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

Seventy-Eighth Session
April 27, 2015

The Committee on Health and Human Services was called to order by Chair James Oscarson at 1:36 p.m. on Monday, April 27, 2015, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4404B of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website: www.leg.state.nv.us/App/NELIS/REL/78th2015. In addition, copies of the audio or video of the meeting may be purchased, for personal use only, through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

COMMITTEE MEMBERS PRESENT:

Assemblyman James Oscarson, Chair
Assemblywoman Robin L. Titus, Vice Chair
Assemblywoman Teresa Benitez-Thompson
Assemblywoman Jill Dickman
Assemblyman David M. Gardner
Assemblyman John Hambrick
Assemblywoman Amber Joiner
Assemblyman Brent A. Jones
Assemblyman John Moore
Assemblywoman Ellen B. Spiegel
Assemblyman Michael C. Sprinkle
Assemblyman Tyrone Thompson
Assemblyman Glenn E. Trowbridge

COMMITTEE MEMBERS ABSENT:

Assemblyman Nelson Araujo (excused)

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Kirsten Coulombe, Committee Policy Analyst
Risa Lang, Committee Counsel
Karen Buck, Committee Secretary
Norma Mallett, Committee Assistant

OTHERS PRESENT:

Samuel P. McMullen, representing Touro University
Andrew M. Eisen, M.D., F.A.A.P., Associate Dean for Clinical Education, College of Osteopathic Medicine, Touro University Nevada; and President-elect, Clark County Medical Society
Samuel Parrish, M.D., Senior Associate Dean for Student Affairs and Admissions, University of Nevada, Las Vegas School of Medicine
Grayson D. Wilt, representing Nevada State Medical Association
Barry Gold, Director, Government Relations, AARP, Nevada
Barbara Paulsen, Member, Nevadans for the Common Good, Boulder City, Nevada
Betty-Jeanne Cousins, Private Citizen, Henderson, Nevada
Rachel L. Blinn, Private Citizen, Reno, Nevada
Stacey Shinn, representing Progressive Leadership Alliance of Nevada; Human Services Network; and National Association of Social Workers, Nevada Chapter
Edward R. Guthrie, Chief Executive Officer, Opportunity Village
Lynn Hunsinger, L.S.W., M.P.A., Director, Professional Services, Nevada Senior Services
Bill M. Welch, President, Chief Executive Officer, Nevada Hospital Association
Jessica Ferrato, representing Nevada Nurses Association
Marlene Lockard, representing Nevada Women's Lobby
Michael Dyer, representing Nevada Catholic Conference
Joan Hall, President, Nevada Rural Hospital Partners
Allan M. Smith, representing Religious Alliance in Nevada; and Lutheran Episcopal Advocacy in Nevada
Jacob R. Harmon, M.A., Northern Nevada Regional Director, Alzheimer's Association
Ryan Beaman, representing Clark County Firefighter's Local 1908
Laura Coger, Nevada Program Manager, Consumer Direct
Barbara Deavers, Private Citizen, Reno, Nevada
Benjamin Schmauss, M.P.H., Government Relations Director, American Heart Association/American Stroke Association

Katie Ryan, Director, Communications and Public Policy, Dignity Health-St. Rose Dominican
Mary Wherry, R.N., M.S., Deputy Administrator, Community Services, Division of Public and Behavioral Health, Department of Health and Human Services
Dave DeValk, Vice President, Saint Mary's Regional Medical Center
Aaron C. Heide, M.D., Director, Center for Neurovascular Care, Saint Mary's Regional Medical Center
Deborah Williams, M.P.A., M.P.H., Manager, Office of Chronic Disease Prevention and Health Promotion, Southern Nevada Health District
Victoria Skorupski, R.N., M.N., Coordinator, Stroke Program, Renown Regional Medical Center
Derek Cox, EMS Education Officer, Las Vegas Fire and Rescue
Kathy McCormick, Private Citizen, Sparks, Nevada
Rick R. Casazza, Chairman of the Board, Northern Nevada Division, American Heart Association and American Stroke Association
Denise Selleck, CAE, Executive Director, Nevada Osteopathic Medical Association
Julie Kotchevar, Deputy Administrator, Aging and Disability Services Division, Department of Health and Human Services; and Member, Task Force on Alzheimer's Disease
Cheryl Blomstrom, Private Citizen, Carson City, Nevada

Chair Oscarson:
[Roll was taken. Committee rules and protocol were explained.] Today we are going to hear several bills. I will begin by opening the hearing on Senate Bill 172 (1st Reprint).

Senate Bill 172 (1st Reprint): Makes various changes relating to the authorized activities of medical students. (BDR 40-797)

Samuel P. McMullen, representing Touro University:
I am turning this over to the panel and letting Dr. Andy Eisen and the other witnesses take over.

Andrew M. Eisen, M.D., F.A.A.P., Associate Dean for Clinical Education, College of Osteopathic Medicine, Touro University Nevada; and President-elect, Clark County Medical Society:
Thank you for the opportunity to present Senate Bill 172 (1st Reprint). Senator Patricia Farley was unable to present it, and I was asked to do so in her stead. I will give you some background with regard to medical schools and medical education. There are two entities in the United States that accredit medical schools. There is the Liaison Committee on Medical Education (LCME)

of the American Medical Association (AMA) and the Association of American Medical Colleges (AAMC) that accredits the 141 medical schools in the United States that award the Doctor of Medicine (M.D.) degree, including my alma mater, Northwestern University; Dr. Titus's alma mater, the University of Nevada School of Medicine; and the two schools in southern Nevada that are in applicant status, the University of Nevada, Las Vegas School of Medicine and Roseman University of Health Sciences. The LCME also accredits 17 schools in Canada. The second one is the American Osteopathic Association (AOA) Commission on Osteopathic College Accreditation (COCA), which accredits all 30 osteopathic medical schools in the country, those that award the Doctor of Osteopathic Medicine (D.O.) degree, and those that include Touro University Nevada, where I currently work, and the Philadelphia College of Osteopathic Medicine, the alma mater of Congressman Joe Heck.

There are literally hundreds of medical schools around the world as well. Currently, some of those schools send students to the United States for clinical experience. Our concern, and the impetus behind this bill, was that those students have not demonstrated their individual clinical competence, and the schools are not accountable to any American institution to ensure that the students are adequately prepared to take care of patients. They have contact in their third and fourth year with patients as practical work, not classroom work. This bill was brought forward to protect Nevada's patients and to ensure that medical students who are working in Nevada and have contact with Nevadans as patients have been properly prepared to do so.

I will present a quick walk-through of the bill. Section 1 requires that any medical student working in a hospital in Nevada be enrolled and in good standing at a medical school that is accredited either by the Liaison Committee on Medical Education or the American Osteopathic Association. Section 2 exempts a number of facilities that are licensed under *Nevada Revised Statutes* (NRS) Chapter 449, including those that depend entirely on faith and prayer, foster homes, and any federal facilities. Sections 3, 4, and 5 allow for enforcement by the Division of Public and Behavioral Health, Department of Health and Human Services, of provisions in section 1.

Section 6 is important. There are a number of individuals who can possess and administer controlled substances in the state of Nevada, and medical students are already included on that list. What section 6 does is clarify that the medical students who can participate under supervision in the possession and administration of controlled substances must be in the course of studies at an accredited institution. Section 7 has similar language but applies to all medications, not just those that are controlled substances under the

U.S. Drug Enforcement Administration. Section 8 has identical language to what is seen in section 1, but this applies specifically to the supervising physicians, those with an M.D. degree or licensed by the Nevada State Board of Medical Examiners. It requires that if they are supervising a medical student, that student be enrolled and in good standing at an accredited medical school, accredited by LCME or the AOA COCA. Section 9 defines the enforcement power of the Nevada State Board of Medical Examiners for that provision. Section 10 is identical language that applies to osteopathic physicians who may supervise medical students. That is in NRS Chapter 633. Section 11 is the enforcement provision for that.

Section 12 is the definition of enforcement powers for the Board of Medical Examiners for long-term care facilities. These medical students will see patients in many settings, including private physician offices, hospitals, long-term care facilities, and surgical centers. This is to ensure that we are consistent across the board in all facilities. Section 12.5 is the portion that was amended in the Senate and that allows for a grandfathering of any activities under agreements between licensed hospitals and accredited medical schools that are executed prior to July 1, 2015. What that will allow is if there is a hospital, not a private doctor's office, and a school that already have an arrangement for medical students to have activity within the hospital, that can continue. Section 13 is the effective date of July 1, 2015. I am happy to answer questions. [(Exhibit C) submitted by Senator Joseph (Joe) P. Hardy was not discussed.]

Assemblyman Thompson:
I have a question on section 1, line 8. What is the definition of good standing in this bill where it says a person is enrolled in good standing? Does it mean that they paid their tuition? Does it mean that they are on the A/B honor roll list?

Andrew Eisen:
The definition of good standing in academic terms is that those students have met the requirements to engage in the activity for which they are assigned. This would mean that a student who is on suspension from a school could not participate. As long as they are in good standing to continue their medical education, including the practical portions of it, they would be able to engage in these activities in the state of Nevada.

Assemblyman Gardner:
The language in sections 1, 6, and 8 says, "A school of osteopathic medicine, as defined in NRS 633.121." However, why does the language in section 10, subsection 2, only say, "A school of osteopathic medicine"?

Andrew Eisen:
It is because the term "school of osteopathic medicine" is defined in NRS Chapter 633 and section 10 is amending NRS Chapter 633, so it is already defined in that chapter, whereas the other sections amend different chapters in the NRS and therefore need the reference for the definition.

Chair Oscarson:
You have a concurrent nod from Committee Counsel.

Assemblywoman Spiegel:
I have heard that foreign medical schools have been buying residencies for their students in the United States, which take spaces that would otherwise go to American students. Would this bill help address that issue?

Andrew Eisen:
This bill is not about residencies. It is purely about medical students, those who have not yet earned their doctorate in medicine or in osteopathic medicine. There is a process by which international graduates can undertake residency postgraduate training in the United States, but in order to do that, they have to be certified by the Educational Commission for Foreign Medical Graduates to demonstrate their competency. It is not about the school's ability but the individual's ability. This bill addresses only those in predoctoral training who are in medical school. We are talking about students and not residents, although it certainly is an issue across the country. Some schools outside the United States are paying enormous sums of money for slots for their students to have clinical experiences in the United States. However, my primary concern is about safety—who has access to Nevadans as patients. That being said, there is no question that this bill would aid in that. If there are people from the University of Nevada School of Medicine in Carson City, they may wish to speak to that as well, as they are moving significant slots for students up north who are currently having clinical experience here in the south. As the University of Nevada, Las Vegas School of Medicine opens and needs slots for its students, that may become more of an issue. This would certainly help in that. However, our motivation behind this bill has to do with safety.

Assemblyman Sprinkle:
Could you give me some examples of what is going on today that this bill is going to help address? This is what is happening already, is it not, that students from these accredited schools are acting in these roles, and it is perfectly acceptable? What is this bill trying to fix?

Andrew Eisen:
This bill is about students who are attending schools that are not accredited by one of these two entities. The schools are outside of the United States, not including those 17 that I mentioned in Canada that are accredited by the LCME. There are students from Shanghai Second Medical University, for example, who may be coming here to get clinical experience, and there is no way for us to know that they have had the necessary preparation to be safe around our patients and to ensure privacy. It is certainly a bigger problem in other parts of the country. There are enormous numbers of these students, particularly on the East Coast like in New York City. The state of Texas actually passed legislation not long ago to address the same issue to ensure that anyone who is acting as a medical student within the state is attending a medical school that is accredited by, and therefore accountable to, an entity here in the United States. This is not about American medical students, and this is not about keeping medical students from other states from having experience here. We want them to do that because we want to encourage them to do their residency training here and ultimately to practice here. This is about folks who are from outside the U.S. system who have not had an opportunity yet to demonstrate their individual competencies and whose medical schools are not accountable to us.

Assemblyman Thompson:
What if you have somebody who is not from an accredited university medical school, but you see that there is some talent there? What do we do with those students who have the desire? The doctor or the proctor can see the talent, but what is lacking is the student is not from an accredited medical school. Is there anything you can do to help that student?

Andrew Eisen:
This bill only prohibits those students from engaging in activity for credit, which would include contact with patients. They could come as observers, as long as the facility would permit them to be there, but they would not be able to have hands-on patients. The bill is about courses for credit, and those require contact with patients for the clinical courses. More importantly, when students move past this portion of training, the clinical clerkships in the last two years of medical school—the residency training—and those students earn medical degrees from their institutions, whether it is from Oxford University, Shanghai Second Medical University, or Ain Shams College in Cairo, Egypt, they can apply for certification from the Educational Commission for Foreign Medical Graduates, which is a United States entity. If they receive that certification, they are then eligible to apply for, be accepted into, and undertake residency training in the United States, after which they can get a license and practice in the United States. Once students have had the chance

to demonstrate their individual abilities, they would have the opportunity to come here and continue their training. However, in the third and fourth year of medical school, that opportunity has not yet arisen for them to demonstrate that clinical competency.

Assemblywoman Titus:
Does this bill affect Caribbean schools and their students who may transfer here if there is an opening in a third- or fourth-year class? In my medical school, we did have two students who transferred in when we had two students drop out in their third year. I am wondering about the accreditation process for that.

Andrew Eisen:
The language is directed at what the student's current status is. As long as they have been accepted into an accredited medical school and are currently enrolled and in good standing, they could engage in clinical activities here. It would not matter where they did their first two years of medical school. This is about students who are not currently enrolled in a U.S. accredited school.

Assemblywoman Titus:
Thank you for that clarification. I just want to make sure that this did not prohibit those students who are able to transfer. Also, I have many high school students and undergraduates who will job shadow with me for a week or so. This does not sound like it would prohibit that?

Andrew Eisen:
You are correct. If you look at the language in section 1, starting on line 4, it says, "participate in any activity at the facility for the purpose of receiving credit toward a degree of doctor of medicine, osteopathy or osteopathic medicine...." Undergraduate students who are shadowing you in your office would not be receiving credit towards one of those courses of study. It would not apply to them at all.

Assemblywoman Titus:
Has there been a recognized problem where students who were not necessarily trained actually came to Nevada and harmed someone? Why was this bill started?

Andrew Eisen:
Certainly, there have been incidents around the United States, and both we and the University of Nevada School of Medicine have seen that there have been students from outside of the United States here, not in large numbers to date, but who are clearly unprepared to be in a clinical setting. They do not know what they are doing. I am not saying that every student is unprepared,

but since these schools are not accountable to anyone in the United States, we do not know who among them is going to be adequately prepared and who is not. While I am not aware of any specific incident in Nevada where a patient has suffered harm, it is not something I want to wait and see happen. We want to be able to avoid this before it occurs and ensure that every medical student who has access to a Nevada patient is appropriately prepared to do so in a safe manner.

Chair Oscarson:
Is there any testimony in support?

Samuel Parrish, M.D., Senior Associate Dean of Student Affairs and Admissions, University of Nevada Las Vegas School of Medicine:
I am here to strongly support Senate Bill 172 (1st Reprint).

Grayson D. Wilt, representing Nevada State Medical Association:
We have submitted a letter of support for this bill (Exhibit D).

Chair Oscarson:
We will now take any testimony in opposition here or in Las Vegas. [There was none.] Is there any testimony in neutral either in Carson City or Las Vegas? [There was none.]

Andrew Eisen:
I really appreciate the opportunity to present this bill. I am available between now and the work session if any member of the Committee has questions.

Chair Oscarson:
I will close the hearing on S.B. 172 (R1). I will now open the hearing on Senate Bill 177 (1st Reprint).

Senate Bill 177 (1st Reprint): Allows a person to designate a caregiver when admitted to a hospital. (BDR 40-512)

Barry Gold, Director, Government Relations, AARP, Nevada:
Over the past several years, AARP has focused attention, resources, and commitment in support of family caregivers. By caregivers, I mean spouses, partners, adult children, and other relatives—even friends and neighbors. Anyone who has a significant relationship with, and provides unpaid care for, a loved one. They are the unsung heroes providing the majority of care for Nevada families. [Continued reading testimony (Exhibit E).]

I submitted a copy of the survey, which is on the Nevada Electronic Legislative Information System (NELIS), that has a lot of the information that I will be referring to (Exhibit F). Most caregivers reported they received little or no training for these complex medical tasks. It is evident that the role of family caregivers has expanded dramatically to include performing medical and nursing tasks of the kind and complexity once provided only by hospitals, nursing homes, and home care providers. I want to refer to another document on NELIS called *Home Alone: Family Caregivers Providing Complex Chronic Care* (Exhibit G). That was a study done by AARP and the United Hospital Fund. [Continued reading testimony (Exhibit E).]

Senate Bill 177 (1st Reprint), also known as the CARE Act, recognizes the critical role family caregivers play in keeping their loved ones out of costly situations. It puts in place some small, but meaningful supports for caregivers during hospital transition, a difficult and stressful time for both patients and caregivers. It will provide communication and training when their loved one is discharged. The result will be smoother transitions home, better aftercare and improved health outcomes, and should reduce costly readmissions to the hospital. [Continued reading testimony (Exhibit E).]

The press release that is on NELIS lists over 50 organizations endorsing passage of the CARE Act (Exhibit H). The CARE Act passed unanimously in Oklahoma and New Jersey during 2014. It has been enacted in five additional states so far this year, passed through both houses and is waiting for the Governor's signature in four more, and even more are still in process. Hopefully, soon we will add Nevada to the states that recognize and support family caregivers for what they do. [Continued reading testimony (Exhibit E).] I am open for questions. [Submitted but not mentioned (Exhibit I).]

Assemblyman Jones:
How does this interact with living wills and powers of attorney for health care? Is there potential for conflict?

Barry Gold:
It does not conflict at all. This has nothing to do with living wills or advanced care directives. This is for people with single, acute-care hospital admissions. When patients are admitted, the hospital will ask if there is someone who takes care of them already. It is not about designating caretakers for the future or having someone to take care of them if something happens. It is really for people who already have someone who takes care of them at home, whether it is a spouse, an adult child, or someone like that.

Chair Oscarson:
This will not interfere with someone who has power of attorney or similar things that already exist?

Barry Gold:
No, it should not. There is language in the bill that says the patient or legal guardian will be able to designate the family caregiver. For example, if someone is under the age of 18, it will be the legal guardian or the parent, most likely, who would designate the family caregiver. If someone has a guardian and is considered incompetent, then the legal guardian would be the one to designate who the caregiver is. There is even language in the bill for unconscious patients coming into the hospital that deals with if they become conscious and are competent. This bill contains lots of research that looked at all of those "what ifs." We have worked very closely with the Nevada Hospital Association to come up with the information dealing with that. Another scenario is if the family caregiver who is designated cannot care for the patient. There is language in the bill for that as well, and the patient can designate someone else.

Assemblyman Thompson:
Section 7, subsection 1, paragraph (a), says, "The patient if he or she is 18 years of age or older and of sound mind." What is your definition of "sound mind," and how do we ensure that it is not subjective when and if that patient wants to designate someone? This could be a person, as you said, who has been caring for the patient for a long time, but the hospital may feel that the patient is not of sound mind.

Barry Gold:
It is talking about if someone has a guardian who is considered incompetent when arriving there. The hospital would make that determination. I am not a psychologist who understands the exact terminology for that.

Assemblyman Thompson:
The reason I asked is because we want to be clearer. Maybe there is an opportunity for us to not lock ourselves in, but it seems very subjective to have a hospital determine that a person is not of sound mind. That person may lose out on the ability to be designated.

Assemblyman Sprinkle:
I am very supportive of what the bill is trying to do here, but I am looking for the protection of the designated caregivers. I do not see much in the way of liability protection built into this. Is that just assumed? Is it something that is under a Good Samaritan type of act? Now that we are specifically designating people and putting that in statute, I want to make sure that should they be

asked to do things that they do not fully understand once the patient comes home, they are still going to be protected somehow.

Barry Gold:
They currently would be protected under the Good Samaritan law. There is language in the bill that says they can decline either to be the designated caregiver or to perform any of the tasks if they are uncomfortable, but most of them are already performing many of these tasks. The intent of the bill is just for someone to show them what to do. When I described the bill to some of the community groups, they were supportive of getting the right information to the right people and showing them what to do.

Assemblyman Sprinkle:
My concern would be that up until this point, these individuals were just simply Good Samaritans helping out a family member. Now that we are specifically designating them, I want to make sure that they are still protected.

Chair Oscarson:
I will now ask for those in support of Senate Bill 177 (1st Reprint) to come forward, both in Las Vegas and Carson City. I will start in Las Vegas.

Barbara Paulsen, Member, Nevadans for the Common Good, Boulder City, Nevada:
Nevadans for the Common Good (NCG) is a broad-based community organization whose members are faith-based and nonprofit social service institutions. Our purpose is to build relational power among diverse people for working on issues of common concern across the Las Vegas Valley. Over the last year, one focus of Nevadans for the Common Good has been issues of concern to seniors. Statistics indicate that for individuals over the age of 65, two-thirds of them will need some type of assistance during their senior years. For many, this is a family caregiver. [Continued reading testimony (Exhibit J).]

We agree with all the information that Mr. Gold has presented in terms of the magnitude of the problem and the number of Nevadans who are giving prime effort and loving care to care for their friends and family members. [Continued reading testimony (Exhibit J).]

Betty-Jeanne Cousins, Private Citizen, Henderson, Nevada:
I am representing Nevadans for the Common Good. My own story is that I have a husband who is 80 years old and was in Sunrise Hospital for an operation. I received a phone call from him saying, "Please pick me up. I have been released." When I got to the hospital, I asked him what the instructions were for his care, and he immediately got very anxious and could not remember. He is having trouble with short-term memory loss at this point as he ages. It took me an hour and a half of running around, trying to find nurses who could find the doctor who gave the instructions. I was finally told what I was supposed to do. To me, the CARE Act, S.B. 177 (R1), is a commonsense bill that whoever the caregivers are, they would certainly be involved. Doctors are so busy that they may not notice that somebody who is elderly may not be able to remember after 30 minutes or an hour what the instructions were. I am absolutely in favor of this CARE Act and S.B. 177 (R1) passing. [Written testimony was also submitted (Exhibit K).]

Rachel L. Blinn, Private Citizen, Reno, Nevada:
I was in an automobile accident when I was 21 and experienced a traumatic brain injury, becoming wheelchair-bound. My mom lived out of state and my family was not able to provide care for me. Due to my level of care needs, the hospital recommended nursing-level care for my discharge. My best friend and college roommate at the time could not bear the thought of me going into a nursing care facility for an undetermined amount of time. Therefore, at the age of 23, with no nursing care experience, she took on the responsibility of my caregiving. Despite my need for nursing-level care, she was provided with no training at discharge, such as how to safely transfer me in and out of the wheelchair, to provide a bath, or to feed me. The CARE Act would have saved me several bumps, bruises, and other injuries, as well as prevented my caregiver from getting a back injury. Simple things like how to transfer me into the car or into the shower would have made a huge difference in my life and my caregiver's life today. This is why I support the CARE Act and would ask you to also support it.

Chair Oscarson:
Congratulations on your recovery and to your caregiver as well for doing such a great job.

Stacey Shinn, representing Progressive Leadership Alliance of Nevada; Human Services Network; and National Association of Social Workers, Nevada Chapter:
I just want to put three organizations on the record in support, and they are the Progressive Leadership Alliance of Nevada, Human Services Network, and National Association of Social Workers, Nevada Chapter.

Edward R. Guthrie, Chief Executive Officer, Opportunity Village:
Opportunity Village serves over 2,100 different individuals, youth and adults with intellectual disabilities, and provides them a large variety of different care. What most people do not realize is that about two-thirds of the people we serve, especially the adults, live at home with a family member, not in a group home and not in an apartment. In most cases, the family members have never applied for guardianship of the individual involved. They may have things such as power of attorney, but they have never really gone out and provided for guardianship. In some of these cases, the families have not even gotten the power of attorney. This bill would allow them to be designated as the caregiver if one of those adult children with an intellectual disability went to the hospital and needed care. For that reason, we are very supportive of this bill.

Another group that we serve lives independently. These are the individuals who serve all the meals to all the military personnel at Nellis Air Force Base and others who clean the parks, airports, and other areas here in southern Nevada. Those individuals live independently, and they would need to have somebody that was designated as a caregiver for them should they need hospital care. We support this bill for them.

Finally, about ten years ago, during the 2005 Session of the Legislature, I had a stroke. As part of the stroke, I was diagnosed and was told I had an aneurism in my brain and I would need to have a coil embolization. That is where they take a catheter, feed it up into your brain, and put a little coil into the aneurism, which helps to seal it off. I had to have sedation for the operation and while I was still under sedation, the doctor gave me my discharge instructions. Needless to say, when my wife got there, I did not remember one word that the doctor had told me. As the woman discussed earlier, we had to chase down doctors to find out what the discharge instructions were, so that I did not do something that would cause me problems in the future. For that reason personally, I support this bill as well.

Lynn Hunsinger, L.S.W., M.P.A., Director, Professional Services, Nevada Senior Services:
I will submit my written testimony for the record (Exhibit L), as we are in strong support of S.B. 177 (R1).

Bill M. Welch, President, Chief Executive Officer, Nevada Hospital Association:
I would like to thank Mr. Gold for working with the Nevada Hospital Association to make sure that we have an effective and meaningful piece of legislation to present to you today. I believe we have accomplished that. The Nevada Hospital Association supports this legislation, as it provides one more tool in helping to ensure a smooth transition from inpatient hospitalization to patients going home and getting the support that they need. There were two questions put forth earlier. I cannot answer the question with regard to the liability of the caregiver at the home setting. However, in regard to the question from Assemblyman Thompson, determining "sound mind" would be clinical decisions that would have to be documented in the charts if they were going to deny patients their rights and would require clinical evaluations. I believe that the patient would be protected. I am happy to answer any other questions.

Chair Oscarson:
We had Committee Counsel check and the language for "sound mind" appears to be copied from NRS 449.6942, which is the Physician Order for Life-Sustaining Treatment language—meaning sound mind—and there is not a definition at that point in time. Therefore, it would be up to the folks in the hospital to make that determination and certainly chart it accurately, as there are many instances in which we do those kinds of things.

Assemblywoman Benitez-Thompson:
I want to thank you, Mr. Welch, for working with Mr. Gold on this bill because when it was being talked about in the interim, I thought it was such a good idea. There was a lot of conversation. The piece that was hardest to figure out was how to make this work by having language that was meaningful and purposeful without being too broad or unrealistic. The way that it has been written and amended, it is now something that is very meaningful and useful.

Jessica Ferrato, representing Nevada Nurses Association:
Many times in these instances, it is nurses who are discharging the patients. We think it is a really good bill and are here in support of it. I know from personal experience that it will arm patients and their families with the knowledge and capabilities that they need, both for the caretaker as well as the patient. Sometimes when you leave a hospital, it is a scary time because you are afraid of what you are going to do to yourself or what a caretaker

would do at home. Something like this will give families the ability to feel ownership of their care. I am here for any questions.

Marlene Lockard, representing Nevada Women's Lobby:
We, too, want to be on record as supporting this legislation.

Michael Dyer, representing Nevada Catholic Conference:
I am speaking for the Catholic bishops and the Catholic Church in Nevada. We solidly support this bill.

Joan Hall, President, Nevada Rural Hospital Partners:
We are also in support of this bill.

Allan M. Smith, representing Religious Alliance in Nevada; and Lutheran Episcopal Advocacy in Nevada:
I am here representing the Religious Alliance in Nevada and also for the Lutheran Episcopal Advocacy in Nevada. Both organizations strongly support this legislation.

Jacob R. Harmon, M.A., Northern Nevada Regional Director, Alzheimer's Association:
On behalf of the almost 40,000 families living with Alzheimer's disease and the nearly 120,000 caregivers, we are in full support of this bill.

Ryan Beaman, representing Clark County Firefighter's Local 1908:
As your paramedics and first responders, we support this bill. We do see it on a continuing basis every day, patients not understanding their discharge, wound care, or medications. They often call the 911 system to help them through that. Anything that we can do to lower readmittance into the hospital, we are definitely in support of.

Laura Coger, Nevada Program Manager, Consumer Direct:
We are a support service for seniors and those with disabilities across the state of Nevada. We are in strong support of S.B. 177 (R1).

Barbara Deavers, Private Citizen, Reno, Nevada:
I am unique in that I have been a caregiver to both my significant other and to my mother, both of whom were in hospitals and have been discharged. I received absolutely no information before taking them home as to what I could expect and how their care should be going forward. I basically live by the seat of my pants, and I think this is an excellent bill and will help numerous people in the future. I am supporting this bill.

Grayson D. Wilt, representing Nevada State Medical Association:
We fully support this bill.

Chair Oscarson:
Is there anyone else here or in Las Vegas in support? [There was no one.] Is there anyone in opposition? [There was no one.] Is there anyone here or in Las Vegas in a neutral position for S.B. 177 (R1)? [There was no one.] I will close the hearing on S.B. 177 (R1). [Submitted but not mentioned are (Exhibit M) and (Exhibit N).]

Assemblywoman Titus:
I would like to make a motion to suspend Rule No. 57 and vote on S.B. 177 (R1) today.

> ASSEMBLYWOMAN TITUS MOVED TO SUSPEND RULE NO. 57 OF THE ASSEMBLY STANDING RULES.
>
> ASSEMBLYWOMAN BENITEZ-THOMPSON SECONDED THE MOTION.
>
> THE MOTION PASSED. (ASSEMBLYMAN ARAUJO WAS ABSENT FOR THE VOTE.)

Chair Oscarson:
I need a motion.

> ASSEMBLYWOMAN SPIEGEL MOVED TO DO PASS SENATE BILL 177 (1ST REPRINT).
>
> ASSEMBLYMAN SPRINKLE SECONDED THE MOTION.
>
> THE MOTION PASSED. (ASSEMBLYMAN ARAUJO WAS ABSENT FOR THE VOTE.)

We will now open the hearing on Senate Bill 196 (1st Reprint). Mr. Schmauss from the American Heart Association will introduce the bill.

Senate Bill 196 (1st Reprint): Makes various changes concerning health care. (BDR 40-84)

Benjamin Schmauss, M.P.H., Government Relations Director, American Heart Association/American Stroke Association:
I would like to acknowledge Senator Hardy, who is not able to be here today, and the efforts of the Senate Committee on Health and Human Services on this bill. The staff of the American Heart Association (AHA) would like to thank Assemblyman Oscarson, Assemblywoman Titus, and Assemblywoman Joiner for their help and support on this bill. Stroke is the fifth leading cause of disease-related death, both nationally and in Nevada. [Continued reading written testimony (Exhibit O).]

This bill adds comprehensive stroke centers to the recognized facility designation list that was created two sessions ago, *Nevada Revised Statutes* (NRS) 449.203. It also requires the Division of Public and Behavioral Health of the Department of Health and Human Services to establish and maintain a stroke registry. That registry data is actually already available, so they can do this by having a "super user" account. That would meet that requirement and provide a yearly report, for which we already have an advisory council through state law that could provide collaboration with the Department of Health and Human Services. That would give us recommendations that are data-driven to improve our system of care and reduce inefficiencies. It encourages medical facility providers of health care and emergency services to share information and data that could improve the system of care.

I brought an infographic that shows where we are currently and where this bill will take us (Exhibit P). We report data from our stroke centers to the stroke registry and are making significant improvement measures individually. However, the problem with the individual data is that nobody is looking at the whole picture. You have the Department of Health and Human Services, nonprofits like the American Heart Association, and multiple partners in emergency medical systems (EMS) and universities that could all improve our entire system of care. The data is already protected and there.

In closing, taking this data and aggregating it together is a win/win solution, which would allow the Advisory Committee for the Prevention and Treatment of Stroke and Heart Disease to meet the goals that they have already created in their state plan of creating a registry, doing surveillance, and providing reports and recommendations. This would lead to that win/win result of increased collaboration, an improved system of care, and data-driven decisions. We always want to improve efficiency in a state where funds are precious. We truly believe that we can improve patient outcomes and our system of care

while increasing collaboration among all partners, who are here today to testify in support. I am open to questions.

Assemblywoman Spiegel:
I could not see in the bill if the registry will contain personally identifiable information. If the registry does have the patient's personally identifiable information, what precautions would be taken to ensure patient privacy?

Benjamin Schmauss:
It does not have personally identifiable information, and when the Nevada Hospital Association and the stroke coordinators speak, I will ask them to address this as well. I believe the data is de-identified before the hospital even sends it in, so it is nowhere in the system as identifiable.

Assemblywoman Titus:
There are already registries out there, such as the Nevada Central Cancer Registry, and it does make us better providers. If we can gather information as to where we are lacking or how we can do better, patient care is really the key. With strokes, there is wonderful documentation at early intervention, and even just recognizing the stroke is an important component in managing the stroke and its outcome. If we can get some outcome data to see where we are failing and share that with each other without risking patient personal information, this bill is very important.

Assemblywoman Benitez-Thompson:
I am looking at section 6, subsection 1, paragraph (b), where it talks about the specific type of data management platform that is established. Could you explain a little more about what that requires?

Benjamin Schmauss:
The stroke centers currently are award-winning Get with the Guidelines-Stroke registry participants. They would continue to provide the data into that platform, which is a national stroke registry. Our state would then get a "super user" account, which would give them state-specific data, so we are not going to duplicate anything. Our hospitals are award-winning in this way, and we are not putting an additional burden on them, but we are tapping into the data that already exists.

Assemblywoman Benitez-Thompson:
That partly answers my question. It sounds like there is a master data platform that is being housed right now by the American Heart Association and the American Stroke Association. The state of Nevada would get a "super user" account. Then the designated stroke centers and other medical facilities would

provide data to the state, which is then responsible for uploading the data to the national center. Do the stroke centers, as defined by NRS Chapter 449, already have user accounts and is the data currently going there?

Benjamin Schmauss:
The hospitals can probably answer that in more detail. However, they all have their accounts already and are entering the data. The state would get the "super user" account and would be able to look at the data as a whole. The hospitals would not be reporting to the state. They would be reporting to the registry, and then the state would be able to look at the data within the registry. There are people here who can speak to that as well, including Mary Wherry, Bill Welch from the Nevada Hospital Association, and doctors and the senior leadership from Saint Mary's Regional Medical Center and Dignity Health Nevada in Las Vegas.

Assemblywoman Benitez-Thompson:
I will reserve my questions because mine are more around who is reporting to whom, and who is responsible for the actual uploading of the data.

Chair Oscarson:
Is there any testimony in support of S.B. 196 (R1)?

Katie Ryan, Director, Communications and Public Policy, Dignity Health-St. Rose Dominican:
My colleague, Kim Dokken, the director of stroke and trauma services, was unfortunately unable to be here today. She wanted me to read her testimony for you (Exhibit Q). Both she and Brian Brannman, our senior vice president for Dignity Health Nevada, testified in support of this bill in the Senate. To Assemblywoman Benitez-Thompson, I do not know the answer to your question, but I will follow up and get that information to you from Kim Dokken. The following is her testimony in support for Senate Bill 196 (1st Reprint):

> I believe passing this bill into law will play a significant role in improving the Nevada system of stroke care. I do not say this lightly. Trauma and stroke care are my business. [Continued reading testimony (Exhibit Q).]

[Submitted but not mentioned is testimony (Exhibit R).]

Chair Oscarson:
Is there any other testimony in support?

Mary Wherry, R.N., M.S., Deputy Administrator, Community Services, Division of Public and Behavioral Health, Department of Health and Human Services:
I am here in support of this bill. We were the barrier in the Senate; not intentionally, but we were concerned about the fiscal note. Amendment 128 removes the regulation requirement, which was our biggest problem. It pushed the fiscal note over our threshold of $2,000, and now by removing that, we have the funds within our budget to purchase the licensure that we would need, which is under $2,000 a year, to be able to afford our portion of that master registry access. Our chief biostatistician has been working closely with Mr. Schmauss, and we have no problem administering the registry and being able to work with our existing prime disease group to move forward with this project. We think it is a great bill. I can answer any questions.

Chair Oscarson:
Collaborating that data is going to be nothing but beneficial in the long term for these management programs that you are currently working on.

Dave DeValk, Vice President, Saint Mary's Regional Medical Center:
I am here in support of Senate Bill 196 (1st Reprint) because we have learned in medicine that the more empirical data we have and the more we can compare ourselves to the best practices in any system of care, the better we become. I am here today with a colleague, Dr. Aaron Heide, who is the medical director for a recently accredited primary stroke center, and I will let him fill you in on what happens.

Aaron C. Heide, M.D., Director, Center for Neurovascular Care, Saint Mary's Regional Medical Center:
I am a vascular neurologist and stroke doctor. I am director of stroke neurology and telemedicine at Saint Mary's Regional Medical Center. I am here to place my support behind this bill and encourage its passage. There is nothing more important to the advancement of medicine than information. I believe there are no better partners that we could partner with on this bill than the Joint Commission and the American Heart Association and American Stroke Association with regard to gathering information. I have opened and directed several stroke centers, worked in multiple states, and have been involved in legislation similar to this in other states. It is very important to use the data not just from a national and global perspective, but also a local perspective. There is something unique about Nevada with regard to delivery of medicine. It is

very important to know what we are doing within the state to make sure that we are getting the best state response.

Personally, I treated my own father for an acute stroke. Although I have been designated as a stroke expert, I do not have all the answers. When I treat my patients or my own family, I want to make sure I have as much information as possible. This bill is a good step forward to gather that information.

Chair Oscarson:
I agree that telemedicine is very important.

Deborah Williams, M.P.A., M.P.H., Manager, Office of Chronic Disease Prevention and Health Promotion, Southern Nevada Health District:
It is important to state that the system includes the continuum from prevention through rehabilitation, focusing on the importance of prevention of stroke. I strongly support all of the comments made by the people who have come before me. I do want to talk about the importance of data for public health. We recognize that public health decisions and strategies should be data-driven. A stroke registry will provide information for public health that will help to identify populations at greatest risk of stroke and help us access interventions that we develop. That will allow us to monitor if they are making an impact and, if not, help us make minor adjustments and accomplish what we need to do. I submitted testimony in writing (Exhibit S), but I did want to make that one point. The Southern Nevada Health District looks forward to working with our fellow stakeholders to continue to prevent and assure quality treatment for all Nevadans.

Joan Hall, President, Nevada Rural Hospital Partners:
I will also state that telemedicine is important because, in rural Nevada, we recognize that without having paramedics or neurological stroke specialists, the increased utilization of telestroke programs will definitely improve stroke care. I am a member of the heart/stroke task force, and there is little data about stroke care in rural Nevada, partially because we are not the comprehensive or primary stroke areas. However, in the task force, we recognized, as previous speakers have discussed, that data is very important. It will assist Nevada in grant opportunities and looking at prehospital and hospital education, among other important issues, as we strive to improve quality of care for our stroke victims.

Victoria Skorupski, R.N., M.N., Coordinator, Stroke Program, Renown Regional Medical Center:
I am excited to be here today to speak to you and share my support of Senate Bill 196 (1st Reprint). I believe passing this bill into law will play

a significant role in improving Nevada's system of stroke care. I do not say this lightly, as stroke care is my business and as a registered nurse, it is my passion as well. Renown Regional Medical Center is a certified primary stroke center. We have been participating in Get with the Guidelines-Stroke program for more than five years. Utilizing the data that has come from the stroke registry has driven decisions which I take to my committee every day. We identify problems and work on solving outcomes for the Reno/Sparks and rural areas. I can say with confidence that our care is significantly better now because of that stroke registry. This morning, I did a stroke list for my hospital that had 25 stroke patients on it. One of them is only 34 years old and another patient is only 37. I would like to do everything possible to help every one of those patients. Our mission statement at Renown asks that we make a genuine difference in the many lives we touch. To make a genuine difference, if we are improving outcomes to the best of our ability by analyzing statewide data and using ideas from other facilities, this will help us in the end. I am available for questions.

Assemblywoman Benitez-Thompson:
I was trying to establish, by looking at the different sections of the bill, the flow for reporting requirements. The way I am reading this is the state will establish the data management platform based on these national measures to collect data. Then the hospitals are going to be responsible to report the information into the Division of Public and Behavioral Health's registry. Then the Division is responsible for maintaining the registry and keeping it in compliance with the American Heart Association. Is that correct?

Victoria Skorupski:
As I currently understand it, if we belong to the Get with the Guidelines-Stroke registry, then we already submit data. I believe the state would pull that data for its statewide analysis, based on the patients in Nevada.

Assemblywoman Benitez-Thompson:
Therefore, the state would have a registry that would include Nevada data numbers, but then individual hospitals, if they are already participating, keep their registry. I know there is language in the bill that talks about efforts to coordinate and to avoid redundancy. Does the data management program clean up data input from Nevada to make sure we are not overrepresenting or underrepresenting the data we are generating since we have different folks putting it in at different places?

Mary Wherry:
I do not know that I have that answer, but I do know there are several other states that are using the same platform for this registry site. I assume you are getting at having duplicated clients who may have been to several different

hospitals. We would only be working with the de-identified data, but there could be duplicated counts within that de-identified data. I have to assume there is some way of cleansing that data to make sure that it is as pure as possible with regard to patient counts. Our chief biostatistician is very good at working with the data people behind the scenes, and I think he has already been in touch with Quintiles, who works with the group that runs the platform where the data sits. He would be working with them to maintain the integrity of the data and ensure that we are cleansing the data as best as possible for the Nevada registry. All the hospitals put in their data and then our chief biostatistician would access and aggregate all of the data available for Nevada so that we can run those reports.

Assemblywoman Benitez-Thompson:
When we say, "Establish and maintain the Stroke Registry," we are really saying that we are becoming one of the users in this data management program. However, the individual hospitals are primarily the ones that are currently uploading the data. As I read section 9, subsection 6, it says the "primary stroke center shall report" their numbers. I just want to make sure there is a clear understanding for the record about who owns what responsibilities. The hospitals will report and then the state gets access to that aggregate data.

Mary Wherry:
One of the things we have discussed is that just because you are reporting and you have committees does not necessarily mean you are going to improve quality. It will be up to each individual hospital to own their data and do something meaningful with it to improve their quality. As Mr. Schmauss was speaking to earlier, with each hospital only having their data without having it aggregated and being fed back as a state picture, they do not get those comparative report cards. Our sense is they would like that comparative analysis. Oftentimes, people get a little more competitive when they have those kinds of report cards. Typically, we would see a performance improvement opportunity becoming a little bit more profound if hospitals started doing comparisons. That would be one of the things you might see happen when hospitals can see each other's activities as they are lined up against each other, once the state has access to everybody's data. As it is right now, hospitals only have access to their own.

Assemblywoman Benitez-Thompson:
Is it optional for medical health facilities other than those designated as a stroke center?

Mary Wherry:
That is my understanding.

Benjamin Schmauss:
To simplify it, you have all of the hospitals putting their data into one place, but nobody is looking at it. We are giving the state access to look at it as a whole. I do not want to give the impression that we are trying to get hospitals to compete. I work with the Nevada Hospital Association. These hospitals have knocked it out of the park by individually participating in that registry because they put information in, and, upon getting it back, they have been improving their systems of care. They have really done a good job. The great example that we have is tissue plasminogen activator (tPA) administration, which if done correctly, can save lives and improve quality of life drastically. However, less than 15 percent of people actually make it to the hospital within that three- to four-hour window for tPA to work. Hospitals need the help of public health entities, such as the American Heart Association, EMS, and other groups. This data can help us look at those gaps, like only 15 percent or less of people who are experiencing a stroke make it to a hospital, and target our collective resources for improvement that will have the greatest impact. The state does not need to create its own registry because it can tap into this registry to get that data as a whole. Then we can improve the entire system of health care.

Derek Cox, EMS Education Officer, Las Vegas Fire and Rescue:
As a training officer with Las Vegas Fire and Rescue, a paramedic in Clark County, and the chair of the American Heart Association's Nevada State Emergency Cardiovascular Care Committee, I have seen how data can drive collaboration and help guide the decisions we make to maximize the value and impact of the limited resources we have. [Continued reading testimony (Exhibit T).] This bill helps us, helps you, helps our loved ones, our residents, and our visitors throughout Nevada. That is why I support S.B. 196 (R1).

Kathy McCormick, Private Citizen, Sparks, Nevada:
I am a stroke survivor. On October 22, 2013, I suffered a mild stroke. Even though it was mild, in the beginning it was very difficult. I had a lot of disabilities, and it took me a while to overcome them. My stroke was caused by high blood pressure and long-term hypertension. After three days in the hospital, I was sent home with strict instructions to change my diet, go to physical therapy, and get plenty of rest. I needed to change everything about my whole life. That is when the hard work really began. It has been quite a while, taking a year before I really felt that I was mostly back to normal. I still have some things that happen with me. However, overall, I feel I am doing very well. I am one of the lucky ones, and I like to think that I am the voice for those who cannot come here and speak. I support S.B. 196 (R1) because I know that this will help people who have strokes.

Bill M. Welch, President, Chief Executive Officer, Nevada Hospital Association:
I want to go on record that on behalf of the Nevada Hospital Association and its members, we are in support of S.B. 196 (R1). We have worked with the American Heart Association on this legislation and feel it is appropriate legislation. I am pleased to say that all of Nevada's designated stroke centers are submitting this data, so once we are able to connect the state to the registry, they will be able to start extracting this data. I am happy to answer any questions.

Assemblywoman Benitez-Thompson:
Typically, with most of our other data collection, such as epidemiology, it stays in-house or it goes to the Centers for Disease Control and Prevention. This is something new to have this kind of partnership with a nonprofit, where we have a statute requiring the state to interact in such a way with a nonprofit. However, it sounds like there are national trends that are remodeling the landscape, if you will, for how these relationships typically work. If you feel like you are the appropriate person, can you put a little of that history on the record for legislators down the road who wonder about this partnership, so they can understand where it came from?

Bill Welch:
Yes, this is a national trend. All of the stroke centers have been becoming part of Get with the Guidelines-Stroke. There is also the Joint Commission and the American Stroke Association. They have all identified specific criteria that they want submitted, and they have all agreed to work together in having all of this data. Instead of asking a hospital to submit the data to a multitude of different agencies, we would submit it to this one central port. Those who utilize that data for research, et cetera, are then able to access that. This is the norm and the most appropriate way to go. They have established the specific criteria for what data are to be submitted for comparative reasons. In the past when we have created a registry here in the state, we developed our own criteria, and then when we were trying to compare it to national criteria, it did not reconcile. This registry will allow us to look at the data the same way they are looking at it on a national level.

Chair Oscarson:
I would be remiss if I did not say that the Nevada Hospital Association and Nevada Rural Health Partners have worked diligently on a lot of these bills we are hearing today to make sure that the information is able to be utilized. For the rural and other areas, these are a great opportunity for sharing the information.

Rick R. Casazza, Chairman of the Board, Northern Nevada Division, American Heart Association and American Stroke Association:
I have been a 35-year volunteer for the American Heart Association and American Stroke Association. I have been around long enough to see the change from stroke being the fourth leading cause of death to the fifth leading cause of death. It is not a coincidence. Data from this registry will improve our system of care. Senate Bill 196 (1st Reprint) will save lives and improve lives.

Ryan Beaman, representing Clark County Firefighter's Local 1908:
We want to go on record as being in support of this bill. What Assemblywoman Titus said earlier is 100 percent right; if we can identify the signs and symptoms in a short period of time, and get a person to the hospital, that is very important. However, if there are other areas that we can improve on for the outcome of those patients, we need to be looking at this data.

Grayson D. Wilt, representing Nevada State Medical Association:
We wholeheartedly support this bill, and we also submitted a letter in support (Exhibit U).

Denise Selleck, CAE, Executive Director, Nevada Osteopathic Medical Association:
As someone who designs continuing medical education programs for physicians, I am always interested in finding the most information that we can possibly get to identify trends in both diagnosis and treatment for patients and to take that further into preventive medicine whenever possible. We are wholeheartedly in support of this bill and look forward to its passage.

Chair Oscarson:
Is there any other testimony in support here or in Las Vegas? [There was none.] Is there any testimony in opposition? [There was none.] Is there any neutral testimony? [There was none.] I will close the hearing on S.B. 196 (R1). I will now open the hearing on Senate Concurrent Resolution 2.

Senate Concurrent Resolution 2: Encourages education of medical care providers and first responders regarding caring for persons with Alzheimer's disease. (BDR R-237)

Julie Kotchevar, Deputy Administrator, Aging and Disability Services Division, Department of Health and Human Services; and Member, Task Force on Alzheimer's Disease:
I am here to represent Senator Hardy. In 2014, it was estimated that 37,000 Nevadans were living with Alzheimer's disease. Because of the changing demographics, by 2025, we expect that 64,000 people will be living

with Alzheimer's disease or another dementia. The Task Force on Alzheimer's Disease created a state plan, and one of the areas that we identified as a need is to strengthen the multidisciplinary workforce that supports these people who are living with Alzheimer's disease. We identified several educational challenges, and the result of that is this concurrent resolution. It encourages the Board of Medical Examiners, the State Board of Osteopathic Medicine, and the State Board of Nursing to approve continuing education programs that provide primary care physicians and other health care professionals with ongoing education and training about research and treatments for Alzheimer's disease. It also encourages primary care physicians to refer persons with cognitive deficits for specialized testing when appropriate and persons with dementia and other family members to other community resources and supportive programs.

Chair Oscarson:
Is there any testimony in support of Senate Concurrent Resolution 2?

Jacob R. Harmon, M.A., Northern Nevada Regional Director, Alzheimer's Association:
We are in full support of S.C.R. 2 building on some of the productive relationships that the Alzheimer's Association and our community partners already have with law enforcement, first responders, physicians, and other health care professionals. We believe that the Legislature taking leadership on this issue can continue to improve the quality of dementia care that the nearly 40,000 families in Nevada living with Alzheimer's disease are currently receiving, as well as give law enforcement and first responders the tools they need in order to effectively manage some of the situations that they find themselves in. In fact, one of our most productive partnerships while working with the Washoe County Sheriff's Office, Reno Police Department, and Sparks Police Department came about because officers of the Washoe County Sheriff's Office noticed just how much time they spent dealing with families living with Alzheimer's disease and dementia and approached us for help. This work is already going on, and the Legislature taking a leadership position on this issue is greatly appreciated. On behalf of all the families living with Alzheimer's disease in Nevada, we appreciate your support.

Chair Oscarson:
Thank you for your leadership role in helping families with difficult situations.

Cheryl Blomstrom, Private Citizen, Carson City, Nevada:
Our father passed away six years ago, in June 2009, from the effects of Alzheimer's disease. Traveling that path with him was a very complicated and difficult situation. I am the eldest of our family, so, a lot of that responsibility fell on me and my next younger brother. This sort of education would have facilitated his care in tremendous ways and would have made our decision-making and receiving of care easier. For that reason and many others, I support this resolution wholeheartedly and would urge its passage. I have also submitted my written testimony (Exhibit V).

Denise Selleck, CAE, Executive Director, Nevada Osteopathic Medical Association:
We are in wholehearted support of this resolution. In fact, in our last annual meeting, which was held last week, out of the 27 hours of continuing medical education program, 3 hours were devoted to forms of Alzheimer's disease and different ways of treating it. We do have one little hiccup with line 24 of page 2, which is asking the boards to approve continuing medical education. In our case, and speaking only for the Nevada Osteopathic Medical Association, we are accredited by the American Osteopathic Association. The Board of Medical Examiners does not approve our programs, as we are accredited by the National Board of Medical Examiners. We do not know if rewording the resolution would be an issue, but we do not want this to be a problem.

Chair Oscarson:
If that is in the form of an amendment, I suggest you submit that to Senator Hardy as soon as possible.

Denise Selleck:
We would be happy to do so. We thought we had covered that already last week, but we will follow up.

Chair Oscarson:
Is there a different version of this resolution? This is the resolution as introduced, so evidently it has not been included. Let him know what you would like to do, and we will follow up with him as well.

Grayson D. Wilt, representing Nevada State Medical Association:
We completely support this resolution.

Chair Oscarson:
Is there any further testimony in support? [There was none.] Is there any testimony in opposition, either here or in Las Vegas? [There was none.] Is there any testimony in neutral? [There was none.] For the record, Julie Kotchevar gave thumbs up for the resolution. I will close the hearing on S.C.R. 2. Is there any public comment here or in Las Vegas? [There was none.] This meeting is adjourned [at 3:21 p.m.].

RESPECTFULLY SUBMITTED:

_____
Karen Buck
Committee Secretary

APPROVED BY:

_____
Assemblyman James Oscarson, Chair

DATE: _____

EXHIBITS

Committee Name: Assembly Committee on Health and Human Services

Date: April 27, 2015 **Time of Meeting: 1:36 p.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
S.B. 172 (R1)	C	Senator Joseph (Joe) P. Hardy, District No. 12	Proposed Amendment
S.B. 172 (R1)	D	Stacy M. Woodbury, Nevada State Medical Association	Letter of Support
S.B. 177 (R1)	E	Barry Gold, AARP	Testimony
S.B. 177 (R1)	F	Barry Gold, AARP	AARP Survey
S.B. 177 (R1)	G	Barry Gold, AARP	AARP Home Alone In Brief
S.B. 177 (R1)	H	Barry Gold, AARP	AARP Press Release
S.B. 177 (R1)	I	Barry Gold, AARP	AARP CARE Act Fact Sheet
S.B. 177 (R1)	J	Barbara Paulsen, Nevadans for the Common Good	Testimony
S.B. 177 (R1)	K	Betty-Jeanne Cousins, Henderson, Nevada	Testimony
S.B. 177 (R1)	L	Lynn Hunsinger, Nevada Senior Services	Testimony
S.B. 177 (R1)	M	Connie McMullen, Personal Care Association	Testimony
S.B. 177 (R1)	N	Chris McMullen, Senior Coalition of Washoe County	Testimony
S.B. 196 (R1)	O	Benjamin Schmauss, American Heart Association	Testimony
S.B. 196 (R1)	P	Benjamin Schmauss, American Heart Association	Nevada Stroke Registry Infographic
S.B. 196 (R1)	Q	Kim Dokken, Dignity Health-St. Rose Dominican	Testimony

S.B. 196 (R1)	R	Brian Brannman, Dignity Health Nevada	Testimony
S.B. 196 (R1)	S	Deborah Williams, Southern Nevada Health District	Testimony
S.B. 196 (R1)	T	Derek Cox, Las Vegas Fire and Rescue	Testimony
S.B. 196 (R1)	U	Stacy Woodbury, Nevada State Medical Association	Letter of Support
S.C.R. 2	V	Cheryl Blomstrom, Carson City, Nevada	Testimony