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

Eightieth Session
April 1, 2019

The Committee on Health and Human Services was called to order by Chairwoman Lesley E. Cohen at 12:46 p.m. on Monday, April 1, 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 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 Ellen B. Spiegel, Assembly District No. 20

STAFF MEMBERS PRESENT:

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

OTHERS PRESENT:

Catherine M. O'Mara, Executive Director, Nevada State Medical Association
Karen Massey, Executive Director, Northern Nevada Emergency Physicians
Stephen Poscente, Manager, Hites Funeral Home and Crematory, Henderson, Nevada
Cari Poscente, Funeral Arranger, Hites Funeral Home and Crematory, Henderson, Nevada
Marla Turner, Private Citizen, North Las Vegas, Nevada
Caroline Mello Roberson, Nevada State Director, NARAL Pro-Choice America
Molly Rose Lewis, Northern Nevada Organizing Coordinator, NARAL Pro-Choice America
Elisa Cafferata, representing Planned Parenthood Votes Nevada
Michael Hackett, representing Nevada Primary Care Association; and Nevada Academy of Physician Assistants

Chairwoman Cohen:
[Roll was taken. Committee rules and protocol were explained.] We will be having our work session after the presentation of the bills to allow more Committee members to arrive. We will open the hearing on Assembly Bill 268.

Assembly Bill 268: Revises provisions related to vital statistics. (BDR 40-1036)

Assemblyman Richard Carrillo, Assembly District No. 18:
This bill seeks to address a need that was brought to my attention during the interim—the issue is one of grieving families and friends attempting to get through the difficult time after the death of a loved one. As anyone who has experienced the death of a loved one knows, there are many emotions that come along whether the death was expected or not. The knowledge that you will not see that person again is more than difficult and painful. Now imagine that the burial or cremation is delayed, not because of religious beliefs or the wishes of the family, but because the mortuary or funeral home is unable to get a signature from the medical professional for the death certificate. I was told by a funeral director that there are occasions when they have to track down doctors or nurses at their jobs or in their offices in order to obtain signatures. Meanwhile, the deceased and the family are waiting.

I started researching the law and found that the *Nevada Revised Statutes* (NRS) [NRS 440.720] currently list a fine of $250 for not signing a death certificate within the 48 hours required in the *Nevada Administrative Code* (NAC) [NAC 440.160]. However, it was brought to my attention during talks with stakeholders that the only way that fine could be assessed would be to take that person authorized to sign the death certificate to court. Then I looked at other states and how they addressed this issue. Of the states I looked at, most imposed graduated fines. All had timelines. Some required the death certificate to be signed within 24 hours; one state allowed as long as 5 days.

I have been speaking with many people on this issue during the last few weeks. I do understand that there are issues with the electronic death registry, and I believe the State

Registrar of Vital Statistics in the Division of Public and Behavioral Health, Department of Health and Human Services, needs to take steps to address those issues with the programming they are using. However, when you have just lost someone you have loved and cared for in life, hearing this as a reason for not being able to proceed with a burial or cremation is not acceptable. To that end, I have brought forward this bill with a conceptual amendment (Exhibit C). With the conceptual amendment, the bill will revise NRS 440.720 to provide a graduated fine structure with a civil penalty that the State Registrar of Vital Statistics shall impose. Those dollars will be directed to the State General Fund. The amendment also provides that the license of a physician or advanced practice registered nurse (APRN) must not be renewed until those fines are paid to the State Registrar of Vital Statistics. I strongly encourage the State Registrar of Vital Statistics and other stakeholders to work together to find resolutions to the programming issues that have been brought to my attention. Having said that, however, those issues should not be the reason cremations and burials are unnecessarily delayed for those left behind who need closure.

Chairwoman Cohen:
Are there any questions?

Assemblywoman Titus:
Thank you for bringing this bill forward. Over my 38-year career as a physician, I have signed many death certificates. The timing was never a problem. In my little rural hospital, when there was a paper death certificate, whoever was in the hospital—the emergency room (ER) doctor or whoever saw the patient and pronounced the patient deceased—was then able to sign the death certificate. During session, I return home Tuesdays, Thursdays, and Saturdays to see patients. As a result I may not get back to my computer until one of those three days, which is a problem now that we have mandated electronic signatures. If one of my long-term patients dies, the ER doctor does not know that patient. Yes, he or she can pronounce that my patient is expired, but they do not know the extended history of the death, so they ask me to sign the death certificate; and, of course, I do. I know the circumstances and not just that my patient has stopped breathing. That can lead to a 3-day delay.

I agree that death certificates need to be signed and that the family should not have to wait, but the process also needs to be adjusted. My concern is that you want this graduated fine to begin on July 1, 2019. Can the Registrar of Vital Statistics have a process where I could sign on from any computer I have? I would love to be able to get that done in a timely manner, but frankly, sometimes you just cannot get it done in a timely manner the way the system is now. Another problem we have is that you cannot get a start until the coroner opens it up, so I cannot access it the moment I am there, and that is another delay.

The concept and what you are trying to do is absolutely right and fair for families, but on the other hand, it is almost impossible for us to do what you are asking at this time until we have the assurance that the electronic boards and all those systems will be able to comply. We want to; we want to help families, but I am really concerned about the process as it stands right now.

Assemblyman Carrillo:
You bring a very good example of what seems to be a problem with the process. Regarding the coroner, this does not affect those issues. It is deaths from natural causes or when they want to transfer a body from Nevada to another state where the deceased was born. That issue was what prompted this. The family was trying to get the doctor to sign off. This process starts, as you know, with the funeral home. With the electronic signature, wherever you are, you should be able to sign off on that. We can definitely work with the effective date and put that into an amendment as well, if that will solve the issue. We do not want to have this fall on deaf ears again and come back in two years and have to address it again. Let us have the conversations now. If we can go forward with a sensible statute, that is what we are looking for.

Assemblyman Thompson:
It is an electronic system now; once the doctor signs the death certificate, is it automatically transmitted to a funeral home or is there a delay in that process?

Assemblyman Carrillo:
The body is delivered to the funeral home. The funeral home starts the death certificate process and, with the family, fills in all the demographic information of the deceased. The death certificate is then sent to the physician or APRN for cause of death and signature. Once the physician or APRN signs, then the death certificate is completed and the funeral home can proceed. The death certificate can be started by the physician or APRN, but this is what is most commonly happening in Nevada. The funeral home starts it, it goes back to the doctor for signature, and that is where the problem is. It does not get signed or they cannot find the doctor or APRN.

Assemblyman Thompson:
It is my understanding that if you are trying to place a lien against an insurance policy, the funeral homes need to have the original documents. It cannot be done electronically, so usually, that original-document process is the holdup. Is that an area you are looking to improve as well?

Assemblyman Carrillo:
That is why they went to the electronic signatures—to speed that process. It does not need to be a hard copy. Once it is signed electronically, the funeral home receives it.

Assemblywoman Titus:
For clarification, it has to be initiated by a funeral home, but, as of last session, the physician can start that process. It can be sitting in my queue, but I may not know there is one in my queue. That can sometimes lead to a delay, until I look at my email and see I have one from a funeral home director. Sometimes I do not know that a patient has died. If the patient is on hospice and it is an expected death, the hospice medical director can sign off. The process is that the folks at the funeral home open up the computerized program, I get a notice that I need to sign off, the cause of death, et cetera. I sign it and the funeral home can go forward

with it and get the necessary documents. The actual death certificate might be weeks in coming, but the process has to happen on the computerized system.

Assemblyman Carrillo:
What Assemblyman Thompson is asking is when the family needs the paper copies. Is that correct?

Assemblyman Thompson:
Yes.

Assemblyman Carrillo:
I believe they have to request paper copies after the fact.

Assemblyman Thompson:
For the funeral home, that is an expense; there is a long laundry list of expenses. For every insurance policy you have, you have to have an original certificate. I believe there are some funeral homes that must get an original before you can have a service.

Assemblyman Carrillo:
This bill is solely about the ability to bury or cremate the body.

Assemblyman Thompson:
What I am saying is that nothing gets done until that original certificate is received. Then the funeral home knows that the insurance policies are good. Of course, funeral homes do their due diligence to help those families, but at the end of the day, we know how expensive funerals are and that can be a big liability on their end.

Assemblyman Carrillo:
I see what you are getting at but what is happening is, even before they can release the body to the family, or let us say for the purposes of insurance and checking accounts and things like that, the problem is that they are not getting the death certificate back from the doctors to even get that far. If that were the case, they would be able to address that, but right now, death certificates are being held up so people's loved ones are being kept in the funeral homes longer than they have to be. In those cases where the deceased is transferred out of state, nothing happens until they get that death certificate in their hands. Of course, Vital Records deals with the actual hard copies of that. The death certificates are released from the Office of Vital Records.

Chairwoman Cohen:
I appreciate your bringing this bill forward because we are talking about such a troubling time for families. Especially in Judaism and in Islam, it is a religious tenet that you get people buried right away. We do not embalm, so it is very important that we give people the option to move the procedure forward.

Can you go into a little more detail about why there may be a holdup? Can you give us a little more understanding about that? I feel as though I am still missing something.

Assemblyman Carrillo:
I have been working with Catherine O'Mara, but I do not know if she will be in opposition.

Catherine M. O'Mara, Executive Director, Nevada State Medical Association:
This issue with electronic death records has been a problem since the law was passed to mandate 100 percent electronic death records. We are opposed but want to work on this problem because we think it is a big problem for our patients, and we want to make sure they can get their family members buried. What might be most helpful is if Karen Massey could run through some of the issues. I can supplement, and we can come back up in opposition at the right time.

Chairwoman Cohen:
Provide the information now. We will not mark you as in support, and then you can come back up and provide your opposition.

Catherine O'Mara:
The problems we have primarily have to do with the technology. What we did last session, in addition to adding APRNs to this process, is allow for the physicians—or hospitals if it is happening in a hospital setting—to generate the death record so that their part, their signing off, is done at the very beginning when the death occurs. The technology has not supported that process. At the time, we thought it would be a good idea because the doctor knows as much as he or she is ever going to know about the cause of death at that point. If there is a way to put it into the system and allow the funeral home to draw it down, that would eliminate the delay.

But the technology has not supported that change. In talking with my members, what happens is the death occurs, you go to the funeral home, and they generate the record. They send the record to the person they think is the attending physician at the time of death. If that is the primary care physician, the delays that are built in are what Assemblywoman Titus is talking about: I did not see the email; I was out of town; or whatever it might be. If it happens in an emergency room setting, you might be sending it to the wrong doctor, and Ms. Massey is going to expand on those problems.

Karen Massey, Executive Director, Northern Nevada Emergency Physicians:
I am a volunteer and legislative liaison for the Medical Group Management Association. In my day job, I manage Northern Nevada Emergency Physicians which is the ER group that provides services at Renown. We are responsible for about 125,000 ER visits a year. Even with that large number, if you take the number of deaths that occur in the ER and divide them by the number of our doctors, it comes out to about two death certificates per year per physician. One of the challenges we have experienced is the technology itself. It is difficult to use. When the doctor becomes notified of the death is another of the big challenges.

The passing of a patient generates an email, but what we have done as a workaround in this new electronic system is, I have a staff member who looks at the queue for our 60 physicians every day. She identifies outstanding death certificates and transfers them to the 4 a.m. physician the next morning so we know we have a timely system for those death certificates to get done. I am not sure every practice has the luxury of that kind of bandwidth to do that.

It is more labor intensive because the doctor the next day does not know the patient, so he or she has to look at the medical record to complete it. We feel as though we have to do this to make the process work. The request for the signature could be made 24 to 48 hours later; it is not necessarily made at the time of death, it is from the time the funeral home makes the request. If the funeral home has gone through their process for a number of days, and then an email arrives asking for the death certificate to be done promptly, unless you have a built-in system to do a workaround as I just described, you can often miss schedules—especially with people who work 24/7 schedules.

I called our 4 a.m. physician this morning and asked for an update to be sure I was not misrepresenting the process. He described that in the Renown ER, we have one computer that has this system on it, because the system will not work well with other software. It is located in one place in our ER. He informed me that when he signs on, it always crashes the first time. He knows that now, so he knows to try it again a second time. He expressed the challenges that have been mentioned. He is often the doctor who pronounces a patient, but is with that family at that terrible time and may not have the history of what led up to that moment. Although he is tasked with completing the death record and is willing to do that, he perhaps cannot paint as complete a picture as one might like for their loved ones to have on a death record—particularly for insurance purposes—but we do our best.

The next step after our physician completes it is that it goes to the state and the state has to marry it up with the Centers for Disease Control and Prevention (CDC) guidelines, which are complicated. So, we are all challenged with this system. The CDC will kick the documents back if there is an abbreviation, if it does not give enough description about the underlying cause of death, et cetera. Even with the workarounds we have put in place, we still experience about a 25 percent rejection rate, and we must start this process again.

Chairwoman Cohen:
After listening to the testimony, do we have other questions? [There was no reply.] All right, we will move to support. Is there anyone in support in Las Vegas or in Carson City? [There was no reply.] Is there anyone in opposition in Las Vegas or Carson City?

Karen Massey:
It is really key for the provider, whether it be a physician or an advanced practice registered nurse, to be able to complete their portion of the death record at the time of demise. That physician knows as much as he or she is ever going to know, and the logistics surrounding having someone do that at a later date, finding the right doctor, or getting it in the right queue, are really challenging. To have that happen, two things have to take place: We need to work in partnership with our hospitals, and we have had that conversation with them and

know that they are willing partners in that endeavor. The scenario in my mind would be that, after a passing, the hospital would reach out to that provider and say, Let us do the death record now. With the assistance of the hospital, that provider would have someone who is used to doing it more frequently, understands the restrictions and the CDC guidelines, to help walk that provider through the process. The second thing that is really key to making that happen is to have information technology (IT) that those folks can navigate. We have now taken provider time and hospital time at 3 a.m. in a busy ER or intensive care unit or wherever the death has occurred. I think there is some opportunity here to redesign the process in a way that really honors families in their time of need.

The second request I would like to make is that whatever IT solution is in place be characteristic of drop-downs. Physicians and other providers are really used to electronic medical records now; we all are. If we could build a system that really supports their making the right decisions that the CDC would accept, I think that would be a huge gain for all of us.

Catherine O'Mara:
I would like to thank Assemblyman Carrillo for meeting with us. We have sent him a lot of information since we met, and I know that the problem he is trying to solve is an important one. We are not necessarily opposed to redoing the fine structure; however, from our perspective, fines are not going to drive behavior. We think we really need to be focusing on how we are going to fix the problem. It is not our intention to slow down the process. It is a terrible experience to have to work through with patients' families, and we want to help them during a time of great sadness.

I want to share an anecdote with you from the rural areas. Last session when we were trying to get this fixed, you all supported allowing us to be authorized to start the records. In the rural areas, we oftentimes have physicians who are visiting from out of state. They will work a couple of shifts and go back home. In the cases where those physicians are pronouncing death, they may get a message saying that the death record is ready, but they may already be back in Idaho, or Utah, or some other state, so the family is unable to take their loved one home. This is a real problem and we acknowledge it, but we do not believe that it is simply because physicians are unwilling to sign the records.

I want to make a point about the bill—the fine attaches upon a request. Now that we are in an age of electronic death records, the request can be made to many physicians, but it might be made to the wrong physician. We are okay with fines if they are applied to the right person, and they had the opportunity to do things the right way and failed to do them. People should be accountable, but in this case, there are so many hiccups that can occur. Perhaps Dr. A is getting the request but Dr. B pronounced it, so it takes more teamwork, and we need to work through the process a little bit better.

I like to offer solutions; we do not relish being in the position of just opposing something. What Ms. Massey pointed to is that we need to spend some time working through the technology. I have been involved in some informal working group meetings dating as far back as 2015. We make some progress but there is no way to report it, and we also do not keep up with things like Ms. Massey's group has done using workarounds. We do not keep up with the level of complaints, so I think some kind of legislatively sanctioned or authorized working group including us, Vital Statistics, hospitals, the funeral home industry, and maybe the coroners' offices makes sense, with a requirement that we report back during the interim to an appropriate committee to make sure we are making progress toward fixing this problem.

We can identify what is necessary in the technology piece. We suggested that a consultant help the state because we think we are having more problems than a lot of other states are having with this. As late as 2017, Nevada and Iowa were the only states with a 100 percent electronic death-record requirement. It might be prudent for us to have an exemption in those cases where a family's burial is being held up because of a clog in the web somewhere. On the technology piece, we sometimes miss emails because we get a ton of them and are really busy. It is not as simple as a drop box where we can fill out a death record and stick it into a drop box and the funeral home can come and pick it up, and I am not sure why not. Why can we not work with the existing technology to make this a simpler process? We have these problems and Iowa has these problems, but not every state has these problems, so I think it is worth looking at.

Again, we are very sympathetic to what Assemblyman Carrillo is trying to do. We would like to keep working on this if this bill is processed or keep working on it in the other house or even before work session, understanding that time is limited. We do think this is not going to change behavior in the way Assemblyman Carrillo hoped it would, but there are real problems that do need to be resolved and not just kicked down the road.

Chairwoman Cohen:
Are there any more questions? [There was no reply.] Is there anyone else in opposition in Las Vegas?

Stephen Poscente, Manager, Hites Funeral Home and Crematory, Henderson, Nevada:
We have one of our funeral arrangers here who would like to talk about the process and give a perspective from the funeral industry.

Cari Poscente, Funeral Arranger, Hites Funeral Home and Crematory, Henderson, Nevada:
I will explain the funeral home's process once a decedent comes into our care—the paperwork, how we create it, and find out what doctor would be signing. That is one of our biggest challenges. When we bring someone into our care, we are given the paperwork from the hospital or coroner. That paperwork includes a face sheet that has the name, date of death, time of death, where the person passed away, what room he or she was in, and some of the medical terminology the nurses and doctors have worked with. Then there are usually one or two sheets from the hospital or hospice. Sometimes a doctor's name will be written where it reads, "physician to sign death certificate." That happens about 30 percent of the time.

We have to start the death records within 24 hours. If we have not met with the family, we will input any information we have at that time. We usually call family members to set up appointments. We do a lot of "ship outs." That is the terminology we use when we are shipping the body to another state or country, and we do hundreds of those a year. So, we meet with the families, but that can take a day or two or even a week because sometimes they are coming in from another state. We need that information from family members to complete the death certificate. We need to know where they were born, their parents' names, mother's maiden name, a lot of information the hospice cannot supply for us. That is a challenge in trying to get a death certificate done quickly, waiting for family members to get us information—if there are any family members.

If it is an out-of-state ship out, we are waiting for a shipping company to get the personal information or the family to email or phone us and give us all this personal information as well.

Once we have that information and we can complete our section of the death certificate, because it is a legal document, any changes that need to be made need to be done before it is registered. We have the families proofread everything. If a doctor signs, and say the social security number is wrong, we are locked out of changing it; so we have a challenge sometimes putting the doctor in right away, and that is something that needs to be addressed with the IT programmers. If we are blocked out, now we have to get the state involved to get the correct social security number in there. That is just an example of problems that happen in our office.

Once we have completed all the information we have and need to, we will always call the hospital to confirm. If there is a doctor's name on that paper, we always confirm that it is the correct doctor. We go into the drop-down menu and put that doctor's name in. There is a button that says, "email doctor," so we email the doctor. From our perspective, now the doctor knows. If there is no name, we will call medical records. It usually takes them quite a bit of time to search to find out which doctor is supposed to sign. A lot of times, the name of the doctor has to be changed. Every time we go in, we input the name of the doctor whose name was written down or whose name was told to us, then we email that doctor. Some of the doctors will say that they did not get the email, were not notified, or that they are not supposed to sign this. Some doctors are not in the electronic death registration system, so then the hospital staff has to find someone else to sign.

Our biggest challenge is, frankly, getting the doctors to sign. We do not have any problems with the coroner's office. I understand that the majority of the problems are IT-driven. It is not that the doctors do not want to sign. We are told that once we email the doctor, that person has 24 or 48 hours to sign, but then we wait. We are the ones who are dealing directly with the families, and they do not understand why the documents are not being signed and neither do we. Some doctors do sign right away, but when we hit that "send email," it is our assumption that the doctor is being notified at that time.

Concerning not proceeding unless there is a death certificate, there is a huge misconception. Once we sign, the doctor signs, and the state verifies that the doctor and funeral home have signed properly, the state then issues us the permit to either cremate or bury. That is the document we need to proceed with the disposition. At that point, once we have the permit, then the health department has everything it needs to create the certified death certificates. Those can take 5 to 7 days for us to get; but the family can go in right away and pick them up. It is the actual permit that is needed to book a flight, to be able to cross state lines, or complete the cremation.

There are some hospitals where we have so many problems getting a death certificate signed that in one case I actually have the chief of staff's personal cell phone number, and he ends up signing most of them. Otherwise, as he has told me, he would have to suspend doctors who do not sign. Those doctors who will not sign tell me the primary physician is supposed to sign, but then the primary physician works in an office and has not seen the decedent in years but we are told that there is a statute somewhere stating that if there is a primary physician, that person needs to sign the death certificate, so the doctors are fighting back and forth. Really, it is about getting the families taken care of and putting their loved one to rest.

Assemblyman Thompson:
Is it up to each funeral home on how to proceed with a family with or without the death certificate and the payment?

Cari Poscente:
When it comes to payment and the death certificate, each funeral home handles that differently. Speaking for Hites Funeral Home, when it comes to insurance policies, if someone has life insurance we work with a company called American Capital Funding. They are a go-between between life insurance companies and funeral homes. We fill out two forms and one of them has the life insurance company's name and the policy number. The beneficiary has to sign off to give the life insurance company permission to work with American Capital Funding. They will go in and find out whether the policy is good and if there is any money in it. If there is money, the go-between company works to get us paid. There is also a 5 percent fee paid to American Capital Funding off the contract amount. The remainder of the money goes to the beneficiary. I believe that is the way a lot of the funeral homes work. We can verify and get paid prior to having a death certificate; we do send the death certificate later, but we do not physically have to have that death certificate.

Stephen Poscente:
Periodically, the reason for death will cause a delay on our end. So, a concern would be a doctor's being aware of or caring enough to record the proper cause of death. Our concern is having it done right on the doctor's end and in a timely fashion.

Cari Poscente:
I have only filed a complaint two or three times. This last time, the doctor asked me why I had not called him. We are very sheltered from the doctors, and that might be an avenue to help us as well. We would rather help correct the difficulties for the families if we had

access to call the doctors. The only way we can find out who the doctor is and then try to get it signed is to call medical records at the hospital. After two or three days of our bugging them, sometimes they will give us an office number, but all we have on our end is a doctor's name and an email address. Maybe better communication between the funeral home and the doctors would help to get it done more quickly.

Chairwoman Cohen:
Is there anyone neutral in either Carson City or Las Vegas? [There was no reply.] Seeing no one, we will invite the bill's sponsor to give any closing comments.

Assemblyman Carrillo:
I was not looking for a problem when I started this whole process, but I found one. Working with the stakeholders, hopefully we can move this process. They know what the problem is, but how do we get them to react to it? Ms. O'Mara does not think fines will have an effect, but hit anyone in the pocketbook or potentially hold up their license renewal, and it might. We just want to have conversations to ensure that this moves forward and to ensure that we are not holding up loved ones who want to have the closure they need to move forward.

Chairwoman Cohen:
With that, we will close the hearing on Assembly Bill 268. We will do our work session now because we have a Committee member who will be leaving shortly to present a bill. We will begin with Assembly Bill 47.

Assembly Bill 47: Makes an appropriation to the Division of Public and Behavioral Health of the Department of Health and Human Services to establish a pilot program to address behavioral health crisis response in certain counties. (BDR S-501)

Marsheilah Lyons, Committee Policy Analyst:
Committee members as well as the public should have before them a work session document that contains four bills for the Committee's consideration this afternoon. The first is Assembly Bill 47 which was heard on March 4 (Exhibit D).

Assembly Bill 47 requires the Division of Public and Behavioral Health (DPBH), Department of Health and Human Services, to establish a pilot program to respond to persons suffering from mental health crises in certain sparsely populated counties. Specifically, the pilot program provides for the transportation of a person with mental illness who is detained on an emergency basis to a mental health facility: (1) by someone other than a law enforcement officer; (2) within a reasonable time; and (3) in a manner that is safe and dignified. Additionally, the pilot program provides for an initial in-person response to a mental health crisis by trained emergency medical personnel or law enforcement officers working in collaboration with a mental health professional, either in person or through telehealth. The pilot program also provides for a follow-up response by a case manager that is designed to address the ongoing needs of the person who experienced the mental health crisis. Finally, the bill makes an appropriation to the Division to pay certain costs of the pilot program.

Pursuant to the hearing, an amendment was presented by the Board [pages 3-6, (Exhibit D)]. In summary, the amendment seeks to clarify the intent of the pilot program to:

- Create a small number of pilot sites within the region represented by the Rural Regional Behavioral Health Policy Board, rather than a regionwide initiative;
- Leverage non-law enforcement services, certified by the DPBH for transporting patients who are capable of billing Medicaid services;
- Receive advice regarding planning and implementation from the Rural Regional Behavioral Health Policy Board;
- Include marriage and family therapists or other professionals eligible to perform services. This provision is contingent upon passage of Senate Bill 37, which in addition to other provisions, revises their scope of practice; and
- Require its implementation to include program evaluation activities.

Chairwoman Cohen:
Are there any questions, Committee? [There was no reply.] Do I have a motion to amend and do pass Assembly Bill 47?

> ASSEMBLYWOMAN TITUS MADE A MOTION TO AMEND AND DO PASS ASSEMBLY BILL 47.
>
> ASSEMBLYWOMAN MUNK SECONDED THE MOTION.

Do we have any discussion?

Assemblyman Thompson:
I appreciate the policy, so I am voting yes for the policy, but I am glad that I sit on the Assembly Ways and Means Committee so I can discuss the appropriation amount because I think there are other areas we can look into instead of out of the state coffers.

> THE MOTION PASSED. (ASSEMBLYMAN HAMBRICK WAS ABSENT FOR THE VOTE.)

Chairwoman Cohen:
We will give the floor statement to Assemblywoman Titus.

Next is Assembly Bill 49.

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

Marsheilah Lyons, Committee Policy Analyst:
Assembly Bill 49 revises various provisions of the Nevada Controlled Substances Act by:

- Requiring the chief medical officer or his or her designee to upload certain information regarding a person who has suffered or is suspected of having suffered a drug overdose to the prescription drug monitoring program (PMP), rather than requiring a coroner, medical examiner, or deputy to upload such information;
- Clarifying that law enforcement agencies only include in the PMP information regarding the arrests involving a prescription for a controlled substance or a report of a stolen prescription for a controlled substance, as prescribed by regulation of the State Board of Pharmacy; and
- Authorizing the State Board of Pharmacy to terminate access of an occupational licensing board to the PMP if the board accesses the database for an unauthorized purpose. In addition, the State Board of Pharmacy is authorized to suspend or revoke a practitioner's registration to dispense controlled substances if he or she violates certain requirements of the PMP.

There are no amendments in the work session document (Exhibit E) for this measure.

Chairwoman Cohen:
Committee, do we have any questions? [There were none.] I will take a motion to do pass.

> ASSEMBLYMAN CARRILLO MADE A MOTION TO DO PASS ASSEMBLY BILL 49.
>
> ASSEMBLYMAN ASSEFA SECONDED THE MOTION.

Is there any discussion on the motion?

Assemblywoman Titus:
I will be voting no on this bill, as I am concerned about the unintended consequences and perhaps misinformation and unfortunate misrepresentation of patients by allowing folks to upload information on those who not only "suffered" overdoses but are "suspected" of having suffered overdoses. Currently, the medical coroner or the doctor uploads that information. Now it would be other people doing that. Unless it has actually been diagnosed, I would be very hesitant to expand who can upload that information.

Assemblyman Thompson:
I will vote yes; however, I want to reserve my right to change my vote. I will let you and the bill's sponsor know if I do. It is because I just cannot get over section 3 where it states that, if someone is arrested, a law enforcement agency should upload information for a pharmacist to see. I think profiling could occur. It is very subjective for a pharmacist to determine, but I think this gives them a reason to not even look at the issue at hand. They will see this alert and automatically decide to decline giving the prescription to that person when it may be a situation where the person really needs that medication.

Assemblyman Hafen:
I will vote no based on my colleagues' comments just now. I also believe it would be circumventing someone's due process rights.

Assemblywoman Krasner:
I, too, have concerns about section 3 of the bill and about why we would want to make available someone's arrest record for viewing by a pharmacist. I have to echo my colleagues' comments about it. It seems like some sort of profiling and I am not really sure why it is needed, so I will vote no for that reason.

Assemblyman Assefa:
I have moved to vote yes on this bill but, based on the concerns raised by my colleagues, I look forward to further discussions, and, if necessary, I will switch my vote to a no.

Chairwoman Cohen:
I asked for anyone who is going to reserve their right, and I want to remind people that you do not have to reserve your right, but please, make sure to advise me and the sponsor in any situation when you are going to be changing your vote. With that, we will vote.

> THE MOTION PASSED. (ASSEMBLYMEN HAFEN, KRASNER, AND TITUS VOTED NO. ASSEMBLYMAN HAMBRICK WAS ABSENT FOR THE VOTE.)

I will ask Assemblyman Carrillo to take the floor statement.

With that, we will move on to Assembly Bill 76.

Assembly Bill 76: Revises provisions relating to regional behavioral health policy boards. (BDR 39-470)

Marsheilah Lyons, Committee Policy Analyst:
[Marsheilah Lyons read from the work session document (Exhibit F).] Assembly Bill 76 requires each behavioral advisory board to advise the Department of Health and Human Services (DHHS), the Division of Public and Behavioral Health, and the Commission on Behavioral Health, both of DHHS, about redundant, conflicting, or obsolete federal, state, and local laws and regulations that relate to behavioral health. The measure also requires each behavioral health policy board to:

- Establish an electronic repository of data and information concerning behavioral health and behavioral health services in the behavioral health region;
- Track and compile data concerning persons admitted involuntarily to mental health facilities, hospitals, and programs of community-based or outpatient services; and
- Identify and coordinate with other entities that address issues relating to behavioral health.

The bill revises the contents of the annual report that each policy board is required to submit to the Commission. Finally, the Commission is required to employ a coordinator for each policy board and provide an appropriation to compensate those coordinators.

Assemblyman Yeager, the Chair of that policy board, proposed an amendment at the February 27, 2019, hearing for the measure [page 2, (Exhibit F)]. He has asked that we revise that amendment to exclude bullet point 3, which would have placed the existing board coordinator position into the statute, including them as an ex-officio, nonvoting member of each respective board. He is asking that the Committee consider all other provisions.

Chairwoman Cohen:
Do we have any questions? [There was no reply.] Do I have a motion to amend and do pass?

> ASSEMBLYWOMAN TITUS MADE A MOTION TO AMEND AND DO PASS ASSEMBLY BILL 76.
>
> ASSEMBLYMAN THOMPSON SECONDED THE MOTION.

Chairwoman Cohen:
Is there any discussion on the motion? [There was no reply.]

> THE MOTION PASSED. (ASSEMBLYMAN HAMBRICK WAS ABSENT FOR THE VOTE.)

I will give the floor statement to Assemblywoman Duran. We will now move on to Assembly Bill 85.

Assembly Bill 85: Revises provisions governing mental health. (BDR 39-443)

Marsheilah Lyons, Committee Policy Analyst:
[Marsheilah Lyons read a summary from the work session document (Exhibit G).]

The bill had some substantial changes to what is commonly called the Legal 2000 process. Assembly Bill 85 requires the State Board of Health (the Board), Division of Public and Behavioral Health (DPBH), Department of Health and Human Services (DHHS), to include regulations governing the procedure for the involuntary administration of medication to certain persons with mental illness. The bill authorizes the Board to adopt regulations requiring a public or private mental health facility or hospital to adopt a plan for the discharge of a person admitted to the facility or hospital and to report certain information concerning emergency admissions to DPBH.

The bill replaces the term "person with mental illness" as used in provisions concerning the admission of a person to a mental health facility or hospital with the term "person in a mental health crisis" and defines the term to mean any person:

- Who has been diagnosed with mental illness; and
- Whose capacity to exercise self-control, judgment, and discretion in the conduct of the person's affairs and social relations or to care for his or her personal needs is diminished as a result of the mental illness to the extent that the person presents a substantial likelihood of serious harm to himself or herself or others.

The measure also prescribes the criteria for determining when a person presents a substantial likelihood of serious harm to himself or herself or others.

The bill revises current requirements for the release of a person admitted to a public or private mental health facility on a voluntary basis to require the immediate release of a person upon his or her request. Exclusive of a petition for an involuntary court-ordered admission, the measure standardizes the time periods a person may be detained to no longer than 72 hours after the change in status or after an application is made for emergency admission.

The bill removes authorization for an accredited agent of the DHHS to initiate or release a person from the process surrounding an involuntary admission to a mental health facility or program of community-based or outpatient services. Instead, the bill authorizes an accredited agent of the DPBH to transport a person alleged to be a person in a mental health crisis to a mental health facility or hospital for an emergency admission under certain circumstances. The measure revises the requirements that a person alleged to be a person with mental illness undergo a medical examination before the person is admitted to a mental health facility by requiring the Board to adopt regulations prescribing a procedure to ensure that such an examination is performed. The bill revises the date on which a district judge is required to set a hearing on a petition for the involuntary court-ordered admission of a person to a mental health facility or a program of community-based or outpatient services. The court is required, upon finding that a person admitted as an emergency admission, other than a criminal defendant, is not a person in a mental health crisis, to order the mental health facility or hospital to which the person has been admitted to release the person within 24 hours unless the person remains at the facility or hospital voluntarily. The measure abolishes a prohibition on transporting a person to a mental health facility without at least one attendant of the same sex or a relative in the first degree of consanguinity or affinity attending. Finally, the bill authorizes the disclosure of certain information concerning persons seeking mental health services to a provider of health care to assist with the treatment of the person.

I have a brief summary of what the amendment proposed at the hearing would do. The amendment:

1. Removes criteria regarding psychiatric deterioration due to its vagueness and potential to unintentionally expand criteria;
2. Removes the diagnoses requirement implied by the term "person with a mental illness" and instead references a "person in a mental health crisis";

3. Clarifies that mental illness as used in this measure is defined in *Nevada Revised Statutes* 433.164;
4. Clarifies that the 72-hour emergency admission period begins when the first section of the application for emergency admission is completed; and
5. Revises provisions regarding notification to an individual identified by the patient in compliance with the Health Insurance Portability and Accountability Act, when a patient is admitted to a mental health facility in an emergency.

Chairwoman Cohen:
Thank you. Are there any questions? [There was no reply.] I am looking for a motion to amend and do pass.

> ASSEMBLYWOMAN NGUYEN MADE A MOTION TO AMEND AND DO PASS ASSEMBLY BILL 85.
>
> ASSEMBLYWOMAN TITUS SECONDED THE MOTION.

Chairwoman Cohen:
Is there any discussion?

Assemblyman Hafen:
Today I will be voting no on this bill. I just cannot agree with the proposed language in section 1 regarding involuntary administration of medicines for persons with mental illness.

Chairwoman Cohen:
Does anyone else have a comment? [There was no reply.]

> THE MOTION PASSED. (ASSEMBLYMAN HAFEN VOTED NO. ASSEMBLYMAN HAMBRICK WAS ABSENT FOR THE VOTE.)

I will ask Assemblyman Assefa to do the floor statement.

With that, we will close our work session and open the hearing on Assembly Bill 373.

Assembly Bill 373: Prohibits certain state and local governmental entities from restricting certain communications and services provided by a provider of health care to provide certain information and services to a patient. (BDR 40-941)

Assemblywoman Ellen B. Spiegel, Assembly District No. 20:
I am here today to speak with you about Assembly Bill 373 which, if enacted, would ensure that Nevada does not interfere with the practice of medicine by mandating unnecessary procedures or dictate the content of a physician's counsel to his or her patients. As you know, health care providers are required by their professional practices to give patients evidence-based care. Unfortunately, many states are passing laws that interfere with the

patient-provider relationship in politically driven ways, creating a conflict between the provider's professional and ethical obligations and the law.

We are living in a time in which people find unsubstantiated facts to support their personal beliefs rather than using evidence-based, scientific findings to shape their opinions. Additionally, we have seen examples of governmental entities not adequately or accurately informing the public about significant health risks, leading to misinformation, confusion, and, in some cases, even physical harm to innocent people. Assembly Bill 373 is designed to address these issues.

Section 1 of the bill mandates that not only would a state or local health district or officer be unable to require that health care providers give patients medically inaccurate information or provide a service that is medically inappropriate, it would prohibit health care providers from giving patients medically inaccurate information or services that are not medically appropriate and evidence-based.

Sections 3, 4, 6, 7, and 10 through 12 enact similar requirements for local governments, public insurance plans including Medicaid, and the state's Aging and Disability Services Division of the Department of Health and Human Services, as well as health care licensing boards. The rest of the bill makes conforming changes.

Assembly Bill 373 is based on model legislation from the Coalition to Protect the Patient-Provider Relationship, which is co-chaired by the National Partnership for Women and Families along with the National Physicians Alliance. Its two dozen members include the American Medical Association, the American Nurses Association, and the American Public Health Association. In short, this bill asks you to make a policy decision to put science ahead of politics.

Chairwoman Cohen:
Can you give us some examples of where we have seen this happen?

Assemblywoman Spiegel:
The most notable one, and the one that struck me, is that a few years ago we learned that while officials in Michigan had data indicating chemicals in Flint's water could lead to lead poisoning, they ignored their data, derided critics who presented proof, and purposely misled the public, telling them for two years that everything was fine. This led to irreversible damage to the residents of Flint, Michigan. There have been examples in multiple states, and someone will be giving an example from here in Nevada; so, it happens.

As far as the other piece I was talking about concerning people relying on information that may or may not be accurate, people go online and find websites that support whatever their position is. For example, there are websites that support the antivaccination movement and there are websites that debunk the evidence presented on the websites. Whatever you believe, you can find a website to support and reinforce your viewpoint and give you an expert to cite, even if that person is not truly an expert.

Chairwoman Cohen:
Do we have any other questions? [There was no reply.] Seeing none, I will ask for any support in Carson City and Las Vegas.

Marla Turner, Private Citizen, North Las Vegas, Nevada:
I am speaking to you today as an individual and retired oncology clinical research professional. I am in support of A.B. 373. Over the course of my career—25 years in oncology and 15 years in research—I saw many nonproven therapies that our patients came in with that impeded or had life-threatening consequences as a result of mixing with traditional Western therapies. Unfortunately, I was not permitted to speak to that; I could only speak to them if there were proven and known consequences. Likewise, I saw nonproven therapies that did show benefits, with data available in the literature showing support for those benefits, that I could not speak to. I saw and participated in a number of double-blind, Phase II and III clinical trials that showed benefits from combining a certain amount of alternative therapies with traditional therapies. Again, I could only discuss those in traditional research settings because there were many traditional physicians who were willing to overlook the data or wished to dismiss the data because it did not match up with their personal values or beliefs or did not match up, quite frankly, with their pocketbooks.

An example from the 1980s is the now-famous leukemia cluster in Fallon, Nevada. This was a result of downwind exposure from the Nevada Test Site. Numerous children were affected with leukemia or died of leukemia because of the nuclear testing. There were years and years of data that showed that was occurring, but the state of Nevada continually refused to accept responsibility for that and denied that it was occurring. As a result, physicians told their children that was not an issue for them and more and more children continued to be affected with leukemia and died from it. Years later, we saw another cluster of that happen involving thyroid cancers as a result of our above-ground testing. Fortunately, at that time the state of Nevada put more aggressive effort into that, did not pooh-pooh the research that came out right away, but it still took some time to get through the mentality of being able to accept the data coming in, to match it up with personal philosophies and beliefs, and be able to get that out to the community,

As a professional in clinical research, desperate patients would ask me all the time—out of earshot of their physicians—what was good for them and what was bad for them. I, who spent more time with those patients than the physicians did, had to be their second layer of disappointment. I was prohibited by law from being able to address their concerns, so I am in favor of A.B. 373 and urge your support.

Caroline Mello Roberson, Nevada State Director, NARAL Pro-Choice America:
I am here to speak in support of A.B. 373. NARAL Pro-Choice Nevada is a nonprofit, nonpartisan organization dedicated to protecting reproductive freedom for all Nevadans through legislative, political, and grassroots organizing. We have more than 45,000 Battle Born, feminist-strong members across the state. We are proud to stand with A.B. 373 because, frankly, we believe in science. This legislation would prohibit the state government

or any local government from mandating a health care provider to educate or provide a patient service unless it is evidence-based and medically accurate.

Providers have tremendous influence on the well-being of their patients, and the advice they give should be based on science, not politics. There is a range of extremely sensitive information and conversations that happen in the privacy of an exam room. Nevadans should be assured that their physician is counseling them on the best medical evidence available, not by mandates from politicians. This may sound hypothetical, but in other states there are laws on the books that require doctors to give out medically inaccurate information. Let us take a stand now to ensure that Nevada's laws must always be based in fact; furthermore, enshrining the sanctity of the patient-provider relationship into law is an important preemptive measure given these uncertain times. It would again send the message that Nevada respects and protects citizens' rights to access the quality health care they need, free from inappropriate government interference.

Now, more than ever, we need to protect the patient's right to complete and accurate medical information and the provider's ability to practice medicine according to their professional judgment and medical training. Assembly Bill 373 is an affirmative protection for Nevadans that comes at a time when, unfortunately, all too many politicians are deciding to intervene in the exam room. We are proud to support A.B. 373 and urge all the members of the Committee to support it as well.

Catherine M. O'Mara, Executive Director, Nevada State Medical Association:
We are in support of A.B. 373. We support the encouragement of the patient-physician relationship that this bill affords. I wanted to highlight for this Committee a letter that was put on the Nevada Electronic Legislative Information System from the Nevada Section of the American College of Obstetricians and Gynecologists (Exhibit H) that has a lot of detail about the experiences that specialty experiences have knowledge of. They also want to let you know that when physicians have interactions with patients, they are guided not just by the code of ethics they have agreed to, but they also have standards of care that are continually developed and updated as new evidence and new research advances. They should be free to have accurate, candid conversations with their patients and allow their patients to have access to all the information they need to make informed, good, and prudent decisions for their own care.

We would oppose any type of mandate in state law that would either gag a physician from being able to share important, relevant, accurate information with a patient or one that would mandate that certain inaccurate statements be required to be shared with patients. This is a very prudent Committee and very prudent Legislature, so while we do not have any specific examples of things happening today, we do see some things happening in other states that cause us great concern, and we appreciate your interest in looking to preserve that patient-provider relationship.

Molly Rose Lewis, Northern Nevada Organizing Coordinator, NARAL Pro-Choice America:
I am here to read a letter from a doctor who could not be here today because she is seeing patients (Exhibit H).

> Dear Chairwoman Cohen,
> The American College of Obstetricians and Gynecologists (ACOG) Nevada Section represented by Dr. Sandra Koch wholeheartedly supports A.B. 373. We believe that enshrining the sanctity of the patient-provider relationship into law is an important preemptive measure. It would send the message that Nevada respects and protects citizens' rights to access the quality health care they need free from inappropriate government interference. Now, more than ever we need to protect a patient's right to complete and accurate medical information, and providers' ability to practice medicine according to their professional judgement and medical training.
>
> In a statement of public policy National ACOG states that "The patient-provider relationship is essential to the provision of safe and quality medical care and deserves to be protected from unnecessary government intrusion. Efforts to legislate elements of patient care and counseling can drive a wedge between a patient and a healthcare provider. Laws should not interfere with the ability of providers to determine appropriate treatment options and have open, honest and confidential communications with their patients. Nor should laws interfere with a patient's right to be counseled by their provider according to the best currently available medical evidence and the provider's professional medical judgement. Laws that require providers to give or withhold specific information when counseling patients or that mandate which tests, procedures, treatments, alternatives or medicines providers can perform, prescribe, or administer are ill advised."

People have asked for examples of this, and Dr. [Sandra] Koch mentions that there have been laws that have prevented science-based discussions about gun safety in the home; that have dictated medically inaccurate statements relating to discussions about breast density; have restricted discussion about the health impacts of fracking; and also required inaccurate and/or unnecessary statements about procedures relating to women's reproductive access.

Elisa Cafferata, representing Planned Parenthood Votes Nevada:
We submitted our written comments (Exhibit I). We just wanted to say that we are in support of this bill and appreciate Assemblywoman Spiegel bringing it, because we believe it is important to protect the patient and health care provider relationship.

Michael Hackett, representing Nevada Primary Care Association and Nevada Academy of Physician Assistants:
Both organizations would like to be on record in support of this bill for all the reasons that have been stated so far. We would also like to extend our thanks to Assemblywoman Spiegel for bringing this bill forward.

Chairwoman Cohen:
Is there anyone else who wishes to speak in support? [There was no reply.] Seeing no one, is there anyone in opposition? [There was no reply.] Seeing no one, is there anyone who is neutral? [There was no reply.] Seeing no one, I will invite the bill's sponsor back up, unless you want to waive the opportunity.

Assemblywoman Spiegel:
Thank you, I do.

Chairwoman Cohen:
That will conclude the hearing on A.B. 373.

[(Exhibit J) was submitted but not discussed and is included as an exhibit for this meeting.]

Do we have anyone who wishes to make public comment? [There was no reply.] Seeing no one for public comment, do we have any comments from the Committee? [There was no reply.] Seeing no one, our next hearing will be Wednesday at the call of the Chair, about 20 minutes after the last morning hearing. With that, we are adjourned [at 2:07 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 a proposed conceptual amendment for Assembly Bill 268, dated April 1, 2019, presented by Assemblyman Richard Carrillo, Assembly District No. 18.

Exhibit D is the Work Session Document for Assembly Bill 47, dated April 1, 2019, including a proposed friendly amendment submitted by the Rural Regional Behavioral Health Policy Board, presented by Marsheilah Lyons, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit E is the Work Session Document for Assembly Bill 49, dated April 1, 2019, presented by Marsheilah Lyons, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit F is the Work Session Document for Assembly Bill 76, dated April 1, 2019, including a proposed conceptual amendment by Assemblyman Steve Yeager, Assembly District No. 9, presented by Marsheilah Lyons, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit G is the Work Session Document for Assembly Bill 85, dated April 1, 2019, including a proposed amendment by the Northern Regional Behavioral Health Policy Board, presented by Marsheilah Lyons, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit H is a letter to Chairwoman Lesley E. Cohen, Assembly Health and Human Services Committee, dated April 1, 2019, authored by Sandra Koch, M.D., Nevada Section, American College of Obstetricians and Gynecologists, and presented by Molly Rose Lewis, Northern Nevada Organizing Coordinator, NARAL Pro-Choice America, in support of Assembly Bill 373.

Exhibit I is a letter to Chairwoman Lesley E. Cohen and Members of the Assembly Health and Human Services Committee, dated March 31, 2019, presented by Elisa Cafferata, representing Planned Parenthood Votes Nevada, in support of Assembly Bill 373.

Exhibit J is written testimony submitted by Theresa Bohannan, Private Citizen, Reno, Nevada, in support of Assembly Bill 373.