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

Eightieth Session
May 30, 2019

The Committee on Commerce and Labor was called to order by Chair Ellen B. Spiegel at 2:55 p.m. on Thursday, May 30, 2019, in Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/80th2019.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Ellen B. Spiegel, Chair
Assemblyman Jason Frierson, Vice Chair
Assemblywoman Maggie Carlton
Assemblyman Skip Daly
Assemblyman Chris Edwards
Assemblywoman Melissa Hardy
Assemblywoman Sandra Jauregui
Assemblyman Al Kramer
Assemblywoman Susie Martinez
Assemblyman William McCurdy II
Assemblywoman Dina Neal
Assemblywoman Jill Tolles
Assemblyman Steve Yeager

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Senator James A. Settelmeyer, Senate District No. 17
Senator Julia Ratti, Senate District No. 13

STAFF MEMBERS PRESENT:

Carol Stonefield, Deputy Research Director
Patrick Ashton, Committee Policy Analyst
Wil Keane, Committee Counsel
Earlene Miller, Committee Secretary
Olivia Lloyd, Committee Assistant

OTHERS PRESENT:

Danny Thompson, Private Citizen, Las Vegas, Nevada
Janine Hansen, State President, Nevada Families for Freedom
Miranda Hoover, representing Board of Homeopathic Medical Examiners
Lancette VanGuilder, Legislative Chair, Nevada Dental Hygienists' Association
Caryn Solie, Member, Nevada Dental Hygienists' Association
Alan Mandell, Vice Chairman, Pyramid Lake Paiute Tribe, Nixon, Nevada
Wendy Madson, Executive Director, Healthy Communities Coalition of Lyon and Storey Counties
Edward Coleman, Private Citizen, Reno, Nevada
Shaun Griffin, Board Member, Healthy Communities Coalition of Lyon and Storey Counties
Helen Foley, representing FirstMed
Marla McDade Williams, representing Reno-Sparks Indian Colony
Michael Hackett, representing Nevada Public Health Association; and Nevada Primary Care Association
Joelle Gutman, Government Affairs Liaison, Washoe County Health District
Judy Zabolocky, Private Citizen, Dayton, Nevada
Sarah Adler, representing Pyramid Lake Paiute Tribe
Patti Mason, Private Citizen, Carson City, Nevada
Sydney Anne McKenzie, Member, Nevada Dental Hygienists' Association
Antonio Ventura, President, Southern Nevada Dental Hygienists' Association
Jessica Woods, Private Citizen, Las Vegas, Nevada
Bianca Velayo, Private Citizen, Henderson, Nevada
Khoa Nguyen, Private Citizen, Las Vegas, Nevada
David L. Mahon, Private Citizen, Henderson, Nevada
Civon Gewelber, Private Citizen, Las Vegas, Nevada
Antonina Capurro, Nevada State Dental Health Officer, Nevada Oral Health Program, Division of Public and Behavioral Health, Department of Health and Human Services
Cody L. Phinney, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services

Chair Spiegel:
[Roll was taken and Committee rules and protocol were reviewed.] We will open the hearing with Senate Bill 98 (1st Reprint).

Senate Bill 98 (1st Reprint): Revises provisions governing the practice of homeopathic medicine. (BDR 54-519)

Danny Thompson, Private Citizen, Las Vegas, Nevada:
Senator James Settelmeyer was unable to be here this afternoon. He has asked me to read his statement into the record.

> Thank you, Madam Chair and members of the Committee. For the record, I am James Settelmeyer, representing Senate District No. 17.
>
> In the 2017-2018 Interim, I was a member of the Sunset Subcommittee of the Legislative Commission. I am here today to present Senate Bill 98 (1st Reprint).
>
> Initially, S.B. 98 (R1) contained a recommendation from the Sunset Subcommittee to terminate the Board of Homeopathic Medical Examiners and transfer its licensing authority to the Department of Health and Human Services.
>
> The Board was created by the Legislature in 1983. It consists of seven members appointed by the Governor.
>
> The Board is authorized to:
>
> - Regulate the practice of homeopathic medicine, including issuing credentials and investigating complaints; and
>
> - Transact all business relating to its duties.
>
> The Board was reviewed by the Sunset Subcommittee at its meeting on March 21, 2018. At that time, the Subcommittee learned that the Board owed approximately $145,000 to the Office of the Attorney General for services rendered. This debt has been accruing since 2004. By the end of fiscal year 2018, that debt had increased to about $150,000. I understand that it is larger now.
>
> Representatives of the Board testified they had a verbal understanding with the Attorney General that it would provide services to the Board and not charge fees. The Sunset Subcommittee then asked the Attorney General for

information on its relationship with the Board and to recommend a solution to the debt situation, which has dragged on for years. The Attorney General replied with an explanation of charges that have not been paid by the Board.

The letter from the Attorney General, in response to the Subcommittee's inquiry, has been posted to the Nevada Electronic Legislative Information System (NELIS) for today's meeting (Exhibit C).

Let me remind you, *Nevada Revised Statutes* (NRS) 232B.240 places on a Board the burden of proving that there is a public need for the Board's continued existence. We did not view the Board's record of management of its operations as meeting this standard. Instead, the Board has shown it is inefficient and ineffective in managing its affairs. The Board did not prove to us that there is a continued need for its existence. Therefore, the Sunset Subcommittee voted unanimously to recommend terminating the Board and transferring oversight to the Department of Health and Human Services with actual licensing functions performed by the Department of Health and Human Services.

The Sunset Subcommittee members also voted to request that the Legislature, the Governor, the Attorney General, and the Board work to resolve the matter of the outstanding debt.

Senate Bill 98 (1st Reprint) has been reviewed by the Senate Commerce and Labor Committee and Senate Finance Committee and there was an amendment adopted by the Senate Finance Committee that addresses some of the Sunset Subcommittee concerns.

I will direct my comments today to the revisions to Senate Bill 98 (1st Reprint). Before I begin, I would like to add that the chair of the Sunset Subcommittee in the 2017–2018 Interim—former Assemblywoman Irene Bustamante Adams—was consulted on the provisions of the amendment and supports these changes. I think I can speak for the members of the Sunset Subcommittee when I say that our purpose has always been to give the homeopathic practitioners a functioning licensing board.

With that in mind, let me summarize Senate Bill 98 (1st Reprint). The name of the Board will be changed to the Nevada Board of Homeopathic and Integrated Medicine Examiners. The number of board members will be increased from seven to eight. The new member must be an advanced practitioner of homeopathic medicine. Since the board will consist of eight members, the president may vote only in the case of a tie.

> The terms of the current members of the Board will expire on June 30, 2019. Initially, the Governor must appoint four new members with terms of two years and four new members with terms of four years—this will stagger the membership. After initial appointments, all members will have terms of four years. The fees are increased for all categories of licenses. At the first and last meetings of the Sunset Subcommittee in the next biennium, the new Board must report to the Subcommittee on its progress in improving its functions and performance. Any contracts or other agreements entered into by the existing Board or a representative of the Board will remain in effect managing the business operations relating to that licensing authority.
>
> The Sunset Subcommittee's objective with S.B. 98 (R1) is to clean up the financial mismanagement and set the licensing of this profession on a solid footing. It is time that the Legislature take action with regard to this Board. Thank you Madam Chair. I urge your support for S.B. 98 (R1).

In addition, there is a letter to the Attorney General relating to the debt, which shows the Nevada State Board of Homeopathic Medical Examiners and the new board will continue making payments of $1,500 a month, starting in April 2019 (Exhibit D). Payments will be made for all current bills and bills accrued going forward until that debt is paid off to the Attorney General.

Chair Spiegel:
I know there are a number of questions associated with this. We will start with the Committee.

Danny Thompson:
Carol Stonefield is in the audience, and she will be able to answer all the questions.

Chair Spiegel:
Do you know what changed Senator Settelmeyer's mind from the recommendation of the Sunset Subcommittee to terminate the Board and have it under the Department of Health and Human Services, to then have it come back, still be a stand-alone board, but with a different name?

Carol Stonefield, Deputy Research Director:
I was the committee policy analyst to the Sunset Subcommittee in the last interim, and as an employee of the Legislative Counsel Bureau, I will neither advocate nor oppose the provisions of this bill. The objective of the Sunset Subcommittee is to ensure that these licensing boards are functioning to serve the licensees and also to serve the public. It was the opinion of the Sunset Subcommittee that the current Board was not meeting the needs of the public, so the recommendation was to terminate the Board. There have been discussions with board representatives and others. The former Chair, Assemblywoman Irene Bustamante Adams, and Senator Settelmeyer came to the conclusion that reconstituting the Board would be the proper thing to do. This is not something new; the Sunset Subcommittee

recommended something like this in the 77th Session, when it first recommended terminating the Nevada Funeral and Cemetery Services Board, then through negotiations and assurances the Legislature agreed to reconstitute and revamp that board with all new members, a new director, et cetera; that board was then required to report to the Sunset Subcommittee.

The Sunset Subcommittee continues to maintain its interest in all of the boards to assure that they are fulfilling their agreements. Because this proposed new board would report back to the Sunset Subcommittee throughout the next interim, it would certainly be within the purview of the Board to come back and recommend termination of the Board if it continues to not function as it agreed to. It tends to work out for the best for these licensing professions to have boards that are focused upon the actual profession or occupation. Some of those people are active market participants, others are public members—but they have more knowledge. It is in the best interest of the profession to allow people who practice that profession to participate in the governance. The overall objective is a fully functioning licensing board.

Chair Spiegel:
I saw the letter to the Office of the Attorney General regarding the payment plan of the debts outstanding. Do you know if the Attorney General accepted the payment plan and if payments have been made?

Carol Stonefield:
I do not know if payments have started. I do know that there was a check provided to the chief financial officer of the Office of the Attorney General in March for a down payment of $30,000. I understand this agreement was anticipated to be implemented. I have not personally checked with the Office of the Attorney General to determine if the April or May payments were made, but I do know that is what was anticipated.

Chair Spiegel:
Do you have any insight as to what the reserves are?

Carol Stonefield:
I do not. I know the Division of Internal Audits released an audit in June 2018, which indicated the reserves available to the Board were approximately 2.8 months. I believe the legislative auditor suggests that these kinds of licensing boards should have somewhere between six months and a year of reserves. There has been a history with this Board where they have occasionally expended more than they had coming in—but I do not know. I can get that for you.

Chair Spiegel:
Do you know how many licensees the Board has now?

Carol Stonefield:
As of December 2018 there were 30 homeopathic physicians, 10 assistants, and approximately 18 advanced practitioners. Over the years the numbers have varied between roughly 65 and 75 individual licensees.

Chair Spiegel:
In the bill itself there were recommendations for fee increases, both for initial applicants as well as ongoing licenses. Do you know if anyone has crunched the numbers to see if these fees would be sufficient to cover the proposed budget? If they were at the caps, would the Board still be able to function and pay its debts?

Danny Thompson:
I believe those numbers would be sufficient for the operation of the Board.

Chair Spiegel:
Do either of you know how we would ensure the Board would be functioning appropriately in the future?

Carol Stonefield:
The assumption is they would continue to be reviewed by the Sunset Subcommittee and they are required to submit a balance sheet. The statutes vary depending upon the size of the budget, revenues, and expenditures of these licensing boards. The Nevada Board of Homeopathic Medical Examiners is a relatively small board; it is required to produce a balance sheet that is submitted to the legislative auditor, who then monitors those, along with every other board, and provides a report twice a year to legislators. The assumption would be if the legislative auditor is aware of anything that would be of concern, he would mention it in his letter to the legislators, and certainly to the Sunset Subcommittee. The auditor worked very closely with the Sunset Subcommittee in this last interim.

Assemblywoman Carlton:
I have worked with this Board off and on for numerous years, and as I look through the letter from the Attorney General, I see a lot of familiar names. Unfortunately, over the years this has been a very litigious board; when someone does not get their way, they take them to court—and there have been high court fees. Whether you win or lose, the court fees are still there—so I have some concerns. When I look at what has been charged to them for the services they have been provided under the previous administration, I have concerns. I would like to look into some of those legal bills to find out what was encapsulated in them. In the amendment, you are changing the name to the Nevada Board of Homeopathic and Integrated Medicine Examiners. Who are integrated medicine examiners, and what is their scope of practice?

Senator James A. Settelmeyer, Senate District No. 17:
I took over this bill at the request of Irene Bustamante Adams when we served together on the Sunset Subcommittee. The concept and discussion was to form a different name, so everybody knew that some of the problems had gone away, just as we did in a previous

session with the concept of the Funeral Board. We renamed it so that people understood there were new people in charge and things had changed. They are still the individuals who will be homeopathic doctors and it will be up to the Governor to make those appointments. We felt it was best to leave it to him, since when something goes wrong with the Board, it always comes back upon the Governor. He will find individuals within the field. I know there has been a good search of individuals who are being recommended from people who are far more familiar with homeopathic medicine than I am. I tend to be more of a traditional individual. I go to a regular doctor rather than a homeopathic doctor. In that respect, it will be the Governor who will make those appointments from individuals within the homeopathic medicine field.

Assemblywoman Carlton:
I do remember the conversation about the Funeral Board; we were here very late one evening. In changing the name, they did not change the scope of practice. This would actually, as I am reading it, add another layer of practice—they would be calling it integrated medicine examiners. Without knowing who that is, and without a scope of practice, we would not know who would be applying. It would be adding another scope of practice. The way it reads, it is Homeopathic and Integrated. Who and what is integrated practice? We know that scope of practice is like "stay in your lane" in this building. We had an issue we spent too many hours on this session between a number of boards. Who is this intended to actually cover?

Senator Settelmeyer:
Individuals within this specialty, who are more familiar than I, said this is a new niche of individuals who have that ability. We could get someone up to explain it, or at this late date in the game we could easily delete and move forward. I was told, as with many of our statutes within NRS, things change. I remember looking at the workers' compensation bill, Senate Bill 377 (1st Reprint), and there are a lot of things listed under osteopathic medicine that I did not even realize were specialties. I was told that was why it was being included, to try to make sure we recognize that the field is changing in order to update the statutes to recognize that change. That is what it is about. I am not familiar word for word. I will do the research of what exactly that modality is and send it to you and the Senate Committee by email. That is the best I can offer at this time.

Assemblywoman Carlton:
I just want to be sure, if we are going to be licensing somebody new, we give the Board guidance on whom to license. Because if they decide integrated medicine is acupuncture, physical therapy, or something else, they could start picking pieces of other scopes of practice and we could end up with a turf battle royal with 100 hours of session to go. In essence, this current board would be disbanded and have all new members. That is something we have tried to avoid in the past. We like to have institutional knowledge, but it appears to me this is a total change of the Board. I like staggered terms, but there would not be one person there for the institutional knowledge. I would have concerns that we might be

setting up the new members for failure. If they do not know where things are and how things are done, just going back and looking at meetings does not give you the idea. I am not sure if the staff might be able to help; but I would be concerned with a total cleansing of this Board.

Senator Settelmeyer:
We wanted to leave it up to the Governor as to that issue. If someone from the previous board put their name in and the Governor chose to accept them, that would be his responsibility to accept that individual. When we did the Funeral Board, we left the same opportunities to Governor Sandoval at the time, and he chose to go a different route. He chose all new individuals in an effort to avoid any of the problems that some felt had occurred in the past. As you remember, the Sunset Subcommittee tried to kill the Funeral Board. Instead, we brought it back to life and gave it the power to tax dead people. That is my short answer—we wanted to give the Governor flexibility. I would like to have my constituent try to answer that better.

Danny Thompson:
That is exactly right—there would be nothing to preclude the Governor from reappointing those same people or a group of those same people. I do not think there was anything magical about the name, and I certainly appreciate Assemblywoman Carlton's concern about turf battles. The whole idea was that there are so many people—I am a homeopathic patient. I was here when Senator James I. Gibson created the homeopathic field. There are a lot of people who see homeopathic doctors for all sorts of things. There was nothing magic in any of this, other than to keep it alive and not let this board, through mismanagement and missteps, go by the wayside. The name of the board does not matter as much, and the Governor is within his authority to reappoint whomever he wants.

Assemblywoman Carlton:
I remember doctors of homeopathy are also doctors of medicine (MD) in this state. When you add this other term to it, I am not sure if they would be MDs. Because you have the word "and" in there, it means there are actually two different categories. I would not want to put upon this Board that is not functioning at its optimum level the responsibility of having to come up with a scope of practice on a whole new section of medicine, and then have a couple of the people in this lawsuit sue them again. Most of these lawsuits are about people trying to get licensed and being told no, because the Board's responsibility was to protect the public; and because they protected the public, they went into debt. I would hate to set them up for failure again by having the "and" in there. It is not the Homeopathic Integrated Medicine, it is the Homeopathic "and" Integrated Medicine; I think that is where your problem might be.

Danny Thompson:
I totally agree. If you want to make that change, that is fine.

Chair Spiegel:
In section 5, subsection 7, it talks about the renewal fees and it referred to the maximum of $1,200 per year being the same whether someone is a physician, an advanced practitioner, or an assistant. Earlier in section 5, there are higher fees for physicians than for assistants, which seems to make sense based on a physician's salary being higher than an advanced practitioner, who would in turn earn more than an assistant. As this is written, I am wondering if that would leave enough room for the Legislative Commission to have different fees assessed for these different categories.

Senator Settelmeyer:
We wanted to leave the flexibility for this Board in order to try to recover fees, because we know they have a minor legal bill that they need to pay off. This would all go through the Legislative Commission once they revise the *Nevada Administrative Code* (NAC) in order to review the fees, and if they were problematic they could be denied.

Chair Spiegel:
What I was asking was, in this section there was one number that covers all three categories. As this is written, in section 5, subsection 7 [page 4, lines 5 through 9], would there be enough latitude in how it is written for the Legislative Commission to approve different fees for different categories of practitioners?

Wil Keane, Committee Counsel:
The language on page 4, lines 5 through 9, which is subsection 7 of section 5, is not clear that the fees would have to be the same. I have seen in other chapters where the Legislature wanted to make sure that the fees could be different, but those fees were broken out separately.

Chair Spiegel:
So if we amended the bill and listed out each fee but with the same cap, each on a different line, would that afford the Legislative Commission some flexibility?

Will Keane:
Yes, definitely. If they were on separate lines, then each one could definitely be its own fee.

Chair Spiegel:
Are there any other questions from the Committee? [There were none.] Is there anyone to testify in support of S.B. 98 (R1)?

Janine Hansen, State President, Nevada Families for Freedom:
We have been very interested in this bill from the beginning. We were very concerned with the original bill because it placed the Board of Homeopathic Medical Examiners under the Department of Health and Human Services. We feel there may be some antagonism in

the traditional medicine focus of the Department of Health and Human Services with a more nontraditional medicine approach like homeopathic medicine. We are very appreciative of Senator Settelmeyer's hard work in trying to rescue the Board and provide a focused board for homeopathy, and we support this bill.

When my son came off his mission, he had lost 25 pounds and could not keep a tablespoon of food down. I took him to a regular doctor, who wanted to put him on psychotropic drugs because he said he was depressed. I took him to my doctor, who is an MD and a homeopathic doctor. He said my son had three different kinds of food poisoning, including salmonella, hepatitis A, and genetically modified food poisoning. It took him six months, but he did get better. I have gone to a homeopathic doctor since the 1990s.

There was a huge outpouring of people who were also concerned about this bill; they want this Board focused on homeopathy and not under the Department of Health and Human Services. We really appreciate this particular legislation which resolves our concerns, and we think it will be more positive going forward.

Chair Spiegel:
Is there anyone to testify in opposition to S.B. 98 (R1)? [There was no one.] Is there anyone to testify in the neutral position?

Miranda Hoover, representing Board of Homeopathic Medical Examiners:
I would be happy to address a few of the questions from the presentation. In answer to the question, has the Attorney General accepted the payment plan and whether that has started, yes, the Attorney General signed the agreement in April and the Board of Homeopathic Medical Examiners has made two payments; the first being a $30,000 down payment and a $1,500 first installment, the second one being $1,500 for the month of May. We are now working on our third installment. I believe it will be sent to the Attorney General next week.

The second question was regarding the reserves of the Board. Ms. Stonefield is correct, we have about 2 to 2½ months in reserves; which obviously is not as much as we should for a healthy board, which is 6 to 12 months. How many licenses? Ms. Stonefield was correct, there are not a lot of licensees. In regard to the fee increases, we have small bills that accrue every month. Based on the current court case and the original bill of $170,000, if we continue on our payment plan of $1,500 a month, including the current bill that is due monthly, the Board hopes to pay off their debt in about six years. If the fees increase, obviously the Board hopes to pay those off much sooner.

Regarding the Board's future functioning, there have been many plans submitted and constant discussions. I hope this bill moves forward, and it is our biggest hope that the functioning will be better. To answer Assemblywoman Carlton's question, it was interesting that integrative medicine was what was included in the new name of the Board, as the discussions over the past five-plus years have been to eventually try to incorporate the naturopaths, which actually is integrative medicine. I do not know if that is the intent of the current bill, but that has been the conversation.

We have one concern regarding the composition of the Board, that increasing the Board number up to eight might be difficult because there is not a large pool of current licensees and certificate holders. We have one board member whose term expired quite a while ago and has never been replaced. It is because either no one has applied or no one has been referred to the Governor's Office.

Regarding the fees, because there are three different types of bifurcated certificates and licensees, one license and two different certificate holders, the Board would say that so their bylaws and their NACs can correlate with statute, it might be easier if the Board can recommend a bifurcated fee structure in the statute.

Assemblywoman Carlton:
I did a search for integrative medicine and found a couple of different things. There is a [national] board and it does focus on naturopathy. It says, if graduated from an accredited four-year naturopathic college. It is my understanding they could be an MD and get a specialty in integrative medicine, or they could just go to the naturopathic college. Are you familiar with naturopathic colleges?

Miranda Hoover:
I am not familiar with the colleges; I do know that of the homeopaths as a whole in our state, many are actually physicians in other states who come to Nevada to get their license. We are one of only two states in the country that actually issue licenses. They do have constant discussions with naturopaths to try to get them more involved with the state so at some point they can be licensed, as there are not a lot of states that license naturopaths.

Assemblywoman Carlton:
It opens it up for the continued discussion that we had earlier. By calling this "and" Integrated Medicine, this would be opening it up for a new scope of practice within the state, and recognizing a scope of practice that we have not really delved into before.

Miranda Hoover:
Again, I do not know if that is the intent of this bill with this new amendment, but it would be my understanding that would be correct, based on previous discussions I have had with the Board and with their licensees.

Assemblywoman Carlton:
Madam Chair, I would be very apprehensive about creating a new board and a new scope of practice without having a thorough vetting on it. I think with the "and" in there we have a problem, but with "Homeopathic Integrative," we could protect the public at the level where those would still have to be doctors to be able to do it—they would have to have the MD behind it and get the specialty credential through the Department of Health and Human Services. Otherwise we would be having a whole new medical practice in the state by virtue of an amendment—which could cause problems. In reading a little further, I just had

someone send me a message. My concerns about acupuncture and oriental medicine are well-founded; integrative medicine encompasses acupuncture and we have the State Board of Oriental Medicine. I have been in one turf battle this session; I am not up for two.

Chair Spiegel:
I guess that leaves some open questions and issues to be resolved. Seeing no one else who wishes to testify, Senator Settelmeyer, do you want to come up and make some closing comments?

Senator Settelmeyer:
If there are any aspects of the bill you wish deleted, I think the main concept is to allow the Governor to have the freedom to go forward and try to solve and resolve some of the issues and not be plagued by something someone may have left him.

Chair Spiegel:
Thank you, Senator. There is still time left. I would encourage you to work with Committee members and see if we can come up with an amendment to address the concerns raised during the hearing so we can move forward in a way that will work for the people of the state. We will close the hearing on S.B. 98 (R1), and we will open the hearing on Senate Bill 366 (2nd Reprint).

Senate Bill 366 (2nd Reprint): Establishes provisions relating to dental therapy. (BDR 54-661)

Senator Julia Ratti, Senate District No. 13:
Senate Bill 366 (2nd Reprint) seeks to address current and pending shortages of oral health professionals in the state of Nevada, which is resulting in a lack of access to affordable high-quality oral care.

Lancette VanGuilder, Legislative Chair, Nevada Dental Hygienists' Association:
I am here to speak in support of S.B. 366 (R2). [Ms. VanGuilder spoke from prepared text (Exhibit E).] I have been a dental hygienist for 24 years. The last 20 years have been in my own home state of Nevada. I have worked in private practice, public health, mobile dental settings, higher education, and professional leadership.

I grew up in rural Nevada—Ely, Elko, Eureka—and have seen firsthand the lack of dental care and services across the state. I have seen children miss school, adults miss work, and people of all ages showing up at the emergency room because of dental problems and pain. Millions of dollars are spent each year in Nevada at emergency rooms as a result of preventable dental problems.

Many published articles exist linking a child's academic performance to oral health, as well as a person's ability to get proper nutrition, to get a job, to have good self-esteem, and even the ability to smile. Staggering rates of untreated tooth decay, gum disease, dental infections, oral cancer, and dental-related emergency room visits are common among all socioeconomic

groups. In fact, 50 percent of working adults have untreated tooth decay; one person dies every hour in the United States from oral cancer. Forty-seven percent of the population over the age of 30 has gum disease. One out of every two children in the state of Nevada qualifies for free and reduced lunch. These are serious health concerns. Mounting evidence is linking poor oral health to a host of many other systemic illnesses, such as diabetes, heart disease, stroke, cancers, and Alzheimer's disease.

I speak in favor of S.B. 366 (R2), which is a bill to introduce a highly educated, safe and effective, mid-level dental provider called a dental therapist. Mid-level providers are not new to medicine. For over 50 years, they have been enhancing the medical field with models such as advanced practice registered nurses and physician assistants.

Nevada facts: Yes, we do have more dentists entering the work force; however, there is a large documented shortage across our state recognized by federal and state agencies well beyond 2025. A recent report lists Nevada as forty-eighth in the nation for children's dental health. Nevada ranks twenty-fifth in the nation for the number of dentists per capita, but ranks forty-ninth in the nation for dental care and services. According to the Nevada State Health Division, "Nevadans experience many oral diseases and conditions in greater number than their national counterparts . . . and additional work is needed to reduce disparities."

Introducing a new mid-level dental provider in Nevada is intended to increase access to and the affordability of dental care and services for all Nevadans, no matter where they live.

National facts: The Federal Trade Commission (FTC) encourages legislators to consider expanding general supervision of dental hygienists and licensing dental therapists in an effort to increase consumer choice, reduce prices, enhance competition, and increase access to care. The American Dental Association (ADA) Council on Scientific Affairs has issued a policy statement: "Many published studies demonstrate that appropriately trained mid-level providers can provide high quality services, including irreversible procedures such as restorative care and dental extractions." The National Governors Association (NGA) is working on best practices to assist states with the triple aim: better health, better health care, and lower costs. In 2014, the NGA included a statement: "States can consider doing more to allow hygienists to fulfill these needs by freeing them to practice to the full extent of their education and scope of practice."

Education and Safety: Dental therapists would be required to first graduate from a dental hygiene program, which takes four to five years of college. They would have to get an additional two to three years of college and receive a master's degree from an accredited dental therapy program that is accredited by the same agency that accredits all dental and dental hygiene programs. They must pass national and regional board examinations, obtain professional licensure, be mandated with continuing education, and maintain liability insurance to ensure public safety with the same standards dentists and dental hygienists currently must adhere to.

Nine states have already passed dental therapy legislation, with nearly a dozen others currently pursuing it. Dental therapists practice in 54 countries around the globe. A recent review of 1,100 academic papers concluded that: "There is no question that dental therapists provide care for children that is high quality and safe. None of the documents reviewed found any evidence of compromise to children's safety or quality of care . . . and the profession of dentistry should support adding dental therapists to the oral health care team."

Dental therapists have now been practicing in Minnesota for 10 years. I urge this Committee to make a decision based on data. In 2018, the Minnesota Department of Health and the Minnesota Board of Dentistry produced a workforce brief collecting data on the last 10 years of dental therapists. They concluded: "Dental therapists are a safe, cost-effective, and productive workforce."

The passage of S.B. 366 (R2) would allow Nevada to join the ranks with other states in addressing the massive oral health crisis that we have in our country. The dental therapist enhances the dental care team. There are many barriers for Nevadans. Dental care is expensive. Many people do not have dental insurance, and if they do, they may not be able to find a provider who will accept their insurance. There are long wait times, and the location and hours of dental practices, lack of transportation, and lack of knowledge/education on the importance of a healthy mouth are also barriers. Dental hygienists continue to advocate for more emphasis on dental education and prevention, early intervention, and cost-effective measures to alleviate dental pain and suffering. Implementing a highly educated additional provider may reduce wait times and cost, serve vulnerable populations, and improve the current dental delivery system.

Eighty-one percent of respondents to a public survey do favor "a new type of dental provider similar to a nurse practitioner" to be allowed to work in their state. Dental therapy is one of the key issues that has had bipartisan support across the U.S. In S.B. 366 (R2), dental therapists may practice in public health settings, nonprofits, public health, rural, urban, tribal, and frontier settings for a broad reach to the population. Dental therapists must work in collaboration with a supervising dentist and can only perform duties that are outlined in a written practice agreement.

We have worked extensively on amendments to S.B. 366 (R2), and the amendments before you have been agreed upon between the Nevada Dental Hygienists' Association and the Nevada Dental Association. Senate Bill 366 (2nd Reprint) is a direct result of a lot of hard work by many parties to ensure this new provider can help serve the public in a safe and effective manner.

Caryn Solie, Member, Nevada Dental Hygienists' Association:
I am a resident of Sparks. [Ms. Solie spoke from prepared text (Exhibit F).] I am a practicing registered dental hygienist in Nevada and have been since 1972. I am the immediate past president of the Nevada Dental Hygienists' Association and served as the president of the American Dental Hygienists' Association in 2010-11. Governor Sandoval appointed me to

the Board of Dental Examiners of Nevada in 2012 and I served until 2015. I wish to thank Senator Ratti for sponsoring this bill that will help address the oral health care disparities that are present in our state. I would like to highlight some of the facts my colleague alluded to in the Minnesota study.

The Minnesota legislature created the first dental therapists in the lower 48 states in 2009, with the first dental therapist licenses granted by the Minnesota Board of Dentistry in 2011. Several case studies compiled by the Minnesota Department of Health, in partnership with the Minnesota Board of Dentistry and the Minnesota Dental Therapy Research Stakeholder Group, have proven that the utilization of dental therapists has seen an increase in access to care, reductions in costs to patients, and complete satisfaction with services.

The Amherst H. Wilder Foundation and the Delta Dental Foundation of Minnesota in 2017 conducted case studies at Grand Marais Family Dentistry and Midwest Dental. They noted that the addition of dental therapists to the dental team decreased client wait times from three or four weeks to one week. The Grand Marais clinic saw an increase in monthly production with a dental therapist of 13 percent, which averaged to about $16,926 per month. Midwest Dental reported an estimated average monthly increase in revenues of over $10,042.

The Pew Foundation's 2017 case studies with Apple Tree Dental concluded that a dental therapist at a veterans home increased the number of diagnostic and restorative services that were provided at the home. Apple Tree Dental reported $52,000 in savings in a year by using dental therapists in one of their Minnesota veterans homes. In addition, the Minnesota Department of Health has catalogued 35 reports, peer-reviewed journal articles, and studies that document the growth and impact of these providers on oral health access in the state.

The primary practice setting for 49 percent of the Minnesota dental therapists in 2017 was a dental clinic, and 47 percent work in community-based nonprofit organizations, Community Health Centers, Federally Qualified Health Centers, hospitals, schools, and mobile clinics. The remaining 4 percent are working in academic settings. Minnesota dental therapists also provide services in community and rural health settings at more than 370 mobile dental sites throughout the state in schools, Head Start programs, community centers, U.S. Department of Veterans Affairs facilities, and nursing homes. The Minnesota dental therapists are geographically distributed in proportion to their state's population. Fifty-five percent of Minnesotans live within the seven-county greater Twin Cities metro area where 59 percent of dental therapists are employed. Forty-five percent of Minnesotans live outside of the metro area where 41 percent of working dental therapists are employed.

Dental therapists are more diverse than other oral health professions in Minnesota—12 percent are Asian, 3 percent are Hispanic, 2 percent are American Indian, and 9 percent are of multiple other races. Minnesota dental therapists report high levels of career satisfaction with 98 percent indicating career satisfaction in the last 12 months; 96 percent are satisfied with their careers overall; and 84 percent plan to practice for 10 years or more.

Liability insurers note that there are no additional costs for professional liability coverage for employment of a dental therapist compared to the employment of a dental assistant or dental hygienist.

Since the first dental therapists were licensed in 2011, the Minnesota Board of Dentistry has had no discipline or corrective actions against a dental therapist. Dental therapy is safe and cost-effective, and Nevadans have the right to that same type of care.

Alan Mandell, Vice Chairman, Pyramid Lake Paiute Tribe, Nixon, Nevada:
My background is as a systems and network administrator. For approximately the past 25 years, I have been working in the field of rural telecommunications, which has been pretty difficult. When I first came back from San Francisco to Nevada, I found it to be a challenging and daunting task because there are still some areas within Nevada that are not capable of having high technology, which we are going to talk about today. Those are still some of the challenges we face. Our health director, Donna Brown, was unable to be here and she was the one who brought to our attention that this dental therapist program was created approximately 15 years ago in Alaska by the tribes there. Dental therapy is a solution that tribes in Alaska brought to America over 15 years ago and since has been successfully implemented in other states and tribal health centers around the country.

There are only 9 or 10 tribal health centers in Nevada, yet there are 25 tribal locations. The Pyramid Lake Paiute Tribe is proud to take the lead on this for the Nevada Indian country as we feel we are health care innovators. An example of being a health care innovator is that we have recently implemented a U.S. Department of Agriculture telepharmacy program through the Distance Learning and Telemedicine Program. We serve remote tribes without pharmacists, using remote dispensing machines which are interfaced with Scriptpro Robotic Inventory Management system, which is interfaced with a remote dispensing system. We do all of this through the electronic health records and then we finalize and complete a visit via videoconferencing. We use a telemedicine cart called the AFHCAN Telemedicine Cart. The AFHCAN Cart enables provider-integrated biomedical peripherals for telemedicine. For example, the synchronous intraoral camera, which a dentist can use, would provide the ability for real-time optics that can be viewed remotely by a dentist or oral specialist. The telemedicine cart can also provide real-time vitals, electrocardiograms, images, and videoconference capability.

The need for more sustainable access to dental care, in tribal Nevada especially, is great. The cost saving by having some of the services provided by a dental therapist would be an important component in providing better and more services to our constituents. We are very confident that by using electronic means, a supervising dentist can work effectively with the dental therapist remotely. We strongly support the dental therapy program because it empowers tribes especially to tackle our own oral health challenges and put our own people to work in areas that struggle to recruit and retain quality, culturally competent staff.

Wendy Madson, Executive Director, Healthy Communities Coalition of Lyon and Storey Counties:
We are in support of S.B. 366 (R2) (Exhibit G). We in Nevada have seen progress around our oral health services from the passing of the Volunteer Health Services Act [Assembly Bill 228 of the 77th Session], which has allowed out-of-state providers to come into the state to participate in humanitarian outreach efforts such as remote area medical. We currently have school-based varnish and sealant programs. Oral health presentations are currently in our schools. We are on a forward-moving path. The addition of the dental therapist will allow greater access as we work toward a more proactive rather than a reactive approach. It is understood that the dental therapist cannot address the extreme cases, which is much of what we see in our rural communities. As we continue to create better preventative efforts, this will allow us to tackle the minor issues before they turn into the extremely painful and expensive cases.

In 2017 through efforts of school-based varnish and sealant programs in Lyon County, with early prevention and intervention as the focus, within three Lyon County schools 86 children were seen. Of those seen, 38 percent, 53 percent, and 68 percent were identified with untreated decay. This was in two elementary and one intermediate school. Those identified with urgent dental needs were 21 percent, 32 percent, and 41 percent—clearly we have a problem. As we continue to work together and see the efforts in prevention and early intervention reaching students and their families, a dental therapist is a much-needed addition creating greater opportunity for care and keeping people from escalating to a place of great need. Increased access to care means greater relief sooner. There is an impact in cost savings, as the need for emergency room services can be reduced as well as the cost for extensive restorative procedures billed to Medicaid.

Just this morning, I received a call from a gentleman in need of dental services. This is the fourth call our office has received in the month of May. We are not an oral health coalition. We are a prevention coalition. We could not help but notice the dire need in our rural communities for dental services—so we had no choice but to get involved. It really changed how we looked at things when we had two brothers who were both on different occasions in their garage pulling their own teeth with pliers. That was the beginning of our work collaboratively. We have made great strides in this work. We have had great support from dentists in outreach events. They are amazing. I am really hopeful of what the passage of S.B. 366 (R2) can bring to our rural communities with that extra layer of bridging the gaps.

Senator Ratti:
This was a highly negotiated bill. Sections 1 through 57 of the bill have been removed. That would be your first indication of how much work has gone into this bill. I will take you through the bill. Section 59 and on is the language that creates the new oral health professional of a dental therapist. They must have their education from an institution accredited by the Commission on Dental Accreditation (CODA) of the American Dental Association.

On page 4, you start to see the scope of practice. This bill limits the practice of dental therapy to a list of public health settings. This bill limits the practice to under a written agreement of a dentist. That scope of practice can be limited by that dentist in that written agreement. It requires direct supervision early in the dental therapist's career and that is tiered.

Section 61, subsection 1, paragraph (a) says if a dental therapist who has practiced in another state moves to Nevada, they would need to have 500 hours of direct line-of-sight supervision with a dentist. If they are a dental hygienist with five years of experience who is now moving into a dental therapist practice, they would need to have 1,000 hours of direct supervision by a dentist. If the person was new to the field and went straight through with their education to the dental hygienist and dental therapist work, they would need 1,500 hours of direct supervision. After they get those direct supervision hours, they are still operating under a written agreement with a dentist, but they are no longer required to work only in line of sight. They could be in an off-site location, but still under the written practice agreement with the dentist.

Section 61, subsection 3 provides the list of public health settings that the practice has been limited to—Federally Qualified Health Centers, rural health clinics, a hospital, a school-based health center, and a mobile van. These are the places where we serve our lowest-income Nevadans and people who are unable to access health care services for a host of reasons. In its first iteration, that is how this program is set up—limited to public health settings. Subsection 4 assures that the dentist who has that written agreement is an active dentist. They have to have their license, maintain a location, and be actively seeing patients. We were not interested in just setting up a business model for a retired dentist who has a license to have dental therapists who are out there doing the work and the dentist is receiving income. They need to be working with an active dentist.

Section 62 goes through the written practice agreement. Section 62, subsection 10 requires disclosure, a requirement that when an appointment is made for a patient, it must be disclosed to the patient whether the patient is scheduled to see a dentist or a dental therapist so they know whom they are seeing. Section 62.5 limits the number of dental therapists that any single dentist can see to four full-time equivalents. There is a ratio of 1 to 4.

Section 63, subsection 2 requires that if the patient needs additional services, they are to be referred to a dentist. Section 64 gives a lot of details about the scope of practice.

There is an amendment to section 64, subsection 2 (Exhibit H) that removes lines 19 through 24 on page 8 up to the word "performed." This language would have required that they would not have been able to see a patient who has not already seen a dentist. That would be impractical in the public health settings. I believe there is broad agreement to the amendment.

Section 65 is more details about the scope of practice. Section 67 limits the prescribing of controlled substances. Section 68 talks about continuing education. Throughout the remainder of the bill, it mostly just adds the words "dental therapy" to the oral health licensing chapter.

Section 74, subsection 2, paragraph (b), "Prevents a dental therapist or dental hygienist from administering local anesthesia for pain management during treatment or using X-ray radiation or laser radiation for dental treatment or dental diagnostic purposes, upon authorization of a licensed dentist." The written agreement does not allow a dentist to go outside the scope of work. They cannot license the dental therapist to do these pain management functions. Section 88 includes the fee for application and that is $1,000.

As excited as we are to bring forward innovation in the field of oral health care and replicate a model that on the traditional medical side of the mid-level practitioner has been very successful in increasing access to care, I would like to acknowledge that this is the first step. We need to get the dental therapist into statute before we can start talking about how we educate our own. When we pass this bill, our only supply of dental therapists will be people who have gotten their education in another state. There will still be multiple steps that need to be taken in terms of how we educate our own, what is the career ladder, how we recruit people into the profession. It all starts with a first step, and this first step has required significant discussion that I stand behind.

Chair Spiegel:
I have a question about whether or not there are any programs in the state for continuing education or if there have been discussions with any of our institutions of higher learning or if our dental therapists would have to go out of state for their continuing education.

Lancette VanGuilder:
Although we do not have a program for dental therapists to receive their education in our state, we have many resources where they could receive all of their continuing education in our state. Roseman University of Health Sciences has an accredited program and they do have approval as a continuing education provider through the Academy of General Dentistry. That would be a great source for continuing education as well as through our local and state dental associations, societies, and dental hygiene associations. They would most likely be able to receive all of their continuing education in state.

Assemblywoman Carlton:
If it is good enough for public health, why is it not good enough for private practice also? There is a great need in public health, so I think you are focused in the right area for the first step. I would see this as a great way to expand access. We have issues with access in urban Clark County. I think it is really important to talk about the public health side of this.

Senator Ratti:
The question is how you incentivize professionals to get into the most challenging places to deliver services. The first version of this bill had an incentive included in the bill, which was if you were willing to go into the public health care settings, including rural, tribal, and Federally Qualified Health Centers in the urban environment that will serve some of those health care shortage areas, then you can have independent practice. If you did not want to go into the public health care settings, you could practice anywhere. It was a mechanism to incentivize people to get into those settings. There were significant concerns raised by the existing oral health community about independent practice. As we did more research, we learned there is not a state currently in the U.S. that has independent practice. So we needed to step back from that in terms of getting this program established in Nevada.

When we eliminated independent practice and did not have that incentive, the question remained for some of my colleagues in the Senate of how are we going to get these professionals to go into the rural settings? Because we lack a funding source to put some money behind that with monetary incentives such as paying for people's educations to bring people into the rural areas, we were left with, frankly, limiting it to a public health setting. Initially, there is some cause for concern because we will have so few. The only way we are going to get a dental therapist is if they move here from another state and are encouraged to go into those public health settings. The way you get to a place where you serve everybody across the spectrum is to have an adequate number of professionals. Over time, we are going to have to figure out how to build that pipeline and make sure there are enough so the concern about limiting them to public health care settings will go away because we will have an adequate supply.

In the first stages, I was convinced that with the limited supply that we were going to have, we need to make sure they get into those pockets in Clark County and Washoe County where income is the driving factor for lack of access, and into rural and tribal settings where there may be income but there may be other access issues. If you look at the list of public health settings, it is broader than just rural and tribal—Federally Qualified Health Centers, hospitals, school-based settings, and a catchall provision that talks about any community group that is serving at least 50 percent of people who qualify as needing greater access.

Assemblywoman Neal:
In section 64, I am looking at the list of things that may be performed. Is the dental therapist equal to a dentist?

Senator Ratti:
It is a mid-level provider. It is one person on a team of oral health care providers. It is distinct from a dentist. There are some overlaps in their scope of practice, but their scope of practice is very much matched to their education.

Assemblywoman Neal:
With all of the services that they do, in section 67 it says they cannot prescribe a controlled substance. If they were removing sutures—which I hope would be anesthesia-based—who assists the dental therapist? Is there a dentist who will be supervising since they cannot do the anesthesia?

Senator Ratti:
In practice, this is everything on the list of things they have been educated to do. In some settings, they may be operating independently but they would be under a written agreement with the dentist, and that dentist can put a limited scope on that dental therapist in that individual setting and the protocols for that setting. For example, they could be in a school-based setting and moving through a significant number of children to get cleanings and fluoride. That dentist in that school setting would list the protocols and what the dental therapist may do. In that case, they would not have a dentist in the room or anywhere nearby because of the scope of practice that has been limited by that dentist in that written agreement, and the skills they are using do not require it. In other cases, they could be practicing in a clinic that has a dentist right there. That dentist may be administering the pain medication or doing some of the other aspects that are within their scope of practice and the dental therapist could be performing some of the things that are within their scope of practice. In all cases, the dentist retains the ability under their written agreement to set that scope of practice for the dental therapist they are supervising as well as the protocols to follow.

Assemblywoman Neal:
I want to know about liability. If there is no dentist, what is the liability of the dental therapist? And if there is a dentist at the public health site, who is liable? Are they coming under an umbrella?

Senator Ratti:
The details of liability insurance will be part of the regulatory process. It is also in the written agreement. Depending on the written agreement between that dentist and that dental therapist, that will be covered as well.

Lancette VanGuilder:
Under the pain management piece, I want to clarify that there are two different sections. Dental therapists will have the ability to provide pain management as far as local anesthesia, which is injections to get numb, the same as dental hygienists currently have the ability to do. They will not be able to write prescriptions for controlled substances. The liability insurance would be determined with the Board of Dental Examiners of Nevada during the rulemaking process. I have my public health endorsement, and I am required to have my own liability insurance. When I work in a public health setting, that is my own individual liability insurance. That could be worked out in multiple ways depending on how the Board of Dental Examiners of Nevada wants to address that in the rulemaking process.

Assemblywoman Neal:
It sounds like you hope that the Board of Dental Examiners of Nevada will set regulations where the contractual terms that they may set are not prohibited. I do not know where the section is in this bill that requires at least some framework around that contract versus your getting contract terms that you know you cannot meet or you will not agree to, yet they are being set forth by the Board that is saying, Here are the terms we are offering and if you do not accept these terms, you will not practice. To leave that door open to say that the contract will be prescribed in regulations or be in a written agreement is a wide-open door for chaos and limited practice. I want quality care, and I do not want a situation because it is a public health center, which happens to include low-income individuals who do not know how to advocate for their health or articulate their needs, that this is the thing they are given because we have lack of access. I understand all of the dynamics around lack of access. It is a serious problem, but that does not mean that a person should receive service that is less than stellar for their oral health needs. I get we need to fill the gap, but I want it done in a certain way.

Senator Ratti:
This is not about a lesser standard of care. We get defensive about making sure that all Nevadans get what they deserve and that there are not some Nevadans who are treated differently. I feel the same level of passion for mid-level providers. When people try to describe advanced practice registered nurses or physician assistants as somehow lesser, I get upset. It is not about more or less—it is about matching an appropriate education to an appropriate set of services. They have an education to do a certain set of services. In many cases that education is as good, and—I would go so far as to say, if we look at the examples of our advanced practice registered nurses—even better in some things than physicians, who are considered to be higher on the hierarchy. It is not about hierarchy, it is about matching the education to the set of services that can be provided.

I will go to bat for mid-level providers as some of the best providers in our health care system. My mother has been going through some significant issues and she glows about her physician assistant. Her physician assistant spends more time with her, has the skill set, and we have empowered them to be able to provide the care they are trained to deliver. For many of these individuals, they will have a health care provider, in some cases for the first time, who is going to be in their neighborhood, is going to take time to meet their needs, and will provide them with a very high level of care because they will have the education and the experience to do so.

Chair Spiegel:
Are there any other questions from the Committee? Seeing none, I will open for testimony in support of S.B. 366 (R2).

Edward Coleman, Private Citizen, Reno, Nevada:
I am here to support S.B. 366 (R2). There are issues with our current dental system for adults ages 19 to 64, according to the *Journal of the American Dental Association*. Dental care has been fairly flat for several years. Cost is by far the top reason adults avoid going to

the dentist. Despite steady reductions and cost barriers to dental care for adults in recent years, there has been no appreciable bounce back in utilization. The author of the article goes on to state that in his view, the dental sector is in low-level equilibrium. We will not see major expansions in dental care, use and sustained improvements in oral health in the coming years, especially among those in the highest needs, under the status quo model. The addition of dental assistants has provided measurable increases in oral health. A report by the University of Washington found the following: children and communities with more frequent access to dental therapists had lower rates of tooth extractions, less use of general anesthesia, and more preventative visits. Additionally, the W.K. Kellogg Foundation reviewed more than 1,100 academic papers. Based on their findings, they suggested the following: given the findings, the profession of dentistry should support adding dental therapists to the oral health care team.

The Commission on Dental Accreditation (CODA) approved the accreditation standards for dental therapy in 2015. The Commission on Dental Accreditation is an independent entity recognized by the U.S. Department of Education as the national accrediting agency for dental, allied dental, and advanced dental education programs. Dental therapists are less expensive to educate and employ, but they are roughly reimbursed at the same rate as a dentist for the procedures in their scope of practice. A report from Community Catalyst found that a dental therapist costs less than 30 cents to employ for every dollar of revenue he or she generates. For these reasons, I think this bill should be supported and passed.

Shaun Griffin, Board Member, Healthy Communities Coalition of Lyon and Storey Counties:

I am the former founding executive director of Community Chest in Virginia City, Nevada. I am also on the Healthy Communities Coalition Board. Over the past ten years, we have held four volunteer medical and dental events. I have the pleasure of serving at those events. I want to tell you about two stories.

In the first story, I was sitting at the desk and there were 500 people coming to get dental care, but only 125 were going to receive it that day. I had no way to choose. It was a Faustian bargain with every single person there. I got a coffee can and I had them put a number in it. I had them choose who was going to get their teeth fixed and who was not. The people to my left and the people to my right on that table all needed dental care. None of them got it—375 people walked away that day in tears. This happened less than 30 miles from here.

In the second story, the woman whose baby I held got her teeth fixed so she could look presentable to her family for the first time in her life. She was in such horrific pain that the dentist had to ask her three different times, are you sure you want to do this? Are you sure you are willing to live with this pain? I watched this and it was horrific. We need this care. I have worked in rural Nevada for 40 years, and there is no greater need for dental care in our state.

Helen Foley, representing FirstMed:
FirstMed is a Federally Qualified Health Center in southern Nevada. It is not just rural areas. In the inner city we have many underserved, disadvantaged, and medically fragile people. We believe that with the passage of this bill, we could serve about 5,000 more individuals just at FirstMed through the use of dental therapy because of the lack of availability of dentists. We strongly urge you to support this legislation.

Marla McDade Williams, representing Reno-Sparks Indian Colony:
Tribal health clinics and possibly other underserved areas in the state struggle to keep experienced dentists, or they get practitioners who are assigned from the National Health Service Corps. They are not going to be there for any length of time and patients are not going to be able to establish a relationship with those providers. Mid-level providers seem to be looking for more permanent practice areas, and that would help these communities that are in need.

Michael Hackett, representing Nevada Public Health Association; and Nevada Primary Care Association:
Both organizations are in full support of this bill. For the Nevada Primary Care Association, our Federally Qualified Health Centers provide oral health care services to the Medicaid and uninsured populations that we serve through an integrated policy of health care. That includes a mobile dental van employed by Nevada Health Centers. However, we are not immune to the shortage of all health care providers. Simply put, this bill will allow us to meet the oral health care needs of more patients we serve. We urge your support.

Joelle Gutman, Government Affairs Liaison, Washoe County Health District:
We are here today in support. Senate Bill 366 (2nd Reprint) is an access-to-care issue for us, and primarily an access-to-care issue for our most vulnerable Nevadans. According to the U.S. Health Resources and Services Administration, the entire state of Nevada is considered a dental health professional shortage area for general care. We know that mid-level providers, such as advanced practice registered nurses and physician assistants, have helped the state alleviate some of our access-to-care challenges, and we see dental therapists in the same light. We know that preventative care is the best way to keep people healthy while avoiding unnecessary health care costs for treating prolonged untreated health care concerns. Fifty-eight percent of children in northern Nevada have untreated tooth decay, which is the same percentage of children in northern Nevada who are on Medicaid.

Judy Zabolocky, Private Citizen, Dayton, Nevada:
We have two dental practitioners in Dayton who have state-of-art offices; but they are wildly expensive. There is a Dayton Peeps Facebook page, and I constantly see questions asking where can we get dental help for myself or my children, because I have gone to—and they will name the two dentists—and they are too expensive. This bill would be fabulous for our Dayton people who are not privileged. I hope you support this bill.

Sarah Adler, representing Pyramid Lake Paiute Tribe:
I am president of the board of Healthy Communities Coalition (HCC) of Lyon and Storey Counties. Not only have we had access to the rural medical care events that Wendy Madson and Shaun Griffin told you about, but HCC took our skill and created a remote area medical event at Hug High School in Washoe County. Senator Harry Reid was there and he could not believe the number of people who needed dental care. This is an urban, rural, and tribal problem. I spent many years being the state director of United States Department of Agriculture Rural Development. We have 27 apartment complexes that are only for very low-income seniors and disabled, which is 694 units. As you know, Medicaid in Nevada does not pay for adult dental care, nor does Medicare. These people are very low income and many of them have dentures or partials. Often people get sores or ulcerations because of misadjusted partials. If they could have access to a dental therapist, they might be able to get immediate relief. Chronic irritations can lead to more serious infection and problems, and if left untreated can even lead to precancerous lesions. Imagine if these 694 people had regular access to dental care at a rural health clinic or through a mobile van, they could have received preventive services, which would have kept them from acute care. If they got that original care, it may lead to more work for dentists, because we are going to create relationships with dentists or the authorizing dentists of the dental therapists who do payment plans.

Patti Mason, Private Citizen, Carson City, Nevada:
Less than a year before my mom died, she got dentures and they were ill-fitting. Because of her severe disabilities from a lifetime of rheumatoid arthritis, she was not able to go to the dentist as often as she should, and the dentist had other offices so he was not always there when she was available to go and when the van was able to take her. Within three months, she ended up with oral cancer and had half her tongue removed, as well as all of her lymph nodes. If she had had access to a mobile van or a dental therapist, it could have had profound implications on her life and comfort.

Sydney Anne McKenzie, Member, Nevada Dental Hygienists' Association:
This month marks my forty-fifth year of being a dental hygienist team professional, and I am very proud of the work we have all done. I am a cofounder of a nonprofit for Nevada and past president of the Nevada Dental Hygienists' Association. In the next few days, you will be making a very important decision for all Nevadans. Before your make your decision, I wish you could see the children in every single community and rural area in Nevada who have no memory of a day without pain. I wish you could witness the seniors in every community and the people in the hot lunch lines who cannot eat a nutritious meal. I wish you could understand the fiscal impacts of constituents of all ages who seek emergency relief in emergency rooms by the thousands, only to receive short-term pain pills, ineffective antibiotics, and no treatment. I wish you could hear the despair of the voices in the many phone calls I get in the health clinics that I go to when I tell them there is a two- to five-year wait to treat their dental pain.

Just for a moment I would like you to feel a fraction of the pain that many of your constituents suffer through night and day and calculate the true loss to our society with missed days of work and school, missing teeth, and accelerated systemic diseases. If you vote against S.B. 366 (R2), you are condemning your most vulnerable constituents to continued pain and suffering with little or no access and no hope. However, if you vote in favor of S.B. 366 (R2), you uplift the entire dental population. Please take this small step to improve the dental profession, policies that will become a giant leap towards improved dental health and thereby enhancing physical, mental, and fiscal health for all Nevadans. Please let us uphold the oath to serve and protect all Nevada citizens. [(Exhibit I) was also submitted.]

Antonio Ventura, President, Southern Nevada Dental Hygienists' Association:
[Mr. Ventura spoke from prepared testimony (Exhibit J).] I am a licensed and practicing dental hygienist, and I am interested in becoming a dental therapist. I am representing the Southern Nevada Dental Hygienists' Association as their current president. We are in support of S.B. 366 (R2). Health disparities among low socioeconomic communities and minorities in Nevada still exist. The dental therapist workforce model is a proven safe and effective method in reducing dental access-to-care issues. The distribution of dentists in our state tends to favor high-income and urban areas, leaving many low-income and rural areas with poor oral health outcomes.

As you may have learned, the Health Resources and Services Administration has outlined many of Nevada's counties as designated dental professional shortage areas. Research shows that dental therapists can make a difference in the access and financial burden of obtaining dental care. This workforce is positioned to expand access to restorative, therapeutic, and preventative care to highly susceptible communities to help decrease oral disease and improve overall health outcomes. The dental therapist workforce has been shown to reduce wait and travel times for our patients and provide care that is equally as safe as a dentist. Dental therapists, unlike dental hygienists, view the importance of education and preventative care as a first step in preventing and reducing oral diseases. Many oral diseases begin as small manifestations that can be treated with early interventions by a dental therapist. This prevents them from progressing into larger problems. This bill is a great start to increasing access to oral health care to all Nevadans. Thank you for your consideration and support of S.B. 366 (R2).

Jessica Woods, Private Citizen, Las Vegas, Nevada:
As a public health dental hygienist who has practiced in many rural areas within the state of Nevada and is currently working for a Medicaid dental provider for a Federally Qualified Health Center lookalike, I have seen firsthand what the lack of access to dental care is doing to the residents of this state. This is why I am in support of S.B. 366 (R2). When you practice in these types of areas, the dental professional shortage that exists in many of our counties becomes more evident. Had I been able to provide services as that of a dental therapist, I would not have had to leave my patients with dental pain—pain that could only be alleviated by driving over 100 miles to be treated. There was no dentist to see them in their

own town or any of the surrounding towns around them, either because there was not one physically present or because the ones there did not take their insurance or provide financial options that were feasible for them.

Senate Bill 366 (2nd Reprint) would help hygienists like myself help patients whom I see in a safe, convenient, and affordable way. Having previously practiced in a state that allows for advanced practice of dental hygienists, I would have the experience and willingness to quickly mobilize in Nevada, after receiving my out-of-state training, to bring these much-needed services to our residents. The addition of the dental therapist to the dental team in Nevada would help alleviate some of these barriers that our most vulnerable residents face. Now is our chance to provide Nevadans with the same opportunity for access to dental care that has been proven safe and effective in many other states and countries, by supporting S.B. 366 (R2).

Chair Spiegel:
Is there anyone to testify in opposition to S.B. 366 (R2)?

Bianca Velayo, Private Citizen, Henderson, Nevada:
I am a general dentist and am equally as passionate as the former testifiers about improving oral health care for all Nevadans. I also know S.B. 366 (R2) is not the solution. I want to clarify some important statistics that were falsely reported. Lancette VanGuilder falsely reported that Nevada ranks forty-eighth in the nation for children's dental health. The article she references is from WalletHub.com, an online personal finance service. If you read the entire article, Nevada actually ranks twenty-seventh in overall oral health, but forty-seventh when considering the oral health habits of its citizens, which has nothing to do with access of underserved populations. More accurately, the Health Policy Institute cites that in Nevada, 96 percent of publicly insured children live within 15 minutes of a Medicaid dentist. That is an underserved population that is misrepresented.

Give Kids A Smile is a national campaign of the American Dental Association Foundation. Specifically in southern Nevada, dentists have invited students from over 20 Title I schools to participate every February over the past 16 years. Fifty percent of the students enrolled in these schools receive free or discounted lunch meals. Of those 20 elementary schools invited annually, fewer than 100 children take advantage of the opportunity to receive free dental care. We are doing these dental programs.

Proponents of this bill also falsely claim the success of dental therapy legislation in Minnesota. It was not disclosed that since its implementation almost 10 years ago, the percentage of Minnesota's Medicaid children receiving any dental service has stubbornly remained around 41 percent. Adding almost 80 dental therapists did not budge the rate at all, nor did it reduce dental costs. The federal government has put the state on notice and it is at risk of having Medicaid money withheld.

Chair Spiegel:
Are you representing the Southern Nevada Dental Society?

Bianca Velayo:
I am a delegate for the Southern Nevada Dental Society, but today I am speaking just as a concerned dentist and resident of Nevada.

Khoa Nguyen, Private Citizen, Las Vegas, Nevada:
I am a Nevada native, a graduate of the University of Nevada, Reno and the University of Nevada, Las Vegas School of Dental Medicine, and a general dentist. Overall employment of dentists is projected to grow 19 percent from 2016 to 2026, which is much faster than the national average for all occupations. Nevada ranks twenty-fifth nationally in dentists per capita, perhaps the highest provider ratio of any medical profession in the state. Annually, Nevada awards approximately 85 doctorates of dentistry to add to Nevada's workforce—constantly improving our state's dentist-per-capita ratio. Rather than introduce a new provider type to Nevada's dental workforce, augmented by non-Nevada residents, as suggested by Senator Ratti, the state should invest in programs which reward the University of Nevada, Las Vegas School of Dental Medicine graduates who serve those areas that demonstrate need.

According to the Health Policy Institute of the American Dental Association, 39 percent of Nevada's dentists participate in Medicaid and Children's Health Insurance Program (CHIP), which is above the national average. Ultimately, the bottom line of this issue is appropriate funding to make sure that serving these markets becomes economically feasible. Under the current state reimbursement rate, dentists receive about 25 percent of the typical fees. An increase in Medicaid reimbursement for dental care providers is the clearest path to improvising utilization for the most vulnerable patient populations. Studies prove that states that have committed to a payment model that moves Medicaid reimbursement in line with commercial insurance rates have all but closed the gap in access to care. This is not about profit sharing but merely covering expenses. For the safety of our patients, I urge you to vote no on S.B. 366 (R2).

Chair Spiegel:
This question is for any of the dentists who are in opposition to the bill. Do you also go to the rural areas and provide dental care to Nevadans? We had testimony from Mr. Griffin that was very impactful about the need for people to have dental care when there are hundreds of people who cannot get served. Do you practice in the rural areas?

Khoa Nguyen:
I just graduated this last May. We have served underserved populations through Give Kids A Smile and we have done a lot of volunteering. It is heartbreaking to see the underserved community. I do not believe dental therapy is the way to solve that problem.

Bianca Velayo:
Since I moved to Nevada, I have participated in a lot of these outreach programs. I have hosted mobile dental clinics that serve the underprivileged areas in town. When we are looking at access to care, we want to look beyond dental therapists. If we incentivize dentists who want to work in these underserved communities, that would help improve the access to care. As someone who has graduated and has close to $500,000 of student loan debt, I know when I speak for all dental students or new graduates, that we are torn on how we can best use our degrees.

David L. Mahon, Private Citizen, Henderson, Nevada:
I have practiced dentistry in the state of Nevada for 20 years. Eighteen years ago, I practiced in a mobile dental practice, providing dental care to casino employees who lived in company-owned housing in Primm, Nevada. We were able to perform an incredible amount of dentistry, dental services that were comprehensive in nature and truly benefited the small community.

I oppose S.B. 366 (R2) because it will diminish my profession and the quality of dental care in communities throughout the state. Senate Bill 366 (2nd Reprint) may be the golden ticket for some dentists. This is a social experiment for our state. If this bill passes, future litigation will further shape the provisions of this bill. The Federal Trade Commission determined Minnesota's geographic restrictions to be unenforceable. Dental therapists now work in all practice settings across the state. Senator Goicoechea voiced his concerns for this likely eventuality. What if you have an unscrupulous dentist who employs these therapists and there is no supervision? Inevitably, there will be someone or some unscrupulous entity that will exploit this leveraged provider arrangement and ultimately harm an unknowing public. The ambiguous language regarding collaborative practice agreements creates a loophole to exploit this practice model.

Nevada's dentists and corporate employee dentists will be able to supervise four dental therapists who essentially practice dentistry. For example, some fillings can be technically challenging—crowning a tooth can be a far simpler procedure. This bill allows dental therapists to prepare teeth for crowns and place temporaries. There is digital technology available to fabricate permanent crowns, circumventing the need to take impressions. A dentist may only be required to cement the final restoration, probably the least technically involved aspect of the procedure.

One final point that Senator Ratti overlooked is in section 133.5; it requests that the State Dental Health Officer provide an audit of this program in the year 2025. There are no fiscal notes reflecting this expense to the state and it should be included.

Assemblywoman Carlton:
I have faith in the Chair of Finance in the Senate and our staff, and if they would have truly seen any fiscal impact that was beyond the threshold that we build into the cost of doing business for the State Dental Health Officer, they would have put a fiscal note on it. I have faith in my staff that they did the appropriate thing. So if there is no fiscal note—there is no fiscal note.

David Mahon:
That state office is not funded for the next biennium.

Chair Spiegel:
Nobody in this building hesitates to put a fiscal note on when it is warranted.

Civon Gewelber, Private Citizen, Las Vegas, Nevada:
I am a general dentist in Las Vegas, Nevada. There was an event in 2018 called Medical Miles for Rural Smiles, which was put on by the Nevada State Oral Health Program. The State Dental Health Officer is working to bring dental care, outreach, preventative services, and everything they absolutely can to Nevada, but it is a funding issue. They do not have the funding to put on these events. In 2018, they provided $33,000 of donated dental services. I am not sure where the funding will come from to do it again.

Chair Spiegel:
Is there anyone to testify from a neutral position? [There was no one.]

Assemblywoman Carlton:
Is there a representative of the Board of Dental Examiners of Nevada available? [There was no one.] There are questions which I feel will need to be addressed. We want to make sure that we understand, will this be a collaborative practice and how do they see the contracts being done? They will be the regulatory body for this new position. I am apprehensive that we will go through all of this and then run into an obstructionist board. That is why I was hoping they would be here to give us some level of comfort on how they plan on progressing. I would hate to see them draft regulations that the Legislative Commission would turn back and then we would not allow these practitioners to come into the state because the regulations would not get implemented. I would like the Committee to reach out to the Dental Board to get something on the record with them. I do not want to slow the bill down for that.

Chair Spiegel:
I also find it disturbing that the Board chose not to be here for this hearing.

Assemblywoman Neal:
There were some things about dental health access that were put on the record that we need to clarify. There were several people who came to the table to challenge the data. I want some discussion about whether or not there are pockets that lack access in a Federally Qualified Health Center census tract where there is a need for this kind of service or companion service.

Antonina Capurro, Nevada State Dental Health Officer, Nevada Oral Health Program, Division of Public and Behavioral Health, Department of Health and Human Services:
Geographically, Nevada is the seventh-largest state in the nation. We are a very vast state. We have counties in our state that are not only rural, but they are frontier because there are such limited resources in those counties. Out of our 17 counties, only three are large enough to have populations that are considered urban. Our health professional shortage area will reflect the level of provider shortage in a specific area, its mental health, physicians, and dental access.

There are 441,382 Nevadans who live in dental health professional shortage areas and there are 16.5 percent without access to care. This is one of the reasons that last spring, the Nevada State Oral Health Program launched the Medical Miles for Rural Smiles (Exhibit K) project with the Southern Nevada Health District out of a small state grant. We also opened the Southern Nevada Health District Dental Clinic as part of that project to serve those underserved members in urban areas. As it was pointed out, there are pockets even within Las Vegas and Reno that are underserved. We have many limited resources in our state and the Nevada State Oral Health Program is trying to do what we can, but we are a very small program with very limited resources. We need to encourage providers to go out to those rural areas to provide services. There is more need than there are hands to do the work. Also in the rural areas, there is a lack of infrastructure. We have many providers who do not take Medicaid. We have many issues in our state that need to be addressed.

Assemblywoman Neal:
That is helpful because there are not a lot of people who have the information and understanding about oral health dynamics that are going on in the state of Nevada.

Assemblyman Edwards:
What is the Medicaid reimbursement for dental services?

Cody L. Phinney, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services:
I would be happy to get you those numbers and what they are based on. There is not currently a reimbursement for services for the practitioner that you are considering. That would be developed once it is in statute.

Assemblyman Edwards:
I was wondering more about the current reimbursement for the dentists. That seems to be an impediment to dentists because it is so low that they cannot even cover their costs.

Cody Phinney:
We hear that complaint. It is also relevant to note that there are limitations on what Medicaid currently covers for adults in particular. That is currently limited to palliative care currently. I can get you the information on what we are reimbursing currently and we have some other information that may be of interest.

Assemblyman Edwards:
Can you show how we are ranked? I hear that complaint from providers as well.

Chair Spiegel:
Is there anyone else to testify? Seeing no one, Senator Ratti, will you please close?

Senator Ratti:
I mentioned earlier that my mother loves her mid-level practitioner, the physician assistant she has been seeing. She also loves her dentist. He is doing an amazing job for her, and she needs that scope of practice. I never intended for this bill to be anti-dentist and it saddens me that I have found myself on the opposite side of a number of dentists who are concerned about this new mid-level practitioner. I think it is the same place that many of our former colleagues found themselves when physician assistants and advanced practice registered nurses were created. Changes in scope of practice are always interesting. I stand on the record in other states and the fact that there is a demonstrated shortage. I do not know how you get past people having to put their names in a bucket in a rural high school gym to see if they will be one of the lucky ones who get to have their teeth taken care of that day.

Are there other things we should be doing to address the oral health shortage? Absolutely. I am not standing up here today and telling you the creation of a mid-level dental therapist will solve our dental health problems—it will not. We absolutely need to raise our Medicaid rates. We absolutely should be looking at how we buy down the high cost of education for dentists so they could be incentivized to move into rural communities or underserved communities to provide that care. We absolutely need to be funding programs like the ones described by our own Department of Health and Human Services to get these services out into communities and applying for every grant available.

Dental therapists are not going to solve some of the problems that you have heard today, but I think they are one innovative step forward. The reason you see that there are 8 states that have already approved them and 11 more that are considering it is because it has proven to be one method that does lower costs and increase access. This is the first step in a very long journey to get to the place where we can educate our own and figure out how to find the funding to do some of the other things that are necessary. I do not want it to escape us that there is a real need and we should be doing everything we can.

I want it to be known that Senator Goicoechea did support this bill coming out of the Senate. We put a lot of work into this, and we accepted almost every amendment that was provided to us. It was mentioned that we have a higher than average participation rate in Medicaid, but that rate is still just over a third. It is a low bar. There is a lot of work to be done to increase access to oral health in the state of Nevada on a lot of different fronts, but none of that means that we do not move this bill forward. I ask for your support of S.B. 366 (R2).

[(Exhibit L), (Exhibit M), (Exhibit N), (Exhibit O), (Exhibit P), (Exhibit Q), (Exhibit R), (Exhibit S), and (Exhibit T) were submitted but not discussed and are included as exhibits for the hearing.]

Chair Spiegel:
I will close the hearing on S.B. 366 (R2). Is there any public comment? Seeing none, we are in recess [at 5:08 p.m.].

The meeting is reconvened [at 6:30 p.m.]. The meeting is adjourned [at 6:30 p.m.].

RESPECTFULLY SUBMITTED:

_____
Earlene Miller
Committee Secretary

APPROVED BY:

_____
Assemblywoman Ellen B. Spiegel, Chair

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a letter dated June 6, 2018, to Irene Bustamante Adams, Legislative Commission, Sunset Subcommittee, from the Office of the Attorney General, regarding the debt owed by the Board of Homeopathic Medical Examiners to the Office of the Attorney General for legal services, presented by Danny Thompson, Private Citizen, Las Vegas, Nevada.

Exhibit D is a letter dated March 28, 2019, to Attorney General Aaron Ford from Governor Steve Sisolak regarding the Board of Homeopathic Medical Examiners, presented by Danny Thompson, Private Citizen, Las Vegas, Nevada.

Exhibit E is testimony in support of Senate Bill 366 (2nd Reprint), authored by Lancette VanGuilder, Legislative Chair, Nevada Dental Hygienists' Association.

Exhibit F is testimony in support of Senate Bill 366 (2nd Reprint), authored by Caryn Solie, Member, Nevada Dental Hygienists' Association.

Exhibit G is a letter dated March 28, 2019, in support of Senate Bill 366 (2nd Reprint) to Chair Spiegel and members of the Assembly Committee on Commerce and Labor, authored by Wendy Madson, Executive Director, Healthy Communities Coalition of Lyon and Storey Counties.

Exhibit H is a conceptual amendment to Senate Bill 366 (2nd Reprint), presented by Senator Julia Ratti, Senate District No. 13.

Exhibit I is testimony in support of Senate Bill 366 (2nd Reprint), authored and presented by Sydney Anne McKenzie, Member, Nevada Dental Hygienists' Association.

Exhibit J is testimony in support of Senate Bill 366 (2nd Reprint), dated May 29, 2019, authored and presented by Antonio Ventura, President, Southern Nevada Dental Hygienists' Association.

Exhibit K is a brochure titled "Rural Mobile Health Clinic and Medical Miles for Rural Smiles," submitted by Antonina Capurro, Nevada State Dental Health Officer, Nevada Oral Health Program, Division of Public and Behavioral Health, Department of Health and Human Services, in relation to Senate Bill 366 (2nd Reprint).

Exhibit L is a fact sheet titled "The Oral Health Crisis in Nevada," submitted by Lancette VanGuilder, Legislative Chair, Nevada Dental Hygienists' Association, in support of Senate Bill 366 (2nd Reprint).

Exhibit M is a copy of an issue brief titled "Dental Therapy in Minnesota," submitted by Lancette VanGuilder, Legislative Chair, Nevada Dental Hygienists' Association, in support of Senate Bill 366 (2nd Reprint).

Exhibit N is a tabulated excerpt of Dental Therapy State Comparisons submitted by Lancette VanGuilder, Legislative Chair, Nevada Dental Hygienists' Association, in support of Senate Bill 366 (2nd Reprint).

Exhibit O is a copy of a University of Minnesota School of Dentistry, Doctor of Dental Surgery Program fact sheet submitted by Lancette VanGuilder, Legislative Chair, Nevada Dental Hygienists' Association, in support of Senate Bill 366 (2nd Reprint).

Exhibit P is a copy of a chart titled "Cost of Dental Therapy Education," submitted by Lancette VanGuilder, Legislative Chair, Nevada Dental Hygienists' Association, in support of Senate Bill 366 (2nd Reprint).

Exhibit Q is a copy of a map titled "Half of American Adults Suffer From Gum Disease," submitted by Lancette VanGuilder, Legislative Chair, Nevada Dental Hygienists' Association, in support of Senate Bill 366 (2nd Reprint).

Exhibit R is a flyer titled "Dental Pain, Nevadan's use of our Hospital Emergency Rooms," submitted by Lancette VanGuilder, Legislative Chair, Nevada Dental Hygienists' Association, in support of Senate Bill 366 (2nd Reprint).

Exhibit S is a packet of letters in opposition to Senate Bill 366 (2nd Reprint).

Exhibit T is a packet of letters in support of Senate Bill 366 (2nd Reprint).