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

Eighty-First Session
May 24, 2021

The Committee on Health and Human Services was called to order by Chair Rochelle T. Nguyen at 1:36 p.m. on Monday, May 24, 2021, Online and in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, 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/81st2021.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Rochelle T. Nguyen, Chair
Assemblywoman Sarah Peters, Vice Chair
Assemblywoman Teresa Benitez-Thompson
Assemblywoman Michelle Gorelow
Assemblyman Gregory T. Hafen II
Assemblywoman Lisa Krasner
Assemblyman Andy Matthews
Assemblyman David Orentlicher
Assemblywoman Shondra Summers-Armstrong
Assemblywoman Clara Thomas
Assemblywoman Robin L. Titus

COMMITTEE MEMBERS ABSENT:

Assemblywoman Annie Black (excused)

GUEST LEGISLATORS PRESENT:

Senator Dina Neal, Senate District No. 4
Senator Fabian Donate, Senate District No. 10

STAFF MEMBERS PRESENT:

Patrick Ashton, Committee Policy Analyst
Karly O'Krent, Committee Counsel
Nick Christie, Committee Manager
Terry Horgan, Committee Secretary
Melissa Loomis, Committee Assistant

OTHERS PRESENT:

Jessica Flood, Coordinator, Northern Regional Behavioral Health Policy Board
Katie Roe Ryan, System Director, Nevada Government Relations, Dignity Health-St. Rose Dominican
Kendra G. Bertschy, Deputy Public Defender, Washoe County Public Defender's Office
Joan Hall, President, Nevada Rural Hospital Partners
Gillian Block, representing Nevada Coalition of Legal Service Providers
Amy Honodel, Staff Attorney, Legal Aid Center of Southern Nevada
Bailey Bortolin, Statewide Advocacy, Outreach and Policy Director, Nevada Coalition of Legal Service Providers
Kendall Lyons, Director of Health Policy, Children's Advocacy Alliance
Joanna Jacob, Manager, Government Affairs, Clark County
Calvinia Williams, Founder and President, Lupus of Nevada, Inc.
Olivia Whiteley, Western States Advocacy Officer, Refugee Advocacy Lab
Manuel Mederos, Language Access Specialist, Language Bank, Northern Nevada International Center, University of Nevada, Reno
William Pregman, Communications Director, Battle Born Progress
Bradley Mayer, representing Southern Nevada Health District; and Washoe County Health District
Margarita Salas Crespo, Senior Advisor, Office for New Americans, Office of the Governor
Sean Sever, Administrator, Division of Management Services and Programs, Department of Motor Vehicles

Chair Nguyen:
[Roll was taken. Committee rules and protocol were explained.] We will now move on to our first agenda item and open the bill hearing on Senate Bill 70 (2nd Reprint).

Senate Bill 70 (2nd Reprint): Revises provisions governing mental health. (BDR 39-418)

Jessica Flood, Coordinator, Northern Regional Behavioral Health Policy Board:
[Jessica Flood presented a PowerPoint, Exhibit C.] I included a few slides at the beginning that talk about the background of the Northern Regional Behavioral Health Policy Board. We started this work in 2017 to prepare for the 2019 Session and successfully passed

Assembly Bill 85 of the 80th Session, modernizing and clarifying the mental health crisis hold process [page 2, Exhibit C]. In that process, we had a deeper understanding of *Nevada Revised Statutes* (NRS) Chapter 433A, and Senate Bill 70 (2nd Reprint) is a continuation of that work. Part of the product of A.B. 85 of the 80th Session was that we developed this brochure [page 4] that we sent out to all the hospitals—10,000 copies in the last year. I hope that type of work will continue with S.B. 70 (R2) if it were to pass.

I want to start with a brief overview of mental health crisis holds [page 5]. All 50 states in the U.S. have involuntary mental health hold laws to protect people and communities from risk of harm to self or others or inability to care for self due to mental illness. It is the greatest loss of individual rights in society other than arrest and is based upon the constitutional ability of police intervention for harm to self or others. Nevada's mental health crisis hold lasts for 72 hours, which is common among the states. It includes the process of detention and application for emergency admission, medical evaluation, and certification that the individual is indeed in a mental health crisis. At any time after medical evaluation and certification, that individual may be admitted into an inpatient psychiatric facility under emergency admission. If the crisis lasts longer than 72 hours, the petitioner needs to petition the court for an involuntary court-ordered admission into an inpatient psychiatric facility for treatment for up to six months [page 6]. I want to also note that, since 2014, Nevada has also had an involuntary outpatient treatment mechanism in the law as well that is known as assisted outpatient treatment and also lasts up to six months.

This is a quick overview of what I just discussed showing the steps of the mental health crisis hold [page 7]. These are the changes we made in S.B. 70 (R2) [page 8]. We tackled many pieces of the mental health crisis hold process. You will see that we updated the terms, definitions, and criteria for the mental health crisis hold process. We updated the chemical restraint definition and the family petition process. We clarified and defined the emergency admission, updated the involuntary court-ordered admission into inpatient psychiatric hospitals, updated conditional release, updated assisted outpatient treatment, and created a clearer process.

I want to note that many of these concepts are not likeable, per se, but they are necessary. Sometimes we have legislators who have wanted to vote against these, but by voting against this, you are voting against clarifying the law. The effort of S.B. 70 (R2) is not to create any new mechanisms, just to clarify and update those mechanisms so we have a more transparent process that patients, families, and providers can understand. We are trying to get everyone on the same page; so we really see this as upholding patient rights.

In the process of developing S.B. 70 (R2), we had very diverse stakeholder involvement. I facilitated a statewide mental health crisis hold work group at the request of the Northern Regional Behavioral Health Policy Board since 2017. We have had very strong participation from Clark County's Judge Yeager, Washoe County's Judge Lu, the public defenders, the Division of Public and Behavioral Health within the Department of Health and Human Services (DHHS), the Nevada Hospital Association, et cetera. You can read the list yourselves [page 9]. On the youth side, we had a lot of participation from the Department of

Education; the Clark County School District; Clark County, Washoe County, and rural child welfare agencies; the Division of Child and Family Services, Department of Health and Human Services; and children and family advocates from Nevada PEP Statewide Family Network.

At 70 pages, the bill is huge. It is complex, but it can be broken down into five elements [page 10, Exhibit C]. It updates and modernizes the mental health crisis hold law, and it updates assisted outpatient treatment and conditional release. We did not recreate the youth mental health crisis hold process that was created in the 2019 Session; we adjusted some pieces so it is workable and aligned with parental rights. We updated the chemical restraint definition as well, and I will walk you through each one of these processes.

The first element involves updating the mental health crisis hold process and defining terms [page 11]. As I said, A.B. 85 of the 80th Session made a few changes, but as we got into NRS Chapter 433A, we realized that it was written in 1975. Because there have not been any changes since then, it reads as though it is from 1975. Right now, it reads that a law enforcement officer detains an individual and applies for emergency admission into an inpatient psychiatric facility. It is a one-step process where they detain and take the individual into an inpatient psychiatric facility for evaluation. That is not our current system. Our current system is now detainment and you are brought to either a mental health crisis center or to a hospital emergency room (ER) where you are evaluated and observed. A large percentage of people are taken off that hold because they are found to be stable or to not meet the criteria. That step was missing in our statute, and we tried to break apart that first mental health crisis hold and the emergency admission to modernize the law.

Our proposed solutions are in sections 28 to 32, updating the mental health crisis hold process to align with current practice and clearly separating the mental health crisis hold from emergency admission. In sections 3 through 8, we developed definitions for the terms that were used in the law so everyone can be on the same page. In section 26, because we adjusted the "application for emergency admission," we are now using a more neutral term—"mental health crisis hold." Before, the Attorney General would approve forms for the admission of people to inpatient psych; and now, they will approve the forms for detainment, evaluation, treatment, and conditional release, so that expands the added terms we developed.

We clarified the family petition for court-ordered pickup [page 12]. The problem was that the process in law was unworkable and vague, so we updated it. Section 9 develops the petition process for court-ordered pickup and evaluation of individuals suspected to meet criteria for mental health crisis. Section 36 removes the ability for a spouse, parent, adult children, or legal guardian to petition for straight admission to an inpatient psychiatric facility. Because we are always trying to think, it is nice to have screens and filters for people to go into inpatient psychiatric facilities. With the current process, it makes sense for them to go to a hospital ER. If they are deemed appropriate, and based on their insurance, they can go into an inpatient psychiatric facility. This one-step process straight into the inpatient psychiatric facility is reminiscent of the 1970s and no longer necessary.

We clarified the hospital and court procedure for individuals who cannot be medically cleared in 72 hours [page 13, Exhibit C]. That process was really unworkable in the law, and we made it so that it is clear. Hospitals did not have a place to turn to in the law to understand what process to take when those individuals are not medically cleared within that time, so we corrected that. We also updated hospital times for notifying guardians and courts [page 14]. Currently in law, hospitals are required to provide a notice of discharge to courts and guardians for patients who are under involuntary court-ordered admission ten days prior to discharge. That is actually a longer length of stay than the average length of stay for people in inpatient psychiatric units, which is now about seven days. We brought those times down to three days prior to discharge. We also allow for flexibility for hospitals because there are people who only stay for one day sometimes. We tried to create more reasonable guidelines for that notification, because it is an essential part of the discharge process. Sections 39, 47, 48, and 48.5 made those changes.

We clarified the involuntary court-ordered and county transfer process [page 15]. Patients were getting lost in the system if they were transferred between counties, and there was no standard timeline that existed to ensure detention does not extend beyond the legal limits. Section 39 requires a person who submits such a petition to notify a court if the subject of the petition is currently admitted to a mental health facility or hospital and has been transferred to another facility. That helps courts who have ordered people in to keep track of where these people go. Section 41.5 clarifies the court transfer process when examining personnel are not available and the county of residence is responsible. Again, there are times when, say, Esmeralda County does not have the resources to be able to do this court-ordered admission. By law, they are able to transfer that to another county and it was vague in the law. We have been able to clarify it so the courts can be on the same page with that. Then there is direct filing in the county of treatment which allows a mechanism for the petitioner, for instance a rural hospital—knowing that the person is going to West Hills Behavioral Health Hospital in Washoe County—can petition Washoe County to do the court-ordered admission. That way, Washoe County can have oversight of that patient while that person is in the Washoe County system. That creates a more streamlined process and also conforms to current practice.

Continuing this update of the involuntary court-ordered and county transfer process, one problem was that courts throughout the state order patients into state services without the necessary evaluation and acceptance process [page 16]. This happens a lot with Northern Nevada Adult Mental Health Services and Southern Nevada Adult Mental Health Services. There needed to be an actual acceptance process from the hospital following admission guidelines, so we clarified that once a person is involuntarily admitted to a mental health facility, the admitting court can transfer the case, and the mental health facility is required to notify the court if the person is transferred. Actually, that is already in law. Once you do one court-ordered admission, that is it. You have that court-ordered admission. Currently what is happening is some rural courts will do the court-ordered admission and then try to transfer the case to the urban areas. You can see it is messy because there is not much clarity in the law. Section 50 of this bill prohibits the transfer of a consumer who has been admitted to a mental health facility or required to receive assisted outpatient treatment to another facility or provider of treatment unless arrangements are made regarding the cost of treatment. Again, we need to be on the same page when there are transfers and work according to the system we have regarding insurance and such.

Section 48 abolishes the requirement that an evaluation team evaluate a person who is under a court-ordered admission in a mental health facility or required to receive assisted outpatient treatment before the person can be unconditionally released before the expiration of the order [page 17, Exhibit C]. Right now that does not happen, and all the stakeholders thought that was an unnecessary step. Section 23.5 updates the term "person professionally qualified in the field of psychiatric mental health" so the term is used for both public and private. This allows us to have a shorthand term for that type of person as opposed to continuing to list all the people who would be able to fit under that term. In section 3.5, we applied the term "consumer" to the entirety of NRS Chapter 433A so we can be on the same page with definitions. Then we closed a loophole. Prior to S.B. 70 (R2), what is in current law mandates courts to seal records in cases of court-ordered admission but not for all these other people who are in the system and still going to court. Therefore, there would be a person who could go to court, have their case heard, the court would deny it, and there was no mandate that the court would seal that record. There were other cases like that, so we wanted to make sure there was standardized privacy across the board.

For assisted outpatient treatment (AOT), the court-ordered outpatient treatment, these programs were written into law in 2014 and they were specific programs funded by the Substance Abuse and Mental Health Services Administration within the U.S. Department of Health and Human Services, the federal funding arm for mental health [page 18]. They were unique programs with one in Clark County and one in Washoe County. We had a technical assistance provider come and tell us that it is actually a generic mechanism of treatment across the board and that these are not specialized programs. We worked to develop a law that allows for that generic use in all counties and not just in Washoe and Clark Counties. We also had an interesting part of Nevada law. It was the only state that first required that the patient meet criteria for inpatient hospitalization and then meet AOT criteria. Basically, the courts needed to find that someone was a danger to self or others before ordering them into outpatient treatment in the community. We made some improvements in this with the criteria so people are able to see the specific criteria in the population that this court-ordered treatment would fit. The proposed solutions are in sections 11 through 21, 20.5, 24, and 43, which develop specific assisted outpatient treatment criteria and program procedures and clarify and update current law for implementation in all counties. It creates a separate AOT process so that the AOT process is interwoven into the inpatient process and now it is very easy to read and understand. You will see that there is this requirement that the same counsel must continue to represent the person, so section 42 moves that piece into the AOT section so it is all one cohesive format.

As I was saying, we created a generic term, and we think this creates a clear and transparent process so individuals will know what AOT is and how to petition for the program [page 19]. It enables community providers to provide AOT services in coordination with courts. In my region we have certified community behavioral health clinics (CCBHCs). Those agencies are able to provide the services of AOT, so it is possible for us to expand assisted outpatient treatment, at least in my region, into other regions that have CCBHCs without needing state funding. As I was saying, it clearly identifies the target population instead of just saying the person is a danger to self or others; for instance, if the person is over the age of 18, has a mental illness, and has a history of poor compliance. There are even basic outcomes the person needs to meet; for example, been hospitalized, receiving services in a behavioral health unit, in a detention facility for 48 months, et cetera. The last one is that the person must be capable of surviving in the community in which he or she resides without substantial likelihood of serious harm to himself or herself or others if he or she receives AOT.

Conditional release is another mechanism that provides a level of care in the community that we are working toward [page 20, Exhibit C]. These are individuals in inpatient psychiatric units. I used to work in one as a discharge planner. You get them stabilized so they are no longer a danger to self or others and they are under a court-ordered admission, but you know that without necessary supports, they are going to deteriorate when they leave. In those situations, it is hard to discharge because it is essentially an unsafe discharge. Many hospitals may decide to keep that person until the end of the court-ordered admission and if they still have not found a great solution, the person is discharged without good support and deteriorates—as we suspected would happen.

What this mechanism creates is a discharge plan on steroids where the hospital, if the individual is still under inpatient court-ordered involuntary admission, can try the individual out by coordinating with a team in the community and having the individual agree to certain terms. They may tell the person, you are going to go to treatment, a community team is going to check in with you, and we are really going to try to create a warm handoff into the community. The hospital can provide that information to the court, and this is really important in a place like Clark County because they have 20 hospitals. You have people constantly going all through those hospitals and they are re-creating the wheel with every discharge plan, every treatment plan. The court can serve as a central entity and be able to coordinate that care so if that individual comes back in, the court can say, "This is what the last treatment team said worked; here are the medications," and be able to provide that to the next hospital for continuity of care. If the individual looks as though they are starting to deteriorate, the community organization working with the individual can come to the court and at least inform them of the deterioration that is happening. We are really trying to create another supported level of care in the communities. Sections 22, 39, and 47 clarify and update the conditional release process. This was already in the law. It was completely unworkable. We think that having more court oversight will provide more due process for individuals.

Looking at the youth mental health crisis hold, as I was saying, they were using inaccurate terms when the law was written [page 21]. The way the law was written also was saying that hospitals have to notify the parents of the youth being detained on a hold 24 hours after that emergency admission. It is hoped that the youth would never be admitted to an inpatient psychiatric facility without parental consent or knowledge or without some other due process. We thought what it is really trying to say is that hospitals have to notify the parents within 24 hours of the placement of the hold, so we made small changes like that. Section 33 clarifies and changes the time hospitals detaining a youth must notify a parent or legal guardian of holding a youth under a mental health crisis hold from 24 hours to 8 hours. That was a big request from the family advocates, and we thought that was reasonable from the hospital's perspective. As a hospital, that is the first thing you should be doing if a youth is coming in without a parent. Section 35 also creates a mechanism for youth to be released from a mental health crisis hold to parent custody if the guardian or parent agrees to treatment or accepts physical custody of the youth. Right now, there is no place on the form for that, so we wanted to create that option and mechanism.

This next slide [page 22, Exhibit C] is titled "chemical restraint," and everyone is probably concerned about it. Nevada's chemical restraint mechanism was developed in 1975, is outdated, and does not take into account innovations, new medications, and new uses of medications in health care approved by the Food and Drug Administration (FDA). The solution was in sections 2, 65, 66, and 68, where the term "chemical restraint" is used, and excludes modern FDA-approved interventions for treatment from the definition of "chemical restraint." This was proposed by the Division of Public and Behavioral Health, DHHS, whose staff worked closely with the chair of the Commission on Behavioral Health, also within DHHS. That was the last slide, and I am happy to accept questions.

Chair Nguyen:
Assemblywoman Titus, who sits on the Northern Regional Behavioral Health Policy Board, also has a presentation in support of S.B. 70 (R2).

Assemblywoman Robin L. Titus, Assembly District No. 38:
I have been seated on this board now for two sessions, and I know Ms. Flood gave you an overview of what the board does. There are now five boards that all have representatives from the Legislature sitting on them. Those of you on this Committee know we have been working for many sessions on what we know as the original "Legal 2000" hold, trying to fix this statute. The ultimate goal was to make sure that a person's rights were upheld, that the person got medical and mental attention in an expeditious manner and was able to get treatment. During these many sessions we tried to identify where the hiccups were on this, and over the years we heard testimony concerning people being stuck in emergency rooms because they needed a medical clearance or medication or a place where they could be sent.

I want to give credit to Ms. Flood. What she did was engage every single aspect of this large bill and not just from the medical aspect, which is what we would get hung up on, but also the judicial aspect—whether it was in the rurals or in the urban areas, whether it was a little hospital or a big hospital. The key was trying to look at what the needs were throughout the state and making sure patients in mental health crises were treated both from a medical aspect and, at the same time, making sure their legal rights were upheld. Again, thank you for hearing this bill.

Chair Nguyen:
Thank you, Assemblywoman Titus, and thank you, Ms. Flood. I know in talking with many of the stakeholders that you spoke with that you often met weekly, if not twice a week, throughout the entire pandemic to make sure you were incorporating all the stakeholders. Do we have any questions from Committee members?

Assemblywoman Thomas:
Thank you to Assemblywoman Titus and Ms. Flood. Are hospitals equipped to handle the mentally ill or people who they suspect are mentally ill? I know in the south there are several private mental health facilities that can assist because that is what they do. However, the hospitals do not seem to be zeroing in on just that subject.

Assemblywoman Titus:
I would say that the hospitals absolutely were not, which is what was critical to another piece of legislation. We passed a bill involving crisis stabilization centers which were critical to looking at the overall mental health of our state. One thing we identified is that we do not have adequate mental health care throughout our state. The little hospital where I practiced is an eight-bed hospital. We did not have a mental health area where we could stabilize patients who were in mental health crises. That was a component we are addressing throughout the state, and we are getting better at it, but this bill addresses that. This bill says what do I do in the ER in my rural area, how long were patients sitting in a big urban emergency room with no access to adequate mental health within that ER because neither my little hospital nor that ER were mental health centers. So, partly, we are trying to address that with this legislation and other bills we have seen here.

Jessica Flood:
As Assemblywoman Titus said, we are trying to develop that alternate behavioral health crisis response system. That 988 legislation [National Suicide Prevention Lifeline], the crisis stabilization unit—it is pretty amazing watching that be built. We have acknowledged that hospitals largely cannot respond to mental illness, so creating those crisis stabilization centers and the crisis call line are essential to being able to adequately respond to people who are in mental health crises.

Assemblywoman Thomas:
If I am understanding this, once that person is admitted to the ER and they know this person is basically unstable, are they transferred to another facility that actually can get them the help they really need without a court order?

Assemblywoman Titus:
When we start a mental health hold, there has to be a medical screening before they get admitted to the medical facility. That is where our ER would come in. The person would be brought to me, I would evaluate them and make sure their mental health crisis is not due to a medical reason like low blood sugar, stopping their medications, or some other medical reason. Once we have cleared them medically, we cannot release them until we have an accepting facility. That warm handoff, as Ms. Flood mentioned, is a critical component, as is

having access to a bed. For example, there have been times when they would stay in our ER for days until we could get them into a facility.

Jessica Flood:
I would like to add that a court order is not always necessary. Sometimes people can be on a hold, and if they voluntarily want to go into a facility, that hold can be discontinued; or if the crisis ends, the hold can be discontinued. People are going to hospital ERs, but the goal is for them to go to holds in these crisis stabilization units. In my region, we have the Mallory Behavioral Health Crisis Center that works as a psychiatric ER.

Assemblywoman Thomas:
When you mentioned a conditional release, I was trying to understand how the courts are in the role of assessing whether the person is deemed to be released. A doctor can determine whether this person is able to be released yet the courts have to give permission. Is that what you meant during your presentation?

Jessica Flood:
The courts do not give approval for a discharge; the hospitals decide the discharge. The courts are only notified that the conditional release has occurred. The courts get the form that the hospitals have done with the community provider so they can be a central repository of coordination, but there is no approval from the courts.

Assemblywoman Krasner:
Thank you for the presentation. I appreciate the intent of the bill, but I have questions. The first one is about an involuntary health crisis hold. The word "involuntary" scares me. Here in the United States we value our individual rights and liberties, our freedom of movement under the *Constitution*, so "involuntary hold" should give all of us pause. I understand there are people who really are going through mental health crises who do need this, but as legislators, we have to be thoughtful and think about odd cases—a worst-case scenario. What if somebody is taken against their will in this involuntary mental health crisis hold for 72 hours and really does not belong there? My first question is, at every point along the way during the 72-hour extended hold—if somebody decides they are going to go for an extended hold—does that individual have the right to petition the court for release or at least a hearing?

Jessica Flood:
Yes, they do. In NRS Chapter 433A we have habeas corpus where the individual can petition the court at any time. Actually, that was why we started this work in the first place. The law is not well understood, so patients were not able to understand what their rights were. Prior to A.B. 85 of the 80th Session, the hold started at a very ambiguous time after medical clearance. You could be held against your will for, let us say 8 hours, and you would ask, When does my 72 hours end? They would say that it had not even started until after medical clearance. That was pre-2019, and we clarified all that so we could create education. That pamphlet I showed you [page 4, Exhibit C] talks about your right to go to the court at any time and have a hearing on that. There is also the Nevada Disability Advocacy and Law Center that is able to advocate for individuals with mental illness in those

situations as well as the American Civil Liberties Union. Those are definitely why those pieces are in place, and there is due process for anyone who requests it.

Assemblywoman Krasner:
Thank you. Is the adult or child given notice that they are entitled to a phone call within three hours? In NRS 171.153, a person who is arrested—again, their liberty is taken away, their freedom of movement—the law states that they must be allowed to make a phone call, or more than one reasonable phone call—a local phone call—within three hours. In your bill I do not see that, and I think that should be added. I wonder what your thoughts are about allowing somebody to be notified that they can make a phone call, whether it is an adult or a minor, within three hours of the time they are taken against their will. Do you have thoughts on that, please?

Jessica Flood:
In NRS Chapter 433A, the patient does have the right to access the telephone—not even just within three hours, but during their entire stay at a hospital. When we created that brochure, it has all these rights listed. I would be open to your thoughts if we need to add the three hours, but having blanket access to a telephone through the entire stay is really important.

Assemblywoman Krasner:
Also in your presentation, did you state that your recent addition is that a minor, a person under age 18 who is taken involuntarily, it is no longer going to be within 24 hours that the parent or guardian must be notified, it is going to be within 8 hours? Did you state that?

Jessica Flood:
Yes.

Assemblywoman Krasner:
That is a good start, but as a mom, if I did not know where my child was for eight hours, I would be in a huge panic. I feel it is so important, for a minor especially, that they are allowed within three hours to make phone calls to a parent, a guardian, a friend, a grandparent—somebody. In NRS 171.153, if we are allowing someone who has been arrested to have that right, we certainly should allow a child to contact a parent, a guardian, a trusted friend, a grandparent—somebody. I feel strongly that should be included in this. I appreciate all your hard work, and I know I am bringing up nuances, but as a parent I feel it is so important that we have that language in here. What are your thoughts on that?

Jessica Flood:
I think your request is reasonable. As a hospital, it should be happening as soon as a child comes in. If law enforcement brings a child in, you would think the first thing the hospital would want to do is try to get ahold of that parent.

With this diverse stakeholder group, there is a lot of push and pull and tension. There are the hospitals saying that there are situations in which they will not be able to do that. Then you have the parent and family advocates who say that it should be as you said, within three hours. I think that is reasonable, but I do not know what the stakeholders think about that; however, I would be open to seeing what the stakeholders think about it.

Assemblywoman Krasner:
That is a vague response.

Chair Nguyen:
Assemblywoman Krasner, I will ask you to follow up with Jessica Flood. I know she is speaking on behalf of her position as coordinator for the Northern Regional Behavioral Health Policy Board, so she probably has a difficult time answering that on behalf of all the stakeholders she has been speaking with.

Assemblywoman Krasner:
I appreciate that. I just remember, when this bill came in, reading that a minor could be taken without the consent of the parents or guardian and held for basically 23 hours and 59 minutes without notifying the parents. One of the directors of a local youth mental hospital reached out to me and said they were mortified by the bill. They thought it would further traumatize children if they were not allowed to have that kind of contact or make a phone call to a parent or guardian, so for the record, I wanted to see if we could put that in there. Since we give that right to people who are arrested, I thought we could also give that same right to people who are taken against their will.

Jessica Flood:
Chair Nguyen, I appreciate your comment. This has been a group effort with probably 30 stakeholders. I have my own opinions, but in terms of the agreement and the process we have put in, I do not want to just agree to something because I am present in this hearing and they are not. On the other hand, I think it is very reasonable to think about three hours.

Assemblywoman Krasner:
Thank you.

Chair Nguyen:
I know a lot of work went into this during the 2019 Session, and a lot of the work in S.B. 70 (R2) plays off the corrections and clarifying language that were needed to further implement some of those protections for patients within the legal system, as well as within their medical care. You mentioned telephone access. The way I read it is they have access to the telephone to make those kinds of calls and make those requests for a hearing at any time—whether in the first five minutes of them coming into contact with the system or if it is three or four hours later. Is that correct?

Jessica Flood:
That is correct.

Chair Nguyen:
Do we have any other questions from Committee members at this time? Seeing none, I will open up testimony in support of S.B. 70 (R2).

Katie Roe Ryan, System Director, Nevada Government Relations, Dignity Health-St. Rose Dominican:
I have provided the Committee with a letter [Exhibit D] on the record in support and wanted to let everyone know that we have been a grateful partner in this process and are very grateful to Ms. Flood for all the work she put into this.

Kendra G. Bertschy, Deputy Public Defender, Washoe County Public Defender's Office:
I also want to thank all the stakeholders for meeting with our office to try to address the due process concerns we had and, more importantly, for continuing to work on this extremely important area of law. By way of context, my office represents those individuals, those adults, who are involved in the involuntary commitment hearings. In 2020, we had 2,185 individuals who went through that process. We appreciate the work that was done in the last session and that has continued on here, to work on reworking our antiquated statutes and attempts to clear up the ongoing, systematic issues and provide clarity for parents, patients, and hospitals about the requirements.

To address Assemblywoman Krasner's question, I am happy, Ms. Flood, to work with you to see if there is anything else that needs to be done to ensure that everyone understands that they do have rights to reach out to their parents or loved ones so that everyone knows where they are located.

Joan Hall, President, Nevada Rural Hospital Partners:
We are here in support of S.B. 70 (R2). This is an important clarification in our statute in keeping the law aligned with current clinical practices and clear verbiage that will assist patients, family members, providers, first responders, as well as the judicial system, when caring for patients who are in crisis. This bill has had tremendous time and expertise expended to ensure that it is a well-vetted product, and I would like to thank all those who were involved in this process, and would appreciate your passage of this bill. Thank you.

Chair Nguyen:
Is there further testimony in support? [There was none.]

[Exhibit E and Exhibit F, letters in support, were submitted but not discussed and will become part of the record.]

At this time, I will start testimony in opposition to S.B. 70 (R2). [There was none.] I will start testimony in neutral on S.B. 70 (R2). [There was none.] With that, I will turn this back over to Assemblywoman Titus and Jessica Flood for any closing remarks.

Assemblywoman Titus:
I appreciate the Committee hearing this bill. This has been a decade-plus in the making, trying to refine what was accomplished last session with A.B. 85 of the 80th Session. Nothing is ever perfect, which is why we come back all the time, but I think this has been a collaborative effort with many stakeholders throughout this process, and I would appreciate your support for this bill.

Chair Nguyen:
With that, I will close the hearing on S.B. 70 (R2) and open the hearing on Senate Bill 158 (1st Reprint).

Senate Bill 158 (1st Reprint): Revises requirements to receive assistance from the Kinship Guardianship Assistance Program. (BDR 38-504)

Gillian Block, representing Nevada Coalition of Legal Service Providers:
Thank you, Chair Nguyen, and members of the Committee. Amy Honodel, representing the Legal Aid Center of Southern Nevada, is on Zoom with us and will be available for questions. Senate Bill 158 (1st Reprint) is based on recommendations that came out of the interim Legislative Committee on Child Welfare and Juvenile Justice. I would like to thank Senator Ohrenschall for bringing this legislation forward.

Senate Bill 158 (1st Reprint) amends *Nevada Revised Statutes* (NRS) 432B.623, which concerns the Kinship Guardianship Assistance Program, or KinGAP. The KinGAP program provides financial assistance to a relative who becomes a legal guardian of a child in foster care. Currently, a child's relatives are only eligible to receive financial assistance through the program if adoption and reunification have been ruled out as permanency options. Basically, that means that even if it is not determined to be in the best interests of the child, as long as reunification or adoption are technically out there as options, that relative caregiver would not be eligible for funding.

Senate Bill 158 (1st Reprint) will revise this requirement so that instead of requiring ruling out adoption and reunification, a child welfare agency can determine that being returned home or adopted are not appropriate permanency options for the child. This is a small change to the law that would ensure that the state law is not more restrictive than federal requirements, which would expand opportunities to utilize federal dollars and ensure more permanency for kids. The language matches the federal Title IV-E eligibility language so we are not being overly restrictive about who can access federal dollars because there is a technical legal difference between "not possible" versus "not appropriate."

Maintaining family, community, and cultural ties is important for children, and adoption may not always be the best option. A child might have a strong relationship with their relative guardian. Parents may not wish to terminate their parental rights. The parents and the guardian may have a good relationship too, and placement with relatives may allow a parent and child to remain in contact. Subsidized kinship guardianship is a way to offer families another choice to help get children into supportive, more permanent, placements.

Senate Bill 158 (1st Reprint) expands opportunities for federal funding, gives families more options, and provides more permanency for children.

Chair Nguyen:
I see we have a couple of questions from Committee members.

Assemblywoman Titus:
Thank you for bringing this bill forward; I think it is important. I have a question specific to the bill. In section 1, subsection 1, paragraph (c), it reads that ". . . services must determine that being returned home or adopted are not appropriate permanency options for the child." Does that eliminate a family member from adopting the child?

Gillian Block:
I will let Amy Honodel elaborate on this, but no, this should just make it so that the more restrictive language in the NRS is not controlling here and it will match the federal language.

Amy Honodel, Staff Attorney, Legal Aid Center of Southern Nevada:
I represent youth in foster care. No, it does not eliminate adoption as an option for these families. The way the amendment is written, adoption will still be on the table, and actually, it is best practices for us and the courts to do what is called "concurrent" planning so that two plans may be developed with the idea that we do not have to wait for one to be eliminated to get a youth out of the system. There are times when adoption may not be what the child desires; for example, if he or she is an older youth. No, adoption would still be on the table. It would also be used in a case where a parent may not want to relinquish their rights and the evidence is not concrete to terminate their parental rights.

Assemblywoman Titus:
Thank you for that clarification. I wanted to make sure it was on the record that the intent was not to totally eliminate adoption as an option for the child or the children.

Chair Nguyen:
Do we have any other questions from Committee members?

Assemblywoman Thomas:
Thank you, Ms. Block, for bringing this bill forward. I have a vested interest in it as I visited the facility in North Las Vegas. I had a relative who had to take in her three grandchildren because their mother had died. She did not receive any help from the state in order to take care of those children. If I had taken the children, I could have received foster care money. I am hoping this bill will eliminate that because this was a grandparent—or an aunt or other relative—and that a relative can receive money from the state. Is that what is happening with this bill?

Amy Honodel:
All relatives are eligible for financial assistance when they take children in. They are able to become licensed foster parents and there is a shortened class requirement. It is called kinship

licensing, but this bill does not affect that. What we are hoping to do going forward in other areas is help with the Clark County Department of Family Services and the Division of Child and Family Services within the Department of Health and Human Services. Washoe County is also working on this to make sure relatives are given information very early on because it is a significant financial undertaking when they take on relatives' kids, but this bill will not affect that. This bill in fact requires those relatives to become licensed before the case gets referred for kinship guardianship. The bill is so that the initial investigators are telling these relatives that they can become licensed as foster parents as well as identifying what other social service help there will be.

Assemblywoman Thomas:
I am not fully understanding that because it seems as though there may be a misunderstanding on my part that a grandparent, because they either have to adopt that child or reunify with the parent, would receive assistance.

Amy Honodel:
I am not sure where the confusion is coming from. Right now, the way title IV-E funding and the foster licensing programs are written and prepared, any person—relative or nonrelative—can become a licensed foster parent to take care of a kid. Ideally, at the beginning of a case when children are removed from their home, they do better with family. The law requires a preference for family placement. The social worker or case manager who is doing the placement should be advising these people, whether it is a grandparent or another relative, of the availability of licensing for them to provide a financial subsidy to them. The bill that is before this Committee does not affect that. However, it does contain the requirement that anyone who does this gets licensed and the kids are in the home with that person for six months prior to the time the guardianship is granted, so it forces the conversation. In the case you were referring to, that grandparent would have been eligible from the beginning, but it is not affected by this bill.

Assemblywoman Thomas:
Thank you. If I understand what you are saying, that grandparent or relative would need to be a licensed foster care person in order to receive assistance from the state.

Amy Honodel:
That is correct and that is regardless of what the plan is for the child. If the child will be going home or can be adopted, that does not affect that relative's eligibility to become licensed. We want these people to be supported when they have this unexpected request to take care of children who are in their family.

Assemblywoman Summers-Armstrong:
I have one more point of clarification. I see that in order to become a licensed foster care person, there is a referral to NRS 424.030. What is the timeline on this? A lot of these things happen so quickly. It could be death; it could be anything. How much time? As an example, when I leave here, I work full-time. Where do I find the time to become a licensed foster care person? If I am getting my licensing under NRS 424.030, are there online

classes? Do I have to go someplace? If I do not do it fast enough, are you going to take my grandbaby from me? How does this work, because this is really scary.

Bailey Bortolin, Statewide Advocacy, Outreach and Policy Director, Nevada Coalition of Legal Service Providers:
Yes, it is a scary process for everyone involved. KinGAP is a federal assistance program to financially assist families who are relatives who take in their children for the foster care system. I believe the agency works with you and works around that timeline because we have a preference for working with family members and the law to ensure that we are putting children with their relatives whenever possible.

What this bill is fixing, to put a finer point on the question you were asking, Assemblywoman Thomas, is, everyone in the state of Nevada could agree that, in a child welfare case, the most appropriate placement is to have this permanency plan of guardianship with a relative. That is why we have this federal KinGAP program; a lot of families cannot afford to just pull back and have no financial assistance and have the case closed under a guardianship with grandma. She needs that financial assistance. The federal KinGAP program that exists closes that loophole by providing that funding, but the way we currently have interpreted that eligibility standard in the NRS is more restrictive than the Title IV-E federal funding actually requires us to be. By saying "not possible," we have cases where it becomes a debate in the legal system as to what "not possible" means. Everyone could be on the same page: the social services agency, the child's social worker, the family members, the child wants this. Everyone wants the permanency plan to close this case and be guardianship with grandma. However, if it is determined that it is "possible" to adopt the child, then that could restrict access to the federal funding. By changing that word to "appropriate" when everyone in the child's life agrees that this is the best case going forward, we do not have to have legal arguments about whether it is "possible" for grandma to adopt. If grandma wants the kid, she should adopt the kid, and that will come with an adoption subsidy. In a narrow set of cases, we get into a legal argument that is unnecessarily restrictive just because of the way it is currently drafted in NRS. Whenever it is possible and appropriate, this will allow us to get these families the federal funding. This slight tweak in NRS will ensure we are giving those families that federal funding.

Chair Nguyen:
Thank you for that clarification. To further clarify, this makes it a lot easier in situations with grandma such as those Assemblywoman Thomas and Assemblywoman Summers-Armstrong mentioned.

Bailey Bortolin:
Yes.

Assemblywoman Benitez-Thompson:
The program is run through the Temporary Assistance for Needy Families program. I want to say that there is an income threshold, so some people might not be eligible for it just because they do not meet a certain percentage of poverty. I think 275 percent of the federal

poverty level is what the qualifying guideline is. Everyone who qualifies financially and is taking in a relative or kin—and kin is defined—can get this. If there are people out there who are not getting this, it is because they are not eligible. There is still an eligibility piece, and that might be a consideration for people who have incomes higher than what the federal poverty level is calling for on this.

Further down in the statute, there is language on adoptions saying that enrollment in this program should not hold up or in any negative way affect the possibility of adoption down the road, and I think it says those adoption subsidies as well. That is important to know. When this was put in statute in 2011, there was a lot of consideration for that. We did not want to inadvertently create a financial incentive to have to choose a path to walk down such as, do you want to do guardianship now and never adopt, or do we want to leave all doors open for that child to have permanency with their family? I think we have that covered. I just know that, in this bill, we do not see that piece of the statute, but I believe it does still exist in statute.

Bailey Bortolin:
Yes, there are a lot of considerations that go into this; however, in this bill, we are looking at one consideration where we have found that the NRS in some cases has been interpreted to be unnecessarily restrictive. You will still have to otherwise qualify for the program, but the unfortunate situation we have seen happen is when everyone agrees that grandma should take the child—that is the plan and what all parties involved want the plan to be—and we have actually seen the guardianship be granted by the court as a permanency plan, but the KinGAP federal funding has not been attached to it which leaves grandma with a financial hardship. In some cases that relationship will no longer be sustainable, and the child will end up back in the child welfare system. The funding is not necessarily indicative of whether the guardianship will be granted, it is whether the guardianship will come with financial assistance. In those cases, this will help the family members have access to that additional support when appropriate and when they otherwise qualify through the program.

Assemblywoman Benitez-Thompson:
I think the longest piece of becoming licensed is completing the fingerprint and background checks, so you are waiting for that process to play through. It would probably be tricky to try to adjust or undo that because it has all kinds of implications. It can either take 90 days or three months, whichever comes faster.

Chair Nguyen:
Are there further questions from Committee members? Seeing none, I will begin testimony in support of S.B. 158 (R1).

Kendall Lyons, Director of Health Policy, Children's Advocacy Alliance:
For the reasons that have already been stated you have our support, and I wanted to reaffirm it here with you today.

Kendra G. Bertschy, Deputy Public Defender, Washoe County Public Defender's Office:
My office represents parents in those dependency NRS Chapter 432B cases. We are in support of this legislation. To add to what Ms. Bortolin was saying, when I was a children's attorney, I had several cases in which we had this issue where everyone wanted the grandparent or the relative—the aunt, uncle, sibling—to have that child and where it was best for the child to remain with the family member, but because the plan had to be guardianship and there was no financial support, that added a lot of angst and issues for the entire family. I urge your support of this bill.

Joanna Jacob, Manager, Government Affairs, Clark County:
We worked with legal aid and stakeholders on this bill during the interim leading up to this legislative session. I want to put on the record that a great number of our foster care kids are with relatives and in relative placement. As of March 2021, we had over 1,100 children who were staying with their relatives. It is something Clark County supports.

I also want to put on the record that what we are talking about here is the subsidy. It was important to Clark County that we have the language in this bill mirror the federal Title IV-E language so we can get financial assistance to our relative placements. We need them to be in that placement. You will see in the bill that they have to be with that relative for six months. During that time we work with our relatives to get them licensed, and we have expedited licensing procedures. If the licensing is delayed, it delays the subsidy. It is not a situation in which we would remove the child from that family placement. We want to avoid disruptions to the fullest extent possible, and I wanted to state that for the record.

We appreciate legal aid's goal in working on this bill. Because of the language that was in the statute, there were some issues with how that language was being interpreted. That is why we worked with them on this bill to mirror the federal Title IV-E language which will enable us to get the financial support to our families. To Assemblywoman Thomas and Assemblywoman Summers-Armstrong, if you would like me to follow up with you about that process, especially if you have seen some issues in your communities, I would be happy to do that after the hearing.

Chair Nguyen:
Do we have any testimony on the line in support of S.B. 158 (R1)? [There was none.] Is there any testimony in opposition to S.B. 158 (R1)? [There was none.] Is there any testimony in neutral on S.B. 158 (R1)? [There was none.] With that, I will call our bill presenter back up to the table for any closing remarks.

Gillian Block:
I will reiterate that this bill makes a small change to a narrow piece of the NRS to ensure that the eligibility requirements are not more restrictive than federal requirements and creates and expands opportunities for families and for children. Thank you for hearing the bill today.

Chair Nguyen:
At this time, I will close the hearing on S.B. 158 (R1) and open the hearing on Senate Bill 175 (1st Reprint).

Senate Bill 175 (1st Reprint): Enacts provisions relating to lupus. (BDR 40-8)

Senator Dina Neal, Senate District No. 4:
I am here to present Senate Bill 175 (1st Reprint). Senate Bill 175 (1st Reprint) is legislation I brought forth on lupus. I have been trying to tackle a couple of diseases that are considered invisible diseases. Last session I tackled sickle cell anemia; this session I was going after lupus because it is one of the diseases that is hard to diagnose, affects predominantly women, and predominantly affects women of color—Hispanic and African American. I have a copresenter who may be on Zoom. She is a member of the Lupus of Nevada organization.

Chair Nguyen:
If you are on Zoom, please unmute yourself. No, I do not see her.

Senator Neal:
In your exhibits there should be some data concerning emergency visits and inpatient admissions from the U.S. Department of Health and Human Services, giving you the specific data on Nevada [Exhibit G]. There was a second document uploaded titled "National Public Health Agenda for Lupus 2015: A Blueprint for Action" [Exhibit H]. I submitted those two exhibits because the bill helps us to align with the national policy agenda around lupus. The first document also shows lupus-related emergency department visits by demographics and sex and lays out the number of visits, roughly about 1,500 total admissions [page 1, Exhibit G]. This is the data we currently have, and this bill would expand that dataset and allow us to grow in terms of the variants we would be able to identify.

Getting into S.B. 175 (R1), sections 2 through 12 give definitions. Section 4 is very important because there are four types of lupus. This bill would get documentation about systemic lupus, cutaneous lupus, drug-induced lupus, and neonatal lupus which affects newborns. Section 5 lays out the duties of the Chief Medical Officer and what that person would be responsible for doing. We are creating a registry and a system so that the record and the cases of lupus and its variants are reported to the state. The Chief Medical Officer is responsible for conducting a comprehensive epidemiologic survey of lupus and evaluating the appropriateness of the measures for the treatment of lupus and its variants. It also includes how hospitals, medical laboratories, and other facilities are a part of this reporting scheme because they are on the front lines providing screening, diagnostics, and therapeutic services to patients with respect to lupus. They shall report their information to the State Board of Health of the Department of Health and Human Services. Also in section 5, subsection 4, it states, "Any provider of health care who diagnoses or provides treatment for lupus and its variants, except for cases directly referred to the provider . . ." must also report the information.

When you get to section 6, this lays out the information that is required to be kept based on S.B. 175 (R1). The State Board of Health, shall, by regulation, prescribe the manner in which information will be maintained: basic name, address, age, and ethnicity of patient; the variant of lupus; the method of treatment; any opioid prescribed for the patient and whether the patient has adequate access to an opioid; and any other diseases from which the patient suffers. The reason why the diseases are important is because there can be several offshoots. You can end up with cardiovascular disease, stroke, rashes, painful joints, inflammation, fatigue, and some cognitive issues. I met some patients over the summer, and there is a clear case based on the women that they are being misdiagnosed when they go into the hospital. If Ms. Calvinia Williams had been on Zoom, she would have told you that in her situation they believed she was having a stroke. If the doctors had had their way, they would have given her medication which probably would have ultimately caused her death because what was really happening was that she was having a lupus-related incident that needed to be diagnosed. It turned out that there was only one doctor who happened to pass her as she was laying in the hallway, identified her symptoms, and was then able to treat her. She is now living with us today.

I ran into women who, when encountering issues with their rheumatologists, are then challenged with the care model being presented to them because they are being told that they are not really sick, that they do not have lupus, but yet they have been diagnosed for ten years. I recently heard a story about a woman who had been on lupus medication for the past 20 years then ran into her rheumatologist who took her off all medications and placed her on Tylenol for her pain and inflammation. Tylenol has the effect of damaging kidneys in lupus patients, so she is now in a pickle because they are saying that she is a problem patient rather than listening to her and understanding that she knows her care better than anyone else and that she is trying to tell the doctor exactly what is going on with her, but yet he is not hearing her. Now she is in a state of panic because she needs to find another doctor who can take care of her. She is worried about the absence of the medications because he removed those medications from her, and now she is on nothing and trying to figure out how she can tell her story to a physician and, hopefully, get to a primary care physician who can get her back on her medications and manage her care.

This is an invisible population. It is very important that we document the method of treatment, which is in section 6, subsection 2, paragraph (c), any other diseases that the patient suffers from [paragraph (d)], and the information concerning the usage and access to health care services by the patient [paragraph (e)]. That is key because they are running into roadblocks in terms of their access to health care and it being properly established that they are lupus patients and not something else. The bill talks about confidentiality, which is in section 6, subsection 3, and that there will be a protocol established by the State Board of Health around the appropriateness for access to and preserving the confidentiality of the records of the patients needed for the research into lupus and its variants. In section 7, the chief administrative officer of the health care facility shall make available to the Chief Medical Officer, or his or her representative, information around each case of lupus and its variants. The Division of Public and Behavioral Health within the Department of Health and Human Services has the responsibility to abstract from those records information and compile it in a timely manner, not later than six months after the Division abstracts the information or receives the information from the health care facility, what is going on with lupus and the lupus variants. There is a timeline.

Section 8 is the reporting and what the report shall be based on and references sections 5, 6, and 7. Based on the information obtained pursuant to sections 5, 6, and 7 of the bill, the Division shall make other appropriate uses of the information to report and assess trends. That is very important because this section is going to assess the trends in the usage of and access to health care services by the patients with lupus and its variants in a particular area or population. It will also be important for this section to be applied because they will advance research and education concerning lupus. There are several organizations already in play on the national level. The Centers for Disease Control and Prevention (CDC) has been running surveillance projects in a couple of other states. It would be nice if, once we pass this bill and get aligned with the national standards, we could become a part of a surveillance project and start to develop and lift up these patients so we can identify their associated disorders and the variants and the access-to-care issues they are facing.

Further on in section 8, subsection 1, paragraphs (a), (b), and (c), it lays out the information concerning the locations in which patients diagnosed with lupus and its variants reside, the demographics of those patients, the utilization, and the information in paragraph (b) specific to patients diagnosed with lupus and its variants who are over 60 years of age, and the transition of patients diagnosed with lupus and its variants from pediatric to adults upon reaching 18 years of age. This is important because the continuity of care is important for a young person who may have been diagnosed before age 18 and what that continuity of care will be from rheumatologist to rheumatologist. If they are coming from another state, this will also allow them to at least have some kind of connection to build that transition. This language was similar to an issue I dealt with in sickle cell patients because they literally had a drop-off at age 18. Because of the drop-off at age 18, there was an absence of care between becoming the age of majority and then having to find their own health care—a primary care physician and a rheumatologist who would help them continue their medications and be able to manage their disease.

In section 9, the Chief Medical Officer or any qualified person or designee shall analyze this information pursuant to sections 5, 6, and 7. In section 9, subsection 2, the Chief Medical Officer or designee will determine if there is a trend that exists in the usage of and access to health care. This is important because it lays out that after they make the determination, they are then supposed to work with appropriate government, educational, and research entities to investigate the trends and advance research into the trends and facilitate the treatment of lupus and its variants and associated disorders.

Section 10 allows the Division to apply for and accept grants, gifts, and donations to carry out sections 2 through 12, and continues to discuss how they are going to coordinate and administer any other state programs related to lupus. I wanted to make sure this bill tied them into any federal activity or any state activity going on so they are coordinating at every chance they possibly can with other states to move themselves ahead. With that, I am open for any questions.

Chair Nguyen:
Thank you, Senator Neal. Go ahead, Assemblywoman Titus.

Assemblywoman Titus:
I appreciate your bringing this forward, and I absolutely share your passion and caring for your constituents and all Nevadans. I have a couple of technical questions about the bill. Under section 5, subsection 3, you mention that hospitals, medical labs, and other facilities should provide screening, et cetera, and that you have to provide that information unless it has been provided by someone else. How would they know that, so as to prevent double reporting? How will they know it has already been provided?

Senator Neal:
That will be a key piece that the Department will have to deal with. For the data, right now we are using the International Classification of Diseases (ICD)-10 codes in order to identify whether they went to an emergency room or have inpatient care. There is an absence of data, so this bill would help refine and make sure we are not getting double the information. We do not have the full set of data we need in order to do the analysis and determine access to care and the treatments around the variants. That is what I thought was unique. When I asked what data they actually had on lupus, I asked that the biostatistician send me anything they had on lupus. That is why I uploaded what I did receive in the exhibits because we need to actually collect data. I cannot tell you that it will not be duplicated. We need to get into the fray and find out what is there, pull it from all the areas, and then do the analysis. From that benchmark, we need to make sure that the standard of the information being recorded is just coming from one entity. I do know that there is a small subset outside of the hospital because they either see a rheumatologist or a primary care doctor.

Assemblywoman Titus:
As a primary care doctor, a family practice doctor, I have seen many patients who thought they might have lupus or who were subsequently diagnosed with lupus, so it is not something just limited to women of color. It is throughout the spectrum, but especially in women. Getting in to see a rheumatologist is the X factor. We have to do all these tests prior because we have so few rheumatologists in the state. Before I could refer a patient, I would have to send all the tests I ordered. In order to get permission from their insurance companies to obtain the tests, I would have to use an ICD-9 code to justify the tests, so I wanted clarification on how they were reporting and on duplication of reporting. I certainly understand your comment that in order to even start, we have to have some sort of template to get started with the data. Then we can go through it later. Do any other states have this model? Would Nevada be the first state that does this, or are you using some other state's successes?

Senator Neal:
I pretty much built this bill off my sickle cell bill, but they are doing it in California. It is my understanding that they are also doing some work in New York and Georgia and maybe in another state. In 2011, Illinois passed a lupus education awareness act; in 2014, Georgia created a council on lupus for education awareness, so other states have done different variations. California has been the surveillance project that has been with the CDC, but Illinois and Georgia focus more on education awareness. This bill, S.B. 175 (R1), is getting into reporting and doing a registry which I was trying to match with what California is doing.

Assemblywoman Titus:
Thank you for that, and thank you for your passion, Senator Neal.

Chair Nguyen:
Next we will go to a question from Assemblywoman Thomas.

Assemblywoman Thomas:
I love the bill and I would also like to be a cosponsor on the bill. I know this is crunch time, but, for the record, I would like to note that. My question concerns the reports. After all the reports are in, is there a way for the Legislature to get the reports so they do not just sit on someone's desk collecting dust?

Senator Neal:
I want to acknowledge Assemblywoman Titus because what she said is true. If you look at the data, 88 percent of people with lupus are women. To your question, Assemblywoman Thomas, I have not considered giving this information to the Legislature because the reverse may occur—reports sit on legislators' desks, so I have more interest in it going to the Department where they are more engaged and active in looking at the information. The way the bill is set up, the Chief Medical Officer will engage in analysis and do an assessment to determine trends. If it went to the Legislature, you would see it as a report—and we get many reports. Unless you specifically look for it, it has value only to the person seeking it out. I am not going to say this in a negative way, because we tie ourselves to legislative reports. We believe that the Legislature is this esteemed body, but unless you are totally engaged in making sure something happens—following your legislation, looking at the reports, the data, and acting upon those agencies—that is the only value of the legislative report. You have to actually make the Legislature, esteemed body that it is, have the power and authority to go to the person and say, You have not responded to this data and I need you to respond to this data. For now, I am going to keep it with the Department of Health and Human Services.

Assemblywoman Thomas:
Thank you, Senator Neal, I appreciate that, but I also had a vested interest. You mentioned neonatal lupus. I am very concerned about that.

Senator Neal:
I will add you to my bill.

Assemblyman Matthews:
I appreciate the question from Assemblywoman Titus, as I was curious along those same lines. In response, I think you said that California has a registry along these lines. Could you speak to what they are doing with that information? Has it led to policy changes, or are policy changes in the works? Have there been any changes or improvements in health outcomes? I guess that would depend partially on how old the registry is or how long they have been doing this, but I was hoping you could speak to what has occurred in California as a result of this.

Senator Neal:
California attempted legislation twice, once in 2011. It did not pass then, so they tried again in 2014, and then they got connected to the CDC. It is my understanding that the work they have been doing is a part of the National Lupus Patient Registry. They have managed to get consecutive funding from Congress of about $9.5 million. They also funded $10 million for a lupus research program in which California—and possibly Georgia—is a part of the CDC's surveillance project. In addition, in 2020 because of the work that has been happening—giving information to the CDC and the national group—they got $2 million for the lupus program. Also, the National Institutes of Health, the largest public funder of research, was given an increase of $1.25 billion. It is my understanding that, since roughly 2014, they have been building this National Lupus Patient Registry and they have been able to leverage funding and create research programs in order to help other states.

I wanted S.B. 175 (R1) to become a part of this national work and that Nevada get into play. I did not find out that we were behind the times until I got this document from Director Richard Whitley who told me that S.B. 175 (R1) aligned with a 2015 agenda around lupus work. Since it is now 2021, I said we should get in the game—we are six years behind—and start playing in this national work.

Assemblyman Matthews:
In terms of the initial consequences in California, it has resulted in access to additional funding. It is perhaps premature to say whether that is getting us on the road, presumably to improved health outcomes and changes in policy beyond that. They are still in the phase of bringing in financial funding for this at this point. Is that correct?

Senator Neal:
The latest report from the CDC said that they were able to document 16,000 new cases per year. I think the registry has helped them reach that 16,000-per-year number. I would not say that they are in the forming stages. They probably started at an infant stage around 2014 or 2015, and then they have successfully grown. I just want Nevada to be a player because we have a lupus population here that feels as though they are drowning and not a part of the care. Ms. Calvinia Williams created an organization in order to do the work in Las Vegas and is doing it all on her own, reaching out to women. This gives her a chance to take the work she has done and leverage it into the state and, hopefully, into a national conversation to say that Nevada has lupus patients who need to be a part of the work.

Assemblywoman Peters:
Thank you for bringing this bill. We have a familial connection with lupus, and it is a pretty terrifying disease with the unknowns and some of the ways it expresses itself. The information around it is not readily available. My question is about the reporting expectations in the bill. Are you expecting that the reporting would be defined through the regulatory structure?

Senator Neal:
Yes. In section 6 it is by regulation.

Assemblywoman Peters:
From there, are you expecting that the regulations will ask for reporting per case or on an annual basis? By which provider will this happen, the individual provider or the facility in which the provider works?

Senator Neal:
The intent is that whether it be a hospital, medical laboratory, or other facility that is either providing the screening or the diagnostic or therapeutic services, they are reporting that information to the State Board of Health. That is the goal.

Assemblywoman Peters:
Will that be annual, or is it more important to get it up-front and see it as the diagnosis is happening?

Senator Neal:
It is supposed to be happening when they go, within that six-month window. It is not annually, but they will be reporting when those cases come through, and there should be a compiling moment. In section 7, subsection 2 where it says, ". . . the manner and not later than 6 months . . ." the Division abstracts the information and then we have the analysis that occurs. We are collecting, then we are going to abstract the information, then we are going to do the analysis to determine if there are trends.

Chair Nguyen:
Do we have any other questions from members? Seeing none, at this time I will begin testimony in support of S.B. 175 (R1).

Calvinia Williams, Founder and President, Lupus of Nevada, Inc.:
Senator Dina Neal, thank you so much, and I would also like to thank the Committee on Health and Human Services. I am pleased. Lupus of Nevada, Inc., our agency, is advocacy and education awareness. One of the things we want to see with S.B. 175 (R1) is accountability, the reporting process in this. When our lupus individuals go to the doctors, and this has been over 17 years in Nevada doing this, they will come out with no answers at all. The second thing I would like to have is the demographics of this. That is what we really wanted, to hold that accountable so the registry can get their hands on it and we can fight to get grants. We do not know how many people in Nevada have it. My people call me

daily complaining about the fact that they went into their doctor, went to California, have been diagnosed for 16 years, moved here 6 months ago, one physician told them they did not have lupus, took all their medicine away, and now they are told to get on Tylenol. We need accountability with this because we need to figure out what is going on for someone who has been on medication for 16 years. Now this individual does not have any doctor. I get concerned and agitated because I am a major advocate for this. We need your help, and this bill is going to do it for us. It is going to set boundaries and standards determined by the diversity of the people who have it here in the west side, the south, the southwest. A lot of people are not going to the doctors because they are not going to get the outcomes that they are expecting to get. That is why I feel it is so important for this bill.

Chair Nguyen:
Is there anyone else to testify in support? [There was no one.] Next, I will go to testimony in opposition to S.B. 175 (R1). [There was none.] Do we have anyone testifying in neutral? [There was no one.] With that, I will call our bill sponsor up to make any closing remarks.

Senator Neal:
I want to thank the Committee for hearing S.B. 175 (R1). If this bill gets out, it will do really good work for patients who have an autoimmune disease who want to have proper care and transparency around their disease. Thank you for your time.

Chair Nguyen:
With that, I will close the hearing on S.B. 175 (R1) and open the hearing on Senate Bill 318 (1st Reprint).

Senate Bill 318 (1st Reprint): Makes various changes relating to improving access to governmental services for persons with limited English proficiency. (BDR 40-955)

Senator Fabian Donate, Senate District No. 10:
Today's conversation on language access is something that is long overdue, and I am glad we can be here to address a much-needed gap that is always ignored until it is too late. The COVID-19 pandemic has shown just how valuable information access can be for those who may not have the adequate education or resources to understand and take part in relevant health information. Failing to prioritize information access can result in public health disinformation and distrust, which is in direct alignment to an environment that can foster vaccine hesitancy. Vaccine hesitancy, as in the refusal of vaccines despite the availability of these services, is a very real problem here in Nevada that will become apparent within the next few weeks, especially as we begin to expand our reach to marginalized groups that have been abused and neglected for years.

In public health, we use the term "health literacy" to describe a person's ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others around them. Health literacy is an important thing to consider in developing programs that improve the community's health status, mostly because it acknowledges any present limitations and emphasizes the ability to use health information, not simply to just understand it. To make well-informed decisions, health literacy skills are needed. This means that the wide range of our population must have the adequate foundational knowledge of a health problem before even considering the implications that may arise.

As legislators and public servants, the reality of this pandemic is that we have not done our best with how this response has taken shape, mostly because we did not have the right infrastructure in place to carry out a good response. If we want to fix the disparities observed in communities of color, we have to take the right step to invest in public health services that will achieve good outcomes. The biggest takeaway from today is that health literacy starts at the distribution of information, and information is accessible when it is done in a culturally competent manner within your own native language. Your language is your culture, and your culture can modulate your perceptions of what health can mean to you. With the permission of the Chair, I will turn this over to Ms. Olivia Whiteley, Western States Advocacy Officer from the Refugee Advocacy Lab, to give her remarks on the bill language and a brief rundown on the intended outcomes on Senate Bill 318 (1st Reprint).

Olivia Whiteley, Western States Advocacy Officer, Refugee Advocacy Lab:
Thank you, Chair Nguyen, and members of the Committee, for hearing S.B. 318 (R1) and allowing me the opportunity to speak to this critical proposal. I will provide an overview of the development of this bill, the components of the bill, and additional remarks related to the outcome of the bill.

Over the past several months I have surveyed Nevada's resettlement agencies, and the number one shared concern of these agencies is language access, particularly for refugees who speak uncommon languages. Organizations that serve Nevada's refugees report that qualified interpretation and translation services are often unavailable as clients interact with essential state agencies and programs such as small business support or the Department of Motor Vehicles. These barriers have been amplified with the onset of the pandemic, as reliable, up-to-date public health information regarding the coronavirus is continually needed to enable refugee and limited English proficient Nevadans to protect themselves and their families.

This bill was drafted based upon similar legislation previously introduced in other states—including Alaska, Pennsylvania, New York, Michigan, California, Hawaii, Washington, Illinois, New Jersey, Virginia, and New Mexico—the Department of Justice's "Language Access Assessment and Planning Tool for Federally Conducted and Federally Assisted Programs," and feedback from local community groups.

Senate Bill 318 (1st Reprint) has two primary components. First are the COVID-19 relief provisions. Senate Bill 318 (1st Reprint) requires the Division of Public and Behavioral Health of the Department of Health and Human Services and each health district or department to record the preferred language of every individual who receives COVID-19 services; provide limited English proficient individuals with interpretation services, either in-person or remotely; translate vital documents such as applications or notices related to COVID-19; translate governmental orders related to COVID-19; and collaborate with community-based organizations to ensure all local languages are represented.

The requirements for language services are proportionate to the number and language of limited English proficient individuals served by the division or health district, ensuring smaller health districts do not have to provide services in the same frequency or breadth as larger health districts. If a health district only serves individuals who speak Spanish, Arabic, and Hindi, that district only has to provide services in those languages. The Division of Public and Behavioral Health submitted a zero-dollar fiscal note for S.B. 318 (R1) as they already have the requisite federal funds to implement the provisions of section 2, and sections 3 and 4 which apply to district health divisions and departments are operative "to the extent that money is available for these purposes" and intended to guide the appropriation of American Rescue Plan Act of 2021 dollars. Senator Donate spoke artfully to the critical nature of these provisions.

Second, S.B. 318 (R1) addresses language access for governmental services beyond COVID-19 by requiring state agencies to create language access plans. Each executive agency's language access plan is required to include:

1. An outline of existing regulations and compliance;
2. Demographic information on individuals served by the agency;
3. An inventory of current language services and training resources;
4. A review of COVID-19 language access measures; and
5. Estimates of additional funding, employees, and resources necessary to meet identified needs.

Senate Bill 318 (1st Reprint) also requires a public comment period for the drafted language access plans, to ensure the voices of interpreters, translators, and English-learner clients are adequately taken into consideration.

One point to be clear on is that S.B. 318 (R1) does not require agencies to implement their language access plans, only to "develop" and "revise" the plans. Section 7, subsection 4, of the bill requires agencies to include implementation costs in their 2023-2025 budget requests, allowing the Legislature to consider the full funding required for the implementation during the next session. Following the initial amendment of the bill which clarified the distinction between planning and implementation, many agencies eliminated or significantly decreased their fiscal notes [Exhibit I, Exhibit J, Exhibit K, and Exhibit L]. Senate Bill 318 (1st Reprint) is a relatively low-cost, first step toward ensuring language access throughout the state.

Currently, there is no state-level standardized process for ensuring state agencies take reasonable steps to ensure meaningful access to eligible limited English proficient individuals. There is no relevant statewide requirement in the *Nevada Revised Statutes*. There is no mention of linguistic accessibility in the 2020 State Administrative Manual. This prohibits a significant amount of Nevada's population from accessing public goods, services, or benefits. According to data from the 2019 American Community Survey from the U.S. Census Bureau, between 10.7 percent and 13.8 percent of Nevada's adults and 5.8 percent of Nevada's children speak English less than very well.

The implications of a lack of statewide guidance or resources can be found in the following case study. Within the Department of Health and Human Services (DHHS), the Division of Child and Family Services (DCFS) has the most comprehensive set of publicly available language access policies—a limited English proficiency (LEP) policy from 2017, and a culturally and linguistically appropriate services policy from 2018. These policies contain several praiseworthy components that S.B. 318 (R1) would require of all agencies. However, even these policies are four to five years old and lack standardization. For example, the culturally and linguistically appropriate services policy defines an interpreter or translator as an individual who has a bachelor's degree from an accredited institution, preferably in languages or linguistics, and possesses at least one year of specialized experience, while the LEP policy has no such definition or qualifications requirement. As both policies are specific to the same program area within DCFS, Children's Mental Health Services, this fundamental determination of who is competent to interpret or translate treatment options, eligibility requirements, or medical conditions to parents whose children are facing mental health difficulties should be standardized.

If you look through other publicly available DHHS LEP policies, you will see a further lack of standardization. Some of these policies are a single paragraph, and some are not publicly available. The agency or division an individual is dealing with should not determine an individual's ability to access essential information in their preferred language about programs that they are eligible for but which are funded by their tax dollars—nor should an individual's ZIP Code.

It is possible and likely that the agency and its divisions have additional policies, plans, and resources for ensuring language access that are not readily available to the public. Further, this is not intended as a comprehensive evaluation of the existing language access work of these departments. Across the state agencies and departments we have spoken with, all have expressed a very strong desire to expand their language access offerings, but have a general lack of resources to do so. Senate Bill 318 (1st Reprint) provides a statutory basis for all agencies to include funding to support the implementation of their language access plans in their biennial budget requests, bridging the gap between agency intent and the resources available to each agency.

My final remark, and perhaps my most important remark, is that S.B. 318 (R1) is a civil rights issue that underlines all other activities of this Committee. One primary objective, if not the primary objective, of the Civil Rights Act of 1964 was to prevent the discriminatory use of public funds, ensuring that all who paid taxes were able to access the goods and services those dollars subsidized. The Act's prohibition of discrimination on the basis of national origin was explicitly extended to language access in the Supreme Court's 1974 *Lau v. Nichols* decision. Senate Bill 318 (1st Reprint) attempts to actualize those protections and that promise that all Nevadans, regardless of language, can access governmental services. Every bill, program, or full-time employee currently under consideration by this Committee, each of those is only a just use of taxpayer dollars if all Nevadans—Spanish-speaking, Lingala-speaking, or Kinyarwanda-speaking—can understand the related application forms, notices, or systems to have the needs of their families be understood by staff. I humbly ask Committee members to invest in this two-year, civil rights planning exercise, and I am now open to questions.

[Assemblywoman Peters assumed the Chair.]

Vice Chair Peters:
Do we have questions from the Committee? [There were none.] I had a question related to some of the exhibits that were provided for this hearing. It looks like most of your fiscal notes have been removed. To be clear, this is a policy committee and not the fiscal committee, but I am curious about these removals post-passage from your house. Are any fiscal notes still retained and, if not, why did the amendment not get them all removed?

Senator Donate:
Over the last couple of months we have had extensive conversations with each of the departments and agencies as to how this would be implemented once it becomes law. I think it is very clear from our conversations with each of the agencies and departments that this is something they have wanted for a very long time, but the question is how do we get to language access?

Part of the amendment we submitted in the Senate was to reiterate to the departments and agencies that Ms. Whiteley and I are not looking for implementation. We are looking for them to determine what they need to implement language access. That has been made clear by the fiscal notes that have been removed. There is only one fiscal note outstanding, and that is with the Department of Corrections. We made clear to them that our bill only creates an access plan and is simply an exercise and not for implementation.

Vice Chair Peters:
Thank you. I did look at some of that language and the fiscal note. It is my understanding from your language that you are not requiring an additional person, just somebody who may have interest in this who can champion it through their offices. Are there any other questions?

Assemblywoman Benitez-Thompson:
Thank you for this bill. In previous conversations, the intersection between language access and health equity is the new, big policy frontier we are going to have to battle moving

forward. Future Legislatures will decide whether we do it piecemeal, statute-by-statute, or here and there.

Section 7 deals with a language access plan for the Executive Department. Can you tell me more about what you would hope to see as that work product? When I look at some of the pieces, some have more readily handy data and would not necessarily need a new way to pull up that data. For instance, section 7, subsection 2, paragraph (b), talks about the relevant demographics. If we are looking at Health and Human Services, Medicaid, or Temporary Assistance for Needy Families, there is lots of data on demographics there. For some other departments, tell me more about the type of work product you are hoping to see from them.

Senator Donate:
I will turn that over to Ms. Olivia Whiteley, who can speak more to that.

Olivia Whiteley:
There are a couple of outcomes we are hoping to see from the language access plans that are required under section 7. One of the primary purposes for creating the plans required under section 7 would be to allow agencies to develop a robust, detailed understanding of what costs would be associated with implementing that language access plan and ensuring that all Nevadans could understand and access their services. The bill requires agencies to submit that fiscal note in the 2023-2025 biennium so that can be a discussion occurring in the Legislature during that period. All the language access planning components are purposed toward ensuring that agencies can then take that next step to implementation.

In regard to the content of the plan, you are correct in that, first, it does require agencies to gather demographic data; this can be done in a couple of different ways. Second it requires agencies to include in their language access plans an inventory of existing services. This inventory was based off the U.S. Department of Justice's language access assessment and planning tools. It goes through things like what training is provided to employees, and it is fairly specific. It asks them if they provide employees with training on how to talk with a limited English proficient individual over the phone, via email, or in person; so it goes through a checklist of those existing services. The language access plan also requires agencies to report on ways where laws might need to be modified to better serve limited English proficient Nevadans. It requires agencies to evaluate where areas that translator and interpreter certifications are not listed for their particular agency activities. Perhaps in conjunction, there would be workforce development opportunities. Sometimes for these less frequently spoken languages, there is even a lack of local interpretation or translation resources available for agencies to use, so it also attempts to fill some of those gaps.

Assemblywoman Benitez-Thompson:
I appreciate that. I know it is a long, hard road. I already have a June 10 meeting on my calendar for the Information Technology Advisory Board. It is the committee that looks at the technology of the state. Obviously, our meetings were disrupted during the pandemic, but in that committee we talk about the work just to become compliant with the Americans

with Disabilities Act (ADA). The last comment from about six months ago was that we are more than a decade away from being fully ADA-compliant just on our state's websites.

What I have learned is, wherever you can fit it in to different pieces as they are moving, jump on it there. As long as we are having the conversation about modernizing some of our systems and we talk about accessibility, we should make sure to add language to that accessibility as well. For those pieces we are starting to modernize now, at least we can look at a language component and play catch-up on everything else. As much as you can, I would hope you would want this section to be liberally construed to make sure that the Executive Branch departments, where they see an opportunity to do this work, that they can. It may not be a symmetrical kind of progress; it might be asymmetrical where you will see certain departments moving ahead of others. Some may be more organically equipped and come at this from a different direction than others. You can tell by the fiscal notes we get from some departments when we ask for culture change—systemic culture change—how willing they are. That is the first bellwether as to who is interested in doing this or not. I think it is headed in the right direction. Hopefully, they will engage in this work in a meaningful way. I understand that they are busy, but this will lead us to a better place.

Assemblywoman Titus:
Senator Donate, thank you for bringing this forward. This problem is real. During this COVID-19 epidemic we had significant issues reaching out to our guest worker programs in my community. We bring in a huge number of guest workers and needed to make sure they had information regarding COVID-19 and knew the measures to be taken such as washing hands, social distancing, and wearing masks, whatever those measures were. Initially the information was not in Spanish, which is the language of our guest workers. I want this on the record now that I reached out to Assemblyman Flores and Assemblywoman Torres to help me put together information even though the state had information out there. I asked for help interpreting that information, and I got recommendations; so having a process, not only in Spanish, but also in a format that someone reading it would understand and not be threatened by. This was more a comment, but I wanted to thank you for bringing this forward. I think this is important, and for those doubters, it was a significant aha moment for me this last summer when we could not get the information out that we needed to get out, not only in their language, but in whatever the translation was they would accept and trust. The health care system is all about building trust. We do not just want some bureaucrat to write it in Spanish, which was not really their language anyway. It was a textbook kind of interpretation, so I think there is a huge need here.

Vice Chair Peters:
Are there any more questions from the Committee? Seeing none, we will move on to support testimony on S.B. 318 (R1).

Manuel Mederos, Language Access Specialist, Language Bank, Northern Nevada International Center, University of Nevada, Reno:
I run a program called the Language Bank. I am giving testimony in full support of S.B. 318 (R1) because it is critical that each Nevada state agency is really able to create their own

language access plan. This plan would help state agencies meet the language needs of Nevadans experiencing significant barriers to accessing state services related to COVID-19 due to the lack of materials and information translated. I cannot say enough and emphasize enough the importance of providing appropriate access to language services which would provide much-needed culturally and linguistically appropriate services to our growing, diverse communities. As many of you have recognized today, Nevada is an extremely diverse state. It is beyond Spanish; it is beyond English; there are a multitude of languages in our state. Providing [unintelligible] services to clients regardless of their spoken language is a crucial component in the provision of trauma-informed, nondiscriminatory, safe and effective assistance to all members of our communities throughout our wonderful state of Nevada. Today, the focus is COVID-19; however, in the future, it could be something else—a disaster of some sort, another pandemic, or a statewide emergency. This bill would allow each state agency and personnel to make language access plans appropriately. Furthermore, this bill would allow and help state agencies train their personnel so that they can effectively communicate with limited English individuals and can effectively work with language interpreters.

Lastly, the COVID-19 pandemic has disrupted nearly every aspect of our lives and reached into nearly every community in our state. Our ability to keep one another safe and healthy depends on every Nevadan having access to credible, trusted information about how to prevent the spread of COVID-19, the types of supports and services available, and how to comply with federal and state and local orders. We know certain communities are disproportionately impacted by this pandemic, and one way we can shift that injustice is by meeting our obligation to communicate in ways that are accessible and culturally and linguistically relevant. We need S.B. 318 (R1) to ensure that our underserved communities can access lifesaving information and care. Thank you for hearing me today, and please support S.B. 318 (R1).

William Pregman, Communications Director, Battle Born Progress:
We rise in support of S.B. 318 (R1). Since the beginning of the pandemic, Nevada families who either are not fluent in English or do not speak English as their primary language are often alienated from COVID-19 public resources. Luckily, a network of community support ensured these materials were translated to help folks connect with housing, health care, food, or other resource assistance they needed. We thank Senator Donate for bringing forward this bill to provide information on state resources in multiple languages. We support this effort to make our social safety net accessible to all communities, regardless of which language they speak so they have accurate information on how to find what they need. We urge your support of this bill.

Vice Chair Peters:
Next caller, please. [There was no one.] Is there anyone who would like to testify in opposition to S.B. 318 (R1)? [There was no one.] I will now ask for neutral testimony on S.B. 318 (R1).

Bradley Mayer, representing Southern Nevada Health District; and Washoe County Health District:
I wanted to acknowledge the sections of the bill that apply to us. We really appreciate Senator Donate and Ms. Whiteley for working with us early on. Senator Donate engaged us right away when this idea emerged. He worked with us on the bill throughout the course of hearings in the other house to get it to a place where we can ensure maximum effectiveness from the health districts' perspective and execution of this, especially as it relates to money being available for these services. We thank him, and we wanted to acknowledge that.

Vice Chair Peters:
Is there other neutral testimony on S.B. 318 (R1)?

Margarita Salas Crespo, Senior Advisor, Office for New Americans, Office of the Governor:
I am testifying in neutral for S.B. 318 (R1). The Office for New Americans in the Office of the Governor was created to ensure the civic and economic integration and inclusion of immigrants and refugees in the state of Nevada which account for 20 percent of the population in our state. Providing language access services helps bridge the communication barrier with individuals who cannot speak, understand, read, or write fluently in the host country language. A Nevada language and demographic data report provided to our Office for New Americans indicates that 5.2 percent of Nevada immigrants and refugees have a limited English proficiency.

Senate Bill 318 (1st Reprint) seeks to bridge the gap of communication by proactively ensuring that the Division of Public and Behavioral Health in the DHHS and each district's health department take reasonable measures to ensure that persons with limited English proficiency have meaningful and timely access to services to restrain the threat of COVID-19. As we all know, immigrants and refugees and people of color have been disproportionately affected by the COVID-19 pandemic, and trying to ensure the access to benefits and resources in a language they understand and in a culturally competent manner is one way to ensure an equitable COVID-19 response. In addition to addressing language access for the COVID-19 response, section 7 of this bill requires each Executive Department of state government to develop and biennially revise a language access plan as an initial step toward ensuring that each state agency provides high-quality and appropriate language services to the constituency they serve. A language access plan will help in the success of the state's efforts to ensure that all Nevadans have access to other timely and vital information in the language they understand and in a culturally competent manner.

Sean Sever, Administrator, Division of Management Services and Programs, Department of Motor Vehicles:
I want to comment on our fiscal note. We are neutral on the bill, of course, but after receiving clarification that the bill calls only for the formation of a language access plan and not the actual implementation of the plan, we have determined that the Department of Motor Vehicles' fiscal note can be revised to indicate there is no fiscal impact.

Vice Chair Peters:
Thank you for putting that on the record. As this is not the Ways and Means Committee, we will ensure that is on the record for the bill and will pass that information on to our fiscal committee. Is there anyone else on the line for neutral testimony? [There was no one.] Does the bill sponsor have any closing remarks?

Senator Donate:
Thank you so much for the opportunity to speak with you today. I would like to share one thing. When I first started on this journey in the Senate, trying to decide which bills I wanted to push forward, I knew that language access in public health had to be one of those priorities, for the sake of my family and for the greater immigrant community. Senate Bill 318 (1st Reprint) is an effort that can address many of the observed gaps we see in translation of services and, most importantly, it reframes the conversation of increasing access for the COVID-19 vaccine and for public health. In reality, it provides leverage to Nevada families who have been ignored or forgotten for far too long, so thank you for your consideration today.

Vice Chair Peters:
Thank you, Senator Donate. With that, I will close the hearing on S.B. 318 (R1). That concludes the bills we had on the agenda for today. Our last agenda item is public comment. Is there anyone who wants to testify under public comment? [There was no one.] Are there any comments from Committee members? Seeing none, that concludes our meeting for today. Further meetings this week will be upon the call of the Chair. Thank you so much, Committee. We are adjourned [at 4:00 p.m.].

RESPECTFULLY SUBMITTED:

Terry Horgan
Committee Secretary

APPROVED BY:

Assemblywoman Rochelle T. Nguyen, Chair

DATE: ______________________________

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a copy of a PowerPoint presentation titled "SB 70: Modernizing and Clarifying The Mental Health Crisis Hold Process," dated May 24, 2021, presented by Jessica Flood, Coordinator, Northern Regional Behavioral Health Policy Board, regarding Senate Bill 70 (2nd Reprint).

Exhibit D is a letter dated May 24, 2021, signed by Lawrence Barnard, Nevada Market President, President/CEO, Siena and Rose de Lima Campuses, Dignity Health-St. Rose Dominican, submitted by Katie Roe Ryan, System Director, Nevada Government Relations, Dignity Health-St. Rose Dominican, in support of Senate Bill 70 (2nd Reprint).

Exhibit E is a letter submitted by Laura Drucker, Legislative Co-Chair, Nevada Psychological Association, in support of Senate Bill 70 (2nd Reprint).

Exhibit F is a letter dated May 21, 2021, submitted by Cynthia Lu, District Court Judge, Department 5, Second Judicial District Court, Washoe County, in support of Senate Bill 70 (2nd Reprint).

Exhibit G is a document titled "Lupus-Related Emergency Department Visits, Inpatient Admission, and Deaths," dated January 4, 2020, submitted by Senator Dina Neal, Senate District No. 4, regarding Senate Bill 175 (1st Reprint).

Exhibit H is a document titled "National Public Health Agenda for Lupus 2015: A Blueprint for Action," submitted by Senator Dina Neal, Senate District No. 4, regarding Senate Bill 175 (1st Reprint).

Exhibit I is a copy of an email dated May 24, 2021, submitted by Sarah Nick, Management Analyst, Legislative Liaison, Department of Education, regarding Senate Bill 318 (1st Reprint).

Exhibit J is a copy of an email dated May 24, 2021, submitted by Sandra J. Anderson, Executive Director, Board of Massage Therapy, regarding Senate Bill 318 (1st Reprint).

Exhibit K is a copy of an email submitted by Mandi Davis, Deputy Administrator, Administrative Services, Division of Child and Family Services, Department of Health and Human Services, regarding Senate Bill 318 (1st Reprint).

Exhibit L is a copy of an email to Senator Donate submitted by Gary K. Landry, Executive Director, Board of Cosmetology, regarding Senate Bill 318 (1st Reprint).