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

Eighty-First Session
February 8, 2021

The Committee on Health and Human Services was called to order by Chair Rochelle T. Nguyen at 2:09 p.m. on Monday, February 8, 2021, Online. 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 Annie Black
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:

None

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Patrick Ashton, Committee Policy Analyst
Karly O'Krent, Committee Counsel
Abigail Lee, Committee Manager
Terry Horgan, Committee Secretary
Trinity Thom, Committee Assistant

OTHERS PRESENT:

Lisa Sherych, Administrator, Division of Public and Behavioral Health, Department of Health and Human Services
Julia Peek, Deputy Administrator, Community Health Services, Division of Public and Behavioral Health, Department of Health and Human Services
Nicki Aaker, Director, Carson City Health and Human Services
Kevin Dick, District Health Officer, Washoe County Health District
Fermin Leguen, District Health Officer, Southern Nevada Health District

Chair Nguyen:
[Roll was taken.] Let us get started with our first presenter. We are going to take a deeper dive into some of the state agencies, so we will turn this over to the Division of Public and Behavioral Health in the Department of Health and Human Services.

Lisa Sherych, Administrator, Division of Public and Behavioral Health, Department of Health and Human Services:
Several of us will be sharing today's presentation [Exhibit C]. Moving to our first slide [page 2, Exhibit C], this provides an overview of our division's vision and mission. The next slide [page 3] provides an overview of our division's organizational chart, and the subsequent slide [page 4] provides an overview of our agency's operations. As you can see, we are composed of five service branches—community health, regulatory and planning, clinical, behavioral health policy, and administrative services.

The next two slides [pages 5 and 6] provide an overview of our public health program, and the next three slides [pages 7-9] provide an overview of our division's accomplishments. Of note, I am particularly proud of the work the Division of Public and Behavioral Health has continued to do related to addressing COVID-19's spread within Nevada's licensed facilities. Comparing the national average of the percentage of deaths in facilities, Nevada has consistently been under 25 percent, whereas the approximate national average is 40 percent, with some states as high as 80 percent. Additionally, Nevada has been under 20 percent since August and, as of today, we are at 15.8 percent. That is 1.5 percent lower than it was a couple of weeks ago. The next slide [page 10] provides information on our division's public health priorities. Now I will turn it over to Julia Peek who will provide a further overview of our presentation.

Julia Peek, Deputy Administrator, Community Health Services, Division of Public and Behavioral Health, Department of Health and Human Services:

One of the easiest ways to understand public health is to understand the historical accomplishments in the field. I have provided a link in the PowerPoint of ten great public health achievements [page 11]. I will note the top five which the Centers for Disease Control and Prevention (CDC) notes as: vaccination; motor vehicle safety; safer workplaces, which is related to safety in mining, manufacturing, and construction; control of infectious diseases, which includes clean water and sanitation; and decline in deaths from coronary heart disease and stroke. This centers around risk modification including smoking cessation, blood pressure control, early detection, and better treatment. The report goes on to list another five accomplishments that range from maternal and child health to other areas. I encourage anyone interested to access the link that has been provided. That said, even in this top five, you can see the great diversity in scope and responsibility of our public health partners.

This next slide [page 12, Exhibit C] is a diagram we commonly use to show the public health system. It illustrates the diversity of our partnerships in place to address and improve the health of our residents. Depending on the issue at hand to tackle, the specific partners we work with can vary. For example, with COVID-19, there is not one partner on this diagram we have not worked with to address it in our state.

Going to the next slide [page 13], as we talk again about the scope of public health, it is very broad and flexible in scope and responsibility because it relates to the health of our public generally. As a rule, our efforts are driven to understand why people get sick and why they die. Our overarching vision is for each person to live a long and healthy life. If we can understand the health issues in our population and subpopulations, we can try to intervene to prevent that negative outcome. We often find our focus is on infectious disease because it can spread quickly through the population.

This next slide [page 14] is a model we use often in public health, and we can really speak about the issue as it relates to this. It is called a social-ecological model and it helps us understand the many levels of an issue, especially as it relates to population or public health. This model starts locally with the individual and then there are peers and family. It evolves to the highest level—the influence of policy. This model helps us understand which level has an impact on the health issues so we can develop specific interventions at each of those levels.

The next slide [page 15] shows an example concerning childhood obesity. With childhood obesity we look at the child. That child's personal demographics are a primary factor in the weight, but we also look at the parents' weight and food preferences in the home. The policy level, in that same scenario, is where the larger population efforts occur around childhood obesity, for example, seeing nutritional details on food items or on restaurant menus. Also, the taxing of certain items can change behavior. Those are all policy opportunities as we look at obesity and healthy living.

I would like to speak about the amazing universities in our state, specifically, and nationwide as well. There is great diversity in the field of public health, and what you are seeing here is a list of the specialties or core competencies that our public health professionals can focus on [page 16]. This is truly a holistic approach to addressing public health. Again, I want to acknowledge our universities in the state that have been such a pivotal part of our response to COVID-19.

I am going to provide a highlight and a link on the next slide [page 17]. Public health, like all topics, evolves over time. We are in a period of time coined "Public Health 3.0." While public health professionals a century ago may have focused on very granular outbreaks or crises, now we function more as strategists to pull partners together to look at inequities and opportunities for intervention.

In public health, we often get asked about our relationship with health care. It truly is a partnership. Health care focuses on the health of the individual patient. We focus on how all the patients together become population health, the health status of the collective group, and how to intervene.

Public health is in constant evolution. With Public Health 3.0, we focus much more on collective impacts and reaching our residents where they are. We also understand more and focus on social determinants of health that lead to a particular health outcome. You will hear that a person's ZIP Code is often more a reflection of that person's health than that individual's genetic code. That is one of the things we look at as we delve into public health data. For example, you may have health insurance due to the Patient Protection and Affordable Care Act, but you might not be getting preventative screening even though it is an allowable service. In public health, we try to understand why that is occurring. What is the barrier if it is no longer health insurance, and how can we help address any health issues a person might have and intervene?

I am going to transition from global public health comments to concepts about public health in Nevada. Nevada is one of only two states nationally that has a largely decentralized public health structure. The bulk of our population is served by a district health department, but the state still provides direct service in many counties. We have also delegated some authority, for example, to Carson City Health and Human Services [page 20, Exhibit C].

Going to the next slide [page 21], the structure and functions of public health are in several statutes, but I will highlight just two. Those are found in *Nevada Revised Statutes* (NRS) Chapter 439 and in NRS Chapter 441A. These have been of particular interest during the COVID-19 response. You will hear later from our two district health departments that function largely as independent health agencies, as well as from Carson City Health and Human Services, which operates as a regional health department under delegation of authority that is allowed in that law.

The next slide [page 22] shows the county boards of health. In this case, I am focusing on our rural and frontier counties related to population size in the statute. Each county is

required to have a county board of health represented by the county commissioners, the sheriff, and a health officer. We work a great deal with the designated health officer. One of the challenges we had, as it relates to COVID-19, is that every rural county looked different. In some rural counties, there was a very functional board of health that was meeting on a regular basis and tackling population health issues locally. In some cases, there was no board of health. Trying to have that stood up and to identify a county health officer in the midst of the COVID-19 pandemic was problematic. That said, the counties have moved mountains in this regard, and now that functional necessity of a public health system at the county level is incredible. I want to acknowledge all the efforts there. They have really stepped up.

The next slide [page 23, Exhibit C] is a short list of what we have learned. In public health we have a wide variety of partners we work with when we address a specific issue, but one of the challenges is that we had to become the convener in many cases, not the doer. We had to work with our counties and county leadership, but specifically, we had to work with emergency management. That includes people locally including our National Guard and the Division of Emergency Management within the Department of Public Safety at the statewide level. They have really helped with the logistics—to operationalize these incredible public health interventions. We also clearly identified a need for flexible funding to support a public health crisis in real time and support basic infrastructure. As you know, our federal partners did come through with funding for epidemiology, lab work capacity, immunization, public health preparedness, and other items, but we did function with what we had for several months in the beginning. With the exception of COVID-19 funding, we do not have the ability to address the need locally. We have many public health crises, but we do not have basic infrastructure funding.

I also talked about decentralization of public health. Again, I cannot speak highly enough about how our rural and frontier counties stepped up. They had no infrastructure prior to the pandemic, but they accepted delegation of authority from our chief medical officer. They have shown such great work. I see great value in watering that effort and continuing to see it grow with other diseases outside of COVID-19. That will take some infrastructure funding so they can set up such structures.

We try to get as much money as possible out into the field for direct service because the funds are so limited. As a result, as a division we skimp on our own funding for things such as human resources support, information technology (IT) infrastructure support, and fiscal support, because the need for direct service in our counties is so great; however, that creates a huge challenge for us. We received $430 million for the response to COVID-19, but as a division we need to get those subawards out and ensure that the spending is appropriate and correct, and that is a big ask. That has been a challenge for us. I want to acknowledge our IT staff because another huge challenge is that we had a very antiquated system for infectious disease, yet our lab reporting rose 8,000 times above what we were used to, which really crippled our system. In some cases, we were largely functioning on faxed reports, and that quickly became unmanageable. We have had to use some of the funding to develop things within our public health infrastructure that will have an impact on all diseases going forward.

Another major challenge we had was the expectation that we could release data in a day. Related to public health, it is not typically real-time surveillance, so we were really challenged. With HIV data, for example, we take a year and a half to clean it before we release it to make sure it is the most accurate record on file. Those are things that were reasonable expectations of our community and of people who needed that information, and it has been an incredible lift on behalf of the public health structure.

The last slide is related to public health funding [page 24]. Each biennium, we report where public health spending in Nevada is ranked nationally. According to the America's Health Rankings, we are the least healthy state as far as public health funding is concerned. Alaska is the best at $289 per capita, and Nevada is at $50 per capita. That said, we have had investments in the past several years related to family planning, women's health connection, and other services, but we are still much further behind than many other states. One report shows that an investment of $10 per person in evidence-based programs can save the country $16 billion annually within five years.

An important point is who benefits most from public health, and it is children, infants, and underresourced communities. A huge ask of us is to identify inequity and disparities and offer suggestions as to how we can intervene and ensure they are removed. That concludes the Division of Public and Behavioral Health's presentation.

Chair Nguyen:
Some of those numbers were quite impressive. I like to make a point of highlighting when our state is a leader nationally. Specifically, you mentioned that our numbers were about half in the long-term care facilities. I believe you said we were at 20 percent and even lower more recently. Can you highlight what we are doing right, and are we sharing these best management practices with other state agencies and other regulatory responders?

Lisa Sherych:
Early on we created what are essentially strike teams. We have always had an Office of Public Health Investigations and Epidemiology. We also have our Health Protection and Preparedness team and our Health Care Quality and Compliance team. Early on we made a concerted effort to make sure those three teams were working very closely together along with the facilities to identify infection control issues and provide a lot of technical assistance. We are coming from the angle of improving a situation rather than taking punitive actions. We have also done work with the Department of Corrections. Our staff has been out to a couple of those facilities and has provided information on how they can address certain infectious disease control issues. I do not have any information concerning sharing with other states, but I will check and provide that information later.

Julia Peek:
Ms. Sherych mentioned the health facility epidemiology team. That is something unique to Nevada. We learn from our crises in public health and we developed that team as a result of the hepatitis C outbreak in Clark County. We knew we had to have a strike team that could intervene immediately. We had that relationship and structure built prior to COVID-19, so

we were able to make minor modifications to that. Other states that had not worked so directly with epidemiology and health care-associated infections had to build that from scratch. That is something we are really proud of.

The other thing we learned as a result of COVID-19 is that we were on separate reporting systems at the districts and the state. Now we are all going to move to the same infectious disease reporting system so we have a standardized way to collect data. We understand that county lines are not solid, and we need to be able to see how people go across the state, especially with infectious diseases. We are learning a lot and making foundational public health improvements. I will note that for COVID-19 vaccination, we have the highest administration rate in our region, so we are talking with our regional partners, telling them what we are doing, and offering suggestions concerning what is working and what is not. With this crisis, we are a leader in the region.

Assemblywoman Summers-Armstrong:
Are you collecting demographic information on COVID-19 rates? How is Nevada looking as compared to national rates of COVID-19 infection and deaths in the black communities in our state? I hope we are collecting that data and that you can report that information.

Julia Peek:
We are collecting information on race and ethnicity. We also are one of the only states that added questions related to LGBTQI issues. We will not know of disparities until we look at the data and see if there is truly a disparity in any areas. I think we are pretty standard, and I am happy to pull that data for you directly. I would like to explain some of the challenges with public health data in this capacity. We get that data from lab reports, so the cases you see on the Nevada Health Response dashboard are because we needed it in real time so we could see what was happening with the disease; however, lab reports required by our federal partners now often do not have race or ethnicity, so we were going off a lot of data that was unknown and trying to investigate those cases so we could get that information added. It is a huge effort. I hope our laboratory partners continue to improve in those areas because we need to know what the inequities look like in our community.

We are also collecting that information related to vaccinations. The Governor has reported that he is going to focus on equity as we move forward. A challenge we experience with equity is that it is self-reported. Sometimes people are uncomfortable sharing that information, so we have to communicate effectively about why we collect that data and how we are going to use that data. We are doing a lot of effort in that regard right now, but across the board, Nevada is trying to be as progressive as possible in asking as many questions across all the pieces in the hope that we can find inequities of race, ethnicity, and otherwise, and then address them.

Chair Nguyen:
If you can provide any of that data to our committee secretary, we will distribute it to the rest of the Committee.

Assemblywoman Summers-Armstrong:
Can you tell me, as a representative for my community, what can those of us who are elected officials do to help improve the confidence among our community members to report this data to you so you can have better data to report and collect? What can we do to help?

Julia Peek:
You truly are the champions in the community. What you say will be heard. For our part in public health, we will make an effort to get you the talking points and information you need to then go champion that back to your community. I will send information to you all, specifically around vaccinations, but also concerning the importance, in any disease and investigation, of providing that information to the public health partners and understanding that it is confidential. It is used by us to bring resources to the community and identify if there are disparities. I am happy to get you some talking points to share with your community.

Assemblywoman Titus:
Thank you to all of you who are presenting today, for what you are doing for the public health of Nevada. I know these are challenging times, and it would have been challenging without a pandemic.

Recently in the news there has been information about disparity concerning the vaccines and who has been receiving them. In the money committee, I have discussed receiving COVID-19 funds, where they are going, and making sure we have that outreach and trust. Our Attorney General made a big point when he got his vaccine because he wanted the communities to be reassured that it is okay to get the vaccine. As we know, there is a huge amount of distrust in the process and, frankly, rightfully so.

My concern is that there is significant disparity about who has gotten this vaccine. Is it because you were following what the Office of the Governor set up concerning different lanes and tiers? In the first tier were first responders, then people over the age of 70 were in the second tier, and there were those kinds of criteria. How was it decided to give those vaccinations? You were just following the tiers as directed, but has that changed at all, now we know that may not have been good enough?

Julia Peek:
Regarding funding, the disparities and inequities have been something our federal partners have been emphasizing since the start of the pandemic, and those are reflected in the data we have as well. Related to the vaccination grant, at least 10 percent of that award has to go directly to addressing disparity in the community and equitable distribution. That includes racial and ethnic disparity, but also rural residents were specifically called out. Those are things each of our local health departments will build into their budgets as they spend that award. There is also an equity task force that is a requirement of that award. In Nevada, we are one of the states that developed staffing within the Department of Health and Human Services' Office of Minority Health and Equity from the beginning of the COVID-19

response, which has been working with us on testing, how we message that appropriately, and now on vaccination as well, as has our coalition. We will continue to work in that area.

Related to the playbook, that is such an important discussion and point. If we looked at straight population distribution, then we would look at the folks within a certain ZIP Code getting the level that is appropriate, based on their overall piece of the population. As you mentioned, that is not how this works; it is related to lanes or tiers. It has been called different things, but we based our playbook and our recommendations on the Advisory Committee on Immunization Practices recommendations and what our CDC partners said. It might look like there is inequity in certain ZIP Codes or age groups, but it is a result of following the playbook.

Anything we present can be improved on, so it is a matter of drawing more attention to it and ensuring that we have data collected. This goes back to how important it is to share accurate information with the person vaccinating you on address, race, ethnicity, et cetera, so when we pull the data, especially when it becomes more general population-based, that we can ensure there is a level of equity. The other thing we are doing is looking at how we reach populations that might have a hard time getting vaccinated, so we will be looking at mobile outreach. You have seen it before with the Mammovan—where we can go to a community and vaccinate or test that community with that mobile resource. It will be particularly helpful to target specific ZIP Codes when we eventually get a one-dose vaccine for COVID-19 like the Johnson & Johnson. Again, that is most important when it becomes a general-population vaccination.

We are working again with equity across the 70-plus-year-olds. The biggest challenge is the supply issue at this point. We have a limited number of vaccinations, so it is challenging for folks to get the resource. Something we have done to implement equity and address barriers presented is develop the call line. Though not perfect, it is getting a huge number of calls. We are walking people through how to sign up, so if you do not have a smart device or you are having a hard time navigating the website or the various pharmacy websites for enrollment, you can call our helpline and we will walk you through. We are not perfect by any means, but we are certainly trying to get better eyes on it and better data so we ensure equity at every level we have control over.

Assemblywoman Titus:
To follow up on that, could you get us some numbers? Not just on the COVID-19 vaccine, because as you said, this is a unique situation and we developed the best plan we could. As you said, it may not be perfect, but there have been some real disparities in getting vaccines in general. We will get control of this pandemic, but we may not necessarily get control of the need to reach out and get more people vaccinated, and not just with the COVID-19 vaccine, but with the flu vaccine. We are at the bottom as related to numbers of folks who actually get vaccinated for the flu. I think only 44 percent of our population gets the flu vaccine, so this goes far beyond COVID-19. What COVID-19 has done is show us the holes in our system and bring them to the forefront. If we could see some data on what the traditional vaccination rates are across the board for all vaccines available and how we need

to do better for all members of our Nevada communities, that would be helpful. We are still lacking on some of these vaccines that need to be given or that people should consider getting. Hopefully, when we get some of this data you say you are now gathering, we will get information about the disparity rates in overall vaccines and who is getting them.

Chair Nguyen:
If Committee members have further questions, I would ask you to reach out directly to our presenters, and we can get you their contact information. The next presentation is from Carson City Health and Human Services.

Nicki Aaker, Director, Carson City Health and Human Services:
We have a county board of health. Carson City's municipal code, as relates to our board of health, requires a Nevada-licensed doctor, whereas NRS Chapter 439 does not. Carson City elected to create its county board of health in 2003. The board of health's composition includes a county health officer, the Carson City board of supervisors, and the sheriff. [page 28, Exhibit C].

We are a local health authority, not a district, since Carson City is a consolidated municipality. To be a district, two or more counties or cities need to join together. It is a city department within Carson City. Our department received public health accreditation in May 2016 after many years spent working on that endeavor. The core documents of accreditation are the community health needs assessment, the community health improvement plan, and the strategic plan. Some other important plans include the quality improvement plan, workforce development plan, risk communications plan, and the public health emergency operations plan. Right now, we are in the midst of going through reaccreditation.

Staffing at the health department before COVID-19 was 38 full-time equivalents (FTEs). Currently we have 65.5 FTEs. This slide shows our organizational chart [page 30]. The disease control and prevention division and public health preparedness organizational charts will be on other slides. The budget for Carson City is $9.4 million [page 31]: 29 percent is general-funded; and 63 percent is grant-funded, which is currently higher due to the COVID-19 grants we received. There is also 8 percent from revenue received. The revenue includes an interlocal agreement.

One of our divisions is chronic disease prevention and health promotion. The adolescent health program conducts abstinence and comprehensive sexual health classes for youth and families-talking-together classes that teach parents how they can talk to their children about sex. Staff have been researching creative ways to conduct classes since schools are not allowing outsiders in due to COVID-19, although some of the alternative schools for troubled youth have allowed our instructors to teach in person.

We also have a Ryan White Retention in Care Program that attempts to find individuals who are out of care and have been diagnosed with HIV, determines what their barriers are, and helps get them back into care. This is mainly focused on the rural and frontier counties. We have our Tobacco Control and Prevention Program that focuses on providing educational

presentations to the youth, discouraging initiation of the use of tobacco products and vaping. We collaborate with the Nevada Tobacco Prevention Coalition and other agencies to educate decision makers and the public on the benefit of policy solutions to address e-cigarette use among youth and young adults. We continue promoting counter-marketing campaigns about the danger of the use of tobacco products and e-cigarettes. We facilitate referrals from providers that serve the youth to the My Life, My Quit program. This program is researching different ways to reach its audience due to the COVID-19 restrictions. We also have a small grant for diabetes outreach. The staffing for the chronic disease prevention and health promotion division is 4.5 FTEs and this division is 100 percent grant-funded.

We also have clinical services, and the services we provide are listed [page 33, Exhibit C]. We receive Title X funding directly from the federal government and we subgrant some of that funding to Douglas County. We receive other funding from the state either as pass-through grants or from state funding. Currently the clinic is seeing patients and we are taking measures to protect the staff and the clients from COVID-19. The staffing in that division is 10 FTEs and that division is 9 percent general-funded, 61 percent grant funded, and 30 percent revenue. We bill different insurances and we also collect cash payments on a sliding scale for services provided to those who are uninsured or who do not wish to use their insurance.

Another division is disease control and prevention which consists of environmental health and epidemiology. Speaking about the environmental-health side of the division, I have listed the establishments that our health inspectors inspect and permit [pages 35 and 36]. We provide environmental health services to Douglas County through an interlocal agreement. Other duties are also listed here; please note that a couple of the duties are only in Carson City. Staffing within that program is 6.5 FTEs, and that program is 34 percent general-funded, 2 percent grant-funded, 55 percent interlocal-funded, and revenue makes up 9 percent.

The other side of this division is epidemiology. Having both environmental health and epidemiology under one division created some really big challenges when the pandemic started, and we will be looking at something changing in the future.

Our epidemiology program is very involved in COVID-19 contact tracing and reporting [page 37]. Along with COVID-19, there continue to be other reportable diseases that need to be investigated. Currently we have 1.5 FTEs working on those other diseases. Staffing for this entire program currently is 16.5 FTEs. Prior to COVID-19 it was 2 FTEs. We also have some individuals helping us who are not included in our staffing. We have two from the National Guard, we have two behavioral health ambassadors, and we have two CDC Foundation employees until March 31. We will be adding the two CDC Foundation employees to our staffing. This epidemiology program is 2 percent general funded and 98 percent grant funded.

I have added our organizational chart [page 38]. Carson City Health and Human Services is different from other Nevada health authorities by having human services within the health

department [page 39]. This division provides health, welfare, and community assistance as required by NRS along with some of the other activities previously listed. I would like to talk about the Forensics Assessment Services Triage Team. This is a collaboration with other service agencies that go into the county jail and attempt to connect inmates with services so they will have that upon release. This division has 8 FTEs and is 45 percent general-funded and 55 percent grant-funded.

As this is a public health emergency, our public health preparedness division is leading a COVID-19 response [page 40, Exhibit C]. Testing and vaccination efforts are being led by this division, along with working with other city, county, and governmental entities. We do have delegation of authority from the state and counties to provide COVID-19 service to Douglas, Lyon, and Storey Counties in addition to Carson City. Our staffing prior to COVID-19 was 5 FTEs, and we are now up to 20 FTEs for the COVID-19 response. We have one volunteer registered nurse doing testing, and we have 10 to 14 National Guard members for two to four days per week. This division is 100 percent grant-funded, and I included the organizational chart for this division [page 41].

I included the COVID-19 timeline showing our response [page 42]. We have been at this for a year since we started with planning for the repatriation of our 15 residents from the Grand Princess cruise ship. As part of our COVID-19 response, we have conducted 92 testing events since May, along with testing at the health department Monday through Friday. We have conducted 35 vaccination events since the end of December. The quad counties' cumulative positive cases are 10,910, and we have had 7,934 recoveries. As of February 6, 2021, we have received 11,975 vaccinations, and we have given 11,258 vaccinations. We do have 700 second-dose vaccinations that we will be administering this week. Our partners include our city and county governments, the state of Nevada, the Division of Public and Behavioral Health, the state of Nevada's immunization program, the state's Division of Emergency Management, Immunize Nevada, the National Guard, area hospitals, and our area doctors. As you saw earlier, we have utilized a lot of those partners in Ms. Peek's chart in this endeavor.

I have included pictures on the following slide [page 44]. We did a vaccination clinic at the Carson Valley Inn. It was snowing that day, which led to our decision not to conduct any more outdoor events. The lower picture in the middle is our trailer which contains everything we need, so we are taking the show on the road.

We see our challenges as opportunities for improvement. As was talked about, we have a challenge with public health funding, and we have seen some big challenges with ZIP Codes that cross county lines. Our public and the diseases do not recognize county lines. Our health department is very lean, which was mentioned during our accreditation site visit. As a result, it was very difficult at the beginning of the pandemic to get the work done. We were working long hours to get it done, so we opened up a quad county emergency operations center. Many of us wear different hats, so keeping up with all our other duties has been challenging. We are limited on space. Currently, we are finding sites for testing and vaccination. We are planning a mass vaccination when we get a higher allocation, but

sometimes finding sites for testing and vaccination can be difficult since we are in four different counties.

Our IT infrastructure has been pushed to its limits. Our current scheduling system is a challenge right now, but I am hoping for that to improve. Working with four counties and four separate governmental boards and four different health officers creates challenges sometimes because not everyone thinks the same way. In 2003 when Carson City's board of supervisors voted to have a board of health, regionalization was being discussed. The quad counties concept has been successful for the public health preparedness program, so in the future an opportunity will be to continue to explore the value of having a quad counties health department to serve the region with a single board of health.

Chair Nguyen:
Does anyone have any questions? [There was no response.] The next person on our list is Mr. Kevin Dick.

Kevin Dick, District Health Officer, Washoe County Health District:
The Washoe County Health District was established under NRS Chapter 439 under the provision for counties with populations of less than 700,000 [page 48, Exhibit C]. That provides for cities and the county to come together to establish a health district. That was formally done in 1972 through an interlocal agreement among Reno, Sparks, and Washoe County. We have a seven-member district board of health with two members appointed by each jurisdiction, one of which is elected, and those six members appoint a physician as the seventh member. Per NRS Chapter 439, we have jurisdiction over all public health matters in Washoe County.

The mission of public health is to protect and improve the health of the community [page 49]. It is a population- and community-level approach which makes it quite distinct from health care which provides medical care to individuals. As part of this activity, we assess the health status of our community, and in that work we identify the factors that drive mortality and morbidity in our community. We find inequities in some populations that are shaped by demographics, and social and economic disparities are driving a lot of the poor health outcomes we see.

I like to compare public health to an intelligence agency. For the most part, we operate 24/7 quietly in the background, we identify public health threats, and then we develop strategies to eliminate or control them. If we are successful with that, no one really notices us and what we do. It is pretty difficult, however, to hide a pandemic, so we have been very visible in the news this past year with COVID-19. Usually the community is not so aware of our activities.

We are conducting surveillance. We get reports of reportable diseases identified by the labs under NRS Chapter 441A. We also have some real-time surveillance we used to look at ambulance response and the types of cases they are responding to, information from emergency departments, and reports concerning admissions into hospitals. We have an

intelligence platform that provides us with information about medications sold over the counter at the pharmacies and drug stores in our communities.

We also use disease prevention to control and prevent disease. Part of that is the disease investigation work we do on reportable diseases. Immunization programs are a component of that. We have established regulations for a number of types of establishments and operations that pose public health threats in our community. We also mitigate against the spread of disease. People have become quite familiar with mitigation from the COVID-19 response, the masking and social distancing and the reductions in capacities for some businesses. Other mitigations are isolation and quarantining of individuals who have been exposed to diseases. We also perform mosquito abatement and issue boil water orders when a water system has been disrupted.

Communications are also very important for public health. They can alert our community to public health threats so the community can respond appropriately, as well as educating the community on healthy practices and behaviors.

This next slide provides an organizational chart for the health district and the allocations of FTEs across our different programs [page 50, Exhibit C]. We are organized with four divisions providing public health services to our community as well as the administrative health services office and the office of the district health officer. The slide also provides information on the membership of the district board of health. We have about 166 FTEs normally operating at the health district. That has been expanded significantly by the COVID-19 response.

I am going to run through the different divisions that provide services [page 51]. In community and clinical health, the community health component is really the chronic disease prevention program. In Washoe County, we focus on tobacco and substance misuse as well as overweight and obesity as some of the driving factors for the chronic disease burden we see. Our clinical services are all designed with a public health intention of improving community health and reducing the transmission of disease in the community. We are not a medical care clinic; we have two Federally Qualified Health Centers, Northern Nevada HOPES and Community Health Alliance, that provide excellent medical/clinical services for our community. Our services are oriented around family planning. We provide reproductive health services and immunizations that focus mostly on childhood immunizations. We have a small maternal, child, and adolescent health program and a WIC program [Special Supplemental Nutrition Program for Women, Infants, and Children] that provides nutritional support for infants and mothers as well as education and counseling regarding nutrition and breastfeeding.

Our sexual health program works to prevent the transmission of sexually transmitted diseases as well as provides testing to identify and treat those diseases. Our HIV program is involved in testing for HIV and connecting people who are found to be HIV positive with the appropriate medical care. Our tuberculosis (TB) program also does testing and provides

treatment for TB as well as disease investigation of those who might have been exposed to people infected with TB in our community.

Our epidemiology and public health preparedness division houses our epidemiology program which is responsible for the surveillance and disease investigation functions. Our public health preparedness program develops plans for pandemic response, bioterrorism, and radiological attacks, and exercises those plans with community partners. Also, everyone at the Washoe County Health District is trained under the federal incident command system so we are ready to stand up and function either independently or as partners in an emergency response.

We have vital statistics, so we are responsible for recording births and deaths in Washoe County as well as issuing birth and death certificates. Also, Washoe County is unique in that the health district has oversight of our regional ambulance franchise for services through Regional Emergency Medical Services Authority (REMSA). In addition, we also have an emergency medical service (EMS) program that is focused on oversight and coordination among the EMS partners, our fire agencies, dispatch, and REMSA to keep the EMS system functioning efficiently.

This is an organizational chart of the different programs we have in environmental health services [page 53, Exhibit C]. These are organized to prevent public health threats posed by different establishments and different operations in Washoe County. You can see the different types of establishments we regulate. I would like to help out with a few of the acronyms on this page. Under food safety are the "HACCP/Operational Plans" which are the hazard analysis critical control points. These are plans around critical points within a food service establishment for addressing risks. We are trying to take a very risk-based approach with our regulatory oversight for these different entities. Under special events you will see "EPI/FBD Complaints." We respond to epidemiology and food-borne disease complaints in that program area. Under our commercial plans and permitted facilities you will see "IBD." We regulate invasive body decorations which are body piercing and tattoo parlors. We also regulate what are listed as "RV/MHP;" those are recreational vehicle and mobile home parks. Under our waste management functions, you will see "UST," which are underground storage tanks; we provide permitting for the construction of those.

We are unique in Nevada in that we provide air quality management programs [page 54]. Under state statute, the health district is designated to implement the federal Clean Air Act in Washoe County. We have a network of monitoring stations and we put out daily air quality information and alerts as necessary. We have a planning area where we work to try to prevent deterioration of our air quality in Washoe County, so we have a woodstove program that addresses use of certified clean-burning stoves and the issuing of burn codes when we have inversions. We also have a smog check program and programs to address ozone precursors coming from vehicles. Our permitting program addresses stationary air pollution sources, surface disturbances for dust control, and demolition and remodeling activities in regard to asbestos abatement. We do inspections and enforcement if we find problems with those permitted facilities.

The office of the district health officer falls under me directly, and we work to support the board of health and its monthly board meetings [page 55]. We also are an accredited health district. We received our national accreditation in 2019, and we work with the other divisions across the health district to maintain that accreditation status. We do health assessments, and through those we work with our partners to identify how to work together as a community to improve the priority areas we identified in the assessments. Currently we are focusing on areas of housing and homelessness, behavioral health, and physical activity and nutrition with a number of community partners, with a plan for moving forward which we have been implementing over the past few years.

We lead our quality improvement and workforce development efforts as well as our communications. I want to also acknowledge our government affairs liaison, Joelle Dodson. You may see her presenting testimony, public comment, or communicating with you during the session.

This is our $24 million budget for 2021 without the additional funding we have received for COVID-19 [page 56, Exhibit C]. Our largest funding comes from the general fund transfer from Washoe County and is about 40 percent of our budget. Under statute, we are also able to charge fees for services such as permitting and other regulatory oversight activities. We collect revenue from the sale of tires in Nevada that supports some of our solid waste management efforts. Our air quality program is supported through a $1 fee on the smog certificates issued in Washoe County.

The federal and state grants that compose just over 25 percent of our budget are mostly federal funding that is either direct or passed through the state. As was mentioned, Nevada has a very low state investment in public health, and so we receive 1.8 percent of our budget from state funding through grants. We have received an additional $16.8 million in federal funds for the COVID-19 response in addition to our $24 million budget, so you can see that is a significant additional source of funding.

Here is a quick overview of our COVID-19 response [page 57]. We activated our department's incident command system on January 17, 2020. Our first case occurred on March 5, and then we moved to a regional response. We have been at it ever since. These pictures are of our response. We have learned and improvised as we learned more about the disease. You will see here some historic photos that span our premask days and our mask days and response.

Since the pandemic started, we stood up a drive-through COVID-19 testing operation that we had operational within one-and-a-half days of having our first case identified in Washoe County on March 5. We have learned from and improved that operation since that day and have expanded it dramatically. We are now using that same facility for our COVID-19 vaccination point of dispensing (POD). We set a new record last Friday with 1,800 people vaccinated. We stood up a COVID-19 call center, and we now have 24 people dedicated to staffing that. The call center does the scheduling for testing as well as for administering the vaccines. It provides for reporting of test results and does an incredible amount of data entry

work on the backside of providing those vaccines, to get that information into the data management systems the federal government has set up.

We have increased the number of disease investigators from 3 to over 50—to contact the positive cases and have them isolate and to identify close contacts for quarantine. We have over 85 people working in our field operation for testing and vaccinations.

Much like Ms. Aaker was talking about in Carson City, space has been a requirement as we have expanded staffing. When I send an email to all health district staff, it now goes to a list of 366 people. We have taken over buildings C and D of the county complex in addition to building B that we normally occupy. We have benefitted from many people who are remotely working because we have been able to take up some of the space they used to occupy. Scott Oxarart, our communications manager, has done a phenomenal job. We put out over 330 press releases over the last year, and I held over 60 media briefings over the course of the year. Mr. Oxarart has led our regional information center which created two websites, one on the COVID-19 response and the other specifically on the vaccine, now that it is available, and how we are managing that. There are also several social media platforms and accounts that have been established. We could not have done all this without the partners we have. The National Guard is integrated into our operation. We have the community emergency response team and medical reserve corps volunteers all helping with our operations.

COVID-19 has laid bare the social inequities in our community for health outcomes. Many people are living on the edge. They have to work to provide food for their families and a roof over their heads. These are essential workers. Many work jobs that earn below minimum wage. They are not able to work remotely; they do not have paid sick leave; and they often live in close quarters with other family members. As a result, we have seen a disproportionate impact within our Hispanic community throughout this pandemic. We also need to understand that the data on testing show that the Hispanic population is being tested in disproportionately low numbers relative to their population in Nevada, so these numbers may not be reliable [page 59, Exhibit C]. We have also seen a devastating impact on our elderly population with the number of deaths occurring in that segment of our population.

Fortunately, we are trending better with the number of cases we are experiencing in our community. While this figure is from last week, as of yesterday, our seven-day moving average for new cases in Washoe County is down to 90 and our positivity rate has declined to 11.1 percent [page 60]. Not so long ago, the positivity rate was 22 percent, so we are grateful to see this. We are not out of the woods yet; we want to continue to see these numbers decrease, but we think we are seeing good outcomes with everyone working together, the mitigation measures, and the pause the Governor instituted. Sadly, 616 deaths have been reported in Washoe County to date. When we were surging here in Washoe County, it was very frightening. Our health system was under great stress, and we were seriously looking at the possibility that we would need to ration medical care, so I am very relieved to see these numbers going down as they are.

This is a picture on December 15 of our first shipment of Pfizer vaccine arriving at the health district [page 61]. Fortunately, we were able to obtain an ultracold freezer, so we were able to receive and store the Pfizer vaccine as well as the Moderna vaccine here at the health district. We also have a number of PODs providing the vaccine in the community as shown here [page 62]. We have a retail pharmacy vaccine program in which we have pharmacies that are vaccinating staff and residents of long-term care facilities. We also have community partners and POD strike teams doing vaccinations; our fire agencies have been engaged in providing PODs, and the Community Health Alliance also is providing vaccines in a POD at its parking lot.

The rest of my presentation consists of a few pictures [pages 62-66, Exhibit C]. There is an aerial view of six lanes at the Reno-Sparks Livestock Events Center, of the vehicles stacked up in those lanes, and the testing stations we use. We also have a view of stations with modular roofing we put together and of the inside where the vaccine is dispensed by pharmacists and we collect the paperwork. The next slide shows our vaccine distribution statistics [page 67]. As of today, we have administered over 29,000 vaccine doses through the health district. The next slide provides you with the website for our vaccination information which people could use to find out how soon they might get vaccinated [page 68]. We are maintaining a waiting list for seniors, and we also have a phone number available which is 775-328-2427.

Chair Nguyen:
Are there questions?

Assemblywoman Peters:
Thank you for your presentation and all your hard work. I know Washoe County has had a particularly difficult time because our homeless population has been increasing and now the winter months have hit. I would like to hear a little about treating and testing our homeless population, managing care for them, housing them in facilities that are accommodating their needs, and how you are balancing that.

Kevin Dick:
We are working closely with the human services agency and our other regional partners regarding the homeless population. Some of the first pictures you saw relating to COVID-19 were photos of testing we were doing at the Reno Events Center. We utilized that facility so we could provide additional distancing for the shelter population because there was limited space at the Record Street community assistance center. The county also has been able to stand up new facilities for women and families at the Northern Nevada Adult Mental Health Services campus so that is providing additional capacity there. A men's shelter has been established on Fourth Street to increase the population that can be housed there. A positive result of this has been the work done together across the region on plans for a larger area for the homeless—a campus and complex, an area called the Governor's Bowl. For people who are homeless and who have tested positive for COVID-19, we have a contract regionally with WellCare. They are able to accept those people who do not require hospital-level care and provide them with support services and housing during their isolation period.

Assemblywoman Peters:
If you have data on the virus contraction rates in our homeless population, as well as the demographics, it would be really good to see that information. Can you follow up with staff on that?

Kevin Dick:
I can follow up on that.

Chair Nguyen:
Are there any other questions? [There was no response.] I will now move to our last presentation of the day, the Southern Nevada Health District.

Fermin Leguen, District Health Officer, Southern Nevada Health District:
In southern Nevada, we have our board of health and there are 11 members of the board with representation from different cities and the county [page 70, Exhibit C]. We now have more than 680 employees, which is significant growth from our previous numbers. About two years ago, there were fewer than 500 employees here.

There are five divisions in our health district, among them community health, environmental health, critical services, administration, and a Federally Qualified Health Center (FQHC), which is a new development within the health district. We received an award from the Health Resources and Services Administration (HRSA) within the U.S. Department of Health and Human Services in September 2019, and we were able to start the FQHC operations. Recently we received a second award from HRSA that allowed our operation for the next three years. Right now, we are still developing our health center, but it is fully functional.

We have a similar administration as the ones presented by our colleagues, so I will not present an organizational chart or how the divisions operate. Those are very common among the health districts. I just want to emphasize some of the areas where we have a different approach. For example, two years ago we started offering a preventive medicine program. That is something that was created because there is a need for preventive medicine physicians in Nevada, and we saw the opportunity to really contribute to that effort. That is a partnership between us and the University of Nevada, Las Vegas (UNLV). The residents spend the first year doing their master of public health programs at the university and then, the second year, they do their clinical and management rotations here with us at the health district. We also have been working on other projects regarding opioid reduction. We received a grant from the Centers for Disease Control and Prevention (CDC) for overdose data collection with the engagement of surveillance and preventive action for a drug overdose.

This was our budget at the beginning of the fiscal year beginning on July 1 [page 72]. It was $98 million. Our current budget is $139 million. Because of COVID-19, we received almost $32-$33 million from the CDC to support our enhanced surveillance activities, contact tracing, and testing. The federal grant represents about 22 percent of our budget, so it is a

little bit different from what the slide shows because there was almost a 30 percent increase in our budget because of COVID-19 activities. We do have concerns about our budget for this coming fiscal year because our budget normally receives between 25 and 28 percent from local property taxes, and our expectation is that those taxes might decrease next year. That would have a negative impact in our activities, so this is something we have been talking with the county about, and we also are trying to prepare for that for next year.

This is a picture of our dashboard and it is available online [page 73]. This is the site where we share information with our community and anyone in the country who has an interest in our data. We have here the current number of cases that have been reported in Clark County, hospitalizations, and also the number of deaths. In the main menu of the dashboard there are seven areas where people can click and get additional information. We have data by ZIP Code and mapping. Also, under the "Characteristics" tab, people can look at trends. The last thing we incorporated into our dashboard was the place of possible exposure. There we share with the community the areas that our cases report as being visited within the previous 14 days. That is something we utilize with our environmental health division. We have that information in conjunction with additional data we receive from our patients. Then, of course, there is the trend of the pandemic in Clark County from last year until now. For the last few weeks, we have seen a very big decrease in the number of cases. We hope it continues that way.

This is the incidence of COVID-19 in Clark County by race/ethnicity [page 74, Exhibit C]. Since the beginning of this pandemic, in Clark County we have seen that the Hispanic population has been the one with the largest impact in terms of cases. This has been very consistent throughout the pandemic. With the Hispanic population in Clark County, this high incidence they are experiencing actually does not appear to translate to mortality. The reported mortality for Hispanics in Clark County is the lowest among the different racial and ethnic groups.

This is our ZIP Code map, and this is something we use in addition to the community one for the whole pandemic [page 75]. For this one, we use more recent data—the last 14 days—so that helps identify new areas that could be affected by the pandemic. What you see here is that most of our high-incidence areas are in the central part of the county. Those areas belong more to the City of Las Vegas and the City of North Las Vegas. What you see to the right is the east area of Las Vegas: ZIP Codes 89110, 89142, and the others. Those are the areas where we consistently have seen the largest impact of the pandemic. These areas also are highly populated by members of the Hispanic community as well.

This is the first day the vaccine arrived in Clark County [page 76]. It was December 14, and we distributed the vaccine immediately, as soon as we received it. Actually, that very first day, we had a POD at one of our local hospitals and then we continued distributing the vaccine through the valley during that week.

I also want to mention that for the vaccination campaign we have developed a very strong partnership with the county and local jurisdictions and also with local universities: Touro

University Nevada, UNLV, Roseman University of Health Sciences, the College of Southern Nevada, and other institutions. All of them are participating in the pandemic whether it is supporting PODs or providing staff to participate in our operations. We also have met with representatives of churches in the valley, the business community, and representatives of the Hispanic and African American communities as well. We also have communications and presentations with the Asian community through the Filipino nursing association and their partners.

At this point in Clark County, we have administered more than 200,000 doses—until yesterday, it was 214,000 doses. Those were distributed all over the county. We have big vaccination sites at Cashman Center, and we offer vaccinations at Western High School, at Jerome Mack Middle School on the east side of the city, and at Eldorado High School. Recently we opened the Las Vegas Convention Center to offer second-dose vaccinations.

I also wanted to share with you some data regarding the vaccine here. Fifty-eight percent of the people who received the vaccine are females. That might be because of the weight of health care workers in this population. Health care workers at this point represent more than 40 percent of the individuals who have been vaccinated in Clark County.

Also, in terms of race and ethnicity, 41 percent are white, 10 percent Asian, 10 percent Hispanic, 6 percent African American, and about 30 percent of the individuals are either "other" or "unknown," complicating the issue of race/ethnicity analysis, but it is important to know that. In terms of who administered the vaccine, 64,000 doses have been administered by hospitals, representing more than 30 percent of both doses; 58 percent has been administered by the health district at Cashman Center.

This is a ZIP Code map showing the distribution of doses in Clark County [page 79, Exhibit C]. What we want to highlight here is that until last week, the numbers in Clark County of vaccine distributed did not match what was happening with the incidence of COVID-19 in Clark County [page 80]. To the left is the incidence-by-ZIP-Code map. To the right is the vaccine-administered map. The vaccine-administered map does not match geographically the incidence-by-ZIP-Code map.

As you probably are aware, there were recent comments or declarations about health inequality in Clark County and the way that we distribute the vaccine. I believe those were unfair because until now, more than 40 percent of the vaccines have been distributed to health care workers. Also, we have issues with the race/ethnicity analysis in terms of the weight of the unknown and other groups.

Having said that, we do have a plan on how to address the health inequalities in Clark County. In addition to the large vaccination sites that we have and are planning for in the future, we will be targeting some communities with smaller teams and PODs in collaboration with elected officials and representatives of community-based organizations and churches in those areas. When we offer the vaccine at those sites, most of the population who receive the vaccine will be the ones who actually live in the area.

This issue is important to mention. I was reading an article in *The New York Times* recently that mentioned health inequalities in this country. An example was given of some large metropolitan areas deploying large vaccination sites mostly in affluent areas because it was easier to do that. This is not the case in Clark County. Our PODs are all within the areas where we have more cases; Cashman Center is just in the middle of all that action, as are all those schools where we have opened PODs. Those large vaccination PODs do not allow for that kind of control, and that is why we emphasize a small operation when it comes to health inequality. The thing is that the vaccination is open to everybody, and we want everybody to receive it.

Chair Nguyen:
Do you have any kind of breakdown by Assembly districts of COVID-19 positivity and vaccination rates that you might be able to provide the Committee with, even if it is only by ZIP Code? That question is also for our previous presenters if they are still on the line.

Fermin Leguen:
Yes, I will ask our data people because that most likely will require census tracts; ZIP Codes are very unlikely to match the area.

Chair Nguyen:
Thank you for your presentation. A lot of times people did not know exactly what the health districts did or what they are responsible for. Now we have a pandemic that they are responsible for, and we appreciate all the challenges and the unique and creative responses your agencies are trying to accommodate and thrive in this situation.

With that, I will close the presentation. Do we have anyone for public comment? [There was no one.]

Wednesday's agenda includes an overview of mental health in Nevada. In addition, we will hear from the Division of Public and Behavioral Health within the Department of Health and Human Services. These are important topics for us to know about as a Committee going forward with some of the bills we will be seeing. We will also have presentations from the regional behavioral health policy boards. I will ask everyone to come prepared for the two bills we will be hearing. The first is Assembly Bill 62. If you want to obtain more information about the Nevada ABLE Savings Program which was addressed last session, I will have links sent to you. Our first bill draft, Assembly Joint Resolution 1 from Assemblywoman Titus, will also be presented. Again, reach out to our policy analyst or our legal counsel if you have any questions while reviewing those bills.

Are there any comments or questions from Committee members? [There was no response.] Meeting adjourned [at 3:56 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 "Assembly Committee on Health and Human Services: Overview of public health issues, status and handling of the COVID-19 pandemic, and other public health programs," dated February 8, 2021, and presented by Lisa Sherych, Administrator, Division of Public and Behavioral Health, Department of Health and Human Services; Julia Peek, Deputy Administrator, Community Health Services, Division of Public and Behavioral Health, Department of Health and Human Services; Nicki Aaker, Director, Carson City Health and Human Services; Kevin Dick, District Health Officer, Washoe County Health District; and Fermin Leguen, District Health Officer, Southern Nevada Health District.