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

Seventy-Ninth Session
May 19, 2017

The Committee on Health and Human Services was called to order by Chairman Michael C. Sprinkle at 2:40 p.m. on Friday, May 19, 2017, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4406 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 Michael C. Sprinkle, Chairman
Assemblywoman Amber Joiner, Vice Chair
Assemblywoman Teresa Benitez-Thompson
Assemblyman Richard Carrillo
Assemblyman Chris Edwards
Assemblyman John Hambrick
Assemblyman William McCurdy II
Assemblywoman Brittney Miller
Assemblyman James Oscarson
Assemblyman Tyrone Thompson
Assemblywoman Robin L. Titus
Assemblyman Steve Yeager

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Senator Joyce Woodhouse, Senate District No. 5

STAFF MEMBERS PRESENT:

Marsheilah Lyons, Committee Policy Analyst
Mike Morton, Committee Counsel
Kailey Taylor, Committee Secretary
Trinity Thom, Committee Assistant

OTHERS PRESENT:

Tom McCoy, Nevada Government Relations Director, American Cancer Society Cancer Action Network
Veneta Lepera, Market Director, Palliative Care Services, Dignity Health-St. Rose Dominican
Kim Anderson, Vice President, Business Development, Infinity Hospice Care and Nevada Palliative Care
Barry Gold, Director, Government Relations, AARP Nevada
Mendy Elliot, representing Nevada Osteopathic Medical Association
Michael Dyer, Director, Nevada Catholic Conference

Chairman Sprinkle:
[Roll was called. Committee rules and protocol were explained.] There may be a slight delay after work session. We will open up the work session.

Marsheilah Lyons, Committee Policy Analyst:
We will begin the work session with Senate Bill 151 (1st Reprint).

Senate Bill 151 (1st Reprint): Authorizes the establishment of a public health laboratory in certain counties. (BDR 40-752)

Marsheilah Lyons, Committee Policy Analyst:
This bill authorizes the district board of health in a county whose population is 700,000 or more (currently Clark County) to establish, equip, and maintain a public health laboratory. If a district public health lab is established, it may: (1) analyze the purity of food and drugs; (2) investigate cases and suspected cases of human exposure to certain dangerous agents; (3) investigate cases and suspected cases of infectious diseases and debilitating conditions; and (4) undertake other laboratory duties in the interest of public health. There are no amendments in the work session document (Exhibit C).

Chairman Sprinkle:
Are there any questions or comments?

Assemblywoman Benitez-Thompson:
I have some comments for the record. In doing this traditional model with the branches in place, the state health lab's ability to serve and be able to carry out its purpose would not be affected. Specifically, I wanted to make sure and have assurances that the Newborn Screening Program will remain intact. There is actually statutory language that talks about who does the Newborn Screening Program. I was worried that perhaps the language that discusses undertaking other laboratory's duties in the interest of public health would include the Newborn Screening Program, but I got assurances it would not. The second was that there would not be an impact on where State General Fund dollars flow. There would be no disruption there. Third, I want the interim health committee to see that the reason why

49 other states have a central state lab system with branches throughout the state is that they are mostly funded by competitive grants. Now, we will have two entities competing for what is a very limited selective pool of grants. I just wanted to keep an eye on that during the interim to ensure that the state health lab remains intact and that we do not have any anticipated budget holes, should grant funding get too competitive, so that we are able to still meet the needs of all Nevadans.

Chairman Sprinkle:
I would like to thank you for all of the hard work you have put into this in the last few days. I will also state for the record that we as a body are here to take care of our state. We are a state legislative body, so I will be watching that very closely to make sure that the state health lab is not negatively impacted fiscally. Are there any other questions or comments?

Assemblyman Thompson:
Section 1.4 talks about setting reasonable fees. Are we talking about fees to vendors or are those fees to constituents and clients?

Mike Morton, Committee Counsel:
Based on the language, the district board of health would have the regulatory authority to set either, depending on what sort of tests they are doing and who is requesting them.

Assemblyman Thompson:
I will vote this out of Committee. I have been in discussion with the bill sponsor because I want to get some clarification on that. I do not want to see that there are even more fees that can go to my constituent base if they cannot afford it, but they need the help and health lab. I will vote it out, but I still have some concerns before voting for it on the floor.

Assemblywoman Titus:
I share some of Assemblywoman Benitez-Thompson's concern regarding the competitive grant process and if this would take away from some of our state monies. I appreciate your concern about that. I appreciate your following through on it during the interim. I will vote this out of Committee, but may change my vote on the floor.

Chairman Sprinkle:
Are there any other questions or comments? Seeing none, I will take a motion for do pass.

> ASSEMBLYWOMAN BENITEZ-THOMPSON MOVED TO DO PASS SENATE BILL 151 (1ST REPRINT).
>
> ASSEMBLYMAN EDWARDS SECONDED THE MOTION.
>
> THE MOTION PASSED UNANIMOUSLY.

Chairman Sprinkle:
I will take the floor statement.

Marsheilah Lyons, Committee Policy Analyst:
We will move on to Senate Bill 291 (1st Reprint).

Senate Bill 291 (1st Reprint): Revises provisions relating to health care records. (BDR 54-350)

Marsheilah Lyons, Committee Policy Analyst:
Senate Bill 291 (1st Reprint) requires a custodian of health records to: (1) retain the health care records of patients for at least five years; (2) make available to investigators certain health care records of a patient who is suspected of having operated a motor vehicle while intoxicated; (3) maintain a record of information provided by a patient relating to health insurance coverage; and (4) provide to the Department of Corrections the health care records of an offender at the State prison. A custodian of health care records is defined as any person having primary custody of records or a facility that maintains the health care records of patients.

The measure requires a custodian of health care records to make the relevant records available for inspection, including any records that reflect the amount charged for medical services or care provided to a patient. A health care records custodian who is not licensed and violates the requirements in this bill is guilty of a gross misdemeanor, and a civil penalty of not more than $10,000 may be collected for each violation. Any action to recover a civil penalty must be brought by the district attorney of the county in which the action is brought.

Finally, the bill authorizes the Board of Medical Examiners to take possession of health care records of a licensee's patients in the event of the licensee's death, disability, incarceration, or other incapacitation that renders the licensee unable to continue his or her practice. The Board may provide a patient's records to the patient or the patient's subsequent provider of health care. A licensee must provide certain disclosures to patients concerning such records.

An amendment was proposed at the hearing by the Nevada Association of Counties. In addition, a subsequent amendment was provided to address concerns regarding the civil penalty imposed for certain violations. Both are attached to the work session document (Exhibit D).

Chairman Sprinkle:
Are there any questions or comments?

Assemblywoman Benitez-Thompson:
I just want to thank the folks who worked with me to address concerns that the fees might be too heavy-handed. It is meant to be a stick, not to completely shut down a business. I also

had concerns about an unfunded mandate by requiring the county district attorneys to bring the cases instead of allowing folks to use their normal resources at hand to follow through with this. I thank them for accepting the amendments.

Chairman Sprinkle:
Are there any other questions or comments? Seeing none, I will accept a motion for amend and do pass.

> ASSEMBLYWOMAN BENITEZ-THOMPSON MOVED TO AMEND AND DO PASS SENATE BILL 291 (1ST REPRINT).
>
> ASSEMBLYMAN McCURDY SECONDED THE MOTION.
>
> THE MOTION PASSED UNANIMOUSLY.

Chairman Sprinkle:
Assemblyman McCurdy will take the floor statement.

Marsheilah Lyons, Committee Policy Analyst:
We will move on to Senate Bill 388.

Senate Bill 388: Revises provisions relating to persons who provide personal care in the home. (BDR 40-613)

Marsheilah Lyons, Committee Policy Analyst:
Senate Bill 388 requires an employment agency that contracts with persons who provide nonmedical personal care services in the home to elderly individuals and individuals with disabilities to obtain a license from the State Board of Health. The bill also: (1) specifies the nonmedical services such agencies may perform; (2) requires the Board to adopt regulations governing licensure of such employment agencies; (3) requires an employment agency to conduct certain background checks on persons with whom it contracts; and (4) imposes civil penalties on such an agency for failing to conduct required background checks.

There were no amendments for this measure (Exhibit E).

Chairman Sprinkle:
Are there any questions or comments? Seeing none, I will take a motion for do pass.

> ASSEMBLYMAN THOMPSON MADE A MOTION TO DO PASS SENATE BILL 388.
>
> ASSEMBLYMAN YEAGER SECONDED THE MOTION.
>
> THE MOTION PASSED UNANIMOUSLY.

Chairman Sprinkle:
Assemblyman Thompson will take the floor statement.

[(Exhibit F) and (Exhibit G) were submitted but not discussed.]

Marsheilah Lyons, Committee Policy Analyst:
Next in the work session is Senate Bill 481 (1st Reprint).

Senate Bill 481 (1st Reprint): Creates the Nevada Commission for Persons Who Are Deaf, Hard of Hearing or Speech Impaired. (BDR 38-604)

Marsheilah Lyons, Committee Policy Analyst:
Senate Bill 481 (1st Reprint) makes various changes to the Subcommittee on Communication Services for Persons Who Are Deaf or Hard of Hearing and Persons with Speech Disabilities. Specifically, the bill:

- Changes the Subcommittee's name to the Nevada Commission for Persons Who Are Deaf, Hard of Hearing or Speech Impaired;

- Requires the Governor to appoint the director of the Commission and provides the director serves without compensation;

- Revises membership requirements and the duties of the Commission; and

- Requires the Legislative Committee on Health Care to study during the 2017–2018 Interim, grants and other sources of money that may be available to transform the director position into a full-time, paid position. The Committee must report its findings to the Department of Health and Human Services, the Governor, and the director of the Legislative Counsel Bureau.

A conceptual amendment was received subsequent to the hearing that is included in the work session document for consideration (Exhibit H). It is uploaded on the Nevada Electronic Legislative Information System (NELIS). It is titled Amendment Submitted by Assemblyman Sprinkle for S.B. 481 (R1). That is to include an appropriation of $25,000 per fiscal year for per diem travel and administrative costs for the Nevada Commission for Persons Who are Deaf, Hard of Hearing, or Speech Impaired.

Chairman Sprinkle:
Are there any questions or comments?

Assemblywoman Miller:
Is the $25,000 a reduction from what was originally requested, or is that an increase? The fiscal notes were much higher, and it seems like such a low amount.

Assemblywoman Benitez-Thompson:
The fiscal note was attached to the original bill on the Senate side. The amendment removed the bill. While we heard testimony about the fiscal note as it was presented to the Assembly Committee, there was not a fiscal note attached. The amendment had removed it. In additional follow-up conversations with Senator Spearman, a champion of the bill, the talk was that perhaps it makes sense to advocate for resources for the Commission that are traditional of other commissions, which is to include travel costs and per diem. This is actually adding a fiscal note on for consideration of those dollars, but those are dollars that typically accompany commissions.

Assemblywoman Miller:
So this is pretty standard?

Assemblywoman Benitez-Thompson:
It is a ballpark number. The thought of adding dollars to support the Commission was a more recent one. The Fiscal Division will do an actual assessment, but it was a ballpark of the number of commission members, and what it would take to support that structure. My understanding is that other commissions have more and some have less. We will work on a finite number.

Assemblywoman Miller:
I am not at all arguing. I want to make sure that we are servicing people with amounts so that their programming can be robust and that we can service the community.

Assemblyman Oscarson:
I think some kudos go out to Senator Spearman, Assemblywoman Benitez-Thompson, and Mr. Olsen. He has been trying to do this for several years. He is a huge advocate for this community and a huge advocate for this process. I am very happy to support this.

Chairman Sprinkle:
Are there any other questions? Seeing none, I will take a motion for amend and do pass.

> ASSEMBLYMAN OSCARSON MOVED TO AMEND AND DO PASS SENATE BILL 481 (1ST REPRINT).
>
> ASSEMBLYWOMAN MILLER SECONDED THE MOTION.
>
> THE MOTION PASSED UNANIMOUSLY.

Chairman Sprinkle:
Assemblyman Oscarson will take the floor statement.

Marsheilah Lyons, Committee Policy Analyst:
The final measure in the work session is Senate Bill 509 (2nd Reprint).

Senate Bill 509 (2nd Reprint): Authorizes the imposition of an assessment on the operators of certain agencies and facilities. (BDR 38-980)

Marsheilah Lyons, Committee Policy Analyst:
Senate Bill 509 (2nd Reprint) authorizes the Division of Health Care Financing and Policy of the Department of Health and Human Services—after polling the operators of agencies to provide personal care services in the home and the operators of certain medical facilities in an operator group and receiving an affirmative vote from at least 67 percent of the group—to impose by regulation an assessment on those operators. The revenue generated must be expended to increase payments to Medicaid providers, unless new federal laws or regulations are enacted or adopted prohibiting the use of such revenue for these purposes.

The bill requires the Division to adopt regulations establishing administrative penalties for failure to pay an assessment. If an operator fails to pay a penalty or assessment within 30 days of the date on which it is due, the Division may deduct the unpaid amount from future payments owed to the operator by Medicaid. Before doing so, the Division must notify the operator of the intended deduction and may negotiate a payment plan. There are no amendments to this measure (Exhibit I).

Chairman Sprinkle:
Are there any questions or comments?

Assemblywoman Titus:
I will vote yes to get this out of Committee, but I am not quite convinced I can get behind it on the floor.

Assemblyman Oscarson:
Thank you for your work on this bill. I, too, have had many questions. I met with the agency. They have assured me that there are a lot of things in process on this and there will be opportunities to participate or not. For that, I am grateful, and I will be supporting this.

Chairman Sprinkle:
Are there any other questions? I am seeing none. I will take a motion for do pass.

> ASSEMBLYMAN EDWARDS MOVED TO DO PASS SENATE BILL 509 (2ND REPRINT).
>
> ASSEMBLYMAN McCURDY SECONDED THE MOTION.
>
> THE MOTION PASSED UNANIMOUSLY.

Chairman Sprinkle:
Assemblyman Edwards will take the floor statement. The work session is complete. We will close the work session. I will open the hearing on Senate Bill 136 (1st Reprint).

Senate Bill 136 (1st Reprint): Makes various changes concerning health care. (BDR 18-143)

Senator Joyce Woodhouse, Senate District No. 5:
I am here to introduce Senate Bill 136 (1st Reprint). There is a very thorough definition of "palliative care" in section 4 of this bill. It is specialized medical care for people facing serious and chronic illness that is focused on providing patients relief from the symptoms, the pain, and the stress, regardless of the diagnosis.

Section 7 of the bill creates the Advisory Council on Palliative Care and Quality of Life within the Department of Health and Human Services and prescribes the qualification and duties of members on the Council. The Director of the Department is authorized to appoint the members in any number deemed appropriate as long as at least nine members are appointed. The Council shall meet at least twice annually and each member serves without compensation.

Section 13 sets forth the initial terms of the members. Section 9 authorizes the Council to apply for any available grants and accept any available gifts, grants, appropriations, or donations to carry out the palliative care and quality of life consumer and professional information and education program that is established by section 10 of this bill. Section 10 further requires the Department to maintain an Internet website with links to appropriate external Internet websites offering information concerning: (a) The delivery of palliative care in a home and in primary, secondary, and tertiary environments; (b) Best practices for the delivery of palliative care; and (c) Educational materials and referral information for palliative and hospice care.

Section 12 provides that on or before January 1, 2018, the Department should encourage all hospitals, assisted living facilities, and facilities for skilled nursing within the state, with 100 beds or more, to educate their physicians, nurses, and staff members regarding palliative care and provide information to patients or residents regarding palliative care.

When this measure was in the Senate, there was a fiscal note placed upon it; however, I am pleased to inform you that fiscal note has been removed after Dignity Health-St. Rose Dominican offered to have a member of their staff from palliative care services, Ms. Veneta Lepera, provide the leadership and training needed for the Advisory Council on Palliative Care and Quality of Life to carry out its responsibilities.

At this point, I would like to turn the presentation over to Mr. Tom McCoy of the American Cancer Society Cancer Action Network and Ms. Veneta Lepera of Dignity Health-St. Rose Dominican and one other person. I believe very strongly that the benefits of this legislation will bring immeasurable relief to patients and their families. Thank you very much.

[(Exhibit J) was submitted regarding the removal of the fiscal note.]

Tom McCoy, Nevada Government Relations Director, American Cancer Society Cancer Action Network:
The American Cancer Society Cancer Action Network provides advocacy support for the mission of the American Cancer Society. As we have heard from Senator Woodhouse, the goal of the legislation is simple—to improve the quality of life for any Nevadan of any age dealing with any chronic illness, such as cancer, and their families and caregivers. Even though the American Cancer Society Cancer Action Network championed this bill, it is broader than just cancer. It is for any serious illness. Speaking of cancer, advances in cancer research continue to provide patients with new and more effective treatments, but therapies do not meet all of the needs. If the focus is solely on the disease, then other issues are not addressed; issues like emotional distress and physical symptoms such as pain, fatigue, and nausea. Treating the person and not just the disease is the benchmark of palliative care. While such care is in the best interest of the patient, barriers remain to the widespread adoption of such care, and that is one of the reasons for this legislation.

On a personal note, today is my granddaughter Katelyn's sixth birthday, and she is blessed with good health. However, cancer is the leading cause of death by disease for kids ages 5 to 14 years. It is within that age group that I want to make a couple of comments. Treatment toxicities still cause a majority of our kids that are experiencing cancer to experience distressing side effects and late effects that continue into adulthood and often into a lifetime. Pediatric palliative care improves quality of life for children and families, but we lack that resource in Nevada. We need that pairing of pediatric palliative care with delivery of anticancer therapies in our state.

From a cost standpoint, studies have shown that palliative care, when applied quickly within two days of someone being admitted to the hospital, reduced costs from between 22 to 32 percent in New York. When palliative care was available to Medicaid patients, an average savings to the state was $6,900 per patient. In summary, the Nevada Advisory Council on Palliative Care and Quality of Life will improve quality of life for our state's chronically ill and save health care costs for the patient and the payer.

[(Exhibit K) was submitted as additional testimony.]

Veneta Lepera, Market Director, Palliative Care Services, Dignity Health-St. Rose Dominican:
Palliative care, a clinical specialty, is an approach to people with serious illness. It focuses on their quality of life, seeing the person beyond the disease, representing a paradigm shift in health care delivery. According to a recent report published by the Institute of Medicine, if palliative care teams were fully integrated into the nation's hospitals, total savings could exceed $6 billion per year. Palliative care programs help acute care hospitals and health care systems within the community achieve the ultimate win-win health care scenario—patient/family-centered high quality, well-coordinated medical care at a lower cost. Palliative care is a multispecialty discipline. It takes a team to deliver this type of

personalized quality care. Further education and training on palliative care with a focus on individualized quality of life goals is critical for physicians, nurses, nursing assistants, and other supportive fields such as social workers, chaplains, and volunteers.

To illustrate what palliative care can provide for a patient and family, I would like to share with you John's story. John, at 74 years old, had been diagnosed with Stage III prostate cancer, which had spread to his liver, lower back, and pelvis. He was a retired university professor of history and he loved teaching and spreading knowledge. He served in the Navy where he met his wife, Tina, in the Philippines. They married in 1980 and often went home to the Philippines to their small plot of land, and the house they built with their own hands, by the beach and rice fields in Barbaza.

John did not wish to have any further cancer treatments when I met him. He spent two years fighting cancer, and he had enough. He was weak, he was in pain, and he was waiting to die. We discussed prognosis, but we focused on his wishes, his quality of life goals, and what would provide him happiness and peace. John's goal was to go home to the rice fields of Barbaza, stick his feet in the China Sea, and be with his family when the end of his life arrived.

The physician and I had little issue managing his pain and reducing the medication as we helped him build his strength, from bed-bound, to walking a few feet, to sitting in a wheelchair for a 14-hour stretch. The reason for this is that he needed to tolerate the flight to Manila that was 12 hours. This goal took 6 weeks to achieve. John got stronger each day. He was going to be able to make the flight. Another week of physical therapy and weaning the medications, increasing his respiratory capacity and eating, along with a great deal of talking, communicating, caring, problem solving, and hope. It took all of us on the team working together to make this goal a reality. The day arrived. At 5 a.m., medications taken, and supplies gathered, John and Tina were going home. They boarded the plane in Las Vegas and landed in Manila without incident. When he arrived at his home on the beach, his family cooked for him, and they often took him out in the China Sea by boat to fish. I received a letter about eight months after they were home, thanking me and the team for making his dream a reality. He spoke of the peace and the joy he was experiencing, and how truly alive he felt, even though he knew he was dying. In July 2012, Tina forwarded me the final letter John wrote before he passed in October of that year—28 months after we met. These are John's own words:

> Veneta and team, here I am in the Philippines at 77 years of age, and I am still alive. We have our house here on the rice fields. It is a simple life. I am better, but I cannot walk on my own any longer. I have a television in an air-conditioned room with a big window and I can even see the sea and beach from my bed. I went with much help yesterday and put my feet in the China Sea for the last time. Everything is very green and the rainy season is here now. Do not worry about me. I have lived a good life. I am home. Thank each of you for all you did for me. I will send this to you to share with everyone. Love to you all, John.

John's journey illustrates what skilled, patient-centered, goal-directed palliative care can achieve. Education for clinicians directed at understanding his shift to quality-of-life, goal-directed care for individuals with a life-limiting illness is the right thing to do. Nevada clinicians deserve access to quality education and training in palliative care. The citizens of Nevada would benefit from an accurate understanding of palliative care services. Thank you very much for your time.

[(Exhibit L) was submitted as additional testimony.]

Kim Anderson, Vice President, Business Development, Infinity Hospice Care and Nevada Palliative Care:
Infinity Hospice Care is the largest hospice provider for Nevada. We serviced over eight counties with 1,700 patients in 2016. I am here today speaking on behalf of S.B. 136 (R1) and in support. Over 36 years ago, Infinity Hospice Care started providing palliative care under Nevada Palliative Care. We used specially trained doctors, nurses, social workers, and others who work together with the patient and doctors to provide that extra layer of support. This is for patients of any age, at any stage of the prognosis, and any diagnosis. Patients typically are receiving a curative treatment at the time we are seeing them.

I want to share a brief patient testimonial. On August 20, 2014, a 43-year-old woman was transported to a 220-bed hospital here in Las Vegas. A diabetic of 38 years, she presented with uncontrollable vomiting and was determined to be in diabetic ketoacidosis; her blood sugars were off and her chemistry was at a fatal level. Unable to sustain her own breathing, she was placed on a mechanical ventilator, central line, and was placed under the care of the intensive care unit team. Upon being downgraded in the hospital, she went into cardiac arrest and had to be resuscitated. Once stabilized, it was determined her gallbladder needed to be removed.

No hospital staff mentioned palliative care to her, her husband, 15-year-old daughter, or parents and friends who all had been sitting vigil. She simply went home. Less than 90 days later, she presented to the same emergency room with identical symptoms, plus more to include memory loss and extreme headaches. A full work-up was done again, including neurology, oncology, cardiology, and ear, nose, and throat. Upon the resolution of diabetic ketoacidosis, follow-up appointments were discussed and the patient was discharged with no mention of palliative care, even though at this point it was very clear that she had two or more chronic diseases and a clear functional decline.

Only 20 short days later, she presented back to the same emergency room with the original symptoms—vomiting, diabetic ketoacidosis, headaches, memory loss, pain, and confusion. After seven days in the intensive care unit, and many more tests, she was discharged. Again, there was no mention of palliative care. On Father's Day, she was hospitalized yet again. She presented with the same symptoms and had most of the same tests performed. It was clear that her overall health was declining. Her chronic diabetes somehow had turned into a life-limiting illness. She now had neurological issues, decreased kidney function, and an autoimmune disorder. No one in the hospital ever addressed the stress this placed on her and her family and what it was doing to their quality of life. Palliative care was never mentioned.

The person that I am talking about is me. After I was hospitalized for the fourth time in team member. I not only speak today as a professional, but also as a patient who has seen the results of what palliative care can do at the age of 43. Just one of the things the team did for me was to create a solid plan. For once, everyone sat down and we looked at the whole picture of what was going on and how to proceed so that I was not going to end up in the hospital or the emergency room again. I am happy to tell you I have not been back. We also have a social worker that updated my advanced care directives. That was a big deal for me. I wanted to make sure it was clear that I did not want to go back on a ventilator again. My daughter needed some spiritual counseling. She was afraid that every time I left the house I was going to end up in the hospital and never come back.

I am so blessed because I had the option and the knowledge of palliative care and what it was capable of doing, but I sadly wonder how often many patients in that 220-bed hospital could have, should have, and needed the expertise of palliative care, but it was never mentioned. You have to remember that most patients in our states have never heard of palliative care. Again, I had the access, the knowledge, and the ability to receive it. For that, I am so grateful because my quality of life is better.

I am here speaking with you. Again, I am proud to be in this profession, but even more proud to know there is a solution for so many Nevadans. We deserve to have that access. I am here supporting S.B. 136 (R1) and the conversations and education that begin with it, personally and professionally.

Chairman Sprinkle:
Are there any other comments, Senator Woodhouse?

Senator Woodhouse:
That concludes our presentation.

Chairman Sprinkle:
Are there any questions from the Committee?

Assemblywoman Titus:
I have a statement. I just want to thank you for bringing this bill forward. There are so many questions on what palliative care means amongst providers and citizens. It is kind of a gray zone, and I deal with it most days in patients I see in nursing homes. They are not ready for hospice, but they need some other care besides acute; you get well, or no you are not going to get well. It is in-between care. Thank you for bringing this forward. These are critical needs to Nevadans.

Assemblywoman Miller:
I come from a family where we had to become caregivers—and thankfully, my mother is a registered nurse—for Alzheimer's disease. That is a debilitating disease in a physically healthy body that goes on for years. I have a heart for caregivers. I noticed it says we are going to encourage this for hospitals and skilled nursing with 100 beds or more. But, I am also thinking about the rural communities where we need to make sure we are providing more medical care. Is there a reason why that is not in the bill?

Senator Woodhouse:
At this point in time, this is our first step. I believe we took language that the American Cancer Society Cancer Action Network had and crafted this piece of legislation. If we are successful, then next session we can proceed to make those other kinds of changes that need to be in place in order to address the issues for all of Nevada. I certainly do not want to leave out rural Nevada, small communities, or large communities. I, for one, had a similar experience of a loved one. I did not need palliative care and I did not even know about it, but we had family members just like you, who were able to take care of things. In these days, with so many people working, we need the extra support system. That is one of the things this bill will provide. By having the Council, and having someone like Veneta help with training, we can get on the website to get information out to caregivers and providers so they know how to address these issues with their patients.

Chairman Sprinkle:
Are there any other questions? I am not seeing any. Thank you for your presentations. We will take testimony in support. Since it has been a long day, I will ask everyone to keep your testimony short and to the point.

Barry Gold, Director, Government Relations, AARP Nevada:
I have submitted written testimony (Exhibit M). This is all about access to quality care and improving the quality of life for Nevada families. AARP, on behalf of our thousands of members across the state, strongly supports this bill and urges you to pass it.

Mendy Elliot, representing Nevada Osteopathic Medical Association:
We, too, would like to thank Senator Woodhouse for bringing this bill forward. The Nevada Osteopathic Medical Association was very supportive of this bill when they reviewed it. It was unanimously supported. We appreciate the comments, especially the ones from Assemblywoman Titus. We are in strong support.

Michael Dyer, Director, Nevada Catholic Conference:
The Catholic Church strongly supports this bill. It is highly compatible with all Catholic teachings, and it is something well worth having, as an aside. When we first started looking at this two years ago, I did some online research to find out more about states and palliative care. Remarkably, Nevada shows as being one of the top states for palliative care, which was very surprising. I think this bill goes a long way to carrying that into reality.

Chairman Sprinkle:
Is there anyone else here in support? [There was no one.] Is there anyone in opposition? [There was no one.] Is there anyone neutral to the bill? [There was no one.] Do you have any closing comments, Senator?

Senator Woodhouse:
I do not have any.

Chairman Sprinkle:
With that, we will close the hearing on Senate Bill 136 (1st Reprint). Is there any public comment? [There was none.] It is deadline day, so we will be standing in recess [at 3:22p.m.]. We will be sure to let you know by email what is going on.

[An email was sent at 4:51 p.m. to notify the Committee of adjournment.]

RESPECTFULLY SUBMITTED:

Kailey Taylor
Committee Secretary

APPROVED BY:

Assemblyman Michael C. Sprinkle, Chairman

DATE: ______________________________

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is the Work Session Document for Senate Bill 151 (1st Reprint), presented by Marsheilah Lyons, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit D is the Work Session Document for Senate Bill 291 (1st Reprint), presented by Marsheilah Lyons, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit E is the Work Session Document for Senate Bill 388, presented by Marsheilah Lyons, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit F is an excerpt from Section 3503 of the *Medicaid Services Manual*, submitted by Connie McMullen, representing Personal Care Association of Nevada, in relation to Senate Bill 388.

Exhibit G is a copy of a document titled "Agency to Provide Personal Care Services in the Home," tabulating interpretive guidelines under *Nevada Revised Statutes* 449.0021, submitted by Connie McMullen, representing Personal Care Association of Nevada, regarding Senate Bill 388.

Exhibit H is the Work Session Document for Senate Bill 481 (1st Reprint), presented by Marsheilah Lyons, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit I is the Work Session Document for Senate Bill 509 (2nd Reprint), presented by Marsheilah Lyons, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit J is a letter from Jill Berntson, Deputy Administrator, Aging and Disability Services Division, Department of Health and Human Services, dated May 19, 2017, to Assemblyman Michael C. Sprinkle, withdrawing the removal of the fiscal note for Senate Bill 136 (1st Reprint).

Exhibit K is written testimony in support of Senate Bill 136 (1st Reprint), presented by Tom McCoy, Nevada Government Relations Director, American Cancer Society Cancer Action Network.

Exhibit L is written testimony in support of Senate Bill 136 (1st Reprint), presented by Veneta Lepera, Market Director, Palliative Care Services, Dignity Health-St. Rose Dominican.

Exhibit M is written testimony in support of Senate Bill 136 (1st Reprint), submitted by Barry Gold, Director, Government Relations, AARP Nevada.