)	PowerPoint Presentation
Agenda Item V A-1	Tami Conn, Maternal, Child and Adolescent Health Section Manager, Bureau of Child, Family and Community Wellness, Division of Public and	PowerPoint Presentation

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
	Behavioral Health (DPBH), DHHS	
Agenda Item V A-2	Kyra Morgan, Chief Biostatistician, Office of Analytics, Department of Health and Human Services (DHHS)	Memorandum
Agenda Item VI	Antonina C. Capurro, D.M.D., M.P.H., M.B.A., Deputy Administrator, Division of Health Care Financing and Policy (DHCFP), DHHS; and Briza Virgen, Social Services Chief I, Medical Programs, DHCFP, DHHS	PowerPoint Presentation
Agenda Item VII A	Alexia Benshoof, Health Bureau Chief, Office of Analytics, DHHS	PowerPoint Presentation
Agenda Item VII B	Deepa Nagar, M.D., M.B.A., F.A.A.P., Newborn Intensive Care Unit Medical Director and Chair, Department of Pediatrics, Siena Campus, Dignity Health-Saint Rose Dominican	PowerPoint Presentation
Agenda Item VIII	Andria Peterson, PharmD, Executive Director, EMPOWERED, College of Medicine, Roseman University of Health Sciences	PowerPoint Presentation
Agenda Item IX	Brian K. Iriye, M.D., President, Hera Women's Health, and Managing Physician, High Risk Pregnancy Center	PowerPoint Presentation
Agenda Item X	Sarah Rogers, Nutrition Unit Deputy Chief, Office of Food Security, DPBH, DHHS	PowerPoint Presentation

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
Agenda Item XI A-1	Sarah Rogers, Nutrition Unit Deputy Chief, Office of Food Security, DPBH, DHHS	PowerPoint Presentation
Agenda Item XI A-2	Sarah Rogers, Nutrition Unit Deputy Chief, Office of Food Security, DPBH, DHHS	Memorandum
Agenda Item XII	Karissa Loper Machado, M.P.H., Agency Manager, Child Care and Development Program, Division of Welfare and Supportive Services, DHHS	PowerPoint Presentation
Agenda Item XIII A	Marty Elquist, Department Director, Early Education and Development, The Children's Cabinet; and Denise Tanata, Director, Early Childhood Comprehensive Systems, The Children's Cabinet	PowerPoint Presentation
Agenda Item XIII B	Annette Dawson Owens, School Readiness Policy Director, Children's Advocacy Alliance; and Jamelle Nance, Strong Start Prenatal-to-Three Director, Children's Advocacy Alliance	PowerPoint Presentation
Agenda Item XIV	Paula Hammack, Chief Strategy Officer, Foundation for Positively Kids	PowerPoint Presentation
Agenda Item XV	Sarah M. Horsman-Ploeger, M.Ed., Health Program Manager III, Nevada Early Intervention Services (NEIS), Aging and Disability Services Division (ADSD), DHHS; Lori Ann Malina-Lovell, DrPH, Part C Coordinator, IDEA Part C Office, DHHS; Rique Robb, Deputy Administrator, Children's Services, ADSD, DHHS; and Fatima Taylor, M.Ed., C.P.M., Clinical	PowerPoint Presentation

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
	Program Manager II, NEIS, ADSD, DHHS	
Agenda Item XVI	Fabian Doñate, Senate District 10	Handout

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