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

Eighty-Second Session
March 24, 2023

The Committee on Health and Human Services was called to order by Chair Sarah Peters at 1:35 p.m. on Friday, March 24, 2023, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda [Exhibit A], the Attendance Roster [Exhibit B], and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/82nd2023.

COMMITTEE MEMBERS PRESENT:

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

COMMITTEE MEMBERS ABSENT:

Assemblyman Brian Hibbetts (excused)

GUEST LEGISLATORS PRESENT:

Assemblyman Howard Watts, Assembly District No. 15

STAFF MEMBERS PRESENT:

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

OTHERS PRESENT:

Brian Labus, Ph.D., Assistant Professor, School of Public Health, University of Nevada, Las Vegas
Scott Hamilton, Senior Director, ASSE International
Greg Esposito, Public Relations and Government Affairs Director, United Association of Plumbers, Pipefitters and Service Technicians, Local 525
Mandi L. Wilkins, Executive Vice President, Mechanical Contractors Association, Las Vegas; and Sheet Metal and Air Conditioner Contractors
Marc Ellis, President, Communication Workers of America, Local 9413
Susie Martinez, Executive Secretary-Treasurer, Nevada State AFL-CIO
Fran Almaraz, President, Nevada Silver Haired Legislative Forum
Matt Lydon, Business Manager, United Association of Plumbers, Pipefitters and Service Technicians, Local 525; and President, Nevada State Pipe Trades
Alfonso Lopez, representing International Association of Sheet Metal, Air, Rail and Transportation Workers, Local 88
Eduardo Zavala, Field Representative, International Union of Bricklayers and Allied Craftworkers, Local 13
Liz Sorenson, President, Nevada State AFL-CIO
Sue Bird, Private Citizen, Fernley, Nevada
Paul Catha, representing Culinary Workers Union, Local 226
Rita Weisshaar, Member, Nevada Alliance for Retired Americans
Marlene Lockard, representing Service Employees International Union, Local 1107
Joan Hall, representing Nevada Rural Hospital Partners
Jessica Ferrato, representing Fresenius Medical Care North America
Chris Ferrari, representing DaVita, Inc.
Brian Evans, representing Nevada Health Care Association
Blayne Osborn, representing Nevada Rural Hospital Partners
Izack Tenorio, representing Valley Health System of Hospitals
Amy Shogren, representing Nevada Hospital Association
Ted Owens, Executive Director of Governance, Incline Village Community Hospital
Barry Cole, Private Citizen, Reno, Nevada
Randy Soltero, Soltero Strategies, Las Vegas, Nevada
Christopher Ruch, Director of Education, National Energy Management Institute
Dion Abril, Executive Administrator, Western States Council, Sheet Metal, Air, Rail and Transportation Workers of California, Arizona, Nevada and Hawaii
Kent M. Ervin, Ph.D., State President, Nevada Faculty Alliance
Kathy Preston, Private Citizen
Arielle Edwards, Director, Government Relations, Nevada HAND

Chair Peters:
[Roll was taken. Committee rules and protocol were reviewed.] We will move on to our agenda. What is not on our agenda is a bill introduction, but this is the same as all our bill introductions. It does not obligate you to support the bill, but it allows us to introduce the bill on the floor. This is Bill Draft Request (BDR) 40-1057, which revises provisions governing

halfway houses for persons recovering from alcohol or other substance use disorders. I would now entertain a motion.

BDR 40-1057—Revises provisions governing halfway houses for persons recovering from alcohol or other substance use disorders. (Later introduced as Assembly Bill 403.)

ASSEMBLYWOMAN GONZÁLEZ MADE A MOTION TO INTRODUCE BDR 40-1057.

ASSEMBLYMAN NGUYEN SECONDED THE MOTION.

THE MOTION PASSED. (ASSEMBLYMEN GRAY AND HIBBETTS WERE ABSENT FOR THE VOTE.)

We are going to go in order on the agenda today. We have Assemblyman Watts here to present Assembly Bill 263, which enacts provisions relating to the transmission of Legionnaires' disease by building water systems in certain health care facilities.

Assembly Bill 263: Enacts provisions relating to the transmission of Legionnaires' disease by building water systems in certain health care facilities. (BDR 40-125)

Assemblyman Howard Watts, Assembly District No. 15:
It is my pleasure to present Assembly Bill 263 for your consideration today, which is aimed at reducing the transmission of Legionnaires' disease particularly among vulnerable populations in health care facilities. Joining me to help present the bill today and providing neutral expert testimony about Legionnaires' disease is Brian Labus with the University of Nevada, Las Vegas (UNLV) School of Public Health. Joining us by Zoom is Scott Hamilton, Senior Director of SSE International, and I am joined by Greg Esposito with the Nevada pipe trades. I am going to turn it over to Mr. Labus to provide a high-level overview of the issues we are seeking to address. After everyone is finished, I would be glad to answer any questions the Committee may have.

Brian Labus, Ph.D., Assistant Professor, School of Public Health, University of Nevada, Las Vegas:
I am an infectious disease epidemiologist and assistant professor of epidemiology and biostatistics at the UNLV School of Public Health. In 1976 there was a respiratory disease outbreak in Philadelphia. This was a new disease, and this outbreak resulted in 200 cases and 34 deaths. This was our first experience with what we would come to know as Legionnaires' disease—named because it occurred at the American Legion Convention. It took some time to figure out what was going on, but over the next 50 years, we developed ways to identify the bacterium, *Legionella pheumophila*, responsible for the disease. We could test patients for it, test the environment, and, as a result, we are able to treat patients and remediate the environment. Most importantly, we were able to find ways to prevent this disease.

Unfortunately, in those 50 years, we have seen cases and outbreaks of this disease all over the country and all over the world, including here in Nevada. Most recently, there was an outbreak on the [Las Vegas] Strip earlier this month. It is not something that is common by any means, but it is also not something that is rare. So, what is Legionnaires' disease? It is a respiratory infection that causes a high fever, cough, shortness of breath, muscle ache, and headache. For most patients, it progresses to a pneumonia fluid in the lungs and makes it very difficult to breathe. Ninety-five percent of the people infected with this disease wind up being hospitalized for it. About one out of eight people who get this disease die from it; however, the rate is actually one in four when you look at patients who acquire it in health care facilities. If somebody has underlying health problems and they get this disease, the death rate is very high. Eighty percent of the cases are in people older than 50 years of age, and 60 percent of the cases we see nationwide are in men. We also see higher risk of disease with people who have underlying lung problems—smokers, people with diseases like emphysema or chronic obstructive pulmonary disease (COPD), or those who have weakened immune systems either because of medications they are on or health problems such as cancer or diabetes. People in those groups are at higher risk of infection, and as a result, there is a higher risk of disease and death in that population. In 2022, there were 43 cases in Nevada, which does not sound like much, but the problem is this disease is vastly underreported. It is not something that is hard to identify if you are looking for it, but routine clinical testing does not regularly identify this disease, so you really have to be thinking that it is Legionnaires' and run the appropriate test to find it.

Most times, people are diagnosed with some sort of pneumonia, get treated with antibiotics, get better, and they never really figure out what it is. That is why we are concerned about this disease. Every case we find is the tip of the iceberg. *Nevada Administrative Code* (NAC) 441A.580 says that two cases connected to each other are sufficient to define an outbreak. We recognize there are a lot of cases we miss, so the numbers we see really do not tell the true story. The other problem we have is that hotel casino outbreaks tend to grab the headlines, which also gives us a misleading picture of this disease. If you look nationwide, about 15 percent of all Legionnaires' cases identified are associated with travel and typical stays in hotels—not just in Las Vegas or Reno, but around the world and around the country. Twenty percent of the cases—more than we see with travel—are associated with health care—either hospitals or long-term care facilities. As I said, the death rate of cases acquired in those places is double what we see in general for this disease.

Where does this organism come from? It is everywhere in the environment. We find it all around us all the time. If you go home and test your faucets, you may find this organism. That does not mean you are going to be at risk for disease; however, when the organism gets a foothold, it can multiply and get to levels that can lead to disease. When you turn the shower on, that water comes through the pipe and kicks up whatever bacteria is there and aerosolizes it. You breathe it in, and that is how you wind up being infected. We see it in things like swimming pools, decorative fountains, cooling towers, misters, hot tubs, but also in the potable water system itself. We also have issues potentially with heating, ventilation, and air-conditioning (HVAC) systems depending on how they are designed. That is the way

the outbreak in Philadelphia in 1976 occurred. It was the water that was being used as part of the air-conditioning system.

The big challenge for us here in Nevada is the temperature of water. *Legionella* does best between 77 and 108 degrees. Our hot water systems are usually not above 108 degrees because it is dangerous; you do not want somebody to get burned. But in the summertime, it is difficult to get cold water out of your tap, because everything is warmer when you are in the middle of a desert. So, that is one big challenge for this disease and can be more of an issue in Nevada, but it really is an issue nationwide. However, this disease is preventable. Prompt identification of cases and investigation of those cases and clusters allow us to prevent additional people getting sick. What we want to do is prevent the disease in the first place, and that comes down to the environmental and mechanical systems we use in our buildings to get us water and keep us comfortable. Proper design, installation, and maintenance of those systems is necessary to prevent this disease. In most places, it requires putting in some sort of comprehensive water management program that involves not only the appropriate design of these systems but regular testing and maintenance of the systems to ensure they function the way they were designed. Those programs need to follow national standards which are well developed, are used throughout the country, and allow us to prevent these sorts of things. Regular maintenance and testing allow us to quickly identify problems and remediate them in the facilities. That is what the bill in front of you today is talking about—water management programs that go toward preventing disease, especially in high-risk settings such as health care facilities where we know people have underlying health problems that lead to greater risk of infection and, unfortunately, greater risk of death.

Assemblyman Watts:
Next, we will move to Mr. Hamilton on Zoom to provide some additional detail. This bill aims to take a first step in trying to eliminate Legionnaires' disease by focusing on the vulnerable populations in health care facilities.

Scott Hamilton, Senior Director, ASSE International:
[Supplemental information concerning ASSE International was submitted, Exhibit C.] As the Committee deliberates this important legislation, I wish to serve as a technical resource to answer any questions you may have. Assembly Bill 263 pertains to the health and safety of the immunocompromised, health care workers, facility visitors, and also the workers performing the water quality tasks. For context and background, the organization I am representing, ASSE International, is a renowned ANSI [American National Standards Institute]-accredited standards development organization in the mechanical and plumbing industries that has been providing technical assistance to model code bodies and government since 1906. ASSE International has developed standards and certification programs which have been adopted by facilities for decades, such as the ASSE 6000 for medical gas installation and the ASSE 5000 backflow testing and repair. ASSE's water quality expertise has been utilized extensively by numerous state and local governments, including those in New Jersey, due to the high quality of standards it publishes. Along with industry, ASSE developed the ASSE 12000 certifications in response to the growing threats to U.S. water quality that have been emerging in recent years. The legislation before you today seeks to

include the ASSE 12000 certification in order to reduce the presence of *Legionella*. On June 2, 2017, the Centers for Medicare and Medicaid Services (CMS) released a mandate requiring that all certified Medicare and Medicaid facilities have water management plans that meet American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) 188 industry standards to reduce the risk of *Legionella*. The ASHRAE 188 Standard provides minimum *Legionella* risk management strategies for the design, construction, commissioning, operation, maintenance, repair, replacement, and expansion of new and existing buildings and their associated pipe systems and components.

The standard informs the facility what should be done. The Centers for Disease Control and Prevention (CDC) produced a toolkit for building owners and facility managers. The CDC toolkit aims to provide an easy-to-understand interpretation of ASHRAE Standard 188 to help building owners and managers evaluate the water systems and devices in their buildings to see if they need a program, and then develop an effective water management program. All mechanical fire protection potable water systems are required to be mapped, assessed, monitored, controlled, verified, and documented to ensure compliance. Again, the CDC toolkit informs the facility what should be done. The ASHRAE 188 Standard offers an integral part of the solution needed to protect water safety by establishing vital criteria and procedures to combat *Legionella* risk. However, an additional component is needed in this strategy, a requirement that such programs be administered by persons with requisite technical qualifications to do this work properly. This is essential given the highly complex and challenging nature of modern water systems and the lethal threat posed by *Legionella*. In 2018, the industry approached ASSE and together through the open consensus ANSI-accredited process, the ASSE series 12000 Water Management infection control risk assessment for building systems was developed. The standard was developed to cover all water quality issues including chemicals, metals, and bacteria like *Legionella*.

The design and implementation of water management plans, or WMPs, under ASHRAE 188 involve highly complex, sophisticated operations. Specifically, the development of reliable water management plans requires in-depth knowledge of all water structures and systems as well as specialized skills required for building surveys, including sampling procedures, detection of hazardous conditions, system monitoring, and incident response. In addition, persons responsible for these programs must have sufficient training needed to identify, assess, and prioritize water quality risks wherever they may exist in a given system. They must also possess requisite expertise and skills for implementing corrective actions and control measures when hazardous conditions are found and have the capabilities to modify piping, fixtures, or other system components to prevent hazardous conditions from occurring in the first place. Unless clear qualification standards are established for persons responsible for water management plans, these programs can easily fail or have only marginal impact results, which are unacceptable when battling a fatal disease.

Unfortunately, one can find examples of *Legionella* and other bacterial outbreaks which might have been avoided utilizing individuals certified to ASSE 12000 water management teams. One example I want to share with the Committee is an incident that took place in a nursing home in western Wisconsin. The facility has been in operation for years. In 2020,

residents of the facility contracted *Legionella*. Due to limited resources, they called their local mechanical contractor. Fortunately, that contractor and its employees were certified to the ASSE water quality standards series 12000. Because that type of facility cannot evacuate its residents, the contractor, through training, knew the most effective way to stop the spread. These ASSE-certified professionals installed point-of-use filters on all potential harmful outlets as well as tested various personnel in the facility to identify infective locations and began an investigation. It is important not only to mitigate the bacteria, but also know the reason for its growth. They found that the maintenance personnel, in an attempt to save energy and costs, shut down the hot water circulating pump at night when everyone was sleeping and turned it back on in the morning. It was determined that this was the action that allowed for *Legionella* growth. The contractor worked with the facility to mitigate the bacteria and set up a management plan which included sampling and testing.

The last example also occurred in 2020 at Brigham and Women's Hospital in Boston where the facility saw a number of infections and three patient deaths from bacteria. The hospital sampled cultures from sink showers of each of the rooms occupied by the patients, but the bacteria levels were nonexistent or too low, ruling out that as the likely source. Experts did find high levels of bacteria from ice and water machine samples on the cardiac surgery intensive care unit, but records showed that the machines had been cleaned and maintained properly. Further testing revealed that the chlorine levels and problematic units were undetectable due to a commercial water purification system the hospital had installed in the plumbing lines leading to these units. The filter included a carbon filter and UV [ultraviolet] irradiation unit, both of which decreased chlorination concentrations. These systems were designed to improve the taste, odor, and purity of the water, but allowed bacteria normally killed off by chlorine to proliferate.

In closing, there is no question that ASHRAE 188 is viewed as the gold standard for water quality management. ASSE recognized this and, with industry, designed the ASSE 12000 series to establish appropriate skill standards for persons responsible for implementing water management plans under ASHRAE 188. ASHRAE 188 and ASSE 12000 are both vital to securing safe water quality and protecting public safety. Contractors and technicians install, maintain, and service the facility water systems. With the training and ASSE 12000 certification, they can play a vital role in facilities' water management teams and provide the technicians and tools necessary to incorporate facilities' water management plans.

Assemblyman Watts:
Mr. Esposito will walk through the sections of the amendment [Exhibit D.] There is some significant streamlining of the language, and that is what Mr. Esposito will be going through.

Greg Esposito, Public Relations and Government Affairs Director, United Association of Plumbers, Pipefitters and Service Technicians, Local 525:
[Greg Esposito also submitted background material Exhibit E.] Going through the bill, sections 2 through 8 are definitions. Section 4 has a lot of strikethroughs and eliminates the calling out of different systems. Section 5 talks about where immunocompromised people might be. It calls out very specific conditions and diseases we feel are important to leave in

because the intent of the bill is to make sure all patients in hospitals are safe. In section 5, we added subsection 4, which is intended to include senior living facilities, because, as you heard earlier, they are at high risk of contracting Legionnaires' disease if their water systems are infected.

Section 9 is the real intent of the bill. What section 9 says is a health care facility has to have a person on their water management team who is certified in ASSE 12060 or 12080. That results in about 28 hours' worth of training. It does not have to be per facility; it states that a health care facility has to have a team in place—a person who knows what they are doing. That is the intent of this bill. Further, in section 9, more or less all of subsection 3 is crossed out. That was where we had detailed where the sampling needs to happen. It was redundant because ASHRAE 188 is already in place. All of section 10 regarding cooling towers is eliminated because it is covered in ASHRAE 188.

Sections 11, 12, and 13 are reporting requirements. As you heard from Brian Labus, Legionnaires' disease cases are underreported. Sections 11, 12, and 13 create standards where if a health care facility does find there is an outbreak, they need to report it to the State Board of Health. Section 14 talks about the penalty for not following this standard. The most important change in this bill is a January 1, 2025, implementation date, which is 18 months after the end of this legislative session. The reason for the change is to give plenty of time for the training to be put into place—the training to be spread throughout Nevada—this way, people who are qualified can get the training they need and meet the obligations of the law.

Chair Peters:
There are a couple of questions from Committee members.

Assemblyman Hafen:
We started out saying that this problem arose in 1976 in Pennsylvania at a facility. My understanding is that the CDC and CMS put into place requirements for these health care facilities to address Legionnaires' disease, including the water management plans you are talking about as well as testing. I am curious. Is it that we do not trust the CDC, or are we trying to address a different problem?

Assemblyman Watts:
Standards have been adopted by CMS for what has to be done, but one of the things that has recently been adopted is certification to make sure that the expertise is in place for individuals developing that. There is a plan, and it has to have certain things. You heard about the complexities in some of these water systems, so even though there may in general be a plan, there have been some recent cases where despite that there have still been outbreaks. This makes sure somebody has the training to thoroughly identify and mitigate potential risks involved in developing a plan. So, in short, yes, we do trust the framework that has been adopted, but this is to make sure the extensive training and expertise will go into the development of those plans.

Assemblyman Hafen:
As you know, I am a licensed water operator in the state of Nevada, and I go through the whole certification process. Why are we developing a new process for testing and everything else when it comes to water quality rather than just adopting the current standards and training currently in statute for these additional facilities?

Assemblyman Watts:
I will ask Mr. Hamilton to provide some additional context, but it is important to differentiate between the standards for what has to happen and the standards and training for who would be doing it. Mr. Hamilton, would you like to provide some additional context?

Scott Hamilton:
To recap, ASHRAE created and developed the 188 Standard for health care facilities. Actually, it is for any facility, except for a single-family residence, to help them mitigate the risk of *Legionella*, but it tells you what has to be done, what should be done, and it leaves it up to the facilities to incorporate it with the resources on hand. If you want to break ASHRAE 188 down to the simplest terms, it says you have to have a water management team. It could be 1 person; it could be 10 people; it could be 100 people, but you have to have a team, and they have to have a program in place. That program could be to test the water once a year. That is all our resources allow. The problem is, ASHRAE 188 is great and the testing procedures we have are good, but we need another person, the people who work on these systems, who installed these systems, and service and maintain these systems are not necessarily the people who know when you change these systems, a reaction can take place downstream. Unfortunately, the plumbers and everybody else who install these systems do not have that type of training. They are not familiar with ASHRAE 188 and everything that goes beyond it.

With ASSE 12000 we go beyond *Legionella*, we also cover lead and PFAs [perfluoroalkyl] substances and PFOs [perfluoro-1-octanesulfonic acid] in the training and certification. That is why the industry identified a gap between ASHRAE 188 and the training of those who are installing and maintaining these systems. The training we have had for hundreds of years is insufficient. We need extra training and some kind of certification to prove to the end users and to the facilities that these people working on their water management teams have the working knowledge to be able to protect the occupants of that building no differently than in the 1990s with the hospitals. The NFPA [National Fire Protection Association] 99 standard was how to install medical gas systems, but up until the mid-1990s, there were a lot of cross connections. A lot of people were seriously hurt or died from improper medical gas installations. At that point, the industry came to ASSE and asked it to develop ASSE 6000 for medical gas installers. Since then, those casualty numbers dropped off to next to nothing. Those who had incidents subsequent to ASSE 6000 used people who were not certified and trained.

A number of *Legionella* cases take place in nursing homes and hospitals even though ASHRAE 188 is in place and management teams are in place, but there is a piece missing because there are still outbreaks. The missing piece is having the contractors and technicians

trained and certified. They can help and assist on water management teams and provide possible solutions—not just test and sample, which is the easy part—but understanding where the bacteria may be growing, why it may be growing, and stopping it. If they do what they are supposed to do, sampling and testing are going to show negative every single time because they are on top of their game on the first part of the system; sampling and negative testing results validate everything they are doing is working.

Assemblywoman Thomas:
Thank you for this legislation. It is important for our community, especially if we are going to use it in nursing homes. This is a community that cannot help itself, and for us to do anything to help them is great. I have questions regarding section 9, subsection 4, paragraph (b). I have heard standards and pieces are missing, and I am looking at stopgap measures that can be attained. Looking at line seven, it says the owner or operator shall maintain records of the water management program and all sampling details and results for at least 3 years. Such records must be made available for inspection by the Board or health authority upon request. "Upon request" troubles me. If you have a team looking at your water treatment plant and measuring to see if any bacteria is growing, and you want to see if *Legionella* is in your system, if you are not recording that on a continuous basis—once a month or however the standards tell you to do it—and recording it; and you are allowing the facility manager to say in a report, Yes, I did this. or Yes, this was done, I do not believe that is a good stopgap measure because you would have to rely on whether this is actually happening.

Assemblyman Watts:
We are trying to make sure the data is available. In section 11 of the bill, if there is a positive test, it has to be reported immediately. That is a requirement that would trigger getting the health authorities involved and proactively checking out the rest of the records. One of the things we are trying to do is balance this with the length of time that records need to be kept. We do not want to inundate the health agencies with a lot of negative test results, but make sure that is there. To your point, if something happens to pop up, that will trigger a look back. If there are any discrepancies or missing records, that could trigger some of the penalties included in the bill. The goal, as Mr. Hamilton discussed with medical gases, is once we have this whole picture together and this framework set up, just one of those incidents is going to be enough to show that anyone who tries to skirt the intent of the law will end up in trouble if something happened. That is the way the information reporting is envisioned.

Assemblywoman Thomas:
I appreciate your answer, but I hope you would look at it again and consider the stopgap measure because it is so important to the community you are trying to serve. If you do not have something in there in the beginning and you say you are going to have it at the end, what if something happens, how do you measure something that happened in the beginning? It could go months, even years, until you get a positive and you have no data to back you up. That is all I am saying.

Assemblyman Watts:
Another thing I should mention is that this is based on the capacity of the different health care agencies. The purpose of "upon request" is that it will allow random audits or inspections. They could go to facilities and say, We would like to see your records and what you are doing. That is a scenario where everything could be aboveboard, but if somebody is not keeping up with the testing and the water management plan outlined in the bill, it would be caught.

Assemblywoman Newby:
My question is for Dr. Labus. We have talked about the deaths that have resulted from Legionnaires' disease in some of these facilities, but what are some of the symptoms of this disease and what happens when someone contracts it and does not die, are there long-term effects?

Brian Labus:
For most people, it takes a while for them to recover. It is not like you get the flu, and you are better a week later. People can have all sorts of issues that go on for months until they really get over it because this is quite a debilitating illness for the people and the health care facilities. You are talking about somebody who might have had heart surgery or something like that or is being treated for cancer, and then we add this on top of it. It is hard to say what those long-term effects are because you are taking medically fragile people and adding a bad disease on top of it. It can be months before a person really feels back to normal because it takes so long to recover. It is not something that is known to cause a disease condition for the rest of your life. It is not like we talk about long COVID where a couple of years later, people are still dealing with it. Once you get over it, you can go back to normal, but it is a debilitating disease to have because it is pneumonia, you cannot breathe, and it takes quite a while to get over it.

Chair Peters:
I had a similar question related to the exposure. Can you explain what the exposure effect is? How long is it; is it acute; is it long-term exposure? What concentrations of the bacteria are we concerned about?

Brian Labus:
Within a couple of weeks of being exposed, you will get sick. That is why we see so many travel-associated cases. It is people who visit a hotel, stay there for a couple of nights, and are exposed to the disease in that situation. For hospital stays, it does not have to be a very long stay. You could be there overnight, and that would be sufficient exposure for you to get sick. It comes down to the concentration of the bacteria in the pipes that is getting kicked into the air. If you have a small exposure, it may not be enough to cause disease, but a large enough exposure, even a single time, is enough to make somebody sick. This is not a chronic buildup of a problem over time. It is really an acute exposure. People get an acute disease, think of it like COVID-19, the flu, or other infectious diseases we deal with. You get exposed and you get sick. The difference is *Legionella* does not spread from person to person. It is always an environmental exposure, so you can treat *Legionella* patients, and it is

not going to put you at risk of disease. But if the problem is in the room to begin with, you are going in there and breathing that same air, and you would be exposed to that environmental source just like the patients were.

Assemblyman Gray:
Thank you, Mr. Esposito, for coming by my office to discuss this. I appreciate that. You mentioned that the most recent outbreak was down on the Strip. I was looking at this as a nosocomial infection until I remembered that it is a headwaters issue or a source water issue. Why are you attacking it at the hospital or facility as opposed to going where the disease is coming from and preventing it from getting into the entire water system to begin with?

Assemblyman Watts:
Particularly in southern Nevada and in our urban communities, we have rigorous water treatment standards. But as was noted, chlorine and some of those other disinfectants can break down over time, and water can sit there over time. There might be other filtration systems at different points along the distribution path that remove some of those things, but my understanding is that a lot of our major water systems are putting out water that is not free of those bacteria. As it gets further along the pathway and into some of these situations where it no longer sits there, that allows the bacteria to grow.

We wanted to focus this on where some of the most vulnerable people are and where getting this could have extremely serious repercussions. It is the first area we want to home in on in addressing this issue. I want to note we have been in conversations with different health care facilities and providers to listen to their concerns. Those conversations are ongoing, and we appreciate their feedback.

Chair Peters:
Are there other questions from Committee members? [There were none.] We will move into support testimony in our physical locations and then move to the phones. Please remember to state your name for the record. If you are in the physical locations, you do not necessarily have to spell your name because we should have it. But on the phones, I will ask you to spell your name.

Mandi L. Wilkins, Executive Vice President, Mechanical Contractors Association, Las Vegas; and Southern Nevada Sheet Metal and Air Conditioner Contractors:
I am here to lend our support to the amended version of this bill.

Marc Ellis, President, Communication Workers of America, Local 9413:
On behalf of our close to 700 members who work at Saint Mary's Hospital and our retirees, we are in full support of this bill.

Susie Martinez, Executive Secretary-Treasurer, Nevada State AFL-CIO:
On behalf of over 150,000 members and 120 unions, we are in full support of A.B. 263. It is vital that we take measured steps to ensure our health care facilities are safe not only where people receive the care and attention they need, but also a "workplace" for thousands of

people across the state. Stronger regulations concerning water management plants will not only ensure that patients are protected, but that health care workers are safe in their day-to-day jobs. I would like to thank Assemblyman Watts for bringing this bill forward, and I urge the Committee to please support Assembly Bill 263.

Fran Almaraz, President, Nevada Silver Haired Legislative Forum:
We meet to discuss issues that affect seniors. This issue affects seniors, and I ask for your support on this bill. Seniors are very vulnerable, and this disease is deadly to them. Please think about how this bill will help them, especially if they have other issues, because this disease makes their other issues deadly. So please, I ask your support for this bill.

Matt Lydon, Business Manager, United Association of Plumbers, Pipefitters and Service Technicians, Local 525; and President, Nevada State Pipe Trades:
We stand in support of this bill. We appreciate your consideration and thank you.

Alfonso Lopez, representing Sheet Metal Workers and Rail Transportation Workers, Local 88:
We stand in full support of Assembly Bill 263.

Eduardo Zavala, Field Representative, International Union of Bricklayers and Allied Craftworkers, Local 13:
I represent the bricklayers' union in Nevada. I am here in full support of Assembly Bill 263 and ask the Committee to support it as well.

Chair Peters:
Is there anyone on the public line who would like to provide support testimony on A.B. 263?

Liz Sorenson, President, Nevada State AFL-CIO:
I am here in full support of Assembly Bill 263, and I urge the Committee to support the bill as well.

Sue Bird, Private Citizen, Fernley, Nevada:
I am here in full support of Assembly Bill 263. I urge the Committee to please support this bill as well. I support this legislation because it will keep both patients and health care workers safe by implementing stricter regulations to prevent the spread of Legionnaires' disease and possibly some other ones. I am in my seventh decade. Others in my age group make up a large portion of hospital beds. I am more susceptible to diseases of my lungs, and if I lose my lungs, I am not able to keep myself as healthy as I would like to be. So, please, support this bill and protect our seniors. It is very important to be preventative for our health.

Paul Catha, representing Culinary Workers Union, Local 226:
We support A.B. 263, and we urge the Committee to support and pass the bill as well.

Rita Weisshaar, Member, Nevada Alliance for Retired Americans:
I am in full support of Assembly Bill 263, and I urge the Committee to support it as well.

Marlene Lockard, representing Service Employees International Union, Local 1107:
We are in support of A.B. 263 and urge your support.

Chair Peters:
Are there other callers in support? [There were none.] We will move into opposition testimony. If you would like to testify in opposition to Assembly Bill 263, please come up to the tables and we will get started.

Joan Hall, representing Nevada Rural Hospital Partners:
I appreciate Mr. Esposito talking with me yesterday and giving me a draft of the amendments. That gave us a little better feeling. To our members, safety is very important. We have water management teams, but I am not sure any of our team members meet these criteria for certification. I have looked at it, and in the rural areas, it may be difficult, so I look forward to working with Mr. Esposito to look for solutions.

Jessica Ferrato, representing Fresenius Medical Care North America:
Fresenius Medical Care is in respectful opposition to the bill. I want to start out by talking about dialysis patients. Patients in dialysis clinics have low exposure to Legionnaires' due to the processes in place and the minimum hours they are in a clinic. Most patients are in clinics 3 to 4 hours a day and not for 24-hour periods. In addition, they are there three to four days a week. Dialysis requires heavy use of water. Fresenius clinics have very elaborate water cleaning systems done by their biomass-certified biomedical teams, and filtration systems that provide the quality and safety required for these treatments. Renal dialysis facilities are included in ASHRAE 188 Standard which is referenced throughout this bill. These standards are already factored into all our facilities, and as our facilities are set up, certified ASHRAE employees built the facility when first purchased and rented as well as review and maintenance done on a regular basis in the facilities. Fresenius also follows recommendations by the CDC *Legionella* toolkit. This bill would create an onerous program for each one of our facilities to have to implement and monitor on an ongoing basis. Our number one priority is patient care and safety, and we provide critical care for our patients. Dialysis facilities are complying with safety standards and mitigating the already-low risk for our patients and our facilities.

Chris Ferrari, representing DaVita, Inc.:
We are also here in respectful opposition. I want to thank the sponsor and the proponents for communicating with us on this matter, and we are continuing these conversations. DaVita serves nearly 3,000 Nevadans through its 49 clinics statewide. We go into rural areas as well, including Churchill, Elko, Humboldt, Nye, and White Pine Counties. Based on our review of A.B. 263 as amended—the version we are looking at today—we want to put on the record that we may be seeking an exemption as it appears that the medical water systems in use at our dialysis facilities already meet or exceed requirements contained in the bill. I also want to put on the record that we do not have showers and there is nothing overnight—a couple of those items were mentioned during proponent testimony.

In dialysis, as Ms. Ferrato indicated, water quality is critical, so we are very much in support of water quality, especially when it comes to treating the most vulnerable. In doing so, there are very precise specifications that must be met. The systems we use in our outpatient clinics are designed and maintained to provide a chemical and microbial quality defined in Association for the Advancement of Medical Instrumentation ISO 23550. This certification is sanctioned by the FDA [Food and Drug Administration], CMS, and CDC to define the physical quality and quality monitoring required to provide hemodialysis treatments for the U.S. end-stage renal disease population. Again, we are in gentle opposition and will continue to work with the sponsor and proponents and appreciate the Committee's time today.

Brian Evans, representing Nevada Health Care Association:
[Supplemental information was provided by the Nevada Health Care Association, Exhibit F.] The Nevada Health Care Association represents assisted living and skilled nursing facilities throughout the state. We thank the sponsor for working with us and hearing some of our concerns. I just want to note that 20 cases in Clark County and 1 case in Washoe County a year is the average from all reported cases, not just from medical facilities. So, I want to mention the incidence is not as high as we would think, but it is something we support. We want to make sure our water systems are safe, but I want to let everyone know that is the number of cases we see on average in the state of Nevada.

Chair Peters:
Are there other people in opposition in Carson City or Las Vegas? [There were none.] Would you check the public lines for opposition testimony on Assembly Bill 263? [There was none.]

[Exhibit G, a letter in opposition to A.B. 263, was submitted but not discussed and will become part of the record.]

We will move to neutral testimony on Assembly Bill 263. [There was none.] Do the bill sponsors have closing remarks? They are waiving closing remarks.

We will close the hearing on Assembly Bill 263 and move on to our next bill.

I will open the hearing for Assembly Bill 277, which establishes provisions governing rural emergency hospitals. Assemblyman Koenig will be presenting today.

Assembly Bill 277: Establishes provisions governing rural emergency hospitals. (BDR 40-637)

Assemblyman Gregory Koenig, Assembly District No. 38:
I am pleased to come before you today to present Assembly Bill 277, which is seeking to establish rural emergency hospitals in our state. It is an honor to be able to discuss a topic that is close to my heart and of great importance to our health care landscape: The struggles of rural hospitals in Nevada and across the country, and how the establishment of a new Medicaid provider type—the rural emergency hospital—can make a difference in providing

essential health care in underserved rural areas. Rural hospitals in Nevada and throughout the nation are facing a crisis. In recent years, many of these facilities have struggled to maintain their operations and meet the needs of their communities. The consequences of the struggles are far reaching. When rural hospitals close, communities lose access to essential health care services such as emergency care, primary care, and behavioral health services. This can lead to long travel times to access care, worsening health outcomes, and the exacerbation of existing disparities in health equity between rural and urban Nevada. It is a domino effect that impacts the entire community, from the families who rely on these hospitals for care to the health care professionals who lose their jobs and the local economies that suffer.

Recognizing the urgent need to address this crisis, the Centers for Medicare and Medicaid Services (CMS) has created a new provider type, the "rural emergency hospital" which has been available since the beginning of January of this year. This innovative concept aims to support rural health care by creating a specialized hospital type that caters to the unique needs of rural communities. According to CMS, the designation may help certain rural hospitals avert potential closure and continue to provide essential services for the communities they serve. Rural emergency hospitals focus on providing access to emergency services, observation care, and additional medical and outpatient services. These facilities can help bridge the gap in health care in rural areas. Implementing this new provider type will require the support and collaboration of various stakeholders including us, the policymakers. We must work together to create an environment that enables the success of rural emergency hospitals, ensuring they receive the resources and recognition they need to thrive. We, the Legislature, can further contribute by authorizing Nevada Medicaid to seek additional federal funds to increase reimbursement rates for rural emergency hospitals. With that, Chair Peters, I would like to turn the time over to Blayne Osborn from Nevada Rural Hospital Partners to explain the bill.

Blayne Osborn, representing Nevada Rural Hospital Partners:
I want to thank you for hearing A.B. 277 today and thank Assemblyman Koenig for sponsoring the bill and for all of you who have signed on to it as well. This is an exciting bill for us because, as you heard, this is a brand-new type of hospital designation from CMS, and this is an instance where Nevada gets to be proactive and not behind the eight ball. This is a new tool in the toolbox to keep rural hospitals open and in their communities. We have provided the Committee with a Medicare learning network fact sheet on what rural emergency hospitals are [Exhibit H]. You are going to hear me refer to rural emergency hospitals as "REH" because it is a little bit shorter. I want to stress a couple of points on what an REH is first. An REH is not a freestanding emergency department, and we are not going to have them popping up all across the state. To become an REH, you have to already be licensed as a critical access hospital or a small rural hospital with fewer than 50 beds. In total, we only have 13 of those in the state that could qualify for this. If you are one of those hospitals and you are struggling financially to stay open or if you do not have enough inpatient missions, this lets you close your inpatient unit and keep your hospital open. That means you must keep your emergency department and your outpatient services like lab and imaging, and you can keep any distinct part units like long-term care, psych, or rehab. You

must meet the same conditions of participation including having a transfer agreement in effect with trauma centers. You have to meet certain staffing requirements, meet certain quality measures, et cetera. On the bottom of the fact sheet it discusses meeting certain licensure requirements, including being located in a state that provides for licensing for such hospitals under state or local law, be licensed under such law, and approved by the state or local agency as meeting the standards for such licensure. That is what we are trying to do with A.B. 277.

Even though this designation just went live two months ago in January 2023, seven states have already passed similar bills licensing REHs. The National Council of State Legislatures has a great Web page with links to all of the laws. Each year, we have about 25 percent of our critical access hospitals operating in the red, and although no rural hospitals have closed in Nevada since 2015 when Tonopah closed, this is a wonderful option in comparison to closing your hospital. We have all seen the devastation that can occur when a hospital is forced to close. This has the ability to keep hospitals open and operating in our rural communities. With that, I would appreciate your consideration of A.B. 277 and would happily take any questions.

Assemblyman Koenig:
I talked to some people from Tonopah. They feel if this had been in place in 2015 when they had to shut down—mostly for financial reasons—they would still be up and running today.

Chair Peters:
Thank you for the presentation. Are there questions from the Committee?

Assemblyman Gray:
Will it encourage some of these hospitals running in the red to close down? That is concerning. I love the idea, and thank you for bringing this, but I am concerned that there may be a dearth of other specialties.

Blayne Osborn:
That is a great question. Recognize that this is not a situation any of our rural hospitals want to find themselves in. Again, this is another option to be able to keep your hospital open.

Assemblyman Koenig:
Instead of encouraging them to close, this is a mechanism to help them be able to stay open.

Assemblywoman Newby:
Thank you, Assemblyman Koenig, for bringing this bill. It is a great idea. When you spoke of this allowing inpatient beds to close, is that considered a permanent closure or a temporary one? If you did not have any patients, could you close it for a week or a period of time, and then if somebody comes in and needs it, you could open it back up?

Blayne Osborn:
Yes, that is a more permanent closure than a temporary one; however, CMS does have a process in place that if the hospital's finances improved, they could convert back to a critical access hospital. Those conversions are not necessarily easy or quick, but there is a process in place for that to occur.

Chair Peters:
Are there other questions? [There were none.] We will go ahead into support testimony on Assembly Bill 277.

Izack Tenorio, representing Valley Health System of Hospitals:
Valley Health System of Hospitals includes Desert View Hospital, a critical access hospital in Pahrump. We urge the Committee to support this important piece of legislation. Our rural communities need the ability to provide these critical emergency crisis services, and we thank you for your time.

Amy Shogren, representing Nevada Hospital Association:
Hospitals, as you know, are facing many challenges in the current environment, especially our rural hospitals. We need to provide them with every option available to preserve health care services in the communities they serve.

Ted Owens, Executive Director of Governance, Incline Village Community Hospital:
Incline Village Community Hospital is a small, four-bed, critical access hospital. The importance of this designation, just a nuance, is the requalification as a critical access hospital can be challenging for small rural hospitals. One of those situations might be in our case; if we do not have two patients in two of our four beds on the day of the survey, our designation might be at issue. This designation is important because it gives some rural hospitals the ability to use this designation, which more accurately reflects how they operate anyway. They may stay as a critical access hospital or they may choose. The other benefit, of course, is maintenance of reimbursement rates because Medicare and Medicaid are very important to rural hospitals. It helps them stay alive financially. So, I came today to urge strong support on A.B. 277.

Fran Almaraz, President, Nevada Silver Haired Legislative Forum:
On behalf of the Forum and the many seniors throughout the state we serve, I am strongly in support of this bill and ask you to please move it forward.

Marc Ellis, President, Communication Workers of America, Local 9413:
On behalf of many of my members who work in the rurals, including me, we are in strong support of this bill.

Alfonso Lopez, representing International Association of Sheet Metal, Air, Rail and Transportation Workers, Local 88:
I represent the Sheet Metal, Air, Rail and Transportation Workers Union, Local 88, and we are also in full support of A.B. 277.

Chair Peters:
Seeing no one else coming up to the table in Carson City or in Las Vegas, we will move to the phones. Is there anyone on the public line with support testimony for Assembly Bill 277?

Sue Bird, Private Citizen, Fernley, Nevada:
Living in a rural area, it is very important to keep our rural clinics open. I had an incident several years ago—a terrible reaction to a vaccination for pneumonia. My arms swelled and my hands constricted almost into a ball. When I called Renown, I was told I would have to go to Reno, but I live in Fernley. They told me to get there as soon as I could, but if I stopped breathing along the way, to get an ambulance. However, there would be no way for an ambulance to find me on Interstate 80. So, we need these rural hospitals for emergencies, not only for cost savings but to save lives. Thank you, and please support this bill.

Rita Weisshaar, Member, Nevada Alliance for Retired Americans:
I am here in full support of A.B. 277 and urge the Committee to support it as well.

Chair Peters:
Is there anyone else testifying in support of Assembly Bill 277? [There was no one.] Is there anyone who would like to provide opposition testimony on Assembly Bill 277? [There was no one.] We will move on to neutral testimony. Is there anyone who would like to provide neutral testimony?

Barry Cole, Private Citizen, Reno, Nevada:
This is fascinating. I do not feel I have all the details. I am not in opposition, but what troubles me is that I used to be an emergency room doctor in a little town that was in between two freeways, so all kinds of trauma came to me. When I drive from here to Las Vegas, I get into a panic when I clear Hawthorne and am approaching Tonopah/Goldfield and I am thinking there is no more medical care until I get to Las Vegas.

To operate one of these, and I am looking at the fact sheets, what are the equipment needs? Who is going to be staffing this facility? To be open 24/7, to provide emergency care, will require at a minimum an X-ray unit of some kind and a CT [computed tomography]. You do not need an MRI [magnetic resonance imaging], but you need a lab, and you need lab techs to run the tests during the night and day. We will need nurses and at the least a physician or nurse practitioner trained in emergency medicine. While I appreciate A.B. 277 as a way to save rural health care, and I know how critical this can be, I am not sure who is regulating this. Will this be under the Joint Commission or other accreditation standards?

Emergency rooms are very good for hospitals to help them make their bottom line. At the same time, they require a fair amount of equipment and around-the-clock staffing that will have to be considered. That is the part that leaves me neutral. I wish I understood more of this than the basic fact sheet. At the end we can ask the sponsors to fill in a couple of details.

Chair Peters:
That is one of the complications of how we bifurcate some of the information available through the fiscal notes and the policy committees. There is a fiscal note from the Division of Public and Behavioral Health [Department of Health and Human Services] for that licensing process. They would develop those licensures, but that will be discussed in detail.

Are there other folks who would like to provide neutral testimony on Assembly Bill 277? [There was no one.] I would invite the bill sponsor for closing remarks.

Assemblyman Koenig:
I just want to say this is good for my rural constituents, this is good for the rural hospitals, and this is good for Nevada.

Chair Peters:
Thank you so much for bringing the bill. Before I close the hearing, Assemblyman Gray had a comment he wanted to make.

Assemblyman Gray:
I wanted to thank Assemblyman Koenig and Blayne Osborn from Nevada Rural Hospital Partners. I am sure you know the rural communities are in dire straits when it comes to medical care and its availability. I would urge you in this Committee to move this along as quickly as possible to a work session so we can get this through because this is something we really need to do to stabilize health care in our communities.

Chair Peters:
We will close the hearing on Assembly Bill 277 and open the hearing on Assembly Bill 281 which revises provisions governing senior living facilities. Assemblywoman Gorelow will present this bill.

Assembly Bill 281: Revises provisions governing senior living facilities. (BDR 40-457)

Assemblywoman Michelle Gorelow, Assembly District No. 35:
This bill sets forth specific provisions outlining the assessment and standards of air filtration systems in senior living facilities to ensure the best possible air quality for seniors in Nevada. There are many factors that can impact the air quality in senior living facilities. One we must be familiar with is COVID, but that is not the only airborne concern. There is also tuberculosis, meningitis, measles, and the flu to name a few. There are also environmental factors that can affect air quality in senior living facilities. We might remember the fires that caused so much smoke and pollution in the air. Wildfire smoke is composed of a mixture of gases, pollutants—including carbon monoxide—and hazardous air pollutants which include polycyclic aromatic hydrocarbons and particle pollution. Particle pollution represents the main component of wildfire smoke and is the principal public health threat. Individuals at greater risk of health effects from wildfire smoke include those with cardiovascular or respiratory disease and older adults, as it can increase the incidences of asthma, emphysema, chronic lung disease, and other health concerns. The pandemic heightened the

need for high-quality air filtration systems to help minimize the impact of airborne diseases and pollution as we saw disproportionate numbers of cases in these facilities. By improving the requirements of air filtration systems in senior living facilities, we not only improve the air they breathe, but we can also improve seniors' health and quality of life while living in these facilities. To talk more about this legislation, I will turn it over to Mr. Soltero.

[Assemblyman Orentlicher assumed the Chair.]

Randy Soltero, Soltero Strategies, Las Vegas, Nevada:
I have been working with this group of experts who know much more about this stuff than I do. Trying to get the gist of this bill, I would like you to hear from Al Lopez representing the Sheet Metal Workers Union, who actually were the folks who asked to bring this bill forward.

Alfonso Lopez, representing International Association of Sheet Metal, Air, Rail and Transportation Workers, Local 88:
In 2021, legislation was passed for indoor air quality for the Clark County School District. We feel it is very important now to pass this for senior living facilities. I would like also to assure you that the workforce is in place already. We have well over 50 people capable of doing these inspections. They are highly trained, certified as well, and ready to do this work. I would now like to introduce you to Chris Ruch. He represents the National Energy Management Institute and is the expert witness when it comes to answering any technical questions pertaining to this bill.

Christopher Ruch, Director of Education, National Energy Management Institute:
Thank you for the opportunity to speak in front of you. Most of my career was happily spent on roofs making sure ventilation systems work the way they were supposed to. Unfortunately, I can tell you that many times I did not see them working the way they were supposed to, and given concern for the members of our community, I felt it was important for me to come here and talk about what I see and the importance of this.

Indoor air quality should be verified in senior living facilities. This is a proactive way to identify and address vulnerabilities in these facilities, thereby safeguarding the health, well-being, and quality of life of its residents. We know our elderly residents' health is influenced by indoor air quality. Elderly residents have a greater predisposition to respiratory infections. Elderly residents commonly have underlying chronic medical conditions and immune deficiencies that may make them more susceptible to the effects of air pollutants. We also know residents with reduced mobility spend approximately 95 percent of their time inside. The Centers for Disease Control and Prevention (CDC) put out a study that showed 57 percent of all sicknesses can be attributed to poor ventilation.

With that said, elderly residents, along with children, are the two most vulnerable groups in regard to poor indoor air quality. Nevada has done a great job with schools and taken great steps toward making sure indoor air quality is addressed in schools. This bill is a pathway to improving indoor air quality in senior living facilities. One of the most effective methods to

reduce the concentration of pollutants and maintain good indoor air quality is to adequately ventilate and filter indoor spaces. The ventilation verification process within this bill is the first part in section 17. You are looking at a physical verification by technicians who are skilled, trained, and certified, and know what they are doing. They are looking to see how the filters are installed primarily because if you have spaces and gaps between the filters, it does not really matter the MERV [minimum efficiency reporting values] rating of the filter or the efficiency. Is it bringing in the right amount of outside air? Has the room use changed? Are the components working? This is both for energy efficiency and for indoor air quality. These are great components, but if they do not work, it does not do you much good. You are looking at inlets and outlets. You see them around this room. If you do not have the air distributed properly, you are not going to get the benefits no matter how great that unit is working on the roof. You are looking to see if basic maintenance has been done in regard to ventilation, and as a technician, I spent a lot of time on a lot of roofs, and a lot of that maintenance is not done. Are the control sequences set? It was very common for me in the field to find that a unit was set to be going off and on during the day like your house. But for a building like this, with this many people in it, you need the system running all the time. It does not have to be heating and cooling, just bringing in fresh air and filtering. And lastly, a carbon dioxide sensor can indicate if there is a sudden problem with the ventilation system. I can check to make sure the ventilation system is working well today. I would be glad to work with your team and be on the roof today working on it, but I do not know what is going to happen tomorrow. It is a mechanical device, and just like your washing machine or anything else, these things break. Then you move into a heating, ventilation, and air conditioning (HVAC) assessment report that the technician delivers, and they bring it to the mechanical engineer. This allows the mechanical engineer to make a lot fewer assumptions when trying to figure out what to do. They can then meet with the senior living facility and triage what needs to be repaired, what can be fixed, what can just simply be adjusted. That way they can meet the indoor air quality and energy efficiency goals. In section 20, you would see corrective actions would come out and then a final ventilation verification report.

[Assemblywoman Peters reassumed the Chair.]

Randy Soltero:
If you turn your attention to the quite lengthy conceptual amendment [Exhibit I], we will go through it. We applaud the efforts of our Legislative Counsel Bureau (LCB) and the hard work they did on the original draft. We have added some amendments that will better clarify, and these are the amendments I would like to take you through. You actually have two amendments, one from us and one that I will talk about from Nevada HAND [Exhibit J].

Going to the changes from the original bill, sections 4, 5, 6, 7, and 8 [Exhibit I] are definitions we added into the bill to clarify what those things are. Section 9 and section 10 would be the same. You see, there are some items that were struck from the original language to streamline this and make it more defined. In section 11, "qualified testing personnel means either of the following." Those are the proper certifications that should be held for a person who is doing testing in these facilities. Then we get to the meat and potatoes here in section 12:

> "Senior living facility" means any facility that receives any federal funding from Medicare, Medicaid or other federal health care program and which provides living assistance and related care to a resident of the facility who is an aged or infirm person including, without limitation, a facility for intermediate care, facility or skilled nursing, residential facility for groups or home for individual resident care.

The reason I read that is we have been approached by another organization that does care for adolescents who need intensive care who are infirm persons. We will ask the Legislative Counsel Bureau (LCB) to review that to see if this definition, even though it says senior living facility, would take in those folks as well.

Section 13, "skilled and trained workforce," the amendment for the applicable occupation is added to the original language. In section 14, "TAB" means testing, adjusting, and balancing. The new section 15 is legislation from the original bill—everything that was brought originally by LCB. "The Legislature finds and declares that: . . . ." All those parts there and through the next several pages say what this Legislature finds is appropriate through the renumbered section 16, and this is very important and we anticipate that there will be questions on:

> To the extent that money is available, the administrator of a senior living facility shall ensure that the senior living facility is equipped with a functional ventilation system that is tested, adjusted and, if necessary or cost-effective, repaired, upgraded or replaced to increase efficiency and performance. Money shall be considered available if the living senior living facility:
>
> (a) receives federal or state money and allocates such money to equip the senior living facility with a functional ventilation system . . . ; or
>
> (b) As a condition of receiving federal or state money is required to ensure the senior living facility is equipped with a functional ventilation system or improve the ventilation system or indoor air quality in the senior living facility.

That is important because one of the biggest questions we are being asked is, who pays for this and what part of it is paid for? We are going to have Mr. Abril here once I get through this amendment. He can address the funding part of it. He will talk about how federal money is similar to the bill we did in 2021 for the schools. It was federal CARES and CRRSA Acts [Coronavirus Aid, Relief, and Economic Security Act and Coronavirus Response and Relief Supplemental Appropriations Act] funds we used at that time, but I will leave that to Mr. Abril to talk about.

We do have an amendment from Nevada HAND [Exhibit J], and I believe you have that. It goes back to section 16. After paragraphs (a) and (b), it would add a new paragraph (c) which would be, "Facilities that qualify under 319.147 may utilize the federal funding pursuant to section 16a to upgrade and maintain ventilation systems." There is someone here

from Nevada HAND who will testify as to the reasoning for those purposes. Then, I will talk about their other amendment we are happy to adopt.

In the conceptual amendment [Exhibit I], after section 16, subsection 2, the words "or cause such persons to be contracted, to perform a Ventilation Verification Assessment" are added. This is language of interest to folks who would be qualified to do this work. Section 17, referring to Ventilation Verification Assessments, describes what the administrator of the facility would be tasked to do as far as documentation, testing, physical measurements, all the different things that would be required. In paragraph (g), "Verification of unit operation and that required maintenance has been performed in accordance with ASHRAE . . . ." Again, Mr. Ruch is here to answer any of those technical questions.

The next pages continue to enumerate all the things that have to happen in order to make sure the system is properly installed and operating. Section 21 is the effective date, and then the amendment from Nevada HAND is a new section 22. We ask for your acceptance of this amendment as well. The program section sunsets when federal funding is no longer available. Language from the rest of the bill has been struck. I will have Mr. Abril talk about the funding piece, which was a big question we had from stakeholders, and we want to make sure it is addressed on the record.

Dion Abril, Executive Administrator, Western States Council, Sheet Metal, Air, Rail and Transportation Workers of California, Arizona, Nevada and Hawaii:
We identified a few federal funding options. Currently, we believe the Nevada Governor's Office of Energy is in the process of receiving funds from the federal bipartisan infrastructure law and the Inflation Reduction Act of 2022. Another option we have identified is the State Energy Program. These funds can be used to perform HVAC upgrades and retrofits to buildings, including facilities talked about in this bill. We are not aware of any other funds at this moment, but we do have subject matter experts in Washington, D.C., and we would be glad to have them come in and talk with the Committee and go over all the other funding options we have.

Chair Peters:
Thank you. One of my questions concerned the federal funding options. Sunsetting on available federal funding is an interesting way to address policy; there are conversations we can have around that piece. Assemblywoman Taylor had questions, but she had to leave, so I am going to ask her questions and get them on the record. Can you talk about some of the health impacts of poor indoor air quality?

Brian Labus, Ph.D., Assistant Professor, School of Public Health, University of Nevada, Las Vegas:
This is a broad issue. Air quality can be everything from allergens that annoy you and cause allergy problems to things like particulate matter that can make their way into the house. When we see bad air days in the community, we know we will see an increase in heart attacks. It can be infectious diseases such as things that stay in the air for extended periods of time like measles. The more air exchanges you have per hour in a space, the more

reduction in those diseases you will see. It will not completely eliminate things; you are still going to be around people who can spread disease to other people. But exchanging the air more frequently reduces the risk of all sorts of disease transmission. We talked about *Legionella* earlier today. With a properly maintained system, Legionnaires' is one disease you will not see if things are running the way they should be. Assuming it is not contaminated, and everything is working properly, you will not be exposed to *Legionella*.

There are all sorts of respiratory viruses. When COVID-19 came out, a lot of the directions we gave to people were around how to handle air in their homes. We said things like open the windows and exchange the air more often, something that you cannot do in large buildings frequently, which is why we have to rely on the large HVAC systems to do that for us. It can really cover a lot of different things all the way from minor annoyances to serious health problems. The difference between allergies and somebody who has an asthma attack. Those can all be affected by the indoor air that is around you every single day.

Chair Peters:
The next question has to do specifically with residents of senior living facilities. What are the poor indoor air quality concerns for that demographic population or in those facilities?

Brian Labus:
It is the same things I talked about before, but we are talking about a high-risk population. If you have a younger, healthier population exposed to the same things, the health effects are going to be less than you would see with an older population with a lot of underlying health conditions. As we get older, we start to have more and more chronic conditions. Some of those are respiratory problems to begin with—things like COPD [chronic obstructive pulmonary disease] and emphysema. People just have more and more problems breathing as they get older. Even minor respiratory problems for a healthy person could be a serious issue for somebody who is much older, so it is not that there are any different problems. It is that you have a much higher risk of disease if you are exposed when you are older, and typically, the outcomes tend to be worse if you are older.

Chair Peters:
Thank you for those responses. Are there other questions from the Committee?

Assemblywoman Newby:
I do not recall what section it was in, but I remember seeing the definition of a highly skilled workforce as 60 percent of the individuals attending or going through an apprenticeship program. Is that the standard definition within the *Nevada Revised Statutes* or is it different?

Christopher Ruch:
I can only speak to what I know from this state in the past. This is the same language I believe was used in the past bill for the schools doing the same thing and has to do with making sure you have the right people doing this work.

Chair Peters:
Are there other questions from the Committee? [There were none.] Seeing none, we are ready to go into testimony.

Randy Soltero:
We have had a lot of folks come to us. We have been working with Nevada HAND and some other organizations that had concerns. We are hoping we delivered on our promise to make sure everybody has an opportunity to have their say and do what we can do to get this bill to the right place. I am hoping that we will hear some folks today whose testimony will reflect that.

Chair Peters:
We will open support testimony on Assembly Bill 281 in our physical locations and then go to the phone lines.

Greg Esposito, Public Relations and Government Affairs Director, United Association of Plumbers, Pipefitters and Service Technicians, Local 525:
When I introduce myself to legislators, I share our mission statement, which is to protect the health of the nation. This is a bill that will go a long way toward doing so. We appreciate Assemblywoman Gorelow bringing it forward and fully support the bill.

Fran Almaraz, President, Nevada Silver Haired Legislative Forum:
I am representing the Nevada Silver Haired Legislative Forum. Seniors are the most vulnerable population. Many seniors have no choice except to live in a community building. Air quality is so very important because many of them have asthma, COPD, and other infirmities, and the air they breathe is very important. I urge you to please think about this bill and please pass it.

Matt Lydon, Business Manager, United Association of Plumbers, Pipefitters and Service Technicians, Local 525:
I am also president of the Nevada Pipe Trades. We rise in support of this bill.

Marc Ellis, President, Communication Workers of America, Local 9413:
On behalf of my retirees, we are in full support of this bill.

Susie Martinez, Executive Secretary-Treasurer, Nevada State AFL-CIO:
Seniors deserve living facilities that allow them to live with dignity and respect. We must also prioritize protecting workers in such facilities and ensure their workplace conditions are up to par. This is a critical bill that would ensure good air quality in these facilities and ensure the safety of both residents and the workers who work in them. Additionally, we are facing a health care provider shortage, and we simply cannot afford to risk the health of our workers. I would like to thank Assemblywoman Gorelow for bringing this bill forward.

Kent M. Ervin, Ph.D., State President, Nevada Faculty Alliance:
Please support A.B. 281. Our main interest is the indoor air quality of our classrooms and lecture halls; however, senior care facilities are obviously more critical because typically in my chemistry lecture, there is only one vulnerable senior. I would like to explain why carbon dioxide monitoring in this bill is so important. Carbon dioxide sensors are cheap and an easy way to monitor ventilation in this room right now. The carbon dioxide level, according to my little sensor here, is 762 parts per million. The background level is 450 parts per million, and when the room was full, it was hovering around 800 parts per million. Why is it higher than outside? It is because we are all breathing out carbon dioxide, so unless we are bringing in outside air, the carbon dioxide builds up in the room. This is very good—800 parts per million—from what I have read about ventilation, and I am not an expert.

Ventilation in the Legislative Building overall seems quite good, except in the Assembly Chambers during a joint session when it builds up a little bit more. Why is that also important? It is an easy way to monitor if your system is working. Along with breathing out carbon dioxide, we are breathing out aerosol particles that, if one of us is sick, could contain coronavirus or other infectious particles. It is a way to ensure the safety of indoor air quality. Please support healthy indoor air.

Eduardo Zavala, Field Representative, International Union of Bricklayers and Allied Craftworkers, Local 13:
I strongly urge the Committee to favor Assembly Bill 281.

Liz Sorenson, President, Nevada State AFL-CIO:
I am in support of A.B. 281, and I urge this Committee to vote in favor of it as well. Thank you so much for your time.

Sue Bird, Private Citizen, Fernley, Nevada:
I am strongly in support of A.B. 281. Being a senior, I know if I do not get up and move, my life is shortened. Catching a disease in my lungs can shorten my life dramatically. This is very important to any of us who should go into a nursing home, not only for ourselves but for our nurses. We know that our medical field is tired and has worked very hard, and they need all the help they can get. I urge you to please support A.B. 281.

Paul Catha, representing Culinary Workers Union, Local 226:
The Culinary Union supports Assembly Bill 281, and we urge the Committee to support it as well.

Marlene Lockard, representing Service Employees International Union, Local 1107:
We are in full support of this bill.

Kathy Preston, Private Citizen:
As a senior, I am in full support of A.B. 281. I strongly urge the Committee to pass it.

Arielle Edwards, Director, Government Relations, Nevada HAND:
Nevada HAND is the state's largest affordable housing developer and builder and a nonprofit organization. Nevada HAND provides the only truly affordable assisted living communities in the state of Nevada. We provide 180 apartment homes for seniors in need of assisted living. We are in support of the amended version of A.B. 281. At this time, our assisted living communities are facing sustainability challenges, and we are hoping to have these challenges addressed this legislative session so we can continue serving our seniors. This amended language in A.B. 281 will make this optional for us to take the grant dollars as well as allow us to access the funds later once we are able to figure out the cost of maintenance in light of our sustainability challenges. The sunset part is also to ensure when the federal program monies are gone, the statute does not require assisted living facilities to upgrade systems without federal support. We would like to thank the bill sponsor, Assemblywoman Gorelow, and the stakeholders for working with us on this bill and accepting our amendment. We thank you all for your leadership.

Chair Peters:
Please connect the next caller in support. [There was no one.] We will move to opposition testimony. Is there anyone who would like to provide opposition testimony on Assembly Bill 281?

Joan Hall, representing Nevada Rural Hospital Partners:
We are here today in opposition but willing to work with the sponsor and Mr. Soltero on definitions. First, the definition about receiving federal money. All skilled nursing and intermediate care facilities receive federal and state money by means of Medicare and Medicaid. Later, in section 16, it talks about receiving federal or state money: It needs to be clarified that those are grant funds or other funds and not the federal and state money we already receive. The bill establishes increased requirements for ventilation and filtration systems. If this does not have a sunset, as stated in the proposed Nevada HAND amendment, that could impose a huge issue for current facilities to meet new regulations. We would need a longer period of time, especially if we cannot use those grants. My members are unaware of these two grants, so we are looking forward to finding out more about them.

Brian Evans, representing Nevada Health Care Association:
We would like to thank the sponsor for taking time to meet with us. I echo a lot of Ms. Hall's comments. We have some concerns on the mandate, the funding sources, the ongoing maintenance, and other things that could be included if there is not the sunset. We will continue to work with the sponsor to address those concerns.

Chair Peters:
Thank you. Are there other folks in opposition here in the physical locations? [There was no one.] Not seeing anyone in Las Vegas or Carson City, we will move to the phones. Is there anyone on the public line who would like to provide opposition testimony on A.B. 281? [There was no one.] Is there anyone who wishes to provide neutral testimony on A.B. 281? [There was no one.] I would like to invite the bill sponsor back up for closing remarks.

Assemblywoman Gorelow:
I appreciate you and the Committee listening to Assembly Bill 281. We are still working with many of the stakeholders and are willing to discuss the funding source and how this would be paid for as well. So, thank you very much.

Chair Peters:
Thank you so much. With that, we will close the hearing on Assembly Bill 281. That brings us to the last item on our agenda today, which is public comment. We will start public comment here in Carson City and in Las Vegas and then move to the phones. Is there anyone in Carson City or Las Vegas who would like to provide public comment today? [There was no one.] Is there anyone on the public line for public comment today? [There was no one.]

We will close public comment, and that brings us to the end of our day. If there is no further discussion from members, we are adjourned [at 3:36 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 supplemental information titled "Your Water Management Plan; How the ASSE 12060's will enhance the plan!" submitted by Greg Esposito, Public Relations and Government Affairs Director, United Association of Plumbers, Pipefitters and Service Technicians, Local 525, in support of Assembly Bill 263.

Exhibit D is a proposed amendment to Assembly Bill 263 submitted by Assemblyman Howard Watts, Assembly District No. 15.

Exhibit E is background materials submitted by Greg Esposito, Public Relations and Government Affairs Director, United Association of Plumbers, Pipefitters and Service Technicians, Local 525, in support of Assembly Bill 263.

Exhibit F is supplemental information dated March 23, 2023, submitted by Brett Salmon and presented by Brian Evans, representing Nevada Health Care Association, in opposition to Assembly Bill 263.

Exhibit G is a letter dated March 23, 2023, submitted by Marcy Savage, Director of Policy and Government Relations, Alliance to Prevent Legionnaires' Disease, in opposition to Assembly Bill 263.

Exhibit H is a fact sheet titled "Rural Emergency Hospitals," dated October 2022, submitted by Blayne Osborn, representing Nevada Rural Hospital Partners, in support of Assembly Bill 277.

Exhibit I is a proposed amendment to Assembly Bill 281 submitted by Assemblywoman Michelle Gorelow, Assembly District No. 35, and presented by Randy Soltero, Soltero Strategies, Las Vegas, Nevada.

Exhibit J is a proposed amendment to Assembly Bill 281 submitted by Nevada HAND and presented by Randy Soltero, Soltero Strategies, Las Vegas, Nevada.