MINUTES OF THE
SENATE COMMITTEE ON COMMERCE, LABOR AND ENERGY

Seventy-Seventh Session
February 27, 2013

The Senate Committee on Commerce, Labor and Energy was called to order by Chair Kelvin Atkinson at 1:34 p.m. on Wednesday, February 27, 2013, in Room 2134 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412E of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Kelvin Atkinson, Chair
Senator Moises (Mo) Denis, Vice Chair
Senator Justin C. Jones
Senator Joyce Woodhouse
Senator Joseph P. Hardy
Senator James A. Settelmeyer
Senator Mark Hutchison

GUEST LEGISLATORS PRESENT:

Senator Donald G. Gustavson, Senatorial District No. 14
Senator Tick Segerblom, Senatorial District No. 3
Assemblywoman Teresa Benitez-Thompson, Assembly District No. 27

STAFF MEMBERS PRESENT:

Marji Paslov Thomas, Policy Analyst
Dan Yu, Counsel
Wynona Majied-Martinez, Committee Secretary

OTHERS PRESENT:

Louise Sutherland, Nevada Mental Health Counselors Association
Tricia Woodliff
Adrienne Sutherland
Renee Arbogast, Nevada Mental Health Counselors Association

Erik Shoen, Community Development Director, Community Chest Inc.
Gary Waters
Helen Foley, Marriage and Family Therapist Association of Nevada
Cynthia Baldwin, Ph.D.
Cheri Jacobsen
James C. Euler, Marriage and Family Therapist Association of Nevada
Shauna Rossington, Executive Director, Mountain Circle Family Services, Inc.
Dr. Don Huggins
Jim Jobin
Adrienne O'Neal, Marriage and Family Therapist Association of Nevada
Colleen Peterson, Ph.D., President, Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors
Douglas C. Cooper, C.M.B.I., Executive Director, Board of Medical Examiners
Bradley Van Ry, Board of Medical Examiners
Barbara Longo, Executive Director, State Board of Osteopathic Medicine
Lawrence P. Matheis, Executive Director, Nevada State Medical Association
Valerie Wiener, Alzheimer's Task Force
Carol Meyer
Ruth Gay, M.S., Director, Public Policy and Advocacy, Alzheimer's Association of Northern California and Northern Nevada
Gini Cunningham, Nevada Task Force to Develop a State Plan to Address Alzheimer's Disease; Humboldt Volunteer Hospice and Alzheimer's Association in Northern Nevada; Winnemucca Alzheimer's Support Group
Debra Fredericks, Alzheimer's Association
Susan Van Beuge, Nevada Advanced Practice Nurses Association
Constance McMenamin, M.S.N., R.N., A.P.N., Nevada Advanced Practice Nurses Association; American Nurses Association
John Griffin, Nevada Advanced Practice Nurses Association
Melinda Hoskins, A.P.N., R.N., IBCLC, The Hoskins APN Clinic
Debra Scott, M.S.N., R.N., F.R.E., Executive Director, State Board of Nursing
Barry Gold, Director, Government Relations, AARP Nevada
Diane McGinnis, D.N.P., A.P.N., Beatty Medical Center; Nevada Health Centers
Martha Drohobyczer, National Advanced Practice Nurses Association
David Hald, M.D., President-elect, Nevada State Medical Association
Teresa Carroll
Vance Alm, M.D.
Randy Idler, M.D., Nevada State Society of Anesthesiologists
Donald Farrimond, M.D., Nevada Academy of Family Physicians
Marlene Lockard, Nevada Women's Lobby

Marta R. Malone
Shelley Chinchilla, Administrator, Nevada Equal Rights Commission, Department of Employment, Training and Rehabilitation
Jon Sasser, Southern Nevada Senior Law Project; Legal Aid Center of Southern Nevada; Nevada Commission on Services for People with Disabilities
Bob Ostrovsky, Nevada Resort Association
Sean Higgins, Porter Gordon Silver
Jack Mallory, Southern Nevada Building and Construction Trades Council
Tray Abney, The Chamber
Brian McAnallen, Las Vegas Metro Chamber of Commerce
Randi Thompson, National Federation of Independent Businesses
Nicole Rourke, Clark County School District

Chair Atkinson:
We will start with Senator Gustavson who will present Senate Bill (S.B.) 155.

SENATE BILL 155: Revises provisions relating to the practice of clinical professional counseling. (BDR 54-714)

Senator Donald G. Gustavson (Senatorial District No. 14):
I am here to open the discussion on S.B. 155. I wrote in my prepared statement this will enhance the availability of mental health services to all Nevadans, especially families and children by expanding the scope of practice for clinical mental health counselors (Exhibit C). We believe this change in the law is necessary.

Louise Sutherland (Nevada Mental Health Counselors Association):
I am a Licensed Clinical Professional Counselor (CPC). I will read my written testimony in support of S.B. 155 (Exhibit D). In addition I cited the intent of A.B. No. 424 of the 74th Session. Also contained in Exhibit D are letters of support from Joyce Larson, Ryan Gustafson, Adrienne Sutherland and Renee Arbogast.

Senator Hutchison:
I see a big need for the education, training and certification requirements you cite in your testimony. Why has it been unauthorized or, as you put it, "illegal" for CPCs to provide this type of counseling service to families?

Ms. Sutherland:
I studied the rules, laws and regulations of 52 licensing entities across the Country, focusing on each scope of practice. Forty-eight of the fifty states, Washington, D.C., and Puerto Rico have no caveats regarding CPCs, Licensed Professional Counselors as they are sometimes called, working with families and couples. It is accepted practice that they work conjointly with and refer to marriage and family therapists (MFTs). Nevada is the exception to the general practice.

When I worked in Massachusetts as a licensed mental health counselor, I sometimes referred some of my clients to MFTs because the clients needed something that I was not able to offer. It is a specialty in every state but California and Nevada. All the providers work well together as they coordinate and advocate for mental health services.

Senator Hutchison:
Why has Nevada been an aberration along with California? Is there a rationale for it? Was there a problem in the past? Was there someone who was sued or were there abuses? Do you know any of the background to the prohibition?

Ms. Sutherland:
I am not aware of any litigation that may have led to this. Marriage and family therapy has been a recognized and licensed profession in Nevada since the late 1970s. Nevada, however, has resisted licensing of CPCs from the late 1990s, when efforts were under way to pass a law recognizing the profession. There were various arguments, but you will have to decide for yourself when you hear all the testimony as to what might be behind the resistance to expanding the scope of practice for such highly educated and trained professionals.

Tricia Woodliff:
I am experienced in another state as a CPC for children and their families and am speaking as a private individual in favor of S.B. 155. I specialize in treating children who have had significant trauma. Ethically and clinically, it does not make sense to address the trauma of young children without working with their caregivers. I will read my written testimony (Exhibit E). I urge the Legislature to reconsider the current statutes that limit the scope of practice of CPCs.

Chair Atkinson:
How many other states limit this practice?

Ms. Woodliff:
California is the only other state that has limits. However, California has the caveat that if you have experience treating families or couples and have the continuing education to go with it, exceptions can be made. We are the only state that has no exceptions.

Chair Atkinson:
How did you get experience?

Ms. Woodliff:
I moved here from Oklahoma; I had years of experience there.

Adrienne Sutherland:
I ask that you pass S.B. 155. I will read my written testimony included in Exhibit D.

Renee Arbogast (Nevada Mental Health Counselors Association):
I support S.B. 155. I graduated from a CACREP-certified school (Council for Accreditation of Counseling & Related Educational Programs), and I have 18 years' experience working with families and couples. I find it ironic that with all the great experience I have with insurance companies and the U.S. Department of Defense, the State of Nevada will not deem me competent. I am discouraged by that.

Passage of this bill would help me and professionals who follow me. It would help citizens get the quality mental health care they need and deserve. Frankly, there is a shortage of that kind of care here, and we are in dire straits. I have submitted written testimony (Exhibit F).

Chair Atkinson:
Are there a certain number of hours required for CPC licensure?

Ms. Arbogast:
It is preferred that a CPC should acquire 3,000 hours under supervision. I have 4,000 hours, and 2,400 of those are related to couples and family work.

Erik Shoen (Community Development Director, Community Chest Inc.):
I work for a variety of professional counseling entities. Today, however, my comments are in support of S.B. 155, expressing the crucial role of CPCs and reflecting my opinion only.

I am thankful we have MFTs supporting us because they are the acknowledged specialists in the family system. They are valuable partners. Fortunately, Nevada has recognized there are other valid ways to work with families: social workers, psychologists, psychiatrists, drug and alcohol counselors. The CPCs are the only ones who cannot work directly with families. I urge you to support S.B. 155. It is a strong bill. I am submitting my written testimony (Exhibit G).

Gary Waters:
As a Licensed Clinical Social Worker and licensed MFT in Nevada and California, I urge passage of S.B. 155. I have practiced in Nevada for 37 years and was involved in the 2007 work to enact legislation expanding the Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors to include licensed professional counselors (LPCs) and MFTs. I have dealt with LPCs in Nevada for several years. Their training has undergone considerable improvement in recent years and includes appropriate safeguards for family and marital therapy. I am in favor of this bill.

One of the Senators asked why this proposal to expand the scope of work for CPCs was put into the legislation initially. I can tell you, since I dealt with former Senator Joseph J. Heck at the time. It is almost impossible to separate family work from individual therapy. It would be like asking a physician to work on a leg but ignore the knee, so they were going to place the LPC and MFT licenses under the same regulatory board. Doing that created the need to differentiate between the LPCs and MFTs. I do not recall many discussions regarding differences in expertise or training. Mostly, the legislators wanted the differentiation because the two would be under the same board. I thought that was a structural mistake at the time, I still think so. I would go further and recommend a separate bill that would establish an independent licensing and self-governing board. That would be prudent and in keeping with how the LPC has emerged in our State and in other states. I support this legislation. It is in the best interest of the State.

Senator Hutchison:
I appreciate your contributing the perspective of someone who was there when these questions of differentiation arose. Do you agree with the prior testimony? Do you have any knowledge other than what you just described regarding the need to differentiate the two types of practices through board affiliation? Were there any concerns about abuse or inability to practice in a particular area because of lack of training or anything else?

Mr. Waters:
I recall no discussions of that at all nor have I heard of any issues of abuse or boundary violations. As a matter of fact, I have heard the contrary. There is deep concern on the part of LPCs not to infringe upon the practice area of MFTs because it was not an area in which they are legally allowed to operate, although they were trained to do so.

In addition, the initial CPC training and available continuing education in the aftermarket post-graduate training is effective and adequate. The regulatory board could easily differentiate the training elements to ensure that CPCs were adequately trained. In statute, there would be no problem, and it could easily be something into which the Board could look and make certain the training was indeed in place before the license was issued.

Senator Hardy:
I understand you are in favor of this bill. If you propose a new board, it would call for a fiscal note. You would become a person who would not be loved by the people you want to help.

Mr. Waters:
Creating two separate boards for the LPC and the MFT licensees would be a wise move.

Helen Foley (Marriage and Family Therapist Association of Nevada):
I also was there in 2007. I have represented MFTs since before 2000. A reading of minutes of the 2000 meeting demonstrates we always have been supportive of LPCs. We are opposed to S.B. 155.

We did not want a super board that included all the different mental health professions, which is what former Senator Heck was proposing. We did support bringing in new mental health professionals who had a minimum of master's

degrees and the appropriate credentials and supervision to serve the great needs of our State.

I was surprised that Ms. Sutherland did not say why the statute contained the prohibition against CPCs practicing MFT. She was an integral part of that negotiation in 2007. No CPCs had yet been licensed in Nevada, but they were willing to accept that provision. The statute also provided that CPCs were not to practice in the area of psychology and other areas. While we are in opposition to the bill, we are not opposed to CPCs dealing with families and couples. We are in favor of CPCs having the proper education, credentials and supervision enabling them to do the job. We propose to amend S.B. 155 (Exhibit H).

A couple of testifiers today clearly would qualify for the kind of licensure we propose. They have demonstrated vast experience while working in other states. Some also spoke about the different courses they took in marriage and family therapy. The Board for MFTs and CPCs needs to evaluate what types of training and experience are required to qualify them to practice. Unfortunately, S.B. 155 was introduced and posted for hearing with a short lead time, so the Board did not have an opportunity to take positions. I would like the Board members, experts in the field, to have the opportunity to take a position before we continue with any hearings.

We need professionals in this State, but many family situations emerge that are not dealt with in some areas of practice. When the areas do overlap, appropriate training and credentialing are key.

It is not entirely true that only California, Nevada and maybe New Jersey have these provisions. In many states, CPCs can address couples issues but not family concerns. At least 10 states say that an LPC cannot do family work without MFT licensure. We would like to look carefully at existing statutes and provisions that describe scope of practice in other states and come back with something that is more reasonable.

Clinical professional counselors did not have a new board because they did not have any board when we started. They predicted they would license from 253 to 300 people, that the gates were going to open and all these people were going to come forward. Only about 60 have been licensed, so it would be extremely expensive for them to have their own board.

Senator Jones:
I do not see any provisions in other parts of *Nevada Revised Statute* (NRS) 641A.065 that specify education for an excluded person. Why would that kind of language be included here? We do not put that kind of language in the practice of psychology or medicine or any other area.

Ms. Foley:
We have an automatic exclusion. Where it says in S.B. 155 on page 2, line 2, "The assessment or treatment of couples or families;" we would have preferred to be as specific as possible, but we did not have anything to put there. If we wanted just to have it determined by the Board for MFTs and CPCs, it would give them more leeway, but it would not define things more clearly. That is a matter for further deliberation with individuals who are experienced in this area.

Senator Jones:
You said there has not been a flood of individuals interested in practicing as CPCs. Could part of it be these limitations regarding their ability to see a child but not talk to the parent?

Ms. Foley:
I do not have the answer, but I am sure that individuals on the Board would know.

Senator Hutchison:
Do you have any observations or comments about the CPCs' education or requirements for licensure that we heard earlier in this hearing? Also, would they be adequate for the Board's purposes?

Ms. Foley:
There are others who can answer that better than I can.

Senator Hutchison:
Would you like to say that you are not against this concept and that you are not against CPCs providing treatment for couples and families? You recognize there is a big need for legislation, but you want the Board for MFTs and CPCs to consider this and come up with reasonable criteria for experience and education.

Ms. Foley:
That can be the case. I know there are some MFTs who feel strongly about certain requirements. However, when we meet, we can all get together and hammer this out.

Cynthia Baldwin, Ph.D.:
I came to Nevada in 1998 to teach marriage and family therapy at the University of Nevada, Reno (UNR). Because of a heart ailment for which I had surgery, I was not able to continue teaching, but I have remained in the field and have continued to do supervision for MFTs. I have submitted a handout (Exhibit I).

I listened to CPCs from other states who are well-trained, and I am glad they are in Nevada. I want to see some mechanism to license them so they can do what they do well. The program here at our university has not done the same job with our people as has been done in other states. This is why we have such a different licensing structure.

I have listed the things we have in common under "Areas of Study," Exhibit I. I took this from the Board for MFTs and CPCs. This is what they use to determine whether someone qualifies to be licensed as a CPC and as an MFT. There are 11 courses in marriage and family therapy, more than half the credits required for a master's degree in MFT. The ethics, human sexuality, marital and family systems, therapy and supervised practicum are all related to marriage and family therapy. Candidates also must do postgraduate work, which is specifically with MFT supervisors. This is a 2-year commitment after which candidates must take and pass an MFT national exam.

One group has been trained thoroughly for their specialty. Persons in that group spend more than half their program, 60 hours of coursework, to become MFTs. Meanwhile, the CPCs do not undergo the same program. Persons studying to be CPCs have a 48-hour credit requirement, and they do not have to take the additional courses required of MFTs.

This is my main concern. We could have people posing as MFTs who have not had adequate training and background. This is not to say that they should not or could not and might want to, or that they have been trained as MFTs in other states. I would love to grow the pool of CPC candidates who see the value of working in family systems. I would love to see them get better educations. As it

sits, we are not providing candidates with the background they need to be CPCs. That is why I oppose this bill.

Senator Jones:
I understand your concerns, but if all but one or two other states are doing it, why should we be different?

Dr. Baldwin:
In reference to a previous speaker who came from a CACREP program and supported this bill, those programs are vigorous and exciting, and there are 60 hours of credits required. Our program is very different. I am not sure ours would be CACREP approved.

Senator Settelmeyer:
Do you know someone who can get us more information about the requirements in some of those other states? Playing off Senator Jones' inquiry, are those states' requirements so much more than ours? Is that why theirs would meet the standards and ours would not?

Dr. Baldwin:
I do not have that information. My information came from the criteria used by the Board for MFTs and CPCs. I assume that the states have varied standards for CPCs in relation to MFTs. Notice the kinds of courses, however, that are required for the MFT and that are not required here. We heard powerful testimony from people who trained and practiced outside Nevada. They were well trained, and they spoke on behalf of this bill.

Senator Hardy:
From Exhibit I, I get the impression that a clinical professional in Nevada could have earned 9 credits and still qualify as a clinical counselor. Is that correct?

Dr. Baldwin:
In this chart, I listed the courses that are common to CPC and MFT training and I listed the courses that are MFT-specific. I did not list the courses that are CPC specific. I did not in any way intend to say that CPCs have had only 9 hours. The requirement is a minimum of 48 hours. The MFT curriculum is 60 hours of coursework at the graduate level.

Senator Hardy:
Is the Nevada requirement 48 hours?

Dr. Baldwin:
That is my belief. I am not trying to speak about the qualifications in other states. I am looking at our people and our predicament. I would love to see the CPCs in Nevada have the courses that are also related to marriage and family therapy. If we could find a compromise, I would be delighted.

Senator Hardy:
I get the impression from your chart that they need 9 hours and they do not need any clinical application. Nevertheless, testimonies tell us that there is clinical application and clinical supervision.

Dr. Baldwin:
Of the people who have been speaking to you, would you ask how many have received their training in Nevada? I am specifically trying to talk about our State and our situation. The previous speakers were well versed in marriage and family therapy. They sounded like wonderful colleagues. I am glad they are here. It sounds, however, as if their programs are different from the one that exists in Nevada.

Senator Hardy:
Being the professor, do you know a professor who has your level of knowledge, who is on the other side of the fence and who can evaluate what we are doing in Nevada?

Dr. Baldwin:
Yes, in southern Nevada.

Cheri Jacobsen:
I am in favor of expanding the education and scope of practice for CPCs. I would love to see our CPCs get more MFT hours. Standards of care, however, are important. There is no comparison between the CPC courses offered here in Nevada and the MFT courses. There is definitely a difference. That is my biggest concern.

Working with couples and families is more difficult than working with individuals. You are dealing with all kinds of dynamics. You have individual and

personal issues. You really need to be trained. Our couples and families come to us for help and healing, and they need a clinical professional who is well trained in these areas.

I have been in private practice for about 18 years. I taught at University of Phoenix in the Counseling/Marriage and Family programs for 6 years. I was chairman of that department for 2 years. I am well versed in the University of Phoenix program; the University of Nevada School of Medicine program is similar.

Marriage and Family Therapists take marriage and family courses, and couples counseling, and they take systems theories courses, which involve relationships. The CPCs do not take those courses. There is also an undergraduate internship that is about 600 hours for which I was the supervisor. The CPC students mainly had clinical hours with individual clients. The majority of hours for MFT students was primarily with couples and families. I am also a clinical supervisor for interns who have graduated. Their requirement is a total of 3,000 hours. I supervise MFT and CPC interns. The CPC interns have clinical hours with individuals. MFT interns are with couples and families. This is the differential that is the real issue.

I have a CPC intern who is going to go to the UNR and get her MFT hours. She wants to work with couples and families. It is hard work. The only thing I can relate it to is this situation.

There was an internist in Carson City who decided to become a cardiologist. He moved his family and went to do a 2-year fellowship in cardiology. He is well respected and back in Carson City. If CPCs want to do couples and family work, they should be able to get that training. It is an important part of our profession. It is extremely important for the clients.

Senator Hardy:
Is there a means and method by which the Board for MFTs and CPCs would establish a standard that would be able to meet the criteria for counseling? Is the Board suggesting such a standard with this amendment? Is this a non-board, lobbyist action? By approving this amendment, would we be facilitating access to CPC training?

We struggle with the Nevada System of Higher Education giving credits in one institution and finally coming to recognize that those credits may or may not be accepted by another institution. Regarding your human sexuality course, is it the same in both CPC and MFT programs and at both institutions? Or does it have a different title? We may not accept it because it has a different name. Those are the kinds of things we deal with in higher education.

Ms. Jacobsen:
Dr. Don Huggins can speak to that. He is on the Board. While I was teaching, the CPCs took a lot of the same courses as the MFTs. They are very similar, but CPCs were lacking the courses in systems theory, marriage and family therapy, couples therapy and child and family therapy.

Senator Hardy:
Are those seven courses?

Ms. Jacobsen:
There were two marriage and family courses. There were probably not seven but quite a few.

James C. Euler (Marriage and Family Therapist Association of Nevada):
I will read my testimony (Exhibit J) in opposition to S.B. 155 as currently written.

Shauna Rossington (Executive Director, Mountain Circle Family Services, Inc.):
I represent the private therapeutic business community. I am the CEO of Mountain Circle Family Services, a private nonprofit foster family agency. As a professional and business owner working in Nevada and California, I will only hire licensed MFTs, interns or licensed therapists. I have not and will not hire CPCs. I am adamantly against this bill.

Clinical Professional Counselors are not qualified to work with families and children with severe emotional or behavioral problems. Marriage and family counseling is a dynamic field of knowledge, and learning and can only be implemented and utilized with proper education, training, supervision and passing the American Association for Marriage and Family Therapy (AAMFT) national exam.

I am halfway through my doctorate program in business administration and am a licensed MFT intern who just took the rigorous AAMFT exam. I probably studied 250 to 300 hours for that exam. It is an incredible and invaluable refinement process that prepares a candidate to work in this field. I would not have it any other way.

Dr. Don Huggins:
I will not read my testimony. I am going to answer some questions that came up earlier in the hearing.

I also was here in 2007. Dr. Baldwin was here in the 1990s, having these discussions about a bill to expand the CPC scope of practice. The Senate and Assembly decided to exclude the practice of marriage and family therapy from the CPC scope of practice because of the lack of training and the lack of demonstrable competency in the areas of couples and family therapy.

Please refer to the chart you have before you regarding the curricula, Exhibit I. Missing are the classes that CPC students take in Nevada that do not overlap with those taken by MFT students, such as group counseling and career counseling. The three supervised CPC practicums are taught in individual counseling—not family counseling, not couples counseling. Even though the titles overlap, they are distinct in terms of what they do in the courses.

You have heard from members of the community and people from other states who represent a national association of certified counselors. Any association that lobbies your body makes me wonder about its purpose. It seems consistently to have been an issue of turf, of finding a scope of practice that will enhance the members of their association. What you have heard in opposition to this bill, or at least in support of the amendment, is we are not looking at turf. We are looking at competency.

We all agree that CPCs would be welcome to see families and couples if they were properly trained. I have invited some of those who have testified in favor of the bill to work with me to come up with legislation to that effect.

Chair Atkinson:
Are you saying that with the amendment you would be more in favor of this measure? Or are you saying that both still need help?

Dr. Huggins:
I defer to Dr. Colleen Peterson in Las Vegas, who can carry the discussion further.

Senator Hardy:
We have heard repeatedly that CPCs are wonderful, they are well trained and we welcome them into Nevada. But we have not welcomed them. Does your Board for MFTs and CPCs have a mechanism for accepting someone and allowing that person to practice according to his or her training, which would be equal to or significantly better than what we have seen here? Does the Board have a mechanism that would allow CPCs to practice their craft by way of reciprocity, endorsement or something else? Have we in Nevada effectively said we do not train them so we cannot have them and we only accept them from out of State? But we do not even accept them from out of State. You might be impressed with all the people who testified and with all the criteria they have met. But why are we not allowing them to do what they do?

Dr. Huggins:
That is a question to be directed to Dr. Peterson and the Board for MFTs and CPCs, who license both professions. They need to work that out. That is part of why we are here. That is one of the issues the amendment will help resolve. Members of the Board would like to work together to come up with a solution. I offered the Board members more than a year ago the option of working with me to come up with such a plan.

Jim Jobin:
I am opposed to S.B. 155 as it is written. I stand in opposition today because I know that students like me, who are training to be CPCs, have no experience and training in systems at this point.

Many of those who have testified on both sides have pointed to their extreme qualifications and experience. I do not hear anyone on the other side, saying that they are not. They are saying that they need to be the only ones who practice because they are the qualified few and others should probably earn that right as well.

I am neither experienced nor qualified. I have just completed my master's in marriage and family therapy, and I am a student intern. I am presently going

through the process of getting my hours. I am 7 months into it. It has been an incredibly draining and overwhelming experience.

While I have worked with many individuals with all sorts of obstacles holding them back, the most challenging have been couples and families. It is like playing chess with a roomful of people and yourself. There are no rules, and you have to catch everybody cheating all the time. Couples and family work is a different animal. I have been overwhelmed and defeated at nearly every turn.

I am somewhat successful as an MFT student intern because of the competency and guidance of my supervisors. Each has more than a decade of experience working with couples and families. When I approach them with my challenges, things with which I am overwhelmed and I have no clue what to do next, they calm me down and guide me to the right answer fluidly and easily because they have seen it all before. They are experts. Their strength gives me strength, their guidance counsels me and I in turn, am able to counsel those who have put their trust in me and my supervisors. I shudder to think what would happen to my clients who are couples and families if it were not for the guidance of my supervisors.

It is interesting how different individuals are from relationships. In a relationship, you are not just dealing with individuals. We are greater than the sum of our parts. I am more than a collection of cells and bone and muscle. I am a human being with infinite possibilities. Relationships and families are similar, with an infinitude of possibilities. You cannot understand relationships just because you understand individuals. You must understand the system. You must understand the organism that is created through relationships. Anybody who is married or has children knows it is impossible to understand the whole family merely by understanding a member of it. Anybody who seeks to be successful in the group would need to be trained adequately.

I almost have a master's degree in this discipline, and yet I am overwhelmed and often confused. It is only by the guidance of my supervisors that I am becoming qualified to work with couples and families. I would not have it be otherwise. The supervisors of CPC students going through the same kind of internship that I am now have no experience working with Nevada couples and families. If this bill passes, on day one, there will be no qualified CPC supervisors except those who come from out of state. Nevada CPCs will be

unable to work with couples and families. They will have zero days of experience. That is unacceptable and ought to be taken into consideration.

As a student who is seeking to become qualified, I know I could do more damage than good if I did not have the supervisors I have with all their qualifications. I am not ready to heal the broken relationships and the broken families. They are too complex. I will need every minute of my internship to be ready.

I urge the Committee to amend this bill or reject it outright.

Adrienne O'Neal (Marriage and Family Therapist Association of Nevada):
Our opposition to S.B. 155 is expressed in my testimony, which I will read (Exhibit K).

Colleen Peterson, Ph.D. (President, Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors):
Although I am president of the Board for MFTs and CPCs and am on the University of Nevada, Las Vegas (UNLV) faculty in the marriage and family therapy program, I am here representing myself in opposition to S.B. 155.

One of my frustrations is that the Board was not notified of S.B. 155 in time for us to have a meeting to address it and to be in compliance with the Open Meeting Law. I am happy to answer any questions, but there is not an official position from the Board for MFTs and CPCs related to this bill.

You have my written testimony in opposition to S.B. 155 (Exhibit L). I am not in opposition to those who have the appropriate competencies to provide couples and family therapy. The issue is one of competency.

The information and statistics in the exhibit are the regulations put in place by the Board to determine education and core experience requirements for the CPCs and the MFTs.

Senator Gustavson:
There is a lot of controversy about S.B. 155. I would like to get together with the opponents and proponents.

Chair Atkinson:
Proponents and opponents should address their concerns to Senator Gustavson so you can bring something back to the Committee's work session.

We will now close the hearing on S.B. 155. We will open the hearing on S.B. 162.

SENATE BILL 162: Revises provisions governing the practice of medicine. (BDR 54-108)

Senator Joseph P. Hardy (Senatorial District No.12):
The purpose of Senate Bill 162 is to mirror the goals of osteopathic physicians (D.O.) and allopathic physicians as much as possible so we can establish the same level of standards for both, enlist the understanding of medical boards and have the best health care for patients. Medical school training for osteopathic and allopathic physicians consists of 4 years. In addition, the osteopathic student takes basic clinical sciences as well as 600 to 800 hours of osteopathic musculoskeletal diagnosis and treatment. There are some differences, and that is why there are two boards.

Douglas C. Cooper, C.M.B.I. (Executive Director, Board of Medical Examiners):
Senate Bill 162 contains administrative changes. There are nine changes relating to changing the word "within" to "no later than" and 20 references address "knowingly" or "willingly." Six other changes also are included. If at some point, there is opposition to S.B. 162 because of the legalese related to "knowingly" or "willingly," the Board of Medical Examiners would like to pursue its original request to change NRS 633.3065, as shown in section 7.

We begin on section 1, subsection 2. We do a biennial report to the Governor and the Director of the Legislative Counsel Bureau concerning any disciplinary action taken against physicians during the previous biennium. We would like to add all our licensees so we can give a fuller and more complete picture of the Medical Board's activity and give credit to the Medical Board, the Legislature and the Executive Office for all they do.

We are asking to add a new subsection 3 to section 2 of S.B. 162, which is our endorsement statute to expedite and recruit clinical doctors who could work in Nevada's specialty centers, such as the Cleveland Clinic's Lou Ruvo Center for Brain Health and the Whittemore Peterson Institute for Neuro-Immune Disease.

We could provide that certain physicians do not have to meet all the licensing requirements. They are renowned physicians, physicians with rare specialties, as well as foreign physicians who offer us something and who usually have a sponsor and are recruited to come here to do this kind of work. This is an expedited endorsement process. We are finding that those physicians who want to be administrative physicians, which is the opposite of what we are seeking with this statute are trying to use the endorsement statute to gain licensure. Administrative physicians cannot see patients. They do no real clinical medicine. It is not what the Legislature intended, and we would like to be able to stop it by adding paragraph 3:

> The Board shall not issue a license by endorsement to practice as an administrative physician except for the limited purpose of practicing as an administrative physician, as an officer or employee of a state agency; or independent contractor pursuant to a contract with the State.

If we have a sister department in government that has a position open, and they need someone with extensive medical training but who will not have to do clinical medicine, then we want to be able to fill that spot as soon as we can.

The rest are administrative changes. We propose that section 9 be amended to allow the Medical Board to examine medical competency, using psychiatric evaluations, psychological evaluations, or physical evaluations of our licensees. It mandates that physicians who examine our licensees should write reports that are not privileged communications. That means we can acquire the report. We order the report and sometimes we pay for it, so we certainly want to be able to get it.

We have so many examinations that are not conducted by physicians. They are conducted by Ph.D.s in neuropsychology, forensic psychology and addiction medicine. We need to have those individuals who conduct the examination report to the Medical Board with communications that are not privileged. So in section 9, subsection 2, paragraph (b), we add “persons” instead of “examining physicians” to allow us to complete the examination process smoothly.

Sections 10 and 11 refer to summary suspensions and to filing complaints. Bradley Van Ry, general counsel for the Medical Board will explain the legal intent and the rationale behind our changing these two paragraphs. The two

deletions in section 10, subsection 1 and section 11, subsection 1, eliminate the executive director of the Medical Board as the officer who orders summary suspension or files a complaint. The executive director has no business being part of the prosecutorial team. My job as chief administrative officer is to make sure we have enough money to operate on, to make sure we have the personnel we need and to ensure we comply with all facets of law including the Open Meeting law. I was against this provision in the law when it was first proposed. I am still against it. I would like to see the executive director position taken out as part of the prosecutorial team.

In section 13 of S.B. 162, we propose to address a special desire to update our service of process for formal complaints. The Medical Board orders anything that needs to be delivered or delivered by service of process. We are looking to do it electronically as long as the electronic mail address designated by the licensee is given to us by the licensee and with his consent. We also will want to establish a system for delivering a service of process.

Bradley Van Ry (General Counsel, Board of Medical Examiners):
Sections 10 and 11 address procedural process issues that arise in the prosecution of these cases, including summary suspensions. We want to adjust and narrow time frames for filing against a doctor after an order of summary suspension. In section 10, subsection 2, we propose that if a formal complaint is not filed within a particular time, 60 days, then the summary suspension will lapse and the license will be reinstated. Section 11 also regards procedural issues. Mr. Cooper addressed the issue of the executive director getting out of the business of signing these complaints. We are adding that the legal counsel can file the complaint. There also is a procedural issue in section 11, subsection 2, with regard to a respondent's answer to a formal complaint. The goal is to avoid getting stalled and move these proceedings forward.

Senator Hutchison:
My experience with commissions or committees like this is that the legal counsel typically does not sign a complaint. In civil litigation, we do that all the time, but typically it is the executive director or the head of the committee. Why do you want to get the executive director out of the business of signing the complaint, and put you in the business of doing it?

Mr. Van Ry:
The executive director needs to be in an administrative position. The prosecution portion of the Medical Board's responsibilities needs to reside with the prosecutors. There can be a conflict of interest for the chief executive officer also to be the chief prosecutor. It would just be cleaner for someone else to sign off on this.

Senator Jones:
Is there anything in S.B. 162 that would allow the Medical Board to go after those who are not doctors but are pretending to engage in the practice of medicine? We have had a lot of those issues in the Las Vegas Hispanic communities.

Mr. Cooper:
There is nothing in S.B. 162 that will allow us to go after unlicensed physicians. Let me rephrase that. They are not "unlicensed physicians," they are criminals, and we do not do criminal investigations. We do, however, cooperate extensively with law enforcement. We share information daily, and we do anything we possibly can to aid the criminal investigation, but we do not have the investigators trained to go after that kind of criminal activity.

Barbara Longo (Executive Director, Board of Osteopathic Medicine):
We support Senator Hardy's bill, S.B. 162, and what it does for us. Our intent is to mirror most of the testimony on NRS chapter 633 already provided by Mr. Cooper. If the Committee decides to mirror where appropriate, we are fine with the endorsement language in section 2, subsection 3 and the earlier testimony regarding legal counsel's signing the formal complaints. This has not been a practice with the Board of Osteopathic Medicine. We prefer to continue with the executive director as one of the signers of the complaint.

Lawrence P. Matheis (Executive Director, Nevada State Medical Association):
We support S.B. 162. Physicians have asked me to raise two points. Throughout, where the existing statute says "willingly" or "knowingly," the Medical Board only requests changes for section 7. Where there is a willful standard and there have been problems demonstrating that the licensee had knowingly acted. For some courts, that seems to matter. I am not a lawyer, so I apply a different common-sense standard. It seems like legalistic overkill where there has never before been a problem with applying the standard.

The other point is the one Senator Hutchison and the Medical Board's counsel discussed. Rather than being an amendment or a deal-killer, this is a suggestion. When sufficient grounds are found for a formal complaint and the entire board is going to hear the case, if the investigative committee chair is not available, we propose that the executive director will sign the formal complaint. We agree that is probably inappropriate, given the setting. It also is probably not appropriate for legal counsel to do it. The prosecutor divides the Medical Board from that viewpoint. It probably would make more sense for any member of the investigative committee to sign the order. They all would be recused from participating in adjudication of the complaint. It gives the Medical Board several additional people who can do it. That is just a suggestion, not anything more than trying to ensure that the procedures work and that we are not back here next time discussing the same issue. We support S.B. 162.

Chair Atkinson:
We will now close the hearing on S.B. 162 and we will open the hearing on S.B. 69.

SENATE BILL 69: Revises provisions governing advanced practitioners of nursing. (BDR 54-549)

Valerie Wiener (Chair, Alzheimer's Task Force):
We are bringing S.B. 69 forward because Nevada is short on services, providers and access to health care. Our geographical significance and uniqueness, where the major communities are in the corners of the State, have contributed to this situation. Reno-Sparks-Carson City, Elko and Las Vegas are in these corners. We have vast stretches of open road and smaller towns between them. Patients in our rural areas are isolated. They have many challenges preventing them from accessing health care and we have difficulty recruiting providers. We have particular difficulty recruiting specialists in neurology or geriatrics. People who live in these far-flung communities must travel to get their needs met.

According to the University of Nevada "Nevada Rural and Frontier Health Data Book," 2011 edition, the most recent compilation of statistics, the average distance between acute care hospitals in rural Nevada and the next level of care, tertiary care, is 114.7 miles and the average distance to the nearest incorporated town is 46.5 miles. Consequently, primary health care delivery is a major issue. These residents are so challenged that they can only hope to know about a problem in time to get adequate care.

Eleven towns with federally designated Critical Access Hospitals are an average 45.5 miles from the nearest incorporated town, an average 54.4 miles from the next hospital and an average 104.8 miles from the next level of care, the tertiary care hospital.

Senate Bill 69 would allow advanced practitioners of nursing (APNs) who are highly qualified and are already recognized in their scope of practice to offer the kinds of services we are proposing today. This workforce is ready, able, and credentialed to provide assistance to those who cannot access care. They are eager also to aid the special population served by the Nevada Alzheimer's Task Force.

People with Alzheimer's have a disease that is more than individual; it is a disease of family and community. It is happening to people all over Nevada. As a member of the Task Force who is bringing this measure, I come from the Alzheimer's perspective. This measure, however, is not limited to people with Alzheimer's. Senate Bill 69 will help many underserved people. As we think about health care unfolding with new federal legislation, we are going to have even greater challenges to providing services. As health care policy and technology changes, we will be even more challenged. Nurse practitioners can help us meet those challenges.

Senate Bill 69 will allow APNs to provide services under the scope of practices that is already in the statute. They would not need to be supervised by a physician. People who need care would be able to receive it in a timely manner.

Senator Hutchison:
Not only are you recommending this, but so is Dr. Charles Bernick. I put a lot of faith and confidence in him. Do you know of anyone better qualified than Dr. Bernick to tell us whether APNs have the skills and training to do this? His endorsement goes a long way based on my own personal experience.

Ms. Wiener:
Dr. Charles Bernick, one of the leading Alzheimer's researchers and treatment specialists in the country, was a member of the Task Force. He is located at the Cleveland Clinic Lou Ruvo Center for Brain Health in Las Vegas. He has the ability to scrutinize these issues that we have brought before the Legislature.

His endorsement means a great deal, since he knows much of what is best for Nevadans.

Senator Settelmeyer:
Would APNs carry their own medical malpractice insurance and not need to rely on doctors? Would carrying their own insurance relieve the doctors of responsibility or liability? Some doctors are concerned about that.

Ms. Wiener:
That is not something we addressed. I cannot respond to that other than to say this bill would release them from the supervisory constraints tied to the position. We did not go into that part of it.

Carol Meyer:
I support S.B. 69. I am a certified nurse-midwife and certified family nurse practitioner, and I have had the pleasure to work with Dr. Bernick at the Center. We had an office in Reno for a few years, giving me the opportunity to travel up and down the State conducting memory exams to anyone over 18 who wanted them. I administered tests at a senior center, an American Indian colony, a store front, a diner, someone's home. For anyone who was worried about where he or she left car keys, I was there to do a memory screen. The folks who screened positive were offered a scheduled visit from the Center, via the telemedicine system. These visits were conducted in the patient's hometown and they were seeing world-renowned specialists.

Often patients wait years for diagnosis, but these patients were identified, diagnosed, given a treatment plan, which could include medication, imaging, laboratory, doing nothing, or behavioral counseling and counseling for end-of-life issues. It was a beautiful thing if there was a primary care provider available in these small towns to continue the care. For patients who had primary care providers, the process was seamless. I am certain we kept some people out of facilities. I am speaking today for those who could not identify a primary care provider for various reasons. It could have been because one was not available or would not accept Medicare. They were left without follow-up, creating a situation of "You win some, you lose some." That was unacceptable.

I began thinking about what was happening with the specialty practices that included some sophisticated telemedicine in the areas of cardiology, nephrology and neurology. After complaining and looking for people to listen, finally

someone heard us, and it was the Alzheimer's Association of Northern California and Northern Nevada. They were hearing the same stories from caregivers, patients and families. We realized that a workforce was out there already in place. They were APNs. They were innovative, skilled and highly qualified, with proven track records, and they were available. However, there were some barriers to care. I often think now I should have thought of that. It was a good idea to improve my own profession to help care for these folks but the Alzheimer's Association as a consumer advocacy group was there. Many of the things we accomplish first start out in the grassroots. By the time we professionals get to the program, it is sanitized.

The Alzheimer's Association came to the table with this bill, S.B. 69. I could not be happier to join them. Consumer advocacy trickles down to our patients and families and at the end of the day, patients figure things out anyway. I would just like to see us put the systems in place without patients having to figure things out on their own.

I encourage you as Legislators and as consumers of care and as patients to support S.B. 69.

Ruth Gay, M.S. (Director, Public Policy and Advocacy, Alzheimer's Association of Northern California and Northern Nevada):

There are 29,000 people with Alzheimer's in Nevada and around 130,000 caregivers. We talk about the need for care for people with Alzheimer's and how important it can be for families to have local resources. Whether you live in a rural area or in one that is just a bit underserved, families need help, support and education. If we were to have APNs as added resources to serve families, these areas would be better served. We know that more than 50 percent of people who have Alzheimer's or dementia are never diagnosed. The family might think they have something, but they do not know for sure. Also, they do not know if it is a reversible illness; S.B. 69 would help.

I recently worked with a family where the husband was mostly functional during the day, although confused. He would wake up at night at 2 a.m. or 3 a.m. at which time he would not recognize his wife of 47 years. He would ask what she was doing there or who she was? He would say she needed to leave. He wanted to go home, but this was his home. She found that sometimes if she put him in the car, drove around for a while and came back and said, "There, we're home," it would allay his agitation and fear, and he would be happy to be

at home. She could settle him into bed for a few hours. Usually, that would work for the rest of the night. Sometimes, she would have to do it twice. She was 70; he was a little older. After a few months, she was exhausted. She was not doing well herself, developing colds, flu and pneumonia. One day, she dressed her husband, took him to the local hospital, holding onto his belt so he could not get out of the car, and left him there. She was no longer able to care for him and did not know what else to do.

Medicare now allows for annual wellness visits that include a cognitive screening. It is reimbursable; it can be performed easily by APNs; and it could be the first step in early and better diagnosis. In addition, even if you identify the presence of cognitive impairment, you can start looking at care coordination. An APN is an ideal person to look at how to coordinate care; to see whether medications are being dispensed properly and to determine whether the patient needs someone to come in and support the caregiver and provide help in the home. The APN also provides support to the caregiver, becoming their caregiver. He or she can address depression, blood pressure and other health concerns that come up for a caregiver. These conditions are exacerbated for the caregiver when taking care of someone with dementia. This bill can address these issues in a large way and would expand the availability of medical resources. We strongly support S.B. 69.

Gini Cunningham (Nevada Task Force to Develop a State Plan to Address Alzheimer's Disease; Humboldt Volunteer Hospice and Alzheimer's Association in Northern Nevada; Winnemucca Alzheimer's Support Group):

I have varied involvement with Alzheimer's groups. I strongly support S.B. 69 in my testimony, which I will read (Exhibit M).

Debra Fredericks (Alzheimer's Association):

I am testifying on behalf of the Alzheimer's Association in support of S.B. 69, which removes the mandatory contract between an APN and an M.D. My comments apply not only to the rurals. I practice in Reno and have done so my entire career.

I was on the faculty of the University of Nevada Reno School of Medicine and worked for about 12 years with Dr. Bernick, developing these statewide programs that later were acquired by the Cleveland Clinic. I have spent almost

20 years of my career focusing on Alzheimer's-related dementias. I have worked with thousands of patients and families over the years.

We have all seen the numbers; we have all seen the demographics and heard the predictions. We know we are in crisis, which is going to get worse as we provide for geriatric and particularly Alzheimer's families. Senate Bill 69 provides a solution without compromising quality of care. The APNs' scope of practice would not change with S.B. 69. The bill does not impact the quality of care. It is not a particularly novel solution. Many states have legislated independent APN practice, so there is a great deal of data out there and I am sure the representatives from the Nevada Advanced Practice Nurses Association (NAPNA) will have as much data and research findings as you need to address your concerns.

I am speaking primarily for Alzheimer's conditions that affect people. Multiply the examples you hear about today by thousands. Alzheimer's diagnosis and cure requires a broad range of collaboration. We depend upon our primary care providers, and neurologists must be involved when you are following the state-mandated guidelines for diagnosis. My contract with my collaborating physician is minimalist, given the type of services I provide and the type of clients I serve.

We are asking Legislators to undertake a paradigm shift. We have to think about Alzheimer's in interdisciplinary and intra-disciplinary terms, as opposed to a multi-disciplinary approach. Our approach most certainly needs to go above and beyond what is provided with medical diagnosis and medical management. The APN treats the whole patient within the context of the illness, while MDs treat the illness within the context of the whole patient. We do not duplicate. We complement.

Susan Van Beuge (Nevada Advanced Practice Nurses Association):
I am here to testify in support of S.B. 69 on behalf of the 350 members of NAPNA. I am a certified family nurse practitioner and an assistant professor of nursing at the UNLV School of Nursing. I am not representing UNLV. I am here as a citizen.

We have approximately 790 APNs in the State who have certificates of recognition. The provisions of S.B. 69 have been reiterated by every speaker.

This is not an expansion of our scope of practice. This is not so APNs can practice medicine. We practice APN, and we are proud to do so.

Nevada ranks low in access to primary care. We are number 46 of 50. That is pretty dismal. We would like to improve on that number. Senate Bill 69 would allow APNs to be part of the goal to increase access to primary care.

The National Governors Association published a report in December 2012, "The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care," calling on states to consider easing the practice restrictions and encouraging greater APN involvement. Utilization of nurse practitioners has the potential to increase access to care, particularly in historically underserved areas, according to this report. In 2010, the nonpartisan Institute of Medicine of the National Academies wrote in "The Future of Nursing: Leading Change, Advancing Health," that the future of nursing lay in leading change and advancing health. Nurses play a critical role in responding to increasing demands to satisfy patient needs expected from the Affordable Care Act, it said. It is predicted that 10 months from now, approximately 280,000 Nevadans will be seeking primary health care. We can be part of the solution to help provide that care.

Of the states that are near us, New Mexico was the first to give nurse practitioners full practice authority. That was 20 years ago. Las Vegas is very near Arizona, where the law allows APNs to have full practice authority—what we are asking today. In 2011, the Arizona rural health workforce put out a trend analysis in which they looked at all health care professions to see what happened with providers between 2002 and 2007. That state experienced a 52 percent increase or 782 nurse practitioners. The largest group went out to the rural areas, similar to Jackpot and Elko and some of the small towns that do not have care. Perhaps we could be a little like Arizona and see some of those changes that would benefit our citizens. Utah, Idaho, Oregon, Washington, Colorado, Wyoming, Alaska and Hawaii all have extended full practice authority for nurse practitioners.

Our requirements for practice keep potential providers from coming here and staying. Students often graduate and then leave because they want to go to a state where the practice authority is less restrictive. They have the same education as their colleagues in those states but they can go to Arizona and have a different professional career as an APN. This means that potential providers, citizens, taxpayers and highly educated individuals are leaving our

State and going someplace else. They are taking their knowledge and expertise and going someplace with a more favorable environment. People who might contemplate moving to Nevada often decide this is not the place for them. They move someplace else. I respectfully ask that you consider passing S.B. 69.

Constance McMenamin, M.S.N., R.N., A.P.N. (Nevada Advanced Practice Nurses Association; American Nurses Association):
I am licensed as an APN and RN in Nevada and Colorado. I am nationally certified in family practice through the American Academy of Nurse Practitioners and am an active member of NAPNA and the American Nurses Association. I am here to ask for your support for S.B. 69 with the goal of removing the mandatory collaborative relationship for APNs, removing barriers to care and improving access to care. Please see my testimony (Exhibit N).

John Griffin (Nevada Advanced Practice Nurses Association):
We are more than happy to codify insurance requirements in S.B. 69. I want to address a question asked by Senator Settelmeyer and put on the record that a number of people have questions about malpractice insurance. Most APNs that I am aware of carry their own insurance. There is no legal requirement that they do so but we are happy to put that protection in the bill. We can provide any amendment to that effect that is necessary.

Melinda Hoskins, A.P.N., C.N.A. (The Hoskins APN Clinic):
I submitted my testimony supporting S.B. 69 (Exhibit O). However, I do want to discuss some points regarding physicians' liability when working with nurse practitioners. The language of the Nurse Practice Act and the *Nevada Administrative Code* (NAC) 630.490, subsection 13 promulgated by the Board of Nursing holds that we may have a collaborative agreement with physicians. One nationally recognized definition of collaboration is: the cooperative working relationship with another health care provider, each contributing his or her respective expertise in the provision of patient care. Such collaborative practice may include discussion of patient treatment and cooperation in the management and delivery of health care. I am a certified nurse-midwife (CNM). This sort of collaboration is mandated by my scope of practice, which is outlined by the American College of Nurse-Midwives. My competence is tested by the American Midwifery Certification Board.

When the collaborative language went into the Nurse Practice Act NAC 630.490, subsection 13, the Board of Medical Examiners made the

physicians responsible for the medical services performed by the APN. With this language, the Medical Board has created a situation in which few physicians are willing to work with CNMs. If the physician does agree to work with CNMs, his liability is increased. We are the only state that has vicarious liability for the physician. I have been told that it is cheaper and more convenient to hire another obstetrician than to work with a CNM.

Nearly 9 years after becoming eligible for APN status, I still have not been able to practice to the full extent of my education and professional scope of practice as a CNM. I have chosen to remain in the ranks of the licensed and regulated APNs. My husband is a family practitioner. He has signed my collaborative agreement. Because the NAC 630.490, subsection 13 regulations require my collaborative agreement to be within my scope of practice, it is limited only to women's health care. My husband does not do obstetrics because of the liability situation in Nevada.

When potential candidates review Nevada's licensing and regulation environment compared to other states, they decide that Nevada is not for them. Sadly, I have to tell aspiring midwives that Nevada is not friendly to the practice of midwifery, nor is it friendly to other APNs.

Primary care physicians consult, collaborate and confer for management with specialists as a routine of medical practice. APNs ask that we be extended that same courtesy—to be part of the team rather than being seen as usurpers.

I urge you to pass S.B. 69.

Debra Scott, M.S.N., R.N., F.R.E. (Executive Director, State Board of Nursing):
Our board supports S.B. 69. We have a good reputation for being accountable and taking responsibility for the practice of nursing in Nevada. You have my testimony in (Exhibit P), but I want to answer one of the questions that has arisen: If not a physician, then who is accountable, and who takes responsibility for the practice of these APNs? Several entities take such responsibility. First the Board of Nursing licenses and registers and makes sure APNs are working within their scope. They also have licenses with the State Board of Pharmacy and are responsible to the United States Drug Enforcement Administration, the U.S. Department of Justice, because they prescribe controlled substances. Advanced Practitioners of Nursing are nationally certified by national certifying

bodies that have requirements for them to remain competent and to maintain their certification.

The Board of Nursing voted to support S.B. 69.

Senator Hardy:
Could you elaborate on the certification process and/or the recertification process? How often does that happen? How does a person decide under what specialty or scope of practice he or she will operate? Could you also elaborate on the training of the nurse practitioner?

Ms. Scott:
In 2011, the Board of Nursing, along with other nursing stakeholders, supported S.B. No. 205 of the 76th Session, which now requires national certification for all APNs. The certification process is based on the APN's specialty. A bachelor's degree, master's degree or doctorate is required for practice within a specific scope and with a specific population or demographic. The national certification process varies among the different types. At this hearing, APNs can tell you about their certification. Initial certification, however, is based on meeting certain requirements and passing a test. The time period for recertification depends on the specialty.

Ms. Hoskins:
I can speak to the certification requirements for CNMs and possibly to some of the others. Because of the consensus model for the APN regulation, which is part of what is driving some other bills, standardization is becoming the norm. The CNM specialty was one of the earliest to have a certification. That started in 1971. At the time, it was issued as a lifetime certification. I testified in 2011 to support the action toward national certification.

The certification board then went to continuing education and an 8-year cycle where we had to complete modules that brought us current with changes within our specialties. Now, we have a 5-year cycle. A practicum requirement is being considered for the next evolution of this process.

Family nurse practitioners already have a practicum requirement for recertification. They must have a certain number of continuing education hours and be able to show they have had a certain number of practicum hours.

Barry Gold (Director, Government Relations, AARP Nevada):
You have my written testimony (Exhibit Q). On behalf of the 309,000 AARP members across the State, we support S.B. 69 and urge the Committee to pass it to increase consumers' access to health care.

Diane McGinnis, D.N.P., A.P.N. (Beatty Medical Center, Nevada Health Centers):
I am a nurse practitioner. You have a copy of my testimony (Exhibit R) in support of S.B. 69.

I practice in Beatty, in the middle of rural Nye County. There is a hospital in upper-mid of Nye County but not all the way at the top. There is one in the southern corner of Nye County. From Beatty, it can take up to 1.5 hours to travel to the nearest physician on Monday, Wednesday and Friday. In addition, the hospital in Tonopah has opened a clinic where a physician is available on Tuesdays and Thursdays. These are two different clinics. I am the sole provider for patients in Beatty on Monday, Wednesday and Friday. By being there, I keep patients out of the emergency room and prevent emergency room overcrowding. I can do sutures, I have an X-ray machine and I read and interpret X-rays. Then I have an over-read by a physician. I do have a collaborative agreement.

It is rare for my schedule to be filled with as many as 20 patients, but I have treated that many in a day. In addition, if my collaborating physician were to pass away in the middle of the day and nobody bothered to call me for the rest of that day, I would still see patients. I would be breaking the law. It does not change the way I practice or the way I would see those patients because I have no idea he is not there. This is more of a paperwork reduction action. I still collaborate with and refer to physicians. I referred patients to Dr. Joseph P. Hardy when I worked in the emergency room. It is less an issue of whom are these patients going to see than it is an issue of helping our Medical Board and Board of Nursing to do their jobs correctly. Those jobs are to make sure our patients are getting safe care.

Chair Atkinson:
If the doctor was just out of town, and you could not reach him, would you still be violating the law?

Ms. McGinnis:
No. He would have to be dead to void the agreement. If he is out of town, I have been known to call some of my colleagues. I will call one of my emergency-room physician friends; or emergency room APN friends. I have resources. Also, when my collaborator is out of town, he makes an informal agreement for me to chat with one of his colleagues. I do not usually have questions. I have been well trained, and rarely do I need to call and ask questions.

Martha Drohobyczer (National Advanced Practice Nurses Association):
I have submitted my testimony (Exhibit S) supporting S.B. 69. In addition, I want to make two points. The U.S. Department of Veterans Affairs has stated that APNs are competent to give care without the supervision or collaboration of a physician. Also, the U.S. Department of State has APNs in consulates and embassies throughout the world. Those APNs give safe, competent and effective health care without a collaborating physician or physician oversight. When the federal government states we are safe, effective and competent, the citizens of Nevada, especially in the rural areas, should feel that we are safe, competent and effective.

David Hald, M.D. (Nevada State Medical Association):
I am a board certified practicing urologist in Nevada. We have submitted our comments, which include a lot of data (Exhibit T). While the Nevada State Medical Association (NSMA) strongly supports the professional work and increased capacities of both the physician assistant and the APN, we oppose the basic proposal in S.B. 69.

I have worked with APNs throughout my career in many different models, including Kaiser Permanente and the U.S. Department of Veterans Affairs, where there have always been physician-led teams. Part of the reason the physician-led team has worked so well is the training is quite different for a physician, compared to the advanced practice of nursing, particularly when we look at sub-specialty care. It is simply a matter of hours and experience gained through the training that allows us to identify rapidly the information we have at our fingertips.

Scaling of information, emphasized often in the business world, is the reason collaborative care works well with physicians and APNs. That is what you get when an APN comes to a clinician to work in a complex-care model. The

physician has the experience and knowledge to scale the information and provide the care at a higher level if it is a complicated case. In addition, the provisions in S.B. 69 do not limit APN independent practice to primary care. We have heard a lot about shortages in primary care but many APNs choose to work in subspecialties. They do not necessarily focus on serving rural Nevada. The number of APNs going into primary care has dropped by 40 percent since 2004, and a recent study by the Robert Graham Center for Policy Studies in Family Medicine and Primary Care shows that APNs, nationally, choose an urban area over a rural area.

Senate Bill 69 does not limit the APN to an independent practice of primary care. Many work in specialty care. Section 1, subsection 2, paragraph (b) demonstrates one of the provisions I find problematic. Stricken from the proposed bill is the designation of collaborative physician and protocols.

Section 1, subsection 3, paragraph (b) says the Board of Nursing can delineate the APN's authorized scope of practice. My concern as a super-specialist is that the Board of Nursing does not have urologic input. The development of a protocol would be difficult at the State level. I have concerns that without the collaboration we still would need protocols to define the standards of care. In addition, I have a concern in section 1, subsection 1, paragraph (a), where the proposal strikes the word "medical."

In other places, the bill strikes "medical diagnosis and treatment." This is an interesting proposal, intended presumably to indicate that the APN is not engaged in the practice of medicine. Striking a key word does not change the action contemplated for the care given. The word "medical" should not be stricken in these instances. The effort acknowledges the conflict in oversight and accountability contained in the bill. Six states already are confronted with the same reality of overlapping scopes of practice between the APNs and primary care or sub-specialty care providers. This well may be needed to clarify what each licensed professional can do, and who actually has responsibility for the care.

Without accountability, there are no professional standards, and this needs to be sorted out. Also, Senator Settelmeyer asked a key question. Who is legally liable for an error of omission or commission? With an APN, I am legally liable for an error and assume that responsibility gladly because I work in a collaborative effort to manage the care. The fact that the most complicated

cases are managed by the clinician with the most experience is what allows the APN the luxury of becoming knowledgeable. The problem in medicine is that you do not know what you do not know if you do not know it. Occasionally, something seemingly simple may be quite complex and if missed can have dramatic consequences with morbidity.

Senate Bill 69 does not improve availability of APNs or any other practitioners in rural Nevada. The proponents seem to believe that removing the requirement that APNs must have a written agreement will increase availability. Increasing the health-professional workforce is important, and we are working on that with telemedicine and other modalities. I hear a lot of concern about distance of travel. I trained in a metropolitan area where to go 7 miles would take 1 1/2 hours. It is not always just a mileage issue. There are certain costs, but there is also a time issue. I just do not believe that the bill as written deals with the fact that there is primary care and there is sub-specialty care, and that a significant number of APNs are practicing in specialties.

The NSMA values advanced training and all the efforts of nursing and the contributions made to the health care system. Without nursing, neither I nor any of my colleagues can do our jobs and deliver the quality of care of which we are capable. While national APN advocacy groups support bills like S.B. 69 to eliminate a team-based approach, the NSMA believes that as policy makers, patients can be better served by protecting the collaboration and respecting the educational and training differences between physicians and APNs. To that end, we encourage consideration of potential harm in some of this language. The NSMA stands ready to assist in all efforts and to protect the highest quality of medical care.

Senator Hutchison:
After passage of the Affordable Care Act, the tremendous influx of patients we expect because of it and the small number of physicians coming into the market, how can we manage unless we have some additional care providers?

Services well may have been offered in the past by primary physicians or through collaborative care. Is it not just a reality of life now that we have to do something different?

Dr. Hald:
There is some truth to that, but I do not believe that collaborative agreements preclude expansion of APN practice with physician-led teams. The real issue is graduate medical education. If primary care is completely taken over by APNs, because of the length of time it takes to train a family practitioner, we will have even a greater shortage of practitioners to provide that kind of care. Nevada, as it turns out, is one of the toughest among the states in which to get a medical license. For example, we have well-qualified physicians trained in foreign countries who come to the United States and have to redo residencies for 3 to 5 years to practice their craft.

This training by the APNs is excellent, but it is different. We feel that there is a need, but the level of provider utilization of an estimated 280,000 new Medicaid patients is not known by anyone. That utilization and the Medicaid expansion will be based on economics and will include some young people who will not have great needs. In addition, patients actually do get the care. They just do not get it in the environment where it is cost-effective and efficient. Workforce needs are a great problem. Working together is the best approach to fulfilling the need, rather than further fragmenting a system that is already fragmented.

Senator Hutchison:
Dr. Hald, this question is about section 4 on pages 3 and 4, where it refers to certificates issued by "the Board and the State Board of Nursing." Would your concerns be alleviated if there were more collaboration and input by the Medical Board or medical professionals, such as M.D.s, who would not just leave the arrangements to the Board of Nursing? We are going to be involved in that as well. It would be a collaboration, so maybe we really could come to some agreement on qualifications and criteria for the APNs.

Dr. Hald:
I would agree it would help solve problems regarding the protocols that are continually and rapidly evolving as health care technology and science change. I could argue that the section does help to solve the problem, but there is still the issue of whether the boards can collaborate. I would like to see the nurses collaborate with the physician-led team, because the physicians have the most training and experience.

Senator Settelmeyer:
What is the average coverage level for medical malpractice insurance for doctors? Is it $1 million, $1.5 million, $2 million? On my ranch, I have to carry about $5 million.

Dr. Hald:
The most common is $1 million per incident and $3 million total.

Senator Jones:
Several states already have gone to the proposed "de-collaboration" model. Do you have any studies or information showing the care provided in those states is less than what is provided in Nevada or other states where collaboration is required?

Dr. Hald:
One of the problems in medical care in general is that evidence-based medicine is lacking because it takes a long time to accumulate. Institute of Medicine of the National Academies researchers have argued for additional training of APNs to fill the void. They have gone back to look at certain studies (i.e. the Emergency Room, and when a physician would prescribe inhalants and steroids versus antibiotics for asthma). It was found that physician assistants and APNs use antibiotics at a higher rate, which leads to antibiotic resistance. That is one study. There are not a lot of studies because this is all new and needs to be evaluated.

Teresa Carroll:
I want to testify about the benefits of the collaborative agreement. I have 18 years of experience. I work in pediatrics, and the past 11 years were in pediatric gastroenterology. Having a protocol identifies to the physicians with whom I work the types of patients who are appropriate to treat within my scope of practice, not only regarding my education but within the realm of the training I received from them. There is no pediatric gastroenterology nurse practitioner residency or fellowship or any kind of formal training. It is all on-the-job from the physicians with whom you share the collaborative agreement. Also, it takes several years to gain that experience. Because of that agreement, we were able to build our fund of knowledge. The protocol allows for guidance on the types of patients who are appropriate for a mid-level provider to treat versus one needing physician oversight or physician care. Consider, for instance, liver disease or inflammatory bowel disease. They are conditions I can work up but

I am not qualified to treat as are the physicians who had those 12 years of education and training.

The depth and breadth of educational backgrounds are completely different. Physicians acquire vast breadth. They go over every organ system, head to toe, body diagnosis that is not part of the APN's education. The depth I can get in specialty care is almost comparable, but I do not have the breadth of the entire body and organ system. That is where the benefit of the collaborative agreement comes into play. I am always going to have a question. There is always going to be a condition that may stump me, since I do not have the entire medical education that a physician has.

As time progresses, people with 20, 30 years behind them gain invaluable experience. They are not going to need that person to talk to so much, because they have experienced so much. Having that collaborative agreement, however, gives me a dedicated person whom I can contact any time when I come across that one patient with the red flag. I will give you a quick example. On February 8, I saw a 3 year-old who came in for a suspected gastroenterology problem. As it turns out, it was not a gastroenterology problem. There were a lot of red flags. It was a nephrology problem. The child had nephrotic syndrome. He could have gone into respiratory failure from pulmonary edema. I had to talk to someone immediately. I benefited, and so did the patient. The patient received appropriate and timely care because I had someone I could go to. It was not because I was unqualified; it was because I needed something more than what I had experienced. The collaborative agreement provided that structure.

Vance Alm, M.D.:
I have two different perspectives in opposition to this bill. First, as a practitioner of family medicine, I am self-serving. I do not want competition. That is something the Committee should look at. Second, as a citizen, I want a doctor as my provider. I want someone who has the experience, training, and additional points of training, who from day one, was trained to be an individual provider. That doctor is expected to know how to do everything, know everything, and if challenged, make a referral to a specialist.

We now have APNs who originally were trained as nurses to follow the instructions of the doctor and do exactly what they were told. We now have people who feel they have the experience since they have gone through

2 additional years of training and feel they now have the same level of training I have after 11 years. As a citizen, I feel there is a problem there. As a physician, I also see a problem. Alongside training, specialty should be considered. My understanding is that they start with a limited specialty.

There is a problem with the APNs in Nevada. I have worked with several. Many are very good. I enjoy the fact that I go to an APN for my care, but that APN has a supervising physician. If that APN has questions, he or she will go to that physician and clarify. I have also worked with APNs in a situation of urgent care. Many times they turned to me for the answer because it did not seem as if it was coming. They did not have everything "cookbooked." It did not fit the algorithm. They had to turn to someone with more experience. I have also had the opportunity to work with people in aesthetic dermatology. Many APNs and physician assistants are turning to that. It is very lucrative. They can go in as an APN and from a family practice specialty, work in a dermatology setting and make more money than I made last year. There is a little bit of selfishness. I do not want them taking my job. I do not feel it is appropriate that someone with 2 years of experience decides to switch specialties and now is working in a situation that ordinarily takes a 5-year residency. I think it is strange, and I do not think it should be allowed.

Here is another reason this bill should not be passed. There are too many loopholes. The argument for passage has been: We are going to work in rural areas. As Dr. Hald mentioned, that is not the experience we have seen nationwide. The APNs find it is far more lucrative to work in a specialty and not in a rural setting. The situation we have discussed with many of the APNs is that they have the capacity to turn to somebody. They say they turn to their physicians. They do not have to be geographically close. There has been the concern that we need more practitioners. That is not going to be addressed by S.B. 69. This bill merely allows the APNs to act independently. There are no additional personnel as providers. If you need to put all medical providers under one board—I do not know if that would be appropriate—but that is the situation we are discussing.

Additionally, we have the situation where, if we wanted to do so, we could have another hundred providers within a day because physicians who are trained in 4 years of medical school and a year of internship are still prohibited from practicing. It is a good thing that we make sure they have all the experience they need. They have now had 5 years of medical training, and they

are not able to go out and practice on their own. In 45 of the 50 states, physicians at that point in their training are allowed to practice. If anything, open it up so we can have additional resources, not just from people who are put out on their own.

Randy Idler, M.D. (Nevada State Society of Anesthesiologists):
In answer to Senator Hutchison's question, I am a practicing anesthesiologist representing the Nevada State Society of Anesthesiologists. We oppose S.B. 69. I submitted my testimony and two supporting documents (Exhibit U, Exhibit V and Exhibit W).

I am a big supporter of APNs as are almost all physicians I know. This is not an anti-APN testimony. We need them desperately to fulfill the coming needs. We are talking about the most efficient way to manage the fulfillment of those needs. The efficient method is the team model where there is stratification by severity of disease and by expertise to cope with the disease. Abandoning the team model is not a good idea. We are against it. The hallmark of the team model is communication between the physician and the non-physician provider in the team. This bill would eliminate a lot of that or serve as an obstruction to much of the communication that is necessary. We should have a relationship between an APN and physician where a simple phone call could list the issues, ask "What do you think I should do?" and get an answer.

We will not have that system if we have APNs operating around the State as islands working without any type of agreement with physicians. Among the points being advanced by proponents is that APNs will increase the availability of care to the rural counties. That has not been the case in the past and is difficult to prove. Experience has dictated otherwise. The litmus test of any bill being considered should be whether it increases the communication between these entities or diminishes it. I strongly oppose this bill.

In answer to Senator Hutchison's question, I am not convinced that the numbers on the rolls will increase the actual demand. Now those patients are being seen and being cared for. They are being seen through the emergency room and probably in an inefficient way. The most efficient method is through the team model. Senate Bill 69 does not increase the number of APNs. It does not increase the number of physicians. We are dealing with a finite labor supply. The only hope is to increase efficiency. That is what the team model does.

Donald Farrimond, M.D. (Nevada Academy of Family Physicians):
I represent 500 physicians associated with the Nevada Academy of Family Physicians in opposition to S.B. 69. I would like to start by acknowledging the great value I and most physicians see in APNs as team members and in the importance of the team (Exhibit X). It is clear, however, that the training of APNs is not equal to that of primary care physicians by a magnitude of many times. Had I done the same amount of hours as an APN, I would have left less than halfway through my first year of residency and been able to practice without doing any more training. One of the things we teach residents is that perhaps the most dangerous thing is not knowing what you do not know. As we go further in our training, it becomes clear to us what we do not know. We try hard to fill in those gaps and study, as I am sure APNs do. There is significant disparity in training and education. Any family physician is a proponent of a team-based approach to dealing with the problems we have here in Nevada.

Marji Paslov Thomas (Policy Analyst):
Elisa Cafferata, president and CEO of Nevada Advocates for Planned Parenthood Affiliates, submitted her testimony on behalf of the agency in support of S.B. 69 (Exhibit Y).

Chair Atkinson:
We have some concerns with this bill that we will try to address and bring them back to a later work session. We will close the hearing on S.B. 69 and open the hearing on S.B. 70.

SENATE BILL 70: Provides certain protections for employees who care for family members. (BDR 53-542)

Mr. Gold:
I will read my testimony (Exhibit Z) in favor of S.B. 70. On behalf of the 309,000 AARP Nevada members across the State, we strongly support S.B. 70 and urge this Committee to pass it. I also have a letter from Diane Ross who owns the Continuum Health and Wellness Center (Exhibit AA). She is also the chair of Nevada Caregiver Coalition, an employer and facilitator for a caregiver support group. She urges support. Erik Shoen also turned in his testimony in support of S.B. 70 (Exhibit BB).

Senator Settelmeyer:
I appreciate the concept of only using the earned hours and approved hours an individual already has accrued. What other states utilize the same or similar type of law? Are we unique, or are there other states?

Mr. Gold:
I have another handout (Exhibit CC) that addresses what other states are doing. There are only four states and the District of Columbia that have enacted laws providing explicit protections for family caregivers, including child care, elder care and care of individuals with disabilities; and those laws go beyond the federal protections. Those states are Connecticut, Alaska, New Jersey and Oregon. I will make sure the Committee gets a document that explains those laws in more detail.

Senator Hutchison:
I want to ensure that the definitions as expressed in the bill are doing what you want them to do and that they preserve the intent of S.B. 70. I just did not see that kind of language in the bill. Can you point me to it? The language I am looking at is the definition of family caregiver. These very broad statements include everyone. It is someone who is related by blood, marriage and legal custody. So, if I am taking my son to his doctor's appointment, I qualify, even though I am not taking care of somebody who has a disability necessarily. Or I am taking him to soccer practice. I am still caring for somebody who is related by blood. The next definition is domestic partner where you have a family relationship. Can you help me understand in terms of how this legislation is restrictive in the way that you are suggesting, as opposed to making it broad for the many people we are not trying to capture?

Mr. Gold:
Several of the outside groups have come to me to talk about that. We will continue to work on it and come back to the Committee with some mutually agreeable language. It talks about the persons who are receiving care and have those disabling health conditions.

Senator Hutchison:
While the first concern is the breadth of the definition, the second thing is the need for this. I appreciate that some of these caregivers are just overwhelmed by life and the care they are giving to their loved ones. This legislation seems to gather family caregivers into a protected class of those we know have had

a long history of discrimination. Section 7 of S.B. 70 surfaces from the Civil Rights Act of 1964, where there is extensive development in terms of a document of discriminatory practices against people of race and national origin. It would be interesting when we have more testimony to hear about this need as you said for this kind of protection. I have been an employer since 1996, and I do not think I have thought about this before in terms of discriminating against someone who has to take care of aged parents or even making it a factor.

Mr. Gold:
Senator Hutchison, regarding the 42 percent of workers who have provided elder care in the past 5 years and 49 percent who expect to provide such care, more than 1 in 6 work full- or part-time. Caring for sick family members has become something new in this country. We are talking about the sandwich generation. If you work in the aging network or with autistic children or in the health care industry, you frequently hear stories about the discrimination that occurs. I am glad to hear that a lot of companies are doing the right thing by having policies for dealing with family caregivers and making sure caregivers get to do what they need to do. We have heard these stories. You are going to hear some of them today.

A lot of these family caregivers have been suffering in silence. Not all of them are fired outright. Some are, but a lot more suffer in silence or are harassed until they quit. I spoke with a woman yesterday at the Alzheimer's Association Event Day. She is interested in this bill. I asked whether she would like to come and speak about this. She said that she had settled a lawsuit, and because of the horrible things that had happened to her, she was not comfortable coming to speak. She was concerned that speaking might violate the terms of the settlement. This suffering has gone on for a long time.

The prevalence of family caregiving is only increasing with the aging of the population. This is an issue whose time has come. You will understand from those who testify about the prevalence of family caregivers and the need to protect them from this kind of discrimination. These are people who need to continue providing care to keep their charges from ending up in hospitals and nursing homes, and most likely we will all be paying for that.

Our Medicaid rolls will grow. When these caregivers lose their jobs, they will have to go on welfare. We need to support these people to make sure they can keep their jobs and provide the care their loved ones need.

Marlene Lockard (Nevada Women's Lobby):
Nevada Women's Lobby represents women, children and families, and we strongly support S.B. 70. Yesterday's testimony on the early onset of Alzheimer's Disease showed what can happen to young people in their 50s and 60s and what families have gone through to care for family members when no other care is provided or available because of their age. One young girl testified about the toll that Alzheimer's took on her family. She was 13 when someone in her family was first diagnosed. She worked outside the family; her two older brothers worked; her mother went to work when she never before had to do so. It was heartbreaking to hear about this tag-team family effort to care for their father and husband and to earn sufficient funds to keep the family going.

We strongly support this measure and feel there is a need.

Assemblywoman Teresa Benitez-Thompson (Assembly District No. 27):
I am here to testify in my non-Legislative role as social worker with a hospice company. This bill, which I support, addresses family situations that I encounter every day. About 80 percent of the patients and families with which I work are seniors and elderly who are diagnosed as terminal. That means that their life expectancy is 6 months or less. Some people live longer, up to a year. One of the biggest concerns, however, is what happens with the caregiver. When the caregiver is in place, the patient is going to be safe.

The biggest element in keeping the patient safe and comfortable in the dying process is having a good caregiver. For caregivers who are employed, how they juggle the requirements of their jobs while caring for a terminal loved one is always an issue. Conversation is always taking place about whether they qualify for FMLA [Family and Medical Leave Act]. If they qualify, I encourage them to start the family leave paperwork right away and get the application in process. However, through the course of that period of 6 months to a year, there are times when changes in condition occur so family members might have to change their plans when leaving for work, or they might get a call at 10 a.m. to leave work. Employees take their earned time.

It can become trying for the employer and the employee when it is not planned. You cannot always plan for changes in condition. You cannot plan for a decline.

My experience with caregivers exposes their guilt and nervousness about taking their earned time at the drop of a hat because something is happening with their loved one. I have to applaud many employers because there are so many great ones in the State. They are understanding, will work with family members and are kind and generous with their time. That is the best situation to be in. However, a handful of situations are problematic.

I dealt with one situation in which a man was caring for his mother who had brain cancer. Every day was different; everything was touch and go. His employer told him he did not need to fill out FMLA paperwork, but just take the time. He had worked for a local casino as a bartender for 16 years and a week after his mother's death, he called to say he had been let go. They had told him that everything would be fine. He did not fill out the paperwork and now there he was, let go without cause. He could not even apply for unemployment benefits. It was tragic because he was doing what any of us would do, which is being present when needed in those last couple of weeks when time is precious and important. With the growing senior population, this is a conversation we as legislators will hear repeatedly until we arrive at some kind of a solution. There is opposition. There are employers who are concerned, and I appreciate their testimony. My hope is that we can find a policy that is workable so we can get ahead of this problem before the upcoming senior population boom, which we expect.

Marta Malone:
I support S.B. 70 addressing family caregiver employee discrimination. I was terminated from full-time employment but believe I was discriminated against because I was a caregiver, taking care of my mother and father during the last month of my mother's life. I encourage the passage of this bill to help others so they do not have to go through what I did. I will read my testimony (Exhibit DD).

Chair Atkinson:
You said it was not until that last moment they advised you could have applied for family medical leave. Had you applied for it yet? Were you off on medical leave by the time you were terminated, or did you never get the chance?

Ms. Malone:
No. It was the day before I left to go on Thanksgiving vacation. My mom died right after Thanksgiving.

Senator Segerblom:
I am here in my private capacity as a lawyer. Mr. Gold asked me to explain a few things about how this law works. There are a couple of gaps that this would fill first. Family medical leave only applies to companies that have 50 or more employees. The majority of companies have less than 50. It does not, however, apply to small companies. They have to have at least 15 employees. So, only those companies that have between 15 and 50 employees would be impacted.

The great thing about these discrimination laws is they are self-enforcing. Private lawyers step in to help with the enforcement. You do not have to worry about prosecutors, lots of big government entities or bureaucracy. If it is a good case, a lawyer will take the case, and if it is not a good case, there will not be a lawyer. The way personnel systems work today, there are human resource directors who know the laws very well and they educate their workforces about what a person can and cannot say or do to avoid being sued. There exists a litigation potential, and employers will educate managers and workforce about rights and responsibilities. A lot of litigation is prevented because employers know that if they do not comply, they can be subject to lawsuits. It is a great way to discourage discrimination without having to use the bureaucracy.

Chair Atkinson:
If an individual is on FMLA but did not accrue time and someone is sick, is that person still able to use FMLA?

Senator Segerblom:
They have 120 days. They just would not be paid during that uncovered time.

Chair Atkinson:
There is unpaid time?

Senator Segerblom:
They still have protection. This would not require an employer to provide insurance or pay. It would put the person in a special category. Any employer would want to be careful before they do anything untoward to the worker.

Senator Hardy:
We have heard reference to taking off time that is already allocated and due, but I do not see that anywhere in the bill.

Senator Segerblom:
The FMLA is a federal law. Senate Bill 70 does not go that far at all. It is a rudimentary effort that says somebody cannot be treated differently because he or she is a caregiver. Frankly, if the person is a caregiver and did not show up for work or forgot to call in, if the call-in policy said the person could be fired, the employer could fire that person. If however, other caregivers were not fired, then there could be a finding of discrimination. It is a little protection. It is nothing close to FMLA.

Senator Hardy:
This is not where employees are using vacation time that they have already accrued is it? Is there any time they would need to give care?

Senator Segerblom:
It does not even say they would be allowed to take the time. They just cannot be treated differently. For example, if you allowed people who were sick or disabled to take off time, you would have to treat this person who is a caregiver the same as you treated those people. It puts them in a special category where they cannot be treated differently from other protected people.

Senator Hardy:
If I read the bill correctly, you cannot not hire somebody if you know that they are a family caregiver.

Senator Segerblom:
If that is the reason. You have to be able to prove intent. These are intentional laws. Just because they were found to be a caregiver does not mean that they could sue you because you did not hire them. But if that is the reason why you did not hire them, then you can be sued.

Shelley Chinchilla (Administrator, Nevada Equal Rights Commission, Department of Employment, Training and Rehabilitation):
On behalf of the Nevada Equal Rights Commission, Department of Employment, Training and Rehabilitation, we believe this new protection would be congruent with our mission, policy and duties. I am here in support of S.B. 70. We do not

see a significant impact to our caseload or the way in which we would operate, because the Nevada Equal Rights Commission has the ability to take similar complaints of caregivers under Title VII of the Civil Rights Act of 1964, and State law protects gender in gender-stereotyping caregiver cases. Additionally, caregiver protection is afforded under the Americans with Disabilities Act (ADA) to a certain degree. The ADA extends protection to individuals associated with persons with the disability. If an employee is caring for an elderly parent who has a disability under the ADA and the employer treats the worker differently, the worker can file with our office or with the federal U.S. Equal Employment Opportunity Commission (EEOC). That protection already exists to a degree.

We think S. B. 70 would clarify and expand protections, and we feel it would be within our mission to act as the agency to ensure that companies are in compliance. My only concern has to do with the definition in S.B. 70. Section 1, subsection 4, says that a family caregiver is a person who cares for another person. I would ask the Committee to consider that the word "care" needs to be expanded. Somehow this bill needs to identify the type, quality or quantity of care so it is possible to know what is required for a person to qualify for this kind of protection. It is written very broadly.

Jon Sasser (Southern Nevada Senior Law Project; Legal Aid Center of Southern Nevada; Nevada Commission on Services for People with Disabilities):
The Commission voted unanimously to support this legislation. In addition, the two legal aid programs that represent seniors and know how important caregivers are to those seniors want to echo their support.

Bob Ostrovsky (Nevada Resort Association):
Senate Bill 70 is not about expanding the FMLA to cover smaller employers. It is not about having a bill of rights for hospice care. Both might be something you would want to consider. The FMLA applies to employers of 50 employees or more; it does have a wide gap from smaller to larger employers. Federal officials decided to restrict the number of employees because educating all small employers about how to respond to the needs of their employees under the federal law is not easy. The practical decision was made for 50 to be the cutoff point. Some states have lowered that. It is not likely that any state has openly and broadly established a new protected class, which is what this bill requires an employer to do.

It also does not provide any particular rights under the definitions to a caregiver

to someone in hospice care. Perhaps we do need a statewide hospice care bill of rights so we know the rights of hospice caretakers. It is difficult to know that the end is near and the loved one is not going to be with you very long. We have problems with the definition as indicated by the bill sponsor. It is broad as it stands, addressing anyone who provides care, including child care. If a person is a parent, he or she is a caregiver and under the definitions here.

My background is human resources. I am a former human resources executive with MGM and Bally's and have had as many as 25,000 employees report to me. I have only dealt with large employers. Senator Segerblom is right, however, in that large employers have a lot of time and money to spend educating supervisors and managers on compliance. Here is a real-life problem I see with S.B. 70. If an applicant applies for a job, I tell my interviewers not ever to ask whether the person has children at home because the EEOC has decided that if we ask about children at home we could build a discrimination case against women. In the past, women as primary caregivers were cut out of the workforce, and men were hired and promoted because employers thought if they hired a man, they would not have to worry about child care.

We hire someone and ask questions after making the hiring commitment. Then, we can ask about children when signing them up for insurance. That is also the point at which under ADA you can ask whether an employee needs an accommodation. My concern is, for example, if we will ask the question at this point and the person is a caregiver and cannot work swing shift because of having to care for someone after 5 p.m. when the spouse goes to work. But this may be a swing-shift job. Then, if that person wants a day job, you will have to bump someone off shift.

I have faced this problem before, having to look at union and company seniority lists and consider the bumping rights of someone who asks for an accommodation. This issue needs to be addressed if we are going to process this kind of bill. The administrative burden here is high. If we want to look at FMLA expansion or hospice care, we want to start slowly. Otherwise, we become the only state in the nation that has this benefit. This would be just another issue to consider for employers coming to Nevada. It does not make it right or wrong, but there are other ways we ought to address issues of people who have problems. I am not going to defend bad employers. We do have bad employers. They will use any excuse to get rid of somebody they think makes too much money. I would suggest that you talk to Senator Segerblom because

he is an excellent lawyer at defending people whose rights have been violated. I will be happy to work with the parties to see if there is anything we can support in this manner.

Chair Atkinson:
You mentioned about expanding FMLA. You know it is a federal law, right?

Mr. Ostrovsky:
Yes. It is a federal law, but some states have lowered the threshold. They have taken the federal law and made it a state law applied to smaller employers. Instead of 50, they have taken the limit down to 15. That is an alternative. I do not want to tell you exactly which states. I think Mr. Gold has information about some states that have expanded the pool of protection.

Sean Higgins (Porter Gordon Silver):
The states that have dropped the threshold are Maine, Minnesota, Oregon, Rhode Island, Vermont, Washington and the District of Columbia. Anywhere from 15 to 25. Under FMLA, a caregiver is not a protected class. Protected categories are race, color, creed, sex, sexual orientation, gender identity or expression, religion, disability or national origin. They are all inherent conditions. We understand about the issues of family caregivers and are sympathetic to them. Most employers are sympathetic. There are always the bad actors. To be honest, I do not believe we should govern to the lowest common denominator of bad actors. They will always be there. Laws are always in place in Nevada for people who violate these laws, whether FMLA, EEOC or ADA. Under any of these policies, you can come after someone who discriminates based on any of these categories. These laws are on the books. To place another law on the books, especially one that has such a broad definition of family caregiver would be going too far. We would be the first state to do it. The laws are in place to take care of this. Senator Segerblom also said putting the threat of a lawsuit on an employer is no way to govern.

Chair Atkinson:
Let us be clear. Senator Segerblom is for S.B. 70.

Jack Mallory (Southern Nevada Building and Construction Trades Council):
I find myself in odd company and in an odd position here. Typically, folks from organized labor support legislative measures that expand worker protections and worker rights. To that extent, we are sympathetic to bill supporters and believe

there is potential for clarifying existing statute to ensure that people in this situation are not harmed or discriminated against. I am happy about the Equal Rights Commission testimony regarding ADA. The key thing with ADA is that you have to request a reasonable accommodation. If the accommodation cannot be met by the employer, there are provisions under which the accommodations need not be honored. The portion of the bill I find troubling is that it applies to apprenticeships.

Apprenticeships are a form of postsecondary education. There is no provision in Senate Bill 70 that says a college organized under the Nevada System of Higher Education cannot discriminate or take action against an individual who has missed class because he or she is taking care of a family member or a spouse. Yet, they are trying to apply the same principle to an apprenticeship program where there are requirements for individuals who attend class. Students in our apprenticeship programs who have issues of this nature can talk to us. We make a reasonable accommodation so they can take care of their family member or spouse or other personal bit of business. They can make up class later. That is why we are in opposition to the bill. We support the concept of extending the worker protection. At the same time, we cannot support it the way it is written.

Chair Atkinson:
You cannot support it because of the apprenticeship part of it or the bill as a whole?

Mr. Mallory:
We are concerned with S.B. 70 as a whole. Not only do I act as a representative of working people, I act as an employer. I am concerned about the potential impact on our small administrative office if this were enacted.

Tray Abney (The Chamber):
We are worried about the broad terms in S.B. 70, specifically the term, "cares for" and what that means. It does not say "medically cares for" or "status as a family caregiver" or "familial relationship." We think the terms used in the bill are very broad, and we are concerned about that. This legislation requires no burden of proof or documentation of any of these things. Also, we are concerned about the potential for litigation because of the broadness. We know that every dollar spent on lawsuits is one less dollar an employer can use to hire people.

Brian McAnallen (Las Vegas Metro Chamber of Commerce):
If you form one, I would like to be part of a group to work on these issues. It has been pretty clear that the definitions are overly broad and need a great deal of focus. One issue that has not been brought up and which raises a brow is on the first page. There is a fiscal note showing no effect on local government, but an effect on the State. This affects employers of all classifications, not just the private sector but certainly public sector employers as well. It could have a significant impact on all of them, especially on the hiring side as they retool. All employers will have to adjust over time or bring in extra staff when employees are away under this category. We have significant concerns that this will be a litigation haven and be overly challenging for small employers and small businesses that might want to expand. This will weigh heavily on their minds. I know that from having spoken with them.

Randi Thompson (National Federation of Independent Businesses):
I represent employers who have 50 or fewer employees. Rarely will you hear me say this in any legislative session, but I agree with Mr. Mallory that employers do make reasonable accommodations to employees. The biggest investment a small business makes is in its employees. This is not something any employer will take lightly. I want to thank Mr. Mallory for standing with us today. I would second Bob Ostrovsky.

Chair Atkinson:
Mr. Mallory wants it noted for the record that he is not necessarily standing with you.

Nicole Rourke (Community and Government Relations, Clark County School District):
As a large public employer, we have concerns similar to those mentioned by Mr. Ostrovsky and Mr. McAnallen.

Mr. Gold:
The AARP, supporters and opponents of S.B. 70 are willing to work on these definitions and issues, and hopefully we can come to terms and do something that can provide protections moving forward.

Chair Atkinson:
We will close the hearing on S.B. 70. We are adjourned at 5:45 p.m.

RESPECTFULLY SUBMITTED:

Wynona Majied-Martinez,
Committee Secretary

APPROVED BY:

Senator Kelvin Atkinson, Chair

DATE:

EXHIBITS

Bill	Exhibit		Witness / Agency	Description
	A	1		Agenda
	B	20		Attendance Roster
S.B. 155	C	1	Sen. Donald Gustavson	Written Testimony
S.B. 155	D	9	Louise Sutherland	Written Testimony
S.B. 155	E	1	Tricia Woodliff	Written Testimony
S.B. 155	F	2	Renee Arbogast	Testimony
S.B. 155	G	2	Erik Schoen	Written Testimony
S.B. 155	H	1	Helen Foley	Proposed Amendment, Marriage and Family Therapist Association of Nevada
S.B. 155	I	1	Cynthia Baldwin	Chart—Which Therapist Do You Want For Your Nevada Family?
S.B. 155	J	1	James Euler	Written Testimony
S.B. 155	K	2	Adrienne O'Neal	Written Testimony
S.B. 155	L	2	Colleen Peterson	Written Testimony
S.B. 69	M	3	Gini Cunningham	Written Testimony
S.B. 69	N	3	Constance McMenamin	Written Testimony
S.B. 69	O	4	Melinda Hoskins	Written Testimony
S.B. 69	P	2	Debra Scott	Written Testimony
S.B. 69	Q	1	Barry Gold	Written Testimony
S.B. 69	R	1	Diane McGinnis	Written Testimony
S.B. 69	S	2	Martha Drohobyczer	Written Testimony

S.B. 69	T	11	David Hald, M.D.	Comments and Supporting Documents, Nevada State Medical Association
S.B. 69	U	1	Randy Idler, M.D.	Statement in Opposition, Nevada State Society of Anesthesiologists
S.B. 69	V	1	Randy Idler, M.D.	Chart—Know Your Doctor, Training and Education
S.B. 69	W	2	Randy Idler, M.D.	Chart—Anesthesiologists and Nurse Anesthetists, Education, Training
S.B. 69	X	1	Donald Farrimond, M.D.	Primary Care 21st Century, Physician-Led Teams
S.B. 69	Y	1	Marji Paslov Thomas	Statement, Planned Parenthood from Elisa Cafferata
S.B. 70	Z	3	Barry Gold	Comments, AARP
S.B. 70	AA	2	Barry Gold	Letter from Diana Ross, Continuum Health and Wellness Center
S.B. 70	BB	1	Barry Gold	Letter from Eric Schoen
S.B. 70	CC	2	Barry Gold	AARP Handout
S.B. 70	DD	1	Marta Malone	Written Testimony