MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Eighty-second Session
February 16, 2023

The Senate Committee on Health and Human Services was called to order by Chair Fabian Doñate at 3:31 p.m. on Thursday, February 16, 2023, in Room 2134 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412E of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Fabian Doñate, Chair
Senator Rochelle T. Nguyen, Vice Chair
Senator Roberta Lange
Senator Robin L. Titus
Senator Jeff Stone

STAFF MEMBERS PRESENT:

Destini Cooper, Policy Analyst
Eric Robbins, Counsel
Norma Mallett, Committee Secretary

OTHERS PRESENT:

Julia Peek, Deputy Administrator, Division of Public and Behavioral Health, Nevada Department of Health and Human Services
Megan Comlossy, Associate Director, Center for Public Health Excellence, University of Nevada, Reno
Caleb Cage, Interim Administrator, Central Nevada Health District
Kevin Dick, District Health Officer, Washoe County Health District
Fermin Leguen, M.D., District Health Officer, Southern Nevada Health District
Alejandro Rodriguez, Nevada System of Higher Education
Andrea Gregg, Chief Executive Officer, High Sierra Area Health Education Center
Sheila Bray, University of Nevada, Reno
Michael Hillerby, Renown Health

Stephen Wood, Carson City
Jimmy Lau, Dignity Health - St. Rose Dominican
Michael D. Brown, District Board of Health, Washoe County Health District
Vinson Guthreau, Executive Director, Nevada Association of Counties
Colleen C. Lyons, M.D.
Jeanette Belz, Nevada Public Health Association
Blayne Osborn, President, Nevada Rural Hospital Partners
Emily Walsh
Nancy Bowen, Chief Executive Officer, Nevada Primary Care Association
Caryn Solie, Nevada Dental Hygienists' Association
Eddie Ableser, Nevada Dental Association
Mercedes Maharis, Chaplain, Nevada Silver Haired Legislative Forum, District 3

CHAIR DOÑATE:
We will hear a presentation from Julia Peek, Deputy Administrator, Division of Public and Behavioral Health, Nevada Department of Health and Human Services, on governance of public health in Nevada.

JULIA PEEK (Deputy Administrator, Division of Public and Behavioral Health, Nevada Department of Health and Human Services):
Public health governance is a way of classifying a public health structure within states and to understand what other states are doing. This affects how public health services are funded and delivered. It defines roles and responsive authority across states and levels of government.

I provided a handout (Exhibit C) summarizing this information. On the first pie chart in Exhibit C, a slice is pulled out which indicates decentralized or largely decentralized public health services. Nevada is one of only two states with a largely decentralized structure. Most others are fully decentralized being operated by local public health agencies. Centralized or largely decentralized, as shown on the chart, means that much of the services provided to our residents are done by local employees versus State employees. Mixed structures, as shown on the chart, are a rare type of public health governance. Shared or largely shared is a combination more unusual than having a fully decentralized public health governance.

The Nevada Department of Health and Human Services (DHHS), Division of Public and Behavioral Health (DPBH) is the State public health agency or State public health authority. The Division has local public health agencies, such as

Carson City Health and Human Services, which is considered a local public health agency serving the county. Washoe County Health District and Southern Nevada Health District are urban health districts. The newly formed Central Nevada Health District is our first rural regional health district, and we are proud of the work they have done.

Much of the work in public health around governance is shown within *Nevada Revised Statutes* (NRS) 439. It is a much larger section, but it is what the Division follows. The State Board of Health oversees much of the processes done by DPBH, including regulatory processes. The Division has a chief medical officer who oversees the agency and provides guidance from policy to basic public health services. Defined in NRS 439 are the county boards of health and county health officers, health districts and district health officers, and city boards of health and health officers.

Nevada Revised Statutes 439 discusses assessments. Before the Great Recession, DPBH used to get money from the General Fund, which supported services for tuberculosis, sexually transmitted diseases and other diseases. Some of that money was pulled back and, within NRS, assessments started to be charged. Those assessments are defined here and are in the counties where DPBH serves as their health authority and contributes to the services provided. These include nursing, environmental health, infectious disease control and others.

What does local governance look like? This is common as most of our counties have county governance and must have a county board of health and a county health officer. If that position is not appointed by the end of January after every election, the State chief medical officer must appoint the county health officer for the county. The counties must oversee sanitary conditions for the county and adopt regulations. Those regulations are taken to the State Board of Health for approval. The counties may choose to do other activities as noted in Exhibit C. There are several options for counties as they look at how they want to deliver public health services in their communities.

The Central Nevada Health District went forward to remove the assessment. Effective July 1, 2023, they will no longer pay DPBH for those health services. Approval was received from the Governor and the Interim Finance Committee (IFC). Within six months, the Central Nevada Health District will no longer

contribute to an assessment. They are putting forth a plan to do locally what the State was doing and, ideally, to do it better.

The State supports regionalization, especially for rural counties, because much of the work in the rural counties is done by DPBH. Regionalization is a benefit for rural counties for many reasons, but primarily for the investment. We have limited public health dollars. Looking at a single county and based on their per capita in the rural region, it would be difficult for them to support a big workforce. A single person could be funded by five different grants and much of their work would be reporting, not actually providing public health services. However, with regionalization, and Central Nevada Health District did this, you have more funds to hire the experts needed. One of the things that must happen is an agreement to dissolve the county boards of health and dissolve the county health officer position to be governed by a district board of health, which looks slightly different and has slightly greater duties.

There are two longstanding health districts in the State, which are the Washoe County Health District and the Southern Nevada Health District. Our newest member is the Central Nevada Health District, our first rural regional health district in the State established on December 3, 2022. It includes the counties of Churchill, Mineral, Pershing, Eureka and the city of Fallon. Carson City Health and Human Services, Nevada's first accredited public health agency, has done an outstanding job over the years. They are not considered a health district, but a health authority, and much of their work is done through delegation. Carson City Health and Human Services serves a quad-county region, which includes Carson, Lyon, Douglas and Storey Counties. They provide oversight through delegation by the State chief medical officer and grant funding. It is specified within the funding that they must serve the counties to the level that the State would have provided services. For this quad-county region to become a rural regional health district, they would need to dissolve their local boards and have one single district health officer.

There are specifications as to what these health districts look like based on population size, not atypical within NRS, but it is something that must be considered. At least for the Central Nevada Health District, one of the challenges noted within NRS is that one county must be an adjacent county to be part of that partnership. In forming the Central Nevada Health District, it matters more which counties have like minds about how they would like public health services delivered versus sharing a border. You will see in the upcoming

bill that we propose to delete the word "adjacent" to allow counties that choose to regionalize to work better together. The counties must have all their governing bodies choose to dissolve and then be approved by the State Board of Health. The Public Health Governance map (Exhibit D) indicates how other states are organized, provides resources that discuss governance more broadly and the benefits and challenges of each.

SENATOR NGUYEN:
I saw that hyperlink to other states and how they organize. Are there any states that do it better?

MS. PEEK:
I would not say better, but more established. Most of the western states are fully decentralized, Exhibit D. If Nevada could become fully decentralized in the next decade, most of the services residents would receive would come from local employees versus State employees. There is value and great benefit in having local employees. They know the local resources far better. The main reason many western states are decentralized is because of geography.

CHAIR DOÑATE:
We will open the hearing on Senate Bill (S.B.) 118.

SENATE BILL 118: Revises provisions relating to public health. (BDR 40-334)

Senate Bill 118 was requested by the 2021-2022 Joint Interim Standing Committee on Health and Human Services, which heard testimony from State and local health authorities about the continuing and critical need for stable funding and structural support for public health in Nevada. This bill addresses that issue by creating a dedicated account in the General Fund for the purpose of improving public health in our State. It also promotes increased access to public health resources by allowing non-adjacent counties to create a health district.

During the COVID-19 pandemic, S.B. No. 209 of the 81st Session passed. Throughout that time, the State tried to figure out what could be done to improve our public health system. The Interim Study on the COVID-19 Health Crisis required the Joint Interim Standing Committee on Health and Human Services to look at a few things. One was to examine the public health infrastructure in the State, the strengths and weaknesses that were observed,

and how local governments could respond better to future public health emergencies. Considerations and recommendations were given for increased public health funding, examining the health and economic impact of the pandemic, the long-term impacts on the healthcare system and workers on the front lines, and the challenges and benefits of creating a public health service core in Nevada. Various roundtables were held throughout the Interim Session regarding what our public health system could look like. We engaged with many stakeholders concerning what legislation could potentially be brought forward.

MEGAN COMLOSSY (Associate Director, Center for Public Health Excellence, University of Nevada, Reno):

Senate Bill 118 came out of the 2021-2022 Joint Interim Standing Committee on Health and Human Services and was a result of the time and effort that Committee members and stakeholders put into the Interim Study. The bill comes from studying and evaluating what happened during the COVID-19 pandemic. The focus of public health is on keeping entire communities healthy, as noted in the slide presentation (Exhibit E). It is not about individual health care. When our families go to the doctor or a hospital to seek assistance with healthcare needs, public health services and public health practitioners work to keep entire communities healthy. The goals are to understand what causes people to get sick and die and then develop and implement strategies to prevent those illnesses and promote or increase interventions that keep people healthier.

The public health system is comprised of governmental public health agencies at the State and local levels as well as community partners, which may be public, private or nonprofit. The challenge for public health is that when public health activities are working, we do not necessarily hear about them. The accomplishments of public health are taken for granted. Many of us may not have been familiar with the term public health prior to the COVID-19 pandemic.

Public health as a field has existed for more than a century and has grown and evolved as science has advanced, but it is something that happens in the background and is invisible. Even though it is unseen, it has an impact on our daily lives, whether or not it is realized. There are daily ongoing efforts to keep communities and people in Nevada healthy. Public health is difficult to understand because it involves as many as 19 different areas to keep people healthy, as identified in Exhibit E.

Food safety is important to Nevada's tourism industry. If you think about the large events that happen in Reno and Sparks, such as the Nugget Rib Cook Off, public health in the Washoe County Health District is there to ensure that the food provided to the public is kept at safe temperatures and does not result in mass sickness.

Public health emergency planning and preparedness is another area of public health, as we need to be ready for the next crisis. You may see public awareness campaigns related to tobacco or vaping, but much of the work happens in the background.

The problem that S.B. 118 aims to solve is twofold. The first is public health funding, which is critical to public health infrastructure, workforce and technology. The second relates to public health administration, pursuant to NRS 439.370, stating that counties must be adjacent to form a health district. This is a slight change that could make a big difference in Nevada.

The State currently spends the least amount of money on public health per person than any other state, except Wisconsin, with which it ties. Even though State and local governmental public health agencies play a critical role in ensuring the safety, security and prosperity of local communities, they have been consistently underfunded for decades. The overwhelming majority of public health funds are obligated for a specific purpose and most funds come from the federal government. This means the State and local public health agencies do not have flexible funding to use when a crisis arises. Funding is directed to chronic disease prevention, cancer, asthma or maternal and child health. But what happens when the next COVID-19 hits? What happens when the Zika virus happens or another disease outbreak about which we do not yet know? Funding is not available and so it impacts the ability to react because public health agencies do not have flexible funding. Finally, some of the most vulnerable populations and under-resourced communities are impacted the most by changes in public health funding.

Research shows that $1 invested in public health results is a return on investment of more than $5. Investing in the public health system is an investment in the health of Nevadans. The public health budget of DPBH for this coming biennium is 3 percent from the General Fund, 57 percent from federal funds and 40 percent from other funds. About $19 million in the General Fund goes to public health and there has been an increase in State funding to public

health in recent sessions for specific purposes, which is something to celebrate. It would be great to see additional funding for public health that provides that flexibility in the future.

Senate Bill 118 addresses the public health workforce. A 2021 analysis looked at the gap in the existing public health workforce and across the Nation. An additional 80,000 full-time staff are needed to provide foundational public health services, which are a defined set of services that only governmental public health agencies provide. Nationwide, 54,000 of those are needed in local health departments and 26,000 are in state health departments. Nevada is experiencing a public health workforce shortage. This analysis also showed a 15 percent decrease in staffing due to the lack of consistent investment in governmental public health services.

The lack of funding affects the ability to staff public health agencies. Public health practitioners are the core people who provide public health services. It is challenging to provide adequate public health without the workforce needed. As seen with other workforces in the COVID-19 pandemic, the shortages experienced were exacerbated by the pandemic. A survey of the national public health workforce indicated that 32 percent of the workforce is considering leaving their organization in the next year. Of these, 50 percent are considering leaving due to pay and 41 percent due to workload and burnout. During the pandemic, they were dealing with a lot in a short period of time, and they continue to work hard to keep people healthy. People thinking of leaving due to stress is 37 percent and another almost 40 percent because of the pandemic.

The other piece of public health infrastructure is technology and data modernization. The field of public health is data-heavy and relies on the ability to collect and share data quickly. Unfortunately, many public health agencies have outdated and old data systems that do not talk to each other. There is a lack of interoperability. Data modernization is a focus for national, state and local public health agencies.

The other problem, in addition to infrastructure and funding, is public health administration. There are challenges for the Central Nevada Health District because there is one word in the statute that says the counties must be "adjacent" to each other. This impacts the ability of the State to move toward the decentralization of public health services that may be better for the people of Nevada.

Senate Bill 118 is important for the health of our constituents and the health of the economy, which depends on having strong public health systems. These are the services and systems that keep communities safe and healthy during normal times and crises. Healthy people are productive people who contribute to a stronger economy. Healthier workers are more likely to show up for work and be productive when they are at work. Improving health at the population level can reduce state costs, for example, in Medicaid and the Nevada Children's Health Insurance Program.

On February 14, 2023, several Medicaid managed-care organizations presented what they are doing in terms of community health initiatives. Community health is public health, and they are investing in those initiatives because it keeps the people they serve healthier and saves them dollars. It is cheaper to provide care to people who are healthier and receive services on the front end, and whose health conditions are prevented or treated early in the process, rather than waiting until they are worse. If Medicaid managed-care organizations are implementing public health measures to save costs, it seems only reasonable that the State would do the same across Nevada.

Finally, investing in robust systems that detect, prevent and address public health threats is more cost-effective than responding to public health emergencies. Money invested in public health now makes Nevada a State that is more prepared and ready to respond to the next public health emergency. It is better than saving that money and trying to address an emergency when it happens.

Section 5 of S.B. 118 requires an account to be created in the General Fund to be administered by the administrator of DPBH within DHHS for the purpose of improving public health in Nevada. Section 6 requires money to be allocated to each health authority annually based on the population under its jurisdiction. It also requires health authorities to evaluate the public health needs of residents, prioritize those needs and expend the money in order of priority.

Sections 7 and 8 remove the requirement that two counties must be physically adjacent to create a health district. Section 9 appropriates $15 million to the account for public health improvement from the General Fund each year of the biennium. The $15 million represents a State investment of $5 per capita per year, based on the State's population of 3 million. If public health funding is increased in Nevada by $5 per capita per year, Nevada will move from

forty-ninth to forty-fourth place in public health rankings. It is not a huge jump; however, it is progress.

An amendment has been proposed (Exhibit F) that would require health authorities, as defined in section 4 of the bill, to submit a report to the Director of the Legislative Counsel Bureau for transmittal to the IFC. It would report on the use of money received no later than 45 days after the end of the fiscal year in which the money was received. The report shall include a description of the process used to evaluate the public health needs of residents in the health authority's jurisdiction, as well as a description of how the level of priority was determined. The goal here is to build accountability so the Legislature can see how and why this $15 million is appropriated.

The second proposed amendment shown in Exhibit F revises the definition of a health authority to mean the district health department or, in a location not part of a health district, the DPBH or its designee. Carson City Health and Human Services does not currently fit into the definition of health authority as outlined in the bill. This amendment would allow money to funnel through DPBH to Carson City Health and Human Services for the purpose of this per-capita allocation.

CALEB CAGE (Interim Administrator, Central Nevada Health District):
I am addressing the importance of sections 7 and 8 of S.B. 118. Central Nevada Health District is Nevada's newest health district. It is Nevada's first rural health district made up of four counties: Churchill, Pershing, Mineral and Eureka. It also includes the city of Fallon, which is the county seat of Churchill County. It was a lengthy process to establish a new health district that was carried out through 2022. The communities who were involved received support from the Governor, the State Board of Health and the IFC to make all the administrative changes necessary. They also passed ordinances that abolished their local health boards and created interlocal agreements that established the Central Nevada Health District, which will be fully operational on July 1, 2023. They are working aggressively to ensure all the pieces are in place to provide services by that date.

The one part of existing law that prevents the complete governance structure of the Central Nevada Health District is addressed in sections 7 and 8 of this bill, with the deletion of the word "adjacent." Three of the counties in the Central Nevada Health District are adjacent; however, Eureka County is not.

Lander County separates it from Churchill County. It has joined the Central Nevada Health District through an interlocal agreement. Services to Eureka County will be provided as far as operations are concerned, but we need to fully make them a member of the District. Both Eureka County and the District would benefit from full and complete membership and not the interlocal agreement that is in place.

If health districts for the State are to be pursued to serve the needs of rural Nevada, requiring counties to be adjacent will limit progress in the future. Removing this word would be a benefit to the District and our operations. It would also allow other counties to pursue their own relationships as they see fit and set up these important health districts within their communities.

KEVIN DICK (District Health Officer, Washoe County Health District):
Washoe County Health District (WCHD) had the opportunity to work with the national Public Health Foundation to assess our staffing adequacy to provide foundational public health capabilities and service areas. Those capabilities and areas include equity, community partnerships, communication, policy, emergency preparedness, communicable disease control, chronic disease and injury prevention, environmental health, maternal and child health, and access to clinical care.

The Foundational Public Health Services (FPHS) are services that every public health department must have to support public health programs and services needed by the community. Those programs require additional staffing and are designed to meet community-specific needs and are not considered "foundational" or part of the foundational workforce assessment.

The de Beaumont Foundation work and the 2021 *Staffing Up* report, which provided the workforce numbers in an earlier presentation, found that additional public health workforce staffing is required nationally. A calculator tool developed by the University of Minnesota was utilized, based on results from FPHS workforce assessments that have been conducted in several states. That calculator was used to assess our current staffing against what the calculator tool estimated WCHD needed for a community our size.

Each position in WCHD was examined to determine how many full-time equivalent (FTE) employees were invested in the different foundational areas. It found that WCHD is 24 FTEs short for a community of our size just in the

foundational service areas, and that was not accounting for other staffing needs to provide more community-specific programs. This is the result of underfunding and understaffing of public health that left us so poorly prepared to respond to the COVID-19 pandemic. If WCHD had the Public Health Improvement Fund (PHIF), those funds could be used to help fill that gap by supporting health equity efforts, working to address the health disparities that were so starkly amplified by the COVID-19 pandemic.

The assessment also showed WCHD needed more epidemiology and disease investigation staff. The PHIF could be used to retain staff that will be lost at the end of the COVID-19 grant funding. During the pandemic, communities were clamoring for information on how the disease was impacting different populations and where outbreaks were occurring. The PHIF could be used to address inadequate data platforms and provide more meaningful data to inform ourselves and our community.

During the great recession, the Home-Visiting Program for at-risk new mothers and their infants had to be eliminated. It was not an evidence-based program. If the PHIF were created, it would allow the State Board of Health to consider using the funds to establish an evidence-based Nurse-Family Partnership Program like the one in the Southern Nevada Health District (SNHD). During the pandemic, it was determined public health is essential to our economy and lives. Senate Bill 118 will provide flexible, non-categorical funding that is essential for the WCHD to provide the programs and services vitally needed for our community.

FERMIN LEGUEN, M.D. (District Health Officer, Southern Nevada Health District):
This year's budget (Exhibit G) for the SNHD is about $180 million, which is great. However, it is at considerable risk because almost 50 percent of our budget is federal grants that might disappear at any time. The SNHD has concerns about how to sustain that workforce two years from today if those funds disappear.

We have listed the different interventions and projects that are needed in this community (Exhibit H). Those projects include enhancing the public health lab, behavioral and mental health needs, maternal and child programs, and increasing our work with the homeless community to ensure a linkage is established to primary care and mental health services for them. The need for expanding

capacity in our facilities is evident, but the need to keep most of the workforce once the federal funds disappear is another challenge.

SENATOR STONE:
Reviewing the chart in Exhibit E indicates the Governor's recommended budget for the 2024-2025 biennium is comprised of 3 percent General Fund, 57 percent federal funds and 40 percent other. Can you discuss what the 40 percent "other" includes?

MS. PEEK:
They include fees and assessments; however, the largest portion of those funds come from the Governor's Finance Office through the American Rescue Plan Act funds. They are considered federal, which is why we put them under "other," because they are a transfer from another agency within the State government.

SENATOR STONE:
Often, a budget reflects its organizational values. It is concerning that Nevada is at the bottom as far as investment in public health funding. Have other states been looked at and are they receiving more federal funds or are they contributing more general funds to their programs? What are we doing that is not funding public health appropriately in Nevada?

MS. PEEK:
The State ranks relatively well for federal grants. Competitive grants are often applied for and some of those grants have been won. For example, DPBH won a competitive award to study Alzheimer's disease in public health with a new approach. In some cases, grants are not competitive because the federal government already has in mind what states they want to fund. Where we find the most deficiency is in State funding. That is the biggest difference between Nevada and other states.

SENATOR STONE:
Several speakers talked about the antiquated technology in the State. Does public health have a capital improvement plan on where the State wants to go and the cost? This is a struggle not just for Nevada. This is a struggle for other states too, but technology can make us run more efficiently and lower the cost of delivering services to people and expand those services to even more people. What needs to be done? Is there a plan and, if not, how do we get there?

MS. PEEK:
That is one of the biggest struggles because there is so little funding to invest in IT systems and it is difficult because humans are needed to do the job. For example, staff was doing data entry from fax machines when DPBH was getting COVID-19 cases versus receiving the cases and investigating them. That is where the problem was very apparent. It goes back to funding; most of the funds are categorical.

The Division is excited about the partnership with our federal partners through the Centers for Disease Control and Prevention. They are funding large data-modernization projects and the grant we have now is for five years. Hopefully, they will continue to fund this project because modernization is continuous for these IT systems. Some modernization with those funds will happen, but it is expensive. Consultants and contractors will need to be hired so that money will only go so far. Prior to the COVID-19 pandemic, we had nothing.

SENATOR STONE:
Have other states with a similar population been investigated to find out if the technology they are using is off-the-shelf software? I have concluded that every state does not need to have its own unique software system. That could be expensive versus modifying an off-the-shelf program that works in another state.

CHAIR DOÑATE:
There will be more presentations later in this Session and we will discuss this in further detail at that time.

SENATOR TITUS:
Looking at the amendment in Exhibit F, I want to be confident that this report can be done within 45 days after the fiscal year. I am concerned whether there is enough time to get that report done since it takes a long time to get the bill, especially in the healthcare realm. Can you get a report no later than 45 days after the end of the fiscal year in which the money was received?

MS. COMLOSSY:
The amendment proposes to submit a report that describes the process used to evaluate the needs of the residents as well as how the level of priority was determined. It does not explicitly require a definition of where and how much

funding was appropriated to each priority. That could be included and then the deadline extended. The bill currently requires health authorities to state how the needs were evaluated and describe how those needs were prioritized. This is having them explain their thinking and how that money is allocated.

SENATOR TITUS:
The amendment reads "a report on the use of the money received no later than 45 days after the end of the fiscal year in which the money was received". I just worry that is not enough time.

MS. PEEK:
There is a 90-day closeout period with federal funds as the final expenditures are calculated. As far as actual spending, a 90-day consolidation period makes sense. However, as part of the funding that DPBH wanted to keep, hiring an evaluator to look at how all the counties are using these funds is necessary and appropriate. That evaluator could develop a dashboard. For example, if it is your hiring nurse that is being evaluated, how many clients did that nurse serve? Hopefully, this data could eventually be looked at in real time. When it comes to that closeout, we can give you some statistics. Financial close-out could potentially be a 90-day period like our federal partners.

SENATOR TITUS:
I would like the 45-day closeout period changed to 90 days to mirror our federal partners.

There are people in this audience who have worked hundreds of hours putting the new rural health district together and I want to acknowledge how these people made this happen and cooperated with each other. It is amazing how a small group of people can really move a lot of ground and accomplish things. The COVID-19 pandemic brought it to the forefront and has been an issue for a long time and these people stepped up. I want to get on the record that I am proud of them, especially my Churchill County people who made this happen because they have been the driving factor.

There is a reason for changing the language stating the counties do not have to be adjacent or contiguous. It still allows for the independence of the county in the middle that did not want to be part of a larger, contiguous district. Instead, they want to take care of themselves with some State assistance. Moving forward with this bill does not mean that all counties will be subject to these

kinds of public health formations. It is still up to the individual counties to be able to do this should they so choose.

MS. PEEK:
You are correct. This would make it easier should counties choose to become health districts. There is no mandate that the State would no longer offer services on their behalf.

ALEJANDRO RODRIGUEZ (Nevada System of Higher Education):
The Nevada System of Higher Education has long-standing support for public health and strongly supports S.B. 118.

ANDREA GREGG (Chief Executive Officer, High Sierra Area Health Education Center):
The High Sierra Area Health Education Center is in support of S.B. 118. Over the last 15 years, the Center has prioritized providing internships and job placement opportunities for public health professionals. We are recruiting public health students into our pathway programs by prioritizing public health and the integration of this diverse field into our programs. The Center has seen firsthand the positive impact that investing in public health infrastructure can have on our agency and the communities being served. Our investment in public health professionals has had a profound impact on the quality of outreach efforts, enabling us to reach even more people through the provisions of our mission by prioritizing diversity and inclusion in our recruitment and retention efforts.

Public health is a key component of the State's healthcare workforce development efforts. It provides the necessary foundation and support for healthcare professionals to effectively address the health needs of the population. It also ensures access to quality care, which in turn creates healthier communities and reduces the burden on the healthcare system.

Nevada has the potential to revolutionize the health outcomes of its residents with an investment of approximately $5 per capita per year. Imagine the progress that could be made toward building an equitable and healthier society by investing in public health infrastructure. The State can better serve its population and address the evolving public health challenges that it is facing. This bill will provide the necessary resources and flexibility to meet these challenges, ensuring that Nevada has a strong and sustainable public health system for years to come.

SHEILA BRAY (University of Nevada, Reno):
The University of Nevada, Reno supports S.B. 118. The University is involved in public efforts Statewide, both rural and urban, with a firsthand look at the importance of prioritizing public health infrastructure and services for all Nevadans. This bill would allocate funding to address individual community public health needs of utmost concern.

MICHAEL HILLERBY (Renown Health):
Renown Health is a nonprofit and the largest health system in the region. We support S.B. 118 and are deeply committed to population health and to strengthening our partnership with the health districts.

STEPHEN WOOD (Carson City):
Carson City supports S.B. 118 and the amendment that was presented today.

JIMMY LAU (Dignity Health - St. Rose Dominican):
Dignity Health - St Rose Dominican supported this measure out of the Joint Interim Standing Committee on Health and Human Services and continues to support S.B. 118.

MICHAEL D. BROWN (District Board of Health, Washoe County Health District):
I am one of the seven board members for the Washoe County District Board of Health and we are in full support of S.B. 118.

VINSON GUTHREAU (Executive Director, Nevada Association of Counties):
We are in full support of S.B. 118. It is a local-driven solution to local needs by allowing flexibility for those counties.

COLLEEN C. LYONS, M.D.:
As a family physician in the Carson area for 30 years, I encourage the Nevada Legislature to fund a public health improvement account within the General Fund for uncategorical use by the health districts and health authorities for the benefit of Nevadans. I am an advocate for an improved healthcare delivery system and have made a private study of the topic along with joining forces with state and national organizations to work to improve health outcomes in America.

America spends more on medical care than any other developed nation and achieves the poorest health outcome in general, with Nevada ranking poorly

among states. There are many contributors to the expense of health care in America, but without a doubt, one of those is America's poor investment in public health efforts across the Country. Nevada's investment is tied with Wisconsin at the bottom of the barrel. The U.S. spends approximately one-third as much as other industrialized nations on public health and two to three times as much on medical care after the fact. Because dollars are not invested, it costs us thousands of dollars in medical bills.

Unfortunately, states and the U.S. taxpayer pay approximately two-thirds of those medical bills in America in one way or another. Additional medical illness, injury and chronic disease account for massive decreases in economic productivity and personal income.

To name only one aspect of public health, we are constantly behind the curve on infectious disease outbreaks and spending emergency funds to catch up. Immunization rates are progressively declining to place all of us at a greater risk for outbreaks of previously controlled diseases, like measles and pneumococcal pneumonia.

Robust and sustainable public health efforts are needed to save money and lives and to prevent illness and disability. Let us have Nevada get started in providing funds that do not require an outside entity to decide whether there is a need to apply for a grant and administer it to get something done.

JEANETTE BELZ (Nevada Public Health Association):
What a great return on investment of $5 per person. The Nevada Public Health Association strongly supports S.B. 118.

BLAYNE OSBORN (President, Nevada Rural Hospital Partners):
We support S.B. 118. The Nevada Rural Hospital Partners is a consortium of 13 critical-access hospitals in the State, 3 of which belong to the newly formed Central Nevada Health District including one rural health clinic in that District. The Nevada Rural Hospital Partners support sections 7 and 8 with the word "adjacent" and support our partners in public health with any investment in public health funding.

EMILY WALSH:
I support S.B. 118 and the creation of a public health fund from the General Fund. My younger brother died one month before his eighteenth birthday from a

rare disease. Even though we knew the disease was in the area, we were unable to prevent the death of another young man, almost 20 years old. Mr. Kevin Dick with WCHD spoke about possibly hiring an epidemiologist after the COVID-19 money runs out, and I am in strong support of that. In the case of these rare diseases that are public health issues, at least in the Hantavirus case, the nearest specialist is in New Mexico and there is no treatment in Nevada. We had to have a test and wait seven days before finding out what killed my brother. Hantavirus is present throughout the entire State and is more rural in nature but both deaths were in Washoe County in 2019 and 2020. I urge your support of this bill.

NANCY BOWEN (Chief Executive Officer, Nevada Primary Care Association):
We are in support of S.B. 118. The Nevada Primary Care Association represents the State's eight community health centers, also known as Federally Qualified Health Centers. A key part of our mission is to identify and measure the impact of the work we do on the health of these centers. Public health data collected at the community level are crucial to the health center model.

CHAIR DOÑATE:
The hearing on S.B. 118 is now closed.

SENATOR NGUYEN:
I move to amend S B. 118 but with a further amendment to change it from a 45-day closeout period to 90 days. With those two amendments, I move to amend and do pass.

> SENATOR NGUYEN MOVED TO AMEND AND DO PASS AS AMENDED S.B. 118.
>
> SENATOR TITUS SECONDED THE MOTION.
>
> THE MOTION CARRIED UNANIMOUSLY.

* * * * *

CHAIR DOÑATE:
We will open the hearing on S.B. 44.

SENATE BILL 44: Revises provisions related to dental and oral health care. (BDR 38-221)

MS. PEEK:
I have overseen the Nevada Oral Health Program in DPBH for many years. I am presenting S.B. 44 and have provided a 2019 letter of intent from the Legislature (Exhibit I) to secure sustainable funding for the Program and included the salaries of the State dental health officer and State public health hygienists. This bill helps us ensure that DPBH can keep the commitment to have those positions and oversee the Nevada Oral Health Program.

Senate Bill 44 is designed to improve the hiring and retention of these two positions and streamline the management of the Nevada Oral Health Program. If passed, this bill would be effective July 1, 2023. Sections 1 and 2 change the language to allow the director of DHHS to appoint the State dental health officer and State public health dental hygienists. It also requests the reference to the Division of Health Care Financing and Policy to be replaced with the Department of Health and Human Services. The information related to residency, education, training and experience is to be left on; however, the licensure requirements are permissive for both positions. This will allow greater ability and flexibility to recruit and retain individuals in those positions. This will mimic the requirements of the chief medical officer position at DPBH and ensure we can still have opportunity and flexibility.

We request removing language that requires both positions to devote full-time employment to the office and limit any ability to hold another business or vocation outside of that role. It has been a challenge to recruit these positions based on salary, and we must support them. Removal of this language is especially important to the dental hygienist position because we only have funding to support that position part-time.

Sections 3 and 4 replace Division with Department as it relates to the oversight of the Advisory Committee on the State Program for Oral Health. It replaces division administrator with director to appoint positions to the Advisory Committee. Sections 5 and 6 replace Division with Department and administrator with director to oversee the State Program for Oral Health.

SENATOR TITUS:
I am fine with two-thirds of the bill, but I need help with the positions not having to be licensed in Nevada. I know our chief medical officer is not licensed and I have issues with that. Our State mandates that the Attorney General has a license to practice law in the State. There are other agencies where the person giving the advice must be licensed, such as the State Bar of Nevada. However, why our State chief medical officer and dental hygienist would not be licensed is something with which I do not agree.

I understand you need to be able to hire people for these positions. Perhaps, if you had language that you could hire them while their application was pending or that within a year of being hired, they had to be able to get a license. I understand there is a delay in licensure, but I have a tough time not having them licensed. I would point out that they may not actually practice dentistry, but they are going to be giving dental advice and not be licensed to do that. That is my issue with the bill. Everything else is good.

MS. PEEK:
Again, this just allows flexibility. The dental hygienist position was vacant for six months. Even worse, the dental health officer was vacant for 18 months. This is a Program of two people and losing one or two of those people means there is no longer a Program. It is a matter of saying we give you the flexibility to at least have a State Oral Health Program, which DPBH has been unable to do since we have had one or both positions vacant that support the Program. We also do not want to have a vacancy and not offer the service because it is mandated that the Nevada Oral Health Program happen.

SENATOR LANGE:
It looks like the position used to be full-time and now will be part-time. I do not see anywhere in the bill how it quantifies the amount of time they are going to spend performing in these positions. Who would monitor that time?

MS. PEEK:
Funding determines how much time can be devoted to those positions to do the work. It was approved that the State dental health director be a full-time position funded at 40 hours per week or more and is a non-classified position to work on behalf of Medicaid. The State dental hygienist is funded by Healthy Nevada and has only been able to fund that position half-time. If we were to apply for and receive a federal grant, and receive funds from S.B. 118, we

could make that position full-time. The State medical health officer reports to the Medicaid administrator and the State public health dental hygienist position reports to me.

CARYN SOLIE (Nevada Dental Hygienists' Association):
I am a registered dental hygienist in Nevada and represent the Nevada Dental Hygienists' Association (NDHA). The NDHA unanimously supports S.B. 44 (Exhibit J). The existing statutory requirements have excessive and restrictive language that do not exist for other State positions. This limits the pool of candidates that may apply for employment. This bill removes the restrictive language and would provide DHHS the flexibility to consider a broader pool of applicants. It would ensure we could get the best and most qualified candidates. Consideration could now be given to retired clinicians, part-time clinicians and disabled clinicians.

The existing language has conflicting requirements for licensure and clinical practice. Updating this language would resolve conflicting language and align the requirements with the job roles and responsibilities. The State oral health positions are administrative under Nevada Medicaid and do not require clinical hands-on practice. The NDHA unanimously supported the bill language in 2019 and the existing language has been problematic for many years.

The bill language was included in the 2021 Legislative Session as part of the larger oral health bill that was vetoed by the Governor. However, that language was not controversial. The language was supported by all leading dental and dental hygiene associations in our State and was passed by both houses with bipartisan support. The language in this bill reflects changes that are needed to adapt to the ever-changing healthcare landscape and to continue efforts to ensure that all Nevadans have access to dental care. The State Oral Health Program plays a vital role in protecting, promoting and improving oral health in Nevada. Oral health is integral to our total health. Thank you for your consideration of the proposed language that would bring the State Oral Health Program in alignment with what is needed for the future of the oral health of Nevada.

EDDIE ABLESER (Nevada Dental Association):
The Nevada Dental Association supports this bill and echoes the sentiments of the Nevada Dental Hygienists' Association and their support of the needed changes in the NRS. I want to identify some points of interest that show why

we might want to have that licensure provision in statute. The University of Nevada, Las Vegas, School of Dentistry also does not have mandatory licensure for teachers in that realm and they instruct and engage with many students. Some teachers may have a provisional license, and some may operate without a license and be dentists. The licensure provision in NRS warrants the proposed language to find qualified individuals for both these vital positions.

MERCEDES MAHARIS (Chaplain, Nevada Silver Haired Legislative Forum, District 3): I am in support of S.B. 44 and have worked with prisoners and parolees for many years. We need licensed dental care providers in each of our major Nevada Department of Corrections institutions. Oral health is obvious and determines whether our paroled prisoners can be hired. Overall, the lack of oral health and dental care in our prisons costs the State a fortune. It is easier to give them the help they need so they can be hired and become taxpayers and happy people. Nobody can smile with missing teeth and no one wants to hire those with missing teeth. I invite you to go to the parole center to talk and meet with the many people whose mouths are lacking basic care.

Remainder of page intentionally left blank; signature page to follow.

CHAIR DOÑATE:
The hearing on S.B. 44 is now closed.

It was heartwarming to see the support for public health. One of the things we have learned throughout the COVID-19 pandemic, not just in this State but nationally, is that we could have done a little better. However, bills like this remind me that if there is one more life we could save with the right resources, the fight will always be worth it.

Having nothing further to come before the Senate Committee on Health and Human Services, we are adjourned at 4:49 p.m.

RESPECTFULLY SUBMITTED:

Norma Mallett,
Committee Secretary

APPROVED BY:

Senator Fabian Doñate, Chair

DATE:

EXHIBIT SUMMARY				
Bill	**Exhibit Letter**	**Introduced on Minute Report Page No.**	**Witness / Entity**	**Description**
	A	1		Agenda
	B	1		Attendance Roster
	C	2	Julia Peek / NV Department of Health and Human Services	Presentation
	D	5	Julia Peek / NV Department of Health and Human Services	Map
S.B. 118	E	6	Megan Comlossy / Center for Public Health Excellence, UNR	Presentation
S.B. 118	F	10	Megan Comlossy / Center for Public Health Excellence, UNR	Proposed Amendment
S.B. 118	G	12	Dr. Fermin Leguen / Southern NV Health District	Presentation of SNHD Budget
S.B. 118	H	12	Dr. Fermin Leguen / Southern NV Health District	Budget Summary
S.B. 44	I	20	Julia Peek / DPBH, NV Department of Health and Human Services	2019 Letter of Intent from the Legislature
S.B. 44	J	22	Caryn Solie / Nevada Dental Hygienists' Association	Letter of Support