# MINUTES OF THE
# SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

## Eighty-first Session
## April 29, 2021

The Senate Committee on Health and Human Services was called to order by Chair Julia Ratti at 3:36 p.m. on Thursday, April 29, 2021, Online and in Room 2134 of the Legislative Building, Carson City, Nevada. Exhibit A is the Agenda. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

**COMMITTEE MEMBERS PRESENT:**

Senator Julia Ratti, Chair
Senator Pat Spearman, Vice Chair
Senator Dallas Harris
Senator Joseph P. Hardy
Senator Ben Kieckhefer

**GUEST LEGISLATORS PRESENT:**

Assemblywoman Teresa Benitez-Thompson, Assembly District No. 27
Assemblywoman Melissa Hardy, Assembly District No. 22
Assemblywoman Brittney Miller, Assembly District No. 5
Assemblyman David Orentlicher, Assembly District No. 20
Assemblywoman Sarah Peters, Assembly District No. 24

**STAFF MEMBERS PRESENT:**

Megan Comlossy, Policy Analyst
Eric Robbins, Counsel
Vickie Polzien, Committee Secretary

**OTHERS PRESENT:**

Kate Ballard
Barry Gold, AARP
Eric Jeng, Asian Community Development Council
Joy Avendano, Asian Community Development Council
Maya Holmes, Culinary Health Fund
Elizabeth MacMenamin, Retail Association of Nevada

Gillian Block, Nevada Coalition of Legal Service Providers
Christine Saunders, Progressive Leadership Alliance of Nevada
Joelle Gutman Dodson, Washoe County Health District
LaLo Montoya, Make the Road Nevada
Jamie Cogburn, Nevada Justice Association
Maria-Teresa Liebermann-Parraga, Battle Born Progress
Melanie Kelly, Safeway Pharmacy
Doralee Martinez, Nevada Action Coalition
Paul Moradkhan, Vegas Chamber
Cyrus Hojjaty
Nick Vander Poel, Reno + Sparks Chamber of Commerce
Stephanie Woodard, Psy.D., Senior Advisor on Behavioral Health, Division of Public and Behavioral Health, Department of Health and Human Services
Lea Case, Nevada Psychiatric Association
Jessica Ferrato, American College of Emergency Physicians, Nevada Chapter
Trey Delap, National Alliance on Mental Illness Nevada
Tom Clark, Nevada Association of Health Plans
Barbara Richardson, Commissioner of Insurance, Department of Business and Industry
Dave Wuest, State Board of Pharmacy
Cheryl Cooley, Southern Nevada Children's Advocacy Center; Children's Advocacy Centers of Nevada
Jesse Haw, Children's Advocacy Centers of Nevada
Peg Samples, Washoe County Child Advocacy Center
Joanna Jacob, Clark County
Neyda Becker, Children's Advocacy Center Foundation
Tess Opferman, Nevada Women's Lobby
Cole McBride, Washoe County Child Advocacy Center
Ross Armstrong, Administrator, Division of Child and Family Services, Department of Health and Human Services
Nicholas Shepack, American Civil Liberties Union of Nevada
Lisa Rasmussen, Nevada Attorneys for Criminal Justice
Lisa Lee
Jessica Johnson, Southern Nevada Health District

CHAIR RATTI:
We introduced a bill draft request at our last meeting that was incorrect. We need to rescind that introduction.

I will ask for a motion to rescind Bill Draft Request (BDR) 40-1107.

**BILL DRAFT REQUEST 40-1107**: Creates the Public Health Resource Office. (Later introduced as Senate Bill 424.)

SENATOR HARRIS MOVED TO RESCIND THE PREVIOUS ACTION TAKEN ON BDR 40-1107.

SENATOR SPEARMAN SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR RATTI:
I will open the work session on Assembly Bill (A.B.) 35.

**ASSEMBLY BILL 35**: Revises provisions governing certain programs to assist senior citizens and persons with disabilities with costs relating to health care. (BDR 40-288)

MEGAN COMLOSSY (Policy Analyst):
I will read the summary of the bill from the work session document (Exhibit B).

CHAIR RATTI:
I will entertain a motion on A.B. 35.

SENATOR HARDY MOVED TO DO PASS A.B. 35.

SENATOR HARRIS SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR RATTI:
I will open the work session on A.B. 138.

**ASSEMBLY BILL 138 (1st Reprint)**: Revises provisions governing the eligibility of certain convicted persons for public assistance. (BDR 38-760)

MS. COMLOSSY:
I will read the summary of the bill from the work session document (Exhibit C).

CHAIR RATTI:
I will entertain a motion on A.B. 138.

SENATOR HARDY MOVED TO DO PASS A.B. 138.

SENATOR SPEARMAN SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR RATTI:
I will open the work session on A.B. 426.

**ASSEMBLY BILL 426**: Makes various changes relating to the protection of children. (BDR 38-516)

MS. COMLOSSY:
I will read the summary of the bill from the work session document (Exhibit D).

CHAIR RATTI:
I will entertain a motion on A.B. 426.

SENATOR HARDY MOVED TO AMEND AND DO PASS AS AMENDED A.B. 426.

SENATOR SPEARMAN SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR RATTI:
I will open the hearing on A.B 177.

**ASSEMBLY BILL 177 (1st Reprint)**: Revises provisions relating to prescriptions. (BDR 54-61)

ASSEMBLYWOMAN TERESA BENITEZ-THOMPSON (Assembly District No. 27):
I will read from my written remarks (Exhibit E) to introduce A.B. 177. In addition, I will review the "Nevada County Age, Sex, Race, and Hispanic Origin Estimates and Projections 2000 to 2038 Estimates from 2000 to 2017 and Projections from 2018 to 2038" (Exhibit F) and "The 2020 Census in Nevada Snapshot #7" (Exhibit G).

Exhibit G, available on the legislative website, shows the percentages of the populations who speak English less than very well. The link on Exhibit G will take you to the information.

We also have a conceptual amendment (Exhibit H). *Nevada Revised Statutes* (NRS) 639.2801 is the requirement for labeling containers for prescription drugs. This law has nine different components that comprise the label that is required to be on a prescription drug bottle.

We are asking that subsection 6 of NRS 639.280, which is the "specific directions for use given by the prescribing practitioner," be translated into languages other than English, and this is what section 1, subsection 1 of the bill does. The amendment clarifies we are requesting specifically subsection 6.

Section 1, subsection (2), paragraphs (a) and (b) ask for a sign to be posted in a conspicuous place in a pharmacy stating the patient has the right to request the information on the label be printed in a language they speak. A list of languages will be available for them to choose from.

The State Board of Pharmacy will adopt regulations to carry out the sections of the bill. I referenced the demographers and the U.S. Census Bureau information in my written remarks to promote a good conversation among the Board members to say what languages will be translated and what makes the most sense for our State. It makes sense to do it county by county, otherwise every county will have to translate to the Clark County standard. If you are a national pharmacy doing a lot of programing, it may make sense to set yourself to that

higher standard. If you are only operating in one county, the Board has the ability to look at each county's demographics and decide the languages that are appropriate for translation.

Item 1 of the conceptual amendment will restore section 1, subsection 5 from A.B. 177 as introduced. This is the language regarding liability protections for pharmacies that use third-party translation services.

We are asking for additional time for implementation from January 1, 2022, to July 1, 2022. This will give the time necessary to get the pharmacies ready to provide the translation services.

I have worked in the healthcare sector for a decade and know the difference of being in a clinical setting where you have access to translation services 24 hours a day. On the back of your badge, you have the number for your translation service when you need to communicate with someone in the hospital. You would call the number on your badge and have your conversations translated; this has become a good practice.

When you go to a home-based environment, that support goes away. When people go to pick up their medications and take them into the home environment, they are left without the ability to know what is in the bottle and how to take it. This is why I am asking for this bill to be considered by the Committee.

I have left many homes nervous about a family's ability to understand what is in those bottles. There are oftentimes opioids, strong drugs, fentanyl patches, lorazepam and morphine that are prescribed, and you hope the family is communicating about what is in those bottles and how to take the medication.

CHAIR RATTI:
There was an amendment submitted earlier that had only one section and we received a second amendment, Exhibit H. Assemblywoman Benitez-Thompson reviewed the additional amendment with us, and this is the correct amendment to the bill.

SENATOR KIECKHEFER:
Are you suggesting the insertion of subsection 6 of NRS 639.2801 so the only piece of information required to be translated is the instructions on the label on how to take the medication?

ASSEMBLYWOMAN BENITEZ-THOMPSON:
That is correct. We had conversations about the relevant pieces of the label to be translated which would be the instructions on how to take the medication. For instance, take twice a day, three times a day, morning and evening. Information such as the prescription serial number would not need to be translated because they are not as relevant to the patient.

SENATOR HARDY:
There are pharmacies who are now providing translation services. Will this be enough, or are you requiring any and all languages translated on prescription labels? As a physician, we are required to have a translation service which does not include a family member. Are there any other boards that require this information in writing?

ASSEMBLYWOMAN BENITEZ-THOMPSON:
In the pharmacy setting, pharmacists are required to have verbal translation services for communication purposes. This bill takes over once a person leaves a pharmacy. The label will have the instructions on how to take the medication in English and translated into the language of the person for whom the medication was prescribed.

Senator Hardy, were you asking if there are other licensing boards in the State or other pharmacy boards in the Nation requiring translation services?

SENATOR HARDY:
Licensing boards, please.

ASSEMBLYWOMAN BENITEZ-THOMPSON:
There are no other licensing boards in the State that require the ability to translate. There are other boards nationwide that have the requirement; one is Oregon. We learned a lot from the bill in Oregon, but our bill has taken a different path. California has done it differently, placing the responsibility on their board. It has been a less successful model having the board translate

versus the pharmacy. There may be one or two on the municipal level in New York that have required the translation of the label.

SENATOR HARDY:
I have not heard of a physician's office requiring translated conversations with patients. Would this be different in that it would be printed information, not only translated verbally?

ASSEMBLYWOMAN BENITEZ-THOMPSON:
The prescription label only will be required for a written translation. Section 1, subsection (1) of the bill states "upon the request" of the person who can request the translation from the pharmacy.

SENATOR HARDY:
Will pharmacies that have a translation service posted have to figure out how to print a label in a different language?

ASSEMBLYWOMAN BENITEZ-THOMPSON:
The translation services the pharmacy has are specific to the employees translating to a patient when they pick up their medications. There is one pharmacy that has a customer service number you can call, but you need to have an intermediary. When you have someone who is not English proficient calling a number that is English-based, you do not have the intermediary for that translation to happen. That would not be considered meeting the intent of the bill. The intent is the written piece on the label.

SENATOR SPEARMAN:
Demographics are important. We have 25 percent to 35 percent of the world speaking more than one language. It is unique to this Country that we require one language throughout elementary, middle and high school. I can see the merits in this bill.

KATE BALLARD:
I am a registered nurse in Oregon. I was one of the primary advocates for a similar Oregon bill, Senate Bill 698 of the Oregon 2019 Regular Session which passed and went into effect January 2021.

The Oregon law came about after nursing students working with patients with limited English proficiency (LEP) noticed a high rate of medication error among

this population. There was a highly educated mother from the Middle East who spoke multiple languages: English was not one of them. She could not read the labels on her child's inhalers and was unintentionally giving him the incorrect inhaler during an acute asthma attack. This child was hospitalized for life-threatening asthma attacks that were unknowingly going untreated.

After this bill was introduced to the Oregon Legislature, there was an outpouring of support. This commonsense legislation resonated with health care professionals, community organizations and private citizens. The bill was passed out of the Senate and House Committees with unanimous bipartisan support.

In one physician's testimony, he said "the only difference between a medicine and poison is understanding how to use it."

Current practices are not enough. Language services among pharmacies are variable and most do not provide any translated written materials. It is important to note that verbal interpretation alone is not enough. It is not realistic to expect a patient to memorize the instructions for multiple medications after a single review session at a pharmacy counter.

Peer reviewed studies and legislative testimony document the danger of providing patients with English only prescription labels. Patients with LEP are twice as likely to experience medication errors than English speaking patients. In a study that tested the use of optimized translated prescription labels, patients with LEP taking multiple drugs per day were significantly more likely to take the correct dosages when provided with these labels.

Case studies have also documented medication errors. An infant was hospitalized after her parents, who could not read the English instructions, gave her 12 times the intended dose of liquid iron. A survey of 120 Wisconsin pharmacies published by the American Academy of Pediatrics show more than half reported never, or sometimes, providing translated prescription labels. Approximately two-thirds of the pharmacies reported never, or sometimes, communicating verbally with patients with LEP.

What do we need to understand about the cost of compliance? A large portion of the cost projected by chain pharmacies are front-loaded costs to integrate the translation software into their complex systems. Since the passage of

New York's law in 2012, followed by California and Oregon, chain pharmacies have had the time and legal imperative to integrate their translation software.

Cost to pharmacies will vary depending on their size and the software they have. It cost one large hospital system in Oregon $25,000 to translate 1,000 instructions into 14 languages.

In analyzing the financial impacts of A.B. 177, it is important to consider the significant cost savings this bill would bring. The average cost of a single hospitalization for a medication error is $15,000, which totals in the billions of dollars nationally each year. We do not know what percentage of those billions of dollars are related to language barriers because those numbers are not tracked. However, experts on healthcare economics agree that costs from language-related medication errors will continue to increase over time unless healthcare providers meet demands for improved translation services.

How do we know translated prescription labels are safe? Certified translation companies use a rigorous multi-step vetting process in their translation of prescription labels. The risk of a medication error is far lower than sending an LEP patient home with a bottle in English they cannot read or understand.

Why is it important to have both English and the translated language on the label? Dual language labels ensure both patients with LEP and their English speaking pharmacist, caregivers and providers know what the prescription label says. An example of the label would have the instructional phrase "take one tablet by mouth daily" and would be translated. Both the English and the translation would be on the label.

Will there be enough space on the bottle for both languages? In most situations, yes. However, there are several options to address uncommon instances where extra room is needed, including pull-out tabs or folding a second label in half and placing it on the bottle. This is a common practice pharmacies use called "flagging."

Why is it not sufficient to give a patient the translation on a separate piece of paper, rather than on the label? The reality is that many patients have upwards of five medications, plus children with medications of their own. It is not realistic to expect a patient to keep track of five plus instruction packets and then match the correct packet with the correct medication. If the translated

instructions are not on the bottle, the safety of Nevadans will continue to be at risk.

What has Oregon learned since the passage of its law? The effective date written in the law was January 2, 2021. The pandemic hit and everything froze. Pharmacies are in an informal grace period to account for pandemic-related delays. Until the Board of Pharmacy can safely resume inspections, we do not have data on overall compliance; however, we do know that many pharmacies are having early success with this law.

Pharmacists have a code of ethics that requires them to communicate with patients in terms that are understandable and to respect personal and cultural differences among patients. Assembly Bill 177 enables pharmacists to meet their ethical requirements.

BARRY GOLD (AARP):
Lifesaving prescription drugs do not work if you cannot afford them. Equally, you can say lifesaving prescription drugs do not work if you do not know how to take them. People and their families need to understand how to take the medicine they are prescribed to have positive health outcomes. For example, are you supposed to take one of these once a day or two of these four times a day? This is a big difference that would change the outcome. For these reasons, and the fact that this is a simple solution to a big problem, AARP supports A.B. 177.

ERIC JENG (Asian Community Development Council):
I will read from the written testimony provided by Carlo Miciano (Exhibit I) in support of A.B. 177.

JOY AVENDANO (Asian Community Development Council):
There are 68,000 LEP households across the State. The Asian Community Development Council is a partner of Nevada Health Link, and we have bilingual staff in Tagalog, Vietnamese, Chinese, Spanish and Korean. Members of the Filipino community prefer reaching out to Filipino doctors. It is difficult to understand some grammar in medical terms. Having English and Filipino printed on the label of the bottle would be beneficial since many Filipinos have households with English and mixed language proficiency. The availability of both languages would mean Filipinos could easily double-check instructions and will not need to keep booklets provided with the medication which can get lost. Their confidence when navigating medical terms will increase.

MAYA HOLMES (Culinary Health Fund):
The Culinary Health Fund is a nonprofit labor management trust that provides health benefits for 60,000 culinary union workers and their dependents; approximately 125,000 lives. We operate two free pharmacies for our members and their dependents. One is located across from the Stratosphere Hotel, and the other is at the intersection of Nellis and Lamb in Las Vegas. Our culinary health center is within a five-mile radius of approximately 40,000 of our members. The membership of the culinary union is diverse and members hail from all corners of the globe.

Our priority is ensuring access to high-quality affordable care in Nevada. Over the years, we have worked on many pieces of legislation to address the high cost of prescription drugs and access to those drugs. Our pharmacies are part of that effort. We call them free pharmacies because at our pharmacies our members have no copays for their prescriptions. Our nonprofit pharmacy at Nellis is one of the busiest in the State having sold over 30,000 prescriptions in March.

We support A.B. 177 and appreciate Assemblywoman Benitez-Thompson's work with us to address our concerns on the bill. We need to review the revised conceptual amendment, Exhibit H, regarding the focus on subsection 6 of NRS 639.2801 but believe this is an important piece of legislation that will ensure patients have access to language translation for their prescriptions.

ELIZABETH MACMENAMIN (Retail Association of Nevada):
The Retail Association of Nevada supports A.B. 177. Because Nevada has such a diverse population, this bill as amended, will create an added layer of safe medication for LEP individuals and/or any patients in Nevada. Pharmacies and public health officials have a strong history of reaching mutual public health goals together, as we saw during the recent pandemic. We appreciate the sponsor adding back the third-party liability to the language and protecting our pharmacists going forward. We also appreciate limiting the translation of the directions to use the medication, as this is the most important part on the prescription label. This will increase medication adherence.

GILLIAN BLOCK (Nevada Coalition of Legal Service Providers):
The Nevada Coalition of Legal Service Providers supports A.B. 177 because we support efforts to make prescription drug labeling more accessible to the community members we serve who oftentimes primarily speak a language other

than English. This bill aligns with our consumer protection goals to ensure people have meaningful access to the important information needed to make critical decisions and protect their health.

CHRISTINE SAUNDERS (Progressive Leadership Alliance of Nevada):
The Progressive Leadership Alliance of Nevada supports Assembly Bill 177 as a simple solution that will address a discriminatory practice leaving many Nevadans unprotected at a time when they are most vulnerable. It will provide vital steps to safeguard patients, reduce long-term costs and provide language justice for Nevadans.

JOELLE GUTMAN DODSON (Washoe County Health District):
The Washoe County Health District supports A.B. 177. Prescription directions written in the proficient language for the prescribed patient is a patient-centered and public safety commonsense practice. Taking a prescription incorrectly due to LEP is dangerous and could be fatal. Additionally, medication administration mistakes can be an unnecessary cost to our healthcare system.

LALO MONTOYA (Make the Road Nevada):
Make the Road Nevada supports A.B. 177. We are a nonprofit organization that gives voices to immigrants and working-class Nevadans committed to organizing tomorrow's leaders to become advocates for their families. We feel this a critical step to ensure healthcare parity for all Nevadans and brings the equity needed for Nevadans with LEP.

Nevada has the highest per capita immigration population, which has nearly doubled in the last 20 years. We have seen first-hand the diverse population of the immigrant community hailing from Latin America, Asia, Europe and Africa. According to a new American economy of Nevada report, immigrants make up 30 percent of entrepreneurs in Nevada, with immigrant owned businesses generating nearly $800 million in business, employing over 60,000 people. It is safe to say that immigrants are an essential piece of the fabric of our State. About 250,000 LEP Nevadans speak Spanish as their first language and cannot read the directions for their prescription medication.

Assembly Bill 177 will support the Latino and immigrant communities by translating their prescriptions into Spanish. As a young boy, I had to translate every piece of documentation for my parents. As I got older, I realized no child should have to bear that responsibility. No child should have to wing it, or

attempt to translate a critical piece of information like medical bills or prescription medications. This is an important opportunity to advocate for language justice in Nevada.

JAMIE COGBURN (Nevada Justice Association):
In principal, this bill is a good idea, but the Nevada Justice Association opposes A.B. 177. We have a concern with the conceptual amendment, Exhibit H, presented this afternoon. It provides immunity to the pharmacy if the translation by the third party is not done correctly and may lead to medication errors. Our biggest concern is who the translation company is. If it is a company out of China, or India or another foreign country, or they are not insured; there is no ramification or responsibility for anyone who has made an error. A pharmacy can hire another company and have immunity, leaving the person who is hurt by the negligence of the translation with no repercussions.

MARIA-TERESA LIEBERMANN-PARRAGA (Battle Born Progress):
Battle Born Progress supports A.B. 177. I grew up in a non-English speaking household. This will help people like my mother, who is not as proficient in English as I am. I found myself in situations when after surgery, I could not clearly understand what my prescriptions were. I needed to have a friend with me in case my mother did not understand. Not everyone has someone outside the family who speaks English well enough to help out in situations such as this. This will help everyone in a family who is not English proficient or has mixed proficiency.

MELANIE KELLY (Safeway Pharmacy):
I am a Nevada licensed pharmacist working in Sparks. I work for Albertsons Companies which operate 36 pharmacies in Nevada under the Albertsons, Safeway and Vons banner. Assembly Bill 177 addresses the needs of patients with LEP; however, in its current state, it overlooks the needs of a pharmacist to be protected in the event errors occur in translation. Third-party companies, with the translation technology and expertise, will be vital in ensuring the directions can be translated into the necessary language for the patient. As a pharmacist, I will not be able to verify with certainty the translation is accurate, and will have to rely on the expertise of a third-party translation company. For this reason, it is imperative the language which was amended out of the introduced bill be added back into law.

Please consider adding back the language from subsection 5 to give pharmacists protection as they rely on third-party companies to translate the directions which appear on the prescription label. This language reads:

> If a pharmacy enters into a contract with a third party for the translation of the information that the pharmacy is required to provide pursuant to this section, the pharmacy and any employee of the pharmacy are not liable in any civil action for any injury resulting from the translation by the third party which is not the result of negligence, recklessness or deliberate misconduct of the pharmacy or employee.

Additionally, I would ask that the effective date of this law be changed to one year after the Board of Pharmacy completes the rulemaking process. This will ensure there is adequate time for necessary testing and implementation once the full set of languages has been established.

DORALEE MARTINEZ (Nevada Action Coalition):
The Nevada Action Coalition supports A.B. 177.

PAUL MORADKHAN (Vegas Chamber):
The Vegas Chamber was originally opposed to A.B. 177. Based on the latest conceptual amendment, Exhibit H, the Vegas Chamber is now neutral on A.B. 177 because of the restoration of section 1, subsection 5, and change to the implementation date. We are neutral now because of concerns about the cost to pharmacies.

CYRUS HOJJATY:
I appreciate the efforts to improve public health and the stability of individuals; however, I have some concerns. This brings the incentive that people will not learn English. There are many private services, such as Google Translate, that can help with translation. I am also concerned this will increase the cost of doing business.

The high immigrant population mentioned earlier does not take into consideration that many people are not citizens and are here illegally. Why are we having such population dynamics, and what benefits are we getting out of this? How do we know these trends will continue? Being a minority does not mean you have LEP.

NICK VANDER POEL (Reno + Sparks Chamber of Commerce):
I echo the remarks made by my colleague from the Vegas Chamber in support of A.B. 177.

ASSEMBLYWOMAN BENITEZ-THOMPSON:
I want to thank the pharmacists from the spectrum of pharmacy who took time to talk with me. It has been a long road but a road where there was dialogue and purposeful thought by everyone involved.

CHAIR RATTI:
I will close the hearing on A.B. 177 and open the hearing on A.B. 181.

**ASSEMBLY BILL 181 (1st Reprint)**: Revises provisions relating to mental health. (BDR 40-522)

We just received a new proposed conceptual amendment (Exhibit J) from Assemblywoman Peters, with the purpose of clarifying the providers that must report, and what data must be reported to the Chief Medical Officer.

ASSEMBLYWOMAN SARAH PETERS (Assembly District No. 24):
This bill came to me in two parts from separate parties with different interests. I saw the potential to create what looked like a cornerstone of data collection in an underrepresented area of health care.

The first part of the bill deals with suicide data collection related to mental healthcare issues. The second part is related to mental health parity. The purpose of this bill is to focus on people; the patients in need of services provided by both sides of this healthcare equation.

There is no one who can say that suicide is not a concern in Nevada. We have consistently been identified as having some of the highest rates of suicide among most demographics reported, including vulnerable populations such as veterans, lesbian, gay, bisexual, transgender, queer youth and others. Data on completed suicides show we are too late with providing intervention services.

The first part of this bill proposes collecting data prior to suicide through attempts at identifying people and patients who need help today. Stephanie Woodard will go over the first part of the bill that was brought to me

by the Division of Public and Behavioral Health (DPBH) of the Department of Health and Human Services (DHHS).

STEPHANIE WOODARD, Psy.D. (Senior Advisor on Behavioral Health, Division of Public and Behavioral Health, Department of Health and Human Services):
We have worked a long time, primarily on fatality data, recognizing the best practices supported by the Centers for Disease Control and Prevention (CDC) and other national organizations that prioritize prevention of suicide. We need the data to understand the magnitude of the issue so we have ample opportunity to intervene. By collecting information on suicide attempts and intentional self-harm, and having that information reported to the DPBH, we will be better armed to develop responsive prevention and intervention strategies and expand our postvention support.

This data supports our efforts to bring zero suicide in Nevada to scale. We cannot change what it is that we cannot see. We believe collecting this data will help us shine a light on suicide and ultimately save lives.

An important part of this bill requires the DPBH to develop regulations specific to the reporting of suicide attempts and intentional self-harm. These regulations would be promulgated through the DPBH and approved through the State Board of Health. We are seeking to collect a very minimum data set, which would allow us to understand the frequency in which suicide attempts are being treated in emergency rooms and inpatient settings.

ASSEMBLYWOMAN PETERS:
The proposed conceptual amendment, Exhibit J, clarifies the legislative intent of sections 6.2, 6.4, 6.6 and 6.8. We wanted to work with stakeholders on clarifying that this data is intended to come from providers of health care in a medical facility or the medical facility itself. This helps to alleviate the pressure on our small doctor's offices or general practitioners who may hear about people's feelings but not necessarily become problematic in the intended suicide track.

The second part of the bill deals with patient coverage for health insurance. The federal government requires compliance for the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. This is mentioned in our statutes. However, there is a lack of clarity in the health and insurance industry as to what parity metrics are.

We are not proposing a prescription to remedy this parity ambiguity today. We are requesting the Division of Insurance (DOI) have the authority to proactively review parity metrics from insurance providers in Nevada to determine what the baseline of parity is. The State process for assessing parity starts on the backs of our vulnerable populations who have felt their right to parity of services has been violated. These individuals have to submit a complaint with supporting evidence to the DOI for review of their case. This is done when a patient learns the services they seek are not being covered and not accessible for their immediate needs. This bill requests this activity be completed proactively rather than on the backs of patients already in need of support.

There is recent federal legislation that has passed related to the reporting requirements of insurance companies related to this Parity Act. We have been working with the DOI and other stakeholders to ensure the language in this bill allows the DOI to incorporate those federal requirements while meeting the desired parity outcomes proposed through the adoption of this bill.

Finally, bringing the two pieces of this bill together, we have included requirements that the data collected by both the DPBH and DOI be prepared in reports and provided to the Patient Protection Commission for their consideration in assessing access and coverage for mental and behavioral health services in Nevada.

LEA CASE (Nevada Psychiatric Association):
I will walk through section 9 of the bill, if necessary, which requires the parity report being submitted to the DOI. I also have background on the federal Parity Act if there are any questions.

SENATOR HARDY:
As I understand it, the reporting requirements require a physician to report an attempted suicide. I am not sure how that works with the concept of confidentiality.

DR. WOODARD:
Like all data that is collected through the DPBH, we have some of the highest standards related to confidentiality. We are mirroring the language after the language that was developed as part of the overdose reporting requirements established in A. B. No. 474 of the 79th Session.

There is not a lot of detail in the legislation because we intend to provide more granular information related to what will be reported and who will be reporting and under what circumstances through the regulatory process. Our intent is to not be broad with the implementation of this bill. We do want to bring stakeholders forward in the development of regulations to ensure we have their voices heard. We will continue to hold confidentiality of patient personal health information in the highest regard and continue to provide the necessary protections for that data.

SENATOR HARDY:
If a doctor has learned someone has attempted suicide, what does he do? What is the burden on the physician? Is the information reported for data collection only to keep a count of the number of attempted suicides?

DR. WOODARD:
We are able to collect some of this data through billing and claims data; however, the problem we have is the billing and claims data has a lag, and most of that data goes through a considerable process. Based on the billing and claims data for 2020, there were just over 866,000 emergency room visits of which 1,300 were identified as suicide attempts.

We have other mechanisms we can use to have a sense of what is happening through syndrome surveillance. Unfortunately, we do not have all hospitals reporting through this surveillance. While it is good at helping us to detect, the accuracy is not there.

We felt having this timely data would assist us in gathering the necessary information as we are starting to see surges in any one geographic area or within a hospital related to the amount of suicide attempts being reported. Ultimately, this can help us understand what the need is for getting individuals the help they need for postvention and continued efforts for suicide prevention. This data can also be helpful to the hospitals reporting it, especially those working to implement the zero suicide initiative. Being able to package this data and provide it back to hospitals so they have their own data to understand how frequently this is occurring will help them in those efforts. We do not intend that outpatient providers would be reporting this information. We are looking for information provided through hospitals and providers in those hospitals.

We have three different methods that the overdose reporting is being provided to us depending on what the hospital chooses as a method. The first is via fax and the second is through data extract. Hospitals have been able to develop a batch data extract they can transmit to the DPBH or through an electronic form. We have looked into augmenting that electronic form with two data fields that would need to be changed to operationalize it. We have the ability to do this to support the implementation of this legislation.

SENATOR HARDY:
Are only hospitals going to be required to report this information?

DR. WOODARD:
At this point, it would only be hospitals. As we start to build out crisis stabilization centers, there is a possibility we would need to expand, through regulation, the reach to crisis stabilization centers knowing we may have individuals presenting for care in those settings.

SENATOR HARDY:
*Nevada Revised Statutes* 441A.220 could include the crisis centers?

DR. WOODARD:
Yes, through the regulatory development process.

SENATOR KIECKHEFER:
The intent of the bill is to capture data upon an initial suicide attempt. A doctor could be treating someone in a hospital and discover they may have attempted suicide a week ago or a month ago. What prevents dual reporting?

DR. WOODARD:
Through the regulatory process, we intend to clarify this would be at the point of care where someone was receiving care for a suicide attempt or intentional self-harm. That would be done through specific ICD-10 codes. A provider would have to determine if the individual met criteria for those diagnoses, and those diagnoses would be reported through this mechanism.

We would hope the information would come from a point of care where the patient is receiving care at the time of the incident so we could alleviate dual reporting. Through our data cleansing mechanisms, we can also try to mitigate any dual reporting.

SENATOR HARDY:
Does the second half of the bill with regard to parity refer to the parity for mental health and addiction?

ASSEMBLYWOMAN PETERS:
The data collected would be modeled after the federal legislation and those requirements. We would not be requesting that insurance companies duplicate their reporting or provide more information than they are required to report federally. It would include mental, behavioral and addiction metrics.

SENATOR HARDY:
Are you looking for data on someone being treated for an appendix removal at one hospital that could have had this procedure at a different hospital, or is it for mental health and addiction parity?

ASSEMBLYWOMAN PETERS:
This is specifically related to the types of coverage regulated under the Mental Health Parity and Addiction Equity Act.

JESSICA FERRATO (American College of Emergency Physicians, Nevada Chapter):
The American College of Emergency Physicians supports A.B. 181. We are seeing an increase of attempted suicides in our emergency rooms, in particular, at a frightening rate. This is mostly due to the pandemic and some of the mental health challenges in homes with children, specifically in Washoe and Clark Counties.

TREY DELAP (National Alliance on Mental Illness Nevada):
I will read from written testimony (Exhibit K) in support of A.B. 181.

TOM CLARK (Nevada Association of Health Plans):
The Nevada Association of Health Plans is neutral on A.B. 181. We would like to thank Assemblywoman Peters for working with us on section 9 of the bill dealing with the reporting of information on mental health parity.

BARBARA RICHARDSON (Commissioner of Insurance, Department of Business and Industry):
The Department of Business and Industry is neutral on A.B. 181. We echo the support from others and appreciate a positive vote.

CHAIR RATTI:
I will close the hearing on A.B. 181 and open the hearing on A.B. 178.

**ASSEMBLY BILL 178**: Revises provisions relating to prescription drugs. (BDR 57-71)

ASSEMBLYWOMAN MELISSA HARDY (Assembly District No. 22):
I would like to present A.B. 178 which ensures Nevadans have access to their prescription medications during a state of emergency or declaration of disaster.

The Covid-19 pandemic highlights the need to reconsider the rules that limit access to needed prescription drugs for Nevadans such as older adults and people with underlying health conditions during a declared state of emergency or disaster.

Insurance companies generally impose strict limits on the frequency of medication refills. Outside of times of crisis, there are valid reasons insurance companies limit when and how much of certain medications people can obtain at one time. They could be misused, misplaced or even sold on the black market. Therefore, many people obtain a one-month supply of medicine, which works well for them.

Over a year ago, to facilitate the State's response to the Covid-19 pandemic, Governor Steve Sisolak declared a state of emergency. Nevadans were asked to limit nonessential activities due to the pandemic and were encouraged to limit their trips outside their homes to gather essential items such as food and prescription medications to stay safe and healthy.

During this time, the CDC encouraged those at higher risk, particularly older adults and those with underlying health conditions, to have at least a 30-day supply of prescription drugs and talk to a healthcare provider, insurer or pharmacist about obtaining an extra supply of their prescriptions, if possible, to reduce their trips to a pharmacy.

This bill came from a personal experience with my mother in a situation early in the shutdown. She needed some of her medications refilled and, at first, was unable to go to the doctor as they were not seeing patients during the pandemic. Because of the risk with her health, she did not want to go to the doctor or to a lab. She is self-sufficient and takes care of everything herself, but

in this case, it took some time and jumping through hoops on my part to help her get her medications refilled. From that experience came the desire to bring this legislation forward.

During the Covid-19 pandemic, people needed easy access to their medications which was difficult during times of social distancing and their inability to meet with healthcare practitioners. States throughout the Country have addressed prescription medication refills in times of natural disasters or a declared state of emergency. At least eight states including Arizona, California, Florida, Maryland, Oklahoma, South Carolina, Texas and Washington allow pharmacists to dispense early, and/or provide emergency refills of a prescription under certain circumstances.

Assembly Bill 178 requires insurers, including Medicaid, the Public Employees' Benefits Program (PEBP) and local governments that provide coverage for their employees to:

> Waive any restrictions on the time period within which a prescription may be refilled for an insured who resides in the area to which a state of emergency or declaration of disaster applies if the insured requests the refill within a certain time; and authorize payment for a supply of a covered prescription drug for up to 30 days for any insured who requests a refill under those conditions.

The Commissioner of Insurance may extend the time periods as he or she determines necessary.

To respond effectively to urgent demands during a state of emergency or natural disaster, the public may need increased access to therapeutic pharmaceuticals. Meeting this need requires safely expanding access to pharmacy services and providing temporary and limited relief from certain regulatory restrictions to enhance operational capacity, flexibility and efficiency operations.

A pharmacist may refill a prescription only for the number of times authorized, or for the number of times authorized by the prescribing practitioner. This bill creates an exception to this rule to allow:

> [A] pharmacist to fill or refill a prescription in an amount that is greater than the amount authorized by the prescribing practitioner but does not exceed a 30-day supply of the drug if: the drug is not a controlled substance listed in schedule II; the patient lives in an area where a state of emergency or disaster applies; and the drug is necessary for the patient's maintenance of life or the continuation of therapy for a chronic condition and interruption of therapy using the drug may be detrimental to the person's health or produce physical or mental discomfort.

A pharmacist who dispenses drugs under these conditions is required to issue and maintain a written order for dispensing the drug and notify the prescribing practitioner.

The fiscal notes from the Department of Business and Industry, DHHS and PEBP are on the legislative website, and the State Board of Pharmacy indicates there is no fiscal impact. Most of the local governments also note there is no fiscal impact.

Assembly Bill 178 helps people to maintain a continuous supply of medications during a declared state of emergency or disaster. The bill requires an insurer to waive restrictions on medication refills during a declared state of emergency and authorizes payment for a supply of the prescription drug for up to 30 days.

The measure also authorizes a pharmacist to fill or refill a prescription drug to a person living in an area that is declared a disaster or state of emergency in an amount greater than is authorized by a prescribing practitioner but does not exceed a 30-day supply of the drug under certain circumstances.

I have reached out to and been working with stakeholders to get their input and continue to make every effort to find solutions to any concerns.

SENATOR HARDY:
Was there thought given to continuing drugs such as buprenorphine which is used to treat someone who has had an addiction to opioids? If we do not, we run the risk of them getting back on opioids.

DAVE WUEST (State Board of Pharmacy):
The law would allow that as a Schedule III drug. The only restriction would be Schedule II drugs. If the pharmacist made the determination that it was in the best interest of the patient, the law would allow that.

ASSEMBLYWOMAN HARDY:
This bill will give peace of mind and reassurance to Nevadans relying on medications, knowing they will have access to those medications if we are ever in a state of emergency or disaster.

CHAIR RATTI:
I will close the hearing on A.B. 178 and open the hearing on A.B. 228.

**ASSEMBLY BILL 228 (1st Reprint)**: Establishes provisions relating to children's advocacy centers. (BDR 38-358)

ASSEMBLYWOMAN BRITTNEY MILLER (Assembly District No. 5):
I am here today to present A.B. 228. It is traumatic for a child to experience abuse and neglect. It can cause lifetime harm to children, their families and communities. Many children who experience maltreatment are pulled into a system that requires them to relive the trauma over and over as they have to share their story with law enforcement, child protective services, caseworkers, lawyers, investigators and judges.

This bill provides children who have experienced abuse or neglect a faith and child-focused environment. The bill requires State and county child welfare agencies to ensure children who are the victims of abuse or neglect have access to a multidisciplinary team (MDT) through a children's advocacy center (CAC). These teams include professionals with backgrounds in criminal justice, law enforcement, child protective services, mental health, and medical and victim advocacy to help children heal from the trauma of abuse or neglect.

CHERYL COOLEY (Southern Nevada Children's Advocacy Center; Children's Advocacy Centers of Nevada):
This bill legitimizes and brings attention to a multidisciplinary approach to dealing with child abuse. A lot of our forensic interviews surround children who have been sexually abused. When a child makes an outcry of sexual abuse to their teacher, for instance, they are letting out the biggest family secret their family has, and the offenders have tried to keep it quiet. When you have to talk

to a teacher, then a principal, then the police, then child protective services, then a doctor, you are losing traction with what is happening, often in a negative way.

The Children's Advocacy Center brings the child to a CAC where they have a forensic interview, a research-based, child-led interview. This is so the children can tell their story of abuse in their own words. We do not want to lead or influence the children in any way. A child can go to a CAC and get the advocacy and support they need after they disclose such a big secret.

I will now play video testimony from a young college student, Lexi, who has gone through that process which can be seen on YouTube on the following link: <https://www.youtube.com/watch?tv=rOox5bQkUq>.

JESSE HAW (Children's Advocacy Centers of Nevada):
Lexi is not alone. One out of four girls and one out of six boys nationwide will have something like this happen to them by the time they are 18 years of age. Moving towards this legislation, Nevada will join 34 other states who have gone to best practices and MDTs like the CAC. We did not create this model; we researched the Country to figure out which was the best.

CHAIR RATTI:
If we have four existing CACs in Nevada, why is it important we make it a law that we have CACs?

MR. HAW:
Two of the CACs are accredited by the National Children's Alliance (NCA) standards. This bill will set out what the guidance for the CAC is, which will change over time, and the NCA will help guide us on what the most up-to-date practices are.

We have two CACs rising to get that accreditation, which is a long, tough process. A lot of people will not donate to these types of programs because if it is not in statute, they are not sure it is a legitimate program. Having a defined legitimate CAC helps us fundraise and operate them. It determines that best practices will be followed; that you will not have someone starting one up that is not following what will hopefully be the law.

CHAIR RATTI:
I want to ensure you have done extensive research and taken a good look at the language set out in NRS to make sure it matches the standard, and that we are not doing anything that will disrupt the work of the current CACs.

MR. HAW:
We have had great cooperation with many departments in the north and the south because it does touch on things from police to district attorneys and is all encompassing.

SENATOR KIECKHEFER:
The NCA is a single organization. Are there competing organizations that do the same work? Are we picking one versus another; is it restrictive in any way?

PEG SAMPLES (Washoe County Child Advocacy Center):
There are other nonprofit organizations that work with CACs across the Country. The NCA is the largest and most widely recognized accrediting agency in the Country.

JOANNA JACOB (Clark County):
Clark County supports A.B. 228 because it has real-world impacts. It is rare this Session that I get to talk about the good things in Clark County child welfare, and this is one of them. It is difficult to watch the video of Lexi and not know about the good work that the Clark County Department of Family Services does, and our southern Nevada CAC does every day.

NEYDA BECKER (Children's Advocacy Center Foundation):
The Children's Advocacy Center Foundation (CACF) supports A.B. 228. Through our public, private partnership with the Clark County Department of Family Services, the CACF serves as the nonprofit and advocacy arm for the Southern Nevada Children's Advocacy Center (SNCAC). The CACF works directly with key county personnel and SNCAC team members to provide services to and improve outcomes for child abuse victims and their families.

I have witnessed first-hand the hard work and dedication of Cheryl Cooley, her team and agency partners in serving the needs of at-risk children and their families in southern Nevada. I have met and spoken to survivors, and have seen the impact the SNCAC has made in their lives.

I was once told the SNCAC was southern Nevada's best kept secret. My question at that time was to ask why. As the number of suspected child abuse and neglect cases in Nevada continue to rise, why keep child advocacy centers secret. They should be acknowledged for the important work they do.

As you move forward with your deliberations, I urge the Committee to consider the testimony we have heard today, and think of Lexi and the thousands of other children and families helped by CACs each year. Please help bring CACs out of the shadows and vote in favor of this bill.

MS. BLOCK:
The Nevada Coalition of Legal Service Providers supports A.B. 228. We support multidisciplinary and holistic support for youth to emphasize healing from trauma. We support legislation that aims to help children heal and move on from trauma in a supportive and healing-centered environment.

TESS OPFERMAN (Nevada Women's Lobby):
The Nevada Women's Lobby supports A.B. 228. Child abuse can be complicated to address and navigating the process is not easy. It is difficult and traumatic for children to share their story, especially if it requires rehashing their story with one person after another.

COLE MCBRIDE (Washoe County Child Advocacy Center):
The Washoe County Child Advocacy Center supports A.B. 228.

ROSS ARMSTRONG (Administrator, Division of Child and Family Services, Department of Health and Human Services):
I was involved in setting up the CAC in Pahrump and can tell you the amazing power this model has in empowering young people who have been abused is incredible.

The Division is neutral on this bill. Part of this bill has the Division setting up an account that can take and distribute donations to qualifying entities. We have no concerns about the operational part of the bill. We are happy to do our part in terms of supporting this model throughout the State.

CHAIR RATTI:
I will close the hearing on A.B. 228 and open the hearing on A.B. 345.

**ASSEMBLY BILL 345 (1st Reprint)**: Revises provisions relating to drug paraphernalia. (BDR 40-978)

ASSEMBLYMAN DAVID ORENTLICHER (Assembly District No. 20):
Assembly Bill 345 addresses the problem of opioid overdose deaths in Nevada, which has been a significant problem for a number of years. There has been a recent increase from the problem of fentanyl-laced heroine and other drugs. Users are buying heroine or methamphetamine and may or may not know that it is laced with fentanyl which can cause an overdose. One way to prevent overdose deaths is to distribute fentanyl testing strips so users can know what they are buying. Fentanyl is considered illegal drug paraphernalia in Nevada.

This bill excludes fentanyl testing strips from the definition of drug paraphernalia. There is an information sheet (Exhibit L) on the legislative website on Fentanyl Testing to Prevent Overdose showing how fentanyl testing strips work.

There is a conceptual amendment (Exhibit M) to broaden the bill because it is fentanyl today; tomorrow, or next year, there may be another adulterant that causes overdose deaths. This way, we do not have to come back for a new bill. The conceptual amendment, Exhibit M, allows other testing products in case there is a different adulterant within the next two years.

The bill now states testing for adulterants are for use in cutting controlled substances, and there may be other controlled substances that are adulterated that we may want to also test.

The existing provision, section 1, subsection 2 has not been amended. That is previous legislation to ensure needles and syringes can be distributed and are not considered contraband. The bill is being interpreted in a restrictive way, so we have been asked to consider expanding some of the items to tourniquets to ensure people do not get into trouble.

We are working with law enforcement, and they are comfortable with what we have done so far on the bill and the conceptual amendment, Exhibit M. I have not had occasion to speak with them about further broadness.

CHAIR RATTI:
The intent of the bill started with fentanyl testing strips but has been broadened in the conceptual amendment, Exhibit M, to test for anything. You will have something for us by the time we work session the bill that would broaden it beyond narcotics to other controlled substances. Also, to add to the list of paraphernalia in subsection 2 that would not be considered criminal.

ASSEMBLYMAN ORENTLICHER:
In section 2, subsection 2, paragraph (a) it says, "hypodermic syringe, needle, instrument, device or implement," which should capture a broad range. Apparently, there have been issues with this. The suggested language we received from people who work in the field would be to add "including sterile injection equipment provided by syringe services programs including mixing or cooking devices and tourniquets."

NICHOLAS SHEPACK (American Civil Liberties Union of Nevada):
The American Civil Liberties Union of Nevada supports A.B. 345 and believes we can save lives by decriminalizing certain testing items and items used to administer drugs. I went to high school during the peak of the opioid crisis. I buried too many of my friends who fell victim to addiction through prescription drugs and heroine. Once fentanyl arrived on the scene, things got uglier. Fentanyl is found in what is perceived as prescription medication. Exempting test strips from Category E felonies will save lives.

The war on drugs has criminalized everything from behavioral health issues to simple testing equipment. It is beyond time we start addressing these issues as they are, which are behavioral health issues, and stop criminalizing simple items such as a syringe or test strip.

LISA RASMUSSEN (Nevada Attorneys for Criminal Justice):
Nevada Attorneys for Criminal Justice supports A.B. 345 as written and with the conceptual amendment, Exhibit M. Consistent with what Mr. Shepack stated, we believe this is a productive decriminalization of what is currently categorized as paraphernalia but should be considered life-saving tools. We want people to stop using or possessing illicit drugs that were not prescribed to them. Unfortunately, that is not the reality we live in.

What we are seeing on the street today with regard to our clients and cases coming forward, are a lot of high-potency drugs. Even though we would not

want to encourage illicit drug use, having the test strips available is appropriately decriminalizing the use of them in a manner that could allow people to be safe and not end up in an accidental overdose situation.

LISA LEE:
I support A.B. 345 and its proposed amendment, Exhibit M. As a person in long-term recovery from opioid use disorder, a doctorate student in public health and a person who conducts harm reduction outreach and peer support in my community, I am terrified the people in my life will all die. I am saddened by the friends I have lost to overdose. In our community, there is fentanyl in pressed pills, methamphetamines and heroine. Thanks to fentanyl test strips and naloxone, we are able to stay ahead of a steeper trend of fatal drug poisoning.

While it is important to test for fentanyl, we know this is the adulterant du jour, and we need to keep in mind there will be emerging adulterants threatening more lives. All sterile injection supplies distributed by syringe service programs should be explicitly decriminalized.

DR. WOODARD:
In 2020, we had 484 opioid-related overdose deaths, which was more than we had previously when we considered the peak of the opioid crisis in 2011, and 110 more opioid overdoses than in 2019. This resulted in a 40 percent increase Statewide and a 44 percent increase in Clark County.

Synthetic opioid overdose statistics have increased six-fold since 2010, from 39 to 246 in 2020. These deaths now account for over 50 percent of the overdoses in Nevada. Similar to naloxone, fentanyl test strips are an essential overdose prevention strategy that must be available within a community.

The Substance Abuse and Mental Health Services Administration announced on April 7, 2021, that states are now able to use federal funds to purchase and distribute fentanyl test strips. These test strips are an essential harm-reduction strategy to reduce opioid-related overdose deaths. The surge in drug overdose statistics nationally, and in Nevada, is driven in large part by fentanyl found in a broad range of substances including methamphetamines. Many people are often unaware their drug supply contains fentanyl, resulting in fatal overdose. These test strips allow individuals to test their drugs prior to use to determine if they contain fentanyl.

There is a growing body of research that has demonstrated when individuals are able to test their drug supply for fentanyl, and fentanyl is identified as being present, they change the way they are using those drugs to be safer and reducing harm. Without explicit exemption of fentanyl test strips and other such testing supplies as drug paraphernalia, distribution by the State and community organizations would be significantly hindered, and individuals in possession of testing strips would be at risk for further charges.

JESSICA JOHNSON (Southern Nevada Health District):
The Southern Nevada Health District is neutral on S.B. 345. By now, you are familiar with the opioid epidemic and its impact on drug overdose statistics, which are now the leading cause of death in the U.S. for people under the age of 50. Unfortunately, according to the Southern Nevada Health Districts 2020 mortality data, the new wave in the overdose epidemic is fueled by adulterated and counterfeit opioids, primarily fentanyl. This preliminary data suggests fentanyl is being used in counterfeit pills and impacting younger Nevadans when compared to non-fentanyl fatalities.

While fentanyl is currently the most recognizable adulterant in the drug supply, it is not the only one of concern. Numerous other adulterants exist for which there is much less available data. In the past year alone, approximately 27 novel psychoactive substances were identified; that is more than two per month.

Research has demonstrated that comprehensive drug checking is an evidence-based strategy and should be part of a broader approach to address the risks associated with the proliferation of fentanyl and emerging adulterants in our drug supply. Given this evolution, broadly including adulterant testing would allow for a more rapid response to emerging novel psychoactive substances in our communities.

CHAIR RATTI:
I will close the hearing on S.B. 345. Seeing no public comment, the meeting is adjourned at 6:14 p.m.

RESPECTFULLY SUBMITTED:

Vickie Polzien,
Committee Secretary

APPROVED BY:

Senator Julia Ratti, Chair

DATE:

| EXHIBIT SUMMARY | | | | |
|---|---|---|---|---|
| **Bill** | **Exhibit Letter** | **Begins on Page** | **Witness / Entity** | **Description** |
| | A | 1 | | Agenda |
| A.B. 35 | B | 1 | Megan Comlossy | Work Session Document |
| A.B. 138 | C | 1 | Megan Comlossy | Work Session Document |
| A.B. 426 | D | 1 | Megan Comlossy | Work Session Document |
| A.B. 177 | E | 1 | Assemblywoman Teresa Benitez-Thompson | Written Testimony |
| A.B. 177 | F | 1 | Assemblywoman Teresa Benitez-Thompson | State Demographer Report submitted by Jeff Hardcastle |
| A.B. 177 | G | 1 | Assemblywoman Teresa Benitez-Thompson | Nevada Census Snapshot 2020 submitted by Daniel Liden / Guinn Center |
| A.B. 177 | H | 1 | Assemblywoman Teresa Benitez-Thompson | Revised Proposed Amendment |
| A.B. 177 | I | 1 | Eric Jeng / Asian Community Development Council | Support Statement of Carlo Miciano |
| A.B. 181 | J | 1 | Senator Julia Ratti | Proposed Conceptual Amendment provided by Assemblywoman Sara Peters |
| A.B. 181 | K | 1 | Trey Delap / National Alliance on Mental Illness | Support Statement |
| A.B. 345 | L | 1 | Assemblyman David Orentlicher | Fentanyl Test Strips Information Sheet provided by Dr. Stephanie Woodard |
| A.B. 345 | M | 1 | Assemblyman David Orentlicher | Conceptual Amendment |