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

Eighty-Second Session
February 20, 2023

The Committee on Health and Human Services was called to order by Chair Sarah Peters at 1:30 p.m. on Monday, February 20, 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
David Nauss, Committee Counsel
Eric Robbins, Committee Counsel
Terry Horgan, Committee Secretary
Ashley Torres, Committee Assistant

OTHERS PRESENT:

Lea Case, representing Shatterproof
Brian K. Iriye, M.D., High Risk Pregnancy Center, Las Vegas, Nevada
Lisa Durette, M.D., Child and Adolescent Psychiatrist; Founder, Pediatric Access Line
Karin Esposito, M.D., Interim Chair, Department of Clinical Services; Senior Executive Dean, Roseman University of Health Sciences
Kristen Pendergrass, Vice President of State Policy, Shatterproof
Jeanette Belz, representing Nevada Psychiatric Association; and Nevada Public Health Association
Nicole Winckelmann, Policy Intern, Nevada Coalition to End Domestic and Sexual Violence
Barry Cole, M.D., Private Citizen, Reno, Nevada
Leann McAllister, Executive Director, Nevada Chapter, American Academy of Pediatrics
Amanda Haboush Deloye, Chair, Clark County Children's Mental Health Consortium
Katie Ryan, Director, Communications and Public Policy, Dignity Health-St. Rose Dominican
Deepa Nagar, M.D., Private Citizen, Las Vegas, Nevada
Dora Martinez, Private Citizen, Reno, Nevada
Denise Tanata, Chair, Early Childhood Advisory Council
Patti Oya, Director, Education Programs, Office of Early Learning and Development, Department of Education
Zoe Houghton, representing The Children's Cabinet
Zach Bucher, Government and Community Affairs, City of Las Vegas
Jamelle Nance, Director, Strong Start Prenatal to Three Initiative, Children's Advocacy Alliance

Chair Peters:
[Roll was taken. Committee rules and protocol were reiterated.] We have two bill hearings on the agenda for today, so I will be stepping down and Vice Chair Orentlicher will take over during that hearing. For the bill hearings this afternoon, I have allocated equal time for testimony in support, opposition, and neutral after each bill presentation. Each person providing testimony is allowed a maximum of two minutes. Staff will be timing each speaker to ensure everyone is given a fair opportunity to speak. A reminder on providing testimony, per Assembly Standing Rule 54, a person must state for the record whether they

support, oppose, or are neutral on the measure before the Committee. Support consists of approval of the measure as written or as written along with proposed amendments that have been approved by the sponsor of the measure. Opposition consists of not supporting the measure as written or as revised by an amendment that has not been approved by the sponsor of the measure, and a neutral position on the measure is one in which the person offers particular insight on the measure but expresses no position on the measure. We are going to take these hearings out of order and start with Assembly Bill 138, which I will be moving to the front of the room to present.

[Assemblyman Orentlicher assumed the Chair.]

Vice Chair Orentlicher:
I will open the hearing on Assembly Bill 138.

Assembly Bill 138: Provides Medicaid coverage for certain types of behavioral health integration services. (BDR 38-332)

Assemblywoman Sarah Peters, Assembly District No. 24:
I am happy to be introducing Assembly Bill 138 to the Committee today. Assembly Bill 138 requires the State Plan for Medicaid to include behavioral health integration models such as collaborative care as part of the services covered in the State Plan for Medicaid. The collaborative care model, supported by a behavioral health provider acting as a case manager, is an effective way to provide integrated and comprehensive care to patients with mental health conditions. This model requires a team-based approach that involves psychiatrists, pediatricians, and primary care physicians working together to provide coordinated care to patients. Today, we have several experts with us to help explain the bill and the impact it will have on Nevadans. I want to mention that this was an interim committee bill that came out of the 2021-2022 Interim and was approved out of committee for a BDR [bill draft request] introduction this year.

Lea Case, representing Shatterproof:
I am not the expert on this. I am here to offer a bill walk-through after the doctors have their presentations.

Brian K. Iriye, M.D., High Risk Pregnancy Center, Las Vegas, Nevada:
I want to give you background on myself [page 2, Exhibit C]. I am the former president of the Society for Maternal Fetal Medicine, the biggest and most prestigious high-risk pregnancy organization in the U.S. and in the world. I am the current president of Hera Women's Health. I ran two workshops for national organizations in the United States, authored over 25 research articles, and currently serve as the primary investigator for the PRIME [Prematurity Risk assessment combined with clinical Interventions for improving neonatal outcomes] trial which is the largest preterm birth study in the U.S. in the last two decades.

What is the collaborative care model [page 3]? It is where health care providers use a model to address both the physical and mental needs of a patient in as few visits as possible and with a team-based approach. There is a coordinated form of communication between primary care providers and mental health specialists that allows the care to be provided quickly, succinctly, and with expert opinion. It allows primary care providers to do initial assessments and screening and then refer and stay in communication with more specialized mental health treatment for support. Then these people can coalesce because they are often in the same environments, do regular check-ins, case conferences, and really coordinate care. Research models have shown this model is much more effective than traditional care, producing better mental health outcomes and reduced overall health costs.

Our current model is one where most patients will talk to their primary care provider about mental health issues, but at that time, the primary health care providers have to decide whether to refer the patients out or try to treat the patients themselves [page 4, Exhibit C]. If they try to treat the patients themselves, they are usually not the most effective people to do it. If they refer the patients out, they have to go to other visits. It is hard to get timely appointments, and this model just does not appear to work, which exacerbates our current mental health problems. The collaborative care model, in contrast to this, provides primary care site integration either via telemedicine or people present there, with a behavioral care manager who works in collaboration with a psychiatrist on more significant and difficult cases. They utilize organized assessments for analysis and for treatment, and this organized approach between the patient, behavioral health care manager, primary care provider, and psychiatric consultant allows for one-stop shopping of mental health care and avoids having patients fall through the cracks. It helps on social determinants of health such as problems with transportation and child care cost; so, much improved.

In our office, we have an opioid use disorder clinic where we have a collaborative care model with a behavioral mental health practitioner who has addiction specialty training and a psychiatrist [page 5]. My office sees these patients during pregnancy and places them on medications that are much more effective and safer for pregnancy. Because of this, we avert things such as neonatal abstinence syndrome, which you can think of as an addiction of the neonate when born due to prolonged opioid exposure. This makes about a 15-day hospital admission in the NICU [neonatal intensive care unit] for these babies. Because of what we are able to do in our office—putting them on safer medications and using behavioral health at those visits—we get people who stay in our therapy and are at decreased risk of neonatal abstinence syndrome. We are saving about $45,000-$55,000 in immediate costs, and that does not count the costs in regard to long-term improvement for neonates into school age and adulthood.

We would also like to get to maternal mental health. One in seven people have postpartum depression, and 60 percent of people who commit suicide postpartum never saw a mental health provider in the previous month. It is estimated that 20 percent of all people have mental health disorders during pregnancy, and those are increased in people below the poverty level. There are estimates that if you treat women during pregnancy with this collaborative care-type model, you will save $32,000 per mother/child pair in the first five

years of life. Our problem is that we cannot set up some of these clinics or they are likely to fail over time because almost no commercial insurance supports collaborative care billing, and Medicaid and the Medicaid managed care organizations (MCOs) do not recognize these codes at all [page 6]. Hence the model cannot grow and is rather limited. We are the only practice in Nevada specializing in the collaborative care model. Although we generate cost savings, we cannot bill for the services that we provide effectively. In our office, our partners took money out of their own pockets, and we have lost about $200,000 per year in our first two years, but we did it because it was the right thing to do. After that time, we were able to get federal and state grants, but this is not sustainable for a program. We want to set up a mental health model, but it is with our other funding. It is difficult to set this up, and the sheer number of cases would overload our practices. As I said before, one out of eleven people below the poverty level have been stated to have severe depression, and 40-60 percent of those in poverty have some depressive symptoms. It has made it really hard for us to get referrals to services, or these services are just not provided to these patients. Additionally, we have problems with primary care providers getting mental health care contracts because it is a huge hurdle to set up these programs [page 7, Exhibit C]. It is time intensive to do it, and physicians have to try to get separate contracting. Mental health contracting is separate from physical health contracting. You would have to do time intensive contract negotiation, and the physicians lack the skills because they do not usually do mental health contracting. Also, mental health is usually reimbursed at a lower rate than physical health. Last, there are separate processes for credentialing of behavioral health physicians as opposed to physical health physicians, and that is an additional problem.

My request [page 8] is that the collaborative care codes be recognized by Medicaid, Medicaid MCOs, and commercial payers; and that the payment for these models not require separate contracting but be paid under the single contracting price of the main physical health contract. Mental health affects physical health, especially in things such as pregnancy, and the cost savings are dramatic. For collaborative care providers, if we could get credentialling performed in the same ways and processes for mental health providers as for physical health providers, that would be a huge help.

Lisa Durette, M.D., Child and Adolescent Psychiatrist; Founder, Pediatric Access Line:
I am going to talk about a collaborative care model that exists statewide—our child psychiatry access program [page 1, Exhibit D]. Should this bill pass, this is one of the pathways to help sustain this program. You all are very aware that children's mental health has become a hot button issue, and the majority of kids with behavioral and mental health problems do not even receive care [page 2]. Of those who receive care, the vast majority are receiving it in the primary care space, but pediatricians, family medicine doctors, and nurse practitioners often feel that they lack the training to treat these mental health problems and combine that with the fact that we have a national shortage of mental health providers.

If you go to Mental Health America, they do rankings of the states, and these are rankings that are determined by metrics [page 3] each state submits to the feds every year. Our state has consistently ranked fifty-first in children's mental health metrics and tied to that is the fact that we have a severe statewide shortage of child psychiatrists. You can see in Washoe

County and in Clark County we have child psychiatrists, but we are far behind the national ratio with only 3 per 100,000 versus the national average of 14 per 100,000 [page 4]. Part of why we have these providers in Washoe and Clark Counties is because both regions have training programs.

We are not the only state that has been struggling with this. In 2004, Massachusetts pioneered a model that is called MCPAP, the Massachusetts Child Psychiatry Access Project [page 5]. It is a unique model that aims to provide child psychiatry support to primary care providers to enhance their skills, expertise, and knowledge about treating mental health disorders in kids such that the children are not even getting referred to child psychiatry. Washington came next, and in 2011, the National Network of Child Psychiatry Access Programs was born [page 5, Exhibit D]. We are the forty-sixth state to join the national network, and we now have our own program.

What is a CPAP or a child psychiatry access program [page 6]? It is a physician-dedicated telephonic hotline. Ours, for example, operates from 9 a.m. to 5 p.m. Monday through Friday, and primary care clinicians—physicians assistants, nurse practitioners, pediatricians—working in any setting—hospital, private practice, federally qualified health center—can all call the line. It is free of charge, and it is mental health block grant-funded. They call the line, they speak with a care coordinator who helps triage the call, and they are able to talk to a psychiatrist any day of the week for free. It is same-day telephonic support. We discuss diagnoses, we discuss management, we discuss medication options, we discuss psychotherapy referrals, and our team provides intense care coordination. For about 10 percent of the consultation calls that we have, we offer a one-time tele-video consultation for the patient to help clarify diagnoses and clarify treatment planning or for the primary care doctor to pull out.

Here is our website for the statewide program [page 7]. Ours is unique. We are a three-legged stool, and the legs include the Kirk Kerkorian School of Medicine at the University of Nevada, Las Vegas (UNLV), Chicanos Por La Causa (CPLC), and the Center for Community Solutions [page 8]. I am the founder of this program. I also started our child psychiatry fellowship at UNLV in 2013. I am currently the Interim Chair for Psychiatry and Behavioral Health, and I have been involved in local advocacy through the Commission on Mental and Behavioral Health. Chicanos Por La Causa is an enormous multistate organization, and our Nevada CPLC chapter is really dedicated to mental health. They are the managers of The Homeless Courtyard Resource Center and provide services through the Courtyard as well as to two rural- and frontier-certified community behavioral health centers. Finally, the Center for Community Solutions is our web host and also provides all the background data. If you are trying to access the program and you do so through a mobile device, you can instantly request a consultation, and it is a HIPAA-compliant [Health Insurance Portability and Accountability Act] portal through which consults can be requested.

We have a really simple website [page 11]. It is easy for anyone to access, and most importantly has one-page infographics and handouts for primary care clinicians to help give them the quick and simple: What do you do with depression? What do you do with anxiety?

All of these have hyperlinks to different rating scale screening tools, and we aim to make this a really educational resource. Since inception, we have provided 563 consultations, but that number was from the first of the month and there have been more since [page 12]. Our care coordinators have had over 1,500 encounters. Common diagnoses for which we are taking calls are very different than what I thought starting the program [page 13]. I assumed it would be a lot of disruptive behavior and attention deficit hyperactivity disorders (ADHD)—although there is a lot of ADHD. You will see that the numbers do not add up to 100 because it is usually more than one thing such as depression and autism spectrum disorder or ADHD and anxiety. It is a little bit of everything.

We received IRB [institutional review board] approval to survey primary care clinicians involved with our program one year after the launch [page 14, Exhibit D]. We discovered that there is a statistically significant improvement in perceptions of access to child psychiatry as well as a statistically significant improvement in primary care clinicians' comfort in making behavioral health diagnoses, demonstrating that there is a long-lasting impact of this type of program.

Let us talk about sustainability [page 15]. You heard Dr. Iriye describe the fact that these are currently not funded programs. The annual cost of our program is $750,000. Some of that money can be offset through opening up the collaborative care codes. The benefits of the program, not just the costs, are spilling out to so many patients because there is immediate mental health support for primary care clinicians statewide. These clinicians have demonstrated improved comfort in working with mental and behavioral health diagnoses, which means fewer referrals into an already overburdened system, and it is an improvement in access to care statewide. Our rural and frontier areas especially now have quick access to child psychiatry. Within the national network, there have been some great examples of sustainable funding, one of which includes a legislative line item for the flat rate of the program, and others include insurance surcharges that would help with the sustainability of the program as well as what we are talking about today such as creative support through Medicaid, including managed Medicaid. Here are a lot of resources—more than you probably want to read [page 16].

Karin Esposito, M.D., Interim Chair, Department of Clinical Sciences; Senior Executive Dean, Roseman University of Health Sciences:

I am going to speak to you about the EMPOWERED program at Roseman University. EMPOWERED is a program for pregnant women and postpartum women with substance use disorder, opiate use disorder, or stimulant use disorder, or women who are using opiates or stimulant prescription medications during pregnancy. We work very closely with Dr. Iriye's program and share a lot of patients. EMPOWERED provides care management services, therapy services, and as well, a coordinated care model with the supervision of a psychiatrist. We are very familiar with women who are struggling to find resources. Knowing it is difficult to get mental health care and having a collaborative model where we are able to leverage psychiatric services and use them to their fullest ability to provide service to the largest number of people, I think is critical here. You heard Dr. Durette mention the shortage of child and adolescent psychiatrists. In general, there is a shortage of

psychiatrists in Nevada and nationwide in many places in the country, so being able to use these resources in collaboration with primary care is powerful and provides an evidence-based model that has been supported by the American Psychiatric Association as well. I would like to add into what both Dr. Iriye and Dr. Durette said in terms of sustainability. EMPOWERED is also currently grant-funded, and having the sustainability, the long-term ability to bill for collaborative care models would really help expand the program, give access to more women, and allow a continuation of care beyond that first year postpartum when people still need support, still need primary care services, and often still need mental health services, whether it is for substance use disorder or for some comorbid psychiatric condition such as depression or anxiety.

Lea Case:
I was going to offer to do a section-by-section walk-through on the bill; however, you have heard from the presenters what the bill does. I want to clarify that A.B. 138 only applies to Medicaid and not to private insurance companies. Medicaid does cover over 50 percent of the births in our state, so it would be hugely beneficial for the high-risk pregnancy center and the EMPOWERED program because that is a majority of their patients. As you heard, it would support our existing workforce, those who are understaffed in the mental health and primary care workforces, and it would expand access to mental health care in those primary care settings where folks are most likely to let somebody know they are struggling.

Assemblywoman Peters:
Ms. Case and I were commiserating over our own prenatal and post-natal journeys and the lack of collaborative care in most cases. Navigating those referrals and organizing your own data to share with doctors is a burden all of us have experienced. For my own daughter, I have been going around and around trying to get an ADHD referral for her. We got in to see her physician, got an assessment, and then we were referred to a child neuropsychologist, but I cannot get in to see them for another four months. It has been a three-month process for us, and all she needs is a quiet space where she can finish her work in school. If her doctor had been able to refer her in-house to a psychiatrist in their facility, we would not be dealing with that.

That timeline, the collaborative care model, is designed to treat a whole person. We all know the health care referral dance of obtaining records, getting preapproval of referrals, et cetera. This model helps reduce barriers to care and enables providers to work together to meet the needs of their patients. These billing codes we are talking about would cover the cost for providers to coordinate that care for patients, ensuring the care they are prescribed and receiving is truly meeting the need and iterating the care, in some cases in concert with each other rather than siloed, which can result in significant delay in receipt of care.

I hope we have shown you the benefits of collaborative care and the population in our state it can touch. I am looking forward to hearing the testimony that comes up next, but I hope that we have earned your support for this bill.

Vice Chair Orentlicher:
Thank you, all, for the helpful information. Do we have questions from members of the Committee?

Assemblywoman Taylor:
I have never heard of the collaborative care model, so I want to go back to something you alluded to in the presentation. You mentioned there are a few states that have this kind of a model.

Brian Iriye:
I do not know how many states have this model, but this was born out of research and a model from the University of Washington over a decade ago and has been utilized in many places around the country. These codes are in our handbooks of medical codes; however, our state Medicaid program does not recognize the codes. When you do not recognize the codes, it is as though they do not exist, and you cannot use them for the usual billing purposes as they are used all over the United States.

Assemblywoman Taylor:
I appreciate that, Doctor. Thank you so much.

Assemblywoman Peters:
Kristen Pendergrass has a response as well.

Vice Chair Orentlicher:
Yes, please go ahead.

Kristen Pendergrass, Vice President of State Policy, Shatterproof:
I am the Vice President of State Policy for Shatterproof. We are a national nonprofit that is working with states to get Medicaid to cover these codes around the country. I want you to know that 22 states currently cover the codes for collaborative care models in their Medicaid programs, and there are a lot of private insurers that do so as well.

Assemblyman Nguyen:
I know that we are trying to put in a lot of different partners all around to ensure that the patient is taken care of. Does the model have any involvement from the school district? You mentioned something about having been diagnosed and then they can go back to the school setting in an accommodating environment. Is the model including the school setting because that is a major part of the child's life?

Lisa Durette:
Other states do have models for child psychiatry access programs that will directly help in schools where the child psychiatry team can interface directly with school counselors, school nurses, and school administration. With funding, we would be able to expand the program statewide to do such a thing. We fully support this bill, and I think it is going to have an enormous reach statewide. The type of program that we do is similar, but a little bit

different, in that the cost is for the program itself, which is not just the psychiatry services but the care coordination, the infrastructure, the back of the house. With additional funding, you would be able to expand the Pediatric Access Line into schools.

Vice Chair Orentlicher:
Are there other questions?

Assemblywoman Thomas:
I think it is a 504 Plan [Section 504 of the 1973 Rehabilitation Act] for children when they are in school, but they need to be able to go to a psychiatrist. Assemblywoman Peters said that her daughter just needed a quiet space for taking tests, and this would help with other students who may have some learning challenges. Will it mean that you would not have to go to a psychiatrist and that your primary doctor could recommend the 504 Plan, if I am understanding it correctly.

Lisa Durette:
You are speaking of the 504 Plan, and you are correct. The 504 Plan as well as individualized education plans (IEPs) fall under the Individuals with Disabilities Education Act of 1974 and are federally protected resources for kids for which a doctor's order or recommendation is not needed. I think that is an unfortunate misconception in the world of education and, unfortunately, gets leveraged inappropriately. The whole role of our program is to initiate or help support the primary care clinicians' ability to initiate treatment. For example, we will talk through with the pediatrician how to start a medicine for ADHD. How to start a medicine for anxiety. We will give recommendations for types of psychotherapies that could be helpful for a child struggling with depression or struggling with anxiety. Our care coordinators provide education to the families in both English and Spanish as well as helping connect them and providing a warm handoff into the community. Those are the specific services a program like ours is able to provide.

Assemblywoman Newby:
In A.B. 138, there is a requirement that the state pay the nonfederal share for Medicaid. I assume that means these rates are already set somewhere, and we are just including that in our plan for Medicaid. Is that what we are doing here?

Lea Case:
That is correct. I believe Ms. Pendergrass from Shatterproof has more information, and we can provide you with a handout on those codes and rates that have been used at the national level and adopted by other states.

Kristen Pendergrass:
My understanding is that most states start with a percentage of the Medicare rate. These codes have been covered by Medicare, and CMS [Centers for Medicare Services] approved them a couple of years ago, I think in 2018. Most states start with a reimbursement rate that is somewhere around 85 percent of Medicare. As we all know with the behavioral health

crisis that this country is dealing with, other states have made it equal with Medicare and some are even looking at increasing it beyond Medicare levels.

Vice Chair Orentlicher:
I think we can now move on to testimony in support, opposition, and neutral. We will begin with testimony in support of A.B. 138.

Jeanette Belz, representing Nevada Psychiatric Association; and Nevada Public Health Association:
We are in support of this bill. There was a point brought up earlier about leveraging psychiatric services. I see this as extending them so that they are available, and access is available. A number of barriers were testified to in terms of connecting people to those services and being able to do it through the primary care setting, which is where patients are more likely to initially come in contact. It provides greater access to these services. With what we are dealing with in our state, I also wanted to mention that this is not just restricted to pregnant moms at high-risk pregnancy centers or children through the educational system. This is regardless of age.

Nicole Winckelmann, Policy Intern, Nevada Coalition to End Domestic and Sexual Violence:
I am here today in support of A.B. 138, hoping to provide a violence prevention perspective within the issues covered today. Access to mental health care is necessary for violence prevention and intervention, yet unfortunately for so many Nevadans, access to mental health care is challenging, or worse, unobtainable. After an incident of intimate partner violence, victim survivors are at a heightened risk of PTSD [post-traumatic stress disorder], substance abuse, and mental illnesses such as depression and anxiety. These risks are heightened even further for pregnant and postpartum victim survivors and their children. Additionally, perpetrators often target those with untreated mental illnesses because of their vulnerability and likely previous victimization. Repeat victimization and untreated mental health symptoms keep victim survivors from adequately functioning in society, making it challenging to maintain employment, parent their children to the best of their abilities, attend schools as students, and, as such, have detrimental effects. Mental health interventions are necessary to address and reduce violence in our communities, so expanding Medicaid is an important step in creating mental health access and preventing violence.

Barry Cole, M.D., Private Citizen, Reno, Nevada:
I have been a psychiatrist in this state since 1986, and I am in support of this. I attended a national training through the American Psychiatric Association in October in Minnesota. This is being promoted throughout the United States, and it may solve a problem that will occur when the public health emergency ends on May 11. It will be able to extend mental health providers, so you are not just looking at this in Nevada, it is in other states. We think this is a viable model that allows psychiatrists to collaborate with their primary care provider colleagues and have mental health support staff working directly with those people, then the psychiatrist would be giving advice and answering questions. There are not enough of us to go around, and if you see this white hair, it is real. I did not dye my hair. I am retired and I

am exiting my career in medicine after 42 years, but there are not enough people coming into psychiatry. Nevada has 20 graduates every year coming out of our three psychiatric residencies; however, my concern is that 75 percent of them are leaving for California, Utah, and Idaho, so that means a net gain of 5 providers, so anything we can do to extend mental health is a net win for us.

Leann McAllister, Executive Director, Nevada Chapter, American Academy of Pediatrics:
We are in support of A.B. 138. The American Academy of Pediatrics (AAP) strongly encourages collaboration between pediatricians and mental health specialists to determine the best course of treatment for patients. Mental health is an essential component of overall health. Mental health challenges—from individual symptoms to diagnosed mental illness—impact all children, adolescents, and families. The American Academy of Pediatrics supports a developmental approach to children's mental health that encompasses primary prevention through promoting social and emotional health and safety and nurturing relationships; secondary prevention through screening, identification, and assessment; and tertiary prevention through treatment and co-management with mental health professionals. The Nevada AAP looks to Medicaid to reduce the administrative and financial barriers to access care and allow collaboration.

Amanda Haboush Deloye, Chair, Clark County Children's Mental Health Consortium:
I am the executive director of the Nevada Institute for Children's Research and Policy; although I am here today representing myself as well as the Clark County Children's Mental Health Consortium on which I currently serve as chair. Our 10-year annual report has shown that we have a severe lack of services for mental and behavioral health for our children and our families. One of the goals in our plan is to increase access to a spectrum of different services. We believe that increasing this coordination and ability for reimbursement will serve that purpose and help increase access to care for individuals. We have also experienced firsthand—through parents' stories as well as stories from myself and colleagues—the benefits when families are able to be directly connected to the services they need through either their primary care physician or just a warm handoff and not just a referral slip to another service. Coordination between primary care and mental and behavioral health services helps reduce the stigma and prejudice against mental health in our community, so this will serve another purpose to move that forward.

Vice Chair Orentlicher:
Is there anyone else in Las Vegas who would like to testify in support of A.B. 138? [There was no one.] We will now move to callers in support.

Katie Ryan, Director, Communications and Public Policy, Dignity Health-St. Rose Dominican:
St. Rose is here today in support of A.B. 138, which will require Nevada Medicaid to cover collaborative care medical models that include behavioral health and substance abuse disorder treatment. Medical care should treat the entire patient—both physical and mental—and this is a great step toward clinics and help systems having the ability to bill for all

services. Assembly Bill 138 will also make for better outcomes for pregnant women and their babies along with better mental health services for children and all patients.

I want to bring to your attention a piece on *60 Minutes* that aired last May that discussed an innovative behavioral health model for children in Wisconsin that uses a collaborative care model within pediatricians' offices, emergency departments, and behavioral health clinics. I can send the link around to the Committee members so you can watch, as it clearly describes how this will be able to help just one subset of our patients.

Deepa Nagar, M.D., Private Citizen, Las Vegas, Nevada:
I am a neonatologist and medical director of the neonatal intensive care unit (NICU) at St. Rose Dominican hospital in Henderson, Nevada. I am also the Chair of Pediatrics. I am a pediatrics-affiliated physician. Our group covers pediatric care in pediatric intensive care units, pediatric emergency room patients, along with the neonatal intensive care unit across Nevada and the country. As you know, there is an unprecedented number of children with suicide, suicide attempts, and overdoses in the last few years. Nevada, unfortunately, is one of the highest. We absolutely need support for our patients. As a direct physician who takes care of patients, I was involved in the EMPOWERED program as a co-founder. When we started this program there was a decrease in withdrawal instance. In 2017, we had approximately 40 percent of our NICU filled with babies who had neonatal abstinence syndrome. In collaboration with the EMPOWERED and other programs, there has been a significant decrease in the overall admissions to the NICU for this significant problem. We are now currently less than 10 percent of our infants admitted to the NICU for this. This is a direct impact when clear, good, concise way of collaborating shows the impact, and I cannot support this measure more.

Dora Martinez, Private Citizen, Reno, Nevada:
I represent the Nevada Disability Action Coalition. We are people with various disabilities. This is what we need, especially people with disabilities, a one-stop shop. For some people, like myself, who are blind and cannot legally drive, it is hard to get from one appointment to another and to schedule appointments with transportation and doctors. My coalition absolutely supports this, and we are behind you 100 percent.

Vice Chair Orentlicher:
Are there any more callers? [There were none.] Let us move now to opposition testimony. Is there anyone who wants to testify in opposition? [There was no one.] Let us now move to neutral testimony. [There was no one.] Do you have any final remarks, Assemblywoman Peters?

Assemblywoman Peters:
I want to express my thanks to Ms. Belz for bringing up the expanded communities and patients. She is correct that this collaborative care model expands to all demographics who search out health care and who need collaborative care regardless of where they are, especially those who are on Medicaid. I told you at the beginning of this session that my goal is to reduce barriers, expand access, increase treatment and continuity of care, and

increase transparency. I believe this bill covers all of those issue areas and with that, I thank you for your time today and for hearing this bill. We hope that we have earned your support.

Vice Chair Orentlicher:
Thank you very much for bringing this bill. This closes the hearing on Assembly Bill 138.

[Assemblywoman Peters reassumed the Chair.]

Chair Peters:
Thank you for taking over, Vice Chair. We appreciate the opportunity to present our first bill in Committee. We are going to move on to our next bill hearing and open the hearing on Assembly Bill 114. This bill revises provisions governing the Nevada Early Childhood Advisory Council.

Assembly Bill 114: Revises provisions governing the Nevada Early Childhood Advisory Council. (BDR 38-788)

Assemblywoman Clara Thomas, Assembly District No. 17:
It is my pleasure to present to you Assembly Bill 114 concerning the Nevada Early Childhood Advisory Council (NECAC). Before I begin, I would like to point out to you the exhibits which are both available on NELIS [Nevada Electronic Legislative Information System]. First, you will find a presentation on the Council and the bill overview [Exhibit E] and second, there is an amendment I am proposing to A. B. 114 [Exhibit F].

I would like to talk about the importance of early childhood development and the Nevada Early Childhood Advisory Council. Early childhood development refers to the period of growth and learning that occurs in children from birth to age eight. This is a crucial time in a child's life as it lays the foundation for their physical, emotional, social, and cognitive development. Research has shown that early childhood experiences have a significant impact on a child's future outcomes such as academic success, health, and economic stability. In fact, the first five years of a child's life are critical for brain development, with 90 percent of a child's brain growth occurring during this time. That is why it is so important that we invest in early childhood development. We need to ensure that children have access to high-quality early learning experiences that promote their development and prepare them for success in school and beyond. For instance, growing research consensus shows that high-quality preschool programs prepare children better for school, especially in terms of academic skill development. Research also shows that modifiable factors in a child's early years can greatly affect the child's health and learning trajectories.

We need to support families and caregivers to help them provide a nurturing and stimulating environment for young children. This is where the Nevada Early Childhood Advisory Council comes in. The council is a group of experts from across the state who provide guidance and support to improve the quality of early childhood programs and services in Nevada. Their mission is to promote a comprehensive high-quality and coordinated system of early childhood services that support the development of young children and their families

throughout Nevada. The council works to strengthen state-level coordination and collaboration that support early childhood development such as increasing access to high-quality early learning programs supporting the professional development of early childhood educators and advocating for policies that promote family-friendly workplaces and support for working parents. Now, I will hand this presentation over to my two co-presenters who will provide you with more details on the council and an overview of A.B. 114.

Denise Tanata, Chair, Nevada Early Childhood Advisory Council:
I also serve as the early childhood comprehensive systems director at The Children's Cabinet. We are going to walk you through two pieces, but first I want to share a little bit of detail on the Nevada Early Childhood Advisory Council—going over the history, purpose, and current membership [page 2, Exhibit E], and then I will pass the presentation to Patti Oya who will walk through the provisions of A.B. 114.

Most states have an early childhood advisory council of some sort that was required through the federal Head Start Act in 2007 [page 3]. In 2009, our state Early Child Advisory Council was created by executive order and that executive order was continued in 2011. In 2013, the Nevada Early Childhood Advisory Council was established in the *Nevada Revised Statutes* (NRS) through NRS 432A.076. Since that time, it has undergone a couple of revisions. I will not restate the vision and purpose as Assemblywoman Thomas went over that, but I want to re-emphasize that the purpose of the Early Childhood Advisory Council is to serve as an advisory body looking at the early childhood system in the state of Nevada and focusing on safety and healthy development with an outcome of ensuring children have an opportunity to thrive during those first years of life [page 4]. This slide depicts the current membership rules that are outlined in the NRS for the Nevada Early Childhood Advisory Council [page 5]. I will not go through each one of these individually, but we currently have 20 member positions on the ECAC. As of right now, we only have one vacant seat on the council. Twelve of those members are specified based on their roles in NRS 432A.076. Eight of the current members of the Early Childhood Advisory Council are in section 1, subsection 1, paragraph (m), which is "Such other members as the Governor determines are appropriate" to serve on the council.

At the end of 2021, the Early Childhood Advisory Council underwent a strategic planning session to develop our 2022-2024 Strategic Plan [page 6]. A lot of that emphasis was around creating a comprehensive early childhood system. What we recognized is that the early childhood period involves more than just early childhood education. We really wanted to make sure that we are including focus on health protection, mental health as well as early learning supports. We created the 2022-2024 Strategic Plan which is focused away from just looking at programmatic supports, but really looking at how we can improve our early childhood comprehensive system in the state of Nevada to be inclusive and take a holistic view of children and their families. On November 30, 2022, the Nevada Early Childhood Advisory Council approved recommended changes to the membership and the role of the council to be able to expand membership to be inclusive of that holistic approach to early childhood. Those recommendations were included in our annual report which was submitted

to the Governor's Office as well as to this body on December 1, 2022. At this point, I would like to hand it over to Patti Oya to talk about the bill.

Patti Oya, Director, Education Programs, Office of Early Learning and Development, Department of Education:
I will be going over the summary of the changes in this bill [page 7]. Throughout NRS 432A.076, suggested changes remove the word "education" and change it to "early childhood program" so this aligns with the systems work that is being done across the state. We know early childhood is more than just the educational piece of development. It should also include health and family leadership and support, so this change encompasses that thinking. We also are suggesting five members be added to align with early childhood systems work, and this includes the Division of Public and Behavioral Health, which include responsibility for maternal, child, and adolescent health; public school members serving children in kindergarten through third grade; and a tribal organization—we have been working closely with tribes across the state of Nevada to include them in the early childhood system—and a representative of the Program for Child Care and Development, which is our child care and development funds under the Division of Welfare and Supportive Services; as well as a parent or guardian of young children. That is the most important piece because we want to have the parent voice at the table.

Another change would add the definition of "early childhood program" [page 7, Exhibit E]. Assemblywoman Thomas gave you that definition, and it is here on the slide. It is really to look at the ages from 0-8 and looking at that holistic approach. Our proposed amendments are small language changes under section 1, subsection 1, paragraph (e) under the membership. The way it currently reads, it says a representative of the Department of Education whose duties include responsibilities for programs under section 619 or Part C of the Individuals with Disabilities Education Act . . . . That makes it sound like both of those roles are under the Department of Education, when actually the Part C office is under the U.S. Department of Health and Human Services. While it is still an "or," we want to make sure it is clear that one role is under the Department of Education and one role is under the Department of Health and Human Services.

In section 1, subsection 1, paragraph (q), subparagraph (5) it reads "The Special Supplemental Nutrition Program." It should read "Supplemental Nutrition Assistance Program," otherwise known as SNAP. The last change is in section 1, subsection 5, the "early childhood program" definition. This is a small change. It bullets out the components, but really it should read as a sentence, because all those things—"nutrition, health care, mental or behavioral health, protection, or play and learning . . ."—stimulate physical, cognitive, linguistic, social, and emotional development.

The fiscal note included with this [page 8] might look unusual in that it is $0 for fiscal years (FY) 2024, 2025, and 2026, but that is because as the responsibilities and membership of the Early Childhood Advisory Council grow, it is recommended that two positions are needed to support the council's work. One of those is an education program professional and one would be an administrative assistant. Both of those are currently written into a federal

preschool development birth-to-5 grant that the Department of Education received at the beginning of the year. That is why there is a $0 fiscal note, but it is important to note that those positions are needed. The grant is a three-year grant, so it will end in FY 26. In FY 27 we have a fiscal note, but we wanted to be clear that we do have federal funding to support these positions.

Chair Peters:
I have a few questions from Committee members.

Assemblyman Nguyen:
I am heartened to hear that we are diversifying and adding more voices to the table, making sure that these programs are well thought out. Concerning the members you are planning to add, was any thought or discussion given about reducing barriers and creating more access? The two roles I am most concerned about adding are the nonprofit role and the parent role. Was there any consideration to adding a member from a bilingual household? As a parent in a bilingual household, sometimes these programs think of us as an afterthought, and I want to make sure we can get ahead of that and ensure that bilingual households are at the table. If anyone can help me clarify that, it would be great.

Denise Tanata:
We definitely appreciate that recommendation. Concerning the parent role, the reason we did not just state one is because we wanted to have the opportunity to have more than one parent so we could have diversity, particularly among our parent representatives serving on the council. We would be open to including some language to ensure representation from a bilingual household.

Assemblyman Nguyen:
Great, I appreciate that.

Assemblyman Hafen:
You stated that you have one vacancy, but I see we are proposing to add additional members. I think the additions to the council would be good, but I want to ensure that you will be able to fill those spots and there will be adequate representation. In the rural areas of Nevada when we limit the roles to be filled, we struggle to find individuals willing to volunteer their time to do the work. I want to make sure we are not going to be set up for failure and this will be successful.

Denise Tanata:
I echo your sentiments. As Chair of the Early Childhood Advisory Council, I can tell you that the council is required to follow the Open Meeting Law, so a quorum is something we keep a close eye on. We are very excited right now that we are at almost full membership. The ability to fill these slots was a big part of the conversation we had when we were putting these recommendations together. I want to note that the Division of Public and Behavioral Health is currently not represented, but the division is a partner and participates in the Early Childhood Advisory Council, so we do not anticipate filling that seat and having the

division's participation being an issue. The new position from the Program for Child Care and Development would be a transfer from seat (m), which is those other members as appointed by the Governor. The new slot for a member who is a representative of a public school would also be a transfer from seat (m)—other members as appointed by the Governor, so we have individuals who are filling those roles right now, they are just not specified in statute. We also have one member who is a representative of a tribal organization. We have local early childhood advisory councils that participate in our state Early Childhood Advisory Council. One of those is the tribal early childhood advisory council, which is overseen by the Inter-Tribal Council of Nevada, so we anticipate that they will be able to fill that seat and they will participate because they participate in our regular meetings.

For the parent and guardian piece, we have several places to pull from right now. One is the newly established Nevada Early Childhood Family Leadership Council where we are working with family leaders who have lived experience in early childhood systems to be able to support them and provide them with training experience to serve in leadership and decision-making roles. Our partner at the Children's Advocacy Alliance has the Child Advocacy Ambassador Program and has several parents who are interested in serving in leadership and decision-making roles in the state.

Assemblyman Hafen:
I am happy to hear that you have already thought about this, run through the struggles, and made sure to address them.

Chair Peters:
That is an impressive list of folks who are interested in this issue area, but it does touch quite a few areas of interest. I have a quick follow-up on that question that has to do with any of your representatives potentially filling two of those member roles. Do you ever have that happen, or is it always just one member filling the single role?

Denise Tanata:
In response to your question, I can look into it to see if it has been an issue in the past. We have had some individuals who potentially could have filled one of the designated roles but were put into another member category, but from my recollection that is the only overlap we have had.

Assemblywoman Gorelow:
I am glad to see that there is that parent voice and you will take more than one parent if more than one is interested in fulfilling a role because many parents could fill a variety of roles with their experiences. Could you elaborate on what the federal and state early childhood programs are? Would early intervention services count or the nurse/family partnership?

Denise Tanata:
These are federal and state early childhood programs listed as "including but without limitation," so we are not trying to limit to just participation. We wanted to make sure we were including parents who have lived experience with an early childhood program so they

could bring that experience, whether it is with a child care subsidy program, Head Start, Early Head Start, home visiting, early intervention, or other programs. We are looking at that holistic view of family and needs experience they would be able to bring to help make decisions. It is not meant to be an exhaustive list.

Assemblywoman Taylor:
Early childhood education is where it begins and the graduation rate is the end, so I appreciate the early effort. My question is about the federal grant that will cover the first few years of this. Is there any possibility that your grant might get extended, that we could reapply?

Patti Oya:
It is possible. This is a continuation of a grant that Nevada received a few years ago called the federal Preschool Development Planning Grant. This is the implementation piece of it and is a three-year grant. Different states are in different cycles of those grants—planning and implementation—and from what we have heard, they are planning on continuing implementation grants, which would be great. We also have the child care and development dollars as another federal source from the welfare division to the Department of Education that we could also use down the road. This is the first time we have addressed the positions needed to support the council.

Chair Peters:
Are there other questions from Committee members? [There were none.] We will move to testimony in support, opposition, and neutral of A.B. 114, beginning with testimony in support here in Carson City.

Zoe Houghton, representing The Children's Cabinet:
On behalf of The Children's Cabinet, we are in support of A.B. 114. Since 1985, The Children's Cabinet's mission has been to keep children safe and families together by providing services and resources that address unmet needs through a unique and effective cooperative effort between the private sector and public agencies in Nevada. There is no wrong door, and The Children's Cabinet ensures those who need services are provided services at no charge. Today, The Children's Cabinet serves more than 11,000 Nevada families each year from six locations throughout the state in Reno, Carson City, Las Vegas, and Elko. We appreciate the sponsor for bringing this bill, and we are in full support.

Zach Bucher, Government and Community Affairs, City of Las Vegas:
I am with the City of Las Vegas. As a provider of early childhood education, the City of Las Vegas supports A.B. 114 for expanding the membership of the advisory council to include representation and input from agencies and individuals that are closest to the population this council aims to serve. This bill also gives parents and educators working in early childhood a voice and seat at the table. Given the current challenges and incidents with children and youth behavioral health, it is critical that input and membership is given to behavioral and public health agencies. We would like to thank the bill sponsor for bringing this bill forward and offer our support.

Jamelle Nance, Director, Prenatal to Three Initiative, Children's Advocacy Alliance:
I would like to share my support of Assembly Bill 114 to revise the provisions governing the Nevada Early Childhood Advisory Council. Current provisions primarily focus on early childhood education programs, and as an attendee of the Early Childhood Advisory Council, I can attest that it is heavily represented in the area of education. There is a need to expand membership to reflect the entire system of care that impacts young children and families. In my previous work as a coordinator of family services and a home visitor for families with children birth through age five, I was able to experience firsthand the impact of that cross-sector coordination. It truly takes a team to see families thrive. This means that leaders in health care, mental health, and the workforce as well as parents and caregivers must have a seat at the table. Section 1, subsection 2, paragraph (g) of the current provisions outlines that the role of the Nevada Early Childhood Advisory Council is to "Develop recommendations for increasing parental involvement and family engagement in early childhood education programs" [page 3, Exhibit F]. To make such recommendations, it is imperative to have parents be fully involved. The Nevada Early Childhood Advisory Council plays an important role in convening and providing recommendations to strengthen state-level coordination and collaboration in the early childhood programs. This cannot be adequately done without true representation of the systems that directly touch the lives of our children. Today, we are asking your support for the revisions proposed for A.B. 114.

Amanda Haboush Deloye, Private Citizen, Las Vegas, Nevada:
I am the Executive Director of the Nevada Institute for Children's Research and Policy. We also house the Southern Nevada Early Childhood Advisory Council. However, today I am representing myself and not my job. As part of that community though, I have been involved with the Nevada council since its inception. While in practice we recognize that it takes a holistic approach when looking at early childhood and that those children and families live within a system that addresses health, family engagement, education, as well as other forms of the committee, we also have deep discussions around diversity, inclusion, and equity. I feel these changes to the proposed membership help solidify and address some of those discussions that we have to make it a formal process to make sure that we have full representation on the council. Therefore, I urge you to support A.B. 114.

Chair Peters:
Is there anyone else who would like to add testimony in support of A.B. 114? [There was no one.] Now, we will move into opposition testimony to Assembly Bill 114. Is there anyone who would like to testify in opposition to Assembly Bill 114? [There was no one.] Seeing none, we are going to move into neutral testimony. Is there anyone in who would like to testify in the neutral position for Assembly Bill 114? [There was no one.] Seeing none, would the bill sponsor like to make any closing remarks?

Assemblywoman Thomas:
Assembly Bill 114 ensures that the council's critical work continues so that all children in Nevada reach their full potential by investing in early childhood development and supporting the work of the Nevada Early Childhood Advisory Council. We can ensure our youngest

children have the best possible start in life and are prepared to succeed in school and beyond. It is our hope that you will support A.B. 114.

Chair Peters:
I am going to close out the hearing on Assembly Bill 114 and move on to our next agenda item, a Committee bill draft request (BDR) introduction. This BDR establishes a program to provide structured family caregiving to certain recipients of Medicaid. Again, this is a Committee BDR. Your vote to move this to be introduced on the floor does not commit you to this potential bill.

BDR 38-297—Establishes a program to provide structured family caregiving to certain recipients of Medicaid. (Later introduced as Assembly Bill 208.)

ASSEMBLYMAN ORENTLICHER MADE A MOTION FOR COMMITTEE INTRODUCTION OF BDR 38-297.

ASSEMBLYWOMAN GORELOW SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

Chair Peters:
We are going to go ahead and open public comment. Is there anyone who would like to provide public comment at this time? [There was no one.] We are going to close that item on the agenda and move on to any final comments from members of the Committee. [There were none.] That concludes our meeting for today, our meeting is adjourned [at 3:03 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 "Collaborative Care Model," presented by Brian K. Iriye, M.D., High Risk Pregnancy Center, Las Vegas, Nevada, in support of Assembly Bill 138.

Exhibit D is a copy of a PowerPoint presentation titled "Child Psychiatry Access Programs," presented by Lisa Durette, M.D., Child and Adolescent Psychiatrist; Founder, Pediatric Access Line, in support of Assembly Bill 138.

Exhibit E is a copy of a PowerPoint presentation titled "Assembly Bill 114," Presented by Denise Tanata, Chair, Early Childhood Advisory Council and Patti Oya, Director, Education Programs, Office of Early Learning and Development, Department of Education, dated February 20, 2023, in support of Assembly Bill 114.

Exhibit F is a proposed amendment to Assembly Bill 114 provided by Assemblywoman Clara Thomas, Assembly District No. 17.