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

Eighty-Second Session
March 1, 2023

The Committee on Health and Human Services was called to order by Chair Sarah Peters at 1:31 p.m. on Wednesday, March 1, 2023, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4406 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:

Assemblywoman Lesley Cohen, Assembly District No. 29

STAFF MEMBERS PRESENT:

Patrick Ashton, Committee Policy Analyst
Terry Horgan, Committee Secretary
Ashley Torres, Committee Assistant

OTHERS PRESENT:

Zach Conine, State Treasurer
Erik Jimenez, Chief Policy Deputy, Office of the State Treasurer
Ashley Cruz, representing Touro University
Marlene Lockard, representing Service Employees International Union Local 1107
Nick Schneider Government Affairs Analyst, Vegas Chamber
Ron Aryel, Private Citizen, Reno, Nevada
Kierra Capurro, representing Nevada State Society of Anesthesiologists; Nevada Orthopedic Society; and Northern Nevada Hopes
Susie Martinez, Executive Secretary-Treasurer, Nevada AFL-CIO
Runzhi Hu, Private Citizen, Reno, Nevada
Joan Hall, representing Nevada Rural Hospital Partners
Joelle Gutman Dodson, Government Affairs Liaison, Washoe County Health District
Djecko Estacio, Private Citizen, Reno, Nevada
Eric Jeng, Acting Executive Director, One APIA Nevada
Valerie Haskin, Chair, Rural Regional Behavioral Health Policy Board
Megan Comlossy, representing Nevada Health Care Workforce; and Pipeline Development Work Group
Michael Johnson, M.D., Director of Community Health, Southern Nevada Health District
Sarah Watkins, representing Nevada State Medical Association
Briana Escamilla, representing Planned Parenthood Votes Nevada
Barry Cole, Private Citizen, Reno, Nevada
Andrea Gregg, Chief Executive Officer, High Sierra Area Health Education Center
Steve Messinger, representing Nevada Primary Care Association
Steve Walker, representing Lyon County
Donna Laffey, representing Dignity Health-St. Rose Dominican
Austin Brown, representing University of Nevada, Reno
Kent Ervin, State President, Nevada Faculty Alliance
Kennedy McKinney, representing Human Services Network; and National Association of Social Workers
Annette Magnus, Executive Director, Battle Born Progress
Amanda Vaskov, Director of Government Affairs, Associated Students, University of Nevada, Reno
Lea Case, representing Nevada Psychiatric Association
Athar Haseebullah, Executive Director, American Civil Liberties Union of Nevada
Cyrus Hojjaty, Private Citizen, Las Vegas, Nevada
Trey Delap, Director, Group Six Partners, LLC
Cody Phinney, Deputy Administrator, Regulatory and Planning Services, Division of Public and Behavioral Health, Department of Health and Human Services
Jimmy Lau, representing Dignity Health-St. Rose Dominican
Adrienne O'Reilly, Private Citizen, Las Vegas, Nevada
Dora Martinez, Private Citizen, Reno, Nevada

Joanna Jacob, Government Affairs Manager, Department of Administrative Services, Clark County
Jill Marano, Director, Family Services, Clark County
Greg Esposito, representing Nevada CASA Association

Chair Peters:
[Roll was taken.] We have two Committee bill introductions, and I am going to take them first. The first Committee bill draft request (BDR) is BDR 38-328 which makes revisions relating to Medicaid. I want to remind you that voting for the introduction of these bills does not connect you to these bills. We have to move them to the floor so that they can come back to the Committee for vetting.

BDR 38-328—Makes revisions relating to Medicaid. (Later introduced as Assembly Bill 237.)

ASSEMBLYMAN NGUYEN MADE A MOTION FOR COMMITTEE INTRODUCTION OF BDR 38-238.

ASSEMBLYWOMAN TAYLOR SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

The next bill draft request is BDR 38-323. This establishes provisions related to commercially sexually exploited children, and this is an Interim Health and Human Services Committee bill.

BDR 38-323—Establishes provisions relating to commercially sexually exploited children. (Later introduced as Assembly Bill 238.)

ASSEMBLYWOMAN TAYLOR MADE A MOTION FOR COMMITTEE INTRODUCTION OF BDR 38-323.

ASSEMBLYMAN NGUYEN SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

We will now open the hearing for Assembly Bill 45, today presented by our State Treasurer. [Rules and protocol related to bill hearings were reviewed.]

Assembly Bill 45: Creates a program to repay the student education loans of certain providers of health care. (BDR 18-359)

Zach Conine, State Treasurer:
It is great to be here to present Assembly Bill 45. The Treasurer's primary role is serving as the State's chief investment officer. Over the last four years, our office has focused on ways we can work to invest in programs and services that increase the quality of life for working families across Nevada. In 2019, my office worked with then-Speaker Jason Frierson and Assemblyman Watts to pass Assembly Bill 383 which established Nevada's first-ever student loan ombudsman. Over the last three years, our student loan ombudsman has worked tirelessly to help borrowers understand their rights while also working to give them access to public sector loan forgiveness programs. During the pandemic, the work of our ombudsman became even more important, as many borrowers struggled to understand various changes to the student loans that came about as a result of the federal freeze on student loan payments. As we continued with this work, we recognized student loan debt is one of the largest issues facing Nevadans, and it became clear we needed to do something as the pandemic kept going. When our congressional delegation stepped up to provide much needed aid to the State of Nevada, we found ourselves with $6.7 billion to respond to the COVID-19 pandemic. Of this, $2.7 billion from the American Rescue Plan Act of 2021 (ARPA) was more flexible and could be used for a number of new programs to help us recover from the pandemic.

To better understand how those dollars could be invested in building a better state for all of our residents going forward, former Governor Sisolak and I kicked off the largest constituent engagement effort in state history through the Nevada Recovers Listening Tour. The tour consisted of 123 community events over 82 days where we listened directly to members of the community and worked to find solutions to improve quality of life. The bill before you today is a direct result of conversations we had in almost every single community on this listening tour. From rural communities to tribal reservations and in our urban neighborhoods, we heard consistently about the challenges people faced not being able to find qualified health care providers near them. From doctors to dentists to women's health care providers, people told us over and over again we needed to find more ways to incentivize health care professionals to come and practice in some of our most underserved communities. Assembly Bill 45 seeks to address this problem by incentivizing new health care professionals who have graduated from a Nevada institution with sizable amounts of student loan debt. They would be granted student loan repayment funds in exchange for committing to practice in communities greatly in need of their services. I want to thank all the medical professionals and stakeholders who have helped strengthen this bill over the last few months, including the University of Nevada, Reno and the University of Nevada, Las Vegas Medical Schools, the Nevada Dental Association, and organizations like Planned Parenthood. I am hopeful this bill can become an important piece of the puzzle to solving provider shortages in communities across our state. With that, I am happy to walk through the various sections of the bill.

Chair Peters:
I am interested in your proposed amendment, so please walk through the bill with the amendment.

Treasurer Conine:
The amendment is posted on NELIS [Nevada Electronic Legislative Information System] in case anyone is looking for it, and we will work through it [Exhibit C]. Sections 2 through 5 are definitional sections. Section 6 of A.B. 45 establishes the Student Loan Repayment for Providers of Health Care in Underserved Communities Program in the State Treasurer's Office. The goal of the program is to provide up to $120,000 in student loan payments to health care providers who commit to practicing in an underserved community in Nevada. Section 6 also states that the State Treasurer should prioritize applications under this program for certain providers of primary care and providers who commit to serving patients covered by Medicaid and the Children's Health Insurance Program or CHIP.

Section 7 of the bill [page 3, Exhibit C] establishes the eligibility criteria for this program. In order to be eligible to receive student loan repayment funds, a health care professional would first need to fall into one of the provider types listed in section 4 of the amendment. We worked with a number of stakeholders to make sure this list is intentionally broad, so we have the flexibility to cover a wide variety of potential providers. Then a provider would need to meet the following criteria:

- Be a current Nevada resident graduating on or after April 30, 2023, from an institution within the Nevada System of Higher Education or another accredited institution of higher education in Nevada with a degree in a health-related field, for instance, Touro University.

- Be actively licensed or certified to practice in Nevada.

- Commit to at least five years of clinical practice in an underserved community.

In this bill, we are defining underserved communities to include qualified census tracts in an area with a high social vulnerability according to the CDC's [Centers for Disease Control and Prevention] social vulnerability index; in a community with limited English language proficiency; on tribal lands or in a community where tribal members commonly reside; or in a community that has been subject to historical instances of redlining, segregation, or other discriminatory practices.

Section 8 [page 4] requires a provider of health care who meets the qualification set forth in the previous section to apply directly to the State Treasurer's Office in order to be considered for student loan repayment funding. Additionally, in section 8, the Treasurer is given regulatory authority to establish the procedures and standards necessary to administer the program. As part of these regulations, the Treasurer is required to establish a sliding scale for determining the total amount of loan repayment providers would be eligible to receive

under the program. The scale would take into account someone's specialized degree type and average loan burden for that particular field when establishing the amount of repayment.

Section 9 of the bill provides the Treasurer with the ability to employ necessary staff to administer the program. Additionally, section 9 requires the Treasurer's Office to post information on our website about the program along with various requirements and how to apply. Section 10 creates the Account for Student Loan Repayment for Providers of Health Care in Underserved Communities. Funds in this account are designated only to be used for providing student loan repayment to providers and for program administration costs.

Section 11 of the bill [page 5, Exhibit C] has additional statutory provisions requiring the Student Loan Ombudsman in the Nevada Treasurer's Office to assist borrowers who are pursuing degrees in health-related fields in becoming aware of, qualifying for, and applying for the program. Section 12 creates a permanent funding mechanism for this program which allows us to administer the program without having to come back to the Legislature every two years for continued funding. This section allows for $5 million to be transferred from the Abandoned Property Trust Account to support this program, much in the way we already do to help fund the Governor Guinn Millennium Scholarship Program and the Grant Matching Account on an ongoing basis. This funding mechanism is incredibly important because it will allow providers who participate in the program to know continued funding will be available for them as they work their way through school.

Student loan repayment is one of the many things we need to do in order to recruit and train high-quality health care professionals in communities across our state. Through this program, coupled with increased funding for residency programs and other innovative solutions, I am hopeful we can start to move the needle and increase health care for all Nevada residents.

Chair Peters:
We have several questions.

Assemblywoman Newby:
How would this program work with the federal government service loan repayment program where if you work for a government or nonprofit for ten years, then your loans are forgiven?

Treasurer Conine:
Our intention is for them to be complementary. With the federal loan program, often you have to work ten years in a certain community. What we found among the first group of people going through this program, and why the student loan ombudsman was originally created, was that the rules and regulations around that program are incredibly restrictive. We find that most people who apply to it have their applications denied. In the first round of applications, more than 99 percent were denied. We wanted to create a focused way for individuals who might qualify for that program down the road, but we would be able to use them for four or five years before they qualified for that program. We think of it as a complementary stopgap.

Assemblyman Gray:
I have several questions, but in the interest of time, choose the one you want to answer. I am from a rural community, and by these regulations, it does not look like we are going to qualify in any way, but we have a dearth of health care providers. Why is this bill not inclusive? Why is it not looking at income in communities? It is only looking at protected classes. That is my first question.

To my second question, we are trying to attract doctors. That is what we need in Nevada, but why only Nevada-trained physicians? Would we tell a Harvard-trained doctor, no, you cannot come here and practice in a community that needs you, and you need to repay your loan? That is cutting off our noses to spite our faces. The third question is, are these not duplicative of federal programs, for instance with the Indian Health Service and the National Public Health Service? These are commissioned corps, where they get their education funded through those programs. Finally, and this may be confusion on my part, but you talk about doctors, primary care providers, and in another spot, you mention health-related fields. Is this going to be available to anybody in a health-related field such as health care managers? If a person has a degree in health care management, administration, dieticians, physical therapy assistants—where do we draw the line?

Treasurer Conine:
I am going to go in reverse order. The intention is to bring health care providers, right? So, whether they are dentists or doctors or registered nurses or mental health professionals or psychiatrists, I want to be as broad as possible. Getting to your first question, this was designed as we traveled through our rural communities. As we were in West Wendover, as Assemblyman Hafen and I were in Pahrump, you talk to these communities and realize the necessary pieces. The bill language is intended to, and we believe it does, focus on qualified census tracts which would bring in the vast majority of our rural communities; and also, communities that are currently underserved by medical professionals, which would bring in basically everyone else. That is our intention here.

We are going to prioritize communities where there is no health professional and also communities where the time to wait for a health professional is too long. We think both are necessary; and that gets to the third question which is a duplication. Yes, there are certainly other programs that do this kind of work; but if they worked, we would have health professionals in every town, but we do not and we need to do more. This is an opportunity for us to fill some of that gap. Your last question was why Nevada providers first, Nevada-bred doctors first. We spend a lot of money and a lot of time encouraging folks to either go to medical school here or stay here for medical school, whether in the north, in the south, Roseman, or Touro, or whatever. We want to keep the doctors we are paying for with all these other programs in our state. Right now, the state is not competitive when it comes to the opportunities that could be available in other states. Certainly, our rural communities and the underserved in our core communities are not competitive when it comes to the wages able to be provided. The goal here is to make sure to keep the individuals we have already paid for through scholarships, through the Governor Guinn Millennium Scholarship, through whatever has kept them in Nevada all this way or brought them here in the first place.

We want to make sure we keep those doctors. Granted, we could offer it to every doctor at some point, but the dollars and cents do not work. We are trying to be fiscally responsible, but I appreciate the comment. We would love to get doctors from Harvard, though.

Chair Peters:
I have several other questions from Committee members.

Assemblywoman Gorelow:
I have the same question my colleague just asked. I was also wondering why we are not expanding this to professions or people who are going out of state and encouraging them to come back. We know when we educate people locally, they tend to stay locally, so I would be interested in seeing or hearing what the conversations were about possibly expanding this to include our neighboring states and bringing those individuals into Nevada to help fill some of the gaps.

Treasurer Conine:
I believe our Chief Policy Deputy, Erik Jimenez, can answer that.

Erik Jimenez, Chief Policy Deputy, Office of the State Treasurer:
We had a lot of conversations about this topic. As the Treasurer stated, we have already invested money in these folks in the residency programs. I know there is a great deal of work that is going to get done this session on that and on the existing financial aid we are providing folks. We wanted to make sure this program can get off the ground and running and show success before we come to you for a larger dollar figure. Our hope is the Public Health Service Corps, included in another bill, gets more funding for its program. We have funding for this program, but at some point, we are going to run out of funding, and then it will be a conversation about how we can expand or what other provider types we might try to get from Utah, Idaho, and other states.

Assemblyman Nguyen:
Looking at one of the criteria in section 7 [page 3, Exhibit C], in subsection 4, paragraph (c) you mentioned a "community in which, . . . at least 20 percent of households were not proficient in the English language." Where did that "20 percent" come from? A follow up to that is, if we are able to obtain providers who speak those languages we need, but they do not fall within the Nevada requirement or are not being trained in Nevada institutions, perhaps they could do their residencies here. Would there be exception to that?

Erik Jimenez:
I will take the first part, and I think we can have a conversation on the second part. This language came largely from work we have done through the State Infrastructure Bank, which has a goal of locating 40 percent of projects in these types of geographic communities. One of the things we based that off is the federal government's Biden-Harris Justice40 Initiative, so a lot of this language is coming from standards we are hearing from the federal government.

To the second part, you bring up an incredible point, particularly when it comes to some of our API [Asian Pacific Islander] community. If a doctor does speak a particular language, we would like to determine how we can make them a part of this program, so we would be happy to have those conversations.

Assemblyman Nguyen:
I would appreciate a follow-up on that.

Assemblyman Koenig:
My question has to do with my own experience as an optometrist. An optometrist is a gateway; we are a gatekeeper profession. We treat a lot of disease, but I refer a lot more disease. Three or four years ago, I was looking for an associate. It took me two-and-a-half years to find someone to come work for me in my clinic. I have three rural clinics, and all of them are full. In fact, my clinic in Fallon has about a two-month wait because I am here not seeing patients. There is not an optometry school in Nevada, so if you are only reimbursing doctors who attend school in Nevada, you have eliminated optometrists from the equation. We need more optometrists, especially in the rural areas. I am not sure if there are enough optometrists in the big cities, but in the rural areas, there are not. To eliminate only people who go to school here in the state when that program is not even offered in this state, is not fair and is not helping my rural constituents. Do you have any ideas or thoughts on including some of these professions that do not have schools in the state?

Treasurer Conine:
What an exceptional point, and I totally agree. To the extent that we can figure out the right way to do this, and to the extent that a program does not exist within the state of Nevada, that would be a wonderful exception to the conversation we were having earlier about wanting to make sure we are able to incentivize and retain the Nevadans whom we have paid to go to school.

Chair Peters:
That is a great point and working opportunity. I look forward to seeing where that goes.

Assemblyman Hafen:
I carried a very similar bill in 2019, and you are right, we did hear a lot about this during the listening tours. I do have some concerns on some of the language, and I am hoping that we can sit down after this and try to make this something that can work. One of my concerns is section 7. As some of my colleagues have mentioned, it is nearly impossible to get medical professionals into the rural areas; but section 7 seems to encompass just about the entire state, or at least every community and city in the state, because I think that every single community will fall into this. Could you explain how that prioritization would work when every city or town would qualify in some way, shape, or form? The last thing I want to do is invest $10 million and not get medical professionals to the areas where we have none at this time.

Treasurer Conine:
I am happy to discuss as much as possible to make sure we have the best bill in front of us. Through the regulatory processes, it was our intention to prioritize communities where either there is not a provider or the wait is so long that there is effectively no provider—bringing optometrists to Fallon, bringing health care providers to West Wendover and Pahrump—making sure there are enough health care providers to meet the needs of the population in areas we can bring those health care providers to. Prioritization in the regulatory process is where the rubber is going to meet the road. We have tried to create a bill with enough flexibility that we can work with stakeholders throughout that regulatory process to make sure what comes out the other side really does meet the intent of bringing health care providers to communities where there are none, and then expanding the amount of coverage in communities where there is a provider, but the wait is simply too long.

Assemblyman Hafen:
I appreciate that. From a prioritization standpoint, I would rather get a general practitioner into West Wendover than get a music therapist into Las Vegas, so I want to sit down and try to work some of this out. As I said, I did bring a very similar bill in 2019, but that $10 million fiscal note always seems to get stuck in the Ways and Means Committee, so I thank you for bringing this.

Assemblywoman González:
My first question involves the definition of "underserved communities." Is it just people who are provided Medicaid and/or CHIP [Children's Health Insurance Program] services, or is there any other way we are defining underserved communities? I see there are definitions for "program" and for "provider of health care."

Erik Jimenez:
The definition of "underserved communities" is in section 7, subsection 4.

Assemblywoman González:
Is it only if they are provided Medicaid and CHIP services, so doctors who may have low-income residents who do not qualify for these programs would not fall under this?

Erik Jimenez:
I would not say that is accurate. In the amended language in section 6 [page 2, Exhibit C], essentially a provider would have to practice in one of the communities in section 7, subsection 4, but if doctors or providers are committed to serving Medicaid patients, they could be prioritized within that. We heard a lot from health care providers that it was very important. Some of those providers may not want the strings attached with serving Medicaid patients, but we wanted to have it both ways. We could still accept someone if they were not serving Medicaid patients, but we wanted to strongly encourage them to do so.

Assemblywoman González:
Are there any other states that do this, and how did you decide on five years? Even as a teacher, as an educator in the federal program, we have to be in the program for at least ten years and not miss a single payment. So, I am curious as to how you got to five years.

Treasurer Conine:
I will take the second part of the question before the first. In the Student Loan Ombudsman's office, we have talked to a lot of practitioners, a lot of teachers and a lot of others who were willing to do something for five years or seven years, but they are not willing to do it for ten years. As a result, they never enter the field of public service, either in teaching in a low-income community or in providing health care in low-income communities—the kind of communities we are talking about in this bill—because ten years is too long, but they could work five years. Our goal here is to try and fill some of that gap by having a program for individuals who are willing to commit to some level of service. Hopefully, they will find that our rural and underserved communities are lovely places to live and where they want to stay for the rest of their career but understanding that some of them will not. They want to go off to somewhere else where they can make more money. We want to get them for five years, and we are looking for a way to get that benefit for some period of time and fill that gap.

Erik Jimenez:
On the second question, a number of states have these types of programs. Many of them are similar to something we have currently through the University of Nevada, Reno, which is the Public Health Service Corps, which is actually in the federal tax code as well, but is exempt from federal income tax. What differentiates Nevada from a lot of other states is they invest additional dollars into that program, which I think is a good thing to do. But, as the operators of the Public Health Service Corps program would tell you, they cannot provide aid to a lot of provider types that we have in section 4 of the amendment. What we are trying to do is be complementary to the work they have asked us to do and also make sure we can fund a social worker who may go to a community that needs one. So, lots of states have them, but the level of state support varies.

Assemblywoman Taylor:
Thank you for your creativity and the ways we can provide some assistance in this much needed area in our state—health care providers. In this Committee, we have heard a lot about that. Has there been any thinking around something similar for educators, another field in our state where we know we have a great need as well as for those who work in our schools. Related to that, does it matter if they work in schools or any of these that you have designated?

Treasurer Conine:
I do not believe it would matter if they worked in a school. If they are providing that service, they would be eligible for the program. As to the first question, we would love to. I think that the amount of work that needs to be done to attract teachers to our state, to attract individuals trained in certain construction industries, to attract people who are trained in advanced manufacturing, to attract capital and large-scale businesses, to attract health care

providers is immense, and as a state we should be investing. This is one piece of the much larger pie necessary to build the Nevada we deserve to live in. We started with health care providers, because in some communities it is not that they have five teaching spots open out of the ten that are available, it is that they do not have a primary care provider or that the wait for a primary care provider is much too long. While we have a number of different revenue streams, this is a more targeted approach. But you are right; we would love to run this program for every type of individual our communities need.

Chair Peters:
Thank you for the questions today, Committee. This is a really important issue and one that we do not hear often in the Health and Human Services Committee. Usually, these loan bills end up in the Commerce and Labor or Government Affairs Committees, so it is lucky for us to be hearing this bill. I do not think we will be hearing many of the other bills coming out of several of the behavioral health policy boards in the state as well as from some other entities.

Assemblyman Hafen:
There have been a lot of questions on in-state tuition. My understanding is it costs roughly $1 million to educate a medical doctor per student when the tuition is about $120,000, which is what is being proposed to be paid here. To me, what you are proposing is trying to get that return on investment. We are investing $1 million in each student, that student's portion is $120,000, which is 12 percent of the cost of educating them. Is that an accurate assessment?

Treasurer Conine:
When we look at the return on investment, that is exactly what we are going for here. The state spends a massive amount of money educating Nevadans, and we want to make sure those Nevadans can continue to be here, and we remove barriers that might make it easier for them to go to other places to practice the skills that we, in part, have paid for.

Chair Peters:
I also want to point out this is a multipronged area. It is not just post graduation; it is pre graduation. How do we establish folks in the right student loan for them? How do we make sure they are in the right field of interest for them? How do we make sure there are jobs out there that can grab them out of school? How do we support them in those communities to establish their home bases and their families? It is a big ask of the state to encompass all the needs of making sure our state can keep the medical professionals we are graduating. This is just a single component of it, but an important component of the return on investment and making sure we have skin in the game. Making sure our students stay in Nevada.

Assemblyman Gray:
This is a hugely important problem, and I came from a health care background. So, talk about the return on the investment. Say a student from Utah comes to a graduate med school and is doing graduate medical education here under a residency with UNR at the Veterans Administration. Are they eligible, and vice versa? What if one of our medical students goes there and they are doing their general medical education there. I am still not seeing the clear definition of who is eligible.

Treasurer Conine:
As we walked into this Committee, we were thinking about individuals who spent the full component of their education career within our state's borders. As Assemblyman Koenig pointed out, we are going to need to move a little bit there to make sure we hit the intent, and I think we can certainly look at what to do if someone comes here for residency but went to school somewhere else. Where do we want to draw that line? Is it a prioritization, or do we look at them the same way? We are open to feedback, so I am sure we can get somewhere perfect.

Chair Peters:
Thank you, there is a lot of interest in this, and we are looking forward to getting into testimony. I am going to invite the folks who are in support of A.B. 45 to the witness table both here and in Las Vegas. We are limiting support, opposition, and neutral testimony to 20 minutes apiece so that we can get through the other two bills we have today.

Ashley Cruz, representing Touro University:
Touro University is the largest medical school in the state of Nevada, graduating 180 doctors every year. The cost of medical school is extremely high, and any opportunity to help students get through medical school and start practicing without an overwhelmingly suffocating debt is extremely helpful. With a severe physician shortage in the state of Nevada, Touro University believes that this legislation will help to keep more graduating medical students here in Nevada and increase access to care. Touro University is in support of A.B. 45 and thanks the bill's sponsor for bringing it forward.

Marlene Lockard, representing Service Employees International Union Local 1107:
I represent 11,000 nurses and health care professionals, and I am here in strong support of A.B. 45. I would like to thank Treasurer Conine for bringing this bill that would create a fund to repay student loans for nurses and other health care providers who commit to at least five years of practice in our underserved communities. For so many years, we have recognized the need to adopt meaningful policies to address the critical shortage of nurses and doctors here in Nevada and nationally. In fact, I have a headline in a newspaper that reads, "Wanted, a prescription for nurse shortages." The article was dated 1981. Year after year, legislation has been introduced that did nothing to impact the core issues causing the crisis. The Service Employees International Union recognizes the urgent need to address the shortage of nurses and doctors, particularly in areas that lack adequate access to health care services. Nurses are the backbone of our health care system, and they play a critical role in delivering quality care to patients. However, many talented individuals who aspire to become nurses face significant financial barriers due to the high cost of education. This bill would create a much-needed incentive for nurses to serve in underserved communities by providing loan repayment assistance, which would make it easier for them to pursue their passion for nursing without the burden of overwhelming debt.

Nick Schneider, Government Affairs Analyst, Vegas Chamber:
The Vegas Chamber is in support of A.B. 45. In the wake of the pandemic, we have seen workforce shortages across all industries, but our medical staff shortages are among the most

universally felt throughout the entire state. Assembly Bill 45 is a major step in addressing a severe shortage in available health care. We believe that incentivizing our up-and-coming health care providers to stay in-state through an education loan repayment program is a valuable step in filling those workforce gaps. We urge your support of A.B. 45.

Ron Aryel, Private Citizen, Reno, Nevada:
[Ron Aryel provided additional written testimony Exhibit D.] I am a pediatrician by trade, and for 11 years I ran a medical practice—a kind of last resort medical practice for many—and an outpatient ICU [intensive care unit]. I am here to strongly support A.B. 45. I want to address Assemblyman Gray's comment that it takes $1 million to educate a health care professional and that $120,000 is 12 percent of that. To a graduating student, the $1 million dollars is not relevant. The only relevant thing is $120,000. If I am making a decision to practice here in Nevada or go someplace else, I do not care that the state invested $1 million. What I care about is that I have a loan bill for $270,000, or whatever it is. I am going to go where that loan bill gets taken care of; so, if Nevada takes care of it, I will stay here. If somebody else takes care of it, I will go there. That is how we need to think about this. Incidentally, I am an import. I went to medical school in Philadelphia, so Nevada imported me.

In particular, I am here to push for this bill because, as amended, it supports psychiatry, and we have a problem here. We have a great shortage of psychiatrists. The average in the country is 30 psychologists per 100,000 population and 15.6 psychiatrists per 100,000 population. In Nevada, there are 14.5 psychologists and 9 psychiatrists per 100,000 population. We are short on psychotherapists. We are short on substance abuse counselors. We are short on pretty much everything, and the percentage of patients here who have substance abuse disorders or who have clinical depression is much higher than the national average. We are desperately short of mental health professionals, and this bill is going to address that adequately.

Kierra Capurro, representing Nevada State Society of Anesthesiologists; Nevada Orthopedic Society; and Northern Nevada Hopes:
I am happy to lend our voice and support of Treasurer Conine and of A.B. 45 on behalf of the Nevada State Society of Anesthesiologists, the Nevada Orthopedic Society, and Northern Nevada Hopes, a community-based organization in northern Nevada that provides wraparound services to our communities' most vulnerable population. We urge your support of Assembly Bill 45.

Chair Peters:
For the record, a previous commenter mentioned Assemblyman Gray had said something about the cost to educate doctors. I believe that was Assemblyman Hafen.

Susie Martinez, Executive Secretary-Treasurer, Nevada State AFL-CIO:
On behalf of our 150,000 members and 120 unions, we strongly urge your support for A.B. 45 as amended. Inaccessibility for health care has been a long-lasting issue in our state. In fact, Nevada currently has over 70 health professional shortage areas, which means more

than one million Nevadans do not have access to the care they need. We must ensure that we can recruit and retain health care professionals across our State, so every Nevadan has access to high-quality affordable health care they deserve. This bill, as amended by the Treasurer's Office, would do exactly that by extending the list of health care providers who are eligible to participate in the Student Loan Repayment for Providers of Health Care in Underserved Communities Program. All in all, it would create a healthier future for our state and ensure that no Nevadan will go without vital care. I would like to thank the Treasurer's Office for the hard work on this issue, and I urge the Committee to support Assembly Bill 45.

Runzhi Hu, Private Citizen, Reno, Nevada:
I am an undergraduate biochemistry-molecular biology student at the University of Nevada, Reno, and I have devoted the past 18 years of my life to working towards a future career in medicine. This is my passion: to continue learning; to challenge myself; and, most importantly, to help others. However, watching inflation skyrocket the price of everything from college tuition to everyday essentials, financial concerns have begun to cloud my future, something I had previously thought was so clear. I know that my fellow premedical peers also share this concern. That is why I am here today in support of A.B. 45. We want to be able to pursue our dreams without financial concerns. I am also here today for the health of current and future Nevadans. According to the United States Census Bureau, by 2060, 25 percent of the United States population will be 65 years or older. Assembly Bill 45 will ensure that we maintain a stable workforce of health care professionals to provide for our increasingly elderly population in addition to our youth and adults. I urge you all to vote in support of A.B. 45. This bill has the potential to change the lives of everyone in the state from the future of students like me to the quality of health care offered to our people. If A.B. 45 were to be passed, I could continue my studies and eventually serve as a health care professional in the state of Nevada. Please consider investing in our health care system, in our students, and in our future.

Chair Peters:
Thank you for your time and thank you so much for your testimony. I hope that we do you justice and keep you in the state of Nevada.

Joan Hall, representing Nevada Rural Hospital Partners:
Rural Nevada Hospital Partners represents 13 critical access hospitals in rural and frontier Nevada and their 17 affiliated RHCs [rural health clinics]. I appreciate the comments that have been made about assuring that the individuals who get the scholarships go to rural Nevada. We would love them all to come to rural Nevada but know that the tertiary hospitals and areas that are underserved also need specialists and primary care, and we appreciate that. Maintaining an adequate health care workforce in rural Nevada remains one of the key challenges we face providing quality care. Data and statistics support our needs, and if you need to see those data or statistics, the NHA [Nevada Hospital Association] has a great guide that is easy to read. For those who like lots of information, the University of Nevada, Reno, puts out this guide—the *Rural and Frontier Health Data* book. It has an amazing amount of information that supports the needs in rural Nevada. As you heard earlier, you will hear

several other bills this session. I pray that you do not consolidate them into this one because we need as many tools as possible in our toolbox to meet Nevada's needs.

Joelle Gutman Dodson, Government Affairs Liaison, Washoe County Health District:
We are here in support for this bill. There are several bills similar to this one going through this session. One is from the Washoe County Behavioral Health Board, and we are supportive of that bill, too. We appreciate the inclusion of behavioral health in all the amended professions added today. We all know that improved access to care creates a healthier community, and we are in support.

Djecko Estacio, Private Citizen, Reno, Nevada:
I am a neuroscience student in my freshman year of undergrad at the University of Nevada, Reno. I am not one of those people within the medical field due to a late relative. In fact, becoming a doctor was not originally a dream of mine, but more a dream that was imposed upon me by my family. Luckily enough, I have way more than expectations to keep me motivated to stay on the pre-med track. By that I mean I enjoy being here. I enjoy learning about how vaccines work and how the brain functions, or how a cancerous tumor can be treated as a separate parasitic organism. While yes, this is a path that has been put upon me, this is one that I have come to embrace.

Something I feel is important to take note of is that I am a first-generation, low-income, immigrant college student. Currently, I work on campus to help pay off my tuition. For someone with a similar background to mine, luck plays a bigger role than it would for a regular student, as financial issues present themselves as one of the primary obstacles. This is precious time I could be spending nurturing relationships—very important for someone my age—continuing my education, or even saving up for med school instead of my current tuition. This is a struggle common to medical students, and a concern that should not be put aside simply due to the amount of a doctor's salary.

Last night, I got a call from my little brother that my mom is in the hospital. I am genuinely scared for her because I did not get much detail about her condition. I am also concerned for myself, because I am here trying not to get stranded—both financially and emotionally. This is why I am here. I urge you all to vote for A.B. 45. This is a bill that will greatly benefit not only future medical professionals, but also the people of the state. Public health is one thing that should always be prioritized.

Chair Peters:
Thank you for your testimony. I am sorry to hear about your mom. I hope she pulls through.

Eric Jeng, Acting Executive Director, One APIA Nevada:
We are here in support of A.B. 45. Nevada is home to over 392,000 Asian Pacific Islander Americans (APIA). At around 12.5 percent, we are the fastest-growing community. We are aware the infrastructure to support our community in a tangible way is lagging and lacking. Here are the challenges and barriers our communities are facing. First, I think everyone knows that according to the Department of Education, we lead the nation in having the

highest student loan default rate. On the national level, Asian-American students have the highest financial needs. We see multiple segments in health care—nursing school and medical school—when it comes to higher education. The 2018 American Community Survey put Nevada as having the third-highest rate of APIAs in the health care workforce—about 19 percent, which is close to 20,000 people.

We are very excited for this bill and for this proposal that would relieve the student loan burden to our community. Also, we would like to applaud Treasurer Conine and Chief Deputy Jimenez on the inclusion of limited English proficiency service. Currently, 68,000 households in Nevada are limited-English proficient, so, we want to see this come into fruition and make sure we can help promote the program. In 2019, our organization's top priority was to help create the Office of Student Loan Ombudsman and we are very excited to see it in action. We are excited our federal advocacy for both health equity and language justice, as well as student loan forgiveness, is met here in a creative State-based solution. This bill will be a win for health care providers, will be a win for our limited English proficient community, and will be a win for health equity, so we want to thank the State Treasurer's Office and this Committee.

On a personal note, by the end of this week, I will reach my five-year anniversary of serving the limited English proficient APIA community here. Hopefully, this bill can encourage more of our community members to stay here to really serve our community and make Nevada a better state.

Valerie Haskin, Chair, Rural Regional Behavioral Health Policy Board:
As the priorities of the board have already been addressed by the previous speakers, I would like to ensure that the board's support of A.B. 45 is on record.

Megan Comlossy, representing Nevada Health Care Workforce; and Pipeline Development Work Group:
[Megan Comlossy submitted a letter in support Exhibit E.] This group is a statewide initiative that aims to improve, grow, and diversify Nevada's public health, behavioral health, and primary care workforces. The group brings together more than 40 leaders from across the state. They represent a variety of sectors and are working to break down the silos in which workforce development has traditionally occurred. One of the work group's priorities is increasing incentives for health care professionals to practice in Nevada, including expanding eligibility for and the use of loan repayment programs, and A.B. 45 does just that. It would complement existing loan repayment programs and serve as one of the many solutions needed to help recruit and retain the wide range of health care professionals Nevada so desperately needs.

There are two things that are great about this bill. It would be another tool in the proverbial toolbox to address workforce development. And the second thing is the Treasurer's Office has identified a funding source to fund this loan repayment program, which is creative and resourceful and one of the challenges we often face in trying to fund workforce shortage

initiatives. I appreciate the opportunity to provide the work groups' comments and appreciate your consideration of the bill.

Michael Johnson, M.D., Director of Community Health, Southern Nevada Health District:
The Southern Nevada Health District is here to express our strong support of A.B. 45. Working with our partners, we recently released the Southern Nevada Community Health Improvement Plan, a community-wide strategic planning effort that was a collaboration of government agencies, health care providers, nonprofits, and academia. Through this effort, we identified public health priorities in four key areas and one of those is access to care. This bill would help expand access to qualified health care professionals in areas of highest need, and we are fully in support of these efforts.

Chair Peters:
I would like to state for the record that we have reached 20 minutes of support testimony. I am going to entertain those on the phone line, and we will assess where we are at after that.

Sarah Watkins, representing Nevada State Medical Association:
I am representing my members and board and would like to support A.B. 45.

Briana Escamilla, representing Planned Parenthood Votes Nevada:
We are in strong support of A.B. 45. It is no secret to anyone who has ever tried to receive medical care in Nevada there is a provider shortage. That shortage is felt strongly in the reproductive health care sector, especially after the *Dobbs* decision last summer which caused an influx of patients from other states. We are proud to stand behind a bill that seeks to address provider shortages while also providing incentives for students to pursue careers in health care, particularly in Nevada's underserved communities. We urge you to support this bill.

Barry Cole, Private Citizen, Reno, Nevada:
[Barry Cole submitted an email in support Exhibit F.] I am a volunteer with the Department of Psychiatry, and I have practiced psychiatry in towns of 10,500; 7,500; and 4,500 and successfully run practices. I cannot tell you how delighted I am there has been a declaration that psychiatry is now a primary care specialty. I am almost 70, and I never thought this day would come. I want to remind you that beyond A.B. 45, which is a start, we still need more high-quality postgraduate education, more residencies, more fellowships, and then jobs when people finish. Being incrementalists, it means we take steps towards the goal, and this assistance with potentially crippling student debt should incentivize more Nevada health care graduates to consider caring for our fellow citizens and staying in Nevada. Thank you again for A.B. 45, supporting it, and helping psychiatry feel like it is now at the table.

Andrea Gregg, Chief Executive Officer, High Sierra Area Health Education Center:
Our Nevada Area Health Education Center (AHEC) Program aims to build a strong and diverse health care workforce for Nevada's underserved communities through education, training, community partnerships, and through our boots-on-the-ground efforts. We hear

countless times how many concerns come from our students who aspire to be the future practitioners for our state, purely because of the fear of payment and coverage and allowances for them to pursue those careers. This is a great step forward. Kudos to Treasurer Conine and your team for your thought, innovation, and most importantly, for identifying a sustainable funding source to support such an effort. Student loan repayment programs are not just a matter of financial relief for the individual borrowers, but also strategic investments that alleviate the burden of student debt while allowing those graduates to pursue careers based on their skills and their passions rather than their debt repayment obligations. This is really going to help retain talent within the state as well as attract new talent and make genuine investments where we need them most, which is the talent pool our state currently has. So, High Sierra AHEC would like to express our support for A.B. 45.

Steve Messinger, representing Nevada Primary Care Association:
I represent the Nevada Primary Care Association and our federally qualified health centers that serve underserved areas and populations including in rural areas and patients best served in a language other than English. We support A.B. 45 as amended and believe this proposal could be a great benefit to our members and patients. We would like to thank the Treasurer and his Office for listening to our concerns and proposing this innovative solution.

Steve Walker, representing Lyon County:
Finding ways to encourage health care providers to work within rural areas is difficult. We see this as a strategy with the potential to have positive impacts on the shortage of providers working and willing to work in rural Nevada. Additionally, I agree with Assemblyman Gray. We need to refine the definition of eligibility for the counties and cities in rural Nevada.

Chair Peters:
I am going to assume that was a support statement for the bill as amended, but please follow up with the Treasurer on your last statement.

Donna Laffey, representing Dignity Health-St. Rose Dominican:
St. Rose is proud to support A.B. 45 to assist in increasing the number of providers in Nevada.

Austin Brown, representing University of Nevada, Reno:
[Austin Brown provided a letter signed by John D. Packham in support Exhibit G.] We would like to voice support for A.B. 45. As a university involved in public health efforts statewide in both rural and urban areas of Nevada, with a firsthand look at the importance of prioritizing public health infrastructure and workforce of our state, we urge you to support A.B. 45. At the University of Nevada, Reno, School of Medicine, John Packham runs a loan repayment program. Through the creation of the Student Loan Repayment for Providers of Health Care in Underserved Communities Program, this bill would help address critical shortages in our public health and health care workforce throughout the state while also creating sustainable funding sources. Thank you for your consideration of support for A.B. 45.

Kent Ervin, State President, Nevada Faculty Alliance:
As state president of the Nevada Faculty Alliance, the association of professional employees at Nevada's public colleges and universities, we support making college affordable. There has been a long-term trend of declining support for public higher education, leading to higher student fees and tuition. The high student fees are being funded in great part through student debt, which can be onerous. While those larger systemic issues require systemic solutions beyond this Committee's purview, we support A.B. 45 because it provides student debt relief for a very important population while also encouraging health care providers to serve underserved communities in Nevada. Thanks to Treasurer Conine and thank you all for working on A.B. 45.

Kennedy McKinney, representing Human Services Network; and National Association of Social Workers:
Knowing time is limited, I wanted to keep my comments short and say that both organizations are in full support of A.B. 45 and the proposed amendments.

Annette Magnus, Executive Director, Battle Born Progress:
We are here today in strong support of A.B. 45. We know that student loan debt is a huge issue for so many across our state, and we also know that access to health care and providers is a major issue across our state. This bill helps with both issues and keeps more of our talented students in Nevada and practicing in key communities across our state. These are the types of programs we must start offering to Nevadans to get ahead and meet the needs of our people. We thank the Treasurer for his work on this innovative measure and hope that you will continue to expand programs like this to other borrowers in the future. Please support this important measure.

Amanda Vaskov, Director of Government Affairs, Associated Students, University of Nevada, Reno:
We support this bill recognizing the need for qualified health care professionals in our state and understanding firsthand the difficulties of navigating higher education as health care students. Thank you for your consideration of this bill today.

Lea Case, representing Nevada Psychiatric Association:
We wanted to get on record and say thank you to the Treasurer and his policy analyst. I had many students and residents reach out to me via text, email, and phone calls for the past 24 to 48 hours asking: How can we support this? What can we do? I gave them the phone number to call in, but they are medical students and residents who are working and in school, so I want to say thank you for hearing this bill and for supporting our future psychiatrists in Nevada.

Chair Peters:
I want to direct our Committee's attention to several exhibits we received that are letters of support [Exhibit H, Exhibit I, Exhibit J, and Exhibit K.]. If you can review those letters, it would be great. We do not have anybody else in Carson City at the table. I missed one person on the call-in line, so I am going to go back to our last testimony in support.

Athar Haseebullah, Executive Director, American Civil Liberties Union of Nevada:
We believe this bill is a significant and proactive step in advancing civil rights, and we are fully supportive of this bill. We also want to thank the sponsor for bringing it forward.

Chair Peters:
We are going to move into opposition testimony. Is there anyone who would like to provide opposition testimony on A.B. 45? [There was no one.] We are going to open neutral testimony on A.B. 45. Is there anyone in Carson City who would like to provide neutral testimony on A.B. 45? [There was no one.] Is there anyone in Las Vegas who would like to provide neutral testimony on A.B. 45?

Cyrus Hojjaty, Private Citizen, Las Vegas Nevada:
There are a lot of great things about this bill. I just wish this bill was being passed at a time when other problems such as underserved communities and language barriers were being solved. I understand this would be helpful, but I see this as more of a Band-Aid to the problem, but not solving the entire structure or root causes.

Chair Peters:
Is there anybody else who would like to provide neutral testimony on A.B. 45? [There was no one.] I am going to invite the bill sponsor back to the table for closing remarks.

Treasurer Conine:
I want to thank members of the Committee for the comments and feedback. Our Office will reach out to your attachés to meet sometime in the near future.

Chair Peters:
Thank you so much for bringing the bill. We look forward to seeing any future amendments that may come out and please keep us informed. I am going to close the hearing on Assembly Bill 45 and open the hearing on Assembly Bill 132.

Assembly Bill 132: Creates the Committee to Review Overdose Fatalities. (BDR 40-721)

Assemblywoman Leslie Cohen, Assembly District No. 29:
[Assemblywoman Cohen distributed supplemental information in support of the bill Exhibit L.] Presenting with me is Trey Delap from Group Six Partners. Mr. Delap has worked in behavioral health addiction and recovery policy for years and specializes in advocating in the spaces where they converge. As you are aware, the opioid epidemic has swept through the country causing death to people in all walks of life regardless of age, religion, education, race, social standing, and the like. Now fentanyl has caused a bad situation to be even more dire. Mr. Delap is going to provide a brief history of opioid legislation in Nevada, and then we will discuss the bill and our conceptual amendment [Exhibit M].

Trey Delap, Director, Group Six Partners, LLC:
Thank you for hearing A.B. 132 today, and thank you, Assemblywoman Cohen, for bringing this legislation. For the past four sessions, the Nevada Legislature has addressed the opioid epidemic through legislation. In 2015, Governor Brian Sandoval signed the Good Samaritan Drug Overdose Act into law, a criminal immunity harm reduction law targeted at encouraging medical care for people at risk of overdose. In 2017, prescribing of opioid medications was addressed by expanding the utilization of the Prescription Drug Monitoring Program and reducing overprescribing of opioids—a successful response to the first wave of the opioid epidemic. In 2019 and in 2021 expanding access to naloxone in schools passed thanks to Assemblywoman Cohen's Assembly Bill 205 of the 81st Session empowering every school in Nevada to have naloxone on hand with personnel trained in its use. I am happy to report that most schools in Nevada do have naloxone on campus, and lives have been saved because of it.

Assemblywoman Cohen:
I want to mention that A.B. 205 of the 81st Session was cosponsored by now-Senator Robin Titus, and it was begun with work in 2019 by former Speaker Hambrick, so this has been a truly bipartisan effort. As was mentioned, A.B. 205 of the 81st Session has been successful in schools, and we have had reports of it preventing deaths of students in schools by allowing opioid antagonists in schools. Given that success, I contacted Mr. Delap prior to this session because of his knowledge on the subject and contacts in the field and asked what legislation we should consider looking at to continue the work we are doing to mitigate the issue of opioids in Nevada to try to prevent more opioid deaths in our state. Mr. Delap reached out to stakeholders and came back to me with the idea of the Committee to Review Overdose Fatalities.

Trey Delap:
Overdose fatality review (OFR) is a locally based, multidisciplinary process for understanding the risk factors and circumstances leading to fatal overdoses and identifying opportunities to prevent overdoses. The basis of OFR, like all fatality reviews, is that overdose fatalities could have been prevented with the right action, timing, intervention, and response. Overdose deaths can be prevented with four key capacities: to coordinate prevention strategies with timely implementation of evidence-based interventions; community mobilization; and engaging supportive families and friends. The shared understanding that overdose deaths are preventable guides the entire overdose fatality review process. Federal agencies such as the Bureau of Justice Assistance and the Centers for Disease Control and Prevention are strategically coordinating to mobilize local communities to develop and implement OFRs throughout the country. One of several programs in Nevada using federal grant dollars to combat the opioid epidemic is the Nevada Overdose Data to Action (NVOD-2A). Focused on examining data on overdose fatality, NVOD-2A found that 77 percent of decedents had at least one potential opportunity for linkage to care prior to death, or implementation of a lifesaving action at the time of overdose. These potential care opportunities were: recent release from an institution like prison, jail, treatment or hospital within the past month; a previous non-fatal overdose; a mental health or co-occurring mental health diagnosis; prior treatment of substance use disorder; or a bystander was present when

the fatal overdose occurred and witnessed fatal overdose taking. This is where fentanyl kicks in. The remedy to each of the things I just listed is more access to naloxone. One in three deaths due to overdose of opioids is attributable to illicitly manufactured fentanyl, which was found in 36 percent of all opioid deaths. Also, 81 percent of opioid fatalities occurred in the home.

The high potency rate of fentanyl has precipitated us into wave 3 of the epidemic. Wave 1 was overprescribing; wave 2 was heroin; now we are in wave 3 with the prevalence of synthetic fentanyl. With thorough analysis, opportunities for resource deployment reveal themselves, but two problems remain: First, data is so delayed that the information is forensic rather than actionable. Second, the State is unable to mobilize resources and interventions fast enough to prevent overdose deaths that could be prevented. The solution is to engage a robust OFR at the community level comprised by stakeholders active in opioid response already with the capacity to advocate or implement effective interventions to support and empower them to ensure public health responsiveness likely to have the greatest impact. Nevada is diverse and a single response to opioid fatalities is not likely to be culturally competent in a top-down approach. Three of the four core actions OFRs may address are community- and family-based. The aim of A.B. 132 is to empower and engage appropriate local agencies to conduct OFRs and craft, implement, and evaluate community responses. To optimize OFRs, A.B. 132 grants access to vital information to collect and conduct the OFR.

The NVOD-2A did a pilot project for OFR, and they released two recommendations: leverage the existing fatality review, and support the dedicated fatality review resources, facilitation and documentation. Assembly Bill 132 provides a statutory opportunity to implement these recommendations. Ongoing surveillance will provide ongoing information and analysis. Research on OFRs in all the states that have them concludes that overdose fatality review is an effective means of understanding the opioid epidemic, strengthening coordinated interventions, and informing the local and state health departments' overdose strategic planning.

Strategic planning teams have a unique vantage point from which to view systems-level gaps and policy issues because of their collaborative nature and the quality of data provided by the agencies that directly served the decedents. Assembly Bill 132 is an opportunity for Nevada to prevent future opioid deaths by learning everything possible from those who have already passed. With intention, Nevada can expand culturally relevant prevention intervention, promote recovery, and restore families and communities.

Assemblywoman Cohen:
As detailed in the exhibit for the bill [Exhibit L] and as Mr. Delap detailed, overdose fatality review has been found to be successful in assisting with providing data necessary to curtail opioid overdose deaths. When we began this process to introduce overdose fatality review to Nevada through this bill, we initially thought the review would be most effective if it were similar to the Committee to Review Suicide Fatalities, which is currently housed in the Department of Health and Human Services (DHHS). However, per the CDC [Centers for

Disease Control and Prevention] and the Bureau of Justice Assistance of the Department of Justice, we found the best practices require more flexibility than the suicide review committee structure allows. Moreover, as we have proceeded and consulted further with the recovery community and stakeholders, we have determined that the overdose fatality review may be more effective by focusing on work to be done at a more local level than at the state level. As such, our conceptual amendment allows for the sharing of aggregate data with agencies and institutions throughout the state at a more local level. By this conceptual amendment [Exhibit M], local agencies and institutions that want to use the data constructively will have that opportunity. Using the data at a local level effectively and immediately—and "immediately" is the key part—can be seen in other jurisdictions. For instance, a county in Indiana immediately used local data to determine there was an overdose spike occurring and the local authorities were able to respond by increasing the availability of naloxone, thereby saving lives. Three Indiana counties worked together and utilized the data to determine there was a trend of deaths occurring with individuals right after they visited the dentist, but it was not a particular dentist. The dentists were not doing anything nefarious, but there were prescriptions happening. The counties got together and provided training to dentists regarding substance misuse risk screenings, and those three counties were able to break the trends in their counties through prescriptions from dentists.

If we pass this legislation, an example of how this would work would be something like, let us say a local health district in Nevada or a hospital in a particular city realized that overdoses were happening regularly around the same time in a given week. They could use the data to determine that it was happening around the time there was a regularly held street fair in the area. That health district or hospital could do a few things with the data, such as making sure there were more EMTs [emergency medical technicians] with naloxone onsite at that street fair. They could also set up booths to hand out naloxone kits at the fair or teach fair goers about dangerous opioids, overdosing, and fentanyl as well. It would be an immediate reaction—an immediate ability of the health district or the hospital to react and to save lives. Again, the key is to allow local agencies and institutions access to the data with enough time to have a rapid response.

Our bill language will be amended. We have not gotten there yet, it is a work in progress, but it is going to allow the agencies and institutions at the local levels to have access to aggregate data regarding overdoses. This is going to align with best practices in 12 states which have already worked with overdose fatality reviews and that work at the local level. Another thing the amendment is going to do that is different than what came out of bill drafting is that this is going to be only for opioid deaths. It will allow us to have data as quickly as possible regarding opioid deaths. The concentration is going to be on opioids because we know that 65 percent of overdose deaths involve opioids. We have this epidemic of opioid deaths unlike anything else, but we also have a tool in naloxone, which is like any other tool we have for preventing deaths from overdose. We need to maximize the ability to use that tool, so that will also be part of our amendment.

Chair Peters:
Thank you so much for the presentation. Do we have we have Ms. Phinney in the audience from DHHS? Could you respond to where data is at the State and what kind of data we are collecting? How early are we receiving it upon an overdose death, and what does that sharing look like today?

Cody Phinney, Deputy Administrator, Regulatory and Planning Services, Division of Public and Behavioral Health, Department of Health and Human Services:
The collection of data is a multifaceted area. We have our Office of Analytics that has access to much data. Having it in time, as Mr. Delap and Assemblywoman Cohen alluded to—having it fast enough to be actionable—is challenging at times. For example, when they are using Medicaid claims data, it is not going to be actionable in a spike situation; however, some of that data is. I would be happy to facilitate a meeting with the Office of Analytics and invite Mr. Delap, Assemblywoman Cohen, and any other interested parties. We could make sure we identified where those data sources are and if it is technically possible to get information fast enough for the purpose they describe. I want to make sure I do not promise something we cannot technically do, and that is not a part I usually do. If that is a possibility, we can speak to the Department and say we are eager to do that.

Chair Peters:
Thank you so much for being available to answer that question. I have been thinking about Assembly Bill 181 of the 81st Session where we discussed a lot of similar issues related to suicide deaths, suicide attempts, and trying to obtain data early. It is not easy; it is a burden on our facilities to try and obtain that data. The more we can work together to try to get that, the better off we will be. Are there questions from the Committee?

Assemblyman Hafen:
I was doing a quick Google search. It appears Nevada already has the NVOD-2A program, and there is an extensive list of individual organizations—the Southern Nevada Health District, DHHS, the State Board of Pharmacy, et cetera. I will not read them all, but it appears a program is already in place, and they already are doing overdose surveillance. The most recent data they have available is January 2023—at least for statewide data. The data is only a month old, so is it your idea to replace all those different organizations to try to get faster expedited data, or am I missing something?

Trey Delap:
The Nevada State Unintentional Drug Overdose Reporting System (SUDORS) is the likely report. You are looking at the Nevada SUDORS [page 1, Exhibit L]. It does provide monthly information, but if you look at the source of the information it will say when it was obtained. It is an abstracted and aggregated data system that lives at the State, so they get information when they get it, as does another program that the State has mainly in the Office of the Attorney General. It is the Overdose Detection Mapping Application Program (ODMAPS) [page 2]. It is an overdose mapping system. The idea behind ODMAPS is similar to a biotoxin. If you see an instance of ricin appearing somewhere, you have a major issue. The idea with ODMAPS is that when first responders administer naloxone, they

would report it to the system. Because of the "cluster phenomenon." Basically, what happens—and this is what we have seen in the last few years—one student at a high school overdoses and dies. Within 12 or 24 hours another person, then another person, and then another person. The likely source of their substances was the same place. The instant the information was reported it is used to provide a heat map. Public health authorities' resources can be mobilized to go into the mapped area with naloxone and engage however is appropriate. The problem with ODMAPS—and that is its intention and design—but it is relying on EMS to put the data in or however they integrate it into their system. The other challenge we have, and Ms. Phinney mentioned this, is that a lot of the information about overdoses is obtained through billing data—ICD-10 codes [International Classification of Diseases, Tenth Revision from the World Health Organization]—which are only as good as the person encoding them and only make it into the system as fast as they make it into it. Often, one of the wrinkles that Overdose Data to Action (OD-2A) has noted as the limitation for SUDORS and ODMAPS is someone has to do this and if they are not doing it in a timely fashion, that is the point. What is lost, particularly in SUDORS, is the opportunity to get as much information as possible quickly about the person who died that could determine trending or could be used for assessment as a risk factor. As an example, Assemblywoman Cohen mentioned about the dental office. Who would have thought that? But that is the power of a local community keeping an eye on things that has stakeholder buy-in to a reporting system. They can identify a spike no one could have anticipated and respond accordingly. There is data, but the delay is a problem, and it is not uniform by counties. Not all counties report, period.

Assemblyman Hafen:
I am looking at the data, and you are correct. It is not January, the data in the statewide report is from December 2022, and it is being prepared by DHHS in conjunction with UNR [University of Nevada, Reno] and Nevada Opioid Response.org. There is an alarming rate of opioids being used in the southern rural counties and in Washoe County, especially in comparison to Clark County. My question concerning whether this new committee would replace or supplement what is currently being done with the NVOD-2A was not answered. Could you answer that for me?

Trey Delap:
This is not intended to replace; this is intended to optimize. Data is being collected; it is being aggregated. Overdose to Action discloses that the biggest limitation in their SUDORS and these other programs is the delay in the data being reported and then abstracted. The concept here is an entity with the capacity to do this, take on this project, perform opioid fatality reviews, would be given access through this bill to this information ensuring that confidentiality is maintained. It would enhance current systems and make them faster. That is the key.

You know that the urban areas do have higher spikes, and that is where an ODMAP or spike map would be the most helpful. One of the challenges Nevada has as a small state with a major population center and a giant geographic area is that when you are looking at per capita or aggregate data, it is always population-based, so that is a barrier.

Assemblywoman Cohen:
No one is being forced to do anything, but it is making sure that if a local agency wants to do something it has the ability to get the data to do it. They can get it quickly; and by statute, they are permitted to get that data. That is all this bill is doing—making sure they have access to the data so they can make a quick response if they choose to do so.

Assemblyman Hafen:
I also want to clarify, the SUDORS program is not what I am looking at. I am looking at the Nevada Drug Overdose Surveillance program that comes from DHHS. I agree having the data in real time would be more beneficial. If we had law enforcement that could have the information immediately, they could go into a school and investigate what is going on. I may have misspoken, the data I am looking at shows Nye and Lincoln Counties have bigger opioid overdose problems than Clark County on a per 100,000 population basis. I agree that real-time data would be wonderful, especially if it could get into the hands of law enforcement. We need to tighten up some of our penalties when it comes to those who are distributing fentanyl. There is a bill on the Senate side to do that, and I look forward to that because it is a problem.

Chair Peters:
Thank you for that comment. I do not think we will be hearing that bill as it will go to the Judiciary Committee, but it is something to keep an eye on.

I want to direct the Committee to the February 17, 2022, presentation to the Interim Health and Human Services Committee which addressed a lot of the issues being discussed today, including the lag time on data receipt. Historically, we have waited on mortality data, which depends on the local coroner to determine the cause of death. That can take months. There have been several attempts to get earlier data. It is about coordinating in the communities how to do that, so I look forward to seeing how this bill comes out. Are there other questions from the Committee? [There were none.]

I would like to ask about your conversations with local governments. How do they feel about their ability to either obtain data locally or utilize this data? Have you had discussions with them, Mr. Delap?

Trey Delap:
"Local government" is an interesting question when we talk about southern Nevada. Most of the naloxone distribution and fentanyl strip distribution happens at the Southern Nevada Health District, which is overseen by several municipalities. We have city and county staff working together. The intent of this is to create the opportunity if an entity, a government, for instance the Lyon County Sheriff, the Lyon County Fire Department, or whoever wants to take this on and meets certain criteria, then they can do this process of opioid fatality review. To answer your question simply, no, Las Vegas, the city or whoever, is not chomping at the bit to do this. That is why we want the legislation to be enabling.

Chair Peters:
Are there any other questions from the Committee before we move on to testimony? [There were none.] We will move into support testimony.

Trey Delap:
I would like to make a quick closing statement. I want to thank you for dedicating your very precious legislative time. In preparation for this, it occurred to me that I am like the ghost of death. Every time I come before this Committee, for three sessions in a row, I talk about dying, death, and dying kids. I apologize for that. It is an unpleasant topic, but it is very important. I am here in a private capacity because I represent two categories of people. The first category are nonprofit agency organizations who cannot take positions for or against, but they are slugging it out every day in the field trying to help people recover. The second category are families, the affected, afflicted, or people at risk for opioid overdose death. Whether it is their first or 100th dose that kills them, either way, their voices are gone, and the result is pain, anger, frustration, and stigma, and that keeps a lot of people quiet. Through this bill, we are asking for the opportunity for capable stakeholders to look at everything that surrounds an opioid fatality in order to learn how we can prevent them, understanding that they are preventable. These are unintentional overdoses.

Finally, I want to extend profound thanks to Assemblywoman Cohen. For three consecutive sessions, she has put her name on bills to advance life-saving measures, specifically A.B. 205 of the 81st Session. There are young people today going to school who are alive because of what she brought and what the Legislature did in creating the enabling legislation, even though they may not know she and you are to thank for that. By having this conversation, by having a hearing on this bill, you are demonstrating the value of having these conversations free of moral judgment and stigma.

Chair Peters:
I appreciate those comments. It is an issue area that is not sexy nor is it desirable to have these conversations. We know people turn their noses or their cheeks to these conversations around addiction, and drug overdose in particular. We often think of leaving it to law enforcement when it can be something that we integrate into our community as a support system for folks before overdose occurs. I appreciate that sentiment and thank you so much for the presentation.

Assemblywoman Cohen, it has come to my attention that there is another amendment in our exhibits from James Fleming [Exhibit N]. Is it a friendly amendment, or have you seen it?

Assemblywoman Cohen:
I have seen it, but I think it was because the gentleman had not yet realized we were taking this out of DHHS. I emailed him to let him know we are taking it out of DHHS, but I do not know if he wants to continue with it. No, I do not consider it friendly.

Chair Peters:
We are going to move into support testimony on A.B. 132. Is there anyone who would like to provide testimony in support of A.B. 132?

Jimmy Lau, representing Dignity Health-St. Rose Dominican:
We are in support of the concept of increasing access to this type of data at the local level. We appreciate Assemblywoman Cohen clarifying that and also clarifying there would not be any mandates associated with it. The expansion of the access to this data can really help folks be reactive to the growing problem of overdoses in our society.

Adrienne O'Reilly, Private Citizen, Las Vegas, Nevada:
I am here today to honor my cousin who was taken from us by a heroin overdose. I spent years volunteering on the streets with our homeless neighbors suffering with heroin addiction. In the height of the pandemic, I lost two clients in one camp due to heroin overdose in the span of two weeks. They lived one street in front of me, and I carried the overdose rescue drug naloxone with me. Overdose death is preventable death, and I am also here today to honor them. I respectfully support A.B. 132 as proposed, which will create the Committee to Review Overdose Fatalities. My understanding is this committee will review overdose fatalities from both intentional and unintentional overdose deaths. The creation of this committee will promote organized analysis of overdose fatalities in our state. This will allow us to better understand trends, risk factors, and strategies for prevention. The information gained may also help us propose additional helpful legislation regarding overdose fatalities in Nevada. Getting a better understanding of what causes them and who is impacted by overdose deaths in our state can help us better address the situation and try to reduce the number of overdose fatalities Nevada experiences. Overdose death is preventable death. Please vote yes on A.B. 132.

Dora Martinez, Private Citizen, Reno, Nevada:
I am founder of the Nevada Disability Action Coalition. I agree with the prior caller and also with the comments the gentleman made regarding Assemblywoman Cohen. From the disabled community, thank you so much for all you do.

Cyrus Hojjaty, Private Citizen, Las Vegas, Nevada:
I support this bill and say, Ditto to all the positive support testimony. I also wish you folks can address how these drugs are coming into our society.

Chair Peters:
Are there other callers in support of A.B. 132? [There was no one.] We are going to move to opposition testimony. Is there anybody who would like to provide opposition testimony to A.B. 132? [There was no one.] We are going to move into neutral testimony. Is there anybody who would like to provide neutral testimony on A.B. 132?

Joan Hall, representing Nevada Rural Hospital Partners:
We house two of the rural behavioral health coordinators, and I agree that local entities, especially behavioral health regions, need this information sooner rather than later and would

appreciate this. However, from the hospital perspective, I think the current law says hospitals have 24 hours to report overdoses. Some of the rural communities do rapid screens, but they have to be confirmed by an outpatient lab, so that timing is not fast and, as Ms. Phinney said, the process takes a while. We are looking forward to seeing what solutions there are to do this.

To Assemblyman Hafen's comment about the data, when it is per 100,000 population, it could be one person that makes Lincoln County the highest just because of their small population, so it is an interpretation.

Chair Peters:
Is there anyone else who would like to provide neutral testimony on A.B. 132?

Barry Cole, Private Citizen, Reno, Nevada:
I am calling in as neutral because I think A.B. 132 is a starting point that will need some continued evolution. The DEA [Drug Enforcement Administration] is launching a "One Pill Can Kill" campaign and has removed the restrictions for the prescribing of buprenorphine so you do not need a special DEA X waiver, you do not need a special DEA number, and you do not have any restrictions on the numbers you can treat. As this committee forms, it will be looking for root causes of overdoses, but what scares me is that patients I treated in the past year have told me to go out and look for fentanyl products. They know full well that fentanyl is in them, but rather than being frightened when there are clusters of overdoses, it seems to pull them towards the drug. As we all know, the disease of addiction has been termed "the disease of stinking thinking." I do not find that many substance users do any kind of cost-benefit analysis when they choose to use. So, we have a situation where there are lethal products on the street like "sleepy dope"—the mixture of fentanyl and methamphetamine—with a high probability of an overdose that is fatal. We have illicit drugs being sold as knockoff counterfeit drugs that look like what you are looking for, but do not contain what you are expecting to get. There is going to have to be some linkage of this piece of legislation with criminal justice related to who is dealing drugs, what is in them, and how we are going to stop this. So, I am neutral at this time until we can clarify the details.

Chair Peters:
Is there anyone else who is neutral on A.B. 132? [There was no one.] I am going to invite the bill sponsor to the table again for closing remarks.

Assemblywoman Cohen:
Clearly this is a work in progress, and we plan to keep working on it. This is enabling language trying to make sure local agencies are able to get the data they need in case they want to have programs or want to start something to be able to work in their communities. We will continue to work on this and get language to use soon, so the Committee will have a chance to review that language and take its time with it.

Chair Peters:
I am going to close the hearing on Assembly Bill 132. We look forward to hearing those amendments.

Now, I am going to open the hearing for Assembly Bill 136 which requires certain facilities to be licensed as child care institutions.

Assembly Bill 136: Requires certain facilities to be licensed as child care institutions. (BDR 38-326)

Assemblywoman Clara Thomas, Assembly District No. 17:
I am introducing Assembly Bill 136. Clark County submitted this request to the Joint Committee proposing to update Nevada statutes to align with guidance from the federal Children's Bureau within the Department of Health and Human Services on implementation of the 2018 Families First Prevention Services Act, a broad federal policy bill that shifted the model for foster care to focus more on prevention services and evidence-based, trauma-informed care. The federal Families First Prevention Services Act's primary goals were to build community capacity and reduce the unnecessary use of congregate group care. In furtherance of that goal, the Families First Act defined a program known as the qualified residential treatment program or QRTP. You will see more discussion of this model on slides five through eight from the state's presentation to the Joint Committee in April. I will now hand the presentation over to Joanna Jacob from Clark County Government Affairs for further explanation of this bill.

Joanna Jacob, Government Affairs Manager, Department of Administrative Services, Clark County:
Assemblywoman Thomas referenced slides from the Interim Joint Standing Committee on Health Care. I will make sure and submit those to the Committee so you can see the state's presentation on this model and will not have to look it up. We submitted this bill to the joint interim standing committee over the summer and are looking to implement it in Nevada to come into compliance with guidelines from the Families First Act referenced by Assemblywoman Thomas. The federal program guidance states that foster care group home models, meaning not a family setting but a group home model, is no longer reimbursable under the federal funding stream Title IV-E unless the home is a family-based setting except under very limited circumstances, one of which is the QRTP model referenced by Assemblywoman Thomas. Qualified residential treatment program is for kids who are under 18. It requires an assessment of the child and a determination that the child's needs cannot be served in a less restrictive family-based setting. It means they need more support; it is usually for children who might have serious emotional disturbances or other conditions. It is supposed to be a less restrictive setting, and it is a federal model. We worked with the State and Washoe County on this over the interim, and what we are trying to do in Clark County is set up the framework so we can build this model in Clark County and eventually build the federal funding stream for this model.

When you look at A.B. 136, in section 1, subsection 1, the federal guidance tells us that QRTPs by federal definition are child care institutions and they must be licensed by the State, meaning the Department of Health and Human Services, as child care institutions. What we are trying to do is add to the definition of child care institution and incorporate the federal definition. This is designed to allow us the flexibility to have the State license this model. Then, if we want to move forward and implement this model—and we are working toward that in Clark County—we will be in place to try to build federal funding for it, which is really important for Clark County. You will see a package of bills on child welfare this session to address some of the conditions we have seen in Clark County.

I will tell you, this is a necessary level of care in Clark County. We have a large number of children at our shelter, Child Haven, right now. Jill Marano, the newly appointed Director of the Clark County Department of Family Services, and I have worked very closely together trying to figure out how we can build towards this model and what changes we need to the statute. That is why we are adding the definition in section 1, subsection 1, paragraph (b) and we are defining it. There is a reference to a federal statute there, and it says, "regardless of the number of children who receive care and shelter from the program." That is the federal definition of "childcare institution" under the Families First Act. It says you can serve up to 25 children. Our Nevada statute [section 1, subsection 1, paragraph (a)] as you can see reads "16 or more children." We would like to serve a smaller number of children, so we are working on a model where we have a smaller setting. That is where we are going to align with the federal guidance and why we felt the need to change the statute.

We worked with the State agencies on this over the interim, and this was their preferred approach, as well as Washoe County's. I do not want to speak for them, but I can speak to the work we did with those agencies, and we touched bases with them before the hearing to make sure we were all good. I think everybody is comfortable with this approach. It would enable us to move toward it if we want to. That is the goal, so we will be able to access that federal funding stream and also build a very necessary level of care that is needed in Clark County. I was going to talk about Child Haven today. As of today, we have 90 children in that shelter. About 40 of them would be better served in this level of care. This is an interim, mid-level of care that is a more appropriate setting for them, and we want to work toward providing that service in our community. The goal of the bill is as simple as that. This is going to allow us to work with the State and move toward accessing federal funding.

Chair Peters:
Are there questions from the Committee on this bill? [There were none.] You said the federal definition has a cap of 25 children, which is greater than the floor we currently have in the state of Nevada, but the goal is to provide services to fewer than that number. So, we are looking at a duplicated effort: between 16 children and 25 children, and then below 16 children. Would this definition capture those facilities?

Joanna Jacob:
I have the definition and I am going to read it to you. The definition is "a private childcare institution or a public childcare institution which accommodates no more than 25 children

which is licensed by the state in which it is situated or has been approved by the agency of the state responsible for licensing for approval of institutions of this type as meeting the standards established for the licensing." You see that we have to be licensed as a child care institution up to 25 people. It was designed to give us flexibility. We went back and forth on how to put this in and in discussion with the State and Washoe County, it seemed to be easier for us to create the extra category, so we do not modify the definition for other types of child care institutions in the state. We are looking to a smaller setting because there are some issues with Medicaid billing for things that are over 16 beds.

Jill Marano, Director, Family Services, Clark County:
Our main goal in bringing this forward and not wanting to use the current definition is because the current definition requires that you have 16 beds in the child care institution. While we have recognized the need for this qualified residential treatment program, which is more of a group care setting with a staff on eight-hour shifts coming in and out of the home. That is never our preferred option for children. We prefer children to be in family-based settings, but we also recognize that sometimes children need more structure, more treatment intervention than can be provided in a traditional family care setting. However, if we have to go higher than that, we still want to try and maintain as much of that family-based setting as possible. Our vision or goal for a qualified residential treatment program would be something like maybe a six-bed program, but it would still be in a home in a community so a child is still living in as normal a placement as possible. The children are still going to their own school, they are still seeing the same people they normally would see, they are still going into the same stores, and they are still feeling like they are a part of the community. If we are restricted to 16 beds or higher, it creates more of an institutional feel. We are trying to balance the home setting and the residential treatment setting. This is a middle ground between the two, which is why we want the flexibility of the lower number.

Chair Peters:
Thank you for the response. I have a couple of questions from Committee members.

Assemblywoman Newby:
I was really struck by something you said about 90 children being in Child Haven right now. Can you give us an idea of what is currently happening with that population? What are the options for both the higher-needs residential children and as we step down into more community-based care?

Joanna Jacob:
Our county manager, if you heard him speak before this body, talked about the second wave of the crisis we have seen. As our community struggled to respond to COVID-19 and we got back up and running, we still found that foster care parents or even regular parents—because our system serves everybody—were struggling to find community-based care. So, some of what we have seen has been more children coming into Child Haven. For the Committee members who do not know, Child Haven is our emergency shelter. If our staff sees domestic violence or if there is an issue about the safety of a child, we will take temporary custody of the child to keep them safe. That is the purpose of that shelter, but Child Haven is not set up

to serve the needs of some of the kids who have been coming into our system because of unmet mental health needs. We have also had some parents who have had to surrender their kids to the child welfare system. That is the most heartbreaking part about it because they cannot find community-based care, and they know that our doors are open, and they might be able to find care there. This has been something we have been working on. When I referenced a package of bills and budget presentations this session, we have been working with the State, with the legal aid society, and with many partners to address this situation.

What we have also seen is an increase in acuity of the children who are coming in. They have more needs that we need to serve in these models, which is really the preferred model. Ms. Marano said we want to try and keep kids in the least restrictive setting and the most appropriate setting so they can find the care they need in the community at the time they need it. That is the hardest thing we have seen. Child Haven is always open or the UMC [University Medical Center] emergency room. We have had kids dropped off at the UMC emergency room, and then they end up at Child Haven because there is nowhere else to go. We have been working with the State to build services, and we worked with the State on an interim package of American Rescue Plan Act (ARPA) funding to try and build out the community-based care. This is a piece of that as we look toward the sustainability of that ARPA funding we worked on over the interim. If we set up this model, then we can offset some of our costs with the Title IV-E funding, and this is the preferred model under the federal act. Also, we can work towards sustainability.

Jill Marano:
The addition of a QRTP adds an additional level of placement services we can offer. It is one piece of the solution to the problem of 90 kids being in a congregate-care shelter today. There are a variety of other pieces, but we estimate that about 40 of those 90 children are there because we are missing an interim level of care. There are some children who are there because of a shortage of regular foster homes. Some children are there because there is a shortage of treatment-level foster homes. Some children are there because they are part of a large sibling group and we do not have homes big enough for them. Some children are there because, on the developmental services side of the house, we do not have resources for them either. It is a complex problem with probably at least seven or eight solutions, and I think this is one of them.

Assemblyman Gray:
My question focuses on section 1, subsection 1, paragraph (a). That definition seems to be pretty broad, and I am wondering about providing developmental guidance. When we look at unintended consequences, I am looking at the Nevada National Guard's Battle Born Youth ChalleNGe Academy, an academy for at-risk youth in Carlin. They provide services such as life coping skills, health and hygiene, education, all of that. In the broadest sense, it would almost seem that this definition would apply to that school. Was that your intent? They have more than 16 kids but less than 100, or whatever the cut off is, but I cannot see them having to register as a "facility."

Chair Peters:
We do not have legal staff in the room right now, so if this becomes a legal question, we will have to defer to staff in a follow-up question, but please, if you have a response, go ahead.

Joanna Jacob:
These are licensing types you can choose to do. It is not our intent to make anybody get licensed as a child care institution. A child care institution right now is like a daycare, and daycare facilities get licensed this way through the State. That is how the State oversees those types of facilities. I do not think the intent would be to cover the school you referenced. It is the regulatory stamp under *Nevada Revised Statutes* (NRS) Chapter 432A. They have regulatory oversight over certain types of facilities.

Cody Phinney, Deputy Administrator, Regulatory and Planning Services, Division of Public and Behavioral Health, Department of Health and Human Services:
The Bureau of Health Care Quality and Compliance licenses child care facilities, and we have a couple of mechanisms to do that. They have historically fallen under the child care licensing program which will continue should all the bills we have proposed pass this session to license daycare and activity programs, child care programs. Child care institutions will continue to be licensed by the Bureau of Health Care Quality and Compliance. If a program meets the criteria and the definition, they would need to be licensed by us in order to continue their programming. I have not reviewed the program you are talking about with my staff to determine whether these criteria would be met. In general, the purpose of our licensure is to ensure that there is a basic level of quality and safety ensured to the children who are receiving those services. I would be happy to review that particular program. There are also oversights for schools, and that is separate. Does that answer your question?

Assemblyman Gray:
Not really, but we can talk more about it later. "Provides developmental guidance" [A.B. 136, section 1, subsection 1, paragraph (a)] is a very, very broad term that can apply to almost any institution where the kids do not return home every night. These kids are out at the academy, and it is administered by the National Guard. Your intent, I do not think, is to make them register or get licensed, but looking at it . . . .

Cody Phinney:
It is not that any one criterion of the definition would cover them. They have to meet the full definition, but I would be happy to talk with you more about that particular program.

Assemblyman Gray:
Then that may require a change because it does not say "and," it says "or." So, it is either paragraph (a) or paragraph (b).

Chair Peters:
This is a legal question we need to have staff check on. It might be the section of NRS that is causing the confusion or a variety of potential issues, and we are just not seeing the entirety of this chapter in front of us when you are just looking at the bill language. I am going to ask

staff to follow up with legal and follow up with you on the response and share it with the Committee. Are there other questions from the Committee? [There were none.] We are going to move into testimony, and I am going to open support testimony on A.B. 136.

Greg Esposito, representing Nevada CASA Association:
I am a Court Appointed Special Advocate (CASA) in Clark County. If you are not familiar with the program, please grab me in the hallway because I love to explain what we do. I cannot stress enough how important more facilities in our metropolises are. I have seen firsthand where these kids are coming from. Where these kids are. If you think back to your teenage years, how much you valued your space. How much you needed your space to grow, to develop, to process things. Now, imagine that there are five or six other young people in the same facility as you. You do not have your space, and you do not have your solitude. You do not have time to process and that just compounds whatever issues you are going through and, trust me, if you are in the system, you are going through the roughest time of your life. Expanding the availability of facilities and expanding the quality of care for these kids who need it the most right now is critical. I truly hope you support this bill and I welcome any questions either now or later as to the importance of it.

Chair Peters:
Is there anyone else who would like to provide support testimony for A.B. 136? [There was no one.] Is there anyone who would like to testify in opposition to A.B. 136? [There was no one.] Is there anyone who would like to provide neutral testimony on A.B. 136. [There was no one.] I would invite the bill sponsor and copresenter for last remarks if you would like.

Assemblywoman Thomas:
In closing, this bill will provide a path forward for our child welfare agencies to implement this model in the state and to access federal funding for these critical services.

Joanna Jacob:
I want to say thank you to Assemblywoman Thomas for helping us. This was a Joint Interim Health Care Committee bill. She stepped forward on this journey with Clark County, and we are always appreciative of those efforts. As she said, this is not only about those goals but also about making sure we have the right service array at the lowest level possible with the least restrictive level that we can for these kids. That is our goal with this bill.

Chair Peters:
Thank you, Assemblywoman Thomas. We really appreciate you presenting this bill on behalf of the interim committee. We are going to close the hearing on A.B. 136.

The last thing on our agenda today is public comment which can be done in a variety of ways—in person, via email or snail mail, fax, and via phone. I am going to open public comment. Is there anybody who would like to provide public comment at this time? [There was no one.] I am going to close public comment. Are there any comments or last-minute items from the Committee? [There were none.] That concludes our meeting for today. The meeting is adjourned [at 3:59 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 proposed amendment to Assembly Bill 45, presented by Zach Conine, State Treasurer.

Exhibit D is a letter dated February 27, 2023, submitted by Ron Aryel, M.D., Private Citizen, Reno, Nevada, in support of Assembly Bill 45.

Exhibit E is a letter dated March 1, 2023, submitted and signed by Megan Comlossy, representing Nevada Health Care Workforce and Pipeline Development Work Group and also signed by Andrea Gregg, Chief Executive Officer, High Sierra Area Health Education Center, in support of Assembly Bill 45.

Exhibit F is an email dated February 28, 2023, to members of the Assembly Committee on Health and Human Services submitted by Barry Cole, M.D., Private Citizen, Reno, Nevada, in support of Assembly Bill 45.

Exhibit G is a letter dated March 1, 2023, signed by John Packham, Ph.D., Co-Director, Nevada Health Workforce Research Center and submitted by Austin Brown, representing University of Nevada, Reno, in support of Assembly Bill 45.

Exhibit H is a letter submitted by Zachary Stamp, President, Student Government Association, Great Basin College in support of Assembly Bill 45.

Exhibit I is a letter dated February 28, 2023, submitted by The Members of HOSA—Future Health Professionals of the University of Nevada, Reno, in support of Assembly Bill 45.

Exhibit J is a letter dated March 2, 2023, submitted by Patrick D. Kelly, President and CEO, Nevada Hospital Association, in support of Assembly Bill 45.

Exhibit K is an email dated March 1, 2023, submitted by Carissa Klarich, M.D., Private Citizen, Reno, Nevada, in support of Assembly Bill 45.

Exhibit L is a document titled "AB132—Creating Overdose Fatality Review Committee," presented by Assemblywoman Leslie Cohen, Assembly District No. 29, in support of Assembly Bill 132.

Exhibit M is a proposed conceptual amendment to Assembly Bill 132 presented by Assemblywoman Leslie Cohen, Assembly District No. 29.

Exhibit N is a proposed amendment to Assembly Bill 132 submitted by Jim Fleming, Private Citizen, Reno, Nevada.