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

Eighty-First Session
March 29, 2021

The Committee on Health and Human Services was called to order by Chair Rochelle T. Nguyen at 1:34 p.m. on Monday, March 29, 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:

Richard Whitley, Director, Department of Health and Human Services
Nick Shepack, Program and Policy Associate, American Civil Liberties Union of Nevada
Jim Hoffman, Member, Legislative Committee, Nevada Attorneys for Criminal Justice
Kendra G. Bertschy, Deputy Public Defender, Washoe County Public Defender's Office; and representing Clark County Public Defender's Office
Maria-Teresa Liebermann-Parraga, Deputy Director, Battle Born Progress
Gillian Block, representing Nevada Coalition of Legal Service Providers
José Silva, Environmental Justice Organizer, Progressive Leadership Alliance of Nevada
Christi Cabrera, Policy and Advocacy Director, Nevada Conservation League
Joelle Gutman Dodson, Government Affairs Liaison, Washoe County Health District
Dora Uchel-Martinez, Private Citizen, Reno, Nevada
Bradley Mayer, representing Southern Nevada Health District
Joanna Jacob, Government Affairs Manager, Clark County
Jeffrey B. Klein, President/CEO, Nevada Senior Services
Cheyenne Pasquale, Social Services Chief, Aging and Disability Services Division, Department of Health and Human Services
Tom Wellman, Private Citizen, Las Vegas, Nevada

Chair Nguyen:
[Roll was taken.] Today we have three bills, including the first one that I am going to present, so at this time I will turn the meeting over to Vice Chair Peters.

[Assemblywoman Peters assumed the Chair.]

Vice Chair Peters:
We will begin the hearing on Assembly Bill 358.

Assembly Bill 358: Enacts provisions to improve access to Medicaid for persons released from incarceration. (BDR 38-919)

Assemblywoman Rochelle T. Nguyen, Assembly District No. 10:
I am here to present Assembly Bill 358, which improves access to Medicaid for people who are recently released from prison. I had submitted a Committee on Health and Human Services bill that did the same thing when I saw that Speaker Frierson had also submitted this bill, so we were thinking alike. With me today is Richard Whitley, Director of the Department of Health and Human Services; Suzanne Bierman, Administrator of the Division of Health Care Financing and Policy; and Robert Thompson, Deputy Administrator of Program and Field Services for the Division of Welfare and Supportive Services.

I want to give you some information about the intent of A.B. 358. It is to improve care transitions to the community for incarcerated individuals who are eligible for Medicaid. Let me give you some background. Individuals who are incarcerated often have significant physical and mental health care needs. For example, they may experience chronic and infectious diseases such as hepatitis C, and they may suffer from severe mental health and substance use disorders and other physical health issues associated with mental health and substance use disorders. And they occur at a much higher rate than in our general population. The COVID-19 pandemic showed us how vulnerable many of these individuals are, and many suffered from this horrible disease while incarcerated when we had severe outbreaks in our prisons.

We want to improve health care for individuals who are recently released from prison. This action in this bill will help improve health in our communities, lower spending of state health care, and potentially advance public safety goals such as successful reentry and reduced recidivism. Currently, we have many individuals in our criminal justice system who qualify for Medicaid, especially since Nevada expanded eligibility for low-income adults through the Patient Protection and Affordable Care Act. Medicaid has a key role in providing support to these individuals, and as you know, people who are incarcerated are often disproportionately poor and people of color. This bill also helps address some of those health care inequities while advancing health care and racial equity in our state.

As of 2019, 43 states—so we would be asking to join those 43 states—already have a policy or have enacted policies that suspend Medicaid eligibility for an individual person while in prison, and 42 states had a policy to suspend eligibility for an eligible person while in jail. Six additional states are considering this policy, including us here today with A.B. 358. This bill provides that same policy to suspend Medicaid while someone is incarcerated, rather than terminate them from Medicaid when they are sent to prison.

Section 1 of the bill requires the Department of Health and Human Services to suspend, rather than terminate, Medicaid eligibility of an individual who is incarcerated. If an individual is not eligible for Medicaid, or if eligibility was terminated prior to incarceration, he or she can apply for Medicaid up to half a year before his or her scheduled release date. I am sure my copresenters will talk about the cost savings we will have, as well as the continuity of medical care upon their release from prison. Upon a release from prison, the Department shall reinstate or institute eligibility for and coverage under Medicaid to a person as soon as possible if the person otherwise meets eligibility requirements at that time.

Section 2 of the bill requires the director of the Department of Corrections to complete the Medicaid application paperwork for an individual who is incarcerated as soon as practicable after the individual is authorized to enroll in Medicaid as outlined in section 1. As you can see, the bill's provisions aim to improve access to Medicaid for a person who has just been released from prison. Ideally, a person will have Medicaid coverage on the day of his or her release from prison without gaps in coverage.

Currently, we have about 19,000 people incarcerated in our state prisons, and we need to find a way to ensure continuity of health care coverage and provide relevant social services for those who are incarcerated and transitioning back into our communities. Connecting these people to Medicaid early on can facilitate their integration back into the community by increasing their ability to address their health needs. This bill will contribute to greater stability in their lives and provide broader benefits to all our communities and help reduce recidivism within this population. I urge you to support this bill. Now, I would like to turn over my time to Director Whitley and his staff for additional remarks.

Richard Whitley, Director, Department of Health and Human Services:
Thank you for the opportunity to speak on behalf of this bill. The Department of Health and Human Services (DHHS) sees this as good policy. For evidence of why this legislation is needed, go to DHHS.NV.gov/analytics and scroll down to the corrections outreach dashboard [Exhibit C]. For some time, we have been collecting information on inmates who are being discharged and matching it to identify if they have been enrolled in Medicaid. We do not do a good job; we definitely can do better. I think we do a good job in our detention facilities in Clark and Washoe Counties with getting inmates who are leaving enrolled, but we could do better in the Department of Corrections. So this legislation, with the combination of enrollment and suspension, will go a long way toward those improvements.

Assemblywoman Nguyen also identified the benefits, and continuity of care is the big one. Many of these inmates with chronic health conditions, whether serious mental illness, HIV, or other conditions, are stabilized while they are incarcerated. To continue that care upon discharge could dramatically support their continuity of care. The other element is that the Department of Corrections, with General Fund money, currently pays for 30 days of discharge medication. We believe there would be a savings through enrollment in Medicaid upon exit. The day they leave, they would be enrolled in Medicaid and that pharmaceutical cost could be covered, drawing down a federal match for that, which would result in a savings for the state. So those are the two drivers.

We currently have a contract out for our managed care. In the urban areas—Clark and Washoe Counties—Medicaid utilizes a managed care model. We have included in the request for proposal (RFP) for managed care a highlight of the criminal justice-involved population with scoring on strategies for transition to be included in the response. That RFP is currently out, and we are looking forward to innovations from the managed care companies to assist us with the transition from facility to community, and we will be scoring those applications based on the response. With me are Administrator Bierman and Deputy Administrator Thompson to answer any questions.

Assemblywoman Nguyen:
Do they have any presentations or are they here to answer any questions?

Richard Whitley:
They are just here to answer questions.

Assemblywoman Nguyen:
We are ready to answer questions.

Assemblywoman Summers-Armstrong:
Director Whitley said "We" when he spoke about the Medicaid costs in the first 30 days after release. Could we get clarity on who is paying for that? How is that being financed?

Richard Whitley:
"We" means the State of Nevada. The Department of Corrections currently provides 30 days of discharge medications to an inmate leaving. That is paid for with General Funds. If the inmate were enrolled in Medicaid, we would work with our managed care organizations to cover the cost and get the inmate an appointment prior to the 30 days of medication running out.

Assemblywoman Summers-Armstrong:
If we can enroll those who are going to be released before they are released, not only do we have an opportunity to have a federal match for Medicaid, which would save money, but we would also have an opportunity to get them an appointment with the person who will provide that continuing care so we can have a better opportunity for that person to remain stable. Am I understanding this correctly?

Richard Whitley:
Yes, both are the two key pieces: saving General Fund money and then the connection to an appointment prior to the medication running out.

Assemblywoman Black:
I do not see a fiscal note on the bill. I understand that there might not be one for the people who were on Medicaid who will now be suspended instead of removed, but what about new people coming on? How does that not cost any extra money?

Richard Whitley:
These individuals are all eligible for Medicaid, so they are entitled to application and enrollment. In the case of those leaving on medication, we believe they may be presenting a burden to our emergency rooms or having a crisis needing intervention, because that continuity of care is not currently as tight as it could be if they were enrolled in Medicaid. But their eligibility would already be covered, and they would mostly be newly eligible, which is the higher federal match. You are correct, there is no fiscal note on this, not only for the operation of the enrollment, nor for the actual delivery of services under Medicaid. There would not be an additional cost. The enrollments may go up, but people who are eligible for Medicaid can apply at any time, and we would not deny anyone who is eligible for Medicaid the enrollment.

Assemblywoman Black:
Is there any way to know roughly how many new people there might be? If we do not automatically enroll them, they may never enroll in Medicaid. I cannot believe that there is

not an added cost. I understand that they would be eligible, but apparently there is not an added cost. Is there some way to quantify that?

Richard Whitley:
As you can see on the dashboard I made reference to, we would continue that out to actually show the follow-up services inmates received. We could match that with the recidivism or reduction. But like any population, we review their application for eligibility. If they get a job and exceed the income, they would be terminated from Medicaid just like any other population.

To your point, probably what would be interesting to look at is how many people leaving corrections end up in the emergency room, perhaps with uncompensated care, or with a more costly crisis because that continuity did not continue. We have not looked at that, but we certainly could.

Vice Chair Peters:
For reference, the link Director Whitley was talking about, that dashboard, is available on the Nevada Electronic Legislative Information System if you would like to check it out. Are there other questions?

Assemblywoman Gorelow:
I have a question regarding success with local jails. How has that been going for you?

Richard Whitley:
I can speak most comprehensively about the Clark County Detention Center and the Washoe County Detention Center. We have eligibility workers who go in. We have a good working relationship with the captains at each facility. The models are a little different in rural Nevada; it is relationship-based with sheriffs and whether they want us in their facility. The solutions in the jail are largely written applications. We continue to look at making it as easy as possible and certainly as less interruptive as possible. In the Clark County Detention Center, prior to COVID-19 we were averaging a few hundred applications a month. With COVID-19 and some of the restrictions on our staff being able to go in and assist with eligibility, those numbers have gone done. Captain Teel with Clark County Detention Center said that "This is so good for our community"; they have directly seen a reduction in recidivism and asked us to get this back up—get our staff outfitted with PPE [personal protective equipment] so they could go back in. I would aspire to have our state Department of Corrections have outcomes like our large detention centers. Our welfare and eligibility workers do a fantastic job with getting folks enrolled.

Vice Chair Peters:
Is there quantifiable data related to the detention center in Clark County you were referencing that we could see? That may help answer some of Assemblywoman Black's questions about the results we are getting from lack of recidivism and the care provided through Medicaid offered to those inmates.

Richard Whitley:
Yes, we have Clark and Washoe detention centers data we can provide going back to 2019.

Vice Chair Peters:
As related to that, would you have the dollar amount of what is currently being spent on the purchase of medications as inmates are leaving the system—those 30 days of medications they are getting?

Richard Whitley:
I do not. Within the Department of Corrections' budget, I do not know if they carve out their pharmaceutical costs that way. As we have this huge opportunity for improvement in the enrollment, it would be an important piece of data to capture—not only for that 30-day medication issue, but did they get their appointment before the 30 days, and also that cost. I can follow up with the Department of Corrections and ask that question.

Vice Chair Peters:
Thank you. That would be helpful in understanding the kind of win this would be. I also have another clarification for you about the Medicaid match. What is the percentage of Medicaid match right now? Can you give us, dollar for dollar, on what the state puts in and how much is matched through the federal programs?

Richard Whitley:
I believe primarily this population would be newly eligible, so it would be a 90 percent federal match.

Vice Chair Peters:
So for every ten cents the state puts in, ninety cents from the federal government would be matched to that?

Richard Whitley:
Yes.

Vice Chair Peters:
Thank you for the clarification. Are there other questions from the Committee?

Assemblyman Hafen:
What is the state currently spending on medication for inmates?

Richard Whitley:
I do not have that information from the Department of Corrections. Currently, health care of inmates is in the Department of Corrections' budget, and that would include their discharge medications. I would be happy to reach out to them and get that information.

Vice Chair Peters:
Are there other questions from the Committee? [There were none.] I will move into testimony. Do you have anyone testifying in support, Assemblywoman Nguyen?

Assemblywoman Nguyen:
I do not believe there is anyone else. Director Whitley, was there anyone else testifying in support?

Richard Whitley:
No, I am speaking for our Department in support of the bill.

Vice Chair Peters:
We will take support testimony from the phone lines now for A.B. 358.

Nick Shepack, Program and Policy Associate, American Civil Liberties Union of Nevada:
Formerly incarcerated individuals suffer disproportionately from health-related problems and can pose health risks to their family members and their communities. Prisoners experience infectious diseases such as HIV-AIDS, hepatitis C, and tuberculosis at a rate five times higher than those in the general public. Many suffer from a variety of mental illnesses—some very severe. Health problems can also hinder a formerly incarcerated person's ability to secure employment. Access to health care is an essential yet often ignored aspect of successful reentry. Medicaid expansion under the ACA [Affordable Care Act] has offered an unprecedented opportunity for formally incarcerated people to gain access to health care. There are many barriers for formerly incarcerated people that make it difficult to enroll upon release. For one, they are dealing with other urgent issues such as housing or employment and may not have the time or bandwidth to seek health insurance post-release.

The Henry J. Kaiser Family Foundation, using data from the annual Medicaid budget, found 38 states are working with prisons and 32 are working with jails to help facilitate Medicaid enrollment prior to an inmate's release date. Additionally, in 37 states, Medicaid benefits are suspended rather than terminated upon being incarcerated in prison. Half of the states also report that they are working to enroll parolees in Medicaid. By ensuring that all eligible parties are enrolled in Medicare or Medicaid upon release from prison, we can reduce recidivism rates, reduce the community spread of communicable diseases, and provide one more tool for success for those being released from prison. We urge you to support this very important piece of legislation.

Vice Chair Peters:
Before we continue with support testimony, I want to restate that testimony is limited to two minutes per caller. You are always welcome to send in written testimony up to 48 hours after the Committee hearing. We will be taking 20 minutes of testimony in support.

Jim Hoffman, Member, Legislative Committee, Nevada Attorneys for Criminal Justice:
Nevada Attorneys for Criminal Justice (NACJ) supports A.B. 358. Health care is an important part of preventing recidivism in formerly incarcerated people. In particular, a lot of theft and drug crime is driven by untreated mental health problems or drug abuse. By ensuring that people have access to mental health treatment and drug counseling immediately upon their release, we reduce the likelihood that they will reoffend. This is better for the people involved and better for the community as a whole. Therefore, NACJ supports A.B. 358.

Kendra G. Bertschy, Deputy Public Defender, Washoe County Public Defender's Office; and representing Clark County Public Defender's Office:
I am testifying in support of A.B. 358 on behalf of the public defender's offices in Washoe County and in Clark County. We want to thank the bill's sponsor, Assemblywoman Nguyen, for bringing this important bill forward. This Committee and the legislative body last session passed A.B. 236 of the 80th Session. The whole purpose of that bill was to enhance our criminal justice system and provide individuals with services to ensure that they do not enter into the criminal justice system in the first place. This bill will expand on that and help to ensure that those who are involved in the criminal justice system, when they are leaving jail or prison, have Medicaid so they are able to successfully reenter society and reduce recidivism.

As of 2019, 43 other states have already implemented these suspension policies for those in prison and over 42 states have done the same for jails. Currently, in the Clark County Detention Center, it costs $190 per day for healthy inmates to be housed. In Washoe County, it is $130 up to $300 or $500, depending on the medication needs of the individual. Because of a lack of housing, sometimes our clients are stuck in custody waiting for bed space or waiting for other services because their Medicaid has been terminated. That is time in custody, and if we had the ability to provide them with resources more quickly, they would be able to reintegrate sooner, which would save us money in the long run, as well as reduce recidivism. Thank you again for this bill and for your time.

Maria-Teresa Liebermann-Parraga, Deputy Director, Battle Born Progress:
I want to say "Ditto" to what everyone else mentioned. Everyone pretty much covered the reasons we support this bill. We want to thank Assemblywoman Nguyen for bringing this forward, especially at a time when, for people who are released, health care access is more important than ever during a pandemic. We ask for everyone's support.

Gillian Block, representing Nevada Coalition of Legal Service Providers:
The low-income Nevadans legal aid providers serve often depend on Medicaid for their health care services, and access to health care is a vital piece of the puzzle of supporting individuals who are reentering the community following incarceration. Assembly Bill 358 will ensure that people leaving the criminal justice system have the ability to quickly regain access to health care services, ensuring quicker access to medications, mental health services, and other essential services that people need to get back on their feet and be stable following incarceration.

Terminating Medicaid coverage for incarcerated individuals unnecessarily delays access to critical health care while suspension instead of termination provides continuity of care to formerly incarcerated people at a time when these individuals are particularly vulnerable. Assembly Bill 358 promotes both individual and community health, reduces the risk of mortality and recidivism, and helps people succeed. For those reasons, we support A.B. 358.

Vice Chair Peters:
Are there any more callers in support? [There were none.] Next, we will hear testimony in opposition to A.B. 358. [There was none.] Is there anyone wishing to testify who is neutral on this bill? [There was no one.] Assemblywoman Nguyen, do you have any closing remarks?

Assemblywoman Nguyen:
I do not. I do not know if Director Whitley has any closing remarks. I know he has been working on this a lot with local jails to get people covered. I do see this as a cost savings for our General Fund. The idea that we are paying for medication for people who are eligible for what is essentially a 1-to-9 federal match is crazy to me, especially during a time when we are trying to do more with less. This puts us in line with 43 other states in preventing recidivism or reducing recidivism, saving our state money and also continuing the continuity of care for people who are incarcerated and who are trying to reintegrate successfully into our communities. Director Whitley, do you have anything you want to say in closing?

Richard Whitley:
I do not think I could say it any better than you just did, so thank you.

Assemblywoman Nguyen:
Did we hear any testimony in neutral?

Vice Chair Peters:
I did call for testimony in neutral but there was no one on the line, nor was there anyone on Zoom.

Assemblywoman Nguyen:
Thank you, and again, I would ask everyone to support A.B. 358.

Vice Chair Peters:
With that, I will close the hearing on A.B. 358 and transfer the chairmanship back to Chair Nguyen.

[Assemblywoman Nguyen reassumed the Chair.]

[Exhibit D was submitted but not discussed and will become part of the record.]

Chair Nguyen:
I will open the hearing on Assembly Bill 343 and turn this over to Assemblywoman Thomas.

Assembly Bill 343: Provides for walking audits of urbanized areas. (BDR 40-742)

Assemblywoman Clara Thomas, Assembly District No. 17:
I am introducing Assembly Bill 343 which addresses the health and walkability of our communities. Assembly Bill 343 is aimed at improving accessibility and public health. We Americans have come to appreciate the link between urban planning and the health of our citizens. Being able to walk to stores and restaurants serves the dual purpose of improving our health and reducing greenhouse gas emissions. By making cities safe and accessible for children, older adults, and persons with disabilities, we improve the quality of life for all of us. Walking paths, bike lanes, safe crosswalks, and curb cuts give us a chance to get outside and move or commute to work without a car.

There are initiatives in states all over the United States that recognize this link between pedestrian- and bike-friendly communities and the improved public health outcomes that follow. Nationally, the Centers for Disease Control and Prevention (CDC) and AARP, along with many land-use and transportation-planning organizations, have endorsed the use of walking audits to better understand a community's needs. Our own regional transportation commissions and Nevada's Department of Transportation participate in a similar program known as Complete Streets. But it is my hope that this bill will take these efforts to the next level in Nevada by assembling a diverse group of people to conduct walking audits and to include accessibility to healthy food options.

"Food deserts" are a well-documented problem in many inner-city communities, and Las Vegas is no exception. The pandemic has made it painfully clear that a lack of access to healthy food to fight diabetes and other preventable diseases continues to be a national issue.

I want to mention that, while I do not have any amendments to present to you today, I am working with stakeholders on a possible amendment to the bill. I will make sure to share any possible amendments with you prior to a work session. One of the amendments I am exploring is whether there are other agencies better suited to conduct or organize the audits, such as the regional planning agencies or regional transportation commissions. Another aspect would be the incorporation of geographic information system, or GIS, mapping as a way to make data from the audits more broadly available.

With that background, let me briefly go over the key provisions of the bill. Section 1 lays out the requirement for the district health departments to conduct walking audits of urbanized areas within their jurisdiction every three years. The state Division of Public and Behavioral Health would be tasked with conducting the audits in urbanized areas not covered by the two district health departments in Clark and Washoe Counties. The audits will be organized by census districts in urbanized areas to determine whether the physical environment contributes to the health of the community or detracts from it.

Section 1 further provides that audit results will be submitted to the city council, county commission, and any planning commission or regional entity with jurisdiction over the area. In addition, the audit results would be posted on the health district's and Division's Internet

websites. Section 1, subsection 2 lays out the makeup of the audit groups and the goals of assessing land use, site design, and other factors contributing to public health, such as lighting, curb cuts, crosswalks, sidewalks, and benches. I have also included access to healthy food in the walking audits because too many inner-city residents have limited grocery and restaurant options. It is hard to eat well and be healthy when you are relegated to shopping at a convenience store or eating at a fast-food restaurant.

Lastly, the audits would include suggestions on ways to enhance all these factors and thereby improve public health in the audited area. In closing, I urge your support of A.B. 343 and the concept of walking audits to better understand our communities and their needs so we can work towards improving public health.

Chair Nguyen:
Do I have any questions from Committee members?

Assemblywoman Titus:
This is a new concept for me, so how many other states have this? I live in a very rural area, and one would have a tough time walking there. I understand this addresses certain population sizes. Can you give me some statistics or where to turn concerning other cities that have this and their results? I understand the intent. I believe in getting out in local communities; I believe in being part of your community. As a doctor who still makes house calls, nothing opens your eyes more than going out into your community to see what the realities are for these folks. I would really appreciate having some direction so I could do my homework and look into this further.

Assemblywoman Thomas:
Just about every major city in the United States has walkability audits such as New York. In our own state, back in 2005, Assembly Bill 231 of the 73rd Session had walkability for our public schools. We have walkability audits dealing with our children and public schools to see about transportation and whether two miles was adequate for them to walk to school.

I want to improve on the concept of A.B. 231 of the 73rd Session which would be for our general community, especially now in 2021. There are so many things I noted this past summer when we were going around the community to see if children were able to engage on the Internet. There were places that were very dark. There were places where sidewalks were crumbling. There were places where we needed curb cuts. Just walking around during my campaign, I noticed these things. We have to move to the twenty-first century as far as having food accessibility for our citizens. If we can have our children walk two miles to school, surely we can have a grocery store within two miles of our communities.

Assemblywoman Titus:
Thank you for that. I look forward to having more information and some data.

Assemblywoman Thomas:
Yes, I will get that.

Chair Nguyen:
Thank you, Assemblywoman Thomas, and if you could provide that to Patrick Ashton, he will get that documentation out to the rest of the Committee. Are there any other questions?

Assemblyman Orentlicher:
I have a question about section 1, subsection 2, paragraph (b) which lists several things to look for. Those are all important things to look for, and you also say "including, without limitation," so they can look for other things. One thing that occurs to me that might be worth including specifically is to look for commercial operations that might foul the air with toxic chemicals that might be produced at the site. We know those are more common in minority and lower-income communities. Perhaps that is picked up somewhere else, but it is an important thing for us to know about.

Assemblywoman Thomas:
We will look into that also.

Assemblywoman Black:
What is an "urbanized area"?

Assemblywoman Thomas:
An urbanized area generally would be what we would consider the urban community.

Assemblywoman Black:
That is my concern. I do not know what it is. There is no formal definition.

Assemblywoman Thomas:
I can get a formal definition for you [Exhibit E], but it is the same thing for a rural community. Is there a definition for that?

Assemblywoman Black:
If you are saying we are going to study an urbanized area, we need to be able to identify what an urbanized area is. Is there a population threshold? Is there a density threshold?

Assemblywoman Thomas:
You are correct. There is a population threshold. As the bill indicates, with Clark County there is "a population of 700,000 or more." In less populated areas it would be less than 700,000.

Chair Nguyen:
We have Ms. Karly O'Krent, our Legislative Counsel Bureau committee counsel, with us. She might be able to describe what that means in statute.

Karly O'Krent, Committee Counsel:
The provisions of this bill only apply in a county that is over 700,000 people. Currently, that is only Clark County, so an "urbanized area" would be Clark County.

Assemblywoman Black:
So the purpose of this is to collect the data and then the data is put on the health department's website. Say there is not a store where you can buy healthy food; we have simply identified that. We have not taken any steps to change it; we would just say that an area is lacking this or needs cuts into the sidewalks. It is just collecting data. I would like to understand what the intent is.

Assemblywoman Thomas:
Yes, the bill wants to clarify what those areas are lacking, and we want to present it to the county commissioners, as I stated in my address, and other entities so that we can afford this change. There is one thing we have to remember: urbanized areas are missing a lot of grant money from the federal government. When you change the way an area is and you can document it, you can apply for a grant; and with those grants, you can make changes. When we identify that certain areas are missing healthy food options, that is a big thing, and the reason why we can afford change is to, hopefully, get these grocery stores that can give us healthy food options to build.

Assemblywoman Summers-Armstrong:
This issue is very near and dear to my heart as I represent a community that is within the urbanized area of Las Vegas, Assembly District 6. The gathering of this information is very important for all the reasons she stated. Once a problem or situation is identified, then we have quantifiable data we can use as the basis for grants and to try and find funding to resolve some of these issues. Have you had an opportunity to meet with anyone from our local regional transportation commissions, either Washoe or the Regional Transportation Commission of Southern Nevada (RTC), to see what they have gathered, how they gather, and whether there is an opportunity for collaboration?

Assemblywoman Thomas:
We have been in contact with the transportation commission. This week we will be sitting down with all the stakeholders to clarify the language in the bill. We will get all concerned entities together so we can get this information. Right now, some of the things Washoe County and Clark County representatives—Joanna Jacob and Joelle Gutman Dodson—their concern is putting the weight on the health districts. I agreed that since we already have a way of assessing the audits through the RTCs, that perhaps we can get together with them and then the costs would not be burdensome on the health district because this is something they already do. We can quantify what A.B. 343 is looking to do because they already have a way of auditing certain communities.

Assemblywoman Gorelow:
I have a question regarding section 1, subsection 1 and the three years that the audit needs to take place. How was the three-year time period determined versus two or four years?

Assemblywoman Thomas:
Looking at A.B. 231 of the 73rd Session, we got the information from that bill. As I said, going back to the stakeholders meeting we will be having, we will decide whether it will be

three years or five years. That would be in conjunction with the transportation commission and/or RTC. When they walk to get their information, we want to make sure we are not putting due pressure on them to get another. We want it to be concisely done together, so I will be addressing that and I will get that answer for you.

Assemblywoman Gorelow:
I believe there are zones the federal government has already established, like Level 3 zones, which are economically disadvantaged zones. If you get SBA [Small Business Administration] loans in those areas, you can get some forgiveness, so this would really help that process. They would know what they could build in those areas and what the area actually needs. Am I putting those puzzle pieces together correctly?

Assemblywoman Thomas:
I have not discussed zoning or zones. I will bring that question up with the stakeholders this week.

Assemblywoman Gorelow:
Again, I may not be putting those puzzle pieces together correctly, but I remember some work I did in my other job. We were getting loan possibilities and they were talking about economically disadvantaged areas. I am thinking that this would work wonderfully, by determining what is needed in those areas, to encourage investors to build in those areas so they can get some benefits for that through the federal government.

Assemblywoman Thomas:
Thank you so much, and I will include that in our conversation. It sounds like a good idea.

Assemblyman Hafen:
We have the Nevada New Market Jobs Act which allows certain business entities to receive a credit in certain communities if they make these investments being talked about today. Have you talked to Clark County and their planning department to see if they are currently working on something similar? I know that in Nye County we looked at this, not as extensively as this bill proposes, but some of our recommendations came out to go into our master plan, to expand bike lanes and things of that nature. I did not know if there was any coordination with Clark County, and I was curious.

Chair Nguyen:
Assemblywoman Thomas, I see Ms. Jacob from Clark County on the line. Possibly she can answer Assemblyman Hafen's question after we have taken testimony in support, opposition, and neutral.

At this time, we will begin testimony in support of A.B. 343.

José Silva, Environmental Justice Organizer, Progressive Leadership Alliance of Nevada:
We are here in support of A.B. 343. For years, constituents in Clark County have been raising awareness on issues that add significant pressure to communities of lower incomes. Not everyone who lives in the county is the sole owner of a vehicle. Many times, a vehicle is shared between household members and not all folks can get where they need to when they need to.

I live about a mile away from a supermarket. It is a 4-minute drive, but if I was to walk there, it is a 30-minute walk, and walking back is also an additional 30 minutes. One side of the street has a paved sidewalk, and the other side does not have a paved sidewalk. This street in general is very dark during the evening. Creating a process to help increase feasibility of pedestrian travel would be an important step in raising quality of life for non-vehicle-owner constituents. Although this may sound detached from the feasibility of being a pedestrian, the importance of reducing vehicle contamination from our communities and neighborhoods plays a crucial role in maintaining the health of Nevadans. In addition, the American Heart Association, in a 2019 ozone report, ranked Las Vegas as the thirteenth most ozone-contaminated city in the U.S. Contamination can lead to Nevadans becoming ill, it increases medical costs, and in worst-case scenarios, it takes lives away. I urge your support of this legislation to address the public health impacts of our neighborhood environments.

Christi Cabrera, Policy and Advocacy Director, Nevada Conservation League:
I would like to echo the comments of the previous speaker. Nevada is ranked the eleventh most dangerous state in the nation for pedestrians, and we must do more to make sure our streets are safe for everyone. We believe this bill will help our state better understand and address walkable neighborhoods and move toward creating safe environments for pedestrians, bicyclists, motorists, and transit riders. Walkable neighborhoods increase physical activities and promote healthier communities and can make our communities more safe, accessible, and enjoyable for everyone. Increasing walkability can also encourage people to leave their cars behind, thus reducing greenhouse gas emissions and pollution. We would like to thank Assemblywoman Thomas for bringing this bill forward, and we urge the Committee's support.

Chair Nguyen:
Let us go to our next caller in support. [Additional support testimony from Dora Uchel-Martinez was taken after opposition testimony.]

Do we have any callers in opposition?

Joelle Gutman Dodson, Government Affairs Liaison, Washoe County Health District:
I want to thank the bill's sponsor for having an in-depth conversation with me, and I look forward to further conversations. While we are certainly in support of the concept and work in the areas Assemblywoman Thomas has addressed regarding environmental justice, nutrition deserts, air quality, and walkability to resources, unfortunately as written, we are in

opposition to the bill today because it is essentially an unfunded mandate for the health districts that we cannot afford right now. I have submitted a fiscal note, although I do not see it on NELIS [Nevada Electronic Legislative Information System].

Right now, health districts in general might not be the appropriate placement for this bill and would require a professional skill set and technology database or system we do not have now. It would require hiring and purchasing that kind of equipment. There are several things happening in each of our communities north and south that may meet some of the Assemblywoman's needs for this bill, and I look forward to a conversation, possibly with the RTCs of northern and southern Nevada as well as with the Truckee Meadows Regional Planning Agency and the Southern Nevada Regional Planning Coalition. I think we can get to a solution, and I look forward to further conversations.

Dora Uchel-Martinez, Private Citizen, Reno, Nevada:
I apologize. I was calling in support but I had so much trouble with my phone. May I proceed or do you want me to call back?

Chair Nguyen:
I know everyone is having difficulty and I am flexible on this situation, so go ahead and testify in support and I will ask the Committee secretary to reclassify your testimony.

Dora Uchel-Martinez:
I am calling in support of A.B. 343. I am totally blind and have a service dog. I live in north Reno in District 27. I utilize the sidewalks. Pretty soon my kids will be going into the military and I will not have a driver and I cannot always depend on buses. Sometimes they are late and sometimes they are cancelled due to mechanical issues and lack of drivers. Usable and accessible sidewalks are awesome. My service dog and my husband, we walk a lot, and if there was a sidewalk all the way to Carson, I would be there too.

Chair Nguyen:
We will go back to testimony in opposition to the bill. [There was none.] We will go now to callers in neutral to the bill.

Bradley Mayer, representing Southern Nevada Health District:
Certainly the intent of this bill is good for public health. We are working with the Assemblywoman. We have been in contact with her and we are working on this bill together; but we at the health district are also engaged in some of these walking audits—specifically we are doing one with the City of Henderson in conjunction with their parks and recreation department that also focuses on low-income census tracts. We are also working with the City of Las Vegas and University of Nevada, Las Vegas to help develop a decision-support tool for city public works. It is a tool that planning, public works, and transportation professionals use to grade health, safety, and equity-related considerations to land use to support safe, walkable, bikeable, connected communities. So we are doing some of this work.

We are still evaluating the fiscal and operational impact of this. The bill came out last week, and then of course is being heard today. We are looking forward to working with the Assemblywoman as she works on some amendments for this bill ahead of the work session.

Joanna Jacob, Government Affairs Manager, Clark County:
I am calling in to see if I can answer the question raised by Assemblyman Hafen. I am also speaking in neutral on this bill. I tried to work with Assemblywoman Thomas last week to connect her to appropriate people at the RTC in southern Nevada because they are engaged in transportation planning and that includes walkability for the regions they serve, including Clark County. This is the bread and butter of what they do so we are trying to engage in this process. As Assemblyman Hafen noted, our comprehensive planning department does assess this, especially a Complete Street policy, as we are rewriting our codes right now. We are engaged in looking at this in a comprehensive way. We have added bike lanes and sidewalks where feasible every time we update a street in Clark County. We always address ADA [Americans With Disabilities Act] compliance, so this has been something discussed at our board, so Assemblyman Hafen, yes, we are engaged in doing this work as well as in a comprehensive planning way that we do in unincorporated Clark County. We will continue to work with the Assemblywoman on this bill and take part in the stakeholder groups, Madam Chair, and assist where we can.

Chair Nguyen:
Do we have any other callers in neutral? [There were none.] At this time, I will turn this over to Assemblywoman Thomas for any closing remarks.

Assemblywoman Thomas:
As I stated earlier, we are working to solidify this bill to make it amenable to just about every agency that has a hand in affording the walkability for our residents. We know that this is something that is probably new to the state of Nevada because when I first moved here in 1982, they did not have sidewalks. So we are gradually moving into the twenty-first century and I look forward to meeting with the stakeholders this week.

Chair Nguyen:
With that, I will close the hearing on A.B. 343 and open the hearing on Assembly Bill 344. Assemblywoman Thomas, you may begin when you are ready.

Assembly Bill 344: Authorizes the establishment of a program to facilitate transition of the care of older persons and vulnerable persons. (BDR 38-743)

Assemblywoman Clara Thomas, Assembly District No. 17:
Thank you for the opportunity to present Assembly Bill 344 before you today. This bill aims to improve care coordination and continuity of care for elderly Nevadans and individuals with disabilities following discharge from the hospital. Before I begin, I would just like to draw your attention to the amendment I submitted which should be on the Nevada Electronic Legislative Information System (NELIS) and which I will discuss in a minute [Exhibit F].

Being in the hospital is hard, and when a person is discharged, there are often aftercare instructions to follow, new medications to take, and follow-up appointments to attend. The post-discharge time can be hard for anyone, but it is especially hard on elderly individuals and those with disabilities—and particularly for those who do not have a support system, or whose caregivers are not familiar with navigating the health care system. I recently experienced this firsthand when my mother was in the hospital. After her stroke, no one realized that this was the onset of dementia. Mom became very confused and frustrated whenever seeing her doctors and could not remember what she was advised to do. My brother, as her caregiver, would ask to go into the examination room so he was able to get the information and assist Mom with her meds and other doctor's orders.

The goal of this bill is to authorize the Department of Health and Human Services (DHHS) to create a program to improve care coordination and continuity of care for vulnerable Nevadans after they are discharged from the hospital. Specifically, section 1, subsection 1 of A.B. 344 authorizes the Division of Aging and Disability Services (ADSD) within DHHS to establish a program through regulation to help older Nevadans and Nevadans with disabilities with the transition from the hospital to their home.

Currently, the bill language refers to "older persons" and "vulnerable persons." However, in working with ADSD on this bill, I am proposing an amendment to replace the term "vulnerable person" with "person with a disability," which is language currently used in *Nevada Revised Statutes* (NRS). This amendment does not change the intent of the bill but ensures consistency in the use of existing terms.

If ADSD creates this type of program, it must provide for cooperation between hospital staff who are responsible for discharging these individuals, as well as the individuals and their caregivers. It must also facilitate the coordination of health care and social services to support these individuals and their caregivers.

Section 1, subsection 2 of the bill allows ADSD to limit the program to certain groups of older individuals or people with disabilities based on funding. It authorizes the Division to accept gifts, grants, and donations in order to establish and operate the program, and to use other available options to fund it, including billing third-party payers—such as health insurance—for services provided by the program. That brings me to another amendment I am proposing in section 1, subsection 2, paragraph (c), which follows "Use other options available to fund the program, including, without limitation, billing third parties for the services provided by the program" for current plan members. That is the additional verbiage—"for current plan members."

Section 1, subsection 3 of the bill defines "older person" to mean an individual who is 60 years of age or older. It defines the term "third party" to include various health insurers, and it defines "vulnerable person." However, as I mentioned, the proposed amendment would replace the definition of "vulnerable person" with the term "person with a disability."

Finally, this bill should not have a fiscal impact to the state, as it authorizes ADSD to establish the program to the extent money is available for this purpose. At this point, I would like to turn my time over to Jeffrey Klein, President and CEO of Nevada Senior Services. Mr. Klein's organization currently has a program that is doing this type of work, which has been extremely effective. We have submitted two documents that I believe he will discuss so that everyone has a better understanding of the type of program we envision through this bill. After his presentation, we would be happy to answer any questions, and I believe Cheyenne Pasquale, Social Services Chief, ADSD, DHHS, is available to answer any technical questions from the Division's side.

Chair Nguyen:
The amendments you were speaking about in your presentation were uploaded onto NELIS this morning.

Jeffrey B. Klein, President/CEO, Nevada Senior Services:
I am also a member of the Nevada Commission on Aging and chair its legislative subcommittee. My thanks to Assemblywoman Thomas for bringing forth A.B. 344 and my thanks for the invitation to be here today.

The PowerPoint [Exhibit G] we have submitted has more material than I intend to cover, but it will be useful reference information for you. Nevada Senior Services operates two adult day health care centers [page 2]. We provide in-home respite, home modifications, clinical geriatric assessment, we have a wellness set of initiatives, and we are the Nevada Care Connection Resource Center for Lincoln, Nye, Esmeralda, and the majority of Clark County. We are very much on the ground floor of the development of what we call "Hospital 2 Home" which is a care transitions program for some of the most difficult populations we have.

As you know, Nevada is among the states with the fastest-growing senior populations, if not total populations, in the country [pages 3 and 4]. With that comes the issue of dementia. Nevada has seen an astronomical increase in deaths from dementia. Our Alzheimer's disease deaths have increased 261 percent since 2000 [page 5]. It is the sixth leading cause of death in Nevada and a major driver of hospital admissions and readmissions. We are faced nationally, but very much in Nevada, with the fact that while lifespan is much longer, health span is becoming more problematic because we live longer. We have people with multiple chronic conditions which ultimately lead them to be greater consumers of health care and more likely to be admitted to the hospital.

Persons with dementia and the frail elderly typically will have care partners, family members, who are responsible for assisting them and maintaining themselves in the community [page 6]. Those folks can be very stressed when family members have chronic diseases. We know that dementia in particular increases the burden on acute care systems. Any hospital executive will tell you that, and I was one for most of my career. It creates excessive resource consumption, higher complication rates both in the hospital and after the hospital, and generally results in poorer outcomes. They are more likely to be hospitalized

than the general population over age 65 [page 7]. About 25 percent of all hospital patients aged 65 and over have a dementia, and there are all sorts of studies about the issue of dementia in the record. Very few of the folks that are hospitalized or who even have a dementia have it existing openly in their hospital record. To quote my wife's grandmother, "Don't let them know how old you are and don't let them know if you are having problems thinking." There is a fear factor in seniors in particular, but also in other vulnerable populations, in having the hospital staffs even be aware the patient has this kind of fragile situation. Hospitalization rates for persons with dementia are more than twice what they are for the cognitively healthy.

A third of hospitalized persons with Alzheimer's disease average one-and-a-half to two hospital stays a year [page 8]. People with dementia comprise 40 percent of total hospital 30-day readmissions. Hospitals are faced with the huge problem of people who are living alone at home with dementia representing an unsafe discharge which clogs hospital beds because the hospitals have difficulty even discharging them. Clark County, for instance, has one of the highest readmission rates in the country with over 35 percent of Medicare patients being readmitted to the hospital. They are more likely to not regain their health [page 9]. For people with discharge issues associated with their ability to function in their homes, it makes them a more complicated discharge and more dangerous to discharge to the home without successful supports. They are more likely to get discharged to a nursing home, which we know is not the location of choice as we found out during the COVID-19 epidemic. They are also three to seven times more likely to be living in a nursing home three months after discharge, which represents both a human cost and an economic cost to the state of Nevada.

Our Hospital 2 Home program started originally with a pilot program funded by the Aging and Disability Services Division as a subset of a federal Administration for Community Living program grant [page 10, Exhibit G]. We piloted what we thought was an innovative approach to dealing with this population. We brought 25 dyads or 50 people through the program to test it, and it worked so well that we were invited by the federal Administration for Community Living to apply for a much larger three-year grant which just ended.

Because of the grant, this population was focused heavily on the dementia population—persons with intellectual developmental disabilities who were at much higher risk for a dementia, the frail elderly who were hospitalized for any medical condition, live-alones, and, most recently, COVID-19-related admissions and discharges [page 11]. Right now, we have a caseload of over 150 of those persons in Clark County who have either been directly or indirectly impacted by COVID-19 and have been discharged from hospital to home. We use a model originally developed by Rush University Medical Center in Chicago, adapted it for our environment, and developed a collaboration initially with the seven hospitals of Valley Health System [page 12]. Now, it has spread to most of the hospitals in southern Nevada. Collaboration is really important, and one thing it brings, in addition to hospital collaborations for the clients, is post-discharge care transitions wraparound for all the services they need.

These days, the approach is both in-person and/or telephonic because of the COVID-19 limitations [page 13]. The first contact is within one to two days post-discharge if we do not catch them in the hospital first. The duration of the core program is 30 days. It focuses on the values and desires of the individual, and that is really critical [page 14]. We talk about being person-centered, but it is more than that. People crave autonomy, and those of us in the health care field, and even as family members, crave safety. Very often we are inclined to sacrifice the wishes of the person trying to be discharged from the hospital or its complex in favor of what we think is going to keep them safe. That push and pull is really important in Hospital 2 Home. We start with the desires of the individual and we look to see how we can do that in a safe way. It includes both internal and external referrals for ongoing supports.

We start with this 30-day program, we develop personalized care plans, we deal with behavioral and psychological symptoms, and the goal is to support these folks to not only make the transition, but to be able to engage access to supports which keep them safe in the community [page 15]. We have added a fairly innovative feature to the program called "respite coaching" [page 16]. Right now, we are evaluating what the best personnel would be to ultimately, long-term, deliver that service—we are starting to think community health workers which has a special place in Nevada. The idea of the respite coach is to decrease post-hospitalization stress and caregiver burden because we know that caregiver burden is likely to cause readmission or long-term care placement. It provides a short-term, intensive respite but also allows us to provide training so the family caregiver can handle what is going on in the home and make connections for long-term supports [page 17, Exhibit G]. These respite coaches, which are teams, are an intrinsic part of this whole idea of care transitions which is unique to Nevada and to our program.

The service delivery also ties into referrals to community public and private resources [page 18]. We have licensed social workers on the team. We provide case management and long-term services and supports, which is a natural for our aging and disability resource centers; basic needs programs; and caregiver education and support, which is really important. How do we educate family caregivers to be better navigators of the health care system and the social services system both coming and going? We have created a series of workshops for family caregivers and for health care professionals [page 19].

Outcomes—and these are last year's numbers [page 20]: out of 363 clients/participants who came through the program, the readmissions for the same diagnosis-related group was zero. Not one person was readmitted to the hospital, and we are excited about that not only because of the human savings, but for the financial savings of keeping people successfully in their homes—not having them bounce in and out of the hospital. There were 6 out of the 363 who ultimately were readmitted for a different diagnosis; for example, someone had a stroke and then three months later fell and broke a hip—that was a different admission.

A couple of interesting things came out of some of our studies that I think will help you understand the pragmatics of the program and how important they are. If you take a look at what we call "first tier" discharge challenges, insufficient support at home is 66 percent of

the cases [page 21], so we know that this is a critical factor. Concerning referrals for caregiver support [page 22], 76 percent of the people discharged required caregiver support, 75 percent required respite care, and then home modifications were 36 percent. These are critical for wrapping this into the whole idea of a successful discharge. Basically, what is happening with this program now is it is more ubiquitous. We started with dementia and then moved on to broader cognitive impairments, then COVID-19, and now the broad arena of people who are complex—have family caregivers or have an array of problems which make them difficult to be discharged. We know that it clears beds in the hospitals faster. We know it eliminates unsafe discharges to homes. We know it predicts outcomes. We know it keeps people out of long-term care and therefore reduces their risk for things like COVID-19 or pneumonias or even the flu. It has been a highly successful program.

We are very supportive of the state of Nevada having a broad-based program to assist hospitals, to have this resource available and most importantly, to assist our seniors and those persons who are at highest risk to be able to get back to home and stay there—without readmissions, without possible utilization of services, and without the need for long-term care placement. My thanks to Assemblywoman Thomas for taking on this very tough issue and one that has a big impact on an aging and fragile population.

Assemblywoman Thomas:
We are open to answer questions.

Chair Nguyen:
Assemblywoman Titus, go ahead with your question when you are ready.

Assemblywoman Titus:
As a provider, having been administrator and director of a long-term care unit and working in emergency rooms discharging patients, there is already a mandatory requirement for safe discharges. We have discharge planners, patient advocates, and communications. We have to have that "warm handoff," that safe discharge. Does this bill change any of that? That is my first question. My second question is, are we now limiting this to just persons with disabilities? Do we now not have to have that safe discharge for all the other patients I discharge? And finally, I would like some more details on some of the studies you did. It sounds as though you are already doing this. What will this law change that you are not already doing?

Jeffrey Klein:
One of the issues about this kind of Hospital 2 Home program is that it focuses on the most complex cases that traditional discharge planning does not get to. The example I always give is a 45-year-old who had gallbladder surgery and the discharge planner comes through the door and says, "When can your person pick you up? You are going home today, and make sure you take your medications and get back to your doctor." If the hospital has a good care transitions initiative, they follow up to make sure you filled your prescription and you booked your doctor's appointment. To a family caregiver who is so totally fried that they are basically immobile because they have been taking care of a loved one for a long period of

time who has now ended up in the hospital, that person needs way more help and supports; that person has issues. To give you an example, very often they do not have a working refrigerator when they go home, there is no food in there and no way to fill the medications. What Hospital 2 Home tries to do is decompress that family caregiver and get life back under control. In the first couple of days in particular, we try to take away a lot of those really pressing issues that have so immobilized those family caregivers so they can clear the air, deal with them, and then have a support system. That is fairly unique, and not necessarily a program everyone needs. We think for our highly complex, more fragile family caregiving situations—whether in the elderly population or in the adults-with-disabilities population—they find it very valuable. Not only is it humane, but it is financially beneficial.

Assemblywoman Titus:
Just to be clear, you are already doing this. You have this program. Do we need legislation to enact a program you are already doing?

Jeffrey Klein:
It is not available to everybody. It was done originally through a federal grant which is now over. We have it available on a limited basis through some minor funding we have available through ADSD—Older Americans Act—or COVID-19 money which will expire on September 30 of this year—or through a limited number of insurers that are willing to pay for portions of the service. It is not yet covered by Medicare as we know it, nor is it yet covered by Medicaid as we know it. It only exists to the extent that we are able to provide funding and do it for free for people.

Assemblywoman Titus:
Nowhere in this legislation does it mandate that Medicaid or Medicare pays for it, but does it enable you to accept grants to expand the program?

Jeffrey Klein:
The ADSD would be able to accept those grants and then contract with us or others to help deliver the program. More importantly, I hope it sets a platform for Medicaid to cover the services where it will be cost-beneficial. Also, it encourages the hospitals to urge their managed care partners to participate in it. Right now, we have several managed care organizations that are looking at it, but certainly, encouragement from the State of Nevada would help.

Assemblywoman Titus:
That brings me back to your statement about readmissions. You testified that no one was readmitted for the original diagnosis. What was the length of time? Was it within 30 days that no one was readmitted for their original diagnosis? Was the diagnosis limited to mental dementia? What was the diagnosis no one was readmitted for, and over what period of time?

Jeffrey Klein:
The study had 363 people in it over a 3-year period of time—really it was over 2.5 years because the first 6 months was a planning cycle. It included a wide range of diagnoses from

surgeries to heart failure, chronic obstructive pulmonary disease, the late effects of diabetes—so there was a wide range. The initial work was limited to persons with a dementia—not necessarily diagnosed dementia, but a perceived dementia if no diagnosis was available. Later it became broadly available to complex families with COVID-19. Some of those numbers are people who had a COVID-19 diagnosis or who were admitted to the hospital with a suspected COVID-19 diagnosis.

Chair Nguyen:
We also have Ms. Pasquale, Chief of ADSD, and she might also be able to answer the question concerning why this legislation is needed if we are already doing it in some aspect.

Cheyenne Pasquale, Social Services Chief, Aging and Disability Services Division, Department of Health and Human Services:
To Mr. Klein's point, they piloted this program and were able to develop a model that can be replicated to scale. This legislation offers ADSD the opportunity to build capacity across the state and make this type of program available to a broader population.

Chair Nguyen:
Assemblywoman Titus, does that answer your question?

Assemblywoman Titus:
There is nothing that prohibits this from happening since we are already doing it in some form. I guess the answer to my question is that it enables them to potentially expand the program and look at future payment resources.

Chair Nguyen:
I will follow up with that to see if we can get some clarity on the record. Ms. Pasquale, would this enable us to apply for different grants and funding? Without this, would we not be able to?

Cheyenne Pasquale:
It would not prevent us from applying for grants if we did not have this legislation. What it does do is it gives us a little more "backing," I would say, when applying for grants to say that this is a priority for the state. It is a legislatively approved program and that can help make us more competitive in our grant writing.

Chair Nguyen:
Am I correct in saying legislative backing or support would enhance applications of people who wanted to get into a grant program? Is that correct?

Cheyenne Pasquale:
Yes, it can help to support that. This legislation specifically also provides an opportunity for the Division to explore other funding mechanisms.

Chair Nguyen:
Are there other questions from Committee members before I go to testimony in support, opposition, or neutral? [There were none.] At this time, we will begin with testimony in support of A.B. 344.

Gillian Block, representing Nevada Coalition of Legal Service Providers:
I am speaking in support of A.B. 344. The Legal Aid Center of Southern Nevada and Washoe Legal Services serve older persons and vulnerable persons, providing representation to seniors and adults with disabilities who are facing or who are under guardianship, to ensure the adult's legal rights are protected. We support increasing opportunities for collaboration between hospital staff and caregivers to coordinate health care and social services for older persons and persons with a disability such as our guardianship clients. Care coordination programs can help to improve continuity of care, improve outcomes, and provide smooth transitions home for people who are most vulnerable and in need of ongoing support.

Chair Nguyen:
Is there another caller in support? [There were none.] Do we have any callers in opposition? [There were none.] Is there anyone testifying in neutral? [There were none.] I will turn this back over to Assemblywoman Thomas for any closing remarks.

Assemblywoman Thomas:
Thank you, Chair Nguyen, and Committee. I am hoping that you will support A.B. 344. It is necessary; it is a good program for the most elderly persons in our communities and those with disabilities.

Chair Nguyen:
Thank you for that presentation. I will close testimony on A.B. 344 and go to public comment.

Tom Wellman, Private Citizen, Las Vegas, Nevada:
I am a resident of Assembly District 1. I successfully retired from the Clark County School District and currently serve as president of the Nevada State Education Association-Retired program (NSEA-R). I am here to make public comment about a very serious issue—the retirees in the state of Nevada and our retired members' health care. One of the major expenses all senior citizens and our members face in retirement is the continuing escalating cost of health care. Retirees who live in rural Nevada also face the additional burden of accessibility to quality health care because it requires them to drive over two hours or more to see a doctor or go to a hospital. Any measure that can be put in place to help curb this runaway train is greatly appreciated. The NSEA-R is asking that along with everything else you are faced with, you make access to retiree health care a priority and address the rising cost of medication. However, please keep in mind that Nevada is a WEP [Windfall Elimination Provision] and GPO [Government Pension Offset] state, and many of our retired members who desperately need this assistance may not qualify for access to either social security or Medicare. Please consider as you move forward that active educators and support

professionals will also need to have access to quality affordable health care when they retire. Working together, we can help solve this problem for the employees who continue to handle these life-changing assignments on a daily basis.

Chair Nguyen:
Are there other callers for public comment? [There were none.] Are there any comments from Committee members before we adjourn the meeting? [There were none.] We are adjourned [at 3:30 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 link to the Division of Welfare and Supportive Services, Department of Health and Human Services website, corrections outreach dashboard, dated March 29, 2021, submitted by Richard Whitley, Director, Department of Health and Human Services, regarding Assembly Bill 358.

Exhibit D is a letter dated March 29, 2021, submitted by Christine Saunders, Policy Director, Progressive Leadership Alliance of Nevada, in support of Assembly Bill 358.

Exhibit E is a statement submitted by Assemblywoman Clara Thomas, Assembly District No. 17, regarding Assembly Bill 343.

Exhibit F is a proposed conceptual amendment to Assembly Bill 344, dated March 29, 2021, submitted and presented by Assemblywoman Clara Thomas, Assembly District No. 17.

Exhibit G is a copy of a PowerPoint presentation titled "Hospital 2 Home Dementia Capable Care Transitions: Better Care, Better Outcomes," dated March 29, 2021, submitted and presented by Jeffrey B. Klein, President/CEO, Nevada Senior Services, in support of Assembly Bill 344.