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

Eighty-First Session
April 23, 2021

The Committee on Health and Human Services was called to order by Chair Rochelle T. Nguyen at 12 p.m. on Friday, April 23, 2021, Online and in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/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:

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

STAFF MEMBERS PRESENT:

Patrick Ashton, Committee Policy Analyst
Karly O'Krent, Committee Counsel
Nick Christie, Committee Manager
Terry Horgan, Committee Secretary
Trinity Thom, Committee Assistant

OTHERS PRESENT:

Robert Nathan Slotnick, M.D., Ph.D., Director, Medical Genetics and Genomics, Invitae Corporation
Abbi Whitaker, Private Citizen, Reno, Nevada
Connor Cain, representing Comprehensive Cancer Centers of Nevada
Tess Opferman, representing Nevada Women's Lobby
Wesley Falconer, Chief Operating Officer, Cancer Care Specialists, Reno, Nevada
Sowjanya Reganti, M.D., Private Citizen, Reno, Nevada
Erin Lynch, Chief, Medical Programs Unit, Division of Health Care Financing and Policy, Department of Health and Human Services
Joan Hall, President, Nevada Rural Hospital Partners
Mary Walker, representing Carson City and Carson Tahoe Health
Trey Delap, representing Nevada Chapter, National Alliance on Mental Illness
Dan Musgrove, Chair, Clark County Children's Mental Health Consortium; Member, Clark County Regional Behavioral Health Policy Board
DuAne Young, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services

Chair Nguyen:
[Roll was taken. Committee rules and protocol were explained.] Today, we have two bill hearings. At this time, I will open the bill hearing on Senate Bill 251 (1st Reprint). Welcome, Senator Gansert, and please begin when you are ready.

Senate Bill 251 (1st Reprint): Revises provisions relating to genetic counseling and testing. (BDR 40-478)

Senator Heidi Seevers Gansert, Senate District No. 15:
Today I am joined by Dr. Nathan Slotnick and my friend Abbi Whitaker. Dr. Slotnick is an expert on genetics and will be talking at length about hereditary mutations for the breast cancer (BRCA) 1 and breast cancer (BRCA) 2 genes. Dr. Nathan Slotnick is a medical geneticist and high-risk obstetrician and is board-certified in both disciplines. He has also seen many pediatric and adult obstetric patients for 18 years, and he relocated to Nevada in 2003. In 2005, he was asked to start a cancer genetics program by a local oncology practitioner group. That group has grown dramatically and now has a total of more than 4,000 cancer patients seen. He has also been a University of Nevada, Reno School of Medicine faculty member and has been widely published on a number of cancer, genetic, and

high-risk obstetric topics. In November 2020, he was named medical director of reproductive genetic medicine at Invitae Corporation, a large international genetic testing and services organization.

I also have Abbi Whitaker, who is a long-time friend of mine, with me on Zoom. She is a well-respected, award-winning communications specialist and entrepreneur who founded her own business, The Abbi Agency, with her husband Ty. The Abbi Agency's tagline is "Where Chutzpah Meets Acumen," which perfectly describes my friend. What people do not know about Abbi is that she is also a cancer survivor. Since Abbi is with us today, I am going to have her share her own story, but I will say, when Abbi first called me about sponsoring a bill about BRCA, I said I would do it, of course. I realized she was one of a half-dozen friends who have been affected by the BRCA 1 and 2 genetic mutations. Each of my friends had cancer at an early age or had a family history and possible genetic link but it had not been connected. They were not told, so their diagnoses sometimes were quite late. The screening, referral, and testing contemplated in Senate Bill 251 (1st Reprint) is very important for each woman and is also critical for the families of women who have tested positive for BRCA mutations. I will now ask Dr. Nathan Slotnick to give us a brief review of BRCA 1 and 2 mutations, and then I will ask Abbi to tell her story.

Robert Nathan Slotnick, M.D., Ph.D., Director, Medical Genetics and Genomics, Invitae Corporation:

I am a medical geneticist. I have had a long-standing and abiding interest in cancer hereditary predisposition, testing, molecular genetics, and ways of offering these opportunities to both clinicians and patients in the state of Nevada. I have put together a short presentation that will detail the clinical and scientific background that allows us to address these issues [Exhibit C].

Today we are going to address the issues of genetics and genomics in cancer, but I will put a plug in at the end of my presentation about how the technology that allows us to have this discussion today is applicable to virtually every other clinical entity in medicine and how we should consider it when we think about future directions that medicine and medical practice will take.

Let us start first talking about the genetics of cancer and about what the etiology, or cause of cancer, really is [page 2]. Cancer is due to an alteration in the DNA of specific genes within specific cells of the body. If the alteration occurs within one of the many cellular control genes, normal cellular control can be lost. That damaged cell reproduces into more control-less cells, and a tumor can develop. Further loss of control results in spread away from the original cell's location. That is called "metastatic disease." Therefore, all cancers are genetic, meaning that they have a DNA etiology, but not all cancers are hereditary. In every sense, then, cancer is a genetic disease.

Let us talk about what that means [page 3]. Every geneticist I have known all the years I have been in practice has the habit of, whenever we come across something unusual, we have a file cabinet and when we have a chance to look back at it or as technology advances,

we are able to make some statements in that regard. Starting in the 1950s, genetics doctors have put into their file cabinets very interesting family trees having to do with cancer. What they found was something called "hereditary breast and ovarian cancer syndrome" or HBOC. Each of the family trees have specific predictions they manifest. Hereditary HBOC family trees generally show breast cancer before the age of 50, ovarian cancer frequently at any age, male breast cancer—which is really rare otherwise—frequently multifocal or bilateral breast cancer, and frequently associated with certain ethnic backgrounds as well. These can be contrasted with non-hereditary types of cancers, which do not have these characteristics. As we have learned more about HBOC, it has evolved into a direct association with BRCA 1 and 2 genes.

Looking at what this means in a clinical context [page 4, Exhibit C], by age 40, 1 in 200 women in the population will have developed breast cancer. But if you have a mutation in BRCA 1 or BRCA 2, it is more like a 10 to 20 percent risk that breast cancer will occur. By age 50, 2 percent of the population of women will have breast cancer; a BRCA mutation will increase that dramatically to 33 to 50 percent. Over a woman's lifetime, 12 percent of the population of women in this country will develop breast cancer. With a BRCA 1 or 2 mutation, that risk goes to 56 percent up to 87 percent. These ranges occur because different studies make different predictions; but one way or the other, this is a huge increase in the risk of developing breast cancer.

It also affects the development of ovarian cancer [page 5]. Approximately 1 percent of the female population in this country will develop ovarian cancer during her lifetime, but with BRCA 1 or 2 gene mutations, those risks go up dramatically. I am sure all of you know that ovarian cancer is frequently not diagnosed until it has disseminated throughout the body and then it is very difficult, if not impossible, to treat.

If you look at all the HBOC patients [page 6], you will find that approximately 80 to 85 percent will have either a BRCA 1 or BRCA 2 mutation. However, it has become obvious that there are many other genes involved in this hereditary predisposition as well. It is more than just the development of cancer; it includes considerations of the development of a second, independent cancer [page 7]. Five percent of all women who will develop breast cancer within five years of the original diagnosis will develop a second breast cancer, but if you have a mutation in either BRCA 1 or BRCA 2, that number goes to 12 to 20 percent. Over a woman's lifetime, if she develops breast cancer, the risk of a second primary breast cancer is about 11 percent, but with a mutation in either BRCA 1 or BRCA 2, it goes up to 40 to 60 percent. So knowing a patient's BRCA status is crucial in knowing how to treat her well, how to treat her medically.

It is more than just recurrent disease [page 8]. A patient with male breast cancer is remarkably rare, but if you have a mutation in BRCA 1 or 2, especially BRCA 2, that risk goes up to 7 percent of the male population will develop breast cancer. Prostate cancer risks go up dramatically. We are currently recommending BRCA 1 or 2 testing for every prostate cancer patient. Melanoma risks go up dramatically and pancreatic cancer risks go up as well,

and we are currently recommending BRCA 1 or 2 testing for patients diagnosed with pancreatic cancer.

Why are we doing this? Obviously, knowing in advance makes it easier to identify patients at risk and surveil them differently, but it is more than that. We know that if you have a mutation on BRCA 1 or 2, something as simple as administering tamoxifen, which is a medication, will reduce that patient's risk of breast cancer by 50 percent [page 9]. Ovarian cancer risk can be modified as well. Something as simple as a patient taking birth control pills can reduce the risk of that patient developing ovarian cancer—even if she has a BRCA 1 or 2 mutation—by up to 60 percent. You can do more.

We are currently recommending patients with BRCA 1 or 2 mutations consider bilateral mastectomies [page 10, Exhibit C] as a risk-reducing prophylactic measure. Usually, discussion with a breast specialist is recommended and can be done in the 40- to 60-year-old age range. That can reduce risks dramatically. We know we can further reduce a woman's risk of breast cancer by removing her ovaries and fallopian tubes, usually recommended at age 35 to 40; and we know we can reduce the risk of an ovarian cancer developing by removing a patient's ovaries and fallopian tubes. Usually this is discussed with 35- to 40-year-olds.

Let me try to present the concept of more than one genus involved here. Every human adult has approximately 30 trillion cells in their body. Those 30 trillion cells are the result of many cell divisions from a single fertilized egg. Every time a cell divides and there are two products, we assume that those two products should be genetically identical, but they are not. Every time a cell divides, the 3 billion base pairs of DNA that are in the mother cell need to be reproduced, and we know mistakes happen. The fidelity of replication of DNA is imperfect. Every time a cell divides, instead of having two genetically identical daughter cells, you have two daughter cells that are not genetically identical. Every time those errors occur, one type of error, as you can see on the left side of the screen [page 11], is something called the DNA double-strand break. Every time that occurs, all the genes that are listed here in pink, blue, and gray are called to attention. They work together to attempt to repair the mistake that happens during cell replication—that DNA double-stranded break. If everything works well, the repair works fine, and we are back to a normal state. Any time there is a mutation in any one of the genes you see here, mistakes are not corrected as easily; they can accumulate, and cancers can occur. When we talk about genetic testing, although we are focusing today on BRCA 1 and BRCA 2, we need to also consider all these other genes that are potentially related to the inability of DNA repair and the development of cancer.

Again, what is the process here? We use a sequencing tool. Remember, of the 3 billion base pairs of DNA, when we look at the DNA and judge whether there are mutations, we sequence that DNA [page 12]. The cost of sequencing the whole human genome 20 years ago was $100 million up to $300 million, and those numbers come out of the Human Genome Project. I am anticipating that within the next two years, we will be able to DNA sequence a whole human genome, clinically use that information for less than $500. It is going to create some rather dramatic changes in our ability to identify patients at risk—not

just for cancer, but for cardiovascular disease, developmental delay in children, birth defects, and many other conditions as well. It is all because these sequencing tools have become much more powerful and much less expensive.

Chair Nguyen:
Senator Gansert, do you have any other presenters?

Senator Seevers Gansert:
I wanted to thank Dr. Slotnick for going over that with us. There are two numbers I want you to remember from that presentation: 87 and 44. As a woman, if you test positive for BRCA 1 or 2 during your lifetime, the odds of your getting breast cancer are as high as 87 percent and 44 percent for ovarian cancer. Now my friend Abbi Whitaker will tell you her story.

Abbi Whitaker, Private Citizen, Reno, Nevada:
I am a cancer survivor. I had cancer ten years ago. It was not breast cancer; it was an HPV-related cancer, but it leads into this story. I have been getting mammograms for five years, and this year I switched to Reno Diagnostic Center for my mammogram. For the first time, they gave me a screening that asked some questions about my family history and flagged me for genetic testing. It was free, they gave me the genetic test, and it came back positive for BRCA 2. I had already been through chemo and radiation with another cancer, and those of you who have been through that experience know that the chemo and radiation are part of the crappiness, but the five-year waiting period to make sure you do not come out of remission is also a tough situation. When I found out I was BRCA 2, I decided I wanted to have a double mastectomy. I had a double mastectomy last Thursday. I am eight days out and I am definitely still not myself, but I am really glad, especially after hearing Dr. Slotnick's presentation, that I had the chance to do that.

Even being a cancer survivor, I would never have known—if Reno Diagnostic Center had not asked me those questions and flagged me for genetic testing—I would never have known I was BRCA 2, and I would have never been able to make that decision to have a double mastectomy and take my health care into my own hands. Senate Bill 251 (1st Reprint) is going to give every woman that chance through different types of screening. As moms, as sisters, as grandmothers, as legislators, we have so much on our plates, and we do not always know what is wrong with us. This bill gives women a chance to know that and to make a decision, as I did, to have a double mastectomy or, as Dr. Slotnick said, some of the other options. I thank you for listening, and I thank Senator Seevers Gansert for all the work you put into this and all the cosponsors from all sides of the aisle. Women in Nevada are going to be healthier and better off because of this. Thank you very much.

Senator Seevers Gansert:
This bill raises awareness around the BRCA 1 and 2 mutations in a couple of ways. It also makes sure that if a woman has a high probability of having the BRCA 1 or 2 gene—which is a personal history or family history—she gets referred for counseling and testing. Under the ACA [Patient Protection and Affordable Care Act] with the United States Preventive

Services Task Force, that is covered. This does not expand or require any more insurance coverage or any more payments. These services are covered. The way the awareness should go up is that when you get a mammogram, you will receive a notice. Right now, you receive a notice if you have high-density breast tissue. This adds another notice to make you aware that certain types of cancers are indicators and that you should talk to your physician or primary health care provider about potentially getting screened or getting tested. It also requires that your primary health care physician does that type of assessment—which they should already be doing—but we are putting it in statute. These types of services are already covered under federal law. We are putting this in Nevada statute to make sure they continue to be covered.

Again, I want to thank Abbi Whitaker for her story and also want to tell you a brief one. I had a friend whom I knew for 25 years. I never knew her without cancer. I met her when our daughters were in first grade. She died last year of breast cancer. More recently she was tested, so this connecting the dots—that you could be BRCA 1 or 2—is not always being connected, to make sure they get testing. Well, she tested within the last five years and she tested positive for BRCA. While she ended up dying, what was so significant about her testing and getting tested was that her daughters needed to be tested. Also, one time when she was fighting breast cancer, her sister was also fighting breast cancer. In the end, there are six cousins between the two mothers, and all of them are positive for BRCA. One who is 32 years old has already had a bilateral mastectomy because that was the choice she made when she conferred with her physician.

Women need to get tested so they know their risk, and then their daughters and potentially their sons need to get tested. The male breast cancer risk is lower—about 7 percent—but that is significant as well. Women who test positive for this gene and connecting those dots is so important. The test is really easy and inexpensive and sometimes it is free. Thank you for your attention today.

Chair Nguyen:
Thank you, Senator, and thank you, Ms. Whitaker, for sharing your story and being here. I forget how accessible we are this session under these protocols that allow someone to come here, share their story, and make a real impact, considering your circumstances. I do appreciate that. We have a couple of questions from Committee members.

Assemblyman Orentlicher:
Thank you, Senator Gansert, for bringing this bill. I very much like it. One of the reasons you are proposing this is because it is a recommended screening by the United States Preventive Services Task Force, which makes me wonder: should we be thinking about broadening this? Are there other recommendations by the Task Force that we should be making sure doctors follow when they see patients?

Senator Seevers Gansert:
Right now, we are focused on BRCA 1 and 2 because there are probably other ones out there. What is helpful for these is that they are covered by insurance. We wanted to make sure we

at least addressed these two mutations because of the research that has been done and the obvious numbers. When Dr. Slotnick and I first talked, he was interested in a lot of different mutations that could potentially be evaluated, but since these are the ones before us, we are focusing on these. There may be legislation brought forward in the future that would cover more.

Assemblyman Orentlicher:
In section 1, subsection 3, on page 3, lines 24 to 26, you talk about sanctions for failure to comply. There are no criminal penalties, which makes sense, and no professional discipline, so I assume you are leaving open the possibility of a malpractice lawsuit for failure to comply. Is that correct? It seems odd that you could be sued for malpractice and held accountable but no follow-up for professional discipline.

Senator Seevers Gansert:
Nevada Revised Statutes Chapter 457 is the Nevada chapter on cancer. In that chapter, if you do not follow everything in there—and there are a variety of things including child support payments—you can have a misdemeanor or felony. What I was trying to do was make sure that physicians or primary care providers were providing these assessments, but not penalize them with a misdemeanor or felony. They are already doing some family history, but this is more because you have to ask about grandparents, aunts, uncles, and so forth. I did not contemplate anything about malpractice insurance. This is about trying to get women assessed and taking the first step to see if they need to get genetic testing.

Assemblywoman Benitez-Thompson:
I appreciate the conversation about this. During the past decade, it has been so interesting to watch how our legislation has responded to advances in medical care—starting off with requiring mammograms and talking a couple of years later about dense breast tissue. We have had hearty debates in this Committee about how we respond to the new sciences coming out and then being here with the BRCA testing. That is just an observation about the evolution of our statutes to respond in medicine. Sometimes we cannot keep up with all the good things that are out there.

For the record, so we can flesh out the continuing education piece, typically, and what I imagine you would want, is that once enacted, the licensing boards would set the number of hours of continuing medical education required. That is typically how it works if the class you attend is three hours long, it would be worth three hours of credits. The typical model. I do not see any hours prescribed in here, so I assume the intent is for the licensing boards to promulgate regulations as they ordinarily would in regard to the amount of credits for the hours spent in that educational activity.

Senator Seevers Gansert:
I wanted to make sure, if you take courses on genetics, that they qualified and were acceptable to whichever organization was your licensing agency. I was not requiring a certain number of hours in genetics. We wanted to make sure that if you took classes in genetics that had been qualified—usually by a national organization—that they would be acceptable toward the CMEs [continuing medical education].

Responding to your first comment, you and I know what a heavy lift some of those were—making sure mammograms were covered and prostate screens, and so forth. As a result, I am really happy to bring this forward, especially because it is already covered at the federal level. It used to be very difficult to have some of these things that really save money in the long term. Preventive health services are truly important, so thank you.

Chair Nguyen:
Are there any other questions? [There were none.] At this time, we will begin testimony in support, opposition, and neutral. There is no one in person, so we will go to the lines for callers in support of S.B. 251 (R1).

Connor Cain, representing Comprehensive Cancer Centers of Nevada:
We encourage your support of this important bill.

Tess Opferman, representing Nevada Women's Lobby:
We want to thank Senator Seevers Gansert for her hard work on this bill. Here are some numbers to do with the BRCA mutation: About 13 percent of women in the general population will develop breast cancer sometime in their life. By contrast, 55 to 72 percent of women who inherit the harmful BRCA 1 variant and 45 to 69 percent of women who inherit the harmful BRCA 2 variant will develop breast cancer. For ovarian cancer, it is also significantly higher for those who have the BRCA 1 and BRCA 2 gene mutations. These numbers are significant. Ensuring that women are screened and those who are at risk have the ability to get genetic testing is critical to preventive care. This bill will, quite literally, save lives. We urge your support and thank you for your time today.

Wesley Falconer, Chief Operating Officer, Cancer Care Specialists, Reno, Nevada:
We would like to express the utmost support for this bill, and we believe preventive screening is the way to go with all cancer treatments going forward.

[The following testimony in support was taken later in the meeting and reclassified here as requested by Chair Nguyen.]

Sowjanya Reganti, M.D., Private Citizen, Reno, Nevada:
I am a medical oncologist at Cancer Care Specialists. I would like to totally support this bill and say "thank you" to Senator Gansert for bringing it up because it is very important for prevention when there is a family history.

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

Chair Nguyen:
At this time, I will ask if there are any callers in opposition to S.B. 251 (R1). [There were none.]

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

Is there anyone who would like to testify in neutral to S.B. 251 (R1)?

Erin Lynch, Chief, Medical Programs Unit, Division of Health Care Financing and Policy, Department of Health and Human Services:
The Division is testifying in neutral on S.B. 251 (R1). Within Nevada Medicaid, we already cover BRCA 1 and 2 screening, testing, and genetic counseling for women who meet the criteria of the bill in the United States Preventive Services Task Force. Therefore, we have a zero-dollar fiscal note on this bill.

Chair Nguyen:
Madam secretary, please reclassify the testimony from Dr. Reganti into support testimony. Is there anyone else on the line? [There was no one.] Senator, I will turn this over to you for any closing remarks.

Senator Seevers Gansert:
Thank you, Madam Chair, and members of the Committee. I also want to thank Dr. Reganti. She was seeing patients and was texting me that she was delayed. I also want to thank Erin Lynch who testified that there was a zero-dollar fiscal note. This will increase awareness and help connect the dots so women who have the indications that they need to get counseling and testing will get it. The numbers are astronomical as far as your odds of getting breast and ovarian cancer and other cancers, and that is why it is so important for a woman and her family. I appreciate the time today, and I would appreciate your support for the bill.

Chair Nguyen:
At this time, I will close the hearing on Senate Bill 251 (1st Reprint) and open the hearing on Senate Bill 156 (1st Reprint).

Senate Bill 156 (1st Reprint): Revises provisions relating to crisis stabilization centers. (BDR 40-488)

Senator Julia Ratti, Senate District No. 13:
Senate Bill 156 (1st Reprint) is one component of several I will bring forward to you over the course of the remaining portion of the session that seek to address basically rebuilding the way we respond to a person who is experiencing a behavioral health crisis. I have a four-minute video I would like to show you which is an overview of how we could look at behavioral health crises [page 1, Exhibit F]. I was fortunate enough to be part of a group working during the interim through the Legislative Committee on Health Care that participated with a group of folks who made a field trip to Maricopa County to check out the

work being done in Arizona to change the system. Arizona was one of the earliest adopters trying to look at how we respond to crisis differently. Since then, several other states have adopted this approach to crisis intervention.

I was astounded at the difference they have been able to make there in terms of outcomes for people who are experiencing behavioral health crises. Certainly, in the year this nation has experienced, and with the results of the George Floyd trial we are all grappling with this week, I think there has been a growing understanding in our nation that law enforcement is not the appropriate tool for crisis response. For too long, we have not built an appropriate crisis response system based more on using behavioral health professionals and peers with lived experience. Instead, whenever we have a person who is in crisis, someone calls 911. That operator on the other end says, "Police, fire, or health emergency?" If it is interpreted as being police or health, we are going to roll a law enforcement officer and an ambulance, neither of which is actually the appropriate tool in most behavioral health crises.

This model is continuing to evolve into how we roll the right resource in the very beginning. Today's bill deals with the third part of the model, which is the crisis stabilization centers. That is a critical part of the model in terms of when someone is in a crisis and being able to divert them either from the jail system or emergency rooms (ERs). I will be bringing a couple of other bills forward to you that will deal with the crisis call point of care, which is really the triage that will make sure the right resources are getting out, and another bill that will talk about licensing of the peer professionals—those people with lived experiences who would be part of that response in many cases, instead of law enforcement.

Now I will focus more on the system of care so you understand where this fits in, and then I will talk about the specifics of this bill. Based on the Crisis Now model, the first step is that high-tech crisis call center. In Nevada, we have Crisis Support Services of Nevada, a statewide, national suicide hotline. That is a huge asset for us as a starting point.

These are the four components: the call center; the 24/7 mobile crisis teams; the crisis stabilization centers; and the underlying set of essential principles and practices that are critically important [page 2, Exhibit F].

If we look at the high-tech crisis call centers, these crisis call centers have behavioral health specialists who can do both the de-escalation of a crisis on a phone line as well as some follow-up case management and care [page 3]. So we have helped the person de-escalate and then we are making sure they are connected to whatever follow-up resources they may need. That is the first important step. In research from where this model is operational in other communities, 90 percent of calls concerning someone in a crisis can be stabilized over the phone and can be responsibly triaged for follow-up care. What is important for this model is that the crisis call center is high-tech. Because of that, there is a system in the background where they communicate with all the care facilities. They know where there are outpatient appointments, where medication can be accessed, and where there are beds that can be accessed. If that person does need care, they can be immediately placed into that system of care.

The next part is 24/7 mobile crisis teams [page 4]. We have done some work in the state to set up mobile crisis teams. In the 2019 Session, we created CCBHCs, which are certified community-based behavioral health centers. One requirement of those is to have a mobile crisis team. So we have taken some steps forward, and there is additional work happening now concerning how we make sure there is a good Medicaid model to reimburse these crisis teams. There is some work coming on the national level on more support for mobile crisis teams.

We have taken care of the 90 percent, but now there is the 10 percent who cannot be stabilized over the phone. That high-tech, high-touch call center can dispatch a mobile crisis team. That mobile crisis team is a behavioral health professional—a licensed social worker, psychologist, psychiatrist, APRN [advanced practice registered nurse] with a psychiatrist endorsement—and a peer with lived experience—someone who is in recovery from a behavioral health disorder or substance use disorder and can relate to that person in a very different way sometimes than a differently situated behavioral health professional can. In this case, this is where you start to see the alleviation of rolling law enforcement at all or rolling an ambulance at all. If there is not a medical emergency and there is not a safety issue, but you have an individual in crisis, this is the appropriate team to deal with that crisis.

That brings us to the point of this bill—the crisis stabilization centers [page 5, Exhibit F]. There is a small portion—about 1 to 2 percent—who cannot be stabilized by either the phone or the crisis team, and they need to go to a facility. As the video indicated, in our current model they end up in one of two places. They either end up in the jail because the behavior associated with their mental health crisis is perceived to be violent or they are harming someone, or they end up in the emergency room so they do not harm themselves. In either case, they typically end up in some sort of isolation where there is a great period of time during which they are getting no contact from anybody except for being checked for vitals and making sure they stay alive. In this model, they go to something known more as a "living room model." These are short-term, subacute care for these individuals. In this living room model, there are recliners and chairs and tables set up for conversation. The staffing is behavioral health professionals and peers with lived experience. So the exact opposite happens because there is as much engagement as can possibly be done in 23 hours and 59 minutes. That 23 hours and 59 minutes is important because once you get past one day, it flips the patient into "other licensed facilities," so if someone needs more than 23 hours and 59 minutes of care, that person can be leveled up to an actual inpatient center. At that point, it is appropriate for them to go into an inpatient setting. If they can be stabilized and leveled down, they can be discharged with an appropriate case management plan so they are connected to ongoing outpatient services and medication—whatever their needs are for them to stay stable. In the 2019 Session we passed legislation to create these crisis stabilization centers, but we did not get it quite right. Senate Bill 156 (1st Reprint) seeks to get crisis stabilization right, and that is why I am here with you today.

I want to touch on essential crisis care principles [page 6]. Whether you are talking about the call line, the mobile outreach team, or the crisis stabilization, these principles are very important:

- That it has a recovery orientation. The idea going in is that people have the ability to recover.

- That it is trauma-informed. For many folks experiencing a behavioral health crisis or substance use disorder, part of the reason is that they have experienced some sort of trauma in the past.

- That it has a significant use of peer staff—people with lived experience who look like, talk like, and have something in common with the folks they are helping.

- A commitment to zero suicide and suicide safer care principles—something the Health and Human Services Committees have talked about a lot.

- Strong commitments to safety, of course.

- Collaboration with law enforcement, so when that call comes in—it might come in to 911, it might come in to a new phone number we are developing, but if those two systems are not talking with each other, and law enforcement on the street is not aware of and collaborating closely with this parallel system, then it does not work.

We are very fortunate in the state of Nevada that we have created something called MOST [mobile outreach safety team] teams which is a social worker riding along with law enforcement. They will be the critical connection between these two systems, along with the triage that has to happen at the phone-call level to make sure folks get into the right place.

That is the system. So again, S.B. 156 (R1) focuses on the third aspect of the system, the crisis stabilization centers and making sure we get the licensing correct. The reason it is important that we get the licensing correct is, if we get the licensing correct, then these facilities will be more eligible for Medicaid billing, and Medicaid dollars will be able to flow through to create the business model that allows these to be successful. As these crisis stabilization centers were originally set up, we imagined them to be psychiatric hospitals, but that was a very narrow group of facilities that could actually step up and serve in that role, so the whole purpose of this bill is to broaden the number of facilities. As long as they meet the licensing criteria, they could step up and fill the role of crisis stabilization centers.

I very much appreciate the indulgence of the Committee to allow me to take you through the entire crisis care model because I am hoping I will be coming back before you with the other pieces of it; but today, it is a relatively simple bill on the licensing of the stabilization centers.

Chair Nguyen:
Thank you for your presentation. Do we have any questions from Committee members?

Assemblywoman Summers-Armstrong:
This issue is of utmost concern. My district includes many of the community groups that serve people who are homeless, and many who have mental illness come to our community for assistance. Do you see these mobile response units replacing the MOST teams? Mobile outreach safety teams almost always include a police officer. I have not asked for any data, but I am not sure how that is being received or their success rates. If you have any information about that, I would love to know.

Senator Ratti:
The MOST teams were funded by the state, but then pushed out to the local level, so to get data about effectiveness or impact, we would need to have the folks from Clark County and Washoe County talk about that. In Washoe County in my role—I work with and am familiar with the MOST teams there—and the answer is no. I do not see the mobile outreach teams replacing the MOST teams, and here is why. For some people who are experiencing a behavioral health crisis, there is a true public safety issue. It would be inappropriate to roll a peer and a behavioral health professional into that situation. You can imagine issues around domestic violence; you can imagine issues where someone is further along the suicide ideation process and is getting close to actually using a weapon to fulfill their own suicide. I am sure, if I had a MOST team social worker here, they could talk to you about the wide variety of reasons why there are certain calls they would not want to roll on without law enforcement.

The way it would need to work is at that first level when the calls are coming in, that triage is critically important and that the right questions get answered. Nine-one-one systems are already pretty brilliant at this. They have very detailed "if this, then what" processes and systems to figure out what is the right resource to roll and to give the folks who are rolling the most information possible. As they are going through that triage system, if this appears to be a behavioral health case that does not have a public safety issue, then it should go over to a different system and the suicide hotline system. If it still has a public safety issue, we should still be rolling law enforcement. In the best-case scenario, that is a MOST team that includes a social worker. Then you have the benefit of a social worker and law enforcement in those public safety scenarios.

The other piece that has happened in Washoe County that I think is incredibly important is that, for these officers who are rolling with social workers, it is an on-the-job training that is irreplaceable and priceless because they get to see how the social worker is interacting with the person they have come upon in this crisis, as opposed to how law enforcement would interact. While I think it would be very difficult to quantify, I think we have seen tremendous benefit in Washoe County in terms of how law enforcement is starting to approach behavioral health crises when they are paired with a social worker and what they are learning from that. So for the public health reason and for the training—because law enforcement is going to be the response for some of these calls—I think we want to have MOST and we would want to have triage and know when we have to roll MOST and when we have to roll behavioral health crisis teams.

Chair Nguyen:
Do we have any other questions from Committee members? Seeing none, we will begin testimony in support, opposition, and neutral on S.B. 156 (R1).

Joan Hall, President, Nevada Rural Hospital Partners:
We are here today and very supportive of S.B. 156 (R1). We are very appreciative of Senator Ratti for working on language to allow rural hospitals to be involved in this important process. These crisis stabilization centers are important in the Crisis Now system of care. I was very fortunate to have actually seen them in practice in Colorado. The positive impact on patients in crisis, law enforcement, and EMS [emergency medical services] was phenomenal. I am very excited to see the impact this will have in Nevada, and I urge your support.

Mary Walker, representing Carson City and Carson Tahoe Health:
We rise in support of S.B. 156 (R1) regarding crisis stabilization centers. There is also a letter of support [Exhibit G] from Alan Garrett, CEO and President of Carson Tahoe Health, on NELIS [Nevada Electronic Legislative Information System]. Senate Bill 156 (1st Reprint) is an important bill for expanding access to care for mental health services in Nevada. Senate Bill 156 (1st Reprint) allows hospitals, not just psychiatric hospitals, the ability to provide crisis stabilization services with the proper Medicaid reimbursement rates.

Several years ago, Carson Tahoe Health opened the Mallory Behavioral Health Crisis Center to treat the most critical mental health needs in our area. The Mallory Center has helped alleviate overcrowding in our ERs and jails; and the best thing of all is that these patients actually get the appropriate treatment they need through the Mallory Center rather than languishing in ER beds or the jails without treatment. Over the last several years, hospital representatives from Clark and Washoe Counties have talked to Carson Tahoe's behavioral health department regarding whether their own hospitals could open a similar crisis center. However, when it became known that Medicaid only paid observation or office visit rates for these crisis services, the other hospitals lost interest. We believe S.B. 156 (R1) will incentivize other hospitals to open their own crisis stabilization centers. It is a critical piece of access to care that is missing in today's health care marketplace. We would like to thank Senator Ratti very much for bringing this bill forward and thank you for your time today.

Trey Delap, representing Nevada Chapter, National Alliance on Mental Illness:
[Trey Delap submitted his prepared testimony and additional information, Exhibit H.] I am speaking in support of S.B. 156 (R1). The National Alliance on Mental Illness is a grassroots mental health organization dedicated to building better lives for the more than 400,000 Nevadans affected by mental health concerns. The National Alliance on Mental Illness believes that public policies and practices should promote access to care for people with mental health conditions. We support the development and expansion of mental health crisis response systems in every community. As noted by Senator Ratti, S.B. 156 (R1) addresses the third core element of national guidelines for crisis care. Crisis stabilization programs should provide a no-wrong-door access to mental health and substance use care, including

accepting all walk-ins and ambulance, fire, and police drop-offs. Data suggest that a high proportion of people in crisis who are evaluated for hospitalization, LOCUS [Level of Care Utilization System] levels V and VI, can be safely cared for in a crisis facility, and that the outcomes for these individuals are at least as good as hospital care, while the cost of crisis care is substantially less than the cost of inpatient care and accompanying emergency department medical clearance charges, and reduces law enforcement as the primary role as first responder to behavioral health emergencies.

A well-designed crisis response system can be the difference between life and death for people experiencing a psychiatric emergency. Senate Bill 156 (1st Reprint) advances an essential piece of an effective community-based response so all people have access to the right treatment at the right time. Thank you for hearing this bill, and we urge your support.

Chair Nguyen:
Are there any other callers in support?

Dan Musgrove, Chair, Clark County Children's Mental Health Consortium; Member, Clark County Regional Behavioral Health Policy Board:
Today, I am also representing a number of clients in the Las Vegas Valley Health System, the hospitals, and WestCare Nevada, Inc. This idea that the Legislature has been working on for the last two sessions—the Crisis Now model—is so very important to the system of care we have in Nevada, especially in Clark County where hospital emergency rooms are always [unintelligible] those who need care in a much better location than the hospital EDs [emergency departments] can provide. I want to compliment Senator Ratti for her leadership on this subject as well as the Legislature. We are absolutely in support of moving in this direction.

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

Chair Nguyen:
Do we have any other callers in support? [There were none.] Do we have any callers in opposition? [There were none.] Do we have any callers in neutral?

DuAne Young, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services:
I want to thank you and Senator Ratti. We are here to answer questions, but, of course, this is good policy and there is no fiscal note. The changes in the bill will help a lot of providers, particularly those servicing the rural areas, be able to utilize this model and receive reimbursement from Medicaid.

Chair Nguyen:
I will turn this over to you, Senator Ratti, for any closing remarks.

Senator Ratti:
First, I need to correct myself. I am using the term "social worker" too loosely. The MOST team members who are the behavioral health specialists are licensed clinicians. Some of them could be licensed clinical social workers, but they are licensed clinicians and not necessarily all social workers. While there is no fiscal note on this bill, a critical piece is that the billing of Medicaid is. You are just shifting it from putting a more expensive service to a less expensive service. Over time, I believe there will be savings, but we are still standing up the model and all its components. In Phoenix, from the time they started working on it until the time they had it fully in place was about a 13-year time frame. We are about three years into the process here in Nevada. I think we can accelerate that significantly by being focused in our work and because so many folks have gone before us. I am sincerely grateful to you for making the time today for me to present this bill, and I hope you will support it.

Chair Nguyen:
With that, I will close the hearing on S.B. 156 (R1). At this time, we will go to the lines and ask if there are any callers in public comment. [There were none.] That concludes our meeting for today. Meeting is adjourned [at 1:09 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 copy of a PowerPoint presentation titled "Genetics And Genomics In Cancer Diagnosis, Prevention and Treatment," submitted by Robert Nathan Slotnick, M.D., Ph.D., Director, Medical Genetics and Genomics, Invitae Corporation, regarding Senate Bill 251 (1st Reprint).

Exhibit D is a letter dated April 22, 2021, submitted by Lillian Bronson, President, Nevada Affiliate, American College of Nurse-Midwives on behalf of the American College of Nurse-Midwives, in support of Senate Bill 251 (1st Reprint).

Exhibit E is a letter submitted by Robbin Palmer, Ph.D., Certified Genetic Counselor, in opposition to Senate Bill 251 (1st Reprint).

Exhibit F is a copy of a PowerPoint presentation submitted by Senator Julia Ratti, Senate District No. 13, in support of Senate Bill 156 (1st Reprint).

Exhibit G is a letter dated April 22, 2021, signed by Alan Garrett, President and CEO, Carson Tahoe Health, submitted by Mary Walker, representing Carson City and Carson Tahoe Health, in support of Senate Bill 156 (1st Reprint).

Exhibit H is written testimony and additional information dated April 23, 2021, submitted and presented by Trey Delap, representing Nevada Chapter, National Alliance on Mental Illness, in support of Senate Bill 156 (1st Reprint).

Exhibit I is a letter dated April 21, 2021, submitted by Taylor Allison, Northern Region Behavioral Health Policy Board Chair, in support of Senate Bill 156 (1st Reprint).