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

Seventy-Seventh Session
March 27, 2013

The Committee on Health and Human Services was called to order by Chair Marilyn Dondero Loop at 1:35 p.m. on Wednesday, March 27, 2013, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at nelis.leg.state.nv.us/77th2013. In addition, copies of the audio record may be purchased through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

COMMITTEE MEMBERS PRESENT:

Assemblywoman Marilyn Dondero Loop, Chair
Assemblywoman Ellen B. Spiegel, Vice Chair
Assemblywoman Teresa Benitez-Thompson
Assemblyman Wesley Duncan
Assemblyman Andy Eisen
Assemblywoman Michele Fiore
Assemblyman John Hambrick
Assemblyman Pat Hickey
Assemblyman Joseph M. Hogan
Assemblyman Andrew Martin
Assemblyman James Oscarson
Assemblywoman Peggy Pierce
Assemblyman Michael Sprinkle

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Assemblyman David P. Bobzien, Washoe County Assembly District No. 24
Assemblyman James Ohrenschall, Clark County Assembly District No. 12

STAFF MEMBERS PRESENT:

Kirsten Bugenig, Committee Policy Analyst
Janel Davis, Committee Secretary
Macy Young, Committee Assistant

OTHERS PRESENT:

Lawrence P. Matheis, Executive Director, Nevada State Medical Association
Dan Musgrove, representing The Valley Health System
Bill M. Welch, representing Nevada Hospital Association
Steven L. Phillips, M.D., HealthInsight Nevada
Sally P. Hardwich, Private Citizen, Carson City, Nevada
Barry Gold, Director, Government Relations, AARP Nevada
William Berliner, M.D., Medical Director, HealthInsight, Medicare Quality Improvement Organization, and Member, Nevada State Medical Association Physician Orders for Life-Sustaining Treatment Coalition
Don Nelson, representing Nevada LIFE, Nevada Right to Life, and Pro-Life League of Nevada, Inc.
Melissa Clement, representing Nevada Right to Life and Pro-Life League of Nevada, Inc.
Janette Dean, Intern, Assemblyman Ohrenschall
Chris Giunchigliani, Private Citizen, Las Vegas, Nevada
John Sagebiel, Private Citizen, Carson City, Nevada
Kyle Davis, representing Nevada Conservation League
Max Carter, Private Citizen, Las Vegas, Nevada
Jason King, P.E., State Engineer, Division of Water Resources, Department of Conservation and Natural Resources
Steve Walker, representing Carson City, Lyon County, and Truckee Meadows Water Authority
Andy Belanger, representing Southern Nevada Water Authority
Robert Sack, Division Director, Environmental Health Services, Washoe County Health District
Daniel LaRubio Jr., P.E., R.E.H.S., Environmental Health Engineer, Southern Nevada Health District

Joseph L. Pollock, R.E.H.S., Public Health Engineer, Program Manager, Environmental Health Section, Public Health and Clinical Services, Health Division
Bob Foerster, Executive Director, Nevada Rural Water Association
Alex Ortiz, representing Clark County

Chair Dondero Loop:
[Roll was called. Rules and protocol were explained.] We are going to go a little out of order today. I will open the hearing on Assembly Bill 344. Welcome, Assemblyman Bobzien.

Assembly Bill 344: Provides for the use of Physician Orders for Life-Sustaining Treatment in this State. (BDR 40-682)

Assemblyman David P. Bobzien, Washoe County Assembly District No. 24:
I may be at a disadvantage. This is the Nevada State Medical Association's bill. I will do my best to present this bill. My interest in end-of-life issues really began my freshman session in 2007 when I ran a bill in collaboration with the Nevada Center for Ethics & Health Policy at the University of Nevada, Reno (UNR) dealing with end-of-life issues, specifically with the advance directive which is a great tool for codifying what your own personal wishes are for end-of-life medical treatment should you find yourself in an unfortunate situation where you may not have the capability to communicate with medical professionals as to your wishes.

I like to set the table by reminding folks of the Terri Schiavo incident that happened many years ago. It was a very tragic incident and a troubling issue from a moral standpoint. It raised a lot of provocative questions about what is the most appropriate way to handle end-of-life issues.

Regardless of what your personal conscience might dictate, what moral perspectives you may bring to those questions based on religion or other factors you might have, the best way to avoid tragic situations is to properly plan for the possibility of yourself in that situation and your loved ones, and to try and figure out what is the best way forward for life-sustaining treatment. The advance directive and preplanning and making sure that is filed away, and is easily accessible to medical professionals was something that we tackled in 2007. We created the Living Will Lockbox, which is still housed in the Secretary of State's office. It allows for a safekeeping place for Nevadans to fill out their document, have it in a secure location, and have it only accessible to medical professionals should they show up in the hospital and direction is needed for unfortunate circumstances.

Before us is a bill on Physician Orders for Life-Sustaining Treatment (POLST). Essentially, this is the next chapter. The Nevada State Medical Association could explain this better. This is a stronger version of an advance directive that is done in collaboration with your doctor; thus, the physician order.

The use of POLST is not a new approach to improving end-of-life care decisions. The state of Oregon formed a task force in 1991 that resulted in the first POLST form being used in 1995. Almost ten years later, the national POLST paradigm was established. As of today, over half of the states use POLST forms. A POLST is a standardized form uniquely identifiable with a uniform color that records the wishes of the patient and directs the health care provider regarding provisions of resuscitation and life-sustaining treatment.

A POLST is also a way to encourage doctors and their patients to have an open discussion about their wishes. I realize that the topic of end-of-life care can be uncomfortable for some individuals, but the converse of not having a clear and documented conversation about one's wishes is such that wishes may not always be honored when a person can no longer speak for themselves. Moreover, the pressure is taken off of loved ones having to make the difficult decisions of determining what a person's wishes would be.

The benefit to having clearly documented orders is particularly important in emergency situations. Emergency medical technicians (EMTs) surveyed in Oregon reported the POLST form has helped to provide clear instructions about patient preferences when determining the treatment provided.

This bill aims to implement the use of a POLST form in Nevada. This is accomplished by the State Board of Health establishing a standardized form that indicates a patient's designation for anatomical gifts, use of emergency care, and life-sustaining treatments. Section 16 prescribes that a physician must explain to a patient the availability of a POLST form and how it differs from an advance directive if a physician diagnoses a patient with a terminal condition, a patient's life expectancy is less than five years, or a patient requests it.

Section 17 allows a POLST form to be revoked at any time, in any manner. You can always change your mind. It is important to know that you are not locking anything in—the individual is still in charge. Section 18 resolves any conflict between an existing advance directive. Sections 19 and 20 afford similar immunity to health care providers as with advance directives. We had this discussion extensively. Section 22 prohibits life insurance or health care from being withheld due to an executed POLST form. The company should not be assuming that a person is at risk because that person could be clearly planning to not be around much longer. We do not want that to happen. Section 23

recognizes POLST forms executed in other states as valid in Nevada. Lastly, sections 28, 29, and 32 allow a POLST form to be included in the registry in the advance directives for health care, the Living Will Lockbox, and for a patient to apply for a do not resuscitate (DNR) identification card. I would like to turn it over to Dr. Matheis who can give some more background and information on this program and fill in the gaps that I left open.

Lawrence P. Matheis, Executive Director, Nevada State Medical Association:
I am speaking today as someone who facilitated a statewide Nevada POLST Coalition and worked on trying to develop a proposal on the POLST. I tried to look ahead in how we are going to deal with advance directives in the future with electronic health records, et cetera. As we move forward in the reform, one of the issues is that we have to improve the patient participation in all the key decisions. That means there has to be a significant amount of conversation about what those mean especially when you are in advanced care.

Assemblyman Bobzien already went through the bill. The AARP research document I provided (Exhibit C) gives an overview of the intent. The Coalition that we had included emergency medical providers, prehospital emergency providers, physicians from a number of different specialties, emergency doctors, doctors who deal with hospice care, nurses, hospital representatives, HealthInsight, the Nevada Partnership for Value-Driven Health Care, AARP Nevada, and patient advocates. We had representatives from various state agencies, not to support this, but to advise on anything we were proposing and if it stepped on any toes or created any legal problems. The result in A.B. 344 achieves the purposes we set out for.

I brought a PowerPoint presentation (Exhibit D) that goes through the background of what POLST forms are. Essentially, it is a generation removed from a DNR order. A DNR order expects minimal interaction between the doctor and the patient. This is an advance planning directive, but not the advance directive like wills that we have become accustomed to. Those are often created when we are healthy and looking down the road, and we make decisions about what kind of care we want in the event that we get ill. The POLST is for much later in the process, maybe long after we have created a living will. We are now facing chronic conditions and having to revisit what we really meant when we gave the advance directive. The POLST is that conversation. It is also a physician order, so it means that once the patient says what he wants, it must be followed by all the professionals and facilities. The explanation is in the bill about how they are protected. At any time the patient or the patient's representative can say: "We do not want that, we have changed our minds." It could be changed if the circumstances or the condition changes.

On page 3 of the presentation (Exhibit D), there is map of states in which the POLST paradigm has been inaugurated. It was a West Coast phenomenon in Oregon for about 20 years, and in California and Washington about a decade ago. With the exception of Arizona, all of the states surrounding Nevada have the POLST. Several of them also have the Living Will Lockbox. The states that have integrated and made the POLST available on the Living Will Lockbox have found that it has stimulated discussions between doctors and patients and more advance directives are exercised. It has helped the Lockbox as well. It also means that the interstate movement within the POLST would be honored.

The AARP research document (Exhibit C) is a good introduction to thinking about how to more engage patients and their families in discussing what is uncomfortable, but nevertheless, has to be engaged in. So far, the POLST is the next step in encouraging those conversations and doing it in a way that is neither off putting nor driven by what the doctor wants or what the family wants, but comes out of the conversation that is had. In the document, I mention a study in *The Journal of the American Medical Association* that found this could put pressure on families to exercise in only one direction as to what care they do not want to see. About 50 percent of the exercise documents said they indicate they just want comfort care; they do not want extraordinary care. The other 50 percent indicate they want special treatment. That is also part of the conversation.

The Wall Street Journal did an analysis of the POLST and found that it was good in terms of having the patients involved in early decision making on the course of care. There is also noncompliance that often happens by doctors in hospitals. They get busy and if they do not have the documents immediately available, it often means that a course of care will be engaged in that was not wanted by the patient or the patient's family. Those are significant costs in many of those cases. There is also an ongoing nursing study in California that is mentioned in the presentation (Exhibit D) that is very likely to have a major impact.

In the presentation (Exhibit D) I also break down what the sample form is that we have developed through this Coalition with the questions and options that are in there. The Board of Health and the Health Division would adopt regulations, but this was simply so they would have a working document. We met with folks from all of the states that have adopted POLST and had them look at the document to make sure that we were not repeating a mistake they had made. We think this is a state-of-the-art document.

Assemblywoman Spiegel:
If somebody has an advance directive and then they create a POLST and they do not say the same thing, which document has priority?

Larry Matheis:
The newest, most recent document would have priority on that issue. It would negate any others that are addressed in the advance directive.

Assemblywoman Spiegel:
I was trying to read the POLST form you provided, but the print is too small. Will the form clarify that for the patient so that they are aware of the situation and so the family does not have a conflict later down the road?

Larry Matheis:
Yes, it does. In the PowerPoint (Exhibit D), pages 10 through 13 go through what is on the form. It goes into whether or not there has been one exercise. Part of the conversation would be about that. The intention is to make sure the patient is engaged at every point, and that the patient can stop at any point should they become uncomfortable.

Assemblyman Bobzien:
It is my understanding that an individual's interaction with that system is very good. The system is good about making clear how you make subsequent filings and what that means to the previous filings. In the context of also using the Living Will Lockbox, this should fold together nicely.

Assemblyman Sprinkle:
I deal with this a lot in my profession. I am appreciative of this bill and the direction we are going with this concept.

Section 15, subsection 3 reads: "Gives direction to a provider of health care or health care facility regarding the use of emergency care and life-sustaining treatment." Will this form actually spell out what care is to be provided? Within my profession, we work under protocols and we are not allowed to deviate from those protocols unless we get physician consent over the radio. Do you think there will be a conflict with this language?

Larry Matheis:
No, we do not think so. We had prehospital responders work with us on this. The specific areas where they are saying do this, but not that, is very straight forward in the POLST. They were comfortable that it overcame that problem you are talking about. The form is not going in statute; the Board of Health will be adopting the form. We are going to keep the Coalition around to be able to

advise us through the implementation and make sure that the form addresses everything. As we go down the road, this will be part of the Nevada Health Information Exchange. I think we have addressed it. The emergency responders who were a part of the Nevada POLST Coalition thought it was addressed, but it is open until a form is actually adopted.

Assemblyman Sprinkle:
Section 17, subsection 1, paragraph (a) reads: "The patient who executed it, without regard to his or her age or mental or physical condition;" can revoke it. Does that mean that somebody who has now become incompetent mentally could somehow indicate, even if they are not competent, that they no longer wish to have this and we would have to abide by that?

Larry Matheis:
No. Paragraph (b) says: "If the patient is incompetent, the representative of the patient; or," may be revoked. There are a number of mental behavioral problems that do not make one incompetent to make decisions. If it is not possible for the person to understand what they are being asked, then it goes to their representative.

Assemblyman Sprinkle:
I understand that. I had read paragraph (b), and I think that is where my question originated from. What happens if a medical emergency occurs, the person is incompetent, but their representative is not present? If they somehow indicate that they have a mental condition, is there the potential for them to remove this?

Larry Matheis:
I am not sure if I can follow the hypothetical completely, but I think it is worth thinking about. We were trying to make a distinction that there is a difference between being incompetent to exercise a legal action and having what may be a mental health problem that can come with the chronic disease or reaction to the drugs, but it does not make one incompetent to make that choice. That is where there needs to be close conversation to understand why a patient would be revoking it.

Assemblyman Duncan:
I had a similar question. I am looking at section 16. Is there going to be any sort of inquiry by the physician as to the capacity of the person executing this? For example, if you are executing an advance directive at a legal office and they look at testamentary capacity. I read it in the way Mr. Sprinkle did. It almost appears that someone can revoke it if they are incompetent, and similarly

execute this document if they are incompetent. I would like to hear your legislative intent. This may be an area that we need to clean up.

Larry Matheis:
It may be. I do not think so. This did not come up. We wanted to make sure that if a patient was clearly incompetent to make a legal judgment on either exercising or revoking that they were not being asked to do that. That is also the case in section 16. The idea is we are going to lean toward what it is that the patient wants and says they want. We will have to make sure that is part of the conversation if their condition has changed. It is less about when it is initiated than possibly at the time of consideration of revocation or someone else has talked to them about something. I think this is clear, but I defer to those with legal experience.

Assemblyman Bobzien:
I would direct the Committee to look at section 16, subsection 4, paragraphs (a), (b), and (c). It reads:

> "A POLST form is valid upon execution by a physician and: (a) If the patient is 18 years of age or older and of sound mind, the patient; (b) If the patient is 18 years of age or older and incompetent, the representative of the patient; or (c) If the patient is less than 18 years of age, the patient and a parent or legal guardian of the patient."

I think that covers it. It might be worth it to ask your legal counsel if that is ambiguous at all or needs to be cleaned up, but I think the intent is clear.

It is an interesting question that Mr. Sprinkle raises in section 17 that the form may be revoked at any time and in any manner by someone. Pretend we are at the scene of an accident and you say, "I have lost my leg." I am now feeling "shocky" and I do not want this POLST form. The person is not incompetent, they are just going through some stress. There are hypotheticals and I am open to engaging in some conversations about it, but I think we need to try to put the possibility of those scenarios into the greater context of what is likely to happen.

Assemblywoman Benitez-Thompson:
When I blow up the POLST form to 200 percent that Mr. Matheis has provided for us, I cannot really make it out. It looks like it is a two-page document. In the world of end-of-life orders between advance directives and different types of DNRs, would you have a preference for which kind of form is used? I am thinking specifically for when a physician does a DNR and then there is this

scribbled signature; it is quick and easy, not a two-page form. I did not know if there might be directions to physicians about a preference for what type of end-of-life documentation the profession should pursue.

Larry Matheis:
Pages 10 through 13 on the presentation (Exhibit D) are blown up by each section of the POLST form so you get an idea of what kind of questions are on the form. It is a two-page format front and back. We are navigating, so we are enabling this to be used as paper now and as we transform into electronic, it will be on electronic format and available that way at the Lockbox. I think there is going to be a period where there will be DNRs in a traditional way. These are intended as the direction we should be going for the most part where the patient can be engaged as the advanced care is beginning to be developed and look at changing what advance planning or advance directive they want through the POLST. I think we are going to see it as a phase-in process. It will be a lot of education for doctors, nurses, and emergency responders. In the end, it will clarify a lot of situations that have been very painful.

Assemblywoman Benitez-Thompson:
I am looking at section F on page 13 of the presentation (Exhibit D) where it shows the signatures required. I cannot quite tell what is required here and I was wondering if we could clarify it for the record. One thing that I like about this form is it seems like it is looking at the same place for both the physician signature and the patient signature with the traditional DNR orders. If it is just a physician order, it is just a physician signature. I know there are different signatures required for different things, so I wanted to clarify the signatures needed to make this a valid document.

Larry Matheis:
If you look on page 13 of the presentation (Exhibit D), Section E and Section F are the slides about signature information. Is it too small to read?

Assemblywoman Benitez-Thompson:
Yes. I have it blown up at 200 percent, and it is difficult to see.

Larry Matheis:
It does put into one place all the necessary signatures and the decisions about those things.

Assemblywoman Benitez-Thompson:
For clarification, what are those signatures?

Larry Matheis:
There is a spot for the physician's, the representative's, and the preparer's information. All of the potential options are covered in the document.

Assemblyman Oscarson:
Like my colleague, I have been in emergency rooms where these forms could not be found, decisions had to be made, EMS providers could not find forms, and physicians had to make decisions based on what somebody was saying. Mr. Matheis, working with your group, I think it is important that these things get implemented and taken care of.

We were talking about language in some of the discussion. I will note that a lot of the western states—about seven of them—have adopted this. There are 5 eastern states, so that gives us 12 total. There are about 19 states considering legislation. I think that speaks volumes to what you are trying to do here. The intent and the idea to get this done and do so as quickly as possible is important. There is going to be implementation and education. I know some of the hospices now have the form that includes the five reasons for what you are going to do. A lot of the hospitals have done a great job when people come in and start that dialogue about the Lockbox system. I applaud those efforts and I hope that Nevada will be one of the early adopters with some of these other states.

Assemblyman Bobzien:
Thank you. I can tell you that a lot of the implementation issues and the need issues that we discussed in 2007 with the creation of the Lockbox were very specific to districts such as yours, Mr. Oscarson. Contemplating a rollover accident on the highway and ending up in a rural hospital, what is the access to the document that is back in Las Vegas or Reno in a shoe box? That was really the impetus behind the creation of the Living Will Lockbox. There is always an access issue that we need to make sure our medical providers can overcome and the education that goes with it. Thank you for your support.

Chair Dondero Loop:
I notice the map on page 3 in the presentation (Exhibit D) shows that in a couple of states, including Nevada, the color barely touches and it says that it is in progress. Would it not be a whole state that can propose an area?

Larry Matheis:
That has been done in some of the Midwestern states around the metropolitan areas. About ten years ago, there was an effort to adopt a POLST and the effort was based in Reno at the Center for Aging Services and was not successful. This would be statewide. I think those states that have gone

statewide have had much better compliance levels and it has worked much better in general. The states around us, with the exception of Arizona, have all adopted it statewide.

Assemblyman Eisen:
I want to go back to the signature section of the POLST form, and I am looking at the blown-up version on page 13 of the presentation (Exhibit D). I see that there are essentially three signatories on the form: patient health care agent, guardian, the witness—who could be a spouse or an adult child—and then the preparer. I am struck by the fact that this is a physician's order and it would be possible that none of those would be the physician. You could have the patient sign the first line, the spouse sign the second line, and someone else who is not a physician but helped to prepare the form sign the last line. This is a physician's order; it seems that it should have to be signed by a physician somewhere. If the preparer was intended to be the physician, could that potentially be clarified that it specifically say physician?

Larry Matheis:
Yes.

Chair Dondero Loop:
We will go to those in support of A.B. 344.

Dan Musgrove, representing The Valley Health System:
We were a part of the working group that Mr. Matheis talked about. Our ethics committees within our hospitals have been very concerned about this issue for many years and appreciate the efforts of Mr. Bobzien with the advance directive as well as the POLST program that you learned about today.

It is interesting that we have seen occasions where the advance directive has not been honored by the attorney or the person who has taken over the guardianship of the patient. This gives us one more tool in the tool box to make sure that the patient's wishes are followed. That is what this is about. It is giving that opportunity to make sure their end-of-life situation is not something that is tragic for them, as well as their family members. We have seen occasion upon occasion where folks will languish in nursing homes, come back to hospitals for infections or sores, or things that occur because you have a person who is as near as possible to the end of their life. We appreciate this bill and concerns and questions of the Committee. Anything we can do to strengthen it and make it a better document, we are in favor of.

Bill M. Welch, representing Nevada Hospital Association:
The Nevada Hospital Association is supportive of this legislation and would be supportive of any further clarification that this Committee was to bank on the proposal. We think it is in the best interest to make sure that the patient's wishes are always informed and are able to be met. We think this bill will help facilitate that process.

Steven L. Phillips, M.D., HealthInsight Nevada:
I am a practicing geriatrician in favor of this bill. I have been in Nevada since 1992. I also represent HealthInsight, the Nevada Admissions and Transitions Optimization Program for the Innovation grant.

The advance directive and POLST do not negate each other; they are each separate documents. The POLST is very different in that it starts the discussion of advanced care planning because the physician is involved. Why POLST? If one goes back into the late 1980s, studies in the *New England Journal of Medicine* and *The Journal of the American Medical Association* were supported by George Washington University and Duke University. Over 50 percent of people in the intensive care unit had executed a living will or an advance directive and were being resuscitated because the information was not available and/or the individual's form was not able to be located. This is what created the actions in Oregon back in the early 1990s. I was actually part of the initial discussions because of colleagues within the American Geriatrics Society.

As mentioned, in California the POLST is now legislated in all long-term-care settings. It is not about doing less; it is about doing what is correct. It finally affords dialogue between patient, family, and a physician. There is a recent study out of New York which does not call it POLST, it calls it Medical Orders for Life-Sustaining Treatment (MOLST). It is the exact same concept. Within 45 to 60 minutes, a POLST can be completed. I have been practicing as a geriatrician since 1987, and exclusively in the terms of long-term care, that is the best hour I can spend with a patient and their family. It is truly another form of prescription for better health. This bill will greatly enhance our ability as health care providers to take care of Nevadans.

In my practice yesterday, we received a woman who was 92 years old from California who had a POLST. I am licensed in New York, California, and Nevada. I have used MOLST and POLST and it would be nice to see this in Nevada.

Sally P. Hardwich, Private Citizen, Carson City, Nevada:
I was formally the Director for the Nevada Center for Ethics & Health Policy. I have been working on the POLST for 15 years. You may wonder why I had

such persistence, but it was because of the people I encountered when I was in the capacity of director. I spoke to numerous health care providers and I never had to explain the POLST to them. I would simply show it to them and they immediately understood the value.

The POLST is different than the advance directive. The advance directive talks specifically to resuscitation. The POLST form has several other aspects to it. I am looking at the presentation (Exhibit D) on the Section B slide that talks about other treatments. People do not only die from heart attacks. They can die of many other things but, very often, we apply different treatments to them that they may not wish to have. This form only applies when someone is incapable of expressing themselves. If you are not able to speak for yourself and you have some other disease process that is leading to death, you may have treatments that you never wanted. They may have spoken to you about resuscitation, but if you are not having a heart attack then these other treatments may apply and you may want to be allowed to die, yet you receive treatments. The POLST will prevent that from happening.

In addition, as Mr. Matheis said, it is not a matter of imposing this on patients. The patient can decide that they do not want to complete one at all; they can decide that they want full treatment. It gives that option, and many people choose that, which is a good thing to know because health care providers do not necessarily know if someone wants more or less treatment. It is an option in all of those respects.

I do not know if we have had any patients or their families presenting, but the Nevada Center for Ethics & Health Policy has been closed for over two years, and I still get calls because my name is on the Internet associated with the POLST. I still get calls from people who are from other states asking if their POLST from another state will be acknowledged or they ask when Nevada is going to get a POLST. I am thrilled that I soon might be able to tell them, "yes."

Assemblyman Sprinkle:
I am assuming that this is a universal form?

Sally Hardwich:
What do you mean by universal?

Assemblyman Sprinkle:
As in, it would be the same form in California or Utah.

Sally Hardwich:
There are some variations from state to state.

Assemblyman Sprinkle:
Is it acceptable in Nevada or would a Nevada form have to be utilized?

Sally Hardwich:
Nevada would have to approve it. In the statute, it says we would accept POLST or MOLST and other variations from other states. Is that answering your question?

Assemblyman Sprinkle:
Yes, I think I am just asking it in the wrong way. If a visitor were to come from California and they had a POLST, Nevada would still recognize it and adhere to it?

Sally Hardwich:
Yes.

Chair Dondero Loop:
Are there any others in support?

Barry Gold, Director, Government Relations, AARP Nevada:
Despite the proliferations of laws and advance directives and the growing embrace of the less legally focused concept of advance care planning, questions remain as to their impact on actual treatment decisions. [Continued to read from prepared testimony (Exhibit E).]

William Berliner, M.D., Medical Director, HealthInsight, Medicare Quality Improvement Organization, and Member, Nevada State Medical Association POLST Coalition:
One thing that has not been brought up was the fact that many hospitals will not recognize an order from a physician who is not on the attending staff. Most physicians are not members of every hospital in the community. The POLST would allow the physician from another staff to give the order about POLST.

Chair Dondero Loop:
We will now hear opposition for A.B. 344.

Don Nelson, representing Nevada LIFE, Nevada Right to Life, and Pro-Life League of Nevada Inc.:
A lot of the concerns we had today have been answered. It looks like the POLST form is better than the one we saw in California. We were worried that

it did have enough options. We may wish to speak with some of the bill sponsors if we have any more concerns.

We are concerned with what the training will be for the people who are discussing this with their clients. Some people will be taking a two- or three-day or week course and not be a front-line physician, and they may not be qualified to talk about some of these end-of-life issues and different treatments. We are also concerned that some of these places across the country where POLST may be implemented without there being an existence of a terminal illness. This scares us because we think that we can perhaps get into a condition where there was a POLST, but no terminal condition, and it could be some kind of situation where the attending physician might be in a condition of having to cooperate with an assisted suicide or voluntary euthanasia.

Another concern we have is for religious institutions; for example, Catholic institutions. Someone might say they do not want any life-sustaining nutrition or hydration because it is against their faith and morals. I hope I said that right. We are also concerned that some of the groups behind this may be economically driven. Maybe there is some kind of impetus to get people to avoid end-of-life treatment.

The commentary from the National Catholic Bioethics Center on Health Care and Life Science was that they had reviewed some of the statements in training materials and they found that the program for facilitators is heavily fear-based, is biased in favor in refusing life-sustaining treatments, and emphasizes all possible burdens of accepting treatment while minimizing burdens associated with refusal of treatment. This makes me nervous. My mother died of cancer and I would hate to think that someone was encouraging her to refuse certain treatments. The last weeks of her life were incredibly meaningful and people could miss out on something like that because of a negative description of life-sustaining treatment.

Chair Dondero Loop:
This is a terminal issue or patient request. For example, if your mother did not request that, then she would have to in order for that to go into place. If you read the bill carefully, it is certainly not the intent for anything having to do with economic standards or people making money. I appreciate your concerns.

Melissa Clement, representing Nevada Right to Life and Pro-Life League of Nevada, Inc.:
We recognize that end-of-life issues are among the most difficult and painful decisions any person has to face, especially the person having to deal with a loved one. We recognize the need to deal with the kinds of issues that a family

has to ease that process. We have to err on the side of life. Many of our concerns have been dealt with today, and I would like to reiterate that we are going to speak with the sponsor of the bill to clear up other questions we may have.

Chair Dondero Loop:
Are there questions from the Committee?

Assemblyman Eisen:
Mr. Nelson, you asked about what kind of training people would have to discuss this with the patients. What is being proposed here is a physician order so it would be the physician that would have this discussion. Are there specific items on this list to be discussed with the patient that you think would not be something a physician is not trained to do generally?

Don Nelson:
We were worried that people who would be trained to go over this order with the patient were not doctors. We had reports from some states that this had happened. I would not think a doctor was incompetent. If we had somebody go into a two- or three-day class or a two-week session to learn how to talk about end-of-life issues, then we would have a problem. I am not accusing doctors of not being competent to talk about those things.

Assemblyman Eisen:
You had mentioned concerns, and I wanted to make sure if there was a specific section of the form that was of concern to you.

Chair Dondero Loop:
Is there anyone in the neutral position? [There was no one.] I will close the hearing on A.B. 344. I will open the hearing on Assembly Bill 215. Welcome, Assemblyman Ohrenschall.

Assembly Bill 215: Provides for the collection and application of graywater for a single-family residence. (BDR 40-3)

Assemblyman James Ohrenschall, Clark County Assembly District No. 12:
This could be the best bill of the session. I am going to turn it over to Janette Dean who will walk us through the bill.

Janette Dean, Intern, Assemblyman Ohrenschall:
I am helping to introduce this bill because it is important that we support the efforts of state residents who are willing to invest their time and money in household water conservation activities. As we well know, water is a precious

natural resource and this bill would make it easier for residents to reuse their household graywater, which is water directed from clothes washers, bathroom sinks, tubs, and showers, for landscape irrigation.

The 2012 long-term study on landscape irrigation using household graywater by the national water research education foundation, which is a public-private partnership between municipal utilities corporations, academia, industry, and the federal government, shows that in a typical household graywater of nearly 28 gallons per person, per day, is nearly 50 percent of the total wastewater generated. This would typically supply about 30 percent of the landscape irrigation needs of a household and could increase to even 100 percent for xeriscaped landscapes where plants with lower water needs are being used.

I would like to emphasize that the report, which was also the most comprehensive study to date on the use of graywater in household irrigation, concluded that reuse of graywater is not unsuitable for household residences in comparison to any possible risks to human health, soil, and other water sources with proper application, but that future studies will be of interest. This bill includes necessary guidelines for safe graywater systems.

I will go over the key provisions of the bill. I would like to begin by defining the term graywater as used in this bill. It means: 1. Wastewater that is collected separately from sewage; 2. Originates only from a closed washer, bathroom tub, shower, or sink; 3. Does not contain industrial chemicals, hazardous waste, or wastewater from toilets, kitchen sinks, or dishwashers. [Continued to read from prepared testimony (Exhibit F).]

Assemblyman Ohrenschall:
I am happy to answer any questions, or turn it over to Ms. Giunchigliani.

Chris Giunchigliani, Private Citizen, Las Vegas, Nevada:
I am a Clark County Commissioner representing District E in Las Vegas, Nevada. In 2009, Assemblywoman Sheila Leslie introduced Assembly Bill No. 363 of the 75th Session. We have discussed the issue of water importation from the rural counties and how you actually define conservation and reuse. As I was exploring issues in southern Nevada, I found out that we used to have all of our uniform plumbing codes recognized and allowed for graywater use forever. Unfortunately because of the policy that was taken by the Southern Nevada Water Authority Board, a restriction was placed on residential homes in the valley. I believe you will be receiving an amendment from them which speaks to that issue. That policy then restricted residential homeowners from being able to establish a graywater reuse system. I voted against that for the one

term I was on the Board. I was in the minority on that issue because it comes down in their minds to the issue of return flow credit.

This bill tries to set the policy. It allows for residential homeowners to establish a reuse system for graywater the same as any large commercial business currently can; the same way as the Springs Preserve that is run, owned, and managed by the Las Vegas Valley Water District, and the same as many of our golf courses are permitted to.

The issue it really comes down to is safety. It is absolutely safe and it is across this nation that graywater has been allowed and used. Many of our surrounding states, New Mexico, Colorado, Arizona, and California, allow for graywater use and they are all fed by the same river as Nevada—the Colorado River. This is also about electricity and reducing our carbon footprint. Water makes electricity, so less water used saves the environment but saves us money costs. This is about reuse, conservation, energy cost, less carbon use, and creating a sustainable community.

I wanted to try to address some issues. The water authority in one of its own studies said that their analysis suggests that this is a less expensive way to conserve water and encourage efficiency rather than building new water supply such as the water importation plan from the rural counties. There are ways to be able to save people money and promote an additional method of conservation. That is what graywater use is all about. This is an energy issue more than just a strict water issue. The bottom line is that any irrigation that you use requires water. You can choose to use your potable water or you can use graywater for irrigation, but either way, we have to use water. Using graywater saves an enormous amount of energy. Saving energy reduces our carbon footprint as well as reduces the amount of water used in producing electricity.

For example, from the Southern Nevada Water Authority, a 1,000 square foot lawn in southern Nevada will receive 73,000 gallons of water each year; that is more than 300 tons of water. Most of the urban west's water is pumped uphill to users which create substantial energy demands. It typically takes between 3 to 10 kilowatts to treat and deliver 1,000 gallons of pressurized water to a customer. Las Vegas averages about 6.5 kilowatts per hour per 1,000 gallons. Coincidentally, a typical family of four could generate about 50 gallons of graywater per person per day. That equals exactly 73,000 gallons for a family of four over the course of one year, which is exactly what it takes to upkeep a 1,000 square foot lawn with desert landscaping. For example, meeting the water needs of a Las Vegas lawn will consume 470 kilowatts of electricity in water treatment and pumping. Producing the energy discharges about another

436 pounds of carbon into the atmosphere. This means that a typical family of four, using graywater to irrigate, could eliminate a ton of carbon from the atmosphere every year. That is significant. The carbon footprint of the lawn's water usage alone is more than 90 times that of a gas-powered lawn mower and 25 times more than that if it is sequestered by a lawn.

The Institute of Electrical and Electronic Engineers estimate that it takes, on average, 25 gallons of water to produce 1 kilowatt hour of electricity—more for coal and nuclear; slightly less for natural gas—but not all of that water is used at the generating site. Graywater could actually save 12,000 gallons of water in a generating plant, and that is not an insignificant amount when multiplied by the potential graywater-using households in Las Vegas.

My constituents say that we should do everything we can to conserve. We have done a tremendous job and I know the Southern Nevada Water Authority will tell you that. We should not take all of our tools out of our toolbox. An additional tool that should be allowed to residences is the use of graywater. There are a variety of different ways that this could be approached. If you go back to the 2009 minutes, they are actually noted in there. They wanted to be able to design residential homes containing graywater systems automatically built into them. That was not allowed, so that is less conservation, less sustainability, and less jobs. That market was not allowed so that company was not able to do that.

You have an opportunity through this bill to still allow them to collect their credits, but allow a homeowner to have the same opportunity that a commercial building does. They have already paid; I have paid for it to come into my home. If I choose to use it to water my lawn, I would like to be able to do that. It saves water and saves electricity. It treats the residence the same as you do with anybody else who is a large consumer of water. In the long run, this is about making sure that we have one more opportunity or feasible way to do energy conservation along with water conservation.

I know that there was an amendment (Exhibit G) that Assemblyman Ohrenschall sent to me which is exactly the same amendment from my reading of it from 2009 which would basically gut this bill. I personally would not support that, in that the intent is to allow people to have the opportunity. You can do it through a permitting process; you do not want to go to the extent that California legislation did which became too cumbersome for residences as well as business. Graywater use is safe, it is the right direction to go, and at a minimum, we should not adopt a policy that prohibits us from being able to use this in the state of Nevada.

Chair Dondero Loop:
We will address the amendment at some point.

John Sagebiel, Private Citizen, Carson City, Nevada:
I am here to speak in favor of this bill. I am testifying as a private citizen and I do not represent my employer, or any group, and I have no financial interest in this. My expertise in this area comes from a variety of sources. [Continued to read from prepared testimony (Exhibit H).]

I appreciate Ms. Giunchigliani's comments because they are exactly correct. I support all of what she said in regard to energy. The nexus of energy and water is critical especially in an arid state like this one. This is simply another way of doing that. Graywater is safe. I have been doing it for ten years and have had no issues. [Continued to read from (Exhibit H).]

Assemblyman Hambrick:
Since you designed a home, the design would be easier, but what would your estimation be, for an average homeowner who is in existing housing to try and accomplish this? Would it even be feasible? What obstacles besides cost factors might we see especially with home owner associations (HOAs)?

John Sagebiel:
The question of cost is one I am not familiar with. I am not a contractor or a plumber. The question of feasibility I can kind of address. If your home is built on what is called "slab on grade" which is a concrete slab with the plumbing underneath, I would say that is really unfeasible. I guess it is possible, but I could not imagine someone wanting to do that. If your home is built with a crawl space and the piping is accessible in the crawl space, then it would be feasible at that point to gate off the appropriate sink or bath tub into a graywater system.

I think it would be reasonably large expense for retrofit. This is the kind of thing that we want to put in place as we are moving forward in replacing our housing stock and building new housing stock. These builders have the option of doing that and it is very inexpensive in construction. We originally plumbed our system out right next to each other. You can see this in the photos I submitted (Exhibit I). If in the future, you want to gate them together, the valving is already there. All you have to do is close one valve and the graywater system is essentially gone. I have a standard septic system.

Assemblyman Ohrenschall:
This bill does not address *Nevada Revised Statutes* Chapter 116. I think it would be up to each association whether they want to allow or prohibit it. The HOA issue is not something we tried to touch on in this bill.

Assemblyman Eisen:
While I appreciate the efforts in terms of water conservation, and I am a native Nevadan born and raised in southern Nevada so I understand the idea of water and energy conservation, but I am trying to get my head around the incentive of someone wanting to do this. I recognize if someone is driven to do this for the good of the planet and they are in the position to do so, they may be willing to pay whatever costs are necessary, but even in the course of construction when it would be considerably less expensive than retrofitting a house if you even could, aside from the plumbing there would have to be the storage of the graywater for use. How much water can be saved by that? How does it translate to dollars? What is the return on investment that would be a motivation for the average person to put out the initial investment for this kind of a system?

John Sagebiel:
I honestly do not know. That would depend a lot on the rate that the individual is paying for the total of water. It is one of those sorts of things that you can look at as a long-term investment. If you anticipate rates may have to go up, then your investment pays off faster. It can be done relatively inexpensively; it is not a requirement to have a storage system, you could simply filter it into an irrigation system if that is appropriate for your application. This is a personal opinion, but water is too cheap. It is not necessarily about saving the planet's resource; we are really talking about the state's resource. This is what we are looking at. This is very local and it is about looking out for each other's neighbors.

Personally, I am on a well, but that is a shared resource—not the well, I have a private well—but I am on an aquifer that is shared. I recognize that even though we cannot see it. I have enough hydrology background to know that we are sharing a resource. We have to be careful with these sorts of things. The answer is that it probably does not make good economic sense, it only makes good neighborly sense.

Chris Giunchigliani:
I think the incentive is to allow the building industry to have the opportunity and ability to design a more sustainable home. That request came into southern Nevada several times, but they were denied the opportunity. That would cost

pennies because you would simply lay out your pecks at that very same time so that it captured your graywater and went into the irrigation system.

The other incentive is for those people who wanted to retrofit, at least they could go through the application process to spend the money out of their own pockets to be able to irrigate their own lawn. It comes down to the fact that the water has been paid for to come into my own home and now I would like to be able to use it in my home. You pay for it once and you get two uses out of it. That is a pretty good incentive for conservation purposes. This legislation is really about enabling people to be able to be a more sustainable community if they choose to—not mandating it—but putting back on the books, the authority we used to have until the issue of return flow credits came about and took that option away for residences.

Assemblyman Ohrenschall:
I was initially contacted about this bill by a constituent who was interested in doing this. That is only one constituent, but as Ms. Giunchigliani said, there is additional interest in this issue. One thing I found out in working on this bill is that there is a lack of uniformity throughout the state. There are some parts of the state that allow it with regulation, but where we are from, it is prohibited. There is no graywater, it is all black water. Considering we are the most arid state in the union, I do not know if that is good public policy.

Chair Dondero Loop:
We will call up those in support of A.B. 215.

Kyle Davis, representing Nevada Conservation League:
We are in support of this bill today. We also supported the bill in the 2009 Session. We think it is a good piece of public policy. I think Ms. Giunchigliani outlined a lot of the environmental benefits that we think would come from being able to use graywater in certain areas. It makes logical sense in terms of effective use of our natural resources to use every drop that comes into our homes. We think that this is a bill worthy of our consideration.

Graywater is being used very effectively in some cases in southern Nevada, most specifically at the Springs Preserve operated by the Southern Nevada Water Authority (SNWA). They have already shown that this can work correctly. It is worthy to be expanding this to homes and businesses.

Max Carter, Private Citizen, Las Vegas, Nevada:
I am approaching this from a different angle. Ms. Giunchigliani did an excellent job of summing up the arguments. Our country moved to embrace the concept of victory gardens. We are now moving back toward that local, self-sufficient

ideology. This bill helps enable citizens of southern Nevada and the whole state to embrace that and use all of our resources to create their own systems within their property.

The feasibility of retrofitting was discussed. Laundry to landscape systems are a very easy system that makes the system accessible to existing slab on grade construction. It has been proven to work in Arizona, California, and surrounding states. What about the financial impact? It was stated earlier that if you have xeriscape lawn, that 100 percent of the water irrigation usage for that xeriscape lawn could be provided by a typical family of four household. Effectively, a household could cut their water bill in half. The argument about denying—it has been told to me that the SNWA looks at it as stealing their water by not giving it back to them for return flow credits—is a totally moot point. We are talking about aquifer recharge. All of the water that is applied goes directly into the aquifer that southern Nevada relies on. I am in favor of this bill as written. It allows responsible use, it encourages conservation, and it also creates an environment of participation.

The water boards have created wonderful systems like the Las Vegas Wetlands Park and the Springs Preserve that are using the effluent, either graywater or treated effluent to create these oases in our desert. Why are we denying that right to the residents of Clark County? All of the parameters laid out in section 2 of the bill are common sense, to a point, and go far enough to protect our neighbors in our communities from irresponsible use. We are not talking about putting a plumbing system or waste system that is going to be installed by a professional plumber. It does not need to be covered under the Uniform Plumbing Code. Generally, we are talking about a homeowner-installed irrigation system. It is refreshing to see some common sense legislation proposed.

Chair Dondero Loop:
We will now hear opposition to A.B. 215. Please come forward.

Jason King, P.E., State Engineer, Division of Water Resources, Department of Conservation and Natural Resources:
Before I go into the provisions of why our Division does not support A.B. 215, I would like to applaud the bill sponsors for promoting reuse in the driest state in the nation. This is the right thing to do and it is being done statewide, but not enough. Our state should be number one in water reuse, but only where existing water rights are not impacted. Many of you may not be aware the decisions made by our office over the decades have taken into consideration return flows to rivers from wastewater treatment facilities, and recharge to

ground water basins from septic systems when calculating an amount of water that might be available for future appropriations.

I am not going to get into the impacts related to the return flow credits in southern Nevada, I will let SNWA do that. We have already heard Ms. Giunchigliani talk about those issues, but that is obviously a major issue when talking about capturing graywater. For example, multiple rulings from our office on change applications filed for the use of water in the Truckee Meadows in the Reno-Sparks area specifically address the return flow to the Truckee River in analyzing the amount of water that could be transferred and the impact to other water-right holders. Additionally, water right decisions made in Pahrump, Sandy Valley, and many other basins, especially those involving interbasin transfers, have taken into account recharge from septic systems to those groundwater systems. If graywater is now allowed to be used in those basins, it could affect those calculations and could call into question some of those decisions that have already been rendered. While some may argue that no additional water will be used, in other words, the use of the graywater will simply offset the same amount of public water being used, we do not believe that that statement can be made with absolute certainty, at least not how it is drafted in this bill. Perhaps more landscaping would be put in. It is uncertain whether or not additional water will be used.

Typically speaking, graywater and sewage water make up effluent which is sent to a wastewater treatment facility for treatment. In our water law, *Nevada Revised Statutes* (NRS) 533.440, the provision requires that reuse of effluent be subject to primary and secondary permits issued through our office. If this bill is to move forward, then those provisions would need to be clarified down the road.

Our office believes that there are areas within our state that the reuse of the graywater, as proposed, makes great sense, at least in terms of water quantity and would not upset previous water rights decisions. It does not work everywhere. I would be happy to work with the bill sponsors on our concerns.

Steve Walker, representing Carson City, Lyon County, and Truckee Meadows Water Authority:

Carson City uses all of its water that comes to the sewer plant, stores it in the hills to the east. In the summer, it irrigates prison farms, all the parks, and golf courses. That water is committed through permits. If you had widespread application of graywater systems in Carson City, you would reduce the water that is going to public use right now. That is the basis of why we are against the bill as it is written.

We have looked at the amendment proposed by SNWA (Exhibit G) and agree that graywater systems are fine and would be best used with domestic wells and individual septic tanks.

Andy Belanger, representing Southern Nevada Water Authority:
I am here today to express some concerns with the bill as it is presently drafted. We submitted an amendment (Exhibit G). Essentially, we believe that the state of Nevada has to do a much better job in reusing water throughout the state. It is up to local communities to decide what is the best way and the best manner for communities to develop and manage wastewater resources.

In southern Nevada we have managed our wastewater resources holistically and comprehensively. Since the 1970s we have been able to secure return flow credits, which means nearly every drop of water that hits the sewage system gets recycled and reused. That stretches our water supply significantly by about 200,000 acre feet per year. The state of Nevada received the smallest allocation of the Colorado River when we negotiated that agreement back in the 1920s. Return flow credits are the most significant way for us to stretch that meager supply much further.

I understand the concern about the amount of energy it takes to return the water to the lake, treat it, and bring it back to our valley. Our community and board directors and every member agency in southern Nevada recognizes that concern. In the mid-1990s, and before that, in the city of Henderson, we saw the development of regional wastewater facilities. There is the Desert Breeze Aquatic Facility which is located at Desert Breeze Park in the southwest part of the valley and the Northwest Water Resource Center which are regional satellite facilities. They take treated wastewater from all of the homes in the surrounding area, send it to local facilities and apply it to large scale turf areas like parks and golf courses.

In essence, what we are doing on a grand scale is what this bill is trying to do on a micro scale, and we applaud the efforts of the sponsor of this bill to bring this idea forward. I think everywhere in the state of Nevada that we can encourage the use and reuse of water makes a lot of sense. Our amendment (Exhibit G) says if you have an existing water recycling program in place that you are not going to be prohibited from that program. It precludes the use of graywater in those areas, particularly in southern Nevada where we are already doing the recycling, of not just the gray portion of the water, but the black portion as well. Our amendment says that you can do graywater in every part of the state except for the areas where there is the reasonable potential for return flow to a river system or lake or if there is a requirement for return flow

effluent to a river system as the state engineer previously mentioned, or if there is an existing alternate recycled water program in place.

I want to be clear that this amendment will not preclude the use of graywater systems in Clark County. People who are on wells will be able to use graywater systems. There are many parts of Clark County that do not contribute to the return flow credits and those parts of the valley would be able to develop graywater systems if they would like to. Even in Clark County, this bill, as we have amended it, would allow the limited expansion of graywater systems. Our concern is that people in the Las Vegas basin who have already expended significant infrastructure dollars building regional wastewater facilities, that they are not being burdened with doing something that they think is helping to save water, but in essence, is duplicating what we are already doing on a regional basis.

Robert Sack, Division Director, Environmental Health Services, Washoe County Health District:
We are opposed to the bill based on some basic public health concerns. Graywater, in its application, is untreated wastewater that is different than treated effluent that comes from a sewer plant, which is being extensively reused, has been tested and treated, and is applied in an approved manner. In Washoe County, we have the authority to oversee on-site sewage disposal systems, which would be septic systems. We issue permits for those and do the construction permits. Also under that authority we have developed regulations for installation of graywater systems like these, but it requires a subsurface disposal and would not allow for surface disposal because that is an exposure to humans of direct sewage that has not been treated.

From our point of view, we are looking for something that would allow permits to be issued because they do need to be designed properly so that they are not overloaded. We would want to have construction inspections as part of that. We do not have the authority to oversee or permit anything that is hooked to the sewer system. If this were to go forward, it would need to have some sort of permitting authority within the urban environment to make sure that these are properly designed and installed for the type of flow that comes out of that system. We are definitely not in favor of two aspects: 1) not having any permits for the construction; and 2) that it cannot allow for surface distribution of this untreated sewage.

Daniel LaRubio Jr., P.E., R.E.H.S., Environmental Health Engineer, Southern Nevada Health District:
The language in this bill could have adverse effects on the Southern Nevada Health District (SNHD) because portions of both NRS Chapter 444 and

NRS Chapter 445A are being amended. In addition to these specifically designated amendments, a trickle-down effect will cause other statutes and regulations to be evaluated and changed for continuity. [Continued to read from prepared testimony (Exhibit J).]

First, we do not separate graywater from black water. In our regulations, all wastewater is black water. Second, to distribute wastewater onto the surface is a bad idea because it would bring pathogens to the surface. We will allow for subsurface drip irrigations in our regulations only after the effluent goes through an advanced treatment system. Third, the SNHD is exempt from this bill. There is a fiscal note that says there will be no effect to local government. We feel contrary to that because our regulations would need to be changed and that is something that would cause quite a bit of expense to our program. We also would need to have several man-hours taken away from other funded programs to search out and allow for graywater to be used in a manner of A.B. 215.

Assemblywoman Spiegel:
Since your regulations do not differentiate between graywater and black water and pathogens in the water, do you have an opinion related to your comments on pathogens if we use the definition of graywater that is in this bill versus your definition of black water?

Daniel LaRubio:
Graywater is still effluent and carries the same pathogens as black water. We would have to treat that water in an advanced treatment system prior to allowing the effluent to go out as a subsurface irrigation.

Assemblywoman Spiegel:
To my understanding, the graywater does not include things like sewage and dishwater that would have a great deal of pathogens versus bathtub water. Could you speak to some of the differences?

Daniel LaRubio:
The way it is defined in the bill, graywater is from clothes washers, bathtubs, sinks, and showers. Those places still have the pathogens that have to be treated in a normal effluent system that would go to a subsurface irrigation or subsurface in a leach field of a normal septic system when it is all considered black water and it all gets treated together. You cannot separate out graywater and say that it does not have pathogens.

Chair Dondero Loop:
Is there anyone in the neutral position?

Joseph L. Pollock, R.E.H.S., Public Health Engineer, Program Manager, Environmental Health Section, Public Health and Clinical Services, Health Division:
We are in agreement with Washoe County Health District's comments. We have concerns with the surface application of graywater. We believe that it should be subsurface. The other concern is we feel that there should be some regulatory oversight with graywater systems.

In 1999, the Nevada State Board of Health passed regulations concerning graywater. We do have the mechanism for people who are on individual sewage disposal systems to install graywater systems through a permit process in our office. Carson City uses the same regulations that we do.

The only area in the state where graywater systems are not allowed is southern Nevada. We do not have the authority for sewer systems. If that were to come up, and you were on a community sewer, we need the authority to regulate that should you choose to amend the bill to regulate those types of systems.

Bob Foerster, Executive Director, Nevada Rural Water Association:
I am here representing our water system membership, Kingsbury General Improvement District. I am here to discuss some unintended or unforeseen consequences.

A graywater system at a residence being served by a public water system constitutes as a potential cross-connection to the public water system and would need to be regulated in the system cross-connection control program. For stand-alone residences, subsequent homeowners would be in danger of misconnecting the potable and nonpotable systems. [Continued to read from prepared testimony (Exhibit K).]

Assemblyman Ohrenschall:
I would like to turn it over to Ms. Dean and Dr. Sagebiel to address some of the points made.

Janette Dean:
Our intention was for the bill to allow graywater irrigation only to the subsurface level. We will review the bill to clarify that and make it very clear.

John Sagebiel:
My system permitted in Washoe County is subsurface and the growth field in which the water is applied, as you can see in the photographs (Exhibit I), has a pond liner underneath it which prevents this water from going anywhere else.

I disagree with some of the statements that have been made about pathogens. There should not be pathogens in graywater, or we are all in big trouble. This has been successfully used over and over again by myself. I am here and I am healthy.

For those of you who are not familiar with the use of septic tanks, think about that word for moment. They are not treated. Going septic—if you are in a medical profession—that is not a good thing. We are talking about protecting public health because what goes into that can go back into the groundwater. As stated, they count on that. If we are putting all these pathogens in our graywater and they go into our septic tank, is it not going into groundwater then being pumped back up for drinking? I do not like that notion; I would rather put it into a biologically active root structure of a plant and let them deal with it because they are good at it. I encourage you to support this because Nevada needs this.

Assemblyman Ohrenschall:
This bill does provide for regulations. It simply exempts residential users under 250 gallons from requiring a permit. It is used in Arizona and California and the sky is not falling there. I hope the Committee will consider processing this legislation.

Chair Dondero Loop:
Thank you. I will close the hearing on A.B. 215.

[This meeting was recessed at 3:32 p.m. and reconvened at 8:03 p.m.].

Chair Dondero Loop:
I will open the hearing on Assembly Bill 457. Please welcome Assemblywoman Benitez-Thompson.

Assembly Bill 457: Requires a hospital to provide certain information upon discharge to certain older patients. (BDR 40-116)

Assemblywoman Teresa Benitez-Thompson, Washoe County Assembly District No. 27:
I am here today as a member of the Legislative Committee on Senior Citizens, Veterans, and Adults with Special Needs. This legislation came out of contemplation from the meetings that we had regarding aging, specifically the aging population in Nevada and aging services. I want to start off by saying that the language is close to the intent that we sought as the Committee, but there is still a good amount of work for us to do. I will state the intent for the record and tell you that I have touched base with Washoe and Clark Counties

social services who have talked with the Department of Health and Human Services (DHHS) and with the Nevada Hospital Association. We will be coming together to bring forth an amendment that better gets us to the intent.

The intent is to create a better nexus for our senior and aging population and those who present frequently to the hospitals and social services in the community. It used to be that county social services had folks inside the hospital to help with referrals for nonmedical items. Due to budget cuts and changes over the years, that relationship no longer exists. What we see is a silo with the hospitals providing services to those who present appropriately or inappropriately for care. Then we see social services in the community addressing different issues.

We are trying to appeal to our seniors who present to the hospital more than one time a month, and target that population so that when they leave the hospital, they have the number for state aging services and the resources available from there, as well as the number and contact for their local county aging services. There seems to be some agreement among the group that we can find a way to make this happen. We will be bringing forth an amendment that will hopefully reach that intent.

Assemblywoman Spiegel:
Is this going to be just for hospitals or would it also apply to rehabilitation centers? I know sometimes our seniors go from a hospital to a rehabilitation center and that is ultimately where they get discharged from.

Assemblywoman Benitez-Thompson:
The skilled nursing facilities were not contemplated in this particular legislation. The nexus of the conversation came from discussing Medicare, Medicaid, and dual eligibles and the senior population because the hospitals have their requirement to answer to patients who have multiple admissions within 30 days under Medicare.

The thought was, is there a way to get at what percentage of those who are seniors, and are presenting multiple times—there is a social service aspect to that—and is there a way to help mitigate them presenting at the emergency room for reasons that are nonmedical? This could be due to a lack of housing or they were discharged at the forefront without the social services to help keep them stable in their home. That is why we were more specifically just looking at hospitals.

Assemblywoman Spiegel:
This bill is not addressing patients who are in a facility and contract Methicillin-resistant Staphylococcus aureus (MRSA), for example, and then wind up going back in?

Assemblywoman Benitez-Thompson:
Not unless the reason why they keep re-presenting is something like they do not have a caregiver at home to help them take their antibiotics or follow doctor orders, or because they are homeless, or any of those types of social service issues that keep them re-presenting. We are trying to create some type of nexus between the hospitals and local social services.

I do not want to leave the impression that just by making sure the patients walk out the door with this information, that necessarily means they are going to follow through on the referral, but I feel, as a legislator, at least we can have a better conscience in our due diligence to make sure they are walking out with that information.

Assemblyman Eisen:
I just want to be clear on the intent. There is no intent that this would, in any way, preclude a hospital from reaching out on behalf of that patient to those agencies even if it is not a second admission in 30 days?

Assemblywoman Benitez-Thompson:
Absolutely not. In talking with the Nevada Hospital Association, the conversation has been good. We talk about the difference between someone who presents at the emergency room (ER) and they are not admitted and sent home, versus those who are actually admitted, trying to get at both of those populations. The social workers are often in the ER and on hospital staff looking at the discharge planning component. A lot of this in some way is captured, but it is not standardized in consistent policy through every hospital. This would be setting more of a standard for basic information that ought to go out, but would, in no way, prevent the hospitals from going above and beyond.

Assemblyman Hambrick:
What is the genesis of this bill?

Assemblywoman Benitez-Thompson:
At each meeting we had, we contemplated our aging population and our aging services. As a Committee member, for me, the growth that we expect in our senior population is going to be a huge public policy issue. We do not necessarily have the resources in place through our state aging system and through our county senior services to support all of those needs that are there.

At the same time, we are asking hospitals to do more and be responsible for those patients in many ways after they leave the hospital environment. The idea asks the question: how do we build that bridge; how do we build a nexus between the folks who presented at a hospital and have social welfare and social service issues? We want to try to create a way by which those who might need additional services are getting access to that information.

Chair Dondero Loop:
In regard to the information that an agency may request, does that fall under the Health Insurance Portability and Accountability Act (HIPAA) laws? How is that handled so it is not violated?

Assemblywoman Benitez-Thompson:
That is one of the issues that we have contemplated. The social workers on staff at the hospital can make referrals when appropriate to agencies like elder protective services or even 9-1-1 if they think there is a real emergency issue. In order to get around HIPAA, we would have to put information into the patient's hand and then the patient would have to make a decision to act upon that information. The hospital could not send discharge records or information for social services to follow up on.

Assemblyman Sprinkle:
The bill says, in several different places, "the hospital shall." Does the hospital have any discretion when they are looking at this patient as to whether or not there is a necessity for doing this? Oftentimes I think they can. Through the interviewing that the social workers end up doing, they know if there is a family structure and a support structure already in place that might alleviate the need for the hospital to be following through with this.

Assemblywoman Benitez-Thompson:
There is quite a bit of discretion right now for the hospitals and the social workers who interface with patients to make referrals as needed. The social workers in the agency do not do discharge planning. The way that you discharge someone who is admitted is different than when you are just releasing someone from the ER. One of the things the Nevada Hospital Association has been good at, and what we will continue conversations on are—regardless of which exit point you leave the hospital, an admission or not—there is some way for a basic level of information to be given to our seniors who are presenting more than one time a month. We are working on what exactly that is.

When this legislation was drafted, we did not have a lot of details about the Affordable Care Act (ACA). There may be some opportunities with expanding that Medicaid population and having the hospitals have so much eligibility-driven

part with folks coming in and presenting and signing them up on Medicaid and how new Medicaid system and information is going to be shared within the world of health and human services, that there might be an opportunity to find a better way to connect people with social services as needed when they are leaving the hospital.

Assemblyman Eisen:
Going back to the question Mrs. Spiegel asked about rehabilitation facilities, we may need to come back and clear this up and get a clear, legal opinion. When I look at the definition of "hospital" in NRS Chapter 449, I do not see a distinction for a hospital for rehabilitation purposes. I think skilled nursing facilities are a different ball game, but we are talking about inpatient rehabilitation facilities. What will often happen is that a patient will go from a hospital, to a rehabilitation facility, to home, and it is whether the rehabilitation facilities would be held to the same standard. We need that clarification. I was looking around in NRS Chapter 449 to see if there was something different for rehabilitation hospitals versus an acute care hospital versus a hospital that provides mental health services exclusively so long as it is licensed as a hospital, it would apply here. I ask that we follow this up and clarify so we know exactly which facilities are responsible for this.

Assemblywoman Benitez-Thompson:
We can work with the Nevada Hospital Association on that. Going back to the intent of where the bill came from, it grew out of conversations around the Medicaid population and the reporting that hospitals are required to do around multiple admissions within the 30-day time frame. We are trying to get a better idea of those people who are presenting more than one time. Is it necessarily all medical, or is there a social service component that keeps them presenting?

Assemblyman Eisen:
The other thing we need to clarify is if a patient does go from an acute care hospital to a rehabilitation facility, does the acute care hospital have to provide this information if they are not discharging them to home? We may need to clarify a discharge "to where." If they are being discharged to another facility, this may not be the case. We talk about multiple admissions in a 30-day period. They get admitted into the hospital, they are there for a week, and then they get transferred to a rehabilitation facility. I think we need to clean this up a little bit so that we are not putting an expectation on that rehabilitation hospital that they do an affirmative outreach to the agencies because it really is a continuation of the prior hospital. I am sure that the Nevada Hospital Association and our legal division can help with that.

Assemblywoman Benitez-Thompson:
Good. The bigger conversation is within the continuum of care. If they are leaving the hospital and they are going somewhere safe and their needs are being met, then it is not an issue. The issue is being discharged into the community without any kind of a safety net. That is what we will try to drill down on in this working group.

Chair Dondero Loop:
Thank you. Mr. Ortiz, would you like to comment?

Alex Ortiz, representing Clark County:
I am here in the neutral position for this bill. Interestingly enough, we own University Medical Center of Southern Nevada. The hospital and Department of Social Services down south have a different take on this. Considering that their viewpoints are a little bit different, we are in the neutral position. We will work with the Assemblywoman to come up with some legislation that will benefit both of our agencies and the entire state, as well as the community.

Chair Dondero Loop:
Are there any questions or comments from the Committee? [There were none.] I will close the hearing on A.B. 457. The meeting is adjourned [at 8:23 p.m.].

RESPECTFULLY SUBMITTED:

_____
Janel Davis
Committee Secretary

APPROVED BY:

_____
Assemblywoman Marilyn Dondero Loop, Chair

DATE: _____

EXHIBITS

Committee Name: Committee on Health and Human Services

Date: March 27, 2013 **Time of Meeting: 1:35 p.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
A.B. 344	C	AARP	Research Document
A.B. 344	D	Larry Matheis	PowerPoint Presentation
A.B. 344	E	Barry Gold	Testimony
A.B. 215	F	Janette Dean	Remarks
A.B. 215	G	Andy Belanger, Southern Nevada Water Authority	Proposed Amendment
A.B. 215	H	John Sagebiel	Testimony
A.B. 215	I	John Sagebiel	Photos
A.B. 215	J	Daniel LaRubio, Southern Nevada Health District	Testimony
A.B. 215	K	Bob Foerster, Nevada Rural Water Association	Testimony