MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-Ninth Session
March 15, 2017

The Committee on Health and Human Services was called to order by Chairman Michael C. Sprinkle at 1:05 p.m. on Wednesday, March 15, 2017, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4406 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/79th2017.

COMMITTEE MEMBERS PRESENT:

Assemblyman Michael C. Sprinkle, Chairman
Assemblywoman Amber Joiner, Vice Chair
Assemblywoman Teresa Benitez-Thompson
Assemblyman Richard Carrillo
Assemblyman Chris Edwards
Assemblyman John Hambrick
Assemblyman William McCurdy II
Assemblywoman Brittney Miller
Assemblyman James Oscarson
Assemblyman Tyrone Thompson
Assemblywoman Robin L. Titus
Assemblyman Steve Yeager

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Susan E. Scholley, Committee Policy Analyst
Mike Morton, Committee Counsel
Terry Horgan, Committee Secretary
Trinity Thom, Committee Assistant

OTHERS PRESENT:

Denise Tanata, Executive Director, Children's Advocacy Alliance
Sheniz Moonie, Ph.D., Associate Professor, School of Community Health Sciences, Department of Environmental and Occupational Health, Program of Epidemiology and Biostatistics, University of Nevada, Las Vegas
Jessica Lamb, Policy Manager-Health, Children's Advocacy Alliance
Caroline Moassessi, Private Citizen, Reno, Nevada
Leila Moassessi, Private Citizen, Reno, Nevada
Michael Hackett, representing Nevada Public Health Association
Lindsay Anderson, Director, Government Affairs, Washoe County School District
Dana Balchunas, Director, Student Health Services, Washoe County School District
Graham Galloway, representing Nevada Justice Association
Lynn Row, Director, Health Services, Clark County School District
Sheila Story, R.N., Chief Nurse, Carson City School District
Jessica Ferrato representing Nevada Association of School Boards
Mary Pierczynski, representing Nevada Association of School Superintendents and Nevada Association of School Administrators
Charlene Frost, Statewide Family Network Director, Nevada PEP
Erik Jimenez, representing United Cerebral Palsy of Nevada
Shirley Campbell, Private Citizen, Las Vegas, Nevada
Judith Koller, Private Citizen, Las Vegas, Nevada
Edward Guthrie, Chief Executive Officer Emeritus, Opportunity Village, Las Vegas, Nevada
Brian M. Patchett, Chief Executive Officer/President, Easterseals Nevada
Edward Ableser, Administrator, Disability and Aging Services Division, Department of Health and Human Services
Amber L. Howell, Director, Washoe County Department of Social Services

Chairman Sprinkle:
[Roll was taken. Committee rules and protocol were explained.] Is there anything from the Committee this afternoon? [There was no reply.] At this point, I will open up for one of two rounds of public comment. Anyone wishing to come up at the start of the hearing, please come up. [There was no one.] Seeing no one, we will close public comment. I will now invite the presenters for Assembly Bill 156, and we will open up the hearing.

Assembly Bill 156: Authorizes public and private schools to obtain and use an albuterol inhaler in certain circumstances. (BDR 40-581)

Assemblyman Steve Yeager, Assembly District No. 9:
It is my pleasure to present Assembly Bill 156, which authorizes public and private schools to obtain and use an albuterol inhaler in certain circumstances. With me at the table I have Denise Tanata from the Children's Advocacy Alliance. I would like to give some brief opening remarks, and then turn it over to Ms. Tanata to walk the Committee through the

amended version of the bill (Exhibit C) that you will find on the Nevada Electronic Legislative Information System (NELIS), and then we have some presenters to help support the bill.

This issue is really important to me because as a child, I suffered from fairly severe asthma. Fortunately, I have mostly outgrown that; I still have a little bit of exercise-induced asthma, so I brought with me today my inhaler that I have a prescription for. I tend to have this with me just in case, but I remember as a child I was hospitalized several times for asthma—sometimes for a week or two at a time. I remember the feeling of not being able to breathe, what it feels like to have an asthma attack. It feels like someone is squeezing your throat, and you really feel like you cannot breathe. It is a truly terrifying feeling. I also remember the instant relief that would come from one of these inhalers. By taking one of these, your airways would open up and you would feel like a new person. This inhaler could literally feel like the difference between life and death.

As a child, I always tried to remember to carry it with me. I do not remember ever forgetting it, but I can tell you that there were moments of panic when I did not know if I had it on me. I would be looking in my pockets, my backpack. Maybe it was in the bottom of the backpack, and I remember that feeling of absolute terror as I wondered if I had my inhaler with me or not. What this bill seeks to do, for children who are diagnosed with asthma, is make sure they do not experience that same feeling when they are at school. It would require the school to stock an inhaler so in that unfortunate circumstance where a student forgot the inhaler or could not find it and was experiencing an asthma attack, that child would be able to get relief from an inhaler. I say that as background, because that is why this issue is particularly important to me.

In terms of the bill, I would like to hand it over to Ms. Tanata who will talk more about where the bill is right now and where we came from.

Denise Tanata, Executive Director, Children's Advocacy Alliance:
I would like to start by walking you through the bill. This bill would require public and private schools to obtain and maintain albuterol inhalers to be provided to children who have been previously diagnosed with asthma. Section 1 allows for a school nurse or other employee, if they have received training, to administer a dose of albuterol. Section 3, subsection 1 requires a school to maintain an order to stock an albuterol inhaler and not less than two spacers to be maintained at the school. This language was amended to allow for a school to save a used spacer and label it for a specific individual's use. The spacer is something that goes on the inhaler to allow that inhaler to be reused without contaminating the actual inhaler. These have been federal Food and Drug Administration-approved for reuse. There are some schools that utilize spacers rather than throwing them away. If they have a child that comes back more than once, they can just label the disposable spacer rather than throw it away.

Section 3, subsection 2 allows for an inhaler maintained by a public school to be administered by a school nurse or any other employee of the public school who has been designated by the principal or site administrator, and requires them to receive training on the proper storage and use of an albuterol inhaler. This language has been amended to be an individual designated by the principal or site administrator. Section 3, subsection 3 allows for a school to administer a dose of albuterol to a pupil who has been diagnosed with asthma by a health care provider. This section has been amended to restrict use of the inhalers only to those students who have been previously diagnosed with asthma. Section 3, subsection 4 allows for a school to accept gifts, grants, and donations from any source for the support of the public school in carrying out the provisions of this section. That could be for donations of inhalers or spacers the school might receive by some of the pharmaceutical companies.

Section 4, subsection 1 requires for the albuterol inhaler to be stored in a designated secure location that is unlocked and easily accessible. Section 4, subsection 2 requires each school district to establish a policy regarding the proper handling and transportation of albuterol inhalers. Section 4, subsection 3 requires each school district and charter school to submit a report each year to the Division of Public and Behavioral Health of the Department of Health and Human Services identifying the number of doses of an albuterol inhaler that were administered to pupils.

Section 5 requires each public school and each charter school to develop a comprehensive action plan concerning symptoms of asthma. This section was amended to replace the term "symptoms of respiratory distress" to "symptoms of asthma."

Section 6 requires a charter school to designate a school nurse or other employee to administer doses of albuterol inhaler and also requires the training in the proper storage, handling, transportation, and use of albuterol inhalers.

Section 7 requires that the chief nurse can ensure that each school nurse coordinates with the principal of the school to designate employees of the school who are authorized to administer albuterol inhalers and have training regarding the proper storage and use of an albuterol inhaler.

Sections 9 and 10 similarly allow a private school to maintain albuterol inhalers and require them to develop an action plan concerning the symptoms of an asthma attack.

Sections 11, 12, and 14 authorize physicians, osteopathic physicians, physician assistants, and advanced practice registered nurses to issue an order for one albuterol inhaler and not less than two spacers or holding chambers designed for use with that albuterol inhaler to be maintained at a public or private school for the treatment of asthma. This section was amended to replace the term "symptoms of respiratory distress" with "symptoms of asthma."

Sections 11, 12, 13, 14, and 15 provide immunity from liability to a physician, osteopathic physician, physician assistant, advanced practice registered nurse, or other employee of a public or private school who is designated pursuant to sections 3, 6, or 9 for any error or omission not resulting from gross negligence or reckless, willful, or wanton conduct. These sections have been amended to include a designated employee.

This concludes a walkthrough of the bill. We have individuals who will provide additional testimony. One we would like to call up first is Dr. Sheniz Moonie, a professor at the University of Nevada, Las Vegas. She has been asked to present data and research on the prevalence of asthma among school-aged children in Nevada. Dr. Moonie is not present to provide either support or opposition to this bill; she was asked to present data based on her research and expertise on the topic.

Sheniz Moonie, Ph.D., Associate Professor, School of Community Health Sciences, Department of Environmental and Occupational Health, Program of Epidemiology and Biostatistics, University of Nevada, Las Vegas:
I have 15 years of asthma research background. I am here to discuss some data surrounding A.B 156, and I am testifying in the neutral position. Approximately 10 percent of Nevada's children have ever received an asthma diagnosis. There are about 3,600 deaths a year nationwide, some of which have been attributed to lack of access to rescue medication. In Nevada in particular, emergency room visits have been on the increase. The highest emergency room utilization is among youth under the age of 18. In addition, Nevada children with asthma have been shown to have increased absenteeism compared with their healthy classmates. They also have been more likely to demonstrate the need to repeat a grade—grade retention, basically. The cost for one person per year with asthma is approximately $3,000.

Jessica Lamb, Policy Manager-Health, Children's Advocacy Alliance:
Today I will be reading to you a letter from JoAnna Strother of the American Lung Association (Exhibit D).

> More than one in ten children in the U.S. have asthma. Each year, more than half of them will experience a sudden attack that makes it difficult for them to breathe. These attacks will lead to 750,000 emergency department visits and 200,000 hospitalizations. Because attacks can occur anytime, anywhere without warning, children with asthma should always have access to medication that can quickly reverse the blockages in their airways. This lifesaving medication, called a short-acting bronchodilator, is easy to administer, inexpensive, and very safe. Despite the need for this medication, 80 percent of children with asthma do not have it at school. This problem affects all children—rich or poor, private-schooled or public-schooled, urban or rural. There are many reasons why they might not have medication—they forgot it, they could not afford it, they unexpectedly ran out, or it might have expired. When children do not have medication, schools have very few options. A parent might not be immediately accessible or close enough to

> respond promptly. Even if they can, there is a delay during which the attack often worsens. In such cases, the school must dial 911. Doing so is likely to lead to an ambulance transport costing $500 or more, and an emergency department visit costing thousands more. Such events also take children out of the classroom for days at a time and further impede their learning.
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> These adverse events are, in many cases, avoidable with a simple, low-cost solution—stock inhalers. Schools can purchase a single inhaler containing a short-acting bronchodilator that can be used for anyone diagnosed with asthma who experiences the sudden onset of cough, shortness of breath, and chest tightness that signals an asthma attack. Tucson, Arizona, where stock inhaler policies have been studied in two school districts, found, in the year following implementation, a stock inhaler was used to manage 222 asthma attacks in 55 children in 22 schools. After implementation, 911 calls fell 20 percent and emergency medical service transports fell 40 percent. School nurses reported greater peace of mind and lower job stress. Parents and children felt their schools were safer; however, school nurses were afraid that giving this lifesaving medication could potentially expose them to liability. Such concerns have led eight states to adopt legislation permitting use of stock inhalers in schools by trained personnel and indemnifying their good-faith use. Enacting legislation in Nevada will provide a simple mechanism to protect the health and well-being of our children.
>
> Some have expressed concerns about the cost of stock inhaler programs. No school will be required to implement such a program if no funding is available; however, should they choose to do so, this legislation will provide the necessary legal framework for them to do so safely and without fear. For schools that choose to adopt, the program cost would be approximately $77 per year for a smaller school and $112 a year for a larger school, based on a single inhaler retail cost of $62 and a small supply of disposable holding chambers costing $3 apiece. I urge you to support the proposed stock inhaler legislation which would provide a safe inexpensive fix for an important health challenge faced by children and the schools that educate them.
>
> Signed,
> JoAnna Strother
> Regional Director of Public Policy
> American Lung Association

Chairman Sprinkle:
Thank you for reading that. Is there anyone else at this time?

Assemblyman Yeager:
We originally hoped we could have Bobbi Shanks, a nurse from the Elko County School District, here today. Unfortunately, she was not able to be with us. I believe we have a letter

from her on NELIS (Exhibit E). I do not want to read it to the Committee, but I do think it is important testimony. They have inhalers in Elko that they have used quite often. I will ask the Committee to look at her letter, because I think it provides some valuable insight to what is happening in the Elko School District.

Chairman Sprinkle:
Yes, the last letter that was just read and this one are both on NELIS.

Caroline Moassessi, Private Citizen, Reno, Nevada:
[Caroline Moassessi spoke from prepared text (Exhibit F).] I am the parent of two asthmatic children, I have asthma myself, and I volunteer with the American Lung Association. I have served as a past officer on the southwest regional board, and I have been an Open Airways instructor for the American Lung Association. The Open Airways program is where we go into schools, often Title I schools, and teach children with asthma how to manage it. We do that over a five- or six-week period. In the first class, I ask how many kids have their inhalers. There are usually eight to ten kids in the class. Maybe one or two will raise their hands. I ask them why not: It is in my gym bag; it is in my locker; it is in the classroom; my mom did not refill my expired container; I am feeling really good and do not need it. That is a problem, and is the point of that class. Hopefully, at the end of the class, at least 70 percent of the kids have their inhalers in their pockets. I am here today because I realize and see how many children who need those inhalers do not have their inhalers on them.

In 2013, I worked with Senator Debbie Smith to pass the stock epinephrine law. What I learned is that good laws like that one save lives. This morning we are honored to have Andrew Casata with us. He is a young man who, while in middle school, had a first-time allergic reaction in a cooking class. He passed out; it was extremely severe. His physician said that he might have died if they had not had stock epinephrine in that school. The point is that when we have these mechanisms in place, we save lives. As a parent, that is what I am hoping for. I am in support, and I hope we continue the conversations. When we worked on the stock epinephrine bill, what I found so inspiring as a citizen was watching how everyone came together. We all knew we wanted to save kids, but everyone worked together—the nurses, the different stakeholders, the legislators, and I was excited to see that process.

With your permission, my daughter Leila will show you how to use the spacer.

Leila Moassessi, Private Citizen, Reno, Nevada:
I am 13 years old, and I have asthma. This is my inhaler that I carry everywhere. I typically use it before and after sports events or whenever I am wheezing or feel tight and do not feel good. Today I will be demonstrating the disposable spacer for you. [Leila Moassessi inserted the inhaler in one end of the spacer and took a breath.] It is as simple as that. Thank you for your time.

Chairman Sprinkle:
Thank you, Leila.

Assemblyman Yeager:
Mr. Hackett is going to come up and provide brief testimony.

Michael Hackett, representing Nevada Public Health Association:
We are in support of this bill. Anything that improves access to health care services and health care treatment in this case is a very important consideration for us as an organization. On a personal level, and to dovetail on what Caroline Moassessi was saying, I had the pleasure of being involved in the legislation in 2013, Senate Bill 453 of the 77th Session, on behalf of the parent advocates and their families. The effect and benefit from that bill was immediate, dramatic, and continues to this day. The legislation before you is not identical in a lot of ways to that particular piece of legislation, but its intent and potential benefits are very similar. Therefore, I really hope that you support this bill.

Chairman Sprinkle:
Are there questions from the Committee?

Assemblywoman Titus:
There is nothing scarier for patients in my practice than when they come in and they cannot breathe. It is very scary for them and especially for the children. They do not know what is going on, so anything we do to help that is a good thing. I appreciate that, but I have several questions. On page 3, at line 30 in your amended version (Exhibit C), you added a pupil "who has been diagnosed with asthma by a healthcare provider." I have concerns about adding that language. What if that child is short of breath, and that child is not with a parent because he or she is out on the playground and suddenly has an asthma attack. As one of your presenters said, not uncommonly the first case might be exercise-induced, so the child has not been diagnosed with asthma but suddenly now cannot breathe. I am worried about that line being added. When they come in they are having a reactive-airway problem; they are tight, cannot breathe, and may or may not have been diagnosed, but you probably want to give that child an inhaler at that time.

In your description of who can administer you say that this bill authorizes a trained designated public or private school employee. I want to understand the intent of that. A lot of schools do not have a school nurse in-house. I am sure that is what you meant—someone covers for them, and it might be someone who is not a nurse, because on page 2, lines 40 and 41 of the [Legislative Counsel's Digest] of the bill, it reads, "provides that a nurse is not subject to disciplinary action." It may not be a nurse who is administering this; it might be a certified nurse's aide; it might be the school secretary who takes the training.

As an observation and as a rural country doctor, for those of you who have asthma and do not have a spacer that costs $3, an empty toilet paper roll works as a great spacer, and it is free.

Denise Tanata:
In regard to your first question, the language was amended to restrict this to kids who had already been diagnosed after some conversations with school nurses. The concern is that there is not a nurse in every school, and their fear was having a nonlicensed person making a

diagnosis of a child. We know this is not the case in every state that has put these policies forward. From our perspective, I would be open to that conversation. Originally our intent was to make this available to any child who showed symptoms of an asthma attack, whether or not there was a diagnosis on file.

Assemblywoman Titus:
If you limit it to children diagnosed with asthma, then the way they have access is they have to be identified in some manner. I fill out forms all the time because I send kids to school with their little inhalers, so the information that they have asthma and allowing them to use their inhalers is at the school. They have to self-identify. Will the parents know? Will word go home in school folders that the school has inhalers now, so please let us know if your child has asthma? I am worried about that process. Would the forms get back to the schools? To me, that is a hindrance.

Denise Tanata:
To your second question around the language concerning who could administer the albuterol, it was for the same purposes because in some districts there are nurses in every school; in other districts, which are some of the larger ones, we do not have nurses. The idea is that there is training available, and it is fairly straightforward training that almost anyone could go through. That was the idea—that it would be someone designated by the school nurse or the principal who would take this training and would therefore have the skills and knowledge. You saw how easy it is to do the administration.

Assemblywoman Titus:
I want it to make it clear on the record that you do not intend that this has to be a health care professional taking the training. I think that is a good thing.

Assemblyman Oscarson:
Assemblyman Yeager, thank you for bringing this. I was involved in the Epi Pen legislation that has led to multiple individuals' lives being saved. Physicians have told us that it has made a difference. This is the next step. There is certainly an education component that goes with it, and I like the use of the spacers. As a former pharmaceutical representative, I saw more people who did not know how to use their inhalers than those who did. There is significant value to a spacer being utilized in those environments, especially for kids, but also for adults.

In section 9, subsection 3 of the bill it says "during regular school hours." I am concerned about after-school activities that may fall outside of those regular school hours. What is the opportunity to have that available or continue to be able to use it in those instances? The other thing I want to make sure of and want to state for the legislative record is that whenever a child is administered an albuterol inhaler, the parents should be notified. That should be the norm. There are so many kids who are noncompliant. I raised a son who was asthmatic and I have an asthmatic grandson, so I am keenly aware of the challenges that face these kids. They just want to continue to play. They say they are okay and that they are just out of breath, but all of a sudden it turns into a crisis. It can become critical very quickly, so I applaud this, I am glad you are doing it, and I want to help you however I can.

Assemblyman Yeager:
Regarding spacers, I think you hit the nail on the head. I am looking at my inhaler. I think there are 200 doses in it. The idea is to try to limit the cost as much as possible and be able to use this over and over or until we run out of the 200 doses or it expires. Mine expires August 2018, so it might be two-and-a-half years before you would have to get a new one.

In relation to your question about regular school hours, that is how it is drafted now. My hope would be that we continue to work through this and talk about how we make it available. You make a great point about after-school activities, particularly recreational activities. My hope would be that we could talk to the schools about how that works and who is on staff for those events and hopefully, make it available for that as well. I think that is a fantastic suggestion.

With respect to your second question, I do not think it is addressed in the bill, but I agree wholeheartedly that the parents should be notified any time an inhaler is used at school, so we would be happy to add that to the bill.

Assemblyman Carrillo:
I do not know what the albuterol dose is. For instance, if you had an inhaler, could I use it if I had an episode? It is not a prescription, per se. You mentioned about 200 doses out of one little bottle, but are there varying strengths? Can one person use another person's inhaler? Is it one-size-fits-all?

Assemblyman Yeager:
I believe it is a standard dosage. This inhaler states that every dose is 90 micrograms of albuterol. The prescription I have, and it is probably the case with all prescriptions, says take up to two doses at a time as needed. You take one dose and wait a few minutes to see if that relieves the problem. If it does not, you would take a second one.

Assemblywoman Titus:
It is a single dose; it does not matter how big or little you are. In the emergency room, we will use it every five minutes if we need to. Ideally, it is every four hours, but it is not weight-based.

Chairman Sprinkle:
Are there other questions from the Committee? [There was no reply.] I have a couple. Unlike some others on the Committee, the amendment and specifying exactly who is receiving it actually puts me at a lot more ease than being able to administer this to just anyone. You mentioned the training program. Could you explain more in depth what exactly these nonmedical people are going to be learning that makes you feel comfortable

coming before us today, saying that they can administer a drug into another person and are able to diagnose on the spot in an emergency situation why this is an appropriate action to take?

Denise Tanata:
There has been extensive training developed by physicians and nurses that is being utilized across the country. There have been tool kits developed for both licensed professionals and unlicensed professionals in this capacity. Albuterol is different from some other medications or drugs, and different even from an Epi Pen—much less invasive. I am not a medical professional, but this is what I have been told. From our understanding, it does not have any negative consequences, even for someone who does not technically have asthma, unless there is a very rare case of someone with a severe heart condition that it might have some negative consequences for.

The training would go through in great detail recognizing the signs of an asthma attack, so that anyone, licensed professional or not, would be able to recognize that. As you have seen with the administration demonstration of the albuterol, most kids self-administer. This is not a drug that has to be injected or even has to be that tightly watched. Most kids who have asthma who have a prescribed inhaler, even at school, carry them on their persons and administer themselves. The training is fairly basic, and I am happy to share it with the Committee members so you can see what it looks like. We felt comfortable with it, and it is being utilized throughout the country with both health professionals and non-health professionals in school settings.

Chairman Sprinkle:
If you could, I would appreciate seeing that. That is in essence the heart of the question I just asked—what that training is. When I am working in my other capacity in an emergency setting, one thing we have to do before we give albuterol is listen to lung sounds—and that is a pretty technical and difficult skill—to identify if this would be an appropriate medicine as opposed to other medications to give. To me, it seems that the intent of this bill is to save a life, but one intent of this bill is kind of enabling for those people in the school setting to administer; especially for the nurses, originally. That has been changed a little bit now with the amendment, so they are able to actually give a medication that they would not necessarily have been able to give before this. Am I correct with that assumption?

Assemblyman Yeager:
You are correct with that assumption. The heart of what we were getting at, and through the amendment as you mentioned, is that we have students who are going to be diagnosed with asthma, so they have their own inhalers. These are typically going to be students who know how to use the inhalers. This is really for the situation where, for some reason, they do not have the inhaler and they need it. Right now the way the law operates, the school does not have any ability on its own to obtain inhalers or spacers, so there is enabling language that the school would have the express authorization to get that prescription and have it there. Also, the designated employee would be able to assist with the administration of the albuterol. I think, more practically speaking, most of these students are probably going to be

able to administer it themselves, so it is just a matter of having it there at the school as a backup. The nurse can make it available to the student and perhaps help administer it if possible. That is the intent of the bill for those situations where someone runs out, cannot find it, or it has expired. Instead of calling 911 and the expense that entails, this would be something economically feasible, safe, and quick to get that student back on his or her way.

Chairman Sprinkle:
That was the way I took it upon reading this bill, and puts me a lot more at ease with the amendments. We know that, at least at some point, a medical professional has already diagnosed—even if it is not the emergent situation—that this is probably an appropriate procedure for this child. I would add the caveat that, from your last comment, if the situation were to occur, you still better call 911 so that professionals show up to at least evaluate. With the amendment, you have answered a lot of the questions I had, so I appreciate that. Is there anything else from the Committee?

Assemblywoman Miller:
How often is this occurring in the schools? How many asthma attacks are happening, and how many kids have their inhalers versus kids who do not?

Denise Tanata:
We do not have a lot of good data in our state. In talking with the various school districts, some of them collect the information about those diagnoses. Some ask for it but do not always get the information from the parents, so the data collection varies from district to district. Dr. Moonie presented some data on the number of school-age children in Nevada. From the information in the letter from Bobbi Shanks with the Elko County School District (Exhibit E), they have 250 students who were diagnosed by a health care professional with asthma. There are 205 students who have inhalers in the health office. Some of these inhalers may be backups for those who carry their own. There are also 179 students who carry their own inhalers. That is based on a total population of about 10,000 students. They also indicated in that letter that they have administered approximately 30 doses of stock albuterol since implementing this program about a year ago.

Assemblywoman Miller:
So we do not actually have numbers. That is saying how many kids have asthma and how many kids are carrying or not carrying their inhalers, but we do not have numbers of how many kids have actually had attacks during the school day. I would think that is something we could get from the nurses' offices or from the health departments of the schools.

Denise Tanata:
It is possible we could. There may be some representatives from the school nurses here who might be able to answer that question.

Assemblyman Carrillo:
How many states currently have this type of legislation on their books?

Denise Tanata:
There are eight states that we are aware of that have this legislation in place. There are a few other states the American Lung Association is working with that are looking at legislation, and they are in the same process as we are now.

Assemblyman McCurdy:
Thank you for bringing this piece of legislation forward. As a child who had respiratory problems, I believe this will definitely help other young children in our schools. Do you think just one inhaler will be enough? Do you think 200 doses or pumps will be enough?

Assemblyman Yeager:
There are several places in the bill where it indicates that if the inhaler that is maintained is depleted or expires, the school must then discard the inhaler and get a new one or replace the spacers. The idea behind one is, obviously, there is a cost component to this. I know we are not a money committee, but we wanted to keep the cost as low as possible for the schools, yet give them the ability to acquire another inhaler. That is why we went with one because we did not want to have each school perhaps stocking two and then having one go to waste because it is never used. There is a provision where they can quickly get another one if they have one that runs out.

Chairman Sprinkle:
As there are no other questions from the Committee, thank you for your presentation today. We will go ahead and open up testimony in support of A.B. 156. [There was no one.] We will move on to opposition to A.B. 156.

Lindsay Anderson, Director, Government Affairs, Washoe County School District:
I want to thank you and Assemblyman Yeager for working with us. We have been a member of the working group and have been participating in lots of phone calls to discuss this issue. We appreciate being included and being able to address some of our concerns. We met with the bill's sponsor yesterday to give him a heads-up that we still had concerns based on the amendment that was circulated yesterday, but we will continue to work in good faith on those things.

Student health is obviously a top priority for the district. We do not mean to minimize that at all. You have hit on a lot of our concerns already in your questions, but we still have two main concerns. The first, and you have already talked about it, is nonmedical staff assessing, diagnosing, and treating young children—sometimes as young as three years old. The training may teach them how to use the inhaler, which would be great, but shortness of breath is a symptom of lots of different types of health conditions, as I am sure Assemblywoman Titus can attest to. In our case, we have 42 school nurses covering 93 schools and 64,000 students. That is roughly 1 school nurse for every 1,500 students, so you can imagine the demands that are on a school nurse. In our schools that do not have a school nurse, we have what we call a clinical aide. In order to be a clinical aide, you have to be a high school graduate and want to work with kids. They are not trained medical professionals, and asking them to make these kinds of calls is something we cannot get past at this point. There has been mention of the Epi Pen bill, and I wanted to bring to light the fact that we also participated in the Epi Pen bill and we started with a very similar process. A working group initially opposed it, but we were able to work together; by the end of the legislative session, we supported the bill.

That brings me to our next concern. In the Epi Pen legislation, there was someone in the working group and at the table who was willing to donate the medication to the school district. In this particular instance, there has been no such offer to donate the medication to the school district. We will talk about the money when we get to the money committee, but that is one reason we are here in opposition today.

Dana Balchunas, R.N., Director, Student Health Services, Washoe County School District:
I supervise the 42 school nurses who are registered nurses. I also supervise the 22 licensed practical nurses who work on our staff delivering services. I supervise the 93 clinical aides in rendering health services to students. We have a huge operation that we feel maintains the health and safety of 64,000 children every day, all day, during summer and intersessions and after-school programs. I am committed to the health and safety and well-being of children. There are some snags in this bill that really concern me as a health professional. I want to mention what Ms. Anderson already mentioned, and that is that we have people with high school diplomas working in schools. Luckily, the Nevada Nurse Practice Act provides specific guidelines on how those people are to be supervised. Essentially, they are under the supervision and licensure of the school nurse who is responsible for extensive training and ensuring competence of those people. They do not have a lot of experience in crises, so, in order to ensure the safety of children, there is a definite health care plan—mostly physician-driven. The exception is the stock Epi Pens where we, in partnership with the immunologist at the University of Nevada, Las Vegas, and others, developed the standard health care plan to address symptoms of anaphylaxis so that there is a menu those people can follow.

When we get into the second area, respiratory distress, as Ms. Anderson mentioned, this can be a symptom of many different things. We recently had a child who, under physician direction, was administered albuterol multiple times. It was ineffective, and later a pacemaker was installed. This is not a light decision when it comes to deciding as a professional what could be going on, and you go through your usual nursing process to find that out. We are asking nonnurses to make decisions and assess the difference between a child who may have some other condition, or who may have an anxiety attack, or who may have some other respiratory issue. That is probably our primary concern. If we were to limit this bill to only those who are diagnosed, my concern is that the nonprofessional is going down a list to decide whether or not to administer albuterol. There are the ones who can get it because they have a physician's order; then you have a list of kids with no physicians' orders. You are really trying to serve all kids, and yet you are restricted to giving stock albuterol to only those with a diagnosis. As you know, kids in Title I schools do not have access, so they could be underserved if that happened.

I can address numbers. I would say that there are between 4,000 and 5,000 children in the Washoe County School District with diagnoses of asthma. Relative to incidents, most of them, if they are experienced in asthma, can be calmed down pretty quickly. If there is a physician-ordered albuterol, of course we trained those people to administer it. The parent is always called when there is an event such as that.

If this bill were passed and we were to put in the hands of nonlicensed, nonprofessional people the decision to administer albuterol, that would be tagged with a 911 call. There is no way I, as chief nurse, would want an unlicensed person being presented with a child in acute distress, trying the albuterol, trying it again in five minutes—this is not physician-driven, this is nurse-trained—and then deciding that things are getting worse, and 911 is required. So, it would be tagged with a 911 call; therefore, probably not cutting down on 911 calls.

As far as field trips and after-school activities, schools are up and running pretty much from 7 a.m. when students who need breakfast start eating—we have about 175 children with diabetes who eat breakfast—and it can go until late. Some field trips get back at 9 p.m. We are not bound by the law to send the stock Epi Pens with students, because the school site would not have a stock of epinephrine. If this bill were looked at, we would not want to make these mobile. If you start sending medication that is available during the school day on field trips and after school, then you do not have it available if it gets lost or is not returned.

Graham Galloway, representing Nevada Justice Association:
Our organization approves and supports the proper administration of albuterol inhalers in the school setting by school employees. As a parent of a child who suffers from asthma, I applaud the intent of this bill, but we have some concerns, too. We would concur with the concerns just expressed by the school district. Beyond that, we have some concerns about the immunity language that is contained in this bill. Our intent is to speak to the sponsors and propose some modifications. Hopefully, we can reach some language that everyone can agree with.

Lynn Row, Director, Health Services, Clark County School District:
In regard to the number of asthma students in our district, parent-reported is 89,528. Parents report supplemental information every year, so determining between a parent report and a doctor diagnosis would take further investigation. We have 21 percent of our students with an asthma diagnosis.

We are here to discuss opposing the bill as it is currently written and the cost with implementation. We do appreciate Assemblyman Yeager's efforts to work with us on the amendment. Funding is an issue for the Clark County School District. The cost for albuterol inhalers would be extremely high; however, a nebulizer would lower the cost and increase efficiency. The nebulizer is a better system for delivery of medication to students who are presenting with asthma symptoms. A student who has a severe asthma attack presents with a lot of anxiety, so their airway is already closing down. To think that they are going to use an inhaler in an emergency, exhale the air and try to inhale from an albuterol chamber is pretty difficult. I would like the bill to state the choice of a nebulizer or an inhaler. A nebulizer machine takes the work out of a child trying to get that medication in. There are other states that have implemented it with either one. Giving the districts a choice would be a better delivery system. Other states that have implemented this type of program have piloted it for a year. By using the word "may," Nevada school districts could develop their own pilots for policies, procedures, and training. This way the district could support students, allow ample time to evaluate, and provide a better foundation for the asthma plan. Asthma symptoms can often mimic other symptoms, as was mentioned by some of the other nurses. Thank you for your time and we are continuing our efforts to work with Assemblyman Yeager.

Sheila Story, R.N., Chief Nurse, Carson City School District:
In Carson High School, we currently have 150 students who are clinically diagnosed with some history of asthma. Currently, we oppose this bill due to the fiscal responsibility of each school district within the state of Nevada. In Carson High School and/or any other schools within Carson City, we have one or more asthma attacks per day. When the child presents to the nurse's office with an asthma attack, and we have a registered nurse (RN) at every one of our schools, our RNs listen to the lungs and take a pulse oximetry reading. We have oxygen available if needed. We also look at the color of the skin, are they able to talk, are they coughing. There are several different signs and symptoms of an asthma attack. Then what we do is, if they have an inhaler, we administer that inhaler. If we do not have an inhaler that is prescribed to them, we call the parent. With this being said, sometimes we cannot get hold of those parents. Sometimes there are five, six, seven, or eight numbers we call. If we cannot get hold of a parent or a guardian or someone who could possibly bring that child the inhaler, then we call 911 as a backup plan. As a school nurse, this time is very scary. You do not know if a child is going to go downhill and have a more increased form of asthma attack. If we could have standing-order albuterol within our schools, it would be very, very helpful. Several years ago, Dr. Stuart Stoloff, a local physician in Carson City experienced with asthma and allergies, donated albuterol inhalers to all the Carson City schools, and we used them all the time. Of course once he retired, our albuterol went away. If we are able to find funding and/or a pharmaceutical company that could step forward, as they did with the epinephrine bill, and help these school districts with stock albuterol, it would be wonderful. With the epinephrine bill, we have been able to stock our schools for three years, and, hopefully, a pharmaceutical company will come forward and do the same thing for this albuterol.

Referring to after-school activities, the Carson City School District has a cardiopulmonary resuscitation/automated external defibrillator (CPR/AED) program, and all our schools have AEDs outside that anyone can access. Under the AED is a yellow box for our Epi Pens, so after school hours when there are activities, they can be utilized as needed. That is probably how we would go with albuterol. We have people onsite at our schools who have been trained to use an AED, to use an Epi Pen, and if this bill is passed, we will also train them to administer albuterol after school hours. We have given our athletic trainer at Carson High School an AED and an Epi Pen, and we will also give him an albuterol inhaler if this bill is passed to help with our athletes after school hours.

Jessica Ferrato, representing Nevada Association of School Boards:
I want to thank you for your time and I want to thank Assemblyman Yeager for his work on this bill. We have the same concerns that have been presented by everyone else—concerns about nonmedical professionals administering this medication and concerns that respiratory distress can present itself in different ways and could have some greater concerns besides an asthma attack.

This is not a money committee, but we do consider this an unfunded mandate, and we will have to replace these inhalers as they expire. We would love to continue to work with the Assemblyman. He has been very gracious with his time, as have you, Mr. Chairman, and we appreciate that and hope we can get to a place where this works out for everyone.

Mary Pierczynski, representing Nevada Association of School Superintendents and Nevada Association of School Administrators:
We certainly appreciate the spirit of this bill. The health of our students is a major issue in our schools, but we have concerns. Assemblyman Sprinkle, you expressed one of them in your question about the training, the assessing, the diagnosing, and putting our untrained people in a position of making a diagnosis and deciding whether to use the inhaler or not. The second issue is the fiscal note on it. Right now, it is an unfunded mandate. I know this is not a money committee, but it is a concern of our schools. We look forward to continuing to work on the bill.

Chairman Sprinkle:
Were there more comments in southern Nevada? [There was no reply.] Is there anybody else in opposition to A.B. 156? I am not seeing anyone, so we will move on to neutral. Is there anyone here neutral to A.B. 156? I am not seeing anyone.

Assemblyman Yeager:
I want to thank the Committee for hearing this bill today. Everyone who came up to the table, in whatever position they were in, wants to get this right, and that is really encouraging to me. I have heard from everyone who testified today about the concerns, and we are still working through those. I do think there is a need for this. I did some quick addition, and there are about 100,000 students in Nevada currently diagnosed with asthma. I think that demonstrates there is a need for what we are trying to do here. I wish there was a school nurse at every school. It sounds as though Carson City has it down in terms of how they are doing it, and I know there are fiscal issues here. I want to let the Committee know that I am certainly committed to working on this going forward, and hopefully we can get to a point where everyone can come to the table and support it. I would be remiss if I did not recognize the great help that the Children's Advocacy Alliance has been on this bill. Denise Tanata and Jared Busker have been immensely helpful in shepherding this through. We started working on it in November, and I think we still have some work to do yet, and I am committed to doing that.

Chairman Sprinkle:
Thank you for bringing forward A.B. 156. It does sound like people are willing to work with you, so I would applaud that effort and recommend that everyone reach out to you on this bill. I am sure you will be keeping me up to date on what is going on. With that, I am going to close the hearing on A.B. 156.

[(Exhibit G), (Exhibit H), and (Exhibit I) were submitted but not discussed and are included as exhibits for the meeting.]

I will open the hearing on Assembly Bill 224.

Assembly Bill 224: Revises provisions relating to persons with disabilities. (BDR 39-780)

Assemblyman Richard Carrillo, Assembly District No. 18:
I will hand it over to Ms. Charlene Frost to present the bill.

Charlene Frost, Statewide Family Network Director, Nevada PEP:
I am the mom of two sons with disabilities. I brought the concept of this bill to Assemblyman Carrillo after hearing stories throughout the Las Vegas and Reno communities about being unable to access services through the regional centers due to their children not meeting criteria as being intellectually disabled or because their child had a dual-diagnosis—that being an intellectual disability or a developmental disability as well as a mental health diagnosis. When I brought this issue to the Assemblyman, he was supportive almost instantly, as he had also received concerns from his constituents regarding assisted living, job training, and other services that they may need for their children as they are getting ready to finish high school.

One common scenario is a story like Joey's. Joey is 17, he has an IQ of 75. According to the regional centers' criteria, Joey does not qualify for services from them; however, Joey does have several medical diagnoses which fall under the umbrella of developmental disabilities. As a small child, he was found eligible for an individual education plan (IEP) under developmental delay through Child Find, and has received special education services throughout his school career. Joey has had a hard time remembering when to take baths and often seems unconcerned about personal hygiene. He has a visual impairment as well, and he is unaware of what most of us would consider common safety concerns such as stranger danger, crossing the street safely, et cetera. Joey's mom would like Joey to live on his own, but she is concerned that he cannot seem to keep a schedule and needs some job training. Joey really wants to work in a retail setting stocking shelves. Mom thinks he could do it with the proper training, but he is going to need some assistance. At school, the IEP team keeps offering Joey job training, but they have only offered him training to do janitorial work or food service. He has no interest in either of those vocations. Joey's mom feels that he could be successful living on his own, but he may need help periodically throughout his life.

This is just one example of a myriad of possibilities of children, youth, and adults who currently have needs and could be served by the regional centers but who are not served. Joey's IQ is slightly higher than what is considered an intellectual disability; however, under the language that is proposed, he would be able to be served in a manner that could work for him. Things his mom would like to see would be job training, a living situation where someone could come in and help him with scheduling his daily activities such as personal hygiene and household tasks. She would also like to see him get training for a job he would be interested in and would be able to excel at. This bill seeks to ensure that persons with disabilities who have long-term, support-service needs will be served in a community-based setting, and that families can be assured that their loved ones are prepared to live and work in the communities they live in with as much or as little support as is needed. All persons with disabilities deserve the ability to have the level of support they need in order to achieve success in living and working independently in the community. As mom of an individual with a disability, I understand the fear of how my child is going to navigate the community; wondering how he will gain all the skills he needs in order to hold a job and enjoy all the benefits of living on his own. Some of our kids have more long-term support needs, but that does not negate their ability or their desire to live and work in their community. However, that ability could be hindered without access to additional supports. This bill seeks to ensure that those supports are there for those who need them. Without supports, families run the risk of caregiver burnout, but the people themselves often end up excluded and isolated from their communities, friends, and neighbors. They have a lower quality of life and poor health outcomes which oftentimes lead to more frequent and costly trips to the emergency room and, potentially, homelessness or institutionalization.

With your permission, I will go through Assembly Bill 224 and lead with the conceptual amendment that was submitted yesterday (Exhibit J). When the bill was originally drafted, we felt it was important to use recognized language to define the population, and we were using language that fits within the *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition and the World Health Organization's International Classification of Diseases. In both of those recognized resources, the term intellectual disabilities fell under the term developmental disabilities. The Aging and Disability Services Division (ADSD) was uncomfortable with that language. They believe it may limit access to services for individuals with intellectual disabilities, and our intent was absolutely not to limit but to ensure those who needed long-term support services had access to those services. After many discussions with ADSD, a conceptual amendment has been submitted which amends the term "intellectual disability" back in and further defines "developmental disability" in Nevada.

There were concerns that the definition that was originally proposed was too broad. The conceptual amendment was a compromise that we believe will fulfill the intent of the original language. Throughout the bill you will see the deletion of the term "and persons with related conditions" which is substituted with the term "developmental disabilities," which is defined in section 17 of the bill. Under the conceptual amendment, section 17 of the bill will also define intellectual and developmental disability center as an organized program for providing appropriate services and treatment to persons with intellectual and developmental disabilities. Throughout the bill, anywhere that intellectual disabilities center was removed, we have replaced that with intellectual and disability center.

In section 45 of the bill, language has been added that matches some of the language in the federal Workforce Innovations and Opportunities Act (WIOA), which provides that students who are transitioning from school to adulthood have the opportunity to be provided training for competitive, integrative employment. This section of the bill serves to codify WIOA into Nevada statute. Any of you who have read the Guinn Center's report "Pathways to Nowhere: Post-Secondary Transitions for Students With Disabilities in Nevada" will recognize the importance of recognizing WIOA and making sure we are providing a pathway to somewhere for our students with disabilities. This bill is really about updating antiquated language and making sure that we are serving people based on need and not picking and choosing who is going to get help and who is not based on an IQ or the name of the condition.

Assemblyman Carrillo:
We worked with a lot of stakeholders on this and have come to the table many times with the conceptual amendment. There was one last change that we needed to ensure that 99 percent of the stakeholders were on board with the bill. We tried to do all this beforehand, so we are not having to deal with this in Committee.

Chairman Sprinkle:
I appreciate that. One of the biggest concerns I had was addressed by this conceptual amendment. Committee, any questions? [There were none.] Anyone here in support of A.B. 224, please come forward.

Denise Tanata, Executive Director, Children's Advocacy Alliance:
We are 100 percent in support of this bill with the amendments that were presented today, and we thank Assemblyman Carrillo for bringing it forward.

Erik Jimenez, representing United Cerebral Palsy of Nevada:
We have been working diligently with Assemblyman Carrillo so far on this, and we look forward to seeing what that amendment comes out to be. In concept, we are supportive and thank him for his leadership on this issue.

Chairman Sprinkle:
Is there anyone else in support? [There was no one.] Anyone in opposition to A.B. 224, please come forward.

Shirley Campbell, Private Citizen, Las Vegas, Nevada:
I am a parent of a developmentally disabled adult. As I was reading over the different information on this bill, it is great to change the wording so more kids are included in it, because a lot of times they do not have a diagnosis at the beginning. With my son, they did not have a title until he was 28 years old, but he definitely had some problems.

I think this bill is good for a few—giving them the opportunity when they get out of high school to see what they could possibly do, and that would be great. However, there are a lot of adults who fall through that crack. When my son was 27 or 24 years old, or in that range, he went over to vocational rehabilitation. After two weeks of getting minimum wage, they said that he could not read or write and was unemployable in the community. Also, he could not stay on task because he was hyperactive. In the past 20 years, he has worked at Palace Station, Sears, Tony Roma's, and Red Lobster. On all of these jobs, there was someone who worked with him—helping him stay on task. He has been able to sustain a job for 20 years now.

By hiring people just by minimum wage, I think a lot of kids are not going to be able to have jobs to earn minimum wage. They would have to do that minimum-wage job, stay on task, and there are so many who would not be able to do that. In turn, they would be left out and left at home, which means that their parents cannot work. I think that for the state it would probably be five times more expensive making this minimum-wage law effective. As far as it goes, within the last 20 years, my son—except for those two weeks, the only time he earned minimum wage—has always worked. At the age of 43, he chooses to be in a resource center. Working out in the community has been too stressful for him. If it was not for the resource centers and workshops that pay below minimum wage, he would not be doing anything. This is one of the reasons why I am totally against pressing the fact of minimum wage, because there will be so many clients, children, who are going to be sitting at home, looking at those four walls when they could be doing something.

Judith Koller, Private Citizen, Las Vegas, Nevada:
I have two sons who are developmentally disabled. One just turned 50 and one is 46. Over the years, the oldest one has had many jobs trying to stay in the community. At one time, he could; now, at his age, he cannot. He was fired from Burger King because he cannot do anything but pick up the trash. He cannot take orders, he cannot take money, he cannot use the cash register, so they let him go. James, my younger son, has been hired and fired for the same things, and right now they are both working at Opportunity Village. They work hard; they love it, and they could not, cannot, and will not work in the community any more. Without Opportunity Village, they would be home with me. I could not be here testifying; I could not be working; I could not be doing anything, so I am really against this legislation.

Chairman Sprinkle:
Thank you for your comments. Is there anyone else in southern Nevada wishing to come up in opposition to A.B. 224?

Edward Guthrie, Chief Executive Officer Emeritus, Opportunity Village, Las Vegas, Nevada:
We sent you some prepared testimony last night (Exhibit K). We have not seen the conceptual amendments that have been proposed, so we really cannot speak to those now. As the two parents who were here today were saying, there are a number of people who will not be able to meet the productivity requirements of jobs, even with reasonable accommodations, and those people are the people who are served in our facility-based

programs in Opportunity Village. Opportunity Village is on track to place 55 people in community-based employment this year at or above minimum wage. Last year, we placed 60 people in community-based employment at or above minimum wage. We believe in community-based employment.

I also want to let you know that no matter what laws are passed, no matter what regulations are imposed, you will not get a change in the system unless you have some rates that allow people to provide the services you want provided. During the interim, I had the chance to meet with Assemblyman Oscarson, and I showed him some information that came from the state of Oregon that has rules similar to the ones being suggested here for Nevada. The rates in the state of Oregon are 40 percent higher than the rates for similar services in the state of Nevada. You cannot ask for a Harvard education and only be willing to pay community college tuition. You have to be able to pay what is needed to provide the services; otherwise, any regulation you impose will simply deny people services and not allow us to expand those services.

Chairman Sprinkle:
Thank you for your comments. Is there anyone else in southern Nevada in opposition? I am not seeing anyone. Is there anyone in the north? [There was no one.] We will move on to neutral. Is there anyone wishing to come up in neutral to this bill?

Brian M. Patchett, Chief Executive Officer/President, Easterseals Nevada:
I really like some of the language I heard today about including folks with disabilities in the services delivered by the regional centers. Easterseals provides assistance from direct services to information and referral services to about 8,500 people across the state of Nevada. Many of those folks we serve through the regional centers. Given that, and we look at our employment services specifically, the vast majority of those folks are in the community and the majority of those are receiving minimum wage. I understand what Mr. Guthrie said, and that is probably why I am coming forward as neutral. I do appreciate the intent of this bill; I have not been able to read all the language that has been changed. I am concerned that the word "choice" is not in the bill so that families such as the ones who have already presented would be able to have the choice for their sons or daughters or themselves to be employed at minimum wage or something that would at least be an opportunity for them to be in the community. Many years ago, I traveled to Vermont where I expected to see that folks with intellectual developmental disabilities had all been employed in the community. In fact, what I found was that about 35 percent of those were in the community. The rest they claimed were no longer in work opportunities—either community- or facility-based. They were at home without the ability to do anything. In my young life at age 18, I was given the opportunity to be in a sheltered workshop. I was not interested in doing that, but at least at that point I had the choice, so I understand some of those concerns. I would be very willing to support this if I can understand some of the language, and maybe we could see something in the bill about choice.

Edward Ableser, Administrator, Disability and Aging Services Division, Department of Health and Human Services:
The division is neutral on this and has worked diligently with Assemblyman Carrillo on proposed conceptual language that can change the definition of developmental disability. Conceptually the idea of removing other related conditions and inserting developmental disabilities is on par with other progressive states that are doing well-rounded services for the totality of the population. We believe as a division that, with the new definition, this is a population that we can codify in statute and which should be served. We will provide services moving forward to the expansion of that definition with one exception. I call your attention to the notion that visual impairment is currently not being served amongst many of the divisions across the state. While we welcome the idea to expand this to a population that is severely underserved in this state, it will require a fiscal note in order to serve the population that meets the substantial-limitation criteria for visually impaired. My staff is working on that, and once we get the finalized language for the conceptual amendment, we will be proposing that in the money committees for you to consider.

That said, we do believe that the language change is a step in the right direction by codifying developmental disabilities and being explicit in the population which we serve. To the issues regarding minimum wage, that tends to align with some of the federal community-setting rules they are looking at. They are identifying in this bill a population of 25 years and under, so there is a change to the age range. For many of the individuals in the south who I know are concerned about this, that age range might change their opinion on the bill as well.

Amber L. Howell, Director, Washoe County Department of Social Services:
We are supportive of increasing services and making sure the net is wide enough to serve as many people as possible. We do not provide the services at the Washoe County level. That is our state folks, so we have been working closely with them to see what we can do about the fiscal note. Washoe County submitted a fiscal note of $9 million in the first year and $13 million in the second year. The reason we had to submit the fiscal note is that currently Washoe County pays a Medicaid-capped amount to the state in the amount of $1.6 million. We also pay $712,000 a year to Sierra Regional Center. We were looking at what we were currently paying for as a base line and what this would open up for additional populations, so our fiscal note was based on that alone. We are looking forward to the conceptual amendment to see if we can drop that number down quite a bit. I am optimistic that we can. At this point, we are supportive of opening services, but we are fiscally cautious.

Chairman Sprinkle:
Is there anyone else in neutral? [There was no one.] Assemblyman Carrillo, do you have any last remarks?

Assemblyman Carrillo:
Committee members, thank you very much for indulging A.B. 224, and we look forward to any more questions or conversations we need to have. We will make it happen.

Chairman Sprinkle:
Thank you. It does sound as though you have worked with some people, but there may be others who have not reached out to you yet. I would strongly recommend that they contact you to work on this bill. We will close the hearing on A.B. 224 and open it up again for public comment. Does anyone wish to come forward under public comment for a second time? [There was no one.] We will close public comment. We are adjourned [at 2:41 p.m.].

RESPECTFULLY SUBMITTED:

Terry Horgan
Committee Secretary

APPROVED BY:

Assemblyman Michael C. Sprinkle, Chairman

DATE:

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a proposed amendment to Assembly Bill 156 provided by Assemblyman Steve Yeager, Assembly District No. 9.

Exhibit D is written testimony by JoAnna Strother, Regional Director of Public Policy, American Lung Association, read into the record by Jessica Lamb, Policy Manager-Health, Children's Advocacy Alliance, in support of Assembly Bill 156.

Exhibit E is written testimony dated March 13, 2017, submitted by Bobbi Shanks, School Nurse Coordinator, Elko County School District, in support of Assembly Bill 156.

Exhibit F is written testimony submitted by Caroline Moassessi, Private Citizen, Reno, Nevada, in support of Assembly Bill 156.

Exhibit G is a Health Policy Brief titled "Emergency Albuterol Inhalers 2017" submitted by Jared Busker, Policy Analyst, Children's Advocacy Alliance, in support of Assembly Bill 156.

Exhibit H is a cost comparison of various albuterol inhalers and spacers/holding chambers submitted by Jared Busker, Policy Analyst, Children's Advocacy Alliance, in support of Assembly Bill 156.

Exhibit I is written testimony dated March 13, 2017, submitted by Debbie Pontius, Health Services Coordinator, Pershing County School District, in support of Assembly Bill 156.

Exhibit J is a conceptual amendment to Assembly Bill 224 dated March 15, 2017, submitted by Assemblyman Richard Carrillo, Assembly District No. 18.

Exhibit K is written testimony submitted by Edward Guthrie, Chief Executive Officer Emeritus, Opportunity Village, Las Vegas, Nevada, in opposition to Assembly Bill 224.