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

Eighty-First Session
March 31, 2021

The Committee on Health and Human Services was called to order by Chair Rochelle T. Nguyen at 1:31 p.m. on Wednesday, March 31, 2021, Online. 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/81st2021.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Rochelle T. Nguyen, Chair
Assemblywoman Sarah Peters, Vice Chair
Assemblywoman Teresa Benitez-Thompson
Assemblywoman Annie Black
Assemblywoman Michelle Gorelow
Assemblyman Gregory T. Hafen II
Assemblywoman Lisa Krasner
Assemblyman Andy Matthews
Assemblyman David Orentlicher
Assemblywoman Shondra Summers-Armstrong
Assemblywoman Clara Thomas
Assemblywoman Robin L. Titus

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Assemblywoman Lesley E. Cohen, Assembly District No. 29
Assemblywoman Daniele Monroe-Moreno, Assembly District No. 1

STAFF MEMBERS PRESENT:

Megan Comlossy, Principal Policy Analyst
Karly O'Krent, Committee Counsel
Abigail Lee, Committee Manager
Terry Horgan, Committee Secretary
Trinity Thom, Committee Assistant

OTHERS PRESENT:

Trey Delap, Director, Group Six Partners
Joseph Heck, representing Nevada Osteopathic Medical Association
Kendra G. Bertschy, Deputy Public Defender, Washoe County Public Defender's Office; also representing Clark County Public Defender's Office
Jamie Ross, Executive Director, PACT Coalition
Lindsay Anderson, Government Affairs Director, Washoe County School District
Brad Keating, representing Clark County School District
Hawah Ahmad, representing Clark County Education Association
Tara Raines, Private Citizen, Las Vegas, Nevada
April Clyde, Owner, Serenity Birth Center, Las Vegas, Nevada
Genevieve Burkett, Director of Nursing, Serenity Birth Center, Las Vegas, Nevada
Katie Ryan, System Director, Nevada Government Relations, Dignity Health-St. Rose Dominican
Gabrielle Carr, Juvenile and Family Court Master, Sixth Judicial District Court
Buffy Okuma, Chief Deputy District Attorney, Washoe County District Attorney's Office
Janne Hanrahan, Chief Deputy District Attorney, Clark County District Attorney's Office
DaShun Jackson, Director of Children's Safety and Welfare Policy, Children's Advocacy Alliance
John McCormick, Assistant Court Administrator, Nevada Supreme Court
Alexis Tucey, Deputy Administrator, Division of Child and Family Services, Department of Health and Human Services

Chair Nguyen:
[Roll was taken.] We have three bill hearings today, and I will now open the hearing on Assembly Bill 205.

Assembly Bill 205: Makes various changes concerning the acquisition, possession, provision or administration of auto-injectable epinephrine and opioid antagonists by schools. (BDR 40-98)

Assemblywoman Lesley E. Cohen, Assembly District No. 29
Presenting with me is Mr. Trey Delap from Group Six Partners. Mr. Delap has worked in behavioral health addiction and recovery policy for years and specializes in advocating in the spaces where they converge, so I am going to turn this over to Mr. Delap.

Trey Delap, Director, Group Six Partners:
My role is to update on the state of affairs with regard to some statistics that are relevant to this population of young Nevadans [Exhibit C]. I want to talk about what has happened in 2020, which was the largest year for overdose deaths Nevada has seen so far. The preliminary data for 2020 show opioid-related overdose deaths increased by 27 percent over the prior year to the highest single-year number of fatalities since 2010 for all age groups. Fifty-one percent of these deaths are attributable to synthetic opioids like fentanyl. Fentanyl is 50 times more potent than heroin and 100 times more potent than morphine. Preliminary data show the number of unintentional opioid overdose deaths in 2020 was twice as high as the previous peak of four deaths in 2015. Between 2010 and 2019, the average annual number of opioid overdose deaths among the 8 to 17 age group was 1.7. In 2020 alone, these eight deaths represent a 371-percent increase over the average established over the past decade.

Nevada's youth are at higher risk of opioid overdose death rate because 18.5 percent of Nevada high school seniors reported using prescription pain killers that were not prescribed to them, in comparison to the same age group in neighboring states, including 9.6 percent in Utah and 14.8 percent in Arizona. Nonmedical forms of these prescriptions are manufactured nefariously and often include a blend of various substances including fentanyl. Seizures of these illicitly manufactured drugs have increased 117 percent, according to Nevada HIDTA [High Intensity Drug Trafficking Areas]. The combination of increased supply of highly potent synthetic opioids indistinguishably and deliberately manufactured to appear like other medications, and a higher rate of use, accounts for an increased risk of opioid deaths. That risk has shown to be realized as the data show when broken down from 2010 to 2020. The dramatic rise in overdose deaths among 8- to 17-year-olds has lowered the median age of unintentional opioid overdose deaths from 49 years to 29 years in a single year.

Substantial federal dollars have been granted to states to promote harm-reduction strategies inclusive of the wide distribution of naloxone to lay persons. State-targeted response grants have been distributed to states to expand access to naloxone. Nevada has distributed over 16,000 doses of naloxone since February 2018. There is hope for young people in recovery. For young people with addictive disorders, there is hope at Mission High School in Las Vegas. This comprehensive school is the first public high school for young people seeking recovery in the United States. Fifty percent of the students there are credit-deficient. One hundred percent have used alcohol or drugs; 38 percent have been involved with the justice system. At Mission High School, students are surrounded by peer, community, and supportive adults, giving them their best chance of recovery from addiction occurring so early in their lives.

This bill would expand access to naloxone to more people, therefore increasing the opportunity that overdoses may be reversed. The key here is that the synthetic opioids are so potent that the risk is so much greater. That is why this bill is very important.

Assemblywoman Cohen:
The federal government, in an effort to stop the health crisis that has been escalating, has been giving out the opioid antagonist to prevent overdoses. This is without qualification. In other words, the medication is safe and can be given without harm, and this is confirmed by the following organizations: the Nevada Osteopathic Medical Association, which provided an exhibit for today's hearing in the form of a letter [Exhibit D]; the National Association of School Nurses; and the Substance Abuse and Mental Health Services Administration (SAMHSA) of the United States Department of Health and Human Services. According to the Nevada Osteopathic Medical Association, naloxone—Narcan—is a safe and effective drug for the treatment of suspected opioid overdoses. In the event the drug is administered to a person who is not experiencing a narcotic overdose but other medical event, it will not cause harm. To be clear, if someone is overdosing from opioids, they will die without intervention. But often, lives are lost while waiting for the ambulance to arrive, and naloxone administered while waiting for an ambulance saves lives. At the same time, naloxone is safe and more benign than epinephrine. In fact, if it is administered to someone who is not overdosing, it does not harm them.

Yesterday, I distributed to Committee members a typical naloxone kit from Partnership Carson City. With money from the federal government, the Nevada State Opioid Response reports they have distributed 13,185 kits and there have been 932 reversals from the use of naloxone—reversal meaning someone is overdosing, is given the naloxone, and it basically saves them. That is 932 Nevadans who would have died if they had not received naloxone. If you look at the kits, there are gloves, there is some information about opioids, instructions, and a couple of naloxone sprays. As you can tell from the kit, you do not have to have training to save someone's life; however, organizations such as Partnership Carson City provide free monthly training. The training takes from 30 minutes to 1 hour, depending on the length of time for questions. In that training, the administration of naloxone takes up about 10 minutes. The training also stresses calling for medical help. Even though I am mentioning a Carson City organization, every county has an organization that will provide these kits free to the public and training upon request.

There is a problem in that the rate of our students who are overdosing on opioids and using opioids is rising. There is a way to solve it, which is using the naloxone or the opioid antagonist. That way to solve it does not cause harm if you accidentally give the naloxone to someone who is not overdosing. It does not harm them, so there is something we can do about it. We can prevent the skyrocketing numbers of unintentional overdoses we have seen. That is a 300-percent rise in numbers, so we definitely want to address this issue. This bill is a way to address this issue, so let me go through the bill with you.

We already have laws that authorize specific medical professionals to prescribe and dispense opioid antagonists to anyone at risk of an overdose or to another person who might assist

someone with an overdose. We also have a law allowing for auto-injectable epinephrine in schools for treatment of anaphylaxis. This bill allows for the opioid antagonists to be in our schools.

Section 1 allows a health care professional authorized to prescribe an opioid antagonist to issue to a public or private school an order for an opioid antagonist for treatment of an opioid-related drug overdose. That section also provides information that is required in the order to the professional who is providing the antagonist. The section also includes that the health care professional is not liable for an error or omission related to that order which is not gross negligence or reckless, willful, or wanton conduct.

Section 2 authorizes a school nurse or other designated employee of a public or private school who has received training in the storage and administration of opioid antagonists to administer it to anyone on the premises of the school who is reasonably believed to be experiencing an opioid-related drug overdose. As you can see in that section, it is adding opioid-antagonist language to the auto-injectable epinephrine language for having those in schools.

Section 3 is conforming language in the maintenance and administration of auto-injectable epinephrine statutes. Section 4 establishes requirements related to the storage, handling, and transportation of opioid antagonists in public schools and requires each school district and charter school to report to the Division of Public and Behavioral Health of the Department of Health and Human Services the number of doses of opioid antagonists administered at each public school during each school year. This language is duplicative of the auto-injectable epinephrine language.

Sections 5 and 8 require the board of trustees of each school district and the governing bodies of each charter school or private school that obtains an order for an opioid antagonist to establish a policy to ensure that emergency assistance is sought each time a person experiences an opioid-related drug overdose on the premises of the school and the parent or guardian of a pupil to whom an opioid antagonist is administered is notified as soon as practicable. Sections 5 through 8 of the bill require training in the storage and administration of opioid antagonists to be provided to designated employees of the public or private school that obtains an order for an opioid antagonist. Again, schools do not have to do this, but if they do, there are guidelines they have to follow. Section 5, subsection 2, and section 8, subsection 2, are clear that the schools may obtain opioid antagonists; this is not a requirement. It is a "may" and not a "must."

Sections 5 and 8 additionally exempt a school, school district, employee of a school, and certain other persons affiliated with the school from liability for certain damages related to the acquisition, possession, provision, or administration of auto-injectable epinephrine or an opioid antagonist not amounting to gross negligence or reckless, willful, or wanton conduct. I am working with a stakeholder on this, and you will probably hear from them. We want to clarify what these protections are and that the protections apply only in an emergency

situation. We are still working on that, but we are very close. We are in agreement; it is just getting the language.

Section 9 requires a registered pharmacist to transfer an order for an opioid antagonist to another registered pharmacist at the request of the public or private school for which the order was issued. That same section exempts pharmacists who dispense an opioid antagonist pursuant to the order from liability for certain damages related to the acquisition, possession, provision, or administration of an opioid antagonist not amounting to gross negligence or reckless, willful, or wanton conduct. Again, this is duplicative of the auto-injectable epinephrine language. Section 10 is the effective date.

Chair Nguyen:
We have quite a few questions.

Assemblywoman Titus:
Thank you for bringing back my bill. This was a bill I presented in 2019, and I have to give credit to former Assemblyman Hambrick who initially presented the bill. Trey Delap and I worked hard on this bill. We got it across the finish line through both houses and then it sat on a desk and died, so I am glad you brought it back. I appreciate that, but I definitely wanted to give credit to Assemblyman Hambrick. This was one of his priority legislations.

We were getting ahead of the opioid epidemic and the overdose deaths until this pandemic showed us where we were really lacking. This surge is real. Hopefully, the members of this Committee will support this. It was pretty well vetted. This bill is very similar to the one in 2019.

A previous concern brought up during multiple testimonies was the availability of Narcan. This is a nasal spray, unlike the EpiPen, the auto-inject, where there is a syringe involved. As Assemblywoman Cohen pointed out, there is zero risk. That was one of the other concerns in previous testimony, how do you know for sure if you use it? Well, we testified that there was really no harm to give it. You have an unconscious person. We give glucose in case they are diabetic, or you give them Narcan and see if they wake up. There were always worries about the shot and availability, so has the supply increased now? Can we adequately supply everybody with Narcan?

Assemblywoman Cohen:
I would like to address something before Mr. Delap answers. I want to be clear about the history of what happened last session. Certainly, this is Assemblyman Hambrick's bill, and I promised him I would bring it back. It did not sit on a desk and die; it was basically really getting watered down to the point that it did not seem that it would have any effectiveness. That is why I said to him that if he would agree, I would bring it back because we wanted it to be effective.

Trey Delap:
Your question was about the available supply of nasal naloxone. That is something I would have to check, but this preparation of it does not require needles. This is the nasal administration spray; this is what is given to the lay public. I would envision that this is the most appropriate delivery system. This nasal spray eliminates the needle fear and worry concerned with that. Naloxone has been around and proven safe since 1971. Thousands of doses have been distributed to the public. If the question were whether we would have enough to put some in every school, I am confident that we could.

Assemblywoman Titus:
When we heard this in the past, there were volunteers, some funds, and lots of grants for the schools because this comes with a cost. Is that funding still available so that agencies and schools that wanted to get this could have some assistance? Also, is there any agreement on the shelf life and return of unused packets?

Assemblywoman Cohen:
Referring to cost, we need to keep in mind that this is a policy committee, but also this is not obligatory. For the schools, it is a "may." There are some federal funds, but that is not really the point of the bill. We want to get something in place. If a school decides they want to do this, they will get the materials. They will get the sprays.

Trey Delap:
The naloxone distributed to the community is paid for by the federal government, and I find that to be a very compelling note for two reasons: one, federal grant dollars are being used to buy a medication to give to the lay public for the administration to people who may need it. That is a key detail. All the doses we have mentioned have been dispensed to the community, the state, and all have been paid for by a variety of grant sources from the federal Substance Abuse and Mental Health Services Administration. The Opioid STR [state targeted response] Grant was a major chunk of money that came into the state for the distribution of it. There are a number of resources that have dashboards and data. Covering the cost of the product was probably the easiest part to solve.

Chair Nguyen:
Our policy analyst might be able to clarify that this is not an unfunded mandate because of the "may" language.

Megan Comlossy, Principal Policy Analyst:
It is enabling language so school districts or a school would choose to participate in the program. What was said before is accurate. There are lots of sources for federal funds for these types of naloxone kits, and they are being distributed widely. It may even work for a school or school district to work with local nonprofits or local community organizations to obtain naloxone.

Assemblyman Hafen:
My question was regarding the fiscal notes that were attached and the conversation we are just having that the feds were paying for it. I know this is enabling language; however, I am still confused. Are we putting enabling language so the schools can obtain federally paid antagonists?

Assemblywoman Cohen:
To be clear, the fiscal note is zero. We are allowing the schools to obtain the naloxone, to have it in the schools, and to use it if they choose to have someone at the school trained to use it, which is a very short training session and not extremely technical. If the schools "choose." It is not that we are saying they can get the money from the feds; we are saying they can do this and we are saying that the feds have been distributing and providing funds for the kits, but they are not correlated.

Assemblyman Hafen:
It was not the fiscal note from the state; however, it was from local governments. The Clark County School District is showing roughly $182,000 over the biennium, and a number of other school districts are also showing fiscal impacts to this. I understand we are trying to get help from the feds, and I think this is a good program, but I wanted to get on the record that there are fiscal notes from local municipalities.

Assemblywoman Cohen:
I am not seeing those. I am only privy to what is on the Nevada Electronic Legislative Information System (NELIS) for the public. I am not seeing anything from the school districts. Oh, there they are. However, I would just remind you again, as Ms. Comlossy said, this is enabling language so they can choose to do this or not. They can choose to do it and pay for it; they can choose to do it and find other resources to pay for it, but they will choose whether or not to do it.

Assemblywoman Peters:
I am looking at the fiscal note and it looks as though there is some confusion from the school districts as to accessibility of resources and the need for training. I would encourage that a letter be sent to them letting them know where they can find this. My question has to do with accessibility. In thinking about 16- and 17-year-olds I know, some of them are incredibly capable people. With the prevalence of the supply, is there anything that inhibits a student from administering something like this at their school? If it is available to the public, what is the importance of having the enabling of the health care professional language in the bill?

Assemblywoman Cohen:
To your first point, in case any districts are watching and interested, in March there was a grant announced by the federal government. It is on the SAMHSA page with information about how to get a grant for the kits. What were your other questions?

Assemblywoman Peters:
It was about students potentially having a kit in a backpack. Because they are careful and thoughtful people, can they administer that on school property? My other question concerned the importance of having the enabling language for health care professionals spelled out. What is the purpose of that?

Assemblywoman Cohen:
From what I know about this, students probably could do it, but this bill does not allow for it. That would have to be done by a different vehicle. The bill is for an employee in the school to be trained to do it. Maybe we can ask Ms. O'Krent why that language is in there. The bill very much follows the existing epinephrine language about the prescriber, and I think the bill drafters thought it was necessary. Also, because it is going to a school, maybe that is why we needed to specifically say that it is okay for the prescribers to prescribe it.

Karly O'Krent, Committee Counsel:
That is precisely it. As this bill was originally drafted, that section tracks the epinephrine statutes and so required the training that was required for epinephrine. It is certainly not a requirement that the bill maintain that same training requirement [unintelligible] for this legislative process but that is why it was drafted that way.

Assemblywoman Peters:
That makes sense. I was curious about the availability of Narcan. I have a box of it at my house that I was intending to take to an event this summer, so I know it is available. I think it is important to understand whether students can administer this on school grounds if they have it available or whether there is liability associated with that. It sounds like that is a separate issue from what we are talking about today, so I can clarify later.

Assemblywoman Gorelow:
What would it look like if someone were overdosing? If I am at the grocery store, a mall, or in a park and someone falls over, I am not so sure this would have been my first thought—to grab a Narcan and administer it. What might some of the symptoms be for someone who is overdosing?

Assemblywoman Cohen:
That is part of the required training. Mr. Delap, you told me a story about someone who was overdosing.

Trey Delap:
This would look like a variety of things. The training basically says if you encounter someone who is unresponsive—not conscious or in and out of consciousness; they may not be able to talk; they are difficult to rouse—the protocol would be to call 9-1-1 or activate EMS [emergency medical services]. If you have the nasal-administered Narcan, you would open it. The instructions about how to use it are in the package, and you would administer it. Narcan is very effective only if someone has opioids on board, period. It has been described

as a Lazarus drug. It does one thing; blocks the effect of the opioid, so the person will immediately reverse.

One case that got some media coverage was a highway trooper in the middle of nowhere. A person riding a bus was overdosing and unresponsive, so the bus driver pulled over. The first responder was a highway trooper who had just gotten his training on Narcan. His body cam footage shows the entire encounter. He was attempting to talk to the person, but the person was unresponsive. They did a sternum rub, but he was unable to rouse. They took him off the bus; someone was doing CPR [cardiopulmonary resuscitation] and rescue breathing. Then the trooper remembered his Narcan and administered it. In the meantime, the trooper had called for a medivac helicopter, so a helicopter was coming. He administered the Narcan and the patient woke up. This is critically important, especially to communities where help is not five minutes away. In Las Vegas, you might call an ambulance and two ambulances are going to show up within five minutes, but in other parts of the world that may not happen.

The major piece of legislation that passed in 2015 was the Good Samaritan Drug Overdose Act, which created NRS Chapter 453C. Its intent was to protect individuals who would administer this to others. The thing in the balance is the life of the person, and the intent of that bill is to relieve any hesitancy in that. Assemblywoman Titus mentioned that sometimes in a clinical setting, this is used as an assessment tool: if they administer Narcan and there is no change in the patient's condition, it is something else, but if it does change the patient's condition, it shows there were drugs on board. It would look like someone who is unresponsive—maybe breathing, maybe not. The critical detail with this, and why the spike has been so bad, is the fact that the synthetic opioid with fentanyl is so tiny. When you look at the data from 2020, there was one death of a 14-year-old or younger. All eight of the deaths we talked about from 2020 were unintentional overdoses. That means someone was taking something and it overwhelmed their system. That is a key detail.

Another example was brought up. There is a computer program called "ODMAP" [Overdose Detection Mapping Application Program] that tracks the use of naloxone by EMS. If there are a number of reports in a specific area, that triggers an alert. Now you know there is a batch of fentanyl-laced stuff in a particular area and overdoses are going to start happening. From a surveillance perspective, that is critical information, so the administration of Narcan is an indicator that opioid overdoses are occurring. That indicator prompts a stronger public response.

Chair Nguyen:
Are there any more questions? [There were none.] We will go to callers in support of A.B. 205.

Joseph Heck, representing Nevada Osteopathic Medical Association:
On behalf of the Nevada Osteopathic Medical Association, I voice our strong support for A.B. 205. We have provided a more complete statement for the record that is available on NELIS [Exhibit D]. While all attention has been fixated on the COVID-19 pandemic, we cannot lose sight of other public health crises which include the opioid epidemic that is

plaguing our nation and state, and the isolation and depression associated with COVID-19 mitigation measures. That is why we applaud Assemblywoman Cohen's efforts to make naloxone—trade name Narcan—readily accessible in schools across Nevada. This safe antidote has proven effective in saving lives when administered by lay persons. Taking the same approach as the Legislature did when making epinephrine auto-injectors available in schools is a logical and much-needed next step in combating opioid overdoses. We urge its swift passage.

Kendra G. Bertschy, Deputy Public Defender, Washoe County Public Defender's Office; also representing Clark County Public Defender's Office:
On behalf of my office as well as the Clark County Public Defender's Office, we want to thank Assemblywoman Cohen, as well as Mr. Delap, for bringing forward this important bill. We hope and believe that this will save lives, especially the lives of our children. So we appreciate this effort.

Chair Nguyen:
Could we go to our next callers in support? [There were none.] Are there any callers in opposition to A.B. 205? [There were none.] We will begin testimony in neutral at this time.

Jamie Ross, Executive Director, PACT Coalition:
I work in substance misuse prevention. We have free Narcan in our naloxone trainings at our agency. With the increase of illicitly manufactured fentanyl in our drug supply in Nevada, our concern is the increase in fatal overdoses of children under 18 that occurred in 2020. Most of the fentanyl seen in Nevada is in fake pressed pills that cannot be differentiated from pharmacy-manufactured pills. Youth who may not use heroin but perceive a pill of oxycodone to be safer than heroin would not be able to tell that this pill had fentanyl in it. The goal is to decrease overdoses and increase access to naloxone. It is a safe and effective way to do that. There is currently a grant open through SAMHSA's First Responders-Comprehensive Addiction and Recovery Act for funding for additional naloxone.

Lindsay Anderson, Government Affairs Director, Washoe County School District:
We are testifying in neutral today because of the enabling nature of this legislation and wanted to provide some context for the Committee's consideration. Currently, our school police officers carry these kits through a grant at the Office of the Attorney General. We have a school police officer at every high school campus and share them among the middle and elementary schools. We have less than 40 school nurses and more than 100 school campuses. Our clinical aides at each school do not have medical training. Asking them to decide among administering Narcan, epinephrine, an automated external defibrillator (AED), or other tools at their disposal, to an unresponsive individual is a great responsibility. We have not had a documented opioid overdose case on school campus in the recent past. I know this is a policy committee, but at least last session, the bill did not go to the Assembly Ways and Means Committee. I would hope that this session we may get an opportunity to discuss the potential fiscal impact in Ways and Means, if necessary.

Brad Keating, representing Clark County School District:
We are calling in a neutral capacity on this bill because this is a policy committee. I wanted to pass along a few important facts for the Committee to know. Assembly Bill 205 is proposing to have schools acquire and maintain storage and provide training to licensed and unlicensed employees to recognize the signs and symptoms of an opioid overdose and then to accurately administer an opioid antagonist while monitoring the student's response. Unlicensed, assistive personnel at schools are often reluctant to be trained in administering injections, particularly during a medical emergency when there are varying circumstances to consider, and careful ongoing monitoring of the student needs to take place.

Also, the current basic life support guidelines recommend an AED be available when administering an opioid antagonist. Automated external defibrillators are only in high schools and administrative buildings in the Clark County School District; therefore, they would be the only sites equipped to manage an opioid overdose. Administration of those opioid antagonists would not be safe to administer in elementary and middle schools without the proper emergency equipment available, including AEDs. Again, this is a policy decision by the Legislature, and the Clark County School District is testifying in neutral and wanted to provide you with those facts as you make a decision on this bill.

Hawah Ahmad, representing Clark County Education Association:
The Clark County Education Association is the official bargaining partner for the Clark County School District and represents more than 18,000 licensed professionals, including school nurses, counselors, psychologists, and social workers. The Clark County Education Association is testifying in neutral on A.B. 205. We appreciate the intent of the bill, but we do have questions on the policies for administration and notice that may potentially be given to parents, and we are concerned about the implementation date being so soon, with our current retention issues for teachers and licensed professionals. This is not to say that we are not supportive of the intent of the bill. It is completely necessary, and we do believe it will positively impact our students, especially our students struggling with opioid addiction.

We ask that the members on this Committee who are also on the Ways and Means Committee consider payment for the opioid antagonists from the Attorney General's opioid settlement funds or a request that the Office of Grant Procurement pay special attention to the SAMHSA funds. We look forward to working with the sponsor to ensure implementation of the bill is impactful and prevents all unnecessary deaths caused by opioid overdoses. We are also looking forward to ensuring that this does not take money away from our classrooms. We are very thankful to the sponsor for stimulating discussion on this topic and bringing this bill forward.

Chair Nguyen:
I will remind those testifying in support, opposition, and neutral that this is a policy committee, so if you have concerns with some of these other issues, I suggest you bring them up with the bill's sponsor or in our money committees. Do we have any other callers in neutral? [There were none.] At this time, I will turn this back over to Assemblywoman Cohen for any closing remarks.

Assemblywoman Cohen:
Mr. Delap, would you like to make any closing statements?

Trey Delap:
Thank you for the opportunity to talk about this. For as long as we have had awareness that opioid overdose is a public health issue, we have been working on a number of fronts. This is a piece of a much wider public health effort that involves how prescriptions are written and how much the prescription monitoring program is used. When we use the example of the lay person administering the naloxone, that is the expectation. It is the intent of the Good Samaritan Drug Overdose Act to protect people to encourage that kind of activity. There are a number of schools, and the National Association of School Nurses offers a number of resources in designing proper school policy. One I found was with the Albuquerque Public Schools that had a policy and they cited their Good Samaritan law as the rationale for that.

With regard to the implementation and how it might mesh with other policies, this one is interesting and nuanced in that we are educating the lay public with no medical training and no obligation to administer this drug. If they do it and the person does not need it, there is no consequence. I do not know of any other medication or substance that has been publicly funded for mass distribution. One thing about the expiration date, for example, is that the FDA [Food and Drug Administration] has extended the expiration for three years, so now they are good for three years instead of one year. Where it might be deployed in a school, I think there are a number of resources that can work with that, because there are school districts and states that have done this successfully.

The policy brief done by the Nevada Institute for Children's Research and Policy indicated that a survey of school nurses showed that only 5.2 percent of school nurses ever administered naloxone. If that 5 percent did, that means there was one less student's life lost. If we have the opportunity to do that, that is very valuable. Also, the education about opioid use and especially the extreme prevalence of the synthetic opioids are very compelling to some sort of action. This is a dynamic process. There are a lot of community partners involved in this who have done a lot of work. The Legislature has done a lot of work. There are a lot of resources and stitching that together is something we can certainly do. I would be willing to have a conversation or work out the details, as far as what the expectations are with this particular intervention. Again, this is so important. I want to emphasize the final detail here is the tremendous spike—eight in Clark County between the ages of 8 and 17 in one year. The peak was four, so it is a huge spike. Also, 27 percent statewide of unintentional overdoses of the synthetic opioid, so we have a greater risk with these substances. I really do think we should do as much as we possibly can to overcome whatever barriers there are. I know that the autoinjector bill had some barriers and took some time, but we do not have a lot of time, when we see such a profound impact in a single year. Thank you for considering this legislation.

Assemblywoman Benitez-Thompson:
I would like to understand some of the neutral comments by the school districts related to cost. I was trying to identify where in the bill those concerns about cost originated. Also,

someone had a concern about the implementation date. I also heard mention of this bill going to the Committee on Ways and Means which is not practical because we only send things to Ways and Means that are under the purview of the state's budget, and this is not. Obviously, their budgets are their budgets, but I wanted to hone in on the bill a little more concerning where they thought specific costs were coming from. In looking at Washoe County, I did the math and it looked like $150 each to get the naloxone into 120 schools, but I do not see anything in the bill language that says that. Clark County talks about "indeterminant" costs, and I am seeing different levels of response to the bill, so it would be helpful to know I am reading the bill the same way they are.

Chair Nguyen:
We are trying to get them back on the line, but I do not know if we are going to be able to. I believe Assemblywoman Cohen can probably answer some of these questions. I know she has had conversations with them.

Assemblywoman Benitez-Thompson:
It is fine for the school districts to give us that information. It is their argument to make, but I think that would be helpful information for them to get to the Committee. If they could just cite the specific section that is causing the fiscal impact, if they could help us understand the thinking behind that number, that would be helpful for me. That way we do not have to wait for them to come back on the line.

Assemblywoman Cohen:
I will just wrap up. The mention of the Ways and Means Committee was my mistake, and I think they were just following along with what I had said. However, I want to address a few things that were said that I have found to be an issue and kind of confusing from the parties who were in neutral.

We have heard that there are not nurses in every school and the aides do not have any medical training. Well, you do not need medical training to do this. You just need the training that is offered for free and is available online, so that should not be an issue. Also, someone mentioned the bill should address that the funds are going to come from the Attorney General's opioid settlement funds. My understanding is that those are not our funds to play with; they are the Attorney General's, so that is not relevant. On top of that, another thing I want to address and stress is that this is enabling language. School districts do not have to do this if they do not want to. I hope that if we pass this bill, they will see their way clear to wanting to do this. Also, I am getting a message from a doctor that there was a misrepresentation by the Clark County School District of the need for the AED with use of Narcan [Exhibit E]. There is no need for there to be an AED as part of the emergency response kit with Narcan. It is my understanding that these are two separate treatments and two different problems. If a person is unconscious or unresponsive, without a pulse, an AED is the first intervention that should be applied, but they do not necessarily have to be done together.

I will also reiterate what Mr. Delap mentioned. When medical professionals do not know what is wrong with someone, they will give them the Narcan first because, again, it does not hurt them. So if they are in anaphylactic shock, and you give the Narcan, it does not hurt them. The reverse is if that person is overdosing, and you give the medication for anaphylactic shock, that can harm them, and that is something to keep in mind. I will certainly keep working with the school districts and try to get them to a place where they are wanting to do this. I will also provide more information about the AEDs to clarify that. With that, I thank you very much for the hearing.

Chair Nguyen:
I will reach out to the people who testified in neutral and have them try to address those issues and get that information to the Committee for your consideration. With that, I will close the hearing on A.B. 205.

[Exhibit F was submitted but not discussed and will become part of the record.]

We will now open up the hearing on Assembly Bill 287. Welcome, Assemblywoman Monroe-Moreno.

Assembly Bill 287: Providing for the licensing and regulating of freestanding birthing centers. (BDR 40-799)

Assemblywoman Daniele Monroe-Moreno, Assembly District No. 1:
[Assemblywoman Monroe-Moreno submitted a proposed amendment Exhibit G.] I am here today to present for your consideration Assembly Bill 287. Joining me here today is Dr. Tara Raines, Ms. April Clyde, owner of Serenity Birth Center in Las Vegas, and Ms. Genevieve Burkett, Director of Nursing at Serenity Birth Center. During the 80th Legislative Session, I presented, and this body passed with an overwhelming majority Assembly Bill 169 of the 80th Legislative Session, which established the Maternal Mortality Review Committee. It was important to pass that legislation because maternal mortality was, and still is, rising in the U.S. as it is declining in other countries. Sadly, we continue to be the only high-resource country whose rates are rising. Black women face significantly higher maternal mortality risk, currently at 44 deaths per 100,000 of live births, compared to their white counterparts and women of other races who are at 13 to 14 per every 100,000 live births. But that was last session, and this is 2021. We are still battling maternal mortality, it is still an issue, but it is an issue while we are battling COVID-19. During the beginning of the COVID-19 crisis, pregnant people were often forced to deliver in hospitals alone without their partners or family members. That was important because it was for the safety and protection of the hospital staff and other patients. While I do not disagree with the decision that was made, I do understand the stress it caused for families. I understand that because I had a number of constituents reach out to me and ask why we did not have more options to have healthy babies where families could be involved, thus A.B. 287. Madam Chair, with your permission, I would like to share a short three-minute video that can explain what a birthing center is much better than I can [Exhibit H]. Families in my community, and I am sure, in yours, are looking for healthy options, and I believe free-standing birth centers are one of

those options. Assembly Bill 287 simply defines, in Nevada statute, what a free-standing birthing center is. Now, I will turn the remainder of this presentation over to my copresenters.

Tara Raines, Private Citizen, Las Vegas, Nevada:
[Tara Raines presented a PowerPoint explaining birth centers Exhibit I.] I would like to talk about birth centers, the rise of birth centers in the United States, some outcomes associated with birth centers, projected cost savings related to birth centers, and ways in which they address disparities. As was explained in the video, birth centers can be considered more a maxi-home than a mini-hospital [page 3]. They are a safe place for birthing people and their families to have babies, receive prenatal care, and then receive postpartum support. The major tenets of birth centers are prevention, sensitivity, safety, appropriate medical intervention, and cost effectiveness [page 4]. Birth centers are centered in the midwifery model of care which by its nature is relationally oriented. Birth centers respect and facilitate birthing persons' rights to make informed choices about their health care based on their values and their beliefs. Birth centers allow birthing people to define "family" as they see fit, and also allow them to have family members present during their labor and delivery [page 5].

The proliferation of birth centers is on the rise. Currently, particularly in the wake of COVID-19, we have seen an increased number of birth centers [page 6]. There are currently 384 free-standing birth centers in the United States; there are none in Nevada [page 7]. There is one birth center on the brink of opening; however, because there has been no definition, there have been some struggles and my copresenters will speak more about those. Of all U.S. births, birth centers make up a little less than 1 percent. This data has been updated by the American Association of Birth Centers (AABC), and it is now a little more than 1 percent, which is a 200-percent increase in births in the last ten years.

We know the outcomes associated with birth centers include lower rates of cesarean sections, cost savings, and increased client satisfaction [page 8]. As previously mentioned, the U.S. currently ranks really poorly in relation to its peers in regard to maternal mortality health outcomes and infant mortality outcomes [page 9]. Most notably, the racial disparities in these outcomes are tremendous. Black women are exponentially more likely not only to not survive childbirth, but to suffer severe disability following childbirth [page 10]. We know there is an abundance of literature saying that implicit bias in the medical community plays into this. There have been several high-profile stories, including Serena Williams, in which it has become clear that in the medical community, for whatever reason, Black women's explanation of their pain is not believed by providers. Another reason why this relational approach, this midwifery approach, to care is so important.

Looking at the value, we see that about 42 percent of births nationally are covered by Medicaid [page 11]. In Nevada, it is more like 60 to 70 percent of births are covered by Medicaid. Birth centers are poised to save the state a tremendous amount of money, if nothing else, through the reduction of high intervention during birth. Again, looking at the cost savings, most recently Washington, D.C., engaged in a Medicaid study to estimate about how much it would save to utilize birth centers for their low-intervention Medicaid births.

What they found was they saved around $1,163 per birth [page 12]. These numbers I am reporting for Nevada would not entirely be the case, and Nevada would have to do a cost study to see how much it would save the state; however, based on my estimates, with 41,233 birth certificates issued just in Clark County in 2020, and if we estimated that 60 percent of those births were Medicaid-funded, if every Medicaid-funded birth in Clark County went to a birth center and we saved the same as Washington, D.C., it would save the state over $28 million. Realistically, we know it would be closer to 1 percent of births coming to birth centers, however, that would still save the state a few hundred thousand dollars just in Clark County.

We know that if more pregnant beneficiaries use birth center services during the prenatal period for the duration of their care, they are more likely to experience better outcomes. Birth center care is a high value for Medicaid beneficiaries [page 13]. Currently, only a small fraction of Medicaid beneficiaries are able to obtain birth center care and that is due to a lack of birth centers. The birth center model relies heavily on the Strong Start model of care [page 14]. This is the use of the midwifery model in addition to group prenatal care which allows birthing persons to build relationships during that prenatal period and find that peer support, find a group; and it offers wraparound services, family care in-home to help support things like nutrition and lactation in those first few weeks postpartum. Using the Strong Start approach, the AABC versus national data found that in a number of maternal and infant health indicators, the Strong Start approach was much more successful and produced better outcomes [page 15, Exhibit I].

Specifically in relation to race, I think it is important to note that using the Strong Start model with African-American birthing persons reduced the cesarean rate by more than half [page 16]. To close out the birth center model of care benefits, it is time-intensive, but it is relationship-based. It includes referrals to needed resources, health education, and emotional and mental health support. Midwives see fewer clients per day than obstetricians (OBs) and as such, they are able to really connect with their clients in a different way and support these positive outcomes [page 17]. Incentivizing birth center use for prenatal care could result in lots of savings to Medicaid. These cost savings also come in the postpartum period because we know that you have better prepared parents, you have healthier breastfed/chestfed babies, you have lower rates of cesareans and lower rates of interventions.

I would like to tell my story [page 18]. I had two birth center deliveries in Colorado. I had read the outcomes about the Black maternal health crisis and I did not feel safe going to a hospital. I was not certain that would be a place where my needs would be met and my voice would be heard. I went to an OB for my initial appointment when I found out I was pregnant. Having a history of miscarriages, having a previous loss, the OB said to me, "Okay, where you are sitting right now, it looks pretty good. You have a 10- to 15-percent chance of miscarriage at this point." The next day, I had an appointment with a midwife at the birth center. After I told her my story, she said, "Knowing what we know, you are looking at an 85- to 90-percent chance of having a healthy baby." The difference in that perspective, the emphasis on the life I was growing, was what it took for me to realize that

having a birth center birth is what would make me feel like an empowered, educated, knowledgeable person during my delivery.

A lot of these slides were taken from the AABC. Monet Nicole Photography was kind enough to allow us to use photographs for this presentation. All the photos in this presentation were taken during birth center births, and I would like to thank the incredible community of birth workers in Nevada and across the country who work to empower their clients, and my partner who allowed me to quit a tenured faculty position to pursue this work here in Nevada.

April Clyde, Owner, Serenity Birth Center, Las Vegas, Nevada:
I started my career at Sunrise Hospital in 1998 as a labor and delivery nurse practitioner. The birth center pictures you saw of the building and inside are of my birth center that is, hopefully, weeks away from opening. I started the process, first getting laws changed and now opening the center, but actively working to get the center open for the last three years. It has been such a challenging process that I do not know whether anyone following behind me, without some law changes, would be able to see it happen. Most of that three years was working through city, fire, and state agencies, and we are still working with the health department.

As you can see, the birth center is ready to go. It is stocked with medical equipment. Instead of using the Commission for the Accreditation of Birth Centers, a national organization that licenses and accredits birth centers, think hospital—The Joint Commission that accredits hospitals—they are the experts in that, they do that—rather than looking toward the state and city to do the licensing and accrediting. What is left for birth centers like mine is lots of people arguing and not understanding what we are, so the two closest templates that fit what a birth center is in Nevada are an ambulatory surgery center and a nursing home. We are neither of those. We do not have people who are anesthetized, our moms are healthy, low-risk women. They are walking in in labor. They are our existing patients. We do not have someone showing up at the door who did not have prenatal care with us. They are walking out. We have an agreement with a collaborative physician, and University Medical Center (UMC) is ten minutes away, so there is a plan.

Because there is not an understanding of this among health department officials and city officials, we are being met with things that are really delaying the process and not increasing patient safety. So, it is my hope that no one else has to go through the journey I have gone through because there is incredible evidence to support that freestanding birth centers and the midwifery model of care increase maternal and child outcomes.

Genevieve Burkett, Director of Nursing, Serenity Birth Center, Las Vegas, Nevada:
I am a registered nurse and work for April Clyde. Tara Raines and April Clyde have covered the majority of the information. I want to add to what Tara and April have spoken to. The website evidencedbasedbirths.com provides an incredible amount of research showing that the midwifery model of care provides the safest and best outcomes for low-risk women. The Commission for the Accreditation of Birth Centers, our soon-to-be accrediting body for

Serenity Birth Center, goes over an incredible amount of thorough review of birth centers before they are allowed to be accredited. We are working on an immense amount of policies and procedures. We provide training and drills in safety to all our staff who are registered nurses and certified nurse-midwives who are required by the state of Nevada to attend each birth. I am grateful to be a part of it and was a beneficiary of April Clyde's services as well.

Chair Nguyen:
Assemblywoman Monroe-Moreno, do you have anything else or should we ask for questions?

Assemblywoman Monroe-Moreno:
Whatever you want.

Chair Nguyen:
I know we have quite a few questions, and I will begin. Thank you for bringing this bill. When I was pregnant and looking for birthing centers in Clark County, I quickly realized there were none. Can you explain how you think the changes in this bill would allow birthing centers to become more prevalent and avoid some of the regulatory confusion Ms. Clyde has gone through?

Assemblywoman Monroe-Moreno:
I think it was explained very well by Ms. Clyde. She has had to jump through hoops to adhere to provisions for a traditional medical center that she is not. In our statutes, we did not have a clear definition of what a birthing center is. By putting that definition within our *Nevada Revised Statutes* (NRS), it will make it not only easier for her, but for other people in our community who qualify and want to be accredited to build birthing centers and give options so we can have healthy moms and healthy babies, give them options. By making a distinct definition, it will make that process much easier.

Assemblyman Matthews:
How many other states have this licensing and regulation of birthing centers, and in the states that do, is there any statistical correlation between the licensure and health outcomes?

Tara Raines:
Currently, 40 states have active birth centers, and the findings have overwhelmingly been that outcomes for birth center births are better as far as prenatal satisfaction, labor and delivery satisfaction, and postpartum support.

Assemblyman Matthews:
When you say, better, as compared to what? Births in other circumstances or better health outcomes in those states in general? Would you mind clarifying that, please?

Tara Raines:
Better in relation to their peers in hospital births. The studies I will reference are listed at the end of my presentation [page 20, Exhibit I]. Many of those studies are looking at birth center

births versus hospital births or birth center prenatal support versus hospital or more typical prenatal support.

Assemblywoman Gorelow:
Going through the bill, I was hoping you could clarify the difference between a freestanding birthing center and an obstetric center. Also, in section 12, subsection 2, how was that distance of 30 miles to a hospital determined?

Genevieve Burkett:
A freestanding birth center is not attached to a hospital. The state of Nevada determined it wanted to call a freestanding birth center an obstetric center in their legislation.

April Clyde:
It has been called an "obstetric center" for decades in the NRS and never got changed. It was before birth centers were as prevalent as they are now. It is a holdover and has just not been changed. There really is not a difference because we are talking about the same thing. The problem is when you call it an obstetric center, I think people are confused because a freestanding birth center is called out in functional guidelines in other regulatory wording. It is not called an obstetric center in other states or in other regulatory wording.

Assemblywoman Gorelow:
I had the impression an obstetric center was mostly just for deliveries but that the birthing center did the prenatal care, did the birth and postpartum care, so it encompassed more care than what an obstetric center would cover.

April Clyde:
Correct. The birthing center does all of it. It is care through what we call the "birthing year." From preconception until two months after delivery, we care for moms and babies.

Assemblywoman Gorelow:
Again, can you also explain how we came to a birthing center being 30 miles from a hospital?

April Clyde:
I am not sure. There is some research that supports being within 30 minutes, or 60 minutes, that outcomes are better when there is that distance from the birth center specifically to a tertiary care hospital—a big hospital.

Tara Raines:
Research from late 2019 looked at distances for rural birthing people to hospitals. They found for low-intervention births where the birthing person knew in advance they would be far away from a hospital, there was no benefit to being closer to the hospital. The key to that would be making sure people are prepared to be farther from a hospital. I know that is part of this legislation, but it would be phenomenal if it were not, because birth centers are poised

to really support our rural communities and places where there are obstetric care deserts in Nevada. Having an anchor to a hospital could be limiting.

April Clyde:
Speaking to that, I have had a home-birth practice. I have worked both in hospitals and out of the hospital, but I have many families who travel from hours away in Nevada to birth here because there is not a hospital where they live.

Assemblyman Hafen:
My question has to do with the current birthing center up north here. It is not a freestanding birthing center, which this bill is addressing, but I want to clarify on the record that there would not be additional licensing requirements for that current birthing center.

April Clyde:
Are you referring to the Melinda Hoskins Birth Center in Minden? That is the only one I am familiar with.

Assemblyman Hafen:
It is my understanding that there is a birthing center associated with Renown up here. I am from down south, so I am not very familiar with it. I want to be sure we are not putting additional burdens onto the current birthing facilities.

Assemblywoman Monroe-Moreno:
This legislation would only refer to freestanding birthing centers. It would not have an impact on those birthing centers associated with our hospitals or cause them to have to get any other licensure.

Assemblywoman Benitez-Thompson:
When we talk about licensing questions and where people fall within licensure, we can only regulate what happens if the state has put onto the law books about licensure. It was interesting to hear the testimony that you are living between two different licensing types—an ambulatory surgical center or a nursing home but were neither one of those things.

I guess this is more a comment than a question. What we have experienced before is someone with less transparent intentions—and we have seen this happen in other types of licensing groups, where people start practicing and because we do not have a clear law about what they can and cannot do, we cannot go in and regulate them. We had this problem for years with group homes, and then we were trying to define group homes. Our state ombudsmen would go to inspect and say, "You look like a group home", and be told, "No, I am not because here is what you say a group home is and I am not licensed as that. Since I am not licensed, you cannot touch me." So we were constantly chasing through the 2011 Session, the 2013 Session, and the 2017 Session, trying to get these people onto the map. One thing I have appreciated when it comes to saying "here is a clear path for licensure" is you know everything that is happening in your community and everyone who is willing to hang out a shingle and be transparent is known, and we have a better idea of what is

happening versus if we only have a space where people exist ambiguously, without state oversight, they will exist there. That is what I always appreciate when we talk about trends in a community. If we think it is worthwhile and ought to be done safely, then we ought to have a serious conversation about regulations and licensure and how we ensure it is done safely.

Assemblywoman Monroe-Moreno:
I appreciate your saying that and I appreciate the staff at Serenity Birth Center. They could have started this business three years ago and just opened their doors because they were in-between. But it is very important to them and other midwives I have been working with to make sure our policies as a state—the statutes in our NRS—are clear and concise. They will take as long as necessary to be sure they are following those guidelines and making sure that within this legislation there is enforcement. You will see that in sections 17, 18, 20, and 25—to make sure they are adhering to what we will set forth in this policy as we move forward. So thank you to them for following the guidelines they had in that in-between space.

Assemblywoman Titus:
I did my OB training as a second-year resident at Los Angeles County General Hospital. As a medical doctor, I spent two months delivering babies every third night—sometimes 50 babies a night. It was everything wrong that this bill tries to solve: no prenatal care, it was an amazingly intense experience, and I was pregnant at the time. When I chose to have my babies, I had them at Saint Mary's Hospital in Reno where they have wonderful birthing rooms. You can have someone with you, the baby never leaves the room, and it was a wonderful experience for me.

Someone testified that, in order to partake in this, you already had to have prenatal care or you could not go to one of these birthing centers. Is that correct?

Tara Raines:
No, I would like to clarify. I went to an OB in trying to decide whether to pursue a typical route versus a birth center. The birth centers provide OB care, and in many cases birth centers provide fertility support and well-person care for folks who are trying to conceive.

Assemblywoman Titus:
Are these birthing centers all for-profit birthing centers?

Tara Raines:
No, it is a mixture. It depends on the model of the owners and operators.

Assemblywoman Titus:
So there are some nonprofits?

Tara Raines:
Absolutely.

Assemblywoman Titus:
If a person walks into a birthing center and is going to have a baby, are there any EMTALA [Emergency Medical Treatment and Labor Act] violations? What rules do you have to follow? Can you turn someone away?

April Clyde:
It is not like a labor and delivery unit at a hospital where you can just show up. You have to be a healthy, low-risk woman. Having no prenatal care risks you out for care in a birth center.

Assemblywoman Titus:
Will you accept Medicaid payment, cash payments, and will you accept someone who has no means of payment?

April Clyde:
Yes, and it is far less expensive when you are comparing vaginal birth to vaginal birth—apples to apples—to birth in a birthing center. We do accept women with late care, for instance, someone beginning prenatal care in their second trimester or even in their third trimester; but you cannot, as you can in a hospital, just show up and have had no prenatal care.

Assemblywoman Titus:
Having done OB in rural Nevada with no backup, I know birthing can be a wonderful experience. It was something that I felt, as a family practice doctor, to be a complete family doctor, I needed to do OB, and we would select our low-risk patients. At the same time, unfortunately, even with low-risk patients, there is statistically about 20 percent of the ones I just looked at will be transferred to a hospital—that is the current rate I am seeing nationwide. Twenty percent, even in the low-risk moms, will be transferred to a hospital center for some sort of assistance with delivery, some sort of medication, recovery. How do you deal with that? How do you deal with the transfer? Do you have to have agreements with local hospitals for those situations we know will happen, even in the best of circumstances? How will you deal with those pregnancies?

April Clyde:
I think the number is 12 percent; the 20 percent may be total transfers and we are talking from the beginning of prenatal care?

Assemblywoman Titus:
Correct. That is the figure: 20 percent total transfers.

April Clyde:
Most of those are happening through prenatal care. Someone gets gestational diabetes, someone has high blood pressure, and then they are not a candidate. We are the experts in normal—which is the vast majority of pregnant people in the United States. That is what we

are the experts in. Speaking for our practice, we have a collaborative agreement with the UNLV School of Medicine, Department of Obstetrics and Gynecology.

Assemblywoman Titus:
So, you have an agreement with another center. Will there be a requirement that there is an agreement with other facilities for the known complications, or the "safe handoff"? Living in the world and having had it happen, it is important that you know when it does happen, you have that "warm" handoff. Do you have any kind of requirements for that?

Tara Raines:
Currently, there is no requirement for that in the legislation. I believe that is to reduce barriers. What other states have found is that some of the hospitals have not been as excited as we are to see birthing centers in their communities, despite the positive outcomes associated. Of course, AABC and all birth centers would be strongly encouraged to develop formal relationships with hospitals. What April Clyde said is that the early risk out, so those folks are encouraged to find other care long before delivery. Building relationships with both emergency departments and local OBs has been incredibly helpful for birthing centers and transfers. The birthing center where I delivered had a relationship with a local hospital and I was encouraged to check that hospital out ahead of time, in the event that I had to transfer for one reason or another.

Assemblywoman Titus:
Again, that is where I am going with that question. It is that safe transfer. One of the arguments for this bill is the poor outcome, especially as you quoted, in certain groups of women. If all these requirements are there, you are almost preselecting that these women will not qualify for this birthing center. I want to make sure this is really helping solve the problem you are trying to solve.

Tara Raines:
One of the key pieces of the birthing center is the prenatal education—that nutrition support, that mental health support. We found that with those pieces in place, it reduces morbidity. If I am a super low-income, very young birthing person and I am getting nutrition support and support around healthy choices, I may not develop gestational diabetes that would risk me out. I may not develop some of these other morbidities that we would consider disqualifying factors for birth center supports. The idea is to take a preventive approach.

Assemblywoman Titus:
Liability. What type of liability coverage is mandated for these services?

April Clyde:
The way the law is now, the providers that have to be there for every birth include a nurse practitioner, nurse-midwife, and a registered nurse at every birth. The nurse practitioner and the practice are required to carry $1 million/$3 million policy. This is the same as OB/GYNs.

Assemblywoman Titus:
That was my limit: $1 million/$3 million to practice OB. In these birthing centers, and I like the concept, I like having someone there. I did that; I stayed by their side; it was a wonderful experience to deliver a baby, but having had the experience of home deliveries, emergency deliveries, roadside deliveries, in-my-house deliveries, it can be exciting but it can be terrifying. If you are outside the other requirements for an obstetrical center or a hospital, are you going to be required to have resuscitative equipment there or emergency equipment for postpartum hemorrhage, those kinds of things? Will you be able to use Pitocin? Will you be able to use anything if it does not stop, other than massage of the uterus? What will you be required to have in your facility?

April Clyde:
The Commission for the Accreditation of Birth Centers—think The Joint Commission—requires everything you just described. We have to have a crash cart and resuscitative equipment for mom and baby. We have an AED machine and all the anti-hemorrhagic medication—that all has to be there.

Assemblywoman Titus:
Thank you for the bill and all the questions you allowed me.

Assemblywoman Krasner:
Will these birthing centers have the equivalent of a neonatal intensive care unit (NICU) for babies born in fetal distress?

April Clyde:
We have the same ability as a level 3 NICU—a well nursery. This is what most rural hospitals in Nevada have, as well as what some suburban hospitals in southern Nevada have. We can take care of well newborns. We do have resuscitation equipment, but we do not see preterm babies. You have to be at least 37 weeks to deliver at the birth center. Everyone, the RNs, the nurse practitioners, are all neonatal resuscitation-trained. We also have protocols with the three fire departments that could be responding if there was a situation where a mom or baby needed to be transported to the hospital. Next week we are running drills with them for transport.

Assemblywoman Krasner:
I know there are different levels of hospitals in regard to the urgent care they can provide. This goes to section 12, subsection 2, reading that the freestanding birthing center must be located 30 minutes from a hospital that offers obstetrics and emergency services. When I gave birth to my first son, I was super healthy. It was a low-risk pregnancy and I was offered to give birth in a more rural hospital that did not have the highest level of services for a child born in fetal distress and it was 15 minutes away from a hospital that did. I opted to go to the hospital with the experts. Thank goodness because even though I was a low-risk pregnancy, my son was born in fetal distress and would have died in the 15 miles from that hospital to the other one. Who would have known? I was low risk, and this really concerns me.

April Clyde:
There has been a lot of research comparing what is called intermittent fetal monitoring. This is what is done at a birthing center and moms can be in any position. They can be in the water and we are listening and there is a national protocol for this listening. That is compared to what is done in the hospital which is continuous fetal monitoring. You may be more familiar with this. There is a wire, there is a belt on mom connected to a wire in a machine that is continuously monitoring the baby's heart rate. There has not been found to be a difference between mommy outcomes or baby outcomes with continuous monitoring and intermittent monitoring.

There will be babies who need to be resuscitated just as you are in labor room 1, and they are planning for a normal vaginal delivery, there is distress, and mom gets moved either to the operating room or staff come in for resuscitation of baby. These same protocols are planned for and we have emergency services and personnel there to resuscitate a baby if necessary. We also are not waiting for emergencies to happen. If babies are not tolerating labor well, if we are hearing decelerations in the heart rate, we are going to the hospital and we have oxygen and emergency equipment to be taking mom and/or baby to the hospital.

Assemblywoman Peters:
I want to commend you all on your presentation and the bill. The amendment is fantastic and novel. Great job, wonderfully written and well thought out. I also want to say that having had three kids at home and doing all the research, where you choose to birth is really an intuitive choice. And Assemblywoman Krasner, you used your intuition to decide where the best place was for you to birth. The idea of options is directed at exactly that. We should trust women and their bodies and their intuition and willingness to listen to themselves, take in information, understand what the risks are for them and their babies, and give them the opportunity to make those choices themselves. This is about that right to be a parent. I commend the bill's sponsor and the folks who are advocating for this and the people who are standing up these kinds of facilities. You are enabling women and birthing people to do what is best for them and their families.

Chair Nguyen:
This is a good stopping point to go to callers for testimony in support, opposition, and neutral. We will begin with testimony in support. [There was none.] Are there any callers in opposition?

Katie Ryan, System Director, Nevada Government Relations, Dignity Health-St. Rose Dominican:
I am calling in opposition to A.B. 287, and I provided a letter on behalf of St. Rose and our chief medical officer, Dr. Rodney Buzzas, which describes our issues with the bill [Exhibit J]. We want mothers to have their babies in a comfortable setting, but we also want to make sure that those settings are as safe as possible and close to a higher level of care if needed.

Chair Nguyen:
Are there any more callers in opposition? [There were none.] Do we have any callers in neutral on A.B. 287? [There were none.] With that, I will turn this back over to Assemblywoman Monroe-Moreno for any closing remarks.

Assemblywoman Monroe-Moreno:
Thank you for giving us the opportunity to present this bill. I see a birthing center as another option for moms. We should trust women to know what they want to do with their bodies and where they want to give birth to their babies—if it is at home in the living room, in a pool, in a hospital, or in a birthing center. I urge your support.

[Exhibit K and Exhibit L were submitted but not discussed and will become part of the record.]

Chair Nguyen:
With that, I will close the hearing on A.B. 287.

We will now open the hearing on Assembly Bill 426. We have Buffy Okuma, Chief Deputy District Attorney in the Washoe County District Attorney's Office, as well as Gabrielle Carr, Juvenile Master in the Sixth Judicial District Court, who will present the bill.

Assembly Bill 426: Makes various changes relating to the protection of children. (BDR 38-516)

Gabrielle Carr, Juvenile and Family Court Master, Sixth Judicial District Court:
I also serve as chair for the Subcommittee of the Community Improvement Program (CIP) which is part of the Nevada Supreme Court that was created to create this bill. As the chair, I have been practicing family law and related cases including child dependency for about 25 years, so I have covered this topic from all aspects of dealing with representing the parents, the kid, representing child welfare agencies, and now overseeing these cases. Also with me as a copresenter is Ms. Buffy Okuma, Chief Deputy District Attorney for Washoe County, and also with us to answer questions is Chief Deputy District Attorney Janne Hanrahan from Clark County. So you have Washoe, Clark, and the rurals represented by our presenters today.

The Community Improvement Program was created to allow all of the districts within the state to come together and work together as a team, to improve outcomes for children in child welfare cases. This CIP team involves judges, masters, attorneys, social workers, guardians ad litem, administrators, Nevada Supreme Court staff, and it is managed and controlled by retired Nevada Supreme Court Justice Nancy Saitta.

Every year we have a meeting we call our CIP summit and all the teams come to one place and talk about how to do things better. In 2019 I suggested we create a committee of people to address all the issues we were having with *Nevada Revised Statutes* (NRS) Chapter 432B, and I wound up chairing that committee. I reached out to all the stakeholders who attend

these meetings throughout the districts and created a team, and I shared it with your staff [Exhibit M]. This is a list of all the stakeholders who were contacted who joined this subcommittee along with me. Luckily, I had Ms. Buffy Okuma join me as cochair of this committee. We have been meeting every month, and sometimes every week, for approximately a year, to see what we could do to address all the issues we were having under NRS Chapter 432B.

I believe you all have a copy of this document, so I do not want to spend too much time on it, but I just wanted you to see that we have representatives from the Nevada Supreme Court, the State of Nevada, all jurisdictions except for the Tenth Judicial District, and including the director for the Court Appointed Special Advocates, or CASA Program in Nevada. In meeting every month, one of the things we agreed to do was, whatever changes we wanted to move forward in this bill had to be unanimously agreed to by all committee members, and we did. Our goal was twofold: One, clean up anything that needs to be updated and modified to fit the practical application in the community as we deal with these cases on a day-to-day basis. And, two, address the fact that in 2011 there was a Ninth Circuit Court of Appeals opinion that said, before a child welfare agency can remove a child, you have to have a warrant from the court. That warrant process is different for every jurisdiction, so part of our goal was to codify the need for a warrant and make it more uniform so the districts could have a greater, more uniform application.

Buffy Okuma, Chief Deputy District Attorney, Washoe County District Attorney's Office:

I am the Chief Deputy District Attorney for our child protection services unit. We have a total of eight attorneys who represent the Human Services Agency of Washoe County solely doing matters with regard to NRS Chapter 432B all the way through termination of parental rights. I will do a brief overview. Within our committee, we identified the number of areas we wanted to address. Pursuant to our agreement for everybody to have consensus on what we were going to work on in a pretty short time frame, we decided on several topics and ended up narrowing those down. There were a few heavy-lift topics we were not able to get consensus on to move forward, but the benefit of that is that we now have a platform for how our committee can come together to propose legislation and legislative changes to various chapters we deal with every day.

We ended up with two main topics that we would move forward on. One topic was the warrant process, and the other topic was cleanup of all those things we have all been overlooking and fudging around in order to get our cases going.

Master Carr mentioned the Court of Appeals opinion. The first Ninth Circuit opinion actually came out in 1999 and another one came out in early 2000, so it was on the radar in Nevada for quite a while. It ultimately resulted in the Washoe County Human Services Agency being sued, thus the opinion Master Carr referenced. During that time period between the early 2000s and when that lawsuit occurred, there were conversations all the time about the need for a warrant, and the response was always that we did not have any process. There were all kinds of processes in place for criminal cases, but it had not been

applied in the child welfare world until the early 2000s. It was a struggle to get the process in place, and the implementation across the state of Nevada was extremely slow and disjointed. We talked for years about trying to get the warrant process codified in NRS Chapter 432B so that we would not have to patch together a bunch of case law to figure out what is required; but also, try to be more consistent from jurisdiction to jurisdiction, at the same time recognizing the differences. I think we accomplished that with section 1 of the bill.

Section 2 of the bill was a conforming change. With regard to section 3 of the bill, there is nothing significant in that it provided some clarification. Section 4 of the bill is also a conforming change to recognize the warrant process. When we get to section 5, we added one word, but it is a really powerful word. We added the word that we would have jurisdiction in any county where a child is "domiciled." In Nevada, we have three separate child welfare agencies under three separate jurisdictional overlays. In Washoe County, it is handled by the Washoe County Human Services Agency with the District Attorney's Office representing them. In Clark County, the cases are handled by the Clark County Child Protective Services Division with the Clark County District Attorney's Office representing them. In all the rurals, the cases are handled by the Division of Child and Family Services (DCFS) within the Department of Health and Human Services with the Office of the Attorney General as their legal counsel, though they do not participate in the actual hearings until it gets to a termination phase—so it is a little disjointed, but far better than it was in the 1990s.

When we have jurisdictional issues—and in the north they are often between Carson City and Washoe County—and there are some similar situations in the south. Often, we will have a family that lives in Carson City, but the child is born in Washoe County—generally at Renown because of the specialized services Renown offers. We have this situation multiple times a year where the child is born in Washoe County, but the parents reside in Carson City. Our statute as it currently stands is pretty narrow. It says that a court has jurisdiction where a child resides or where a child is found, so when you have a newborn baby, they do not really reside in the hospital, but they are certainly found there. They have never resided anywhere else. So we have situations where Washoe County has had to take action on that case and go to court in Washoe County, and then there is a big long process to transfer the case to Carson City and then to DCFS, all the while it is taking up time when the parents could be getting services. By adding the word "domicile," we have a lot of case law that says that a newborn child is domiciled where their parents reside, which takes care of that problem.

Section 6 clarifies and expands a provision about persons with a "special interest." In child welfare cases there are a lot of parties—more parties than in typical family law cases. In family law cases you often have mom and dad, maybe grandparents and mom. In child welfare cases, we often have a mom and mom's attorney; dad and dad's attorney; the children and their attorney; the CASA, the social worker and their attorney; and then we have a handful of other people who are involved, like the foster parents. The federal government and our state adopted this provision with regard to persons with a special interest, indicating that the court really needs to hear from some people because they have knowledge about the

child and about the child's needs and the child's need for permanency. This provision in the statute indicates that if a person is designated as a person with a special interest, they are not a party to the case but they are entitled to have notice of any hearings, notice of what the permanency plan is for the child, an opportunity to provide input about that permanency plan, and an opportunity to provide input to the court in court proceedings. It does trigger some additional protections.

We have struggled since the beginning putting that in because how does a person get designated? The statute never said, and so we would constantly have various family members, former foster parents, all kinds of people filing motions in our cases. However, they were not a "party." We cannot open the floodgates to have even more parties in all our cases, so we amended that to identify that a court can designate someone. The foster parent is in court, they are always notified, and someone can tell a judge they think the foster parent should be designated so they get all these extra protections, or a relative comes to the court proceeding and says, "Hey, I would like that designation so I can get these extra protections." Importantly, it also provides for the court to be able to review or modify that designation. We have had situations where a former foster parent is designated as a person with a special interest and a year has gone by and that person is not involved in the case anymore, but we have to continue to notice them because there was never a provision for them to be undesignated.

Section 7 updates and clarifies what is in existing law. Right now, when we have what we call either a protective custody hearing or 72-hour hearing, if a child is placed into protective custody, the agency has to provide notice to the parents. It was an open question as to what efforts they had to make when they cannot find the parent. That is one of the things that takes up a lot of time in our proceedings when we are all arguing over what happens if the parent cannot be found. It also updates the provision. Existing law says that if we are not able to find the parent and either personally serve them or serve them over the phone or orally, that the social worker had to post notice on their door. We are really concerned about that. I got sued four times because the notice blew off the person's door so that person said they did not get proper notice. A whole host of us were caught up in that.

Chair Nguyen:
Ms. Okuma, I am sorry to interrupt you. I see that you are going through the bill section by section. I trust that all our Committee members have read the bill to prepare for today's hearing and I know they have some questions. Do you want to open up for questions?

Buffy Okuma:
Absolutely.

Chair Nguyen:
Some Committee members have another committee meeting at 4 p.m. and I want to make sure they are able to ask questions. Thank you for that presentation. Looking at the 45 people on your list and the idea that you have consensus from that many lawyers is a feat in and of itself. We will now go to questions.

Assemblywoman Gorelow:
I had a question about section 1, subsection 1. It reads that the "designee may request that the court issue a warrant to place a child in protective custody," and then it says, if not needed "in the time it would take to obtain a warrant." Is this an emergency warrant so it works faster than going through a court warrant?

Buffy Okuma:
The way federal law and case law have come out is that you have to have a warrant, unless, in the time it takes to get a warrant, the child would suffer or potentially would suffer harm. This provision allows us to get a warrant when we are able to but leaves open the possibility if we are not able to get a warrant in that time frame. The example I often give is the three-year-old who is found outside alone. You cannot leave that child to go get a warrant, and so that would be an exigent circumstance. Otherwise, we would need to get a warrant.

Assemblywoman Gorelow:
Again, in section 1, subsection 4, paragraph (b), it says it is valid for ten days. Is that calendar or business days?

Buffy Okuma:
Under the new rules of civil procedure, it clarifies in counting days, that if it does not specify otherwise, it would be calendar days, so this would be calendar days. The reason for that is because sometimes we know where the family is, but after we get the warrant, they disappear. So sometimes the agency needs some time to try to find them. However, the court can make that a shorter window if it chooses.

Assemblywoman Benitez-Thompson:
Right now, we are building the legislative record that will be reflected upon for this law and there was so much thought that went into it. I thought it might be helpful to upload the minutes from the meeting to our Exhibits, knowing we might not be able to do a deep walkthrough on the bill. The minutes might help justify the bill or help flesh out understanding about what the thinking was.

For the legislative record, what would be a clear example of "reasonable cause" and the time frame you would be looking to define in statute versus an unreasonable example? For instance, the child on the Pyramid Highway who needs to be scooped up quickly was a great example. Could you give an example of one, such as workers out in the field, that would not meet the standard for the warrant?

Buffy Okuma:
The most common case we see is one where parents are found to be under the influence of substances and a child is present, but the child is not at immediate risk at that moment. The worker is able to step out because most of our warrants can be obtained by phone, so for the worker is able to step out of the immediate scene and apply for the warrant over the phone and get it. That is probably the most common situation we see.

Chair Nguyen:
I am not sure if the Community Improvement Program Committee maintains minutes, but if you do, I would ask you to provide them to Committee staff so we can make them a part of this legislative record. I know you had several meetings with your subcommittee members and other participants in developing the recommendations in this proposed legislation.

Assemblywoman Benitez-Thompson:
I see with the warrant there is a ten-day process and when you get the actual protective order, that is a 72-hour process. It sounds as though this has evolved through case law or through practice. Can you tell us more? It seems that ten days seems generous. It seems long, but is that true? Why does ten days make more sense versus nine days or eleven days?

Buffy Okuma:
We had a lot of discussions about how long a warrant could be valid. Ten days is how long we can have to execute the warrant and not how long we have after you have placed the children into protective custody. It also is expected that that is the outside limit. That is why that provision is in there—so there is a time when we know this warrant is no longer valid. It is our expectation, and I do know that in the Second Judicial District Court, it is anticipated that the court will, in granting the warrant, have a shorter time period. Right now, more often than not, our court is limiting the validity of that warrant to 72 hours. If we have a good reason, we can get an extension up to ten days, based on that example I mentioned of the family that flees and we are trying to find them. It gives you some time to do that.

Assemblywoman Benitez-Thompson:
So we should mean this to be up to ten days and not a static ten days.

Buffy Okuma:
Right.

Janne Hanrahan, Chief Deputy District Attorney, Clark County District Attorney's Office:
I am with the Juvenile Division doing child welfare cases. I lead the committee that put together the warrant statute and wanted to add that the ten days also takes into account what we have down here a lot, as I am sure Washoe County does as well. We have the kind of situation that led to the case that requires us to get warrants, which is a baby born in a hospital, drug-exposed or to a mom who is not appropriate to take that child home. Sometimes those babies are in the hospital for a period of time. They are in the hospital being taken care of, someone is supervising mom being in there. It contemplates that period of time that the baby is in the hospital too and may not be officially removed right away. So the ten days was a compromise. It is true down here as well where we have a lot more volume. The vast majority of warrants are served within 24 to 48 hours of being issued. I do not think this is a situation that will be taken advantage of.

Chair Nguyen:
Do you have any follow-up? Does anyone have further questions? [There were none.] I will go to the phone lines and begin testimony in support, opposition, and neutral to this bill, beginning with testimony in support of A.B. 426.

DaShun Jackson, Director of Children's Safety and Welfare Policy, Children's Advocacy Alliance:
We stand in support of A.B. 426. We believe this bill is crucial to the safety and welfare of children. We also believe this bill would save lives and would also help with many of the issues that these youth face.

Kendra G. Bertschy, Deputy Public Defender, Washoe County Public Defender's Office:
I want to thank the Committee for hearing this bill. As you heard, our state is in great need for reforming our dependency statutes. We appreciate the time everyone put together with this committee. We were involved in the process of negotiating, and the bill you see before you is the product of carefully negotiated and crafted legislation that took a significant amount of time. Although it is not perfect and we have not completely reformed the entire NRS Chapter 432B statutes, we believe this is a very good start and would appreciate your support for this bill.

John McCormick, Assistant Court Administrator, Nevada Supreme Court:
While our Court Improvement Program has been mentioned several times, I wanted to call and register our support for the bill and appreciation for all the work done by the committee members and particularly by our cochair.

Chair Nguyen:
Are there more callers in support? [There were none.] Do we have any callers in opposition to A.B. 426? [There were none.] Do we have any callers in neutral on the bill?

Alexis Tucey, Deputy Administrator, Division of Child and Family Services, Department of Health and Human Services:
I would like to testify in neutral support for A.B. 426. I would like to extend gratitude to the court improvement project for not only working on this bill as well as their continued efforts at improving the system as a whole for our youth and children in Nevada.

Chair Nguyen:
With that, do the presenters have any closing statements or remarks?

Gabrielle Carr:
Thank you for your time. Because of the extensive nature of these committee meetings—and there were three subcommittees within it—we do not have minutes from the meetings we held. However, I would be happy to provide a summary of what the "meat" of it was and why we did what we did, that might give you additional insight and clarity for each of the

sections. It might be easier and faster to read than minutes would have been for the approximately 20-plus committee meetings.

Chair Nguyen:
If we can get that information, it will supplement the record regarding changes in the sections you are proposing. Again, the kind of work you put into this to gather the consensus you have among public defenders, district attorneys, and courts and court administrators is commendable. With that, I will close the hearing on A.B. 426. At this time, I will open public comment. [There was none.] Are there any comments from Committee members? [There were none.] We are adjourned [at 4:05 p.m.].

RESPECTFULLY SUBMITTED:

_____
Terry Horgan
Committee Secretary

APPROVED BY:

_____
Assemblywoman Rochelle T. Nguyen, Chair

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a letter dated March 30, 2021, authored and submitted by Trey Delap, Director, Group Six Partners, containing additional supplemental information, in support of Assembly Bill 205.

Exhibit D is a letter from the Nevada Osteopathic Medical Association submitted by Assemblywoman Lesley E. Cohen, Assembly District No. 29, in support of Assembly Bill 205.

Exhibit E is a letter to Assemblywoman Lesley Cohen, authored by Joseph Heck, D.O., Nevada Osteopathic Medical Association, submitted by Assemblywoman Lesley E. Cohen, Assembly District No. 29, in regard to Assembly Bill 205.

Exhibit F is a letter dated March 31, 2021, submitted by John Packham, PhD., Chair, Advocacy and Policy Committee, Nevada Public Health Association, in support of Assembly Bill 205.

Exhibit G is a proposed amendment to Assembly Bill 287 submitted by Assemblywoman Daniele Monroe-Moreno, Assembly District No. 1.

Exhibit H is an address to a video titled "The Birth Center – There is a difference" published on vimeo.com by American Association of Birth Centers, submitted by Assemblywoman Daniele Monroe-Moreno, Assembly District No. 1, in support of Assembly Bill 287.

Exhibit I is a copy of a PowerPoint presentation titled "Freestanding Birth Centers Nevada AB 287," submitted by Tara Raines, Private Citizen, Las Vegas, Nevada, in support of Assembly Bill 287.

Exhibit J is a letter dated March 31, 2021, authored by G. Rodney Buzzas, MD., Chief Medical Officer, Siena and Rose de Lima Campuses, Dignity Health-St. Rose Dominican, submitted by Katie Ryan, System Director, Nevada Government Relations, Dignity Health-St. Rose Dominican, in opposition to Assembly Bill 287.

Exhibit K is a letter dated March 31, 2021, submitted by Amanda Macdonald, LM, CPM, Reno, Nevada, in support of Assembly Bill 287.

Exhibit L is a letter dated March 30, 2021, submitted by Kate E. Bauer, Executive Director, American Association of Birth Centers, in support of Assembly Bill 287.

Exhibit M is a document titled "Community Improvement Program (CIP) SUBCOMMITTEE 2021 Legislative Changes – NRS Chapter 432B Subcommittee Members and Participants" submitted by Gabrielle Carr, Juvenile and Family Court Master, Sixth Judicial District Court.