MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Eightieth Session
May 13, 2019

The Senate Committee on Health and Human Services was called to order by Chair Julia Ratti at 3:06 p.m. on Monday, May 13, 2019, in Room 2135 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412E of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Julia Ratti, Chair
Senator Pat Spearman, Vice Chair
Senator Joyce Woodhouse
Senator Joseph P. Hardy
Senator Scott Hammond

GUEST LEGISLATORS PRESENT:

Assemblywoman Shea Backus, Assembly District No. 37
Assemblywoman Maggie Carlton, Assembly District No. 14
Assemblywoman Dina Neal, Assembly District No. 7

STAFF MEMBERS PRESENT:

Megan Comlossy, Committee Policy Analyst
Eric Robbins, Committee Counsel
Vickie Polzien, Committee Secretary

OTHERS PRESENT:

Nik F. Abdul-Rashid, M.D., Director, Sickle Cell Disease Program; Cure 4 The Kids Foundation
Gina Glass, Executive Director, Dreamsickle Kids Foundation
Pam White, Adult Sickle Cell Foundation, Inc.
Deonnte Covington
Jayson Barnes

Sondra Williams
Linetta Barnes, President, Sickled Not Broken Foundation of NV
Tina Dortch, Program Manager, Office of Minority Health and Equity, Department of Health and Human Services
Joanna Jacob, Dignity Health-St. Rose Dominican
Tom Clark, Nevada Association of Health Plans
Richard Whitley, Director, Department of Health and Human Services
Bobbette Bond, Culinary Health Fund
Maya Holmes, Culinary Health Fund
Stacie Sasso, Health Services Coalition
Rusty McAllister, Nevada State AFL-CIO
Jim Sullivan, Culinary Union
Marcia Turner, Chief Administrative Officer, University Medical Center
Alfredo Alonso, UnitedHealth Group Inc.
Nick Vassiliadis, Anthem Blue Cross and Blue Shield Healthcare Solutions
Ross E. Armstrong, Administrator, Division of Child and Family Services, Department of Health and Human Services
Kathryn Roose, Deputy Administrator, Division of Child and Family Services, Department of Health and Human Services

CHAIR RATTI:
The meeting is now open, and I am requesting Committee introduction of Bill Draft Request (BDR) 40-1221.

BILL DRAFT REQUEST 40-1221: Creates the Patient Protection Commission. (Later introduced as Senate Bill 544.)

SENATOR WOODHOUSE MOVED TO INTRODUCE BDR 40-1221.

SENATOR SPEARMAN SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR RATTI:
I will open the work session on Assembly Bill (A.B.) 76.

ASSEMBLY BILL 76 (2nd Reprint): Revises provisions relating to regional behavioral health policy boards. (BDR 39-470)

MEGAN COMLOSSY (Committee Policy Analyst):
I will read the summary of the bill and amendments from the work session document (Exhibit C).

CHAIR RATTI:
I will accept a motion on A.B. 76.

> SENATOR HARDY MOVED TO AMEND AND DO PASS AS AMENDED A.B. 76.
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> SENATOR SPEARMAN SECONDED THE MOTION.
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> THE MOTION CARRIED UNANIMOUSLY.

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CHAIR RATTI:
I will open the work session on A.B. 129.

ASSEMBLY BILL 129 (2nd Reprint): Requires certain first responders to receive certain training concerning persons with developmental disabilities. (BDR 40-157)

MS. COMLOSSY:
I will read the summary of the bill and amendments from the work session document (Exhibit D).

CHAIR RATTI:
I will accept a motion on A.B. 129.

> SENATOR HARDY MOVED TO AMEND AND DO PASS AS AMENDED A.B. 129.
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> SENATOR WOODHOUSE SECONDED THE MOTION.
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> THE MOTION CARRIED UNANIMOUSLY.

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CHAIR RATTI:
I will open the hearing on A.B. 254.

ASSEMBLY BILL 254 (1st Reprint): Revises provisions relating to sickle cell disease and its variants. (BDR 40-20)

ASSEMBLYWOMAN DINA NEAL (Assembly District No. 7):
I am here today to present A.B. 254 for your consideration, which is a comprehensive bill on sickle cell disease. In Nevada, and I believe nationally, sickle cell has been a disease that has not necessarily been on the high list of attention. It has also not been on the list in terms of prescriptions, ensuring these particular patients find advancement in treatment and become a priority.

Many people do not know what sickle cell disease is. Sickle cell trait is an inherited condition affecting the hemoglobin in the red blood cells and is considered to be mild. However, hemoglobin is the iron-containing protein which transports oxygen in the red blood cells to the rest of the body. The sickle cell trait is considered to be a carrier state, meaning an individual can never develop the sickle cell disease, but can have children who will develop the trait.

Sickle cell is a blood cell condition where an individual inherits two abnormal hemoglobin genes. The mutation in this gene results in abnormal hemoglobin protein leading to the distortion of the red blood cells from a round shape to a crescent or sickle shape. This sickle cell shape moves through the blood causing anemia and obstructing the blood vessels, leading to recurring episodes of severe pain and multiple organ damage.

I am attempting to get an understanding on why this particular population, as small as it is in Nevada, is being affected and why I am bringing a bill to deal with the comprehensive care and study of these patients.

In Nevada, the majority of sickle cell patients are on Medicaid. According to the tables from the Office of Analytics with the Department of Health and Human Services (DHHS) (Exhibit E and Exhibit F), the total number of patients diagnosed with sickle cell disorder in 2016 and 2017 was about 1,211 patients. This is a very small population, but a population that has a great need for consistent care. When these patients go to the hospital, their disease is not being appropriately treated. Although they come in with pain issues, on the surface they do not appear to be having a pain management episode when, in fact, they are having a severe pain management episode requiring assistance and medication.

This bill is an attempt to remedy some of the issues I learned about over the Interim, and a representation of the conversations I had during that time. There is a Pacific Sickle Cell Regional Collaborative of nine or ten sickle cell states in the west that includes Nevada, Oregon and California. During the Interim, I had a chance to meet with several patients, as well as Sheila James with the U.S. Department of Health and Human Services. She spoke about how the federal government is now making this a priority in an attempt to move the needle around regional care and planning for sickle cell patients.

Assembly Bill 254 section 4.5 gives the definition of sickle cell disease.

Section 6 of the bill would "establish and maintain a system for the reporting of information on sickle cell disease and its variants". This would be similar to the Nevada Central Cancer Registry by creating a sickle cell registry. The reason for the mention of variants is that there can be other traits that are a spin-off, and other diseases which manifest from sickle cell disease.

Section 7 lays out the form and manner in which information should be included in the database, such as the name, address, age and ethnicity of the patient.

Section 8 states the records of the health care facility for each case shall be made available to the Chief Medical Officer and that the Division of Public and Behavioral Health (DPBH) of the DHHS will abstract the information to be compiled from the records of a health care facility.

Section 9 states the information compiled must be published.

Section 10 states the Chief Medical Officer or qualified person shall do analysis on the information. Section 10.5 allows the DPBH to apply for any grants, donations or gifts. This is due to a federal bill which passed out of Congress in December 2018, which allowed surveillance projects and states' participation in federal grants around sickle cell disease.

The Centers for Disease Control and Prevention (CDC) has been running a surveillance project in California and Georgia. There is potential for that to expand into other states to take a proactive approach to sickle cell disease.

Section 11 of the bill deals with the privacy and confidentiality of the information collected.

Section 12 states a person or governmental entity providing information to the DPBH must not be held liable in a civil or criminal action for sharing confidential information unless done in bad faith.

Section 13 states the DPBH may adopt regulations around the variants of sickle cell traits and requires them, when necessary, to determine the presence of certain preventable diseases. This section is important for the parent to gain understanding of the disease, and help in the process and treatment of the disease.

We have been performing sickle cell testing on patients in Nevada since the early 1990s; however, what does not happen is the testing of the parents of a child with sickle cell. Typically, the parent is left with trying to figure out where their child got the sickle cell trait. This led to conversations around ensuring the parent is also tested should the parent choose to do so.

Section 13.5 lays out the services required of a laboratory, which ties into the screening of the parent.

Section 18.2 is the portion of the bill stating "The Director shall include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures". I have spoken with the DHHS and, as it is such a small population, they felt they could absorb the cost.

This section also discusses case management services for a participant under the age of 18 covered by Medicaid who has been diagnosed with sickle cell. These services were not being followed. A child could have pediatric care at the "one" service actually caring for sickle cell patients in southern Nevada. Within their case management, there is no follow through with pain episodes, prescriptions or when they transition from pediatric to adult care. This provision is attempting to focus on case management, visits to specialists, treatment for mental illness and education as needed. It was important for myself and the group to ensure all the variants of the disease were centered on evaluation, counseling and education involved in case management.

A patient is more in a position to know about their disease versus the provider taking care of them. There is an idea to fill in the gap ensuring the providers, hospitals and anyone who encounters these patients, become more aware of the health plan following the patient; that there are services that should be provided when needed.

Section 18 also includes that in the State Plan for Medicaid, the Director shall include a requirement that the State pay the nonfederal share of expenditures for at least two visits per clinical year, and unlimited refills for each prescription drug for the treatment of the disease. The reason for this is because the patients were finding themselves in pain management episodes being treated as a person abusing opioids or other prescription drugs. This was mainly happening due to the lack of knowledge in the hospital emergency room, and patients were being misdiagnosed. Physicians need to be able to manage patient refills in a way that allows them to reduce emergency periods, be eligible to prescribe medications and take care of patient pain episodes as needed. There is no determining when you will have a pain episode; you cannot say every six months or even every two weeks.

Dr. Abdul-Rashid, whose primary basis is caring for sickle cell patients in the pediatric realm, has said a child with sickle cell would need extra supplements not covered by Medicaid. I emailed Medicaid in an attempt to find out how to get PediaSure covered. Because these patients are on Medicaid, and part of the low-income families, they sometimes find themselves without the money for PediaSure, but possibly the money for the prescriptions they require. Section 18.5 is providing for a list of nonprescription supplements to be covered by Medicaid.

Section 18.4 ensures sickle cell and its variants has the meaning as described in section 4.5 of the bill. We are attempting to ensure the Pharmacy and Therapeutics Committee could internally review what supplements and prescriptions are needed for these patients to determine going forward what is necessary for these patients.

Section 18.8, subsection 4 is to ensure, within the formulary for Medicaid, there is a list of prescription drugs to be determined essential for treating sickle cell disease and its variants. There are drugs from pharmaceutical companies that patients may be eligible for, other than hydroxyurea that may potentially come into the market in 2021-2022. We know that since the federal government has begun to move in the sickle cell space, there has been more interest by the pharmaceutical companies to produce a new drug other than hydroxyurea, and progress beyond this drug.

Anecdotally, I have heard sickle cell patients are more than likely the only disease group that has been without actual movement toward advancement in medical care in the last 10 to 20 years. This bill will help to correct that.

Section 18.9 deals with how prescriptions for controlled substances such as opioids should be handled.

Sections 19 through 29 speak to the issuance of health care policies covered under *Nevada Revised Statutes* (NRS) 689A, 689A.330, 689B, 689C, 689C.425, 695A, 695B, 695C, 695C.050, 695C.330 and 695G related to individual health plans for patients under 18 years of age diagnosed with sickle cell and its variants. These sections will ensure they have the same case management services and medically necessary services provided during at least two visits per year and coverage for prescription drugs.

It is also important that we have a care model for patients transitioning from pediatric care to adult care when the patient reaches 18 years of age. There is currently no transition of care and when the patient reaches 18 they are without a provider. The patient would continue with their pediatric provider who would take on the task of finding the patient a new provider.

I ascertained the individual health plans that are not Medicaid plans have almost zero to one patients that have sickle cell disease. I have guests in Las Vegas that I am sure can testify to the numbers. The majority of the patients are Medicaid patients and do not fall under the private insurers, or there is a very small number who are now receiving case management services.

SENATOR HARDY:
This is a wonderful bill. If we give nonsteroidal anti-inflammatory drugs such as Advil and Aleve to a patient who is in sickle cell crisis, it will damage their kidneys causing acute renal failure and death will happen, which is unacceptable. I am heartened to hear your reference to opioids as this is the drug of choice and the one they must have for their pain.

SENATOR SPEARMAN:
Are there protocols to ensure there is cybersecurity for the database? Something happening more often than not is the health care industry is being targeted for security breaches.

I currently have S.B. 470 relating to cultural competency which may be related to what you spoke to in reference to the first sections of the bill, ensuring people are able to accurately make a diagnosis.

SENATE BILL 470: Revises provisions relating to health care. (BDR 40-785)

ASSEMBLYWOMAN NEAL:
The only provisions dealing with privacy, confidentiality or liability, are sections 11 and 12 of the bill. There are provisions for consent and being held civilly and criminally liable for sharing confidential information. We did not deal with whether or not information was going to be leaked or taken from the system. I thought that if other provisions intersect and applied to Medicaid, it would all roll over.

Education is a huge factor related to this bill and why it is inserted into the bill. There is a lack of education just in terms of the disease. Having a comprehensive discussion about case management with the health management organizations and providers forces the conversation around case management, which is the conversation between the patient and the physician.

Currently, in southern Nevada, one provider Dr. Abdul-Rashid, is being the advocate for each one of her patients, ensuring she follows up with her patients having these conversations. Anthem came to the table and was able to implement a number of the items referenced in this bill. There was a question of how they could do it without the financial cost. We discovered having the conversation with providers to explain the barriers for the patient, and how and when they were being lost in the system, helped them to internally change the manner in which they serve the sickle cell patient.

The medically necessary language that the firefighters asked for was added from the Assembly side. They currently have employees with sickle cell disease who are being treated with step therapy. They wanted to ensure they could continue their step therapy within their existing plan of care. I adopted that amendment to meet the needs of what patients felt they needed to navigate the conversation around the needs of the sickle cell patient.

SENATOR HARDY:
The health information exchange, or database of information, will be very helpful to identify those diagnosed with sickle cell so information will be accessible through medical records.

ASSEMBLYWOMAN NEAL:
I have guests in Las Vegas who were a part of the conversations about this bill. We met several times regarding the amendments and ensuring this bill met their needs.

NIK F. ABDUL-RASHID, M.D. (Director, Sickle Cell Disease Program; Cure 4 The Kids Foundation)
For the record, I would like to state that the managed care company Assemblywoman Neal mentioned earlier was actually UnitedHealthcare rather than Anthem.

I have been working closely on this bill with Assemblywoman Neal. I fully support A.B. 254 as I deal with these patients and their families on a daily basis and have been fighting to ensure they receive the care they need. This care includes receiving the correct medication they are unable to get because of coverage or having the medication compounded for younger patients. It will also ensure all patients from birth to adulthood receive the care they require in the clinics and the hospitals. We are hoping with good managed care for these patients, we can continue to make sure they stay healthy and live a long life.

GINA GLASS (Executive Director, Dreamsickle Kids Foundation):
I am the mother of a four-year-old with sickle cell disease. I am also the founder of the first sickle cell organization in Nevada. I am in support of A.B. 254. I met Assemblywoman Dina Neal last year and have been a great supporter of all things sickle cell since then.

Assembly Bill 254 would mandate the collection of data and screening for all variations of sickle cell disease and the sickle cell trait. It would also mandate Medicaid provide coverage for medications regardless of composition and comprehensive care that people with sickle cell disease require.

The absence of legislation requiring the tracking and screening of sickle cell disease in Nevada has led to substandard care for those with sickle cell disease.

It has recently led to the death of a mother and wife who had the disease and was improperly treated at a Las Vegas hospital.

States that lack protection for people who suffer from this rare disease leave room for unnecessary deaths and malpractice. The last data collected on the sickle cell population in Nevada was in 2007 from the CDC.

This bill is important because it addresses the compounding of medication. Hydroxyurea is currently only available in capsule form. My daughter can only take medication in a liquid form. Right now, insurance applies an additional charge to have the medication liquefied. Since I am not a medical professional, I do not feel comfortable sprinkling a capsule over her food or into a drink for her. Consequently, she does not take this medication which could help her better manage her disease and lead to a better life for her.

When we moved from California, it became evident there was a lack of awareness in the community and in the medical field when it came to sickle cell disease. I worked for a large company who stated they had never heard of the disease. I was their first employee dealing with sickle cell disease. When my daughter got ill and I would have to take time off from work, it was not looked at as compassionately as someone with cancer or other issues and I was terminated for missing time away from my job. When you see my daughter, she does not look sick, which is common with those dealing with sickle cell. They often do not look as ill as what is affecting them internally as it is not visible on the outside.

This bill would help address some of the barriers those with sickle cell disease experience. It is not just the person with sickle cell; it is their families and loved ones that are also affected by the disease.

This year, there is an opportunity for Nevada to make changes to address the misfortune that has fallen upon people with sickle cell disease. There is still a need for disparities that people with sickle cell disease face to be addressed locally.

I firmly believe, as a citizen of Nevada and an advocate for all impacted by sickle cell disease, that A.B. 254 is the foundation needed to ensure the needs of minorities with a rare disease such as sickle cell are accounted for in Nevada.

PAM WHITE (Adult Sickle Cell Foundation, Inc.):
I am the founder of the Adult Sickle Cell Foundation, Inc. and the mother of two children with sickle cell disease; one is 19 and the other is 40 years old.

Assembly Bill 254 will be beneficial and supportive to the sickle cell population as a whole. There are many good points to the bill, such as newborn screening, surveillance, confidential collection of data and nonprescription supplements, as well as the case management that is needed.

This is a debilitating disease that can affect the heart, the liver and kidneys, and can also cause strokes. Even though there might be a small population in Las Vegas, there are over 100,000 people who deal with sickle cell disease.

DEONNTE COVINGTON:
My sister Ms. Glass spoke previously. I moved here from Los Angeles, California. My niece is four years old and has sickle cell disease. It is not easy to understand the causes and pain crises experienced by those with sickle cell. When my niece has a crisis, she complains of back pain, stomach pain, and she is not able to eat. This is emotional for me. There are peoples' lives at stake, young people losing their lives not being able to experience a full life.

Supporting A.B. 254 is very important to me and others, as not many people know about sickle cell disease. To bring awareness is important, as not many medical providers know the proper procedures to treat situations in the emergency room. Some patients do not know how to take care of themselves or know the proper procedures, medications or supplements they need to manage their disease and stay healthy. This bill is important to those patients and their families.

JAYSON BARNES:
I have sickle cell anemia and it is sometimes hard to do the activities that other children can because I have so many complications of sickle cell. When I go to school, I sometimes feel left out because no one likes me. I once had an incident with a teacher when I asked to see the nurse. She made me upset and sad when she told me I always had problems because I hurt a lot. I have to get through it because this disease is not going to go away. I am going to do my best with this disease and hope this bill passes.

SONDRA WILLIAMS:
I am 40 years old and have sickle cell disease. It has been difficult living with this disease. As the young man before me said, school is something that is hard to go through as a child, as teachers do not understand. In the nurse's office, they have very little understanding of the patients with sickle cell so you are not treated very well. At the hospitals, transition is even more difficult when you are older. I have a physician who understands; however, there is only one facility in Las Vegas for adults with sickle cell disease.

When you go to the emergency room, they treat you as if you are seeking drugs. You do not get treated like a patient coming in with pain because they do not see the pain. Your vital signs do not show the pain so they do not want to attend to you. I support A.B. 254 as it is needed right now.

LINETTA BARNES (President, Sickled Not Broken Foundation of NV):
I support A.B. 254 and have submitted written testimony (Exhibit G). I have also provided a handout labeled "Sickle Cell Disease Health Disparities" that provides information about a limited number of educated providers who feel comfortable treating sickle cell, as well as a high rate of return to hospitals. I also provided a document that covers the transition of age 18 to adulthood. Patients themselves do not know a lot about their disease and neither do the health care providers. Therefore, they have higher rates of emergency room visits and deaths.

I am a health care provider and listen daily to the stigmas and misunderstandings related to sickle cell anemia and attempt to give guidance to those in crisis. I work with a nurse who works on a transition team. She thanked me for allowing her to work with sickle cell families, as she was one who thought they were all drug seekers because another doctor told her that, and the patient looked like that was the case.

I am hoping this bill will help to limit the number of deaths related to sickle cell disease due to a treatable complication, and that prescriptions can be filled without complication. We need our teenagers to become adults and live long healthy lives.

TINA DORTCH (Program Manager, Office of Minority Health and Equity, Department of Health and Human Services):
The Nevada Office of Minority Health and Equity supports A.B. 254. I will read from my written testimony (Exhibit H).

JOANNA JACOB (Dignity Health-St. Rose Dominican):
Dignity Health-St. Rose Dominican supports A.B. 254. Chief Medical Officer Dr. Chike Nzerue, who is the parent of a child with the disease, testified in the Assembly hearing on this bill, along with families affected by sickle cell disease. He was contacted by some of the members involved in the grassroots efforts about care in the Dignity Health-St. Rose Dominican hospitals. We are glad we were able to meet with some of the patients' families. I wanted to put on the record that Dr. Nzerue, at our highest level of leadership in the hospital, has taken this very seriously. We are educating our emergency room doctors and the people who staff our emergency rooms within our facility, about the barriers the patients have experienced and how we can improve.

Because of our mission and values about dignity, justice, collaboration and stewardship we wanted to signal to the patients that they have our support and ongoing partnership to help work on efforts to improve care in southern Nevada.

Dr. Nzerue has submitted his written testimony in support of A.B. 254 (Exhibit I).

TOM CLARK (Nevada Association of Health Plans):
I reluctantly rise in opposition to A.B. 254. We worked with the bill sponsor when it was in the Assembly. I did have some minor clean-up language, but in Assemblywoman Neal's testimony, she addressed most of that language. We will continue to work with her to ensure the intent is there. This is a horrific disease. As an industry, we want to make sure all medically necessary issues are addressed so these patients get the treatment they deserve.

CHAIR RATTI:
If this clean-up language was included, would you change your opposition to support?

MR. CLARK:
If the language is consistent with what we have and is added to the bill, we will be in support.

SENATOR SPEARMAN:
Is the language you said needs to be cleaned up so egregious that you could not support the bill as written?

MR. CLARK:
It is more about following the rules of the Committee because we have suggested changes to the actual language of the bill that we rise in opposition. We are confident in working with Assemblywoman Neal that these changes have been made. We would then rise in support of the bill.

It was brought up that your bill, with medical facilities understanding the cultural effects of diseases like this, is going to go a long way toward that effort.

CHAIR RATTI:
I will close the hearing on A.B. 254 and open the hearing on A.B. 317.

ASSEMBLY BILL 317 (1st Reprint): Revises provisions governing the licensing and operation of certain medical facilities. (BDR 40-1034)

ASSEMBLYWOMAN MAGGIE CARLTON (Assembly District No. 14):
I am here today to present A.B. 317 for your consideration and will be working from the Proposed Amendment 5880 (Exhibit J) as I go over the bill.

This bill deals with two general concepts. We were thrilled to hear the Governor did include the Bureau of Consumer Protection in his budget. We know that in Nevada, we have been talking anecdotally in the Legislature about the issues with health care. It has been difficult to get actual data, and we have had to decide on bills on the basis of sometimes insufficient information. Nevada has gotten a lot better in this respect, and I believe with the help of the Bureau and the unique identifier, we will be able to get the information we need when we look at the cost of health care.

I found the Legislative Declaration from Colorado was so similar to what we are attempting with this bill that I felt I could use it as an example when writing this bill. We do want more accountability and transparency in our health care system. Being able to look at cost is very important for customers in order for them to make very tough health care decisions.

Having the National Provider Identifier (NPI) proposed in this bill would generate the necessary information, perhaps including the cost associated with seeking those services. The language is geared toward the off-campus locations, or what we have been calling the free-standing emergency rooms. It has been noticed that often these off-campus locations use the same NPI for billing purposes as the affiliated hospital or organization they belong to. Being able to have a distinct NPI for each one of those off-campus facilities would give the Bureau, this Committee and others interested in this issue, real data on what is actually happening. The bill would require all off-campus facilities to get this unique NPI.

It was brought to my attention there are other services being done off-campus; therefore, the language was changed resulting in the Proposed Amendment.

In Section 1.2, subsection 2, paragraph (b), subparagraph (4) of the amendment we are deleting from line 22, "preventive, diagnostic, treatment". We do not need every lab and radiologist to get the NPI. We are looking more for those off-campus facilities. It is focused on ambulatory, surgery, urgent care and emergency room services; we are not talking about blood draws or other services.

One concern related to the Southern Nevada Health District is not making decisions regarding trauma designation based on adequate community needs assessments. In 2005, trauma designation moved from the State to Clark County. We thought taking it to the local counties was a better option at the time. I believe we need to bring the State back in again to ensure that shortage areas are adequately identified and developed according to a two-tier evaluation process.

The language in Section 8 of the bill proposes the American College of Surgeons Needs-Based Assessment of Trauma Systems (NBATS) should be applied to evaluate whether trauma designation should be granted to any applicant. However, this would only be a small portion of the two-tier process this bill envisions. It would concern the initial evaluation of the applications hospitals would submit to the State, while researching how the needs assessments envisioned by the language would be conducted.

We looked at the American College of Surgeons NBATS and read some of the minutes of the meetings they had. It became apparent their goal was to produce a pragmatic and relatively simple tool that could be applied to the data that is currently available. The tool was constructed to aid the assessment of the number of trauma centers needed in a specific geographical region called a trauma services area. This is the key part that I was not thoroughly aware of until I learned more about it.

The assessment tool is not meant to be the designation tool, and there is a definite difference between the two. The American College of Surgeons trauma needs assessment presumes the need has already been evaluated and that we have established the need on that level. This area could range in size from a small county to a multi-state region. In essence, they would be setting up what we commonly call a health professional shortage area, but it would be related to trauma.

We apply a health professional shortage area variable for things such as federal loan repayment and federally qualified health centers on where they would be located. We also use it for J1 Waiver Job Placement Specialists for Physicians. We currently have a system set up in the context of which we could look at an area and decide whether this is a trauma, or for lack of a better term, a desert or shortage area.

Is there an area in which we really need to place a trauma designation? The State would have the responsibility to look at it and use data to figure out what is needed. If there is a request for a trauma center designation, the State would use this assessment tool as a small portion of it. There are four components that would be considered, and the applicant would bring that to the State. The State would look at it and send it to the Southern Nevada Health District for review.

I have heard concerns about the health district's role in this. Not long ago, there were a number of applications that were placed and not approved. It was then discussed that the Southern Nevada Health District would do a community needs assessment to look at southern Nevada holistically as far as trauma goes. It is now two-and-a-half years later, and that community needs assessment has still not been done.

We currently have trauma applications in the queue. You would think more trauma is better, but that is not necessarily true. You need to have the right level of trauma. There is a difference between trauma designation and an emergency room. There are experts here who can go into more detail and walk you through some of those arguments. It is tough to figure out how trauma designation actually works. It is a fine balancing act making sure there are the right services, in the right place, with the right professionals, for the right level of trauma to ensure patients are taken care of. Those of us who have been through a trauma situation with a loved one know that the "golden hour" is very important. We have heard about heart attacks, strokes and numerous emergencies where that first hour is magical.

The concerns that have been brought to my attention are that in order to address this issue, bringing the designation of trauma areas back to the State level could help resolve some of the problems. To be honest, and putting the facts on the table, this would take local politics out of trauma designation. It does not belong there; this is a health care issue. It allows for a measured, thoughtful and consistent approach to decision making when it comes to designating trauma. We would conduct a Statewide needs assessment, review it and decide what needs to be done. There would also be a Statewide evaluation and Statewide reporting. This Body would be able to go to the State and ask where we are on this, what do we need, where do we go and how we address these issues.

On page 9, line 17 of the amendment, the original version was one year, which was my mistake. In order to do a real evaluation, you would need more data than was compiled. It was suggested to make it a five year look back to get real information. We know how things have grown in southern Nevada, and seen a lot of these free-standing, off-campus hospitals pop up in the last five years. Having the unique NPI number for each facility, we will be able to get a good look at what is going on, figure out where we really need trauma centers, and make sure we put them in the right places. There are numerous levels of trauma designation and then there is an emergency room level.

CHAIR RATTI:
It looks like the county still has a role. Page 9, lines 26 through 27 states how the county whose population is 700,000 or more shall adopt regulations and a plan for a comprehensive trauma system. Do you still see a role for the county?

ASSEMBLYWOMAN CARLTON:
Yes. I believe it should be a two-tier process.

CHAIR RATTI:
What are the State and county processes for a hospital that wants to add a new trauma designation?

RICHARD WHITLEY (Director, Department of Health and Human Services):
I believe, as Assemblywoman Carlton mentioned, the needs assessment would be the role of the State. The conditions in which a need is demonstrated and the local regulation, which would be assessing that request for adding a trauma designation, would come forward. That is how we see it working together. The assessment, the role of the State to determine yes there is a need, or no there is not a need. Then the local jurisdiction would work with the requestor to bring that forward.

CHAIR RATTI:
The State would say we have done the full needs assessment, and in this general area there is a need and this other area there is not a need. Anywhere there is a no, it is a no. Anywhere it is a yes, there could be an applicant coming forward and they would have to see how that applicant fits the need in that yes area. Is that accurate?

MR. WHITLEY:
Currently, that is how it works. The service area is defined. Sometimes people access services that are outside of their zip code. The applicant or person interested would bring forward the area they would be intending to serve. This is where the data would come in handy looking at the number of events occurring in the area, the demographics and the distance to existing centers. Having that laid out in a regular way so everyone has the same information, the facility or hospital could apply for a trauma center using those variables to say there is a shortage area and capture that shortage area. It does work well with primary health care and other designations for health care with the federal government.

CHAIR RATTI:
This is what we are doing today. Would the applicant bring that study and data showing the need for a trauma designation to the county, the State or both?

MR. WHITLEY:
I would see them bringing it forward to the county in which they were wanting to pursue a trauma designation because they have utilized the data available to

them. They may work in concert with the State while they are completing the application. Hopefully, the intent would be that it is a transparent process so the data is available to, and utilized by, everyone. That would be the State's role. The local facility would work with the local emergency medical services and their regulations to bring forward that specific request to add a designation.

The State would do the needs assessment at regular intervals, utilizing all the data to make that available for their request. There is some overlap. You get approval from the State in terms of it qualifying as a shortage area. They may actually want to construct an area that does not fit in a way you would naturally look at it because they are defining the service area. They would work with the local entity to better define the area. They would make their request to them utilizing our data that states it does represent a shortage area, so they are not wasting time applying and waiting until it comes to the State to say it does not meet the criteria. We want the known to be there from the beginning so the application could meet with success when they locally apply. It currently works that way with the federal government for the designation of shortage areas, so it is not a surprise to anyone.

CHAIR RATTI:
They would still need a yes from both the county and the State?

MR. WHITLEY:
That is correct.

SENATOR SPEARMAN:
Is there a time span for the survey or reflection to go to the county or the State?

MR. WHITLEY:
What I would intend to do for the State would be to work with the county and stakeholders to establish the criteria and the needs assessment. We would do it in a regulatory way so all of the variables, wait times and demographics are all available to everyone. The Board of Health meets every other month. Sequentially, the local Board of Health that makes a determination, and the Statewide Board of Health could sync up, and within a two-month period get local and State approval once the needs assessment is completed.

One of the reasons we like regulations is because they are nimble. If there is authority to develop something, we can. It still comes back to the Legislative Commission when we finalize regulations.

SENATOR HARDY:
Does the State define the area where someone would want to open a trauma center? Would someone wanting to open a trauma center, with the same information you mentioned, be able to say a particular area needs a trauma center, or would that be up to the State?

MR. WHITLEY:
In terms of the needs-based assessment, and having the data available and the variables that are looked at, would be a step in that process. You would work locally to say you would like to complete an application for a trauma designation and believe you meet all of the States criteria for distance, demographics and serving unmet needs. The key of the needs-based assessment would be to establish unmet needs in a specific geographical area. However, it may be one that is configured by the facility in terms of serving a specific area because it is an underserved area. That assessment would be done by the State first. The local government would then work with the provider in terms of the capacity of the provider to be that designation and gain local approval. Coming full circle with the State, we would be in sync and approval could be granted.

SENATOR HARDY:
How do the State and local government work together to approve a request and make regulations to open a trauma center in a specific area?

MR. WHITLEY:
It would not be a matter of regulations each time a request is submitted. There would be a set of regulations to determine the variables and data that would be used to designate the need, which would be determined up front. Where I think the variable could be is that locally, a hospital will deliberately want to serve people in a specific area as they have done the analysis and determined that area is underserved. When they apply to the State, they are putting a definition to the geographical area. The State has the data and the ability to say this is a shortage area and meets all of the criteria. I can see that same process working. The State would want regulatory ability to lay that out with the stakeholder so we are all utilizing the same information to determine what unmet need is in a unified way. Much like the federally qualified health centers, I would anticipate

the facility making the request would utilize all of this information and have already done the work to determine the unmet need before moving forward with their request.

SENATOR HARDY:
So the State would not make the map of where the facility would be located as much as these are the areas we would include or could be included. Then the organization that wants to open the trauma center would go to the county and show them the area they want to show has unmet need for a potential trauma center. Is this correct?

MR. WHITLEY:
As a facility, I believe they are saying they are ready to open this center and meet the needs that can be identified. The local government would then assess that they can meet the needs to open the center. That is where I believe the role locally, and that of the State, can complement each other. The establishment of need is the State's role as stated in the bill. The role locally would be to demonstrate the ability to accomplish that.

ASSEMBLYWOMAN CARLTON:
The State doing the needs assessment is key for setting up these trauma service areas. Depending on what that trauma service shortage area looks like, and where that particular entity would want to set up a center, the State through their needs assessment would be able to tell exactly what areas truly need a trauma designation.

Using the unique NPI will give us a better idea of what areas need a trauma designation as we currently use the NPI of the center where the services are being provided. We know a lot of satellite hospitals have been opened. If you looked at the numbers right now, it would look like there is only one hospital, but we know there are a number of small, free-standing emergency rooms within ten miles of that hospital. You would think that would be a good area to put a trauma center; however, you have a number of other facilities there so it would not. We cannot quantify them because there is no unique NPI for each one of them.

The identifier language is important in order to tell where and what services are being provided. We need to know if they are simply an emergency room or a Level II or Level III trauma facility. If there is a Level I trauma and an emergency room, and you are missing that mid-level of care that may be a good spot for that mid-level provider. But if you have two Level II trauma centers and an emergency room, you need a Level I trauma center. You need to look at what level of service is needed in a particular service area.

SENATOR HARDY:
I am looking at this as two different bills. One is about the off-campus location of an "emergency room with 16 beds", and a trauma center which is different than an emergency room.

The second being the "trauma center" as opposed to the emergency room, where you get into the different trauma levels. Are you saying that all of the emergency rooms are also under the same State needs assessment before they put up an emergency room?

MR. WHITLEY:
For data purposes, it is important to know what capacity is in the community. There are emergency rooms that are part of a hospital that are off-campus. Currently, they are counted as that hospital from the address of the licensed hospital. This helps us capture a better understanding of where all services are, and of the landscape of services for emergency response in a community, which does go to an overall understanding of what that community capacity or designated area is.

SENATOR HARDY:
My question would be whether the State is going to decide where there is enough need so the local county or health district can decide where a free-standing emergency room with 16 beds is located. Are we going to get into that or is it just the trauma center you are going to have your fingerprints on?

MR. WHITLEY:
I believe I have my fingerprints on both from a licensure standpoint. For the sake of this bill, this does not intend to determine the designation area, only to collect the data so the unique NPI captures the data. Our statute already allows a regulation authority for us to license off-site facilities. What is not captured is that it is physically off-site. The data is only collected as part of the hospital.

There are two parts to this bill. As described, the first part is existing services so we can accurately understand where they are located. We are not trying to manage that with any more controls. We just want to know where they are. The controls are already in place. The licensed hospital is responsible for the services that occur there. Nothing additional is being done regulatory to that method of delivering services. It is just the trauma piece with the two-step approach.

SENATOR HARDY:
So the trauma piece in this bill is where the State has a "dog in the fight" of where the trauma center will be, as opposed to the free-standing emergency room which could be anywhere they think they can make a living without having to go through this two-tiered system.

MR. WHITLEY:
That is correct.

CHAIR RATTI:
For the record, all of this only applies to data collection in 700,000+ population counties?

MR. WHITLEY:
Yes, that is also my understanding.

BOBBETTE BOND (Culinary Health Fund):
We have been working on the trauma system issues with regard to trauma designation in southern Nevada since the Regional Trauma Advisory Board was created. I wanted to clarify what we think would be an ideal structure based on the legislation that is being proposed.

We are hoping to get this bill passed in a way that would allow the State to do a comprehensive needs assessment as there is a gap there. The State has the capacity to do it; the county was supposed to do it and has not. We have a hole we are attempting to fill.

After that happens, we would like a process to ensure that if there is no need, then there is no designation. If a need is found, if there is a shortage of beds, if there is an area where the transport time is not working, if patients are left with unmet needs, then there would be a determination by the State that there is a capacity problem. Then the county would have the responsibility to figure out how to ensure that capacity is filled.

We would promote the idea that the county would create a request for proposal (RFP) rather than a hospital saying we want to fill this role. We would open it up and let all hospitals have the decision on whether they want to serve that need. Then have it be more of a process where you are looking at solving the capacity problem and what resources are best, rather than waiting for the hospital to put forward a desire that may not meet the State's determination of need.

MAYA HOLMES (Culinary Health Fund):
We have heard about the process and the structure the Culinary Health Fund would like. I would like to talk about why we think this bill is so important. We strongly support A.B. 317 and think the State needs to have a clear and vigorous role in identifying areas where there is a shortage of trauma care in Nevada and assessing the need for trauma expansion.

Unfortunately, what we are seeing in southern Nevada is the opposite of this process. In 2016, the Southern Nevada Health District had three applications for hospitals to add trauma services, which would have doubled the number of trauma centers. At the time, the Southern Nevada Health District and the Board of Health determined there was no unmet need in the community and denied all three applications. They directed the Board to do a community-wide needs assessment.

Now a few years later, we have five applications for trauma centers which could nearly triple the number of trauma centers in the southern Nevada area. The final comprehensive community needs assessment has not been done; it is still a work in process. We think this is a very backward and flawed process.

We find that this bill is important because trauma centers are obviously critical to ensuring the health, safety and well-being of residents and visitors. But a flood of trauma centers that does not rely on a comprehensive needs assessment will only undermine our existing system and drive up health care costs. As Assemblywoman Carlton stated, it is really that fine balance of actually understanding what the need is.

In other states, where there has been a proliferation of trauma centers, the results have threatened existing trauma systems. There has also been plenty of research done showing trauma centers need a certain level of patients to ensure quality patient outcomes. Trauma teams need to treat enough patients to develop and maintain their skills and expertise. Trauma centers also need a certain level of patients to remain financially viable.

The Culinary Health Fund believes A.B. 317 will ensure a comprehensive needs assessment is conducted, and will utilize criteria recommended by the American College of Surgeons. The assessment will be incredibly valuable as it will evaluate the impact of new centers on the existing trauma center so we do not oversaturate the system and ultimately undermine it.

We also support requiring the unique NPI number for off-campus hospital free-standing emergency rooms and urgent cares. As has been stated, this is a critical transparency reporting requirement that other facilities such as hospitals and ambulatory surgery centers are already providing. As payers, this is incredibly important information for us to help direct our members to the most appropriate care. It will also be vital information for the DHHS to analyze health care costs and access in the State.

MR. CLARK:
The Nevada Association of Health Plans supports A.B. 317.

STACIE SASSO (Health Services Coalition):
The Health Services Coalition is in support of regulations around expansion to the trauma system as it sits today. Currently, there is limited ability to carefully manage the expansion around the ability to create or expand trauma centers in Nevada. While additional trauma care sounds like a good idea in theory, it poses risks to the entire State by placing the existing trauma facilities at risk of oversaturation.

More trauma centers does not always mean faster or better care. In many cases, patients may still bypass a facility to access care at a higher level trauma center. There is also concern over the cost of care when a trauma patient is activated. Trauma facilities currently charge up to $50,000 for a single activation. There are no regulations in place to set pricing for activation fees. As a result, unnecessary growth of the trauma system will also result in even higher costs of health care for the patient.

In addition to concerns around oversaturation and cost, there are also limited physicians in Nevada. Expanding trauma centers without proven need may create coverage issues at area hospitals and other established centers. It would be helpful to have a process in place where the State has the ability to review the system as a whole, and review growth based on demonstrated need rather than individualized neighborhoods and hospitals.

The missing step today is a process to determine if there is a shortage capacity in the trauma system prior to asking neighborhood hospitals to apply and be evaluated. When a need is identified, an RFP process should be initiated to determine appropriate facilities to be considered for designation. With no proven need, there should be no applications being reviewed.

Your support of the legislation is critical to protect Nevada's current trauma system.

RUSTY MCALLISTER (Nevada State AFL-CIO):
The Nevada State AFL-CIO supports A.B. 317. A vast majority of the members that belong to our organization are covered by health plans that are either an Employee Retirement Income Security Act plan or nonprofit self-funded plans. We are in support of this legislation and believe it is appropriate to have a needs assessment done in a nonpolitical fashion. The plans we currently have are constantly watching our costs as they are nonprofit plans. There are no shareholders. We are trying to keep our costs down.

If you are transported to an emergency room for a possible fractured hip and that facility is now designated as a trauma a center, it may be up to $50,000 to activate the trauma team. This could be for something you would get treated for in the same fashion regardless of whether it was a trauma center or an emergency room. It would be more appropriate to make sure the need is there; that you are not peeling patients off of hospitals that are already trauma centers. If there is a need based on distance, time, travel or other factors, by all means do it in a controlled and organized fashion as opposed to having five hospitals in southern Nevada submit applications for trauma centers purely as a financial means.

JIM SULLIVAN (Culinary Union):
The Culinary Union supports A.B. 317 for all of the reasons my colleagues at the Culinary Health Fund laid out and would like to thank Assemblywoman Carlton for bringing this bill forward.

MARCIA TURNER (Chief Administrative Officer, University Medical Center):
University Medical Center supports A.B. 317 and appreciates the efforts on the local and State level to help address this issue.

ALFREDO ALONSO (UnitedHealth Group Inc.):
UnitedHealth Group Inc. supports A.B. 317 and we thank Assemblywoman Carlton for her hard work on the bill. Transparency is extremely important for our members. The first section of the bill helps with that goal and identifying who these folks are and how they fit in the overall health care landscape. With respect to trauma, you are creating a system that is going to be more robust with more information and data to help make better decisions.

NICK VASSILIADIS (Anthem Blue Cross and Blue Shield Healthcare Solutions):
Anthem Blue Cross and Blue Shield Healthcare Solutions supports A.B. 317.

CHAIR RATTI:
I will close the hearing A.B. 317 and open the hearing on A.B. 387.

ASSEMBLY BILL 387 (1st Reprint): Establishes a program to provide services to families of certain children with a mental illness or emotional disturbance. (BDR 39-1000)

ASSEMBLYWOMAN SHEA BACKUS (Assembly District No. 37):
Today, it is my pleasure to introduce A.B. 387 which creates a pathway for families on the verge of seeking services for their child's serious mental illness or emotional disturbance through relinquishment of parental custody to the Clark County Department of Family Services, despite the absence of abuse and neglect. This is so the child can receive services through an appropriate child-serving agency. To prevent such custody relinquishment, I bring before this Committee A.B. 387.

Assembly Bill 387 is essentially divided into two parts. The first part is to gather data to get an understanding of cases involving children going into the system seeking mental illness or serious emotional assistance when there is no finding of abuse and neglect.

The second part is to establish a task force to develop a program to prevent the relinquishment of custody or voluntary surrender of children to an agency which provides child welfare services solely to allow the children to receive services to address a mental illness or emotional disturbance when there has been no finding of abuse or neglect.

Section 7.5, subsection 1, paragraphs (a), (b) and (c) provide for what data is to be collected and reported by each agency providing child welfare services to the DHHS.

Specifically, each agency is to report:

> (a) The number of children for whom custody is relinquished to the agency or who were voluntarily placed with the agency pursuant to NRS 432B.360 during the last three years due to mental illness or emotional disturbance; and
> (b) Information concerning the length of time the agency provided such service and the status of the children upon termination of such services; and
> (c) Of the children identified, how many remain in custody of or placed with the agency.

This information is to be reported by July 1, 2020. The DHHS is to then submit to the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Child Welfare and Juvenile Justice, a report summarizing this information by July 31, 2020.

Section 3 sets forth the establishment of the task force and who will be appointed by the Director of the DHHS. While the task force members are not entitled to additional pay or per diem, they are to be relieved of their duties without loss of regular compensation or required to use annual vacation or compensatory time for their absence.

Section 4, subsection 1, paragraphs (a), (b), (c) and (d) of the bill provides what the task force shall do which includes:

> (a) Prescribing procedures for conducting the review by a clinical team appointed pursuant to Section 5 of this act and the arrangement of the provision of services pursuant to that section; and
> (b) Develop and carry out procedures to increase the ability of the services described in subsection 3 of section 5 of this act

> throughout this State to allow children to receive those services in or near their homes; and
> (c) Provide for outreach to and education of parents and providers of mental health services concerning the services available through the program developed pursuant to section 3 of this act; and
> (d) Make recommendations to the Department concerning the adoption of any regulations necessary to carry out the provisions of sections 2 to 6 of this act.

Section 4, subsection 2 requires that the DHHS shall adopt regulations necessary to carry out the provisions of this act, including the manner in which the cost of providing such services will be paid. The regulations must also require that the parent use any insurance or otherwise contribute to the cost to the extent of his or her ability.

Section 5 provides for the Director to appoint at least one clinical team to review cases where a child has been admitted to a hospital or mental health facility and is at risk of relinquishment to secure such mental health services but has not been subject to abuse and neglect. The clinical team is also to develop a plan outlining services necessary to treat the child in order to avoid relinquishment or voluntary surrender of such child. The clinical team is also to arrange for the provision of services necessary to stabilize the child for not more than 90 days while a plan of care is being developed.

Section 6 requires the agencies to provide an annual report to the DHHS setting forth the number of children who were relinquished into the custody of the agency or voluntarily surrendered to the agency the year prior because of the child needing services for mental health or emotional disturbance by January 15. The DHHS is to submit a report to the Director of the Legislative Counsel Bureau summarizing this information by February 15.

SENATOR HARDY:
How did we get away from the fiscal note in Clark County without having it in Washoe or any other counties?

ASSEMBLYWOMAN BACKUS:
Primarily, we looked at the data over the next two years. If you look at the last section of the bill providing for the deadlines, most everything is to occur within this biennium

SENATOR SPEARMAN:
Do we have enough mental health facilities in Nevada to accommodate this? Last Session, children were being sent elsewhere because we did not have the capacity here.

ASSEMBLYWOMAN BACKUS:
We were trying to figure out what kind of numbers we were looking at and whether we were looking at hundreds of children for the purposes of A.B. 387. When the Clark County Department of Family Services testified, they said it was about one child per month. That is for the children where there is no finding of abuse and neglect. In my personal experience with representing children in foster care, this is an issue.

One of the bills you will hopefully hear on Wednesday, A.B. 298 deals with adopting a plan for the recruitment of foster homes. There is a friendly amendment centered around how many children are subject to being placed out of State. We have contemplated combining the two bills; however, this one seems limited to the children outside of abuse and neglect and the other one seemed more appropriate.

ASSEMBLY BILL 298: Requires an agency which provides child welfare services to adopt a plan for the recruitment and retention of foster homes. (BDR 38-1061)

ROSS E. ARMSTRONG (Administrator, Division of Child and Family Services, Department of Health and Human Services):
We had 359 voluntary relinquishments in the last fiscal year which included all relinquishments; not just those looking to receive services. The vast majority are biological parents. They relinquish their rights in a negotiated open adoption situation where they would be terminated otherwise in court so they relinquish rather than have them terminated.

CHAIR RATTI:
Do you think it is a relatively small number of children who meet the narrow definition of this mental health challenge that is leading to their relinquishment?

MR. ARMSTRONG:
We do think it is rare, but no parent should have to give up their child just to receive medical care.

CHAIR RATTI:
I will accept a motion on A.B. 387.

> SENATOR SPEARMAN MOVED TO DO PASS A.B. 387.
>
> SENATOR HAMMOND SECONDED THE MOTION.
>
> THE MOTION CARRIED UNANIMOUSLY.

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CHAIR RATTI:
I will close the hearing on A.B. 387 and open the hearing on A.B. 430.

ASSEMBLY BILL 430 (1st Reprint): Providing for a study concerning maternal, infant and early childhood home visitation services. (BDR S-1001)

ASSEMBLYWOMAN BACKUS:
It is also my pleasure to introduce A.B. 430 which requires the Legislative Committee on Child Welfare and Juvenile Justice to conduct an Interim study concerning maternal, infant and early childhood home visitation services.

This bill originated with the concept of establishing a voluntary program for expectant mothers who would likely have a case opened with Child Protective Services following the birth of their infant. This case would likely involve drug abuse or others issues that may give rise to such removal.

The goal was for the mother to engage in early assistance to address issues that could give rise to a finding of abuse and neglect following the birth of her child. However, when the bill came out it did not look that way. It was overly broad. After working with stakeholders on this bill, it was discovered there was a lack of information as to identifying those in need of services, what department would oversee the services, communication to those identified and how the program would work.

Likewise, there were grave concerns about the program not being voluntary and potentially violating one's Fourth Amendment protections. This program was never intended to do such. With the outstanding inquiries, it was realized the best way to work toward the original intent of this bill was through an Interim study.

When we were looking at amending the bill, another point was raised by the Clark County Department of Family Services regarding potential federal grants available. When trying to develop a program that could take advantage of those federal grants, we realized we were missing a lot of information. The best way to handle this was an Interim study. Today, I was reading the *Las Vegas Review-Journal* and provided you with some additional information looking forward to what could be studied in the Interim and what we could do to benefit families. There was actually the loss of a grant program causing one of our Clark County organizations called Healthy Start program to no longer service families of women enrolled in the program who could not be absorbed by any other communities and 140 women were no longer serviced.

We had the pleasure of having Cam Scott with Nurse-Family Partnership join us during the hearing before the Assembly Committee on Health and Human Services. Nurse-Family Partnership currently works with 200 families in Clark County through the Southern Nevada Health District which can currently assist up to 240 families. Mr. Scott offered testimony about the success of the Nurse-Family Partnership, which included the reduction in child abuse and neglect. It also included information on the reduction in emergency room visits from accidents and poisoning, the reduction in language delays, fewer behavior and intellectual problems at age six, and the reduction in pre-term delivery for women who smoke.

In Nevada, Nurse-Family Partnership looked at the cost savings and return on investment of its program. There was a total average cost of $13,383 per Nevada family, having an average enrollment of 614.6 days. The forecast model on the return for a child on his or her 18th birthday would be a State and federal cost savings of $20,006 per family served. When considering broader savings to society, including gains in work, wages and quality of life with the reduction of out-of-pocket payments, child welfare, special education and criminal justice, the benefit equals $56,839 per family served. A copy of the trial outcomes and return on investment in Nevada have been supplied to the Committee Manager.

This bill is now set forth under Section 1.5, subsection 1, paragraph a, subparagraphs (1) through (5) to which the Interim study will consider the following, without limitation:

> (1) Identify communities that demonstrate a high level of risk factors known to impair childhood development, and
> (2) Identify pregnant women who may benefit from receiving home visitation services after the birth of the child; and
> (3) Identify existing programs in this State that provide maternal, infant and early childhood home visitation services; and
> (4) Analyze past efforts in this State to use identified risk factors to address needs and target resources; and
> (5) Evaluate the collection of data concerning families who receive home visitation services in this State.

Additionally, the Committee will provide findings and recommendations for the legislation relating to the study.

SENATOR SPEARMAN:
We heard a bill last week on maternal mortality. I am wondering if this could dovetail on this bill. Is there any connection with respect to the grants they could receive or perhaps some peripheral organizations that could help fund this?

ASSEMBLYWOMAN BACKUS:
I am a co-sponsor on that maternal mortality bill. I did not put the two together until I saw the *Las Vegas Review-Journal* article on infant mortality and realized what the Healthy Start Program was doing. Part of the Healthy Start Program was to look at decreasing mortality rates. I am unsure as to where the sponsor's study is going to fall. This would be specific and could be broader than just looking at maternity, but also looking at early childhood.

KATHRYN ROOSE (Deputy Administrator, Division of Child and Family Services, Department of Health and Human Services):
We would like to thank the Assemblywoman for allowing us to participate in the amendments of these bills. The Division of Child and Family Services, specifically Child Welfare, is undergoing some reform based on the Family First Prevention Services Act. This provides a Title IV-E reimbursement for services to prevent removal of children from their homes. The Nurse-Family Partnership is one of the approved interventions we will be exploring.

CHAIR RATTI:
I will accept a motion on A.B. 430.

SENATOR SPEARMAN MOVED TO DO PASS A.B. 430.

SENATOR HARDY SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR RATTI:
Seeing no further business, we are adjourned at 5:04 p.m.

RESPECTFULLY SUBMITTED:

____
Vickie Polzien,
Committee Secretary

APPROVED BY:

____
Senator Julia Ratti, Chair

DATE:_______________________________________

EXHIBIT SUMMARY				
Bill	**Exhibit / # of pages**		**Witness / Entity**	**Description**
	A	2		Agenda
	B	5		Attendance Roster
A.B. 76	C	9	Megan Comlossy	Work Session Document
A.B. 129	D	1	Megan Comlossy	Work Session Document
A.B. 254	E	1	Assemblywoman Dina Neal	Table Displaying Incidence of Diagnosis of Sickle Cell Disorder and Medical Conditions
A.B. 254	F	3	Assemblywoman Dina Neal	Sickle Cell Disease Summary By Race
A.B. 254	G	1	Linetta Barnes / Sickled Not Broken Foundation	Testimony in Support
A.B. 254	H	3	Tina Dortch / Department of Health and Human Services	Testimony in Support
A.B. 254	I	2	Chike M. Nzerue / Dignity Health-St. Rose Dominican	Testimony in Support
A.B. 317	J	11	Assemblywoman Maggie Carlton	Proposed Amendment