MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Eighty-first Session
March 11, 2021

The Senate Committee on Health and Human Services was called to order by Chair Julia Ratti at 3:31 p.m. on Thursday, March 11, 2021, Online. 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:

Senator James Ohrenschall, Senatorial District No. 21

STAFF MEMBERS PRESENT:

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

OTHERS PRESENT:

Amy Honodel, Legal Aid Center of Southern Nevada
Bailey Bortolin, Nevada Coalition of Legal Service Providers
Leon Ravin, M.D., Psychiatric Medical Director, Division of Public and Behavioral Health, Department of Health and Human Services
Brigid Duffy, Director, Juvenile Division, Clark County District Attorney's Office
Dashun Jackson, Children's Advocacy Alliance
Kendra Bertschy, Deputy Public Defender, Public Defender's Office, Washoe County
Jimmy Lau, Dignity Health – St. Rose Dominican
Patrick Hirsch, Legal Aid Center of Southern Nevada
Alison Caliendo, Ph.D., Executive Director, Foster Kinship

Kathryn Roose, Deputy Administrator, Quality and Oversight, Division of Child and Family Services, Department of Health and Human Services

CHAIR RATTI:
I will open the hearing on Senate Bill (S.B.) 146.

SENATE BILL 146: Revises provisions relating to mental health services for children. (BDR 39-870)

SENATOR JAMES OHRENSCHALL (Senatorial District No. 21):
I will read from my written statement (Exhibit B).

AMY HONONDEL (Legal Aid Center of Southern Nevada):
I have submitted a written statement (Exhibit C) in support of S.B. 146 and will outline the bill and its proposed amendment (Exhibit D) prior to reading from my statement.

Section 1, subsection 1 of the amendment, Exhibit D, requires the admitting staff at a locked mental health facility reach out to a foster child's main treating mental health provider after asking the person bringing the child to the facility if they have a treating psychiatrist or main treating provider. It requires the staff to make reasonable efforts to reach that person.

If he or she is able to reach that person, section 1, subsection 2 of the amendment requires the admitting staff of the hospital to make reasonable efforts to coordinate care with the main treatment provider who sees the child on a regular nonemergent basis. They would also be required to consider input from that treatment provider in determining the level of care the child will receive while admitted to that locked inpatient facility.

Section 1, subsection 3 of the amendment requires the staff at the admitting facility to get consent from the legal custodian of the child and talk to the child obtaining their assent or agreement to coordinate care while in the hospital with the child's team of mental healthcare providers on the outside.

What has become apparent to me from a qualitative observational standpoint and my education on child welfare and practice, is youth in foster care have a significantly higher rate of diagnoses of mental healthcare problems than our general population. An article I read recently states 80 percent of the foster care

population has mental healthcare issues needing treatment, versus 18 percent to 22 percent of the general population. In coordinating care, unlike a child who may be in a one-or two-parent household, what makes it difficult for our population is that our population is transient. Transient means moving foster children between placement as we attempt to get them to their forever home or with family, or caseworkers who are advocating or representing these children through the various child welfare agencies. There is also diffusion of authority in that we have multiple providers, a child welfare worker, attorneys and the court overseeing what happens to these children. This makes care coordination particularly difficult.

This bill is not intended to undercut what is being done by the mental health providers we have. Rather it is to get them to start coordinating care. When the care is better coordinated, the outcomes are better for our foster youth. Many of us will agree we need to improve the outcomes for these children as they are at a significant disadvantage.

We want to make a foundation, or dialog, between the mental healthcare providers who deal with our foster youth who do not have a parent to fight for them. They have a caseworker who may sometimes be an on-call worker or foster parent who does not know them. We want the medical professionals to start communicating to get better outcomes for these youth in the least destructive setting.

BAILEY BORTOLIN (Nevada Coalition of Legal Service Providers):
Our conversations have led to what looks like a scary amendment; however, it contains language everyone agrees fixes a problem and codifies a best practice that could make a difference for our foster youth.

CHAIR RATTI:
Is this bill intended to be for inpatient admitting only?

MS. HONODEL:
Yes. This is to be used for inpatient admission to a locked facility only. While I do not see the wording for emergency or unplanned, I would submit to the Committee that would be the only time it would be used, when we do have planned admissions. We have a separate procedure in *Nevada Revised Statues* (NRS) 432B, Court-Ordered Admission of Certain Children with Emotional

Disturbance to Certain Facilities, to make a request to the court for court ordered admissions.

CHAIR RATTI:
Is this narrowly tailored to an emergency or unplanned admittance to an inpatient facility?

MS. HONODEL:
Correct.

CHAIR RATTI:
It appears there is narrowing language in section 1, subsection 1 of the proposed amendment, Exhibit D, that states "or another healthcare provider authorized to diagnose and treat mental disorders." Can we be clear about what healthcare providers we are talking about?

MS. HONODEL:
From the legal advocacy standpoint, this would be someone who is qualified to diagnose a child with either an emotional disturbance or mental health disorder. We are looking at psychiatrists and psychologists, to the extent that certain level therapists, depending on their training, can make or suggest a diagnosis. We would include them, but this would not be the social work interns working under supervision. We are looking for someone who has a rapport with the child, who is familiar with the child's treatment and has the requisite education and licensure to do diagnose and treat.

CHAIR RATTI:
Perhaps an Advanced Practice Registered Nurse (APRN) with an emphasis in behavioral health?

MS. HONODEL:
Correct. I have a client that does see an APRN supervised by child psychiatrists to diagnose and write prescriptions.

CHAIR RATTI:
We want to ensure this is drafted correctly to be inclusive of those that would make sense.

LEON RAVIN, M.D. (Psychiatric Medical Director, Division of Public and Behavioral Health, Department of Health and Human Services):
The scope of the individuals who could provide input to the inpatient treatment team should include all professions primarily responsible for diagnosis and treatment of the child in an outpatient setting. Most commonly it would be a psychiatrist. We also have to recognize a number of children receiving care from providers such as an APRN since they receive legal rights to practice as licensed independent providers without supervisional collaboration. It is my understanding, with the permission of the Nevada State Board of Nursing, they can practice within the scope of psychiatric mental health when they have the appropriate credentials and qualifications.

In addition, there could be a physician assistant who practices under the supervision of a psychiatrist or primary care provider. We need to recognize many individuals receive help for their psychiatric needs from primary care family physicians so they could be included.

In cases when a child is not in need of psychotropic medications, it is foreseeable a psychologist would be the primary healthcare provider for a child for his or her mental health needs.

CHAIR RATTI:
I heard psychiatrists, APRNs, physician assistants, primary care physicians and psychologists. What about licensed clinical social workers or licensed family therapists?

DR. RAVIN:
I cannot speak on behalf of the licensed clinical counselors. This should be professionals who are typically authorized to have medium privileges to inpatient psychiatric services. These would usually be physicians, physician assistants or APRNs.

CHAIR RATTI:
We will need to ensure the amendment, Exhibit D, includes only those with admitting privileges or any behavioral healthcare professional already connected with a child who may have input. Our challenge is that another healthcare provider authorized to diagnose and treat could be a psychologist or a licensed marriage and family therapist social worker.

DR. RAVIN:
It may make sense to split the professionals into two categories. Section 1, subsection 2 of the proposed amendment, Exhibit D, primarily focuses on determining the level of care for the child, determining whether or not to admit the child to the most restrictive settings of an inpatient treatment facility or to continue treating the child in outpatient settings. This is where you may need a professional who is at the level of qualifying for ten-minute meeting privileges at the hospital. For ongoing coordination of care and discharge planning, any mental health professional primarily involved in treating a child for mental or behavioral health should be included.

CHAIR RATTI:
This makes sense when continuity of care is the goal wherever they are already connected to care.

SENATOR HARRIS:
Why are we limiting this to juveniles who are under the jurisdiction of the juvenile court? These are the children that legal aid often interacts with. Are we seeing this gap with other children as well?

MS. BORTOLIN:
When we started having conversations with treating doctors working within the NRS 432B context, we identified that children who already have a diagnosis and medications are being treated and end up with a different diagnosis and prescribed medications. We were asked to coordinate that care and told this was a best practice and should be happening.

We thought the gap was specific to NRS 432B, so we wanted to solve the problem for our clients. I cannot with any first-hand knowledge speak to what is happening elsewhere, but will say that we have gotten feedback that it may make sense to broaden this.

DR. RAVIN:
I agree the same level of cooperation constitutes good clinical practice across all ages. Overall as a practicing physician, we should not be making the determination on the scope of care provided, or the level of coordination based on whether or not the child has parents and is in foster care or any other facility. Even if the person is an adult, we should still strive to maintain the best cooperation between inpatient and outpatient providers.

SENATOR OHRENSCHALL:
In my experience practicing in the delinquency courts, not in the abuse and neglect sphere, I have heard from parents who have felt frustrated when a child was committed to a State correctional facility having previously had a treating psychiatrist. They felt there was a disconnect between the care plan prior to the child being committed to a correctional facility rather than a mental health facility.

This is anecdotal. I do not have studies as to whether this is an issue, but have observed this in terms of continuity of care and whether there is a disconnect in the treatment plan at the facility.

SENATOR HARRIS:
I have a question on the language in section 1, subsection 1, versus the language in subsection 3 of the proposed amendment, Exhibit D. In subsection 1, we refer "to a treatment facility or other division facility for inpatient psychiatric care." This seems a bit broader than the language in subsection 3 which is "an inpatient psychiatric treatment facility."

Are these two sections congruent, or is there a reason one is broader than the other?

MS. BORTOLIN:
This got lost in translation due to the many meetings with stakeholders and has been recognized by your Committee staff. Clark County Department of Child and Family Services requested subsection 3 narrowing to an inpatient psychiatric treatment facility, and we will now go back to mirror that in subsection 1.

CHAIR RATTI:
The intent of the bill is to apply only to inpatient psychiatric treatment facilities. Is that correct?

MS. BORTOLIN:
Yes.

CHAIR RATTI:
Would this be DCFS facilities only, or would this include private facilities as NRS 432B is specific to DCFS as opposed to private facilities?

MS. HONODEL:
This bill is intended to apply to both, which may be the reason for the conflicting language. Our youth in Clark County are admitted to both State and private facilities on an inpatient basis.

SENATOR HARRIS:
In section 1, subsection 1 there is a change from "before" to "when". Why was this change made, and what does "when" mean?

MS. BORTOLIN:
Some of the concerns were from a practical standpoint. Legally, we agree with you. Practically speaking, we thought "before" made more of a connotation of "we cannot do this unless." We wanted to make it abundantly clear this was a "when practicable," but should not be seen as a basis for denial.

BRIGID DUFFY: (Director, Juvenile Division, Clark County District Attorney's Office):
The DCFS requested to change the "before" to "when", specifically what Ms. Bortolin had expressed. When children are continually cycling into acute episodes for emergency treatment, we have limited providers for our younger-aged children. We wanted to ensure we were not closing opportunities for our children based on facilities stating they could not reach a treating healthcare provider and were unable to admit the child for emergency treatment. We were afraid of how that might be interpreted at 3:00 a.m. by the staff of a hospital, believing it would be clearer for everyone to understand, that when admitting a child, you need to make the reasonable effort to contact the treating provider.

SENATOR HARRIS:
Is there is a reasonable time limit, perhaps within 48 hours? Stating "make reasonable effort" alone seems it would address your concern without making the language change. Would it be possible to put an actual requirement that this reasonable effort be made within a certain amount of time as opposed to leaving it open?

MS. DUFFY:
Reasonable effort was the recommended language of the DCFS. I agree there should be some sort of "no later than," but again, we are all working to compromise and provide the best bill possible.

DR. RAVIN:
From a medical perspective, it would help to not have a specific deadline on how long the treatment team should make a reasonable effort or at what point they should continue. The considerations are that if a child is brought to a facility on Friday night, the outpatient provider may not be available for his or her input until Monday morning. If we say the inpatient treatment team should seek that input no later than 12 to 24 hours from the time of admission, we are risking the possibility they will try to seek the input only for the duration of time outlined in the language of the bill. After that, they will add an entry in the chart stating they attempted to make contact with no response and that would be the end of the effort.

From the clinical care perspective, it would make sense for the treatment team to continue seeking input and coordination of care for the duration of treatment. For whatever reason they were not successful in making contact during the early hours or days of treatment, they will continue to attempt contact for the duration of the treatment episode.

DASHUN JACKSON (Children's Advocacy Alliance):
The Children's Advocacy Alliance supports S.B. 146. This bill promotes the mental and emotional health of a child and recognizes the trauma a child experiences when removed from their home and placed in a facility. This bill allows continuity of care while preventing a child from being overmedicated and reducing the trauma to the child. This will also allow and promote youth having a voice.

KENDRA BERTSCHY (Deputy Public Defender, Public Defender's Office, Washoe County):
The Washoe County Public Defender's Office supports S.B. 146. We appreciate this bill being brought forward to ensure continuity of care for children. I previously worked as a children's attorney and handled the dockets specifically for child commitment hearings. I would agree with the statement that this can be traumatic, and we are potentially preventing future harm to these children by allowing for continuity of care.

JIMMY LAU (Dignity Health – St. Rose Dominican):
Continuity and coordination of care is an important component to the overall improvement of health outcomes, especially to the most vulnerable in our community. We thank Senator Ohrenschall for bringing this legislation and

support his effort to enhance continuity and coordination of care for at-risk children.

MS. DUFFY:
The Clark County DCFS supports S.B. 146 and the policy of ensuring we are coordinating mental health care for our children in foster care. Our children often come with complex levels of trauma and are in need of consistent treatment. When a child has an acute episode and needs emergency placement in a psychiatric treatment facility, it is best practice and in our children's best interest that providers on the outside or the ongoing healthcare providers with an established relationship with our children and the acute inpatient psychiatric care provider are communicating.

Our children are suffering on many levels throughout this pandemic. Twenty-three of Clark County School District children have committed suicide this past year. This is a crisis that is impacting not only foster children but all children across Nevada.

SENATOR OHRENSCHALL:
I have heard the Committee's suggestions in terms of additional detail to the definition of healthcare provider and the idea of expanding to other children.

CHAIR RATTI:
I will close the hearing on S.B. 146 and open the hearing on S.B. 158.

SENATE BILL 158: Revises requirements to receive assistance from the Kinship Guardianship Assistance Program. (BDR 38-504)

SENATOR JAMES OHRENSCHALL (Senatorial District No. 21):
I have a submitted written statement (Exhibit E) outlining S.B. 158.

PATRICK HIRSCH (Legal Aid Center of Southern Nevada):
I will read from my written testimony (Exhibit F).

MR. JACKSON:
The Children's Advocacy Alliance supports S.B. 158.

MS. BORTOLIN:
This is a short and simple bill. The language in the amendment (Exhibit G) mirrors the federal requirements to use federal funding. This does not change anything about the way the program should work. We all agree that guardianship is in the best interest of a child and the most appropriate placement. In some cases, we have issues getting funding around a legal impossibility question—in ten years would it be legally impossible that someone might prefer to adopt a child and do what is in the child's best interest today? We are working through that statute.

MS. DUFFY:
I would like to thank everyone involved in bringing forth S.B. 158 and working with the child welfare agencies to come to an agreement on the amendment that aligns us with federal language and will not impact our federal funding. I was assured that Clark County can remove its fiscal note if the proposed amendment, Exhibit G, is accepted, which changes the original restrictive language drafted and will move us to federally approved language opening up KinGAP guardianship for more children and families.

ALISON CALIENDO, PH.D. (Executive Director, Foster Kinship):
I have submitted written testimony (Exhibit H) in support of S.B. 158.

MS. BERTSCHY:
The Washoe County Public Defender's Office supports S.B. 158. The Kinship Care Program is an important piece of the process, and we appreciate the work to expand this program to help more families. These families are those already taking in their relatives to provide them with a better future. The more we can do to help them and those children the better Nevada will be.

KATHRYN ROOSE (Deputy Administrator, Quality and Oversight, Division of Child and Family Services, Department of Health and Human Services):
The Division of Child and Family Services is in the neutral position to S.B. 158. The Division submitted a fiscal note based on the original version of the bill and will remove it with the amended language.

CHAIR RATTI:
I will close the hearing on S.B. 158.

CHAIR RATTI:
As there is no public comment, this meeting is adjourned at 4:34 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
S.B. 146	B	1	Senator James Ohrenschall	Written Statement
S.B. 146	C	1	Amy Honodel / Legal Aid Center of Southern Nevada	Support Statement
S.B. 146	D	1	Amy Honodel / Legal Aid Center of Southern Nevada	Proposed Amendment
S.B. 158	E	1	Senator James Ohrenschall	Written Statement
S.B. 158	F	1	Patrick Hirsch / Legal Aid Center of Southern Nevada	Support Statement
S.B. 158	G	1	Senator James Ohrenschall	Proposed Amendment
S.B. 158	H	1	Alison Caliendo / Foster Kinship	Support Statement