MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON COMMERCE AND LABOR

Eighty-Second Session
March 13, 2023

The Committee on Commerce and Labor was called to order by Chair Elaine Marzola at 1:32 p.m. on Monday, March 13, 2023, in Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4406 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda [Exhibit A], the Attendance Roster [Exhibit B], and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/82nd2023.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Elaine Marzola, Chair
Assemblywoman Sandra Jauregui, Vice Chair
Assemblywoman Shea Backus
Assemblyman Max Carter
Assemblywoman Bea Duran
Assemblywoman Melissa Hardy
Assemblywoman Heidi Kasama
Assemblywoman Daniele Monroe-Moreno
Assemblyman P.K. O'Neill
Assemblywoman Selena Torres
Assemblyman Steve Yeager
Assemblyman Toby Yurek

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Marjorie Paslov-Thomas, Committee Policy Analyst
Cyndi Latour, Committee Manager
Elizabeth Lepe, Committee Secretary
Garrett Kingen, Committee Assistant

Minutes ID: 458

OTHERS PRESENT:

Whitney E. Koch Owens, Psy.D., President, Board of Psychological Examiners
Lauren Chapple-Love, Ph.D., President, Nevada Psychological Association
Amy E. Davey, Ph.D., Administrator, Office of Traffic Safety, Department of Public Safety
Sandra León-Villa, Ph.D., Licensed Psychologist, Las Vegas, Nevada
Lea Case, representing Nevada Psychiatric Association
Barry Eliot Cole, Private Citizen, Las Vegas, Nevada
Robert Purdy, representing Nevada Latino Legislative Caucus
Patrick D. Kelly, representing Nevada Hospital Association
Dakota Hoskins, representing Service Employees International Union 1107
Lesley R. Dickson, representing Nevada Psychiatric Association
Steven Messinger, representing Nevada Primary Care Association
Karen Oppenlander, Executive Director, Board of Examiners for Social Workers
Susan L. Fisher, representing Alta Skilled Nursing; State Board of Osteopathic Medicine; Nevada State Society of Anesthesiologists; and Nevada Orthopaedic Society
Zachary Gray, Chief Executive Officer and Owner, Revive Health Senior Care Management
Joan Hall, representing Nevada Rural Hospital Partners
Paige Barnes, representing Nevada Nurses Association
Michael Hillerby, representing State Board of Nursing

Chair Marzola:
[Roll was called. Committee protocols were explained.] I will now open the hearing on Assembly Bill 236. This bill will be presented by Assemblywoman Monroe-Moreno. You can start when you are ready. We will take a one-minute recess. [Recessed at 1:34 p.m., reconvened at 1:36 p.m.] Assemblywoman Monroe-Moreno, you may start when you are ready.

Assembly Bill 236: Revises provisions governing the practice of psychology. (BDR 54-799)

Assemblywoman Daniele Monroe-Moreno, Assembly District No. 1:
I am the sponsor of Assembly Bill 236, which revises provisions governing the practice of psychology. I am joined today via Zoom by Dr. Whitney Owens, a licensed psychologist and president of the Board of Psychological Examiners. Practicing psychologists have the professional training and clinical skills to help vulnerable patients cope more effectively with life's issues and mental health concerns. The goal of A.B. 236 is to ensure protection of the public by reducing confusion about what a psychologist is, and to ensure that psychological evaluations that are forensic in nature have proper oversight by licensed psychologists. Currently, there is a national movement to ensure that incarcerated individuals clearly understand who is providing them with psychological assessments and care. Forensic

psychology is a specialization of the field of psychology and treatment. Forensic psychologists must hold a license to practice psychology. The goal is to ensure inmates' rights are upheld by making a distinction between licensed psychologists from nonpsychologists. The Nevada Department of Corrections employs psychologists using job titles ranging from Psychologist I to Psychologist IV, but only a Psychologist III or IV is required to be educated, trained, and licensed as a psychologist, as defined in *Nevada Revised Statutes* (NRS) 641.025. A Psychologist I or II is required to have a master's or bachelor's degree in social work, marriage and family therapy, and other mental health-related fields, but does not need to hold a doctoral degree in psychology. With your permission, I will go over the bill summary.

Nevada Revised Statutes 641.390 restricts the use of the title of psychologist to individuals who have received the training, education, and licensure to engage in the practice of psychology as defined in NRS 641.025. Existing law provides an exception and authorizes a psychological scientist employed by an accredited educational institution or public agency that has explicit standards to represent himself or herself by the title conferred upon them by the institution or the agency.

Section 1, subsection 1 of the bill removes the exception from that prohibition, thereby prohibiting a psychological scientist employed by an accredited educational institution or public agency that has set forth explicit standards to represent himself or herself by the title conferred upon him or her by the institution or agency from representing himself or herself as a psychologist without a license issued by the board. Dr. Owens, who is joining me by Zoom, will now provide background and information of how the Board of Psychological Examiners has worked collaboratively with psychologists and the Department of Corrections to develop this bill. With your permission, Madam Chair, I will pass it to Dr. Owens.

Chair Marzola:
Dr. Owens, you can begin when you are ready.

Whitney E. Koch Owens, Psy.D., President, Board of Psychological Examiners:
I will give you some background on how the Board of Psychological Examiners has worked with the Department of Corrections on this bill. In late 2021, we began contacting psychologists in the Department of Corrections as well as other leaders in the Department of Corrections to talk about this bill, and what it boils down to is creating a name change. For Psychologist I and Psychologist II, it would be making a change to what their title is in the system. All of our conversations with the psychologists and other folks in the Department of Corrections have been very friendly. They understand the Board's concerns about the confusion that it creates to both the public and inmates when people who carry the title of "Psychologist" are not psychologists by training and education. Our goal with this bill is to reduce confusion for inmates and vulnerable populations. We want to ensure that those who are treated or assessed by psychologists can ensure that they are being treated by psychologists when they are there, and when they are not being treated by psychologists, they know the education and training of the person they are being treated by. I am happy to answer any questions that you might have.

Assemblywoman Jauregui:
I was reading the portion that was repealed in section 1, subsection 1. Can someone tell me what a "psychological scientist" is? How is that different from a regular psychologist?

Whitney Owens:
We believe that this bill—the way that it was written—was written in the 1970s. The practice of psychology has come a long way since then. When the language was written back then, I am not sure exactly what a psychological scientist was, or the intention of the bill back then. But because the practice of psychology has evolved to where there are clear guidelines for education, training, and accreditation for schools of psychology, the term "psychological scientist" is outdated and not really used in practice.

Assemblyman O'Neill:
To clarify, hypothetically, if I have a degree in social work or I am an alcohol counselor, I cannot put out my own shingle saying I am a psychologist. I read this to mean I cannot, but I just want to make sure that I cannot go into private practice as a psychologist. This is mainly just for the Department of Corrections, is that right?

Assemblywoman Monroe-Moreno:
I am looking at Dr. Owens and she is shaking her head yes.

Whitney Owens:
Currently, as it stands, anyone who is working within the state system in the Department of Corrections, even if they have the title of Psychologist I or Psychologist II, would not be able to leave that system and then go hang their own shingle. They would have to practice as a social worker or a marriage and family therapist outside of the state system. But in the state system, as it stands, they are eligible to be called Psychologist I or Psychologist II even though they do not have the education or training as such.

Assemblyman O'Neill:
Have we had a problem with this in the past? What is the issue we are trying to resolve?

Whitney Owens:
The problem we are working to solve is that in the Department of Corrections, when a Psychologist I or Psychologist II employee goes to see an inmate, their title is Psychologist I or Psychologist II, which creates confusion for the inmate because they think they are being evaluated by a psychologist. They are not being evaluated by a psychologist or being provided with a forensic evaluation. It creates some confusion about what level of care they are receiving. We are trying to ensure that when any kind of mental health professional within the Department of Corrections sees an inmate, the inmate is very clear on who they are getting care from, whether it is a marriage and family therapist, or whether it is a psychologist. Where it really matters is the scope and training that a psychologist has is unique as compared to other mental health practices. They can do specialty forensic assessments and neuropsychological assessments, which is very distinct to the profession of psychology.

Chair Marzola:
Committee members, are there any additional questions? [There were none.] We will now hear testimony in support of Assembly Bill 236.

Lauren Chapple-Love, Ph.D., President, Nevada Psychological Association:
[Read from written testimony, Exhibit C.] The Nevada Psychological Association is writing in support of A.B. 236, revising provisions regarding the practice of psychology. This bill removes ambiguous language regarding individuals named as "psychological scientists" while employed by public agencies or educational institutions. In so doing, this legislation clarifies the requirements for psychologists providing psychological services in these agencies.

On a professional note, I am a psychologist who does a fair amount of forensic work. Much of that work has been in correctional facilities from the federal side to the state side, and things along those lines. It is our hope that there is going to be much less confusing language that is going to help the people we are serving—those who are currently incarcerated—and also give weight to the fact that as psychologists, we have sometimes 11 or more years of training, which is vastly different from many of our amazing colleagues who are practicing with their master's degree, for example.

Chair Marzola:
Is there anyone else wishing to testify in support? [There was no one.] We will move to opposition testimony. [There was none.] We will now move to neutral testimony. [There was none.] Thank you. There will be no closing statements. I will close the hearing on Assembly Bill 236. We will now open the hearing on Assembly Bill 239.

Assembly Bill 239: Makes various changes relating to government administration. (BDR 23-896)

Assemblywoman Sandra Jauregui, Assembly District No. 41:
[Read from written testimony, Exhibit D.] Today, I am here as the Chair of the Sunset Subcommittee of the Legislative Commission for the 2021-2022 Interim to present Assembly Bill 239, which incorporates various recommendations approved by the Subcommittee. Chair and Committee members, if you recall my presentation on February 10, the primary duty of the Sunset Subcommittee is to review all boards, commissions, and similar entities that are created by statute and determine whether each entity should be continued, modified, consolidated with another entity, or terminated. The Subcommittee must also recommend improvements to the entities that are to be continued, modified, or consolidated. During the 2021-2022 Interim, the Subcommittee held 6 meetings, during which we reviewed 18 entities and received reports from several entities previously reviewed in past interims. The recommendations included in Assembly Bill 239 concern 7 of these entities. I would note that most, if not all, of the recommendations that are presented were requested by the respective boards, committees, and commissions. Thus, representatives from these entities are available for any detailed questions, along with the

Subcommittee's Committee Policy Analyst, Cesar Melgarejo. Chair Marzola, with your permission, I will walk the Committee through the sections of the bill.

Chair Marzola:
Please start when you are ready.

Assemblywoman Jauregui:
Sections 1, 2, 15, and 16 address the Merit Award Board. These sections, respectively, create the Merit Award Account in the State General Fund, remove language prohibiting an award to be paid out of the State General Fund, make an appropriation of $3,000 to fund the administration of the Board, and make an additional appropriation of $25,000 to provide funding for merit awards to state employees from the Merit Award Program. I understand we do not discuss money in a policy committee, but for reference, the Subcommittee recommended these legislative actions because representatives of the Board reported that the Board did not have funds for its operations, nor could it fund employee awards.

For the Merit Award Board, for any of the funds that were not expended, you will notice in the sections that that money is to revert back to the State General Fund. Section 3 of the bill requires that the Advisory Council for Family Engagement submit notification of a vacancy to the appointing authority—either the Superintendent of Public Instruction or legislative leadership, within 30 days before the beginning of the term of any member appointed to the Council, or within 30 days after such a position becomes vacant.

Section 4 revises the makeup of the Committee for the Statewide Alert System to decrease the total number of Committee members from 15 to 11 by decreasing from 5 to 3 the number of members appointed by the Governor who represent local law enforcement agencies and decreasing from 5 to 3 those appointed by the Governor who represent state law enforcement agencies. In addition, the Committee is required to submit to the Governor a list of persons qualified for membership as representatives of local and state law enforcement agencies, with consideration given to whether the nominees will represent the demographic diversity of Nevada.

Sections 5 through 9 make changes to the Committee on Testing for Intoxication, as requested by the Department of Public Safety (DPS). Specifically, section 5 expands the duties of the Committee to require the Committee to study and make recommendations to the Director of DPS regarding the best practices, technologies, and methods of detecting impaired driving substances, as well as to certify devices for the purpose of testing a sample to determine the concentration of a controlled substance or other prohibited substances.

Sections 6 through 8 of this bill revise the authority of the Committee to adopt certain regulations relating to calibrating certain devices and the certification of persons to operate certain devices to test the concentration of alcohol in a person's body to include testing a sample for a controlled substance or other prohibited substances. Section 9 clarifies that evidence of certain tests are not admissible in a criminal proceeding unless it is shown that

the device for testing a person's breath or other sample was certified by the Committee and was calibrated, maintained, and operated as provided in such regulations.

Sections 11 and 12 amend provisions to authorize the Commissioner of Insurance to call a meeting and schedule the time and place of a meeting of the Appeals Panel for Industrial Insurance.

Section 13 amends provisions concerning the Medical Laboratory Advisory Committee to require the Committee to: (1) meet at least once per year; and (2) review member vacancies annually and, if a vacancy exists, submit a letter to the State Board of Health with a recommendation to fill the vacancy.

Finally, section 14 addresses the Credit Union Advisory Council to delete the provisions that entitle members of the Council to receive a salary and clarifies that the Council may meet at least once every six months. Thank you for the opportunity to present Assembly Bill 239. I am open for any questions.

Assemblyman Yeager:
I vaguely remember hearing a presentation about this in front of the Legislative Commission, and I wondered if you could expand a bit on the Merit Award Account and the Merit Award Program. I know you talked a bit about it, but could you refresh my memory on what the purpose of that program is and what the funding would be used for?

Assemblywoman Jauregui:
When we heard the Merit Award Board Account, it was the recommendation of the administration of that division to terminate the Merit Award Board because there was no funding in there to implement what it was created to do. The Merit Award Board provides monetary awards to state employees who come up with programs to help make their department run more efficiently. What we heard from the Human Resources Administration is that they did not have anyone to work the program because there was no compensation provided to them. In addition, they had nowhere to pull money from to give these monetary awards to state employees. As a committee, we decided to create the award budget account and fund it with an appropriation of $3,000 to be able to compensate the state employees who would be reviewing the proposals submitted by state employees to help make their divisions run more efficiently. We also decided to fund it with a $25,000 appropriation to be able to fund these awards to state employees. If a state employee has a plan for his division to make it run more efficiently and to save the division some money, they could submit it to be reviewed, and then they would be entitled to some monetary award for their proposal. If by June 30, the money is not expended, that money goes back to the State General Fund. Everyone on the Sunset Committee and I were very supportive of the work of our state employees and felt that we should keep in statute something that provides an extra benefit for the work that they do, especially if they are going above and beyond to identify processes that would make their departments run more efficiently.

Chair Marzola:
I sat on the Sunset Subcommittee as well, and the Merit Award Program is a great benefit for our state employees. Does anyone else have any additional questions?

Assemblyman Yurek:
Not a question, just a comment. The City of Henderson, where I worked for 20 years, had a similar program, and it absolutely incentivized people to come up with great ideas that ultimately save far more than what you are paying. Great job on that.

Assemblywoman Hardy:
For the one committee where you are reducing the number of members, could you explain why they wanted that reduction? Is it a lack of people willing to serve, or what was the reason for reducing those in section 4?

Assemblywoman Jauregui:
In section 4, the Statewide Alert System also came from the recommendations of that committee. They have not been able to meet because of vacancies. They cannot find people to fill these roles. These are state and local law enforcement officers who have to volunteer their time to fill these committees. Right now, we are reducing it by two people from state law enforcement offices and two local law enforcement offices. These people have to be appointed by the Governor, and the Governor currently has to appoint five people. They cannot meet because they have trouble making a quorum. What we are doing is taking it from five appointees to three appointees for each group, but we are requiring the departments to submit a list of possible law enforcement officers that can be appointed.

Assemblyman O'Neill:
I love the Sunset Subcommittee. In section 14, where we are talking about the Credit Union Advisory Council, we are now requiring them to meet every six months. How often have they been meeting and have they been required to meet if there is no business to conduct? Are we just wasting the members' time to meet? I am curious how often they meet and why are we doing it every six months?

Assemblywoman Jauregui:
We are changing it to "may" to remove the requirement that they have to meet. When it comes to the reduction in salary, they actually requested this. At the moment, whenever they meet, they request that their compensation be kept—that they are not paid. Every time they meet, they have to go through this process of ensuring that they take a vote to not receive their salaries. They have asked for it to be removed from statute so they do not have to go through this process every time they meet. Again, we are changing it from a "shall meet" to a "may meet" so that they can meet, but if they do not need to meet, then they are not required to meet.

Assemblyman O'Neill:
How often have they met in the past couple of years? Do we know at all?

Assemblywoman Jauregui:
The last time they met was in February 2014.

Assemblyman O'Neill:
Do you think we could look at possibly dissolving the board?

Assemblywoman Jauregui:
We did have a robust discussion on that. During the meeting, the Commissioner of Financial Institutions stated that the Nevada Credit Union League would like the Council to remain. But again, these were some recommendations. We did have a robust discussion and ultimately felt that there was some value in keeping the Council around since they are not statutorily required to meet after this. Then, if needed, they would be able to meet with no compensation. I am also a fan of the Sunset Subcommittee.

Assemblyman Yeager:
I want to ask about section 5 and a couple of sections afterward. It is about the Committee on Testing for Intoxication. I want to say, I think this is an important one because that committee really just tests breathalyzers right now, which is important. I like that you put the addition here that they are going to look into best practices, technology, and methods, not just for breathalyzers and alcohol, but also for controlled substances. That technology is always changing, and it is really coming online, especially with controlled substances, including cannabis. I always felt that, as a state, we do not necessarily have a logical place to look at that. I appreciate that you are putting it in here. Did the Committee on Testing for Intoxication think they would be able to take this work on? Were they excited about it? Did those conversations happen? There is a lot going on in this space, so I would think that would amplify their duties quite a lot and hopefully in a good way. I want to get filled in on what those conversations were like at the committee hearing.

Assemblywoman Jauregui:
These recommendations came specifically from this committee. They testified during the hearing that they have so much expertise in their division that they felt it was being underutilized. If you would like to hear from them, we have the administrator, Amy Davey, here in person and the deputy director, Sheri Brueggemann, on Zoom as well. These recommendations came directly from them. They were excited to be able to expand their duties and use some of the expertise that they have within their committee.

Assemblyman Yeager:
I think it would be good to hear from one of them about what the intent is. Every time I read the paper, there is new technology coming out, especially with respect to cannabis and cannabis testing. I would like to get an idea of what you think this looks like going forward, if you have a plan for meeting on a regular basis, and hopefully being able to give our law enforcement officials in the field additional tools to determine intoxication.

Amy E. Davey, Ph.D., Administrator, Office of Traffic Safety, Department of Public Safety:
I am joined by Captain Eddie Bowers on behalf of the Department of Public Safety. The Committee on Testing for Intoxication has been meeting regularly. You are correct; they have a very important statutory function. Committee members may know that Nevada is the only state without a state-level, executive forensic toxicology laboratory. As such, the Committee serves as an oversight body for testing for intoxication and testing methods and standards. The Committee has historically done that for preliminary breath test devices, evidentiary breath test devices, and ignition interlock devices. Ignition interlock was moved into a separate section of statute. They still perform this function on behalf of the state, and also train law enforcement officers, calibrate equipment—they provide that oversight function. To your specific question, you are absolutely right. Technology is changing all the time. I want to express my gratitude to Chair Jauregui and the Committee because, when they contacted us, we asked them, please do not abolish this committee. Please expand the scope of this committee because we are on the verge of some interesting new technology. For example, oral fluid testing has been around for many years and is a proven technology for detecting impairing substances, not just cannabis. This can be done in a preliminary roadside test, similar to a preliminary breath test, which is then done in a confirmatory test in the lab. The committee has indicated they are interested in taking on this work. They are scientists, they find this work fascinating, and they want to continue to look at technology as it becomes available.

Assemblywoman Kasama:
I served on the Sunset Subcommittee, too, and really enjoyed it. I think it is a great committee. Did you state how many boards and commissions we have that the Sunset Subcommittee reviews? I think it is important for everybody to know what the scope is and how many we go through every session to review?

Assemblywoman Jauregui:
Last interim, there were over 200 boards, commissions, and similar entities. I know it is over 200; I am not sure what the exact number is. This last interim, we reviewed 18 boards and commissions for either continuation, termination, or consolidation. In addition to that, we also reviewed an additional 3 boards to review their practices when it comes to reviewing criminal histories for applications.

Assemblywoman Kasama:
Thank you. I think it is great for everybody to know how much work we go through and how much time we spend on each one when we do it. It is a very thorough vetting that we go through. I appreciated the time on that committee too.

Assemblywoman Jauregui:
Our policy analyst just let me know that it is 232 boards, commissions, and similar entities that are available to be reviewed by the Sunset Subcommittee.

Chair Marzola:
Thank you for that information. Committee members, are there any additional questions? [There were none.] We will open for testimony in support of Assembly Bill 239. [There was none.] We will move to testimony in opposition. [There was none.] We will move to neutral testimony. [There was none.] We will close the hearing on Assembly Bill 239. We will now open the hearing on Assembly Bill 267.

Assembly Bill 267: Revises provisions governing cultural competency training. (BDR 40-820)

Assemblywoman Selena Torres, Assembly District No. 3:
Thank you for allowing me to present A.B. 267 for your consideration. Members, I will note that there was a conceptual amendment that should have been made available [Exhibit E]. I apologize that it arrived so late, but due to the speediness of getting the bill, introducing it, getting a hearing scheduled, and wanting to meet with stakeholders to discuss that amendment, we continued to work through this until this morning. This measure has two key concepts that I want to address. The first requires the Office of Minority Health and Equity within the Department of Health and Human Services to support hospitals in completing the mandatory cultural competency training outlined in *Nevada Revised Statutes* (NRS) Chapter 433, which is a chapter that only applies to the hospitals. The second part of this measure requires mental health professionals to complete 6 continuing education units relating to cultural competency, which includes diversity, equity, and inclusion. I want to be clear that these six hours that we are requiring of licensing boards does not apply to NRS Chapter 433. The two chapters are completely separate, so I am not requiring the training outlined in NRS Chapter 433 to be six hours. The six hours only apply to the continuing education units that licensed mental health professionals are already required to have. Although I am presenting this, but with the amendment, I want to let the Committee know that I have had several conversations with key stakeholders, and I believe that we are in a good place. I know we will continue these conversations before we have the opportunity to have a work session on this piece of legislation. I would like to turn it over to Dr. Lauren Chapple-Love, who will define cultural competency. She will be followed by Dr. Sandra Leon-Villa, who will address the need for this legislation. Lastly, I will walk through the bill with the amendment.

Lauren Chapple-Love, Ph.D., President, Nevada Psychological Association:
I am a licensed psychologist providing mental health services and private practice in Las Vegas, Nevada. Cultural competency is commonly viewed as the building of knowledge and skills relating to groups, both similar and dissimilar to my own. Given Nevada's growing diverse population, the medical and mental health providers who serve these communities not only have ethical requirements but also professional requirements to improve our skills. Through recognition that many individuals live within complex constellations of intersectional identities, the continuing education component of our training must also reflect the dedication to providing more equitable care for those communities. Regarding that discussion on the use of the term "cultural competency," one may typically see this as more of an inclusive umbrella, covering a network of educational tools, perspectives,

evidence-based practices, and client- and/or patient-centered skills that each of us clinicians have to build so that we can better serve those communities.

The concepts of cultural humility and cultural responsiveness also give way to the notion that considering oneself competent in the finite sense is not a research-based view. Rather, we professionals are tasked with continuing to build and improve our understanding of these competencies in much the same manner that we continue to build upon other clinical skills needed for our respective jobs. Similarly, experiences or exposure to a particular population is not sufficient to suggest having met a level of cultural humility. I, for example, would not propose that I am competent simply because I identify with a particular population. We also recognize that historically many of our fields have fallen far short of inclusive or equitable care, and at times have full-on caused harm or increased health care disparities with apologies and acknowledgements pouring in from a host of provider associations: American Psychological Association, American Medical Association, National Association of Social Workers, et cetera. The below quote is a summative explanation of the current shift in many of our fields regarding cultural humility. This comes from the article, "The case for cultural competency in psychotherapeutic interventions" [*Annual Review of Psychology*, 2009]. "Ridley, (1985) has argued that cultural competence is an ethical obligation that cross-cultural skills should be placed on a level of parity with other specialized therapeutic skills. As an alternative to the passive, 'do no harm' approach in ethical standards in many helping professions." Hall, et al, in a 2003 article talked about advocating "that ethical standards mandate cultural competence via collaboration with, and sometimes in deference to, ethnic minority communities and experts" and other communities across the spectrum of cultural humility.

We now see training and cultural competencies being mandated at the educational level. We hope to continue to see an increase of that at the professional and continuing education level. We would like to note not only the need for increased training, but also the development of effective training opportunities, insofar that contemporary research efforts have begun to focus upon identifying methods to implement evidence-based strategies towards more efficacious cultural competency training. Notably, preparing for the training by knowing your audience, developing a succinct and accessible training curriculum that is perhaps inclusive of the different needs of populations, employing the most effective methods of presentation, delivery, choosing effective and well-informed trainers that are either from and perhaps can give voice to those populations, or who have done extensive research with and are able to give voice to either evidence-based or the population in and of itself as well as provide opportunities to have participants offer evaluative feedback about how the training was. In short, this is not simply checking a box; this is offering some type of change. It is meant to get a person off of a neutral stance.

Sandra León-Villa, Ph.D., Licensed Psychologist, Las Vegas, Nevada:
Although Nevada is said to be a majority white state with approximately 50.3 percent of the state identifying as white, it must be noted that nearly 50 percent of the state is made up of Black, Indigenous, and other people of color. Nearly 30 percent are Hispanic or Latin, 6 percent are Black, 10 percent are Asian or Pacific Islander, and 1 percent are

Native American or Alaska Native. According to the 2021 Minority Health Report, health disparities continue to predominantly negatively impact BIPOC [Black, Indigenous, people of color] people, or people of the global majority, in all aspects of health, including mental and physical health. These disparities include Black individuals having the highest mortality rates across various health conditions. Mental health is the poorest among Black individuals. The highest depression rates are among Native American or Indigenous individuals. Additionally, Latin and Hispanic populations continue to be the largest affected by the COVID-19 pandemic. In fact, Nevada is ranked thirty-fifth in the country for health equity when it comes to minority, or global majority, health. This is concerning when paired with low levels of education and income, which make up the majority of our population within most households. For example, Latinx families, the largest global majority population in Nevada, report that approximately 39 percent have a level of education lower than a high school diploma, while only 8 percent are college graduates. This is undoubtedly influenced and exacerbated by low socioeconomic status, with more than 26 percent of the population reporting an annual income between $15,000 and less than $25,000. Similarly, nearly 32 percent of Black families or individuals have a high school diploma, while only approximately 41 percent have some college. More than 40 percent of all Black families and individuals in Nevada report making less than $50,000 a year.

Educational level and socioeconomic status, which influences access to services, are important factors that contribute to health literacy, or the lack of. These numbers have some significant implications for health disparities and health literacy. The Centers for Disease Control (CDC) updated the definition of "health literacy" in August 2020 to include both personal and organizational health literacy as follows. Personal health literacy is "the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others." Organizational health literacy is "the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others." The CDC emphasizes the importance of one's ability to use health information, but also that organizations have an obligation to address health literacy, thus placing the responsibility on health providers. However, in order to understand and address health literacy, it is imperative to also understand sociocultural factors that influence health literacy. Currently, health providers in Nevada, whether physicians or psychologists, are predominantly white. This is important to note, given that research, treatment, and interventions have historically been based on the perspectives of members of the global minority, which consequently impacts and contributes to the health disparities as evidenced by the multiple national association apologies regarding the harms various health fields have committed against BIPOC people.

The current policy requiring 2 continuing education hours is not sufficient to make a significant impact on the statistics. For instance, psychologists are currently required to obtain 2 hours of diversity, equity, and inclusion training every two years. That is 1 hour per year. This 1 hour of training does not allow for in-depth learning and understanding of cultural factors. Research indicates that lack of cultural responsiveness may result in a lack of sensitivity to cultural differences in symptom presentation, consequently leaving providers

vulnerable to their own implicit biases, stereotypes, and negative attitudes to certain populations due to their lack of training and culturally responsive assessment and diagnosis. Increasing continuing education requirements will contribute to decreasing health disparities, as it is implicit bias by providers that contribute to these disparities, making diversity, equity, and inclusion training imperative.

Assemblywoman Torres:
This is not the first time that we have had this discussion. During the 80th Legislative Session, we passed Senate Bill 364 of the 80th Session and Senate Bill 470 of the 80th Session, which required medical facilities licensed in Nevada to follow various procedures surrounding cultural competency in the workplace. During the 81st Legislative Session, this body passed Assembly Bill 327 of the 81st Session, which mandated that mental health professionals receive 2 continuing education units in cultural competency. This is an issue that is near and dear to my heart. During my childhood, I experienced firsthand how important it is for health professionals to have cultural competency training. My father, who fled the Salvadoran civil war as a teenager, suffered from post-traumatic stress disorder. While he sought help from health care professionals, he struggled to find someone who understood his cultural identity. If those health care professionals had training, my father would have had access to the services that my family needed much earlier in his life. To effectively serve diverse communities, we need health care practitioners to understand this and respect and value all of our cultural differences and perspectives towards mental health. At this time, I am going to quickly walk through the amendment [Exhibit E]. I am going to focus on the amendment, although I think the amendment clearly refers you to the pages and section numbers that are in the bill.

The amendment in section 1, subsections 1 and 2, restores language and eliminates new language. We want to continue to grant authority to the Board to enforce cultural competency training for health care facilities. In section 1, subsection 3, the duties outlined for the Office of Minority Health in the bill would continue to remain, but we expanded those. One, we would like to request—which I think will end up going to a different committee as well—two full-time employees to the Office of Minority Health and Equity to fulfill the duties required in this piece of legislation. Two, outline the expectations for the training and create model curriculum that may be used by facilities at no cost. Three, create a schedule to approve training for each facility every two years. We recognize that this might be an extreme overload to the system if we require all the training that has already been approved to be done every two years. I recognize that there might need to be a schedule put in place because many facilities have already started this training and have already had a training approved. Four, facilities may submit training for approval. We want it to be clear that facilities, nursing homes, and hospitals could continue to submit their own training. Five, report to the Interim Committee on Health and Human Services and Commerce and Labor by October of each year regarding the approval time to process each application and the status of training at each facility. Six, any party aggrieved by the approval process may seek resolution with the Bureau of Health Care Quality and Compliance, which is where this chapter currently sits.

In section 2, we will be removing all changes to subsections 2 and 4. The reason for that is it applies specifically to the Board of Medical Examiners. If you look at the requirements for licensure for the Board of Medical Examiners or the Board of Osteopathic Medicine for physician assistants as well as psychiatrists, they have significantly more requirements of the training that has been outlined for them. They will continue to receive their 2 continuing education units. However, it does not require them to get more. Additionally, there is language that requires that the board must approve the training that has been provided by NRS Chapter 449.103, which is the chapter that is health care. So, if the physician works in the hospital setting, they can use that. That was a request from many of the facilities.

Section 3 changes the requirement from 2 hours to 4 hours for nurses. The reason we have this change for nurses is to align the training with what is provided within the hospital setting. I went over section 4 because that is under the Board of Osteopathic Medicine. In section 5, there is no change to what that bill is, but that expands hours from 2 to 6 continuing education units for licensed psychologists. Section 6 does the exact same change for marriage and family therapists. Section 7 does the same change for licensed social workers here in the state of Nevada. Section 8 applies to alcohol, drugs, and gambling counselors in the state of Nevada. Section 9 applies to behavior analysts or assistant behavioral analysts. Finally, section 10 has to do with the passage of this bill. I am ready for any questions.

Chair Marzola:
Thank you, Assemblywoman Torres, for your presentation. I have a couple of questions, but I will let the Committee members ask first.

Assemblywoman Jauregui:
It looks like with your amendment you are restoring the functions back to the State Board of Health, correct?

Assemblywoman Torres:
Yes.

Assemblywoman Jauregui:
Then, it looks like we are removing the recommendations for the psychiatrists and physician assistants and only applying it to the—

Assemblywoman Torres:
Yes, that is correct.

Assemblywoman Jauregui:
It looks like most of the requirements are reduced from 6 hours to 4 hours in cultural competency. They were originally required 2 hours, and it looks like the original language increased it to 6 hours. Then, through your amendment, you are reducing it to 4 hours?

Assemblywoman Torres:
No, the only one that would go to 4 hours would be the nurses, but the rest of the professions would be required to have 6 hours.

Assemblywoman Jauregui:
It looks like your amendment also reduces the alcohol, drug, and gambling counselors to 3 hours. Why is there not consistency? Why are some licensees required to have more cultural competency than others? Some have 2, some have 4, some have 6, and some have 3 now. Why is there a difference in requirements for the different licensees? Also, could you clarify if this is increasing the number of continuing education hours for each licensing group, or is it only changing what they currently have to take in regard to the number of hours in cultural competency?

Assemblywoman Torres:
I am going to answer the first question which applies to the Board of Medical Examiners. If you look at the statute for the Board of Medical Examiners, it requires several other types of training, so increasing it to 6 hours for cultural competency would take away their ability to have training in other things. That is why we did not apply that to the Board of Medical Examiners and the Board of Osteopathic Medicine. When we specifically look at nurses, there are other requirements that nurses are required to have in their statute that do not apply to licensed psychologists or social workers, for example. Whereas, if you look at licensed psychologists and licensed social workers, they are only required to have 2 units in suicide prevention training, and then the rest of their 30 credits are completely open. So, we are requiring 6 of those 30. Right now, 2 of the 30 are required to be in suicide training. Currently in statute, 2 of those hours are required to be in cultural competency training, and we are increasing it to 6 of those hours having to be in cultural competency training.

To the question regarding section 8 of the legislation, which applies to alcohol, drug, and gambling counselors, that is a great question. If you look—and I actually think this is a drafting issue—if you look at the piece of legislation, alcohol, drug, and gambling counselors have to renew their licenses annually. Instead of requiring them to do 6 credits annually, we are requiring 3 credits annually.

Assemblywoman Jauregui:
So they are required to do 30 hours of continuing education units every two years? Now 2 hours have to be in suicide prevention and 6 hours will have to be in cultural competency. That makes up 8 of the 30 hours. That is a big jump from 2 to 6 hours. That is a big portion of the total 30 hours. If you could get us a list of what other courses they are required to take, or what this will be taking away hours from—from some other type of continuing education, correct?

Assemblywoman Torres:
If you look at the statute, no. There are 30 units. They can take those units—and they can speak to it as well—they can take those units in anything, but 2 of those have to be in suicide prevention and 6 of those have to be in cultural competency. It is important to remember that

the cultural competency training can be in a number of things. If you look at what is included in the current statute, an individual is only taking an hour per year to cover anything in diversity, equity, and inclusion. That includes anything regarding the LGBTQ community; anything regarding various religious backgrounds; gender; racial and ethnic backgrounds; children; senior citizens; veterans; persons with mental illnesses; persons with intellectual or developmental disabilities; and other populations. That is a very large group of people, and this is key to the work that mental health care does.

Lauren Chapple-Love:
To that point, my current understanding is that this is going to allow whatever particular practitioner—I will use my own particular field as an anecdotal piece of discussion point. As a psychologist, we are mandated to have, I believe, 6 ethics credits in addition to 2 suicide prevention credits and now, of course, the extension from 2 to potentially 6 related to diversity, equity, and inclusion topics. As a psychologist, I can now maneuver utilizing the 30 credits that we are required to take once every two years—many of us get more, but that is the minimum. I can now maneuver and decide what I would like to work on. I have gotten training on specific types of therapeutic modalities for LGBTQ individuals, for example. That is a big part of my current practice, as well as BIPOC individuals. I do not believe this is in the vein of taking away from learning about the foundational components of our job, how to do the treatment modalities. But this is specific to the folks that we see. As a further anecdote, many of the folks that come to see me or Dr. León-Villa, I would imagine—although I cannot speak for her practice—are specifically looking for Black psychologists, queer psychologists, someone who is Spanish-speaking, or someone who has experience in testing across a number of different populations. To me, that is where you can still have the autonomy as the doctor to have ownership over your particular practice. Perhaps, I am doing most of my credits and treatment for disordered eating or autistic spectrum disorder. This simply requires that you are being inclusive of the populations that we serve, which is reflective of what Nevadans look like.

Sandra León-Villa:
I want to piggyback on what Dr. Chapple-Love was just saying. Of course, we are in a field that is predominantly white, so even if folks are looking for Black or Brown clinicians, there are not enough of us. There are not enough of us in the first place, in general, for any clinicians. We have a large mental health gap here in Nevada. As such, it is imperative that the clinicians that are available receive training so they can help work with the community, because I cannot work with all the Latinx people, right? Also, there are not a lot of bilingual testing clinicians here in the state, in general. It is definitely for all providers here.

Assemblywoman Backus:
At first, I thought this bill pertained to mental health care. Then I noticed during the presentation that it also focused on physical health. However, when I am looking at subsections 2 and 4 that pertain to medical physicians as well as osteopathic physicians, it is explicit that it only pertains to psychiatrists. I am not sure if I am missing something. I also took a look at NRS 449.103 that pertains to hospitals, but that is limited to employees. I can

see where the physical health is important, but I feel like it is missing, unless I am missing something.

Assemblywoman Torres:
Nevada Revised Statutes Chapter 449 applies to all hospitals and also, I believe, nursing facilities. Hospitals are not the only type of health care setting that would be receiving the training under NRS Chapter 449. It is my understanding that the training would be provided to all employees. The hospitals can probably chime in when they come up to talk on the bill as well. The other part of this is regarding the licensing credits; that is applying specifically to mental health professionals. To note quickly, we exclude the cultural competency requirements for the Board of Medical Examiners—like the increase, we are excluding with the amendment of this bill.

Assemblywoman Monroe-Moreno:
A lot of the work I have done while being in this building has been with maternal and child health. We have heard testimony after testimony from mothers and fathers who lost their spouse or child because medical professionals may not understand the needs of that family. Thank you for bringing this bill, because it goes to either behavioral health care professionals or medical professionals having the ability to understand the differences from different cultures and giving the patient that dignity and being willing to step outside of their own lived experiences to understand someone else's. As the doctor said, we do not have enough health care professionals in the state as a whole. I often get calls from people who say they really want to talk to a behavioral health care professional that looks like them, understands them, and has lived the experiences that they have lived. Even though we may not have them, having this training would help someone that may not have those experiences understand them. In section 1.3 of your amendment, it asks for two full-time employees for the Office of Minority Health and Health Equity (OMHHE). Can you tell us how many full-time employees it currently has in that department?

Assemblywoman Torres:
I do not have the answer for you, but I know that they are a pretty small office right now. I am happy to get back to you on that.

Assemblywoman Monroe-Moreno:
As for my second question, in that same section, you talk about creating a model curriculum. Is there a model curriculum out there that the OMHHE could bring to Nevada and make it Nevada-specific, or will they have to start from scratch?

Assemblywoman Torres:
In my research, I was able to find that there are some model-like standards that have been outlined by the OMHHE, so I think we can continue to work in conjunction with our federal partners. Additionally, I want to note that there are a number of facilities that already have training that have been approved. Obviously, I cannot speak for those facilities, but I think that many of them would be eager to work together to create a model curriculum that they

would be able to use. I think that they would like it to be clearly outlined what their expectations are.

Assemblyman O'Neill:
In section 1, line 8, you have changed the word, "to" to "shall." Can you explain the difference? I see them as the same thing.

Assemblywoman Torres:
Actually, with the amendment, we are removing the changed language in section 1, subsection 1 and section 1, subsection 2. I am going back to the original language to ensure that the ultimate authority would continue to be under the Bureau of Health Care Quality and Compliance.

Assemblyman O'Neill:
We are back to using "to," correct? Right at the beginning of line 8.

Assemblywoman Torres:
Correct.

Assemblyman O'Neill:
Help me understand. The way I understand it, you are saying that a social worker or others have to take 30 hours, and that they have requirements now in suicide prevention, which is 2 hours. They are currently required to take—what did you say—another 2 hours in cultural awareness, and you are going to expand that to 6. So that is 8 hours of their 30. I would like to know what the other 30 hours—there must be some requirement that they have to be in some kind of field related to their position instead of just taking anything they feel like. It is the same as when I was in college; we could take frisbee golf for our physical education. I did not think that was much for graduation, but that is what they had there. It seems to me we are taking away. Both of the psychologists here—you and other professionals are doing on-the-job training every day as you deal with their clients. Are you not learning something from your clients as to how to improve your standards and your care and capabilities? That is what I am trying to get at. Tell me what I am taking away from. That psychologist up in Eureka, Elko, or Fallon may not have a lot of exposure or need to do this, but they may have a need for some other training that we are taking away from.

Assemblywoman Torres:
I want to be clear that every single psychologist and social worker in the state of Nevada will, at some point, work with individuals from various gender, racial, and ethnic backgrounds. They might work with the LGBTQ community. They might work with children or senior citizens. They may work with veterans. They may work with people with mental illness. They may work with people with intellectual, developmental, or physical disabilities. And they may at some point work with another population that might have some type of need. So I do not think there is any region of the state—it does not matter what part of Nevada I go to—that would not be better off by receiving culturally competent care. But I know that they can speak a little bit more to the—

Assemblyman O'Neill:
I am not disagreeing with that. What I am asking is, they are required to take 30 hours, and we are taking more time away to have them do this instead of other training that may be more related to their immediate fields and the areas they are at. Not everybody practices in Las Vegas. Would you admit to that, please? What I am trying to get at is, what is the other training?

Assemblywoman Torres:
Dr. León-Villa, can you speak to the licensing requirements?

Sandra León-Villa:
Currently, we are required to have 30 continuing education hours for license renewal every two years. As you stated, currently 2 of those hours are required for diversity, equity, and inclusion training; 6 hours are for ethics; and 2 hours are for suicide prevention training. All of the hours that we complete for continuing education have to be approved. At a post-doctoral level, they also have to be sponsored by an association that the Board approves for us to submit. We cannot take any training that we want to take. At this point, when we are talking about diversity, equity, and inclusion, every single person that we touch has multiple identities, and therefore we are not taking away with this training. Because there is so much beneath the umbrella of diversity, equity, and inclusion, that regardless of what I specialize in, or what Dr. Chapple-Love might specialize in, or any other provider, they—as Assemblywoman Torres mentioned—would benefit from the training because, again, we are not a monolith. We are made up of different identities. Even if, hypothetically, I happen to be a white woman, there are still multiple identities that are layered that are important for providers to understand. If anything, providers still have the option to use those 6 hours of continuing education under diversity, equity, and inclusion, and still tailor it to their training. For instance, I specialize in neurodevelopmental disorders and testing. So I can take a testing continuing education course that focuses on autism, and that would suffice as diversity, equity, and inclusion, while still contributing to my specialization.

Assemblyman O'Neill:
That is what I wanted to hear. Thank you.

Chair Marzola:
Does anyone else have questions? [There were none.] The majority of my questions were asked, but I do have one last one. I am trying to figure out the thought process behind going from 2 hours to 6, instead of maybe 2 to 8, or 2 to 10?

Lauren Chapple-Love:
This is on par with our ethical requirements. The number six was not pulled from a hat, if you will. It is also inclusive of recognition—certainly just speaking as a psychologist, not as a social worker, or any other form of the mental health professionals that we are talking about here today, that would be touched by this particular bill draft request—that this is also going to be on par with being able to recognize that you can have some trainings that are applicable for both, for example. And perhaps, to the Assemblyman's question from earlier,

this is meant to address the current health care disparities that, in particular, rural and frontier Nevadans are experiencing. Our hope is that by increasing the number of hours by such a substantial number, while also attempting to maintain the autonomy where you are allowed to take whatever credits you would like that are well within whatever specific parts of the field that you are in, this is meant to really address. It is our hope that if I am a veteran in Elko or wherever, that I still have access to care from someone who has not just anecdotal experience, but evidence-based practices on how to best and most effectively treat me for whatever number of identities that I hold.

Chair Marzola:
Committee members, are there any additional questions? [There were none.] We will open up testimony in support of Assembly Bill 267.

Lea Case, representing Nevada Psychiatric Association:
We want to first thank the sponsor for working with us Friday morning and afternoon, Saturday, and a little bit on Sunday, to come up with the suggested amendment and the proposed amendment. As she stated during her bill presentation, there are a lot of requirements on physicians and psychiatrists, as pointed out by Assemblywoman Torres. Our physicians are licensed under both the Board of Medical Examiners and the Osteopathic Medical Board. The requirement to get more hours of training might be fine for the other behavioral health providers, but it is a little more difficult when it comes to continuing medical education because those have to go through a different accreditation process. It is longer and it is at a national level. Again, there are many more hours that are prescribed in statute for physicians to take. This adds quite a bit to that. There are some psychiatrists here to testify as well, so I will turn it over to the experts.

Barry Eliot Cole, Private Citizen, Las Vegas, Nevada:
I am a member of the American Psychiatric Association and a member of the American Medical Association. It is sort of weird to be up here as a white, male physician originally from California, reared by a feminist woman. That is my background. I am trying to come up with something that makes coherent sense. The *Diagnostic and Statistical Manual of Mental Disorders* V is how I diagnose everything I do. It actually has an embedded chapter on how I am supposed to do a cultural and psychiatric diagnosis, to basically overcome the historical shame that we have had. For our annual meeting this year, we actually did an entire track—8 hours on cultural competency. What you need to appreciate is there are only 250 psychiatrists in the Nevada Psychiatric Association. Yet, we drew 500 from all over the United States and ultimately had our meeting for 1,700 people. In our meeting, what we try to do is bring psychiatric themes back to the idea of cultural competency, whether it is ethnicity as it relates to pharmacology, or whether it is understanding various sexual orientations, or whatever it may be. We have an interesting group of people in Nevada who practice psychiatry, but we all use the same book. Whether a psychologist, a social worker, a psychiatrist, we all diagnose the same way. I am in support of this bill because I think it is important that we do this. After I left Mexico, where I did my initial training, I went to North Carolina, where I assure you I did not know what people were talking about. I had greater cultural shock moving to North Carolina from California than moving to Mexico.

Robert Purdy, representing Nevada Latino Legislative Caucus:
We support Assembly Bill 267. We support this bill because we believe that the cultural competence of mental health professionals is vitally important in treating the needs of diverse communities. We ask you all to support this bill as it is a crucial step in the right direction to addressing the complex health crisis that we are facing as a state.

Patrick D. Kelly, representing Nevada Hospital Association:
We support the general direction of this bill with the amendment. We want to thank the sponsor for taking the time to meet with many different people and to listen to them. Obviously, we want to see the final language of the bill before making any decision. We also want to run it past our members, but I think we are off to a decent start on this and are very appreciative of the sponsor of this bill.

Dakota Hoskins, representing Service Employees International Union 1107:
We currently represent around 11,000 nurses and health care employees. We are in support of this bill. You have heard from many of the other supporters and bill presenters, so we will keep it short. We think that this is a crucial component when addressing health care and diversity in our state. We urge you to support this bill.

Lesley R. Dickson, representing Nevada Psychiatric Association:
I am mostly going to echo what my two colleagues, Lea Case and Dr. Cole said. I do want to add another thing, though. This bill has always seemed to assume that we do not get any training in this stuff anywhere else other than these continuing education units, but I did get ahold of the Accreditation Council for Graduate Medical Education requirements for psychiatric residency. There are three pages devoted to cultural competency issues. Having been a training director myself, I know that we do spend a lot of time addressing cultural issues with our psychiatric residents in their four years of training. In other words, getting to know the patient and understanding where the patient comes from. There may be some bad apples out there that do not do a very good job of that, but I think we have done a lot of training, so my support is of the amended bill with staying at 2 hours of units in cultural competency rather than 6 hours, but I appreciate Assemblywoman Torres for agreeing to change the hours from 6 hours to 2 hours.

Steven Messinger, representing Nevada Primary Care Association:
Today, I am here to talk on behalf of our side project, which is the Nevada Cultural Competency partnership with the High Sierra Area Health Education Center. We are very much in support of this bill. We want to thank Assemblywoman Torres for reaching out and addressing our concerns, and the amendment looks like it pretty much pleases everyone.

Karen Oppenlander, Executive Director, Board of Examiners for Social Workers:
I appreciate that there has been conversation about what the needs are for different levels of social work at the most basic area of continuing education requirements of 30 hours. That would be 2 hours in cultural competency— [Phone line was disconnected.]

Chair Marzola:
Is there anyone else wishing to speak in support of A.B. 267? [There was no one.]

[Exhibit F, Exhibit G, and Exhibit H were submitted in support of A.B. 267 but not discussed and will become a part of the record.]

We will move to testimony in opposition of A.B. 267.

Susan L. Fisher, representing Alta Skilled Nursing; State Board of Osteopathic Medicine; Nevada State Society of Anesthesiologists; and Nevada Orthopaedic Society:
I am speaking on behalf of several clients today: Alta Skilled Nursing, State Board of Osteopathic Medicine, Nevada State Society of Anesthesiologists, Nevada Orthopaedic Society. The other one is neutral on the bill. What I will say is Alta Skilled Nursing is still in the bill. We are opposed to—and the Board of Osteopathic Medicine does not have a formal vote, but from the comments when they discussed it—it was not agendized, so they were not able to take a vote on it when they had their last meeting. They are going to take a vote on it tomorrow night when they meet again—but from the comments that had filtered back to our executive director from board members, they sounded like they were in opposition to it. But, if the amendment goes onto the bill, then I suspect they will be moving to neutral. I cannot guarantee that at this moment. It is the same for the Nevada State Society of Anesthesiologists; if the amendment is accepted, then we would move to neutral on the bill, but Alta Skilled Nursing is still included in the bill, so they would remain—I will let Mr. Gray speak for himself then.

Zachary Gray, Chief Executive Officer and Owner, Revive Health Senior Care Management:
My wife and I own three nursing homes in northern Nevada, representing 489 skilled nursing beds. We are the largest in-house operators in the state of Nevada, and we live here in Reno, so I drove down for the hearing. I want to speak briefly about the administrative burden this puts on a facility. It is not as though we are opposed to cultural competency training. I want everyone to understand how this works in practice. I will go on to say I am a licensed nursing home administrator; I am a licensed certified nursing assistant; I work as a certified nursing assistant in my facilities; I am a licensed phlebotomist who works as a phlebotomist in my facilities as well. This impacts me professionally as well as the oversight of our businesses. I am licensed as a nursing home administrator in seven states including California, New York, Virginia, Pennsylvania, the District of Columbia, Virginia, and I probably missed two, but I am nervous. In addition to that, I have my undergraduate degree in health administration from Georgetown and my graduate degree in master of public health from Columbia University.

A lot of ideas are good in theory, and then you get to practice and the administrative burden that is placed on things. In my opinion, this really has not been thought through. I do not think that it was thought through the first time it was passed two years ago. When it comes to giving this training, I want everyone to understand that 2 hours is a long time. During the

testimony, I heard people say that it is additive and it reduces your continuing education unit hours. That is not necessarily true. For the certified nursing assistants, [unintelligible], this is on top of the additional training they get. Typically, it is done during work hours. Last year, we spent $56,000 conducting cultural competency training for 450 employees. That is $56,000 in a nursing home, which is 80 percent Medicaid. If you increase this to 6 hours, it will cost us $150,000 to conduct the training. That does not compensate for the shifts that are covered. The shifts covered would cost upwards of $250,000. I would like to suggest everyone take the time to consider the administrative burdens that this type of legislation puts on facilities. I would like the opportunity to work with the Assembly on correcting those administrative burdens.

Chair Marzola:
Is there anyone else wishing to testify in opposition to Assembly Bill 267?

Karen Oppenlander:
I am calling back in support of this bill. I am sorry, I got disconnected earlier. I want to let the group know that the continuing education requirements in social work come in two areas. There are three levels of licensure that require 30 hours, and another two areas that require 36 hours. If you are getting 30 hours of requirements; 2 in cultural competency, diversity, equity, and inclusion; 4 hours must be related to ethics, and 2 in suicide prevention, with 10 hours in the field of practice of the licensee. The other two, licensed clinical social workers and licensed independent social workers, must complete at least 36 continuing education hours. Of those 36, that would be 2 hours in suicide prevention; 2 hours in cultural competency, diversity, equity and inclusion; and 4 hours in ethics practice, with 12 hours devoted to the field of practice of the licensee. Thank you for your time. We are in support of this effort and want to make sure that you understand our requirements in the social work department division.

Chair Marzola:
Is there anyone else wishing to testify in opposition to Assembly Bill 267? [There was no one.] We will now hear testimony in the neutral position to A.B. 267.

Joan Hall, representing Nevada Rural Hospital Partners:
We are here in neutral today. I want to thank Assemblywoman Torres for the time she took to listen to our concerns, and I think she incorporated many of those into her amendments. I need to have time to digest it and get it to my members.

Paige Barnes, representing Nevada Nurses Association:
We are here in neutral to the bill. We appreciate the sponsor's working with us on Friday and hearing our concerns on the bill. We are generally supportive of cultural competency continuing education units and worked with Assemblywoman Torres last session on her bill. We want to be sure that the training aligns with current requirements already in statute. We will continue to work with Assemblywoman Torres on this.

Michael Hillerby, representing State Board of Nursing:
We are here in neutral because you set the policy that we enforce. I want to provide a bit of information for the Committee as you consider this, particularly in regard to the implementation of the bill from last session. While it is great, and we already approve all of the training that might be required in NRS Chapter 449 for medical facilities and can also count toward the nurse licensure continuing education, not all nurses work in medical facilities that are licensed that way. You have them in schools and lots of other places, so they will also need to find that training. There were real challenges last time in finding approved training and for approved trainers to get courses developed in time. We have almost 70,000 licensees and their renewal dates are on their birthdays. One of the challenges the Committee might want to consider is the effective date: the effective date of July 1, 2024. Last session's bill was July 1, 2022. We had a lot of nurses that had real problems getting the training and ran into challenges there and were late doing that. We obviously do not want to spend time disciplining people for that if it can be easily avoided. I wanted to point out some of those implementation issues that you might consider as you move forward. Those courses come at some cost, and we work hard to either provide those or approve those from trainers. We want the community to be aware of those things.

Chair Marzola:
Is there anyone else wishing to give testimony in the neutral position? [There was no one.] Assemblywoman Torres, would you like to give some final remarks?

Assemblywoman Torres:
Thank you, Committee, for taking the time to hear this piece of legislation. I would like to make it very clear that, at this time, I have had over 20 meetings in the last week with medical stakeholders regarding this piece of legislation. It is something very well thought out. It is a conversation that we have continued having, and I have had the pleasure to work with many of the stakeholders that spoke here today so we could come to an agreement of what actually makes sense for Nevada. I also want to make it clear that this is not adding the requirement of cultural competency. And for NRS Chapter 443, this is not something new that we are adding; this is something that is already in statute. My goal with this legislation is to streamline this process a bit, to make it easier and more efficient for hospitals so we can make sure we can have that training in every facility as quickly as possible without it being cumbersome. I spoke with many of the facilities here over the last couple of days, and many of them expressed frustration with the system—frustration that it took weeks to get a response, and then they had to redo it, send it back, redo it again, and then find new changes that had to be made. We are trying to streamline this process so that it can be more efficient, because I truly believe that every Nevadan deserves access to culturally competent care. Thank you.

Chair Marzola:
Thank you, Assemblywoman Torres. I will close the hearing on Assembly Bill 267. I will now open up for public comment. [There was no public comment.] Does anyone have any questions or comments? [There were none.] This concludes our meeting for today. This meeting is adjourned [at 3:10 p.m.].

RESPECTFULLY SUBMITTED:

____
Elizabeth Lepe
Committee Secretary

APPROVED BY:

____
Assemblywoman Elaine Marzola, Chair

DATE: ____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a letter dated March 13, 2023, submitted by Lauren Chapple-Love, Laura Drucker, and Michelle McGuire, representing Nevada Psychological Association, in support of Assembly Bill 236.

Exhibit D is a document titled "Assembly Bill 239—Makes Various Changes Relating to Government Administration," dated March 13, 2023, submitted and presented by Assemblywoman Sandra Jauregui, Assembly District No. 41.

Exhibit E is a proposed amendment to Assembly Bill 267, dated March 13, 2022 [2023], submitted and presented by Assemblywoman Selena Torres, Assembly District No. 3.

Exhibit F is a letter dated March 13, 2023, submitted by Lauren Chapple-Love, Laura Drucker, and Michelle McGuire, representing Nevada Psychological Association, in support of Assembly Bill 267.

Exhibit G is a letter submitted by Gil Lopez, representing Nevada Latino Legislative Caucus, in support of Assembly Bill 267.

Exhibit H is an article titled "Developing Standards for Cultural Competency Training for Health Care Providers to Care for Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual Persons: Consensus Recommendations from a National Panel," submitted on behalf of Mary Ann Liebert, Inc., LGBT Health, regarding Assembly Bill 267.