MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Eighty-second Session
May 4, 2023

The Senate Committee on Health and Human Services was called to order by Chair Fabian Doñate at 3:38 p.m. on Thursday, May 4, 2023, in Room 2134 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Fabian Doñate, Chair
Senator Rochelle T. Nguyen, Vice Chair
Senator Roberta Lange
Senator Robin L. Titus
Senator Jeff Stone

GUEST LEGISLATORS PRESENT:

Assemblywoman Tracy Brown-May, Assembly District No. 42
Assemblywoman Lesley E. Cohen, Assembly District No. 29
Assemblywoman Sarah Peters, Assembly District No. 24
Assemblywoman Clara (Claire) Thomas, Assembly District No. 17

STAFF MEMBERS PRESENT:

Destini Cooper, Policy Analyst
Eric Robbins, Counsel
Norma Mallett, Committee Secretary

OTHERS PRESENT:

Molly Walt, Nevada Lifespan Respite Care Coalition; CEO, Nevada Rural Counties RSVP

Mary Pierczynski, State of Nevada Association of Providers
Vanessa Dunn, Nevada Public Health Association
Marlene Lockard, Service Employees International Union 1107
David Nichols, Nevada Lifespan Respite Care Coalition
Dora Martinez, Nevada Disability Peer Action Coalition
Denise Tanata, Chair, Nevada Early Childhood Advisory Council; Comprehensive Systems Director, The Children's Cabinet
Patti Oya, Education Programs Director, Office of Early Learning and Development, Nevada Department of Education
Tom Clark, The Children's Cabinet
Sheila Bray, University of Nevada, Reno
Jamelle Nance, Children's Advocacy Alliance
Dan Lunn, Vice President, Tissue Operations, Nevada Donor Network
Ashley Eliason
Trey Delap, Group Six Partners
John Piro, Clark County Public Defender's Office
Erica Roth, Washoe County Public Defender's Office
Joanna Jacob, Clark County
Cadence Matijevich, Washoe County
Vinson Guthreau, Executive Director, Nevada Association of Counties

CHAIR DOÑATE:
I will open the hearing on Assembly Bill (A.B.) 100. Assemblywoman Tracy Brown-May is here to present this bill.

ASSEMBLY BILL 100 (1st Reprint): Provides for certain assessments relating to caregivers. (BDR S-562)

ASSEMBLYWOMAN TRACY BROWN-MAY (Assembly District No. 42):
This bill originated out of the work of Nevada Lifespan Respite Care Coalition. I am going to allow Molly Walt to talk about the background of the bill.

MOLLY WALT (Nevada Lifespan Respite Care Coalition; CEO, Nevada Rural Counties RSVP):
The Coalition represents respite for Nevada's private and public sectors as well as family caregivers. Our mission is to support caregivers by promoting awareness of, access to, coordination and advocacy of respite services in Nevada across all disabilities throughout the lifespan. Respite care should be a

typical experience and valued service designed to fit the needs and choices of consumers.

Nevada lacks a system to recognize caregiver goals, assessments to address the health and well-being of family caregivers, and hospital discharge planning. This bill is the first step to getting us there.

ASSEMBLYWOMAN BROWN-MAY:
The data is necessary to determine our quality of care, so caregivers can continue. There is a lack of data about the quality of family caregivers and information about the implementation of wraparound support services to help folks remain in their homes.

This bill requires the Aging and Disability Services Division, Nevada Department of Health and Human Services (HHS), to create a caregiver survey done in numerous other states and to deploy it through a pilot program for individuals receiving services through waiver programs. We have pared back the original bill to a targeted pilot program for all those receiving waiver supports out of the Aging and Disability Services Division. It will create and validate a caregiver study to potentially deploy even farther once we identify the right survey tool.

The Division pared down the original fiscal note to something manageable through an easy grant. Identifying the capabilities of our family caregivers is essential.

This idea comes from the family caregivers I work with every day. Moms and dads of adult children with significant disabilities are the primary caregivers. The people and volunteers in Ms. Walt's organization and the people she collaborates with do not know we are out there. My mom has an advanced stage of Alzheimer's. My dad is aged 90 and her primary caregiver. If something happens to my father and we do not know where he is, no one knows to look for my mother. They do not live in Nevada. This is not going to affect them.

There are many families just like mine across our State. Identifying who they are and what they need to safely stay in their homes, with the right support services decreases the cost associated with long-term care support in other settings, and improves the quality of life for all our residents.

SENATOR STONE:
Is it voluntary or mandatory that those receiving HHS funds today or in the future be a part of this survey?

ASSEMBLYWOMAN BROWN-MAY:
It is voluntary. It is a tool the Division will develop and offer to all the folks receiving support services through the Division. No one would be mandated to participate. We would encourage folks to be a part of the development of this tool to help us create better services.

SENATOR STONE:
This is to help better educate caregivers, who do not have any kind of discipline for caregiving, and make them aware of available county, federal and supportive services. I am surprised in this State that a lot of people do not know federal funds exist that can help them.

I assume study results will be disseminated on your website and maybe emailed to many providers who signed up for this valuable information.

ASSEMBLYWOMAN BROWN-MAY:
You are correct. The way this is designed in the bill, any entity that receives funding from the Division or HHS would be offered this tool to deploy to the population it serves. That is the initial target population. Once the data is available, we will identify the needs not being met, rewrite our waiver support services and direct the folks engaged in this pilot program to additional services available federally or via other State funding options.

CHAIR DOÑATE:
The legislation is timely and important to have that conversation. The primary care facility I work with in geriatrics has family caregivers who do not get compensated, and they pick up the mantle sometimes. It may be a full-time job to take care of our family members. In some situations, you have certain family members taking care of an older relative or perhaps dealing with a disability. There is not enough training to understand the actual requirements to do so.

It is not just taking care of them and feeding them any type of food. If they have a feeding tube, you must be aware of how to maintain sanitation and how to help them exercise so they can retain their mobility.

When I saw this legislation, I questioned the need for a study because you can accomplish a lot of this simply by revising the definition of caregiving and making sure folks are compensated. You mentioned wraparound services we do not know of that could exist. We must do a comprehensive analysis to fill those gaps. My hope would be at some point we will come back with the money request. This is important. For these caregivers to children and to senior relatives who do this full time, it is a job, and we have an obligation to get them some benefits for their services. They should be compensated fairly so they do not have to work multiple jobs or go back and forth.

ASSEMBLYWOMAN BROWN-MAY:
I appreciate that and the depth of consideration you have given this piece of legislation. In my 20 years in disability support services, I have met with many families who tell us what they need to be successful. The first thing is identifying how to help families achieve their vision of success. We need to question each one of our families in their situation to determine skill gaps. How do we help them be successful? This tool helps us to first identify the next step we will take.

My dad loves chocolate and ice cream. My mother's condition does not respond well to ice cream. She must have a smoothie with green spinach. If the nurse comes and knocks on the door, he will let her in and then the nurse cares for my mother. My dad is unable to do that. He goes for chicken soup out of a can—not the right nutrition to help her maintain long-term awareness. By developing the tools to identify and resolve skill gaps toward helping our families remain in their homes within community settings and maintaining their quality of life, we expend less money in the long run and have happier citizens.

Cheryl Danielle is a woman I have worked with for a long time. Ms. Walt works closely with her. They thought as a family they had it together. She and her husband have an adult son with significant intellectual disabilities. The question most families ask about adult children with those types of disabilities is what happens to my child when I am gone? Those families are caregivers, moms and dads, taking care of their adult children their entire lives with no end in sight. Most of us have children who reach the age of ten and can feed themselves. By age 15, they are about to drive a car; at 20, they may get married. That does not happen for parents of children with profound and significant disabilities in their 40s, 50s and 60s who require care their entire lives. Cheryl's husband recently had a stroke, and now she is caregiving for two people. Who supports

Cheryl? How do we help her maintain her quality of life in her family so she can continue to work and support both her husband and her child?

This entire coalition of families came together over the Interim. They identified the best place for us to start is here with this tool to figure out what families need and develop the payment piece, the additional wraparound support services and determine how to fund long-term care in our communities.

CHAIR DOÑATE:
Do other states pay family caregivers? Is that something our State is missing that other states have started?

ASSEMBLYWOMAN BROWN-MAY:
Some states do. Nevada has begun to move in that direction. We have some instances where family caregivers are receiving pay. To do that, we have worked closely with HHS.

MARY PIERCZYNSKI (State of Nevada Association of Providers):
The State of Nevada Association of Providers provides services for intellectually disabled individuals throughout Nevada. We are in support of A.B. 100 because we see how important family members are when they are caregiving, especially for intellectually disabled individuals. Family members play a key role in the continuum of care, and those with developmental disabilities depend on them. This bill will help us help caregivers; they in turn will help those they care for to a greater extent.

VANESSA DUNN (Nevada Public Health Association):
Nevada Public Health Association is in support of A.B. 100 which will benefit both caregivers and patients in Nevada.

MARLENE LOCKARD (Service Employees International Union 1107):
Service Employees International Union 1107 and home care workers are in support of this important legislation, and we are appreciative to the sponsor for bringing it forward.

DAVID NICHOLS (Nevada Lifespan Respite Care Coalition):
Nevada Lifespan Respite Care Coalition agrees and is in support of this bill.

DORA MARTINEZ (Nevada Disability Peer Action Coalition):
The Nevada Disability Peer Action Coalition thanks the sponsor for this bill. This will help people with disabilities.

CHAIR DOÑATE:
The Committee received nine letters (Exhibit C) in support of A.B. 100 and a statement (Exhibit D) in opposition. I will close the hearing on A.B. 100 and open the hearing on A.B. 114. We have Assemblywoman Clara Thomas with us.

ASSEMBLY BILL 114 (1st Reprint): Revises provisions governing the Nevada Early Childhood Advisory Council. (BDR 38-788)

ASSEMBLYWOMAN CLARA (CLAIRE) THOMAS (Assembly District No. 17):
It is my pleasure to present A.B. 114 concerning the Nevada Early Childhood Advisory Council (NECAC). Joining me today is Patti Oya, Education Programs Director, Office of Early Learning and Development, Nevada Department of Education, and Denise Tanata, Chair, Nevada Early Childhood Advisory Council.

I have a presentation (Exhibit E) of the bill and an amendment (Exhibit F) submitted by Denise Tanata.

Early childhood development refers to the period of growth and learning that occurs in children from birth through the age of eight. This is a crucial time in a child's life as it lays the foundation for physical, emotional, social and cognitive development. Research shows early childhood experiences have a significant impact on a child's future outcome such as academic success, health and economic stability. The first five years of a child's life are crucial for brain development. Ninety percent of a child's brain growth occurs during this time. It is so important that we invest in early childhood development to ensure that children have access to high-quality early learning experiences which promote their development and prepare them for success in school and beyond.

Growing research consensus shows high-quality preschool programs prepare children better for school, especially in terms of their academic skill development. Research also shows modifiable factors in a child's early years can affect the child's health and learning trajectories. We need to support families and caregivers to help them provide a nurturing and stimulating environment for young children.

Senator Rochelle Nguyen and I formed a four-person Nevada delegation and were invited to participate in The Hunt Institute Early Childhood Leadership Summit last year. At that convention, Nevada, along with 49 other states and the U.S. territory of Puerto Rico, recognized the importance of high-quality early childhood programs and the need to address the holistic needs of children and families in Nevada. This is where the Nevada Early Childhood Advisory Council comes in.

The Council is a group of experts from across the State who provide guidance and support to improve the quality of early childhood programs and services in Nevada. The mission is to promote a comprehensive, high-quality, coordinated system of early childhood services to support the development of young children and their families throughout Nevada. The Council works to strengthen State-level coordination and collaboration that supports early childhood development, such as increasing access to high-quality early learning programs, supporting the professional development of early childhood educators and advocating for policies to promote family-friendly workplaces and support for working parents.

DENISE TANATA (Chair, Nevada Early Childhood Advisory Council; Comprehensive Systems Director, The Children's Cabinet):
In reviewing Exhibit E, I will give a high-level overview of the Nevada Early Childhood Advisory Council and some of the work we have done which led to these recommendations and proposed amendment in Exhibit F. I will go over the overview (Exhibit G).

PATTI OYA (Education Programs Director, Office of Early Learning and Development, Nevada Department of Education):
The reprint of A.B. 114 replaces the word education with early childhood program. It is not just about education, which is important, but it is also about mental health behavior, social services and family engagement. We wanted to make sure it reflected that comprehensively. It also clarifies language.

The bill adds five new appointed members to the Council with one each representing the HHS Division of Public and Behavioral Health whose duties include maternal, child and adolescent health; the Program for Child Care and Development under the Division of Welfare and Supportive Services; public schools serving children in kindergarten to Grade 3; a tribal organization; and a parent or guardian of a child under eight years old. It could be multiple parents

but the representative must have participated in one or more designated federal or State early childhood programs.

The last change adds a definition of an early childhood program as "any program for children less than 8 years of age pertaining to nutrition, health care, mental and behavioral health, protection, play and learning, to stimulate physical, cognitive, linguistic, social and emotional development." It is taking the comprehensive view of development and young children.

A friendly amendment, Exhibit F, was submitted with this presentation to clarify the two roles, one under the Department of Education (DOE) and one under the Department of Health and Human Services. The fiscal note is zero dollars for the next three fiscal years. With two positions to support the work of the Council under the DOE funded through the Federal Preschool Development Grant Birth through Five until fiscal year 2026-2027. We would like to continue those positions once the grant ends on December 31, 2025.

SENATOR TITUS:
I appreciate this and the issues you want to solve because we need to capture these as early as possible to be effective. Are all the positions available under this Council currently filled because you are adding five more?

ASSEMBLYWOMAN THOMAS:
Yes, those positions are filled. We want to inject an early childhood expert because there are none.

SENATOR TITUS:
I wanted to make sure it can function. I see why you are adding more positions and certainly am supportive of that. Many times we hear the Commissions have not met, are not functioning and cannot find people to sit on them. I want to ensure this is functioning and all you need is more input from different levels.

SENATOR NGUYEN:
Adding the voice and how it interplays when children ultimately are in our elementary schools and high schools is so crucial. I am supportive of the bill.

TOM CLARK (The Children's Cabinet):
The Children's Cabinet does a lot of work with NECAC. To Senator Titus's question about functional boards and commissions, this one is working. The

injection of these additional positions is only going to make it better. We support it.

SHEILA BRAY (University of Nevada, Reno):
The University of Nevada, Reno, would like to express support for A.B. 114. The outlined changes are vital to add necessary members to the Nevada Early Childhood Advisory Council. We know how important early childhood education is for the growth and development of our young people. As an institution of higher education, we appreciate the bill sponsor's cohesive expansion of this Council to best represent the array of needs, skills and development necessary for our early childhood members, as well as those she added who can also speak to the training and professional development for early childhood professionals.

JAMELLE NANCE (Children's Advocacy Alliance):
The Children's Advocacy Alliance is in support of A.B. 114. This bill is one that is near and dear to our hearts. It is important to us because we believe in the diverse representation of the members of the Nevada Early Childhood Advisory Council which reflects the true system and how it impacts our children. We know it extends beyond education. It includes our healthcare and mental health providers and, most importantly, our parents.

As this advisory body makes recommendations on the needs and resources for our young children and families, we must ensure we have the right people at the table, and A.B. 114 does that. Recommendations cannot be made adequately without individuals who represent the entire early childhood system and the issues it aims to solve.

ASSEMBLYWOMAN THOMAS:
Assembly Bill 114 ensures the Council's critical work will continue so all children in Nevada can reach their full potential.

CHAIR DOÑATE:
An opposition statement (Exhibit H) was received from the Clark County Republican Party. I will close the hearing on A.B. 114 and open the hearing on A.B. 154.

ASSEMBLY BILL 154 (1st Reprint): Provides for the regulation of the living donation of birth tissue. (BDR 40-455)

ASSEMBLYWOMAN SARAH PETERS (Assembly District No. 24):
This simple bill addresses an issue of education. I have been pregnant three times and had three live births. In each of those situations, learning about what is real and what is available for a person who is pregnant is a challenge. There is misinformation, and many people can take advantage of you in a vulnerable time in your life.

This bill looks at the donation of live birth tissue, which is part of what happens when you have a baby. You have extra tissue, an extra organ that comes out and can be used in a donation for other vital services. You can find other information about how you can handle the tissue or its use. We wanted a safe place for birthing people to go to for information on how to donate safely and to a reliable donation center.

Assembly Bill 154 and its first reprint require the Division of Public and Behavioral Health to maintain a website listing accredited tissue bank entities that can accept birthing tissue. It requires the list be available to birthing people in specific settings through a link. This would be updated regularly and periodically, and ensure accredited entities meet specific standards. People have a place where they know what they are looking at is accurate and accredited.

SENATOR STONE:
A lot of wonderful lifesaving elements come from these organs, namely stem cells. It is important women know in advance of their birth where they can send these tissues so they can help other people. Can you tell me about these banks? Are they nonprofit banks or for-profit banks? And how do they distribute the cells? Do they go to drug companies, or do they go to research? Can you elaborate on that for me?

ASSEMBLYWOMAN PETERS:
We have someone in Las Vegas who can address tissue banks under the specific accreditation organization and what its processors can do with birthing tissue.

DAN LUNN (Vice President, Tissue Operations, Nevada Donor Network):
Tissues used by tissue processors utilize the tissue for wound treatment. In many cases of unidentified treatments, this placental tissue is utilized for wounds and has many successful outcomes. In addition to wound treatment, this is used in dental procedures, sports medicine and ophthalmology. A new

and exciting area of tissue banking is a wonderful thing not only for Nevada but also for moms to have the option of donation.

SENATOR STONE:
Who regulates the tissue banks; is it with the State or federal?

MR. LUNN:
The U.S. Food and Drug Administration is the regulatory body for tissue banking.

SENATOR TITUS:
I have delivered hundreds of babies. At the time of delivery, after delivering the placenta, you evaluate it, making sure it has proper vessels in the core, looking at any infarction, present disease process, all those things, nothing that would prohibit it. Then we would send it as a tissue specimen. When we get the pathology report back, we would not throw it away per se. After the pathology was done, they would destroy it. It is good policy but certainly the tissue banks would not accept a donation prior to doing the basic examination to make sure it was a healthy placenta.

ASSEMBLYWOMAN PETERS:
I wondered about the scenarios when birthing tissue initially can be collected. Specific qualifiers result in the accreditation of the tissue for donation process. Cesarean sections enable collection of donation tissue, but I defer to the experts on the additional criteria.

MR. LUNN:
The physician determines whether problems during childbirth require a need for the placental tissue to go to pathology for further testing. That would come before the tissue could be used. If the physician deems it needs to be used for those circumstances, that will take precedence over the donation itself.

SENATOR TITUS:
We have had a lot of discussion this Session regarding home birth, midwives, etc. In looking at somebody doing a home birth, is there a pathway to proper places for storage and salvaging of this birth tissue?

MR. LUNN:
There is no existing pathway. We have been working with hospitals, but it does not say that pathway could not be further explored or developed.

ASSEMBLYWOMAN PETERS:
Based on input from the midwifery and home-birthing community, they have requested not to be included in the obligation to present this information to their patients because they are unable to provide that service directly to the tissue banking entity. We specifically called out hospitals or birthing center as the only places that have to present this information to the patient because they are the most likely setting for collection of tissue donations.

SENATOR TITUS:
I did not want somebody showing up with her bagged placenta at the hospital.

CHAIR DOÑATE:
I have a family member in California who did a similar process, and there is a national certification. You can get certified in placenta encapsulation. There is a procedure for it. Your bill probably opens for follow-up steps once this bill gets implemented as to what this ecosystem could look like.

ASSEMBLYWOMAN PETERS:
I did that with all three of my placentas. I had them encapsulated by a local woman who is a doula, as well as being trained in midwifery. She offered a processing service.

ASHLEY ELIASON:
I am a resident of Clark County, a mother and two-time birth tissue donor. In 2020, I was presented the opportunity to donate my placenta and umbilical cord during my scheduled Cesarean section procedure by my doctor. Prior to this discussion, I was unaware of the birth tissue process. I had already delivered two children without the opportunity of donating; my placenta and umbilical cord were discarded. From my understanding, this is the routine disposition of birth tissue after donation. The doctor explained the process of donation with Nevada Donor Network, and I consented to donate. The thought of my baby and I helping another person in need aligned with my values and beliefs. Prior to the delivery, I completed my consent and medical history via phone from the comfort of my own home. On the day of the delivery, other than a simple blood draw, the experience of donating my placenta and umbilical

cord was no different to me as a patient than if I had not donated. The only difference was where the tissues were going, and that was to help others.

Following my donation, I received an after-donation packet from Nevada Donor Network which included information about my donation and a sweet little onesie for my newborn. My experience was so great in 2020 that just last year, when I gave birth to my fourth child, I chose to donate again. While our family is now complete, our decision to donate has provided us a legacy of happy times bringing new life into the world while simultaneously helping save lives. I am in support of A.B. 154, ensuring a minimal set of standards and regulations for birth tissue donation in Nevada and increasing birth tissue donation awareness for expecting mothers across the State.

MR. LUNN:
Assembly Bill 154 provides the information expectant mothers should have so they can make informed decisions regarding their birth tissue.

CHAIR DOÑATE:
Testimony in support (Exhibit I) was received from Kimberly Cortes. Testimony in opposition (Exhibit J) was received from the Clark County Republican Party.

I will close the hearing on A.B. 154 and open the hearing on A.B. 132.

ASSEMBLY BILL 132 (1st Reprint): Establishes provisions relating to the review of opioid overdose fatalities. (BDR 40-721)

ASSEMBLYWOMAN LESLEY E. COHEN (Assembly District No. 29):
Presenting with me is Trey Delap from Group Six Partners. Mr. Delap has worked with behavioral health addiction and recovery policy for years and specializes in advocating in the spaces where they converge. The opioid epidemic has swept through the Country, causing the death of people in all occupations regardless of age, religion, education, race or social standing.

Fentanyl has caused a tough situation to be more dire. Overdose fatality review (OFR) has been found to be successful in assisting with providing the data necessary to curtail opioid overdose deaths. Twelve states utilize OFRs as a part of best practices. When we began the process to introduce OFR to Nevada through this bill, we initially thought the review would be most effective and like the Committee to Review Suicide Fatalities housed in HHS. Per the Centers for

Disease Control and Prevention and Bureau of Justice Assistance (BJA) in the U.S. Department of Justice, we found the best practices require more flexibility than allowed by the Suicide Review Committee structure. As we have proceeded and consulted further with the recovery community and stakeholders, we have determined the OFR may be more effective by focusing on work to be done at the local level. The first reprint allows for the sharing of data with agencies and institutions throughout the State at a more local level.

Because of the amendment to the bill, some agencies were not aware of requirements until the last couple of days. We have met with them toward an agreement. After negotiation, we will remove any requirements for police agencies to provide data and continue to center with the other entities in opposition.

An opioid fatality review allows local agencies to use data constructively at a local level to immediately address issues with opioids. Indiana has used this effectively in a couple of ways. Local authorities saw a spike in overdoses occurring and responded quickly, making naloxone available in the area and saving lives.

A group of three counties utilized data in their review to determine a trend of deaths occurring after people had been to the dentist. It was not one bad-actor dentist, but multiple dentists who were giving out prescriptions. The counties provided training to the dentists regarding substance misuse risk screenings and broke the trend. The key for OFR is to allow local agencies and institutions to access data with enough time to be responsive where they see hotspots.

TREY DELAP (Group Six Partners):
I will read my written statement (Exhibit K) in support of A.B. 132.

CHAIR DOÑATE:
I appreciate your efforts on addressing the opioid crisis. Many of us in the State realize this is a pressing issue. We have seen legislation in this and other Chambers throughout this Session to address the opioid crisis. I have the good fortune of sitting on a substance abuse resource group, and we have had great discussions about upcoming settlement money and how to build the infrastructure needed to address this complex issue that has been pervasive for many years.

I have been critical in general of legislation review boards because there are multiple groups and organizations ask this review board for outcomes and diagnosis. Often that requires us to mandate reporting mechanisms from our providers to follow through with such diagnosis.

We would not need to present those bills if we did one simple thing: fund public health as needed, hire the epidemiologists and maintain a level of interoperability. We would not need the different fatality review boards for diseases. Are some of them necessary to investigate the biases we have? Yes, 100 percent.

There is a point in time to consider the infrastructure we have and what it takes to stand it up. When we do that, we could save a lot of time by providing infrastructure in general for public health. Walk us through what was introduced in the other Chamber, the amendments that came through, and what we have in front of us today. That would help us to understand how the bill has migrated to what we have in front of us.

ASSEMBLYWOMAN COHEN:
It started in the other Chamber with a more top-down approach. By the time of the hearing, we had a more bottom-up amendment. This bill is more about finding a hotspot at a local level and responding to it quickly. We went with that at the hearing but only a conceptual amendment. The concern was though this State has mechanisms for both data about opioids and its collection, some of the data are not being collected or reported. Certain entities that should be reporting are not. By the time data are collected, it can be a lot later. We want to enable the right people to react quickly to the hotspot when it happens.

CHAIR DOÑATE:
I understand the sentiments of the gaps you are experiencing. I want to make clear we are not saying opioid cases are a systemic public health issue we are seeing across the board.

SENATOR NGUYEN:
Originally, the State board was involved and then taken out of the reprint of the conceptual amendment. Now it goes to local government entities or institutions. What criteria are local governments to use in making some of these determinations in section 3.5? When entities consider a memorandum of understanding (MOU), subsection 3 says they shall not enter an MOU unless

they demonstrate they can conduct the review and maintain confidentiality. What kind of criteria should those local governments consider when determining that?

MR. DELAP:
The biggest issue is a competent capable entity. The bill outlines the criteria for the MOU—the original version was vague—and that is the key objective—to create an enabling opportunity for someone to do an MOU. The idea then is releasing this information or having to go through a process to a third party, or someone sets up an opioid fatality review process by extending a letter and then getting all the information. This was a concern because it violates some confidentiality.

The idea of the MOU was a solution to the vagueness of the problem. The entities are detailed. The local entity in the hospital and provider of health care can have access. The MOU is verification that the entity is doing this with the capacity to maintain confidentiality, perform the actual opioid fatality review and implement measures while holding the protections at a higher level.

A State or local entity, which could be a police department or the Attorney General's Office, can get it. If an entity has an MOU, the information goes to those entities and not to somewhere unsafe. The design ensures confidentiality, provides for protections of the information that does not go outside the accountable organization.

SENATOR NGUYEN:
You have moved it from the State board to more local jurisdictions. Is that because the counties and cities were more willing to participate in providing the data for those review committees and for different entities?

MR. DELAP:
Extensive research on the efficacy of these fentanyl-related substances (FRS) is in 12 other states; the most effective and impactful level is at the county or community level because it can move fast and get relevant information. The State did not ask for or want it. There was no funding for it. The Department of Health and Human Services had a fiscal note. The idea of a top-down approach does not work for all of Nevada. It is more important the people on the ground are the ones participating in this process because they will know what the community wants. It removes a mandate because that is the other key.

The federal resources issuing grants to the Office of the Attorney General contributed to the inspiration for this bill. The BJA program provides all the technical assistance. With this bill, any entity would go through extensive work to demonstrate it is capable and competent, aligned to get all the assistance and money from federal agencies.

The intent has the most local fatality reviews as more effective and able to move faster. The Indiana experience was fascinating with an interlocal agreement between three or four counties that revealed this dental office, and no one could have predicted that. They know who they are, they can deploy the resources. That is where this goes and why we took it out of the State.

ASSEMBLYWOMAN COHEN:
It is local because you see what is going on whether it is someone in the hospital or someone in the health department. When those hotspots are flaring up, they see it whereas the State level may not.

SENATOR NGUYEN:
I am curious about the transfer of data with these FRS committees or entities. Would they have subpoena power to get that kind of information? How does that work? Was your intention for them to have subpoena power to compel data if need be? Based on the fact the bottom-up approach is more appropriate, it might be a fit for the local jurisdictions.

ERIC ROBBINS (Counsel):
As far as the question of whether they can subpoena, under section 5, subsection 1, paragraph (c) of the bill, yes. They are authorized to petition a district court for the issuance of a subpoena, and then the district court would be authorized, but not required, to issue the subpoena. That is how it works in the bill.

MR. DELAP:
One reason for this extensive language is to provide cover, legislative authority, for the agency to release the information. That is why all these agencies have this information. It is presumed it is private, confidential and maintains confidentiality. They need the authority to share information with someone else. The bill would enable them to have short authority to share this information. That is why the expressed narrow focus is so important.

Think of privacy and confidentiality as normative values in health care. Privacy is an inherent right; confidentiality is the system of maintaining it. When you are dealing with public health versus public safety, it is more important you know everything you possibly can to provide the right kind of care. We will relax our privacy rights to help to prevent future overdose deaths. That will give the OFR the ability to look at everything as much as it can to identify potential opportunities to act and extensive capacity and requirements to maintain confidentiality.

One key detail consistent in this bill and in other states is this information is for secured purpose only. It is not discoverable for criminal investigations. It is independent of investigation. It is not discoverable for civil issues. Anyone participating has a civil immunity if genuinely connected to the express purpose. The purpose is to focus this information and to maintain it forever in confidentiality in the MOU, even if it was a university study. It is important to include that forever and ever, this information is held confidential and private, and only report the results.

For Nevada, the Office of Public Health Information has some mechanisms to identify health and statistical data because the population is so small. If it is three people in Lander County, you can figure out who it is. So they have done some modifications to how the data is reported to ensure confidentially and privacy. That is the objective.

The idea is the information would be held confidential forever and is an expectation of the legislation. The MOU, the entity, the capacity of any organization will handle that.

CHAIR DOÑATE:
Hearing your sentiments, we have established an opportunity to perhaps go through subpoena. I do share some concern about the way the bill is structured. You can have a faculty member or local entities with no jurisdiction or training as to how they control the dissemination of health data. You are walking a slippery slope with no parameters as to how the data is transferred, how providers must respond. I understand the request for real-time access, but you are creating a strike team for entities in the wrong position. That is my interpretation.

SENATOR TITUS:
In section 4, subsection 2, an opioid overdose fatality review is separate from, independent of and in addition to any investigations. I am wondering and worried if you have a hotspot where we have overdoses and suddenly you have people dying from overdoses in a community neighborhood. Law enforcement gets involved right away. If you have fentanyl, we know it is a crisis. We are looking for any solution. A rapid strike team for bad drug overdoses is important. That is the problem we are trying to solve, but I worry that section is opening and may even interfere with law enforcement investigations. It seems the statement is about "independent of." Why would you even want to be independent? Do you attempt to make your own conclusions and not do so in conjunction with all the other people who are trying to solve this problem?

MR. DELAP:
Strike team is exactly what we would love to have. It is the fully realized opportunity. It is important because the prevalence of illicitly manufactured fentanyl creates hotspots, and the ability to mobilize quickly is an excellent public health response. No one does that right now. This bill is enabling and creates the opportunity at the access point for someone to sort out the details.

Before an OFR could launch, given standards from the Bureau of Justice Assistance, it must identify the government committee and administrative lead agency that will be responsible for the coordination, facilitation, data management, interagency data sharing and confidentiality agreements. They will recruit case review, team member agencies and members to work out the data interagency agreement, set OFR ground rules and expectations, review data and determine case selection criteria, develop protocols for secure data access, provide team member training and set the median schedule. All this would need to happen before the first request for information would occur.

This is intended to create the opportunity. If entities can do all this and demonstrate the capacity to do these things, they can go from there. If this bill was passed and signed by the Governor, there would not be hundreds of individuals going and requesting tons of information. This is a narrow purpose.

Let us say an individual wanted to know why his or her child died of an overdose, or a law firm wanted to review OFRs to identify people to sue. This other piece of the bill is important, protecting information from any public use. It is for the public benefit. It is important because if your intention is to find

someone, it is not focused on preventing. This demands every participant be engaged in doing this.

Another reason to move it away from the State is because it delineated who had to be what, and many people serve on committees that have no use. The subpoena power also was interesting because it is carryover language. This would be an extreme case because the whole point of all this is to establish collaboration and cooperation. Having to go the subpoena route would be a large barrier. Who pays for the lawyer? The judge has to figure this out. That seems like an extreme measure.

SENATOR TITUS:
In section 4, subsections 2 and 3, where law enforcement must cooperate, I worry about access to the Prescription Monitoring Program (PMP) we all must sign on to. I look periodically to make sure nobody is filling false prescriptions.

We passed a bill two sessions ago allowing law enforcement to access the PMP when investigating an overdose case. The provider for prescriptions and where the person got the medicines are there. Do you foresee this group accessing the Prescription Monitoring Program? It took less legislative process to have different folks access that.

MR. DELAP:
Nevada was innovative in 1997, starting one of the first PMPs in the Country. That information is vital. Now every state has one. Improvements on the PMP data are still being addressed. It does not communicate with California. It is easy for someone to get a prescription and go across the border to get it filled. Things like access to the PMP with law enforcement involve data integrity. When reported by the dispensing pharmacy, it is solid.

You are referring to a comprehensive opioid prescribing bill A.B. No. 428 of the 79th Session, which addressed phase one of the opiate epidemic—overprescribing. It mandated the queries of the PMP. It mandated certain reporting. Everyone had to register for it. That is a valuable clinical tool. It has never been intended nor designed to be a surveillance mechanism by this State, in contrast to North Carolina. In North Carolina, the medical board started proactively reviewing PMP data, identifying certain criteria which spit out reports to initiate investigations of doctors.

It is not possible for the Board of Medical Examiners in Nevada to initiate any action. It needs a complaint. Surveillance of the PMP has never been intended for that. It was always intended to be a diversion. The idea would be if you have two doctors who are prescribing and someone else is prescribing, the doctors have a conversation, and it is informational. It was always intended to be an instrument for others to act.

What do these cases have in common? Is there anything we can do about it? Like the dentist in Indiana, this envisions the development of a tool.

SENATOR TITUS:
Let me go back to the PMP again because the data we enter is used in the emergency room. We would look before prescribing a narcotic or pain medicine. If somebody comes in with back pain, that is a resource for me to look and see that this person has had five prescriptions at different locations. I never saw it as monitoring the doctor, but a tool to see if the patient was doctor shopping or going to different places for a prescription. We did allow for law enforcement to access that. I worry about an expansion of information. If an entity can conduct its own review of the overdose, will it have access to the PMP? Is that the next step the entity will ask for?

MR. DELAP:
As far as what data would need to be developed, the criteria, how are they going to select the criteria? What information is relevant? That would need to be hashed out and then the proper resources brought together. The next step is to determine if the State, a local agency, or an MOU would oversee the process. All of that would have to be vetted out. It is possible that might be part of the proposal, but it is not necessary. For studies on emergency room physicians specifically using PMPs and increasing their confidence in identifying drug seekers or people, they thought if they did a query and found someone was doctor and hospital shopping, that was an issue; if not, they were more confident. It was always a valuable tool in that regard.

The other detail was PMP morphine equivalency. That is a huge issue. The average doctor, if not living in the world of pain medicine, does not know the difference between micrograms of fentanyl and morphine. The potency is all over the place. Ohio produced a system that when queried, a big number comes up with how much the patient is taking. That valuable tool originally designed as a clinical tool had some diversion of investigative access.

This bill will sit until someone crafts an opportunity, brings these resources together and organizes how to begin this process. To begin this process, it is important that all components be detailed and first demonstrated for capacity.

MR. ROBBINS:
To answer Senator Titus's questions about whether one of these reviewing entities could access the PMP, the answer is an entity that can already access the PMP could; if not, then the entity could not access the PMP. Those entities authorized to do this under this bill, like a State or local governmental entity, such as Division of Public and Behavioral Health or law enforcement entity, have access to it, so they could. The same thing applies with the provider of health care. A provider that is an authorized prescriber would be able to access the PMP within the scope of its authorization. For any other entity entered on an MOU or a governmental entity that does not have access to the PMP, nothing in this bill gives such an entity access.

SENATOR STONE:
We have had 75,000 to 80,000 people die of an overdose in the United States. I think roughly 500 died in the last year in Nevada. I do not know if they have been characterized as accidental overdoses or as suicides. We also take into consideration our doubled population of who visits the State every single month. Some of those overdoses are people who do not live in Nevada.

If you see a hotspot of some type, how do you identify getting to those pockets to prevent deaths? How many deaths are people who think they are using heroin and fentanyl and are dying. How do you distinguish an accidental drug overdose versus somebody who genuinely wanted to commit suicide? May there be conflicts with the death certificate or if someone goes into the emergency room and dies from an overdose? How about a conflict with the death certificate and an ongoing investigation with the district attorney's office? Could there be a conflict between you and the public safety agencies?

ASSEMBLYWOMAN COHEN:
Even a lot of deaths on The Strip do not mean this issue is going to be addressed. A qualified organization must decide to take this on. I do not see a conflict. No one goes back and changes a death certificate because it is not about the people now deceased. It is about taking the data and moving forward, dealing with what is going on in the area and why we are seeing so many deaths in that area or what we can do to prevent it. It is making sure naloxone

is there or training dentists who are giving prescriptions without prescribing naloxone. It ensures we address things moving forward in that area based on the data we have.

SENATOR STONE:
Are you to depend on the medical examiner to make a decision—not knowing if they have much detail with fentanyl, if it was an accidental death or a suicide? We see so many fentanyl deaths. Do you think it might skew the data?

MR. DELAP:
This process would not affect any other determination of death. If the coroner issues a death certificate, this will not reverse any of that. This is intended to prevent future overdose deaths based on information we learned from the collection of information. It is part of a harm reduction strategy.

In Clark County between 2018 and May 2023, 46,000 overdose kits have been distributed and 4,984 individuals have been trained in its use. Since the fentanyl test strips are available, 236 trainings have been held. Thirty-two partner agencies work with the southern Nevada Health District distributing 48,000 fentanyl test strips so people can test their stuff before they use it.

It is too important that the public safety records work continues unimpeded. This is a way of engaging in the process, not interrupting it, by gathering actionable information to prevent future deaths. It is important as with the quality of care a healthcare provider can provide who knows everything needed about a patient without judgment, which is a critical detail. This process is not intended to judge anything. It is intended to find out what is going on and then to respond.

ASSEMBLYWOMAN COHEN:
I take your point about suicide. But let us say a regular street fair occurs once a month, every other month, and a lot of deaths start happening around that time. People who have this data and can use this information see that it coincides around the time people go to this fair. They will use the data and realize it is not an overdose if you have a bunch of people who are hanging out at a festival. But were intentional suicides happening in that area? That is why they need the data to figure that out.

SENATOR STONE:
I appreciate all the intervention programs you are talking about with the kids and the fentanyl strips. If areas of Las Vegas not on The Strip are seeing these spikes, hopefully, we can give people the tools to help themselves identify these dangerous drugs and their potential to kill. There seems to be a lot of moving parts. I am anxious to hear if the public safety agencies see any impediments to their abilities to solve some of these crimes.

CHAIR DOÑATE:
It is appropriate to have conversations as to what response mechanisms can look like in terms of surveillance. We talk about that in public health, but the key part rests with review boards, a post of the encounter. A lot could be solved if we just fix the infrastructure in general.

JOHN PIRO (Clark County Public Defender's Office):
I understand the County will bring up some issues in opposition. We have heard a lot about fentanyl all Session. It is one of the biggest trending topics of the Session. This bill is seeking to get us data so we can move forward in a data-driven way that could guide us better than some other measures proposed this Session. We are in support.

ERICA ROTH (Washoe County Public Defender's Office):
I echo the sentiments of my colleague from the south; we support the bill.

JOANNA JACOB (Clark County):
We are in opposition, not to the intent to address opioid abuse in our community but more on the workload. We did monitor this bill on the Assembly side. We were aware of conceptual amendments, but we came to this bill sponsor when the reprint came out once we saw how the bill was structured. Our concern is that between Clark County and Washoe County, two coroners cover the entire State.

Several bills proposed this Session add additional review committees. Assembly Bill 119 adds the review of elder deaths that are suspected of maltreatment. Assemblywoman Clara Thomas is proposing a fetal and infant review in addition to a child death review, suicide and other review committees that already exist in statute.

ASSEMBLY BILL 119 (1st Reprint): Creates the Vulnerable Adult Fatality Review Committee. (BDR 38-311)

We followed the discussion closely, but there could be multiple review committees in our County. There is some doubt as to this happening. It is enabling to allow several entities: State or local government—which is us—a hospital provider, healthcare group, faculty member and student. Several institutions in southern Nevada have a lot of people who want to work on this issue. We are a bit concerned that we may be juggling multiple requests at one time from one or another specific entity. I would like to see some parameters around that.

In response to Senator Titus's question about section 4, subsection 2, the review is separate from, independent of and in addition to the investigations that we do. The coroner investigates every death, but we also do the investigations for law enforcement. We are responding to everything, and that is where we are a little bit concerned about the timing of these requests.

We want to get the stated testimony as close to real time as possible. Our coroner's office is understaffed now, and there are delays in getting the information to law enforcement. In Clark County, we have seen a drastic increase in overall deaths. There has been a lot of discussion about fentanyl, a 126 percent increase in deaths—32 percent of all overdoses just in the last year and 31 percent in suicide. We are struggling. I would like to see parameters around what that would be. I will concur in the testimony from Washoe County. This impacts not just the coroner but possibly the County because of the request to look for social service agency and child welfare data as well. It is something we would contemplate in having to enter several MOUs, and that is a concern.

CADENCE MATIJEVICH (Washoe County):
We are here in opposition to the implementation components of the bill. We understand this is an issue we must address. Our State and local governments are committed to being part of the solution. We have some concerns with this proposal. Ms. Jacob enumerated several concerns Washoe County has with respect to the public records requests for our medical examiner's office and other departments within the County.

We appreciated some of the questions Senator Rochelle Nguyen asked about how the bill contemplates any entity that enters an MOU with the local government entity. It puts certain requirements on the State or local government that should not enter MOUs until it verified these things.

Mr. Delap gave an extensive list of some important things that need to be reviewed but places the burden on the local government to conduct the review before entering the MOU; if in the diligence we overlook something, this is a potential liability for us. It talks about transferring our copyrights or intellectual property. It is assigning these reviews to the local government and then we must maintain that. It is not something we do. We would have to contemplate how long we would keep that data? Where do we keep it? This places several additional burdens on local government. That is concerning for us.

VINSON GUTHREAU (Executive Director, Nevada Association of Counties):
The Nevada Association of Counties supports all the comments made by Clark and Washoe Counties and echos the comments as well. Adding in our piece on the county impact, every county provides human services. Section 4, subsection 3, paragraph (e) would provide an undue burden on us to implement this. We are also in opposition.

MS. MARTINEZ:
I am calling in support of A.B. 132. People with disabilities and veterans are victims of fentanyl overdoses.

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CHAIR DOÑATE:
We have received testimony in opposition (Exhibit L) from the Clark County Republican Party. I will close the hearing on A.B. 132.

There being no further business in the Senate Committee on Health and Human Services, the meeting is adjourned at 5:33 p.m.

RESPECTFULLY SUBMITTED:

Diane Rea,
Committee Secretary

APPROVED BY:

Senator Fabian Doñate, Chair

DATE:

EXHIBIT SUMMARY				
Bill	**Exhibit Letter**	**Introduced on Minute Report Page No.**	**Witness / Entity**	**Description**
	A	1		Agenda
	B	1		Attendance Roster
A.B. 100	C	7	Senator Fabian Doñate	Nine letters in support
A.B. 100	D	7	Senator Fabian Doñate	Written statement in opposition
A.B. 114	E	7	Assemblywoman Clara (Claire) Thomas	Presentation
A.B. 114	F	7	Assemblywoman Clara (Claire) Thomas	Proposed Amendment Submitted by Nevada Early Childhood Advisory Council
A.B. 114	G	8	Patti Oya and Denise Tanata / Nevada Department of Education and Nevada Early Childhood Advisory Council	Overview
A.B. 114	H	10	Senator Fabian Doñate	Written statement in opposition from Clark County Republican Party
A.B. 154	I	14	Senator Fabian Doñate	Written testimony in support from Kimberly Cortes
A.B. 154	J	14	Senator Fabian Doñate	Written statement in opposition from Clark County Republican Party
A.B. 132	K	15	Trey Delap / Group Six Partners	Written testimony
A.B. 132	L	28	Senator Fabian Doñate	Written statement in opposition from Clark County Republican Party