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

Eighty-Second Session
March 20, 2023

The Committee on Commerce and Labor was called to order by Chair Elaine Marzola at 1:31 p.m. on Monday, March 20, 2023, in Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. Copies of the minutes, including the Agenda [Exhibit A], the Attendance Roster [Exhibit B], and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/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:

Assemblyman Duy Nguyen, Assembly District No. 8

STAFF MEMBERS PRESENT:

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

OTHERS PRESENT:

Sharla Glass, Public Policy and Community Relations Liaison, En-Vision America, Palmetto, Florida
Kristen Beiers-Jones, Assistant Professor, School of Nursing, Oregon Health and Science University
Barry Cole, Private Citizen, Reno, Nevada
Tessyn Opferman, representing Human Services Network; and Nevada Women's Lobby
Elyse Monroy-Marsala, representing Nevada Public Health Association
Jonathan Norman, Statewide Advocacy, Outreach, and Policy Director, Nevada Coalition of Legal Service Providers
Mathilda Guerrero, representing Battle Born Progress
Eric Jeng, Acting Executive Director, One APIA Nevada
Christine Saunders, Policy Director, Progressive Leadership Alliance of Nevada
Elizabeth MacMenamin, Vice President, Government Affairs, Retail Association of Nevada
Joelle Gutman Dodson, Government Affairs Liaison, Washoe County Health District
William Horne, representing SafeNest: Temporary Assistance for Domestic Crisis
Liz Ortenburger, Chief Executive Officer, SafeNest: Temporary Assistance for Domestic Crisis
Serena Evans, Policy Director, Nevada Coalition to End Domestic and Sexual Violence
Tracy Harig, Nurse Practitioner, Reno Orthopedic Clinic
Joan Hall, President, Nevada Rural Hospital Partners
Sarah Watkins, Executive Director, Nevada State Medical Association

Chair Marzola:
[Roll was called. Committee protocols were explained.] I am now going to open the hearing on Assembly Bill 251.

Assembly Bill 251: Revises provisions governing prescriptions. (BDR 54-1006)

Assemblyman Duy Nguyen, Assembly District No. 8:
[Read from written testimony, Exhibit C.] I am thrilled to be here this afternoon to present an update on Assembly Bill 251. It is also an update to then-Assemblywoman Teresa Benitez-Thompson's bill on prescription language access, Assembly Bill 177 of the 81st Session. The bill was caught in regulation in its implementation, and I am here to see this bill through to its end placing.

It is important to consider the significant cost savings this law will bring. A large portion of the costs projected by the chain pharmacies are front-loaded costs to integrate the translation software into the complex systems. This is marginal compared to the high ongoing costs of treatment for medication errors or noncompliance. The average cost of a single hospitalization for a preventable medication error is about $15,000, which totals in the

billions of dollars each year nationally. Experts on health care economics agree that costs from language-related medication errors will continue to increase over time unless health care providers meet demands for improved translation services. Medication errors as a result of language access are two times more likely to make an error. The average hospitalization cost for medical error is about $2,000. One out of five emergency room visits are due to a preventable medication error. Assembly Bill 251 would decrease preventable emergency room visits.

With me today are two experts who could help with some information for the bill language and intent of A.B. 251. With me on Zoom is Sharla Glass, Public Policy and Community Relations Liaison with En-Vision America. Professor Kristen Beiers-Jones is a returning presenter. She is an assistant professor of clinical nursing at Oregon Health and Science University. They will be available to answer any questions from the Committee. With your permission, Chair, I will go over the bill.

If you look at the changes in section 1, subsection 3, "Each pharmacy shall provide the information required by *Nevada Revised Statutes* (NRS) 639.2801 in the ten languages most commonly spoken at home in this State, as determined by the most recent decennial census conducted by the Bureau of the Census of the United States Department of Commerce." For the Committee's record, according to the 2021 American Community Survey for Nevada, those ten languages other than English are: Spanish; Tagalog; Chinese, including Mandarin and Cantonese; Korean; Vietnamese; Arabic; French; German; and Russian. In section 1, subsection 4, there is one more change: "The Board may adopt such regulations as are necessary to carry out the provisions of this section." Before I close and get ready for questions, I want to make a note referencing NRS 639.2801, which was the regulation piece that did not go further.

There will be an amendment coming from the Retail Association of Nevada on which I am a community sponsor. It is working with the representatives from these organizations. There is some concern from pharmacies in terms of how the small bottles can contain detailed instructions for this particular request. I want to make sure that I point out to the members of the Committee that we are still working on the amendment and will present that to you and submit it to the Chair of the Committee when it is ready. With that, I will pause here and be ready for questions.

Assemblyman Yeager:
I remember this bill really well because I had the pleasure of chairing the Legislative Commission during the last interim. I think it is the first time in recent memory we were split 6-6; 6 Democrats and 6 Republicans, which meant that we needed to get crossover support. This was one of the things we were not able to get crossover support for on the Commission.

I have a question here, but I want to relive what I believe was the history of this bill. As you mentioned, ex-Majority Leader Benitez-Thompson passed the bill. The State Board of Pharmacy was supposed to do regulations. They came in front of us the first time and she

did not like the regulation as envisioned, so she asked them to redo it. They came in front of us a second time with a regulation that would have required this information to be affixed to the prescription bottle. We were not able to get support for that. For some reason, that became a partisan issue, which was disappointing to me. So, the regulation failed. We have the law on the books, but nobody knows what they are supposed to do. I remember some pharmacists reaching out saying, Well, what do we do now? I said, Well there is no regulation, so you have to follow the law, but the regulation does not specify how you are to follow the law.

My question here—I was trying to see it in the language—are you envisioning, through this language, that the requirement will be to affix the label to the prescription bottle? Or are you envisioning an insert that goes with the prescription? It also sounded like there might be an amendment you were working on for smaller prescription bottles. Could you walk me through that? I do not want to get into a position where we are in front of the Legislative Commission again and we cannot agree, and so nothing gets done on the particular mandate for this bill.

Assemblyman Nguyen:
Because of what happened through the Commission, my intention for this bill is to address the concern of the smaller prescription bottles having the requirement on the bottle itself with the intention of making it an attachment like a flag or some sort of small booklet. Let me refer to my experts here on the Zoom call and on the phone. They may be able to go a bit further on some of the best practices that are done in other states.

Sharla Glass, Public Policy and Community Relations Liaison, En-Vision America, Palmetto, Florida:
En-Vision America is a provider of accessible prescription labeling and translation services. With our solution, you can have up to 40 pages attached to the bottle, giving you about 10,000 characters. There is a lot of information that can be affixed to the bottle with our solution. I know that there are other solutions and ways you can flag the bottle and provide extra information, whether it is translation information, large print, or whatever. Ms. Beiers-Jones might be able to provide further information on some of the solutions she has seen used in Oregon.

Kristen Beiers-Jones, Assistant Professor, School of Nursing, Oregon Health and Science University:
I work with immigrants and refugees in Oregon. Now that Oregon has this law, I have seen many examples of innovative solutions for attaching the label to the bottle. It is absolutely safe practice. As it is for people who can read English, it is safest to have the directions on the bottle. People lose extra papers. You could give a dangerous medication to your child, and you cannot be expected to try to find some kind of patient information packet. The absolute safest practice is on the bottle. Different innovations I have seen include the flagging scroll. There are some labels that have a long scroll that you can pull out. As Ms. Glass said, it is like a little booklet attached to the bottle. There have been quite a few excellent innovations for that.

Assemblyman Yeager:
I have a comment and then one other question. I agree with that. I think the first proposal ex-Majority Leader Benitez-Thompson gave in front of the Legislative Commission was to give an insert. I think that was the exact concern she had: people misplace things, and once you get home from the pharmacy, who knows where all that paperwork goes? I want to say, as you work through the amendment, just be mindful of that. We want that information, to the extent reasonably possible, to be attached to the bottle. Perhaps there are exceptions—some of these bottles are small—but I would ask that you try to do that because I know it was important to the former Assemblywoman and also important to what we are trying to accomplish here.

Some of the existing language in section 1, subsection 1 of the bill states, "upon the request of a prescribing practitioner, a patient or an authorized representative of a patient, to provide the information required . . . pursuant to subsection 3." I am assuming that the default language would be English, but if somebody makes a request for an additional language, would that be provided? It is not that we are going to provide all ten languages to everybody, but will it be tailored to the request of the prescriber or patient?

Assemblyman Nguyen:
Yes, the intent is to narrow down the 200 languages that could be available throughout our country. In terms of languages, by narrowing it down so that the retailers and the pharmacy can be ready with the top ten languages at any given time, they already know that is coming, so they can be responsive. There is a process in prescribing the medication to the pharmacy, and there may be some compliance verification in between. By narrowing it down to the top ten, the pharmacy can have a bit more of a heads-up in terms of that. They are telling me they have other languages available, but having a top ten will give them a sort of guide to where it goes.

Assemblyman Yeager:
I do not have another question, but an observation. I appreciate that answer. I know the State Board of Pharmacy is great and they know what they are doing, so this is probably already part of what they are going to do. I think it would certainly make sense to have the actual prescribing practitioner make that request to the pharmacy at the time. They are doing the prescription. I just worry that if you have somebody for whom English is not the first language, I am not sure if they are going to know of the ability. Obviously, there is going to be a sign that tells them they have that ability, but sometimes in the hustle and bustle of being in the pharmacy, you are maybe not paying attention to that. I would ask you to perhaps have that conversation to make sure that is part of the notice that goes out to practitioners so that if they have someone who speaks a different language, they would be able to ask for that when they actually do the prescription.

Assemblyman Nguyen:
That is a great suggestion. We will make sure, in terms of promoting this particular benefit, we are going to put that as a way to ensure all of our population can benefit from this and are able to utilize this to its fullest. To circle back to your previous question, yes, the particular intent is for it to be bilingual. It will not be just that language on the bottle; it will be English and the second language on the bottle.

Chair Marzola:
Do you know how many other states have passed legislation such as this?

Assemblyman Nguyen:
I will refer that to our experts on Zoom, either Ms. Glass or Professor Beiers-Jones. With my understanding, as of right now, only Oregon has passed a law, but there may be other states that are doing it already as a practice. I will defer to them.

Sharla Glass:
We know that California and New York have some abbreviated version of translation requirements. Oregon has the fullest implemented laws. Nevada is the fourth state that has passed some kind of legislation. I believe there are three other states that have introduced similar bills this legislative session.

Assemblywoman Kasama:
I certainly understand the spirit of the bill, but there is something I have to reiterate because I did vote against this bill last session. The first concern was a cost factor for the pharmacies. Currently, at each pharmacy, there is a telephone line on which you can call to get translation services. We have made that available as a state. The other concern is that I worry we are going to lose some of our independent pharmacists. The large companies—Walmart, CVS, Walgreens—can afford to absorb these extra costs. I am worried about the small-town pharmacists who cannot afford these extra translation services, and then we continue to drive our commerce to large conglomerates. This was a concern that I had last time. Like I said, I know the spirit is well-intentioned. However, since we are providing translation services as a state, I am concerned about the burdensome regulation and cost to some of our independent and smaller pharmacists.

Assemblywoman Torres:
How many characters are on the average prescription label?

Kristen Beiers-Jones:
Forty characters is typical for a "take one a day." There are certainly some titration directions that are longer and require one of the larger tabs. I also want to respond to the question about the financial burden on independent pharmacies. In Oregon, we thought about not including independent pharmacies in this. Our board reminded the legislators that if this is safe practice for one pharmacy, it needs to be safe practice for all pharmacies. I talked to the Oregon Board of Pharmacy this morning and asked if they knew of any independent pharmacies that had closed because of this. They said absolutely not; there are

some that have closed, but it is all about issues around reimbursement. They have not heard of any pharmacy that has said this was the financial burden that tipped them over.

Sharla Glass:
I want to confirm that as well on our end. We have not had any pharmacies say that it was going to put them out of business. It might set them back a little bit. To add the translation service to our product line is only $1,000 per year. If you divide that between 12 months, that is pretty negligible. I do not see that putting any pharmacy out of business.

Assemblywoman Monroe-Moreno:
Is there software available that is being used in Oregon that, if this law is passed, pharmacists could use here for those translation services?

Sharla Glass:
Yes, and a lot of pharmacies already have access to those translation services. It is only a matter of putting that information onto a label instead of handing it out on a separate sheet of paper. There are quite a few pharmacies in Nevada that are already using our software because of the accessible prescription labeling recommendation that was passed in 2017. They are either using our audible prescription labels or our large view labels, which is what the translation is printed on.

Assemblywoman Monroe-Moreno:
If I heard you correctly, you said the cost may be an added $1,000 on an annual basis, which I think is a much smaller amount of money than the cost of a life. Thank you for sharing that information.

Sharla Glass:
And, let me specify, that is for a retail pharmacy. Obviously, mail orders or larger facilities are going to be at a different cost, but that is only for something like the independent pharmacy.

Kristen Beiers-Jones:
That is a similar cost to what I have heard from a couple of other national companies that provide translated labels for pharmacies.

Assemblyman O'Neill:
When the Chair asked about the other states doing this, you mentioned Oregon is the only one that has a law, if I understood correctly. California and New York are voluntarily doing this, and some other states may have bills pending. Then you went on to say that, right now, pharmacies in Nevada are voluntarily doing this. Is that correct? Explain to me what we are looking at.

Sharla Glass:
The law in California is the top five languages have to be translated. They have retranslated the major—I do not know—top 106 for pharmacies. That is available on the California State

Board of Pharmacy website for pharmacies to utilize. In New York, the law is that if you are a chain pharmacy, you are required to provide translation services. New York did opt independent pharmacies out. As far as saying that everyone is already providing translation or might have access, what I mean is, due to former President Bill Clinton's executive order years ago, translation services are required for printed literature. However, this really has not been applied to prescription labeling until now. As one of the other Assemblymen mentioned, interpretation services have been the most often-used service. Of course, once someone leaves the pharmacy, they might not remember everything that was spoken. Therefore, having the written information in their own language on the bottle is the safest practice that we are trying to encourage.

Assemblyman O'Neill:
With the three states of Oregon, California, and New York, have their overdoses or misuse of prescription drugs gone down? Do you have statistics to show what they had before compared to what they have now, now that they have instituted this statute?

Sharla Glass:
I do not have any statistics on that. It is not always necessarily an overdose issue. It is more about just knowing what to take. Ms. Beiers-Jones, do you have any statistics?

Kristen Beiers-Jones:
I do not know. There is not anybody collecting that data yet. I would sure like that. I can tell you, anecdotally, I think of the family I met who had high health literacy, was highly educated, had newly arrived to the country, and did not read or speak English. Their kids ended up in the emergency room many times. One child had been hospitalized because it was an English-only label, and the mother had mixed up the inhalers for rescue versus maintenance. The providers in the hospital would not have known that; they assumed that the mother was giving the medications as they had prescribed it, but she simply could not read the labels. Over a period of time, she was giving the wrong medication. I have quite a few stories like that which are really heartbreaking. I find myself thinking, if only they had had the label in her language, those kids would have stayed out of the hospital. I wish there were more data that I could provide to you, but there is none at this point.

Assemblyman O'Neill:
I appreciate that because if we are doing it voluntarily now in Nevada, it seems we are going to put a burden on the regular pharmacies that are trying to look at expenses for drugs, and they are doing it voluntarily. I am not sure if I see the full cause for this since we have already discussed it prior.

Chair Marzola:
Committee members, are there any additional questions? [There were none.] We will move to support testimony. Is there anyone wishing to provide testimony in support of A.B. 251?

Barry Cole, Private Citizen, Reno, Nevada:
I am in support of A.B. 251. I speak some Spanish and, obviously, I speak English. When I write a label as a physician to go onto a prescription bottle, I will try to write it in both English and Spanish so that the pharmacist who may not speak any Spanish can type exactly what I wrote. This bill, however, would be a vast improvement because it would come out printed. Nobody writes prescriptions anymore; everything is done by electronic medical records. I generate prescriptions on a computer, and then I can sometimes type in the text box anything additional. If you have taken Synthroid, you will notice that you have a flag-like label on the bottle because the label is bigger than the bottle. On very small pills, even for a three-month supply in a small bottle, pharmacists are already using what looks like a flag that extends beyond the length of the bottle, so it is not going to be that challenging. I think the harder part will be getting the Cyrillic for Russian, and the Chinese pictograph characters, since as I understand, we are actually going to use characters that will require the printer to at least have the languages preloaded. When you say you want it in a certain language, it will come out that way. I do not see this as a challenge, and it would be a lot easier to have a computer do this for me than my attempt to fake it, trying to write it in two languages. I am in support of A.B. 251, and I hope you will give it good consideration. [Written testimony was submitted, Exhibit D.]

Tessyn Opferman, representing Human Services Network:
Many of the individuals our member providers serve are English as a second language. This bill will directly help them in terms of family members who could be caregivers—it could be anyone who does not know English quite as well—and they are trying to help someone else in their family who may not be able to give the medication to themselves. We think this is a helpful bill that will directly benefit those individuals in terms of the ability to read their prescriptions and ensure that the drugs they are taking are the correct ones in the correct amount. We are in full support of this measure.

Elyse Monroy-Marsala, representing Nevada Public Health Association:
We are in support of this bill as it promotes patient safety.

Jonathan Norman, Statewide Advocacy, Outreach, and Policy Director, Nevada Coalition of Legal Service Providers:
Language access is obviously very important. For our clients, we are dealing with kids in foster care. We represent 3,000 to 4,000 kids in foster care around the state. A lot of our foster families may not speak English as a first language. Even if they know enough English to maybe talk with me or their case worker, they may not know enough to deal with really technical things. For foster parents who are contemplating adoption, we will get them a translator, or if they are in court, we will get them a translator even if they speak enough English to get by day-to-day. Certainly, when we are talking about medication, they are reading medication labels that they are giving to our kids in foster care. We think it is important people are able to read that in the language in which they are most comfortable.

Mathilda Guerrero, representing Battle Born Progress:
[Read from written testimony, Exhibit E.] We are in unwavering support of A.B. 251. We thank Assemblyman Nguyen for spearheading this critical measure. The 2020 Census showed us that nationally, Nevada is ranked as the third most diverse state, fourth with the most Asian American Pacific Islander (AAPI) residents, and fifth with the most Latino residents. This bill is one of the necessary first steps to ensure that this body addresses the needs of every single Nevadan, while also meeting them where they are at.

Eric Jeng, Acting Executive Director, One APIA Nevada:
Nevada is home to over 392,000 Asian Pacific Islander Americans. That is now about 12 percent of our total population. Last session, the Nevada State Legislature made strides in addressing language barriers for our community by passing Assembly Bill 177 of the 81st Session. This time, we are coming here to ask you to continue that work and pass A.B. 251. This would be life-changing for more than 68,000 households, not just AAPI, but for our whole community, including Latinos from their country of origin, those from Europe, from Latin America, as well as from Africa. We have 68,000 households that have at least one resident who is limited English proficient here in our state. We have reached out to several community organizations that are impacted by this, including the Nevada Chinese Association, the Las Vegas Korean Association, the Vietnamese-American Community of Las Vegas, the Thai Culture Foundation, and the Healthy Asians and Pacific Islanders Medical Center. We have a community-signed letter that will be submitted as an exhibit [Exhibit F]. Providing prescription information both in English and the patient's preferred language will ensure the patient and everyone in the home understands the medication instructions. To Assemblyman Nguyen's point, people with a language barrier have a 2.5-times higher rate of having an error in taking medication. For us, this bill is not only lifesaving, but also a great way for those of us who have a shared immigrant experience and who translate for our families and our elders. This will be a great way to start. We are here in support.

Christine Saunders, Policy Director, Progressive Leadership Alliance of Nevada:
We are here in support of Assembly Bill 251. As a member of the Nevada Immigrant Coalition, we are proud to have supported Assembly Bill 177 of the 81st Session which had the goal of safeguarding patients, reducing long-term costs, and providing language justice for all Nevadans, yet this important policy has not been implemented. Assembly Bill 251 will set the requirements for pharmacies and maximum policy so that we can ensure Nevadans are able to receive important medication information in their preferred language.

Elizabeth MacMenamin, Vice President, Government Affairs, Retail Association of Nevada:
I thank Assemblyman Nguyen for working with us. I worked very closely with former Assemblywoman Teresa Benitez-Thompson on Assembly Bill 177 of the 81st Session, and I would like to thank Assemblyman Nguyen for considering those situations in which—whether we are talking about a scroll-out label or a label that will not be affixed to the bottle—we can work together to come to a conclusion and get started. Our members have already implemented, are ready, waiting, and looking for direction from legislators as we go

forward. Speaking to our small members, the independent pharmacists, they have already set up the software. I am not sure where they are in the process, but I know that chain members, at this time, are ready and willing to go forward. Oregon also implemented this first, and they took into consideration that there might be exceptions to this. Their law and regulation allow for those exceptions. That was all that we were asking for. In conversations with the former Assemblywoman, that was one thing we are going to work on this session. I thank the Assemblyman, and we look forward to working with him going forward. We support moving forward with this.

Joelle Gutman Dodson, Government Affairs Liaison, Washoe County Health District:
We are in support of this bill because we believe this is a health equity issue, which means this is a public health issue. Language and language accessibility is good practice.

Chair Marzola:
Is there anyone else wishing to testify in support of A.B. 251? [There was no one.] [Exhibit G was submitted but not discussed.] Next, we will hear testimony in opposition to A.B. 251. Is there anyone wishing to give testimony in opposition? [There was no one.] Is there anyone wishing to provide testimony in a neutral position to A.B. 251? [There was no one.] Assemblyman Nguyen, would you like to give some final remarks? Also, while you are getting ready to do your final remarks, I want to say thank you for bringing this bill forward. As an immigrant and as someone who did not speak English until I was about 11 or 12 years old, I know it is frustrating to be somewhere trying to find information and not be able to understand—and I was a child, so I cannot imagine it as an adult and to make it even worse, having to do this with a daily medication that you may have to take. I appreciate you bringing this bill forward.

Assemblyman Nguyen:
As a point of personal privilege on that one, I want to respond to that comment. I am also an immigrant myself, immigrating to this country at the age of 11, and English was never taught in Vietnam. It has been a struggle for many immigrants with similar stories, and I am so glad that I now have the opportunity to serve the immigrant community alongside you, Chair, and the rest of the Committee in ensuring that Nevadans are always being taken care of—and not just some Nevadans, but all Nevadans. Thank you, Chair Marzola, for that comment. In closing, I want to again acknowledge and thank the former Majority Leader, Assemblywoman Teresa Benitez-Thompson, for her work. I am expanding on the great work that she did. I want to remind the Committee that this bill is about lifesaving and life-changing as well as safety practices. As a small business owner myself, I look forward to working with other small business owners, independent pharmacies, and the Retail Association of Nevada, as well as any other stakeholders who are interested, to ensure that we as Nevadans serve our communities in the best way possible. Again, I want to thank Chair Marzola and all of the Committee members for your support, and I would urge you to support A.B. 251.

Chair Marzola:
I will now close the hearing on Assembly Bill 251. I will now open the hearing on Assembly Bill 276.

Assembly Bill 276: Revises provisions governing telehealth. (BDR 54-831)

Assemblywoman Bea Duran, Assembly District No. 11:
[Read from written testimony, Exhibit H.] Today, I am here to present Assembly Bill 276, which revises provisions governing telehealth. William Horne, Vice President for Nevada at Strategies 360, and Liz Ortenburger, Chief Executive Officer at SafeNest, are joining me as well. We also may have a nurse to answer any questions, and I will let them introduce her if needed.

Now, a little background information: The use of telehealth can bring experts to guide other practitioners in providing sexual assault exams to patients throughout Nevada. A health care provider may connect with another health care provider by using video technology to a remote health care provider who has extensive training in how to care for assault survivors and collect evidence for possible criminal prosecution. The use of telehealth improves access and the quality of forensic examinations and expands access to the expertise of health care providers to our communities. In addition, some sexual assault survivors reside in rural areas of our state. They must travel hours for a sexual assault exam. When telehealth services are expanded, they can obtain care closer to home.

As many of you know, sexual assault survivors face health consequences. Assaults can cause physical injuries, sexually transmitted infections, and mental health conditions. If the survivors are cared for on the front end, these risks can be reduced dramatically with the right intervention. Mr. Horne will walk through the bill, and he, along with Ms. Ortenburger, will provide additional information to the Committee and answer any questions you may have.

William Horne, representing SafeNest: Temporary Assistance for Domestic Crisis:
Thank you for taking the time to hear A.B. 276. I will walk you through the short bill. Section 1, subsection 5 authorizes the use of telehealth between appropriately trained health care providers to give instructions to health care providers who are with the patient in person. Section 1, subsection 6, paragraph (c) defines "sexual assault" and paragraph (d) defines "strangulation" as it means in statute. Additionally, the newly established paragraph (e) redefines what "telehealth" is. It has changed that definition to mirror what we are going to be presenting to you today with Liz Ortenburger, and how someone who is remote who has expertise will be giving instruction to a health care provider who is with a survivor of sexual assault or strangulation.

Liz Ortenburger, Chief Executive Officer, SafeNest: Temporary Assistance for Domestic Crisis:
Thank you, Assemblywoman Duran, for bringing this important legislation forward. Last year, we had over 1,700 rapes in Clark County, and those are known rapes. Of those, 105 happened in rural counties where no sexual assault nurse examiner (SANE) was available,

meaning that the travel time is, on average, six hours to get to a qualified nurse. Within Clark County, we had just under 1,300 rapes, some of those happening in Mesquite, Laughlin, and Boulder City, places where there is also a 90-minute travel time. With one SANE in Clark County, you can also wait anywhere from 6 to 48 hours for an exam. In the case of a rape exam, that means not showering, not changing your clothes, just sitting and waiting to be examined. In the case of a strangulation exam, it often also means not showering, waiting, not eating, not drinking. When an examiner is available, then they must find childcare and transportation to get to the emergency room for that exam. This is not the way we should be doing things in Nevada. This is a unique opportunity to follow in the footsteps of Arkansas, Colorado, Alaska, Texas, and South Dakota, allowing clinician-to-clinician telehealth so that no survivor within our state has to wait an inappropriate amount of time or travel an inappropriate distance to get the medical help and the exam they need to seek health and justice.

Assemblywoman Jauregui:
Thank you for bringing this bill forward. I want to make sure I understood it correctly. When I think of health care providers, I think that could be an emergency medical technician (EMT). If someone had an incident and they called emergency services and an EMT showed up, would that allow the EMT to telehealth in an actual doctor?

Liz Ortenburger:
It needs to be done inside a facility. Because of the evidence that is gathered during a rape or strangulation exam, they need to present to a clinic. There are some administrative pieces on the background of any legislation like this, so a clinic would need to sign on to the program because they would need to be administered rape kits in order to be able to do the exam, collect the evidence, and secure that evidence to be sent away to be examined so that it is evidentiary. For that reason, it cannot be done in an ambulance or in the field. It has to be done at a clinic.

Assemblywoman Jauregui:
Is there anywhere in statute where a provider of health care is defined?

Liz Ortenburger:
I am not sure.

Assemblywoman Jauregui:
I can always check with our Legal Division as well.

Chair Marzola:
Once we get that answer from the Legal Division, we will share it with the entire Committee.

Assemblyman O'Neill:
You started to answer this, but I want to clarify and get it on the record. The person that is at the location in the clinic will have to have some initial training and be certified to perform this type of examination, is that correct? In other words, it cannot be just the EMT or the

paramedic or even a nurse unless they have had the training in evidentiary procedures—the training on identification of the medical needs itself. Is that correct?

Liz Ortenburger:
The International Association of Forensic Nurses oversees this program and SANE certification nationwide. There are three levels that a clinician can call in and do this exam. It can be at the novice level, which means they have had the introductory information on, for example, how to open a rape kit. Then the forensic nurse who is on telehealth with them will walk them through piece by piece from how to move the camera two centimeters to the left to get the right angle for the picture, all the way through. They then can choose to get more in-depth training that moves them through the levels of what they are able to do. They are, however, never qualified. They have never reached that examination qualification to do the exam alone. They have never gotten that SANE examination. There are levels within what they are able to do, always with the trained examiner on the telehealth portal.

Assemblyman O'Neill:
Who would end up testifying in court? I ask because you also have a problem on travels, et cetera.

Liz Ortenburger:
Within Nevada, in order to be able to be the clinician providing the expert advice to the untrained clinician, you need to be licensed in Nevada. However, you do not need to be located in Nevada. In an expert witness situation—of course, it is always up to who is called—it is that provider, the forensic nurse, who would be called. The person who is potentially here, but also could be anywhere as long as they are licensed in Nevada, would be able to walk somebody through that exam.

Assemblyman O'Neill:
Could you tell me the other states again, please?

Liz Ortenburger:
The other states are Arkansas, Colorado, Alaska, Texas, and South Dakota. Also, each state has a different way they certify their nurses. In Arkansas, they allow nurses from all over the country to be the trained clinicians. That is not what we have allowed here in Nevada; it would have to be a Nevada-licensed nurse. However, they do not need to be located within the state; they simply need to be licensed by the state.

Assemblyman Yeager:
Thank you for bringing this bill forward. It is pretty startling to think that someone would have to wait 48 hours to have a SANE kit done. Frankly, that is unacceptable. Really, six hours is too long for folks to wait. I obviously understand what you are trying to do here, and I am supportive of it. How do you envision the telehealth working? I am reading the definition of telehealth in section 1, subsection 6(e) of the bill, and it has some big words. I am not quite sure what some of them mean, but would this typically be like a videoconference on an iPad? I read it to mean that you could have a telephone call as well.

It says no email or faxes, which makes sense. In the real world, how do you think this would work for the person doing the exam? How do they bring the other person into the room virtually?

Liz Ortenburger:
There has to be a video component. The pieces that we walk through, in terms of setting this up, have to do with how that video is encrypted. If I am a nurse in my home providing the information, we are taking very sensitive video. There is an encryption platform, and that all has to fall under the Health Insurance Portability and Accountability Act requirements. The video element is required. Audio is also required because of the capture of video. Also, particularly within a strangulation exam, the nurse on the phone would be designating, for example, if A then C, if no A then we are done. They are going to need to be able to see that and walk through that exam visually.

Assemblyman Yeager:
I take it that this is probably more of a problem in our rural communities that maybe do not have someone with this expertise. Are we confident that if someone comes in at two o'clock in the morning and they need one of these SANE kits to be done, the provider is going to have access to somebody else in the state in real time to get that done?

Liz Ortenburger:
Once this is approved and we are able to move forward, we go after federal funding. That federal funding requires some of those mechanisms to be set up. We operate a 24/7 hotline right now. What does that look like when we add forensic nurses to the on-call sheets? It has to be administered, so that is the reality. There also has to be a way for us to capture and report back to interested parties that we had a six-hour downtime on November 11, and we missed three. That will all get set up in the administrative rolling out of the procedures.

Assemblyman Yeager:
If this gets enacted, it is a great thing for the state, survivors, and law enforcement, but we need to make sure our providers know about it. They need to know that it exists, that it is an option. When they get someone who comes in and needs one of these exams, they have the knowledge about where to call and what to do. I know you all know how to do that, but we ask as we move forward in the bill that we make sure we collaborate and get that information out so that everyone is aware of this. Thank you again for bringing the bill.

Assemblywoman Hardy:
Thank you for this bill. Could you clarify what "SANE" stands for? Also, I want to make sure I understand. If somebody came into, say, a rural area or elsewhere, there would be somebody there. Does that person have to have the same certification, or are they reaching out to somebody who has it?

Liz Ortenburger:
A SANE is a sexual assault nurse examiner, one of the pieces under forensic nursing. We are looking at forensic nursing, and SANE is a portion of that. What would happen if somebody

presented at an emergency room or a clinic and needed a rape kit? That emergency room or clinic, in order to be part of the program, would have designated clinicians on staff for whom, if anyone presents 24 hours a day, seven days a week, will then call the hotline and work with that survivor to walk through the exam. They do not have to have the SANE certification, but they need to be designated. In theory, it could be thrown at someone; that is not how we want to set it up though. There is a knowledge base in the hospital and people who are willing to do it within that clinic so that they are willing to work through it and then progress in their training. It is our hope that in 15 years, we would not need something like this because there would be more SANE-trained professionals in every medical outlet in the state, but this helps us bridge that gap.

Assemblywoman Torres:
Thank you for bringing forward this piece of legislation. I think it is critical to have individuals who are able to quickly respond when an incident occurs. I can imagine that it is probably a deterrent for reporting when you know you are going to be waiting 24 hours, or when you know you are going to be sitting in an exam room for 8 hours and cannot shower ahead of time. You are probably less likely to report. My question is, Who is responsible? I imagine that after an individual has completed an exam, there is some type of report that would be produced. Who would be responsible for producing that report? Is it the SANE or the clinician who is assisting?

Liz Ortenburger:
The primary reason for these exams is always the survivor's health. It is ultimately up to the survivor whether or not they want to do a police report and move forward with anything from that perspective. What the SANE exam does is allow for that option to be available beyond the lifespan of the three days in which they had to have the exam. The SANE practitioner creates the report, the medical kit, and the rape kit—if it is in the case of rape. Then, that is sent off. They have access to their medical records, and if they choose to move forward, they have that option.

Assemblyman O'Neill:
Having worked these cases multiple times during my years—maybe I have been out of the system too long—but as I recall, to get a SANE report, you first had to make some kind of police report, did you not? Then, we contacted the hospital and set up the examination. Did you say that anybody can go in and ask for the SANE examination without ever making the notification to law enforcement?

Liz Ortenburger:
Yes, you are able to walk in without a law enforcement identification to receive a sexual assault examination as well as a strangulation exam.

Assemblyman O'Neill:
We have come a long way. Yes, you are right. I appreciate that because I do like this. I truly do. I see it as a big help. I only needed that clarification, so thank you.

Chair Marzola:
I have a follow-up to that. Once the SANE report is completed, how long is it kept if the survivor chooses not to call the police right away?

Liz Ortenburger:
I am going to defer to Serena Evans, the policy director from the Nevada Coalition to End Domestic and Sexual Violence.

Serena Evans, Policy Director, Nevada Coalition to End Domestic and Sexual Violence:
For the SANE exam or SANE rape kit, if a survivor chooses not to report to law enforcement and undergo what we refer to as a Jane Doe exam, it will be kept for the statute of limitations, which is 20 years. If they do file a report, it will essentially be kept for life. They do not necessarily have to move forward with prosecution though. That is outlined in the Sexual Assault Survivors' Bill of Rights.

Chair Marzola:
Thank you for that answer. I wanted to make sure that if someone goes and is initially in shock, they may not want to report right away, but two weeks from now, they may want to report. I wanted to make sure that the record is kept. Thank you for making that clear. Are there any additional questions from the Committee? [There were none.] We will now hear testimony in support of Assembly Bill 276.

Serena Evans:
[Read from written testimony, Exhibit I.] Currently, there are only six locations statewide where a victim-survivor can receive a SANE exam. For victim-survivors in rural communities, this means that they may have to travel upwards of six to nine hours in one direction to receive this exam. Best practices encourage victim-survivors not to eat, shower, or use the restroom before a SANE exam so as not to disturb any of the evidence on their body. Can you imagine having just been intimately violated, your body being a living crime scene, and having to travel that long of a distance to receive appropriate care and have your evidence collected? Simply stated, the current procedures in Nevada for SANE exams are not victim-centered and further place the burden on the victim-survivor.

Because of the long travel times and limited locations, many victim-survivors choose to go without a SANE exam. Because many often do not have the resources to pay for health care services out of pocket, they go without vital care and preventive services like prophylactic medication, sexually transmitted infection testing, strangulation exams, and education about possible health risks. Additionally, by not having their evidence collected, the victim-survivor loses their option to participate in the criminal justice system.

We are currently working with our rural communities, primarily in the Elko area, and Preziveli, a mobile SANE provider, to stand up mobile SANE services, ensuring that victim-survivors in rural communities have access to these lifesaving, critical wraparound services. However, this pilot project is specific to this one rural community, and every victim-survivor

in Nevada should have access to these services. Our victim-survivors in this state deserve better. We must work to reduce the barriers and make lifesaving services more accessible.

Tracy Harig, Nurse Practitioner, Reno Orthopedic Clinic:
[Read from written testimony, Exhibit J.] I am a nurse practitioner in Reno, and also adjunct faculty at University of Nevada, Reno, Orvis School of Nursing and University of Nevada, Reno, School of Medicine. I have everything that everyone has said today, so I am going to go a bit off the cuff here. I do telemedicine in my practice, and it is not perfect. The standards of practice are the same, however, so you strive to provide the best care that you possibly can, in whatever situation you can. It is a great option for patients who otherwise cannot get access to care they need. This morning, my patient lived in town but had COVID-19, so they could not come in. I know that is not applicable here, but when I was an emergency room nurse at Carson Tahoe Regional Medical Center, at the time we were doing sexual assault exams up in northern Nevada and Sparks. If you came in the evening—and we had a gal that came in and had been assaulted and we had to call dispatch, and they knew what that looked like—it was not always super quick. They would put her in the patrol car and bring her up to Sparks, which is about a 45-minute drive. Then, it takes a couple of hours for the exam. Sometimes, they would drop her off and sort of tag team out if it was a shift change thing. It was an all-night event. Typically, she was by herself, and it was always traumatizing. If we can bring this back and make this victim-centered care, or actually patient-centered care, in my world, that is what we strive to do. I think that is a win for Nevada.

Tessyn Opferman, representing Nevada Women's Lobby:
We know that underreporting continues to be a problem. It is difficult for victim-survivors to get the necessary time off from work, find childcare, and get transportation. All of that is made worse when they need to travel across the state six to nine hours to get to a place where they can get an examination done. That means that these victims, who may not get that care, do not get the necessary, critical health care that they need. They also cannot pursue justice if they are not able to get that exam. We feel this is an access to health care, access to their rights, and criminal justice rights issue. We urge your support of this bill.

Joan Hall, President, Nevada Rural Hospital Partners:
The stories you have heard about the distances from rural health care to urban health care for these types of services is very real. It is very traumatic for the nurses as well as the patient, knowing that this patient cannot receive the care in a rural area. There are a lot of barriers to that: the SANE exams, remaining competent when you have had that, and education is an issue. This truly would be a benefit for both the patients and the health care facilities in rural Nevada.

Sarah Watkins, Executive Director, Nevada State Medical Association:
I want to echo previous supporters here. As a physician and patient advocacy organization, we think access to care is important for Nevadans, especially in the rural areas, and believe this bill will be a big help with that.

Chair Marzola:
Is there anyone else wishing to provide testimony in support? [There was no one.] We will move to testimony in opposition to Assembly Bill 276. Is there anyone wishing to provide testimony in opposition? [There was no one.] We will move to neutral testimony. Is there anyone wishing to provide testimony in the neutral position to Assembly Bill 276? [There was no one.] Assemblywoman Duran, would you like to give any final remarks? [There were none.] Thank you for bringing this important legislation forward. We will now close the hearing on Assembly Bill 276. I will now open up for public comment. [There was no public comment.] This concludes our meeting for today. Our next meeting will be Wednesday, March 23, at 1:30 p.m. This meeting is adjourned [at 2:44 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 written testimony presented by Assemblyman Duy Nguyen, Assembly District No. 8, regarding Assembly Bill 251.

Exhibit D is written testimony submitted by Barry Cole, Private Citizen, Reno, Nevada, in support of Assembly Bill 251.

Exhibit E is written testimony submitted by Mathilda Guerrero, representing Battle Born Progress, in support of Assembly Bill 251.

Exhibit F is a letter dated March 20, 2023, presented by Eric Jeng, Acting Executive Director, One APIA Nevada, in support of Assembly Bill 251.

Exhibit G is written testimony dated March 20, 2023, submitted by Deanna Hua Tran, Coalition Coordinator, Nevada Immigrant Coalition, in support of Assembly Bill 251.

Exhibit H is written testimony dated March 20, 2023, presented by Assemblywoman Bea Duran, Assembly District No. 11, regarding Assembly Bill 276.

Exhibit I is written testimony dated March 20, 2023, presented by Serena Evans, Policy Director, Nevada Coalition to End Domestic and Sexual Violence, in support of Assembly Bill 276.

Exhibit J is testimony submitted by Tracy Harig, Nurse Practitioner, Reno Orthopedic Clinic, in support of Assembly Bill 276.