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

Eightieth Session
March 6, 2019

The Committee on Health and Human Services was called to order by Chair Michael C. Sprinkle at 1:34 p.m. on Wednesday, March 6, 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:

Assemblyman Michael C. Sprinkle, Chair
Assemblyman Richard Carrillo, Vice Chair
Assemblyman Alex Assefa
Assemblywoman Bea Duran
Assemblywoman Michelle Gorelow
Assemblyman Gregory T. Hafen II
Assemblywoman Lisa Krasner
Assemblywoman Connie Munk
Assemblywoman Rochelle T. Nguyen
Assemblyman Tyrone Thompson
Assemblywoman Robin L. Titus

COMMITTEE MEMBERS ABSENT:

Assemblyman John Hambrick (excused)

GUEST LEGISLATORS PRESENT:

Assemblywoman Lesley E. Cohen, Assembly District No. 29

STAFF MEMBERS PRESENT:

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

OTHERS PRESENT:

Kyle George, Special Assistant Attorney General, Office of the Attorney General
Brett Kandt, General Counsel, State Board of Pharmacy
Julia Peek, M.H.A., Deputy Director, Programs, Department of Health and Human Services
John Fudenberg, Coroner, Government Affairs, Office of the Coroner/Medical Examiner, Clark County
A.J. Delap, Government Liaison, Office of Intergovernmental Services, Las Vegas Metropolitan Police Department
Joan Hall, President, Nevada Rural Hospital Partners
Catherine M. O'Mara, Executive Director, Nevada State Medical Association
Homa S. Woodrum, Chief Advocacy Attorney, Aging and Disability Services Division, Department of Health and Human Services
Dena Schmidt, Administrator, Aging and Disability Services Division, Department of Health and Human Services
Connie McMullen, President, Senior Coalition of Washoe County
Barry Gold, Director of Government Relations, AARP Nevada
Helen Foley, representing Nevada Center for Assisted Living
Darryl Fisher, President, Nevada Center for Assisted Living
Marlene Lockard, representing Retired Public Employees of Nevada

Chair Sprinkle:
[Roll was taken. Committee rules and protocol were explained.] Let us open up the hearing on Assembly Bill 49.

Assembly Bill 49: Revises provisions relating to the monitoring of prescriptions for controlled substances. (BDR 40-420)

Kyle George, Special Assistant Attorney General, Office of the Attorney General:
Assembly Bill 49 amends portions of *Nevada Revised Statutes* (NRS) Chapter 453 to address issues with the Nevada Prescription Monitoring Program that have surfaced since the underlying legislation was last amended in 2017. The Office of the Attorney General collaborated closely with the State Board of Pharmacy to draft, revise, and vet this bill. Being respectful of this Committee's time, and with the Chair's approval, I would like to avoid duplicative testimony by giving Brett Kandt, General Counsel to the State Board of Pharmacy, the opportunity to present his testimony regarding the background and details of this bill.

Brett Kandt, General Counsel, State Board of Pharmacy:
Assembly Bill 49 makes amendments to several existing provisions in NRS Chapter 453, the Nevada Uniform Controlled Substances Act. It amends some provisions that were enacted by Senate Bill 59 of the 79th Session, regarding Nevada's Prescription Monitoring Program (PMP) database. The PMP was created at the direction of the Nevada Legislature in 1997 to track the prescribing and dispensing of all schedule I through schedule V controlled

substances for the purpose of coordinating patient care and preventing diversion, abuse, and overdoses. However, some critical data does not currently make its way into the PMP, including violations of the Nevada Uniform Controlled Substances Act regarding controlled substance prescriptions or prescription drug-related overdoses, whether they result in a death or not. Senate Bill 59 of the 79th Session was enacted to try to fix this deficiency and ensure that this important data was making its way into the PMP. Senate Bill 59 of the 79th Session required law enforcement to enter data on controlled substance violations and reports of stolen prescriptions into the PMP. It also required that coroners and medical examiners report prescription drug-related deaths into the PMP.

There are two reasons why that information was deemed vital: One, it would enable health care practitioners when they access the PMP to determine whether treatment using a controlled substance is medically appropriate; and two, it would enable licensing boards and law enforcement agencies utilizing the PMP to investigate and act on unlawful prescribing and dispensing activity. While S.B. 59 of the 79th Session was a sound policy proposal, some of the statutory language has proven problematic to implement. The intent of A.B. 49 is to remedy this.

Section 3 eliminates the requirement that coroners and medical examiners report prescription drug-related deaths into the PMP. Instead, the PMP will be granted the authority to access overdose information that is now being reported to the state's Chief Medical Officer, whose office is within the Division of Public and Behavioral Health in the Department of Health and Human Services. That reporting requirement was enacted last session in a different bill—then-Governor Sandoval's omnibus opioid epidemic bill—Assembly Bill 474 of the 79th Session. Right now, health care practitioners are reporting drug-related overdoses, whether or not they result in a death, to the state's Chief Medical Officer. In order to have that information available to users of the PMP, we are asking you to give the State Board of Pharmacy, which administers the PMP, and the Investigation Division of the Department of Public Safety, who receive that overdose information, the authority to share that information and have that information migrated into the PMP. That will include nonfatal overdoses, which is most relevant to practitioners. If someone overdoses and is dead, they are not presenting themselves to a health care practitioner seeking a prescription. What we need to know is information about the people who have suffered nonfatal overdoses. Again, section 1 amends NRS 441A.150; section 2 amends NRS 453.162; and section 3 amends NRS 453.1635.

Section 3 of the bill further amends NRS 453.1635 to simplify the law enforcement reporting requirements by leaving the details of that reporting to be specified in regulation and giving the State Board of Pharmacy and law enforcement some flexibility to address any logistical challenges that may arise in formulating that reporting process.

Section 4 of the bill amends NRS 453.164 to clarify that the State Board of Pharmacy may terminate the PMP access of any other health care licensing board if they access the PMP in violation of Nevada law. Existing law already specifies that the State Board of Pharmacy can suspend or terminate PMP access if a health care practitioner, law enforcement agency,

coroner, or medical examiner accesses the PMP for a purpose that is not authorized under Nevada law. It does not, however, address the licensing boards, and this is critical since the patient data in the PMP is protected health information under the Health Insurance Portability and Accountability Act. It is important that we have the authority and ability to terminate or suspend access if any entity that has been given access is utilizing it for any inappropriate purpose.

Section 6 amends NRS 453.236 to clarify that a health care practitioner can be disciplined for violating any of the laws related to the use of the PMP. These revisions will simplify implementation while still achieving the policy goals and the intent behind S.B. 59 of the 79th Session.

Chair Sprinkle:
Are there any questions from the Committee?

Assemblywoman Titus:
I need some clarification. Because there are certain mandates and responsibilities as a physician, I go on the PMP before I write a prescription but I am unclear how this will really change overprescribing. We and the hospitals, et cetera, are already mandated—as in section 1, subsection 1. We already have to provide that information to you, so the State Board of Pharmacy can certainly see that. Again, how will this change behaviors or change outcomes? That is my first question.

Second, since we have been reporting, we have found some significant problems with it, mainly through what we are required to report. I am sure you are familiar with the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10) codes. These are computerized codes for diagnoses. When this bill was passed two years ago, we were mandated to report overdoses with what are called transaction codes (T-codes). We discovered that there are almost a thousand T-codes that address potential overdoses, but some are not overdoses, some are under-dosing while others can be a myriad of things that are not actually relevant to what the goal is—patient safety, overprescribing, and making sure that we all understand that there has been a crisis with medication.

I am concerned. How is it going to improve anything by now having this extra step that we are already reporting to you? I do not think that changes anything. Also, one thing we did find out that was not good was that this huge plethora of codes was not really giving accurate information.

Brett Kandt:
Let us be clear about what S.B. 59 of the 79th Session did as opposed to what A.B. 474 of the 79th Session—the Governor's omnibus bill to combat the opioid crisis—did. You are referring to the reporting requirements that were required under A.B. 474 of the 79th Session. I know there have been some questions and some things had to be ironed out with regard to how those reporting requirements worked. Those are separate and distinct from

what S.B. 59 of the 79th Session proposed—the policy change this Legislature made in enacting that Senate bill and what we are trying to do in terms of implementing that policy in A.B. 49.

You bring up a very good point. I have been talking in the abstract about why we want information about overdoses and prior arrests on drug-related charges regarding controlled substances. Why is that information important and why would it be helpful to have that in the PMP? Let us look at a specific example of how that information would be helpful. A patient presents to a practitioner, let us say a doctor. The doctor, in the course of evaluating the patient, concludes that perhaps writing a prescription for a controlled substance may be an appropriate course of treatment that would be medically necessary for this patient. Then, per the requirements of A.B. 474 of the 79th Session, the doctor consults the PMP. Under the proposal before you in A.B. 49, the doctor could see whether that patient has prior arrests regarding prescriptions for controlled substances. The doctor could see whether that patient has had prior overdoses resulting from the use of controlled substances. That information would be very relevant in allowing that physician to make an informed decision, in his or her professional judgement, as to whether writing this patient a prescription for a controlled substance would be medically appropriate in this instance. That is really what we are talking about in terms of the benefit of this information within the PMP for the users of the PMP.

Assemblywoman Titus:
I do not disagree with the benefit of information—knowledge is helpful, and I agree with that. Now the Chief Medical Officer, who has this information, is going to upload that to the PMP. That means potentially thousands of folks would be getting this information. What is the Chief Medical Officer doing with the information now? We are already mandated to report the information to that office.

Brett Kandt:
I am not prepared to answer that question because that is all mandated under NRS Chapter 441A which is outside the jurisdictional oversight of the State Board of Pharmacy. In S.B. 59 of the 79th Session, the Legislature found, from a policy standpoint, that having overdose information available to users of the PMP would be helpful. This is the most effective, efficient way we have identified to be able to access that information since it is already being reported to the Chief Medical Officer.

Assemblywoman Titus:
To be clear, the State Board of Pharmacy already has access to the PMP for overprescribing and disciplinary purposes, and the pharmacy board can look at the PMP and know if a doctor or a provider is overprescribing already.

Brett Kandt:
The State Board of Pharmacy together with the Investigation Division of the Department of Public Safety administer the PMP. We have a third-party vendor that actually runs the PMP on our behalf, but we oversee it, so certainly we have access. The whole idea is you have

health care practitioners, you have law enforcement agencies, and you have other licensing boards that license the health care practitioners, in addition to the pharmacy board. We give them the license to prescribe or dispense the controlled substances, but the Nevada State Board of Medical Examiners licenses doctors and the Nevada State Board of Nursing licenses nurses. They have access to the PMP to see if their licensees are acting appropriately. Right now, information on overdoses is not contained in the PMP. Information on overdoses is now required to be reported to the state's Chief Medical Officer. We thought it made sense to allow that overdose information to be migrated into the PMP and be available to the users of the PMP—the practitioners, law enforcement, and the other occupational licensing boards.

Chair Sprinkle:
There might be someone in the audience who could speak directly to this issue.

Julia Peek, M.H.A., Deputy Director, Programs, Department of Health and Human Services:
As part of one of our Centers for Disease Control and Prevention opioid grants, we purchased something for the State Board of Pharmacy called NarxCare. NarxCare can pull in different sets of data, so the clinician has an idea of potential risk factors that might be appropriate to their client. This data site can be one of those things that feeds in, but we have worked with the State Board of Pharmacy and they know the challenges with implementing it the way it is now. We met prior to the implementation of the regulations and thought it was a really good methodology, but now we are learning that using an ICD-10 code or the T-code is not going to be the best way to do it. We had committed to going back, looking at the regulations, and revising. The Board of Pharmacy told us that until we got that detailed out based on the emergency room clinicians' interpretation of overdose, they would not feed into the PMP. So they can happen in parallel, but we know currently it is not ready.

Assemblyman Thompson:
Looking at section 3, can you give me the street version or a scenario?

Brett Kandt:
This was something that was discussed extensively when S.B. 59 of the 79th Session was considered. It had to do with the threshold that would trigger reporting. The original language in that bill read "reasonable suspicion." That was really problematic because that is not an objective threshold. Then, in conversations about what an appropriate threshold might be, we talked about "upon conviction" because that is a pretty objective threshold. The problem with using that as the threshold is that many individuals with extensive histories of being arrested for violations involving prescriptions for controlled substances are never convicted because we have a very effective pretrial diversion program called the drug court. They go to drug court, they successfully complete it, and they never get convicted, but they may have an extensive history of arrest. The language that made it into S.B. 59 of the 79th Session was "probable cause to believe." Since S.B. 59 of the 79th Session was enacted, in talking to law enforcement about how we implement it in reality, we then had to figure out at what point do we determine that probable cause has been triggered and law enforcement has

to report. We agreed that we would interpret that to mean "arrest." That would be the threshold. At the point in time when an individual is arrested and booked into a detention facility, the Nevada offense codes are entered into the Nevada Criminal Justice Information System, but there are no codes that correspond to the violations of Chapter 453 that would trigger reporting to the PMP. However, since we were coming before you with this proposal to improve upon the language from an implementation standpoint, we said, Well, if we are going to interpret it to mean "arrest," let us have the statute say "arrest." That is where in section 3 we proposed to change the existing language from "probable cause to believe" that a crime has been committed involving a prescription for a controlled substance to "agency arrests a person for . . . ." That is a very objective threshold.

Assemblyman Thompson:
If you are arresting a person, the violation is with law enforcement; if I hear you correctly, it is going into two systems. Why does it have to go into two systems? If a person breaks the law, it goes into whatever system law enforcement uses.

Brett Kandt:
Because the PMP is available to the health care practitioners who are mandated to use it to determine whether prescribing a controlled substance is in that patient's best interests—whether that is the best course of treatment from a medical standpoint. Those practitioners have no access to the criminal justice system. They have no way of knowing if the patient has multiple arrests for drug-related offenses. This is a way to provide that information to them so that they can make the best educated decision, in their professional judgement, as to whether to prescribe a controlled substance to that individual.

Assemblyman Thompson:
Would the prescribing individual really look objectively at the needs of that patient? Is this like a profiling? What if in that situation the patient really does need the medicine but is denied it because of some previous behavior and arrests?

Brett Kandt:
The Legislature last session thought it was a good policy proposal; we just had concerns with the implementation. Ultimately, it is for the health care professionals to exercise their best professional judgement as to whether prescribing a controlled substance would be in that patient's best interests. Whether that individual has a history of abusing controlled substances is relevant to that health care practitioner's evaluation. Once again, this is all tied to the opioid epidemic. One thing A.B. 474 of the 79th Session did was try to focus health care practitioners to consider whether there are other alternatives outside of prescribing a controlled substance.

After consulting the PMP and determining this patient has in the past had a history of controlled substance arrests, that does not mean that the practitioner might not conclude that writing a prescription for a controlled substance in this instance is appropriate and still would write the prescription. The whole idea is giving them the data and the information to make the most informed decision possible.

Assemblyman Carrillo:
When talking about controlled substances, I know there are different schedules—schedules II, III, IV, and V. Is medication for high blood pressure still considered a controlled substance? Some people put their medications in little pill boxes. Suppose that person gets pulled over by law enforcement? I just need some clarity. I know prescription bottles say exactly what the medication is, but if the pills are not in that bottle and instead are loose in a pill box, could you clarify that?

Brett Kandt:
I hesitate to speak in generalities because the specifics of any particular instance and the factual circumstances surrounding any interaction between an individual with prescription medication and law enforcement can differ. If I understand you correctly, you have a situation where somebody in the course of detention with law enforcement officers is found to have some prescription medication on themselves and it is not clearly established that it is that individual's prescription because it is not in a bottle or something of that nature. That is a very fair question, but it will depend upon the facts and circumstances. Under the circumstances, that law enforcement officer could run a criminal background check on that individual and discover that the individual has an extensive history of arrests or convictions for offenses involving controlled substances. It could be that the law enforcement officer runs a criminal background check and this individual has no criminal history whatsoever. Depending upon the information, the law enforcement officer may make a professional decision. I cannot answer that question for you. I think it is a fair one, but it depends so much on the circumstances.

Assemblyman Hafen:
In the event that someone is arrested and added to this list, but then is found to be not guilty, is there a way to get off the list?

Brett Kandt:
I do not know that I have an answer. You could have a situation where someone was arrested and it was a single incident. The person was never convicted, had committed no offense, and now wants his or her name taken off the PMP. I think we can address that. Sometimes, incorrect information makes its way into the PMP. Under existing law, patients have a right to all the data in the PMP that applies to them. If they receive their patient profile and identify something in the PMP that is incorrect, we correct it. We have a process for correcting information in the PMP. To the extent that we would need a process for addressing a wrongful arrest or something of that nature, I think we can work that out. I do not think that is something that precludes the solid policy idea of putting arrests in the PMP, but I do not have the details of how we would go about that. That is part of the reason why we proposed allowing the pharmacy board the authority to adopt regulations to iron out the details of how this process would work.

Chair Sprinkle:
Are there any other questions, Committee? [There was no reply.] I have a few questions. There is nothing in statute or within the PMP that dictates to a prescriber how they must perform their duties, is there?

Brett Kandt:
Nothing in S.B. 59 of the 79th Session addressed a prescriber's duties with regard to the PMP, and nothing in A.B. 49 addresses a prescriber's duties with regard to the PMP. There was other legislation that addressed prescribers and what some of their duties are relative to utilizing the PMP and reporting into it.

Chair Sprinkle:
I want to be perfectly clear that statute does not prohibit a prescriber from doing what he or she feels is clinically best for the patient. What we are trying to do here is give them the most information they can have so that they can treat their patient accordingly, is that correct?

Brett Kandt:
Yes, Mr. Chair, I would agree with that.

Chair Sprinkle:
I have a question about section 3. How does this section affect law enforcement's ability to investigate a possible crime? If you look at section 3, subsection 3, it specifically says that they can "postpone uploading such information" if they are in the process of actively investigating a crime.

Brett Kandt:
You are correct, and that is existing law.

Chair Sprinkle:
I would like to go back to the part about the coroner. Are we no longer going to require the coroner to upload information from their investigations, yet that information is still going to be part of the database?

Brett Kandt:
We are not, and there are two reasons for that. First, to the extent that the coroners are uploading information on overdoses, it is already going to the state's Chief Medical Officer. Second, as we talked about, the purpose of the PMP is to allow the practitioner to review the patient's information in the PMP to make a decision as to whether prescribing a controlled substance for that person in the course of treatment is medically appropriate and necessary and in the patient's best interests. The coroner is only reporting on deaths related to an overdose, so those people are not going to be presenting themselves to a health care practitioner seeking a new controlled substance.

Chair Sprinkle:
Is it the opinion of the State Board of Pharmacy that that data will still be accessible so we can continue to gather it to see what the trends are? Are you saying that data will still be gatherable if it is being reported, but not to the PMP?

Brett Kandt:
Yes, that data is still being reported; it is going to the Chief Medical Officer. I want to emphasize that, with these changes, although the coroner and the medical examiners will not be required to put data into the PMP, they still have access to the PMP. They can use that information. When they are conducting an autopsy, they can look to see whether the individual had a history of drug abuse, controlled substance violations, or previous overdoses. Currently, they do utilize the PMP for that purpose and it is very helpful and a good resource for them.

Chair Sprinkle:
Do Committee members have any other questions? [There was no reply.] At this point, I will bring forward anyone who is in support of A.B. 49.

John Fudenberg, Coroner, Government Affairs, Office of the Coroner/Medical Examiner, Clark County:
We do support this bill. To clarify a few things in reference to the question you had, Mr. Chair, we do report our data and we will continue to report our data to whomever wants it. We are very engaged in many different taskforces. Currently, there are a lot of different taskforces nationwide we deal with because there is a lot of grant funding available now. We are fully engaged with every one of them because we do take it very seriously and our data is considered gold when it comes to where the deaths related to opioids are and what types of drugs are being overdosed on. We support the bill and we support anything we can do to combat the opioid epidemic.

A.J. Delap, Government Liaison, Office of Intergovernmental Services, Las Vegas Metropolitan Police Department:
We are here in support of this measure. We appreciate the work Mr. Kandt has done with us through the years in this endeavor. It is at a point where we think it is very workable and usable.

Chair Sprinkle:
Is there anyone else wishing to speak in support of A.B. 49 either here or in southern Nevada? [There was no reply.] Is there anyone in opposition to A.B. 49 either here or in southern Nevada? [There was no reply.] Is there anyone who is neutral?

Joan Hall, President, Nevada Rural Hospital Partners:
I am here in neutral today because my members and I agree in concept with this bill, but we would like it on record that in October at the Governor's Opioid State Action Accountability Taskforce we presented and testified about the T-code issues Assemblywoman Titus talked about. Stakeholders, the Chief Medical Officer, and state agencies agreed with us. We see

that some of what is reported is not what needs to be reported. If all that is uploaded, we think that could cause confusion. As an example, underdosing of antipsychotics and constipation-related opioids fall within those 900 codes. We think the regulations need to be worked on so that inappropriate information is not reported.

Catherine M. O'Mara, Executive Director, Nevada State Medical Association:
We are neutral on this bill as well. We echo the comments of Ms. Hall in terms of the regulations pertaining to overdose reporting. This bill is silent on the regulations and just refers to the NRS, so I think work needs to be done on the regulatory process. We do agree that the reporting should be meaningful to the information the state really wants, and it should not include the underdosing and overdosing of other substances. We are committed to continuing to work on those and the regulatory process.

As it relates to criminal arrests and information being uploaded for the use of health care providers, I do not have a good answer for you today. We did not ask for this provision and I am not sure how the physicians would use it. I spoke briefly with the State Board of Pharmacy and right now it is required to be reported. Again, we are neutral on the bill, but as to whether the physicians have access to that, I do not know that we need the arrest data. Overdose data might be helpful because it would be helpful in their clinical treatment, but we will work with them on that. We may not have an issue at all, but I wanted to flag that because it was not something we had asked for.

There were two provisions, two sections in A.B. 474 of the 79th Session that did restrain the clinical judgement of the physicians and those were sections 52 and 60. We thank the Chair for helping us address those. We know the intent was never to stop a clinician from using his or her clinical judgement in prescribing opioids.

Chair Sprinkle:
Is there anyone else who wishes to come forward in neutral in southern Nevada? [There was no reply.] Mr. Kandt, do you have closing comments? [He did not.] I am going to close the hearing on A.B. 49 and we will open up the hearing on Assembly Bill 228.

Assembly Bill 228: Expands the jurisdiction of the Office of the State Long-Term Care Ombudsman to protect persons receiving services from certain additional entities. (BDR 38-171)

Assemblywoman Lesley E. Cohen, Assembly District No. 29:
During the 2017-2018 Interim, I was Chair of the Legislative Committee on Senior Citizens, Veterans and Adults With Special Needs. Assembly Bill 228 would expand the jurisdiction of the Office of the State Long-Term Care Ombudsman and inform clients about how to contact persons who will advocate for them when services do not meet standards. With me is Homa Woodrum, who will speak to the importance of individualized advocacy for people in Nevada.

As background, *Nevada Revised Statutes* (NRS) 427A.125 creates the Office of the State Long-Term Care Ombudsman within the Aging and Disability Services Division (ADSD) of Nevada's Department of Health and Human Services (DHHS). This Office advocates for residents in long-term care facilities. The ombudsmen are trained to resolve problems and represent the perspective of residents in monitoring laws, regulations, and policies.

During the interim, the committee received a presentation concerning the Office. The purpose of the presentation was to learn about the clients currently served by the Office and how clients are informed of services of the Office. We learned that there are currently 12 ombudsmen providing advocacy to long-term care facilities in Nevada. We also learned that during the 2017 Session, a similar measure was proposed but did not move forward [Senate Bill 97 of the 79th Session]. That measure proposed the extension of the program to include advocacy in supported living arrangement services (SLAs), community-based living arrangement services (CBLAs), and adult day care facilities.

Section 6 of A.B. 228 proposes to expand the jurisdiction of the Office to include advocating for clients from facilities for long-term rehabilitation which provide residential services for rehabilitation from an acute illness or injury for longer than a month, CBLAs, SLAs, and day care centers for adults.

Sections 1 through 5 provide definitions for the expanded list of service providers, sections 6 and 7 provide that the services offered by the Office may be expanded to the new providers, and, as already occurs with facilities for long-term care, section 8 also prohibits retaliation against any person who "filed a complaint with, or provided information to, the Ombudsman or an advocate" regarding a day care center, facility for long-term rehabilitation, or provider of living arrangement services. A person who violates this provision is subject to an administrative fine of not more than $1,000 for each violation.

Section 10 provides a new requirement for all identified service providers to post instructions listing the procedures for making a complaint to the Office. The instructions must include a telephone number, email address, or Internet website for making complaints. The measure also provides that if service providers fail to post this information, the ADSD may implement disciplinary actions against the provider as described in sections 11 and 12 of the bill.

I was approached today by stakeholders who pointed out that the penalty is an up-to-$10,000 penalty. Looking at the bill again, I do see their concern that if you did not post, you could be subject to a penalty of up to $10,000. I am certainly willing to work with the stakeholders and see if there is a way we can get that language more in line with what we are intending. Certainly, I do not think it is anyone's intent to have a facility fined $10,000 if they did not post the correct information.

Finally, section 13 relates to regulations to carry out the expansion and section 14 provides that the components of the measure become effective July 1, 2019.

Homa S. Woodrum, Chief Advocacy Attorney, Aging and Disability Services Division, Department of Health and Human Services:
What is notable and encouraging in so much of the discussion that is happening in the first few weeks of the legislative session is the level of sensitivity and concern shown through various bills for vulnerable persons in Nevada. I commend all of you for your efforts in this field. As Assemblywoman Cohen indicated, the Office of the State Long-Term Care Ombudsman is uniquely situated to advocate for resident rights. In the statute connected to my own position, I am tasked with assisting their Office and have been able to learn from them a great deal about the delicate balance between individual rights and choices and safety. Over the last two years, I have done several ride-alongs where I follow ombudsman staff into settings where they are currently statutorily allowed and see them interact with residents. I see the importance of their ongoing connection with those residents, and their ability to be a safe person with whom matters can be discussed without fear of retaliation.

The ombudsman's role in most of these cases is to advocate for the wishes of a resident. Sometimes this puts these advocates at odds with other programs and services, but it represents the crucial importance of giving residents a voice when they are at the center of it all. I think that A.B. 228 fits within this pattern of trying to look at how we can do more for Nevadans who might otherwise be forgotten in these unique settings such as supported living arrangements, community-based living arrangements, and others.

The State Long-Term Care Ombudsman walks a fine line in giving residents a voice and looks to not project our own biases and values upon them in deciding how they can best live independently and enjoy their lives to the fullest.

Chair Sprinkle:
Are there any questions from Committee members?

Assemblywoman Titus:
Assemblywoman Cohen, thank you for acknowledging the need. This bill is mirror to a bill I had when I was Chair of the 2015-2016 Interim Subcommittee to Conduct a Study of Postacute Care regarding the need for expanding what our senior ombudsman does. When that bill [S.B. 97 of the 79th Session] came through, one of the things we identified was that the current structure of the Office did not have enough personnel to expand its services to all who might need it. I did not see a fiscal note on this bill, and I am curious. Is the current Office able to expand and perform these duties if we pass this bill? I am very supportive of this concept.

Dena Schmidt, Administrator, Aging and Disability Services Division, Department of Health and Human Services:
There is a fiscal note that adds 15 staff to support this expansion.

Chair Sprinkle:
Are there any other questions? [There was no reply.] I have a question. Under section 4, there appears to be a definition change or addition under "Recipient." What led to the need to define "recipient"?

Homa Woodrum:
The use of the term "recipient" occurs throughout the bill. It is an attempt to address the fact that the language is a transition from residents of a long-term care setting into this broad category that will include other settings where people live. I believe it is an attempt to create a broad category so that throughout, they are not constantly reciting the particular locations. Living arrangement services would include supported living arrangement services and community-based living arrangement services, or services from long-term rehabilitation or day care centers. It is meant to create a catchall category for the specific purpose of ease of reading the bill. I do not think it is meant to create a new term of art beyond the confines of the statute.

Chair Sprinkle:
That makes sense. Thank you. I want to delve into section 6, subsection 2, more thoroughly. The language here talks about advocates. Could you explain exactly who is being talked about when using the term "advocates"?

Homa Woodrum:
Staff in the Office of the State Long-Term Care Ombudsman are advocates for the rights of these residents. The way I would read it, section 6 broadly captures what they are doing. What is interesting about the long-term care ombudsman program is that it does not just include state employees, it also includes provisions for a robust volunteer program and vetting people who can come in and assist in these advocacy roles. In other portions of the statute [NRS Chapter 427A] that are not in the bill, the term "advocates" does appear and it is mainly connected to volunteer staff and other people who are under the training and supervision of the State Long-Term Care Ombudsman.

Chair Sprinkle:
That is where I want to be absolutely clear. Are you telling me that advocates include volunteers or other people who could be coming into the agency to assist? Your first comment was advocates are the ombudsman and staff within the Department of Health and Human Services.

Homa Woodrum:
I have the full statute here and I can have a look at it or I can provide follow-up.

Chair Sprinkle:
You can provide follow-up; I would much rather know what your intent is with this legislation for the record.

Homa Woodrum:
This bill comes out of the interim committee which heard testimony. The intent was to allow these individuals to have a safe way to complain or address concerns they have with how they are being treated, with their care, and with things they are entitled to without rising to the level of making a health care quality and compliance complaint. Shadowing the ombudsman, I saw that sometimes the concern is as simple as, "When I send my sweater out in the wash, it does not come back and my clothes are getting lost." You or I might say to ourselves that this seems like a really small problem, but when this is your home or the place you have to be for a long time, then that can start to feel like a point of control. In terms of the cosmic intent, I think the use of the term "advocate" would include other people who could be brought in to assist the individual—like legal services.

Chair Sprinkle:
Now that we are relatively clear about that issue, my next question is, What authority is there that gives these advocates the ability to do some of the things you talk about them doing in this bill?

Homa Woodrum:
Nevada's Long-Term Care Ombudsman Program, as it stands, is a federally regulated and created program. What is unique is that the interim committee believed it was a really neat idea that should be brought to other programs. A lot of the power in the ombudsman program comes from federal regulation, and a bill such as this one would be needed to expand that authority to enter these locations—possibly unannounced—on a regular basis for monitoring, to build a rapport with residents, and to take steps that might be necessary regarding referral for services or other communication efforts. The ability of these advocates to enter these settings often results in our being able to identify policy concerns or systemic issues they are facing such as improper discharges. I think it is meant to be broad so they can pivot as needed to advocate for the specific issues that come up. I believe that the language would give them that authority and I guess it depends on the Legislative Counsel Bureau's feeling about the sufficiency of the language.

Chair Sprinkle:
I am not questioning the need and the desire for these different tasks to be performed. That is what is driving us to hear this bill today, so I am not questioning that at all. I am a little bit concerned that in a definition of "advocates"—and we are not really fully sure exactly what that means—we are now putting significant authority into either agencies or groups to not only do site visits and investigate, but to potentially recommend penalties or other ramifications. What are those penalties or implications? Now, neither the ombudsman nor staff within the Department of Health and Human Services will be advocates. Instead, advocates will come from a volunteer outside agency that we have deemed to be appropriate. These advocates can go in and determine through an investigation that there is a deficiency. What are the penalties going to be for that?

Homa Woodrum:
I apologize if I created some confusion in my response regarding advocates. At all times, the State Long-Term Care Ombudsman is the point person who is responsible for the conduct. It is not an outside organization that is coming in and volunteering. These are people who are trained and supervised by the State Long-Term Care Ombudsman. That is part of the federal rules to try to encourage them to leverage opportunity and ability to assist residents. As to your point about authority, when a long-term care ombudsman is in a setting where they are advocating for a resident, what do those referrals look like? They are not meting out a penalty; for instance, "Oh, you did not help this resident and now I have the ability to fine you." They can make referrals to the Bureau of Health Care Quality and Compliance within DHHS. They can make referrals to Elder Protective Services of ADSD with the consent of the resident, which is why I mentioned the need for adult protective services for 18- to 59-year-olds who are vulnerable.

Also built into the statute is the obligation to assist in finding legal counsel for these individuals. Say they are being treated in a way that is inconsistent with their rights. It may be a matter of contacting the Nevada Disability Advocacy and Law Center, it might be a matter of contacting the local legal aid society, and we have robust relationships with them to provide representation to these residents—if they are experiencing an unjustified eviction notice, for instance. What each case looks like is not a regulatory role; this is a support role for service navigation. The retaliation statute is the only part I would say that really gives a specific penalty associated with what might happen in the service of a long-term care ombudsman. If someone is found to be singled out because they asked for help, there should be a mechanism to mete out a penalty.

Chair Sprinkle:
I do not want to belabor this, but maybe we can talk more about it. I still have a lot of concern over this particular issue.

This piece of legislation requires a lot of training of other people on your part. Do you feel confident that you have enough time and ability to perform all of your duties and also give all the training that is required in this bill?

Homa Woodrum:
I provide legal support to the State Long-Term Care Ombudsman, who is currently Jennifer Williams-Woods. What is really exciting about how all these bills work together is that the budget bill draft request (BDR) for adult protective services is fully funded through two different grants—a grant through the Office for Victims of Crime, which is part of the U.S. Department of Justice, and a grant through the Administration for Community Living, which is part of the U.S. Department of Health and Human Services. Through those, we have already scheduled complete training of Division of Aging and Disability Services staff about communicating with adults within this population. I am part of the team that is helping to present statewide, and those trainings are already scheduled. There is a four-day training both in the north and in the south for Aging and Disability Services Division staff regarding the protective services piece. Those are already planned if this body chooses to permit the

adult protective services expansion BDR. A lot of these play together in terms of training and advocacy, and there is a budget within the State Long-Term Care Ombudsman Program for ongoing training that they are already doing.

Last session, the statute [NRS Chapter 427A] was changed. Initially, individuals over age 60 could benefit from the services of a long-term care ombudsman, but the statute now says "residents of facilities for long-term care." You might be surprised to know that a lot of residents of long-term care facilities may be younger individuals. The staff is already attuned to communicating with and advocating for the wishes of, for instance, a 40-year-old who finds himself or herself in a long-term care facility. We have cases involving veterans who might need that advocacy because of injuries they sustained or a traumatic brain injury that has placed them in long-term care.

Definitely not to overpromise, but I think the Division of Aging and Disability Services prides itself on a lot of robust training for everyone we serve. For quite a few years now, disability services has been merged with aging services and, in my experience with the state, we all play really well together and participate in one another's trainings.

Chair Sprinkle:
Do you feel that your agency has the staff and the time to be able to provide the training that is required in this bill?

Homa Woodrum:
I am not privy to all of the fiscal impacts, but I do a lot of training with our really wonderful staff statewide as part of my governing statute, and this is readily incorporated into the individual rights training we do and the guardianship training. When an issue pops up, we develop a training, meet our people where they are, and make sure they have the tools they need to do a great job. Yes, I think so. Feel free to hold me to it personally, and I will do it.

Chair Sprinkle:
Are there any other questions from the Committee about this bill? [There was no reply.] We will now bring up anyone in support of A.B. 228.

Connie McMullen, President, Senior Coalition of Washoe County:
I am a former member of the Nevada Commission on Aging and had the opportunity to tour a nursing facility that was doing this program. When the ombudsman came into that nursing facility, they were welcomed with open arms by the administrator, and that ombudsman knew almost every resident at the nursing home. The ombudsman heard complaints all the way down to, "My eggs are cold every morning." This program works for people who do not have families who can be their voices, especially in a nursing home setting. It works very well. I saw no pushback from the administrator and I saw a lot of cooperation.

There was a bill carried last session by Senator Julia Ratti [Senate Bill 123 of the 79th Session] in which the federal Administration on Aging, which is within the U.S. Department of Health and Human Services, asked that if the Division of Aging and Disability Services

was going to receive funds, the ombudsman program was not to file complaints if they saw or witnessed elder abuse; however, certain professionals such as employees of the Department of Health and Human Services are to report such activity. That bill passed, so if the ombudsmen do see those kinds of situations, they pass them on, and I do not think that is their role. Their role is to help people who are living in what they consider to be their home. This program is in California as well. My mother received help under an ombudsman in a nursing home in California. That person was so delightful and, because I could not be there, called me regularly about the status of my mother. I think this a wonderful bill, and I support it.

Barry Gold, Director of Government Relations, AARP Nevada:
Long-term care is a description; it is a descriptor of a variety of services that can be provided in a variety of places or settings and to several different varieties of populations. It is important that the state of Nevada provide oversight and protection for people who are receiving long-term care services in these different settings to make sure they really are receiving appropriate services, and that the quality of life they are experiencing is what we want them to have. Nevada found out what can happen, and what did happen, when this oversight and protection is not provided. I think we are all too aware of what happened in the CBLAs.

We need to make sure that we provide that oversight and protection in the variety of settings that this bill attempts to do. On behalf of the 348,000 AARP members across the state, we strongly support this bill and encourage you to pass it to provide oversight and protection through the ombudsman program to the variety of populations receiving a variety of long-term care services in different types of facilities.

Helen Foley, representing Nevada Center for Assisted Living:
We strongly support this legislation. We supported it last session when it came out of the interim Legislative Committee on Senior Citizens, Veterans and Adults With Special Needs. There was a much larger fiscal note on it last time—$6 million. I am pleased that it is less, and I appreciate Chair Sprinkle's discussion about the use of volunteers and how we might be able to reduce that number, if necessary, to pass it. It is extremely important that regardless of where a vulnerable individual lives—whether they are mentally ill, whether they have an intellectual disability, or whether they are aged—everyone needs to have a bit of oversight. We think the ombudsman is there to take care of this need, and we strongly support the legislation.

Darryl Fisher, President, Nevada Center for Assisted Living:
I am also involved with a company called Mission Senior Living that provides care to over 250 elderly folks in an assisted living setting. It is important to note that Nevada has strong rules and regulations regarding senior living and residential facilities for groups. That, in combination with a commitment from providers, generally provides very, very high quality outcomes.

The ombudsman program is a national program. I have been providing care to seniors for over 25 years and have been intimately involved with the program. Their sole purpose is unique. They are there to advocate for seniors—particularly those without families—in a neutral position and resolve issues and take complaints. They are very good at resolving issues at the lowest possible level. I have worked with them for years, particularly here in Nevada. The ombudsman program is very effective.

Different staff members of the Nevada Center for Assisted Living have talked about this for some time now, but when you talk about adding 15 staff members to do oversight of over 500 different locations that are housing elderly and providing care and service, it is surprising that it has slid under the radar screen and they do not have the opportunity to benefit from the ombudsman program. We are supporting this bill strongly because we believe seniors and vulnerable people in Nevada should have access to a nationally recognized supportive program that works.

You mentioned the fiscal impact of this. There is a fiscal impact initially; however, I would submit to you that over time it probably will save money. I think you will find the care, service, and quality will improve over time with the least possible level of care—which results in cost savings, not to mention the savings in human anguish. Frankly, the extra cost should work its way out over time.

Marlene Lockard, representing Retired Public Employees of Nevada:
We strongly support this bill.

Chair Sprinkle:
Is there anyone in southern Nevada wishing to come forward in support of A.B. 228? [There was no reply.] Is there anyone wishing to come forward either here or in southern Nevada in opposition to A.B. 228? [There was no reply.] Is there anyone who wants to come forward as neutral? [There was no reply.]

Assemblywoman Cohen, do you have any final remarks you would like to make?

Assemblywoman Cohen:
As we discussed and as one of the supporters mentioned, we received that report concerning the audit conducted by the Audit Division of the Legislative Counsel Bureau, and it showed a great need for improvement of services offered to adults in CBLAs. The findings reminded us of a need for advocacy for the clients in all facilities where adults reside and receive services. Clients need to know there are persons who will advocate for them when services do not meet standards.

Chair Sprinkle:
Thank you for bringing this bill forward. We recognize the importance of all the work you have been doing since that audit of a year and a half ago, so thank you for that. With that, we will close the hearing on A.B. 228. I will open up for public comment. Does anyone wish to come forward with public comment either here or in southern Nevada? [There was no reply.] We will close public comment. We are adjourned [at 2:48 p.m.].

RESPECTFULLY SUBMITTED:

_____
Terry Horgan
Committee Secretary

APPROVED BY:

_____
Assemblyman Richard Carrillo, Vice Chair

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.