MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Eighty-second Session
May 11, 2023

The Senate Committee on Health and Human Services was called to order by Chair Fabian Doñate at 3:31 p.m. on Thursday, May 11, 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 Robin L. Titus
Senator Jeff Stone

COMMITTEE MEMBERS ABSENT:

Senator Roberta Lange (Excused)

GUEST LEGISLATORS PRESENT:

Assemblywoman Shannon Bilbray-Axelrod, Assembly District No. 34
Assemblywoman Michelle Gorelow, Assembly District No. 35
Assemblywoman Shondra Summers-Armstrong, Assembly District No. 6

STAFF MEMBERS PRESENT:

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

OTHERS PRESENT:

Dan Musgrove, Clark County Children's Mental Health Consortium, Nevada Department of Health and Human Services

Char Frost, Clark County Children's Mental Health Consortium, Nevada Department of Health and Human Services
Sarah Hannonen, Rural Children's Mental Health Consortium, Nevada Department of Health and Human Services
Amanda Haboush-Deloye, Clark County Children's Mental Health Consortium, Nevada Department of Health and Human Services
Jamie Cogburn, Nevada Justice Association
Catherine Nielsen
Brett Salmon, Nevada Health Care Association
Jeremy Kilburn, M.D.
Dana Van Laeys (National Center for Competency Testing)

CHAIR DOÑATE:
We will begin with the first work session bill, Assembly Bill (A.B.) 206.

ASSEMBLY BILL 206: Revises provisions governing the Nevada Commission for Persons Who Are Deaf and Hard of Hearing. (BDR 38-563)

DESTINI COOPER (Policy Analyst):
I have a work session document (Exhibit C) describing the bill.

CHAIR DOÑATE:
I will entertain a motion on A.B. 206.

SENATOR NGUYEN MOVED TO PASS A.B. 206.

SENATOR TITUS SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR DOÑATE:
Let us move onto A.B. 289.

ASSEMBLY BILL 289: Enacts provisions relating to the natural organic reduction of human remains. (BDR 40-606)

MS. COOPER:
I have a work session document (Exhibit D) describing the bill.

CHAIR DOÑATE:
I will entertain a motion on A.B. 289.

SENATOR STONE MOVED TO DO PASS A.B. 289.

SENATOR NGUYEN SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR DOÑATE:
This concludes our work session bills. We will now open the hearing on A.B. 265.

ASSEMBLY BILL 265 (1st Reprint): Revises provisions relating to mental health. (BDR 39-96)

ASSEMBLYWOMAN MICHELLE GORELOW (Assembly District No. 35):
I am presenting A.B. 265 along with my copresenter, Dan Musgrove, immediate past chair of the Clark County Children's Mental Health Consortium. This bill will establish a State children's mental health consortium which will assist in organizing the regional mental health consortiums and provide an opportunity for them to collaborate with each other and coordinate mental health services for children.

DAN MUSGROVE (Clark County Children's Mental Health Consortium, Nevada Department of Health and Human Services):
I will give a history of the consortiums. They were created by this Legislature in 2001 when Speaker Barbara Buckley created the Consortium to end the bifurcation of child welfare. As part of that bill, she thought it was important to create the mental health consortiums for children to make sure that the needs of children were addressed. The wonderful thing about the statutory makeup of the Consortium is that it brings folks from a lot of different silos, agencies, and perspectives all together in one group with a focus on what is in the best interest of children and their mental health.

I am wearing green today. This is Children's Mental Health Acceptance Week, so it is appropriate that we are here today. In the 1800s, green was a symbol of someone being insane. We have come far from that. Now, it means acceptance of children's mental health. It is about a new beginning and focusing on behavioral health needs. Statutorily, three children's consortiums have been created here in Nevada. We have consortiums in Clark and Washoe Counties and the rural region. The membership is specific including someone from a State agency, county agency and parents of children with mental health needs. We have a foster parent who serves and a person like me who represents the business community.

I have been working in mental health for a long time and I am proud to serve as a part of the Consortium. However, there has never been a Statewide consortium in statute. Informally, we have had a Statewide consortium for about nine years. But again, it is because we have had cooperation with the Division of Child and Family Services (DCFS) at the State level. We have had people willing to serve but we thought it important to memorialize it. The Statewide consortium fills an important need; it brings together the interests of a truly diverse State. The needs of the rural areas are different from that of Washoe County and, certainly, from a large urban county like Clark County. It is important to ensure we are working together, not against each other, to get our message across to the State and county agencies as well as this Legislative Body to ensure that the best interest of children is considered, whether it is in the school districts, juvenile justice system, child welfare or the public that deals with these kinds of issues.

Assembly Bill 265 sets up the framework of what the Statewide consortium should be. Section 2.5 ensures that the chair of the Statewide mental health consortium plays a part in the Commission on Behavioral Health that already exists and sets up the membership of who should be on the Statewide consortium. It also requires that we do reporting.

Three reports (Exhibit E, Exhibit F and Exhibit G) were respectively submitted by each consortium in the rural region, Clark and Washoe Counties. You can see the extensive work done by each of those entities. The Statewide consortium will also have a responsibility to see what is happening Statewide and provide that reporting to the State and the Legislature.

It also allows us to bring a bill draft request (BDR) because sometimes we cannot find sponsors to bring our issues to the Legislature. We would like to bring a child-specific behavioral health bill to the Legislature every Session. The consortiums have been such an important part of framing and making State policy since 2001. It is because we work well together. We want to ensure that the State and DCFS continue to recognize that a Statewide consortium is necessary and we want it statutorily defined.

CHAIR DOÑATE:
Section 9, subsection 2, paragraph (b) says that the Statewide mental health consortium shall ”review, make recommendations for and approve programs proposed by the Division to prevent placing children," etc. I agree with "making recommendations," but I am skeptical of the "approve" process because the systems in place do not meet as often due to the infrastructure we have. If you can elaborate as to why this body would review, make recommendations and specifically approve some of the programs and initiatives, that would be helpful for the context.

MR. MUSGROVE:
The approval process is just an internal procedure to take a position. I am not sure that we have the authority to stop DCFS from implementing something. It is important for us, especially as the U.S. Department of Justice (DOJ) is looking at what the State is doing. This category talks about children and facilities located outside of the home or home state of the child and is something we need to focus on. We do the best we can to ensure that this does not happen. When we are talking about programs, it is more of a recommendation from the Statewide consortium and we meet monthly, unlike other boards. In fact, that would be a requirement that we do that.

CHAIR DOÑATE:
To make it easier, I would prefer to reword that subsection to say "review and make recommendations" proposed by DCFS to prevent, etc.

CHAR FROST (Clark County Children's Mental Health Consortium, Nevada Department of Health and Human Services):
I am a member of the Clark County Children's Mental Health Consortium. I am also on the State consortium. The reason that verbiage is there is to ensure that we have multiple lenses looking at these programs because we should be operating under a family-driven, youth-guided system of care. It ensures that all

those perspectives are at our table, which includes foster parents as well as business representatives, therapists and the State. We are all at the table making those decisions together so that we produce the best quality practices for the children and families of the State.

SENATOR TITUS:
I have some concerns and one was the issue about putting you in a position to approve what DCFS is doing because we have a process for regulations, legislative operations and oversight. I am concerned about yet another commission, as I have testified before on this Committee and other committees, but even more concerned because I sit on the Northern Nevada Behavioral Health Care Policy Board. We recognized in 2017 that mental health issues in the State needed to be solved. There are some general State components to it, but each district is unique. At first, we had four districts and now we have five districts because they are all unique. Each one of those boards gets a bill and tries to solve mental health issues. Children are one of the things we talk about at our monthly meetings.

You currently have three children's consortiums: Clark and Washoe Counties and the rural region. This is duplicative. I worry that now that you have recognized that the State is not the one that can solve some of these issues, that they are better solved at the smaller, local level. Now we are creating a State body. I am not sure how it will interact with the three consortiums plus the five behavioral health districts. You have another floating organization with authority because they must now approve some of these programs. I am concerned that it is going to interfere instead of problem solve.

MS. FROST:
I am also the chair of the Clark Regional Behavioral Health Policy Board as well as a member of the Clark County Children's Mental Health Consortium. I am one of the first people to serve on that Board. Mr. Musgrove sits on that Board as well. I serve as the family and consumer member. I recognize how much work I do on my own time for the Board.

We have large issues in the State with mental health. The children's consortiums are critical because we cannot treat children as little adults. We must treat the entire family and, quite frankly, the Clark Regional Behavioral Health Policy Board has deferred to the consortium as far as our priorities relating to children. There have been several bills this Session since the

behavioral health policy boards came online, and none of them deal directly with children.

We used to have a BDR for each consortium that was stripped from us. We did not always use that bill, but we would like to use that BDR process again when we are there. This would have come out of this DOJ investigation and even going into the DOJ investigation, it would have been nice to have a bill to address some of these large issues for our children. Eventually, the children are going to become adults, and we want to relieve some of the adult stressors by getting kids early, treating them when they need to be treated and in the way they need to be treated.

SENATOR TITUS:
We passed a bill last Session that allows people to be on more than one board because we found that we did not have enough people on the boards. Obviously, both of you sit on a couple of boards. Following up on the BDR, because each one of the five Behavioral Health Districts has a BDR, you are proposing that this Statewide children's consortium will get one BDR, is that correct? Then you just testified that the three current consortiums no longer get a BDR, correct? I do not see anything in this bill that says you work or consult with the other three existing consortiums. Is that something I missed, or will you work in tandem and listen to them? I need some clarification here.

MR. MUSGROVE:
Those are great points, but it is important to look at the membership. The membership ensures there is a member from each of the three consortiums. Each consortium is supportive of having a Statewide consortium because it is important for us to get together to understand what each region and each county is facing. Each is unique, but sometimes it is the same thing that each of us is dealing with. We do not have concerns about all agreeing on one bill draft.

Children's issues are unique and, of the five regional policy boards, not one of their bills focused on children. Most of the regional policy boards have yielded to the work of the consortiums because they have been in existence for a long time and do incredible work. If you look at our reports, you see the depth of research and assessment that we do in our own communities to produce these reports. We have always felt that the Statewide consortium is a better place to be that one voice for children. Whether it is the Commission on Behavioral Health or when I have brought reports to the Joint Interim Standing Committee

on Health and Human Services, it has always been on behalf of all three consortiums. We are proud that we work so well together and want to formalize it.

MS. FROST:
It is important to note that this Statewide consortium has been operating under Open Meeting Law. We have been in existence for at least ten years. We wanted to ensure that we were not advocating at cross purposes by region. If there is something going on specifically in a region, and I am lucky enough to be able to attend each consortium monthly, we want to ensure we are supporting one another and addressing those individual needs. We understand the issues in the rural counties are different from the issues in our more populous counties.

SENATOR STONE:
I do not like to see a lot of duplicative commissions, but I do not see this as such. When you are dealing with a State that has significant issues with our foster care programs, behavioral health, substance abuse in children and three geographical areas of this State that are different, having a representative each on the Statewide commission is a great advantage to come up with an additional solution even if it means an additional BDR for us to consider.

In A.B. 265, when I reviewed section 9, subsection 2, paragraph (b) to "review, make recommendations for and approve programs proposed by the Division," I do not interpret this to mean that the Division must follow the recommendations. They either like them or do not like them. Obviously, the Division is going to decide what is in the best interest of children, preventing them from being placed in facilities outside the State. Hopefully, they will be placed within the State and receive treatment for emotional disturbances or substance abuse. I see this as a positive step. I appreciate your service and trying to get more resources for our kids, which is the ultimate goal.

By bringing all these perspectives to the top, representing all these different demographic and geographical areas where one issue may be more predominant than another, it brings it to the head and helps guide DCFS to make good recommendations to the Legislature, which can include a BDR. These consortiums are voluntary. It is not like we are expanding government for the sake of expanding government. These are volunteers who have the best interests of our children at heart and want to contribute as much as they can to try to help improve the quality of life of not only these children but their

families. You made a particularly important point that this is the nexus point to ensuring that we are embracing good programs for the kids. Is my interpretation, correct? This is voluntary and they are recommendations. They are not mandates being placed on DCFS.

MR. MUSGROVE:
Our relationship with the State, DCFS and Medicaid has grown over the years because they see us as an incredible resource. At the last managed care contract request for proposal work, they used us to weigh in on what they need to ask of our managed care companies when it comes to children. We put together many recommendations that were included in the plan and that meant a lot to us because we are being heard. We want to make sure that if, sometime in the future, administration changes and we would not get the support, we can have that Statewide consortium that has voluntarily been meeting for over ten years.

MS. FROST:
We wholeheartedly support this bill. We honor the recommendations of all our consortiums and especially recognize that in Clark and Washoe Counties. So not only are we dealing with this exceptionally large population, but we are also dealing with rural populations as well. We honor each consortium and its perspective. We encourage you to support this bill.

SARAH HANNONEN (Rural Children's Mental Health Consortium, Nevada Department of Health and Human Services):
I serve as vice chair for the Rural Children's Mental Health Consortium. I am also a school social worker in the rural frontier. I get to see these things firsthand and work with families. I am grateful for the opportunity to work on this Consortium because it has made an enormous difference for our community. I hope you consider this bill because it will help us bring more of what we are working on to you. We are all working together and do not work in silos; we are working as a team.

AMANDA HABOUSH-DELOYE (Clark County Children's Mental Health Consortium, Nevada Department of Health and Human Services):
I am the director of the Nevada Institute for Children's Research and Policy at the University of Nevada, Las Vegas (UNLV), but I am not here on behalf of my position today. I am here as the current chair of the Clark County Children's Mental Health Consortium to provide support for this bill. All three consortiums

worked together today to come up for Children's Mental Health Acceptance Day. We had a table outside, and all three were present throughout the day.

Even though there are regional differences, there are issues that do impact the State, like the changes to Medicaid. We want to make sure we have a place to communicate so we are all providing input and not doing something that is going to negatively impact the other consortiums when it is a State bill or regulation. I am part of the Statewide group as well as the consortium and do the best we can to ensure that we are communicating and working with each other.

CHAIR DOÑATE:
Hearing no further testimony in support, opposition or neutral, I will close the hearing on A.B. 265 and open the hearing on A.B. 202.

ASSEMBLY BILL 202 (1st Reprint): Revises provisions governing electronic communication devices in certain health care facilities. (BDR 40-46)

ASSEMBLYWOMAN SHONDRA SUMMERS-ARMSTRONG (Assembly District No. 6):
I am presenting the testimony (Exhibit H) on behalf of Theresa Owens Bigay, one of my constituents. She is the woman who brought this piece of legislation to me in 2022. I met her at City Hall in North Las Vegas, and she was adamant and passionate that this bill come before you. She is at work right now and she could not take off. I promised her I would present the bill and her written testimony in honor of her brother. Ms. Bigay would like this bill to be named after her brother, Henry.

Joining me today to present A.B. 202 is Jamie Cogburn, president of the Nevada Justice Association. This bill governs monitoring of electronic communication devices in healthcare facilities. Existing law establishes certain duties of a medical facility, including a facility for skilled nursing, and specific rights of the patient in such a facility. This legislation is narrowly tailored to allow patients in skilled nursing facilities or their guardians to request installation, at their own expense, of an electronic communication device.

JAMIE COGBURN (Nevada Justice Association):
This bill would give a resident at a nursing home the right to have a camera or a recording device in their room. It could vary from an Amazon Alexa device to an iPad for FaceTime or any other type of recording device. The family and

whomever they designate in writing would be able to access that device. That room becomes their residence in the nursing home; that is their house now. It is no different than having a camera system in our home. I have a seven-month-old daughter whom I can watch at night, even though I am here in Carson City and she is in Las Vegas, because we have a little camera above her bed. It is all the same things that allow you to hear, see and do those things and communicate. That is what this is about; this is their home. They should have that right. If they request this, it is at their cost and does not put a burden or a cost on the nursing home or facility.

You may hear some opposition that it violates the wiretapping law. It does not. Wiretapping has to do with cell phone communications or telephone communications without the party's consent. Here, the person who lives in the room is giving consent. In addition, the nursing home has the right to put up a sign on the door that says there is a recording device in the room.

CHAIR DOÑATE:
I thank Assemblywoman Summers-Armstrong for this bill. I received an email for this bill and there was a documentary from *VICE* news magazine. This is one that I would implore the Committee members to watch because there were several alarming occasions that occurred in Las Vegas from a particular facility where the patient was mistakenly given morphine. That led to a patient error that cost them their life. It is important for Committee members to watch it and to understand issues that are happening in Nevada.

SENATOR TITUS:
Thank you for the bill and for the letter, Exhibit H, as those are all always heartfelt. As most here know, I was a long-term care medical director for over 30 years during the COVID-19 pandemic, now endemic. The State supplied our nursing facility, and many nursing facilities that needed them, with iPads for the patient. It was an issue not to allow families to come into these patients' rooms and so they were able to communicate. Communicating with your family member is paramount to these folks. Whatever that communication is, whether you can see, touch or hear them, it is extremely important.

Most of the facilities now, especially after COVID-19, have gone to private rooms only. Even U.S. Department of Veterans Affairs (VA) hospitals testified in front of us that they are making single rooms now. There is some language in this bill regarding roommates and concerns about the roommate. I am

specifically referring to section 9, subsection 2, paragraph (d), subparagraph (2), sub-subparagraph (I), where the roommate can waive the right to privacy. I worry about the legality and placing the roommate in a position where they feel bad. Or do they even have the understanding that this is going on? Is there any protection for the roommate's privacy?

MR. COGBURN:
The simple answer is yes. There is an amendment (Exhibit I) we submitted that is a specific form. That form is what patients would sign if they are in a shared room. When there is a roommate who does not agree, then the facility would, if they can, accommodate the person who wants to have the recording device. If the facility cannot accommodate the patient because there are no other rooms available or they cannot switch rooms with somebody, then they would not be allowed the recording device. As for who can sign off on that, it would be the roommate if he or she meets all the criteria. If there is a guardianship or some other matter in place for that roommate, then the guardian would have to sign off on it for that to be allowed.

SENATOR TITUS:
You use the term recording device, but I see this as a communication device. There is a distinct difference. If they are recording, it is different than hanging a monitor that watches our kids at home and I can watch it on my phone. I have a security system in my own home and can look at my house and see what is going on. That is different from a communication device. Are you looking at this as something that records the data? Who would keep that data and what about the legality and privacy issues with that?

MR. COGBURN:
Another excellent question. It includes both. It would be up to the patient if they want an Alexa or want an iPad to do FaceTime. Those Alexas can record also. If they want a recording device like the one I use for my daughter, it records the data and then copies over itself after a period of time. The only person who would have access to that data is the patient or if they authorize somebody in writing. It is there because the patient is the only one being recorded; it is his or her room and would be the only one to access that data. It would not be available, for example, for us to watch here. There would not be a YouTube channel or anything like that. The data would stay private if anything is recorded. Many would not choose to record. It gives them that option and it places no limitations on that.

CHAIR DOÑATE:
How do you respond to the question of immunity for residential groups? There was a request that this legislation should give nursing facilities explicit immunity for the use or misuse of recordings. If there is a recording that is leaked online, and there is an employee who was in it, whether the employee was acting maliciously or not, on whom does that liability fall? Does it fall on the person who put the recording device in their room? Does it fall on the provider group? How does that conversation align with what you are proposing?

MR. COGBURN:
The nursing home would not have access to the data, so the nursing home would not be able to leak the data. The patient is the only one who could release that data. In A.B. 202, there are violations, for example, if the nursing home takes the camera and turns it away from the person. Some families are concerned about the safety and welfare of their loved ones and say they would feel more comfortable, and the patient would feel more comfortable, if there was a device, whether it records or not. Somebody could peek in and see what is going on with the patient. We refer to these devices as "nanny cams." So, the patient is the only one who has access to the data.

I assume it is possible that somebody could be hacked, and those types of things are not without question. But the patient is the only one who has access to the data. The nursing home would have no liability because they are not in control of it and do not maintain it. In other states where this has been enacted, it is recommended that sometimes the patient acquire a hotspot that allows access because the Wi-Fi in the facility cannot always be relied on. The patient is the one who bears the burden for the cost and ensures that everything works including any expenses that go along with the device. The only thing that the nursing home is responsible for is helping to make sure it is accessible. Staff cannot move it so it is no longer accessible for the patient.

CHAIR DOÑATE:
The only thing I am not seeing addressed is that the device must be in a fixed location. Maybe it can be accomplished through *Nevada Revised Statutes* (NRS). The cleaners come into the room, the certified nurse assistant (CNA) may come in to turn the patient over, or the camera gets knocked over now causing a liability issue, which is not anyone's intention. Could a policy be put in place that if a camera is used in the room, it must be in a fixed location?

That is my main worry, but I want to make it clear that there are also other ways you can detect patient abuse. Bedsores are the easiest, bruises, etc.

SENATOR TITUS:
We are so regulated in the hospitals, not only by State regulations but by the Centers for Medicare and Medicaid (CMS). Does the federal government give us any guidance on long-term care and monitoring?

MR. COGBURN:
Not that I am aware of, and I am familiar with CMS guidelines, and regulations, as I practice in that area of law. A lot of it becomes state-regulated. So even though there are federal regulations, it is left to the states if there are supposed to be patient-to-nursing ratios and other things. There are recommendations by CMS but no mandates regarding this area.

CHAIR DOÑATE:
Thank you and I stand corrected. Our legal counsel did mention that the bill does say that they must be in a fixed location.

SENATOR STONE:
I am concerned about the recording devices. You have medical personnel performing delicate, intimate tasks that are going to be captured on camera. Sometimes, the recording only tells part of the story about what is going on. There are some statutes that state you must get permission to be recorded. The employees of these homes must sign a release saying they know that they are being recorded, and they must agree to be recorded to provide treatment for the patient.

MR. COGBURN:
Employees are not required to sign a release as part of their work. At most facilities, there are already cameras in the open hallways, considered the public area. This would be in the private room. Section 13 of the bill allows a facility to place a sign at the entrance to the living quarters of a patient stating that such a recording device is in use in that room.

As to the concern of stopping the recording because there is something private going on, they would have the ability to do that. Again, it would be up to the patient. As an example, let us say a CNA comes in to help the patient go to the bathroom. The device cannot be in the bathroom but if the patient says they

want the device turned off because they do not want somebody to see them if their gown may be open or something to that effect, then they can do that.

The patient controls and regulates the device and what the patient feels comfortable with. Again, this is not a normal hospital where it is just a room; this is a residence at that point. The patient lives at these long-term facilities usually for the rest of his or her life. My grandmother lived in a facility for 28 years; she started in a little apartment and then went to a little more secure room and ultimately went to a dementia unit. So, people do not leave because of dementia; it is to make them feel more comfortable. COVID-19 brought this out even more because, as Senator Titus indicated, these patients and families need that warmth, love and touch. Families are not always nearby, so this allows family members who cannot visit on a regular basis to check in if that is the patient's desire.

SENATOR NGUYEN:
In looking at some places like Texas, this has been law for 20 years. I have an Alexa here in my office, and I use it to communicate with my kids. I know it is constantly recording just like my phone is recording me. It is recording me right now. If I start talking about something, it is going to pop up on my phone minutes later. I know that it is always listening and that is the way these devices work. If I were to say "Siri" loud enough, I bet half of our phones here might respond. Under current law, can people that are in nursing homes and these residential facilities not have a cell phone, not have an Alexa, not have any of those devices?

MR. COGBURN:
Actually, they can. It is that many facilities do not allow them. The facility can say we do not want you to have that and so we are not going to give it to you or allow you to use it. This bill says if the patient wanted it, it must be allowed, or the facility must at least make a reasonable accommodation. Again, if there are two patients in a room and one patient does not sign off, you must accommodate both people the best you can. Really the facility is denying that right now.

SENATOR NGUYEN:
Do you know if they are denying everything? It got me thinking about everything that is listening to you in this very room. Even my toothbrush has one of those devices that reports information back to Sonicare about how often

I brush my teeth. There are so many things always collecting data on us. Are people in these residential communities so isolated that there are places that do not allow them to have laptops, iPads or Alexa? Those are all recording communication devices. I am wondering if there are places in the facilities that are prohibiting all forms of communication that we have grown accustomed to in this society, even post-COVID-19.

MR. COGBURN:
I am not aware of any facility that limits all devices. Most facilities are good, but there are always a few bad apples, as with everything. I had an experience where we told people to call the ombudsman because the facility kept turning off their Alexa and they would not let the person use it. That person downloaded what was on the Alexa, and it was her husband screaming for help for hours at a time. Different facilities operate in different ways. Most facilities are good, and they do accommodate and allow, at minimum, phone calls and things like that.

Many of these people need help because they cannot get out of bed and, if it is not within arm's reach, they cannot do anything. They cannot pick up an iPad. Many people at that age do not know how to use an iPad and they need help on those types of devices. It varies from facility to facility, but the facility does govern and control.

CHAIR DOÑATE:
My only request is if the conceptual amendment, the form in Exhibit I, could have one sentence added that says if the patient speaks a different language, the facility will make appropriate accommodations to translate.

CATHERINE NIELSEN:
I am representing myself and my family today. My husband, Matthew, is 33 years old and is in the beginning stages of developing frontotemporal dementia. Some of you may be familiar with this terrible disease as the one that Bruce Willis was recently diagnosed with. During the stages of diagnosis, we required video documentation to assist the medical team in their assessments. Many patients have seizures and other ailments that go along with this degenerative brain condition. For many families, this diagnosis means a nursing home placement at some point in their life, which means many people will be away from the ones that they know and love.

When my husband is exhibiting symptoms or has just had a seizure, my face is the only one that brings him back to us. For those like my husband, cameras and video screens could help alleviate or calm many situations. This condition can also come with behavioral changes that are outside of the patient's normal behaviors. The placement of cameras also provides protection to staff as much as to patients and families. In conclusion, not only will cameras assist in diagnosis and medical care but the safety of patients receiving the care and staff providing the care.

BRETT SALMON (Nevada Health Care Association):
We currently oppose A.B. 202. My written testimony (Exhibit J) is provided. I want to make it clear that we are not opposed to residents being able to communicate with family members. It is more the unintended consequences that the bill might have on how we operate.

Based on Nevada caselaw that went before the Nevada Supreme Court in 1998, there is a wiretap issue, and the liability shifts to the facility. This concern was not addressed in the bill. We look forward to working together to resolve this item and others as addressed in Exhibit J.

SENATOR NGUYEN:
How do you deal with the liability issues of the personal effects like a CD or DVD player that fell over and belonged to a patient? Do those change the practice of the workers in the facilities?

MR. SALMON:
I am not sure I understand your question. Can you help me understand that better as it pertains to people?

SENATOR NGUYEN:
I do not understand what the objection is to allowing people to record or having these devices that can communicate. At what point do you think it is appropriate for someone to own an Alexa? Or do you believe there are certain situations where owning an Alexa is never appropriate? Because those devices are always recording. Your cell phone is always recording and it is always on. Do you not allow those kinds of telecommunication? Do we only have landlines in these facilities?

MR. SALMON:
We have those devices in our facilities and people use FaceTime and Facebook and they do all those things with their devices. Currently, the issue we are being advised by our counsel is that based on that law and, you are right, it is dated, but that is how they interpret it. The argument that they have made to us is we have a similar law to California. The way California handles this is that it is an optional requirement, not a mandatory requirement. You cannot mandate it because of that provision. I realize it is different caselaw, but that is how they deal with it and the facilities there. That is the advice that we are receiving, that liability is there for us. We would like to find a way to address that.

SENATOR NGUYEN:
I suppose you would pass a law like this through the legislative process. If Texas has had a similar statute in place for 20 years, they obviously put it in statute. If there was caselaw that overturned it, that would happen. So, would it fix your caselaw issue that you have from that 1998 wiretapping interpretation?

MR. SALMON:
Our concern is how that applies to the other people that participate in this. The language in section 9 that grants us some waivers needs to be broadened, and it does address it if we can broaden that language a little.

CHAIR DOÑATE:
We did have a clarification from our legal counsel regarding the caselaw so please proceed.

ERIC ROBBINS (Counsel):
Our opinion is there would be no conflict with wiretapping laws. First, as has been pointed out, the law and the case deal with telephone communication. In this case, it would be a communication device or recording device where both the resident and the person on the other end would have consented to the recording. So, you have consent on both ends. As far as the nursing facility, they are regulated facilities. What this bill is saying is that the nursing facility must consent as a condition of operation in this State. Statutes are typically interpreted by courts to align with each other, and it is within the Legislature's power to pass laws that reduce the impact of existing statutes. To the extent that there is a conflict, you would have one statute. The statutes in this bill would be rendered moot by NRS 200.620. That is an absurd interpretation that

we do not believe any court would ever embrace. Instead, we believe the court would, to the extent that there is a conflict which we do not feel that there is, construe the statutes harmoniously and give effect to the statute.

SENATOR TITUS:
I have a comment about that. One of my concerns about the bill is the liability issue for employees, people coming in the room such as the cleaning people, CNAs and others, and recording them.

Section 13 says that the facility may post notice. I do not believe in secretly recording people—with that, I have an issue. I worry about the liability and employees' privacy and the other roommate's privacy. If monitoring is implemented in a facility, it is mandatory to post a notice indicating its presence, rather than optional.

CHAIR DOÑATE:
There are two letters (Exhibit K) of support on A.B. 202.

ASSEMBLYWOMAN SUMMERS-ARMSTRONG:
I want to clarify employee privacy. I spoke to a representative from two of the largest national employers about employee privacy. They informed me that companies like Walmart and T.J. Maxx and others do not request their employees' permission when they are in the work environment. There are cameras present all over the place. Upon inquiring about them, I was informed that they are installed and positioned at an elevated position. Despite the presence of surveillance signs, the employees have not been asked for their consent to be monitored.

SENATOR TITUS:
That is exactly my point. It is not necessary to seek permission from employees, but it is important to inform them that recording or monitoring is taking place. That is my complaint. As Senator Nguyen said, we are being recorded all the time. We are aware that we are being recorded right now. But when you walk into a hospital and/or patients' rooms, recording cameras are in progress. Walmart employees know they are being recorded. I have no problem with the recording—it is just the notification.

ASSEMBLYWOMAN SUMMERS-ARMSTRONG:
Yes, I agree. We shall work on this issue of notification.

CHAIR DOÑATE:
I will close the hearing on A.B. 202. We will move on to A.B. 311.

ASSEMBLY BILL 311 (1st Reprint): Revises provisions governing health care. (BDR 40-983)

ASSEMBLYWOMAN SHANNON BILBRAY-AXELROD (Assembly District No. 34):
I am pleased to present A.B. 311 which allows a greater number of U.S. Air Force medical personnel to serve in our Nevada hospitals. This bill will help to address the healthcare provider shortage that we are constantly discussing in this building. To provide background on this topic, it is important to discuss the Las Vegas Military-Civilian Partnership (LVMCP). Such partnership places active-duty military personnel in local civilian trauma hospitals to maintain their clinical proficiency and provide medical care to the community.

The Las Vegas Partnership is the largest and most integral program in the Country, and it supplies much needed healthcare personnel to the University Medical Center (UMC) in Las Vegas, VA Hospitals and the UNLV School of Medicine. They have worked also in several other southern Nevada facilities. This partnership has steadily grown and achieved its goal of preparing Air Force medical personnel for deployment. Nevada law currently stunts the growth of this program because it is limited to the armed forces medical officers only.

Assembly Bill 311 solves this problem by increasing the number of Air Force personnel who would be permitted to serve in Nevada hospitals. I will now turn it over to Dr. Jeremy Kilburn, a critical care doctor at UMC and a colonel in the U.S. Air Force. He also saved my husband's life, so, he is a rather good doctor in my opinion. Dr. Kilburn will give you additional background and context of why this bill is needed.

JEREMY KILBURN, M.D.:
The LVMCP has been steadily growing for the last 20 years. Originally, this was made possible by NRS 449.2455, which allowed the portability of licensure for medical officers who have licenses, such as doctors, pharmacists and nurses, to work in Nevada hospitals. This has grown; currently there are over 100 nurses, doctors, residents, fellows and technicians, all on active duty, working in our principal location, which is UMC. But as we have grown, we struggle with our ability to involve our enlisted technicians in the hospital.

It began during COVID-19, when we had difficulty getting our Air Force respiratory therapists into UMC to help with contingency COVID-19 operations. Many of the military medical personnel were deployed during COVID-19. A lot of us in Las Vegas were deployed in place, worked at UMC and helped prevent a lot of medical collapses. When we look at Las Vegas as being medically underserved, it is a perfect fit for the Air Force to partner with Nevada and with UMC specifically as our primary hospital partner. The UNLV School of Medicine is our primary academic affiliate. It gets our medics the exposure they need to critical illness and also helps the citizens of Nevada.

CHAIR DOÑATE:
We received an email earlier today from the National Center for Competency Testing. They were requesting an amendment on one of the subsections. Are you aware of this amendment request?

ASSEMBLYWOMAN BILBRAY-AXELROD:
I am not aware of this.

CHAIR DOÑATE:
I wanted to double-check in case it had been recommended or introduced, and wanted to get that clarified before we ask questions.

ASSEMBLYWOMAN BILBRAY-AXELROD:
This is the first time I am hearing about it. This is the first reprint; our amendment was to add cosponsors.

SENATOR TITUS:
This is a good bill, but I need clarification. I trained in Reno and did much of my work as the medical officer of the day at the VA Hospital. We worked with a lot of doctors, nurses and other healthcare providers like laboratory technicians, who were not Nevada-licensed providers. They were all licensed through the federal process and somewhere they had to have a license. They do not have to have a Nevada license. I want to make it clear that this is not just for Clark County and Air Force veterans. People who work at the VA Hospital could serve in this capacity also. This is a great idea.

It goes along with what we have talked about many times before—reciprocity. This could be across the spectrum of healthcare providers and the VA, not just the active military bases because the VA also has these providers. I wanted to

ensure this is not limited to the Air Force and that the federal government is licensing these folks so they may practice at a VA facility, on a base or in Fallon at the Naval Air Station. For clarification, would it relate to your anticipating all federal employees, regardless of active status or veterans?

ASSEMBLYWOMAN BILBRAY-AXELROD:
Absolutely. This was talked about a lot on the Assembly side, and that is enabling language. We just happen to have an amazing program at UMC and that is how I became aware of this.

DR. KILBURN:
Certainly, this should apply to all active duty military personnel. The issue is for federal employees. So, when we have licenses, nurses, doctors and technicians under 10 USC Section 1094, there is the portability of licensure. In the early 2000s, Nevada passed an NRS which also allowed for the portability of licensure for medical professions in the armed forces. The issue that we are having is that the federal government does not necessarily require respiratory therapists in the U.S. military to have licenses at all. They must have a respiratory therapy certification that is registered nationally, but they do not require a license in any state.

The driving force behind this legislation is to support members of the armed forces who do not hold a license in any state. This is because their federal job does not necessitate licenses to practice within their federal scope. This is my interpretation of the bill and the reason behind it. This bill enables them to participate in a training program at Nevada hospitals to enhance their current competencies, whether active duty or reserve personnel. This is the motivation behind the bill, and it addresses a significant need.

SENATOR TITUS:
What you are saying is that it would not apply to the folks who work at the VA hospitals because they are not active military. But they do not have to have licenses either. I was trying to get some clarification on that.

DR. KILBURN:
I have been directing the LVMCP for ten years. That would have to be separate legislation, which would be amazing. That would give more portability to licensure. What this bill deals with is the absence of licensure.

SENATOR TITUS:
Okay, that is a distinct difference.

DANA VAN LAEYS (National Center for Competency Testing):
We support A.B. 311, if amended, to include both equally accredited surgical technology certifications, as mentioned in previous correspondence to you and in NRS 449.24185. We agree with the gentleman from the Air Force regarding his concerns. Unfortunately, they are not unique to Nevada. There are a lot of nuances in this bill. When you choose to regulate fields that go unregulated, this is what other states run into as well. We do a lot of work with the military so I emailed the Committee with proposed language and details.

To support the healthcare workforce and specifically surgical technologists, these amendments accomplish two crucial objectives. They eliminate obstacles that hinder the recruitment and retention of skilled and proficient surgical technicians in your healthcare establishments, which is also the aim of the military. They also enhance and safeguard the sustainable future of this workforce by acknowledging credible and secure routes to becoming a surgical technologist. These pathways include military and apprenticeship training, as well as other forms of training that need not be an accredited program.

We all know that health care in general is experiencing unprecedented workforce shortages. It is in the best interest of all involved to avoid imposing restrictive laws and regulations. I sent you links to show how Oregon and Virginia corrected their laws to fix the same unintended consequences that you are experiencing here.

This is a valid and legitimate concern for this field in general, not just in your State. Similar restrictive legislation is being systematically introduced state by state and purposely naming only one of the two equally accredited certifications. Unfortunately, this creates a de facto monopoly, a bottleneck and accentuates the workforce shortage in an already stressed medical system. It exacerbates the existing staffing shortages by creating more roadblocks for employers to recruit and staff their operating rooms by limiting qualified practitioners' ability to practice. Some of those are our military individuals as well. There are currently only two equally accredited certification exam programs for the field of surgical techniques. The National Center for Competency Testing accredits us.

CHAIR DOÑATE:
To clarify, the last caller should be noted as neutral testimony because they have a conceptual amendment.

ASSEMBLYWOMAN BILBRAY-AXELROD:
I will look at this amendment. We are up against a deadline. Thank you for hearing this bill.

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CHAIR DOÑATE:
The hearing on A.B. 311 is closed. Hearing no further business for the Senate Committee on Health and Human Services, the meeting is adjourned at 5:01 p.m.

RESPECTFULLY SUBMITTED:

Norma Mallett,
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. 206	C	2	Destini Cooper	Work Session Document
A.B. 289	D	3	Destini Cooper	Work Session Document
A.B. 265	E	4	Dan Musgrove / Nevada Rural Children's Mental Health Consortium	Service Priorities Report
A.B. 265	F	4	Dan Musgrove / Clark County Children's Mental Health Consortium	Status Report
A.B. 265	G	4	Dan Musgrove / Washoe County Children's Mental Health Consortium	Annual Report
A.B. 202	H	10	Assemblywoman Shondra Summers-Armstrong	Written Testimony, Theresa Owens Bigay
A.B. 202	I	12	Jamie Cogburn / Nevada Justice Association	Proposed Amendment
A.B. 202	J	17	Brett Salmon / Nevada Health Care Association	Opposition Testimony
A.B. 202	K	19	Senator Fabian Doñate	Two Written Testimonies in Support