MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-sixth Session
April 11, 2011

The Senate Committee on Health and Human Services was called to order by Chair Allison Copening at 3:48 p.m. on Monday, April 11, 2011, in Room 2149 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to the Grant Sawyer State Office Building, Room 4412, 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 Allison Copening, Chair
Senator Valerie Wiener, Vice Chair
Senator Sheila Leslie
Senator Ruben J. Kihuen
Senator Joseph (Joe) P. Hardy
Senator Ben Kieckhefer
Senator Greg Brower

GUEST LEGISLATORS PRESENT:

Senator Barbara K. Cegavske, Clark County Senatorial District No. 8
Senator John J. Lee, Clark County Senatorial District No. 1

STAFF MEMBERS PRESENT:

Marsheilah Lyons, Policy Analyst
Risa Lang, Counsel
Shauna Kirk, Committee Secretary

OTHERS PRESENT:

Norton A. Roitman, M.D., D. PFAPA, Child Psychiatrist
Donna Coleman, Child Advocate
Thomas D. Morton, Director, Clark County Family Services
Kevin Schiller, Director, Washoe County Department of Social Services

Marla McDade Williams, B.A., M.P.A., Deputy Administrator, Health Division, Department of Health and Human Services
Patricia Merrifield, Deputy Administrator, Children's Mental Health, Division of Child and Family Services, Department of Health and Human Services
Peggy Lee Von
Gene P. Etcheverry, Executive Director, Lander County
Mike Sullivan, E.M.S. Coordinator, Emergency Medical Services, Eureka County
Tracey Green, M.D., Health Officer, Health Division, Department of Health and Human Services; Health Information Technology Blue Ribbon Task Force
Jennifer Hadayia, Public Health Program Manager, Washoe County Health District
Joan Hall, President, Nevada Rural Hospital Partners Foundation

CHAIR COPENING:
We will open the hearing on Senate Bill (S.B.) 371.

SENATE BILL 371: Makes various changes concerning the protection of children. (BDR 38-3)

SENATOR BARBARA K. CEGAVSKE (Clark County Senatorial District No. 8):
Over the last decade, there has been an exponential increase in the use of psychotropic medications prescribed for emotional and behavioral disorders in children and adolescents. While it is important that children in the child welfare system receive necessary mental health care, including psychotropic medications, we want to ensure that they receive them in a rational and safe manner. The purpose of S.B. 371 is to strengthen the safeguards for reviewing the use of psychotropic medications in the treatment process and to advocate for the child's mental and overall health-care needs. My written testimony (Exhibit C) covers key provisions in the bill.

The bill seeks to provide an important safeguard to ensure that children in the Nevada child welfare system have access to the best mental health care available. In a traditional family, parents act as the singular caretakers for their children. Many times children in the child welfare system receive fragmented services and care because they lack that singular and specific attention afforded to other children. Once again, this measure seeks to bring that type of attention to each child who is in the custody of a child welfare agency and who requires mental health services. I hope the Committee will give favorable consideration to this bill.

SENATOR WIENER:
Section 6 covers provisions if there is not reasonable care and liability based on negligence. I am thinking of a scenario in which a person or persons with legal guardianship makes a particular decision in good faith. The health-care professionals, in good faith, have a different opinion. Is there an opportunity to appeal because they feel they know what the legally responsible person might need, but is not in sync with them? Is there somewhere, in the best interest of the child, to have one more opportunity to provide a medication they feel medically necessary?

SENATOR CEGAVSKE:
I did not look for or present anything to alleviate that. Maybe counsel knows something that would better answer your question.

SENATOR WIENER:
I am talking about good faith on both parts.

SENATOR CEGAVSKE:
I understand.

SENATOR WIENER:
I do not see in the bill where the legal guardians would have the opportunity, in the best interest of the child, to make their case.

SENATOR CEGAVSKE:
I would ask counsel to respond. Perhaps Dr. Roitman or Donna Coleman in Las Vegas, who know these issues well, might know an answer to your question.

NORTON A. ROITMAN, M.D., D. PFAPA (Child Psychiatrist):
Regarding your question, the model for this bill is to convey the same type of responsibility to the designate as a parent has. The purpose is to show there is reasoning that goes into the decision about the medication. It is the same thing as when I would bring my child to the doctor; I would be the person to reason. It does not mean I have to be right, it means I have to be diligent.

The proposed amendment (Exhibit D) to S.B. 371 I submitted is to clarify that the person who is legally responsible is not the doctor. We are talking about a person who is legally responsible for the procurement and oversight of the

health care of a child. The intent is to amend that phrase in every occurrence throughout the bill.

We have letters of endorsement from the Nevada Psychological Association and the Nevada Psychiatric Association in favor of this bill based on our experience with the practices. I say in my testimony (Exhibit E) that medications are still used for all sorts of purposes other than treatment of illness, and I explain those observations further.

CHAIR COPENING:
I understand S.B. 371 is as a result of things that have gone wrong in the system with children who have had more than one kind of medicine with an adverse effect. Can you confirm that and share some experiences?

DR. ROITMAN:
Regularly, I receive new patients at Caliente Youth Center or at Boys Town Nevada where I have no medical information on them. The case manager is not present to discuss the case. I am told the medications the patient is taking, but there is no transfer summary from the sending organization. I feel an obligation to prescribe for the patient, sometimes by phone, because the child is transferred without a prescription or without a supply of medication. That is a reckless and potentially dangerous situation for our youth.

In my private practice, that never happens. Parents accompany their children and ask questions about the purpose of the medication, alternatives and risks, and the parent makes the decision. It is a standard informed consent procedure. This bill is to give these children who no longer have parents to guard them an individual who is mindful of their medical histories and understands it is the parent or parent substitute who makes the decisions for treatment. I also find that case managers are not aware they are the regulators; the ones who may be in the position to give or withhold consent. The case managers view the doctor as the decider in these matters, but that is not true. I know I do not usually have the comprehensive information needed to understand where the child is in the overall therapeutic plan, what adverse reactions might have been undergone and what medical conditions exist that would cause a problem with these medications. It is an act of faith rather than an act of science when I am prescribing.

CHAIR COPENING:
I do not know the child welfare system well enough, but when a child is placed in the system or taken into custody, is there not a caseworker who might be the person responsible for every aspect of that child's life, their history and medication?

DR. ROITMAN:
In theory, that is true. It largely depends on the motivation of the case manager, and we know they are overworked. Often, it is a custodial parent who may not know the child's history who accesses the doctor and complains of a symptom for which the doctor then prescribes. Maintaining placement is a high priority with the case manager. That practice is different than the proper diagnosis and treatment of psychiatric illnesses, which is what these medications are for. The short answer is, there could be and should be, but often there is not, the presence of a case manager to guard the safety of the child and carry the required medical information to the doctor.

SENATOR LESLIE:
The fiscal notes on S.B. 371 (Exhibit F) from the child welfare system are huge. Caseworkers also complain they could be liable if the person so designated did not do the job properly. I have heard this many times about children getting to institutions without their medical records. I have heard it both ways. When I was in Elko, the nurse told me they wean children off their psychotropic medications as quickly as they can, which is the other extreme. Who is liable? As in the case you described, where a child comes in without a medical history and somebody tells you the child has been taking 'x' drug, you are doing telemedicine, which is not a great way to do an initial evaluation, but I know that happens all the time. Who is liable if you prescribe the wrong drug? Is that on you?

DR. ROITMAN:
There is malpractice liability. Without proper medical information, I am more exposed than otherwise. It is competing values. The child is said to need this medication, and interrupting a treatment regimen of an anticonvulsive could have an adverse reaction. I have to weigh that liability against the risk I take for inaccurate or reckless prescribing. In a model of informed consent, a responsible party—in private practice it is a parent—shares that responsibility with me, makes a well-reasoned decision and proceeds.

In this system, there may not be that party present. It seems to me that once an agency takes on responsibility for a child, there are liabilities that go with it. Somebody needs to be accountable. I do not envision a draconian threat to anyone. I think that instead of being raised by committee, children should be raised by parents and parent substitutes. If the custodial parent or agency could be designated to be that party, that would make prescribing clear. This regulation would require the custodial parent to have the accurate medical history as well to monitor for side effects, and fill in that role. These children are already without their parents, and it seems to me they should have someone to fill in for their parents.

SENATOR LESLIE:
It is problematic no matter how you look at it. I have been concerned about this issue for a long time. I do not know if there is any middle ground, because we do not have an extra $12 million to implement S.B. 371 the way the agencies think it needs to be implemented. I do share the concern that children are showing up in our institutions without adequate medical records following them. I understand that sometimes those records do not exist. Instead of child welfare agencies coming up with impossible fiscal notes, I hope they come up with some other ideas.

DR. ROITMAN:
The bill has a provision for the case manager not to show up and to provide written authorization and written communication, instead of making an appearance at each visit knowing, practically speaking, that their caseloads are so large. Nevertheless, that is not a reason these children should be put at unnecessary risk.

CHAIR COPENING:
How big would you say the problem is? How many children have you come across in situations where they are actually on these psychotropic drugs and run into this particular problem?

DR. ROITMAN:
Every admission I get at Caliente Youth Center does not have proper medical and psychiatric information. At Boys Town Nevada, it is the rule, rather than the exception, that I am without enough information to prescribe safely.

SENATOR HARDY:
On page 5, starting with line 23 of S.B. 371, it says:

> The foster parent or other provider of substitute care for a child in the custody of an agency which provides child welfare service shall not administer a psychotropic medication to the child unless: (a) The person who is legally responsible for the health care of the child has consented to the administration of the medication; and (b) The psychotropic medication is administered in accordance with the consent of the person who is legally responsible for the health care of the child.

Now there is somebody who is responsible for the health care, not just the mental health care. Also, a medicine that may be needed acutely cannot be administered. I get the child on Saturday who cannot be on his medicines until I can get somebody on the phone Monday or Tuesday. Now I am withdrawing a child from medication. The way I see this constructed, I have two problems, I need to treat the child, but I am not allowed, and I do not know with what. This gets at the concept of trying to figure out where the child was before. The way S.B. 371 is written, if I need to continue a medicine the child is already on, but there is no person in place or the person in place is unavailable, out of cell phone range, I am not allowed to treat the child. That is how I am reading the language in the bill. Is that the way you want it, or is there a better way to give a child medicine so we do not automatically take him or her off?

DR. ROITMAN:
The transfer into a new custodial agency or care would be through the case manager in the first place. It seems to me that part of the transfer procedure would involve the authorization of the prescription. It would be a problem if the child just showed up at a new agency or home without this work being done. This raises the level of consciousness of the need for basic medical information. The difference between mental health care and medical health care, to me, is an artificial distinction. I am using medications that affect the health and well-being of the child.

SENATOR HARDY:
I appreciate that, being a family doctor myself. Looking at the construct from a legal standpoint, I see two different things in S.B. 371; the health care and the mental health care. Being a family practitioner, I understand what you are

saying, Dr. Roitman. I am not sure the attorneys are going to understand the distinction unless we make some kind of nexus there.

DONNA COLEMAN (Child Advocate):
I support S.B. 371. On January 22, 2011, the State issued a new policy on the use of psychotropic medicines. The new policy is good, including getting consent from parents and going back to obtain consent from parents whose children are currently on drugs and have not been consulted. What it does not do is designate a particular person to act as a parent when no parent can be found, and there are quite a few children in that category. I sent the Committee e-mails regarding a multistate study by Tufts University on the use of psychotropic medicines in foster care. It was recommended that the agency specify a decision maker to give that informed consent.

THOMAS D. MORTON (Director, Clark County Family Services):
We agree with Senator Cegavske that this problem needs a solution. I am here to express the concerns of Clark County management and the analysis of our civil district attorneys regarding this particular solution, which is the basis of our opposition to S.B. 371. I have contacted other people identified in the legislation as possible legally responsible persons, including children's attorneys in Clark County, who tell me that in their views it would be a conflict of interest for them to assume this role. Secondly, there is no way they would want to assume the liability. I spoke with the director of the Nevada Court Appointed Special Advocate (CASA) association. He said as you know we do not have *ad litem* guardians. We appoint CASA in lieu of *guardians ad litem*. The director was clear that in no way would CASA assume the legal liability for being this person and would decline that appointment.

As a result of a settlement in a prior case, foster parents in Clark County are no longer covered by a blanket liability process, so there is no way Clark County would ask or allow, under their contract, foster parents to assume this role due to the inability to support them regarding the liability provisions of the bill.

The bill suggests parents can be named. Obviously, that is the first intent that parents, to the extent they retain parental rights, should remain in control of the care and treatment of their children. The bill also says we can appoint other persons, but "other persons" are not identified. Regarding parents, Clark County in no way has the staff infrastructure and fiscal resources to ensure that parents preapprove all medical care and attend all appointments or be present or

available by phone for all of the child's visits to the provider, as specified in S.B. 371. Previous testimony said the case manager could be this person, but case managers in Clark County are already overwhelmed. Our foster care case managers are currently carrying an average of 32 children on their caseloads. I do not think these case managers are adequately trained or have the time to look into potential conflicts with other medication.

We do make an effort through our medical passport program to obtain a complete medical history to follow the child. On the other hand, given the circumstances for removal and other factors, it is often the case that we are missing significant parts of the medical history. Our medical case-management units do as well as they can to keep up with the immediate needs for medical information. It is also our analysis that the implications of this bill to implement larger medical case management through hiring nurses to perform this function would carry an annual fiscal impact of approximately $4 million. We point out there has been no analysis of the workload or fiscal impact on the office of the district attorney or the courts for filing petitions. Further, it is not clear who would be entitled to notice of these petitions and what the fiscal impact would be.

Clark County opposes S.B. 371 because of the impracticality of its implementation and the inadequate availability of resources. Due to other potential actions of the Legislature in this Session, I am looking at possible further reductions in staffing. It is possible that by the end of summer, when we look at the full impact of the economy, we will have lost the equivalent of approximately 140 positions created by Clark County and the Legislature in the 2007 Session. The practical reality is in order to maintain the frontline safety net for child protection investigators, case managers etc., we have had to chip away at clinical staff and other staff who provide support behind the front lines that conceivably could have taken on some of this.

In summary, our primary reasons for opposing the bill are that due to the liability and other considerations, none of the people identified as possible persons legally responsible would be willing to accept this. For that reason we would be unable to implement this bill, and without adequate fiscal resources provided by the Legislature, we would not be able to implement the bill.

CHAIR COPENING:
Have you been working on a solution? Do you have anything in mind about how to address this issue?

MR. MORTON:
The policy the State created earlier this year is a good step forward, but we face fiscal limitations in our ability to implement the policy. Again, I would support the primary position for parents who still have legal rights to their children to be in that role. The parents should be sought and informed consent provided by the parents. The primary objective would be to keep every parent empowered. In Clark County, we have fiscal restraints in contacting all parents to inform them, and we have been unable to implement our version of the policy because we do not have funds for a psychiatric consultant who can review the medication prescribed by the psychiatrist or physician.

CHAIR COPENING:
I do not know if this would be a practical approach, to have physicians on staff as the children come in and out to take care of the assessment right then. It seems it would be a lot less than $12 million for that, but I do not know how the process works on your end. Is that even a solution?

MR. MORTON:
It is a potential solution. Clark County is working on an expanded medical clinic located on the Clark County School District's Child Haven campus, so that for the first time, our children will have a medical home and we will have the equivalent of a medical director. It is hoped that through this provision we will be able to meet a critical piece of the current policy to have prescriptions reviewed by the medical staff. At present, when we remove children, they receive a nurse screening, available 24 hours a day, 7 days a week. It is the State's policy that children have an early periodic screening, diagnosis and treatment (EPSDT) examination by a pediatrician within 14 days; we struggle to meet that. It is good policy, but a resource constraint. We hope through the medical clinic we are establishing that we will be able to do better on the EPSDT examinations. I see that as a potential resource relative to the component of the policy I mentioned. When it comes to obtaining full, informed consent from each parent, the time involved for the caseworker contacting, informing, etc. is significant.

CHAIR COPENING:
Do you have an estimated time when the medical clinic will debut? Is its debut being impacted by the budget cuts?

MR. MORTON:
It is anticipated to start operation by June. It is a matter of redesign of the physical facility. The funds are there for the reconstruction which is happening now. All the billing for services of the clinic would be done through State Medicaid. Pending cuts in Medicaid would make the financial operation of the clinic infeasible, but I do not see any problems in that regard.

KEVIN SCHILLER (Director, Washoe County Department of Social Services):
We recognize from the sponsorship of S.B. 371 that it is a needed issue. Over the last couple of years, child welfare has tried to look at this issue and take steps to implement. You have heard about the policy which is one example. One thing Washoe County recognized is the need for qualified individuals to manage how we are administering those medications. A case manager, in relationship to a clinician who is internal, is an example of how we might blend our resources for better management. We also have a medical home model with a pediatrician on staff. We partnered with our juvenile services agency and brought in a psychologist to serve both departments. We are overseeing the medication management for which our case managers are technically responsible in terms of meeting the well-being of these children.

When I look at S.B. 371, and as much as I have heard opposition and fiscal discussion, I believe there is merit for this issue if there is a way to redraft, a way to make it not so detailed in terms of the scope. As an agency, we already have the responsibility for ensuring those children receive their medications appropriately. What we want is to own it and are continuing to work on that. I am willing to support any way possible, in this Session, to do this with a minimal fiscal impact. We have tried, in Washoe County at least, to collaborate with clinical staff qualified to manage this. The policy is one component. But who is carrying out the policy, and who understands psychotropic medications?

An example, that may have been given earlier, is the clinician who sees a child and prescribes medication "A" but that clinician writing the prescription does not know what physician "B" did on the other side. We have a responsibility as the manager for that child to make sure the appropriate information is provided to that treating physician. This bill has merit and is also a concern. We are

willing to work towards any follow-up policy or procedure that statutorily can assist in improving the process, because it does need to stay in the forefront. We have a responsibility that has a direct tie to treatment-level foster care. I want to put on the record we are willing to do that and to assist.

CHAIR COPENING:
We have two days. How quickly can you get an amendment put together?

MR. SCHILLER:
I was not suggesting an amendment, but if there is a way to come up with a level of accountability and responsibility that mirrors our existing resources and is more realistic; that is what I would like to work on.

CHAIR COPENING:
We will close the hearing on S.B. 371 and open the hearing on S.B. 246.

SENATE BILL 246: Makes various changes concerning required training for employees who administer medication to a child at certain entities that have custody of the child pursuant to the order of a court. (BDR 40-796)

SENATOR SHEILA LESLIE (Washoe County Senatorial District No. 1):
I have prepared remarks (Exhibit G) but would like to focus on the primary reason for S.B. 246. We had a federal investigation under the Civil Rights of Institutionalized Persons Act several years ago at one of our youth institutions in Elko. After that federal civil rights investigation, the Legislature passed several bills last Session, one of which was to put into statute to have a legislative auditor dedicated to regularly review all governmental and private facilities for children. These reports come out about every six months and the latest State of Nevada Review of Governmental and Private Facilities for Children (Exhibit H, original is on file in the Research Library) report is dated December 2010. These reports are reviewed by the Legislative Commission's Audit Subcommittee. The audits focus on intensively reviewing a number of issues at these facilities. Auditors make both announced and unannounced site visits. This system helps us avoid further civil rights investigations by providing Legislators with precise information about problem areas before they get out of control.

Medication management regularly surfaced in these reports and is the focus of S.B. 246. The audit report recommends that all facilities' medication

management staff receive extensive training. This is the basis for section 1, subsection 1, paragraphs (a) to (f) in the bill.

In support of the bill, I will give a couple of examples of auditors' findings. Auditors found that 28 percent of the facilities did not completely document physician's orders. In administering medication to a child, the auditors found that 59 percent of facilities reviewed had trouble administering medication. In one report, 6 of 25 files reviewed at our own Nevada Youth Training Center Bureau, Department of Health and Human Services (DHHS), did not contain clear documentation of whether medication was actually dispensed to children. The third area is in the storage, handling and disposition of medication, of which 31 percent of facilities had issues. In one facility, they found copious amounts of medication that had not been destroyed, having been prescribed to graduated youth. In the same facility, the auditors found two large bottles of unlabeled prescription medication, Seroquel and Depakote, which are serious medications. There are many more examples in the report.

SENATOR KIECKHEFER:
In terms of who creates these training programs, I think I understand the nexus for having the administrator of the Health Division (HD), DHHS, issue the certification as part of the licensing through Division of Health Care Financing and Policy (DHCFP), DHHS. Are they really the people to certify which training programs are appropriate or would that be more the Division of Mental Health and Developmental Services (MHDS), DHHS, or Division of Child and Family Services (DCFS), DHHS?

SENATOR LESLIE:
I am open to whoever is the most appropriate. I think we ended up with the HD because they certify the facilities. We are talking basic medication management programs. In the bill we asked the administrator of the HD to maintain the list of certified programs. I believe some of the training can happen on the Internet. Somebody needs to say this is an approved training program and this one is not.

SENATOR KIECKHEFER:
I know with psychotropics there are injectables as well as pills. Would this bill cover all of the above?

SENATOR LESLIE:
I think it would. Obviously, you would have to have different training to inject medication. In the audits I have read, the problems have been more about making sure the right medication gets in the right cup and to the right child, and documenting that. A lot of the audits involved the paperwork trail, which is important for knowing which child took which medication. Also, there are procedures such as "cheeking," which makes sure the child actually swallowed the medication. There is appropriate training for working with children in confined institutions that might be different than in other situations.

CHAIR COPENING:
In section 1, subsection 2, paragraph (a), the Administrator may: "Approve training programs ... ." Now section 1, subsection 4 says, "The Administrator is not required to comply with the provisions of chapter 233B of NRS to approve or provide for training programs ... ." You may not know offhand, but what is 233B of the *Nevada Revised Statutes* (NRS) where is says the administrator does not have to do this?

RISA LANG (Counsel):
Chapter 233B of NRS is the Administrative Procedures Act. This is saying you do not have to have a public hearing to make those decisions.

MR. SCHILLER:
As a county department, we support S.B. 246 and would like it to move forward.

MARLA MCDADE WILLIAMS, B.A., M.P.A. (Deputy Administrator, Department of Health and Human Services, Health Division):
We are neutral on S.B. 246 but wanted to provide some information. The entities covered under the bill include medical facilities currently licensed by the HD as facilities for the detention of children, including specialized foster homes or group foster homes, child care facilities and any DCFS treatment facility or other DHHS facility into which a child may be committed by a court order. It does require employees of these entities to complete the training program successfully before administering medication to these children. Consideration may want to be made to exempt medical facilities in which licensed professionals, such as nurses, administer medication. The training nurses receive for medication administration is more intense than what is given to non-licensed caregivers.

There is a minimal effect on the HD. Currently, we have ten approved medication training programs. We would ask the consideration of not making it a mandate on the HD to ensure the training programs are available, just in case we cannot get enough people in and we are the ones held as not being able to pull them together.

We have private sector individuals who come to us with their programs. We look at those programs and approve them if they are consistent with the regulations in place for medication administration.

SENATOR LESLIE:
I appreciate the point about the nurses, and if we can certify that a facility has that higher level of care, then it should be exempted, and I am fine with that.

If we eliminate the mandate, does that eliminate the fiscal note?

MS. MCDADE WILLIAMS:
The HD did not put a fiscal note on S.B. 246. I believe the DCFS added the fiscal note because they are going to have to pay to get their staff trained.

SENATOR LESLIE:
They need to get their staff trained because that is the point of the bill. Could you be more specific about the mandate in the bill?

MS. MCDADE WILLIAMS:
At line 3, page 2, if it just said, The Administrator "may" ensure that adequate training ... . It is not that we do not intend to do that, and there are a lot of other caretakers that would be eligible for training, but we need to bring our list up to 20 eligible providers to train. The HD does not currently do this training, we simply approve the programs. What happens if the HD cannot meet that mandate to ensure training is available because it is a voluntary system where people sign up?

SENATOR LESLIE:
I think it should not be a problem to find adequate training.

PATRICIA MERRIFIELD (Deputy Administrator, Children's Mental Health, Division of Child and Family Services, Department of Health and Human Services):
We put a fiscal note on S.B. 246, but did not put any money in it because we do not know what it will cost us. We absolutely support training of staff who administer medication. We do that now. We would look forward to enhancing and strengthening that training in any way possible. It will impact our federal cost allocation plan because we would be pulling staff off of direct services. We understand that and did not calculate the amount.

Our understanding is that the training offered focuses on medication management and administration for long-term care facilities for adults. In talking with staff at the HD, some of the details of training for children with severe emotional disturbances may be a little different than adults with dementia, as an example. We are suggesting you may want to look at the timeline for implementation. It may not be until July 1, that we can put together and have the HD approve training specifically for children with severe emotional disturbances.

SENATOR LESLIE:
Section 15 of S.B. 246 says the act becomes effective upon passage and approval for the purpose of taking such actions as are necessary, etc. Actually, it says we would have to have this in place and ready to go on January 1, 2012. Where are you reading July 1?

MS. MERRIFIELD:
It all depends on whether or not we can get enough programs approved and get people trained and ready in six months.

SENATOR LESLIE:
The fiscal note (Exhibit I) shows $28,600 in fiscal year (FY) 2012 and $14,075 in FY 2013, and says this is from the DCFS. If there is a fiscal note, we would have to send the bill to the Senate Committee on Finance. This is not what you said, and I want you to be correct.

MS. MERRIFIELD:
I will double-check and communicate back to you.

CHAIR COPENING:
We will close the hearing on S.B. 246 and open the work session with S.B. 43.

SENATE BILL 43: Makes various changes relating to electronic health records. (BDR 40-443)

MARSHEILAH LYONS (Policy Analyst):
This bill was first heard February 17, 2011, subsequently heard three times in the subcommittee on S.B. 43 chaired by Senator Valerie Wiener and attended by Senator Ben Kieckhefer. As reported in the work session document (Exhibit J), the subcommittee recommends to amend and do pass the bill with a mock-up of the final amendment (Exhibit K). There were a few outstanding issues the subcommittee wanted the full Committee to be aware of and to consider on page 3, Exhibit J. These concerns were brought forward by the Nevada Medical Association (NMA) and the Nevada Eagle Forum.

CHAIR COPENING:
The Health Insurance Portability and Accountability Act (HIPAA) of 1997 already addresses the concerns, does it not?

MS. LYONS:
It is a policy decision of the Committee. However, my understanding is that HIPAA laws do set a precedent for the ownership of the data to be with the patient. The legal counsel may better speak to this, but in the issue of ownership, there are some stewardship responsibilities that the medical provider has who actually puts in the data. Then, there are responsibilities on the part of the patient as far as the control of the data, access of the data and movement of the data. It is a shared ownership. The NMA may speak to it clearer, but the concern comes from litigation in some states where health information exchange (HIE) systems have taken data to use in different ways. According to HIPAA, the data was commandeered, saying it belonged to the system. That is the concern addressed by the amendment to require the director of DHHS to prescribe by regulation or the additional concerns raised about having the Committee give more direction.

SENATOR WIENER:
It partners with the amount and kind of information the patient may want transmitted to another medical provider. It is not just owning, but taking ownership of that data. I have a long history in the Legislature on the identity theft issue. This is not letting that information run afoul, so that the people who have it will be responsible and we know who they are. It was more than just the

transmission of information, but the ownership and stewardship of the information.

MS. LYONS:
The mock-up, Exhibit K, is just that; it was not done by the Legal Division or the Research Division of the Legislative Counsel Bureau, so it is conceptual. When the language is drafted by the Legal Division, it will be different, but the intent is included in the boxes. The subcommittee wants their definition of "Electronic health record" to be used in section 1, subsection 3, instead of the one that was originally in the bill.

The second proposed amendment is to add two new definitions under section 4. Subsection 2, paragraph (a) defines "person" as that term is defined in NRS 0.039 and includes a government, governmental agency or political subdivision of a government. The other definition would be subsection 2, paragraph (b) that "health care provider" has the meaning ascribed in Title 45 Code of Federal Regulations (CFR), action 160.103 for consistency. The third proposed amendment to section 4, as subsection 3, is to add storage and analysis into the definition of HIE system.

The fourth proposed amendment is to section 5, subsection 1, paragraph (a) with additional language to clarify the responsibilities of the director to mirror the terms and conditions of the State Health Information Exchange Cooperative Agreement.

The fifth proposed amendment revises section 5, subsection 1, paragraphs (b) and (c) because they are already covered under section 5, subsection 1, paragraph (a).

The sixth proposed amendment strikes section 5, subsection 1, paragraph (c) as it is duplicative and unnecessary.

The seventh proposed amendment to section 5, subsection 1, paragraph (e) is an effort to ensure that patient information does not become the property of any corporation or nonprofit entity.

SENATOR LESLIE:
This is an area I had questions about and want to be sure I understand. We are adding a specific section requiring the DHHS to have a regulator process to outline who owns the data. Is that the gist of it?

MS. LYONS:
As I understand the request for the amendment, they wanted DHHS to consider rules governing that ownership and stewardship of the information. I do not know whether the regulations would actually say who owns the data. The concern raised is that it would not be owned by the separate corporation or entity that was being created.

SENATOR KIECKHEFER:
I thought that was clearly stated on the record that it is the patient, the individual, who retains ownership of these records under all circumstances and under no circumstances do they belong to the HIE, which would be an IRS section 501(c)3 organization.

SENATOR WIENER:
It would also be medical care providers, the doctors, because they would have ownership of that person's records as well as the patient. It would not be the nonprofit organization, the HIE, as they are just the transmitters of the data. The HIE should not have any ownership of the record.

CHAIR COPENING:
Right now it says prescribed by regulations or rules governing the ownership. Do we want to leave that to regulations, or do we want to strengthen that language by stating in S.B. 43 who has that ownership?

SENATOR WIENER:
For clarity, this should be statutory, because we are already having that conversation. For all the years I have been here, when it goes into statute, it means we have the intention to keep it for a long life. For the continuity of policy, it is important. Regulations are more flexible to address circumstances, conditions, fees, rates, etc. that have flux. This is important to people who are concerned about protection, especially as we address the concerns about those who choose not to be engaged with the HIE. We need to make a clear policy statement on ownership and give as much protection of that to the people whose record it is.

CHAIR COPENING:
Do we agree that the ownership belongs to the patient and the doctor and we want it to state not the administrator, the nonprofit? Is that what I understood in the dialogue?

SENATOR WIENER:
That would be my thought. In our conversations, the medical information was the patient's and the doctor's, so whose is it? The record is in their custody, and they are the ones providing the care. Then it would be the patient's decision as to how that information is used as it is conveyed across the HIE to the next doctor. In that case, the doctor does not decide where the medical data goes after that; it would be up to the patient to collaborate with the doctor to determine what information is transmitted.

MS. LANG:
That is my understanding from the conversations that the patient would determine who else the doctor may share the information with and how it may be transmitted. The medical information would not belong to the HIE itself; they would just be a conduit for transferring information.

CHAIR COPENING:
We will propose an amendment that conceptually says the patient and the doctor are the owners of the medical information, not the nonprofit administrator, and the patient retains control of the dissemination of his or her information.

MS. LYONS:
Amendment 8 to section 5, subsection 1, paragraph (f) is another requirement being added, because Nevada does not have a standardized process for prescription medication prior authorization, which can result in delayed patient treatment. The provision requires the director, jointly with the State Board of Pharmacy and other relevant State agencies, to conduct a study to determine the manner in which to provide for the standardization of electronic transmissions of prior authorizations. It has a deadline for when the study must be completed, which is to be done prior to the implementation of the standards.

Amendment 9 to section 6, subsections 1 and 2, paragraph (d), is to be consistent with the HIE government structure recommendations of the Health Information Technology (HIT) Blue Ribbon Task Force and with the

State HIT Plan submitted to DHHS. This clarifies that the nonprofit entity with oversight over the HIE system will work collaboratively with the director. It cleans up language where it left the impression there were multiple entities with that function.

Amendment 10 adds paragraph (g) to section 6 and subsection 2 also relating to the HIE governing entity being required to comply with the Open Meeting Law.

Amendment 11 adds language to section 7, subsection 1 that the director will prescribe standards to ensure that electronic health records and the HIE system are secure. These changes are made in paragraphs (b), (c) and (d), and in new subsection 2 to further clarify the provisions.

Section 8 of S.B. 43 has several changes to clarify and revise penalties. Health-care providers who choose not to participate can continue their medical practices without penalties. The section also removes language creating a new misdemeanor, and clarifies a minor's right to confidential access to certain forms of medical care.

SENATOR WIENER:
As we discussed, that health-care provider would not just be a medical provider. Would that also include a facility? Is it any provider of care in whatever capacity?

MS. LYONS:
As I understand the question, the particular concern was that the proponents of that type of amendment understood that physicians manage their office as they choose. If I go to one physician who requires the use of my data to go into the HIE system, I could choose another physician. That came out in some of the testimony. The particular concern was for a person in a rural area with only one facility who does not want the data in the HIE system. Would there be protection for that patient to choose not to have the data in this system and still go to that facility without being turned away?

SENATOR WIENER:
For clarification, is it beyond the emergency situation, because that is not part of this conversation?

MS. LYONS:
Yes.

CHAIR COPENING:
I do not know how the rest of the Committee feels, but I would be in favor of adding that language, because there are going to be patients who do not want to be part of this HIE. They should not be rejected as patients if they go to a rural facility.

SENATOR WIENER:
In an urban situation, it is easier to choose another facility. In Elko, where there is only one hospital within a day's drive and you need care, what can one do when the hospital says no? That concerns me if we want health-care opportunities. I do not know what complications there may be in the future because the medical information is not in the exchange. That could be addressed in another legislative session, but we are going to be working our way through this for a long time. I would be reluctant to support something that would deny somebody care just because they are not having acute appendicitis at the time they are admitted to the hospital.

CHAIR COPENING:
I understand, Senator Wiener, you would be in favor of adding language that would put those protections in place.

SENATOR KIECKHEFER:
This is a sticky area, because hospital systems are developing HIE systems ultimately as their sole source of patient data. When seeing a doctor working off of his iPad, you are probably in an HIE. If that is the case, that doctor probably cannot care for you without including you in the system. It is also a private business decision by those private providers over how they provide care to their patients. This is a tough spot, and I think it will be impossible, in some cases, to implement something like that.

CHAIR COPENING:
You make a good point, as did Senator Wiener, about the rural areas. This is an ongoing process. I would be comfortable not putting something in, but looking at language, as this evolves, that would address situations where it is going to be beyond the control of somebody in the rural areas. I think there should still be some freedoms of not having to have certain information accessible, and we

will run into problems with that. I am fine with skipping over it for now and continuing to revisit it.

SENATOR LESLIE:
I tend to agree with Senator Kieckhefer. It is not just the rural areas. We all remember the balanced billing discussion that when you have insurance, they pretty much dictate where you go. I do not know if insurance companies would start dictating that you must also participate in HIE. Probably five years from now, we will look back and everybody will be in it anyway. I do understand the concern and reluctance people have, but I am not sure how realistic it is.

MS. LYONS:
Amendment 17 also requires the director to establish by regulation a process for educating the public on reporting HIPAA violations. This addresses the way people felt about HIPAA violations being reported now so far from Nevada. This is an attempt to bring it closer to Nevada. The request was for DHHS to put forward education pieces to let individuals know how they reported those violations.

Amendment 18 adds new language with paragraph (c) to section 8, subsection 3 after line 10 of S.B. 43. This goes back to proposed amendment 11.

Amendment 19 specifies the standard of reasonable care and removes the reference to "in good faith." That is for a health-care provider who relies upon the health records accessed through an HIE.

Amendment 20 adds new language. The intent is to provide the governing entity and HIE systems with indemnification similar to the levels provided to health-care providers in section 9 of S.B. 43, should there be a problem with outcomes associated with the use of the HIE system.

Amendment 21 corrects a typographical error in section 11, subsection 3.

Amendment 22 removes the effective date of October 1, 2011, and makes the act effective upon passage and approval.

SENATOR KIECKHEFER:
It would be helpful to me to get an actual legal mock-up with the amendments in place before voting. I do not know if this could happen by the end of the week.

SENATOR LESLIE:
I am still reflecting on amendment 7. Does this include that a corporation or nonprofit entity would not be able to sell the data? Surely, if they do not own the data, they cannot sell the data. I want to make sure that is clear.

SENATOR WIENER:
They cannot market it; they cannot profit from it. That is already part of HIPAA.

SENATOR HARDY:
In full disclosure, I will not be voting on S.B. 43, as I am a board member of HealthInsight.

PEGGY LEE VON:
I know there have been times when I have asked for test results and doctor's reports to be sent to me, and recently I have been told they are not sure they can do that. I have referred to previous NRS that say I own the contents of my medical file. In the conversation between the two of you, one said the individual owns the content of their medical file and the other said the doctor and you own the contents of your medical file. I hope it truly is that the individual is the owner of the file and the disseminator is through the conduit or whatever, but that no doctor owns my file—no physician is in control.

Another thing pertains to the medical files and electronic capabilities. Just so you know, I received notice about two and a half years ago from St. Mary's Hospital that a hacker had broken into their patient records. They had my social security number and my credit card numbers, if I paid my bill with credit cards. They had my name, address and my telephone number. I do not think the hospital knew exactly where I was born, which was the only information the hackers did not get. The hospital provided protections through the three credit reporting agencies for a period of time in case that information was used. I am concerned whether or not a person opts out of this, that technology will take care of itself in the course of time. Until then, I thought you were on the right track pertaining to somebody who wants out that they should have that right.

SENATOR WIENER MOVED TO AMEND AND DO PASS S.B. 43 WITH THE PROPOSED AMENDMENTS AND THE ADDITIONAL DISCUSSION ON THE OUTSTANDING ISSUES ON PAGE 3 OF THE WORK SESSION DOCUMENT (EXHIBIT J), INCLUDING ISSUE NUMBER 1 AND PASSING ON ISSUE NUMBER 2.

SENATOR LESLIE SECONDED THE MOTION.

THE MOTION PASSED. (SENATOR HARDY ABSTAINED FROM THE VOTE.)

* * * * *

MS. LYONS:
We are moving on to S.B. 138 in the work session document

SENATE BILL 138: Revises provisions relating to emergency medical services provided in certain counties. (BDR 40-642)

This bill was heard on February 22, 2011. There is a proposed amendment as a mock-up of the bill (Exhibit L), submitted by Senator John J. Lee.

SENATOR JOHN J. LEE (Clark County Senatorial District No. 1):
We were able to identify what "driver" meant. A driver was not just somebody who grabs your child quickly, saying, "You drive the car, I am going out to pick up a body and bring it in." In the rural areas, in an ambulance situation, what a driver would mean is different. We also talked about what constitutes an emergency or catastrophe, so we utilize these people only when we do not have the people who are emergency medical technician (EMT) trained. Also, we discussed how to certify volunteer firefighters to be certified drivers.

GENE P. ETCHEVERRY (Executive Director, Lander County):
Lander County put forward S.B. 138 due to existing situations in our county with the provision of emergency medical services (EMS). As you may be aware, Interstate Highway 80 (I-80) traverses the northern part of Lander County, and U.S. Highway 50 traverses the southern part of our county. Going up the middle of our county are State Highway 305 and State Highway 376 which goes from Tonopah to Highway 50. We cover broad expanses, not necessarily with a lot of population, and therein lies the problem. We have trouble supplying our EMS

with both drivers and EMTs. We had an incident before Christmas, in which I was involved, that took three of us out of the picture for hours because we were involved in an accident on I-80 about 17 miles west of Battle Mountain. It is difficult to have these services on the road and provide two EMTs, one of whom ends up driving and one in the patient compartment providing patient care, let alone, if we can only get one EMT and a driver. In the last mark-up of this bill, we arrived at something that provides us with the opportunity, particularly in an emergency situation, to get someone who can drive that unit and have a qualified licensed person providing the patient care.

Near the bottom on page 11, below section 10 of the mock-up, Exhibit L, where it says "Driver" defined, we would like that removed. Also, the rest of the bill from section 10 on, as submitted, would be removed. Therefore, what is left are the provisions of allowing, in an emergency situation, the board of county commissioners or the incident commander to name individuals who are able to drive those emergency response units, and allow those emergency response units, that may not be ambulances, to respond to such an emergency. It also puts in the provision of review after the emergency or catastrophic event has taken place. The further amendment of NRS 450B would be left off this last mock-up.

CHAIR COPENING:
With all these changes, what does S.B. 138 now do?

MR. ETCHEVERRY:
It simplifies it to come closer to what my commission had envisioned when they had asked for legislation to be considered. What the bill does, in an emergency situation not only for those counties whose population is under 15,000, is provide for either the incident commander or the county commissioners to declare an emergency. In that catastrophic event, it would allow people to operate emergency vehicles without being a driver licensed through State EMS to drive that emergency vehicle. It also provides through NRS 450B for the review of that event.

MIKE SULLIVAN (E.M.S. Coordinator, Emergency Medical Services, Eureka County):
As stated in my written testimony (Exhibit M) we have an official position of neutral on S.B. 138 with concerns. The bill as amended has taken care of most of our concerns. I would like to point out that we have had the authority under

present statute to utilize vehicles and personnel in a catastrophic emergency or other disaster to transport patients, but not care for them. The language clarifies that.

The change that redefines "driver" is a good change. It clarifies what training an ambulance attendant driver needs. Eureka County utilizes a driver, instead of EMTs. I have programs in both our ambulance services for that.

CHAIR COPENING:
Are you aware that it is going to be stricken?

MR. SULLIVAN:
Yes. I just became aware of it.

CHAIR COPENING:
That is correct, Mr. Etcheverry, that you just said you would like to strike that word, "however," right?

MR. ETCHEVERRY:
It is my understanding that in order for S.B. 138 to go through as a clarifying measure, that it be stricken.

MS. LANG:
If the Committee is comfortable with the intent they expressed, I would work with them on language consistent with our statutory language.

SENATOR LESLIE:
To understand where we are going with this; at the hearing when we talked about the ambulance in Austin, and the driver living 30 miles away, that is not what we are talking about anymore. Now we are talking about catastrophic events only?

MR. ETCHEVERRY:
That is correct. Working with State EMS, we have found that most of what we need, upon review of either NRS 450B or *Nevada Administrative Code* 450B, is already there to a certain extent.

SENATOR LESLIE:
A catastrophic event would be like a huge wildfire, and you are envisioning the county commission would meet and decide whether it was catastrophic. I am trying to understand how this would play out. It would have to be something catastrophic—huge. Right?

MR. ETCHEVERRY:
The event with which we were involved was on December 17, 2010. The unit I was in was first dispatched to Elko County, east of us, to three different incidents. Our second unit in Battle Mountain was also out on an incident east of Battle Mountain. Then we were dispatched 52 miles west of Battle Mountain. There had been minimal maintenance on I-80 during a major storm.

SENATOR LESLIE:
So, your county commission would meet and say we have a catastrophe?

MR. ETCHEVERRY:
Either the commissioners would meet or in the case of Lander County, under our code, our sheriff is the emergency manager or the emergency coordinator and he could designate it as catastrophic.

SENATOR LESLIE:
Is this not already covered? If there is a situation like that or a true catastrophe, can you not move people around as needed?

MR. SULLIVAN:
My understanding of the statute is that you are correct. We have used that statute in Eureka County in situations where we did not have either appropriate equipment or enough people. I would caution the Committee that it is better to have trained personnel and licensed personnel to operate emergency apparatus, especially ambulances. But in a catastrophe, we do have that authority. The statute clarifies it and calls for a review afterwards. That will also help.

SENATOR LESLIE:
Under emergency management, do you not normally do a review anyway? I thought most emergency managers, when a catastrophic situation happens, do what is called incident reviews.

MR. SULLIVAN:
What the amended S.B. 138 is calling for is for State EMS to come down. We are supposed to notify the Division of Emergency Management, Department of Public Service (State EMS), and they will review to see if there is something they can do to help us obtain more personnel. I believe that is what you are talking about.

SENATOR LESLIE:
I do not know if the HD can shed any light on it.

MS. McDADE WILLIAMS:
As mentioned, there are already provisions in statute to recognize certain emergency situations. As I understand, what they are doing with this language is proposing to supplement that section of NRS with several amendments, Exhibit L, starting on page 2, line 17:

> ... use whatever resources are available ... and take actions that would best mitigate the emergency using resources provided by the exemptions in NRS 450B.830 (a) Immediately once this action is taken, all individuals requested to support such an incident will be covered by the counties insurance pool ... .

This is followed by an enhancement to the existing statutes, where it states "All equipment used to mitigate said event not owned by the county will be the responsibility of the county and returned back to the owner free of damage... ." Again, that supplements the existing statute. Then in subsection 3 in the proposed amendment, Exhibit L, "If such action is taken ... ." That refers to where the State EMS would come in, analyze that situation and work with the local government agencies or whoever was involved to help identify a plan for future emergencies. Those pieces supplement the existing statutes well.

Regarding the part under subsection 1 on page 2, Exhibit L, about the agency having jurisdiction providing the scene incident commander, I do not know how that will be incorporated in the language. That is going to be new terminology for statute. It would be up to your staff to draft it so that it was consistent with our statutes. I think the other two sections supplement the current statutes.

> SENATOR HARDY MOVED TO AMEND AND DO PASS AS AMENDED S.B. 138 WITH THE INTENT MS. McDADE WILLIAMS CLARIFIED.

SENATOR WIENER SECONDED THE MOTION.

THE MOTION PASSED. (SENATORS BROWER AND KIHUEN WERE ABSENT FOR THE VOTE.)

* * * * *

CHAIR COPENING:
We will open the hearing on S.B. 172.

SENATE BILL 172: Establishes the Statewide Program for Public Education and the Prevention of Sudden Infant Death Syndrome. (BDR 40-826)

MS. LYONS:
Senator Copening requested additional information (Exhibit N) from the HD on what safety programs/campaigns will no longer be funded through the grant, and based on HD data, are Sudden Infant Death Syndrome (SIDS) and other issues addressed in the bill a priority health concern? Also, there is an amendment to the bill submitted by Kim Amato, Founder, Baby's Bounty (Exhibit O). A response to Senator Copening's questions is attached (Exhibit P).

TRACEY GREEN, M.D. (Health Officer, Health Division, Department of Health and Human Services; Health Information Technology Blue Ribbon Task Force):
In the response to Senator Copening's questions, I delineated the program currently at the HD surrounding how we approach SIDS and sleep-related injury and death. The program includes Cribs for Kids, Text for Babies, Safe Sleep brochure and packet that is provided, and Child Death Review. I felt it was important also to provide the statistics from 2009 and 2010 showing the significant impact and reduction of these events through the programs described.

Regarding funding and programs; on page 2, Exhibit P, listed are the eight programs, with subprograms, funded by these dollars. I hope this answers your questions.

As for the amendment, Exhibit O, we stand neutral. Our only request is to change "shall" to "may" in section 2 of the amendment proposed to S.B. 172, Exhibit O. This would allow permissive nature should there not be dollars available.

CHAIR COPENING:
Dr. Green, I am sure you have a team in place that determines the allocation of the money and time and determines the severity of certain issues and what is to be addressed. The reason I have concerns with the bill is I feel it is almost micromanaging and taking out of control your team's ability to say they have done the research and identified the areas to which the resources should go. Even if there were something in the bill that said "you may do," you would still probably follow a process. Can you speak to that?

DR. GREEN:
Many of the actual programs we implement are based on grant guidance. A number of topics are specified in the grant. Within those grant guidances, we create, develop or support existing programs. Not only in the implementation of this program, we would have to ask for redirection of dollars, but also have to ask for elimination of some of the current grant guidance. You are right that we do have a team to make some of the determinations, but many are within the grant goals.

CHAIR COPENING:
We will close the hearing on S.B. 172 and open the hearing on S.B. 245.

SENATE BILL 245: Creates the Statewide Alert System for the Safe Return of Missing Older Persons. (BDR 38-710)

MS. LYONS:
Senator Parks has a proposed amendment (Exhibit Q) to S.B. 245.

SENATOR WIENER:
Could we move this bill to the next work session, so I have a chance to review the e-mails and other material received today?

CHAIR COPENING:
I, too, recently received information on this bill, and will close S.B. 245. We will open the hearing on S.B. 256.

SENATE BILL 256: Revises provisions relating to controlled substances. (BDR 40-419)

MS. LYONS:
There is a conceptual amendment (Exhibit R) to the bill proposed by Senator Joseph (Joe) P. Hardy. I understand that Senator Hardy is deferring to the amendment on page 3, Exhibit R.

SENATOR HARDY:
For the record, I refer the Committee to the document on page 3, Exhibit R, as the conceptual amendment focusing only on the "grow house," so we do not get extraneous issues.

CHAIR COPENING:
For the Committee, you may recall that one to seven plants fell into the medical marijuana range, so this amendment strikes that, eliminating any concerns. We took out anything that dealt with the penalty aspects. This is also what was proposed by the Las Vegas Metropolitan Police Department, and they are in agreement.

SENATOR HARDY:
There is some penalty in the new language, so it does not get rid of the penalties that apply to what is left in the bill. There were extraneous things looked at elsewhere in the bill that did not have the legs to do that.

SENATOR KIECKHEFER:
Does this amendment take out the provisions that relate to which persons may be granted medical marijuana cards?

CHAIR COPENING:
That is correct.

> SENATOR KIECKHEFER MOVED TO AMEND AND DO PASS AS AMENDED S.B. 256.
>
> SENATOR WIENER SECONDED THE MOTION.
>
> THE MOTION PASSED UNANIMOUSLY.

*****

MS. LYONS:
Senate Bill 335 was considered at our last work session. We are waiting for a copy of the summary of the provisions of the state of New York's program that is similar to this for the Committee to review.

SENATE BILL 335: Revises provisions governing drug paraphernalia. (BDR 40-795)

SENATOR HARDY:
During the last work session, we were faced with three choices on section 6. I looked at the U.S. Department of Health and Human Services to reflect their standards, and they do not exist, which would be problematic for what we would do. But in that search, the information we had on the bill had a wonderful Website linking us to the New York State Health Department (NYSHD). It turns out they are the experts about needles and syringes.

They have a program that allows people to get syringes and needles so they have clean things to use when they use drugs. The program allows them not only to have access to the paraphernalia, but to dispose of it, and there is an educational piece in that process. The disposal of these kinds of needles is just as important, if not more so, than any other. That was the remarkable piece that did not show up in the draft. I did take the liberty of talking with the Chair and the bill's sponsor, Senator Parks, to share the research I had done.

The NYSHD had done everything I could see that could be done that made sense. It allowed licensed pharmacies, health-care facilities and health-care practitioners who were interested in providing those items to have a means whereby they could say they wanted to be accepted in that process. It limits the access to persons 18 years or older and does not provide having advertising done as much as would be on a Website available through the NYSHD. Having registered providers in a place where users could dispose of needles and syringes in such a way that it would effectively decrease the exposure to acquired immunodeficiency syndrome and other bloodborne pathogens. If we went to school on what they had done, it would behoove us well.

JENNIFER HADAYIA (Public Health Program Manager, Washoe County Health District):
At the Thursday work session, I presented a summary of sample laws and regulations, including this regulation. This regulation is considered a model for syringe distribution programs and is the basis for the possible amendments (Exhibit S).

SENATOR KIECKHEFER:
I think this is an avenue we should go down. If this is acceptable as a conceptual amendment, that is all right.

MS. LANG:
Would you want to bring all those regulations into our statutes, or would you want to have some authorizing language so that we can adopt regulations similar to those in New York?

SENATOR HARDY:
I would adopt, but recognize the issues with statute and regulation. I would be comfortable either way, but legislation would be firmer if we go with all the things I iterated with what they say the law says, even though they probably mean there is some regulation there. I think, in statute, we would be able to phrase that in such a way to get in everything.

CHAIR COPENING:
Does it make sense that what the law says is what we would want to adopt? What Senator Hardy is saying is that we could identify many of those topics so they would be included in the regulations, if nothing else.

> SENATOR KIECKHEFER MOVED TO AMEND AND DO PASS AS AMENDED S.B. 335 USING THE DOCUMENT FROM THE STATE OF NEW YORK, SPECIFICALLY THE AREA THAT SAYS WHAT THE LAW SAYS, AND THEN TO DRAFT AN AMENDMENT.
>
> SENATOR LESLIE SECONDED THE MOTION.
>
> THE MOTION PASSED UNANIMOUSLY.

*****

MS. LYONS:
Senator Kieckhefer has submitted proposed amendments (Exhibit T) to S.B. 379.

SENATE BILL 379: Revises provisions governing the inspection by the Health Division of the Department of Health and Human Services of certain facilities and offices regulated by the Health Division. (BDR 40-1012)

MS. MCDADE WILLIAMS:
Proposed amendment 1, Exhibit T, deals with the statute that addresses situations resulting in administrative sanctions. The initial interpretation was the facility would pass an inspection if it did not have any administrative sanctions imposed. Looking down the list, those things are clear-cut. If a facility had a ban on admissions, they would not pass. These are exceptions to most of our inspections

One of the sanctions listed in our regulations is a plan of correction. Practically every facility would have a plan of correction issued when we went out, but those facilities would not always be fined. There are always serious offenses. Just the plan of correction itself means it would be that much harder for any facility to pass an inspection. The language says a plan of correction would not exclude a facility from passing. There are times we impose a fine on somebody where the severity and scope of the findings requires it, but in some cases, when the facility presents their plan of correction, the fine goes away.

We are struggling with the language that would take us to where we want to go. The thought is the regulations identify the severity and scope for us. The only facility providers that have regulations for grading are for the group-home providers. A group-home provider could have up to 15 points in an inspection and receive an "A", but the severity finding of any one of those points cannot be higher than 3. It seemed fair that a group-home provider with an "A" grade should be eligible for a pass. That is one of the areas where we are trying to write language allowing those facilities to have a pass on that yearly inspection. I would offer to work with your legal staff to draft something so we can recognize an "A" level provider and then consider a combined severity and scope score for any inspection of 15 points or lower in order to qualify for a pass. It would be easy to add up. For example, a severity of 2, and a scope of 3, is 5 points, and 3 of those would be 15 points. If a facility has more than 15 points, then it does not qualify for a pass.

That is where we are on that first point, because none of these terms—a plan of corrections, severity and scope—are defined in statute, they are only defined in regulations.

CHAIR COPENING:
Can we not put in State law general parameters and regulations, and have you get down to the more detailed aspects?

MRS. MCDADE WILLIAMS:
That is an option.

SENATOR KIECKHEFER:
It would be a good course at this point to direct the HD to adopt regulations for the standards by which a facility would be deemed to have passed its regular inspection.

SENATOR WIENER:
I noticed an initial State licensure cannot happen on the first inspection. A concern from AARP was that if the provider happens to do well on the first inspection, but does not have a long history, we do not know who the provider is yet, just based on the initial inspection; so are we addressing that as well?

MS. MCDADE WILLIAMS:
Number 2 of the proposed amendment, Exhibit T, says, "A facility that passes an inspection is eligible for the provisions of subsection 1 of section 2, if the facility has not had any substantiated complaints in the preceding 12-month period." This would now go back for a history on a provider before it could be considered eligible. At number 3, we say that you would not be eligible for these provisions on an initial State licensure inspection, meaning that a brand-new provider without a history would not be eligible. If you had a follow-up inspection that resulted from any other inspection, again this goes to our grading system, where the provider could ask for another survey if they received a "B", "C" or "D" grade and wanted to raise it higher. In that situation, that provider should not be eligible for a pass because they did not pass the first time. It would be any change that is the result of a change in administrator or change in ownership of a facility, or an inspection that is the result of that change. The proposal is the provider would not be eligible for a pass if they had any of those situations. I believe that is one of the areas testified to at the last hearing, that if you have a change in administrator or facilities change.

There was also a concern about frivolous complaints. There is a proposal, Exhibit T, that, "A facility that received a pass for its next periodic inspection is no longer eligible for the waiver of the inspection if it has a substantiated complaint subsequent to a passed inspection." The substantiated complaints are the best we can do to get at frivolous complaints at this point.

The last number is to ensure that it is not a compounding discount for providers. It is based on the fee schedule in place at the time the facility's renewal came due.

SENATOR KIECKHEFER:
In number 3, subparagraph (3), the intent is to state that if there is, in fact, a change in administrator or owner of the facility, the clock would reset. Perhaps it can be explained whether or not a facility is automatically reinspected upon a change in administrator. I do not know about that.

MS. MCDADE WILLIAMS:
I know they do have to submit a new application. I am not sure about the reinspection.

SENATOR KIECKHEFER:
It is clearly my intent, through the amendment, to ensure that a facility would get a reset on its inspection schedule upon the hiring of a new administrator or a change in ownership.

SENATOR HARDY:
Obviously, if you have a new administrator, you do not want to inspect it when the administrator first comes on as much as you do later after the administrator has the different "culture."

SENATOR KIECKHEFER:
I would still leave it to the discretion of the HD quality and compliance to determine the best time to inspect.

CHAIR COPENING:
In addition to the four amendments, Exhibit T, we also talked about giving permission to the HD to develop the regulations outlining the levels of violation severity. That would replace number 1, Exhibit T.

MS. LANG:
For clarity, when we draft this, we will look at the things about when they are going to be eligible. We could specify the eligibilities as part of what would be included in the regulations for when a provider becomes eligible. Regarding the non-compounding, it is up to the Committee, but the way it is drafted now it would be based on the fee provided in statute. I am not sure it is necessary to change the language there, but I will leave that to your discretion.

SENATOR KIECKHEFER:
If counsel indicates she does not believe number 5 of the proposed amendment is necessary and is currently incorporated in existing statute, then I would heed her advice.

CHAIR COPENING:
It was just pointed out in number 5 that the bill actually directs us back to NRS 449.060 for the fee schedule. It appears we do not need number 5 in there.

SENATOR HARDY MOVED TO AMEND AND DO PASS AS AMENDED S.B. 379.

SENATOR WIENER SECONDED THE MOTION.

SENATOR KIECKHEFER:
For the record, I spoke several times with representatives of AARP, and worked to address their concerns as much as I can. We have adopted several amendments to help with the process and address those concerns. I may not have reached consensus with everyone, but I tried.

THE MOTION PASSED UNANIMOUSLY.

* * * * *

MS. LYONS:
A proposed amendment (Exhibit U) to S.B. 419 was submitted by Dr. Mary Guinan, Dean, School of Community Health Sciences, University of Nevada, Las Vegas; and Steve Langan with Honor Reform.

SENATE BILL 419: Establishes provisions relating to safe injection practices. (BDR 40-518)

MS. LANG:
I think what they are trying to do is ensure that people have training so they are familiar with the Centers for Disease Control and Prevention (CDC) guidelines.

DR. GREEN:
The change to the piece in S.B. 419 in section 1 was to list those licensees that shall be included in the attestation that they have actually taken the CDC course on safe injection practices. It was the recommendation, at the time of the hearing, to add pharmacy students and other students who would fall into that category. It is noted that those students would be represented by a licensed body, but the inclusion of them could be added there.

The second section changes the body of the bill from actually having a course developed by the HD, but instead to have attestation by the licensee that they have taken the CDC course, which is and can be posted on our Website and a number of the other Websites.

SENATOR WIENER:
When you said, "add pharmacy students and others," were there others who would also be in the student category?

DR. GREEN:
It was felt if medical students were involved and/or nursing students, that they too could be included in the student sections.

SENATOR WIENER:
Are those others of pharmacy, nursing, medical and osteopathic? If we put, not limited to, it could include all the others, and I do not think that is the intention.

SENATOR HARDY:
If we are going to list all of these people, then somebody is going to be a student of some of these categories. Realistically, the student has to learn how to give a shot, no matter who is that person, such as the podiatry student. That gets me back to chiropractors, athletic trainers and medical laboratories and my original testimony that a medical laboratory does not actually give a shot. A technician draws blood instead of giving a shot. I do not know of a medical

technician who gives a shot. Likewise, I do not know if athletic trainers or chiropractors give shots. Oriental medicine, obviously, uses acupuncture. Am I roping people in who do not need to be? I think there are people who do not give shots.

DR. GREEN:
I do not know that it is exclusive in those categories and the opportunity to provide education for those health-care areas would be worthwhile. I do understand the question and am not sure if there are chiropractors doing injections and/or whether or not medical laboratory technicians could be included as somebody who would do injection practice. They, of course, could be listed as a blood withdrawer, a phlebotomy-type person. Those are separately regulated under the HD, but I am just not sure they do not provide injections.

SENATOR HARDY:
If we have something else instead, because I am uncomfortable putting down somebody who does not give shots. It does not make sense to me.

JOAN HALL (President, Nevada Rural Hospital Partners Foundation):
Indeed, medical technologists do not inject. They withdraw arterially, capillarily or veinally, but it is not injection. There is an infection control process they should follow, but as specifically stated, the CDC safe injection process is more about one syringe, one needle and no adverse events. That is not what medical technologists would use, so they are out of that, as are nurse's assistants who by the Nurse Practice Act cannot give injections. Perhaps medical assistants can, in the new bill coming up, and I believe chiropractors are not allowed to inject.

In NRS 454.213 respiratory therapists would also do arterial draws, but not inject. This includes radiology technicians, nuclear medicine and respiratory therapists. Respiratory therapists would be just like medical laboratory technologists; they would withdraw blood, not inject.

CHAIR COPENING:
It looks like we may need to do a little more work on S.B. 419, as we may have some conflicts. I agree with Senator Hardy that we do not want to put something in there that does not fit. We will roll this bill to our next work session.

We have S.B. 448 that we need to refer as we took no action when it was heard last week.

SENATE BILL 448: Makes various changes concerning the regulation of mental health services provided to children in this State. (BDR 39-1217)

SENATOR KIECKHEFER MOVED TO REREFER S.B. 448 TO THE SENATE COMMITTEE ON FINANCE.

SENATOR BROWER SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

*****

CHAIR COPENING:
There being no further business before the Committee on Health and Human Services, the meeting is adjourned at 6:24 p.m.

RESPECTFULLY SUBMITTED:

Laura Adler,
Committee Secretary

APPROVED BY:

Senator Allison Copening, Chair

DATE:

EXHIBITS			
Bill	**Exhibit**	**Witness / Agency**	**Description**
	A		Agenda
	B		Attendance Roster
S.B. 371	C	Senator Barbara K. Cegavske	Remarks
S.B. 371	D	Norton A. Roitman, MD	Proposed Amendment
S.B. 371	E	Norton A. Roitman, MD	Testimony
S.B. 371	F	Senator Sheila Leslie	Fiscal notes
S.B. 246	G	Senator Sheila Leslie	Remarks
S.B. 246	H	Senator Sheila Leslie	Review of Governmental and Private Facilities for Children
S.B. 246	I	Senator Sheila Leslie	Fiscal Note
S.B. 43	J	Marsheilah Lyons	Subcommittee Report and Proposed Amendments
S.B. 43	K	Marsheilah Lyons	Mock-up
S.B. 138	L	Senator John J. Lee	Proposed Amendment
S.B. 138	M	Mike Sullivan	Testimony
S.B. 172	N	Senator Allison Copening	Questions
S.B. 172	O	Marsheilah Lyons	Kim Amato Amendment
S.B. 172	P	Tracey Green, M.D.	Response to Senator Copening's Questions Funded Programs List
S.B. 245	Q	Marsheilah Lyons	Proposed Amendment by Senator John J. Lee
S.B. 256	R	Marsheilah Lyons	Conceptual Amendment by Senator Joseph (Joe) P. Hardy
S.B. 335	S	Jennifer Hadayia	Proposed Amendment
S.B. 379	T	Marsheilah Lyons	Proposed Amendment by Senator Ben Kieckhefer
S.B. 419	U	Marsheilah Lyons	Proposed Amendment by Dr. Mary Guinan