MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-Eighth Session
May 4, 2015

The Senate Committee on Health and Human Services was called to order by Chair Joe P. Hardy at 3:39 p.m. on Monday, May 4, 2015, in Room 2149 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412 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 Joe P. Hardy, Chair
Senator Ben Kieckhefer, Vice Chair
Senator Mark A. Lipparelli
Senator Joyce Woodhouse
Senator Pat Spearman

GUEST LEGISLATORS PRESENT:

Assemblyman Tyrone Thompson, Assembly District No. 17
Assemblywoman Teresa Benitez-Thompson, Assembly District No. 27
Assemblywoman Robin Titus, Assembly District No. 38
Assemblyman John Moore, Assembly District No. 8
Assemblyman James Oscarson, Assembly District No. 36

STAFF MEMBERS PRESENT:

Marsheilah Lyons, Policy Analyst
Eric Robbins, Counsel
Ellen Walls, Committee Secretary

OTHERS PRESENT:

Julia Peek, Manager, Office of Public Health Informatics and Epidemiology, Division of Public and Behavioral Health, Department of Health and Human Services
Sylvia Allen, National Coalition of 100 Black Women, Las Vegas Chapter

Melva Thompson-Robinson, DrPH, Executive Director, Center for Health Disparities Research, School of Community Health Sciences, University of Nevada, Las Vegas
Alisa Howard, Las Vegas Urban League
Jennifer Howell, MPH, Health District, Washoe County
Robert Harding, Northern Nevada HOPES; Northern Nevada Outreach Team
Michael Hackett, Nevada Food Allergy and Anaphylaxis Alliance
Caroline Moassessi, Nevada Food Allergy and Anaphylaxis Alliance
Kacey Larsen
Stuart Stoloff, M.D.
Tracey Green, M.D., Chief Medical Officer, Division of Public and Behavioral Health, Department of Health and Human Services
Bill Welch, Nevada Hospital Association
John Sande IV, Universal Health Services of Delaware
Lesley Dickson, M.D., Executive Director, Nevada Psychiatric Association
Janine Hansen, Nevada Families
Sean McDonald, Administrator, Division of Central Services and Records, Department of Motor Vehicles
Ann Yukish-Lee, CPM, DMV Services Manager II, Central Services Processing Center, Department of Motor Vehicles
Sarah McCrea, EMS Quality Improvement Coordinator, Las Vegas Fire and Rescue, City of Las Vegas
Jim Gubbels, BSN, RN, President/CEO, Regional Emergency Medical Services Authority
Joan Hall, President and CEO, Nevada Rural Hospital Partners Foundation
Rusty McAllister, President, Professional Fire Fighters of Nevada
Dan Musgrove, Southern Nevada Heath District
Gerry Julian, Southern Nevada Health District
Steven Tafoya, Manager, EMS Program, Division of Public and Behavioral Health, Department of Health and Human Services

Chair Hardy:
We will open the work session with the following bills and their respective work session documents: Assembly Bill (A.B.) 28 (Exhibit C), A.B. 41 (Exhibit D), A.B. 52 (Exhibit E), A.B. 99 (Exhibit F), A.B. 222 (Exhibit G), A.B. 424 (Exhibit H) and A.B. 456 (Exhibit I).

ASSEMBLY BILL 28: Revises the duties of the State Long-Term Care Ombudsman. (BDR 38-415)

ASSEMBLY BILL 41: Revises provisions relating to funding for indigent care. (BDR 38-327)

ASSEMBLY BILL 52 (1st Reprint): Revises provisions governing the persons responsible for a child's welfare. (BDR 38-192)

ASSEMBLY BILL 99 (1st Reprint): Makes various changes concerning construction and labor camps. (BDR 40-53)

ASSEMBLY BILL 222: Revises provisions governing the imposition of administrative sanctions against facilities for the dependent. (BDR 40-645)

ASSEMBLY BILL 424: Revises provisions governing the Committee for the Statewide Alert System. (BDR 38-545)

ASSEMBLY BILL 456: Abolishes certain committees, boards, funds and panels. (BDR 38-551)

SENATOR LIPPARELLI MOVED TO DO PASS A.B. 28, A.B. 41, A.B. 52, A.B. 99, A.B. 222, A.B. 424 AND A.B. 456.

SENATOR WOODHOUSE SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

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Chair Hardy:
I will open the work session on A.B. 39.

ASSEMBLY BILL 39 (1st Reprint): Increases the cap on the application fee for the Physician Visa Waiver Program. (BDR 40-328)

Marsheilah Lyons (Policy Analyst):
I will read from the work session document for A.B. 39 (Exhibit J).

SENATOR KIECKHEFER MOVED TO DO PASS A.B. 39.

SENATOR WOODHOUSE SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

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Chair Hardy:
I will open the work session on A.B. 42.

ASSEMBLY BILL 42 (1st Reprint): Revises provisions relating to mammography and the reporting of information on cancer. (BDR 40-331)

Ms. Lyons:
I will read from the work session document for A.B. 42 (Exhibit K).

SENATOR KIECKHEFER MOVED TO DO PASS A.B. 42.

SENATOR LIPPARELLI SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

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Chair Hardy:
I will open the work session on A.B. 156.

ASSEMBLY BILL 156 (2nd Reprint): Revises provisions governing family resource centers. (BDR 38-209)

Ms. Lyons:
I will read from the work session document for A.B. 156 (Exhibit L). One amendment is included in the document.

SENATOR WOODHOUSE MOVED TO AMEND AND DO PASS AS AMENDED A.B. 156.

SENATOR SPEARMAN SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

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Chair Hardy:
I will open the work session on A.B. 200.

ASSEMBLY BILL 200 (1st Reprint): Revises provisions relating to persons with impaired speech or hearing. (BDR 38-419)

Ms. Lyons:
I will read from the work session document for A.B. 200 (Exhibit M). One amendment is included in the document.

SENATOR LIPPARELLI MOVED TO AMEND AND DO PASS AS AMENDED A.B. 200.

SENATOR KIECKHEFER SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

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Chair Hardy:
I will close the work session and open the hearing on A.B. 243.

ASSEMBLY BILL 243: Revises provisions relating to testing for the human immunodeficiency virus. (BDR 40-117)

Assemblyman Tyrone Thompson (Assembly District No. 17):
This bill revises provisions relating to testing for the human immunodeficiency virus (HIV). This bill was crafted in collaboration with the Southern Nevada Health District (SNHD), the Department of Health and Human Services (DHHS) and nonprofit community-based and faith-based organizations. This bill will allow the personnel working for community-based organizations to be trained to administer HIV rapid tests throughout our State.

It is a difficult challenge to engage and administer HIV tests to certain populations who are experiencing high incidence rates of HIV. By allowing

community-based organizations to join forces with health districts throughout the State, we will see better results and will ensure those individuals who test positive for HIV access to health care.

Julia Peek, (Manager, Office of Public Health Informatics and Epidemiology, Division of Public and Behavioral Health, Department of Health and Human Services):
We support A.B. 243. I have submitted a presentation on HIV (Exhibit N). Our State reports approximately 437 new cases of HIV each year. Primarily, these cases are comprised of men who have sexual relations with men within African-American or black populations. This bill is important as it increases the opportunities for HIV testing by allowing non-licensed personnel to test individuals for HIV. Testers of HIV will not be required to be certified laboratory technicians. The laboratory director will not be required to be a licensed physician. Under this bill, the testing location can be licensed as an exempt testing laboratory to allow off-site testing of HIV, and not as a traditional public health clinic. Also, thorough training on HIV test proficiency, counselling and reporting for all testers will be established. Because of these allowances, we will be able to reach the at-risk population that is not reached at this time.

Senator Kieckhefer:
Section 1 of A.B. 243 speaks of the follow-up HIV test. What is the error rate of the initial HIV rapid test?

Ms. Peek:
A blood test or oral swab can be performed for HIV rapid testing. Accuracy ranges from 99.8 to 100 percent with 95 percent specificity and 95 percent sensitivity. With the initial off-site HIV test performed, we encourage the individual to receive a follow-up HIV test with a health department or primary care doctor for a definitive diagnosis of HIV.

Senator Kieckhefer:
When an individual is tested for HIV using a rapid test and receives a positive result for HIV, does the counsellor or laboratory technician tell the individual to obtain a follow-up HIV test?

Ms. Peek:
Yes, they receive a referral. Part of this bill would allow for thorough training on referrals in which personnel in community-based organizations advise the tested individual to obtain a more comprehensive follow-up HIV test.

Senator Kieckhefer:
In section 1 of A.B. 243, it states whoever is performing an HIV rapid test will tell the individual that follow-up testing is needed, is this correct? Are the people who are the HIV testers not providing this referral for follow-up at present?

Ms. Peek:
The personnel who are the HIV testers perform this notification well. We want to ensure the notifications continue once additional HIV testers are added in our community.

Senator Kieckhefer:
Do provisions in section 2 have to do with HIV rapid tests or with the much more thorough follow-up HIV tests?

Ms. Peek:
Section 2 refers to HIV rapid tests.

Senator Kieckhefer:
With the changes occurring in this bill, are standards being lowered for laboratory test error rates?

Ms. Peek:
The test we are discussing is one that individuals could obtain from drug stores and perform for themselves. We would not expect a higher error rate based on current error rate standards of 95 percent. An HIV follow-up test would be recommended for any individual who received a positive result from this type of over-the-counter HIV test.

Chair Hardy:
Is the positive HIV result reported to the health district?

Ms. Peek:
As part of the HIV testing curriculum for community-based organizations, the positive HIV test is to be reported. There would be follow-up with the individual who tested positive after the test was reported.

Chair Hardy:
Once the report is completed, is the individual advised to follow up for more thorough testing with a public health clinic or a primary care physician?

Ms. Peek:
Yes, at this point the individual would be advised to undergo the Western blot and HIV viral load lab tests to determine the severity of the individual's HIV infection.

Sylvia Allen (National Coalition of 100 Black Women, Las Vegas Chapter):
I am happy to see such advocacy and support for A.B. 243. This disease has varying impact on our communities, but the African-American community has a disproportionate representation of African-American women who are impacted. While African-American women comprise 13 percent of the nationwide population, we continue to have over 60 percent of the new HIV infections. Your support to ensure education about HIV testing and rapid testing, along with follow-up instruction and patient consulting is important. These measures will improve service and impact HIV disease for those in our community. This disease is preventable. Our community must be properly informed about this disease.

Melva Thompson-Robinson, DrPH (Executive Director, Center for Health Disparities Research, School of Community Health Sciences, University of Nevada, Las Vegas):
Eight years ago, I testified before legislative bodies regarding a perinatal HIV transmission bill. In the bill, HIV rapid testing was recommended for all pregnant women, particularly those who presented for delivery at a hospital and had not had an HIV test. The use of HIV rapid testing is the go-to method in various communities which have individuals in community-based organizations perform HIV testing. Some of these communities are in Hawaii, Arizona, New York City and Chicago. Weather challenges are cited as a reason community-based organizations do not perform rapid tests. I believe community-based organizations are aware of these types of issues. With proper training, these organizations can effectively perform rapid HIV testing.

Alisa Howard (Las Vegas Urban League):
The Las Vegas Urban League supports A.B. 243. I am the minority health services program manager for the Las Vegas Urban League, which is the largest community-based action agency in the State. We serve over 300,000 people per year. Assembly Bill 243 is important. We have a new HIV initiative in the minority health program. We are working with the Division of Public and Behavioral Health (DPBH) to develop an HIV education program to better serve the community in Las Vegas. I have taught 10 HIV education classes within the last 5 months. On average, there have been 20 people attending each class. None of these people had received HIV education prior to the class. The HIV education initiative brings information to individuals in our community, and more HIV testing. It is beneficial for the participants. Afterwards, they may have HIV testing and learn their HIV status. This bill will assist in overcoming current barriers to HIV testing for the individuals in our community.

Jennifer Howell, MPH (Health District, Washoe County):
The Health District of Washoe County supports this bill. It is good to expand HIV testing opportunities to reach populations that have not been previously reached effectively in order to achieve an HIV-free generation.

Robert Harding (Northern Nevada HOPES; Northern Nevada Outreach Team):
Northern Nevada HOPES and the Northern Nevada Outreach Team supports A.B. 243. This bill is important, as it will expand access to HIV testing in our communities. I have been a tester of HIV, using the rapid-test method, for 6 years. Many people do not access HIV testing through community-based organizations or health districts. This bill will allow community-based organizations to go into the community to HIV test these individuals.

Assemblyman Thompson:
This bill will satisfy needs concerning HIV testing, not only in African-American communities, but also in many communities in our State. I appreciate your support of A.B. 243.

Chair Hardy:
The hearing on A.B. 243 is closed. I will open the hearing on A.B. 158.

ASSEMBLY BILL 158 (1st Reprint): Revises and expands provisions relating to obtaining, providing and administering auto-injectable epinephrine in certain circumstances. (BDR 40-66)

Ms. Lyons:
I served as the policy analyst for the interim Legislative Committee on Heath Care, which brought this bill before this Committee. Assembly Bill 158 authorizes a physician, osteopath, physician assistant or advanced practice registered nurse to issue an order of auto-injectable epinephrine to an authorized entity and allows the entity to obtain such an order. An authorized entity is defined as any public or private entity excluding a school—which is covered in another bill that was passed a few sessions ago—where allergens capable of causing anaphylaxis may be present on the premises. The auto-injectable epinephrine maintained by the entity can be provided by a trained owner or employee, agent or another person trained in the administration of auto-injectable epinephrine. Other persons trained to administer epinephrine other than an authorized entity include, but are not limited to, a provider of health care, a provider of emergency medical services, an athletic trainer or a family member. The bill prescribes training requirements and specifies the authorized entity must report to the State Board of Health or district board of health the circumstances for the administration of the auto-injectable epinephrine. Lastly, the bill exempts certain persons from liability for damages relating to the acquisition, possession, provision or administration of auto-injectable epinephrine. Persons exempt from liability include an authorized entity: a physician, an osteopathic physician, a physician assistant, an advanced practice registered nurse, a pharmacist and any person who administers auto-injectable epinephrine. The measure is effective October 1, 2015.

Senator Debbie Smith has issued a letter of support (Exhibit O).

Chair Hardy:
Senator Debbie Smith championed this whole process during the last Session. It was an honor for me to present this bill in the Assembly in her stead.

Senator Kieckhefer:
Section 4 of the bill speaks about distance education being a program of instruction delivered by the Internet. Can videos be used for training, or must it be interactive training?

Ms. Lyons:
It is video-based training.

Michael Hackett (Nevada Food Allergy and Anaphylaxis Alliance):
I am a volunteer for the Nevada Food Allergy and Anaphylaxis Alliance (NFAAA). We support A.B. 158. Last Session, I worked with NFAAA on legislation which required public schools to implement training programs as to how to safely stock, store and administer auto-injectable epinephrine. I will read from my testimony (Exhibit P).

Caroline Moassessi (Nevada Food Allergy and Anaphylaxis Alliance):
The NFAAA requests your support of A.B. 158. Our members are comprised of Food Allergy Parent Education Group in Las Vegas and the Northern Nevada Asthma and Food Allergy Parent Education Group in Reno, along with several allergists and concerned citizens. I will show the Committee an article "EpiPens Save Reno-area Students (with video)", in the *Reno Gazette Journal*, February 25, 2014. There is a picture of a young boy included with the article. See his smile, which tells us, "I am alive and thrilled to be alive." His life was saved by the injection of epinephrine.

The good that has come from past legislation is wonderful, but it only covers children in kindergarten through Grade 12. We want to see access to auto-injectable epinephrine for all Nevadans. We read stories of people dying of anaphylaxis in restaurants, shopping malls and other public places. Last summer, Northwestern University in Chicago released a study. This organization reviewed 1,111 medical records and discovered that 15 percent of those represented adults developed allergies after the age of 18. The median age was 30; people in their 50s had the most severe reactions. The broader concern is why adults are losing tolerance to certain foods and getting allergies.

My daughter, Leila, will now demonstrate how to perform two simulations of epinephrine injections.

Kacey Larsen:
I am a registered nurse and mother of a 5-year old who has food allergies. I will read from my submitted testimony (Exhibit Q) in favor of A.B. 158. This legislation is important. As a nurse and a parent, I know this bill can and will save lives.

Stuart Stoloff, M.D.:
I support this legislation. I am a family physician in Carson City and am a fellow of the American Academy of Family Physicians and the American Academy of

Allergy, Asthma, and Immunology. Twenty percent of all fatalities associated with anaphylaxis occur outside of school settings. They occur outside of homes. They occur in restaurants, sporting events and camps. They occur where people experience insect stings, at food-related events and during adverse medication events. Medications are now the increasing reason for the mortality rates we are seeing. This bill represents an opportunity to do something about this problem. Resources are available for individuals to obtain auto-injectable epinephrine. The process of auto-injecting epinephrine is simple and has been demonstrated to this Committee. Clearly, the method is effective and life-saving.

Senator Kieckhefer:
Has anyone been injured by auto-injecting epinephrine?

Dr. Stoloff:
No one has been injured by the auto-injection of epinephrine, but people have died because epinephrine was not administered.

Chair Hardy:
The hearing on A.B. 158 is closed and we will open the hearing on A.B. 91.

ASSEMBLY BILL 91 (2nd Reprint): Revises provisions governing the admission of persons with certain mental conditions to and the release of such persons from certain facilities. (BDR 39-665)

Assemblywoman Teresa Benitez-Thompson (Assembly District No. 27):
Assembly Bill 91 mirrors Senate Bill 7 of this Legislative Session, which this Committee heard recently.

SENATE BILL 7 (1st Reprint): Revises provisions governing the admission of persons with certain mental conditions to and the release of such persons from certain facilities and programs. (BDR 39-64)

In the current Legislative process, there have been some amendments added to A.B. 91 and some removed. Proposed Amendment 6888 (Exhibit R) relates to this bill.

In the last interim, work was done to address the crisis happening in our hospitals' emergency rooms. Emergency rooms were being shut down in Nevada due to overcrowding. There are three newspaper articles that will remind this Committee why it became an urgent matter to act. The first is a May 1, 2013 article from the *Las Vegas Review-Journal* by Paul Harasim and Yesenia Amaro. The article states:

> The problem reached a critical point Monday afternoon at University Medical Center, which declared an "internal disaster" because of the overflow of mentally ill patients. UMC shut down its adult emergency room to arriving ambulances for 12 hours, the hospital's chief of staff and the head of emergency services said Wednesday.

In the article, Dr. Dale Carrison continued:

> The situation is unfair to the mentally ill patients going untreated and to those with physical ailments whose emergency room waits have gotten longer. ... The worst thing about this is that state government is doing nothing to change it.

On February 26, 2014, the *Las Vegas Review-Journal* published an article called, "Inundated by the Mentally Ill, Valley Emergency Rooms Close to Ambulances."

In August 20, 2014, the *Las Vegas Review-Journal* published another article concerning this subject, "Mentally Ill Patients Overloading Hospitals."

In order to provide background information, I will read from both of these articles concerning the overloading of emergency rooms by mentally ill patients in local hospitals and about the crisis.

Because of this crisis, Governor Sandoval called the Behavioral Health and Wellness Council, which is comprised of a number of different stakeholders from various areas of the State. This Council issued the *State of Nevada Governor's Advisory Council on Behavioral Health and Wellness December 2014 Report to Governor Sandoval*. Assembly Bill 91 contains Recommendation #9- Changes to the Legal 2000 Process. It adds physician assistants as well as advanced practice nurse practitioners to the list of those that can place a legal

hold on a person. With the work of the Legislature with the DHHS and the Governor's Office and this Council, many of the recommendations in the report were established. We have seen positive change. Changes in monetary payments to providers of health care have positively impacted the number of services and hospital beds available to mentally ill persons.

I visited a few hospitals in southern Nevada over the last interim. I saw holding rooms used to move individuals who have mental illness out of the emergency room, to allow for more available hospital beds. These individuals are sent to the holding room while waiting for their Legal 2000 release from the hospital. The Legal 2000 is the State form that allows a person who is mentally ill to be certified and admitted to a mental institution.

This morning, there were 69 people in emergency rooms who had medical clearances, but were waiting for their Legal 2000 holds to be addressed. There is hope that A.B. 91 will address this problem.

I will read from the Summary of Proposed Amendment to A.B. 91 (Exhibit S), submitted by the Legal Division.

The reporting requirements in A.B. 91 were redundant and deleted within Proposed Amendment 6888, Exhibit R. The DHHS calls each hospital every morning to obtain this number, so the reporting requirements were not necessary in this bill.

Notification requirements were also deleted. If notification requirements were in effect and hospital personnel were unable to determine a contact for someone who is experiencing an active psychotic episode, the hospital would be unable to care for the patient and to comply with required statutes.

Delaying treatment is not the goal of this bill. There is language within the judicial process that speaks to notification of a guardian within the Legal 2000 process. I will read further from Exhibit S.

The crafters of Proposed Amendment 6888, Exhibit R, performed due diligence to ensure those professions authorized to be added to the list of providers who may examine a person alleged to have a mental illness are those with more than adequate psychiatric training and high standards with respect to the ability to perform psychiatric evaluations and examinations.

Tracey Green, M.D. (Chief Medical Officer, Division of Public and Behavioral Health, Department of Health and Human Services):
Proposed Amendment 6888, Exhibit R, includes the addition of the physician assistant to the list of individuals who can initiate a Legal 2000 form to send the patient to a mental facility. The current language states these individuals include the professions of psychologists, marriage and family therapists, clinical professional counselors, social workers, registered nurses, agent officers and physicians. Proposed Amendment 6888, Exhibit R, does not change the admission or discharge of the individual from the emergency room by the emergency room physician or the acting physician, but allows for the evaluation of the individual in the emergency room by professionals that are providing these evaluations now. It allows these professionals to sign the Legal 2000 document.

Assemblywoman Benitez-Thompson:
We have been asked why licensed clinical social workers who have proper psychiatric training have been added to this process. We believe there is good precedent. Currently, the community outreach teams of law enforcement use clinically licensed social workers. For example, when law enforcement encounters a mentally ill individual, a licensed clinical social worker is called to mitigate a Legal 2000 hold. They also provide counselling and other services.

Senator Spearman:
Are there any provisions in A.B. 91 that address suicide rates for veterans?

Assemblywoman Benitez-Thompson:
Veteran suicide is not addressed in this bill.

Bill Welch (Nevada Hospital Association):
The Nevada Hospital Association supports A.B. 91, with the proposed amendment, Exhibit R.

John Sande IV (Universal Health Services of Delaware):
Universal Health Services of Delaware supports A.B. 91.

Assemblywoman Robin Titus (Assembly District No. 38):
I am opposed to A.B. 91. I voted on this legislation based on the amendment I recommended. Many Assembly members were concerned about expanding the list of those who could fill out the Legal 2000 form. There is major responsibility

associated with removing a person's civil rights and committing that individual to a mental facility. I understand the backlog in hospitals concerning mentally ill patients; I am not sure this legislation solves the problem. Section 1.5, subsection 5 within Exhibit R was removed. Although the DHHS calls the emergency room departments of our hospitals each day to find out how many individuals are being held by Legal 2000 actions, I asked for the additional language to be added to A.B. 91. Because we are expanding the list of individuals who could evaluate and fill out Legal 2000 forms, I requested that the Legal Division report how many of those other professions listed are already filling out the Legal 2000 forms.

Assemblyman John Moore (Assembly District No. 8):
I oppose this bill, and I would like to echo the statements of Assemblywoman Titus. On the Assembly Floor, I proposed an amendment to A.B. 91 to restrict the types of individuals who could initiate a Legal 2000 form and take away a person's civil rights. The individuals who could perform this were limited to a medical doctor, a psychiatrist or psychologist, or a law enforcement officer. There was serious opposition to this amendment. I worked with Assemblywoman Titus and with Assemblywoman Kirkpatrick on an agreement that would suit all parties. I now find they have taken our recommendations out of Proposed Amendment 6888, Exhibit R.

Lesley Dickson, M.D. (Executive Director, Nevada Psychiatric Association):
The Nevada Psychiatric Association opposes A.B. 91. I have submitted written testimony (Exhibit T). I will read from Exhibit T the reasons for our opposition.

This bill proposes an increase in the scope of practice by physician assistants who must act under the supervision of a physician, in this case, a psychiatrist. I have yet to find a psychiatrist who will state this legislation is a good idea. Most of our State's psychiatrists oppose this legislation and have submitted comments (Exhibit U).

Once the Legal 2000 hold is discontinued and the patient is decertified, as long as the patient wants to leave the mental facility, he or she must be allowed to do so. This bill could put a physician who works in an emergency room in a potentially uncomfortable state if they disagree with the person who wishes to leave. Who has liability if this occurs?

The first sections of the Legal 2000 form have low levels of legal liability when determining and evaluating the answers to the questions regarding the mentally ill patient; this could be performed by a physician assistant under the supervision of a psychiatrist. The area of the Legal 2000 form we are not comfortable having physician assistants complete are sections of the form having to do with the decertifying of the patient. To be able to fill out that part of the Legal 2000 form significantly increases their scope of medical practice.

Janine Hansen (Nevada Families):
I agree with the concerns brought forth by Assemblywoman Titus and Assemblyman Moore. We want to see the previously requested reporting sections put back into the bill.

Chair Hardy:
The reporting is associated with the person initiating the hold on and decertifying an individual. If we do not allow certain professions to perform these activities, is the report still necessary?

Ms. Hansen:
The report might not be needed if additional individuals were added. We would support reporting requirements if the rest of the sections of this bill were passed.

Chair Hardy:
The hearing on A.B. 91 is closed. We will open the hearing on A.B. 248.

ASSEMBLY BILL 248 (1st Reprint): Revises provisions governing reporting of information by physicians to the Department of Motor Vehicles concerning patients with epilepsy. (BDR 40-930)

Assemblywoman Titus:
This bill was originally presented as A.B. No. 406 of the 72nd Session. It was introduced by Assemblyman Joseph (Joe) Hardy and cosponsored by 19 additional members of the Assembly. The bill made its way through committee and to the floor, but never made it to the vote stage. It is very good legislation and deserves to pass this Session.

Assembly Bill 248 removes the mandatory reporting requirement for physicians when a patient has had a seizure.

It is important to note the bill does not allow drivers that are unsafe to be on the highways, instead allows the decision to be with the physician.

One of the purposes of this bill is to encourage patients to report seizure activity to their physicians. Many times, a patient will not report seizures to me as a physician for fear that his or her license will be revoked. As you can imagine, if you are employed and lose your driver's license, it may be devastating to you and your family. In urban areas, taxis and mass transit are inconvenient or expensive, and in rural areas they are not an option.

There is an excellent article published on the National Institutes of Health Website from the Epilepsy Society in 2009, which addresses driving issues and epilepsy. The article, "Driving Issues in Epilepsy: Past, Present, and Future", was authored by Dr. Krumholz. The author remarks there are only six states requiring mandatory reporting of seizures. He concludes that reporting to the Department of Motor Vehicles (DMV) discourages the reporting of seizures by patients to their physicians. He writes although mandatory reporting increases the percentage of patients with epilepsy known to regulators, it does not reduce the crash rate or improve the safety of the public.

Senator Kieckhefer:
This bill will make it illegal to drive on highways if a physician makes a determination that a person with epilepsy is unsafe. We do not want to take it a step further to have the physician ensure the patient does not get a driver's license or revokes a driver's license. The reporting mandate seems to cause individuals who have epilepsy not to report seizure events to their physicians, for fear of losing their driving licenses. In situations where there is not mandatory reporting of seizures, has there been a reduction of automobile crashes?

Assemblywoman Titus:
If a patient of mine has a seizure, I want to know so that I can monitor and adjust the patient's medications as necessary. The patient is not willing to report the seizure due to the mandate of the reporting of seizures to the DMV with the resulting effect on the driver's license. Patients fear I will report them to the DMV and they will have their driver's licenses taken away. If individuals who have epilepsy are clear of seizure events for a period of time, they may get their driver's licenses back. There are many patients, possibly thousands, that have epilepsy and are driving. If these individuals experience an epileptic

seizure, I would ask they report it to me. More importantly, we want to ensure those individuals who have never had a seizure, or those who do not yet drive, report seizure events to their physicians. A friendly amendment is in the works regarding this legislation from the DMV. It may state if the patient is not medically controlled, the physician is absolved of liability if the physician reports the patient to the DMV. We have not read this possible amendment as of this hearing. I want the DMV to be comfortable with this legislation.

Senator Kieckhefer:
We have not seen this possible amendment by the DMV. Section 1, subsection 4 of the bill states, "A physician may, upon the request of the Department, provide to the Department a copy of a statement signed by a patient pursuant to subsection 2." Under what circumstances would the DMV request this information from a physician?

Assemblywoman Titus:
If the DMV had concerns about certain patients with uncontrolled seizures, or if there are questions about the cause of an accident, the DMV could request this information. The DMV, not law enforcement agencies, could request this information.

Chair Hardy:
Can personnel from the DMV speak to us about the possible friendly amendment that may be forthcoming?

Sean McDonald (Administrator, Division of Central Services and Records, Department of Motor Vehicles):
We are neutral concerning A.B. 248. We looked at section 1, subsection 4 of this bill. The conceptual amendment we envision relates to circumstances when a physician has determined in his or her professional judgment that a patient's epilepsy has severely impaired the patient's ability to operate a motor vehicle safely. If that determination is made, then the physician shall provide a statement signed by the patient to the DMV. Therefore, the physician would let the DMV know the individual should not have a license.

Senator Kieckhefer:
Under what circumstance would the DMV know to request a specific record about a specific driver from a specific doctor?

Mr. McDonald:
The physician would report this information to the DMV.

Ann Yukish-Lee, CPM (DMV Services Manager II, Central Services Processing Center, Department of Motor Vehicles):
We are either told by the patient, our customer, that driving issues exist, or it is reported by the physician to the DMV. This process lets us know the individual with epileptic seizures cannot drive. We do not know who the patient's physician is; we would request the patient having seizures take a medical certification form to his or her physician to complete.

Senator Kieckhefer:
Is there any place in the bill that requires a form to be filled out in order for the individual to obtain a license?

Ms. Yukish-Lee:
Yes, they would need a form if there is any indication that the individual's ability to drive was impaired or if the individual was not considered safe to drive. The physician's form would then be required for those situations for the individual's licensure.

Senator Kieckhefer:
Is that requirement written in the DMV's conceptual amendment, or does this exist in current statute?

Ms. Yukish-Lee:
It is noted within our conceptual amendment for these specific circumstances. What exists in current statute is that every individual who has epilepsy will be reported to the DMV. Our conceptual amendment states if the physician feels the individual's epilepsy affects driving ability, he or she is then required to report that information to the DMV.

Senator Kieckhefer:
Does the DMV's conceptual amendment add mandatory reporting, which Assemblywoman Titus was trying to remove?

Assemblywoman Titus:
It does take out mandatory reporting for someone who experiences a seizure, but it allows a physician to determine if the patient is unsafe to drive and

whether to report this to the DMV. If a person experiences a seizure, it does not automatically mean they are unsafe to drive. The patient can be compliant by following treatment protocols and seeing the physician for follow-up visits at a medical office. In a week or so, he or she could feel better. As a physician, if I deem the patient unsafe to drive, I then report this to the DMV.

Chair Hardy:
As physicians, we are obligated to report a patient to the DMV if the patient experiences a loss of consciousness. The form we fill out details the reasons for the loss of consciousness. It does not take long for individuals in our State to realize if they do not tell the doctor about a loss of consciousness, then they can continue to drive. The most common cause of seizures in individuals occurs because he or she did not take the medication which controls the seizures. If the person does not tell the physician about the seizure, the physician cannot change medication or dosage.

Assemblywoman Titus:
This bill is about safety for the patient as well as for those on the highways.

Senator Spearman:
Section 1, subsection 4, paragraph (a) states, "Is confidential, except that the contents of the statement may be disclosed to the patient." Once the information is received by the DMV concerning the patient, how does the DMV make sure the information is protected so that only those individuals who have a need to know can access it as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If disclosure of information is accessed by an unauthorized person, what provisions are in place to ensure it does not happen again, and are provisions in place to punish the individual who gained unauthorized access to information?

Ms. Yukish-Lee:
All information is deemed confidential at the DMV. A specific caseworker assists the patient or our customer with the information. We do not necessarily disclose the information to the patient. We would advise the patient his or her driving ability was impaired and someone advised the DMV that person was unsafe to drive. The patient would need to formally request the information from the DMV for the DMV to disclose it to the patient. There are measures in place at the DMV to protect confidentiality.

There are policies, procedures and penalties in place within the DMV's various divisions to protect information and provide for progressive discipline, up to and including termination of the employee if a valid threat was uncovered.

Chair Hardy:
Is the confidential information dealing with health issues such as seizures HIPAA compliant as well?

Ms. Yukish-Lee:
Yes, it is.

Chair Hardy:
We ask the DMV to provide the conceptual amendment to this Committee.

Assemblywoman Titus:
If the Committee would look at the Website I previously noted, and read the excellent article on driving and epilepsy, most of the concerns and questions the Committee has had would be answered.

Chair Hardy:
The hearing on A.B. 248 is closed. We will open the hearing on A.B. 305.

ASSEMBLY BILL 305 (1st Reprint): Authorizes and provides for the regulation of community paramedicine services. (BDR 40-167)

Assemblyman James Oscarson (Assembly District No. 36):
The topic of community paramedicine was discussed this past interim by the Legislative Committee on Health Care. Community paramedicine programs have been shown to greatly impact a reduction in hospital readmissions, improving health outcomes for high-risk individuals, and particularly in the rural areas, filling in the gaps where we have a shortage of health care workers.

This bill has been a collaborative effort among interested stakeholders from rural and urban Emergency Medical Services (EMS), as well as representatives from the State EMS agency.

I would like to briefly summarize the bill. Beginning with section 2, community paramedicine services is defined as:

> Services provided by an emergency medical technician, advanced emergency medical technician or paramedic to patients who do not require emergency medical transportation and provided in a manner that is integrated with the health care and social services resources available in the community.

What is important to note is persons who receive services through community paramedicine are not in need of emergency services.

In section 4, the State Board of Health must adopt regulations that provide for the issuance of an endorsement on a permit that allows an emergency medical provider and agency to provide community paramedicine services. Community paramedicine services will not be any services that are outside the scope of practice of the emergency medical provider. An endorsement for community paramedicine services will expire on the same date as a provider or agency's permit and is renewable annually thereafter.

Section 5 requires those who obtain an endorsement to provide community paramedicine services to report quarterly to the appropriate health authority information on the type of services provided in lieu of transportation to a hospital; the number of persons served; and the impact of provider community paramedicine services on the overall services provided to patients. Each health authority must submit that information by February 1 of each year to the Legislative Counsel Bureau or Legislative Committee on Health Care.

Section 8 adds community paramedicine services to the statute related to permitting.

Section 9 and section 10 ensure that a person does not provide community paramedicine services unless they have a current endorsement to do so.

Sarah McCrea (EMS Quality Improvement Coordinator, Las Vegas Fire and Rescue, City of Las Vegas):

I have participated in a work group for 18 months and have met with rural, urban, private and public EMS providers across the State. I have also met with fire-based and hospital-based EMS systems providers. All of these EMS providers agree on A.B. 305 and look forward to the additional services we will be able to provide to our communities in order to improve access to health care.

Jim Gubbels, BSN, RN (President/CEO, Regional Emergency Medical Services Authority):
The Regional Emergency Medical Services Authority (REMSA) supports A.B. 305. This legislation will improve health care for our communities.

Senator Kieckhefer:
Would these paramedicine services be provided following an individual's call from an EMS provider, then a determination made whether or not an EMS transport is required—or does this legislation relate to a person who walks into a firehouse and requests assistance, but does not require an emergency transport?

Ms. McCrea:
Within A.B. 305, these programs are closely defined depending on the regulating board of the EMS providers. In the current system, if a county's population is under 700,000, the EMS providers are regulated by the EMS Office of the State Board of Health. For Clark County, the regulation is provided by the SNHD. These boards are responsible for identifying particular protocols, and the services each program provides within the scope of practice for EMS provider level. We are not speaking of people coming to the firehouse for non-emergency transport. While we do have people walking into the firehouse for services, we provide services to them as needed. What this legislation allows is for EMS programs to provide additional services similar to what REMSA has done with regard to hospital readmission reduction and community outreach strategies. In my department, we look forward to helping the homeless population and frequent users of the 911 system with this legislation. The frequent users of the 911 system have chronic illnesses that need further care; they need more than simply an EMS transport to a hospital. These are defined paramedicine programs. It would not be a transition from a 911 call for medical service and having an EMS provider come to the scene and then recognizing the event is not a 911 call—meaning the person does not really need an emergency transport to a medical facility. Under this bill, the individual could be referred to the paramedicine program. The paramedicine program could then provide services the individual needs. It is separate and unique from a 911-service response.

Senator Kieckhefer:
Do paramedicine programs have provider-to-patient relationships? Does the responder of a paramedicine program go to the patient's location or is there a clinic location the patient may visit?

Mr. Gubbels:
The REMSA has a current program with community paramedics, sponsored by the Center for Medicare & Medicaid Services' (CMS) Health Care Innovation Awards, in which they work in three different programs. The first program consists of the paramedic working with patients with chronic medical conditions who are being discharged from the hospital. The conditions could be chronic obstructive pulmonary disease or congestive heart failure. The treating physician could request the community paramedic follow the patient and provide medical services at the home setting, to ensure the patient follows the treatment protocols prescribed by the physician so the patient will not be readmitted to the hospital within 30 days of discharge. Another program deals with frequent users of the 911 system. We can identify those individuals who call frequently for an ambulance and use the community paramedics to see the individual on a non-emergency call basis. The community paramedic can assess social and health care needs during the visit. They may set the individual up for an appointment with a medical clinic or home care which can follow and provide for the individual's health care needs so he or she is no longer in a crisis mode and calling 911 frequently. A physician can call our program to request a review of a patient to determine if the patient needs an ambulance, or if the patient simply needs to have follow-up in the physician's office. Let us consider the physician who receives a call from a patient at 2 a.m.—many times the physician cannot diagnose the problem over the phone and tells the patient to call 911. The program gives the physician the opportunity to call a community paramedic to assess the patient.

Senator Kieckhefer:
Are the services provided by the community paramedic billable?

Mr. Gubbels:
The program is funded by a grant from CMS. We are looking for ways to sustain the program. In the future, health care insurance companies and Medicare and Medicaid could possibly determine these services are payable to the paramedicine program.

Senator Kieckhefer:
Are certain types of paramedicine programs recognized by CMS as ones that may receive payment? Does the State insurance plan cover these services?

Mr. Gubbels:
We are working with individuals in the State Medicaid office with respect to a State Innovative Model grant from CMS and how it could be obtained for Nevada. We believe we need to move forward with this bill so we can have this opportunity in the future.

Senator Kieckhefer:
My concern is that a payer source exists for the paramedicine services and that the costs of these services are not shifted to the individuals that need the EMS transport.

Joan Hall (President and CEO, Nevada Rural Hospital Partners Foundation):
The Nevada Rural Hospital Partners Foundation supports A.B. 305. There is a paramedicine pilot program in Winnemucca. To answer Senator Kieckhefer's question, there currently is no insurance reimbursement for these services. In the pilot program, paramedics are providing services under the direction of a physician. They review home safety issues, medication reconciliation and wound status. The program works very well.

Rusty McAllister (President, Professional Fire Fighters of Nevada):
Professional Fire Fighters of Nevada supports A.B. 305. As an example, I work in the area of Sun City in southern Nevada. Our employees receive calls from seniors. At times, we assist seniors who have fallen, picking them up off of the floor and helping them back into bed. We can determine the type of assistance the individual requires at the time. We then can send a referral card to Chief McCrea's paramedicine program. She has developed a program with social services interns at the University of Nevada, Las Vegas. The intern will contact the person in need of assistance and set up an evaluation. Needs could include lifting devices or perhaps for a nurse to come out to visit a few days a week in order to provide necessary assistance. This community outreach works very well.

Dan Musgrove (Southern Nevada Heath District):
The SNHD will be the regulatory entity in southern Nevada for the paramedicine programs. There have been major collaborative efforts between public and

private entities concerning the establishment of these programs. Those concerned have discussed how to best serve the community. It has been an underserved need and these services will benefit health care in southern Nevada.

Gerry Julian (Southern Nevada Health District):
I am the EMS field representative for the Office of EMS and Trauma Systems. I am here to support A.B. 305 on behalf of the SNHD.

Steven Tafoya (Manager, EMS Program, Division of Public and Behavioral Health, Department of Health and Human Services):
The DPBH is neutral concerning A.B. 305. There is an associated fiscal note with respect to this bill as it requires adoption of regulations. There is a onetime associated cost with this bill. Currently, the EMS Program has a grant though the federal Health Resources and Services Administration that will cover the costs of regulations.

Chair Hardy:
Essentially, the fiscal note on A.B. 305 goes away because it is covered. We will close the hearing on A.B. 305 and open the hearing on A.B. 425.

ASSEMBLY BILL 425: Revises provisions governing emergency medical services. (BDR 40-702)

Mr. Tafoya:
This bill was brought forth by the Assembly Committee on Health and Human Services. Section 1, subsection 3, paragraph (c) of the bill removes the term "firefighter" and allows volunteer EMS providers to be members of the Committee on Emergency Medical Services. Paragraph (d) of the same section and subsection states, "One member who is employed by a fire-fighting agency at which some of the firefighters and persons who provide emergency medical services for the agency are employed and some serve as volunteers." Assembly Bill 425 will create a balance for the Committee on Emergency Medical Services with respect to its members. This Committee meets once a quarter and advises the State EMS Program.

Section 2, by adding the term, "EMS provider for health care," allows EMS agencies access to the Living Will Lockbox though the Office of the Secretary of State. This could allow EMS responders access to needed information during a

911 response call. It will allow EMS responders to follow patient advance directives, such as a do-not-resuscitate order or a physician order for life-sustaining treatment, also known as a POLST directive. The bill may also allow EMS permitted agencies and health care providers to apply for federal grants.

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Chair Hardy:
There being no further business before the Committee, the hearing is adjourned at 5:17 p.m.

RESPECTFULLY SUBMITTED:

_____
Ellen Walls,
Committee Secretary

APPROVED BY:

_____
Senator Joe P. Hardy, Chair

DATE:_____

EXHIBIT SUMMARY				
Bill	**Exhibit / # of pages**		**Witness / Entity**	**Description**
	A	2		Agenda
	B	7		Attendance Roster
A.B. 28	C	1	Marsheilah Lyons	Work Session Document
A.B. 41	D	1	Marsheilah Lyons	Work Session Document
A.B. 52	E	1	Marsheilah Lyons	Work Session Document
A.B. 99	F	1	Marsheilah Lyons	Work Session Document
A.B. 222	G	1	Marsheilah Lyons	Work Session Document
A.B. 424	H	1	Marsheilah Lyons	Work Session Document
A.B. 456	I	1	Marsheilah Lyons	Work Session Document
A.B. 39	J	1	Marsheilah Lyons	Work Session Document
A.B. 42	K	1	Marsheilah Lyons	Work Session Document
A.B. 156	L	4	Marsheilah Lyons	Work Session Document
A.B. 200	M	7	Marsheilah Lyons	Work Session Document
A.B. 243	N	7	Julia Peek/Division of Public and Behavioral Health	Overview of HIV Disparity in Nevada
A.B. 158	O	2	Senator Debbie Smith	Letter of Support
A.B. 158	P	1	Michael Hackett/Nevada Food Allergy and Anaphylaxis Alliance	Testimony
A.B. 158	Q	3	Kacey Larsen	Testimony
A.B. 91	R	13	Assemblywoman Teresa Benitez-Thompson	Proposed Amendment
A.B. 91	S	1	Assemblywoman Teresa Benitez-Thompson	Summary of Proposed Amendment to A.B. 91
A.B. 91	T	1	Lesley Dickson, M.D./Nevada Psychiatric Assoc.	Testimony

A.B. 91	U	3	Lesley Dickson, M.D./Nevada Psychiatric Assoc.	A.B. 91–Voice Your Opinion Survey Responses