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

Eightieth Session
May 3, 2019

The Committee on Health and Human Services was called to order by Chairwoman Lesley E. Cohen at 12:39 p.m. on Friday, May 3, 2019, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4406 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/80th2019.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Lesley E. Cohen, Chairwoman
Assemblyman Richard Carrillo, Vice Chairman
Assemblyman Alex Assefa
Assemblywoman Bea Duran
Assemblywoman Michelle Gorelow
Assemblyman Gregory T. Hafen II
Assemblywoman Connie Munk
Assemblywoman Rochelle T. Nguyen
Assemblywoman Robin L. Titus

COMMITTEE MEMBERS ABSENT:

Assemblyman John Hambrick (excused)
Assemblywoman Lisa Krasner (excused)
Assemblyman Tyrone Thompson (excused)

GUEST LEGISLATORS PRESENT:

Senator Heidi Seevers Gansert, Senate District No. 15
Senator Julia Ratti, Senate District No. 13
Senator Pat Spearman, Senate District No. 1

STAFF MEMBERS PRESENT:

Marsheilah Lyons, Committee Policy Analyst
Karly O'Krent, Committee Counsel
Christian Thauer, Committee Manager
Terry Horgan, Committee Secretary
Alejandra Medina, Committee Assistant

OTHERS PRESENT:

Kenneth MacAleese, Ph.D., Public Policy Chair, Nevada Association for Behavior Analysis; and representing Nevada Association of Behavioral Analysis
Barbara D. Richardson, Commissioner of Insurance, Division of Insurance, Department of Business and Industry
Tom Clark, representing Nevada Association of Health Plans
Catherine M. O'Mara, Executive Director, Nevada State Medical Association
Michael Hackett, representing Nevada Primary Care Association; and Nevada Public Health Association
Jeanette K. Belz, representing Nevada Psychiatric Association
Brooke Maylath, President, Transgender Allies Group, Reno, Nevada
Jody Domineck, Member, Service Employees International Union, Local 1107, Las Vegas, Nevada
Grace T. Vergara-Mactal, Executive Director, Service Employees International Union, Local 1107, Las Vegas, Nevada
Helen Foley, representing the Nevada Center for Assisted Living
Bill M. Welch, President and CEO, Nevada Hospital Association

Chairwoman Cohen:
[Roll was taken. Committee rules and protocol were explained.] We are going to go out of order and start with Senate Bill 258 (1st Reprint).

Senate Bill 258 (1st Reprint): Revises provisions relating to applied behavior analysis. (BDR 39-248)

Senator Heidi Seevers Gansert, Senate District No. 15:
I am here with Dr. Ken MacAleese who is a licensed behavior analyst and also the public policy director for the Nevada Association for Behavior Analysis. We are here today to present S.B. 258 (R1). Senate Bill 258 (1st Reprint) is a cleanup bill from a bill passed last session, Senate Bill 286 of the 79th Session, that created the Board of Applied Behavior Analysis (Board) for the State of Nevada. That bill established the Board last session. When the Board of Applied Behavior Analysis was first established, much of the work that goes around a board start-up was delegated to the Aging and Disability Services Division within the Department of Health and Human Services. That bill also created a new type of position called a "state certified behavior interventionist."

One of the reasons the Board was started was that there was a huge shortage of behavior analysists—people such as registered behavior technicians (RBTs) who work with children with autism and other behavioral issues. We were trying to boost the numbers of people who work in that field. What happened is that the numbers have risen significantly. We went from about 70 RBTs to 900 RBTs in the last two years. Part of what this bill does is remove the state certified behavior interventionist we were going to be creating, because we do not need to do that now. The RBT designation, a national designation, is working very well.

I mentioned when the Board was originally created last session much of the work was delegated to the Aging and Disability Services Division. There is still a considerable amount of work delegated to that Division, but the Board can now assume greater responsibility and will be doing that. One part that they have not been able to assume is the financial part of operating a board. They are not set up to allow the Division to collect money and have the Board disburse it. That still leaves the checkbook with the Division.

This also requires that any continuing education looks toward national standards. We added background checks partially because we were creating this new position—state certified behavior interventionist. When you become an RBT, a level of individual who works with children, a background check will be done. This allows whoever is supervising an RBT to accept or approve a background check if it was done during the prior six months. The supervisor for the RBT does not have to accept that, but they potentially can accept it, and there is permissive language in section 18 concerning this issue.

Kenneth MacAleese, Ph.D., Public Policy Chair, Nevada Association for Behavior Analysis; and representing Nevada Association of Behavioral Analysis:

[Ken MacAleese spoke from prepared text (Exhibit C).] Senate Bill 286 of the 79th Session set up the Board of Applied Behavior Analysis. It is a unique circumstance we put together where the Aging and Disability Services Division is acting as an incubator for our profession. It is a small group, and they are handling and processing much of the licensing and registration of the people who do the work we do.

There was an old credential associated with the certified autism behavior interventionist (CABI), which was part of the Nevada Board of Psychological Examiners. We peaked out at about 78 or 80 of those. We got registered behavior technicians as part of a bill that passed in 2015 [Assembly Bill 6 of the 78th Session]. Then we added this component of registration to be part of the State Board now, but the numbers have moved from 78 to over 900. That is well over a 1,000 percent increase. You will hear that there are not enough RBTs, but we are moving forward. Some policies this group and this Legislature created have helped that.

Senator Gansert also referenced the background check. One of the things we are doing is trying to make sure we are not having duplicative background check standards. The RBT is a particular registration at the national level. There is no standard in practice with the national organization other than requiring that a background check occur. It is actually an international credential, so because every state has different rules, we wanted to make sure we got that check in place. Senator Gansert did a nice job getting that language together and

we worked with the Department of Public Safety as well as with the Division to get that right. This bill will enable businesses from having to do background checks twice.

Senator Gansert also mentioned the interrelationship between the Division and the Board of Applied Behavior Analysis allowing the Board to take on some responsibilities and also to delegate some responsibilities to the Division depending on the circumstances. As the public policy chair for our Association, I want you to know we support S.B. 258 (R1) and its amendments.

Senator Gansert:
Do you want me to talk about the amendment (Exhibit D)?

Chairwoman Cohen:
Please do.

Senator Gansert:
There are some folks who use their knowledge of applied behavior analysis to do other things—for example, tutoring. Someone who specifically tutors came to us and said the way the bill was written, even though the person was not engaged in behavior analysis and was only using the information to provide tutoring, it looks as though everyone has to be registered. So all the tutors would have to be registered. This amendment (Exhibit D) adds the term "otherwise separately" to where we define those who are not required to be licensed by the Division. If the majority of your work, or what you are primarily doing, is applied behavior analysis, you have to be registered. But if you are a tutor, even if you have that knowledge and that knowledge helps how you tutor someone, you do not have to be licensed.

Kenneth MacAleese:
That section references a number of different professionals who do a number of different things that the original bill was not looking to sweep up. Senator Gansert mentioned an example of a tutor, which is paragraph (d) in the amendment. It was never our intention to sweep those individuals in. Many of them are not practicing behavior analysis, but the scope of the work as it was defined suggested individuals doing that would have to become licensed. There are other people as well such as organizational behavior analysts who provide training related to performance management; incentive pay system revision; behavioral safety; and working with adults, the airline industry, and local businesses. We were not looking to capture those into this licensing process. I believe one of Senator Gansert's constituents brought this component to our attention, and we addressed it to make sure they were properly exempted as long as they are not providing services the bill was intending to regulate.

Chairwoman Cohen:
I read the definition of RBTs, but not working in this field, what exactly do those people do? Could you tell us a little more about that profession and where it falls as far as counseling and psychologists?

Kenneth MacAleese:
The RBT is a paraprofessional performing behavior analysis skills. They are not psychologists; they do not provide psychological services. In our state, their primary responsibility is to provide behavioral treatment under the supervision of licensed masters- and doctoral-level behavior analysts—individuals who are required to provide a percentage of supervision of activities designed to usually be provided to children with autism spectrum disorders. It is not the only condition that is treated, but in our state it is the condition that probably 85 to 90 percent of those individuals are working with. If you think about tiers, we have the doctor- and masters-level folks on the top tier, and then a paraprofessional tier of registered behavior technicians—individuals who often provide much of the bulk of the intervention and treatment to children with autism spectrum disorders.

Chairwoman Cohen:
Where do the analysts fall in this field?

Kenneth MacAleese:
Behavior analysts would be at the top in the sense that they oftentimes have doctoral- or masters-level educations. They are already required to be board certified at the doctoral or masters levels by our national organization. They are also already licensed in part of this bill. They were previously licensed through the Nevada Board of Psychological Examiners, but in 2017 when S.B. 286 of the 79th Session was passed, the responsibility for those licensees was transferred to the Board of Applied Behavior Analysis.

Chairwoman Cohen:
Is that why on page 21 in section 35—the section about testing—it looks like the Aging and Disability Services Division can do testing of a professional but it is not required. For instance, to be a lawyer you have to take the test; to be any licensed professional you have to pass a test, but these people are not starting off with a test.

Kenneth MacAleese:
That is not exactly an accurate statement. Section 35 applies if someone was performing services that were problematic. The Division, with the approval of the Board, would have the opportunity to decide to examine those individuals to make sure they could provide the service. If I had a mental health condition that was having an impact on my services and one of my patients brought up an issue about the quality of those services to the Board, this section allows the Board to have people appear before it to be examined to make sure they are competent or to have outside evaluations if necessary. That is a long-standing rule in many of the boards connected with the health professions if there is an issue with one of the licensed people in that profession. This language is similar to what you would see with psychologists or others.

To your question about how the testing standards work—for doctoral- and masters-level behavior analysts in our field, we have a number of classes and requirements from accredited universities and educational entities. There are many hours of supervision required under the direction of a board certified behavior analyst, and then we sit for a national examination

through the Behavior Analysts Certification Board—our national board. That examination is so thorough that, once accepted, if you have this credential, then you have the opportunity to be licensed by the Board of Applied Behavior Analysis, but not before you have your national board certification.

Assemblywoman Titus:
You say there are about 1,000 registered RBTs in the state because the new board was created, but the entity already existed; the professional already existed and we already had folks in our state working with autistic children. What were they called then? I do not think we did not have any of these professionals and now we have 1,000 just because you created a board. You created a board and now these people are called RBTs, but I assume there was already some mechanism for them to be doing this.

Kenneth MacAleese:
Go back to 2009 and Assembly Bill 162 of the 75th Session which was landmark legislation that created health plan reimbursement for behavior therapy for children with autism. Prior to that time there was no way to know how many therapists there were. As part of that bill, the requirement by the Legislature was that individuals like me had to be licensed and this technician-level person we are talking about—this paraprofessional who was unnamed and uncategorized before—was called a "certified autism behavior interventionist." That credential began in 2011 and lasted until 2015. The growth of that credential during that time period was extremely slow. At that time, the Board of Psychological Examiners was the entity that managed that credential. In 2015 another bill came forward that did a number of things with the autism insurance component. That was the first step toward getting the access level to increase for that credential. If you were to ask why that credential took place, it was mainly a driver that our health plans wanted to make sure a credentialed product got in front of their beneficiaries—their members.

We replaced the certified autism behavior interventionist with the RBT in 2015's legislation, The CABI was almost like a new incarnation of the RBT. In 2017, Senator Gansert was attempting to figure out another way to increase access. That certification is like re-creating something that did not work as well before. We are going back to what all the businesses—all the health plans, Medicaid, and all state payers such as the Autism Treatment Assistance Program—require: the RBT. We are going back to that standard since that is the credential that has increased and become the credential for this service.

Assemblywoman Titus:
So the previous ones who were licensed can now be licensed under this definition providing they pass the appropriate national certification. Then, in order to bill Medicaid and other insurances, do they all have national provider identifier (NPI) numbers? To get an NPI number are you required to have this national certification?

Kenneth MacAleese:
That old credential died in the 2015 bill. Because they already had 40 hours of instruction, many of those individuals were able to use that training standard to become RBTs.

Those individuals became registered but were not licensed—although they are regulated by our licensing board. The licensees—the behavior analysts—none of that has really changed. The way we are licensed, the way we are checked and our state examinations at the masters and doctoral levels—that has not changed.

Yes, most companies require an NPI for the registered behavior technician as well as for the masters-level and doctoral-level licensed behavior analysts. Not every health plan requires that in their claims and billing process, but because our Medicaid plan requires it, many of the commercial plans do require it. It is a trend now that it has been established, but it has to do with the way billing and claims are put in. Different insurance companies have different rules about that, but many of them have NPIs. Theoretically, you could have received an NPI without having a credential, but your claim would not be paid without the credential.

Chairwoman Cohen:
As there are no other questions, we will ask for testimony in support in Las Vegas and in Carson City. [There was no response.] Seeing no one in support, is there anyone in opposition? [There was no response.] Seeing no one in opposition, do we have anyone in neutral in Las Vegas or Carson City? [There was no response.] Seeing no one, do you wish to make final statements?

Senator Gansert:
Thank you, Madam Chair and members of the Committee. This is a cleanup bill. We think we have better refined how we need to register and license folks, so I appreciate your consideration of this measure.

Chairwoman Cohen:
With that, I will close the hearing on S.B. 258 (R1) and open the hearing on Senate Bill 234 (1st Reprint).

Senate Bill 234 (1st Reprint): Makes various changes relating to the participation of providers of health care in network plans of insurers. (BDR 57-527)

Senator Julia Ratti, Senate District No. 13:
Senate Bill 234 (1st Reprint) seeks to address a problem that came up during the 2017-2018 Interim that we heard about in the Legislative Committee on Health Care. I am here today as a representative of that Committee to present this bill.

Something we are all trying to dig into is this concept of network adequacy. When Nevadans are purchasing insurance, having it purchased for them by their employers, or participating in Medicaid, they need to have some confidence that the network they are purchasing, and for which they get better rates, is an adequate network that can meet their needs. We had many conversations during the interim about that concept. At the same time, we were also having conversations in that Committee and in other committees about shortages of providers.

I will use the example of behavioral health. I have sat in committee meeting after committee meeting, as I know many of you have, and discussed the fact that there are too few behavioral health providers to meet the need. Then, people came up in public testimony in the interim Legislative Committee on Health Care who said that they were behavioral health providers who had tried to get empaneled on a network but had been rejected. The Committee was having a hard time reconciling the shortage of providers with networks that were not empaneling that specialty. We also had some providers testify that they did not know why they had been rejected.

What S.B. 234 (R1) does is request that the Division of Insurance within the Department of Business and Industry create a form that must be utilized by all carriers and all payer sources to notify a provider when he or she is not empaneled and tell that person why. That same form is also sent to the Division of Insurance so that it accomplishes two things: the individual will know why he or she was not empaneled; and the Division of Insurance will have access to broad-based and confidential data so the Division can see broadly how many people are applying but not getting empaneled, and what the reasons are.

Barbara D. Richardson, Commissioner of Insurance, Division of Insurance, Department of Business and Industry:
[Barbara Richardson spoke from prepared text (Exhibit E).] As Senator Ratti noted, I will review the provisions of S.B. 234 (R1) with you today and then be available for any questions you may have. During this past fall, the 2017-2018 Interim Legislative Committee on Health Care studied network adequacy in the state. They determined that additional data was needed to determine if the plans offered to Nevada consumers provided adequate networks. Senate Bill 234 (1st Reprint) is designed to provide lawmakers with one additional area of network adequacy information: to ensure credentialing of health care providers.

Credentialing is the process whereby a provider applies to be included in a health insurer's network and the carrier verifies the provider's education, training, experience, and competency. Currently, the Division of Insurance provides insurers the approved form to be used during the credentialing process. At this point, however, there is no data available regarding the applicants who are rejected by the carriers. Senate Bill 234 (1st Reprint) requires the Division to develop a form—this is a standard rejection form—to collect data from insurers on these rejected applications, and then provide an annual report of aggregated data to the Governor and to the Legislature.

Section 26, subsection 1, adds language to *Nevada Revised Statutes* (NRS) Chapter 679B and requires the Commissioner of Insurance to develop a form and a form letter that health insurance carriers must use to notify health care providers of any reason why they have been denied access to their network. This form is made available to the carriers on the Division's website, and the carriers are to use this form to provide the reasons for the denial of the applicant. The section also describes that the Division will hold hearings to solicit and consider input into creating this form letter.

Subsection 2 requires insurers to submit to the Commissioner of Insurance a copy of the credentialing denial form for each rejected health care provider at the time the letter is sent to the provider. The forms provided to the Commissioner are to be considered confidential.

Subsection 3 requires the Commissioner to annually compile a report using aggregated data from the forms collected containing trends in denials of credentialing applications. The report must also include the number of total denials, the number of denials by provider type, the number of denials by different carriers, and the reasons for such denials. The report must be posted on the Division's website and provided to the Governor and the Director of the Legislative Counsel Bureau for transmittal to the Legislature.

Section 27.3 of this bill grants that the information contained in the individual credentialing rejection forms is not subject to public records requests through NRS 239.010.

Assemblywoman Titus:
You speak about section 1, but it looks as though everything between section 1 and section 26 has been deleted. Am I looking at the wrong copy?

Senator Ratti:
I had a much more ambitious bill, but sections 1 through 26 were deleted.

Assemblywoman Titus:
I appreciate your using the word "providers" and not specifying any particular group of professionals. One problem we discovered, and I hope this bill will help with it, occurred in 2015 when we created the independent advanced practice registered nurse (APRN). Many individuals took advantage of that, which has really helped improve access to care in our state; however, some of these individuals were being denied on some of these insurance panels. Patients could not see them because those providers were not part of their network. Hopefully, this will also be able to see if an APRN has applied and was denied; and the next step would be to hold them accountable—why was that individual denied? I assume this form will simply say that an individual applied but is not on the insured's plan. Is that correct?

Barbara Richardson:
That is correct. It is going to cover any health care provider and that would include the APRNs.

Chairwoman Cohen:
In section 26, subsection 3, paragraph (a), there is reference to collecting the data to determine what the trends are as related to the denials. Do you have any idea what those trends may be and why we are seeing those denials?

Barbara Richardson:
The bulk of the denials we have been told about involve the networks being full and adequately covered. I am not sure that is accurate, which is why we need to gather this data.

Chairwoman Cohen:
We would not be hearing from citizens that they are having trouble getting treatment if the networks were full.

Assemblywoman Munk:
I have a question about section 26, subsection 1, paragraph (b). Why hold public hearings when the form will be something you will be utilizing?

Barbara Richardson:
We held public hearings to create the initial credentialing form, so we are going to use that same process, but we want to make sure we are getting as much input as possible from all types of insurance carriers.

Assemblywoman Titus:
Looking at this from another aspect, this will not help to answer why providers would not want to sign up with the insurers, which is the next component to this. They may be offered inadequate reimbursement or something along that line, so this will not help with that aspect. This will simply be why an insurance company does not have a provider on its list, if that individual even applied to be on their list. Maybe you will accumulate some information about why people are being denied, but it will not say that they were denied because they wanted adequate reimbursement.

Barbara Richardson:
You are correct.

Chairwoman Cohen:
Is there anyone in support?

Tom Clark, representing Nevada Association of Health Plans:
We are in support because the concept is true to form and what has been testified to. We support collection of the data. The one concern we had was that there was nothing in the legislation that specifically states this could be an electronic transmission. A lot of times when an applicant applies it is done electronically, as is the denial. Speaking with the bill's sponsor and the Insurance Commissioner, in section 26, subsection 1, paragraph (b), that talks about public hearings, we will work with them to prescribe not just the form but also the way that form is submitted to the Division of Insurance so that the information is accurate and collected. It will easily be reported back to the Legislature in two years and also to the Governor.

Catherine M. O'Mara, Executive Director, Nevada State Medical Association:
I want to thank the sponsor for bringing this bill forward and this Committee for hearing it and for your commitment all session to looking at issues of access to care. You have dealt with a lot of issues this session and heard from a lot of patients. Several times I have spoken about our physician shortage, and yet there are still issues with getting physicians empaneled.

We do have a Network Adequacy Advisory Council that advises the Commissioner of Insurance, but we have felt that more data is needed.

We testified during the interim in the Legislative Committee on Health Care on the issue of networks narrowing. Networks are narrowing by design as they try to reduce costs, but at the same time they are also reducing access to care. I think looking at this issue is a very strong first step. We need to start collecting that data, and then we can potentially look at the other side of the coin—why some practitioners are not willing to get on some of these networks. We hear from our physicians that the most common reason they are turned down by a network is because the panel is full. If that is happening and we still have patients in Nevada who are not getting in to see their doctors, then we need to take a closer look at the network adequacy rules in place and make sure the Commissioner has what she needs to enforce those rules and continue to work on this. This is an excellent first step that we strongly support.

Michael Hackett, representing Nevada Primary Care Association; and Nevada Public Health Association:
Both organizations are in support of this bill. In addition, we have been involved in efforts during the past interim and this session to more accurately gauge health care in Nevada. That includes the issue of the adequacy of provider networks, so we very much appreciate Senator Ratti and the other legislators who have chosen to address this issue.

Jeanette K. Belz, representing Nevada Psychiatric Association:
We have been following network adequacy meetings for many years. The Commissioner does a great job pulling folks together. One of the things that has been lacking is data, so more data is good. I agree with Ms. O'Mara that this is definitely a great first step and, hopefully, will lead to more comprehensive data to use to make good decisions.

Chairwoman Cohen:
Seeing no one else in support, I will ask for anyone in opposition to come forward. [There was no response.] Seeing no one, anyone in neutral please come forward. [There was no response.] Seeing no one, would you like to make any closing remarks, Senator Ratti?

Senator Ratti:
Thank you again for your attention. I will do a quick double-check with our legal counsel to make sure there is nothing in the NRS language that would prohibit this from being done electronically. If there is anything, I will let you know before you make any decisions about moving forward. Clearly, we do not want it all to have to be done on a paper form. I hope you will support S.B. 234 (R1).

Chairwoman Cohen:
With that, I will close the hearing on S.B. 234 (R1) and open the hearing on Senate Bill 470 (1st Reprint).

Senate Bill 470 (1st Reprint): Revises provisions relating to health care. (BDR 40-785)

Senator Pat Spearman, Senate District No. 1:
I am pleased to present Senate Bill 470 (1st Reprint) which requires medical facilities to conduct training related specifically to cultural competency for employees. As you all know, Nevada's population has grown faster than that of any other state. As a result, Nevada now has a diverse population of women, people of color, people who are lesbian, gay, bisexual, transgender, and questioning, as well as a wide variety of ethnic and other cultural backgrounds. This is why I believe it is vital that our population should have access to medical services that are culturally competent and reflect their diversity, and that the people treating them understand their specific needs. If not, language and cultural barriers impede information about care and restrict communication with medical providers.

To clarify, cultural competency is a set of behaviors and attitudes within the operation of a system that respects and considers the consumer's cultural background, beliefs and values and incorporates them into the delivery of health care services. I believe this measure ultimately will improve the quality and safety of health care services for Nevada's diverse population.

I will provide a few examples as to why I believe this bill is necessary. During the interim, I received several calls from people who were in rehabilitation centers, hospitals, and other medical care facilities, complaining about the treatment they were receiving. On one occasion, there was a young lady who had been shot. It was determined to be a hate crime and she was in a rehabilitation center. The people in the rehabilitation center refused to change her bandages, and even though the identification on her arm identified her as one name, they had her "dead" name on her arm and on the door outside her room.

Chairwoman Cohen:
Senator, can you tell us what you mean by "dead" name?

Senator Spearman:
When people transition from male to female or female to male, the name that person was born with goes away and the individual wants to be identified by the new name. Her mother had to become responsible for changing the bandages on her daughter's leg. The people in the facility—some of the direct caregivers—made fun of her. On one occasion someone said, In my religion, we do not believe in all of that, so I cannot treat you.

In January of this year, an African-American lesbian was in the hospital. She was admitted on the 25th of January and I got a call around the 7th or 9th of February. She had not been bathed nor had her hospital gown been changed. Earlier last year I received a call from someone who practiced the Muslim faith and was having a difficult time getting them to understand that she did not eat pork. As a matter of fact, one of the nurses said, Well, that is all we have, so I do not know what you are going to eat. On another occasion, someone was making fun of a patient who happened to be an Orthodox Jew and was trying to observe the Sabbath in terms of sundown to sunup.

All of these things led me to believe we really need to make sure we have cultural competency in all our medical facilities. People who are sick or who have been assigned to a rehabilitation center are some of our most vulnerable people, and they do not need to be going through these types of indignities. In the case of the rehabilitation center, the person who called me was a pastor. I asked him to find the person in charge. He found a charge nurse, and I heard her say, "I do not have time to talk to her. She will have to call tomorrow." At that point, I recognized that her understanding was rather limited and called Richard Whitley [Director, Department of Health and Human Services] and asked him to translate for me. He did a very good job, and most of these complaints were taken care of immediately and the others were addressed subsequently.

The bill requires the State Board of Health to adopt regulations requiring a medical facility to conduct cultural competency training for any agent or employee who provides direct care to patients. I have a mock-up of an amendment that will expand that to say "anyone who interacts with a patient." Another atrocity I am familiar with is a doctor who performed a surgery and when the patient asked, What happened, what did you find, what are some of things that need to happen? The doctor basically said, I do not need to tell you. That was not hearsay. That was my sister asking the doctor who performed abdominal surgery on her, and I was sitting in the room when she asked and I heard the doctor's reply.

The cultural competency training is intended to enable an agent or an employee of a medical facility to more effectively treat and understand patients who are from different cultures including, without limitation, patients who are from various gender, racial, and ethnic backgrounds; from various religious backgrounds; lesbian, gay, bisexual, transgender, and questioning persons; children and senior citizens; persons with mental or physical disabilities; or part of any other population that such an agent or employee may need to better understand, as determined by the Board. Finally, the bill requires the Department of Health and Human Services (DHHS) to approve the course of program for the cultural competency training conducted by the medical facility.

I have met with stakeholder groups on this and we have tried to refine the language. I have also tried to address some of the questions such as what it means for doctors who have privileges in a particular hospital; we are going to try to address that in a different way. The bottom line is, whatever is happening with respect to training people in cultural competency, it obviously is not working. We need to make sure that the medical and health care delivery system respects people's dignity—who they are, where they come from, the religion they practice, and the faith they practice. If they cannot understand that, they should do what I told the person who said, In my religion we do not believe in transgender people so I cannot serve you. My response was, "You need to go find a hospital that is operated by your religion, because in this hospital, you do that." No one should have to go through that, which is why I brought you S.B. 470 (R1).

Chairwoman Cohen:
Thank you, Senator. I agree that going into the hospital is hard enough, so having to worry about how you are treated because of who you are is not acceptable in our state or in our country. We do not have your amendment, so if you can get that to us, we will circulate it.

Senator Spearman:
Earlier today, it was brought to my attention that the language appeared to be a little bit narrow. We want to be sure we capture the whole scope of people who interact with patients, so the Legal Division of the Legislative Counsel Bureau is now doing a mock-up and I will make sure you have that before you have your work session.

Chairwoman Cohen:
Is that an amendment to section 4.5, subsection 1, where the language reads an employee who "provides care"?

Senator Spearman:
Yes, it is.

Chairwoman Cohen:
What does "someone who provides care" mean? Are we talking about everyone from the doctors down to the person who brings patients their food?

Assemblyman Carrillo:
Language in section 4.5, subsection 1, on line 7 talks about "for any agent." What is the definition of "any agent" in this case?

Senator Spearman:
That is where the amendment will come it. We are trying to make sure that the language is broad enough to capture those who interact with the patient and who should have that type of training. I understand some professions are already doing that; however, it is my belief that if they are already doing that, then the doctor would not have told my sister, I do not need to tell you. If facilities like the rehabilitation center are already doing it, then that person who was recovering from a bullet wound would not have been treated as she was when they refused to change her bandages.

Assemblywoman Titus:
I need some clarification. As health care professionals we are taught to be sensitive to folks in general regardless of their size, shape, color, et cetera. It does not matter when an individual is seeking care. Hopefully, the physician is compassionate and sensitive to that and to the needs of the patient. The training you are asking for—cultural sensitivity—are there programs that already exist? Is it just to be sensitive to everyone's culture in general, because certainly we basically have that. I would submit to you that denying your sister's question had nothing to do with your sister's color, shape, size or whatever. That physician should have answered her question in a respectful manner regardless of this law or mandate.

Unfortunately, we can enact thousands of laws and there will still be folks who just do not pay attention. I wish a law would fix everyone's bad behavior, but it is just not going to do that. When you enact this law and you are asking a medical facility to have this training, are there other states that do this? Is it a one-hour training? Do we have to do it every year? In my facility, there is a broad swath of folks who interact with patients—from the housekeepers to the people who fix the oxygen tank to our mechanics to the dietician. I agree: all your stories should never have happened, and I wish this bill would fix all that. If it helps to fix these issues, that would be wonderful, but what are you looking at? Is there some standard that has already been established that we need to meet as a hospital? What do you have in mind going forward?

Senator Spearman:
If you look on the second page, section 4.5, subsection 2 on line 23 it reads, "provided through a course or program that is approved by the Department of Health and Human Services." We are not saying, This is how you do it and this is when you do it. It is really up to the facility, but we want to make sure that the understanding of cultural competency is across all levels, wherever patients are and where there is interaction with direct care providers, or whatever—that those people are trained.

Assemblywoman Titus, you are absolutely right. There are laws and other things that do not change people but, having grown up in the Civil Rights Era, I know that Civil Rights legislation may not have changed all behaviors, but it came with consequences if someone did not do the right thing. We might not be able to change behavior by instituting this in statute, but we can use the statute to punish those who ignore it.

Assemblywoman Titus:
Obviously, there needs to be consequences. In the training mentioned on page 2, line 23, it states that training "must be provided through a course or program that is approved by the Department of Health and Human Services." You are talking about the State of Nevada's Department of Health and Human Services, so there must already be programs available that a facility could use and it would be up to DHHS to agree if the program would meet the requirements. Also, if these programs are available, is it recommended that they be repeated every so often? This is broad legislation and I am wondering about its implementation.

Senator Spearman:
In our stakeholder meetings, Mr. Whitley shared that they either have some training or have contracted with people to do the training. There are some who say they already have the training but they are going to partner with DHHS to make sure the training in place right now is adequate, in addition to making sure patients are treated with dignity and respect. The person who was in the hospital and did not have her gown changed happens to own an iPhone and took recordings and pictures. At the very least, a medical facility or medical care-giving facility should want to make sure its employees were trained and doing the right thing. In terms of a lawsuit, something like that could be damaging and quite expensive.

Assemblywoman Titus:
It is good to hear that there already are programs. Previously in this Committee, we heard about using standard information regarding rape crises so one facility is not teaching one thing while a different facility is teaching something else. We need standard rules concerning basic humanity. I think that is important.

Chairwoman Cohen:
Senator Spearman, to follow-up on something Assemblywoman Titus asked, what happens if we have a facility where the training has been set up and implemented and DHHS is still getting reports like the example you related concerning the Muslim person who kept being served pork? If the training is not working, what is the mechanism to hold those facilities accountable?

Senator Spearman:
I will go out on a limb and say if this is a requirement that has to be approved by DHHS, my sense would be that it would have something connected to licensure. If this keeps happening in a hospital or other medical facility, whoever is in charge either has an employee or employees who have limited understanding of the consequences. Part of the retraining would have to be taking additional action. We might not be able to change people's behavior, but we can institute consequences for those types of behaviors. Employees who keep doing that, or even do it once, bring down the stellar reputations of the majority of people in that profession. It only takes one person having a really bad experience in a hospital for them to leave and tell their family members, their friends and everyone, I would not go back there if you paid me a million dollars.

Chairwoman Cohen:
Seeing no other questions, we will call for people in support in Carson City and in Las Vegas.

Brooke Maylath, President, Transgender Allies Group, Reno, Nevada:
I support this bill with the caveat that it does not go far enough. We must have comprehensive training from the chief executive officer to the valet because it does not matter where that negative experience happens if you are treated poorly because of your race, because of your religion, because of your presentation—maybe wearing a hijab—or if you are transgender, as I am. We expect to be treated with comfort, dignity, and respect when we are in a medical health-care providing facility—by everyone. It does not matter who is employed by the facility we are interacting with—we must be able to provide training to them so they have adequate knowledge to be able to treat us properly. Rather than couch the words as being able to have a punishment or having a consequence, I would rather think that when somebody deliberately overrides the education and training they have received, that we have the mechanisms to hold that individual—through the facility—accountable for his or her actions. Accountability can look like remediation, censure, termination, suspension, a variety of different things depending on the basis and codes worked out between employee and employer with the oversight of state licensing. As the state perceives the issues, the state is ultimately the judge of what appropriate equal treatment is under the law.

I urge you to look at this bill and consider the amendments that will be forthcoming. I have been in touch with the sponsor, and we will see what we can to do make this as good as possible so everyone has an equal opportunity for great customer service and patient treatment with dignity in every medical facility throughout Nevada.

Jody Domineck, Member, Service Employees International Union, Local 1107, Las Vegas, Nevada:
I am a registered nurse and an executive board member of the Service Employees International Union (SEIU), Local 1107. We are the largest health care union in the state and represent 8,000 hospital and health care workers across Nevada. The SEIU is in support of this bill. It is important that frontline staff improve our cultural competency, and we ask for the Committee's support.

Chairwoman Cohen:
Thank you. It is good to see that the people working in the hospitals want this to happen.

Grace T. Vergara-Mactal, Executive Director, Service Employees International Union, Local 1107, Las Vegas, Nevada:
We represent 8,000 workers in the state. Our union believes this training will additionally help our members understand one another better as well as ensuring management appreciates our differences, so SEIU supports this bill.

Helen Foley, representing the Nevada Center for Assisted Living:
We support the legislation. We think it is very good that we have training in this area. I question whether the facility should be doing all the training. Everyone who comes into contact with a patient—we call them residents in our assisted living facilities—should have that sensitivity training. Through continuing education, the licensing boards should also be involved in this. We really look forward to working with Senator Spearman and making this bill as good as it can possibly be.

Bill M. Welch, President and CEO, Nevada Hospital Association:
Hospitals do not condone the behavior Senator Spearman related today in her testimony. It is unfortunate that those incidents happened. She has talked with me and with the Bureau of Health Care Quality and Compliance with the DHHS. When made aware of it, we take every action. Most of our urban hospitals have cultural training programs. We support the bill and look forward to working with Mr. Whitley and DHHS to ensure that we have a standard process and standard training programs in place so that we can address these concerns.

Chairwoman Cohen:
With no one else in support, we will move to opposition in either Carson City or Las Vegas. [There was no response.] Seeing no one, is there anyone in neutral?

Catherine M. O'Mara, Executive Director, Nevada State Medical Association:
I want to echo what my colleague Mr. Welch said. We certainly do not condone any disrespectful behavior and we are happy to work with the state on regulations as this moves forward.

Chairwoman Cohen:
Would you like to make any closing remarks, Senator? The remarks are waived, so I will close the hearing on S.B. 470 (R1) and open the hearing for public comment. Anyone with public comment, please come forward. [There was no response.] Seeing no one, we are going to have a work session on Monday. Ms. Lyons has some information for us.

Marsheilah Lyons, Committee Policy Analyst:
To process bills of a noncontroversial nature in a more efficient and less time-consuming manner, the rules of the Assembly as well as the *Nevada Constitution* provide for the use of Consent Calendars. Bills on a Consent Calendar are grouped together under one heading and considered for final action by the Committee at one time. Measures placed on the Consent Calendar do not have proposed amendments, further discussion, or debate. If any member wishes to discuss, debate, or vote no on one or more bills on the Consent Calendar, the member should request that the item(s) be removed from the Consent Calendar. Measures that are removed from the Consent Calendar may have further discussion and a separate vote.

The Consent Calendar will be used to process all the measures on Monday's work session. Prior to calling for a vote to "do pass" all the measures on the Consent Calendar, the Chairwoman will give members an opportunity to remove items from the Consent Calendar. Please let me know if you have any questions about the use of the Consent Calendar or the measures on Monday's work session.

Chairwoman Cohen:
Thank you, Ms. Lyons. Please feel free to reach out to Ms. Lyons if you have any questions about the Consent Calendar. We are adjourned [at 1:46 p.m.].

RESPECTFULLY SUBMITTED:

_____
Terry Horgan
Committee Secretary

APPROVED BY:

_____
Assemblywoman Lesley E. Cohen, Chairwoman

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is written testimony authored by Jennifer Castellanos-Bonow, Ph.D., President, Nevada Association for Behavior Analysis, and co-authored and presented by Kenneth MacAleese, Ph.D., Public Policy Chair, Nevada Association for Behavior Analysis, in support of Senate Bill 258 (1st Reprint).

Exhibit D is a proposed amendment to Senate Bill 258 (1st Reprint) presented by Senator Heidi Seevers Gansert, Senate District No. 15.

Exhibit E is written testimony dated April 15, 2019, presented by Barbara D. Richardson, Commissioner of Insurance, Division of Insurance, Department of Business and Industry, regarding Senate Bill 234 (1st Reprint).