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

Eighty-Second Session
February 13, 2023

The Committee on Health and Human Services was called to order by Chair Sarah Peters at 1:31 p.m. on Monday, February 13, 2023, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda [Exhibit A], the Attendance Roster [Exhibit B], and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/82nd2023.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Sarah Peters, Chair
Assemblyman David Orentlicher, Vice Chair
Assemblywoman Cecelia González
Assemblywoman Michelle Gorelow
Assemblyman Ken Gray
Assemblyman Gregory T. Hafen II
Assemblyman Brian Hibbetts
Assemblyman Gregory Koenig
Assemblywoman Sabra Newby
Assemblyman Duy Nguyen
Assemblywoman Angie Taylor
Assemblywoman Clara Thomas

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Patrick Ashton, Committee Policy Analyst
Shuruk Ismail, Committee Manager
Terry Horgan, Committee Secretary
Connor Schmitz, Committee Secretary
Ashley Torres, Committee Assistant

OTHERS PRESENT:

Julia Peek, Deputy Administrator, Community Health Services, Division of Public and Behavioral Health, Department of Health and Human Services
Fermin Leguen, District Health Officer, Southern Nevada Health District
Kevin Dick, District Health Officer, Washoe County Health District
Nicki Aaker, Director, Carson City Health and Human Services
Caleb Cage, Interim Administrator, Central Nevada Health District
Megan Comlossy, Associate Director, Center for Public Health Excellence, School of Public Health, University of Nevada, Reno

Chair Peters:
[Roll was taken. Committee rules and regulations were reiterated.] Today, we have a presentation on public health and the public health infrastructure in our state. This is another complex topic area with many players, and I encourage you all to ask questions. While we have these experts in the room is really the best time to get some of your foundational questions answered. I believe we are starting with Deputy Administrator Julia Peek with the 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:
I serve as one of the deputy administrators for the Division, overseeing several of the public health programs, but certainly not all of them. We are going to start off with what is public health [page 2, Exhibit C]. Often, public health gets confused with clinical care. Clinical care focuses on the individual's health—personalized health plans and interventions for the individual to improve their health or the health of their families, individual assessment of risk for that individual, and then trying to get them on a better path personally. In public health we have a much bigger focus. We focus on population health. We look at how to reduce the risk of chronic conditions for the entire population. We also have a broader scope in that we look at environmental health factors as well—clean air and water, safe food, prevention, and risk of disease or infection.

The next slide [page 3] is adapted from one I provided in the past that we called the "Easter egg" diagram. This one I developed with folks who worked on COVID-19. The public health system is more often the convener, or what brings folks together to make population health change, but we might not be the doer. In this diagram, you will see that we often partner with nonprofits in the community. We do not have to deliver the services.

Behavioral health providers are often better messengers. Faith-based organizations are also great partners to us, as are our tribal partners and elected and transportation officials. You saw this with COVID-19 as they tried to get people to vaccination services or clinical care or social services. As we look at reasons people have certain outcomes, the access to social services and private health care are things we look at. Laboratories, coroners, correctional settings, et cetera, are all partners we might use in different situations to try to impact the population health.

The next slide [page 4, Exhibit C] is the scope of public health. Broadly and generally, we could say we try to understand why people get sick—which is morbidity—or pass away—which is mortality. We want to understand how people can live the longest, healthiest lives possible. Once we understand why people are getting sick or passing away within our community, we look at strategies to try to reduce that. You often hear public health referred to as "upstream," so we try to go upstream to understand the risk factor or risk factors causing a certain outcome. Then we look at developing interventions to try to reduce the risk for the individuals—ultimately changing the population health. We have an extremely broad and flexible scope and responsibility because there are any number of reasons why people could be getting sick in our community.

Public health systems often function in the background. You do not necessarily know we are doing something until something breaks or goes wrong, and then folks see the public health system in our workers. This happened with COVID-19 when our capacity was reached, and so you saw public health in a number of areas you did not know they were working in. One of the things happening nationally now is looking at foundational public health services [page 5]. The way we look at this in Nevada is to ensure that regardless of the geography, people in our state are offered foundational public health services. The entity providing public health services to your residents may vary; there are many of us doing various things in your community, but we want to assure that the foundational public health services are being met. This is not easy. Foundational public health services are really set by our federal partners for various reasons. Equity was recently included as an eighth addition to the foundational capabilities. That was done in 2022, primarily around COVID-19, and illustrates how inequities caused different health outcomes. Equity really encompasses all the foundational areas, so foundational areas are really activities and efforts. You saw what we did with communicable disease, chronic disease, and injury prevention; or other things that we do, including environmental health, public health, maternal, child, and family health, and access and linkages to care, though often not providing that direct care within our walls.

Foundational capabilities really outline the infrastructure needed to provide services in those foundational areas. Some of the things that we assess in this area are:

- Assessment and surveillance of data. If we do not understand what is happening in our population, then we cannot assess how we are doing and course-correct if needed.
- Community partnership development.

- Equity. Again, equity is the eighth-newest organizational competency, and this has a lot to do with what all of us are moving through with public health accreditation such as for a hospital or other facility that gets accreditation.
- Organizational competencies.
- Policy development and support.
- Accountability and performance management.
- Emergency preparedness and response.
- Communication.

I want to acknowledge the Washoe County Health District's efforts in this area. District Health Officer Kevin Dick's team is truly leading nationally in the areas of foundational public health services. It relates to understanding staffing capacity in these areas based on population and need. Often, we will come to you and say we are underfunded, we cannot meet the service needs, but you actually need tangible information: how many more staff do you need to meet the service to the capacity you think is necessary. Washoe County is leading the way and helping us develop some matrix.

You all saw public health in action during the COVID-19 pandemic, but you might not have seen everything because we had so many teams working nonstop [pages 6 and 7, Exhibit C]. The various teams' efforts included:

- Planning and preparedness: These teams assured integration with emergency management locally, which was huge in this response. They also worked hard to get PPE [personal protective equipment] to the locations necessary so we could deliver services.
- Epidemiology and laboratory capacity: That one is clear, but this team looked at ensuring that we got lab reports. We were able to test people and, based on that data, we were able to follow up with individuals.
- Analytics: Our office of analytics is phenomenal, and during COVID-19 provided us with so much data, but they do this beyond COVID-19.
- Environmental health: This team really helped us look at safe events when we started reopening, safe food, safe events, and infection control and cleaning.
- Immunizations really changed the course of COVID-19.
- Health care and licensure: This is pivotal to ensure that the delivery of health care services in our community is safe. This entire team truly moved mountains. Our medical laboratory team is a small but mighty team that was able to get testing sites stood up so that specimen collection had fidelity and that the lab tests in our state were performed. The Bureau of Health Care Quality and Compliance are heroes who are not seen publicly as much as the rest of the teams.
- Chronic disease and wellness: This team really carried the water when it came to health equity efforts. It looked at working with community-based coalitions and understanding how best to deliver services—which included everything from testing resources to masks to vaccinations. That group, along with the Office of Minority Health and Equity, really helped the public health in that area.

- Access to healthy foods, and more broadly, working with our community-based organizations and faith-based organizations to make sure that during COVID-19, folks had access to the services needed.

I like this illustration [page 8, Exhibit C]. It is called the social ecological model because it helps us understand how we can influence and move health indicators. Often in primary care or indirect service care, focus is on the work of the individual and perhaps the family and peers of the individual and how we can move that individual to better health. What we look at in public health is organizational and up. The efforts for this body are really the policy, the orange outermost layer. Our organizational changes—workplace, cultural, societal—fall under community and policy. You saw this impact when we did things such as mask mandates and that policy change at the largest level. This, for public health professionals, is the way we understand how to impact change and may be the best opportunity to intervene and where to intervene.

Nevada's public health agencies are very diverse [page 9]. Nevada and Texas are the only two states that are considered to have largely decentralized public health entities. That means that the bulk of the population receives services from a local health department, but we are not completely decentralized, as the state's public health department provides services primarily in our rural communities. We are the state's public health agency—the Division of Public and Behavioral Health. We were the health division, but we merged many years ago and took on some behavioral health services as well. We have several local public health agencies that will be presenting after me, including Carson City Health and Human Services, considered to be a county health department; the Southern Nevada Health District; Washoe County Health District; and our newest, the Central Nevada Health District.

Administration of public health is largely defined in Chapter 439 of the *Nevada Revised Statutes* (NRS). I have defined some highlights of that chapter [page 10]. Much of the work is done by state public health and the chief medical officer as far as oversight, assurance, regulation changes, and those kinds of things, but we have requirements for county boards of health, health districts, city boards of health, and that is all defined in that statute. During the Great Recession, there were assessments placed on the counties to provide some funding to support other sections within NRS related to environmental health, infectious disease response, and a few others.

Every county is required to have a board of health and a county health officer [page 11]. If a county health officer is not appointed, the chief medical officer will appoint one on the county's behalf. The health officer must oversee sanitary conditions, adopt regulations, and may do other things not mandated, including working on isolation, quarantine, et cetera. What we moved through this last interim is developing our first rural regional health department—the Central Nevada Health District. What this process included was outlined in NRS Chapter 439. They were required to offer local public health services, so they had to remove the section of NRS that required them to pay the state board assessments to do that on their behalf. The Governor approved it, and the Interim Finance Committee (IFC) approved it as well. Beginning July 1, 2023, those entities will no longer pay assessments for

services but will provide those services themselves [page 12, Exhibit C]. This is a great model, and it is regionalization of four counties that came together and said we are like-minded, and we would like to provide this service locally. This is good because when a single city or a single county chooses to offer services individually, it does create scale issues. We have limited funding, and when federal funding or limited State General Fund money is divided up between counties, especially with the demographics, you can get a situation in which some of the smaller counties could have one full-time equivalent (FTE) position funded out of ten different funding streams. As a result, that individual will not be able to get much work done besides grant reporting.

What else has to happen with regionalization is the county health officers and the county boards of health have to agree to basically dissolve to join the regional health authority. They develop a district board of health and a district health officer. They also must develop regulations, and there is a slightly greater duty in public health to provide, protect, and promote public health in those areas. We have had two longstanding health districts in Nevada, and representatives from both are going to talk to you in a minute. The Central Nevada Health District, as I mentioned, is the first regional rural health district to be established, and it was officially established on December 3, 2022 [page 13]. Carson City Health and Human Services is a county health authority, and it has many delegated services on behalf of the chief medical officer. It does a great deal locally, and it does it well, but it is not a district health authority. It provides services through delegation for Carson City and Lyon, Douglas, and Storey Counties.

There are a lot of challenges as we move forward with a model of creating health districts. There are different requirements within that statute based on population size [page 14]. Clark County has guidance within the NRS, and every other county is different as it falls in the less-than-700,000 population category. As far as policy changes, something you will see come forward is promoting the ability for the rural regional merger of county health boards. In Senate Bill 118, you will see us requesting that the word "adjacent" be removed in case counties want to work together and do not happen to share a border.

What did we learn from COVID as far as infrastructure? As I mentioned earlier, we are often the convener, not the doer [page 15]. Our staff is very small and lean, and we often have to work with partners in order to assure that services are delivered to residents. That means we are constantly building and rebuilding those relationships. I would say those relationships right now are the strongest they have ever been because COVID-19 forced us to work together. That meant working with schools and school districts, working with our emergency management partners, working with private health care to do things differently, working with businesses, et cetera. We suffer from categorical federal grant funding, and I say "suffer from" because it really challenges our ability to be flexible. We get those grants, we work hard to meet the deliverables of those grants, and they do affect our residents positively when we can get those monies, but there are a lot of gaps. As an example of the challenge, when monkeypox hit and we were working hard to get vaccination information out to people and to get them vaccinated, we had no money to do that. Many of our categorical federal grants specifically would not allow us to use that staff for monkeypox. It was for COVID.

We said, Well, this is infectious and just as scary, so we would like to use it, but we could not. However, the Centers for Disease Control and Prevention (CDC) just let us know that we will be funded about $500,000 for monkeypox prevention and intervention. We will go to IFC in April to ask for permission to use that funding, but if you look at the epidemic curve of where we are with monkeypox, luckily, we are on the downhill slope of the curve.

When we do not have flexible funding for public health, we wait until our federal partners are able to give us money, and it is often late—just the way Congress gets money out to our local partners. Having a hybrid, largely decentralized system is difficult, also when many of us, specifically in the rural counties, could be delivering services to a single county, we just have different authority to do it, and that could be challenging for the residents to understand.

There is also the fiduciary responsibility—and this really applies to the state, but certainly the local authorities as well. We received over $400 million in COVID-related funds, with not a huge increase in staff to get that money out—and one of our major roles is to make sure it gets out and the deliverables are met with fidelity. We need much more administrative support in that area, and that challenged us. There is also the importance of informatics and information technology. Prior to COVID, many of us were still working on fax machines. We would have case reports mailed. When COVID-19 hit, we had to quickly get funding to modernize our systems and we are moving through that process now, but that hugely limited our ability to respond.

This last slide [page 16, Exhibit C] has population health data for your counties, and I encourage you and the folks watching to visit our data dashboard on health profiles. It provides a number of indicators by legislative district all the way to the county level so folks can understand within their counties what is really affecting the population health. The data are empowering and can help us make decisions about interventions.

Chair Peters:
Are there any questions?

Assemblyman Nguyen:
When you talked about foundational areas earlier, even though the Division concerns public and behavioral health, I did not see a specific listing for mental health. I know it is obvious, but unless you put it out there, I guess people do not think about it. Could you give me some insight on that?

Julia Peek:
It is a great observation. It has really been challenging for public health for the last many years. When the Division integrated, we at the state were able to look much more closely at how behavioral health, mental health, and substance use combined really affects our population health. We were able to work together more closely to look at population health-based interventions—where can we go upstream on behavioral health and substance use? Federally, there is still a bifurcation. Public health has traditional services, which I mentioned—mental health, et cetera. Within those foundational areas of public health, there

is also opportunity for local-based focuses, and when we were on a call with local health authorities, myself and others said, What is that local-based focus that we add at the bottom? All of us said "behavioral health," no questions asked. For us, behavioral health response is integrated in those foundational public health services; nationally, less so. You have SAMHSA [Substance Abuse and Mental Health Services Administration] versus CDC and HRSA [Health Resources and Services Administration], et cetera, so they can be more bifurcated. For us, we have integrated much more locally over the last many years.

Assemblywoman González:
What do you mean when you say the decentralized public health system? Earlier you said that only two states operate this way—Nevada and Texas. Why is that? What is the history, and do you see yourselves moving into a centralized system?

Julia Peek:
Many states are fully decentralized. I would say a mature public health system is probably more decentralized than centralized and it depends on how they have grown over the years. A centralized system would be one where the state health department offers all the services to the residents; there is not going to be a local health department structure. There could be benefits and risks to that. A benefit could be centralized funding, so one entity would oversee the funding and the resources. A challenge is that you do not necessarily have people locally making decisions for their own residents. What we are moving to in Nevada is decentralized. What decentralization would look like in Nevada is that each resident has a local health department, a local public health agency that is overseeing the resources for them, and the state functions more in an oversight role. The state would also pull money and get it out to the locals. Currently, the Division pulls in funds or has resources and we push that out to the local health departments where there are such entities. Where there is not a local health department, as in many of the rural counties, we provide that service. That means we have nurses out in the communities. It is challenging to fund that model. Sometimes you have a single person in the community offering the resources. To mature, what Nevada would look at is fully decentralized, but as I mentioned earlier, that would take the dissolution of each county board of health. Ideally, they could choose to regionalize in the district, but they could do it locally, but it would take that local authority and remove it from the state.

Chair Peters:
You state that Nevada and Texas are the only ones with our current model. Is the fully decentralized the model of the rest of the 48 states, and we are largely decentralized, which is what makes us the back burner actor?

Julia Peek:
I am happy to provide a map illustration so you could see it. What you would see is that the majority of western states are fully decentralized. Where you start seeing full centralization is at the other side of the nation, but our surrounding states are going to be primarily decentralized.

Chair Peters:
Thank you for clarifying that. It reminds me of some of the challenges our school districts have with providing a nurse for schools that can be on opposite sides of the county in those counties where you do not have a centralized population. It is one of our struggles in the West with just how much space we have to cover as individuals.

Assemblywoman Taylor:
I see that the recommendation is to go fully decentralized, but I think I am a little lost when it comes to the differences between the departments and the health districts. We have a health district in Washoe County. Can you use that as an example so I can get the picture from a structural standpoint?

Julia Peek:
Nevada Revised Statutes Chapter 439 spells out the differences between these, but one is the way they are able to bring in income and revenue to support themselves. They can pull in funding from their county budgets to help support services locally versus paying the Division to provide a service. That is a difference. So structurally, how are they different? They are required to have county boards of health unless they choose to work with other municipalities or counties to become a district. There are a number of reasons why you would want to become a district. The City of Reno, the City of Sparks, and Washoe County came together saying that they think it makes sense not to provide bifurcation of services for the residents in the geographic area, so let us have a health district. The City of Las Vegas, Clark County, et cetera, have decided the same thing. Our first rural regional health district is actually the larger counties choosing to come together under one regional health authority. What full decentralization would look like is if northeastern Nevada and three or four counties chose to come together and dissolve their county boards of health and become one health authority. When we funneled money, we would not keep that money for our nurses. For example, we would push money to them, and they would oversee what the nurses do locally. It is a revenue and expenditure issue; it is an authority issue; and there are a number of reasons why folks have chosen not to do it or chosen to do it. It is a layered and complicated area.

Chair Peters:
We have a follow-up question on mental health, and I have to admit that I was not satisfied with the response about how you integrate mental health care into your foundational core areas.

Assemblywoman Newby:
The Division of Public and Behavioral Health obviously includes behavioral health. Looking at the organizational chart, which is a listing, it looks as though there is NNAMHS [Northern Nevada Adult Mental Health Services] and SNAMHS [Southern Nevada Adult Mental Health Services] and the Bureau of Child, Family, and Community Wellness. Is that under a different division of the Division? I am very interested in mental and behavioral health and am wondering if we are going to have a separate presentation about that because it is a separate division under the Department of Health and Human Services.

Julia Peek:
We are under the same division within the Department of Health and Human Services. They are under different deputies. I oversee child, family, and community wellness, which has many of the traditional public health services. I believe your presentation for behavioral health is this week. My colleague, Cody Phinney, will present on substance use prevention, clinical services, and those kinds of services. It is a different presentation but still within the same division.

Chair Peters:
As I read through your foundational areas listed on slide 5 [page 5, Exhibit C], I believe I heard you say mental health is integrated into each of these. Can you give us some examples or help us spell out how that works with these particular foundational areas?

Julia Peek:
These are foundational areas set by federal partners. We are trying to ensure that we are meeting these foundational areas through public health accreditation. In Nevada, we have the latitude to say what should also be added to this list and where we are going to devote resources and effort. Based on all our community health needs assessments, behavioral health always is at the top. They are going to talk about maternal and child health, but typically, behavioral health is at the top. This illustration provides what the federal foundational public health services are that I will say are nonnegotiable. In order to meet accreditation, we have to prove that we are offering all these services under these capabilities. What we do locally is ask what additional outside of this must we be doing to meet the needs of our residents. I could probably defer to Mr. Dick during his presentation to touch on this too, because they are looking at behavioral health as a separate and unique intervention and resource allocation for that topic. Because it is in our community health needs assessment, it remains on the top of the list.

Chair Peters:
Most of us hear from constituents that behavioral health is one of their top health priorities and that they regularly have issues with either finding services or falling through the cracks. Thank you for clarifying this slide. With no more questions, we are going to move on to the next presentation.

Fermin Leguen, District Health Officer, Southern Nevada Health District:
This is our organizational chart [page 2, Exhibit D]. The Board of Health has 11 members, and they represent Clark County and the cities of Las Vegas, North Las Vegas, Mesquite, Henderson, and Boulder City. We have different program areas, and we deliver most of the traditional public health services for our communities. Also, we have to take care of the millions of visitors we receive every year here in Las Vegas. In addition to those traditional services, there are some things that we do that are not common among most health departments [page 3]. For example, three years ago we received an award from HRSA [Health Resources and Services Administration] to operate a federally qualified health center. That health center is delivering services from two different facilities here in southern Nevada, and of course, helping with access to care, especially as it provides primary care services.

Our team is delivering syringe exchange programs through vending machines. Those are offered in different locations here in Clark County and also are being offered in rural areas. We also have our public health lab which provides services to all southern Nevada. Our organization has a management trauma system that collaborates with hospitals and emergency management services here in southern Nevada and helps with all the designation of trauma levels in collaboration with the State. We also provide mobile health services across the community in southern Nevada and also occasionally at other areas in neighboring southern Nevada.

In terms of recent successes for our organization, last year we received public health accreditation and this was the result of more than four or five years trying to get that [page 4, Exhibit D]. We received that award last year and join our peers in Carson City. In collaboration with the University of Nevada, Las Vegas and multiple community partners, we completed our community health assessment and then we followed up with the community health improvement plan that is already being implemented. Something we feel very proud of is that last year we were able to create a congenital syphilis management program. This is a very important program because unfortunately, southern Nevada is one of the regions in the country with the highest levels of syphilis. Also, unfortunately, we have multiple mothers who do not receive early prenatal care and are diagnosed with syphilis at the end of their pregnancy, so we have many cases of congenital syphilis. We have a team working on that which we want to expand.

We opened a new health center facility as part of our federally qualified health center in Fremont Street, which is an area of need here in Las Vegas. In addition, we opened another small-scale facility in east Las Vegas in collaboration with the City of Las Vegas. Our information technology team and our environmental health and food handling team, in response to the high demand for food cards that we had last year, created an online system that helped us eliminate the long waiting list of people for this service. We have our vaping prevention program [page 5]. More than 7,000 received training from our team and also from the community—not just the Southern Nevada Health District, but also from our community partners and ministers. More than 780,000 COVID-19 vaccines were administered this year.

In terms of challenges that we have for this year and the near future [page 6], there is the implementation of the Community Health Improvement Plan and also the implementation of the Public Health Infrastructure Project. This is a grant we received from the CDC. It is a five-year grant, and the initial year began last December. They allocated $22 million to support this effort. We are working with our local jurisdiction here to expand our public health lab. Our goal is to have $10 million to invest in that expansion. To date, we have reached $6.4 million for that purpose. One of the biggest challenges that we have is advocating for approval in Nevada of sustainable public health funding, which is a big issue here across Nevada. Unfortunately, Nevada is at the bottom in public health funding in the country.

Right now, we are in the process of building a behavioral health center at our main facility at Decatur Boulevard [page 7, Exhibit D]. That is part of the effort for our federally qualified health center to expand behavioral health services here in Clark County in collaboration with all the community partners we have here. We are also planning to build a dental health center at the Fremont Street facility to offer those services to children and adults across the community. Of course, our team is engaged in continuing efforts fighting the tobacco and vaping epidemic as well as the opioid epidemic and the syphilis, HIV, and sexually transmitted diseases epidemic. Again, southern Nevada is one of the regions in the country with the highest level of syphilis and other sexually transmitted diseases.

Chair Peters:
Are there any questions?

Assemblyman Gray:
In your successes slide [page 5] you have two things I would like to know a little bit more about. Concerning the youth trained by the vaping prevention program, has anyone done a follow-up on that to see how many of those kids have started vaping? What was the true success? Also, what is a COVID-19 vending machine project?

Fermin Leguen:
I do not have information regarding the vaping program. I do not have that data with me right now, but I can certainly ask our team to forward it to you.

Chair Peters:
If you could forward that to staff, then they would send it to the rest of the Committee.

Fermin Leguen:
Sure, absolutely. Your second question concerned the COVID-19 vending machine program and what it was. This is making COVID-19 testing more accessible to the communities. This concerns the home kits that the federal government was offering several months ago. We got those machines and placed them at different areas, for example, at the Capitol building in Las Vegas and also at Fremont Street. There is another at the Regional Transportation Commission and at one of the stations here. We have another machine in Mesquite, and I believe there is one in Laughlin as well, and those are free.

Chair Peters:
I am looking at your goals and challenges, and I want to ask what the three top challenges are for your health district. There are several layered goals and challenges listed on your slides, but could you go over three of the top priorities from your office that you may be putting resources toward to advance forward over this next biennium.

Fermin Leguen:
Expanding the capacity for our public health lab is one of our main priorities, and that is why we are requesting assistance from the local jurisdictions, and we are receiving assistance to help with that, also, the public health infrastructure project, which is a grant from the CDC.

It is very important because that will help us to sustain the effort that we are doing now for COVID-19 and also to retain employees. One of the biggest challenges we have here in southern Nevada is retaining talent, and this grant will help us with that. The implementation of the community health improvement plan is very important because this is the result of the community health assessment that, in partnership with multiple community partners, helps us identify areas where we need to enhance our work. We want to expand into behavioral health. That is one of the reasons we are creating this behavioral health center at our main facility. We want to expand our workforce dedicated specifically to behavioral health here in Clark County.

Chair Peters:
I look forward to seeing how you integrate those behavioral health care workers into that facility, and what that model ends up looking like.

Assemblywoman Newby:
I have a question on your slide 6 [page 6, Exhibit D]. Under your public health laboratory expansion—the $10 million investment—for the biosafety level 3 and molecular and microbiology laboratories. Is that the same project as the one that was funded with American Rescue Plan Act (ARPA) funds or is that separate?

Fermin Leguen:
That is separate. The one with the ARPA funds is mostly dedicated to academics, and I also saw a public health component.

Chair Peters:
I know we have lost some laboratories in southern Nevada in the environmental world, so I am grateful to see the standing up of a couple more laboratories although they do not cross over all the time into the same space. Are there any other questions from the Committee?

Assemblywoman González:
What is the district doing for outreach to youth in regard to sexually transmitted diseases?

Fermin Leguen:
That is part of the program that we are doing in general. We used to have a program that was specifically directed to youth pregnancy prevention. Unfortunately, that was a federal grant, and as you may know, federal grants come across and they also disappear. Last year, or two years ago, we lost the funding for that grant; there was some reorganization of that program. What we have now is other components of our community health division addressing the youth through different interventions. What we do not have today is a program specifically directed to addressing all the youth programs here in southern Nevada. That is one of the areas that certainly we need to enhance, but again, we lost that funding two years ago.

Chair Peters:
Is there an action plan in place to try to regain that funding?

Fermin Leguen:
The only way that we can incorporate new programs is by having additional funding. It depends on opportunities for funding, whether from the federal government or the state deciding to allocate funding to address specific issues. That is when we can create or expand programs. We receive certain funding from Clark County—from the property taxes which provide somewhere between 26 percent and 29 percent of our funding. Most of our funding is federal today. Another piece of funding comes from the services that we deliver; but for us to create a new program, first we need to have funding, and unfortunately, the funding we have is very limited.

Chair Peters:
Are there any other questions from the Committee? [There were none.] Our next presentation is by the Washoe County Health District.

Kevin Dick, District Health Officer, Washoe County Health District:
Our District Board of Health is composed of two members from each of the jurisdictions that form our district, one appointed and one elected member from the City of Sparks and the City of Reno, and one from Washoe County. Those five members of our board appoint a physician, the sixth member, to the board. The health district was established in 1972. We have provided services for the county since the 1950s, but there were not a lot of things written down early on in that history. In 1972, we formalized to form the health district under the NRS structure.

Currently, we have about 192 FTE positions, and that is when we are fully staffed at the health district, which does not seem to ever occur [page 2, Exhibit E]. There was a question concerning how we and the state differ with regard to the districts and the department. I would note that for most of the federal funding opportunities, but not all of them, there is a requirement for eligibility to apply for those funds—that you must be a state or a county with 2 million or more population or a city of 400,000 population. So Clark County, the Southern Nevada Health District, is eligible to apply directly for a lot of those funds. Washoe County does not meet those eligibility requirements, so in order to access those funds, we have to work with the State and be included with their grant funding and be able to have a subgrant from the State.

I am going to run through slides showing our direct service divisions within the health district. I will not be able to cover in depth or even touch on each of the different areas that we work in because it is very broad with public health, but I wanted to give you the flavor. During the COVID-19 pandemic, we all experienced the chaos that resulted from that public health emergency, with the lockdowns occurring, essential businesses being the only ones open, the uncertainty all of us faced as to whether we were going to have to be isolated or quarantined and whether that was going to impact our children in their classrooms. Those were massive disruptions. I want you to consider that if we had not done all of these programs in public health day in and day out, that would be our life every day—with that kind of chaos—if we were going without the public health protections we have in place.

We are unique in Washoe County because we have an air quality management division [page 3, Exhibit E]. We are the only health authority in Nevada that has that responsibility, and we implement the federal Clean Air Act for Washoe County. We are impacted by wildfires here in northern Nevada, so one of the important functions we have is our network of monitoring stations and reporting to the communities on air quality—when it is unhealthy and what they should be doing in order to protect themselves. We also are right on the borderline for ozone and being out of attainment with the federal standards. The precursors for ozone come from motor vehicles as a primary source, so the smog control program and smog checks are very important to us, as is regional planning to reduce vehicle miles traveled and electrification of our fleets.

We have a community and clinical health services division which provides a number of different services that you see on the slide [page 4]. We had testing and vaccination drive-through operations earlier in the pandemic and we administered over 218,000 vaccinations for our community. We have our immunization program, childhood vaccinations, as a focus area ensuring that our children receive the vaccines that are required for them to attend school, and we are now planning for our back-to-school vaccination clinics. We partner with the school district to conduct those. We have a Women, Infants and Children program that provides supplemental nutritional assistance to help keep our kids growing up healthy. We also work with the schools on smoking and vape prevention programs.

I wanted to touch on family planning and sexual health. We inexplicably lost our funding, along with the Department of Health and Human Services, and Carson City Health and Human Services under the federal Title X Program, which is for family planning services, and this occurred in a moment of time. We have been receiving this funding for over 50 years, but it was not explained why we did not receive our funding as all of our proposals were approved. We were fortunate to be in a snapshot of time where ARPA funding was available, and Ms. Peek worked to help us with the Interim Finance Committee to get ARPA funding for us to be able to continue to provide those services through December 2026. That was a five-year grant from the federal government that we did not receive. We are able to continue those services because of that ARPA funding infusion, but it is an example of the importance of providing flexible funding for public health and the Public Health Improvement Fund, which we have been advocating for a number of years, and it would have been a potential source of funding to be able to continue providing those very important services for our community.

Our epidemiology and public health preparedness program is, on the epidemiology side, focused on preventing and addressing outbreaks [page 5]. And again, we work very closely with the schools in our educational system to help keep them open, to prevent outbreaks from occurring, and when they do to address those outbreaks, to prevent further spread in the community. A number of our programs are focused on how we keep our children healthy so that they can learn when they show up at school. I think everybody now understands the importance of preparedness planning for public health emergencies as well as working with our regional partners when we have natural disasters that we need to respond to.

We also have an environmental health services division, and this covers a number of areas such as how we help keep our water clean, our food safe, and other general sanitation issues [page 6, Exhibit E]. We have a helicopter that is part of our aerial larvicide treatment program for mosquito abatement to help prevent the spread of West Nile virus and viral encephalitis in our community. The acronym UST on this slide stands for underground storage tanks, one of the things we permit and regulate.

I wanted to touch on our food safety program, a major program we have and for which Washoe County is nationally recognized. This is very important for our economy because of the number of restaurants we have associated with tourism and special events in our community. As an example, we have the annual Best in the West Rib Cook-Off that occurs around every Labor Day in our community. We have cookers from all over the country come, and it is a huge event. We spend significant effort working with that event to ensure food safety. Some years we have had to work with vendors to dispose of thousands of pounds of meat because they had not handled it properly or kept it within the temperatures required for public health and food safety. This is part of the work we do that nobody sees, but imagine if we had a major foodborne outbreak occurring at the Rib Cook-Off. It could really have a huge impact economically for the Washoe County community.

This is an overview of my office of the district health officer and the work we do [page 7]. We are a nationally accredited health district and received that accreditation in 2019. I think that the work we did to have the systems in place, the management structures, the planning structures, the performance and accountability structures, really served us well through our pandemic response. A lot of this work is ongoing and we have to maintain it. One of the items here is our community health assessment and improvement plans. Behavioral health has come up a few times today and questions asked about it. Behavioral health has been a top priority identified in our community health assessments and work in our community health improvement planning.

In Washoe County, we see the role of the health district as helping to ensure that members of our community have access to the behavioral health services that they need, not that we necessarily be the direct provider of those services. We have been working over the past couple of years with our cities, the county, and our health care providers—both providers and payers—to facilitate a discussion and implement planning around how we provide crisis response services in our community. We are in the final phases of that with one of our hospital systems that is negotiating with the State on property to be able to provide a 24/7 crisis response center in our community and also supporting the planning around that entire crisis response system and how we connect the 988 Suicide and Crisis Lifeline with people who can respond, to mobile response units to respond to this crisis, or be able to navigate people to the crisis response center if they are not able to be de-escalated during the phone call.

The other significant area we are working on is health equity. We all saw the disparate impacts of COVID-19 and how, particularly when we were most vulnerable early on in the pandemic, those impacts occurred on our essential workers—the workforce that could not

work remotely and had to show up for work. Many times they had to because they had to keep a roof over their families' heads. They needed that income. Oftentimes, these were workers in our minority communities, and oftentimes without any paid sick leave, living with intergenerational, multigenerational families in tight quarters. We really saw those impacts occur through COVID-19, but we also recognized that those social determinants of health are drivers for either good or bad health outcomes for people in our community. Probably much more significant than the health care they receive is the ZIP code that they live and grow up in. We have made a significant investment in health equity with some grant funding we were able to receive, and we are able to keep some of that staff going with some continuation grant funding. We now have a health equity organizational capacity plan we are implementing. We have some community organizers on board to try to better engage with different parts of our community. We found that was lacking when we needed it during COVID-19, and when we needed some community health workers to work in our clinic services and help with outreach to our community.

I am going to touch on our communications program. We are working to further beef up our communications. I think we did a pretty good job communicating through COVID-19, but there is more and more misinformation and disinformation out there, so it is important for public health to be engaged so the right science-based information can get out to our communities.

I want to talk about some of the work we are doing around our workforce capacity [page 8, Exhibit E]. There has been a lot of work done nationally on staffing and what the right staffing levels are for public health. We had been operating in a cost-control model for a number of years prior to COVID-19 and that really bit us when the pandemic came along. It is important that we make an investment in public health, so we have been working with the National Public Health Foundation, which we brought on to work with us to beta test a new public health workforce calculator that is being developed by the University of Minnesota. This was a calculator developed based on work that has been done in a number of states for assessing what the public health workforce should be to be able to provide those foundational capabilities.

That being the foundation—what you need to have a strong health department to be effective and able to support the additional community programs that you develop based on needs in that community. The calculator is set up to be able to help identify by the size of the population how many staff you should have for those foundational capabilities. We went through each position at the health district and identified FTEs that were providing those different foundational public health capabilities and services in our health district. What we found, just running raw numbers through the calculator, was that we needed about 50 additional FTEs for a community our size to fill the gap. Then we did the second phase of that exercise, which was looking at who else, who are the partners in the community that may be providing some of those services? What proportion of these services is being provided by these different partners and how important are they for our community? Going through that, we ended up with 24 additional FTEs we needed to fill the gap for foundational public health services.

We are currently working on what the staffing needs are to do a good job in providing the additional community-specific programs we have. For instance, immunizations are a foundational public health service area, so educating the community about immunizations and promoting them; ensuring that the providers, the pharmacies, and the doctors are handling the vaccine properly—keeping it refrigerated, et cetera, and administering it properly. That is the foundational area. Actually putting shots in arms is not foundational; that is a community need that we are addressing through the health district. There is what we call "below the base"—and that is what the 24 additional FTEs are for—foundational services, but there is also additional workforce needed for those community needs that we address through our programs.

Chair Peters:
We have been talking about mental health, and you went over the crisis model you are developing. I understand that we are going to be hearing from the regional behavioral health policy boards later this week, but can you give us a little bit more detail on how that fits into the public-facing model? How do you let people know that these services exist? How do you connect people with community-based services? How do you become that provider of the hub of services that our community needs?

Kevin Dick:
The health district does referrals through our clinical programs with people coming to us that way. We also work with the 911 system and EMS [emergency medical services]. We do not do licensing, but we work with how that whole system works together, so we are in the mix with regionalization discussions that are currently going on about how to improve that structure in Washoe County. There are a lot of behavioral health services that end up falling into EMS and law enforcement because of the lack of a system and providers. This crisis response center I was talking about is meant to be a place where people can be taken instead of going to jail or an emergency room because there is no other place to take them. Our goal is to work on the system and have that 988 line be well recognized by the community for people who are experiencing crises to be able to contact that number and either get the de-escalation they need or have a warm handoff and care from the other components of that system. We really need more behavioral health care providers. The bill draft request our regional behavioral health policy board is bringing is to help with loan reimbursement and for faculty for providing us with educated behavioral health providers for our community. There is a lot of work that needs to be done in this area. I think Washoe County sees a role for the county in how to be providing those services.

For instance, with people who do end up going to the jail, how can we provide—through the county—outpatient services that will help them reduce recidivism, going back to jail, and getting the care they need. We have had discussions at the local level. We do not feel that it is appropriate for the health district in Washoe County to be providing those services directly, but for the health district to play the role that we are, which is facilitating discussions in the planning and decision making that help us get those services for people in our community. On the part of the county, there is an interest in how they could be more

engaged with how the state behavioral health dollars are spent and how they could help guide the decision making for how those investments are made in the community.

Chair Peters:
Thank you for that response. It is really an issue of how do we ensure we have enough providers layered into your agency and the folks you need, the 25 or so FTEs that you need, in addition to how we are going to stand up a crisis response center with the FTEs and bodies needed to respond, to staff that facility and other community-based facilities that may blossom out of this model that allow for maybe a little bit less of a triage service and more of a preemptive service. There is a lot of focus right now on building that pipeline, that workforce pipeline, and we are in an unfortunate position of there not being enough folks around to provide these services. You mentioned your health equity plan. Could you provide the Committee with a copy of that, please?

Next on my list I have Nicki Aaker, Director of Carson City Health and Human Services.

Nicki Aaker, Director, Carson City Health and Human Services:
Thank you for inviting us to give you a glimpse of what public health looks like in Nevada [page 2, Exhibit F]. I am the director of Carson City Health and Human Services. I am not the health officer, and we are not a district [page 3]. We are a health authority, and I am going to give you a glimpse of a different model that is not a district. As I said, we have a county health officer, and that is outlined in the *Nevada Revised Statutes* and also within our municipal code. It requires a license to practice medicine in Nevada and may be a Carson City physician, so it is a little bit more prescriptive. When Carson City, which is a consolidated municipality, a city/county, chose to form a board of health, it chose to go with the county health authority requirements. Our board of health composition includes our county health officer, who is chair. She is our county health officer—Dr. Colleen Lyons—and is hired by contract. We have our Carson City Board of Supervisors, of whom there are four; our sheriff; and the county clerk, who is the clerk of the board. We are a department of the city, and as a local health authority we do not pay assessments to the state because we provide our own services. Right now, I have 44.1 FTEs, and that is 63 employees. Currently, I have seven positions that are very hard to hire for and more coming on board that are going to be difficult to hire as well. We achieved public health accreditation in 2016, and it is about measuring up against those national standards, and that is a very important piece. We have put in our documentation for reaccreditation and are waiting for a site visit. The reaccreditation takes place every five years.

I am going to give you a glimpse of our different divisions and what happens within them [page 4]. I have six divisions with fiscal support as well. I have our chronic disease prevention and health promotion division. Within that division, I have three programs: the tobacco prevention and control program, the adolescent health program, and the Ryan White retention and care program. As you can see, those are very limited of what I have in chronic disease. There could be many other things that we could focus on, but we are limited with the grant funding on what we can do. Our adolescent health program goes into schools and detention centers and provides sexual health education. That is where we also provide

information about sexually transmitted infections, how to protect themselves, and how to have healthy relationships. Our Ryan White retention and care program is about getting individuals who are HIV positive back into care if they have fallen out of care. It is getting those individuals back into care.

We have talked a lot about behavioral health here, and that is a program that deals with a lot of behavioral health issues and connecting individuals to providers or finding solutions for them. A lot of times there are barriers of why individuals have fallen out of care. Our tobacco prevention and control—I want to highlight a success that they had. They were working with a pretty large apartment complex here in Carson City and they got that complex to adopt smoke-free policies. They worked very hard on that.

Within clinical services, as Mr. Dick indicated, our application was approved for Title X family planning but unfunded, so we are very grateful to the State for coming through with some funding so we can still provide those services. We see a lot of teens within that program. Within that program, they screen for behavioral health, and if something is an alert, we can connect that person to someone who can help them. We have environmental health, and we do environmental health in Douglas County through an interlocal agreement. You are probably familiar with environmental health, which is those restaurant inspections.

We have our chronic disease prevention and health promotion division. We do all of these services outside of our county as well as in Carson City. We work with partners in Douglas, Lyon, and Storey Counties, and Ryan White works in 15 other counties—the rural and frontier counties. When we take our next grant, that program is going to be statewide.

We have epidemiology, and we do disease surveillance or investigations in Douglas and Lyon Counties [page 5, Exhibit F]. We do this as a delegation of authority from the State and with grant funding. This was a division, but because of COVID-19 we were able to divide environmental health and epidemiology into two divisions. Prior to the pandemic they were combined, but it was recognized that was not feasible during COVID-19, as the workload was way too much for one division. During the pandemic, this division traced more than 11,316 cases, and many of those received individual interviews. When I say "traced," you have your case which could lead to the need for many different interviews with individuals. In Carson City we include "human services," but a lot of times you do not see "human services" within a health department. However, it works really well for us and allows us to also work within that behavioral health realm, not giving direct services but connecting people with services and working within that behavioral health system within Carson City. Human services still provides Carson City's mandated services that we do only for Carson City.

We have a Women, Infants and Children program within human services and we provide that service within Carson City and Douglas County. During the pandemic, human services was instrumental in assisting with services within Carson City such as delivering groceries, picking up medications, and much more. We were also able to connect with the other human services departments in the other counties and they assisted their citizens as well. Talking

about behavioral health, we facilitate the Carson City Behavioral Health Task Force, and that is done within the human services division. It is bringing community partners together to discuss what behavioral health issues we have in the community. One thing we have recognized is it is just not a Carson City issue for us. It is a regional issue, so we started having discussions with the counties surrounding us concerning looking at this regionally. We work very closely with the mobile outreach safety team that is in the sheriff's office. Those individuals go out and assist people who are having crises. We were able to put two teams out, which is very helpful. Our teams consist of a clinical social worker and a sheriff's deputy who specializes in behavioral health issues. We also have our public health preparedness division. With that, we have delegation of authority through the State and grant funding.

You may have heard of the Quad Counties [Carson City and Douglas, Lyon, and Storey Counties] during the pandemic. That is us and mainly public health preparedness. I just want to highlight that during the pandemic we conducted 307 mobile points of distribution or dispensing, sometimes it is both ways. I want to emphasize "mobile" because we went into different counties and into different communities. I like to say that we took our show on the road, and we administered 77,588 vaccinations—and that is across the four counties. Also during the pandemic, we stood up a call center within the department and received more than 40,390 calls. In October we were doing our flu vaccination events, so we went from doing COVID-19 to flu. Last year we were doing COVID-19 and flu, and we conducted 58 flu vaccination events in six weeks throughout the Quad County region. Again, those were mobile.

I want to discuss the community health needs assessment [page 6, Exhibit F]. It is very crucial to public health accreditation. This time we were able to partner with Carson Tahoe Hospital. We did it as a Quad County region because the hospital sees individuals from those other counties. That was our third assessment. You can see the priorities that have risen to the top, which include mental health substance use, which is not surprising. You may be asking why this assessment is important. Well, you need to look at what your region or your community has as far as health services, public health services, and determine what those needs and gaps are. That is what you want to work on. The next step for us is going to be working on that community health improvement plan with our partners and residents. And, yes, I say residents. We want our residents involved, and that will be for the four counties.

Chair Peters:
We have a couple of questions.

Assemblywoman González:
During your overview, you stated that it was really difficult recruiting for seven positions. What are the challenges to hiring these seven positions?

Nicki Aaker:
We have a public health nurse position that has been posted for a very long time. Initially, we wanted a bilingual nurse for the clinic, but we recently had to drop the bilingual requirement. We will be happy with a public health nurse. So we have had a very difficult time with that one. We have had some part-time positions that have been very difficult to recruit for. People in this day and age are looking for remote jobs, and we are not an agency that can work remotely. We need to be in the office and we need to be able to work with our clients on a face-to-face basis.

Assemblywoman González:
In terms of dropping the bilingual requirement, has that made it easier to hire someone? When you get bilingual folks, how do you go about serving those folks?

Nicki Aaker:
We just dropped that requirement and still do not have applications, so no, it has not helped us. We do have bilingual staff who can communicate with our community, and we also have a translation service. The translation service does a wide variety of languages so we can provide those services for whoever needs them.

Assemblywoman Taylor:
I have a question about the immunizations. For the Quad Counties, it looks as though you did quite a number of them. I am wondering if you have any kind of a partnership or relationship with the school districts in any of those counties for those required immunizations for school children.

Nicki Aaker:
Yes, we do have a very good relationship with the school districts, and here in Carson City we went into the schools, but not with COVID-19 shots. We did not want to take those into the schools for the kids, but we do it for the flu shots. Even through COVID-19 we worked very closely with the schools and did some of the events even at the schools.

Assemblywoman Taylor:
Other than flu, do you do anything that would provide the vaccinations that are required for school attendance, or are you just targeting the flu?

Nicki Aaker:
Oh, no. Within our clinic we do a variety of immunizations that are required for school as well as adult immunizations including pneumonia and shingles. We do a wide variety. We have an immunization day, which is Thursday. It is a walk-in clinic day, and people can come in and get their immunizations.

Assemblywoman Thomas:
I have a question about substance use. Do you have data about the people you are serving that shows or would show their drug problems—if they have drug problems? I am assuming

that they do, as I am hearing and reading that in rural communities we have a higher untapped use of substance abuse. Is that something you are keeping track of?

Nicki Aaker:
As far as drug use goes, some of that can show up in our community health needs assessment. The program that we have at the health department is just for tobacco, and then we have some funding for vaping. Even if we really look at the data and look at the drug use within the community, I do not have funding to do anything about it.

Assemblywoman Thomas:
What about mental health? Are you assessing people who have mental health issues that are related to drug use?

Nicki Aaker:
We look at that in our human services and our clinic or if one of our educators or our staff members are out working with an individual, and they recognize that there may be some issues with drug use or something. That is where we can connect them to somebody else within our community. We have those referrals in place, and we know those institutions that provide those services, so we will be that connector.

Assemblywoman Thomas:
The sheriff who sits on your board, does he have an input? I am sure that he receives information about people who might have a substance abuse issue and/or a mental health issue. Is he giving you information on that?

Nicki Aaker:
Our sheriff in Carson City is very involved with behavioral health—the mental health piece of it, the substance abuse. He also sits on our regional behavioral health policy board; so, yes, he does give information to us. He also will do it through the board of health and that is where he was very instrumental in wanting to have our community be serviced by two MOST teams, the Mobile Outreach Safety Teams. Again, those are individuals who will go out to a crisis. They have a clinical social worker and a deputy who specializes in behavioral health issues. If the crisis is bad enough and they feel that the individual needs some very intense treatment, we also have the Mallory Behavioral Health Crisis Center, which is a crisis care center or your mental health emergency room, per se. So, we do have the luxury of having that within our community. The sheriff is a huge proponent for behavioral health in Carson City.

Assemblyman Gray:
As a former member of the Lyon County Board of Health, we did not always agree, but you always did a fantastic job and you and your team just performed wonderfully.

Chair Peters:
The next presenter on my list is Mr. Caleb Cage.

Caleb Cage, Interim Administrator, Central Nevada Health District:
I am proud to provide you with an overview of our brand-new health district today. Throughout the prior presentations, you heard a lot of talk about the foundational public health services. You heard a lot about the challenges and opportunities and different districts and authorities and areas throughout the state and the robust capabilities from organizations like the Southern Nevada Health District, the Washoe County Health District, and Carson City Health and Human Services. As you can see from my opening slide [page 1, Exhibit G], we are so new that our logo was approved after I submitted these slides. We are aspirational of all of our partners and peers throughout the state. We were established through NRS 439.369, which has been referenced a few times throughout this presentation. The Central Nevada Health District is made up of the five communities whose logos are across the bottom of the slide. They are Eureka County, Churchill County, Mineral County, Pershing County, and the City of Fallon.

You have heard a great deal about the lack of health districts in Nevada and Nevada's overall structure [page 2]. There are two health districts that are formally formed here in the state—in southern Nevada and in Washoe County. The rest of the state either falls under a health authority structure or under the Department of Health and Human Services' (DHHS) Division of Public and Behavioral Health. All these communities throughout the state present challenges through diverse community needs. We could pick any rural or more populated area in the State and the needs would be different. The challenges would be different and those are due to the geography where they sit, how many people are in those communities, and what services are provided. The amount of funding that is based on population to support public health also presents a challenge, which was brought up many times. In fact, all of these have been brought up numerous times, as well as the capacity of local communities to provide services. Something all of us are facing in public health and in every industry here in Nevada is the necessary workforce in order to provide those services.

They are not just challenges. There are opportunities as well [page 3]. A lot of these opportunities have been known for a long time throughout Nevada, certainly throughout rural Nevada, but a lot of them came to bear through lessons learned from the COVID-19 pandemic. That is where we see the genesis of the Central Nevada Health District, and it is the relationships and the impetus to develop a public health district overseeing four rural counties and one rural city in order to coordinate the services, in order to serve the largest number of people, in order to maximize the use of available resources. Maximizing the use of everyone's resources comes through a number of ways, and I have listed a couple of them here: improving the capacity of existing agencies to address a wider scope of public health problems, including communicable disease control; increasing community input, which we have heard time and time again throughout these presentations is a critical aspect of what public health districts do in our state; improving preparedness; and providing additional resources through a district model or a regional district model.

Based on the challenges that were present and the opportunities that were available, especially as highlighted through the COVID-19 pandemic, leaders across these four counties—which are highlighted on your map here—sought to establish a single central

Nevada health district as a solution to address Nevada's public health challenges as revealed by the pandemic [page 4, Exhibit G]. I never want to miss an opportunity to say how historic this is as the first rural public health district in the state and the first multi-county public health district in Nevada as well. I am especially proud to be a small part of that, seeing the work since December and making sure we are carrying out the promise of the opportunity of establishing a district. This is done through leveraging current local capacities and increasing local investment. Although the assessment has been waived by the State, this actually costs more money for the jurisdictions that are involved to provide public health, and I think that is a great testament to their commitment to serving their populations and increasing partnership and collaboration with local partners as well as with the Division of Public and Behavioral Health under DHHS.

The goals of the Central Nevada Health District [page 5]—again, we are in the very early days—are to build sustainable resources through partnership. No one community in the state—it does not matter if it is public health or emergency management or any other area—has all of the resources it needs. So how does it work with private sector, nonprofit sector, and public sector partners in order to maximize those resources? How do we work to reduce the duplication in services? This is something we talk about a lot in public service to make sure that we are using the resources to their greatest and best benefit for the community engagement. We keep coming back to this because it is so important to make sure that in order to meet the community's needs, we are listening to the community. We are listening, we are doing those health assessments, we are engaging with the public as much as possible. Of course, we need to remain flexible with such a large amount of land and populations spread sparsely across it as well as the different funding mechanisms that are available to us. We need to make sure that we are agile in our ability to provide the services to the local communities.

I am going to briefly go over the timeline [page 6]. The idea really began in earnest in January of 2022, and I provide this to show how quickly this came together. By May of 2022—still during the pandemic—there was a letter sent to the Governor requesting support and we see that the response to the letter of support was received from Governor Sisolak in June [page 7]. Since June, it has been a rapid building process among the different counties to make sure that all of the work was legally grounded and to make sure the collaborative model was in place. In November, the boards of county commissioners began adopting ordinances which would remove their local health boards and join a health district within the community. The first board meeting was in December after the State Board of Health approved the establishment of the Central Nevada Health District. January and February of this year have been focused on operationalizing all of these ideas—getting through the policy work in the previous year, standing it up, and moving towards that July 1, 2023, deadline when it will be funded and operational.

We are always looking for funding opportunities, and I want to thank our partners at the Division of Public and Behavioral Health as well as the other districts in the state that have been such great advocates for standing this up. I have also provided an organizational chart on the next slide [page 8], which is, again, aspirational. It is where we will hope to build

once we bring in the grant funding and the local contributions from the jurisdictions that support this in order to build out these capacities.

Chair Peters:
Are there questions from the Committee?

Assemblywoman González:
I was just curious where mental and behavioral health would fall under.

Caleb Cage:
Much like you heard from the other partners, mental health and behavioral health are built into the various aspects of this model. It is something that the chair of our board of health has asked us to focus on and we are bringing some materials to the next meeting in March in order to provide an overview. But it is done through partnership. It is done through building out these capacities and making sure we are conducting the community health assessment, making sure we are identifying where the behavioral health issues are, what they are, and how we can address them through these various opportunities to engage with the public, like public health nursing, meeting with members of the public to advise them on health conditions they may have, and joining the tobacco coalition in the state to work on some of those health issues related to tobacco. It is integrated throughout. There is not a central note or vertical here that speaks to behavioral health, though. That is something we have been asked by our board to make sure we are integrating and to come up with novel ways to make sure we are addressing in our communities as well.

Chair Peters:
Thank you for that response. Are there any other questions from the Committee? [There were none.] You have quite the feat ahead of you. Good job and good luck. I did have a quick question. You mentioned tribal partnerships in one of your slides, but can you give us an idea of what that outreach and partnership could look like with the tribes within your jurisdiction?

Caleb Cage:
A number of Nevada's 27 federally recognized tribes are located in these four counties. We have been engaged in conversations on specific programs about managing state programs for these four communities that are within these areas and partnerships with the tribes. It is something that we think is critically important, and the relationship within the communities, usually county to tribal governments, is well established and is an important part of the relationship as we stand this up. We will continue to seek opportunities to build those relationships. They will come through public health preparedness and emergency management, but also through community outreach. As residents of these communities, tribal members will also have access to these programs.

Chair Peters:
I would be interested in hearing how those go. I know one of the issue areas that we have come across with sharing resources as a state with tribal governments is the interlocal

agreement process does not quite fit the bill for those kinds of agreements, so keep us posted and let us know if you need help. It is an interest area of mine.

Next is Megan Comlossy to speak on public health challenges and opportunities in Nevada.

Megan Comlossy, Associate Director, Center for Public Health Excellence, School of Public Health, University of Nevada, Reno:

I appreciate the invitation to be here with you today. You have heard a lot this afternoon about public health. You have heard two hours' worth of information about public health, and that is just a drop in the bucket. I am not going to spend the rest of the day talking about it, but I am here just to wrap up and pull out some key themes that we hope you take away from these presentations. You heard today about how governmental public health agencies work to keep Nevadans healthy and how what we call public health really involves efforts to keep entire communities healthy. Public health entities look at the big picture, at a wide range of factors that affect the health of the entire population of the state, and then figure out how to prevent or reduce the things that harm health and to improve or promote the things that keep people healthy. I think one of the hard things about public health when you are trying to wrap your head around it is that it involves so many things. There are things that we do not necessarily associate with the term "health," but hopefully the presentations and the concrete examples that you have heard today provide a foundation about what public health is and does, why it is important, and why it is something that you might care about.

I hope we have also done an okay job clarifying that public health, the health of communities, and elevating the health of entire groups are different from the health that you seek as an individual in your doctor's office or that your family seeks in a hospital. The other critical thing to reiterate is that when public health activities are working, you do not know or hear about them. We take the accomplishments of public health for granted, and many of us may not have even been familiar with the term prior to the COVID-19 pandemic.

The field of public health has existed for more than a century. It has evolved as science has evolved and it continues evolving with scientific advances, but it is really something that happens in the background, and it is invisible unless it is broken, unless there are issues to be solved. Even though it is invisible, it is important to know that it still has an impact on our daily lives whether we realize it or not. In your role as state policymakers, it is important that you understand what public health agencies and practitioners do, both in your communities and across the health of your constituents. The health of Nevada's economy depends on having strong public health systems, public health systems that keep our communities safe and healthy during normal times, and that will be equipped to handle emergencies when they arise. If we could leave you with one thing today, it is that healthy people are productive people and productive people create a strong economy. On that note, we are going to review a few of the challenges and opportunities that we have heard about.

Public health challenges and opportunities are really two different sides of the same coin. If you think about infrastructure and investment in public health, we are looking at physical infrastructure and funding workforce as you have heard about from all the district health

officers. Technology is super important in public health. It is a data-heavy field. We need that data coming in and we need to be able to collect data quickly and share it. A lot of public health relies on old, outdated information technology and data systems that do not talk to each other, so data modernization is a focus of national, state, and local public health systems. This is not something that we have heard about today and not something that we will discuss more, but it is something important for you to be aware of.

You have heard a lot about local administration of services today—the fact that we have this new Central Nevada Health District and that there are opportunities to remove one word in statute. You saw the picture that Mr. Cage showed. There is one county in between the four counties that are part of that Central Nevada Health District. We need to remove the word "adjacent," so that they can be an entire health district rather than operate through other agreements.

You heard a lot about accreditation, and that is elevating the level of services that are provided. You have heard a lot about public health partnerships and working with the communities [page 2, Exhibit H]. The public health sector also partners with universities and institutions of higher education. That is an opportunity to enhance collaboration, provide opportunities for academic research, inform public health activities, and develop a stronger public health workforce—a pipeline. You have heard about workforce and pipeline needs today. Providing opportunities for real-world experience for students at public health agencies is a win-win as we work to establish stronger relationships between universities like the UNR [University of Nevada, Reno] School of Public Health and the public health agencies you heard from today. That is something we are working on as well. We are just going to hit home with the need for public health funding.

Nevada ties with Wisconsin in spending the least on public health per person among the states in the nation. The funding that it does have primarily comes from the federal government and is earmarked or directed to specific programs or needs—services or crises or whatever. Essentially there is little or no flexible funding for the folks whom you heard from today to address whatever the public health crisis of the day is, whether that is monkeypox, whether that is COVID-19, or whether that is congenital syphilis in southern Nevada. There are issues that crop up all the time in public health, and if the funding is not available, then these agencies are really challenged to respond because they do not have the infrastructure, the capacity, the funding to do it. Investing just $10 per person per year in evidence-based programs, things like programs to increase physical activity or improve nutrition, can save the country as a whole more than $16 billion in five years [page 3]. That is a return on investment (ROI) of more than $5 for each $1 invested. The bottom line is the money that is invested in public health and prevention yields a lot on the back end. As you invest in the public health system, it really benefits some of the most vulnerable populations in the state—children, infants, folks in under-resourced communities, folks in Medicare. A little bit of investment in public health funding impacts them the most.

The public health workforce is another issue you have heard about from everyone today. A recent analysis at the federal level estimated that state and local public health agencies

nationwide need around 80,000 additional full-time staff just to provide those foundational public health services [page 4, Exhibit H], or those core public health services that you have heard so much about. As you heard, the Washoe County Health District has done a full analysis to determine that they need at least 24 FTEs to provide those basic services. These agencies need to be able to serve their communities 24/7 and they have to have access to a wide range of data sources. They have to have robust lab capacity, they have to have emergency preparedness and policy planning capacity, and they have to have the expert staff. They need to leverage all those tools and resources to protect the public health and keep communities healthy. The emphasis here is on staff because without staff, none of those resources they have would be usable or used, and without public health practitioners, the system does not function. The fact that Ms. Aaker has seven hard-to-fill positions that they just cannot fill, that they are missing a community health nurse, that means there is not a person in the Carson City area or the greater Quad County area who is providing those direct services that public health provides.

In the Governor's first or second executive order, he indicated that there is a 24 percent vacancy rate at state departments. That could probably include the Division of Public and Behavioral Health and means that there are not people providing the services that need to be provided to elevate the health of all Nevadans. So workforce is a very important resource within public health. The other piece is the lack of funding that connects to the public health workforce. The lack of consistent investment in government, governmental public health services, has resulted in a 15 percent decrease in staffing, according to this national report [page 5]. Not having funding equals people operating at more than a full-time job, and it leads to burnout and other issues. The 2021 Public Health Workforce Interests and Needs Survey, which is the national survey of the public health workforce, found that generally the COVID-19 pandemic exacerbated existing public health workforce shortages. No surprise; these were the people who were on the front lines of the pandemic day in and day out. The survey found that nearly a third of the public health workforce is considering leaving their organization in the next year, so not only can we not get enough people to work in these agencies, but there is a lot of turnover.

You heard a lot about recruitment and retention and hiring. Fifty percent in this national survey indicated they are considering leaving due to pay. We know that in Nevada, pay for state employees tends to be lower than that at the county level. The counties have trouble getting folks in the door and the state has an even harder challenge because their pay is lower. Forty-one percent are considering leaving due to work overload and burnout. Again, a lot of these public servants whom you heard from today do multiple people's jobs. I am not sure how they do all that they do in a day. They and their colleagues are over capacity. Other reasons for considering leaving are opportunities for advancement, stress, and the pandemic. Bottom line is, workforce is an issue and it needs to be addressed. I hope what these presentations have helped make the connection to today is that no matter your priority, it relates to public health. If you care about access to care, if you care about behavioral health, if you care about having children ready to learn so they can get an education, if you care about economic development or environmental issues or clean air, or if you care about

maternal mortality or the opioid epidemic, then you care about public health because public health addresses all those issues and can help move the needle on them.

Healthy people are productive workers; productive workers lead to a stronger economy [page 6, Exhibit H]. If you want a financial reason to care about public health, it is that if you improve the health of Nevadans, you reduce the cost of health care through the Medicaid program and the CHIP [Community Home-based Initiatives Program] program. The state pays for a large portion of the population's health care through Medicaid, and if we can increase the general health, reduce the number of chronic conditions and issues that people have that cause costly care, then we save the state funding. If we invest in public health, we reduce the cost of Medicaid on the back end. Finally, investing in robust systems that detect, prevent, and address public health threats is more cost-effective than responding to public health emergencies. If we have strong public health infrastructure, if we have the capacity to address the needs of the day, if we have the workforce that can implement all the services you have heard about today, then when the next crisis emerges, we are better prepared, we have less sick people, we have less lost workdays, we have less death, and the state is better off.

Your role goes back to Ms. Peek's slide with those bubbles. The biggest orange one was policy. Policy is one of the strongest levers to improve public health, and a lot of the greatest public health achievements in the last 100 years involved policy change [page 7]. If you think about seatbelts, seatbelt laws—that is public health. Tobacco control and issues to improve maternal and infant health are all public health. The policies that you pass matter, and they have huge impacts not on individual health, but on the health of the entire state and everybody who lives here. I would just encourage you to consider how improving the health of your community and communities in Nevada can help you achieve your legislative priorities, and then think about how understanding what the folks whom you heard from today, what public health agencies and practitioners do will help you evaluate and make decisions about opportunities to improve the health and well-being of your constituents.

This brings us to Senate Bill 118, which is being considered this legislative session [page 8]. It was sponsored by the Joint Interim Standing Committee on Health and Human Services as the result of the last session's study which looked at the COVID-19 response and how to improve public health emergency responses in the future. Essentially this bill would establish a fund with noncategorical funding—flexible funding that could be appropriated or used for whatever local health districts and authorities needed to address the biggest issues or infrastructure needs of the day. It would appropriate $15 million, or $5 per capita, so 3 million people in the state equals $5 per capita. If the state invests $5 per person in the state, then we improve public health drastically.

The third bullet mentions removing the word "adjacent" so that the Central Nevada Health District and other like-minded and collaborative counties could create health districts even if they are not contiguous or adjacent. This is a huge public health bill that you will hear this session, and there will be numerous additional bills that relate to public health on all the topics we have discussed today. You heard about all the challenges that these folks and the

public health authorities are facing, and this bill aims to address it. Fifteen million dollars looks like a lot, but it is literally $5 per person as an investment. And if you think back to that slide on ROI, every $1 of investment results in a $5.60 return on investment. We invest the money now rather than putting it in a piggy bank to address a future public health crisis.

Chair Peters:
I appreciate the in-depth information presented today. Thank you, again, to all our presenters. There are some questions for you.

Assemblywoman Thomas:
My question goes back to slide 3 [page 3, Exhibit H]. I went to the rankings of each state. We are walking hand in hand with Wisconsin so we are not alone in being last. Has anyone researched the fact that the District of Columbia gets $874 to their people there? Even though you put in here that Alaska spends the most, the District of Columbia is actually the largest. How can they get that kind of funding, but we cannot even measure up to the U.S. average?

Chair Peters:
This is an interesting question. I want to make sure that we address both the state obligation, or the local obligation, which is put toward it as a state body, versus the federal obligation, which is what we, as a state, have relied upon for at least a decade or more.

Megan Comlossy:
There is a lot that goes into this. The District of Columbia is different because it is not a state, so I am not familiar with their exact funding.

Julia Peek:
There are a few reports that look at overall state public health funding. The one we are looking at is the Trust for America's Health and America's healthcare ranking. I am happy to provide that to the Committee if they want to review it more closely. We provide data on that. The Chair mentioned the state investment. We do okay on federal investments, but the state investment is really where we fall short. We have some categorical State General Fund that goes into this. We have some funding for the Women's Health Connection Program that does breast and cervical cancer screening, and we have funds for the account for family planning. Each of those is a few million dollars. When you start looking at that specific investment, where we fall short is the state investment in public health. These reports also pull out where we went on federal investments, and I am happy to provide it to the Committee staff.

Chair Peters:
I think that would be helpful, especially in understanding where our state obligation has fallen flat. As a brief side note, we have a limitation on revenue coming into the state, so our pot of money is only the size that it is. When we look at what our state is investing in, we look at the variety of services provided through the state. They are not just isolated to health

and human services, but also education and aging and disability. Then there are other areas that are not specific to our public health districts and public health services.

Assemblywoman Thomas:
I have a question on slide 4 [page 4, Exhibit H], just a clarification. According to the study that you mentioned from the de Beaumont Foundation, there are an estimated 80,000 additional full-time staff needed. Is that for our state or across the country?

Megan Comlossy:
This was a national study, and so it is 80,000 full-time staff for state and local public health agencies across the nation.

Chair Peters:
Thank you for clarifying. Are there any other questions from the Committee? [There were none.] Thank you all so much for your time here today. This is a dense topic area but of importance to all our constituents and of growing concern for all of us as we are looking toward what we want Nevada to look like in the next biennium, so I appreciate your time today.

Our last agenda item is public comment. I will start here in Carson City. Is there anyone in Carson City or Las Vegas who would like to provide public comment today? [There was no one.] Is there anyone on the call-in line? [There was no one.] We will close that agenda item. Are there any comments from Committee members? [There were none.] The meeting is adjourned [at 3:47 p.m.].

RESPECTFULLY SUBMITTED:

_____
Terry Horgan
Committee Secretary

APPROVED BY:

_____
Assemblywoman Sarah Peters, Chair

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a copy of a PowerPoint presentation titled "Public Health Overview," dated February 13, 2023, presented by Julia Peek, Deputy Administrator, Community Health Services, Division of Public and Behavioral Health, Department of Health and Human Services.

Exhibit D is a copy of a PowerPoint presentation titled "Southern Nevada Health District," presented by Fermin Leguen, District Health Officer, Southern Nevada Health District.

Exhibit E is a copy of a PowerPoint presentation titled "Washoe County Health District Presentation," dated February 13, 2023, presented by Kevin Dick, District Health Officer, Washoe County Health District.

Exhibit F is a copy of a PowerPoint presentation titled "Carson City Health and Human Services," dated February 13, 2023, presented by Nicki Aaker, Director, Carson City Health and Human Services.

Exhibit G is a copy of a PowerPoint presentation titled "Central Nevada Health District Overview," dated February 13, 2023, presented by Caleb Cage, Interim Administrator, Central Nevada Health District.

Exhibit H is a copy of a PowerPoint presentation titled "Public Health Challenges and Opportunities in Nevada," dated February 13, 2023, presented by Megan Comlossy, Associate Director, Center for Public Health Excellence, School of Public Health, University of Nevada, Reno.