NEVADA LEGISLATURE
JOINT INTERIM STANDING COMMITTEE ON HEALTH AND HUMAN SERVICES

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

MINUTES

April 8, 2024

The third meeting of the Joint Interim Standing Committee on Health and Human Services for the 2023–2024 Interim was held on Monday, April 8, 2024, at 9 a.m. in Room 4401, Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. The meeting was videoconferenced to Room 3138, Legislative Building, 401 South Carson Street, Carson City, Nevada.

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

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:

Senator Fabian Doñate, Chair
Assemblyman David Orentlicher, Vice Chair
Senator Rochelle T. Nguyen
Assemblywoman Tracy Brown-May
Assemblyman Brian Hibbetts
Assemblyman Duy Nguyen

COMMITTEE MEMBERS PRESENT IN CARSON CITY:

Senator Robin L. Titus
Assemblyman Ken Gray

LEGISLATIVE COUNSEL BUREAU STAFF PRESENT:

Patrick B. Ashton, Principal Policy Analyst, Research Division
Davis H. Florence, Senior Policy Analyst, Research Division
Sarah Baker, Research Policy Assistant, Research Division
Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division
Aaron McDonald, Principal Deputy Legislative Counsel, Legal Division
Jeff Koelemay, Deputy Legislative Counsel, Legal Division
Kimbra Ellsworth, Senior 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 Doñate:

Welcome everyone to the third meeting of the Joint Interim Standing Committee on Health and Human Services (JISC HHS). Today is our Public Health Day. As I mentioned earlier during the interim, we are going to be tackling different priority areas, and today's focus is on public health. I do not know if there has ever been a JISC HHS meeting specifically targeting public health, so it is exciting to talk about different issues that will come up throughout the day.

[Chair Doñate went over housekeeping measures and public comment protocols.]

We will start with public comment.

AGENDA ITEM II—PUBLIC COMMENT

Chair Doñate:

I want to remind folks that we have a full agenda today, and we want to provide each topic sufficient time to be heard and considered. You can submit your public comment in writing if you do not have enough time to speak today.

I am aware there are folks who would like to provide their public comment in a different language today in Spanish.

[Chair Doñate went over housekeeping measures and public comment protocols in Spanish for those who wish to give public comment in that language.]

Let us begin public comment here in Las Vegas.

Patrick Kelly, President and Chief Executive Officer (CEO), Nevada Hospital Association:

During the last interim meeting, I listened intently to the discussion regarding the employment of physicians. As you proceed with your work, please keep in mind some important facts: 2.2 million Nevadans reside in primary medical care professional health shortage areas. Nevada is below the national average in 33 of 39 physician specialties, and in 25 of those 39 specialties, the number of physicians did not keep pace with Nevada's population growth over the last decade. Our focus should be on recruiting and retaining more doctors, not limiting the employment options available to them.

National trends cannot be ignored. Nevada competes for physicians on a regional and national basis. One of the biggest and clearest trends is that physicians are leaving or avoiding private practice. The American Medical Association (AMA) published a study that concluded that physicians are continuing to abandon private practice in favor of direct or indirect hospital employment. In 2022, only 46.7 percent of doctors worked in wholly-owned physician practices. That means that more than half of the doctors in America are not in private practice.

Younger doctors seem to be leading this trend: between 2012 and 2022, the share of physicians under the age of 45 who are self-employed fell by 13 percent. Younger doctors want a salary and work-life balance. In 2022, 31 percent of doctors worked in practices that were wholly or partially owned by hospitals. An AMA analysis found that physicians are leaving private practice because of the need to negotiate better rates with insurance companies, the need to improve their access to costly resources, and the need to better manage regulatory and administrative burdens. If Nevada wants to attract—and perhaps more importantly, prevent the loss of—doctors, we need to recognize national trends and give doctors a variety of employment options. If we do not give them options, especially hospital employment, other states will.

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

Today, as you listen to State representatives give an update on Nevada's immunization rates and public health outreach efforts concerning vaccinations, I ask that you keep top of mind AAP's strong recommendation that all states eliminate laws permitting nonmedical exemptions to school entry immunization requirements. (Agenda Item II)

Immunization requirements for childcare and school attendance are an effective means of protecting people from vaccine-preventable diseases, both by direct protection from the vaccine and indirect protection via communal immunity. Immunization requirements also have a beneficial effect on the timely immunization of children. Because rare, medically-recognized contraindications for specific individuals to receive specific vaccinations exist, legitimate medical exemptions to immunization requirements are important to observe. However, nonmedical exemptions to immunization requirements are problematic, as they create unnecessary risk to both individual people and communities. The Nevada AAP currently has 280 members, most of whom are board-certified pediatricians, both primary and specialty care. Members also include pediatric, nurse practitioners, physician assistants (PAs), 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.

Michelle Maese, President, SEIU Local 1107:

We represent 20,000 workers in Nevada, and 704 of them are at Southern Nevada Health District (SNHD). We are very excited to talk to you today about Senate Bill 118 (2023), and we are excited that this Committee cares about the health and priorities of our community, as we know that a healthy community is a healthy Nevada. We know that to have a good public health system and strong healthy communities, we need a robust infrastructure. We need a fully staffed public health workforce because without the workforce, services cannot be provided.

As you know, we need to continue to support our frontline workers who kept this community safe during the Coronavirus Disease of 2019 (COVID-19) as well as on a daily basis, whether with a monkeypox (Mpox) outbreak, tuberculosis (TB) outbreak, or whatever goes through the workforce. In the last legislative session, SEIU testified on SB 118 to allow flexible funding that would be appropriated and used for local authorities and health districts to address our biggest infrastructure need, which is a lack of resources for the workforce.

We want you to do more than talk about it. We want you to retain, support, and sustain the public health workforce so it does not become a public health crisis. Addressing workforce is vital and will provide the necessary services to support healthy communities in Nevada.

Regena Ellis, Member, SEIU Local 1107:

I am a member of SEIU. I am a registered nurse (RN) case manager at SNHD. We understand that SB 118 establishes the public health infrastructure and improvement account and allocates monies to noncategorical funding to local health authorities on a per capita basis. This fund is for flexible funding. It can be used for what is needed.

According to the 2021 Public Health Workforce Interests and Needs Survey of state and local public health agency staff in the United States, the COVID-19 pandemic exacerbated existing public health workforce shortages. Nearly one-third of the public health workforce is considering leaving their organization in the next year, and 50 percent are considering leaving due to pay. We are here today talking about recruitment and retention at SNHD, and we think that prioritizing this will be beneficial to the citizens and residents here in Clark County and in the State.

In addition, 41 percent of the health workforce is considering leaving due to work overload or burnout. We were the front line for COVID-19. We worked for three years. Many people worked lots of overtime to protect the public, and we did not receive anything extra for doing that. There was no hazard pay. Some people worked lots of overtime that they were not compensated for, but we did that because we are interested in protecting the people here in Las Vegas and the State.

I work in the TB clinic. We have had a 40 percent increase in cases last year, but we have not had a 40 percent increase in staff due to burnout and people leaving. I am currently the only case manager in the clinic, and our staff works very hard to protect the public from TB, which also goes hand in hand with human immunodeficiency virus (HIV), diabetes, and some other illnesses. We are asking you to prioritize our public health services.

Joi Oliveros, Member, SEIU Local 1107:

I am a member of SEIU and a senior community health nurse for SNHD. According to the 2021 Public Health Workforce Interest Needs Survey used for this bill, 50 percent of public health workforce are considering leaving due to pay. As a community health nurse, I am witness to the high turnover due to this, and we appreciate the support of this bill to retain our current workforce.

Chair Doñate:

Is there anyone in Carson City who wishes to give public comment?

Allison Genco, Chair, Nevada Council on Food Security; and Director, Nevada Government Relations, Dignity Health St. Rose Dominican:

I am here to testify in support of the presentation on public health needs and priorities to improve public health in Nevada. We testified in support of SB 118 during the 2023 Legislative Session and wanted to make sure our support was on the record today for sustainable public health funding. We look forward to seeing the outcome of this presentation today. We know that sustainable public health is needed in Nevada, and we want to make sure that comes to fruition in this time around.

Chair Doñate:

Let us continue here in Las Vegas.

Rabea Sharif, Member, SEIU Local 1107:

I am a member of SEIU and an environmental health specialist for the Consumer Health Section at the SNHD. I am here to talk about personal vehicle use for field operations staff. Dining and tourism are our biggest attractions in Clark County, as we all know. We are the only county who serve and protect over 40 million people per year. That means our public health agency is working 24/7 to protect residents, including ourselves, our families, and visitors.

Most field staff use their own personal vehicles every day for work and in their personal lives. Furthermore, staff are covering special events ranging from food operations, body arts, incident command, child care, nursing, and home visits. These special events and unsuspected outbreaks are addressed in addition to maintaining our daily workload. All of this is done in our personal vehicles.

A moment of transparency: I have spent at least $5,000 in a year between gas, new tires, brakes, stress, and oil changes. We need our personal vehicle allowance to continue to assist us with reliable means of transportation for business needs. The impact of wear and tear predominantly comes from work, which is at minimum five days per week, at least eight hours a day. In case of an emergency response or special event, field staff can work up to seven days and use their personal vehicles to accommodate business needs, so we call to request that either SNHD provides us fleet vehicle support or financial stipend support towards our personal vehicle use.

Chair Doñate:

Is there anyone else in Las Vegas wishing to give public comment?

[Chair Doñate asked this question in both English and Spanish.]

Eduardo Moreno, Private Citizen:

[Mr. Moreno gave public comment in Spanish. The following translation was provided by an interpreter.]

I am a street vendor. I thank everyone who is willing to support and listen to us. I apologize because unfortunately I forgot my glasses, but I know that the Health Department has funds available to the street vendors, and we still have not seen use of them. The permit that is required for street vendors has a lot of restrictions and is something that I personally cannot afford, and I am here to petition, if it is possible, that some of those funds be used to help with the cost of the applications for the permits and also to afford a food cart that could assist us with it.

I apologize because I had a long list, but I forgot my glasses, so I am not going to be able to read it. The reality is that there are a lot of restrictions in place with all these permits. The economy is difficult, so we are hoping that some of these funds could be used to help street vendors.

Ektor Giovanni Arevalo, Private Citizen:

[Mr. Arevalo gave public comment in Spanish. The following translation was provided by an interpreter.]

I am a street vendor, and I was hoping that some of the funds could be used to invest in street vendors. It is something that I do not know how to explain, but it is costing us a lot and I was hoping the funds could help.

Chair Doñate:

Is there anyone else in Carson City before we move online? Is there anyone virtually?

Madela Marson, Student, University of Nevada, Reno (UNR):

I am a Master of Public Health Student at UNR. As a student, public health is important to me because it includes the full picture of individual and community wellness. To achieve a state of optimal well-being for all Nevadans, providing sustainable and flexible public health funding is key. Throughout my studies at the UNR School of Public Health, this type of public health funding is continually shown as one of the most important factors for promoting successful public health initiatives.

Nareda Boadilla, Member, Make The Road Nevada:

As a member of Make The Road Nevada, this public health issue lies close to home. When I was three years old, my family emigrated from Mexico to the U.S. in search of a better future. Life here has had its ups and downs. While my brothers and sisters who are American citizens can easily see a doctor when necessary, it has not always been that simple for me. When I get sick, I cannot always afford to see a doctor, and that can be tough.

What truly breaks my heart, though, is seeing kids who are battling serious illnesses like cancer. They go through so much pain and hardship that it is heart-wrenching to imagine what their families must endure. That is why I spoke up for SB 419 (2023), also known as the Hope Act. This important law would have made a world of difference for people like me who struggle to afford health care.

You can imagine how disappointed I was when it did not pass. It is scary to think about people getting sick without good ways to get better. With Make The Road Nevada, I am teaming up with friends, neighbors, and my community to make sure everyone, no matter who they are, can get the health care they need, because let us face it: everyone deserves to see a doctor when they are sick without having to worry about money. I ask you to join us in supporting legislation like SB 419. Together, we can make sure that health care is a right, not a privilege.

Chair Doñate:

Are there any callers online who wish to give public comment?

Broadcast and Production Services (BPS):

The public line is open and working, but we have no additional callers at this time.

Chair Doñate:

I think we have one more in Las Vegas.

Gaudencia Torres, Member, Make The Road Nevada:

[Ms. Torres gave public comment in Spanish. The following translation was provided by an interpreter.]

I am here today as a proud member of Make The Road Nevada, and I am in front of you to pass legislation to make sure there is medical attention for people like myself. Recent decisions, in particular the denial by Governor Joe Lombardo on the Hope Act, have me deeply disappointed in the future of health in Nevada.

It has been a difficult experience to get medical coverage. I applied for Medicaid and never got an answer, so now I have a big debt of approximately $10,000 in medical expenses. I am disabled, and I have had a weakening medical condition for 30 years called lupus associated with arthritis. The call from Governor Lombardo on the Hope Act was a bad decision. A lot was presented during the 2023 Legislative Session. The main objective was to provide benefits to people with medical needs like me who fight to obtain essential medical services. However, his negative impact has caused a loss in hope for people like me who need medical coverage.

The personal experience needs urgent attention from the legislative side to attend to disparities in Nevada. It is unacceptable that some people like myself must face a broken health system full of barriers. The medical attention funds are needed, and we need the Legislature to make sure they provide them to balance the medical help that is needed.

In summary, my testimony here is a call to action in favor of those who fight to receive medical attention in Nevada, and I ask the Committee to take action to reduce disparities to guarantee that everyone in Nevada has medical attention they deserve. Please, Governor Lombardo, I ask for support for people like myself to have attention that we have not been able to get.

I have been here in the U.S. for 30 years petitioning Medicaid but have not gotten a response. I have a son who is 24 years old. I am a single mom, and my son takes care of me and that is why he has not been able to go to school. I ask you from the bottom of my heart if I could get Medicaid so my son could continue with his studies.

Chair Doñate:

Would anyone else like to provide public comment at this time? Seeing none, we will close public comment and move on to the next agenda item.

AGENDA ITEM III—APPROVAL OF MINUTES FROM THE MEETING ON FEBRUARY 16, 2024

Chair Doñate:

We will move on to the approval of minutes for the meeting on February 16, 2024. Committee Members, are there any questions regarding the minutes? Seeing none, I will now entertain a motion from the Committee to approve the minutes. (Agenda Item III)

SENATOR NGUYEN MADE A MOTION TO APPROVE THE MINUTES OF THE MEETING HELD ON FEBRUARY 16, 2024.

ASSEMBLYMAN NGUYEN SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

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

Chair Doñate:

Mr. Robbins will go over the regulations, and like before, if there are any regulations you have questions on, we can pull them at that site and ask specific questions to the entities.

Eric W. Robbins, Previously Identified:

We have five regulations for the consideration of the Committee today:

- LCB File R013-24 of the State Board of Pharmacy (Agenda Item IV A);
- LCB File R002-24 of the Board of Psychological Examiners (Agenda Item IV B);
- LCB File R124-21 of the Nevada Physical Therapy Board (Agenda Item IV C);
- LCB File R004-424 of the State Board of Health (Agenda Item IV D); and
- LCB File R024-24 of the State Board of Oriental Medicine (Agenda Item IV E).

Chair Doñate:

Committee Members, are there any regulations you would like to pull aside for questions or comments? I do not have anyone here in Southern Nevada. Is there anyone in Northern Nevada?

The only one I have questions on is LCB file R124-21 of the Nevada Physical Therapy Board. I do not know if there is a representative in Carson City or virtually.

I have one quick question. Could you give us a brief background of what the intention is and what the Board is looking to accomplish?

Jennifer Nash, Member, Nevada Physical Therapy Board:

The regulations are to clean up language, make it consistent with current practice, and ensure that we are providing free access for veterans. It also provides physical therapist assistants a pathway to have jobs that do not require supervision once licensed—several minor changes like that.

Chair Doñate:

I ask those questions because I noticed there are considerations for foreign-educated physical therapists. Could you elaborate about some of the changes there? I know you referred to a few accreditation boards, both in the U.S. and out of the country. I wanted to make sure that if I was a physical therapist who was already trained and practicing in

another country, this would not add more regulations stopping me. It would be the reverse and would encourage it. Is that correct?

Ms. Nash:

Yes, sir. That is correct.

Chair Doñate:

Are there any other comments or questions from Committee Members? Seeing none, we will close this agenda item and move on to a presentation on public health needs and priorities to improve public health in Nevada pursuant to SB 118 (2023) and policy considerations to address the challenges and gaps in Nevada's public health infrastructure.

AGENDA ITEM V—PRESENTATION ON PUBLIC HEALTH NEEDS AND PRIORITIES TO IMPROVE PUBLIC HEALTH IN NEVADA PURSUANT TO SENATE BILL 118 (2023), AND POLICY CONSIDERATIONS TO ADDRESS THE CHALLENGES AND GAPS IN NEVADA'S PUBLIC HEALTH INFRASTRUCTURE

Julia Peek, MHA, CPM, Deputy Administrator, Division of Public and Behavioral Health (DPBH), Department of Health and Human Services (DHHS):

Each interim, we are delighted that we can talk about public health, and we have a directed presentation this time around. I wanted to quickly highlight our mission, vision, and purpose, with a focus on our purpose: to make everyone's life healthier, happier, longer, and safer. We have gone through an intensive process as we apply for public health accreditation, and some of that is looking closely at our mission, vision, purpose, and the culture of our organization. That is important to us. (Agenda Item V A) (Agenda Item V B)

First, we wanted to focus on talking about our public health workforce. We have a 21 percent vacancy rate at DPBH, but that is an improvement from the 26 percent rate about a year ago. I want to thank our Human Resources (HR) staff and all our staff for focusing on recruitment and retention. We also have a lot of successes in this area. For the first time ever, we have funds that can focus on recruitment and retention. It is a result of the COVID-19-related funding, including the American Rescue Plan Act of 2021 (ARPA) project that the Interim Finance Committee (IFC) approved for us.

A few updates: one of the successes we wanted to note, and I encourage everybody to visit NVhealthforce.org, is a website we developed to talk about what public health workforce looks like and health care as well. We had embedded the opportunity to build a website into one of our ARPA projects, and this will include highlighting the scholarships that you all approved at the IFC, helping people navigate jobs at DPBH because our classified system can be a bit cumbersome, and highlighting specific job opportunities.

In phase two of the development, we are also looking at more interaction for the individual, so if they type in, for example, their education and interest, we can give them opportunities for both scholarships and jobs, if they are ready to enter the workforce. I think that will be a good opportunity, not just for DPBH—we are expanding it to all DHHS agencies as well as our local partners to highlight public health opportunities and better help folks navigate them.

We are thankful that we also got the Public Health Infrastructure Grant (PHIG) as did SNHD. They got funded directly. This is a grant to all states and some localities that allows us the opportunity to focus on infrastructure, and we have never really had that capacity with our federal grants—most of them are categorical. This one has some categories, including data modernization, but there is a large focus on filling the gaps that have been identified by us in Nevada. We have been able to increase staff and information technology (IT) as well as public health preparedness in our Office of State Epidemiology, to name a few.

This subgrant also requires a portion of the grant to go out to our local health districts outside of SNHD, because they got funded directly, and nonprofit health districts and counties. We are thankful that this grant allows us the opportunity to continue to fund projects, such as our Academic Health Department, which has been very fruitful, and we have also partnered with the Nevada Association of Counties (NACO) to continue to fund their public health liaison who will present to you later. There are also subgrants to support various projects, including at our health districts, and they will talk through that. We have also hired contract staff to help in our fiscal and support for our PHIG grant in our pipeline efforts, so we are thankful for that.

Regarding our ARPA projects, you all allowed us to devote funds for an epidemiologist and biostatistician pipeline. The utility of those positions was very clear during our COVID-19 response and remains infrastructure at the Agency for all public health.

You also approved the opportunity to get health care and public health workforce scholarships, including clinical rotations. It also includes health care workforce pipelines that you maybe do not see scholarships for as often, including doulas, community health workers, lactation consultants, and certified medical assistants. We finished the request for proposals (RFPs) and are in the process of getting all those funds out. All of that will be highlighted for folks on the NVhealthforce.org website, so if anyone in the public is interested in any of those pipelines, I encourage them to go there to figure out how to apply.

We also have internal programs to retain staff. Some of the funding approved with ARPA allows skills development for our staff, and we are being thoughtful about who gets that, including a certain duration of time already served with the Division of five years or more, plus the willingness to continue to work. We are growing our workforce for those dedicated State employees.

I am sure you will hear echoed in the presentations to come that the challenges lie in maintaining this good work after the ARPA and COVID-19 funding ends. If we cannot maintain it, good work was done and will be done in the next several years. That will not be lost, but it is great to maintain those if we are able.

We are also funding project-specific staff, including the Nevada Office of Minority Health and Equity, diversity, and immunizations. Those funds will conclude starting in May, but through 2027, we will lose a good number of staff if we do not have a way to retain that funding. Recruiting and retaining stuff is also a huge challenge. We are seeing improvement, but there is always difficulty in that area, so we are thoughtful about that.

Preventing infectious disease is another area we were asked to highlight. As you all saw from COVID-19, epidemiology and contact tracing is a way we can control infectious disease. There are means in which we get information to those who have tested positive and quickly mitigate and find those folks and their contacts.

One of the challenges historically is that we do not have a lot of funding in this area. Federal funding is the backbone, so a federal funding ebbs and flows—a boom-and-bust cycle is what we noted here—that is a real challenge. If folks have degrees in epidemiology, that is wonderful, but a lot of it is on-the-job training, talking to individuals. When we have that boom-and-bust cycle, we must get new staff on, train them, and then often the positions are lost or sunset.

One quick example from our Office of State Epidemiology provides what the State infrastructure looks like: at the peak of COVID-19, we had almost 80 staff, but now we are down to 60 because the funding is decreasing. If we do not get additional funding, in about 2027, when that COVID-19 Fund sunsets, we will have about 15 full-time staff, which is what has been in place since I started about 18 years ago, and that is challenging. When we have a population increase, infectious disease increases because of that population, and if we do not have the staff to focus on that infectious disease response, it is a challenge to stop it.

Interoperability is an area where we have not had a ton of funding in the past, but we are thankful that the federal government and a variety of grants have given us funding for data infrastructure and modernization. When we started COVID-19, much of the State's work in epidemiology was done via a fax machine, unlike the rest of the world, which had upgraded to better technologies. Now that the federal government allowed us to get data modernization funding, we can dedicate time and effort to making our systems much more efficient.

One thing we wanted to highlight is our ability to upgrade our vital records system, which is hugely important to all Nevadans. We are focusing right now on interoperability with Clark and Washoe Counties and are going to look at the rural county coroner's offices next. We are also looking at integrating EpiTrax, our infectious disease system, into this vital records system with a better interoperability so our teams can see data much more quickly.

Another project we are working on is the Health Data Lake, a repository of data that will help us with a variety of things, including a much better opportunity for analytics and utility of the data in real time. That is one of the funded projects we are excited to provide updates on going forward.

Another thing we did was get funding to move from the U.S. Centers for Disease Control and Prevention (CDC) free system, NBS, to EpiTrax, and that has allowed us more ability to customize our data collection systems and do analysis. We also got funding to increase the opportunity to have electronic data exchange with our laboratories, which increases the timeliness of the data so we could follow up more quickly.

Regarding SB 118, I say a huge thank you to this Committee for sponsoring this bill. Your bipartisan support was the backbone of the success of getting this passed. As you recall, $50 million was approved. There was an allocation given to the health district and the counties, though DPBH is not using any of those funds locally. We wanted to do a per capita allocation to every county, and that has been a fun and interesting process. Later, NACO will talk about it in their presentation.

The variety of projects we are seeing come through is incredible. It speaks to the diversity within each county. There are challenges with it because it is a one-time allocation, but there is everything from a specific focus on the seniors in their community to jail-based services to making sure we are thoughtful about sexually transmitted infection (STI)

immunization in that community and not missing opportunities to provide public health services where we can, regardless of location.

The counties are going to speak more to what they are doing, but I want to highlight that theirs is based on local needs assessments; in areas where we do not have funds, there is a real gap in the categorical grant. Great work from them there. I want to highlight that NACO has been a huge partner for us. They are working on ideas for what sustainability looks like and being more thoughtful about how that is allocated, perhaps not strictly on a per capita basis, but also maybe a funding formula as we do with other federal grants.

We would love an opportunity to have funds for statewide efforts, including data modernization and other things that are statewide activities. In the initial bill put forward by this Committee, there was a five percent allocation, and it was removed over the course of the bill.

We would also like a carve-out for our tribal health partners. I know you had a presentation earlier before this Committee, and we are working with our tribal health partners to figure out what that looks like, but a specific carve-out for them with some sort of funding formula would be a huge win if we were able to find sustainability.

I was asked to highlight how we look at Healthy People 2030 and how we utilize that. You heard a presentation a couple meetings ago about our State Health Improvement Plan (SHIP), and Healthy People 2030 is a benchmark our federal partners have developed and is included in our SHIP. We have provided examples of how we utilize that as our goal and as a benchmark. We also have what is called the Network of Care for Public Health and Wellness, and we have data by county for a variety of measures. The benchmark for that is always the Healthy People 2030 goal where there is one that aligns.

We are embedding Healthy People 2030 in our performance metrics; if there is a benchmark for what we should be striving toward for a certain measure, we will use that. Most of our federal partners have a Healthy People 2030 tie for the categorical funds, so we are reporting on that and tracking that closely. If anybody has questions, I am happy to take them now or turn it over to my colleagues.

Chair Doñate:

Let us pause and take a few questions from Committee Members. I know that this was specifically focused on DPBH statewide, so if anyone has questions, now would be the time to ask.

Senator Titus:

It is always good to hear from you. Your work continues to be excellent. With the public health workforce, I appreciate what you are doing and the fact that you have decreased the positions. You talk about rural areas and the rotations students must do, and hopefully you have enough folks they can rotate with for that education. One of the things I have been focusing on is many of these folks, when they get a scholarship to attend these schools and can get reimbursed afterwards, do you have any programs where they are getting a stipend to do these rotations? Not only the students but your own staff?

I want to make sure we can support those who are interested in advancing their degrees and not doing it because they cannot afford to leave their current job or do not have enough

money to spend time in the rural areas. Do you have any programs like the nursing program where the interns and our nurses got paid to rotate?

Ms. Peek:

My preceptor, Brandy Bengo from Lander County, joined me today. She is going to nursing school. She has been working with me remotely. Huge shout out to the School of Nursing at UNR who is allowing her to complete her degree from Lander County. We are doing a similar thing with our rotations but more scholarships. Some proposals put forward that were funded focused on certificate programs, so you could get a certificate in epidemiology that is more remote based. We will train them where they are.

We also have great online programs that will be part of this. Say you want to get your master's in public health with a focus on epidemiology or whatever the case may be; that is a fully online program with a potential opportunity to get internships in the community in which you serve, so good work on that.

Regarding the clinical rotations, I would have to go back and look, but we partnered with the School of Medicine that does have a focus on the rural areas. That is part of their scope. I can provide a full listing of everything so you could see where there is a rural focus to help us promote it. We are in the process of the promotion right now in the subgrant, so if there is opportunity to get the word out locally, we would love to help.

Senator Titus:

One of the things I worry about is driving out to the rural areas is where they are going to live when they do those rotations and the cost of doing that. Do they get a stipend to go out there? I would be very interested in seeing that.

Assemblyman Gray:

With the Health Data Lake project—and I know you have a data governance requirement in there—is there any personally identifiable information involved in that? I am always leery of data breaches and things like that, especially when it comes to somebody's health records, so I wonder if there is any personally identifiable information where somebody could get information they would not otherwise have.

Ms. Peek:

We do have personally identifiable information in our data sets but have a high level of security. I will note that the LCB is doing an audit and will be looking at our infrastructure for data security and how we are handling and storing it. Those are things we take seriously and are also being looked at by your team.

Assemblywoman Brown-May:

As we talk about data we are gathering that came to us through the new systems instituted throughout the pandemic, we are now tracking things differently. Can you talk about what you see the long-term success of that data collection is? Have we been able to identify areas that need further attention? What does the future look like?

Ms. Peek:

As we look at what the future looks like, some of our goals are going to be fewer standalone systems. That has been a challenge for our Division and the local health departments as well. When we were using the free CDC-based systems, we did not have the ability to modify them and add things. For example, we would have to have a new data system if we needed to collect data for health care-associated infections that was not embedded within that system. We are trying to have fewer systems, so we maintain a single system that has as much data as possible.

Also, that is timelier and speaks to the interoperability piece. Prior to COVID-19, much of the work was done via fax, phone call, et cetera. You can imagine the timeliness issues with that and the opportunity for humans to make data entry errors. As we modernize that, having a real-time flow of information from hospitals, labs, or vital records systems into our infectious disease response, as one example, can greatly alleviate the time it takes for staff to understand the scope of the condition and respond appropriately. Also, embedding immunization data into our infectious disease response helps us to understand quickly if the individual is vaccinated or not, and that helps us as we prepare for our investigations.

Our goal is fewer systems that are timelier and more complete and the ability to modify more quickly should we need to collect an additional variable related to a certain condition. That will be something we will achieve and are achieving now, but we will achieve them much better with the investments and the efforts.

Assemblywoman Brown-May:

That is great information. Do you feel like we have the right systems in place now, or is this something we will have to go to RFP for in the future? Are we looking for additional investments in this infrastructure, or do you feel like we are currently on the path?

Ms. Peek:

I cannot say that we would not have to go to RFP in the future. We are still low budget, so other, larger states maybe have better, more efficient systems. If we feel we have outgrown a certain system and there is opportunity to get a better one, we certainly might go to RFP in the future. We would never do that without a funding stream to support it. In some cases, the federal government may require part of a grant to develop a better system, and the current system might not have the capacity, so we might have to go to RFP in the future, but we would never do it independent of an already identified funding stream and need.

Chair Doñate:

It is my understanding that the federal government, the national coordinator of Health Information Technology (HIT) has mentioned that the next stage of data governance is going to focus on public health, so a lot of this will be predetermined with what federal regulations look like.

Senator Titus brought up a good question of how we are doing scholarships for advanced degrees. This is more of a comment than a question, but I know that states have looked at expanding tuition remission programming, not to university employees, which typically they get, but to all public employees. This is probably out of our Committee's scope, but was a quick thought.

With regards to how we fund public health, last year during the presentations in JISC HHS and Senate HHS, we noted that of the funds that both the health districts and the different departments get, about 75 percent come from federal grants, so from the federal government. There is a small amount of money that the State funds. Ms. Peek, can you go over how public health is funded statewide? I think that would be a good conversation starter as a baseline.

Ms. Peek:

It varies. I will speak statewide and then allow the locals with one caveat to speak to theirs. At DPBH, we are mostly federally funded categorical except for the PHIG I mentioned earlier. We generate fee revenue for some of the programs, including the Nevada Central Cancer Registry, Bureau of Health Care Quality and Compliance, and Environmental Health. Those are fee-based funds where we provide support to the community and are reimbursed in some capacity.

We also have general funds. The $15 million not being used by DPBH specifically is a huge increase in what we have seen in the past. We do get general funds for our programs, including our immunization program. You all have funded cocooning projects in the past, a match for our SHIP, and Women's Health Connection screening for breast and cervical cancer. Those are all programs you fund with categorical general funds for a specific purpose, but for the most part, at DPBH, we are federally funded with those categorical grants.

Chair Doñate:

You talked about how there are going to be staff layoffs happening within the next few years. Do you have an estimate of how much revenue or funding you would need to capture those staff members? It is the first time we have had this infrastructure, and now it is disappearing overnight. Do we have an estimate of how much we are going to be in a downfall?

Ms. Peek:

I do not know that we prepared it in that way. We are thinking long-term, which positions do we specifically need? If the position was COVID-19-specific doing investigations, then retaining that position may not be necessary. We are trying to be thoughtful and prudent. We can provide that. I am sure we will provide it during our budget presentations as well when session starts, but I want to highlight—and I failed to do it during the presentation—that the Governor put in his three-year plan dedicated funding for public health services. We are interested in seeing what that looks like, but the positions that have found utility in the Agency beyond COVID-19 response would be things we would consider funding in perpetuity if we had the option through a General Fund or fee-based program.

Chair Doñate:

I want to thank our Governor for including that as part of a strategic plan. The last thing is, when talking about SB 118, there is always a conversation about what equity looks like and if there is potential of revising how the formula is allocated; every county gets a baseline, and whatever you use that money for the baseline, you can come back to our Committee or the IFC to say what you are going to use these funds for. It is a need for every county, not only those with greater populations. Once we receive the baseline, here is how much more

income you are going to get per the formula that we have adjusted. Is that a conversation you think is necessary? What are your ideas of reforming our current formula?

Ms. Peek:

I am not going to steal the thunder of my presenters to follow me, but that is exactly what we are looking at: what funding formulas look like and grants that have been successful. For example, our Public Health Preparedness federal grant is an infrastructure-based allocation, and there is some per capita consideration after that. That model is not bad. It allows the smaller counties to have a level of equity in that you could also specify what that infrastructure funds. You have one position that focuses on public health improvement and accreditation or whatever the Committee deemed appropriate. We are looking at that funding formula and being thoughtful about that.

We are also speaking with states that already have this investment and asking what mistakes they made when they allocated funding. We learned through that effort to specifically carve out funding for your tribes. You need to carve out funding for the statewide initiatives versus per capita. We are hugely thankful for our per capita allocation that this Committee supported, but going forward, if we can do it again, it would be a funding formula and specific carve-outs where other states who have been in our footsteps have learned more. I am sure NACO will present on this much more eloquently.

Chair Doñate:

One last question before we move on to the next presentations. I am sure you have a lot of friends who work in different states who would do the same level of work. Have other states explored section waivers through Medicaid or the U.S. Centers for Medicare and Medicaid Services (CMS) to couple public health funding with Medicaid reimbursement and try to seek federal matches? Does that sound familiar?

Ms. Peek:

We are thankful for leadership at Medicaid who have reached out to us about potential opportunities to partner in public health in ways we were not privy to before. I am excited to see what session brings and what comes forward in that regard, but they have already partnered a great deal. We partnered with them on the Children's Health Insurance Program (CHIP) funding and have also worked many sessions to get the community health workers, maybe not perfect, but in a reimbursement model. Much of the work we do is trying to understand what a public health investment could do that could eventually be sustainable with a private payer, Medicaid, and then if private insurance covered it as well. We have a great partnership with the leadership at Medicaid trying to understand in which lines of effort in public health that could happen.

Also, for sustainability, we are trying to figure out if it makes sense that public health federal grants are an initial investment in the community and then there is a match ongoing to see if we can sustain that with community partners, because federal funding can be cut, and it is unfortunate when we lose entire programs. It is easier said than done to find a local match, but these are things we are talking about to make our infrastructure a little bit more sustainable than relying on grants alone.

Chair Doñate:

That is important. It was good for the first go-around of looking to set this fund up, and now we understand that perhaps there are more disparities in certain small communities that might not have as big of a population. Our goal from a Committee perspective should be to empower those counties that might not have the finite resources to stand up these programs and support them in doing so as a matter of public health. We will turn it over to our next presenters, representatives from different jurisdictions.

Kevin Dick, District Health Officer, Northern Nevada Public Health (NNPH):

We have been asked to cover the state of local public health, our priorities, disease investigations and STIs, public health interoperability and data modernization, SB 92 (2023) and what is going on with sidewalk food vending, Healthy People 2030 and how we measure our progress, plans for the SB 118 public health improvement funds that we will be receiving next year, and recommendations we have for the Committee. (Agenda Item V B)

This is the first time I have appeared before you representing NNPG because we changed our name from Washoe County Health District to NNPG at the end of last August because the cities of Reno and Sparks in Washoe County wanted the community to better understand that we are a regional agency governed by the District Board of Health and not a Washoe County department that falls under the direction of the County Board of Commissioners. It was a heavy lift, but we have accomplished that. I am going to be presenting the bulk of the material this morning. We will have each of the health authorities and districts speak about their plans for that SB 118 funding as we wrap up.

As far as the state of the local health districts and authorities, we are currently in a state of uncertainty and concern regarding our future funding in our public health workforce. We had a massive influx of funds that occurred through COVID-19. We know those funds are going away. We have a one-time shot of funding at this point through SB 118 that we will be getting in July, and we have up to two years to spend that money, but we do not know at this point whether there is going to be future funding beyond that. We are concerned, as we have built much-needed capacity in fund in public health and do not want to fall back into the cycle of neglect and crisis for funding public health. The Central Nevada Health District (CNHD) is brand new. They began their Department in July 2023, so funding for them is very important for their continuing growth as they build their district and sustaining the programs and staff they develop.

Our other concern is our public health workforce, and as we have now built the necessary workforce capacity with the influx of funding during the pandemic, it is important that we learn the lesson from the pandemic that we need to have adequate staffing and maintain our public health capacity, so we are prepared for public health emerging issues and emergencies as they occur. In my health district, we did a capacity assessment of staffing levels against the foundational public health services and what would be expected for appropriate staffing for a community of our size, and we found that we are about 30 positions short in those foundational public health service areas. A lot of the funding we receive for the COVID-19 response went toward COVID-19 disease investigation, contact tracing, and immunizations but not across the range of areas we need to address. We find that our workforce salary and benefit costs are increasing rapidly with inflation, wage growth, and increased benefit costs, so we are stuck in a tough position with those costs going up for us and the uncertainty in our future funding levels.

There was mention earlier in public comment about the Public Health Workforce Interests and Needs Survey conducted in 2021, the increasing turnover that is occurring in public health staff, and plans for people to depart public health. That survey found that over half of our public health workforce has symptoms of Post-Traumatic Stress Disorder following their response to the pandemic. Speaking of turnover, I am going to be retiring this spring. The District Board of Health will meet on Thursday to approve a contract agreement for Dr. Chad Kingsley, and he will be joining our Health District and taking the reins May 13, 2024, if everything goes according to plan.

We have shared priorities in public health, and one is the disease investigation and contact tracing. While we have been able to bolster our staffing in this area, we are already seeing funding ending and being reduced. We have lost funding for years four and five of an enhanced STI investigation grant, and that was due to the negotiations over increasing the debt ceiling, so a clawback of those funds occurred. We have also experienced a 25 percent cut in our STI federal funding occurring this year.

An area we have always recognized as important in public health is health equity, and the inequities we see occurring in our population and across different communities was starkly magnified for us during the pandemic, and we are all very intentionally working to try to do a better job of recognizing areas we need to focus on for health equity in our communities. We were fortunate to be able to receive some pass-through funding from the State. That was a CDC grant, the Diversity Grant, which allowed us to staff up and build a more robust health equity program. Unfortunately, that funding is ending at the end of May this year. As oftentimes is the case, you will get federal funding, and then it runs out. We are fortunate that with that workforce grant, we are able to sustain a few of those staff with that other federal funding source, which will also be running out in future years.

Since the pandemic, we have been redirecting efforts back to different areas that we could not put much focus on while we were overwhelmed with the response. Access to care is an important issue and priority for each of us. I will talk about STIs in more detail as I move forward, but it is a very important area for us, as is the opioid epidemic.

The SNHD is working on implementing their strategic plan and their Community Health Improvement Plan, which includes focus areas of access to care, chronic diseases, transportation, and public health funding. They would also like to expand their public health laboratory to make it a Biosafety Level 3 molecular and microbiology lab that will support bioterrorism counterresponse and communicable disease surveillance. They include advocacy as one of their priorities for funding both from the State and federal levels, outreach and education on priority health issues, behavioral health access, and dental health services. Unlike the other health departments, SNHD is a federally qualified health center (FQHC), so in Clark County they are providing primary care services that others of us do not provide.

The priorities for NNPH are implementation of our Strategic Plan and our Community Health Improvement Plan. Our Plan’s focus areas are social determinants of health, mental health, preventative health behaviors, and access to health care. We are working to implement our Public Health Equity Plan. We are in the second year of that five-year plan, and I think we are making good progress in that area. We are working on construction of a new TB clinic thanks to $10 million of ARPA funding we can receive from the State, so we are very grateful for that. We are developing our informatics capabilities. We have lots of data in public health, but we need to do a better job of analyzing and presenting that data as useful information that can guide our decision making and the decisions other people and

organizations in our community utilize. That is a focus area for us. We are an academic health department in partnership with the UNR School of Public Health, working with them to support future workforce development as well as the continued development of our existing workforce.

Later, I am going to talk about our priorities for the SB 118 funding, but I want to touch on STIs, which is one of the areas we want to focus on with that funding. The increase in STI cases that are occurring across the country and here in Nevada is a serious concern.

The top bar chart is the types of STIs we saw in Washoe County in 2022 and 2023. At the bottom, you will see reported cases of congenital syphilis from 2019 to 2023. During that period, we saw a 30 percent increase in reported syphilis cases in Washoe County, but we saw a 340 percent increase in congenital syphilis cases. In 2023, we had 22 congenital syphilis cases compared to the 13 cases we had in 2022. Those 13 cases were a new record for us, and of course, 22 is tragically even significantly more than that. Largely, these cases are polysubstance abuse mothers who are not seeking medical care. Their only point of contact may be in an emergency department, so we are working with our emergency departments to try to increase testing and working with our hospital infection control committees. It is easily treatable with antibiotics/penicillin, but these women are not receiving care, and it is leading to fetal demise in many cases or birth defects and great harm to the babies.

We have also seen an increase over the past few years in HIV cases occurring in Washoe County. In 2023, we had 39 cases compared to 27 in 2022, and we had a 44 percent increase in HIV in stage three cases from 2022 to 2023. We are very concerned about those areas.

The CNHD is also engaged in disease investigation, and they have the challenge of great distances and dispersed populations over the area they serve, including Churchill, Mineral, Pershing, and Eureka Counties. They are working to provide more rapid testing and diagnosis through the new Churchill County laboratory, and they are also identifying and focusing on high-risk settings that have a greater risk for outbreaks to occur as they build their new programs.

In addition to developing a new rural health laboratory in conjunction with Churchill County, CNHD is working to develop a community health assessment and a strategic plan, and a lot of their effort right now is meeting with different populations and representatives across their area and better understanding the rural needs and rural assets in place. They are also working on their emergency preparedness plan.

Carson City Health and Human Services serves a quad-county area, including not just the city and county of Carson City, but Douglas, Lyon, and Storey Counties. They are conducting outreach for communicable disease control. Tuberculosis is a concern for them. The State funding for treatment of TB ended in 2008, and TB cases can be quite complex. The disease investigation contact tracing that goes with a TB case can become overwhelming, and you have probably seen in the news, the situation occurring in Clark County with TB cases in schools there and large numbers of individuals that may have been exposed. Vector is also a concern. With climate change, we are seeing longer transmission seasons for mosquito-borne diseases and seeing the range of different species of mosquitoes expanding, which can result in new mosquito-borne diseases coming our way.

In Carson City, they are also working on a community health improvement plan, and their priority areas are access to basic needs, access to health care for specific populations, and substance use prevention, treatment, and recovery. They are developing a strategic plan, and their priority is to work to retain positions beyond 2026. They also want to continue to build their partnerships. They had successes to build on from the pandemic, and they are working on their public health reaccreditation. We are also doing that this year.

I thought Ms. Peek did a nice presentation on the public health interoperability, data modernization, and challenges and recommendations, but one of our weaknesses that was exposed during the pandemic is our data management capability. In NNPH, we were managing our cases in a huge Excel spreadsheet, which was very unwieldy as we had thousands, tens of thousands, and then over 100,000 cases. The NBS database was overwhelmed with the number of cases. The State has now migrated to EpiTrax, but we still have siloed systems and duplicate data entry, so there is more work to do on trying to get connections between different systems. Ms. Peek talked about using systems that have more capability so we can do more within one system, but we still need to establish those linkages.

The other areas that will help with that are data standardization. We do not always collect the same data, and we sometimes use terminology in different ways. We need attention to that. Our privacy and security, as Assemblyman Gray questioned, are important for our efforts here. We need to have good, strong data governance and security systems, and we also need more training and capacity building on the technical aspects of how we make all this work. Those are challenges we must overcome to succeed in our data modernization and data sharing. We are trying to work together, but we also have a new distribution formula for the Epidemiology and Lab Capacity (ELC) grants that cover a lot of this type of data. They are now being put out as a competitive grant versus something we had an allocation for before. An additional challenge faced in the rural counties is the limitation of connectivity in rural and frontier areas and the differences in people's use of technology occurring in areas where you do not have a lot of connectivity.

I want to touch on the sidewalk vending bill, SB 92, that was passed last session. From the news coverage of the bill, it left people with a wrong impression that this had reduced or waived public health requirements for sidewalk vending, but that is not the case. This bill affects counties with a population of 100,000 or more, so SNHD, NNPH, and in SNHD, their sidewalk vendors must still follow all their public health regulations. A permit from SNHD is required, and they have not reduced or waived their sanitary requirements. They do not have any sidewalk vendors who have had permits issued to them; therefore, their sidewalk vendors are operating without permits down in Southern Nevada. They are coordinating with their sister agencies to address unpermitted food vending. This is a map that shows the locations of unpermitted food vendors that they have had reports on, so you can see it is widespread in the area.

At NNPH, there is a State task force that has been set up under SB 92 under the Secretary of State's Office with one seat for a public health department representative on that. We filled that seat with Joelle Gutman Dodson. She is participating on that committee, and those discussions with the task force are ongoing. We have worked to create a payment plan for food cart vendors. We are currently working on implementing this plan, but to allow for the permitting cost to be spread over time in smaller increments for the food cart vendors, we are looking to utilize some of our SB 118 funds to see if there are ways we can reduce barriers to entry for food cart vendors.

We always had the ability for people to get food carts permitted in our regulations at NNPH. We have permitted food vendors operating, but we have received about 80 complaints regarding sidewalk food vending since January of 2023. We have hosted and participated in bilingual open house sessions with the City of Reno to provide education on licensing and permitting requirements for people in our communities. While the smaller counties are not subject to SB 92, there is concern this may result in different public health requirements occurring in larger populated areas than others, and people may presume those are the same standards everywhere or may have to adjust how they operate depending on which county they are in.

We were asked to touch on Healthy People 2030, a data-driven, national set of objectives to improve health and well-being over the next decade until 2030. It has 359 core measurable objectives. It has research objectives, social determinants of health objectives, and leading health indicators. Southern Nevada Health District is a Healthy People 2030 champion; they have been recognized for their efforts to present and measure against the 2030 objectives, and they have a progress tracker on their website. The URL is "healthysouthernnevada.org," and this is a screenshot of their dashboard showing their performance compared to the Healthy People 2030 objectives.

In CNHD and Carson City HHS, we are working in alignment with the overarching goals and direction of Healthy People 2030, which are to attain healthy and thriving lives and well-being free of preventable disease, disability, injury, and premature death; eliminating health disparities; achieving health equity; creating social, physical, and economic environments that promote attaining a full potential of health and well-being for all; promoting healthy development and healthy behaviors and well-being across all life stages; and engaging leadership, key constituents, and the public across multiple sectors to take action and design policies that improve health and well-being for all.

In NNPH, we follow these overarching goals through our Community Health Assessment. The bar chart shows how we ranked different public health areas through that assessment, and the four bars that had the highest rankings are focus areas for our Community Health Improvement Plan. We have a strategic plan in which we capture all our operations across the health districts, programs, and initiatives, and we have outcome measures for each of those. The performance management system we have in place is many pages long. We are tracking and assessing our progress across all of these.

We recently launched a new dashboard in conjunction with Truckee Meadows Tomorrow that is inspired by our Community Health Assessment, and it provides our community with easy access to see how we are doing around these different measures of community health. That is at "nevadatomorrow.org," and this is one example of a screenshot that shows how we are doing compared to Nevada and the nation and whether we are improving or doing worse. Now I would like to turn it over to Dr. Cassius Lockett to walk you through their plans for use of the SB 118 funding.

Cassius Lockett, Ph.D., Deputy District Health Officer of Operations, SNHD:

I am here on behalf of Dr. Fermen Leguen to share our priorities derived from local health assessments and some executive team collaboration. Diving into this line item by line item, strengthening the surveillance workforce involves retaining our communicable disease workforce of over ten positions that were managing chlamydia, gonorrhea, and syphilis while these positions were on the brink of elimination due to the CDC grant Mr. Dick referenced earlier being reduced in the U.S. by over $400 million last year.

We have an urgent need to continue to focus on STIs due to Nevada's alarming ranks in syphilis, at one point being ranked fifth in the U.S. for congenital syphilis and at one point being ranked ninth and fourteenth for chlamydia. As Mr. Dick mentioned earlier, STIs going unchecked is not good and could lead to serious implications like pelvic inflammatory disease where a whole generation could become infertile and lead to infant death from congenital syphilis.

Our laboratory expansion will position SNHD to continue to respond to emerging disease threats like Ebola, H1N1, pandemic influenza, and COVID-19. This is important because we anticipate our projected population will increase from currently 2.3 million to about 2.94 million. By 2035, we anticipate adding an additional 600,000 residents to our population. The lab expansion will be crucial for managing increased testing demand to do our investigations properly and track diseases. We also study infectious diseases, monitoring variants during the COVID-19 era, and now we are all dealing with, in the background, highly pathogenic avian influenza moving slowly across dairy farms and affecting workers. We want to make sure any mutations there do not get out of hand, but we must study the disease to make that conclusion.

We also want to enhance access to care in vulnerable and homeless populations by purchasing a mobile van to deliver services curbside, including but not limited to, the administration of vaccines. We want to do sexually transmitted disease screening and treatment. We also want to hopefully do nursing assessments, wound care, urgent care, and make appropriate referrals to our FQHC. If they do not want to have a primary medical home at SNHD, our FQHC will make sure to entertain the preferred provider for that patient.

Regarding FQHC dental clinic, on our Healthy Southern Nevada website’s dashboard of Healthy People 2030 indicators, even though these indicators are green, we have observed two troubling trends moving in directions we do not want to see. Two data points showing rising cancer death rates and declining dental visits, emphasizing the need for additional oral health services. The FQHC is looking to expand our Freemark Center and add a dental clinic. The funding will support infrastructure, equipment, and staffing, ensuring sustainability by generating revenue.

Our opioid intervention program will be used to address a gap in current interventions. One of them is contingency management, which is a psychosocial intervention that involves reinforcing abstinence from substances. You take a urine test, you are clean, and you get rewarded for the behavior, so it helps manage behaviors to manage opioid use disorder.

Regarding youth vaping prevention in Nevada, nearly 40 percent of youth have tried vapor products, which is a gateway to marijuana and tobacco use. To prevent vaping, we will continue to promote CDC best practices through mass outreach campaigns, surveillance, and evaluation.

To promote health equity, SNHD will launch a comprehensive communication campaign that will target underserved communities for various health initiatives. We want to do things with back-to-school, flu, and COVID-19 vaccination clinics. We want to do outreach around measles when needed and other things.

Our Safe Drinking Water Program proposal will increase staff time in our Environmental Health Program to educate operators of water systems and assess conditions that may contribute to water contamination. It is important to know that our public health lab and our Safe Drinking Water Program are both publicly invisible. You do not even know that the

work is going on in the background, but safe water is vital for Nevada's growth and economic prosperity. We would like to thank the Committee for sponsoring this bill; however, we would like to see this funding stream become permanent.

Daren Winkelman, Administrator, CNHD:

We would like to echo those thoughts as well. Thank you for bringing SB 118 and allowing us to obtain some of that funding. Although it is a small portion of our funding, this funding stream comes at a critical time for us as we begin to develop infrastructure in the CNHD. We have partnered with Churchill County and the City of Fallon to purchase a new building for the district, so most of this funding from SB 118 will go toward improving our data infrastructure, infrastructure in general in the new building, and ensuring we have secure data moving forward.

The challenge for us will be how we continue that as we build that infrastructure out. How do we continue to ensure we can still have the services and maintain those services within the District? It is a unique District; we have five entities within the District, all with their unique challenges and unique needs. How do we build that to ensure the District operates wholly and globally together? This funding is critical to get started, but also critical if we can find ongoing funding to help maintain what we develop moving forward.

Chair Doñate:

How much funding are you receiving from SB 118?

Mr. Winkelman:

We received $195,000.

Chair Doñate:

Do you have a description of the allocations of what amounts you are using for each of the projects you mentioned?

Mr. Winkelman:

We do not have that. It is not broken out. We will be looking at servers and data backup systems, mostly data-integrated systems.

Chair Doñate:

Can the Committee assume that most, if not all, these funds will go to data integrations or data infrastructure?

Mr. Winkelman:

Correct.

Nicki Aaker, Director, Carson City HHS:

Thank you for this funding and for sponsoring it. It allows us to put back what is needed within our community, and it is very important since it is noncategorical funding. What we are doing with the money is going to be based on our third Community Health Needs

Assessment. Carson Tahoe Regional Medical Center sponsored this Assessment, and various partners throughout the Quad Counties participated. This is our first Quad County Health Assessment, and we are connected here within the counties, so health issues do not stop at the borders. It is a regional issue with a lot of our health issues we face.

Our funds will be used within four priority areas: access to basic needs; access to health care for specific populations; mental and emotional health; and substance use prevention, treatment, and recovery. Through the assessment, some of those priority areas came up within these categories, and I am going to give you an example of a couple within each area. I am not saying that is exactly where the funds are going to go, and I will explain how we are going to go through that process. Items such as access to physical and social activities for youth; competency of providers to serve specific populations, including knowledge of LGBTQIA+ needs and increasing Spanish speaking providers; transportation to medical appointments; and crisis care.

Currently, a lot of counties have our Mobile Outreach Safety Teams, which deal with when people are in crisis. There are programs and activities to reduce social isolation, increase support, and promote mental and emotional health. We saw through our Community Health Needs Assessment that social isolation has become a real problem since COVID-19, and in Carson City, we see an increase in suicides among seniors, which can be because of that social isolation. For youth, increased coordination between school systems, community providers, and agencies will address prevention and early intervention.

These funds will be available to us by August 1. Right now, staff will be making suggestions to our Board of Health in June. There will be discussions, and we will formalize how the money is going to be spent within these four areas, so we are prepared to start putting the money back into the community when the funds are available. We are using only the Carson City funds at this point. There are counties that we do various services in. They have identified their needs within their community. We are grateful for this noncategorical funding to touch on areas we have not been able to.

Chair Doñate:

To clarify, what was the amount you are receiving?

Ms. Aaker:

It is about $282,000.

Chair Doñate:

Do you happen to know the top-of-mind allocations to each area?

Ms. Aaker:

I am not able to specifically tell you the percentages. That will be figured out in June at our Board of Health meeting, but we will be touching on each of these priorities.

Chair Doñate:

As a follow-up, if you can please submit that to the Committee, we would greatly appreciate it.

Mr. Dick:

I would like to talk about our SB 118 priorities for NNPH, but I want to recognize, commend, and thank DPBH for how they are working with us on our planning for SB 118. This is flexible funding for public health improvement that has been provided for our District Boards of Health to decide how to spend based on our local priorities. It is "out of the box" for how DPBH works with us in allocating these funds through an interlocal agreement, and they have been working to provide us with flexibility in how we can allocate the funds across different priority areas.

I have a list of our priority areas for you. I do not have the specific dollar amounts on them, nor can I tell you that off the top of my head, but I can provide that for you. I believe these go roughly in rank order by the amount of expenditures, with the largest being epidemic and disease investigation capacity, working to maintain capacity that was built during the pandemic response and capacity we know we need when you look at what is happening globally with the new mpox clade in Africa, more locally when we look at avian flu, and nationally with what we see happening with measles cases increasing.

Another focus area for us is STIs. As you heard from SNHD, with the clawback of those federal funds supporting the STI disease investigation, we need these to use these funds to fill that gap with that federal fund funding vanishing for us. Vaping prevention is also a priority to restore a position that we lost this past year. We had vaping prevention funding included in last biennium's budget but not in this biennium's budget, so SB 118 gives us the opportunity to use that to address that priority for us.

Immunization biologicals refers to purchasing vaccines. We have seen the landscape shift for us with the privatization of the COVID-19 vaccine and with the new respiratory syncytial virus (RSV) vaccine and the antibody for babies. This will provide us funds we need to purchase up front those vaccines that we are not allowed to provide our other vaccines to people who have medical coverage.

For food cart vending, we want to use some of the funds to see if we can explore ways to reduce the initial infrastructure costs that food vendors may face with their carts. We are also looking to have a third-party review of our operations in our different direct service divisions to make sure we are operating efficiently and effectively delivering the programs that we have.

Lastly, we have emerging public health issues, priorities, or emergencies. We do not know what is going to come along in the future. In some ways, while the pandemic was horrible, it was international, and it prompted a large national response with a lot of influx of federal funds. That is not always going to be the case for what we are facing for public health emergencies: for instance, if we get measles in our community in Washoe County, the federal government is not going to come rushing to the rescue for us with funds for that, so this is another area where SB 118 and public health improvement funding is important for us to be able to provide flexibility in how we allocate noncategorical dollars.

I now come to our recommendations for you, and that is continued public health improvement funding. It really needs to be sustainable and continuing for it to be useful for us and for us to plan effectively to utilize it. It should be noncategorical, so we can use it for specific needs and our hands are not tied to continue to focus in areas as we have emergencies occurring somewhere else. We want to find a better mechanism for directly providing this funding to the counties so that DPBH is not in the middle of it and needing to

have this complicated dance with us moving forward with it. We also support base funding in addition to the per capita allocation to support particularly our rural counties with smaller populations to be able to meet basic infrastructure needs that are required, and then of course, used to address our local priorities. We have accountability. While we do not want to see this rigidly administered like a grant is in many cases, we need to be accountable, and we are committed to providing our reporting to you on the priorities, how they were determined, how the money was used, and what was accomplished with that.

The need to continue to support and enhance public health funding is vital. Taking 2021 estimates, which were the most recent we could come up with as far as State investment per capita in public health and adding the $15 million that is going to be allocated through SB 118, that brings Nevada to $19 per capita for our public health funding. That brings us to 40 out of 46 of the states. Five states did not provide information on their state funding for public health: West Virginia, Rhode Island, Delaware, Kansas, and Utah. These states have not been on my radar as having less funding in the past for studies of public health. We are well below the median of $37 per capita; $19 per capita is where we are. We allocate roughly half of the median for public health funding here.

We often hear that we find ourselves at the bottom of all the good lists, and we hear a lot about K through 12 education funding and how they are at the bottom of that list. I believe K through 12 gets closer to 80 percent of the average funding for their State funding coming from Nevada. We are at 50 percent, which is much different and much further off in the funding we have for public health here in Nevada than that K through 12 comparison. They are all important needs, but we really need it.

We are grateful to see the Governor place the dedicated funding for public health services in his three-year plan as a priority. We are grateful for the action the Legislature took and that this Committee championed during the last session. We were pleased to see what a bipartisan effort that was and how it was supported across the aisle, and we would love to work with you to enhance that and see it happen again this coming session.

Chair Doñate:

Let us go to questions from Committee Members. Does anyone in Southern Nevada have questions for the health districts or members that presented?

Assemblywoman Brown-May:

I have two questions about SNHD. First, it states that due to increasing federal funds after the pandemic, management is trying to balance its budget to avoid closing public health programs and massive layoffs throughout the Organization. I am wondering if you can qualify what a massive layoff is and how close you are to balancing the budget to be able to preserve those positions. It also said that the workforce grew from 500 employees in 2019 to 860 in the current Fiscal Year (FY). How many of those positions are at risk if we do not balance the budget?

Dr. Lockett:

After the pandemic, we faced reduced categorical revenue sources coupled with the marginal increases in general funds. This has created a structural budget deficit where our expenses exceed our revenues in our budget. To avoid layoffs at SNHD, we need to

implement strategies to reduce gaps and create intentional plans to bring expenses in line with our revenues.

I do not have a crystal ball on what those projections will look like in the future. However, to avoid layoffs, without giving specific positions, we are trying to prioritize internal vacancies when possible. We are shifting positions to different funding streams because we have a massive amount of COVID-19 funding that will end in December of this year. Through our budgeting process, we have implemented zero-based budgeting to try and reduce costs and supplies and things of that nature. We have reduced travel from our General Fund by about 80 percent.

Our overall budget, which for FY 2024–2025 is currently $171 million, is down from $191 million, primarily due to COVID-19 reductions, and right now, SNHD has approximately 866 positions. If we apply benchmark estimates, we almost need to double the workforce. We are trying to do everything we can to hold on and prevent reductions, but I do not have a crystal ball in terms of what that is going to look like because it is complex, funding streams are staggered across different fiscal years, and we are trying to balance all these positions, including funding that will end December 31, 2024.

Chair Doñate:

Thank you for that explanation. I still did not hear when you are planning to have an answer to how many positions are going to be cut and when the budget is going to be balanced. Is there a time frame when we can expect those answers?

Dr. Lockett:

Our budget is balanced right now. We presented our budget, and it has been approved by our Board for FY 2024–2025. Right now, we are trying to keep as many positions as possible.

Chair Doñate:

What is the time frame when you will know how many positions you are going to cut? When should we expect that answer from you?

Dr. Lockett:

There will be two waves for consideration. The first wave will probably be before the end of June 30, and the second wave will be sometime in December 2024. Right now, all that information is in flux. I cannot give you an answer because it is in flux, and we are trying to place people in vacant positions, et cetera. I do not have an exact number for you, but once we get that number, we can circle back to Dr. Leguen and get you that information.

Chair Doñate:

That sounds good. I completely understand. I ask the health district officers who are answering questions today to not be long-winded and to be as direct as possible, simply because we have a lot of questions from Committee Members. Are there any other questions down here in Southern Nevada?

Vice Chair Orentlicher:

I have a question on the projected proposals for Southern Nevada. They are all important areas, and I am looking at a couple of them like the laboratory expansion and the dental clinic. They strike me as projects that might be attractive to philanthropic givers. How much do you explore that? Is that something that might help in these areas?

Dr. Lockett:

I agree with you. We have not explored that fully, but that is always an option, so thank you for that comment. We can circle around and see if we can take advantage of those types of resources in the community.

Senator Nguyen:

Chair, I have quite a few questions. Is it possible?

Chair Doñate:

Let us do two, and then we will move on. We will come back.

Senator Nguyen:

This is directed to representatives from both Northern Nevada and Southern Nevada. You mentioned the uprise in TB. What are we doing to address this? I will start in Clark County because I am more familiar with that. What is going on to address the TB outbreak in Clark County, and is this addressed in the Plan?

Dr. Lockett:

Without being too long-winded, TB has increased in the U.S., and in some places more than 15 percent. We have also had an observed increase in TB cases. One of the things we can do, and we are working with our State partners on, is trying to find a way to change regulations so the number of, let us say, workers, volunteers, and teachers in schools can be screened—not tested, but screened—for TB initially upon hire, which we are not doing now, and also offer a periodic screening to those same three groups every four or five years to close these gaps. If we can get those people screened and tested, we can prevent latent TB infections in the community.

Senator Nguyen:

I do not pretend to be an expert, but it seems like this is easily spread and could be contained if we are looking at our schools, courts, and prisons, areas where it leads to easier transmission. What kind of efforts are you making in conjunction with, for example, the Clark County School District (CCSD) to make sure that all their new hires or teachers are tested or screened?

Dr. Lockett:

Right now, it is voluntary; in this State, the law does not require any legal requirements for screening. That is one of our challenges, and that is why we are collaborating with our State partners to change the regulations to make it mandatory for teachers, workers, and volunteers in CCSD. That collaboration must take place between education at the State level

and our DPBH folks to get that language out and approved so we can have those regulations in place.

Senator Nguyen:

As far as funds that are coming in, is there any allocation of the SB 118 funds that are going specifically towards TB?

Dr. Lockett:

We do not have an allocation to increase our TB workforce at this point for SB 118 funds, but again, if non-discretionary funds in the future become an annual allocation, those flexible funds could be used in such a fashion.

Senator Nguyen:

Is there resistance from the school district in doing this kind of testing, or are they open to it? Are they not open to it because it is not mandated?

Dr. Lockett:

Exactly. They are open to it, but it is not mandated. We have a voluntary screening program for new teachers in place with a web-based form where they could be screened in, and we find out if that screen is positive, and then they could be tested. Again, it is voluntary, and our State partners are moving at a rapid pace to try and get this language changed into the regulations to make it mandated like it is in states like California, not only for school districts but for employment purposes.

Assemblyman Nguyen:

I want to make sure we cover the staffing component. I have not heard a lot about recruitment and retention if we are going to face a crisis in terms of increase of outbreaks. I heard that in the northern part of our State, HIV cases have increased, and down here in the South, I heard of TB, and public testimony earlier said we have one case manager in SNHD. Is that counterintuitive in terms of ensuring we are addressing the urgency right away?

Dr. Lockett:

To respond to that specific case manager in our TB clinic, we have a vacant position because someone retired, and we are filling that second case manager and adding a community health worker position that needs to be filled as well. We also have the PHIG, which is a five-year grant on year two right now, and we have used that to retain over 40 positions, primarily in disease surveillance and control monitoring of the infectious diseases you mentioned.

Assemblyman Nguyen:

My next concern is that yes, retirement and changes in turnover happen. What is SNHD doing in terms of your ongoing recruitment and retention plans? Obviously, turnover happens in every industry. You knew the retirement was happening, and you still have that vacancy. Are there strategies that the senior team are doing to ensure you can respond to

this correctly? I want to see if we have strategies in place so we can continue to serve our public without any pauses due to these changes.

Dr. Lockett:

Recruiting for certain positions is always a challenge, especially clinical positions. We have been fortunate to be able to attract and retain qualified people here at SNHD. Our HR partners are using part of our PHIG to work on recruitment, tools, provide incentives for onboarding people, give them bonuses, and other things that come out of that grant. We have ways to try to retain people post-COVID-19 and reduce stress and anxiety to retain people. One product is called Credible Mind, which is a public health behavioral health system we are planning to launch that will reduce anxiety amongst employees, et cetera. We are also working on trying to incentivize and reward employees through that grant, and we spent money for our Public Health Week this week on a variety of different events for our employees, including hosting breakfast for them. Yes, we are cognizant and aware, and I would say that our retention rate is around ten percent at this point, which is in alignment with industry standards.

Assemblyman Nguyen:

I would like to see—and hopefully the Committee could also see—the people plans because it is important. We cannot get this work done without our workforce. Your one slide on the budget did not mention anything about people and the plans for workforce. If we cannot get the answer today, I would like to see the answer soon on this funding when it comes to expanding our workforce because if we have a bigger outbreak, we need to be prepared. Meeting the 10 percent that you said is critical, but I think we should work on exceeding these metrics, not only meeting the standards.

Assemblyman Hibbetts:

How many active cases of TB are in Southern Nevada right now?

Dr. Lockett:

I do not have the number offhand. However, last year, we went from 54 to around 76 cases comparing 2022 to 2023, so that is a significant bump up, and we are having internal meetings to address active key TB cases moving forward.

Assemblyman Hibbetts:

I would like to ask that you get the number to the Committee.

Dr. Lockett:

Do you want 2024 active TB cases? I just gave you 2023.

Assemblyman Hibbetts:

I would like to know how many there are right now.

Chair Doñate:

I assume you are probably in the SNHD building, or if you have other folks you can message while we ask other questions, maybe you can get that response while we are still in the presentation. That would be helpful.

Senator Titus:

I have a comment and two quick questions. Many of you know and have heard me say that I am an old doctor. I started practice in rural Nevada in 1984, and my TB skin test rapidly switched to positive within a year. I went through the treatment process way back in 1985 and I survived it, so no worries there, but it is common in rural areas to be exposed to TB. This is nothing new to Nevada, from our tribal nations to the rapid visitors we have. At the time when I started to practice, it was some of the Vietnamese from the Vietnam War who had moved. We see this ebb and flow, and TB hopefully gets handled quickly. The only other comment I would make is, fortunately for me, it was a single drug treatment. It was still sensitive. The challenge we face today is resistance, so now they are having to take four to five medications.

Two questions: first, the name change for the Washoe County Health District sent up my little antennas. Must we go back in NRS and change wherever it says "Washoe County Health Department" now that you have changed your name? Maybe staff or our legal counsel can answer that.

Eric W. Robbins, Previously Identified:

I am going to have to look up to see if that term appears in NRS because I am not entirely sure.

Senator Titus:

I think it labels different health districts in NRS, and Washoe County is spelled out, but I am not sure. I would hate to see us have to use one of our bills to change and catch up with what Washoe County did, so we need some clarification.

Mr. Robbins:

Normally NRS does not spell them out. It goes by population caps, so I do not think there would need to be a change.

Senator Titus:

We will confirm that after you have had a chance to look at that. I know I threw that out there randomly. I have another question for Washoe, and thank you for bringing up the increase in syphilis rates. We had two bills last session that hopefully dealt with that, Assembly Bill 192 (2023) and SB 211 (2023). Both involved testing, and the article that I read was about the increase in congenital syphilis numbers. Because we increased money spent and increased access at least somewhat to the testing itself, did we move the needle at all in the number of tests we found and treated? Was there any success in that at all?

Mr. Dick:

I think you are asking, are we catching more cases because we are testing more? Unfortunately, I am aware of cases we have in those numbers I was reporting to you that tests were not done and treatment provided when they could have been. I would have to dig into statistics to be able to provide that information for you.

Senator Titus:

I would like to see that because a number is just a number, and yes, we have an increase in numbers nationwide. However, our State did try to do work, so I want to know, what increased number did we find in testing that we caught and treated? It is always easy to throw out a bad number, but I would like to see good numbers.

Mr. Dick:

Unfortunately, I think most of these congenital syphilis cases where they are positive tests are occurring in babies—

Senator Titus:

At the time of delivery. I understand that. I have delivered babies. I understand you have to test all of those, but I want to know how many cases of syphilis we picked up that we otherwise would not have and were able to treat predelivery.

Mr. Dick:

I phoned a friend on our SB 118 budget items, and I can give you those figures if you would like. For the epidemic and disease investigation capacity, it is over $1 million, and that goes to Assemblyman Nguyen's question about what we are doing to work to have the capacity we need if another outbreak occurs. This is trying to retain staff we have who have developed their expertise and experience through the pandemic response with our ramp-up.

We have about $250,000 for our STI disease investigation staff who are focusing on this area. We have about $400,000 for our vaping prevention program. I was not correct. They did not go in descending order, but the large ones were at the top. Our immunization biological or vaccine budget is $110,000, and $100,000 is for the food cart vending initiative.

I do not think I mentioned the drone training, but we will increase our capabilities for mosquito abatement to prevent mosquito-borne diseases, so that is $14,000 for us to utilize a drone we have purchased, and then our divisional assessment is budgeted at $130,000. Currently, no money is budgeted for emergencies, but we could move dollars between those different budget categories if we do have an emergency. We are getting a total of $2.4 million through SB 118, and the direction I have from my Board of Health is to work to spend that money over two years rather than ramping up sharply with all of it and potentially not having that money in the future.

Chair Doñate:

That is a good segue because I was going to ask you more about SB 92. Let us start with Dr. Lockett. I want to hear from Southern Nevada first. What is the strategy for helping with the prevalence of food vending in Southern Nevada? Let us start with that question.

Chris Saxton, Director of Environmental Health, SNHD:

I think the question was, what are we doing about the outbreak of unpermitted food vendors? We are working with our sister agencies here, whether it is code enforcement or the police, to identify areas where we are getting the most complaints and trying to have a route with inspectors going by with different agencies to address the issue.

Chair Doñate:

During the presentation, it was alluded to that perhaps the pathway the health districts needed to take after the passage of SB 92 was to stratify the public health risk because not every vendor can be treated equally. Where are you in terms of promulgating regulations and meeting with the community to update and make sure the sanitary requirements are assessed to the public health risk and that you are meeting vendors based on their circumstances, as we heard during public comment today?

Mr. Saxton:

Right now, we can permit any of these vendors under our open-air vendor regulation. We can offer waivers if they are lower risk for certain items on their cart, so it is on a case-by-case basis. With community education, we have been working with the County and the other cities in our jurisdiction on town halls to try to educate along with those groups what the requirements are, what they need to do, and when they need to come in and get their permit. We know that could be a hardship, and as part of SB 92, we needed to offer them a payment plan, so we did that over three months where they could come in, pay a small portion to get their permit, start operating, make money, and pay off the rest of their permit costs.

Chair Doñate:

Since the bill's passage, is SNHD still confiscating items on a daily basis for these food vendors?

Mr. Saxton:

Yes, with the complaints and everything going on, the feedback we got is they are the task force, and it is also being discussed there, and we are heavily involved and interested in the discussions of what we might be able to implement and what might help the vendors but also ensure public health for our community.

Chair Doñate:

Walk me through that process. If I am a vendor who gets stopped by SNHD, what do you provide me at that point in time since the bill has been passed?

Mr. Saxton:

We have educational material in English and Spanish directing them on how they can get a permit, the numbers to call to ask if they need any kind of discussion of what they need to get that permit—maybe they do not know what the rules and the laws are—and how we can help them if they are generally interested in getting a permit.

Chair Doñate:

One thing that was frustrating when I went with the Health District was that I was the one translating on behalf of your workers. Have you made any segue with recruiting workers who speak different languages when talking to these vendors?

Mr. Saxton:

Yes. That is always something we highlight when we look at applications for new inspectors: are they able to speak a different language? We prioritize those inspectors for programs where they may run into that population where we need that language. We have lines on our phones with translators available if it becomes an issue, so even if they are not able to speak in that language, they can have somebody on the phone to help translate.

Chair Doñate:

The last thing on SB 92 was that, from my understanding, after the Task Force on Safe Sidewalk Vending creates its regulations, SNHD will begin to develop or identify what they can improve. Right now, you are forcing everyone to go through open-air vending, which does not make sense because not everyone has the infrastructure or the funds to provide, say, a dual sink, et cetera. How long is that regulation process going to take from you?

Mr. Saxton:

Yes, the Task Force does deem some regulations necessary. We will look at that and see if we need to adopt our own regulations since SB 92 gives us until the end of 2025. It is important to see what comes out of that and what is needed.

Chair Doñate:

Is it fair to say that SNHD does not have a current timeline right now because you are essentially sitting on your hands waiting for the Task Force to do its work?

Mr. Saxton:

Yes, we are interested to see what the Task Force comes out with, and that will help direct the recommendations for us to consider for new regulations. As you know, the regulations are not something we can turn out quickly; we must do a business impact statement and community workshops. It will take time.

Chair Doñate:

Why have not you done that yet? It begs the question.

Mr. Saxton:

It takes a lot of time to do that, and so far, we have had zero people show any interest in getting the permit. It is the cost-benefit ratio of staff's time, and as we have it now, we can permit these permanent food vendors if they wish in the spirit of what SB 92 requires.

Chair Doñate:

I would encourage you all as public health to meet people where they are, and I would presume that if you did that work, you would find plenty of vendors who would love to be licensed, but they do not have the ability to do so yet.

That also begs the question: I think SNHD spent a lot of time fearmongering on the news talking to folks about why they should not purchase from vending, but I did not see anything regarding food vending on SNHD's project proposals. If this is such a big public health concern, why have you not allocated any funding to help those vendors be adequately licensed and meet the requirements you set forth?

Mr. Saxton:

The leadership of SNHD got together and asked, "How would we look at this funding? How should it be dispensed?" We decided we should look at our community health assessments and ask, "What is the community and everything showing us to be the biggest issues in our community?" Those were the items that got the funding.

Chair Doñate:

Dr. Lockett, can you walk me through the background as to why SNHD came up with these proposals and who was a part of the decision-making process?

Dr. Lockett:

Our entire executive leadership team, which represents all our divisions and administration, and Dr. Fermin Leguen, our Health Officer, were all involved in those conversations. This information can be found in our *2021 Community Health Assessment* published online, and there were other areas that had their own assessments. For example, we are in the midst of completing our Opioid Assessment and Plan, which is a requirement for our Overdose to Action Report. Without going into too much detail in terms of our lab, to be a Biosafety Level 3 lab, you must be part of what they call a Select Agent Program, which is a CDC program that comes out and inspects us annually and does on-site assessments, which directed our attention to the need to expand our lab to get additional space for testing to do whole genome sequencing and advanced molecular detection, but also for additional space for reagents and equipment, training, and refrigeration. Some of these assessments are in that space as well.

Chair Doñate:

I did not hear anything in the response that you included lower-level front line staff. Is that correct for my assessment?

Dr. Lockett:

That is correct.

Chair Doñate:

Why was that?

Dr. Lockett:

Our executive team had a sense of our priorities, and to be honest with you, some of those priorities are to address concerns from our staff that come to our attention. In terms of involving a direct line staff on the executive team to make those decisions, that was not done, correct.

Chair Doñate:

I am asking all these questions because, as folks in the public may understand, there is a bit of frustration with how the Health District has been doing a lot of their efforts, whether with SB 92 or the proposal we have in front of us. It is saddening, and this is my personal interpretation, that a lot of what you have right now on your project proposal resembles initiatives guided towards your FQHC but not towards public health. If there is a disillusionment of your purpose as a health district, it is to do public health work. If you wanted to do a FQHC work, that is a different mission, because in that mindset, when you have folks come into your facility, you try to ask them for their health insurance and bill as much as you can versus providing the services you were intended to deliver as a health district.

It is saddening that you do not have a lot of public feedback regarding the allocations, especially because we work hard to give it to you, and in the conversations I have had with your own staff, your laboratory assistants do not believe that this funding should even go towards the clinical laboratory. They do not see it as necessary. There are other security concerns that your folks who work for SNHD feel could be important in terms of enhancements to reduce the turnover that we spent so much time talking about this morning, and I do not see that reflected either.

With SB 92, we have spent the last year with SNHD going to different news agencies talking about the prevalence of food vending and foodborne illnesses, yet you still have not developed a proposal in this budget guided towards a campaign to help educate and provide resources to these vendors. Same thing with the TB outbreak: finite resources right now could help CCSD ensure that their staff are being detected for a TB illness, especially given how contagious it can be, and it is still not reflected. I think you need to go back and redo this budget and present it again next month, because it seems to me that you did not do your homework yet. I am going to let other Committee Members ask questions.

Assemblywoman Brown-May:

I have one follow up about SNHD's project proposal for SB 118 funding. It is listed here under the opioid epidemic and smoking that we have an opioid intervention program, but it is my understanding that separate opioid dollars have come into the State. I am curious to know why we are not utilizing those instead of this funding.

Dr. Lockett:

That funding is Overdose to Action, and you are correct that we did not budget for contingency management and did not realize that was a gap until after our assessment. It is something we wanted to allocate because it is a gap to strengthen our opioid response strategy.

Assemblywoman Brown-May:

I am curious to know if there is a way for us to go back to the State dollars to fund that opioid intervention program in that we do have those State monies available. That frees up an additional $247,000 for you to be able to focus on other programs. While we have access, it is important that we continue to focus on the opioid intervention programs and the epidemic in general and utilize those dollars to help us do that.

Dr. Lockett:

We have had conversations with [unintelligible] to put ourselves in a position to be able to apply for the RFP that will be launched in May or June so we can apply for those State opioid settlement dollars. We are in the midst of taking our draft assessment and plan to make sure we are eligible to apply.

Senator Nguyen:

I am going to shift topics. When I look at priority pieces and the funding that SNHD is using with those SB 118 funds, I see that there is a $1.6 million allocation towards developing a dental clinic. Can you talk about what exactly that is being utilized for? Is that construction? Strategic planning? What does that entail?

Dr. Lockett:

Yes, you are correct. It will be for a light construction over at our Fremont location for three to four dental chair seats and startup costs for positions outside of the instruments and dental equipment that will be required. We are talking about a couple of dental hygienists to start us up and a dentist's salary over six months.

Senator Nguyen:

When do you anticipate that would be up and running, and how many people would be able to utilize that? Do you have that information on what the return on investment is? Do you have a more detailed version of what those costs are and what the long-term plan is to continue that?

Dr. Lockett:

Sure, we have a more detailed plan. I can circle back after this meeting and see if I can put the details in your hands.

Senator Nguyen:

I have been working with outside nonprofit organizations that provide mobile dental care and their costs are significantly lower than this, so I am curious what the long-term strategic plan is for that dental clinic and how many people and constituents it would serve, what the priority is for those services, and what kind of referral network there is for services that are outside of the scope of what a three-chair dental clinic would be able to provide. If you could get that information to us, I would be interested in that.

Chair Doñate:

I have a few questions for Mr. Dick. You mentioned that you are retiring. Is that correct, sir?

Mr. Dick:

That is correct, Chair Doñate.

Chair Doñate:

How long have you worked in the Health District?

Mr. Dick:

I started working for, at that point, the Washoe County Health District back in 2010, and then I was appointed the Health Officer in April of 2013, so I have been serving as the District Health Officer for 11 years, which I think is well beyond the national average. It has been an honor and a privilege for me and a very important part of my life that I am grateful for.

Chair Doñate:

Reflecting on your years of service, what would be one piece of advice you can give Legislators regarding public health in the State of Nevada?

Mr. Dick:

Do not ignore it. I think that is the biggest concern we all have. We have been ignored in the past, and when you do not pay attention to public health or maintain your capacity, it is going to come back and bite you, and that is what happened.

Chair Doñate:

I greatly appreciate that. One of the most beautiful things we can do as Legislators is recognize individuals for their work, and I think that public health is very difficult. We spent this morning talking about the lack of funding and infrastructure, and oftentimes for our public health workers, including our leaders. It is difficult because we are tied against a system where we do not always have the resources, but we work behind the scenes until there is a crisis or a pandemic, and we often must rise to the occasion of stress and disaster. Hopefully we do it right. I want to express our gratitude from the Committee, but I think Dr. Titus has a few comments as well.

Senator Titus:

We have worked together a long time, and I am honored to be able to present you with a proclamation from this entire Committee. If you will bear with me, I am going to come down there with my peer, Assemblyman Gray.

AGENDA ITEM VI—OVERVIEW OF NEVADA'S IMMUNIZATION RATES AND PUBLIC HEALTH OUTREACH EFFORTS CONCERNING VACCINATIONS

Chair Doñate:

I wanted to make one comment on the public health presentations. As you may have noticed, NACO submitted a presentation and were going to present on the continual funds of SB 118 for the next legislative session. We made the decision to table that presentation item to another date later in the interim. It seems there are grave concerns with the

allocations made by the health districts, so we will let them do their homework before they come back. Hopefully, by that time we can understand what language needs to be submitted to do continual funding before it comes back to the Legislature.

Kristy Zigenis, M.A., Immunization Program Manager, DPBH, DHHS:

Since Ms. Peek already went over our mission, vision, and purpose, we will dive right into the meat. Starting with school exemptions in Nevada, looking at year over year, this is the breakdown of school type for exemptions. In School Year (SY) 2020–2021, public and charter schools in Nevada had a religious exemption percentage of 3.5 percent and private schools at 5.4 percent. Medical exemptions have remained relatively the same while religious exemptions have increased. (Agenda Item VI)

In SY 2022–2023, private schools were at 8.2 percent for religious exemptions, and public and charter schools were at 4.9 percent. According to CDC SchoolVaxView, any exemption rate nationally is about 3 percent, and in Nevada, we are about 5.6 percent. This breaks down the different school types. As we can see, private schools tend to have a higher religious exemption rate.

Let us dive into the successes of the Program. The Nevada State Immunization Program is coming out of the pandemic, as everybody else is. What we saw as a success from this pandemic is the strengthening and creation of new partnerships across the State, and we cannot do what we do without our partners, so it speaks volumes to that. Recently, we published the *Vaccine Landscape Report*, which takes a deep dive into the data of how the pandemic has impacted the State. Addendums are in the works looking at the 7-Series Schedule and adult immunization rates to come.

Another success is that we have electronic connectivity between Nevada WebIZ, which is our immunization information system, and Arkansas, Connecticut, Delaware, Kansas, Kentucky, Oklahoma, the City of Philadelphia, New Mexico, Utah, Oregon, and the Veterans Affairs in Nevada. What that means is, if an individual receives a vaccine in one of these states and has that immunization input into that state system, it will electronically transfer to ours. We have also improved the public portal, which is an access point for parents and individuals to access their own official immunization record, and that can now be viewed in Spanish.

Another success is our Long-Term Care Facility All Vaccines Access Program, a partnership between our State Program, the local health authorities, pharmacy partners, and other health care stakeholders, to make sure individuals within those facilities have access to all recommended vaccines. We are coming off the tail end of COVID-19, but we are still trying to ensure that access is available at these facilities, not just for residents but for staff as well. In 2022, our Program was audited by Eide Bailly, and of the 16 State programs audited, ours was the only one that had no findings, so that speaks volumes to the staff's work.

Policies that have allowed for expanded access to vaccines that have recently come to fruition are AB 147 (2023), which allows oral health field dentists, hygienists, and therapists to administer vaccines, creating an additional access point for individuals who might not have access to other sources; and SB 172 (2023), which allows for minors to consent to health care services for the prevention of STIs, including receipt of the human papillomavirus (HPV) vaccine.

Moving on to challenges, the increase in the religious exemption rate is impacting uptake across the State. We have also seen supply challenges for the new product for RSV for infants and prenatal use, and when COVID-19 vaccines went to the commercial market, there were hiccups with the rollout and supply constraints. Programmatically, the end of the COVID-19 funding in December will impact staff we have recruited through contracts.

The last major piece on our radar is that the cost for vaccines continues to rise year after year, and new vaccines are continually added to the schedule. Examples of this include RSV, the commercialization of the COVID-19 vaccine, and the Mpox vaccine.

Let us dive into the data on infant immunizations. Typically, we look at the 7-Series Schedule, so up to 24 months we want to see kiddos have at least four doses of Tetanus-Diphtheria-Pertussis (Tdap) and Pneumococcal; three or more doses of Hepatitis B, Haemophilus Influenzae Type B, and Inactivated Poliovirus; and one or more doses of the Measles, Mumps, Rubella, and Varicella vaccines.

This represents children up to date in Nevada as compared with national rates. Unfortunately, national rates only go up to 2020, leaving a bit to be desired in that comparison, but we can see a 3.3 percent decrease in Nevada from 2019 to 2023. Looking at the same data but broken down by race and ethnicity, American Indian and Alaska Native infants and black infants have lower vaccine rates year over year than other races. We recognize that the category of unknown race and ethnicity needs work, and we have data quality staff working on adding that component to records. Here is the same data broken down by region, so counties highlighted in yellow have less than 70 percent coverage rates.

Moving into adolescent vaccination rates, vaccines recommended for adolescents include Tdap, Meningococcal (MenACWY), and the HPV vaccine. Currently in Nevada, Tdap and Meningococcal are the school required vaccines, and HPV is not. Looking at age comparison for the 11- to 12-year-old MenACWY rates compared to 16-to 18-year-olds—and MenACWY is what I am calling out specifically here; there are two vaccines, MenACWY and MenB, which is not tracked on this slide presentation—the age representation on the slide is because a child would receive the first dose at the 11- to 12-year mark and the second dose around the 16-year mark as a booster. According to CDC's TeenVaxView populated by data from the National Immunization Survey, in 2022, Nevada's coverage rates for 13- to 17-year-olds who have received one or more doses of the MenACWY vaccine is 85.9 percent, which falls below the national coverage rate of 88.6 percent.

For MenACWY rates for 11- to 12-year-olds broken down by county, those in yellow represent less than 30 percent coverage rates. Similarly, for 16- to 18-year-olds broken down by county, those less than 70 percent are highlighted in yellow. Looking at the 11- to 12-year-old cohort’s race and ethnicity breakdown, we can see that black, white, and Alaska Native and American Indian children ages 11 to 12 have lower coverage rates compared to Hispanic, Asian Pacific Islander, and non-Hispanic other race categories. Many adolescents are missing that race and ethnicity data component, and we are working to include it in records moving forward.

Here is a similar comparison of the 16- to 18-year-old mark. This data displays an upward trajectory of this vaccine in the age cohort and all races. It is important to note that about one-third of teens do not have the race and ethnicity component on their record, and that is why the other one is substantial. It is also important to note here that the grade 12 school requirement for a second dose of MenACWY was implemented in SY 2021–2022.

Moving on to HPV vaccine rates, children who receive the first dose of the HPV vaccine before age 15 only need two doses, and starting on or after the 15th birthday, they need three doses to be considered fully vaccinated. These two lines are comparing the 11- to 12-year-olds in blue with the 16- to-18-year-olds in orange lines who have received at least one dose of HPV vaccine, and 11- to 12-year-olds have seen a decline year over year for HPV vaccine while the 16- to 18-year-olds have remained steady. For national comparison, according to the CDC's TeenVaxView looking at 2022, Nevada's coverage rate for 13- to 17-year-olds who have received one or more doses of HPV vaccine was 75 percent, which falls 1 percentage point below the national coverage rate of 76.

By county, those that have less than 20 percent are highlighted in yellow at the 11- to 12-year mark, but for the 15- to-18-year breakdown, those highlighted in yellow have less than 50 percent coverage rates. Here is the race and ethnicity breakdown for 11- to 12-year-olds and 15- to 18-year-olds.

I would like to touch briefly on adult immunization coverage rates in Nevada. Data sources include Nevada WebIZ and the CDC's AdultVaxView. There are other components within the CDC's websites for FluVaxView, and they are looking at a respiratory illness season comparison as well.

For COVID-19 in Nevada, those 18 and older who have received a current seasonal dose of the COVID-19 vaccine were at 10.4 percent. The national comparison is at 22.6 percent, so there is lots of room to grow. We are coming to the tail end of the flu season, and in Nevada, 21.6 percent of those 18 and older have received a dose of the 2023–2024 flu vaccine, which is well below the national average of 42.8 percent.

Looking at the pneumococcal vaccine, in 2022, for those 65 and older, Nevada ranks 62.2 percent of those eligible to be covered, and nationally, that rate is 70 percent. The RSV vaccine was newly introduced this last season and looking at individuals 60 and older for the 2023–2024 season, 23.6 percent is the national average, and Nevada's rate is 12.5 percent. For Tdap vaccine uptake, among those 65 and older, Nevada is at 50 percent while the national rate is 59.8 percent, and in Nevada, 39.2 percent of those 65 and older received the Zoster vaccine in 2020, while the national rate is 45.7 percent.

Moving on to Program priorities, equitable access is always first and foremost, ensuring that any Nevadan who wants a vaccine can access it. Part of this comes in looking at additional sources to receive vaccines like AB 147, which introduced a new source for individuals to receive them. It is appropriate to look at other avenues that might be convenient for an individual and make sure underserved populations have accurate information and access to needed services.

Vaccine confidence took a major hit through the pandemic, and it will take a lot to get us back on the right track, but using trusted messengers within each community is a key source of success in other states, and Nevada has been moving towards that as well. We will continue partnership building and strengthening.

Another priority is pharmacy-driven education. Every year, the Board of Pharmacy puts out a Pharmacy Doses Administered Report, and it seems that one of the key sources for adult vaccination are pharmacies, so we are working with pharmacists to understand co-administration and any opportunity to not miss a vaccine. If somebody comes in for a flu vaccine but can get an RSV vaccine with it, we want to make sure it is being offered. The same is true for schools and childcare facilities. We want to make sure they understand

what reports they are required to submit, evaluate where their program or school stands as far as coverage, and offer strategies for improvement as needed.

Data quality and making sure that immunization records are complete is a priority for us. WebIZ, our immunization information system, is maintained and supports our Program, and knowing that the CDC has shared with us, we are coming into some lean years for funding, we are making sure we have what we need to sustain that system. Regarding emerging threats, measles, avian flu, Mpox, and anything you can think of that is emerging worldwide will likely have an impact locally or statewide.

Looking at what other states have done for policy innovation to boost their rates, Hawaii, Virginia, and Rhode Island all have HPV as a school requirement for entry, and it is reflected in their rates. Hawaii and Rhode Island are well above the national standard, while Virginia's policy only speaks to female receipt of the HPV, so it is slightly above the national rate. Other states, including Vermont, Oregon, and Utah, require education when a parent submits a religious vaccine exemption, and that can come through a certificate from completing an online module or having their provider sign a piece of paper that they have been educated on the implications of not receiving the vaccine. New Hampshire, New Mexico, and Alaska have universal vaccine programs which combine private payers, state funds, and federal funds to pool resources to purchase vaccines, so it is not a reimbursement cost basis at the provider level.

Vickie Ives, M.A., Chief, Bureau of Child, Family and Community Wellness, DPBH, DHHS:

I wanted to talk briefly about the role of coalitions in public health and then look at immunization coalitions specifically. There are several different reasons why we work with nonprofits and community-based partners in public health. They can range from a requirement or a strongly encouraged action by our federal funders to work with these community-based partners or coalitions. Coalitions can sometimes be a more effective messenger to reach populations of focus and might be more agile in certain situations than government structures and able to implement programs, engage community members, and change course rapidly if needed more quickly. They can also function as an external partner to a government entity to convene partners with a shared mission and vision to align messaging, especially evidence-based messaging, in a single message statewide to reinforce certain behaviors that are helpful for positive outcomes. They can also complement more formal programs by government entities.

Looking at immunization coalitions specifically in terms of why we utilize those, they help to engage networks of all different types of health care providers and numerous key partners to support efforts to improve vaccination rates and coverage. They provide outreach to specific communities, especially underserved communities, to improve coverage for vaccinations and promote access to vaccines across the whole lifespan. Providing opportunities for immunization education to providers, the public, schools, and different audiences is another function of immunization coalitions, as well as promotion of vaccine confidence and timely and accurate evidence-based messaging sharing.

There are also roles in recognizing immunization champions and their work statewide, but a key piece with the immunization coalitions, especially as it has played out in the State of Nevada, is that they are not administering vaccines but organizing vaccination partners to conduct immunization clinics; that is a key function of coalitions.

There is a national organization for immunization coalitions called the National Network of Immunization Coalitions, and that is part of our federal funding from the CDC. The immunization procedures operations manual we follow stresses the role of immunization coalitions in our work. In addition to immunization coalitions, there are numerous boards, councils, commissions, and advisory, so a diverse array of partners with similar messaging and education roles in addition to the immunization coalition.

Lastly, an immunization coalition provides statewide community vaccination event coordination as opposed to direct services in Nevada, convening of vaccination key partners and providing educational, evidence-based webinars. They serve as a source for media outreach, updates, and education and sponsor public health conferences focused on immunization, public outreach, and messaging on immunizations. They recognize providers who go above and beyond in their work to increase vaccination rates or forge new partnerships for underserved communities and items such as the Protect and Immunize Nevada's Children packets, which includes immunization schedules. Traditionally, working with all the birthing hospitals was an activity that has been done by immunization coalitions in Nevada.

Hands-on education on how to administer a vaccine provided by clinical staff is something immunization coalitions do, and some of the key partners that work in this space are community health nurses with DPBH. Local health authorities are a crucial partner in these efforts, as well as FQHCs, pharmacies, and providers. Our Nevada State Immunization Program all work together to provide statewide services and we want to stress that access to vaccines will not suffer from coalition service changes as they are not vaccinators in Nevada in this role. We now welcome your questions.

Chair Doñate:

Committee Members, are there any questions?

Assemblyman Nguyen:

There is a lot of information on data process there, so I appreciate the details you provided. In reviewing the Coalition, you mentioned that a lot of them are not vaccinators, but they get together and can gather and convene folks. In terms of recent public knowledge on one of your coalition organizations—I am alluding to Immunize Nevada—what is the negative impact? I do not know whether it is going to hinder some of the State's strategies. In terms of oversight, what are you putting in place to prevent things like that from happening in the future?

Julia Peek, Previously Identified:

We had put plans in place over this last year as we were providing technical assistance in case this happened and how we were going to sustain activities. Honestly, probably within an hour of that information becoming public, partners from our community started reaching out from across the board: partners with medical associations, local partners at individual hospitals, or our health authorities asking, "What do you need us to do? We are ready to fill the gap, so you tell us what you need." Part of it is understanding that they filled a role.

A coalition is not government built; it is grassroots built where all these partners come out and say, "We have a shared vision and mission. We want to create something." Between then and now, easily ten, if not more, partners have reached out saying, "How do I fill the

gap? What do you want me to do? Is there a new coalition? We want to be a partner." I think that will naturally occur through grassroots effort.

We are also going to be supporting that. Please get together. How can we help? Can we convene that meeting to get all the partners together to talk about what a coalition looks like in Nevada for immunizations? Like I said, we have short- and long-term plans.

The last part of your question is, how do we avoid this in the future? That is a big, long conversation. We are looking at how we could change policy and maybe have more intensive technical assistance. This is also an opportunity more broadly to better support nonprofit organizations with additional board training.

Regarding the fiduciary responsibility, especially if you are accepting federal and state funds, there are so many strings attached and the reporting is intensive, so understand that our boards understand that scope and can get technical assistance should they be struggling with anything, not only from us. We have community-based partners that support nonprofits. I am going to turn it over to Ms. Zigenis to discuss specifically what we will do related to continuation of services performed by an immunization coalition until a new one forms.

Ms. Zigenis:

Part of our short-term plans include contracting with a mobile vendor who can offer direct services both in rural and urban regions. We will be doing contracting with an agency that can help us do widespread messaging specific to back to school, the additional COVID-19 vaccine recommendation for those 65 and up, respiratory illness season coming into the 2024–2025 season, and additional campaigns as they align with the CDC's broader messaging. We are working with medical societies both in the north and south to promote opportunities for providers to receive webinar education or seminars, and some of it might be in person.

We are also working with the University of Nevada, Las Vegas to continue the work of the Vaccine Equity Cooperative to not lose momentum they have gained through the pandemic and evaluating funding for the next year for this equity collaborative, buying us time to solicit feedback from our stakeholders across the State to inform what the next coalition should look like.

Assemblyman Nguyen:

I appreciate your candor in addressing the issue head on. Thank you, Ms. Peek, for your anecdotal response to the technical assistant piece with the board training. I think that is the key: to get folks to be more accountable in terms of operating and running projects like this in the future. I applaud your insight on that piece about board training and fiduciary responsibility.

I want to ensure we truly embrace this opportunity to further expand our reach into the in-language community. Last session, I was a broken record every chance I got about ensuring that in-language access is a part of your strategy in terms of messaging throughout our communities across Nevada, so I look forward to being included if possible. When we think about how to reach out to our communities across Nevada, especially in my district, I represent a very large in-language community, so that would be helpful.

Last but not least, we still have a lot more work to do, and I would like to see regular updates from these organizations and where they link in terms of DPBH because now that I am sitting in this role, I am learning about DPBH, but I did not know that Immunize Nevada was part of this DPBH umbrella. That was something I learned today.

Chair Doñate:

I want to correct the record. They were a coalition partner. They were not under the DPBH umbrella. I want to make sure that is clear.

Assemblywoman Brown-May:

In the beginning of the presentation, it was noted that there are 16 programs statewide, and DPBH was the only one that had no findings. Congratulations to DPBH, but I am curious to know, given everything we have discussed with Immunize Nevada regarding fiduciary responsibilities and technical assistance needed, are we seeing consistency regarding the findings for each of the other programs that are currently available in Nevada? Is there a way to address those issues before they become more serious?

Ms. Peek:

That was part of our normal audit. There is a full report for every program they audit, and again, the Nevada State Immunization Program was the only one noted that did not have any findings. As far as how we respond when there are findings, we try as best we can to avoid and learn from what we have done in the past, and hopefully, there are not a lot of findings. When there are findings, we look systemically at what policies we are going to change at the Agency so there is not a recurring finding.

For example, if there was a finding in one program related to challenges or inconsistencies in time and effort tracking, our Agency has developed a shared time and effort tracking, so that one program was noted, but now it is systemic across the Agency that we all time track in a certain mechanism. If it was a finding in one, it applies to all. That is often how we deal with the audit findings on our part. Our audit would be specific to DPBH, and the entities also must do their own independent audits, so they are not one of the 16 programs referenced here.

Assemblywoman Brown-May:

For clarification, of those 16 programs, how many are nonprofit organizations? Are you aware of that?

Ms. Peek:

That contract was State agencies or DPBH, so I do not know how many nonprofits contract with that specific company. The audits are provided to DPBH when they are completed by our vendors or nonprofit organizations, so if we needed to compile information related to the audits of our nonprofits, that would be some work on our part. We are referencing our Agency-specific audits.

Assemblywoman Brown-May:

I am certainly not trying to make more work for you. I think it is important that we as a State walk alongside provider organizations wherever we can. State employees doing the

work of the State is good, but it also helps us to get out to our key populations when the voices are shared. The ways we can walk alongside nonprofit organizations or other provider groups throughout our community will help us be more effective in the delivery of immunizations. I was curious, regarding Immunized Nevada, were there things we could have done regarding State assistance that could have prevented this from happening? Are there things we could have done differently with this nonprofit?

Ms. Peek:

In hindsight, I personally would have liked to engage the Board earlier because we were communicating directly with staff of Immunize Nevada. For me, that is something I would probably do differently should we find ourselves in the same situation again. This team spent hours providing technical assistance from programmatically how we write scopes of work and deliverables to understanding how to reimburse. They did site visits, and we had a third-party auditor—though she did not audit in this case—come in and do the review of which I am sure you have seen copies. We also engaged a federal grant assistant who offered numerous times to work with not only the Board but the organization to provide technical assistance, but they did not accept that assistance. I would like to put that out there for all nonprofits.

We are also engaging with the Nevada Grant Lab, a phenomenal organization designed to bring in federal funds, and we have talked candidly with leadership about the great mission and vision we share, but how do we make sure our nonprofits are ready when that funding is successful? We are learning a lot about what we could have done differently about what we put in policy. To the point the audit, my answer earlier is there something systemically we need to look at differently when working with our nonprofit partners like talking with them more specifically about the reimbursement model, if that is not clear, that is a huge challenge for smaller nonprofits to work with state and federal governments.

A lot more education can be done, whether DPBH does it with our partners or whether a bigger organization like Nevada Grant Lab, the Governor's Office of Federal Assistance does it, or if it is available and we reference folks to go take a training, so if you are going to get funded by DPBH, your board members must complete this two-hour training on the process of working with our Agency. We are trying to assess that right now to make sure the training is on the front end and they are very clear on the technical assistance they can get throughout depending on the challenge they are having.

Chair Doñate:

I do not see any other questions in Southern Nevada. Are there any questions in Northern Nevada?

Senator Titus:

I have heard in public testimony and comments here regarding the possible need or recommendation for removing the religious exemption for vaccinations. My concern is that it sends the wrong message to the public. You as an agency and myself as a health care provider need to be improving trust in the system, and when the government comes in and says, "Well, to heck with that, we are going to pass a law and will make you do it," it is giving the wrong message.

I spoke to the School of Public Health at UNR the other day, and I was saying that as a public health person, there is a fine line between what is best for the public and individual rights to health care and individual choices. Never in all the thousands of hours I worked in the emergency room, when somebody had an injury and I recommended a tetanus shot—they might have refused it and said, "Oh, I do not know, doctor, do I really need one? I hate shots," et cetera—but I have never had anybody refuse it when I said, "No, you really do need this." I worry that you are not gaining the trust of folks by reassuring them about these vaccinations and their importance.

You are partnering with nonprofits, and I like flu clinics—they help in our community—and going out to the nursing homes. It helps, but I wonder what the real push is, and hopefully you have a combined effort to restore trust in the system. Going that avenue would gain you a lot more public trust than having the big thumb of the government saying, "Hey, we are taking away this exemption because you are not doing this," as opposed to addressing concerns.

Ms. Peek:

A lot of the work we do is vaccine confidence and having trusted messengers bring that information, but as was mentioned earlier, we will continue training providers on how you talk to your patients or parents differently. That is luckily funded and mission-driven for us to have those conversations and training.

Regarding the public policy piece, we research pros and cons of each, and luckily you are the ones who make the decision about policy, and we can educate as best we can on that. Personally, I do not disagree with you, and I think the conversation needs to be had at all levels from a trusted messenger to that individual and they make the decision they need.

We learned a lot with COVID-19 about requirements and intended and unintended consequences. We use all that in our decision making and how we message to different groups, but this group is not making a policy recommendation right now. We are providing examples of what other states do in that capacity, but I certainly hear what you are saying.

Senator Titus:

I am curious about the overall vaccination rates. Since COVID-19 and the distrust of the COVID-19 vaccines, the overall vaccination rates have fallen. Is that correct?

Ms. Peek:

It is true, and Ms. Zigenis can talk specifically about any of them. I happen to oversee the Community Health Nursing Program that services the rural communities, and they said we have not rebounded. Our client level for all services has greatly reduced since COVID-19, so that is reproductive health, immunizations, et cetera. I do not know if that has happened to the larger system, but I could say anecdotally it has happened in the rural counties. I have watched it.

Senator Titus:

I would say our major charge as public health folks is restoring trust. To that end, I am trying to do my part, and thank you for what you are doing.

Chair Doñate:

Assemblyman Gray, do you have any questions?

Assemblyman Gray:

No, but I would like to echo Senator Titus's remarks. I think it is more about regaining the public's trust and not forcing things on them, taking a gentler approach on the forcing side and focusing more on the education side.

Chair Doñate:

I have a few more questions. I will come back to Immunize Nevada, but I want to go over immunization rates first. Let me start off with childhood and infant immunizations. There are a lot of instances of constituents I hear about where, because we have these requirements—we have worked tirelessly to have the vaccine requirements we have now, and our goal should be to influence and help accept that vaccines are safe, which they are—there are students who, because their parents do not have health care access immediately afforded to them, end up getting suspended and must wait for their parent to figure out a doctor's appointment. Now we are exacerbating the child not being able to retain the education they need because the parent does not have access.

This can be more anecdotal to your experiences as public health folks, but has there been any discussion about looking at a scope of practice for school nurses to administer these vaccines and make it more readily accessible in schools? Oftentimes, the folks we trust in our communities are our community centers or school administrators. Is that something we could potentially entertain as a Legislature? We have talked about other bills like dentists and dental hygienists, but have we looked at what we can do in schools?

Ms. Ives:

In surveying different options that other states have looked at specific to scope of practice and school nurses, the literature is not very robust, honestly. There is a wide range of ways that the state-to-state laws vary around school nurses in terms of immunization supports. The National Association of School Nurses stresses particular pieces around best practices, such as school-located vaccine clinics and the elimination of all exemptions except those necessary for valid medical complications.

The Academy of Health stresses variability and how no state currently authorizes nurses to conduct all elements of immunization practices for all age ranges in a school setting, and expanded authorization of nurses in all states could increase vaccine administration rates. School-based nurses have a unique first line-of-care touch point.

Standing orders programs are mentioned in this context as well as a way to increase uptake of vaccinations, and there is a legal foundation around authorizing delegation of immunization services performed by different types of providers in broad patient populations in different settings and sometimes the engagement of non-physician health professionals. There have been several pilots in the United Kingdom specific to HPV in school nurse vaccinations. and they have found that utilizing certain types of electronic consent has in some cases helped uptake and speed of getting those consent pieces taken care of. In others, it is the speed of getting the consent in and not necessarily higher uptake in looking at that nationally.

It has not been a focus of the Nevada State Immunization Program to date, and Nevada's Department of Education (NDE) would be a key partner in looking at that. Not all states do, but we require some additional educational coursework to receive and maintain a school nurse certification in addition to the RN license, so there might be opportunity there. Massachusetts designates their school nurses as public health authorities. If that is of interest in granting the authority to obtain immunization information directly from health care providers in their statutes to monitor and ensure compliance with immunization requirements in schools, there are pieces focused on health information exchange and access to school nurses as well that have been an area of focus. Those are a few elements in that space in case it is helpful.

Chair Doñate:

I would love to see that legislation from Massachusetts. I do not know how my Committee Members feel about this, but from my perspective, we talk about infrastructure and access to health care and service providers who can be trusted by communities, and schools oftentimes are the first line of resource for many folks in rural areas or parts of Clark County that parents have access to because there is a touch point. I would be interested in seeing what we can do to reform the delivery that school nurses can be a part of.

I have heard concerns of how we can reform and standardize electronic consent for parents and if they should decide they want their child to receive certain a level of health care services, whether it is immunizations or other services, through their school facility. In CCSD, we have piloted Telehealth, so it would be interesting to continue to explore that. Regarding universal vaccine coverage, do you happen to recall how much money has been expended on those types of programs in other states?

Ms. Zigenis:

I did not deep dive into the funding amounts, only the structure of how it came to be.

Chair Doñate:

My understanding of that policy is that we as a State will purchase these vaccines to be administered so folks do not feel the challenge of having to pay for them. We are trying to make sure the service is there to be delivered for people who want it. Is that correct?

Ms. Zigenis:

Yes, that is correct. Two of the states I mentioned only cover children, and Alaska goes up through adults, but it is exactly what you are saying for the purpose and intent.

Chair Doñate:

With regard to Immunize Nevada, my main question was that the articles alluded to contractors not being paid. Have we heard of any complaints from staff members also not being paid? Feel free to push back in case this is subject to investigation. If you are not able to answer that, I understand, but are there any reports of staff not being also paid?

Ms. Peek:

The article mentioned my name, so I have had several staff members reach out to me, and I honestly communicate with them daily about challenges with payment. For a long period of time, we have encouraged those staff to apply for jobs with the State hoping that we can get them into State employment. We have connected them with the Labor Commission to follow up in that realm and served as a liaison between them and Immunize Nevada to try to help them get information on when they should expect payment. That is a difficult outcome, and in some cases these folks have not been paid for a period of time. That is their livelihood and it is unfortunate, but we have been communicating daily.

Chair Doñate:

Do you know if there are other organizations—not contractors, not staff—that have not been paid?

Ms. Peek:

Some organizations have reached out to us directly indicating that they have not had payment for a period of time. As part of what you probably read in our recommendation letter, because we are only aware of a few, and we are certainly not the entire budget of that organization, we asked the Board to do a deep dive and figure out what your expenses have been, what has been paid, not paid, et cetera. As you are aware from the article, a number of those Board members have left, but we think that is an important exercise because folks are reaching out to us indicating that there has been a period of time without payment.

Chair Doñate:

Let us talk about the short- and long-term strategies. It is my understanding that this coalition partner was responsible for a lot of the outreach efforts in rural counties. There are certain services that the government is entrusted to take on, and we partner with coalition partners to continue and extend that work, so now that a gap has been identified, what are the short- and long-term plans you have in action? I know you alluded to it, but maybe you can reference it again.

Ms. Peek:

I will hand it over to Ms. Zigenis again if you would like her to read that, but part of what we shared is that they are the messenger and convener of those events in rural communities. My nurses are also out there. We have county health officers and health districts can promote the events, so I do not see a lack of event promotion, especially with all the partners who have stepped forward. We will have a vendor providing vaccination services, so we will promote those and work with our community partners in that community to continue to promote those. We will also work with a different outreach company we have worked with in the past who did a great job in promoting those events making sure we fill that gap in promotion and convening, but we have been excited about the partners who have stepped forward and said, "You tell us what you need. We are going to do it."

Chair Doñate:

My last question is, in terms of statewide infrastructure, how many staff members do you currently have to run immunizations?

Ms. Zigenis:

I have 16 state full-time employees, 26 contracted COVID-19 employees, and a couple other funded sources, but fewer than five.

Chair Doñate:

I assume the goal is to keep all those who are COVID-19 funded so you improve your infrastructure over time, correct? That is the message we have heard all day today.

Ms. Zigenis:

Knowing that COVID-19 funding will end at the end of December, right now we are prioritizing the efforts COVID-19 staff have done to see what we can maintain.

Chair Doñate:

There is enough work to be done to repurpose them if we wanted to, correct?

Ms. Zigenis:

Definitely.

Ms. Peek:

One of the most important things gained during COVID-19 in the Nevada State Immunization Program was the staff around data modernization and ensuring the WebIZ system is successful and accessible and all of those important activities. That staff could be lost with COVID-19 funding, and we go back to the conversation earlier about if we were to get a sustainable General Fund investment, some of the money the State would use would be for these larger data modernization projects and where we run the registry for the entire State, making sure it is robust and there is investment. If the CDC does not increase funding to the State Immunization Program, that type of staff may be lost.

Chair Doñate:

Nevada is not unique in experiencing these challenges. A lot of my colleagues, different chairs and members of HHS committees across the nation, understand we are experiencing a critical need post COVID-19. It is something we need to prioritize, and I like your recommendation of reforming nonprofits and if they do receive certain amount of funds, what are the adequate training programs they need to go through before they receive them? At the end of the day, we have the obligation to the taxpayers we serve. We look forward to keeping in touch. Are there any closing remarks?

Ms. Peek:

We are happy to work with your staff if you want us to flesh out any of these policy recommendations or the research Ms. Ives alluded to. We are happy to provide that to your staff.

AGENDA ITEM VII—PRESENTATION ON GOALS AND OBJECTIVES SET FORTH IN THE CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION STRATEGIC PLAN 2023–2027 OF THE DIVISION OF PUBLIC AND BEHAVIORAL HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES

[This agenda item was taken out of order.]

Chair Doñate:

We will now move on to the presentation on the Chronic Disease Prevention and Health Promotion Strategic Plan (Agenda Item VII).

Ms. Rogers, Previously Identified:

I got the additional data points Senator Titus requested, so if it is okay, I will go over those now. For pre-COVID-19, in 2017, the food insecurity rate for the State of Nevada was 12.2 percent; in 2018, it was 12.8 percent; and in 2019, it was 12.1 percent, which reminded me that food insecurity did go down in 2020 due to increased resources available through the pandemic.

Senator Titus:

Will you get the rest of those, like the congressional district numbers from 2018, 2019, and then 2020? What I am interested in now is the rebound, so 2022 and 2023.

Ms. Rogers:

I will go over the Chronic Disease Prevention and Health Promotion Strategic Plan. Instances of chronic disease are prevalent with six in ten adults having at least one chronic disease and four in ten adults having at least two or more. As of 2021, Nevada is ranked 49th in dedicated state public health dollars at $14 per person. With the addition of SB 118 funding, we are now at $19 per person, which is better but still below where we would like to see to use these funds to help mitigate and prevent chronic illnesses.

Regarding opportunities and challenges, from 2011 to 2021, four of the five leading causes of death in Nevada were from chronic disease. The onset of COVID-19 changed this trend, but chronic disease deaths continue to rank high. In 2023, 18.8 percent of adults in Nevada reported a health status of fair or poor, an increase from 2022 at 17.9 percent. In 2021, 67 percent of Nevadans were overweight or obese, and obesity rates have continued to rise, increasing from 24.5 percent in 2011 to 31.3 percent in 2021, and preliminary 2022 data currently shows another increase to 33.5 percent.

During SY 2021–2022, an estimated 33.1 percent of kindergartners were overweight or obese, an increase from the previous school year, which was 31.9 percent. Obesity is linked to most new Type 2 diabetes cases. In 2021, 11.3 percent of Nevadans had diagnosed diabetes; an additional 70,000 Nevadans have diabetes but do not know it;

816,000 Nevadans have prediabetes; and it is estimated that an additional 14,800 Nevadans will be diagnosed with diabetes annually.

Tobacco use remains the leading cause of preventable death in the U.S., and youth use of vapor products continues to increase; 44 percent of Nevada high school students have tried vaping products, while 11 percent of Nevada's adults currently smoke tobacco in some form. Nevada has an "F" ranking for funding invested in tobacco prevention and cessation. The CDC recommends Nevada's tobacco control program be funded at $30 million, but Nevada currently ranks 46th in state tobacco funding at $950,000.

The financial burden of chronic disease is huge. The U.S. spends $4.3 trillion on health care with 4 percent of that going to public health and prevention. Diagnosed diabetes costs an estimated $2.8 billion each year in Nevada alone; obesity costs the U.S. $173 billion per year; and smoking-related illnesses cost over $300 billion per year. Contributing to the reduction of chronic disease will not only decrease the burden to the State but also improve the lives of Nevadans and their families.

Primary prevention is key to preventing disease and improving long-term health outcomes, including quality of life. Primary prevention focuses on physical activity status, nutrition status, mental health and well-being, smoking status, and weight management. These are health behaviors that should be encouraged regardless of disease status to improve overall population health. While primary prevention is known to reduce instances of chronic disease and improve quality of life and overall health, there is no dedicated State funding for comprehensive wellness.

Regarding planning and policy, the purpose of the Chronic Disease Strategic Plan is to define specific and reasonable goals to reduce the burden of chronic disease in Nevada over the next five years and guide the work of the Chronic Disease Prevention and Health Promotion section within DPBH. Over 40 state and local partners contributed to the Plan, which looks to guide all agencies, nonprofits, governments, and communities working on chronic disease prevention. The overall vision is to achieve wellness for all Nevadans through the integration of primary prevention, health equity, useful data, evidence-based policy, and strong partnerships.

The strategic goals are to expand evidence-based primary prevention efforts to reduce chronic disease across the lifespan, support efforts to improve health equity, generate timely data and information for action, support policies and promote wellness, and strengthen partnerships and the capacity of our partners. Based on top concerns related to chronic disease, we have compiled a list of innovative policies and practices shown to reduce the burden of disease and improve overall wellness.

Innovative policies for tobacco control include curbing marketing on tobacco products. It is estimated that the tobacco industry will spend $75.3 million to market tobacco products in Nevada alone. Studies have shown that kids are twice as sensitive to tobacco advertisements and more influenced than peer pressure. Therefore, it is important to also increase the State's youth education and awareness on the dangers of cigarettes and the use of e-cigarettes. Expanding the Nevada Clean Indoor Air Act to include workplaces and casinos can safeguard the health of Nevada workers from the harmful effects of secondhand smoke. Banning flavored cigarettes is an important policy that will protect youth since 85 percent of the youth use flavored tobacco. Finally, expanding Nevada's preemption laws to include preemption on licensure would address regulations around over-the-counter tobacco sales and vending machines that include tobacco products.

Additionally, support for statewide comprehensive wellness programs aimed at nutrition and physical activity promotion, education among providers, schools, school-age children, and their parents would be vital in primary prevention efforts and reduce or mitigate the impact of diet-related chronic illnesses. This includes the new statewide Healthy Eating and Active Living Nevada (HealNV) program, which seeks to improve discussions around eating more fruits and vegetables, reducing screen time, increasing activity, and consuming zero sugary beverages.

Increasing the reach and impact of this program can include State focus on reducing sugar-sweetened beverages by reducing marketing and increasing promotion of other options. Increasing fruits and vegetable consumption can be done through education as well as support to low-income families by increasing the purchasing power of fruits and vegetables purchased through the Supplemental Nutrition Assistance Program (SNAP) electronic benefit transfer (EBT) through a Double Up Food Buck program. New York is an example of a state that has supported such a program, resulting in an overall increase of fresh fruits and vegetable sales.

Wellness can also be promoted and achieved by improving nutrition and food security by increasing access to nutritious and affordable foods. This can be done by reducing the number of food deserts, improving expanding participation in nutrition assistance programs like SNAP and Women, Infants, and Children (WIC), school lunch and breakfast programs, and child and adult food care programs.

Additionally, a focus on early cancer detection is vital to promote health. Behind skin cancer, breast cancer is the most common kind of new cancer in women. Black women have the highest mortality rate for breast cancer in Nevada, and the Nevada Breast and Cervical Cancer Early Detection Program provides screenings for early detection and focuses on ensuring proper outreach is provided to black women due to this increased risk in the State. This population has been hard to enhance screening efforts for, as they often do not qualify for the program due to insurance and income status. The Program needs to increase capacity to further conduct outreach, increase screenings, and provide adequate referrals and follow up to screening services they qualify for.

Chair Doñate:

Committee Members, are there any questions?

Vice Chair Orentlicher:

I have two questions regarding tobacco. You described some interesting, innovative policies. Are you bringing these to our attention, or are you endorsing them in your official role? The second question relates to those numbers about the cost of tobacco, $300 billion a year. As you indicate, they dwarf costs from diabetes or obesity. Our current funding is 3 percent of what the CDC recommends to control tobacco. Are there any data on the return on investment if we went up another $1 million, $2 million, or $5 million, how much that would reduce the cost of tobacco-related disease?

Chair Doñate:

On the first question, the agenda item after this speaks specifically to the recommendations folks present and youth vaping is on that, so we will have more time to deliberate.

Ms. Rogers:

These are simply policies we are bringing to your attention that other states have provided to help mitigate the effects of tobacco use. As far as data related to return on investment, I can look for that and get back to you. I do not have those numbers with me.

Assemblywoman Brown-May:

I have one question about the reduced sugar-sweetened beverage consumption. You say we should support the Statewide Comprehensive Wellness Program. Do you have targeted measurements relative to the data on the amount of reduction you are trying to accomplish year over year? Is there a strategy currently in place or an education component relative to what sugar does to the human body?

Ms. Rogers:

The Chronic Disease Prevention and Health Promotion section launched a statewide HealNV program, also known as 5210, meaning five or more fruits and vegetables a day, two hours or less of screen time, one hour or more of physical activity, and zero sugary beverages. We are in the preliminary stages of starting that campaign, and we are focusing on targeting health care providers and increasing messaging in clinics and with pediatricians specifically to talk to their patients, but we hope to expand the Program to be more encompassing of additional education. We would like to look at providing education and materials for schools and workplaces as well. We are starting with pediatricians and working with the health districts to promote to pediatricians. We are also working with the Nevada Chapter of the Academy of Pediatrics. It is a start, but ideally, we would like a robust wellness program out of this HealNV campaign.

Assemblywoman Brown-May:

You would potentially have an additional partner by moving toward autism groups or folks who have intellectual or developmental disabilities given that diet, and sugar intake in particular, is seen to aggravate behavioral outbursts that may be characteristic to that diagnosis. That is something to help you navigate as you work through pediatricians' offices.

Senator Titus:

This is more of a comment than a question. As a primary care doctor who sees a lot of kids and has delivered kids: do not ignore that. I know we have a dearth of pediatricians in our State, and the primary care realm is fully covered with nurse practitioners, PAs, family physicians, and all those folks too to reach out to if you are truly reaching out to all people, especially in rural areas. We do not have any pediatricians in the rural areas. They are rare. I would encourage you to put a broader umbrella out there.

Chair Doñate:

My only comment before concluding this presentation item is that regarding reducing sugar-sweetened beverage consumption and the consumption of nonhealthy foods, there is some effort we as a Legislature can probably take with what is being consumed by students at schools. To my knowledge, there are potential loopholes where fundraisers are taking place, and they are bringing in Jamba Juice, pizza, or other types of vendors during lunch period. Some schools have tried to hone back in on what students can purchase during

school hours, so there is much more we can do to build that program and make it more diverse so students can find school meals appetizing.

I do not have any other questions. A lot of it is already covered based on the policies you recommended, so I appreciate all the sentiments, and we will take them for consideration as we develop our policy proposals. We will now close this agenda item.

AGENDA ITEM VIII—OVERVIEW OF EFFORTS AND POLICY CONSIDERATIONS TO REDUCE FOOD INSECURITY IN NEVADA

[This agenda item was taken out of order.]

Chair Doñate:

We will now move on to the next item regarding food insecurity.

Sarah Rogers, Deputy Chief, Nutrition Unit, Bureau of Child, Family and Community Wellness, DPBH, DHHS:

I will be going over food insecurity for DPBH. As of 2021, the food insecurity rate in Nevada was up to 13 percent from 11 percent in 2020. It is higher than the national average, which is currently 10.4 percent. For race and ethnicity, the black population is more likely to experience food insecurity at 21 percent, followed by Latinos at 14 percent. By congressional districts, District 1 has the highest food insecurity rates at 17.8 percent, followed by District 4 at 13 percent, then District 3 and District 2. (Agenda Item VIII A)

There are many low-access areas in Nevada, also known as food deserts, which are defined as areas with limited access to supermarkets or grocery stores, resulting in inadequate nutritious and healthy foods within a one-mile radius for urban areas and a ten-mile radius for rural areas per Census Track. The image on the left in brown is highlighting low-access areas in Nevada, and the image on the right is highlighting low-access and low-income areas in green.

The Office of Food Security and Wellness falls under the Chronic Disease Prevention and Health Promotion section within DPBH and manages the Funds for Healthy Nevada (FHN) hunger funds, which supports initiatives and programming aimed at reducing hunger, promoting public health, and improving health services. In addition, the Office of Food Security staffs a wellness component, supports the Nevada Governor's Council on Food Security, and supports the implementation of the 2023 Strategic Plan.

The FHN funds support one State full-time staff, the Office of Food Security and Wellness Manager, in addition to $4 million per biennium for our food and security partners. For the 2024–2025 Notice of Funding Opportunity, we received 13 proposals for funding at a request that was almost double what we were able provide, so in total, we were able to fund 11 partners at $4 million. Additionally, the Office of Food Security must supplement to sustain their efforts, and they do so by using other federal grants the Chronic Disease Program has by funding a food security evaluator, a wellness and prevention coordinator, and programming efforts underneath the Wellness Program.

The WIC program also falls within DPBH along with Office of Food Security, and they not only improve food security but also nutrition security. Last month, U.S. Congress approved

an additional $1 billion for the WIC program to sustain the additional monthly allotment of cash value for fresh fruits and vegetables in the WIC package.

It is estimated that 116,000 families in Nevada qualify for WIC. However, only about 50 percent of those families participate. Participation in SNAP for categorically eligible individuals makes them adjunctively eligible for WIC, but there is almost double the participation in SNAP versus WIC for those who are categorically and income ineligible for WIC. Additionally, redemption rates are lower than we like to see them at 57 percent per month, and infant formula and fresh fruits and vegetables are the highest redeemed foods in the WIC package.

To efficiently support and improve food security across the State, the Office of Food Security has the capacity and the ability to do so. The funds that support the Office are not considered to be stable, and FHN proposals continue to be much higher than the amounts we can provide as costs for programs and costs for living for FHN providers continue to increase. The Office of Food Security would benefit from additional staff members to improve technical assistance for community partners, be able to seek and apply for additional federal grants to help sustain the programs, increase support for the Governor's Council on Food Security, and continue implementation of the Strategic Plan.

The State of Colorado has dedicated $14 million of supplemental funding to support initiatives that are very similar to our FHN Hunger Fund initiatives. Additionally, addressing barriers related to food deserts would increase the availability of adequate and quality foods to the most in-need Nevadans. Illinois is seeking to address food deserts by supporting municipally owned grocery stores, and increasing client choice pantries in food deserts has also shown to increase access to fresh food options.

Increasing participation in the WIC program is another important food security measure that DPBH and the Division of Welfare and Supportive Services (DWSS) are currently working on. It is important for health care providers to be knowledgeable of how to determine if a patient is food insecure by screening for hunger vital signs and how to effectively refer them to assistance. The WIC program is also making strides to modernize through two federal grants, the Online Ordering Grant and the WIC Modernization Grant.

Kelly Cantrelle, Deputy Administrator, DWSS:

We are going to talk about life after the Supplemental Emergency Allotment (SEA) that ended as we started wrapping up COVID-19. The first thing we want to talk about is the partnership between SNAP and WIC. Our caseworkers are speaking to anybody with a child aged five and under to see if they have any interest in applying for WIC. We do that with all our interviews, and if they have those children, we are doing an automatic referral to WIC. We email it over when we have a person doing the interview with the eligible person. We also have customers who apply online through Access Nevada, and if they indicate that they are interested, that is an automatic referral. It does not require any intervention from our workers.

Since the SEA ended, we have seen an increase in the number of WIC referrals. For anyone who may not know, for people eligible for food stamps, if they were eligible for anything less than the full amount, the SEA brought everyone up to the full benefit amount, so no one who was on benefits did not receive the full SNAP grant.

Those benefits ended in February 2023, the last allotment went out in March 2023, and we saw applications for SNAP increase, but only for that one month. We did a lot of public service announcements, so we think the big push letting people know these benefits were ending made our application counts go up.

From 2021 to 2022, there was a 22 percent increase in SNAP allotment. Does that match the inflation we have seen? Maybe not, but there has been quite a bit of increase. To put it in perspective, SNAP allotments go up in October every year, and at the end of 2020, a single person was able to receive $204 in SNAP. In 2021, that jumped up to $250. It is one of the biggest increases we had ever seen in the SNAP program, and today, that number is $291. From today's allotment back to 2020's allotment is a 43 percent increase—maybe not enough to fight inflation, but there has been a decent increase. In March 2023, when the last SEA payments went out, we saw an uptick to about 50,000 SNAP applications in that one month, but then they went right back down into that 45,000 range, and they continue to be around that range today.

Pre-pandemic, there were approximately 420,000 SNAP recipients on our rolls, and today we have about 502,000. Pre-pandemic, the SNAP allotment that went out every month was about $48 million, and that allotment today is over $90 million, so you can see it increased not only because of the people who were on assistance, but because of the increase in the actual allotment itself. At the height of the pandemic, we were issuing $137 million every month in SNAP benefits to anyone who was eligible.

When the SEA ended, we were sending an average of 1,000 electronic referrals over to WIC per month. The average now is about 1,400 per month, and these are the automatic referrals that go through the online portal. These are not counting the number that my staff do when they are talking to people.

We will talk about a few things we have in the works right now to hopefully reduce food insecurity in the next couple of years. The first that I am happy to announce is that we applied for the waiver for the Able-Bodied Adults Without Dependents (ABAWD) that you probably heard a lot about recently, and Nevada is once again eligible. We do not have to put those rules into effect yet. We are good through June 30, 2025. We are going to keep applying for the waiver. It is a double-edged sword because if we get it, that means our unemployment rates are higher than the rest of the states because we are over 5 percent right now, but we do not have to lose people to the requirements that come with ABAWD.

Another thing we are working on right now is requesting a waiver from Food Nutrition Services (FNS) to be able to take SNAP applications over the phone. Right now, we do not do that because we do not have a mechanism to store the signature or the rights and obligations that our customers attest to. While we are working on that through IT, we are going to apply for the waiver so we can take them over the phone in the interim until we can store that information. That will help a lot with individuals who cannot get to the office, like people who are disabled or elderly folks. I am glad we are going to get that done, and hopefully that comes along here in the next few months.

The next one is not always 100 percent popular with everyone, so give me a minute here and I will see if I can convince you. We have started exploring participation in what is known as the Restaurant Meal Program, which allows elderly, disabled, and unhoused individuals to use their SNAP benefits at local and participating restaurants. We know there are a lot of people who do not have a home or a place to cook food, and there are a lot of seniors or disabled individuals who maybe cannot cook for themselves.

One of the reasons this program is not as popular as you may think is because we have seen several states roll this out with a lot of fast-food restaurants participating, so there is the argument that it is not healthy food. We have done preliminary work over at DWSS, and we started down in Clark County and spoke to a few restaurants to see what kind of restaurants we can get on board, and we are happy to report that we have interest from places like Teriyaki Madness, which has vegetables and food that is not like a fast-food type of food. We have others too, so we are happy about that.

The UNR Extension reached out and indicated they would like to partner with us in speaking to restaurants that offer more nutritious options, and they have a list of the most nutritious restaurants in the State, so we can work together to talk to those people once we get to a place where we are ready to roll out this program. I am excited about that and curious to see how it goes, and I want Nevada to do it right. I do not want to have all fast food, and we are hoping we can get other restaurants involved that can give nutritious options to the community.

As Ms. Rogers stated, DWSS and WIC have started collaborating more to see if we can close that gap from the number of children on SNAP to the number of children on WIC who are eligible for both programs. We started talking about co-locating folks who do eligibility for WIC into our Welfare offices, so if one of my workers says, "Hey, you are not eligible or you are over income for food stamps," maybe we can say, "But you know, WIC has a higher income limit, and you can certainly subsidize with some of the benefits that they offer over here." We are creating a training to better educate our staff on what the WIC requirements and income limits are, and we are going to make that training mandatory twice a year for all the folks on my side of the house so we can more effectively close that gap and make sure all children who are eligible receive the benefits from WIC. It is an amazing program, and there has been research done that shows the number one food item that WIC or food stamps are spent on is formula. If we could close that gap and say, "Hey, if you could use WIC for a lot of that formula, then maybe you could use your SNAP benefits for other foods that you may need."

The last thing I want to talk to you about today is the Summer Electronic Benefits Transfer (SEBT) program. As part of the U.S. Consolidated Appropriations Act (HR 2617, 117th Congress), they launched the SEBT program. It is a brand-new program, and the first benefits will go out for summer 2024. Because we got the final interim rule in December 2023, we will not be able to get these benefits out before the school year ends this year. They have allowed us to go until the end of September to get these benefits out.

This provides grocery buying benefits to low-income families with school-age children who lose school lunch and school breakfast when they are not in school, and they estimate that close to 30 million American children could benefit from SEBT with potentially up to 350,000 of them being right here in the State of Nevada.

The program provides $40 per month per child for the three months they are out of school. That is $120 per eligible child during the summer months, and starting in 2025, the requirement is that those benefits go out prior to the last day of school, so they are available on the card for parents to use during the summer when free or reduced school lunches are not available. We submitted our State plan to FNS, and our letter intent to participate in the Program, and we look forward to rolling that out. It is a time crunch. We do not have a lot of time left to get it, but we are looking to have those benefits into families' hands by the end of September.

Chair Doñate:

Let us take a quick pause to ask any questions. Committee Members, we can ask questions specifically to this presentation knowing the food banks will present after.

Assemblyman Nguyen:

I am excited to hear about the local restaurant program because I think that addresses the issue if you are unhoused and do not have access to a kitchen, or you live in a room situation where you do not have access to anything that can cook food. How are those restaurants able to participate in the program, and in terms of requirements and reporting, how do you monitor that to see if they are complying with requirements, whether from the federal or state level?

Ms. Cantrelle:

The program has not rolled out here in the State of Nevada, but the way it will work is that restaurants will have to go to FNS and apply to become a participating restaurant. They will have to get the point-of-sale machines in their facilities so individuals can use their EBT cards to pay for those bills, and believe it or not, DWSS will not have a lot of involvement in monitoring all of that. A lot of that is done directly through FNS and the restaurant itself, but we are in our infancy stages right now. There is a lot that we do not know yet, but the more we know, I am sure it will be something that comes up down the road and I can have more information on.

Assemblyman Nguyen:

The program could benefit both not only the folks who are using it, but also the small business in districts all over Nevada. I would love to stay engaged with that, so if you can help me to get connected, I would love to learn more about it.

Chair Doñate:

You mentioned there are several households you would presume to be eligible for receiving WIC, but they are not applying, and I might be misunderstanding. There are households that meet the eligibility criteria that are asked if they would like to apply for WIC. Why not simply use presumptive eligibility to enroll them into WIC? Is there something that federally you cannot do, or do you need authorization to do that?

Ms. Cantrelle:

I am going to take a piece of this and kick it over to Ms. Rogers to answer the WIC side. If we identify someone, we could send their information over to WIC. However, we learned a while back that when we do that, and they reach out to them, they say, "Well, we were not interested in that," or "We did not ask for that," and we do not know why exactly. We know it works better if we ask the individual and they say, "Yes, I am interested," and then we send the referral. That seems to work. I believe there is categorical eligibility though, if they are eligible for SNAP, Medicaid, or Temporary Assistance for Needy Families (TANF), they are automatically eligible for the WIC program. It is a matter of getting them to apply, participate, and be willing to go through those motions on the other side.

Ms. Rogers:

Yes, that is correct. If someone is participating in SNAP, TANF, or Medicaid, they are adjunctively income eligible to apply or to participate in the WIC program. The WIC application is a separate process, so we have different requirements to get them on the program. We can deem them income eligible, but they would still need to make an appointment and come in. There are anthropometric measurements we need to take, there is iron that we need to take, so we need to see them physically in the office for the most part. There are now waivers where we can see them over the phone or get an anthropometric measurements fax to a WIC clinic from the doctor's office, but it is another step to get on the program and get set up with those WIC benefits, which is where we lose people a lot of the time.

Chair Doñate:

My personal understanding of why you would encounter people who do not want to be registered is for two reasons. One, it is either a lack of education of what they receive from such a program or the stigmatization of such programs saying no, they do not need this or want to be affiliated with a government program that is termed as a "safety net," not realizing it could help them. My perspective would be that we should enroll them regardless as long as we have everything in terms of data requirements and we are presuming them to be eligible, and then if they choose to disenroll, that is up to them. That way, we do not have any gaps, and we can identify why people are disenrolled, whether it is because they do not have a clear understanding of what the program is. It sounds like your teams are starting to merge and cross-train with one another, so you are not falling into the footsteps of folks being left behind because they do not know what the requirements are.

The last question that I had was piggy backing off the question on restaurants. One of the quotes my public health professor always told me when I was an undergrad was that there is always this question of, do we limit folks from purchasing chocolate bars or so forth with SNAP benefits? In situations like this, we always forget the human aspect of folks who must follow in these circumstances. I commend you for looking at the restaurant program, and I see this as an opportunity to support small businesses as well. Currently, under statute, are you able to go to farmer's markets and use your SNAP benefits for that, or for local farmers? Is that also something that people can enroll or participate in?

Ms. Cantrelle:

Yes, you can use your EBT card at participating farmer's markets. We even had a "veggie buck truck" that rolled around at one point that also did that. We are getting ready to hear another presentation that will lead into some of this to double your food stamp bucks. There is a program where, if you use food stamps to buy produce, you can double the amount, so say it is $1 per pound for apples and you buy a pound, you could get an additional pound for that same dollar.

Assemblywoman Brown-May:

I have one question about the SEBT program. I want to make sure we are clear. Is this currently funded? It sounded like we are a done deal, I believe I have an IFC agenda item for next week, and I want to make sure that I understand what is happening and what is necessary for us to fund this program.

Ms. Cantrelle:

Today, DWSS has enough to secure the contract with the vendor, and at the IFC meeting on Friday, we are asking for authority to bring in the federal match for that portion. You will see us again at a later IFC and at a later BOE for more of that. We are partially funded today. A lot of this work is taking place in FY 2025–2026, and we are asking for FY 2024-2025 funding to start in 2024, but the benefits will not be issued until 2025. We must come back and ask for 2025 funds. Two summers will be done in FY 2025–2026 because we will do 2024 in September of this year and then in May of next year, we should do summer of 2025. You will see us again. It is not 100 percent secured yet, but we have that plan, and we are on track, so be nice to us when we come back.

Assemblywoman Brown-May:

Do you have any idea what of the dollar amount that will be asked for each one of those? I realize it is in the future, but do you have any idea the total amount you anticipate Nevada will need to put up to draw down our federal match?

Ms. Cantrelle:

The total amount needed to administer summer 2024 is just over $6 million, and the total amount we need for summer 2025 will be just over $8 million.

Senator Titus:

For food insecurity, I am looking at the statistics on page four of your presentation, and you talk about the statewide percent of those who identify as food insecure. Your last data field is from 2020 and 2021. Those are two spot years, so I wonder what it was before COVID-19, if you have those numbers, and if you do not, if you could get them to us, because 2020 was a unique point in time. Businesses shut down, jobs were lost, et cetera, and in 2021 we were not fully recovered. Now, in 2024, we would hope there is a significant amount of improvement, especially with employment data now that more people are working. I would be interested in seeing the numbers pre-COVID-19 versus current data, say 2023 data, compared to what we are seeing at this spot here because it was a skewed time in our lives.

Ms. Rogers:

Yes, I can absolutely get that.

Assemblyman Gray:

A lot of kids will be taking part in summer programs through Boys and Girls Clubs and things like that, so they will not necessarily be going without their lunchtime meal. Is there a way for any of these organizations to tap into or maybe secure that EBT funding that would otherwise be going to the family since they will be the ones picking up the slack?

Ms. Cantrelle:

I do not believe there is any provision for that in the Consolidated Appropriations Act. If I may clarify something, Assemblywoman Brown-May, the totals I gave you were total State and federal, so the State would be 50 percent of what I told you. As I was looking at my notes, I wanted to make sure that I got that back to you.

Chair Doñate:

I do not think we have any more questions, so we will close this presentation and move on to the next one.

Allison Genco, Previously Identified:

I am here today to provide a quick history of the Governor's Council on Food Security, an overview of our membership, an overview of the work the Council has done over the last couple of years, what we are looking to accomplish in the future, and a policy recommendation for this Committee (Agenda Item VIII B).

To give you a quick history, the Council on Food Security was established through an Executive Order by Governor Brian Sandoval in 2014 to implement the goals of the Food Security in Nevada Plan and effectively improve the quality of life and health of Nevadans by increasing food security throughout the State. The council was codified during the 80th Legislative Session. Membership consists of a wide range of stakeholders, including individuals from NDE, Catholic Charities, the U.S. Department of Agriculture (USDA), the State Department of Agriculture, the Governor's Office of Economic Development, et cetera. The Council meets quarterly along with special sessions, which help partners remain aware of various funding streams and assist with improving the quality of service and meals to Nevadans through education recommendations and feedback.

I would be remiss if I did not thank the Office of Food Security, Ms. Laurie Taylor, Ms. Sarah Rogers, and DPBH for supporting the Council and being my right-hand during Council meetings. I would truly struggle without them.

The Council is tasked with overseeing the implementation of the 2023 Food Security Strategic Plan, which was recently published by the Office of Food Security. We are also working to oversee the implementation of the goals in the Food Security Action Plan in the State Health Improvement Fund, which was presented to this Committee by Megan Comlossy with the UNR School of Public Health during the February meeting.

The Food Security Strategic Plan demonstrates a continued commitment to lead conversations with a broad set of food security ecosystem stakeholders and create ideas to build the capacity of agencies tasked with this work. The pillars in the plan are designed to address the root causes of hunger and to generate a healthier food security ecosystem.

This is a quick overview of the food security pillars that are prescribed by the Plan, and in the interest of time, I will not go through each pillar, but I want to quickly highlight one pillar and give you an example of how these are used to inform the goals and objectives in the Strategic Plan and how the Council is working to carry these out.

To emphasize lead, this is looking at enhanced cooperation, communication, and representation to support policy development and resource utilization. The objective is to improve collaboration, communication, coordination, and information sharing among food ecosystem partners. Our strategy under this goal and objective is to organize and host an annual Food Security Summit and Conference. The Council has a work group that is putting together a survey to administer to food security partners and stakeholders.

Right now, we are focusing on a Northern Food Security Conference to be held in 2025. We got the draft for the survey today, so we are working on finalizing that survey and will be

working on the details of that conference so we can bring folks together, talk about food security, and figure out where we need to strategize because our goals and priorities shift in food security. Especially with COVID-19, things are changing daily, and food security is an ever-flowing subject. The conference will then move to Southern Nevada, and that will be held in 2027. We will have another survey come out for those folks in Southern Nevada so we can focus on the other half of the State.

In terms of future goals for the Council, in 2024, we continue to focus on the execution of the Strategic Plan. If you have not had the opportunity to see the Strategic Plan, it is on the Office of Food Security's website and is incredibly robust. The team that put it together put tons of work into it. It is very thorough, and I would encourage this Committee to look at it. It is impressive.

We are tasked with carrying out that Strategic Plan as well as the State Improvement Plan Food Security Action Plan. In fact, one of the goals of that plan was to reach out to this Committee and present to you, but you reached out to us so we get to knock off that goal. We are focusing our discussions and actions around distribution, support, and general food action and then targeted collaboration with our State and local partners.

Next, you will hear from the food banks about the need for greater resources for the Home Feeds Nevada program, which was created through ARPA funding, but we are also looking at including more discussion around transportation to address food insecurity. Our conversations are very robust with the Council on Food Security; like I said, we meet quarterly, but our meetings typically go for hours. I am biased, but I think we have a great group of individuals on the Council who are a wealth of knowledge, and I am excited to see the work that comes out of our Council in the next year. I am also looking forward to seeing what other legislation comes forward related to food insecurity and how the Council can be advocates for food security.

Finally, in terms of our policy recommendation, the Council is asking to add three additional seats to ensure we have full representation of the communities served by our partners. We are asking for a tribal representative, an individual who represents the transportation industry, and someone who has lived experience using SNAP or has gone to food banks and received those resources to be added to the Council.

Chair Doñate:

Let us keep the presentations rolling, and then Members can ask all our presenters questions at the end.

Beth Martino, President and CEO, Three Square Food Bank:

I thought I would focus on the face of food insecurity here in Southern Nevada and the policy issues that are of pressing importance. At Three Square, we serve Clark, Lincoln, Esmeralda, and Nye Counties, and last year, through our network of about 150 nonprofit community partners, we distributed more than 43 million pounds of food. We are on track this year to distribute even more than that to meet the rising need we are seeing here in Southern Nevada. (Agenda Item VIII C) [Due to copyright issues, the presentation is on file in the Research Library of the LCB, Carson City, Nevada. For copies, contact the Library at (775) 684-6827 or https://www.leg.state.nv.us/Division/Research/About/Contact.]

More than 140,000 unique individuals are served through our network of partners, and we know that getting people a meal when they are hungry is incredibly important, but we are also turning our attention to the work that allows people to become food secure and self-sufficient. We are looking for ways we can enhance that work, and one of those is through the supplemental nutrition programs mentioned today.

In terms of need, the expiration of the pandemic-era benefits—specifically SNAP Emergency Allotments, but other programs as well enhanced like Medicaid access and other things—has led to an increase in need here in Southern Nevada. Since last year, we have seen a rise in need through the data we collect from our partners; most recently, from September through the end of February, we saw about a 23 percent increase.

What we see now in the data is not so much new people who are coming into food pantries, but people who were food insecure in the past and are now becoming repeat customers. They are finding that they are not able to stretch their dollar as far. I am sure you have seen many of the same reports about Nevada having the second highest grocery prices in the country, and inflation has been a difficult pressure for consumers to absorb, particularly for those already living in poverty.

Since the pandemic, grocery prices have risen 25 percent on average, and the categories in which those increases have been highest are beef, chicken, fruit, vegetables, and snacks. Some of the most core items in people's diets have become the most expensive for them to put on their tables. We also recently saw a report that those earning minimum wage in Nevada, so $11.25 per hour potentially without health insurance, would need to work 82 hours per week to afford a one-bedroom apartment. I read a story over the weekend that was very frustrating about a family of four making $95,000 a year. She is an administrative assistant at a high school, and he is a machinist, and they simply cannot stretch that budget far enough to keep food on the table. One medical bill sends them into a spiral, and she had a medical event, and they found that they we are not able to make ends meet and had to come back to the food pantry for assistance.

As we are thinking about policy actions that might be able to help support some of that need, one thing I wanted to mention today is SEBT. At Three Square, and I am sure at the Food Bank of Northern Nevada as well, we are very happy the State opted into this program. School breakfast and school lunch, as well as sometimes after-school supper programs, are incredibly important for school children. For many, that is the way they put food in their tummies all throughout the school year.

We also have other programs. A question was asked earlier about Boys and Girls Clubs and YMCAs, and there is a program Three Square operates called the Child and Adult Care Food Program (CACFP) that provides meals to those sites. In the summertime, Three Square provides tens of thousands of meals a week to those sites, but SEBT is another way for kids who are not able to access those programs or cannot make it to a Boys and Girls Club or a YMCA, and our hope is that the State will be able to make that match.

That is the one of the hiccups states are encountering, and if you look across the country, many states who opted into the Program are trying to decide how they are going to come up with the funds to make that match. The good news is most of the cost is being shouldered by the federal government, so states must only make the administrative match, which for Nevada is somewhere in the neighborhood of $5 to $6 million.

The second piece is the administrative component and getting the word out to families that they can participate in this in states or in counties that may not already have a community eligibility provision where everyone is automatically enrolled in reduced or free lunches. Additional communication may need to be done, so getting all that underway is important to help make that program successful. Fortunately, we know it is a successful program. It was piloted during the pandemic because we knew that children were missing school breakfast and school lunch, and in a terrific public policy move, the federal government funded that program, and we found that it increased the amounts of fruits and vegetables children were eating and food security. There are several benefits to it.

The second thing we would like to pursue in the next legislative session is universal school meals. As you can tell, my theme here is that school breakfast and school lunch are incredibly important components of keeping children well fed and nourished so they can learn and ultimately live their best lives. Having universal access to free school breakfast and lunch is something that can make a meaningful difference in the life of a child, but also to a whole family who may be struggling to put food on the table. Expanding school meals to ensure every child in the State of Nevada has access to a free school breakfast and lunch would be incredibly meaningful.

With that, I am happy to defer to my colleagues in Northern Nevada. I would offer in closing that for anyone who has not been to Three Square, we would love to host you anytime for a tour. I can tell you dozens of stories about the people we serve. But one of the best ways to see what we do at Three Square specifically is to come and visit, and we would be happy to host you anytime.

Nicole Lamboley, President and CEO, Food Bank of Northern Nevada:

I am not going to repeat a lot of the things my colleague from Three Square said, except that we cover the remaining parts of the State, so we not only have urban sites but also rural and frontier communities. Last year, we served about 19.2 million meals through our partnership of about 150 partner agencies. The $2 million that was allocated for the first year of the biennium by this Legislature was a significant investment, one of the first we have seen by the Legislature in supporting food purchase dollars. That has allowed us to distribute nearly 1.7 million pounds of high-quality, nutritious food because we have been able to purchase dairy, protein, fruits, and vegetables—items that people most desire. (Agenda Item VIII D)

Over the last year, we have seen about a 27.5 percent increase in the need. Today, we are serving over 150,000 people per month. As Ms. Martino indicated, there are several factors: food prices; gas prices; housing prices; and health care prices are all impacting families, and while there has been wage growth, there has not been enough wage growth to keep up with the rising costs.

From a policy perspective, there are a couple of things we are proud of as food banks. In the 2021 Legislature, this Body supported the Home Feeds Nevada Food Purchase Program, and that was an intentional ask working with people addressing food insecurity in the State how we could create a program like the Federal Commodity Supplemental Food Program where we could support local food producers and manufacturers in supporting people facing food insecurity. There was ARPA funding as well as local food purchase dollars through the USDA that were used to support that program, and it has been very successful, but we are coming back next session asking for continued funding of this program. It is an economic development program helping farmers and food producers have a guaranteed source of

funding to support their growing and production, but also it keeps local foods here in the State supporting people facing food insecurity. We look forward to working with this Body in advancing funding for that as a policy priority and a funding opportunity. There are several programs throughout the country that represent food insecurity policy programs like Home Feeds Nevada.

Secondly, we want to talk about the Section 1115 Waiver, a Medicaid waiver that would help support people facing food insecurity. Food and nutrition insecurity cost the U.S. an estimated $1.1 trillion annually in health care spending and lost productivity. We operate food pantry prescription programs and the Fund for a Healthy Nevada and have been operating these programs since 2016. We are working with health care providers who identify people facing food insecurity, and we have a network of pantry partners who can use that prescription to access healthy, nutritious food that meets their dietary needs.

Oftentimes, we see people who are facing food insecurity struggle at the end of the month when their funds run out and they resort to foods that may compromise their health conditions. Through our prescription pantry programs, we have data that shows that people who have diabetes, when combined with the right care, prescription medicine, prescription food, and diet and exercise, have a better A1C level continuously because of the prescription food pantry. We would like to expand our work in helping improve the overall health of Nevadans by asking for the adoption of the Section 1115 Health-Related Social Needs Waiver. The State of Nevada has adopted a waiver related to housing support, so we think it would only be prudent to think about what that might look like for people burdened by food insecurity who also have chronic health conditions.

Nutrition services are frequently tailored to health risk and designed to support individual nutrition-sensitive health conditions, but we think we can also do more for these individuals. If we can reduce the overall costs for people facing food insecurity related to their chronic health conditions, we believe we will have a healthier Nevada. Many states are pursuing these 1115 Waivers, and this is something many food banks are looking at working with their states as a policy priority. I would be happy to answer any questions.

Chair Doñate:

I think that concludes the presentations, so we are ready for Committee Members to ask questions from all three presenters.

Vice Chair Orentlicher:

I have two questions. I like the idea of the 1115 Waiver. Do you know if our State HHS already has authority to apply, or would we need to authorize it legislatively? I like the idea of using food stamps and SNAP benefits for restaurants, and that made me think about unhoused people in encampments who may also have difficulty preparing meals or going to restaurants. I know we have Meals on Wheels programs for seniors, and you have a program like that. Are there also programs that take meals to these encampments to hand out? Is there a gap, or are we doing a good job there?

Ms. Genco:

I can address the question about the 1115 Waiver. I do not know that the Legislature would have to authorize Medicaid to move forward. I think Medicaid has the authority, but they would not necessarily have the money at this point to move forward with the 1115 Waiver

on their own. They may need legislative authority to have the money allocated to move forward with the Waiver.

Ms. Martino:

As far as feeding individuals who are unhoused or in encampments, at least in terms of in Southern Nevada and from Three Square's perspective, many of our food pantries offer ready-to-eat items for unhoused individuals who may not be able to prepare food or even access a restaurant, and that is an important part of the food we source. A great example of that is food we pick up from Starbucks that is still nutritious and perfectly good food for people to consume, but that the store is not going to sell, so things that are ready to eat. Those are largely products we try to get to nonprofits that serve people who are unhoused or facing that challenge. We also have things like emergency bags that have ready-to-eat food like pop tops or granola bars in them.

In terms of going into encampments to try to work with people, some organizations we work with do that kind of work. Help of Southern Nevada is one that has teams that go into the encampments to try to not only feed people but also do outreach to get folks interested in services. That is a much more difficult body of work for a variety of reasons, and in terms of the people we are serving, it is a smaller set of the neighbors that are served by the food bank, at least here in Southern Nevada. What we find from our partners and what we see through the data they report to us is that we are dealing with a lot more people you would probably classify as working poor. There is a large component to food insecurity of individuals and families who may be unhoused or homeless, but I think a much greater proportion are people who are working as hard as they can and are not able to keep up.

Assemblywoman Brown-May:

First, I want to double down: if you have not done a tour, please do so. As the Chair of the Nonprofit Legislative Caucus, we have spent time working to understand what our nonprofit organizations are doing to support our community, so Ms. Martino, we are completely aware here of what Three Square is doing. We look forward to going to our Northern Nevada Food Bank on Friday, and I would encourage Members to consider that if they have not already.

My question is related to the Food Security Council membership. Ms. Genco, you talked about the recommendation to add three slots: a tribal representative, an individual who represents transportation, and one with lived experience. I am curious to know, first, are all the allocated positions filled for the current Council membership? Is there an odd number? What will that do to voting if there is an action that comes out of that committee? Have we given thought to that?

Ms. Genco:

To answer your question, no. Right now, we have vacancies on the Council, and we are doing a bit of musical chairs. We had some folks expire. I believe we have five vacancies. I do not know off the top of my head, unfortunately, but I can get specifics to you. As far as the full numbers, I do not know exactly if it is an odd or even number, but let me work on that and I will get it to you. I am sure it is something we considered, and we can look at that.

Assemblywoman Brown-May:

I appreciate the detail relative to that. I would hope our people did not expire, but their terms perhaps.

Ms. Genco:

Yes. Thank you for clarifying that.

Assemblywoman Brown-May:

I would encourage consideration of additional diversity, so we are representative of broader groups as we look to fill these out.

Ms. Genco:

Yes, absolutely.

Assemblyman Nguyen:

I am going to triple down on what Assemblywoman Brown-May said. I volunteered for Three Square a few times in my days here in Las Vegas, and it is hard work. I felt out of shape maybe three minutes into the packing and putting things together for our community. I applaud your work, and I look forward to doing the same thing in Northern Nevada, so look for me to come to volunteer up there. I encourage anyone who is watching and listening: please, if you can spare the time, volunteer with the Food Bank.

I know there are many things that must be covered, but I want to make sure the basics are covered. The Asian American and Pacific Islander (AAPI) population is the fastest growing in our State; we have about 12 percent of AAPI residents statewide. The basics of the AAPI community are different in terms of the food insecurity items that are out there, so I am curious here in Southern Nevada and with our Northern counterparts, what are the challenges you may have in terms of serving this community?

Ms. Martino:

It is an incredibly important body of work that we can do more on across the social safety net and certainly within food banking. At Three Square, one of the ways we try to ensure we are well-positioned to meet the needs of all the different communities we serve is by trying to source more raw ingredients as opposed to prepared items. Surprisingly, we have a complex food sourcing plan because we look at everything from how we serve people who are unhoused and need ready-to-eat items to how we serve different racial and ethnic communities. For example, we will have things like rice, beans, fruits, and vegetables we want to source as raw ingredients so those can be distributed and then hopefully adapted to meet needs of the communities we serve. That is a large part of our sourcing strategy, and part of the reason we look at it that way is so we can try to adapt to meet those needs.

Candidly, I think there is always more we can do, and part of that is ensuring we are working closely with our partners to find out who they are serving. That is a somewhat challenging issue. We never want to throw out more barriers to people getting access to food, but asking more questions inevitably leads to more people feeling reluctant to access services, and that is across the board from all the programs you have already heard about today. Our partners use a questionnaire when people are coming in for services, and it asks

for race and ethnicity because that helps us to learn more about who we are serving, but it is a touchy and difficult issue because some people do not want to provide information to us. That is our first step in trying to get information so we can try to adjust that food sourcing plan to meet those needs, but we would be happy to provide information to you about the makeup of the food we are sourcing so you could have a window into what that looks like.

Chair Doñate:

I want to touch on the Universal School Meal Program. First and foremost, thank you for highlighting this as part of the proposal. It is important for us to have these discussions. Thinking back to my personal experience, I was one of the students who was on free and reduced lunch all throughout my life. In middle school, I was reduced but had to pay, but in high school, I was reduced and because of the school population I was in, I did not have to pay anything even though I was on reduced lunch. It is interesting to see the different dynamics.

My own mother was a cafeteria manager. She was a lunch lady at an elementary school, and she would tell me stories of how it would break her heart where there were families who perhaps would qualify for free and reduced lunch, or maybe they did not fill out the paperwork correctly and their kids did not qualify for it, and they would have these balances accumulate and because of that, she had to give them a grilled cheese sandwich. That is probably a story that still rings close to home for a lot of families, and it is this guilt that the poor kid who has this balance accumulate because their parents could not afford to pay it off now must be stigmatized because they are the only one who gets the grilled cheese sandwich versus everyone else.

There was also the consideration that she would order amounts of foods, and some of it went to waste because she could not partner with the food banks. A lot of it had to go in the trash if she accounted for maybe 10 to 15 extra meals, so there is a lot of work we need to do with universal school meals. For me, probably the most important is that a lot of the students I went to school with would have benefited if there was a dinner program. It sounds like we kind of had that, but we have not been as robust in terms of our partnerships, so maybe you can talk about what we can do to draw down more federal funds and coordinate with our schools.

Ms. Martino:

Speaking for a moment to school lunch, I recall growing up in a rural area as a student—I am old enough that we still had punch cards—and the kids who were on free and reduced lunch had a different color punch card than everyone else, which is heartbreaking because it only increases the stigma that already exists for those students. One of the benefits of universal school meals is that it removes that stigma because everyone is getting the same thing.

Regarding the food waste issue, that is a very good question, and it is remarkable that people are so much more attentive to that. It is one of the challenges of administering a federal program because they are very strict about what can be done with food waste. If, for example, the milk is not consumed, it may have to be thrown away because of a federal regulation, which is an example of something that may be coming from a good place and is well-intended, but practically, having to throw away good food is a tragedy.

In terms of dinner programs, yes, the program CACFP, which I mentioned earlier, provides dinner, and at Three Square, we operate that program during the school year and offer the corollary to it in the summer that provides a lunch program. Until SY 2020–2021, we provided that at CCSD sites, which would be the largest way to reach children after school, but CCSD made the decision to bring that program internal and to operate it themselves. They are providing a supper at several sites within the District.

We have been in communication with them since they took over that program because we continue to operate it for non-CCSD sites, so we are at YMCAs and Boys and Girls Clubs. We have heard from some sites as well as after school programs that some of the sites wondered if they could partner with us again because it was transitioned to a snack instead of dinner, so we have tried to stay in communication with CCSD about that. In the rural areas, we are providing shelf-stable after-school meals to try to fill that gap as well at several sites.

I would agree with you. I think getting a meal to children in the afternoon or evening is a very important part of our work. We want to ensure with CCSD running that program that we are here to be supportive in every way we can hope to help support the sites that maybe have transitioned to snacks. We are staying in dialogue about that and looking for other sites around the city like libraries, Boys and Girls Clubs, YMCAs, places like that where we know children are going after school where we can help to feed them.

Chair Doñate:

In your earlier presentation, you alluded to the fact that there are families out there who make too much to qualify for these programs, but not enough to support their families with the growing cost of groceries, rent, et cetera, so it is always impactful to have these conversations in policies we pass. Ms. Genco, did you have a clarification that you want to provide?

Ms. Genco:

Yes. Assemblywoman Brown-May, I was able to get an answer for you on the vacancies and the addition of the three members. Right now, the Council on Food Security has five vacancies and with the addition of the three additional members, we would have 27 members.

Chair Doñate:

That concludes the questions for this presentation, and we will now close this agenda item.

AGENDA ITEM IX—PRESENTATION ON THE STATE OF WASHINGTON'S EXPANSION OF HEALTH CARE COVERAGE TO ALL STATE RESIDENTS PURSUANT TO A STATE INNOVATION WAIVER UNDER SECTION 1332 OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (H.R.3590, 111TH CONGRESS)

[This agenda item was taken out of order.]

Chair Doñate:

With us, we have Ms. Joan Altman joining us virtually, and she is going to provide to us about the innovative work that the State of Washington is doing for access to care.

Joan Altman, J.D., M.P.H., Director of Government Affairs and Strategic Partnerships, Washington Health Benefit Exchange:

Hello from Washington. It is an honor to be here. We often look to your Exchange and your State's policy making as a guide for where we want to go next and what we want to be doing. I have been invited here today to talk about our 1332 Waiver, which is the vehicle we used to extend coverage to people who are undocumented in Washington. (Agenda Item IX A-1) (Agenda Item IX A-2) (Agenda Item IX A-3)

In terms of topics for today, we are planning to cover the Exchange, orient you to where we are relative to your State, and provide background on the Waiver and outcomes we have seen to date. We launched it on November 1, so we have some fresh numbers for you and can take any questions you may have about the launch or the process of getting the approval.

First, I wanted to walk you through the Exchange background. Under the U.S. Affordable Care Act (ACA), we were one of the first state-based marketplaces here in Washington. There are 19 now, which is notable. A significant difference I think we have from your Exchange in Nevada is that we have an integrated platform, so people come to Health Plan Finder, we screen them for the available state programs first through our Medicaid, they are administered through our Medicaid agency, and then we screen them for available private coverage, federal and state subsidies. I have been at the Exchange for ten years; I am a dinosaur here, so there is nothing you could ask that we could not go back to the trove, but having a state-based marketplace is a significant advantage as a state, so I am excited you all went that route as well.

We are a state-based marketplace, and we are a public-private partnership, so we have our funding appropriated by the Legislature, our Board is nominated by the Legislature, and we adhere to certain state public disclosure laws. Otherwise, we have a private side of how we operate that allows us to largely scale up and scale down contractually and do other private side hiring that has helped us along the way.

We serve about two million people through our Exchange. The majority are Medicaid customers, so there are about two million of those and about a quarter million qualified health plan customers. We have robust carrier participation in Washington's 12 carriers. We have sustained active carrier participation for the duration of the Exchange to date, so we are pleased about the competition that exists here in the market.

Overall, we have seen the uninsured rate go from about 15 percent to about 4 percent here at the Exchange. We started around 14 percent uninsured before we did the Medicaid expansion and stood up the state-based marketplace under the ACA. That number today sits around 4 or 5 percent, so we have made good gains. We have been focused largely on who is left. How can we look at access and affordability to further reach those who have been left out? To date, our individual market is small. It is about 5 percent of our overall insurance market, and there are about 5 percent who are uninsured. The majority in Washington are employer-based coverage with a healthy dose of Medicaid and Medicare.

The Legislature has kept us busy over the past few years. We have been lucky in Washington. We have seen a series of major policy initiatives, but there have been two-year implementation windows as we have gone along the way, which have helped ensure we are able to launch successfully. In 2021, we implemented standard plans and public option plans in our Exchange, collectively called Cascade Care Plans. Then, in 2023, we launched a state premium subsidy that sits on top of the federal subsidy, or not, if you are not eligible for federal subsidies. The third piece is the expansion of people who are undocumented under the 1332 Waiver we launched for this year. The initial Cascade Care legislation passed in 2019, we implemented in 2021, and the state subsidy legislation passed in 2021 and we implemented it in 2023. At the same time, the state premium subsidy legislation passed, and there was authorization for us to seek the 1332 Waiver, which we did for 2024.

This is how it comes together in Washington: we have standard plans that we design. We have the public option plans that our Medicaid agency procures by leveraging their purchasing power for the state, and then we have the state subsidy we administer here for people up to 250 percent of the federal poverty level. It is connected to those Cascade Care plans, so you come in, pick the high value, lower premium plans, and there is a state premium subsidy that sits on top of it.

I will move into the background for the Waiver. Being undocumented in Washington is the strongest predictor of being uninsured in our state. We have around 400,000 people who are uninsured in Washington, and about 100,000 of them are undocumented. Being undocumented makes you five times more likely to be uninsured in Washington. That was a driving force behind applying for the Waiver. The goals of the Exchange and the state in pursuing the waiver were simply to ensure that anyone regardless of immigration status could buy health and dental insurance on the Exchange, including accessing our Cascade Care plans.

We wanted families with members of different immigration statuses, of which we have several in Washington, to be able to come through and buy health insurance together. We wanted to maximize the privacy and the protections we have built into our portal, the data safeguards. We wanted to leverage those in the process of expanding coverage, and we also wanted to strengthen Washington's health care sector. There was broad support for our Waiver from providers, hospitals, nurses, labor, industry, and carriers. We had a lot of robust support for allowing people to come in and purchase coverage if they need it.

Regarding the timeline, we applied in May, and it was approved in December. You can count the days: they have 180 days to review, and it took 178, so it is a journey. We were the first, so the hope would be that any state that comes along behind us has a bit of an easier time. We waived the section of the ACA prohibiting people from applying for coverage based on their status. You are not able to waive federal law, that section of the ACA that says people who are undocumented cannot receive federal subsidies, and any attempt you all would make to address affordability barriers for people needs to work around the fact that you do not get a federal subsidy and that is not something you as a state, at least as of today, have an ability to circumvent. Privacy considerations were top of mind for people in our state. We negotiated extra privacy protections as part of our waiver negotiation that we found quite useful.

Regarding the waiver timeline, legislation passed in spring of 2021. We worked on the application for a year and submitted that in the spring of 2022. As part of submitting your waiver, as you all know, you have a massive public comment requirement at the state level,

and then there is a public comment period at the federal level. The feds ask you a bunch of highly technical questions, and you are either approved or not.

Concurrent to getting our approval, we started community engagement because we knew the runway. We had about a year from when it was approved to when we needed to implement and laying the groundwork in community, developing the materials, translating materials, and finding trusted messengers in the community to help get the word out were all important parts of our launch. We started community engagement and then opened the doors November 1, and people started receiving coverage in January.

As for things we did to engage community, you heard about some from the prior speaker like doing the listening sessions, doing the landscape scans, talking to impacted community members, and making funding available to do education and outreach and to provide stipends to community-based organizations. Those were all things we found helpful here in Washington. The top barriers we knew we were going to have to address coming in based on the good community work that people had done in advance of the launch were first, affordability and affordability barriers; second, mistrust of government and government websites; and third, health literacy and language access. That is where we focused a lot of our efforts.

From an affordability perspective, we are lucky to have the state premium subsidy in Washington. You can see that difference that it makes: it brings someone's premium from under $400 down to about $130. Most people who come in under the Waiver to date are receiving state subsidies, so we know this has been critical to people to be able to afford coverage, even the lower-cost public option plans.

Regarding privacy considerations, this was a multipronged approach. First, we were active in working into our negotiation and our Waiver documentation with the federal government assurances that only aggregate data would be required and what the uses of that data would be. Behind the scenes, we worked to change forms and data transfer practices with the feds to eliminate identifiers that could be used to identify people using and leveraging the Waiver, and internally, we did a lot of work on our data privacy policies and updating internal policies and procedures that we use to maximize someone's ability to meet the necessary verifications and requirements, but expanding the types of documentation and materials that can be used to help address those barriers as best as we are able.

From a language access perspective and a health literacy perspective, we were able to work with the Vida Agency, a multicultural marketing firm that helped us streamline and minimize our messaging. Health insurance is complicated. We do health literacy surveys, and terms and acronyms like "coinsurance, deductible," become a lot very quickly, particularly with language barriers, so we focused on basics around health insurance and affordability, privacy, and how information is and is not used when you enter it into our system.

We also tried to work in different formats. We did flyers and brochures as well as videos and prints. We did some digital outreach and local community art projects. We helped provide stipends to local organizations who went out and did in-language work and community-specific work across the state, both the east and the west side, and we saw important returns from the investments there as well.

That is it for the set up. What have we seen? Starting November 1, everyone can come in and shop regardless of their immigration and income level. You can buy both a health plan and a dental plan, access the standard in the public option plans, and if you are up to

250 percent of the federal poverty level, you receive a state subsidy. If you are federally subsidized, you get a subsidy up to $150 per member per month, and if you are non-federally subsidized, you get a state subsidy up to $250 per month. The state looks at the legislative appropriation we get for funding, the utilization of the federal and state subsidies across the population, and calculates those amounts based on final rates.

Here are the quick toplines of the 100,000 uninsured people in the state who are undocumented. So far, about a quarter of them, just over 24,000, have applied for health coverage since we launched the Waiver. We were surprised by that number. That is a significant reach into the uninsured population, and we are thankful to the work in partnership with our state agency partners in the community to reach across all parts of the state. Good news, bad news: lots of people applied and were able to come into the system, so 2,200 have signed up, meaning they have come in and made their first payment, or they are in the process of making their first payment, and 90 percent of the people who have come in are receiving the state premium subsidy. For people who are over 250 percent of the federal poverty level, which is under $40,000 for a single household and $50,000 for a couple, we know significant affordability barriers remain, and we are continuing to try to address that through levers like the public option and otherwise. The average monthly net premium for someone who has come in and signed up so far is over $200 a month.

Looking at the demographics of some of the folks who come in so far, there is a lot of question at the federal level about what the risk profile would be of people who were coming in under the expansion. We see to date that of our immigrant health coverage customers, only 7 percent of them are over 55 as opposed to 30 percent of our existing qualified health plan (QHP) population. We also see significant diversity in who has come in. Nearly 80 percent of the people who have come in so far identify as Hispanic, compared to 14 percent of our overall QHP population, which is notable. The number of nonwhite people who have come in through the system is significantly higher under the Waiver as compared to our overall QHP population.

Assisters matter. We have over 3,000 brokers and navigators who support outreach and enrollment for the Exchange, and we saw nearly 70 percent of people who come in with the Waiver get help from someone local in their community. We also made language assistance available through our call center, but having someone in the community you could speak with who could help you enroll was critical.

Looking ahead, where is Washington going? We are continuing to engage our impacted communities to look at lessons learned and how we can improve and update materials heading into our next open enrollment period. We also have an ongoing special enrollment period for people who are eligible for the state subsidy, which captures the majority of people who have come in with the Waiver to date, so we are waiting to see what attrition looks like and what our new enrollments look like as we move ahead.

In the State of Washington, we are also doing a Medicaid expansion to people who are undocumented up to 138 percent of the federal poverty level, so that captures a good number of the people who came in, applied, and did not sign up under the Waiver. We are working in partnership with our Medicaid colleagues to look at how lessons learned from the QHP expansion can inform the Medicaid expansion and how to transition folks over to that new program as needed later this summer.

That is the general background. You will see in the appendix of your materials, and I think you received handouts too about our Waiver and who has come in so far, that there are

additional resources for your reference and some of the outreach materials we used and additional background on Cascade Care if it is of interest. My colleague, Laura Kate Zaichkin, is on and can help address questions as needed around Cascade Care. We have seen notable enrollment increases in both our standard and public option plans since we launched in 2021. Now, about 70 percent of our Exchange customers are in standard plans, and we have seen continuous growth in our public option plans as the downward pressure on premiums has made those plans the most affordable across the state. We are happy to take any questions you may have.

Chair Doñate:

We will start with questions from Committee Members. I ask for us to be respectful to our colleague from Washington. Hopefully we do not get into a political fight. She has a lot of good insight in terms of health care deliveries, so I want to make sure we are kind and respectful. Are there any questions here in Southern Nevada?

Assemblyman Nguyen:

How many languages do you cover in terms of language access? If you do not have it off the top of your head, it is all right. That has been my calling, and I want to see if I can benchmark Washington and raise the bar for our State.

Ms. Altman:

That is high pressure. If our number is lower, then I am not going to be able to help you. We have a language line through our call center, so we do telephonic interpretation through bilingual Customer Support Representatives (CSRs), and then we can translate into over 240 languages through our call center. For in-language translations, most of our materials for this campaign were translated into 15 languages. Typically, our standard in-language translations is eight languages.

Vice Chair Orentlicher:

This is very interesting, and I hope we can follow along. I am interested in the subsidies. My first two questions may ask the same thing: you mentioned after state subsidies, the average premium is $210, so the combination question is, how do your subsidies compare to federal subsidies, and what would be the average premium if they had federal subsidies? I think those are asking the same thing.

My other question is, are you funding out of general revenues, or do you have a new, dedicated funding source for this?

Ms. Altman:

Those are great questions. Our average premium in the Exchange is around $550 to $600, so without any federal premium, that is where you are seeing public option plans at a little bit lower cost. For frame of reference with the state subsidy, Washington State is now pulling down close to $600 or $700 million per year with the enhanced federal subsidies. The entire annual budget for the state subsidy program is $55 million, and right now it is being funded out of general fund state revenues. We have engaged our Legislature in thinking through additional sustainable funding sources looking at pass-through funding as it relates to our public option as a possible source.

Vice Chair Orentlicher:

Thank you for giving me the gross amount, but for an individual who would pay, you said under your Waiver, $200 a month? If a person with the same income was in the regular and getting federal subsidies, would they pay $210 per month, or would they pay less?

Ms. Altman:

They would pay significantly less. When you combine the federal advanced premium tax credits with our state subsidy for people who are under 250 percent of the federal poverty level, they can get plans for under $10 or $20. We see most low-income Washingtonians who are benefiting from both the federal subsidy and the state subsidy paying less than $25 per member per month for their premium as opposed to $200 to $250.

Vice Chair Orentlicher:

The federal subsidy only would be in what range?

Ms. Altman:

It can range based on where you live, your age, and the benchmark plan in your county, so it is a tough one. I can go back and look at the average premium price for our plans minus the subsidies, but if our typical gross premium is somewhere between $500 and $600, the federal subsidy typically brings you down to somewhere in that $200 to $300 range, because then when you put the state subsidy on top of it, you are getting down to that $10, $20, or $30 range, if that math makes sense.

Chair Doñate:

We can create a scenario: I am a snowbird who is Canadian and loves to come down to Washington during the summertime for whatever reason. God forbid, something happens, and I become ill while I am here in the U.S. in the summer months. Obviously, I am not a U.S. resident or a citizen because I am only there temporarily vacationing, and under the Section Waiver, for noncitizens, if they became ill or wanted to purchase health insurance, they would be able to under the State of Washington. Is that correct?

Ms. Altman:

It depends on if they meet our residency requirement. Under the ACA and through the Exchange, you need to intend to reside in Washington, so I would need to look at the scenario where someone is living part-time in one place and part-time somewhere else. To access coverage under the Waiver, as part of the questions you answer when you come in, you would say, "I live in Washington," complete the application, and submit it. For people who live in Washington, they could access coverage if they were willing and able to purchase it.

Chair Doñate:

The underlying premise is that they are residents, and they live in that state, so they are applying for the programming they were not afforded before under this program. Is that correct?

Ms. Altman:

Yes, that is correct.

Chair Doñate:

What challenges are you experiencing? I am assuming that you presume there are about 100,000 of them. It is difficult to enumerate how many there are because of different data provided from federal partners and what this looks like, so it is hard to predict how many people are going to enroll. It sounded like about one-fifth of the population you estimated immediately applied once it became available last year, but not all of them were able to come on. What challenges are you experiencing as you have gotten this influx of folks who finally have access to care, but we are still navigating them through the process?

Ms. Altman:

We are still learning, and from incredibly early learnings from having launched a few months ago, reach into all communities was not equal. We have relied on trusted community messengers in different pocket communities across the state. We know from looking at our early data that we had good representation among the people who applied, which we were pleased about, and then within the number of people who were able to afford to sign up, we saw less representation across some of the larger immigrant communities that we know exist in our state. We are figuring out how to make inroads and help people who can and want to get coverage complete the application process and sign up. That is something we are taking a close look at, and we are continuing to look at ways that we can improve affordability as the primary barrier.

From a privacy and security standpoint, we feel that 25 percent of people who are eligible came in was a pretty good indicator that we have helped address those fears, but we are continuing to learn and understand what additional efforts we may need to make to help people feel secure in providing all of the personal and income information they need to complete an application under the ACA. We are working in those areas most specifically and then wanting to see the impact of the Medicaid expansion to see when you take away the price tag and offer a free state program, what is the uptake, and how can that inform our efforts on the private side going forward?

Chair Doñate:

I am presuming that you completed an actuarial study that went alongside this Waiver. Is that correct?

Ms. Altman:

We did, yes.

Chair Doñate:

One of the questions we always have is, if we expand access to care, are there potential savings that could be captured for individuals who now will have a health care access? Was that documented, and what are examples of those cost savings perhaps?

Ms. Altman:

We are still a little sore from the bruising in federal discussions on this one, but in the slide in the appendix, I included our projected waiver impacts. We were close on our enrollment projections: we projected about 2,600 people would come in year one, and we got 2,200, so our actuarial projection was close there. Our actuaries, in partnership with our carriers, who also in commenting on the waiver have said they do not expect any adverse premium impacts and if anything, they expected slight improvement in premiums because of expanding the risk pool. Our analysis found that for the small number of people we would get—and it would ramp up over the years—there was about $2 to $3 million in savings, at least initially, that we felt in the first few years we could draw down and recapture as pass-through savings for the state.

Our federal partners felt that the national and actuarial data we can provide demonstrated that we are able to meet federal guardrails to have the Waiver approved, but they were not convinced enough to grant pass-through as part of our initial Waiver application. They said they are open to revisiting it with us in looking at possible combined pass-through savings from a public option and a coverage expansion.

Those are things that we are looking ahead to in years to come, but we think there is a little bit of savings there. Our carriers think there is a little bit of savings there. We will have our federal partners provide additional data and help them get there and hopefully capture pass-through that could help support additional state subsidies as needed to help address these affordability barriers. I am manifesting here in front of you. We will see if there are any federal partners listening to this. We are the first state to have a 1332 Waiver approved as meeting guardrails, but we wanted to pass through, and we did not quite get there.

Chair Doñate:

I know you are early in the process, but there was concern that when you expand access to care for some individuals, that can lead to exacerbating provider shortages. Has that been the case? Are there guardrails? What relationship do you have with your providers in terms of these individuals now receiving access to care?

Ms. Altman:

It is something we are going to continue to keep an eye on now that people have the coverage, what their experience accessing coverage looks like both from the consumer and provider perspective. We know from our Hospital Association, Nurses Association, Provider Association, and Community Health Center Association, there is broad-based support for the waiver and frankly, those providers are largely seeing people anyway in a clinic setting or an emergency room setting. I do not think the opportunity to provide preventative care in primary care and less-invasive care earlier was welcomed largely by our private provider community as opposed to seeing folks when they get sick or injured on the job. We have a lot of different agricultural professions and others that rely heavily on immigrant populations, so folks were seeing this population anyway and were welcoming of the opportunity to provide coverage in advance of some sort of adverse event.

Chair Doñate:

It is my understanding that with risk pools, generally younger people are favorable because we often do not get as sick. I assume that a lot of the enrollments you are seeing around that same trajectory. I know you broke it down into three age groups, but are you seeing a

high enrollment in kids, pregnant moms, or younger individuals? Is that generally the trend you are noticing?

Ms. Altman:

I think we have existing state-funded programs for pregnant women and CHIP kids, so we saw uptake in those existing state programs prior to the waiver, but we are encouraged that in who we have seen come through so far, we seem to be reaching the younger demographic more than we have reached them in our existing overall QHP population and are interested to see as we move forward whether that continues to be the case or not, both for the 18 and younger who are a healthy portion of the 0 to 34 age group, and those young invincibles who are sitting in that 18 to 26 age category.

Chair Doñate:

Have you seen any success stories with migrant workers also now being covered through this program? I know here in Nevada, we have a lot of migrant farm workers who get sick working in the fields and oftentimes must rely on free clinics, and it is not as robust as it needs to be. Their diabetes goes uncontrolled. Have you seen success with migrant workers being able to finally access health care?

Ms. Altman:

We will be following up with our on-the-ground partners who work in rural areas with Yakima farm workers and others and have been highly engaged in the effort. I will say the ACA and expansions can get inherently political, but in terms of bipartisan representation across the state, particularly in rural areas, there has been a concerted effort to try to make sure that our farm workers—and we have grapes, apples, lots of industries that the state relies on that lean heavily on farm workers and others who are benefiting from the Waiver. We hope to hear back from those partners as to the enrollment gains in particular sectors as we move forward, but it is too early to say from the data we have which sectors people have come from. But we know there was active engagement in more rural areas, particularly around farm workers and agriculture to help get people covered from industry and from our small employers and family farms who work most closely with those workers.

Chair Doñate:

Does anyone in Northern Nevada have questions?

Senator Titus:

It is always great to hear what other states are doing, especially similar with agricultural issues and migrant workers. I want to follow up on a question Vice Chair Orentlicher asked regarding the monies and paying for premium subsidies. There is a federal and state premium, but they are coming from your General Fund, which is taxpayer funds, correct?

Ms. Altman:

At the federal level, the premium tax credits are coming in and subsidizing most folks while our general fund state dollars fund our existing Medicaid and state premium subsidies. For the Waiver, we had to designate the portion of the subsidies that would be supporting the Waiver population. Of the approximately $55 million annually that the state provides to

support the state premium subsidies, it is around $5 million of that designated to support the waiver population.

Senator Titus:

It is all basic taxpayer funded, whether it is from the federal government or the state; it is not industry funded?

Ms. Altman:

The Exchange funding is a bit of a combination, but for our General Fund state resources, state revenues support that. We have a slightly different tax structure in Washington. We do not have an income tax here, but yes, generally speaking, state-funded resources pay for it.

Senator Titus:

On page 13 of your presentation, it states that it "enables all Washingtonians to benefit from the state premium subsidies." All Washingtonians can apply regardless of economic status? How does that work?

Ms. Altman:

Every person in the state who is a resident of Washington State can apply for health coverage through the Exchange, and we have an integrated platform, so if you are at designated income levels or lower income levels, you are eligible for the state programs, our Medicaid programs, including our alien emergency medical, CHIP, postpartum, pregnant women programs. All the eligibility categories that existed before the Waiver we still have today, and the waiver simply let someone who is not eligible for any of those Medicaid programs but who is eligible for private coverage through the Exchange to come in and purchase it. You do not get any federal subsidies, but you get a little bit of your state subsidy to help you if you are low income.

Senator Titus:

The final question I have is, did you see, or is it too early to see yet, if your deductibles went up? You said that maybe has lowered the premium. Have you seen that yet?

Ms. Altman:

We have been looking into deductibles and premiums particularly as they relate to our standard plans and our public options, so what we were able to do with the standard plans, and most notably our public option plans, were create plans that have lower deductibles on average and lower premiums, and those plans that have lower deductibles and the lower premiums are what the state premium subsidy is tied to. If you come through our system and you pick one of these higher-value, lower-cost state-sponsored plans, you get the state subsidy if you are income eligible, which helps you afford that coverage and helps the state dollar stretch a little bit further.

Senator Titus:

I have been reading recent news that our own State employees' health insurance coverage premiums will be going up, and I am wondering how everybody fits this math and how that works. It seems like a win-win for everybody.

Chair Doñate:

Are there any further questions? Seeing none, we will close this agenda item. It is always a pleasure to have different states present about the innovative work they are doing.

Ms. Altman:

I look forward to seeing what you all do next.

Chair Doñate:

As you get more data points, if you can keep us in mind to share with us the resources, we would greatly appreciate it.

AGENDA ITEM X—SUBMITTED POLICY RECOMMENDATIONS TO BE REVIEWED BY THE JOINT INTERIM STANDING COMMITTEE ON HEALTH AND HUMAN SERVICES

Chair Doñate:

As a reminder, the way this agenda item works is that we have opened our survey to folks for recommendations. Committee Members can submit their own recommendations to be reviewed by the Committee, and we are soliciting feedback every day from folks in the community. We received a recommendation from Assemblyman Gray to look at the Social Work Licensure Compact. We will start with that one. After that, we had a student submit a recommendation on a ban on flavored vaping products, and our final presentation discusses cardiac event crisis response plans. We will allocate five to seven minutes for each presentation for them to go over their recommendations, and then we can provide feedback or questions.

Assemblyman Gray:

As we are all aware, there is a critical shortage of social workers in Nevada, a concern echoed by the Director of DHHS during our recent meeting. In the 2023 Legislative Session, the minority party proposed an emergency bill for a social workers' compact recognizing the urgent need. Unfortunately, it did not receive a hearing, possibly because the language was ahead of its time. However, since then, similar bills have been approved in five states, including our neighbor Utah. I urge the Committee to consider a bill draft request related to a social worker compact during the upcoming 2025 Legislative Session. (Agenda Item X A-1) (Agenda Item X A-2)

Matthew Shafer, Deputy Program Director, The Council of State Governments (CSG):

My remarks are meant to provide background and educational information on the Compact. We are a nonpartisan member association for elected and appointed state government officials, and through our National Center for Interstate Compacts, CSG has facilitated the development process of all the occupational licensing compacts that exist, including the five that Nevada has already enacted: the Emergency Medical Services (EMS) Compact, the Interstate Massage Compact, Interstate Medical Licensure Compact, and the Psychology Interjurisdictional Compact. Nevada is also a member of 32 other compacts unrelated to professional licensing.

There are approximately 500,000 licensed social workers in the U.S., and despite the high demand for social work services, licensees are currently limited to providing services within the state borders where they hold a license. The Social Work Compact seeks to provide licensees with opportunities for multistate practice while supporting relocating practitioners and fostering workforce development by reducing unnecessary licensure burdens.

The Compact was created through a cooperative agreement between the Department of Defense and CSG. For the past two years, we have been developing the Compact language with stakeholders from the profession including the National Association of Social Workers, the Association of Social Work Boards, and the Social Work Regulatory Agency. The Compact was finalized on February 3.

The Compact will enable social workers to obtain what is known as a "multistate compact license" issued by their home state that allows them to practice in every other part of the Compact rather than having to obtain individual state-specific licenses in every state where they want to work. The Social Work Compact is very similar in form and function to the other licensure compacts Nevada has already enacted. A social worker must hold an active, unencumbered license in their home state to be eligible for a multistate license, and licensees must also pass a background check and meet other eligibility criteria related to examinations and education.

From a regulatory perspective, the Compact preserves the authority of each member state to regulate practice within its borders. A licensee practicing under a multistate license must abide by all the laws and rules where those services are being provided and the Nevada Social Work Board has jurisdiction over anyone practicing in Nevada under a multistate compact license. The Compact benefits military families. If a military family gets assigned to a new duty station because of a basing decision, the service member or their spouse can continue to work on their multistate license without needing to obtain a new license.

Like all licensure compacts, the Social Work Compact will be governed by a commission made up of the member states, and that representative will be a delegate from the Nevada Social Work Board. As mentioned, there are currently five member states, including Utah and Washington from the West, and there is pending legislation in 23 states for the 2024 Session including your neighboring state of Arizona. Lastly, I would like to note that this legislation is supported by the Nevada Social Work Board and the Nevada Chapter of the National Association of Social Workers. I would be happy to take any questions.

Nick Vander Poel, Principal, Flynn Giudici Government Affairs:

My firm represents the Nevada Social Workers Board, and as Assemblyman Gray mentioned, the language was approved in February 2023. It was a little ahead of its time, but since then, across the country there is a dire need for social workers and having the support of the Board and the Association—and as Director Whitley in your previous meeting alluded to, there is a high demand—we believe this is a good solution for social workers in Nevada.

Chair Doñate:

Committee Members, are there any questions or feedback? We do not have anything in Southern Nevada. Northern Nevada, did you have anything?

Senator Titus:

I am curious—especially for the CSG representative. Recently, we had a discussion with multiple Senators, Assembly members, and our Governor regarding the need for professionals across the board in our states, especially in Nevada, not only social workers. You mentioned that we have five different compacts already, and the thought is to not chip away by doing these compacts, but instead look at a broader thought of doing reciprocity across the board for professional licensure. Is CSG looking at anything like that? Arizona has passed a law along that regard, and instead of having this breakdown of every single professional thing and still being behind, looking at the State of Nevada doing reciprocity for professional licensures.

Mr. Shafer:

Nevada currently has what we call "universal license recognition," which says that if you hold a license from another state and the Board deems that if the requirements you satisfied to obtain that license in your other state are substantially similar to Nevada, they will issue you Nevada's version of that license. That is already in place in Nevada.

The difference between compacts and universal recognition is that compacts are the only way where reciprocity is bidirectional. You are providing value for your current Nevada residents to go and work in other states, do telehealth practice, or work temporarily in a state, and you are also making it easier to attract people to Nevada who do not live in Nevada. Compacts are the only way we see where reciprocity is bidirectional. Everything else states are looking at right now is making it easier for people to either move or practice in their state but not providing that same value for their current residents.

Senator Titus:

Thank you for pointing out it is bidirectional with the compacts. I am not sure we want anybody leaving our State who has a professional license here, so I wanted to point that out. Thank you for that clarification.

Chair Doñate:

Are there any other feedback or questions? Seeing none, we will close this presentation and move on to the next one. There was a recommendation of a moratorium on new hospice licenses. We will table this until the next time we meet. We received a proposal to ban flavored vaping products from a couple of students joining us today.

Chiressa Adymy, Student, College of Southern Nevada (CSN):

I am here with two of my peers, and we are respiratory therapy students at CSN. We are due to graduate with our bachelor's degree in Cardiorespiratory Sciences in a few weeks, and we have created an initiative called Flavor Free Nevada, which seeks to educate youth and advocate for legislative changes to better benefit the community. (Agenda Item X B)

The rise in youth vaping and e-cigarette usage has become a significant public health concern in recent years. In response, in 2020 the U.S. Food and Drug Administration (FDA) passed a national guidance enforcing restrictions on the sale of flavored e-cigarette cartridges except for tobacco and menthol flavors. This enforcement failed to address the sale of flavored disposable vapes, which can still easily be accessed at most retail stores here and are also the most widely used device among youth smokers. As previously

mentioned, 44 percent of high schoolers in Nevada have tried vaping products, and the most recent Nevada youth risk behavior survey reported that 47 percent of high schoolers felt it would be fairly easy or very easy to get e-cigarettes.

Amira Ahmed, Student, CSN:

To address this public health issue, we recommend the Committee consider implementing provisions on flavored electronic cigarette products to mitigate the rise of youth vaping. We propose prohibiting the sale of flavored disposable vapes apart from tobacco or menthol flavors as well as capping the nicotine content in electronic nicotine delivery systems.

We ask the Committee to consider enacting legislation like Utah's SB 61 titled "Electronic Cigarette Amendments." Highlights of this bill include prohibiting the sale of e-cigarette products that have not received market authorization or are pending market authorization by the FDA. It codifies a nicotine limit on e-cigarette products and prohibits the sale of flavored e-cigarette products. Violation would result in civil penalty fines that would be allocated towards comprehensive drug programs, youth prevention, and cessation programs in Nevada.

Maria Hurtado-Tovar, Student, CSN:

Most legislation enacted in other states enforces a comprehensive flavor restriction on e-cigarette products rather than targeting flavored disposable vapes. Our focus on restricting disposable flavored vapes seeks to find a balance between limiting youth access while also maintaining the availability of alternative options for current adult smokers. To safeguard the well-being of youth, we advocate for imposing any limits on flavored e-cigarette products, whether it be a comprehensive flavor ban or only flavored disposable vapes. Thank you for the earlier questions on youth tobacco use.

Chair Doñate:

Committee Members, do we have any questions or feedback? I must remind you these are students, so let us take it easy on them.

Vice Chair Orentlicher:

As you have indicated, this is a serious problem. This issue has come up in other settings where people have discussed it, and one view advocates hold is that you should ban all flavorings. The ones you are banning, you say tobacco flavor. I think people understand tobacco flavor, but they would also include menthol, and I notice you do not include menthol. We appreciate your thoughts on why you would allow menthol flavoring.

Ms. Adymy:

We chose to recommend keeping menthol and tobacco flavors to provide an alternative option for adult smokers because statistically, youth smokers favor flavored vapes over tobacco and menthol flavors. If something like this were to be enacted, it would be important to define what "flavor" is. If we follow suit to Utah like we recommended, it would define a flavored electronic cigarette product which would include any taste or smell, fruit, chocolate, vanilla, honey, candy, cocoa, dessert, alcoholic beverages, herb, or spice. Clear language with that type of recommendation would be important.

Vice Chair Orentlicher:

To your point about youth favoring other kinds of flavors, I thought that, but when I looked it up a few months ago, I thought menthol was in the top five or six flavors for youth too, maybe not as high as adults, but still in in their top. Is that correct?

Ms. Adymy:

With the research I have done, it was mint flavors, so mint and menthol. I guess there is a difference with that, but we focused on banning flavor disposables specifically so we can maintain options for adults like menthol or tobacco.

Chair Doñate:

It is interesting that this proposal is coming up, especially as other states are starting to tackle it. It is my understanding that the loopholes that are being exploited by states that have passages—there is still a black market with illicit sales. Have you looked into that in terms of your research? For instance, if Chinese products are not getting cleared by the FDA but are still being sold online, how can the Attorney General's Office or the government make sure those products are not still being delivered to children? Have you done any research, or did that come up?

Ms. Adymy:

That did come up within our research. In some states that have enacted similar policies, people will travel across state to get those products. The recommendation would come from banning being able to purchase these products online. It would be important with enforcement and policing of the policy.

Chair Doñate:

Gotcha. It sounds like to me this is a two-pronged issue. When we think of public health, we think of the environment, enforcement, and access to certain products. This policy recommendation is more towards limiting the access part since it is targeting youth and then figuring out what other products can be curtailed, for instance, in terms of advertising. Is that correct?

Ms. Adymy:

That is correct.

Chair Doñate:

My last question is, what was your rationale? I am assuming this is your first time presenting in front of the Legislature. Why did you think of submitting this policy recommendation, and why is it important for us to think about this further?

Ms. Adymy:

As respiratory therapy students, we spend a lot of time in hospitals and have seen firsthand the impact smoking and tobacco use can cause with chronic issues and chronic disease. We found that a lot of our problems as respiratory therapists deal with patients with chronic obstructive pulmonary disease (COPD) and limiting access earlier on to a product that is

more geared towards youth smokers would ultimately lower the availability and address a public health issue.

Chair Doñate:

Did all three of you go to school here in Nevada? I am assuming yes, and was this something that you encountered through your own high school experiences of teens smoking vaping products? Was that common, or was it more prevalent as you got older in college? If you can talk about your own personal experiences, that would be helpful.

Ms. Adymy:

For me personally, I am a little older than the products that were released, so vaping was not very prevalent when I was in high school. When I went to college, it was more common. I have a younger brother who is in high school here, and he says it is very prevalent and knew exactly the products that I was talking to him about.

Chair Doñate:

Are there any other closing remarks? Seeing none, last but not least, we have the last policy presentation about cardiac event crisis response plans.

Sabrina Schnur, Belz and Case Government Affairs:

On behalf of the American Heart Association (AHA), we appreciate the opportunity to provide a presentation on AHA's policy recommendation related to the adoption of Cardiac Emergency Response Plans (CERPs) in Nevada schools. (Agenda Item X C-1) (Agenda Item X C-2)

Cardiac arrest occurs when the heart malfunctions and stops beating unexpectedly. In seconds, a person becomes unresponsive and cannot breathe. Death occurs within minutes if the person does not receive treatment, but cardiac arrest can be reversible in victims if it is treated quickly. Out of hospitals, cardiac arrest is associated with low survival. Approximately 70 percent of cardiac arrest occurs outside of a hospital setting, but early cardiopulmonary resuscitation (CPR) and early defibrillation can improve outcomes.

The correlation between a person's heart disease diagnosis and their increased risk for a heart attack lies in the progressive nature of coronary artery disease. People diagnosed with heart disease, especially those with significant narrowing of the coronary arteries, are at higher risk of experiencing a heart attack. Nevada has a higher percentage of people with heart disease, putting more Nevadans at risk, and the counties that are highlighted darker red are Nye, Esmeralda, and Eureka.

The chance of heart attack survival often lies in the hands of lay rescuers. Bystander CPR has been shown in multiple studies to improve out-of-hospital cardiac arrest survival and can double or triple the odds of survival. In schools with automatic external defibrillators, approximately 70 percent of children survive cardiac arrest. That is seven times the overall survival rate for children who experience cardiac arrest.

That is where cardiac emergency response plans come in. A CERP is a written document that establishes specific steps to reduce death from cardiac arrest in school settings. A CERP can be a standalone document or part of a school's existing emergency response plans.

When schools develop CERPs, it is important to work with local EMS providers to ensure the plan integrates with the community's EMS response protocol.

A cardiac event can happen anywhere, and schools are a nucleus for a variety of events in all communities. In 2022, Nevada had 447,603 students and 23,557 teachers in schools, and it is important for school facilities to have a plan in place to address cardiac arrest. It is estimated that there are more than 23,000 children in the U.S. under the age of 18 who experience cardiac arrest outside of a hospital each year. Only 40 percent of those are sports related. We recommend implementing emergency response plans for cardiac and other medical events in schools, as CERPs double the survival rate of cardiac arrest, and there should be a CERP in every school.

The AHA recommends that Nevada schools adopt CERPS as part of their existing emergency response plans already outlined in NRS 388. We submitted a typo in the recommendation section that reads "health districts" where it should read "school districts." I clearly had public health day on my mind.

The Legislature can be prescriptive in what should be included in CERPs or leave it up to school districts to determine what their CERP needs to include. The AHA has guidelines that can be provided regarding what CERPs should include. This statutory change would only require the schools to do emergency response planning. That concludes my presentation. I would gladly take any questions.

Chair Doñate:

Committee Members, are there any questions or feedback? I do not see anything down here. Anything in Northern Nevada? Seeing none, we appreciate your presentation, and we will close this agenda item. The Committee will have a recapture of all the recommendations submitted, and we will have further discussion as we get towards the end of the interim. We will move on to our last agenda item, which is public comment.

AGENDA ITEM XI—PUBLIC COMMENT

Chair Doñate:

We will now open the public comment period. Is there anyone who would like to give public comment at this time? We will start here in Las Vegas.

Ms. McAllister, Previously Identified:

I want to stand in strong support of banning flavors as presented by the students who came earlier today, and I wanted to read a quote from Dr. Sandy Chung, the President of the American Academy of Pediatrics: "In 2023, menthol cigarettes and flavored cigarettes are designed and marketed to addict children, plain and simple."

Lorraine Oliver, Private Citizen:

I am a past employee of SNHD. I am here because I would like to provide you with context on questions you raised, not only with the people who oversee us at the Health District. I am a retiree. I am a nurse who worked there until 2020, and then I went back for the efforts regarding Mpox—which is a polite way of saying it these days—and COVID-19, and I also helped in their sexual health clinic.

From the perspective of the employees, not the management, we did not want them to have what we thought would take away from public health when they said they wanted to have the FQHC. Not that we did not think an FQHC was something good to have in the community if we have inadequate services for people, but we thought it would take away from what public health's mission, and we still have many questions about that. I think it was demonstrated quite clearly to you folks in your various comments from management this morning that they are not in the habit of talking to employees and asking for their input, and that is a sad commentary of us. This morning, some staff here were almost in tears when they heard those comments.

There were other things we think you should ask. It is not that we do not want funding, and it is not that we want you to fight for us as workers in the sense of us fighting at the moment in a contract. It is that we felt completely slighted in the way we were treated throughout this time period. Even prior to COVID-19, we took zero pay cuts at times to make sure the Health Department stayed functional. What I would ask if I was you folks is a picture of what have you done for your employees in this time frame. That will give you a picture of saying that we are not just greedy workers.

The second thing is that while other people were doing significant stuff for their front-line staff, they did things like taco trucks and ice cream sundaes and things like that, which do not help your bottom line. I will wrap up. You heard a lot of comments from some of my coworkers where they are about to try doing takeaways. They are going to take away help for their vehicles, and as for money, they are offering us about two percent, which is not even beginning to catch up with what the markets have been doing and what we are going through financially. I am a retired nurse willing to work. I might have to go to Carson City where they are looking for nurses.

Chair Doñate:

Thank you for your years of service. Is there anyone else in Las Vegas? Seeing none, is there anyone in Carson City? Anyone virtually?

BPS:

Chair, the public line is open and working, but we have no callers at this time.

Chair Doñate:

We will close public comment. Our next two meetings will be specifically on behavioral health. The one in May will be focused on adult behavioral health, and the one in June will be on children's behavioral health. We have a lot of work to get done, but I appreciate everyone for participating today.

AGENDA ITEM XII—ADJOURNMENT

There being no further business to come before the Committee, the meeting was adjourned at 4:06 p.m.

Respectfully submitted,

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Sarah Baker
Research Policy Assistant

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Patrick B. Ashton
Principal Policy Analyst

_____

Davis H. Florence
Senior Policy Analyst

APPROVED BY:

_____

Senator Fabian Doñate, Chair

Date: _____

MEETING MATERIALS

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
Agenda Item II	Leann D. McAllister, Executive Director, Nevada Chapter, American Academy of Pediatrics	Written Public Comment
Agenda Item IV A	Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, Legislative Counsel Bureau (LCB)	LCB File R013-24 of the Board of Pharmacy
Agenda Item IV B	Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R002-24 of the Board of Psychological Examiners
Agenda Item IV C	Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R124-21 of the Nevada Physical Therapy Board
Agenda Item IV D	Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R004-24 of the State Board of Health
Agenda Item IV E	Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R024-24 of the State Board of Oriental Medicine
Agenda Item V A	Julia Peek, M.H.A., C.P.M., Deputy Administrator, Division of Public and Behavioral Health (DPBH), Department of Health and Human Services (DHHS)	PowerPoint Presentation
Agenda Item V B	Nicki Aaker, M.S.N., M.P.H., R.N., Director, Carson City Health and Human Services (Health Authority) Daren Winkelman, Administrator, Central Nevada Health District Kevin Dick, District Health Officer, Northern Nevada Public Health Fermin Leguen, M.D., M.P.H., District Health Officer, Southern Nevada Health District	PowerPoint Presentation
Agenda Item VI	Kristy Zigenis, M.A., Immunization Program Manager, DPBH, DHHS Vickie Ives, MA, Bureau Chief, Child Family and Community Wellness	PowerPoint Presentation

	Julia Peek, M.H.A., C.P.M., Deputy Administrator, DPBH, DHHS	
Agenda Item VII	Sarah Rogers, Nutrition Unit Deputy Chief Bureau of Child, Family, and Community Wellness Vickie Ives, M.A., Chief, Bureau of Child, Family and Community Wellness, DPBH, DHHS	PowerPoint Presentation
Agenda Item VIII A	Sarah Rogers, Deputy Chief, Nutrition Unit, Bureau of Child, Family and Community Wellness, DPBH, DHHS	PowerPoint Presentation
Agenda Item VIII B	Allison Genco, Chair, Nevada Council on Food Security, Director of Nevada Government Relations, Dignity Health St. Rose Dominican	PowerPoint Presentation
Agenda Item VIII C	Beth Martino, President and Chief Executive Officer (CEO), Three Square Food Bank	Three Square Handout This is on file in the Research Library of the LCB, Carson City, Nevada. For copies, contact the Library at (775) 684-6825.
Agenda Item VIII D	Nicole Lamboley, President and CEO, Food Bank of Northern Nevada	Food Bank of Northern Nevada Handout
Agenda Item IX A-1	Joan Altman, JD, MPH, Director of Government Affairs and Strategic Partnerships, Washington Health Benefit Exchange	PowerPoint Presentation
Agenda Item IX A-2	Joan Altman, Director of Government Affairs and Strategic Partnerships, Washington Health Benefit Exchange	Washington Data Snapshot
Agenda Item IX A-3	Joan Altman, Director of Government Affairs and Strategic Partnerships, Washington Health Benefit Exchange	Fact Sheet—Washington 1332 Waiver
Agenda Item X A-1	Assemblyman Ken Gray	Social Work Licensure Compact Model Legislation

Agenda Item X A-2	Assemblyman Ken Gray	Fact Sheet—Social Work Licensure Compact
Agenda Item X B	Chiressa Adymy, Student, College of Southern Nevada (CSN) Amira Ahmed, Student, SCSN Maria Hurtado-Tovar, Student, CSN	Flavored Vape Ban Proposal
Agenda Item X C-1	Elise Monroy, Belz and Case Government Affairs	PowerPoint Presentation
Agenda Item X C-2	Elyse Monroy, Belz and Case Government Affairs	Cardiac Event Crisis Response Plan Proposal

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