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

Seventy-Ninth Session
April 5, 2017

The Committee on Health and Human Services was called to order by Chairman Michael C. Sprinkle at 1:19 p.m. on Wednesday, April 5, 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:

Assemblyman Nelson Araujo, Assembly District No. 3

STAFF MEMBERS PRESENT:

Marsheilah Lyons, Committee Policy Analyst
Mike Morton, Committee Counsel
Terry Horgan, Committee Secretary
Trinity Thom, Committee Assistant

OTHERS PRESENT:

Christy Craig, Chief Deputy Public Defender, Office of the Public Defender, Clark County
Elizabeth Gonzalez, Chief Judge, Eighth Judicial District Court
John T. Jones, Chief Deputy District Attorney, Legislative Liaison, Office of the District Attorney, Clark County
David Humke, District Judge, Second Judicial District Court
Frances M. Doherty, District Judge, Second Judicial District Court
Cynthia C. Lu, District Judge, Second Judicial District Court
Jeanette Belz, representing Nevada Psychiatric Association
Cody Phinney, Administrator, Division of Public and Behavioral Health, Department of Health and Human Services
Sarah Adler, representing National Alliance on Mental Illness
Marlene Lockard, representing Service Employees International Union #1107
Catherine A.G. Sparkman, Director, Government and Public Affairs, Association of Surgical Technologists
Travis Kieckbusch, Private Citizen, Reno, Nevada
Cris M. Aguilar, Program Director/Instructor, Surgical Technology Program, Engelstad School of Health Sciences, College of Southern Nevada
John D. Brophy, Private Citizen, Sparks, Nevada
Bill M. Welch, President/Chief Executive Officer, Nevada Hospital Association
Joan Hall, President, Nevada Rural Hospital Partners
Riana Durrett, Executive Director, Nevada Dispensary Association
Chad Warren Westom, Bureau Chief, Division of Public and Behavioral Health, Department of Health and Human Services
Neal Tomlinson, representing Nevada Dispensary Association
Will Adler, representing Sierra Cannabis Coalition
Marla McDade Williams, representing Nevada Cannabis Coalition
Grace Crosley, Private Citizen, Reno, Nevada

Chairman Sprinkle:
[Roll was taken. Committee rules and protocol were explained.] For everyone, but especially for Committee members, Assembly Bill 203 has been removed from our work session for today.

Assembly Bill 203: Revises provisions governing cemeteries. (BDR 40-723)

[This bill was not acted upon during the work session.]

Chairman Sprinkle:
I will open up the hearing on Assembly Bill 440.

Assembly Bill 440: Revises provisions governing involuntary commitment proceedings. (BDR 39-997)

Assemblyman Steve Yeager, Assembly District No. 9:
Assembly Bill 440 revises provisions governing involuntary civil commitments. This bill seeks to streamline the process of assisted outpatient treatment for criminal defendants, as was the original intent of the involuntary civil commitment statute passed by the Legislature in 2013 in the form of Assembly Bill 287 of the 77th Session, which was sponsored by former Assemblyman Lynn Stewart with bipartisan support. For the record, that bill originated in this Committee, and some of you who were here for those hearings in 2013 may have flashbacks to 2013 with this hearing.

I cannot and will not claim to be an expert in this area of the *Nevada Revised Statutes* (NRS). Fortunately, I have two experts assisting me today, Christy Craig from the Clark County Public Defender's Office who has extensive experience dealing with mentally ill criminal defendants. She has been involved with involuntary civil commitments and assisted outpatient treatment since the day the statutory framework was enacted in 2013. Also at the table in Las Vegas is Chief Judge Elizabeth Gonzalez of the Eighth Judicial District Court, who will speak to the last section of the bill.

Christy Craig, Chief Deputy Public Defender, Office of the Public Defender, Clark County:
[Christy Craig spoke from prepared text (Exhibit C). She also submitted a link to a website (Exhibit D), and a copy of Minutes of the Assembly Health and Human Services Committee Meeting, April 8, 2013 (Exhibit E).] Section 1 of the bill addresses who has the right to commence the proceedings for involuntary commitment. Lines 9 through 13 of section 1, subsection 1, list all the parties who are able to commence that process: guardians, family members, a physician in a hospital, a nurse—those are the people who are able to start that process. This bill will add, under section 1, subsection 3, that the criminal court can commence that process. The criminal court can ask assisted outpatient treatment, that court, to consider an individual for entry into the program. What it does not do is set up an assisted outpatient treatment court in the criminal court. The criminal court is no longer involved. It is as if we were standing in the shoes of a person's parent and asking for that court to consider the individual for this program.

Even if somebody meets the requirements of *Nevada Revised Statutes* (NRS) 433A.200 that lists all the things that have to be taken into consideration before someone can enter that program, not every criminal defendant is going to be able to proceed. The individual may end up going to prison and not able to be entered into the program even if they were accepted and there was room. All this bill seeks to do is allow the court an easier process to knock on the door of the assisted outpatient treatment program and ask if a person can enter it. Does the individual qualify and meet the requirements of NRS 433A.200, and will you consider them? That is the only involvement the criminal court would have. The way the bill was before did not allow the court an easy mechanism to ask that question: whether a particular person could be considered for the program. What this bill does is allow that mechanism to be more streamlined. Typically, about five to ten criminal defendants a year are referred to the assisted outpatient treatment program. I do not expect that number to increase in the event this bill is passed. It will just make it easier to ask them to consider a particular person.

Assemblyman Yeager:
Mr. Chairman, with your permission, I would like to turn it over to Chief Judge Gonzalez in Las Vegas to go over section 5 of the bill.

Elizabeth Gonzalez, Chief Judge, Eighth Judicial District Court:
[Elizabeth Gonzalez spoke from prepared text (Exhibit F).] In section 5, upon the determination of the chief judge of a judicial district, we are requesting the authority to utilize judges not elected to the family division for the involuntary commitment proceedings in NRS Chapter 433A. The goal for the Eighth District is not just to have a master hear those cases as currently permitted under our local Rule 1.44, but to have a district judge who oversees that docket and hears objections in those cases and who is familiar with our intertwined mental health treatment options and competency court issues. We believe the participants in the involuntary commitment process would be best served by allowing a district judge familiar with mental health treatment issues to be assigned by the chief judge, even if that judge is not a member of the family division. What this would do would be to allow integration of the mental health issues with one district judge.

Currently, we deal with individuals suffering from mental health issues in a variety of contexts in the Eighth Judicial District Court. The spectrum of contacts is wide and touches almost all of our case types. Some of those contacts involve the treatment programs we are here about today. The primary court-supervised treatment programs are:

- Competency court, which focuses on treating criminal defendants to achieve competency to assist in their trials and other legal proceedings.
- Mental Health Court, which diverts criminal defendants with significant mental health issues for treatment rather than incarceration.
- Involuntary commitment process we are talking about here today, which allows the court to confine individuals with serious mental health issues who pose a significant danger to themselves or others. There are two components to this program—the hospitalization component and the outpatient component, which is called assisted outpatient treatment (AOT). While some participants in the involuntary commitment process are criminal defendants, this program is primarily a treatment option rather than truly part of our criminal justice system.

In the last 12 months, over 7,000 petitions for involuntary commitment were filed, and over 26,000 hearings on involuntary commitment have been scheduled. Not all of those hearings have gone forward because most come off the calendar. Last year, there were 184 hearings where a patient was involuntarily committed, and 1,665 hearings where either the petition was dismissed or there was a voluntary consent to commitment. We have an average of 3 1/2 hearings per week for involuntary or voluntary commitments. The AOT program currently has 70 participants. In closing, the Eighth Judicial District Court would like to take advantage of the complementary nature of these case types to allow the chief judge to assign a district judge, not elected to the family division, to oversee the involuntary commitment program.

Chairman Sprinkle:
So that I am absolutely clear, there is nothing in here that is a mandate, correct? This is permissive language, enabling language; there is nothing that says this must be done by any individual.

Assemblyman Yeager:
You are absolutely correct. All the procedures are permissive, and even section 5 would simply give discretion to the chief judge in the respective judicial district to make the election of whether he or she wanted to designate a particular judge to handle these types of matters. Nothing in here is a mandate.

Chairman Sprinkle:
That is the only question I had. Is there anything else from the Committee?

Assemblywoman Benitez-Thompson:
In section 5, subsection 4, the language here talks about "The family court, where established, does not have original, exclusive jurisdiction . . . ." Does the outpatient program established in 2013 apply to just that particular program or community-based program? This would say across all different types of programs and courts, correct?

Judge Gonzalez:
Nevada Revised Statutes 433A.200, which is referenced in this section, is the beginning of the involuntary court-ordered admission section of the statute that would apply to all involuntary commitments, hospitalization commitments, or the AOT—the outpatient treatment program Ms. Craig spoke about.

Assemblywoman Benitez-Thompson:
Other than the outpatient program that was established in 2013, could you talk about what has been happening in the courts that would bring us to this conversation. It has been exclusively in the hands of family court judges since the provisions were put in place. What has been happening that would make us rethink that structure? Is it really just the one outpatient program? Are there other trends?

Judge Gonzalez:
The current program for both AOT and involuntary commitment is handled by a master under our Eighth Judicial District Court Rule 1.44, which allows a master to hear those cases. The master exclusively hears those cases under the supervision of one of the family division judges at this time. I currently oversee the mental health court program, which is in the civil criminal division, with the assistance of a master in a blended model where I hear all of the objections and issues raised by participants about changes to their participation in the mental health court program. My goal is to try to unify those issues so we have one judge handling both types—the mental health court issues as well as the involuntary commitment and AOT because of the complementary nature of those two case types.

Chairman Sprinkle:
Once again, Committee, are there any questions? [There was no response.] Not seeing any, we will bring people up to testify in support of A.B. 440.

John T. Jones, Chief Deputy District Attorney, Legislative Liaison, Office of the District Attorney, Clark County:
We have worked out some amendments with Ms. Craig, my office, the Clark County District Attorney's Office, and Assemblyman Yeager. I want to thank them for working with us. Those amendments are not yet on the Nevada Electronic Legislative Information System (NELIS), but we will make sure they get there as soon as possible. I just wanted to register our support.

Chairman Sprinkle:
Is there anyone else in support of this bill either here or in southern Nevada? [There was no one.] Not seeing anyone, we will bring up anyone in opposition to A.B. 440.

David Humke, District Judge, Second Judicial District Court:
I am here to provide some history (Exhibit G). In an earlier life, I was Assemblyman Humke. In 1993, we passed Assembly Bill 523 of the 67th Session, which was an addition of the jurisdictional limit for involuntary commitments to the family court. For some reason, it had not been included in the 1991 legislation that created the family courts in the Second and Eighth Judicial District Courts. I have letters here from Judges Charles Magee, James Stone, and Scott Jordan, dated April 29, 1993, to the Assembly Judiciary Committee in support (Exhibit G). Those were letters from the Second Judicial District. From the Eighth Judicial District is a letter from the Honorable Robert E. Gaston writing a letter pursuant to a request from the Committee Chair, the Honorable Robert Sader, who described a poll of the family bench in the Eighth Judicial District and it was unanimous. The bill passed both Houses unanimously in 1993 pursuant to the support of all family court judges in Nevada.

Frances M. Doherty, District Judge, Second Judicial District Court:
[Frances Doherty spoke from prepared text (Exhibit H).] We are appearing on behalf of the entire district and represent the position of our chief judge. I am probably considered one of the family court's historians based on how long I have served in family court. I have been in family court for 20 years—5 years as a master, and the remaining years as a district court judge in Department 12. I have been elected three times and very much appreciate the honor of serving and sharing information with you today.

I would like to briefly remind the Committee of who we are and why we exist. In 1983, Sue Wagner, who served as an Assemblywoman, a state Senator, and as our Lieutenant Governor, tried to create the family court. In 1990, the state of Nevada put Question No. 1 on the ballot, asking the voters of Nevada whether it would be meritorious for the Legislature to create a unified family court in the state of Nevada to serve individuals and families in a separate and unified manner, and to allow the Legislature to define the jurisdiction of the family court and to ensure that that jurisdiction was recognized and protected going forward.

In 1991, you, the Legislature, created family court, and you recognized all of those reasons for the importance of our existence and for our very specific jurisdictional authority.

The importance of our existence was pointed out by experts brought in from all over the country. Those experts testified that families served in family court receive greater expertise in addressing their problems because the judges are trained, committed, and create a unified response to every family in family court, regardless of what door they walk in. They might walk into the divorce/custody arena; they might come in through mental health commitments; they could come in through guardianship cases. Regardless of the door they came in, the citizens of the state of Nevada identified very specific judges who they voted for on their ballots to ensure that the services were provided appropriately. When we created mental health commitment in 1993, my honorable colleague noted that in 1991 it was left out. We did not, however, leave it out in terms of beginning practice, because the family court did not officially form until 1993, so they caught it, added it, and since that time we have had that jurisdiction.

Yesterday in a guardianship case, I oversaw a guardian who had been committed within the last month under the mental health statute. This individual identified suicide and inclinations of despair in that mental health case and suggested use of the protected person's medication to effectuate a suicide attempt. We were able to clear the courtroom and discuss in great detail all the ramifications of that person serving as a guardian. That person was going to require special community support and the understanding and expertise of this family court response to ensure that the protected person was protected while we went through a period of recovery and oversight as a family court for that guardian. That is the type of work you told us you wanted us to perform in a holistic manner—integrated and facilitative of resolutions for families and individuals.

We ask you today to continue our purpose and ensure that you protect the jurisdictional authority of family court to maintain its response to individuals and families to keep them together and to serve them in an integrated way. We respect the efforts of this bill and its good intentions. We will do anything to facilitate an outcome that, in the long run, achieves the benefits overall identified in the bill. But we will not at any point, as a family court or as a district, recognize that there should be discretion in any given arena, let alone the mental health arena, to allow the jurisdiction of family court to be removed and placed elsewhere. I will remind you that the Legislature identified two reasons in which a general jurisdiction judge would serve in family court: The chief judge may assign a general jurisdiction judge to serve in family court if there is a caseload excess, therefore a crisis; or if a family court judge cannot serve. Without those two circumstances being met, the Legislature ensured the jurisdiction was maintained, and we ask you to continue to do that today. Do not allow the jurisdiction to be impeded upon, but allow us to work with those individuals who care about those persons in mental health court and in criminal court and respond appropriately to their needs.

Cynthia C. Lu, District Judge, Second Judicial District Court:
I had the honor of being elected in 2014, so I am a new one in family court; however, in my previous life, I was a chief deputy public defender in Washoe County and represented individuals in involuntary commitment proceedings. I also represented individuals in mental health court for several years, so I am very familiar with these individuals. Currently, I am the family court judge assigned to oversee involuntary commitment hearings in Washoe County. I handle those cases weekly. In Washoe County, we have a district court judge, myself, who handles them. We do not have a court master who handles them. It is my understanding that since 1993, Clark County has always had a court master hearing these types of cases.

Just to give you information, at our hearings, we have the public defender who represents the patients. We have the district attorney who prosecutes the petitions, and we now have the Attorney General's Office who represents Northern Nevada Adult Mental Health Services in our assisted outpatient treatment program. When we have these hearings, we have at least two court doctors testify—possibly a doctor from the Northern Nevada Adult Mental Health Hospital—and a social worker. We are very intertwined with guardianships. Often, many of our patients have guardians who also testify, which creates that additional link Judge Doherty mentioned in her testimony. We also have the patient testify. We have quite lengthy hearings in our county. They last anywhere from 15 to 20 minutes.

I want to speak about the assisted outpatient treatment program and how this bill would affect us in the north. We just started our program in January 2017, so Clark County is definitely ahead of the curve on this program. The only way we were able to start our program is because we obtained a four-year grant through the Substance Abuse and Mental Health Services Administration (SAMHSA). We are not state-funded, as the Clark County Assisted Outpatient Treatment Program currently is. At the end of four years, if the state of Nevada does not fund our program, our assisted outpatient treatment program will end.

We are concerned about this bill, and particularly sections 1 through 4, which indicate that any criminal defendant can file a motion to be heard on that docket. There is no discretion not to put them on the docket; there is no discretion not to hear their motions. It would also require an evaluation team to evaluate those patients. Right now, we have contracts with two court physicians who evaluate our patients for involuntary commitment hearings; however, this would be a whole different team that the state of Nevada would have to create and fund—both in the north and in the south—to do these evaluations for their motions.

We have a referral process we are still fine-tuning in the north, so this bill would potentially add another layer of complexity to how cases are siphoned through our assisted outpatient treatment program. There would definitely be an impact on our fledgling program that I am not sure we would be able to handle at the point when this bill would take effect. We are also still in the process of creating pleadings and formulating our process, which is different from Clark County's. We did a site visit to see what they did, and we borrowed what we could, but not every county can exactly match another county's program because they are suited to the needs of the communities. We are still working out the kinks in our assisted

outpatient treatment program, and the concern with this bill is that we would have a large influx from criminal defendants who want to be part of the civil treatment program. Aside from just the differences between civil and criminals cases in themselves, it would create an absolute complication in adding them to our civil treatment program.

Chairman Sprinkle:
Is there anyone else in opposition to A.B. 440? [There was no one.] How about neutral to A.B. 440?

Jeanette Belz, representing Nevada Psychiatric Association:
The Nevada Psychiatric Association was very involved in the passage of A.B. 287 of the 77th Session. We love the AOT program and the success of that program. I want to bring up a couple of issues in regard to the bill. *Nevada Revised Statutes* 433A.315 requires the development of a written plan before someone is admitted to AOT. Section 3, subsection 1, of the bill requires something called an evaluation. We would like to see that evaluation tied back to the requirements of NRS 433A.315, so that questions like the following could be answered: Does the criminal defendant meet the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, criteria for serious mental illness; has the criminal defendant been treated and is that person stable on psychiatric medications; is the criminal defendant capable of participating in AOT; and what is the treatment plan and status of that person. We feel that if those two things could be tied together, it would strengthen the bill.

Cody Phinney, Administrator, Division of Public and Behavioral Health, Department of Health and Human Services:
I am here today to express that the Division is very supportive of the AOT program in general. We feel that it is a strong program to help divert individuals from the criminal justice system to the mental health system. That being said, we have some concerns about the current language. I look forward to seeing the amendments that have been proposed. I am very appreciative of Assemblyman Yeager and Ms. Craig spending some time with us yesterday to discuss those issues. We want to make sure that the language that goes forward addresses the ability for the Division to ensure we have some control over the risk level of individuals participating in the program. It is unclear here whether the Division would have that authority, and we are concerned that could jeopardize the program as a whole.

Further, to us, this language appears to make it possible to expand the program, although Ms. Craig said it would not. We have provided a fiscal note based on our interpretation that it is possible this would expand the demand for the program. Also, it is unclear in this language how exactly this works with the statutes in NRS Chapter 178 and the procedures we follow. We look forward to clarifying how these two pieces interact in order to make sure that everyone's rights and responsibilities are addressed.

Sarah Adler, representing National Alliance on Mental Illness:
The National Alliance on Mental Illness (NAMI) appreciates the desire of the judicial system to seek treatment rather than incarceration, and we are making a lot of progress in many forms throughout our state, including AOT. Our concerns are twofold: AOT at present is

available to courts through referral by the family court, as was described by Judge Doherty. We think that is appropriate. Our concern is that the involuntary admission statute will be open to all courts and might result in involuntary admissions that are not appropriate for people who really need a social worker rather than a judicial mandate to an involuntary admission. We think it is better to keep access to community-based and outpatient services through the family courts, although I was encouraged to hear Chief Judge Gonzalez's desire for more district court judges to be integrated into the system. We are concerned that not all judges are familiar with the process that the family courts are using very carefully now.

Our second concern is for the potential flooding of the AOT system with referrals of individuals who first require a significant amount of research and evaluation to determine what services and treatment they need. They need that without going through the involuntary admission process. We think we need more AOT team members and more trained judges. While we are at the table, we also need more housing for the people who are in jail diversion and AOT.

Chairman Sprinkle:
Is there anyone else here neutral to this bill? [There was no one.]

Assemblyman Yeager:
I want to thank those who spoke, both in opposition and in neutral. We have had discussions and will continue them. The amendments that are being contemplated refer back to the criteria spoken of in NRS Chapter 433A. With respect to the concern about risk levels, we are working with the district attorney's office to make sure that there is a mechanism where the district attorney would be able to block entry of certain violent, serious offenders, so they would not even be able to knock on the door. The decision about whether they get approved is down the road. We may do some amendments in that regard, and we will provide those to the Committee.

This bill is not meant to be any kind of attack on the family court. Our family courts are fantastic. They do great work, but keep in mind that outside of Clark and Washoe Counties, we do not have family courts, and these civil commitment proceedings are happening all the time in the district courts that exist outside of Clark and Washoe Counties. We heard about family courts being created in the early 1990s. As this Committee knows, the landscape has really changed in regard to mental health evaluation and treatment in the last 25 years or so. All this bill is seeking to do is give a chief judge the discretion—and the chief judge can decide to exercise that discretion or not—to structure the court in the way that is most appropriate, most efficient, ensures treatment for our mentally ill, and, in essence, increases public safety.

With respect to the Second Judicial District, it sounds as though their program is getting up and running. It is going well, and it can continue exactly as it functions today. We have heard that the chief judge of the Second Judicial District does not want to change jurisdiction; the chief judge has that discretion under section 5. In Clark County, I think it is

really important, with the number of judges we have and the number of programs, to allow the judge that discretion to structure the treatment courts and the civil commitment process in the most efficient way possible.

Christy Craig:
With regard to the concern about the number of people who could be using the program if it is extended more efficiently to the criminal courts, currently we send five to ten people a year. These people typically are folks who are already in the system. They have been civilly committed outside of their criminal cases. These are people we all know. In the testimony I provided to you I describe them as "treatment-resistant loopers." These are people who go from the hospital to the street, and then back to the hospital, and then back to the street. Then maybe they get in a fight with a police officer and now they are in jail. They go from the jail to Lake's Crossing, come back to the jail, get released to the street, and come back again.

The treatment-resistant loopers are the people AOT is meant to grab. Today, they may be in my criminal court; two weeks ago they might have been on a civil-commitment calendar. These are people we know; they have records. Someone else who testified was concerned about how we would identify them. Inside the criminal system, under the NRS Chapter 178 process, before we are sure they are competent to proceed to trial, we have evaluations. We get their records from Southern Nevada Adult Mental Health. We know if they have been civilly committed before. These are the people we recommend or suggest AOT consider. We are providing all those documents and all the previous evaluations. We are assured where they are with regard to their competency as it stands under NRS Chapter 178. All those things would be addressed.

Typically for the people we send over, those five or ten a year, their charges get dismissed; there is no more criminal case pending. It is part of the negotiation we go through with the district attorney's office when we identify someone who is appropriate for this program. The criminal case ultimately goes away, but we hold onto it just long enough to be assured that they have made it over to the program, and everything is smooth, that they are entered, and then the criminal charges are dismissed. That is not true for everybody but, by and large, that is how it happens. We carefully pay attention to whom we identify as appropriate for the program. In conclusion, read my testimony, and take a look at a ruling by Judge Linda Bell on the issue of jurisdiction (Exhibit D).

Chairman Sprinkle:
I will close the hearing on A.B. 440.

[(Exhibit I) and (Exhibit J) were submitted but not discussed, and are included as exhibits for the meeting.]

Now I will open the hearing on Assembly Bill 347.

Assembly Bill 347: Establishes certain requirements relating to surgical technologists. (BDR 40-721)

Assemblywoman Amber Joiner, Assembly District No. 24:
When the idea of this bill was brought to me, I was surprised to hear that in Nevada we do not have any laws about the basic qualifications people must have in order to work as surgical technologists in our operating rooms. This, in a time when hospital-acquired infections by antibiotic-resistant bacteria and medical errors are serious concerns for all of us. We need to make sure that every precaution is taken to ensure patient safety.

Although currently some of our hospitals have very high quality in-house training programs that prepare people to work in the operating room, not all of them do, and it is not standardized statewide. We need this bill in order to optimize patient safety and create a minimum standard statewide. This bill ensures that surgical technologists have training, skills, and knowledge when they are assisting in operations being performed on us and on our loved ones.

I would really like to thank the Nevada Hospital Association and some of their member hospitals who took the time to work with me on this bill. I believe that I have addressed most of their concerns in the version you see today; therefore, I do not believe we have any opposition, but it will be interesting to see. There are several experts with me today who will be able to provide many more details about the need and really good reasons why we want to have this in our state. First, I want to walk you through the bill, so you can understand section by section what we are doing. This bill does not create new licensure. Instead, the responsibility will be on hospitals to hire certified surgical technologists, and any violations will be found through the normal hospital inspection process done by our Division of Public and Behavior Health in the Department of Health and Human Services.

Sections 2 and 3 of the bill provide a definition of what a surgical technologist does. I will not read it to you, but you can see they have listed pretty much everything as far as sponging and suctioning, preparing and cutting materials, handling specimens, and making sure that the area stays sanitary and clean. All these different provisions under section 2 are part of the duties of a surgical technician.

Section 4 requires that a health care facility may not employ or allow a person to engage in the practice of surgical technology unless the person has met certain requirements. Those requirements include ". . . Successfully completed a program for surgical technologists that is accredited by a national accrediting organization and is certified as a Certified Surgical Technologist . . . ." They must also successfully complete a training program.

There are a few provisions that create exceptions to be fair to people who are already practicing. We do not want people who have experience to lose their jobs, so on line 25 on page 3 there is a grandfathering provision. If you are working before January 1, 2018, you can continue to work. We also have a provision where if they finish their training, but have not passed the exam or become certified, they can work for 180 days before they obtain that

official certification. In section 4, subsection 3, is an exemption for a health care facility that is unable to find a certified surgical technologist in a rural county, or even here in the north. The training program at Truckee Meadows Community College (TMCC) is just getting started. If there ever were a shortage of these folks, we wanted to make sure there was a way that the hospitals would not be short personnel, so that provides a small exception. They need to make sure they have advertised and tried to seek certified people and demonstrate that they were not able to, in which case, they could hire someone else.

Section 5 requires continuing education of not less than 15 hours a year. This is for both people who are certified and people working under the exceptions. Everyone in this position would need to have 15 hours annually. Both the certification records and the continuing education (CE) records would be maintained by the hospital.

Section 6 specifically clarifies that these requirements for certification do not apply to other professionals. This was a really important piece. This is not about scope of practice at all. We wanted to make sure that anyone who has a license under Title 54, which would include physicians, physician assistants, nurses, or anyone who has an official license in some other capacity in Nevada does not, in addition, have to take this certification. They are allowed to work in operating rooms (ORs) by virtue of their licenses. We wanted to make sure that it was very clear that we are not asking them to do additional things.

Sections 8 through 16 provide for regulations to be developed and for the implementation of these provisions in the same way that other hospital requirements are implemented. As I have gone through the main provisions of the bill, I would like to turn it over to Marlene Lockard for some additional expert testimony.

Marlene Lockard, representing Service Employees International Union #1107:
Surgical technologists are a very important component of our health care association within the Service Employees International Union (SEIU). We have asked Catherine Sparkman from the national Surgical Technologists Association to be here today. She is the real expert in the room and will give you additional information on the bill.

Catherine A.G. Sparkman, Director, Government and Public Affairs, Association of Surgical Technologists:
[Catherine Sparkman spoke from prepared text (Exhibit K).] The Association of Surgical Technologists (AST) is the national professional organization representing nearly 40,000 members and the interests of 75,000 certified surgical technologists nationwide. I appreciate the opportunity to be able to testify in support of A.B. 347. The AST certainly supports this measure, and I want to thank Assemblywoman Joiner for sponsoring this important patient-safety bill.

The legislation, as you have heard in summary, requires that all surgical technologists in operating rooms be appropriately educated and credentialed, and that they remain current in their field through continuing education. It is not licensure; it is not professional regulation; it does not expand the scope of practice. It is an entry-to-practice benchmark for hospitals

and ambulatory surgical centers to hire certified surgical technologists, and thereby assures every patient undergoing surgical or other operative procedures can count on all members of the surgical team to have the competencies and to have an efficient and safe surgical procedure.

You also heard that the legislation grandfathers currently-practicing surgical technologists and creates a hardship waiver for facilities that make good-faith efforts to hire credentialed individuals. This is the singular public policy mission of the AST. I have been with the Association for about a decade. Before that I was a medical malpractice defense attorney. I have great respect for the zeal and attentiveness of this Association and its members throughout the states to work toward this patient-safety legislation. Since I have been with the Association, legislation similar to A.B. 347 has been passed in ten states—Virginia, Arkansas, New York, Massachusetts, New Jersey, South Carolina, Indiana, Tennessee, Texas, and Oregon. There are registration laws in Colorado, Illinois, and Washington that govern these practitioners. In addition to Nevada, we have bills pending in Pennsylvania, Ohio, North Carolina, and Nebraska.

There are surgical technologists with me to talk about what goes on behind the double doors to the ORs. Surgical technologists are such valuable members of the surgical team. They ensure supplies, equipment, and instruments are available and operational. They defend the sterile field; they anticipate the sequential order of surgical procedures; they help to have efficient and expeditious surgical care at the operating room table. One surgeon who testified in support of the Oregon bill said that every minute a surgical patient is under anesthesia it gets worse for them, and efficient and effective surgical technologists shorten that time and create patient safety on that baseline level.

Competency is important; we all embrace that. Preventable medical errors and surgical site infections affect these outcomes and also drive health care costs. Of the eight preventable medical errors defined by Medicare as "never events"—events that should never occur—five of them occur in the OR. Surgical site infections, in the latest study, result in an estimated 13,500 deaths per year. Each readmission to cure a surgical site infection costs a hospital an average of $25,500. In 1998, a landmark study by the Institute of Medicine calculated 98,000 deaths annually were attributed to preventable medical care. Recently, those figures were updated by the *Journal of Patient Safety*. That figure is now calculated at 440,000 patient deaths from preventable errors in hospitals.

Surgical technologists do positively impact these figures. A recent study in Virginia of hospitals that only employed certified surgical technologists showed an 11 percent reduction in surgical-site infection costs. Minnesota publicly reports adverse medical events in that state. Data collected in Minnesota from 2008 through 2015, revealed that adverse surgical events were 40 percent less frequent in hospitals that utilized only certified surgical technologists. Finally, the surgical technologists who were educated in identifying and correcting asepsis are instrumental in providing overall quality care. This, of course, does not address the human costs of patients who suffer retained objects, preventable surgical errors, and sepsis.

Patients assume that all personnel caring for them are properly educated and have appropriate clinical experience. Surgical technologists remain the only members of the surgical team who are not required to meet threshold certification criteria. Passage of this certification bill will obviate this alarming disparity and ensure that all personnel caring for patients undergoing surgery are appropriately educated and meet minimum education standards. Surgical patients in Nevada deserve no less.

Travis Kieckbusch, Private Citizen, Reno, Nevada:
[Travis Kieckbusch spoke from prepared text (Exhibit L) and provided additional proponent testimony (Exhibit M).] I have been a practicing orthopedic surgeon in Reno for approximately 15 years. My life on an everyday basis revolves around surgical technologists and working with them. They play a very large role in the OR, as you have heard, from making sure everything is prepared, to assisting during the case, to maintaining safety and sterility in the room. A lot of that falls on their shoulders. As you have heard, the OR is a very regulated place from the physicians to the anesthesiologists to the nurses. We all have many years of training; however, even I, when I walk into an operating room do not necessarily know the training that the surgical technologist has at that time. You can learn some of that by working with them, but one small error on their part can lead to disastrous problems down the road. I can tell you from personal experience that patient infections are a huge deal that can change the patient's life for a long time.

That is something that can be regulated better than it is. Continuing education for this is also very important because this is an ever-expanding field. If you walk into an OR where we are doing a total joint revision or a major surgical procedure, there can be more than a thousand instruments. Those instruments have to be assembled correctly; they have to be washed; they have to be tracked; and any changes in that function can change the outcome of the case. This bill is very important to maintaining a certain level of competency and making sure that when my patients or my family walk into an operating room there is a certain level of competence. If I talk to my patients at this point, they do not understand the process and that surgical technologists are not all on the same level. Everywhere we look, there can be many different training programs. That can lead to significant patient-safety issues that this bill readily addresses, and I would wholly support it.

Cris M. Aguilar, Program Director/Instructor, Surgical Technology Program, Engelstad School of Health Sciences, College of Southern Nevada:
I have been a certified surgical technologist for ten years, and for the last five years, I have been the surgical program director at the College of Southern Nevada (CSN) in Las Vegas. The surgical technologist program at CSN is programmatically accredited and offers an associate of applied science degree in surgical technology. Our current core curriculum is over 200 pages long. Along with that, our students are required to take an active role in surgical specialties at different times throughout their clinical rotation. They are required to take part in surgical specialties from different areas of surgery in order to graduate.

The complexity of surgery has grown a lot over the years. Surgery changes very quickly. There are surgeries happening today that did not exist ten years ago. There are also surgeries

happening today that were not even thought of 20 years ago, so that education component is really important to how our surgical technologists are trained. It is very important so they can work efficiently.

Surgical technologists need to be knowledgeable in biology, anatomy, physiology, and pharmacology just to name a few, so they can be competent and help in surgery. Our program offers didactic knowledge and clinical knowledge. Those, along with the experience they gain in the OR, makes them competent. It makes them ready to go and able to care for the patient the best they can, so they can be shoulder to shoulder with the surgeons working on our patients. The risk of surgical-site infections is real. If our surgical technologists and the people who are in that OR are not trained to focus on the sterility of the procedure and aseptic technique, that is one of the causes and, unfortunately, it will continue to happen.

The College of Southern Nevada supports underserved communities and also supports using innovative technology. Because of that, beginning this fall of 2017, we will be expanding to northern Nevada. We have a unique partnership with Truckee Meadows Community College (TMCC) and our clinical partners here. Starting this fall, we will be accepting as many as ten students in northern Nevada who will complete their clinical rotations here in northern Nevada to help the need for more certified surgical technologists.

Graduating from an accredited surgical technology program is the main avenue for certification. The National Board of Surgical Technology and Surgical Assisting offers the only approved certification exam. This means that every student who wants to graduate from an accredited program must take that certification exam. That, along with our expansion to Reno, is going to increase dramatically the number of certified surgical technologists in northern Nevada. The formal education process has been embraced by northern Nevada. We have met with several representatives of the facilities here in the north. They are all very excited and have offered their ORs for our students to complete their clinical rotations in. They are also very excited to employ certified surgical technologists who they have had a hand in training.

I asked our current students why certification is important to them, and I am including some of their responses:

- Being a certified surgical technologist validates my skills and education.
- I want to know that in Nevada we are working towards a more uniform and consistent standard of care for our patients.
- Our patients have family and friends attached to them—I need to know why I do what I do in surgery, and my education has helped me accomplish that.
- Knowing why I do what I do allows me to anticipate, which helps me be more efficient, which in turn reduces time that our patient is under anesthesia.

John D. Brophy, Private Citizen, Sparks, Nevada:
I am a certified surgical technologist practicing in Reno and Sparks for the last 28 years. Across the United States, there are thousands of surgeries daily. In Nevada, there are hundreds of surgeries daily. In the overwhelmingly vast majority of these cases, a surgical technologist is present. The surgical technologist is the unknown, masked person behind the red line of the operating room. Unless you work in the OR, or have a spouse who is in the OR, you do not know what we do for a living; but fundamentally, the surgical technologist is responsible for all sterile preparation for a surgery, including the supplies and the instruments. They must have a very good knowledge of pharmacology, biology, and especially of anatomy and physiology, so that they can anticipate the surgeon's needs and achieve a positive patient outcome. Not only is the surgical technologist responsible for all the sterile enforcement and technique, but they are also involved in preincision time out and for counting all the sponges, needles, and any other instrument that may be retained accidently inside a patient. Surgery is very serious business, especially if you are a patient. It is fair to say that every patient going to the OR expects that the person who steps up to the table with his or her gown and gloves on has a certain level of education. By having our surgical technologists formally trained and credentialed through an approved program, patient safety will be optimized. In states where surgical technology legislation has been passed, the incidences of retained objects and surgical infections have decreased dramatically. Patients in Nevada need and expect this type of competence.

Chairman Sprinkle:
I will open it up for questions from the Committee.

Assemblywoman Titus:
Having just lost a very close friend and patient due to a surgical infection/osteomyelitis after back surgery, I appreciate the concept and need for surgical technique sterility in training. My question is to the director of the program. How many total hours of training, not just clinical hours, are there? Then they get an associate's degree, is that correct?

Cris Aguilar:
Our students graduate with an associate of applied science degree. We have a 16-week fall semester which is didactic in lecture—Monday through Thursday, eight hours a day. We have a 16-week spring semester which is lecture and clinical rotations. There are two 8-hour days a week and three 8-hour days in the operating room.

Assemblywoman Titus:
And the cost?

Cris Aguilar:
The approximate cost for Nevada residents, once all is said and done, because there are immunizations and things like that also, is $12,000.

Assemblywoman Titus:
So the cost of the program is $12,000 for residents. Do you know the hourly wage of a surgical technologist?

Cris Aguilar:
There is a big range, but the graduates I have seen receive between $17 and $24 an hour.

Assemblywoman Titus:
I appreciate that you are grandfathering in those who are already doing this job. Especially out in the rural areas where it may be hard to find these folks, though I understand and appreciate the requirement. How many slots are there for training in Nevada at this time?

Cris Aguilar:
There are two accredited programs. There is the College of Southern Nevada in Las Vegas and in Reno this coming fall. There is also the Nevada Career Institute in Las Vegas. The CSN takes ten students every year in Las Vegas, and we aim to accept ten students every year in Reno.

Assemblywoman Titus:
How many existing surgical technologists are there now in Nevada?

Catherine Sparkman:
There are 280 certified surgical technologists who are members of the Association. Our standard rule of thumb is that you multiply that number by a factor of 2, so there are probably between 400 and 500 practicing surgical technologists in Nevada.

Assemblywoman Titus:
So there are 400 or 500 surgical techs in Nevada, and you are producing 20 certified techs a year.

Cris Aguilar:
We will be producing 20 after this fall of 2017. I do not know what the Nevada Career Institute graduates a year.

Chairman Sprinkle:
Once these individuals have completed the program and they get their certification, does that come with a higher pay scale?

Cris Aguilar:
Yes. I can speak for Las Vegas where there are several facilities that provide a pay increase for certified surgical technologists.

Chairman Sprinkle:
Under section 4, subsection 3, how exactly does a surgery center show proof of "a thorough and diligent search"? My concern is that it did not seem as though it was a lot. There was

a really high bar they had to reach to show proof of that, which pretty much takes away the mandate you are trying to get to in this bill.

Assemblywoman Joiner:
The way the bill is drafted it would go to the regulatory process, because there are provisions to allow that to be added to the regulations concerning hospital inspections. It depends on how the regulations are drafted, but there are some currently in law where we do this; where there are exceptions like this, for example, with some of the respiratory therapists. They look at personnel files and do spot checks. They would just need to document that they had advertised and had been unable to find a surgical technologist, but that could be done through regulation.

As for your concern about whether that bar is high enough, I believe any improvement is an improvement. As the number of certified slots rise, and as we are educated and expect to have certified people in the hospitals, I think we will consistently improve. I understand that at the beginning it may be small steps, but every time there is a certified, well-qualified person in the OR, I think that is an improvement over what we currently have, and that will continue to grow.

Chairman Sprinkle:
I am very supportive of what you are trying to do. I just want to be sure that the legislative intent today is that we want these surgical technologists to graduate from a certified program and be certified, and that money or other business opportunities do not dilute what the legislative intent of this bill is.

Assemblywoman Joiner:
My intent is absolutely that everyone in an OR should have this certification. The reason you see the exemptions in this bill is the reality of gearing that up. But my hope is that every one of them would be.

Assemblyman Carrillo:
My question also concerns section 4, subsection 3, which basically says that the health care facility can hire surgical technologists with the qualifications that are laid out in the section. I am worried that we do not have enough programs in Nevada to fulfill the need that has been described here today. Are there any other programs for surgical technologists in Nevada besides the one at CSN?

Cris Aguilar:
There are two: the College of Southern Nevada in Las Vegas that, this coming fall, will be in Reno, and the Nevada Career Institute in Las Vegas. There are also accelerated alternate delivery (AAD) programs—accelerated programs for technologists who are on-the-job trained and want to be certified. A lot of those are online programs. There may be about ten of those programs. If I am an on-the-job-trained technologist and I want to be certified, I can go through one of the AAD programs.

Chairman Sprinkle:
Are there any other questions from the Committee?

Assemblyman Yeager:
I have a question concerning section 4, subsection 1, paragraph (c) which talks about the grandfathering in of individuals who already ". . . engaged in the practice of surgical technology . . . ." Is that meant to apply if someone leaves their current health care facility and seeks employment at another health care facility, or would it just be grandfathered in at the location where the individual currently worked?

Catherine Sparkman:
It is intended to be portable from hospital to hospital, so that the grandfather clause would be extended. I want to talk briefly about the hardship provision. Nearly every state has a version of the hardship clause in A.B. 347. To my knowledge, and we track this very carefully, I have only had one instance where someone contacted me and asked for the provisions. It happened to be in a very rural area in west Texas. The hospital had searched and made efforts to try to find a certified surgical technologist. The facilities take this very seriously and seek to find certified surgical technologists whenever possible. In addition to the colleges here and the AAD, which are distance-learning programs of surgical technology, there are 10, soon to be 12, accredited programs nationwide that allow online training and online courses. The clinical aspects of the courses are then provided by the relevant hospitals in the state. So there is that opportunity for additional certified surgical technologists because it is a nationally accredited education program and a nationally accredited, verified surgical technologist credential. There are 26 programs in California, and there are programs around Nevada as well as the distance learning programs Mr. Aguilar spoke of.

Chairman Sprinkle:
Are there any other questions? [There was no response.] We will open it up for testimony in support of A.B. 347.

Bill M. Welch, President/Chief Executive Officer, Nevada Hospital Association:
I am here to speak in support of A.B. 347. Our hospitals are always striving to make sure that our workforce is properly trained and as qualified as possible. We appreciate the sponsor of this legislation working with us and understanding the workforce shortages and challenges that we have in Nevada. She has worked very closely with us, and we are very comfortable with this legislation and are very supportive of it.

Joan Hall, President, Nevada Rural Hospital Partners:
We are also in support and would like to thank the sponsor for recognizing rural-recruitment issues. We look forward to participating in the regulation process.

Chairman Sprinkle:
Is there anyone else here in support? [There was no response.] Is there anyone here in opposition to A.B. 347? [There was no response.] How about neutral? [There was no one.] Assemblywoman Joiner, would you like to come back up?

Assemblywoman Joiner:
Thank you for your time and for considering this measure. I really do believe that it will improve patient safety in Nevada.

Chairman Sprinkle:
I will close the hearing on A.B. 347.

[(Exhibit N), (Exhibit O), (Exhibit P), and (Exhibit Q) were submitted but not discussed, and are included as exhibits for the meeting.]

Committee, we will switch gears and go ahead and work session the bills on our agenda today, excluding A.B. 203, which has been pulled.

Marsheilah Lyons, Committee Policy Analyst:
As a staff member of the Legislative Counsel Bureau, I may not advocate for or oppose any policies or bills that come before the Committee. At the request of the Chairman, I will be walking the Committee through the work session document today.

The first bill in the work session document is Assembly Bill 46.

Assembly Bill 46: Revises provisions governing services provided to persons with mental illness and other disabilities. (BDR 39-132)

[Marsheilah Lyons read an explanation of the bill (Exhibit R).] Assembly Bill 46 makes various changes related to community-based living arrangement services. It defines this term to mean flexible individual services provided in the home to persons with mental illness or related conditions and designed to assist such persons in maximizing independence. The Division of Public and Behavioral Health submitted an amendment for this measure, which is attached to the work session document. There are two parts to the amendment presented there. The Legal Division of the Legislative Counsel Bureau has information for the Committee's consideration regarding the amendment.

Mike Morton, Committee Counsel:
I would like to direct the Committee's attention to page 2 of the work session document (Exhibit R). The Legal Division has some concerns with the amendment labeled "2. Stakeholder Amendment." There is a good body of case law that comes out of both the U.S. Supreme Court and the Ninth Circuit Court based on the *Olmstead* decision and the Americans with Disabilities Act that states you cannot deny the most integrated services possible based on a person's level of disability. Amendment 2 would do that, so our office would advise this Committee not to consider amendment 2.

Chairman Sprinkle:
Are there any questions from the Committee? [There were none.] Seeing none, I will accept a motion to amend and do pass with the sponsor amendment, number 1.

ASSEMBLYMAN McCURDY MOVED TO AMEND AND DO PASS ASSEMBLY BILL 46 WITH THE SPONSOR AMENDMENT, PROPOSED AMENDMENT NUMBER 1.

ASSEMBLYMAN YEAGER SECONDED THE MOTION.

Is there any discussion on the motion? [There was none.]

THE MOTION PASSED. (ASSEMBLYWOMAN BENITEZ-THOMPSON WAS ABSENT FOR THE VOTE.)

Marsheilah Lyons, Committee Policy Analyst:
We will move on to Assembly Bill 113.

Assembly Bill 113: Requires an employer to make certain accommodations for a nursing mother. (BDR 40-7)

[Marsheilah Lyons read an explanation of the bill from the work session document (Exhibit S).] Assembly Bill 113 requires each public and private employer in the state, other than the Department of Corrections, to provide reasonable break time and an appropriate place for an employee who is a nursing mother to express breast milk. In response to some concerns that were raised, the sponsor of the bill proposes an amendment that is attached to the work session document. The amendment:

1. Deletes authorization for mediation by a local health district.
2. Clarifies the standards for a place to express milk.
3. Makes allowances for undue hardship to public/private employers.
4. Substitutes the Employee-Management Committee for the Personnel Commission for the filing of complaints.
5. Clarifies the applicability of the bill to public entities.

Chairman Sprinkle:
Are there any questions or discussions on this bill? [There were none.] Seeing none, I will accept a motion for amend and do pass.

ASSEMBLYMAN THOMPSON MOVED TO AMEND AND DO PASS ASSEMBLY BILL 113.

ASSEMBLYWOMAN JOINER SECONDED THE MOTION.

Is there any discussion on the motion? [There was none.]

THE MOTION PASSED. (ASSEMBLYWOMAN TITUS VOTED NO. ASSEMBLYWOMAN BENITEZ-THOMPSON WAS ABSENT FOR THE VOTE.)

Marsheilah Lyons, Committee Policy Analyst:
Next is Assembly Bill 176.

Assembly Bill 176: Establishes certain requirements for the operation of seasonal or temporary recreation programs. (BDR 38-702)

[Marsheilah Lyons read an explanation of the bill from the work session document (Exhibit T).] Assembly Bill 176 requires a nongovernmental person or entity that operates a seasonal or temporary recreation program to comply with requirements relating to: certain health and safety standards, the safety of participants, staff, and the maintenance of certain records regarding participants. Assemblyman Frierson proposed an amendment, which is attached. I would also like to note that local governments that operate out-of-school recreation programs are currently mandated to comply with the standards and requirements that are set forth in this measure.

Chairman Sprinkle:
Are there any discussions or questions on this bill? [There was no response.] Seeing none, I will take a motion to amend and do pass.

> ASSEMBLYMAN McCURDY MOVED TO AMEND AND DO PASS ASSEMBLY BILL 176.
>
> ASSEMBLYMAN CARRILLO SECONDED THE MOTION.

Is there any discussion on the motion?

Assemblywoman Titus:
I am going to vote yes to pass this out of Committee, but I may vote no on the floor.

> THE MOTION PASSED. (ASSEMBLYWOMAN BENITEZ-THOMPSON WAS ABSENT FOR THE VOTE.)

Marsheilah Lyons, Committee Policy Analyst:
The final bill is Assembly Bill 236.

Assembly Bill 236: Authorizes an agency which provides child welfare services to obtain the education records of certain pupils. (BDR 38-838)

[Marsheilah Lyons read a description of the bill from the work session document (Exhibit U).] Assembly Bill 236 authorizes an employee of an agency that provides child welfare services and who has access to the case plan of a child in the custody of the agency, to request from a public or private school or school district, any records concerning the child. Assemblyman Sprinkle proposed an amendment, which is attached to the work session document.

Chairman Sprinkle:
Is there any discussion or questions on the bill?

Assemblywoman Titus:
I appreciate the amendments and appreciate your working with me about my concerns with this particular bill. I heartily support this with the amendments, and thank you for that.

Chairman Sprinkle:
Are there any other comments on this bill? [There was no response.] I will accept a motion for amend and do pass.

> ASSEMBLYWOMAN MILLER MOVED TO AMEND AND DO PASS ASSEMBLY BILL 236.
>
> ASSEMBLYMAN McCURDY SECONDED THE MOTION.

Is there any discussion on the motion? [There was none.]

> THE MOTION PASSED. (ASSEMBLYWOMAN BENITEZ-THOMPSON WAS ABSENT FOR THE VOTE.)

Chairman Sprinkle:
We will open the hearing on Assembly Bill 422.

Assembly Bill 422: Revises provisions relating to the medical use of marijuana. (BDR 40-983)

Assemblyman Nelson Araujo, Assembly District No. 3:
I am here to present Assembly Bill 422. I am going to yield my time to Riana Durrett, but I want to take a few seconds to share with the Committee that I decided to sponsor this bill because I care very deeply about the medical marijuana program. If there is one thing I want to come out of this session, it is strong legislation that will seek to protect the medical marijuana program amidst all the transitions that are taking place in this area. I hope the Committee will consider it. Riana Durrett will provide an overview of the bill.

Riana Durrett, Executive Director, Nevada Dispensary Association:
The Dispensary Association represents 80 percent of dispensaries statewide and 90 percent in southern Nevada, many of which are vertically integrated, so the owners also own cultivation and production licenses. In total, our members own approximately 100 of the 187 medical marijuana establishments currently in existence. I would like to start by first thanking the

sponsor, who has been a responsive proponent for the medical marijuana program and medical marijuana patients. We appreciate his help as we know he is busy this session. And thank you to Chairman Sprinkle and the Committee for hearing this bill today.

The dispensary-based medical marijuana program was established by legislation sponsored by Senator Tick Segerblom in 2013. Since that time, 187 establishments have opened. Nevada's program has been commended by many, including regulators from other states, who say that we set the national standard in many areas including testing, seed-to-sale tracking, and our high standards for the appearances of the dispensaries, as well as other areas.

The Nevada Dispensary Association supports the measures in this bill as a way to ensure the survival of the medical marijuana program. When the program was enacted, there was a projection that there would be approximately 55,000 to 65,000 patients within the first couple of years, similar to Arizona. However, currently, there are approximately only 26,000 patients. We believe the primary reason so few have become patients is that obtaining a card in Nevada has been unnecessarily difficult. The Division of Public and Behavioral Health has worked with the industry and patients to streamline the process, but, on top of obtaining a physician recommendation, which is similar to obtaining a prescription, a patient has to submit a lengthy application that must be notarized and then uploaded to a state portal. So these people are submitting their information, including sensitive medical information, online over the state portal. The patient portal has been unavailable on more than one occasion, so patients could not obtain cards at that time, and that portal has been compromised by cyber attacks. This bill would change the amount of information available should the registry be hacked again, and it would reduce the burden on the patients.

The Nevada Dispensary Association is appreciative that Nevada started out its program with this lengthy application in order to be cautious. We understand that when it was implemented, legislators did not know what to expect, and they wanted to ensure that this program was not being exploited by the underground, illegal market. Since that time, we have learned that these are legitimate patients who have a myriad of medical conditions including epilepsy, multiple sclerosis, cancer, chronic pain, et cetera. Since the beginning of this program, we have learned that we should no longer require these patients to jump through unnecessary hoops to obtain medication they need, especially when we do not require an application to the state for any other medication.

Another major consideration underlying this bill is that the 2016 passage of Nevada Ballot Question No. 2 legalized adult-use marijuana. Pursuant to Question No. 2, the current medical marijuana establishments will be the sole retail outlets for the first 18 months of the program. With passage of A.B, 422, the industry is asking, based on the experience of other states that have legalized adult use, that they be allowed to grow, store, and transport medical and recreational marijuana together. In Colorado, this is not allowed. Plants must be segregated throughout the entire seed-to-sale process. By combining the medical and

recreational plants throughout the process, we would streamline the operations of the facilities, allow them to save on overhead, allow the regulating agencies to save time and resources, and help ensure the success of the medical marijuana program.

In June 2016, the Nevada Dispensary Association organized a two-day conference in Colorado to meet with Colorado legislators, regulators, and industry representatives. The trip was attended by several Nevada legislators, regulators, and industry representatives. At the conference, representatives from government and industry related their experiences in Colorado. Many of the Nevada delegates concluded that only one state agency should be in charge of both medical and recreational marijuana rather than having a patchwork regulatory system where it is unclear who is enforcing what and there might be overlap.

Based on the experiences of our neighbors in Colorado, this bill would transfer the medical marijuana program to the Department of Taxation. Here are the main provisions of the bill: Transfer oversight of the medical marijuana program from the Department of Health and Human Services to the Department of Taxation. This transfer would be made to the Department of Taxation because the Department of Taxation is required to regulate recreational marijuana under Question No. 2. In order to have one agency have oversight, it would have to be the Department of Taxation.

Second, allow patients to obtain medical marijuana using their physician recommendation rather than going through a state-approved process. Maintain the current registry, but only require names, dates of birth, and patient card numbers, so law enforcement and other dispensaries can verify that the patient is valid, but we would be protecting sensitive information such as medical records and Social Security numbers.

Currently, there is a requirement that dispensaries must track each purchase of medical marijuana a patient makes. Each time they have to look the patient up, see how many grams they have, and record how many grams they have left. This bill would remove that requirement to keep track of patient purchases. It would remove the requirement to put the patient on equal footing with a recreational customer. We do not want the patients coming in and being slowed down, waylaid, investigated, and verified that they are allowed to use a certain amount of marijuana, when a recreational customer can breeze on by them, and they are admittedly using it for recreation. We want to make sure the patients are not being treated unfairly.

This bill would reduce the patient-purchase limit to one ounce. The bill would eliminate the fees associated with the card—currently $100 to obtain the card and $75 to renew. It would allow the card to last for two years rather than one year. There are also a couple of changes that would help the medical marijuana establishments and the way they run. We want to make the medical marijuana program attractive to business owners, so they will continue to cater to the patients.

This would allow potential employees to apply directly to the state to be able to work in an establishment. Currently, the establishments have to apply for their potential employees.

This would allow the facilities to combine a medical and recreational dispensary, and it would clarify that dispensaries can recognize physician recommendations from out of state. There is overwhelming evidence that when this program was implemented in 2013, the intent was to allow Nevada to have a reciprocity program and recognize physician recommendations from other states that have medical marijuana programs.

The last part of my presentation is to go over the amendments we have requested. We have requested to ensure that the law would reflect that this bill would not establish a new registry, but utilize the one that currently exists. We would like clarification that employees and independent contractors who qualify to work in the industry can work by obtaining one agent card. They would not need to apply for an additional agent card for every facility they are authorized to work in. Currently, there are owners, independent contractors, attorneys, and others who work in the industry, and some have as many as 47 agent cards, so we would like to streamline that process. Once you get a card, you are authorized to work in any establishment.

We have asked for an amendment to allow transfers between all facilities. Currently, there is a restriction on dispensary-to-dispensary transfers on products. It is not really clear why there is that restriction. I do not believe it is important to anyone to keep that restriction. Finally, we have asked for clarification that once this bill passes, as well as a companion bill that will be heard in Assembly Taxation, that the facilities will be able to store their products and transport them together. They will have a single stream of plants and products.

Assemblyman Araujo:
I know that the Committee had specific questions for both the Division of Public and Behavior Health and the Department of Taxation, and they are here to answer those questions.

Chairman Sprinkle:
Are there questions from the Committee?

Assemblywoman Titus:
In section 5, subsection 5, it says, "A listing in the medical marijuana registry expires 2 years after the date of receipt of the written documentation . . . ." I am concerned. When I see a patient and I write a prescription, I am mandated by the Physician Practice Act to follow up, and, generally, a year is the maximum. So, a medical recommendation or card is going to be good for two years; is that the way this reads?

Riana Durrett:
We had requested three years, but the state's Chief Medical Officer weighed in and said he preferred that it be two years and not three years.

Assemblywoman Titus:
If I am treating it like an illness, I am going to ask a patient to come back. If I only recommend it for a year, how is that going to work? Even though I recommend that the card

is only good for a year because I want to see that patient back in a year, you will be able to give them the card for two years regardless of what the medical provider recommends?

Riana Durrett:
That is correct. Administratively we do not have a mechanism to ensure that these cards only last for one year if we go with the system that is being proposed. The reason I mention that the state's Chief Medical Officer weighed in on this is potential support that two years is okay when it comes to medical marijuana. Perhaps not with other medications, but when it is medical marijuana, I do not think there is the concern that they need to visit a doctor more often.

Assemblywoman Titus:
We are giving this for seizures, for severe pain, for nausea, but he is okay with giving the card for two years.

Riana Durrett:
I was not the one who had the conversation with him, but I believe that he was okay with two years given that he opposed the three years. This would not prevent anyone from going to see their doctor. It would not prevent the doctor from telling the patient to come in every year, but it would allow the card to last for two years.

Assemblywoman Titus:
Section 17, subsection 2, says, "The term includes such documentation which is submitted electronically to a medical marijuana dispensary." Does that mean that the medical recommendation/documentation can be submitted electronically?

Riana Durrett:
No. Currently, the patient obtains the recommendation, and then they upload it to the state portal to apply to the state for approval. This would completely change the process and allow the dispensary to upload that to the state portal instead of requiring the extra step of going to the state through an application process.

The reason it is not a big concern that a medical marijuana card lasts for two years is that, if someone wants to refuse to see their doctor and not be responsible, they can just buy recreational marijuana. Now that recreational marijuana is legal, there is not as big a concern when people are using medical marijuana.

Assemblywoman Titus:
In section 43, you are going to accept a medical recommendation for a nonresident with a card, assuming that their medical recommendation truly came from a licensed provider in another state. You will not ask for any other documentation. You are just going to allow nonresidents to do this based on a recommendation from a provider from another state.

Riana Durrett:
Right. That is currently the case. They sign an attestation, so yes, the responsibility is on the patient. If they are fraudulently signing this attestation, then it is a law enforcement issue. Currently, they sign an attestation and provide their physician's recommendation. Many of the physician recommendations that come from California do have information on them like a website or doctor's office you can call to verify, but that is not required.

Assemblywoman Titus:
This would not be doing any verification. There is no mandate for verification. Is that correct?

Riana Durrett:
Correct. It would keep the current system requiring an attestation.

Assemblyman Carrillo:
Under the current statute, these applications for medical marijuana are going through the Division of Public and Behavioral Health which has a state medical officer, correct?

Chad Warren Westom, Bureau Chief, Division of Public and Behavioral Health, Department of Health and Human Services:
Yes, the Division has a chief medical officer.

Assemblyman Carrillo:
I am concerned about who will be reviewing these applications for medical necessity at the Department of Taxation.

Riana Durrett:
Currently, that medical officer does not weigh in on these. We assume that the doctors providing the recommendations are legitimately providing them. It is really between a doctor and a patient currently. The Division of Public and Behavioral Health reviews whether they have passed the current background check requirement, which will no longer be required under this bill; they have submitted the fee and requirements like that. I do not think that our state looks into whether there is a legitimate medical need, because we are relying on the doctors to do that.

Assemblyman Hambrick:
If someone has a concealed weapons permit, does that raise a problem or question in your eyes when they come in? They have a medical need, but is there a potential problem when you sell it? I am concerned that someone could get a card for a legitimate need, but that individual might also be a weapons carrier. Sometimes, that is a bad mixture.

Neal Tomlinson, representing Nevada Dispensary Association:
We have been looking into that and discussing it with law enforcement. There are a couple of considerations. The current federal guidance on the issue right now comes from the Cole Memo from the Department of Justice. There are eight guiding principles. One involves

weapons. We are very sensitive to this area and looking at it, but we are having those discussions with law enforcement and there may be a way, in situations such as this, to allow law enforcement to have access to the registry or a form of the registry.

Chairman Sprinkle:
Are there any further questions from the Committee?

Assemblyman Oscarson:
Currently, you cannot have a medical marijuana card and have a concealed weapons (CCW) permit. Is that correct?

Neal Tomlinson:
My understanding is that when you apply for your CCW, if you are honest on your application and mark that you are a medical marijuana patient, then your application would be denied. I am not sure how law enforcement handles people who have existing CCWs who then later become medical marijuana patients.

Assemblyman Oscarson:
So, if they answer correctly, they are not allowed to have a card.

Neal Tomlinson:
That is correct.

Chairman Sprinkle:
I was here when we started this whole medical marijuana program, and one of the strong arguments for it was the medicinal value of marijuana and how this was going to start generating an industry and a thought process that was more along the lines of research, on science, on how this was beneficial to the patients. This was the strong argument, and very much an argument I agreed with. I understood, and it was one of the reasons I put my support behind this. My concern is where this will end up if we move this to the Department of Taxation. While I heard some of the arguments in the opening statements, I would really like to hear from the Division of Public and Behavioral Health why there is such agreement that this is the smart thing to do with this program—moving it completely out of the Department of Health and Human Services.

Chad Westom:
The Division of Public and Behavioral Health, as mentioned in the opening comments, has worked with the Department of Taxation. It is believed that there would be streamlining and efficient use of state resources if both programs were housed within one department. We have been working together with the industry and with our partners at Taxation to ensure that nothing falls between the cracks, and all the requirements of the law and protection of the patients remain.

Chairman Sprinkle:
So, we do this and we move it forward. At what point do we just simply say that we do not need a medical marijuana program anymore because it is now legalized? I have been told that the regulations are all going to be the same; that the quality of the product is going to be the same. We are now lessening all the requirements for somebody to receive a medical marijuana card. Why even have it anymore? If we go with the notion—take the feds completely out of it—that Nevada has legalized this, it seems to me that you are just blending in that fine line that was very important to me when I first voted on the program four years ago. That line is going to be blurred now, so I do not even know why we continue with it if all the regulations are going to be the same, if the product is going to be the same, if everything is going to be the same, and it is legal for people to buy recreational marijuana.

Chad Westom:
The patient program currently has approximately 27,000 patients. There has been a steep increase in patients. There has been a steep demand for the cards. If the fees are reduced, evidence from other states indicates that patient counts will go up. It is projected that there might be as many as 60,000 patients in Nevada. As I understand it, there are tax incentives for patients. The requirements for medical marijuana have been stringent, and we have gotten recognition from other states as far as having a really well-run program. I think there is a place for patients currently and moving forward. We will do our best to work with our regulatory partners to have a smooth transition.

Chairman Sprinkle:
I am sure we will be having more discussions about this after this hearing, but I will leave it there. Are there any more questions from the Committee? [There were none.] Seeing none, we will bring up those who are in support of A.B. 422.

Will Adler, representing Sierra Cannabis Coalition:
We are also in support of A.B. 422 and the proposed amendment by the Nevada Dispensary Association to update A.B. 422. We support the bill because of what it does. Back in 2000, medical marijuana was thought of as a risky substance to allow Nevadans to use. They had to get a background check and go through a full criminal screening just for the ability to apply to get a medical marijuana card. In our eyes, this update probably should have been done in 2013 or 2015 before the sale of medical marijuana happened. In 2000, getting a medical marijuana card was purposely made to be onerous and hard to prevent unnecessary applicants from coming through. Now that we have recreational marijuana, it does make sense to remove the criminal background check and remove the excess screening that we do. This is for medical marijuana patients who wish to apply, and we believe that is a choice between them and their doctors. It should not be done with state oversight or a background check, because we now have recreational marijuana.

In addition, streamlining the structure to have medical and recreational marijuana under one agency makes sense from an efficiency standpoint. Hopefully, the right people from the current program will move over into the Department of Taxation and bring their expertise with them. We have people who have already been in the industry working with us for years.

They know the patient community. They know how to work with it, and if they can be moved over from the Division of Public and Behavioral Health, we are hoping they will bring that expertise with them to Taxation.

In general, this bill does a lot of updates we would like to see. It also streamlines the card program that says people no longer have to get two or three agent cards to work in the marijuana industry. Right now, if you work at a different location, from cultivation to production or production to a dispensary, or all three, you have to get a card for each facility you work at. This card program update in the amendment will streamline that. If you are an employee able to work in the industry, you should be allowed to work at more than one certain address. For example, one of a delivery service's drivers has 47 cards because of all the places he goes. He has to file a new card application and a new background check for each of those. This is updating the program, streamlining it, and adding efficiencies that are much needed in our eyes.

Marla McDade Williams, representing Nevada Cannabis Coalition:
I would like to extend our appreciation to Assemblyman Araujo for bringing this bill forward. We share his support for ensuring that medical marijuana continues into the future to serve medical patients. The Nevada Cannabis Coalition has a number of members holding 43 total certificates throughout the state. We are currently working with Ms. Durrett and the Nevada Dispensary Association and have some additional recommendations that we have spoken with the bill's sponsor about.

We support revising the patient registry system, but would like it simplified beyond what is currently in the bill. We do prefer having the physician recommendation serve as the authorization for the purchase at a dispensary, and having the dispensary register the patient into the registry system. If a physician has recommended an expiration date for the patient, that date can be entered as well; otherwise, we support not requiring an expiration date for medicinal use and leaving it up to the patient and his or her physician to work that situation out.

We also would ask to eliminate some of the bureaucratic burden that would be placed on the Department of Taxation with the transfer, and the Department not be required to issue a letter of authorization to the patient once the patient has been entered into the system. We support revising the out-of-state recommendation, but we would like to ensure the language is clear that an out-of-state patient is eligible to purchase medical marijuana in Nevada if that patient's originating state authorizes marijuana for medicinal use. We just do not want the language limited to an authorization that is issued by a state or jurisdiction. We support efforts to revise the patient tracking system and eliminate the 14-day limit on purchases. We also recommend allowing a medical marijuana patient to possess up to 2.5 ounces of marijuana rather than limiting that patient to 1 ounce. Doing so would be consistent with the patient's need for medication.

We support clarifying provisions related to independent contractors and agents. First, we believe it should be the responsibility of a potential employee to obtain his or her card on his

own behalf, which makes them eligible to work at a medical marijuana establishment. We would like to repeal any requirements that make the agent card the responsibility of the establishment. We would like to see an arrangement for independent contractors, and we support allowing an agent or independent contractor to work while the criminal background check is pending. Rather than impose a 30-day limit, we would like the language to state that the temporary card is good until the agent is approved or denied by the Department. We support allowing a dispensary to transfer product to another marijuana establishment, and we believe a caregiver should be allowed to be a caregiver to more than one person if that caregiver is caring for children or parents.

Finally, and we are still working through this issue with the Nevada Dispensary Association, but we would recommend, rather than limiting recommendations to a physician, that it be extended to any health care provider. That health care provider would determine whether it was under his or her scope of practice to make a recommendation for a patient. We will continue to work with the bill's sponsor and interested parties.

Chairman Sprinkle:
Is there anyone else here in support of this bill? [There was no one.] Is there anyone in opposition to A.B. 422?

Grace Crosley, Private Citizen, Reno, Nevada:
I am opposing A.B. 422 because I am really concerned about the loosening of regulations that are involved with getting a medical marijuana card. You were talking about what was the point of even having medical marijuana now that recreational marijuana is legalized. As I understand it, there are two benefits. The first is that, if you have a medical marijuana card, you get your marijuana cheaper because of taxes. Also, you can possess more marijuana than a recreational user can. Right now, there is legislation pending in the Senate that would increase even more the amount of marijuana that a home grower could have. It permits them to home grow under any circumstances, which is not the case now. It would make marijuana even cheaper for people of low income. In fact, in some cases, it would be free. Also, there was a discussion about firearms. There is also legislation pending that would give medical marijuana patients the right to get firearms.

Given these benefits—the cheaper marijuana and the ability to home grow and possess a greater amount of marijuana—the issue that arises is primarily the black market. What they found in other states is that medical marijuana card holders buy cheaper marijuana, or they home grow, often in excess of the amounts they are permitted to grow, and then they resell. Not only is that criminal, which is bad, but it also affects the state's bottom line because the state is missing out on the tax revenue it would ordinarily get from recreational marijuana sales, which are taxed higher.

All this is enabled by a second type of abuse, which is for-profit dispensaries that basically act as marijuana mills keeping doctors on staff who turn out prescriptions. There is an epidemic of this type of clinic in a lot of other states. I do not know about our state. We were concerned that marijuana patients were having trouble getting cards right now, or not

enough people have cards; however, certainly in Reno, the first dispensary just opened this last December, so I am not sure the supply has been there.

My big concern about marijuana mills though is not so much the black market; it is harm to actual patients who are considering marijuana for treating their health conditions. In these marijuana mills, someone will go in and pay a fee up front—possibly $150—to be seen. A doctor or registered nurse will see them, possibly on Skype. The person will explain what his or her condition is—headaches, anxiety, cancer, or anything. The doctor will agree that marijuana will help and write a prescription. These types of clinics are not looking out for the patient at all; they are just looking out for the bottom line. In many cases, marijuana mills are paying employees based on how many patients they refer. While keeping dispensaries open, we really need to prevent the proliferation of marijuana mills, both to prevent the black market and also to make sure people are not being given bad medical advice.

The way to do this would be to have the state verify the backgrounds of patients and caregivers as well as of the attending physician, confirm that the attending physician has a bone fide professional relationship with the patient, and that the patient has a condition that could merit treatment with medical marijuana. Exclude dispensaries from the application process and track the amount of medical marijuana purchased, so as to ensure the patient is only buying the amount he is legally entitled to possess. We are pretty much doing the opposite in this bill—placing dispensaries front and center in charge of processing documentation and adding patients to the registry. We are recording no information at all about the recommending physician and not doing a background check to see that physician's professional standing. We are not recording the patient's address or phone number or requiring proof of residence. We are giving them a registry that does not contain their address or photograph and extending the expiration date from one year to two years. We are removing all criteria for designated primary caregivers, and the primary caregivers can actually purchase and grow marijuana, just as the patient can. That is a big concern.

We are removing background checks to see if the patient or the caregiver has been convicted of drug dealing. We are also removing the ability for the Department of Taxation, in this case, to revoke registration if the patient or caregiver has been convicted of dealing drugs or is found to have falsified the documentation. As far as I can tell from the bill, the Department of Taxation would not even see the documentation to begin with, just the dispensary. According to this bill, we are failing to provide any way to remove a caregiver from the registry until their registration expires. We are allowing nonresidents to use doctors' notes to buy medical marijuana. There is a laundry list of things that are changing. I did notice that pretty much everyone in support of this bill is from the industry. I have no doubt that it would serve the industry's interests very well. There may be a concern that medical marijuana patients really do need to have a streamlined process for getting cards; however, I do not think the answer to that is to remove all checks and let anyone who wants to get a card.

Chairman Sprinkle:
Is there anyone else in opposition to this bill? [There was no response.] Is there anyone who is neutral to this bill? [There was no response.] Assemblyman Araujo?

Assemblyman Araujo:
I just wanted to thank the Committee and remind everyone that we clearly, as you heard from the testimony, still have some things to iron out. We will be working diligently to make sure that we all reach a great compromise, and we earn the Committee's support. If there are any questions we can answer, do not hesitate to reach out.

Chairman Sprinkle:
We will go ahead and close the hearing on A.B. 422.

[(Exhibit V) was submitted but not discussed, and is included as an exhibit for the meeting.]

At this point, I would like to open up public comment. Does anyone wish to come forward in either southern or northern Nevada? [There was no one.] Not seeing anyone, thank you, Committee for your hard work today. This meeting is adjourned [at 3:26 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 written testimony submitted by Christy Craig, Chief Deputy Public Defender, Office of the Public Defender, Clark County, in support of Assembly Bill 440.

Exhibit D is a link to an article by Francis McCabe published in the *Las Vegas Review-Journal*, titled "Repeat offenders called too much for Nevada mental health program to help them," dated June 15, 2014, submitted by Christy Craig, Chief Deputy Public Defender, Office of the Public Defender, Clark County, in support of Assembly Bill 440.

Exhibit E is a copy of the Minutes of the Assembly Committee on Health and Human Services meeting dated April 8, 2013, submitted by Christy Craig, Chief Deputy Public Defender, Office of the Public Defender, Clark County, in support of Assembly Bill 440.

Exhibit F is a letter to the Committee on Health and Human Services, dated April 5, 2017, presented by Elizabeth Gonzalez, Chief Judge, Eighth Judicial District Court, in support of Assembly Bill 440.

Exhibit G is an informational packet submitted by David Humke, District Judge, Second Judicial District Court, regarding Assembly Bill 440.

Exhibit H is written testimony dated April 5, 2017, presented by Frances M. Doherty, District Judge, Second Judicial District Court, in opposition to Assembly Bill 440.

Exhibit I is written testimony date April 6, 2017, submitted by Cynthia C. Lu, District Judge, Second Judicial District Court, in opposition to Assembly Bill 440.

Exhibit J is a letter to the Committee dated April 5, 2017, submitted by Brian Stettin, Policy Director, Treatment Advocacy Center, in opposition to Assembly Bill 440.

Exhibit K is written testimony dated April 5, 2017, presented by Catherine A.G. Sparkman, Director, Government and Public Affairs, Association of Surgical Technologists, in support of Assembly Bill 347.

Exhibit L is written testimony dated June 16, 2016, presented by Travis Kieckbusch, Private Citizen, Reno, Nevada, in support of Assembly Bill 347.

Exhibit M is additional written testimony submitted by Travis Kieckbusch, Private Citizen, Reno, Nevada, in support of Assembly Bill 347.

Exhibit N is written testimony titled "Supporting Surgical Technologist Education and Certification," submitted by Nevada State Assembly of the Association of Surgical Technologists, in support of Assembly Bill 347.

Exhibit O is a letter dated August 18, 2016 to the Nevada State Assembly of the Association of Surgical Technologists, from R.L. McElreath, M.D., Western Surgical Group, Reno, Nevada, regarding support for proposed legislation requiring entry-level standards for surgical technologists, in support of Assembly Bill 347.

Exhibit P is written testimony from Dovelyn Krueger, Certified Surgical Technologist, Henderson, Nevada, in support of Assembly Bill 347.

Exhibit Q is a copy of a letter to Chairman Sprinkle, Vice Chair Joiner, and Members of the Committee, dated April 5, 2017, submitted by Kay E. Keehnen, Certified Surgical Technologist, Reno, Nevada, in support of Assembly Bill 347.

Exhibit R is the Work Session Document for Assembly Bill 46, presented by Marsheilah Lyons, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit S is the Work Session Document for Assembly Bill 113, presented by Marsheilah Lyons, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit T is the Work Session Document for Assembly Bill 176, presented by Marsheilah Lyons, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit U is the Work Session Document for Assembly Bill 236, presented by Marsheilah Lyons, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit V is written testimony dated April 4, 2017, submitted by Laurel Stadler, Rural Coordinator and Legislative Liaison, Northern Nevada DUI Task Force, in opposition to Assembly Bill 422.