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

Seventy-Ninth Session
February 24, 2017

The Committee on Health and Human Services was called to order by Chairman Michael C. Sprinkle at 12:30 p.m. on Friday, February 24, 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 William McCurdy II
Assemblywoman Brittney Miller
Assemblyman James Oscarson
Assemblyman Tyrone Thompson
Assemblywoman Robin L. Titus
Assemblyman Steve Yeager

COMMITTEE MEMBERS ABSENT:

Assemblyman John Hambrick (excused)

GUEST LEGISLATORS PRESENT:

Senator Joseph (Joe) P. Hardy, Senate District No. 12

STAFF MEMBERS PRESENT:

Megan Comlossy, Committee Policy Analyst
Mike Morton, Committee Counsel
Terry Horgan, Committee Secretary
Trinity Thom, Committee Assistant

OTHERS PRESENT:

Nicole Rourke, Associate Superintendent, Clark County School District
Heidi Parker, Executive Director, Immunize Nevada
Erik Jimenez, representing Southern Nevada Health District
Joy Davis, Private Citizen, Reno, Nevada
Sara Yelowitz, Private Citizen, Reno, Nevada
Michael Hackett, representing Nevada Public Health Association and Nevada Primary Care Association
Jessica Ferrato, representing Nevada Association of School Boards
Mary Pierczynski, representing Nevada Association of School Superintendents and Nevada Association of School Administrators
Tom McCoy, Chair, Advisory Council on the State Program for Wellness and the Prevention of Chronic Disease; Nevada Government Relations Director, American Cancer Society Cancer Action Network; Member, Subcommittee on Patient-Centered Medical Homes
Daniel Spogen, M.D., Chair, Family and Community Medicine, University of Nevada, Reno, School of Medicine
Nancy Hook, Executive Director, Nevada Primary Care Association; Member, Subcommittee on Patient-Centered Medical Homes

Chairman Sprinkle:
[Roll was taken. Committee rules and protocol were reiterated.] Does anyone wish to make public comment? [There was no response.] We will open the hearing on Assembly Bill 200.

Assembly Bill 200: Requires notice of exemptions from certain immunization requirements to be provided to parents or guardians of children under certain circumstances. (BDR 38-726)

Senator Joseph (Joe) P. Hardy, Senate District No. 12:
Assemblywoman Woodbury and I are sponsoring this bill. The Dean of Touro University Nevada's College of Osteopathic Medicine asked me if we had anything to protect the immunosuppressed or immunoincompetent children in preschools or other schools in Nevada. I told him we might be able to do something, but that there were things the school districts were doing. If a child is on chemotherapy for instance, there is what we call reverse isolation—the person who is not sick wears a mask. Sometimes when we go into a hospital we wear a mask, wash our hands, and do those kinds of things to prevent giving a patient some illness. When the immunocompromised are out in public, they try to protect themselves. One way we protect each other is through immunizations. If a child is immunized, for instance against chicken pox, that child is unlikely to give chicken pox to someone else. If someone does not have a healthy immune system or if their immune system is not capable of producing antibodies, then they need to be protected. That is the genesis of the bill.

This morning I talked with Assemblywoman Titus. After reading the bill, she had a very valid concern. Because of the exemptions in state law for religious or medical reasons, she does not want anyone to know who has not been immunized. I think that is a very rational and reasonable objection, so I would advise you to amend the bill. There are so many interactions child to child and parent to parent, and I do not want people to know what someone else might be doing from a medical standpoint. The Clark County School District has a friendly amendment that will address this problem, and you will hear from them shortly.

The bill would have a parent be able to call and speak to the school district, a given school, or a preschool, and ask whether anyone at that school is not fully immunized according to the law. The school would be able to say, "Yes, there is." No names, no amounts, no rates, and no particular identifying information or classes would be given out. The parent could then make a decision about whether the child, who might not be capable or competent to mount an antibody response, should attend that school.

The bill talks about when a child is initially admitted to a school or child care facility. With the challenge we have with turnover, particularly in Clark County, that is going to be somewhat problematic—the politically correct word for impossible. It would be the same when a student enrolls in a school. For instance, if a school went from everyone being immunized to a new student arriving who was not immunized, everyone would know the school had shifted into a situation where someone was exempt, which means everyone would know who that child was. Those are the problems with the bill as it is written, so I appreciated the school district proposing an amendment, which I consider to be friendly.

Chairman Sprinkle:
I checked with our legal counsel. Section 1, subsection 2, handled that situation, but I understand what you are saying now. Even though no names are mentioned, it would be obvious if someone new enrolled in the school. Are there any questions from the Committee?

Assemblywoman Miller:
I am trying to grasp the necessity of a bill like this. I assume the necessity is public protection; but, if we are in a classroom and every person in the room but one has been immunized against a certain disease, the people in the room would be protected, even if one person had not been protected. That one person who did not get the vaccine would be at more risk than the rest of the room, right? What would we do with the information that a child in the room had not been vaccinated? What do the other students who had received the vaccination do? Do they get an additional vaccination? What happens with that information?

Senator Hardy:
Usually with a contagious disease, there is an incubation period. For instance, a person who has never had chicken pox and never been immunized benefits from the rest of us who have had chicken pox or who have been immunized. That is called herd immunity. It is unlikely

that person is going to get chicken pox, because no one else in that room is going to get it. However, that person who has not been vaccinated will go somewhere else and may be exposed to someone before knowing that person is carrying the virus. The incubation period goes on, and the person gets chicken pox not realizing he or she was carrying the virus. You can actually pass the virus before you know you have the disease.

Assemblywoman Miller:
Is the bill to protect the one child who has not had the vaccination? If we are protecting the child who did not have the vaccination, what would the need be for the notification to the other children who have had the vaccination?

Senator Hardy:
This bill is not so much to protect the person who is normal. This bill is to protect the person who might have had chemotherapy and whose immune system has been cut down. It would also protect the person who has had an immune deficiency from birth who is not able to mount an immune response. This bill is not targeting the person who, for either religious or medical reasons, does not ever want to get the vaccine. If that child cannot mount an immune response, in 10 or 14 days when the virus is gone for you or me, it could be fatal to them.

Assemblywoman Miller:
For clarity, we are not suggesting mass communication throughout the school that would say that there is a child here who has not had a vaccination. We are targeting those few individuals who would be the most vulnerable. They are at much more risk because they do not have the immunity other children have. Would we just be notifying the parents of that child?

Senator Hardy:
If you call the Clark County School District, you can ask what percentage of students are vaccinated, and they will probably tell you. You are going to see how they are proposing to notify interested parties. Notices could be emailed, put on a website, be person-to-person, by phone call, or other means of communication. That notice would allow you the parent, who is concerned about your child for whatever reason, to know what the immune status is of that particular school. This would not be by class or individual, but by school.

Assemblywoman Titus:
My concern is for the unintended consequences of a bill such as this. I live in a small, rural community that has maybe 8 to 12 kids in a class. When someone new comes in who, for whatever reason, cannot have these vaccines or who, for religious reasons, did not get the vaccines, would a call go out to all who attend that school that someone has not been immunized? When only one new kid comes into a school, how are you protecting that information? Everyone would know that kid, for whatever reason, had not been vaccinated. I am concerned about the privacy issue. It is not intended to be that way, but how do you solve those kinds of concerns?

Chairman Sprinkle:
The Clark County School District's amendment (Exhibit C) is being uploaded right now. Maybe we could have a representative from the school district come up and explain the amendment. That might help clarify it.

Senator Hardy:
I recognize that it is impossible because no matter how big the school is, when one new kid comes in, everyone knows. I do not see an easy way around this problem. The Committee can decide if it wants to process this in such a way that we can protect the individual, the community, and the confidentiality.

Nicole Rourke, Associate Superintendent, Clark County School District:
I apologize for the lateness of the amendment, but we just worked out some specifics with the bill's sponsor. Our amendment (Exhibit C) looks to protect the privacy of the student, whether immunized or not. For public schools, we went to section 3, subsection 2. In that last sentence, rather than leaving it "the name of a pupil who is exempt" we said, "or any other information that may lead to the identity of a pupil" who is exempt from immunization. That ensures that we are not revealing any data about it. We see it as a yes or no answer to the question of whether or not exemptions exist in the entire school.

Assemblywoman Titus:
I am not convinced a bill like this is needed. When a family goes to any school, whether it is a preschool or a high school, et cetera, they receive notification that they have the option to opt in or opt out of required vaccinations for "X" reasons. So any child who is enrolled there should know that there might be students in that school who have not been vaccinated. That would be a more commonsense approach to what you are trying to solve. I do not know that we can protect kids who go out to places such as grocery stores. If a parent has an immunocompromised child, they need to be aware of that. It is not just in schools where they are exposed to diseases, it is life. This would not solve any of those problems and perhaps make it very complicated. I am really concerned about it.

Assemblyman Carrillo:
What prompted this? Was there an incident or are there ongoing incidents that created a need for this bill? There is always cause and effect, and this bill is the effect.

Senator Hardy:
There have not been any conditions or problems in Nevada. This is a proactive approach for a child who is immunosuppressed or immunoincompetent, and who will be exposed to many people, whether in school or in public. Those people have been taught the kinds of things they need to do to prevent themselves from getting sick.

Assemblyman Carrillo:
How many states have this already in place in their laws?

Senator Hardy:
I do not know how many, but the National Conference of State Legislatures did some research. Oregon provides information to parents about immunization rates in a variety of ways—online, at the school front office, and directly to parents via paper documents and electronic documents. Assemblywoman Titus mentioned rates of immunization as opposed to individuals who are immunized. If we were to do something, it would probably be in that way. We in Nevada are doing better and better with immunizations.

Assemblyman Carrillo:
Is it just Oregon that you are aware of?

Senator Hardy:
That I know of for sure.

Assemblyman Yeager:
When we look at voting results, sometimes the precincts are so small they will not tell you the individual breakdown of how the voters voted, even if some of us in close districts are curious to know. In a situation like this, is there any sort of carve-out if an accommodation facility or child care facility only had a handful of students? If the parents talk to one another, it might be obvious who the one child or the children are who are not immunized. Is there some thought about not disclosing in those situations?

Senator Hardy:
We can phrase it in such a way that we do not tell anybody anything. We can say something like, "Everyone is," or we can say, "Not everyone is." That is about as close as you are going to get.

Chairman Sprinkle:
That is already implied when they are initially enrolled. As I understand it right now, they have to be told that. Someone who is not vaccinated could already be at that school.

Senator Hardy:
We have to be vaccinated when we go to school unless we have an exemption. If someone has an exemption, we could simply say, "This is not" a completely vaccinated school. In a schoolroom of eight pupils, we do not even want to identify the room. We would just say that the school was not completely vaccinated.

Chairman Sprinkle:
At this point, I do not understand why we would even need to do that.

Assemblywoman Miller:
The term "everyone" was just mentioned. In a school, "everyone" includes thousands of people who are not children. Where does the privacy of the teachers, the staff, and all the adults working in the school district, come into play? Is that the same? Do they need to be

warned that there are adults who have not had certain vaccinations or adults who might be carrying certain communicable diseases? Where will the reach of this go?

Senator Hardy:
You just opened Pandora's box. Yes, that is real. How do we handle all the adults? Does anyone have a requirement that the adults have to be immunized against everything?

Heidi Parker, Executive Director, Immunize Nevada:
California recently passed a law that child care personnel had to be vaccinated against certain diseases—clearly for the protection of younger children, especially babies who may not be fully vaccinated yet.

Nicole Rourke:
Not that I am aware of, but I can get back to you with that information.

Assemblywoman Miller:
I know there is not currently, but a bill like this could reach into that arena. There are a lot of laws protecting our privacy, so when would the medical records and vaccination records of adult staff be required? We know chicken pox is more of a childhood disease, but some other diseases are transferred from adult to child, or child to adult. That is a risk I see.

Senator Hardy:
Let us take pertussis, for instance. We now want to immunize grandmas and grandpas because of the little babies they take care of. You are exactly right. At what point do we start saying that adults should be immunized against pertussis? That is Pandora's box again. I do not know that any state has done that. I will ask Heidi Parker if she is aware of that.

Heidi Parker:
Not that I know of.

Assemblyman McCurdy II:
I have received many phone calls and emails about this bill. I have been thinking about the type of reach we are going to begin to dig into. Let us say a teacher in a small math or government class has a virus. Are we going to start asking those professionals to start reporting? Are we going to allow parents to have access to their information, which violates their privacy and will lead to fearmongering in the schools? I see it going a lot further than where it is now. I do not know if we really want to open that box. We just want to protect people's privacy and allow everyone a safe and easy mind in their institution, wherever that may be. How are we going to protect them, because it will come up. I can see it coming up—a parent requesting the records of whoever is teaching their child. How do we deal with that situation?

Senator Hardy:
I understand your concern, and I think it is real. This bill, limited as it may be, may open that door. I respect the Committee and what you would like to do with this bill.

Chairman Sprinkle:
Are there any other questions from the Committee? [There were none.] For clarification, this bill is related to the parent of a child requesting to be notified, right? This is not a blanket notification that the schools will be mandated to do; it is just when one of these parents or guardians requests that notification.

Senator Hardy:
That is correct. You may hear from folks that it can be wider than that, but that is what the bill addresses.

Nicole Rourke:
I want to clarify one point. The Clark County School District is neutral. We brought our amendment to ensure that we could comply with the bill should it pass through your Committee and out of this body. We wanted to ensure that section 3, subsection 1, was also amended regarding notification to a parent of the ability to make that request. To ease our process, we would put it in our annual set of notifications along with our notice of how to register a child, sign up for the school bus, and things like that.

For clarity we wanted to ensure two things: that we could get that information out easily; and that we were protecting the privacy of students and looking at a yes or no answer.

Heidi Parker:
I do have prepared testimony on the current projects and happenings about school rates and the work being done already under current statute (Exhibit D). I would be happy to present it or just submit it to the Committee.

Chairman Sprinkle:
I leave that up to you.

Senator Hardy:
I will be leaving for a committee meeting in the Senate.

Heidi Parker:
As part of Immunize Nevada's mission to provide trusted information to Nevadans, we collaborated with the Nevada Division of Public and Behavioral Health's (DPBH) Nevada State Immunization Program to develop and maintain a web-based, searchable portal where parents can find the immunization rate within their child's school. This portal is housed at vfcnevada.org, and it identifies the percentage of pupils immunized in accordance with state requirements. It is self-reported annually as required by *Nevada Revised Statutes* (NRS) 392.435 and NRS 394.192. Rates are required to be reported by December 31 to the DPBH, and we have collaborated with the Nevada State Immunization Program to ensure that this online form fulfills this mandate. *Nevada Revised Statutes* 432A.230 and 432A.235 require immunization rate information to also be reported by child care accommodation facilities, and we are currently working with DPBH to include this facility information in the same searchable portal.

The Nevada State Immunization Program can only dedicate 0.25 full-time equivalent employee (FTE) to school enforcement issues given the multitude of daily responsibilities. By recently creating a full-time school immunization project coordinator position, Immunize Nevada has been able to assist with this human resource gap by collecting the rates and following up with the schools that have not reported; ensuring the rates are available to the public. We provide school-level technical support, and we also provide resources for families.

By mandating these rates through NRS and making them accessible and searchable online, Nevada is actually at the forefront in making immunization rates fully transparent. As you heard, not a lot of states are doing that. If they are, they are not searchable or as publicly accessible. We have made the system as simple as possible for not only the school to report, but also for the parent to understand the rates. If a school reports a 99 percent immunization rate, then the remaining 1 percent would be accounted for through a religious exemption or a medical exemption on file with the school nurse. Schools could potentially have conditionally or noncompliant students enrolled, and those tend to be extenuating circumstances, many of which you have already heard in testimony today. Access to this data helps Immunize Nevada identify schools and communities where we need to focus our efforts to ensure that the desired level of herd immunity of 90 to 95 percent is reached. By providing these targeted resources, we had a school pilot project post an improvement in unvaccinated rates in their 17 identified schools from 9 percent to 2 percent. Because of that success, we have made this a permanent project at Immunize Nevada.

By raising awareness of community vaccination coverage during the 2015 measles outbreak and stressing the importance of the measles, mumps, and rubella (MMR) vaccine, Nevada saw a 23 percent increase in vaccinations during that time period over the same time period the previous year. We are in full support of transparency of rates. We know school nurses work very hard to ensure their students are fully vaccinated. They are some of our strongest partners in ensuring a healthy and vaccinated population, and we appreciate their work.

Of additional concern is the threat of the loss of prevention and public health funding under the Affordable Care Act. Nevada's immunization program could lose half of its federally funded budget. This loss would also have an impact on Immunize Nevada's programs. Duplicating duties that already exist during a time of funding uncertainty could add an unnecessary burden on our state. The intent of this constitutes good public policy, and we also support helping parents increase their knowledge of these rates. We want to also empower them to advocate if their school does not report or has a low rate, but we know it is duplicative. As a coalition, we have partners that both support and oppose this, so we are neutral.

Chairman Sprinkle:
Anyone in support of this bill, come forward please.

Erik Jimenez, representing Southern Nevada Health District:
Senator Hardy alluded to it in his testimony, but we are in full support of this bill insofar as it has the potential to protect the most vulnerable members of our community who do not have the ability to produce antibodies or who are immunodeficient. We are fully in support of what this is trying to do.

Chairman Sprinkle:
Is there anyone else in support of this bill? [There was no response.] Is there anyone in opposition?

Joy Davis, Private Citizen, Reno, Nevada:
[Joy Davis spoke from prepared text (Exhibit E).] Although many of my concerns have already been addressed by the Committee, I came because I had a pretty strong concern that a bill like this might create division in our schools. Prejudice, labelling, and suspicion are also big concerns. Most parents know that there is at least one child who is exempt in a school, so I do not understand why a bill like this is necessary. I see the potential for harm from the bill to be a greater threat.

Many of the children who are immunocompromised are exposed to adults who have not had these vaccines. I am 45 and I have had quite a few vaccines, but not all of them. I am around babies and children, so of course I am careful if I feel as though I am sick or am getting sick. My point is that immunocompromised children are around other children in parks, in grocery stores, and in restaurants unless the parent is not taking the child out in public at all. I still do not understand the necessity, but I do see a downside as it relates to suspicion. It is human nature to ask who that unvaccinated person is. They are not going to get a name or any identifying factors, but most people are curious. They want to know and would try to see who the person could be. They would start asking questions, labelling, and profiling. That is my concern.

Sara Yelowitz, Private Citizen, Reno, Nevada:
[Sara Yelowitz spoke from prepared text (Exhibit F).] I am a parent, and I would like to ask the Committee to vote no on this bill. As Joy Davis mentioned, I see a lot of downside to the bill. Parents already know that there are religious and medical exemptions in Nevada, so in any school there are probably several children who have exemptions. I believe this bill is unnecessary. Most adults would technically be considered unvaccinated, because most are not up to date on their booster shots. If children leave their homes, they are around unvaccinated people all the time anyway.

Unvaccinated children do not pose a risk to anyone. I volunteer a lot in the public schools, and unvaccinated children are usually very, very healthy. The parents of unvaccinated children are highly educated and health conscious and have put a lot of thought into it. I do not really see a purpose to the bill. Anyone who is going to send their child into a school knows that some children are vaccinated and some are not, and it does not really matter. What it would do is create an atmosphere of fear and suspicion that is not productive for a learning environment. There are a lot of live virus vaccines such as rotavirus, the MMR,

chicken pox, and flu. All those shed for a period of weeks or months, so recently vaccinated children would pose a risk to the community. I did not see any language in the bill to address that concern.

Chairman Sprinkle:
Is there anyone else in opposition who wishes to speak? Seeing none, is there anyone who is neutral?

Michael Hackett, representing Nevada Public Health Association:
We are neutral on the bill. Originally, I signed in that we were supportive of the bill, but I just received notification that, upon further consideration by the Nevada Public Health Association, we are neutral.

Jessica Ferrato, representing Nevada Association of School Boards:
We are here as neutral on the bill. We think this is duplicative of what is already offered for parents and families in our school districts. We support all of the facts and information Immunize Nevada presented, and believe that they are doing a very good job maintaining this data and providing it as needed. We would be supportive of the Clark County School District's amendment, but are still not comfortable with the bill in general.

Mary Pierczynski, representing Nevada Association of School Superintendents and Nevada Association of School Administrators:
We are also neutral on the bill if the bill includes the Clark County School District's amendment. It helps protect the identity of the students a bit more.

Chairman Sprinkle:
Is there anyone else who wishes to speak in neutral on this bill? [There was no response.] I would ask the bill's sponsors to come back, but no one is here, so I will close the hearing on A.B. 200. At this point, we will have a presentation on patient-centered medical homes.

Michael Hackett, representing Nevada Primary Care Association and Nevada Public Health Association:
The issue of patient-centered medical homes is high atop the Nevada Public Health Association's list of priorities. This presentation will focus on the Subcommittee on Patient-Centered Medical Homes that was created by Senate Bill 6 of the 78th Legislative Session. After my presentation, I am going to be joined by three members who sit on the Subcommittee on Patient-Centered Medical Homes. They will address it from their various capacities with their organizations.

Senate Bill 6 of the 78th Session was brought forward as a means to protect and benefit consumers so that they understood that a practice that was calling itself a patient-centered medical home (PCMH) was actually a patient-centered medical home and had been appropriately recognized. We looked at this as the beginning of the process of transforming how health care is delivered in this state through the PCMH model and the ultimate triple aim of the PCMH model. This transformation seeks to move us from a sick bay system to one

that emphasizes wellness and prevention and provides a continuity of care. I have provided language from the bill so you can see exactly how it reads and what was accomplished. It defines in the *Nevada Revised Statutes* (NRS) what a PCMH is [page 3, (Exhibit G)]. I want to emphasize subsection 2 under this definition where it reads, "Emphasizes enhanced access to practitioners and preventive care to improve the outcomes for and experiences of patients and lower the costs of health services." That is consistent with the triple aim of PCMHs: better outcomes, improved experiences for the patient, and lower health costs. Those three issues are at the heart of what this PCMH Subcommittee will look at as it undertakes its activities.

Senate Bill 6 of the 78th Session also provided for a deeming process for state PCMH recognition [page 4, (Exhibit G)]. If you have been accredited, certified, or otherwise recognized nationally, then by that process the state considers you to be a PCMH. It also provided a consumer resource to find out exactly who the PCMHs are in this state, where they are located, and who the providers are who oversee them. That was accomplished through a link on the Nevada Department of Health and Human Services' website to the national accrediting organizations to be able to determine where in Nevada these PCMHs are [page 5, (Exhibit G)].

Another piece from S.B. 6 of the 78th Session is protection from unfair or deceptive trade practices [page 6, (Exhibit G)]. Something we were not able to accomplish from last session has to do with a payment model of reimbursement that is reflective and consistent with how health care is delivered through a PCMH. That provision was important to allow the PCMHs and insurers to begin to collaborate on what an appropriate reimbursement model would look like. There is legislation this session to provide for an appropriate reimbursement model.

The last provision of the bill authorized an advisory group to appoint committees or subcommittees. What is before you now [page 7, (Exhibit G)] is exact language from the Legislative Counsel's Digest from S.B. 6 of the 78th Session that this committee or subcommittee would be established under the Advisory Council for the State Program for Wellness and the Prevention of Chronic Disease. The next slide [page 8, (Exhibit G)] is the actual provision in the bill that creates this advisory group in terms of who may participate, without limitation, in this particular advisory group.

During this past interim, I presented the findings and results of S.B. 6 of the 78th Session to the Advisory Council. As they went about establishing the PCMH Subcommittee, they had one requirement—that two members of the Advisory Council actually sit on the Subcommittee. To determine who else would be interested in becoming a member of the Subcommittee, the organizations you see listed [page 9, (Exhibit G)] are the ones I reached out to. For the most part, they were all stakeholders in S.B. 6 of the 78th Session.

The next slide [page 10, (Exhibit G)] shows the people who sit on this Subcommittee. Assemblywoman Joiner is a member and also sits on the Advisory Council for Wellness and the Prevention of Chronic Disease. Tom McCoy is presently the Chair of that Advisory Council. As you look at the list of those who sit on the Subcommittee, the interests are well

represented from a provider's point of view, from a consumer's point of view, and from a carrier's point of view. There was a specific request made for the State Dental Health Officer to be part of this, but I do not have that individual's name, so that person was not included but is also a member of this Subcommittee.

Tom McCoy, Chair, Advisory Council on the State Program for Wellness and the Prevention of Chronic Disease; Nevada Director of Government Relations, American Cancer Society Cancer Action Network; Member, Subcommittee on Patient-Centered Medical Homes:

The American Cancer Society's Cancer Action Network (CAN) through advocacy supports the mission of the American Cancer Society. We view PCMHs as an opportunity to address one of our primary mission areas, which is access to affordable quality care. When I first heard about PCMHs, I thought it was some kind of new, boutique approach to health care. Over the years, I have learned the importance and value of looking at primary care, and that is where the emphasis has been placed. We have federally qualified health centers, and those are primary care focused. That is where our health care has to look—at the basic starting point for patients.

One thing I find to be a challenge for Nevada, and certainly one the PCMHs can help with, is that in Nevada, through Governor Sandoval's expansion of Medicaid and through the Silver State Health Insurance Exchange, we have moved our state from one of the worst in the uninsured category to one of the best in the insured category. This is good and we have access to insurance, but do we have access to care? That is the question that remains unanswered. We know we have a deficiency in health care providers, but there is another issue—we have a health literacy problem in Nevada. All these people who are now insured do not know what to do with their insurance. We have people who have insurance cards who are still going to the emergency rooms (ERs) for treatment. That is a waste of resources. Hopefully, we can take a look at this model, this new approach, this new philosophy to health care, and apply it to our state Medicaid program and be in a position to reduce costs.

Daniel Spogen, M.D., Chair, Department of Family and Community Medicine, University of Nevada, Reno, School of Medicine:

[Daniel Spogen, M.D., supplied a document entitled "Presentation: Subcommittee for Patient Centered Medical Homes" (Exhibit H).] We have been working for decades to get a PCMH at the University, but there are two hurdles. One is to actually create a PCMH and the other is creating a learning environment where you teach in the PCMH. Patient-centered medical homes are a way to ensure quality in the patient-physician relationship. The patient is at the center of this relationship. The PCMH uses a team-centered approach where the patients not only receive medical care but also get behavioral health care if needed, nutritional health care if needed, and access to any other aspect of health care needed to improve their health. That is really the key to a PCMH, and the key to making that work is care coordination. Another part of a PCMH is having someone who has the pulse of the care metrics of a patient or of the patient population. It involves a lot more than just the physician-patient relationship.

What Nevada has done by recognizing PCMHs is great, but it has not gone as far as saying that PCMHs are something special. However, it is really hard to move forward with the PCMH aspect if you are offering all those other things to ensure better quality care but getting paid the same amount as if you did not offer them at all. We definitely need to recognize PCMHs as higher quality care. We also have to recognize the fact that if physicians are not paid more for that care, they will not offer that care. Those other things that are so important to the health care of our patients will not be taken care of. A good example of that is what we call social determinants of health. I can tell a person to get a certain medication, but can that person afford or access that medication?

To certify as a PCMH is not a cheap process. There are four recognizing bodies that will recognize a business as a PCMH, with the National Committee for Quality Assurance (NCQA) being the best known of them. It will cost the typical practice somewhere between $10,000 and $12,000 to be recognized as a PCMH, but that does not cover all the costs. You have to run reports to comply with reporting requirements. Those reports cost money, and you have to hire someone to run them. In addition to that, the office has to have an electronic medical record (EMR) that the reports can be run off of. A lot of electronic medical records are not capable of running those reports, so a lot of physicians and physician groups are unable to go any further. It goes without saying that we should really recommend this kind of care be offered to everyone in Nevada. It should be a standard of care for our communities, and with recent legislation it is almost going to be required that primary care facilities offer a PCMH or other way of discerning quality.

At the University of Nevada, Reno, we have been working at becoming a PCMH for a long time. In fact, in 2004 I was brought to the University primarily for that purpose, but we are still not there and it comes down to cost. We have embedded psychologists on our team along with nutritionists, social workers, medical assistants, and nurse practitioners. So we have the team in place, but going that next step in reporting has been very, very costly, and we have not been able to do that. Our current EMR does not have the ability to run the reports. Even though we are offering the service, we cannot be recognized.

Nancy Hook, Executive Director, Nevada Primary Care Association; Member, Subcommittee on Patient-Centered Medical Homes:

At the Primary Care Association, we have been involved in practice transformation for three years with our community health centers through the PCMH model. We are very lucky, because the Bureau of Primary Health Care through the Health Resources and Services Administration has funded us to do that, so at this time, 75 percent of all our clinical sites are recognized through NCQA. I have been asked to present on the current state of PCMH in Nevada (Exhibit I).

Patient-centered medical homes are a promising model for transforming the organization and delivery of primary care based on the principles of comprehensive and coordinated care. The medical home is accountable for meeting the large majority of each person's physical and behavioral health needs, including prevention and wellness, acute care, and chronic care. Providing comprehensive care requires a team of providers.

The NCQA and its PCMH recognition is probably the most widely adopted model for transforming primary care practices into medical homes. Research confirms that medical homes can lead to higher quality, lower costs, and can improve the patient's and the provider's experience with care. Many providers find that working within a PCMH really gives them great job satisfaction. A 2014 study compared health care utilization and payments between NCQA-recognized PCMHs and practices without such recognition. Relative to a comparison group, it demonstrated that total Medicare payments, acute care payments, and number of ER visits declined over a three-year period after practices received the PCMH recognition.

Today, we have more than 11,000 NCQA-recognized PCMH practices in the United States and almost 53,000 recognized clinicians. The 2014 standards emphasized team-based care with significant focus on care management of high-risk populations. A number of local, state, and national PCMH recognition and accreditation programs are available. As you heard, S.B. 6 of the 78th Session established the Subcommittee, defines the term PCMH, and requires that you have national accreditation or recognition.

Currently, there are four national accreditation and recognition programs: the Accreditation Association for Ambulatory Healthcare, Inc. (AAAHC), the NCQA, The Joint Commission, and URAC Patient-Centered Medical Home Certification. The majority of the 238 providers recognized in this state by NCQA are employed by four groups: Southwest Medical Associates, Healthcare Partners Nevada, Renown Medical Group, and community health centers. There are only a small handful of private practices recognized, and you have heard some of the barriers for those small practices to get recognized.

The five AAAHC-accredited medical homes listed on the slide [page 3, (Exhibit I)], are employer-based programs with onsite health centers operated by Premise Health. Three are in gaming and two are in mining companies—a different approach but using the same principles.

What is driving PCMH in Nevada? Although there are no federal PCMH programs in the state, in the last couple of years the Division of Health Care Financing and Policy (DHCFP) in the Department of Health and Human Services spearheaded two initiatives that use medical homes. The Nevada Comprehensive Care Waiver is a care management organization commonly known as a health care guidance program. It encourages patient-centered care for fee-for-service Medicaid members. The program is based on the idea that a patient-centered care approach is key to improving the care quality, outcomes, and health of beneficiaries, and integrates behavioral and physical health.

The DHCFP began exploring PCMH approaches in 2010 when there were only four recognized PCMHs in Nevada. The DHCFP continued to explore the PCMH model in the State Innovation Model (SIM) grant program they received in December 2014. The SIM plan encompassed four goals, one of which was to redesign the state's health care delivery system to contain costs and increase value through the initiation of fundamental programs using PCMHs. Most recently, the Medicaid managed care expansion proposal presented in

the Navigant draft report includes PCMH implementation in phase three. In addition to PCMH being implemented in existing practices as you have heard, the University of Nevada, Reno, School of Medicine is educating their health professionals on the principles of patient-centered, team-based care through their patient-centered family practice center.

For the federal Department of Health and Human Services, PCMH has been a priority goal since 2012 for community health centers. The 2017 performance target is that 70 percent of all community health centers in the country are recognized. We have been very lucky in receiving the investment in becoming PCMHs.

In response to the concerns identified earlier about the costliness and cumbersomeness of the certification or recognition process, NCQA is redesigning the PCMH recognition program and will launch the redesigned program at the end of next month. The redesigned program incorporates feedback from practice staff, clinicians, and certified content experts to improve the process—cut back the paperwork, and simplify the reporting so practices can focus on improving care. As was mentioned, the redesign also considers the changing payment climate, including the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requirements for quality reporting—all in hopes of shifting to value-based care, aligning reporting requirements with the expected MACRA changes, and helping eliminate duplication of work.

Chairman Sprinkle:
Is there anyone else who wants to present today? [No one came forward.] Thank you for giving us this information. Does anyone wish to come forward under public comment in the south or in the north? [There was no response.] Is there anything else from the Committee? [There was no response.] This meeting is adjourned [at 1:43 p.m.].

RESPECTFULLY SUBMITTED:

_____
Terry Horgan
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 an amendment to A.B. 200 proposed by the Clark County School District and presented by Nicole Rourke, Associate Superintendent, Clark County School District.

Exhibit D is prepared testimony dated February 24, 2017, in connection with A.B. 200 presented by Heidi Parker, Executive Director, Immunize Nevada.

Exhibit E is prepared text dated February 24, 2017, in opposition to A.B. 200, presented by Joy Davis, Private Citizen, Reno, Nevada.

Exhibit F is prepared text in opposition to A.B. 200 presented by Sara Yelowitz, Private Citizen, Reno, Nevada.

Exhibit G is a copy of a PowerPoint presentation titled "Patient-Centered Medical Homes" and dated February 24, 2017, presented by Michael Hackett, representing Nevada Primary Care Association and Nevada Public Health Association.

Exhibit H is a document entitled "Presentation: Subcommittee for Patient Centered Medical Homes" supplied by Daniel Spogen, M.D., Chair, Family and Community Medicine, University of Nevada, Reno, School of Medicine.

Exhibit I is a copy of a PowerPoint presentation titled "State of PCMH in Nevada" and dated February 24, 2017, presented by Nancy Hook, Executive Director, Nevada Primary Care Association; Member, Subcommittee on Patient-Centered Medical Homes.