MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON COMMERCE AND LABOR

Seventy-Ninth Session
February 24, 2017

The Committee on Commerce and Labor was called to order by Acting Chair Jason Frierson at 12:28 p.m. on Friday, February 24, 2017, in Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/79th2017.

COMMITTEE MEMBERS PRESENT:

Assemblyman Chris Brooks
Assemblyman Skip Daly
Assemblyman Jason Frierson
Assemblyman Ira Hansen
Assemblywoman Sandra Jauregui
Assemblyman Al Kramer
Assemblyman Jim Marchant
Assemblywoman Dina Neal
Assemblywoman Jill Tolles

COMMITTEE MEMBERS ABSENT:

Assemblyman Paul Anderson (excused)
Assemblyman Nelson Araujo (excused)
Assemblywoman Irene Bustamante Adams, Chair (excused)
Assemblywoman Maggie Carlton, Vice Chair (excused)
Assemblyman James Ohrenschall (excused)

GUEST LEGISLATORS PRESENT:

Assemblywoman Jill Tolles, Assembly District No. 25
Assemblyman Tyrone Thompson, Assembly District No. 17
Assemblywoman Teresa Benitez-Thompson, Assembly District No. 27

STAFF MEMBERS PRESENT:

Kelly Richard, Committee Policy Analyst
Wil Keane, Committee Counsel
Earlene Miller, Committee Secretary
Olivia Lloyd, Committee Assistant

OTHERS PRESENT:

Michael D. Hillerby, representing Nevada Optometric Association
Andrew Boren, Private Citizen, Reno, Nevada
Dan Lyons, Clinic Director, Nevada Eye Consultants, Reno, Nevada
Caren C. Jenkins, Executive Director, Nevada State Board of Optometry
Spencer Quinton, Private Citizen, Henderson, Nevada
Adam Rovit, Private Citizen, Las Vegas, Nevada
Catherine M. O'Mara, Executive Director, Nevada State Medical Association
Randi Thompson, representing Simple Contacts
Peter Horkan, Director of Government Affairs, Opternative, Chicago, Illinois
Derek Brown, Vice President, Government Relations, 1-800 CONTACTS, Draper, Utah
Jeanette K. Belz, representing Nevada Academy of Ophthalmology
Cary Samourkachian, President and CEO, Lens.com, Inc., Las Vegas, Nevada
Misty Vaughan Allen, Coordinator of the Statewide Program for Suicide Prevention, Bureau of Child, Family and Community Wellness, Division of Public and Behavioral Health, Department of Health and Human Services
Dan Musgrove, Private Citizen, Las Vegas, Nevada
Kevin Burns, Coordinator, Veterans Resource Center, Western Nevada College
Justeen Beal, Private Citizen, Reno, Nevada
Mike Dyer, Director, Nevada Catholic Conference
Richard Carreon, Private Citizen, Las Vegas, Nevada
Matthew De Falco, Private Citizen, Las Vegas, Nevada
Michael Kelly, representing Nevada Democratic Veterans & Military Families Caucus-United Veterans Legal Counsel
Heather Dalton, Private Citizen, Las Vegas, Nevada
Crystal Cochran, Private Citizen, Las Vegas, Nevada
André C. Wade, Director of Operations, The Gay and Lesbian Community Center of Southern Nevada
Andrew Pasternak, Private Citizen, Reno, Nevada
Jessica Ferrato, representing Nevada Nurses Association
Chelsea Capurro, representing Nevada Advanced Practice Nurses Association

[Assemblyman Frierson assumed the Chair. The roll was called.]

Acting Chair Frierson:
There are two bills on the agenda to be referred to the Assembly Committee on Commerce and Labor Subcommittee on Energy.

Assembly Bill 206: Revises provisions relating to the renewable portfolio standard. (BDR 58-746)

Assembly Bill 223: Revises provisions relating to energy efficiency programs. (BDR 58-660)

I will refer Assembly Bill 206 and Assembly Bill 223 to the Assembly Commerce and Labor Subcommittee on Energy if there are no objections to that referral. Are there any objections? There being none, A.B. 206 and A.B. 223 are referred to the Assembly Committee on Commerce and Labor Subcommittee on Energy.

I will open the hearing on Assembly Bill 129.

Assembly Bill 129: Revises provisions relating to the practice of optometry and the issuance of a prescription for an ophthalmic lens. (BDR 54-744)

Assemblywoman Jill Tolles, Assembly District No. 25:
Since I have a history of complications with my eyes, I am particularly sensitive to this topic. When I was 8 years old, my mom told me to get something in the grocery store and I became frustrated because I could not read the signs on the aisles. Within weeks, I had my first appointment with an eye doctor who diagnosed me with myopia, or nearsightedness. In no time I had my first pair of eyeglasses. I still remember when he showed me how to put them on and take them off. He demonstrated for me how often the eye doctors on television ripped their glasses off with one hand when they had to tell the patient bad news. He said, "Do not do that! You will break or bend your glasses." I also vividly remember walking out of his office and noticing for the first time every petal on a rosebush because I could see them clearly for the first time.

That was the beginning of decades of care by optometrists and ophthalmologists. Over the years I have had countless eye examinations and prescriptions. In my thirties, I was one of the first patients in Nevada to get intraocular lens implants, and I am happy to say after surgery I now have 20/20 vision, but it has not all been rosy. I have had painful viral infections in my cornea and two misdiagnoses which could have potentially led to permanent damage and vision loss if they had not been caught by a second opinion.

I have a personal and, at times, painful history with the importance of ocular health. Assembly Bill 129 revises provisions concerning the prescribing and fitting of contact lenses; providing that the use of certain automated testing devices constitutes the practice of optometry; and providing other matters properly relating thereto. Briefly stated, this bill

aims to ensure that ocular health remains a key component of eye care and maintains the practice of conducting eye exams when prescribing refractive correction (Exhibit C). Although this bill deals with the use of technology, it is in no way meant to limit the use of telemedicine or thwart technological advances that enhance a physician's ability to care for his or her patient. It is in response, however, to a new method that seeks to bypass the examination process when prescribing refractive correction. We believe it is in the best interest of the patient to clarify these statutes to ensure best practices in patient care are maintained.

I have spoken with the representative of the Nevada Academy of Ophthalmology and other interested groups about some of their questions and concerns. I welcome that continued conversation as the result of the discussion being introduced today.

[Assemblywoman Tolles submitted a proposed amendment to add cosponsors to A.B. 129 (Exhibit D).]

Michael D. Hillerby, representing Nevada Optometric Association:
We brought this bill because we have a number of companies now offering online refraction. They pull one portion of a diagnostic eye exam and offer that online to diagnose a person's refractive error and then provide a prescription. They work with ophthalmologists who are licensed in Nevada. It is less about the technology than about pulling it out of the larger overall examination of eye health.

Section 1 of the bill deals with *Nevada Revised Statutes* (NRS) Chapter 630, which is the Board of Medical Examiners. Section 1, subsection 1 is the important part of the bill. It says, "Before issuing a prescription for an ophthalmic lens, an ophthalmologist in this State must make an assessment of the ocular health and visual status of the patient that does not solely consist of the use of an automated testing device to generate the refractive error of the eyes of the patient." We crafted that language carefully to be sure we did not impact telemedicine. This deals specifically with the diagnosis of refractive error and offering a prescription outside of the exam. It does not prohibit other telemedicine activities.

Section 1, subsections 2 through 6 is existing law that was put into NRS Chapters 630 and 636 in 1987 which list the requirements for a prescription. Whether or not you are approved for contact lenses, we have language involving the expiration. There is no specific date on the expiration for those prescriptions. That is a matter of the medical judgment between the eye-care provider and the patient. It also lists the requirements for the initial fitting of contact lenses if they are prescribed.

Section 2 impacts NRS Chapter 633, which is about osteopathic medicine. Section 2, subsection 1, is the same sentence as section 1, subsection 1. Section 2, subsections 2 through 6 is identical language to section 1. The language about the expiration date, the

requirements for the initial fitting, and prescription requirements were included in NRS Chapters 630 and 636, but not in Chapter 633. We have included that language in NRS Chapter 633 for osteopathic physicians.

Section 3, subsection 1, paragraph (c) adds language to a definition of an examination that says, "including the use of an automated testing device that generates objective refractive data or information to establish the refractive error of the eyes of a patient."

In section 4, subsection 1, it includes the same language as in section 1, subsection 1 and section 2, subsection 1 which says, "Before issuing a prescription for an ophthalmic lens, an optometrist in this State must make an assessment of the ocular health and visual status of the patient that does not solely consist of the use of an automated testing device to generate the refractive error of the eyes of the patient." That sentence is the substance of the bill and appears in all three chapters to make it consistent.

Our members, optometrists who sometimes work with ophthalmologists, routinely take advantage of telemedicine and telehealth. One of the examples is Renown Health has a partnership with Stanford University School of Medicine so infants who may need specialized diagnostic care can have a scan of the retina in the hospital which is shared with ophthalmological specialists at Stanford who will help make a diagnostic decision. This bill does not affect any of that. This is limited to the very specific piece where the refractive error is tested and a prescription is written. We want to encourage members to take advantage of telehealth and telemedicine so it allows data to get back and forth. This does not affect our optometrists' management of glaucoma patients and pre- and postsurgical patients.

By federal law, patients are required to be given their prescription at the end of an exam and can go anywhere to buy their devices. The prescription belongs to the patient and they can shop anywhere. Nevada law in NRS Chapter 636 specifically exempts the sale of safety glasses, sunglasses, and ready-made manufactured eyeglasses.

Acting Chair Frierson:
Regarding adding the language in section 3, about an automated testing device as part of the practice of optometry, I am not familiar with the devices. If somebody is able to purchase a device and use it without the intent of convincing himself or someone else that they had an eye exam, would that result in their practicing optometry without a license?

Michael Hillerby:
The way our professional chapters are written, particularly in health care, there is a very important distinction among NRS Chapters 630, 633, and the rest of the chapters. Physicians are essentially presumed to be able to do anything their medical training allows them to do. We do not differentiate or mention by specialty the radiologists or any of the specialties within NRS Chapters 630 and 636. We acknowledge that. Adding specific language is a departure. Physicians are presumed to be able to do anything. It is about their training, their board certification, and other issues. All of the other health care practices have specific

things that they are able to do because they are more limited than physicians. That is why you see a very specific list of things in section 3 that says the acts, whether done individually or collectively, constitute the practice of optometry. Then you could go to a drugstore, buy an eyechart and conclude you are not going to be violating the practice of optometry. If you do that with the intent of diagnosing and offering a prescription, you would then run into trouble. That is why these are written differently. The specifics of what constitutes the practice of optometry and what optometrists are able to do is specifically limited by statute.

Acting Chair Frierson:
My question is the device itself. It used to be you had to go to the doctor to get your blood pressure checked, and now you can go to Best Buy and get a cuff. I am not practicing medicine by using that cuff at home. I do not want having this device ending up being the unauthorized practice of optometry.

Michael Hillerby:
We will confer with the Nevada State Board of Optometry to be sure, but it is our interpretation that it does not. Using the tool does not provide a prescription or give a diagnosis. It is a tool. We believe these devices removed from the larger exam and being able to get a prescription based solely on that and calling it an exam, is the issue.

Acting Chair Frierson:
The intent of the bill is to make sure that there is not any issuance of a prescription. If someone could describe the devices and how accessible they are, it would be helpful. It does not seem to be your intent to capture people who use these devices.

Michael Hillerby:
That is absolutely not our intent. Blood pressure cuffs, pulse oxygen monitors, and glucose drips can be purchased over the counter to give you useful information at home, hopefully in conjunction with a health care provider who has told you how to use the device and manage your needs. If you were to use one of the devices and present yourself as someone who could offer a diagnosis or prescription, that would be the problem.

Assemblywoman Jauregui:
How is this affecting our rural neighbors who depend on telemedicine? Will this impact them in any way?

Michael Hillerby:
We tried to craft this narrowly so as not to influence the kinds of telemedicine activity that goes on now. In a rural area, you might go to a primary care provider who would then be able to consult with another provider. This would preclude this technology to have an online or app-based service offer a diagnosis of your refractive error and give a prescription. It does not affect other kinds of consultation and collaborations with partners in telemedicine.

Assemblywoman Jauregui:
Do the rural residents use that practice?

Michael Hillerby:
It is a growing and important part of medicine. We spent a lot of time last session on Assembly Bill 292 of the 78th Session to further define telemedicine and what was allowed. It is used widely in the rural areas. We do not know the prevalence at this point and would not have a way to do that.

Andrew Boren, Private Citizen, Reno, Nevada:
I am an optometrist in Reno. American health care is embarking on an important look at itself. We need to improve the costs and outcomes for patients. That is important to me by principle. Allowing a prescription without the exam would be harmful to the public health. I have patients in their nineties who wear contact lenses well and I have high school kids who have damaged their eyes so much that they cannot ever wear contact lenses again. The exam helps to catch problems early before they are far more expensive and damaging to both our health care system and patients.

There are many conditions in the eye that cause pain and vision loss which we can treat if we catch it early. The eye is the only place in the body where we can see blood vessels well without cutting into the body. We find cardiovascular conditions, diabetes, and other problems before they become big problems. I see this almost daily in my practice.

Acting Chair Frierson:
Could you expand on some of the things you can identify in an eye exam. Do you see a significant number of patients who have an eye exam with the expectation of addressing other conditions?

Andrew Boren:
High blood pressure that the patient is not aware of often shows up in an eye exam. It initiates getting them into the health care system to get that treated. It is fairly common to see small embolisms that indicate the patient is in great risk for a stroke. Benign intracranial hypertension most commonly affects young women 18 to 30 years of age. I have seen a good number of patients with that condition and have referred them to a neurologist to reduce the high cervical spinal fluid pressure that can be very damaging. Glaucoma is also detected in eye exams.

Dan Lyons, Clinic Director, Nevada Eye Consultants, Reno, Nevada:
I practice in Reno with four ophthalmologists. We specialize in surgery and tertiary care. We do not sell glasses or contacts from our practice. As an eye care provider, I am significantly worried that there are online businesses such as Opternative and other similar businesses that are placing Nevada citizens at extensive risk for loss of vision and possibly worse. These online businesses are simply performing a vision test to write glasses, and even more dangerous, contact lens prescriptions. All of this is being done without an actual exam of the health of the eyes.

This is analogous to the blood pressure machine that we all use in our pharmacies. The major difference is that there is not a physician-signed prescription if your blood pressure is measured to be elevated. Checking blood pressure alone no more constitutes a complete physical than a vision measurement constitutes a comprehensive eye exam. They are both small parts of the whole. Most websites provide a disclaimer, but what cannot be discounted is the inherent power of a physician signing off on a prescription saying that you see well. The fact that a physician is willing to sign off on what is advertised as an exam, will lead people into a false sense of security that their eyes are healthy. There are a myriad of health conditions that can be diagnosed with a proper eye exam, including sight-threatening ocular conditions such as glaucoma, macular degeneration, and retinal tears and detachments which are regularly identified and treated. Systemic conditions such as diabetes, hypertension, melanoma, autoimmune, and thyroid disorders can also be diagnosed.

According to a recent study, in 2014, eye doctors alone diagnosed 240,000 new cases of diabetes based on a complete eye exam. Diabetes can have a significant impact on the eye. This effect is known as diabetic retinopathy and is the leading cause of blindness in Americans, according to the Centers for Disease Control and Prevention. All eye care providers have examples of serious conditions identified in healthy-appearing adults. One of my colleagues saw a patient last December. She is in her late forties. She came in to get a new reading prescription. She was correctible to 20/20 both distance and near vision. She had no noted systemic conditions and had an unremarkable eye exam 14 months prior. The patient was dilated and displayed diabetic retinopathy in each eye. She was referred to her primary care provider where her blood sugars measured greater than 800. This patient was in significant risk of slipping into a diabetic coma. This case was particular interesting because her exam potentially saved her life, but her occupation was a school bus driver, and it potentially saved the lives of many others.

I ask the Committee to consider the health of our citizens and insist that only the best care be provided to them.

Assemblywoman Neal:
The American Academy of Ophthalmology submitted a letter (Exhibit E) which said although this bill is well intentioned, it would not help Nevada keep pace with new developments in the field. Then they noted a study on technology-based eye care services.

Michael Hillerby:
I have not seen the formal letter. We have heard some of the same arguments from the Academy of Ophthalmology.

Assemblywoman Neal:
In the study, they surveyed people who used a telehealth component. For the patients who felt they needed more, they had face-to-face contact. The language in the bill says that, as long as the examination does not consist solely of the use of an automated testing device

to generate the refractive error of the eyes of the patient. Does that language help the American Academy of Ophthalmology, because it is not just the automated testing device and it makes sure that two things happen?

Michael Hillerby:
The bill seeks to prohibit using the automated technology without an exam to generate a prescription. There is nothing in the bill that prohibits optometrists and ophthalmologists from using a variety of new technologies as a part of the diagnostic portion of the eye exam. They could use the online refractive exams as part of a larger exam. There is a great deal of new technology that can be incorporated as part of the exam. We are trying to not allow in Nevada law the use of the device to offer a diagnosis and a prescription without the larger eye health exam. We worked hard to make sure that language did not cut off the use of the new technologies.

Assemblywoman Neal:
The study also cited that the U.S. Department of Veterans Affairs (VA) sometimes uses the telehealth component because veterans have to travel long distances. Would this bill affect that ability?

Michael Hillerby:
They can practice differently within the VA system because they are under federal law and not subject to state laws.

Dan Lyons:
I worked for three years at the VA Sierra Nevada Health Care System in Reno, Nevada, and a year in Memphis, Tennessee, where we used telemedicine. The biggest differentiator here is that our bill is solely focused on refractive care, which is just the glasses or contact lens prescription. When we talk about telehealth as it associates with the VA or even as mentioned with Renown Health sending images to Stanford for retinopathy prematurity, those are simply retinal images. One of the things we did in the VA system, with patients who could not get into the clinic, was to have photos taken of the patient's retina so they could be evaluated for retinopathy. Nowhere in that process was there a prescription written. There was nothing that had to do with the refractive state.

Assemblywoman Jauregui:
How does the patient take the exam, because you have to physically have the device.

Michael Hillerby:
Some of the online exams rely on your computer monitor and an app on your iPhone. In that case, you would not have to have a unique piece of equipment.

Assemblywoman Jauregui:
Optometrists use automated examination machines in addition to other exams.

Dan Lyons:
The machine is just a beginning to an exam.

Acting Chair Frierson:
Is there anyone in support of A.B. 129?

Caren C. Jenkins, Executive Director, Nevada State Board of Optometry:
The Nevada State Board of Optometry voted yesterday to give me the authority to support this measure in their behalf. The Board is tasked with the regulation of optometrists only. I would like to address the changes proposed in NRS Chapter 636. The Board not only regulates optometrists and works to ensure the integrity of the profession, but it protects the public against potential harms with regard to the practice of optometry. One of the regulations of the Board in the *Nevada Administrative Code* (NAC) 636.190 defines 11 steps that must be included in any optometric exam. If the exam does not include all 11 processes, that needs to be disclosed to the patient in an advertisement or at the time of the exam. The public is not aware of the legislative distinction between an optometric exam and a vision test. Reading a vision chart is not optometric exam. No prescription is going to be offered after reading a vision chart. The 11 steps are critical to eye health. Ocular health is of great consequence. At the very least, the distinction should be made clear for an online access by the public to an exam that uses a computer to determine the need for a correction. There needs to be at least a box for the public to check if they understand that this is not an ocular exam, but simply a vision test.

I saw the American Academy of Ophthalmology's "Early Experience with Technology-Based Eye Care Services (TECS)" (Exhibit F). In the telemedicine portion, under design, it says, "The ophthalmology technician follows a detailed protocol that collects information about the patient's eyes." The premise is that the patient is face to face with someone who is able to look into the eye and report those findings and photographs to an ophthalmologist or another trained professional before a diagnosis is made. That is different from what is being offered on the Internet now. People are getting prescriptions, but they are not getting an eye health exam. Telemedicine is a lot closer to an eye health examination than the opportunities that are being offered to the public on the Internet today.

The document, "Early Detection Critical to Treating Glaucoma" (Exhibit G) dated December 21, 2016, reinforces that the American Academy of Ophthalmology reminds the public of the importance of eye exams and the Academy recommends that everyone have a comprehensive eye exam at age 40. We would encourage people to have an exam more frequently than every 5 or 10 years. If I could be helpful in regulating the practice or determining whether the access to automated technology is part of the practice of optometry, I would be happy to be available to the Committee.

Acting Chair Frierson:
Are there any questions from the Committee? [There were none.] Are there others in support of A.B. 129?

Spencer Quinton, Private Citizen, Henderson, Nevada:
I have been a practicing optometrist in Henderson, Nevada, for a little over 17 years. I support A.B. 129. I love technology. I use it in my life and my office. We are at the forefront of technology, and I love innovation. It is constantly changing, and it is very different than it was 10 or 15 years ago. I enjoy keeping up with the advances, especially in ways that will enhance my patients' vision or improve my ability to assess their eye health. I also love healthy competition; I believe it makes us all better. By staying on top of the latest and greatest things, we provide better care for our patients.

Those in opposition to A.B. 129 would have you think that this bill is antitechnology or anticompetitive. It will simply require anyone prescribing glasses and contact lenses in Nevada to uphold the current standard of care which is to examine the ocular health and visual status of the patient before writing a prescription. Assembly Bill 129 is a small but incredibly important clarification meant to codify what is already the standard of care. This will not change the way ophthalmologists and optometrists currently practice in Nevada. It will help protect the eye health of Nevada's residents from what Dr. James Madara, CEO of the American Medical Association, has called "digital snake oil of the early 21st century."

Nevada's optometrists and ophthalmologists are committed to our patients and we recognize the potential for telehealth and the ability to expand access and help meet the needs of people in rural areas. We also know that safeguards are necessary to protect the public and provide continuity of care with examinations in person or remotely that enhance the doctor-patient relationship rather than replace it. The online apps are not telehealth and they are not telemedicine. They give patients the false sense of security that they have had their eyes checked, because they have a prescription signed by an ophthalmologist or optometrist. Disclaimers will not help that perception.

I see patients on a regular basis who come to get new glasses or contact lenses with no other conditions or risk factors. We identify conditions or risk factors for conditions that need to be treated or monitored on a regular basis. Many of these conditions can affect their vision and cause irreparable damage. Many of those do not have symptoms until the conditions are advanced and irreversible. I have personally seen glaucoma, cataracts, diabetic and hypertensive retinopathy, macular degeneration, keratoconus, amblyopia, retinal holes/tears, brain tumors, and ocular melanomas. Many of them are in the 18- to 40-year-old age range who had no other symptoms or worries other than getting new glasses.

True advances in technology should improve patient care and enhance their vision, not require people to sacrifice good care for perceived convenience. Please consider the approval of A.B. 129 to protect Nevadans' eye health.

[Laura Holt Maloney, EyeDentity EyeCare, LLC, Las Vegas, Nevada submitted testimony in support of A.B. 129 (Exhibit H).]

Acting Chair Frierson:
Is there anyone else in support? Seeing none, I will go to opposition.

Adam Rovit, Private Citizen, Las Vegas, Nevada:
I am a practicing pediatric ophthalmologist and have been practicing in southern Nevada for the past ten years. I am also the president of the Nevada Academy of Ophthalmology and I oppose A.B. 129 in its current wording. Telemedicine in pediatric ophthalmology has been one of the greatest innovations that we have had recently, not only in reaching rural areas but also in being available to give cost-effective care to infants who normally would not be able to have access to this.

This technology, as amazing as it may sound to the members, allows a person to sit at a computer and hold a cell phone to get some approximation of the refractive error. I do not think the time is far away when you can probably turn on your cell phone and do the same thing. We need to make a distinction between eye health, eye examinations, and refractive error. This does not change the guidelines of the American Academy of Ophthalmology for when examinations need to be done for important conditions such as glaucoma, macular degeneration, cataracts, and so forth. One of the reasons I went into pediatric ophthalmology was that most of the conditions that are serious and blinding in ophthalmology occur in elderly populations. The companies that have come up with this technology have limited the age groups to which it applies and have stated in their documentation that it is not an eye exam, but a check for glasses. With these proper safeguards in effect, this technology has a place in terms of accessibility and affordability. With all the young patients and families I see, this is going to be the future. People are going to access health care in different ways, and I think there is an appropriate group here who can be serviced in a safe and effective way. That is why I think this bill is too limiting.

Acting Chair Frierson:
Are there any questions from the Committee? Seeing none, is there any other testimony in opposition?

Catherine M. O'Mara, Executive Director, Nevada State Medical Association:
We join the Nevada Ophthalmologic Association [Nevada Academy of Ophthalmology] in opposing this bill, and we support their amendment (Exhibit I).

Randi Thompson, representing Simple Contacts:
I have provided testimonies and supporting documents to the Committee (Exhibit J). Simple Contacts' platform was developed by a team of fellowship-trained surgical ophthalmologists and has strict eligibility requirements. Only patients with no history of eye disease are permitted to use the platform. In addition, patients with chronic illness such as diabetes and high blood pressure are ineligible. Strict guidelines allow only the lowest-risk patients to renew their prescriptions via telemedicine. Telemedicine in ophthalmology is vital to patient care advancements. Limitations on such innovation would be detrimental to innovation in patient care and the practice of medicine. Limited-scope telemedicine exams are safe. In fact, these exams offer some advantages over in-person exams, such as the ability to renew and review patient examinations via video which can be done in an office

once the patient has left. I think it is important for rural Nevada to have access to this emerging technology.

Acting Chair Frierson:
Is your position based on current technology or the concern about the advent of technology in the future that this might prevent? In your experience, what number of patients come forward with the hope of addressing other issues like high blood pressure or diabetes?

Peter Horkan, Director of Government Affairs, Opternative, Chicago, Illinois:
I think there is a notion that this is a rubber-stamped one-size-fits-all for refraction exams. This is an in-home test. From the distance of ten feet using your smart phone and your computer, you can take the vision test that is used with your prior prescription, medical history, and prescreening questions. That technology is reviewed by an ophthalmologist. About 33 percent of people who sign up for our platform through Opternative are disqualified before they are able to get to the testing part of the exam because of the prescreening questions. We have a 15 percent denial rate because of deviation from a prior prescription. At no point are you getting your first pair of contact lenses from this technology. The prior prescription is set from an in-person comprehensive eye exam. When the patient is denied, if he or she is in the 33 percent pool on the front end or the 15 percent pool on the back end, he or she is referred at no cost to an optometrist or ophthalmologist and recommended to have a comprehensive eye exam.

Acting Chair Frierson:
Will you provide your testimony in opposition?

Peter Horkan:
Opternative is a telehealth tool that allows ophthalmologists along with a prior prescription, prescreening questions, and prior health history and test results, to renew contact lenses or glasses prescriptions for healthy people between the ages of 18 and 50 who want to renew their contact lens prescription in a convenient and affordable way. It is not an application; we do not employ ophthalmologists, and we do not sell glasses or contact lenses. It is a tool that ophthalmologists can use to prescribe a renewal for contact lenses or glasses. It is important to note that safeguards are in place. This is something that is regulated by the U.S. Food and Drug Administration (FDA). We are registered as a Class I medical device and are currently going through filing. There is a body that regulates this. They are very active in ocular components to make sure we follow laws and regulations. We refuse to believe that this bill can be sold as pro-telehealth. It is limiting access and limiting telehealth tools that ophthalmologists use to service, especially the rural parts of Nevada.

The notion that nothing is better than something is not true. The stories we heard earlier today signify that there is a significant amount of the population that neglects their eye health. Removing access to screening and testing tools is not the way to address that, especially when it is not a one-size-fits-all rubber stamp and you have a 33 percent denial rate on the front end and a 15 percent denial rate on the back end. These people are being driven to in-person comprehensive eye exams. This is among the population who have

historically neglected their eye health. We heard about a diabetes diagnosis. Nevada is a rarity if it allows optometrists to diagnose diabetes. They can detect, but the diagnosis is done through a comprehensive blood test as are other disorders, addressed in the earlier testimonies, which are detected through a physical examination. The notion that we are trying to prevent technologies and screening, especially for rural parts of Nevada, is not acceptable nor is it the intent of this bill. That is why we oppose A.B. 129.

Acting Chair Frierson:
Are there any questions from the Committee?

Assemblywoman Neal:
How long have you been in business?

Peter Horkan:
We went through FDA compliance and clinical trials, which take a significant amount of time before you can launch. We have been live in Nevada for 18 months. When you listen to those in support of this bill, you are hearing from individuals who do not like this technology. It is removing a component of what they do. When we are seeing eye health issues, especially diseases of the eye, a lot of those things happen from stretching the use of contact lenses. We are trying to be a convenience tool for the residents of Nevada to allow them to renew contact lens prescriptions and prevent diseases. I would like the Committee to ask, where are the people who have been hurt from this technology? Where are the patients who have suffered some kind of eye health illness? They are not here. It they were, there would be a parade behind me. I would like the Committee to understand that this is a proven technology. Not only have we had clinical trials but we have appeared in person on *Good Morning America*. This works. It is a healthy alternative for the individuals who we can allow to take this test. Ophthalmologists support this.

Assemblywoman Neal:
Was the impetus of your business model to create convenience for people who were midterm in their prescription?

Peter Horkan:
In states like Nevada, where there are volume limitations on prescriptions, you get a one-year supply, but those will tear. You may go through the lenses faster than normal. In order to receive your next round of contact lenses, you stretch out the use of your last pair and subject yourself to disease and eye health issues. Our goal has been to make an accurate and affordable alternative to a comprehensive eye exam. The demographic of individuals who use this technology include lower income, rural, and parents of children who cannot take the time off of work to go to an optometrist. There is a significant cost component outside of the cost of the test. Our goal is to digitize the prescription to make sure there is a significant cost savings to all of your constituents so they can have the prescription and take it to 1-800-CONTACTS or shop locally. We need to do our best to control health care costs and that is why we are here.

Assemblywoman Neal:
I get my contacts through 1-800 CONTACTS. I ordered using a prescription, but it had been over a year and they allowed me to get a new set of contact lenses without a new prescription. I realized it was a glitch in the system. We want to avoid giving people contacts when they do not have a prescription to make sure that the patient's eyes have not changed.

Derek Brown, Vice President, Government Relations, 1-800 CONTACTS, Draper, Utah:
I have rarely heard that story. We have about 22,000 current customers in Nevada. We verify every prescription. We ask to see the prescription, and if they do not have the prescription, we call the optometrist to verify it. We have a policy that if the prescription has expired, the system will not accept your order and you will be told to go back to the optometrist. We have 100 people whose job it is to make sure that we follow the federal guidelines.

Assemblywoman Neal:
I would be happy to share my emails with you.

Derek Brown:
Our customers in Nevada are all over the state, including a lot of people in the rural areas. We work with a number of companies, but we are mostly concerned about health care and making sure eye health care is accessible, affordable, and of the highest quality. Our viewpoint is that the best way to do that is to trust the health care providers to make the decision that makes the most sense for their patients. A few years ago there were no companies in this telemedicine space. Now there are approximately 12, and in 10 years there may be 100. The best safeguard is to trust the physician and trust that the physician understands the best approach in caring for the patient. About a month ago, a very similar bill was introduced in Virginia. It was controversial—the retailers and the ophthalmologists opposed it and the optometrists were in favor of it. They worked on it to find middle ground. It makes no sense to do away with this telemedicine technology in the ocular space. We also need to be concerned about patient health and safety. The parties worked out language that took everyone's thoughts into consideration. The Governor of Virginia signed that bill today which had passed the Senate and the House unanimously. There is room for middle ground on this issue. It is an issue about which people are passionate because it has to do with health, safety, and the intersection with innovation.

Acting Chair Frierson:
Are there other states that narrow the practice of optometry as this bill proposes?

Derek Brown:
There are a number of states that have been looking at this issue. This concept is not new to Nevada. There are no patients we know of for whom the physicians have used this technology in an irresponsible way. The trend we are seeing is that states are realizing this technology can benefit people who live in their state.

Peter Horkan:
Opternative operates in 39 states. We partner with 1-800 CONTACTS and Lens.com. We do not have patient complaints against us. Currently, Indiana, Georgia, and South Carolina are states with an ocular-specific prohibition for telehealth. South Carolina is being litigated now based on constitutionality. We are working aggressively in Indiana to introduce a pilot and to repeal the ban. This is a scope battle. We support the amendment from the ophthalmologists. We can walk away with all sides understanding that you cannot generate your first pair of contact lenses from an online prescription, and there are safeguards in place that respect the medical licensure and the education of an eye physician.

Acting Chair Frierson:
I do not know that the intent of this bill is to prevent businesses like yours from existing. I think the impetus is to prevent not having an eye exam and getting a prescription. In those states that address this statutorily, you would still be able to provide the service to the physician who issues the prescription. I do not interpret this as a ban on telemedicine.

Peter Horkan:
This is a ban on telehealth companies. Ophthalmologists opt to use our technology as a test. Georgia is the rare exception where ophthalmologist April Maa, the head of ophthalmology for the Atlanta VA Medical Center, continues to operate an ocular platform of remote telehealth, even though it is banned in Georgia, because she is not handcuffed by state regulations. She is cited in the article from the American Academy of Ophthalmology (Exhibit F).

Acting Chair Frierson:
I have not heard anyone say that anyone was hurt by this as much as that people may be hurt by relying on it only. This is saying the benefits of the traditional eye examination provide a broader service that one could benefit from and that they are not going to get if they rely on this alone.

Peter Horkan:
We refuse to believe that nothing is better than something. Removing access to a screening process like this or a test is going to allow for a decrease in eye health issues. The eye health issues we heard before were found in an environment that had an absence of telehealth. I do not think it is in the best interests of the citizens of Nevada to limit access for this.

Jeanette Belz, representing Nevada Academy of Ophthalmology:
I met with some ophthalmologists and optometrists. Their concern was that this technology is not an eye exam. I thought, if you are clear that it is not an eye exam, and you say it is an eye test, that through disclosure, people are not misled that it is something it is not. Based on that, I developed the language in the amendment (Exhibit I). It would be a deceptive trade practice to advertise that the service you are providing is an eye exam unless it is an in person assessment. The Executive Director of the Nevada State Board of Optometry said there is a definition for what should be included in an eye examination which is in NAC 636.190. I would encourage all of us to get together to talk about what that should include. If those

requirements are not met, then it is not an eye exam and it should be called an eye test and advertised as such. The nature of our amendment was to focus on not eliminating the technology, but being clear about what the technology is and that there is space for the technology. We do not have issues with the statutes mirroring each other in terms of the ophthalmic prescription, and we have left it in the bill language. We recommend the language in section 2, subsection 1, discussed by Mr. Hillerby, be excluded from all sections of the bill.

Acting Chair Frierson:
Are there any questions from the Committee?

Assemblyman Kramer:
I do not see in this amendment where it prohibits doing this exam if someone has never had an eye exam before. It seems there are two standards for an eye exam.

Jeanette Belz:
There are regulations about what has to be included in an eye exam. Based on that, there is no way that these people provide an eye exam because there are things that you cannot do through a computer screen or a cell phone. We are not attempting to define what an exam is. We are saying that if you do not meet the requirements, that you cannot claim to be an eye exam, much less a comprehensive eye exam, and therefore are really a vision test. A lot of health care is self-directed.

Acting Chair Frierson:
Is there other testimony in opposition?

Cary Samourkachian, President and CEO, Lens.com, Inc., Las Vegas, Nevada:
I am the founder of Lens.com (Exhibit K). My company was founded in Nevada in 1998 with a sincere belief that contact lens prescriptions should be accessible and affordable to everyone. Lens.com was founded in Las Vegas, where we are still headquartered. We have grown to be the second-largest online seller of contact lenses in the nation. Next year, we intend to create up to 100 additional jobs for call center employees in Las Vegas. I hope that shows how much we support Nevada. I want to ask you to show how much you support the Nevadans who wear contact lenses.

The tools that Opternative and others provide will further enhance vision and not curtail vision health. There is a clear distinction between an eye test and an eye exam. What these tools are providing is a mechanism where two people are not face to face. In Nevada we have a lot of rural areas where customers with vision needs cannot travel to an eye doctor. It is like that nationwide as well.

A transparent test process and flat pricing to educate and empower customers is important. This is about beginning the prescription and very little about health. It is about money, not about health. This bill is limiting so the patient has to go to the eye doctor, wastes travel time, misses work, and spends gas money to get an eye exam. In most cases the prescriptions

do not really change. We have over 2 million customers nationwide. Most of the time people are begging to get a contact lens because they are out of them. Each time they go to the eye doctor, they pay $127 on average.

Let us not be fooled as to what this is really about. This is about prohibiting competition and opening rural areas to what major cities have. I would not want my fellow Nevadans to suffer financially and overpay for something they could get easily. Technology is changing. Preventing this today in its infancy is really dampening and limiting. I oppose this bill.

[Cori Cooper, CEO Family Eyecare Associates, Sparks, Nevada submitted a letter in opposition of A.B. 129 (Exhibit L).]

Acting Chair Frierson:
Is there anyone to testify from a neutral position? Seeing none, I will close the hearing on A.B. 129 and open the hearing on Assembly Bill 105.

Assembly Bill 105: Revises continuing education requirements relating to suicide prevention and awareness for certain providers of health care. (BDR 54-32)

Assemblyman Tyrone Thompson, Assembly District No. 17:
This bill revises continuing education requirements relating to suicide prevention and awareness for certain providers of health care. There are alarming rates of suicide in our state. We are losing our active and retired military, members of our lesbian, gay, bisexual, transgender, questioning (LGBTQ) community, children due to bullying and harassment, our seniors, and most important, our mentally challenged.

The crux of this bill will require medical professionals to take continuing education classes about suicide prevention in an effort to close the gaps and continue to save lives. We will have a presentation by Suicide Prevention Coordinator Misty Vaughan Allen. In 2003, due to the alarming rates of suicide, the Legislature created the position of Suicide Prevention Coordinator, and Ms. Vaughan Allen has been in that role since 2005. She will give an overview of suicide statistics and key areas we are looking to address in this bill.

Misty Vaughan Allen, Coordinator of the Statewide Program for Suicide Prevention, Bureau of Child, Family and Community Wellness, Division of Public and Behavioral Health, Department of Health and Human Services:
I was thrilled to hear the testimony of the last bill because they gave an example of why this bill is so important. When the optometrists and ophthalmologists recognized other life-threatening conditions because of their awareness of symptoms, that is exactly the same for mental health crisis and suicide. We need the opportunity to share the tools with physicians because they are seeing those at risk for suicide in different venues other than mental health.

Last week, I presented to a roomful of health care providers. The night before my presentation, Beacon Health Options came out with a white paper, "We Need to Talk About Suicide." I want to share this information. Over the past ten years, deaths from people having heart attacks have decreased by 38 percent. They discussed in this white paper the reason for that is because they came to a "door-to-balloon" technique. People in crisis of heart attacks were getting a team of people ready to respond at the emergency department. They decided what would work and got the stent in immediately. In the past, tests would be run and there would be hours and hours of waiting to determine what was needed. In that time frame the heart muscle was dying. We are seeing this with people going to the hospital for thoughts of suicide and suicide attempts. They can often languish in their suffering for up to 72 hours without talking to anyone. We are missing opportunities for their spirit and will to die. We have tools and systems that work so we can prevent that suffering.

There is extensive research and others will give you more data. It has been shown that almost 50 percent of those who have thoughts of suicide have reached out to their health care provider within the month of their death (Exhibit M). Some research shows 20 percent of the suicide victims saw the provider the day they took their lives. This shows that people know they need help and they want help, but it is not being recognized. When they go home, all hope has been lost. They were hoping someone would give them the help they needed. There are missed opportunities.

The Zero Suicide Initiative is a national initiative being used in multiple health care settings. It is the aspiration that they can have a zero suicide event. Many systems are showing this to be effective. It is a system wide operation. Training, education, and awareness are a big part of that. This is a philosophy that is very different. When I was presenting to health care providers, I was able to hear their stories of working in this field. One person said, "Every time I come to work, I see suicidal transfer." There is an attitude that a mental health crisis is not the same. Health care providers get into the profession because they want to save lives, and these people are thinking of ending their lives. Suicide is not about wanting to die, it is about pain, loss, and being overwhelmed. People seeking help do not see their options for help. We know this, but others have a different attitude. The health care provider said, "We just cannot wait for them to get out of our facility." Placements in mental health care facilities are very limited, so they wait in the hospital for 72 hours. Another health care provider said he or she ran around and worked to get this person help and he had no will to live. There is a punitive attitude that brings up anger for these providers. I understand it because these are scary and difficult situations. I said that the patients' will to live is there because they are still alive in your facility. The patients' will to live was there when they called the hotline because they picked up the phone to ask for help.

What we need to do is find out what is putting their will to live at risk. We have to ask questions about why they are thinking about suicide. We have to hear their reasons for dying. The health care provider said they did not want help. The patients cannot see their options for help until we hear their reasons for dying. They are not ready to take the help

until all of that pain is released. Their hope is in there; we have to help them find it. Anyone can do that work. That is why awareness education, assessments, and management of suicidality can make such a difference.

We lose about an airliner full of people every day to suicide in the United States. In Nevada, we have the eleventh-highest rate in the nation. This is the first time in history that we have been out of the top ten. We are the only state in the nation over the past ten years that has not seen an increase. Something is working, and I believe it is because we have a powerful partnership and comprehensive strategies with schools, law enforcement, mental health, parents, and youth. Health care is a big piece of that comprehensive strategy that we have not tapped into effectively yet. That is why this bill is so important.

For Nevadans ages 15 to 34, suicide is the second-leading cause of death. For ages 10 to 14, it is the third-leading cause of death. For the first time nationwide, ages 10 to14 lose more people to suicide than car crashes. This is an alarming crisis across the life span. We know that if we work with health care providers and improve tools in health care systems, we are going to decrease rates across the life span.

On page 8 (Exhibit M), the graph shows how we are improving. The nation's suicide rate has been going up over the past 15 to 20 years and Nevada's rate has not. That is where the birth of a zero suicide initiative originated.

The Nevada Youth Risk Behavior Survey on page 9 (Exhibit M) from 2015 indicates that 85,000 students in Nevada feel hopeless at any time. Almost one in five, or 44,000 students, has had thoughts of suicide. Of the students surveyed, the equivalent of 40,000 have made a suicide plan and 24,000 attempted suicide. Of those attempts, about 780 students needed care from a health care provider. Those percentages are estimates, but they are self-reports from high school students in Nevada. Middle school rates are actually higher. We want everyone, wherever our people at risk for suicide turn, to recognize those risks. Anyone can do this.

Nevada has had the highest suicide rates for older adults in the nation over multiple years. In 2015, we had the fourth-highest rate for adults over 65 years old, but the red line in the chart on page 10 (Exhibit M) has been true for decades. We know that due to stigma and other barriers to care, older adults, veterans, and military personnel are not turning to behavioral health care for help. We need primary care, hospitals, and physicians to be able to recognize signs, because that is where people are getting served.

I often hear that if we recognize this, we have nowhere to turn, especially in the rural communities. It is true. Access to mental health care is limited. There are resources growing, but a lot of intervention can be done in human-to-human conversation. A lot of crisis and suicidality can be de-escalated by knowing the tools and how to talk about a difficult topic. Training is a big part of this bill. Assembly Bill 93 of the 78th Session elevated the conversation around suicide prevention to a new level. People did not want to talk about it, including mental health providers who are supposed to treat it. It is scary

to everyone. When we learn that it is not about dying but about needing help, and it is the biggest scream for help we need, it changes the conversation and attitudes about giving and offering help.

We have worked over the past two years to grow trainings. On page 12 (Exhibit M) is an array of what the Nevada Coalition for Suicide Prevention and the Office for Suicide Prevention, Division of Public and Behavioral Health, Department of Health and Human Services offer. There are anywhere from one-hour to two full-day classes about suicide first aid. We are only looking at two hours to be required, so we have several options. We also know that capacity to meet training needs can be a challenge. We have several online options for people. If we get down to the wire, we want to make sure they are connected. We do not want practitioners to be in jeopardy of not being able to practice. The intent is to improve recognition, assessment, and management of suicidality. We worked with Truckee Meadows Community College for A.B. 93 of the 78th Session. They have a two-hour online course. It is a gatekeeper training that would be pertinent to all health care providers. We also promised to partner with them to add modules. If there is a specific module that might help with nursing or some other provider sector, it is our commitment to develop and grow those options.

Acting Chair Frierson:
Are there any questions from the Committee? [There were none.]

Assemblyman Thompson:
Even though a lot of the statistics are alarming, by no means are we trying to discredit our professionals who are saving our lives every day. We want to make sure that the proper tools are in place so we can continue to save lives.

I will walk through Assembly Bill 105. In section 1, subsection 2, paragraph (c), the language changes from "at least 2 hours of instruction" to "at least 3 hours of instruction," and delineates "assessment, treatment and management." I will talk about conceptual amendments as well as considerations. We have a lot of concerns about how to make this work and make it good for everyone. We will most likely revert the number of hours back to "at least 2 hours." We were saying 3 hours because safeTALK is one of the training modules that seems to be significant and evidence-based that we felt would be good for professionals. In section 1, subsection 5, it talks about the 3 hours of instruction. In subsection 6, it says, "A holder of a license to practice medicine may not substitute the continuing education credits" for required ethics training. We will continue to discuss this.

In section 2, subsection 5, it uses the language, "The Board shall encourage . . .," and this has been the conversation since the end of last session. There has been a lot of interim conversation and it is important that it say "require" instead of "encourage." Another important part in the same subsection is to change the language "clinically-based" to "evidence-based." "Evidence-based" includes "clinically-based," but it has a few more factions in it. Pretty much the rest of it changes the "2 hours" to "3 hours."

We want to change the requirements to say at least 2 hours of continuing education, so the provider can do the safeTALK training should he or she choose to do so. One of the organizations asked if I would consider instead of saying "evidence-based," to say "promising practice." I still want to talk that through. We do not want to lose the sight of "evidence-based." We know that it is solid. "Promising practice" is in the queue, but it is not quite there.

Due to an oversight, we will be adding *Nevada Revised Statutes* (NRS) Chapter 633 to add the osteopathic physicians. In section 4, there were concerns from the social workers who want to align it with their reporting.

Assemblywoman Teresa Benitez-Thompson, Assembly District No. 27:
Last session, I introduced Assembly Bill 93 of the 78th Session. It established the initial criteria to embed within NRS a requirement for medical education units or continuing education units across behavioral health professions. My initial legislation focused on the behavioral health professions. We put that in place, and we have had the two continuing education unit (CEU) credits for the cycles which are required by the boards. Assemblyman Thompson will work with me to be sure the corrective language that I am bringing to address the unintended consequences of A.B. 93 of the 78th Session dovetails with his efforts. Specifically, when you look at the bill, section 3 is psychologists, section 4 is marriage and family therapists, section 5 is the social workers, and section 6 is the alcohol, drug, and gaming counselors. Those were the behavioral health professions that I targeted last session. We had a hiccup in the way one of the boards interpreted the collection cycle versus the licensing cycle and I will be working to correct that. Of course, the intent as Misty Vaughan Allen stated is never to provide an opportunity to lose licensure over a missing CEU requirement. We want to make sure that we have everything lined up. I am excited to be working with Assemblyman Thompson to have our two pieces dovetail.

Acting Chair Frierson:
Are there any questions from the Committee? Seeing none, I will invite those wanting to testify in support.

Dan Musgrove, Private Citizen, Las Vegas, Nevada:
I have the honor of serving as the chair of the Clark County Children's Mental Health Consortium. The consortiums were created by the Legislature in 2001. Former Assemblywoman Barbara Buckley, when she was working on the bifurcation of child welfare, put three consortiums together—rural, Washoe County, and Clark—to be the stewards of behavioral health issues for children. Statutorily, our consortium has members from Division of Child and Family Services, Department of Health and Human Services, Juvenile Justice Services of Clark County, the school districts, providers, a business community representative, and, most important, parents. Every meeting we have, we focus on issues of suicide with children. One of our four priorities for the legislative session is working with the providers and the schools to make sure we have the tools to intervene with children and their behavioral health needs. As you saw in the statistics in Misty Vaughan Allen's presentation, I want to emphasize how scary they are. The graph she showed on

page 9 of her presentation (Exhibit M) indicated that 44,000 kids seriously considered attempting suicide, 39,000 actually made a plan, and 24,000 made an attempt. That is why it so important that bills like this pass. We are completely in support.

Kevin Burns, Coordinator, Veterans Resource Center, Western Nevada College:
I am the Chairman of the United Veterans Legislative Council (UVLC). By way of background, the UVLC is an umbrella group over all the nationally recognized veterans service organizations in Nevada, including the American Legion, Veterans of Foreign Wars, Disabled American Veterans, Vietnam Veterans, and Order of the Purple Heart. We are elected by these groups to have one unified voice to represent all 300,000 veterans in Nevada.

In the interims of the Legislature, we conduct two symposia for the veteran community along with the Department of Veterans Services. The purpose is to get all of the veterans in the state together to find out what the priorities are for the upcoming legislative session. We hold one in southern Nevada in Las Vegas and one in northern Nevada in Reno. The number one priority from both symposia last year was to do something to stem the epidemic that is veteran suicide within the country and the state.

The U.S. Department of Veterans Affairs (VA) has put forth a new statistic stating that every day 20 veterans kill themselves in this country. Some believe the number is higher based on how coroners sometimes record deaths in order not to cause any more pain to families. The number we are working with is 22 a day, and that is over 8,000 a year. In the state of Nevada, that equates to a veteran killing himself or herself every 2.75 days. According to VA estimates, 6 of the 20 daily suicide victims were users of VA health care services. That means 70 percent were using the public health care system. Recently, the Centers for Disease Control and Prevention, the federal agency tasked with looking at those numbers, did a 15-year study. Over that period, suicide rates increased 24 percent, so it qualifies as an epidemic in this country.

Assembly Bill 105 is an attempt to stem that tide. The veterans community is so grateful to Assemblyman Thompson for pursuing this legislation for the second session. We are grateful for Assemblywoman Benitez-Thompson for allowing us to support her last session for the work she did.

I am sure many in the medical community will push back against this as they did last session. I probably would if I were in their shoes, when you look at the number of continuing education units that are required for their licensure and renewal. I am sure some within the medical community feel they are being targeted for the suicide epidemic. In actuality, nothing could be farther from the truth, because suicide is a societal problem. As Assemblyman Thompson stated, they are the opposite of this. They are uniquely placed to be able to assist in this effort, and that is why there is a push for these additional continuing education units. The push is to make it a requirement, not an encouragement.

I provided the Committee with a study (Exhibit N). The study is called "Health Care Contacts in the Year Before Suicide Death." Dr. Brian K. Ahmedani and others from Michigan State University and the Henry Ford Health System performed the study. It is one of those studies with a whole bunch of doctorates and a list of references and end notes a mile long. He is also the principal investigator for the National Institute of Mental Health, U.S. National Institutes of Health research network. This study deals with suicides for those who are involved with health maintenance organizations. The bottom line of this study is that 50 percent of people who killed themselves saw primary care providers within the month that they did so. Perhaps even more alarming is that 75 percent of those who died had not previously had a mental health diagnosis.

I run the Veterans Resource Center at Western Nevada College in Carson City. I have 175 veterans for whom I am responsible to guide through the academic process. I am also an Applied Suicide Intervention Skills Training (ASIST) trainer for the State of Nevada and I work under Misty Vaughan Allen. I do the two-day intervention training on how to do first aid and how to get people involved with health care. Last year I did six interventions with my 175 veterans. I was amazed to learn how many continuing education credits are required for a lot of the licensure in the medical community. I was amazed to see terrorism training, nuclear, biological, and chemical warfare training. Those of us in the military and veteran community understand and applaud those efforts, but we are the ones who went into those ugly parts of the world to stop this from happening. We get a lot of thanks for that, but there are three veterans a week who are going to die in this state. If you really want to thank us, please do something tangible and help us.

Justeen Beal, Private Citizen, Reno, Nevada:
I am part of the UVLC. My husband, Josh, committed suicide on June 6, 2015. He was a 28-year-old active-duty Marine for eight years. He served three combat tours, two in Afghanistan and one in Iraq. He got out of the Marine Corps in June of 2013. To say we struggled is an understatement. We struggled mostly with physical pain, and he was seeing a counselor every three months for post-traumatic stress disorder. He took his medications on a daily basis, but several months before he died, he attempted suicide by overdosing on all of the medication that he had received from the VA. I thought he was having a stroke, so I rushed him to the emergency room at the VA hospital. When he got there, he vomited hundreds of pills. He was watched closely by nurses. The doctor did not see him more than three times while we were there. Upon his release, the doctor came in and looked at my husband and me. He told me my husband was a smart man and that he did not try to commit suicide. He told us to keep his regular counseling appointments. The doctor had a huge opportunity to encourage him to seek more or better help. The doctor did not do that.

I cannot tell you what it is like to be a 26-year-old widow. His future was gone, but my future was as well. The ripple effect of suicide does not stop at me. I had over 500 people in attendance at his funeral. Passing this bill would not only save lives of veterans, but would help save the lives of their dependents as well.

Acting Chair Frierson:
Thank you for telling your story. It is what we need to hear in considering policy that will help people.

Mike Dyer, Director, Nevada Catholic Conference:
We are the organization through which the Catholic bishops in Nevada speak on matters of statewide interest. We strongly support this legislation.

Richard Carreon, Private Citizen, Las Vegas, Nevada:
I am a retired Army staff sergeant with 14 years of military service, and I am the president of the Nevada Veterans Association. We do not talk about the difference in suicide statistics between active-duty military and veterans. About one active-duty service member commits suicide a day. One hundred percent of the military caretakers including civilians are trained in suicide prevention. The template they use is the ASIST template, and it has been widely successful. Within the first 72 hours of the training, there is an intervention by the person who received the training. I am ASIST-trained. At first, I did not realize how important the training was. That changed when I left active duty four years ago and I received a telephone call from a journalist here in Las Vegas who was going through some issues. She had gone to a medical professional, talked to her mother and her friends. They were not able to get her help. Had we not had a conversation about suicide prevention, she would not have reached out to me prior to be admitted to the hospital after slicing her wrists. It was a difficult situation, and if I had not had the training, I probably would not have been able to do the intervention and get the proper medical attention. The value of safeTALK is two-pronged. It increases the awareness of suicide prevention and it reduces the stigma and creates a venue where people can understand how to talk to people and get them the right medical attention. On the active military and veteran sides, the suicide rate should be zero. I strongly support A.B. 105. Since the last session, 11 of my own soldiers have died from suicide. One of them lived in southern Nevada. I appreciate the due diligence of Assemblyman Thompson in presenting this bill.

Matthew De Falco, Private Citizen, Las Vegas, Nevada:
I am one of hundreds of thousands of military veterans who have served from here in southern Nevada. I left the University of Nevada, Las Vegas (UNLV) for the United States Army in 2008 during the height of the surge in Iraq. I ended up serving as a Patriot missile operator. I spent ten months deployed overseas working security in support of Operation Enduring Freedom in Afghanistan. Veterans like me served to protect all Americans and to promote human rights for all. We do not serve for either political party. Veterans issues should be nonpartisan. What happened in the last legislative session was a disgrace. This bill will save lives and it did not even get a vote. In America, we lose 22 veterans every day to suicide. Tragically, here in Nevada some studies show that veterans kill themselves at nearly a 75 percent higher rate than the rest of the nation. Veterans tend to not seek out mental or behavioral health care, but they do receive health care in different capacities that are more comfortable. We need to make sure that health care providers are trained to recognize if someone is at risk for suicide. I am not asking you to put your life on the line 10,000 miles away in some far away combat zone in a war you may or may not agree with.

We will do that for you. We will shoulder that burden—that heavy burden that every generation of Americans before us have so bravely taken on. To be able to look into the eyes of our sons and daughters and the next generations of American and tell them that we did everything in our power to make sure the next generation of Americans will have even more opportunities than we did to be happy, successful, and safe. I am not asking you to do that. I am asking you to simply do your job. Our unit never lost a soldier when we were overseas. But since we have been home, we have lost more soldiers and veterans to suicide than I can count. It breaks my heart. This legislation will save lives. If you do not vote in favor of this bill, let your conscience never be clear.

Michael Kelly, representing Nevada Democratic Veterans & Military Families Caucus-United Veterans Legal Counsel:
This morning I was speaking with a friend of mine who is a 28-year Army officer. Approximately two and a half weeks ago, while his wife was attending a doctor's appointment off base for an injury she received when she was on active duty, her doctor started observing some of her responses. The doctor realized there was a problem and she was in crisis. She was admitted to the hospital for a suicidal ideation. The doctor, who was a former military physician, had the training to inform them about suicide prevention. I am in full support of A.B. 105. Military life is difficult, and there are unintended consequences that affect the military family members. It does not change. There are the stresses of family, there is isolation, loneliness, house-maintaining issues, and behavioral issues with children. All these issues exist all of the time. They cause stresses. When my friend went home after he learned that his wife was being admitted and why she was being admitted to the hospital, he went home and opened her nightstand drawer. He found his wife's will, her insurance paperwork, and a note telling him that she loved him and that his life would be better without her. He is devastated and feels a great sense of guilt. It is the same during war or peace—the stresses are the same. Right now there is a ship in Asia that was supposed to go on a four-month deployment. These people were expecting to be home by Thanksgiving. Now they have been out for eight months with no idea of when they will be home because of operational commitments. Imagine if you came to Carson City on February 6 and you were told on June 5 that you could not come home and you were going to be sequestered in Carson City indefinitely without having the ability to see your family or being able to go home. That is what those sailors are experiencing now in Singapore. It is a stressor that will impact military families every day. The training that this bill requires will save lives. If it were not for that doctor observing my friend's wife and knowing what to look for, I would be going to a funeral. I urge you to support this bill.

Heather Dalton, Private Citizen, Las Vegas, Nevada:
I am a proud six-year U.S. Navy veteran and a single mother of five. Currently, I am an undergraduate student at UNLV and the president of our Student Veteran Association chapter for Rebel Women Veterans serving 317 women veterans at UNLV.

As a member of the Rebel Women Vets, our mission is to connect veterans on campus with resources, support, and advocacy while in school and beyond. After four veteran suicides at UNLV from 2013 to 2014, the military and veterans service center with support from the

Nevada Suicide Prevention Office hosts SafeTALK training on campus each semester. Myself and other student veterans underwent a four-hour safeTALK suicide alertness training workshop on campus. We were given the tools to recognize a person at risk for suicide, and know how to connect them with a person trained in suicide first aid intervention, or the resources to help keep that individual safe.

Last month, I lost a friend and fellow female shipmate to suicide. Unfortunately, it happens a lot. For me, it was my first. Her sudden death snuck up on me and it hit me hard. I questioned everything, every line of every post, the size of every smile in every photograph. It was too late, and I felt helpless. I did not give up. I opened my heart and shared my plea for everyone to reach out to a friend they might feel is in danger. With my access through our Rebel Women Veterans organization, my post was shared 28 times and reached almost 5,000 people. Nine days later, like an flashing alarm going off in front of my face, another friend and fellow veteran was hurting. He started using words on social media like "after tonight ... it won't matter." I immediately went into action! I tried desperately to get him on the phone. When that did not work, I contacted the police in his state and informed them that he was in trouble. That did not work either. When I finally got him on the phone, he told me that he was thinking about suicide. I talked to him for a while and convinced him to trust me by bringing in another person to our phone call. I had already informed my very knowledgeable veteran advisor on campus that I had a friend in serious trouble, and I needed his assistance. We ended up talking to him that night for several hours. We reminded him that his life has meaning and that the people around him needed him, especially his young daughter. He is still alive, taking it day by day. And I check on him all the time. He is not my only intervention story, and he probably will not be my last.

I am not a health care provider. But I am a veteran and I care very deeply about the lives of my fellow brothers and sisters from every branch and in every state. Life is but a series of minutes, and the few precious minutes we spend on this kind of training could mean a lifetime of minutes to someone thinking about suicide. I ask you to please think about your brothers and sisters in life. Suicide affects everyone! Without my continued training and experience, I feel like I would not have been as prepared to help my fellow veteran in need.

Crystal Cochran, Private Citizen, Las Vegas, Nevada:
My husband, Staff Sergeant Justin Cochran, took his life on Christmas Eve 2015. He had been to the doctor on Wednesday and nobody noticed and took these things into consideration. He killed himself three days later. I am in support of this bill because health care providers need to be held accountable. It is too late for my husband, but it is not too late for others.

André C. Wade, Director of Operations, The Gay and Lesbian Community Center of Southern Nevada:
The Gay and Lesbian Community Center of Southern Nevada, known as "The Center," is a community-based organization that supports and promotes activities directed at furthering the well-being, positive image, and human rights of the LGBTQ community, its allies, and

low- to moderate-income residents in southern Nevada (Exhibit O). Our program serves many clients who experience suicidal ideations and have attempted suicide, and unfortunately some who have committed suicide even as recently as two months ago.

Many people at risk for suicide do not seek help. Health care providers who have increased knowledge in warning signs, know how to have difficult conversations and where to access additional resources, can prove to be a viable early-intervention mechanism in the prevention of suicide. The need for health care providers to have these skills cannot be overstated and is a critical part of protecting the health and safety of individuals who are at risk. According to the American Foundation for Suicide Prevention, suicide is the eighth leading cause of death in Nevada and the tenth leading cause in the United States. Additionally, the Movement Advancement Project reports that U.S. surveys suggest that lesbian, gay, and bisexual persons have two to six times higher rates of reported suicide attempts compared with comparable heterosexual people. In health care, there is a long history of anti-LGBTQ bias, which leads many in this community not to access health care. The lack of education and cultural competence of health care providers is a leading cause for this discrimination. This, coupled with less training on detecting behaviors that may lead to suicide, only compounds the issue for LGBTQ patients.

With such high needs, The Center supports the increase to three hours of training on suicide prevention and awareness for certain providers of health care. Therefore, The Center supports A.B. 105.

Acting Chair Frierson:
Are there any questions from the Committee?

Assemblyman Kramer:
I am a veteran and have friends who are getting old and having thoughts about their value in life to other people. Is there a version of this training available to non-medical people?

Assemblyman Thompson:
The training program safeTALK is universal. Misty Vaughan Allen will be able to give us information about all the trainings.

Acting Chair Frierson:
No one has signed in to testify in opposition. Is there anyone to testify from a neutral position?

Catherine M. O'Mara, Executive Director, Nevada State Medical Association:
We are neutral on this bill, but we appreciate Assemblyman Thompson's compassion and accessibility on policy matters. This is an important issue in Nevada. Assemblyman Kramer hit the nail on the head by asking how the average person can access this information. This should be a communitywide comprehensive approach to suicide in our state. If we can raise the level of discourse for the public, that would be great. We are here on the technical matter of mandating continuing medical education (CME) as tied to licensure. The current bill

requires three units, which may go down to two tied to a licensure of every two years. We have asked the bill sponsor to look at that. We have physician practitioners who never see patients. They are the doctor's doctors, like radiologists, who all have requirements of CMEs that they need to take. There are many important issues that they need to keep up on in their continuing education. That is not to say that this is not important. It is assuredly important, but we need to make sure we have communications so the physicians are receiving the education that is going to most help them be good physicians for their patients.

Acting Chair Frierson:
As being in neutral, I am assuming that means you have suggestions, but would be fine regardless.

Catherine O'Mara:
Yes, we are here and we want to be partners. We gave Assemblyman Thompson suggestions of things we thought would improve the bill. We are here in neutral because we are committed to helping to work through this.

Andrew Pasternak, Private Citizen, Reno, Nevada:
I am a family practice physician in Reno, Nevada, and I am the current president of the Washoe County Medical Society. As a primary care physician, I see patients with mental illness. Approximately 20 to 30 percent of my patients have depression, anxiety, and bipolar disorder. In primary care, when we see those statistics of how often people come in, those are things our primary care doctors already know.

As a primary care physician, in medical school we do rotations in psychiatry. In residency, we do required rotations in psychiatry and we are tested on psychiatric issues. We have to be board-certified and one of the board certification modules that we can choose is depression. We have 50 hours of CMEs that we have to do every year. Most primary care physicians, because we see mental health as such a big issue, are getting this addressed. We believe that treating depression, anxiety, and bipolar disorder is very important, but most of our primary care physicians are already getting this without a mandate from the state.

I would like to see something bigger with this. Physicians and health care providers getting CMEs is probably part of the equation, but I would like to see more state funding to help with these issues. We are hearing a lot from veterans, and I think putting together some programs to help the veterans who are at a high risk would help. We are happy to be part of the solution, but I think we need a bigger solution and a more comprehensive approach.

Acting Chair Frierson:
As neutral, you are fine if the bill moves as is?

Andrew Pasternak:
That is correct.

Jessica Ferrato, representing Nevada Nurses Association:
The Nevada Nurses Association worked with Assemblywoman Benitez-Thompson and Assemblyman Thompson last session and took their work very seriously. Our association has received a grant from the Statewide Program for Suicide Prevention. They have been helpful to our organization in terms of educating our nurses on this topic. The grant allows us to provide a trainer/trainee program. We have 25 nurses throughout the state who are becoming trainers and receiving training through the Statewide Program for Suicide Prevention. They then go out into their communities. We have nurses in northern Nevada, southern Nevada, and throughout the rural areas. In order to keep their certification, they have to provide three trainings in their first year to nurses in their areas and two trainings a year after that. The trainers and trainees receive CEU credits for the trainings.

Chelsea Capurro, representing Nevada Advanced Practice Nurses Association:
We have taken this very seriously and are having a CEU event on March 4, 2017, when we are having someone from the VA presenting on suicide prevention to our advanced practice nurses.

[Heather Shoop, Chairperson, Nevada Coalition for Suicide Prevention, submitted a letter of neutral support for A.B. 105 (Exhibit P).]

[Keith Lee, representing the Board of Medical Examiners, submitted a breakdown of continuing medical education requirements (Exhibit Q).]

Acting Chair Frierson:
Is there anyone else to testify? Seeing none, I will hear public comment. [There was none.] The meeting is adjourned [at 2:54 p.m.].

RESPECTFULLY SUBMITTED:

_____
Earlene Miller
Committee Secretary

APPROVED BY:

_____
Assemblyman Jason Frierson Acting Chair

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a summary written and submitted by Assemblywoman Jill Tolles, Assembly District No. 25, regarding Assembly Bill 129.

Exhibit D is a proposed amendment to Assembly Bill 129 presented by Assemblywoman Jill Tolles, Assembly District No. 25.

Exhibit E is a letter dated February 22, 2017, in opposition to Assembly Bill 129 to Chair Bustamante Adams, written by Cynthia Bradford, M.D., on behalf of the American Academy of Ophthalmology.

Exhibit F is a document titled "Early Experience with Technology-Based Eye Care Services (TECS)," submitted by Jeanette Belz, representing Nevada Academy of Ophthalmology.

Exhibit G is a copy of an article titled "Early Detection Critical to Treating Glaucoma," submitted by Jeanette Belz, dated December 21, 2016, representing Nevada Academy of Ophthalmology.

Exhibit H is written testimony submitted by Laura Holt Maloney, EyeDentity EyeCare, LLC, Las Vegas, Nevada in support of Assembly Bill 129.

Exhibit I is a proposed amendment to Assembly Bill 129 submitted by Jeanette Belz, representing the Nevada Academy of Ophthalmology.

Exhibit J is a collection of material submitted by Randi Thompson, representing Simple Contacts and 1-800 CONTACTS, in support of Assembly Bill 129 consisting of the following:

1. Written testimony authored by Derek Brown, representing 1-800 CONTACTS, dated February 17, 2017; written testimony authored by Kathleen Maloney, optometrist at Warby Parker, New York; and written testimony authored by Saya Nagori, ophthalmologist, New York University, to the Connecticut General Assembly Public Health Committee regarding H.B.6012.
2. A letter dated February 13, 2017, authored by Derek Brown, Vice President Legislative Affairs and Strategy, 1-800 CONTACTS, to the Washington State Senate Ways and Means Committee regarding SB 5411.
3. A letter dated May 16, 2016, authored by South Carolina Governor Nikki R. Haley to the President of the South Carolina State Senate regarding her veto of R.178, S.1016.
4. A copy of an article, dated March 30, 2016, from USA Today titled “Newt Gingrich: Don’t let lobbyists raise health costs.”

Exhibit K is a letter authored and submitted by Cary Samourkachian, CEO, Lens.com, Inc., Las Vegas, Nevada in opposition to Assembly Bill 129.

Exhibit L is a letter authored and submitted by Cori Cooper, Founder and CEO, Family Eyecare Associates in opposition to Assembly Bill 129.

Exhibit M is a copy of a PowerPoint presentation titled "Office of Suicide Prevention," presented by Misty Vaughan Allen, Coordinator of the Statewide Program for Suicide Prevention, Bureau of Child, Family and Community Wellness, Division of Public and Behavioral Health, Department of Health and Human Services.

Exhibit N is a copy of an article titled, "Health Care Contacts in the Year Before Suicide Death," submitted by Kevin Burns, Coordinator, Veterans Resource Center, Western Nevada College, in support of Assembly Bill 105.

Exhibit O is a letter dated February 24, 2017, in support of Assembly Bill 105 to the Assembly Committee on Commerce and Labor, authored and presented by André C. Wade, Director of Operations, The Gay and Lesbian Community Center of Southern Nevada.

Exhibit P is a letter dated February 22, 2017 regarding Assembly Bill 105 to Chair Bustamante Adams, written and submitted by Heather Shoop, Chairperson, Nevada Coalition for Suicide Prevention.

Exhibit Q is a document detailing continuing medical education for doctors, submitted by Keith L. Lee, representing the Board of Medical Examiners.