# MINUTES OF THE
# SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

## Eighty-third Session
## May 13, 2025

The Senate Committee on Health and Human Services was called to order by Chair Fabian Doñate at 3:33 p.m. on Tuesday, May 13, 2025, in Room 2134 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 7 of the Nevada Legislature Hearing Rooms, 7120 Amigo Street, 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 Angela D. Taylor, Vice Chair
Senator Roberta Lange
Senator Robin L. Titus
Senator Jeff Stone

**GUEST LEGISLATORS PRESENT:**

Assemblymember Max E. Carter II, Assembly District No. 12
Assemblymember Heather Goulding, Assembly District No. 27
Assemblymember David Orentlicher, Assembly District No. 20

**STAFF MEMBERS PRESENT:**

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

**OTHERS PRESENT:**

Peggy Stephenson
Jodi Collins
Andre Collins
Jamie Cogburn, Nevada Justice Association
Mike Stephenson
Tia Smith, Policy Attorney, American Civil Liberties Union of Nevada

Jonathan Norman, Coalition of Legal Service Providers
Terri Laird, Executive Director, Retired Public Employees of Nevada
Denise Robinson
Catherine Nielsen, Executive Director, Governor's Council on Developmental Disabilities, Nevada Department of Health and Human Services
Carol Matrone
Athar Haseebullah, Executive Director, American Civil Liberties Union of Nevada
Kaylah Maese, Civil Rights Analyst, American Civil Liberties Union of Nevada
Jennifer Lazovich, Davis Funeral and Cemetery
Andrew LePeilbet, Chair, United Veterans Legislative Council
Jason Frierson, Palm Mortuaries
Mary Devine, Director, Nevada Department of Veteran Services
John Drew Lawton, Sierra Memorial Garden Cemetery; Hillside Cemetery
Amy Hyne-Sutherland, Nevada Association of Counties
Nehal Naik, Elite Medical Center; Valley Health Systems
Kris Deeter, Chair of Pediatrics, School of Medicine, University of Nevada, Reno; Renown Children's Hospital
Jen Howell, Northern Nevada Public Health
Tim McFarren, American College of Obstetricians and Gynecologists
Ian M. Hartshorn, Nevada Faculty Alliance
Allison Herzik, Dignity Health-St. Rose Dominican
Sabrina Schnur, Nevada Primary Care Association
Patrick Kelly, Nevada Hospital Association
Blayne Osborn, Nevada Rural Hospital Partners
Bradley Mayer, Southern Nevada Health District
Jamelle Nance, Children's Advocacy Alliance
Jacquelyn Nguyen, Nevada State Medical Association
Nicole Flangas, Nevada Association of Health Plans
Adam Plain, Insurance Regulation Liaison, Division of Insurance, Nevada Department of Business and Industry
Angel Hood, Intern to Assemblymember Orentlicher
Nina Kohn, Professor, Syracuse College of Law
Paula Luna, Deputy Director, Battle Born Progress
Todd Inglesby
Suzanne Brice
Matilda Miller, Native Voters Alliance Nevada
Steven E. Tackes, Kaempfer Crowell
John R. McCormick, Guardianship Commission
William Voy, Director, Pro Bono Services, Southern Nevada Senior Law Program

Jeffrey Luszeck, Solomon Dwiggins Freer & Steadman, LTD
Lea Cartwright, Nevada Psychiatric Association
Debra Bookout, Directing Attorney, Guardianship Advocacy Project; Legal Aid Center of Southern Nevada
Shauna Brennan, Advocacy Attorney, Rights of Older Persons, Persons with a Disability, an Intellectual Disability or a Related Condition; Aging and Disability Services Division, Nevada Department of Health and Human Services
Alvin Chan

CHAIR DOÑATE:
We will start with Bill Draft Request (BDR) 40-1037.

**BILL DRAFT REQUEST 40-1037**: Revises provisions relating to health care. (Later introduced as Senate Bill 495.)

This bill is an act relating to health care; establishing a competitive funding program to address shortages of providers of health care in the State; prescribing certain requirements to expedite the credentialing and privileging of providers of health care; authorizing paramedics who serve as employees or volunteers in hospitals under certain circumstances. It transfers the responsibility for administering the Graduate Medical Education Grant Program to the Department of Health and Human Services and makes certain other revisions relating to that Program.

It imposes certain requirements governing prior authorizations for medical or dental care, requires the Department to explore ways to use federal financial participation in Medicaid to support graduate medical education; makes revisions relating to applying for and determining eligibility for Medicaid; creates and prescribes the duties of the Office of Mental Health in the Department; prohibits certain noncompetition covenants governing providers of health care, with certain exceptions; requires a prioritization of certain applications for licensure as a physician; and requires certain reports of the Board of Medical Examiners and the State Board of Osteopathic Medicine.

There are plenty more provisions, but this—as you may know—is in the Governor's bill on health care. I will entertain a motion to introduce the bill.

SENATOR TITUS MOVED TO INTRODUCE BDR 40-1037.

SENATOR LANGE SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR DOÑATE:
We'll start with Assembly Bill (A.B.) 60 on our work session documents for today.

DESTINI COOPER: (Committee Policy Analyst):
The bills for consideration by the committee today are summarized on the work session documents, which are available on the legislative website. As part of the nonpartisan staff of the Legislative Counsel Bureau, I cannot advocate for or against any legislative measures. My role is to walk the committee through the bills and any proposed amendments.

I will read the summary of A.B. 60 from the work session document (Exhibit C).

**ASSEMBLY BILL 60 (1st Reprint)**: Revises provisions relating to certain behavioral health services. (BDR 39-434)

CHAIR DOÑATE:
Do the committee members have any questions? I will entertain a motion to amend and do pass A.B. 60.

SENATOR TAYLOR MOVED TO AMEND AND DO PASS AS AMENDED A.B. 60.

SENATOR STONE SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR DOÑATE:
We will now move to the work session on A.B. 244.

MS. COOPER:
I will read the summary of A.B. 244 from the work session document (Exhibit D).

**ASSEMBLY BILL 244 (1st Reprint)**: Enacts prohibitions relating to the use of disposable foodware containers containing polystyrene foam by certain food dispensing establishments. (BDR 40-685)

CHAIR DOÑATE:
Do the committee members have any questions? I will entertain a motion to do pass.

SENATOR TAYLOR MOVED TO DO PASS A.B. 244.

SENATOR LANGE SECONDED THE MOTION.

THE MOTION CARRIED. (SENATOR TITUS VOTED NO.)

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CHAIR DOÑATE:
That concludes our work session for today and now we will go ahead and move on to the bills. Let's begin with A.B. 368.

**ASSEMBLY BILL 368 (1st Reprint)**: Revises provisions governing electronic communication devices in locations where certain services are provided. (BDR 40-878)

ASSEMBLYMEMBER MAX E. CARTER II (Assembly District No. 12):
I represent Assembly District 12 on the east side of Las Vegas and the north side of Henderson. Assembly Bill 368 expands on the good work we did with A.B. No. 202 of the 82nd Session regarding cameras in skilled nursing facilities. Skilled nursing facilities are narrowly defined in the *Nevada Revised Statutes* (NRS). The bill last session left out a huge demographic that we want to address.

With me today is a constituent of mine, Peggy Stephenson, and her husband Michael Stephenson. When you hear their story, they've been through hell. Down south, I also have Jodi Collins and her son, Andre Collins—who, as it

happens, is celebrating his birthday today. Andre lives in Betty's Village which is a supported living arrangement; it is not a facility. I am going to ask Ms. Stephenson to tell you why this is so important.

PEGGY STEPHENSON:
In the United States, there are about 1.2 million licensed units, which means beds, for people that have a need for assisted living. That's about 31,000 communities nationwide. The western part of the United States has approximately 41 percent of the beds and 56 percent of these are owned by chains. There are a handful of states that have some semblance of a camera law—they are all different. And there's no real standard. Our goal, after everything that we have gone through, is to make Nevada a model state to help our vulnerable population, so hopefully our leaders in Washington can mandate some sort of national reform because "Houston, we have a big problem here with health care."

I am here because my mother and father were good role models. They'd be here if they could. When we left mom to do this, I held her hands and I told her that she was going to help a lot of people, and she gave me a big smile.

In 2023, A.B. No. 202 of the 82nd Session was a start. But it was narrowly written, as Assemblyman Carter said, for skilled nursing only and skilled nursing does not have the corner on the market for abuse and neglect of loved ones who need extra care.

This past Veterans Day, I went to the Boulder City VA home where Governor Lombardo was speaking to honor all of our veterans who served. It was there that I told him about the long, hard road that we have traveled and that A.B. No. 202 of the 82nd Session needed to be expanded. He listened and told me to get together with my Legislator and he [Governor Lombardo] would sign this. So that is what I did.

Max Carter is our Assemblyman—thank you all for your service and listening and supporting this. My mom is a survivor of many things. And now it is really only the lines on her face that can tell the story of her life in the past six years. But my husband and I are here to tell you more.

My mom was born in Munich, Germany in 1930; she was a child under Hitler. Seventy years ago, my mom and dad were a love story when they met during

the Korean War, when dad was stationed in Munich. They got married and moved to New York State, which is where my dad was from. My mom was naturalized in 1969. They are both good people who live by the golden rule. Dad worked and retired from Revere Copper and Brass. He was the superintendent of shipping. He loved and supported all sorts of sports and even coached our current commissioner of baseball in the Mesa Leagues in Rome, New York. And my mom retired from the Rome State School which, in its day, was an institution for mentally handicapped individuals. She was a nurse's assistant and manager. She pioneered the concept of group homes for higher functioning people so they can enjoy more of a family atmosphere. Many weekends, she would bring someone home to spend the day with us. And I have fond memories of those times. They retired in Las Vegas in 1991, and my dad passed in 2009.

When my mom was 85, she needed open heart surgery and it left her addled from the anesthesia, so the details of everyday living were too complicated for her after that. And it was difficult for her to articulate her thoughts. But at times, it clicked, and I have been an advocate and caregiver since then. Time passes, bodies decline, and you add a little elder dementia, and I call mom's 50 percent dementia. She has great instincts and appropriate responses. She knows what she is saying, but we do not always understand what she is saying—but sometimes it clicks. She loves being in the mix of life. She is filled with love for everyone and animals and she knows who is bad. When we needed extra help, we only looked at A-rated facilities and it has been six facilities in six years. There's no hyperbole in any of this.

This is my mother's story, but she is not the only one. This is not an isolated story. In no particular order: She slept in the same soiled sheets for at least two days; she was told to remove her wedding ring and her mother's ring before she was showered, and it was never returned. And of course you know, staff will blame the residents. Rooms are not regularly cleaned or maintained. Cold food was delivered in boxes to a room instead of community dining as promised for socialization. There was irregular laundry service, missing clothing, meds left in a cup for her to take on her own, which she needed help with, knees and legs with broken skin, no wound care or explanation. She had bad bruising on her wrists and forearms, torn skin, UTIs from having soiled pants on too long, passing out in the shower multiple times. Reports of mom's aggression towards staff led to overmedicating her for anxiety or sedation. And you [the families] do not know what the truth is until you find out what the real truth is.

And that is where our 36-hour days began as advocates. We lobbied for four months to get cameras in a facility, ombudsman and hospice. They did not have a policy, but "no" was the answer. One facility finally relented. We put one camera in her studio and one in her bathroom. Camera signs were posted and that is where we began to see the real truth. Mom would be dragged by her forearms quickly across the room, at the employee's pace, not being respectful of her then 92-year-old pace. That is what caused the bruising and the tears that were on her forearms. In the shower, she was ushered onto a cold fiberglass seat and then the water was turned on and adjusted, maybe. I could not tell from the camera whether it was actually adjusted—and we all know it is cold when first turned on. That's why she screamed and fought. We hired a psychologist to come in and she explained to us that it was "fight or flight" and that is why Mom kept passing out or fought. Mom had a stuffed dog that was her baby and one day she was in bed, she was tired, and an employee wanted her out of bed. She yanked the dog away from my mother and said, "I am going to put your dog in jail if you do not get up." Mom was crying for her baby.

A different time, two other staffers wanted mom out of bed, and they were pulling at her arms and grabbing at her feet. Mom was repeatedly saying, "Leave me alone." So, they got a third person, and the third person came in and took the strawberries and cream that I had brought for her (which was one of her favorites) out of her refrigerator. And he sat down on what happened to be a new sofa that we had supplied her unit. He was taunting her and, sticking his hands in her container eating her strawberries taunting her by saying, "Inga, come on, come on, get out of bed." Then, when she did not want to get out of bed." he wiped his hands on the sofa when he was done and put everything back in the refrigerator.

There's night staff who are supposed to bed check every room every two hours, and that never happened. So, there were ten people in that unit and the caretakers had no idea if everybody was all right or not. We were not allowed to see staff schedules to know who was helping mom. They were internal documents, so we were not privy to that, but they had 24-hour visitation so we could find out for ourselves. And so that is what I did.

I was there checking on different shifts to see who was assigned to mom, and there were staff there who were not allowed to help her but were there anyway. We were not allowed [to see] the staff log sheets which is, in facilities, what are used to determine the level of care; they are maintained by the

caregivers. I use the term loosely, sorry; they are the same people that are inconsiderate and cruel. They're the ones that make the daily log sheets and those reports are used to determine the meds that will be recommended for her. Consequently, the caregivers prefer sedated residents as it is less work for them.

I recorded the abandonment of a ten-person unit for greater than 25 minutes. I was retaliated against for sharing evidence to the management. I had to remove cameras. There was a new policy they created; there were no cameras because it was a violation of a dressing room law. They then said that mom needed total lockdown, and it was going to be $2,600 more a month. The facility policy was to report to them so that they could fix the problem. This is a picture of my mother on her 93rd birthday; the day before that we had gone to Chico's, and she picked out her outfit and she was really excited and happy and mobile. Two weeks after that, she was abandoned in a common area. The two caregivers that were supposed to be there were not accounted for, she fell down, broke her hip and that changed the course of the end of her life.

I want you to remember, this bill only potentially helps people with active advocates, and it is only a snapshot of time in rooms. You have no idea what is going on elsewhere in the common areas. We can watch our dogs live-stream all day at doggy daycare and know that they are comfortable and happy; and that makes us feel good. You can watch your kids in school all day and have some comfort in that too. But we can't watch our loved ones who depend on us, and we have to live with the guilt of subjecting them to this kind of care. I am told that the service providers who sell and promise levels of care are a hard no on cameras in bathrooms, where abuse, theft and injury occur under the cloak of invasion of privacy. This is a misconception. There is no privacy in assisted living. Strangers have access to your room 24 hours a day. Strangers are helping you toilet; strangers are helping you shower. There is no privacy. Cameras are witnesses and help both sides of the story. It is not just a one-sided need. Also, I am told that it is a hard no, with informational onboarding documents, stating camera laws and reporting guidelines for violations.

I can't understand that. There was very little publicity for A.B. No. 202 of the 82nd Session and people in their time of need are usually exhausted or frustrated or any number of emotions, but they are looking for help. And when you go looking and you go to an A-rated facility, they have shiny glossy

brochures that are filled with all sorts of promises and they do not deliver, but they are somehow in control of our loved one's care and do not really have to follow through on all their promises. That's what we have discovered.

There are several other issues with A.B. 368 as it is now. And sadly, there is more work that is left to be done, but I guess we have to start somewhere, and I hope that you'll help now and pass this along so we can continue trying to make things better.

CHAIR DOÑATE:
Thank you so much for sharing your story. We are so sorry for your loss, but of course, we greatly appreciate your advocacy. Do you want to go specifically to the provisions of the bill?

ASSEMBLYMEMBER CARTER:
I would like to provide some context. Existing laws allow a patient in a skilled nursing facility or their representative to request the installation of an electronic communication device in their living quarters. If approved, the patient is responsible for choosing the device and paying the associated costs. Assembly Bill 368 proposes to expand that to more than just skilled nursing facilities and instead use the term "facility" for "assisted living." Sections 3 through 6, defines the health care facilities included in this bill. Most importantly, it defines "facility" for "assisted living" which will be used throughout the bill.

Sections 8 through 14 broaden the applicability of existing law to now apply to assisted living facilities instead of only skilled nursing facilities for the purpose of installing electronic communication devices. It is important to note that skilled nursing facilities are still included under this new definition.

Additionally, in the Assembly, the bill was amended (Exhibit E) to allow residents in living communities for people with disabilities to install such devices, which can be found in sections 24 through 31. An additional amendment prevents a provider of supported living arrangement services in the home from entering into a contract that prohibits the use of an electronic communication device in the home.

In a nutshell, what has been added are assisted living facilities. And when we talk about supported living arrangements, we are specifically—for those of us

from down south—we are talking about Betty's Village, which is the independent living facilities associated with but not part of Opportunity Village.

CHAIR DOÑATE:
Will you walk us through the amendment once again so we make sure we know what you are adding?

ASSEMBLYMEMBER CARTER:
While working on the amendment, Exhibit E, we had to refine the definitions of the facilities. We worked with both the trade group for assisted living facilities and the Aging and Disability Services Division and on the final amendment to make sure that we codified the proper facilities. We've tried to make sure we did not capture arrangements where somebody is doing a supported living arrangement in a residential facility where a person has one or two people that are living with them under contract. That was the part about being able to enter into a contract, excluding that for those individual residential facilities.

SENATOR TAYLOR:
Thank you to the Stephenson's and Collins' families for being willing to share your story to help somebody else. Your mom's memory will live on and help other people. Just a couple of questions. You mentioned a couple of things that I want to make sure that I understand. This is skilled nursing facilities now and you are expanding the definition to supportive facilities. Did I get that right—to supported living arrangements? That would still include skilled nursing facilities and also assisted living facilities, and you said independent living facilities as well?

ASSEMBLYMEMBER CARTER:
A little bit twisted up there—assisted living facilities is what we were focusing on to begin with. The definition now includes skilled nursing facilities; we added supportive living arrangements, which are those facilities like Betty's Village, which are for independent living for the disabled community. What I talked about with the other ones is we did not want to sweep in those small independent in-home care facilities. We wanted to stay away from that for right now. And yes, we are talking about dealing with elder abuse here.

CHAIR DOÑATE:
I remember a conversation with former Assemblymember Summers-Armstrong, who worked on this bill last time. I know that there were privacy concerns that

were raised in that bill regarding the form that folks have to fill out for permission to have, for instance, a roommate. Obviously, we will hear HIPAA concerns as a part of this. I believe we ironed out the issues with that bill; and so, what you are seeking is to expand the types of facilities for other senior residents. Are you using the same requirements and forms that we established, building off of the last law? Only now, you are expanding the folks it applies to. Or maybe there are other changes that we should be aware of?

ASSEMBLYMEMBER CARTER:
The answer is yes, we are expanding on A.B. 202 of the 82nd Session. That is the frustration that you heard from Mrs. Stephenson—trying to toughen up those rules and require mandatory posting in the facilities. We could not make that happen this time around. My hope is that we can see some work done in the interim on this issue.

CHAIR DOÑATE:
By mandatory notices, are you referring to section 29 of the bill? That talks about making sure there's a conspicuous notice of the rights that folks have for this type of service. Is that what you are referring to?

ASSEMBLYMEMBER CARTER:
No, it is not. We were looking for mandatory communication with residents and new residents, about what is expected—mandatory communication. We are looking for more detailed and more strict notifications in those posters that were required, but we are not changing that at this time.

SENATOR TITUS:
Thank you for sharing your story. Those are hard stories to hear. Having been a medical director for long-term care for 30 years, I am pretty appalled by your story.

Looking at the bill, you are changing the definition. In section 3, the definition for facility for assisted living will mean: a facility for intermediate care skilled nursing; residential for groups, senior care, care for persons with dementia, for a home for individual residential care nursing. It is a dramatic expansion of the definition. Is that limited to just this bill? Maybe Legal knows if it will change? Are there other chapters out of NRS that by changing that will be affected by the definition, or would that just be limited to this bill regarding cameras?

ERIC ROBBINS (Committee Counsel):
No, the definition here in section 7 incorporates that definition that you are talking about, and it just applies to the provision about cameras.

SENATOR TITUS:
That does not have anything to do with anything else—with the rest of NRS. I just want to make sure that we are not having some global changes by changing the definition of what an assisted living facility is. So, it would just affect where you could use a camera?

MR. ROBBINS:
That is correct and, actually to clarify further, the suggested amendment is to provide additional clarification so that it gets rid of the term "facility for assisted living," and just states the type of facilities that this applies to, just to avoid confusion like you are talking about.

ASSEMBLYMEMBER CARTER:
Yes, that was quite a lengthy process with differing people joining and not always agreeing. It has been worked over a lot.

SENATOR TITUS:
That's a good thing because there could be a lot of ramifications, things like reimbursements and licensing, and all of those.

ASSEMBLYMEMBER CARTER:
The final piece that we had to change had to do with Medicare and Medicaid definitions to make sure that we are compliant.

CHAIR DOÑATE:
In section 28 of the bill: I know it goes through the penalties associated for first offenses and so forth. Are these the same penalties that we established last session or are you changing them because of noncompliance?

ASSEMBLYMEMBER CARTER:
No, we did not change the penalties. We are just carrying it over from the last time.

JODI COLLINS:
This is our son, Andre, who is celebrating his 30th birthday. He is profoundly deaf, has cerebral palsy and uses an electric wheelchair. I want to thank the Assemblymembers and Senators who passed A.B. No. 202 of the 82nd Session, the last legislative session. That bill allowed cameras in skilled nursing facilities. But we are hoping to expand that, as they have said.

Andre moved into his own apartment last year. He lives alone with the assistance of Medicaid waivers through Desert Regional Center (DRC). My son has lived in our home with multiple cameras since 2007. So, when he moved into his own apartment, he wanted cameras as well. We were told that he could not have them because it was a rights violation or rights restriction for Andre, that he needed to live in his own apartment without cameras. When DRC staff spoke with Andre and he told them that he wanted the cameras, he was told that it was a privacy issue because of the 24-hour caregiving.

I believe that it is essential for vulnerable populations such as my son to have cameras. People such as those with disabilities, the elderly, the non-verbal, those in memory care and individuals like this are often unable to talk about things that are happening or express mental or physical abuse that may be going on. Without cameras, neglect and abuse can occur without accountability. I believe cameras would be an extra layer of insurance for the client or the patient and the staff who care for them. If there's any kind of accusations made on either side, the cameras can offer objective testimony.

Unfortunately, I know this from experience because my son has had two incidences of staff falling asleep while caring for him, even though they are supposed to be awake 24 hours. If we did not have the cameras, we would not have had clear evidence of what took place that day.

The 1999 landmark Supreme Court case [*Olmstead v. L.C.* 527 U.S. 581 (1999)] established as a right the least restrictive community integrated setting for those with disabilities. And we knew as a family that it was important to allow Andre his independence. He was very adamant that he wanted to live alone. Andre would just like to add something; he uses a communication device.

ANDRE COLLINS:
I like living in my own apartment. I would like to have cameras. I use this device to communicate.

MS. COLLINS:
We thank you for listening today and we hope that you will support A.B. 368 to include cameras for all vulnerable populations who may not be able to speak out or have someone to speak out for them. I have also submitted a letter of support (Exhibit F).

JAMIE COGBURN (Nevada Justice Association):
I should start by apologizing for last session because I worked with Assemblymember Summers-Armstrong on A.B. No. 202 of the 82nd Session and it was fully our intent to include all facilities. So, unfortunately, we are back here trying to fix that and expand it to all assisted living facilities and any group homes where there are people who need protection.

MIKE STEPHENSON:
I am going to tell you a little bit about care facilities and their operations and the frontline workers. The frontline workers consist of certified nursing assistants (CNA) and caregivers. I am going to focus on the caregivers because they are the true frontline personnel who interact with our vulnerable loved ones the most.

To become a caregiver in Nevada requires you to do eight hours of online training. You heard that right—eight hours of online training—and then eight hours annually. So, you can do that with the help of your buddies or with the help of open books or anything else. There is zero hands-on training; there's zero accountability on if you completed it yourself or not. In those eight hours of training, you do not get to train on changing patients' underwear, helping them bathe, administering medication, doing anti-choking techniques, feeding them, their hygiene or medications. Caregivers are normally hired at a minimum wage. There's not a requirement for a caregiver to have a high school diploma or GED. Bottom line, they are minimally trained, minimally paid, minimally educated with minimal supervision.

The *Nevada Administrative Code* does not provide a CAN-to-caregiver staffing ratio requirement. It simply says it is sufficient to meet residents' needs, which is an open book for the facility to decide what they need to do. This is a perfect storm for having cameras to verify what the caregivers are doing, and what the CNAs are doing. It is a perfect way to partner with these facilities to ensure that what they say is happening is documented and they are backing up their paper

records with a verifiable video record. My father always quoted "trust but verify" and there's nothing that verifies it more than a 24/7 video camera feed.

TIA SMITH (Policy Attorney, American Civil Liberties Union of Nevada):
We support this bill, and we urge the committee to support it as well.

JOHNATHAN NORMAN (Nevada Coalition of Legal Service Providers):
If people want to have a camera in their own space and that makes them feel safe and comfortable, they should be allowed to do so. We support the bill.

TERRI LAIRD (Executive Director, Retired Public Employees of Nevada):
We have nearly 7,000 members in 17 chapters statewide and have been in existence for nearly 50 years. As many of our members are retirees who are aging, including myself, elder care is something no one should take for granted. You never know when you might find yourself in a senior care facility, whether it is assisted care or medical care that you require. The last thing anyone wants is to find themselves in a facility where abuse is present. I know from experience—my mother was forced to place my grandmother in such a facility, though she had no idea her mother would be abused, but the facility was what she could afford. And therein lies the problem.

Costs should never be a factor in whether a loved one ends up in a poorly run facility and is abused at the hands of a caregiver. That should never be accepted. But unfortunately, it happens as you have heard today. Recent testimony, when this bill was heard, showed that the facility in question was not a low-cost facility and yet their loved ones suffered at the hands of caregivers at the facility in question. The family suspected abuse, so they put in a camera, which proved their suspicions.

It is heartbreaking because they were forced to remove the camera, which was their only proof of the abuse. As previous testimony showed, we have cameras in day care for our children, cameras in animal shelters, but there's no such protection for our elderly citizens. Every one of us should be concerned about this. And, as such, we support A.B. 368, and we hope you will too.

DENISE ROBINSON:
My son Ryan resides at the Intermediate Care Facilities (ICF) at DRC, and I am 100 percent in favor of this bill for assisted living and for places like the ICF. We are currently in a situation where my son was abused. It was caught on

camera in the common area. And I believe that incident continued in his room, but there was no camera in his room. He suffered a gash to his head and had to have three staples at the hospital. Had we had a camera in the room, we could have seen if what had happened out in the common areas continued in his bedroom. It is currently under investigation. It has been under investigation for going on 60 days. The police are waiting for the identity of the person from DRC, who actually did the slapping, and is being withheld by DRC. They're not giving that information to the police, and we are sitting here now in limbo.

Cameras in job and day training sites are also something that needs to be addressed. I agree with the wonderful mom that said privacy is a nonexistent thing in these facilities. It absolutely is. My son cannot have a conversation and tell you what happened to him. And it is vitally important that he is taken seriously and given the protection that he needs. As his guardian, I am being denied, over and over and over again, access to the videos to see what happened or to talk about what happened. And I am being left with leaving it all up to the people who supposedly know nothing about it.

This bill is incredibly important for so many populations and every single one of us will have to have these services at one time in our lives. I support A.B. 368 100 percent, and I hope you will too.

CATHERINE NIELSEN (Executive Director, Governor's Council on Developmental Disabilities, Nevada Department of Health and Human Services):
Our office has received numerous phone calls from families like Ms. Robinson's reporting horrific abuse and neglect in residential care settings across Nevada. These families often have no recourse because the current law does not permit objective documentation through electronic monitoring. Cameras provide neutral verifiable evidence that can protect both residents and staff ensuring accountability and transparency. Our hands are often tied with the inability to help these families beyond advocating and educating them on measures like these. Thank you so much for hearing this bill today.

CAROL MATRONE:
I represent myself and my daughter, Maria. When Maria moved into her apartment, she requested cameras. She is 34 years old and significantly physically challenged. However, she is very bright and articulate on her assistive technology devices. I am in support of providing cameras under A.B. 368. This is something that we would like to weigh in on. Not only does it provide peace

of mind for her and her caregivers and her family members, but it also provides accountability and credibility to the agencies. Also, if there is a discrepancy, they can review those cameras and make sure what the situation was before proceeding with disciplinary action. I am in support of this bill. Thank you very much for your time and for the hard work that has been put into this bill, and we look forward to it going out of this committee and on to the Governor for approval.

ASSEMBLYMEMBER CARTER:
I just want to say this is one of those bills that, as a Legislator, you hope to get. It is a constituent who brought a problem to government, and it worked through to the proper place. And I hope that we find a way to help us move this important piece of legislation forward.

CHAIR DOÑATE:
We have received letters of support for A.B. 368 from Ryley Svendsen, Nevada Coalition to End Domestic and Sexual Violence (Exhibit G) and Robert Collins (Exhibit H).

Having no testifiers in opposition or neutral, I will close the hearing on A.B. 368 and open the hearing on A.B. 350.

**ASSEMBLY BILL 350 (1st Reprint)**: Revises provisions relating to cemeteries. (BDR 40-874)

ATHAR HASEEBULLAH (Executive Director, American Civil Liberties Union of Nevada):
I am the executive director for the American Civil Liberties Union (ACLU). This hearing will probably be pretty concise. We spent a significant amount of time working through things we did not necessarily know existed in Nevada, just the nexus for the bill for us. This also came from member concerns that we received surrounding adequacy-related considerations at cemeteries statewide.

We will not get into too many specifics there. But the two initial points we are looking to address are with respect to the definition of orderly conditions at cemeteries, to provide consistent standards, as well as addressing issues related to exhumations, to ensure that the process for an exhumation occurring was a bit more organized. As it stands, this section of law is not routinely opened. So, some additional considerations came in. I am going to turn it over to my

co-presenter, Kaylah Maese. She's on my staff, a civil rights analyst with our team. Then we will be able to answer questions.

I do know and I wanted to share that we were able to work with a variety of different counties statewide as well as a multitude of cemeteries to bring this to fruition. An additional piece that was offered, which Kaylah will be speaking about with respect to veteran cemeteries has brought to light some additional considerations that were raised.

KAYLAH MAESE (Civil Rights Analyst, American Civil Liberties Union of Nevada):
I will be walking through the first reprint of the bill as well as the conceptual amendment (Exhibit I).

Section 1 of the bill provides that before cemetery authority may disinter or remove any human remains interred in all or any part of the cemetery, the cemetery must petition the district court of the county where it is located for an order authorizing internment and removal. The petition must include a concise statement as to the necessity of the proposed action, accompanied by adequate documentation to justify a hearing on the petition. Once the court sets a hearing, the petitioner shall provide notice and a copy of the petition to every person who holds or has right of internment of that plot. If any individual wishes to oppose the petition, the person must appear before the court at the hearing. The court must issue an order for the internment and removal of human remains interred in the cemetery, if it is found by clear and convincing evidence that this internment is necessary.

Jumping to section 1, subsection 6, paragraph (a), the cemetery authority must maintain a written record for each person whose remains are disinterred and removed. Those records must include the name of the person, a description of the plot from which the remains were removed, and the locations where the remains are reinterred, if they are reinterred. This documentation must be provided to a local health officer, county coroner or the Nevada Funeral and Cemetery Services Board upon request.

The provisions in this section do not apply to a certain group of people: a person to whom a permit for internment has been issued pursuant to NRS 451.045, which is the local health officer, a county coroner in the performance of his or her official duties or a person who is authorized to order burial or cremation of

human remains pursuant to NRS 451.024. This includes individuals like next of kin or beneficiaries or executors left through [testamentary] documents.

Sections 2 through 4 of this bill make conforming changes relating to the issuance by the court, rather than by the cemetery authority, of an order of internment and removal of human remains in a cemetery.

Section 5 makes changes relating to maintenance of the cemeteries. Currently, this chapter in NRS is very vague, which is half the reason why we are here today. Cemetery owners are required to keep their cemeteries in an orderly condition, but orderly condition has no definition in NRS. We are going to look at the conceptual amendment to go through section 5.

With the conceptual amendment, we are amending section 5, subsection 1, paragraph (a) to include a provision that excludes mowing and maintaining any grass in which grass growth is dormant based on temperature conditions or when city, state, county or national water management agencies limit the irrigation water supply due to drought conditions.

Section 5, subsection 1, paragraph (b) is amended to include a provision that annual weed treatment can suffice for compliance within the subsection. Section 5, subsection 1, paragraph (f) clarifies that tombs, monuments, gravestones or other structures within the limits of the cemetery are properly placed on the intended spaces as documented in sales or interment records. Added to section 5, subsection 1, paragraph (g) to allow for the temporary removal and subsequent replacement of any tombs, monuments, gravestones or other structures to allow access of equipment, memorial installation or other activity required for the normal operations of a cemetery.

We are amending section 5, subsection 2 to include a provision that if an owner of a cemetery fails to comply with the order to any action necessary to bring that cemetery into an orderly condition, as prescribed in the bill, the county or city in which the cemetery is located may take any action necessary to bring the cemetery into such condition at the owner's expense. We would omit any references in the bill to the city or county accepting the transfer of a title of a cemetery that is not in compliance.

And lastly, we are looking to add section 6 to this bill which allows members of the National Guard or a reserve component of the United States who do not

meet the eligibility requirements outlined in NRS 417.201, but do meet the definition of a veteran as defined in NRS 417.005, to be eligible for interment in a state veterans' cemetery. That is the bill and the conceptual amendment, and we are happy to take questions.

SENATOR TITUS:
Living in rural Nevada, we have a lot of old towns that have old cemeteries and frequently, there are volunteer groups that may fence them off so people do not ride motorcycles through them, but they are owned by the county. I am concerned that some of the regulations will infect their mandate that then the county gets engaged in taking care of that old cemetery.

MS. MAESE:
With this bill, we are not looking to apply these provisions to any cemeteries owned by the county, by the city or owned by the federal government. The cemeteries in rural Nevada would not be affected by this bill.

SENATOR TITUS:
Not uncommonly, we have Native American land. And sometimes, we might find, suddenly, that there's human remains that are native graveyards. Does this bill affect anything along that line?

MS. MAESE:
It does not, Senator.

JENNIFER LAZOVICH (Davis Funeral and Cemetery):
Davis Funeral and Cemetery has been operating funeral homes in Las Vegas for 75 years. They have a couple of locations: 35 acres at Patrick and Eastern, and Bunker's Memory Garden and Bunker's Eden Vale. Over time, they've always taken pride in how their cemeteries look. We really, really appreciate the bill. It took a lot of time to make sure that the language was right. It is a very interesting bill, and a lot of technical issues go into maintaining a cemetery that we had to work on. So, with that, we are supporting this bill.

ANDREW LEPEILBET (Chair, United Veterans Legislative Council):
I am the chairman of the United Veterans Legislative Council for all of Nevada, the 250,000 veterans in our State, and when you count their families, there are 500,000 in our State. We are in support of A.B. 350 as it is amended to include provisions for our [Army National] Guard and Reserves to be interred.

JASON FRIERSON (Palm Mortuaries):
I want to echo the sentiments expressed earlier, thanking the bill's presenters for being so open and sitting down, talking and working out some challenges. With those suggested changes, we are in support.

MARY DEVINE (Director, Nevada Department of Veterans Services):
I am also in support of A.B. 350. It would be a wonderful thing for our National Guard and Reserve members.

JOHN DREW LAWTON (Sierra Memorial Garden Cemetery; Hillside Cemetery):
I thank you for the opportunity to speak today and I wanted to acknowledge that the proposed amendments in this bill are well drafted; language is thoughtful; use of industry terms is accurate and appreciated.

That said, I am in support of the bill, but I do have two concerns that I would like to raise. Both of which relate to scenarios that, while uncommon, are very real. First, the language in the portion of the bill regarding petitioning the court for an order, and authorizing disinterment seems ambiguous and therefore creates confusion. It states that none of the provisions for the section apply to the disinterment, of plots owned in fee simple. On its face, this could be interpreted to mean that remains in fee simple plots could be disinterred without judicial oversight. I do not believe that is the intent, but this is how the statute could be interpreted. I just wanted to make that known.

For context, as the owner of Hillside Cemetery, a non-endowment care cemetery in downtown Reno, in which most of the plots are held fee simple with no further fees for care and maintenance. While I do not have plans for disinterment, that does not mean at some point in the future, the needs of the community—namely the health safety, comfort and welfare of the public—might be best served by contemplating disinterment. Judicial review should remain an option for all owners regardless of how the land is held. Denying access entirely could raise serious constitutional concerns in my opinion, and I respectfully suggest that that section be clarified to ensure that the judicial process remain open to all cemetery owners.

Secondly, regarding Hillside: I would like to address the issue of the requirements as I referred above. The language appears that the Hillside Cemetery is a non-endowment care cemetery, which is a problem that I have inherited and not created. But the current language appears to apply to the

maintenance and financial obligations of a no endowment care cemetery. That simply is not feasible in a case like this cemetery where there's no endowment care fund or active sales. So, imposing them would be unduly burdensome and frankly unworkable. For that, I would ask that the bill revise the exemption to add non-endowment care cemeteries.

ERIC ROBBINS (Committee Counsel):
I just wanted to clarify Senator Titus's question from earlier. The exemption for government-owned cemeteries, actually only applies to subsection 2 of section 5. So basically, everything in this bill would still apply to government owned cemeteries. The only thing that they would be exempt from is subsection 2 of section 5, which authorizes a cause of action to enforce the provisions of section 5, like the duty to maintain the cemetery. And so there would be no cause of action against a government-owned cemetery for that. But, in theory, it still would apply to them.

SENATOR TITUS:
I think that I would have a little concern about that because we have—even in my old valley—we have several very old cemeteries that are now in parts of fields and those kinds of things. I just would worry about the impact if it would mandate that they are culpable or responsible if the care is not there. So, I have some concerns.

MR. HASEEBULLAH:
Thank you again for your willingness to hear this bill. Our viewpoint in discussing this with the county municipalities, and with the Nevada Association of Counties (NACO), was to remove a potential civil cause of action. Other provisions that are included would actually mitigate it against any potential challenges there.

We're happy to make that clearer if that is necessary. We do know that portions we included in the provision that was included were done for that reason. The other portion that was also included, Senator Titus, to your initial question—the sort of removal of the transfer authority—we did that in part because we know that for many government entities, owning or possessing a cemetery is not a fruitful financial decision and not easy to maintain. There's very little benefit. We try to be as comprehensive as possible. I am certainly happy to work on that.

SENATOR TITUS:
Just a quick follow-up question. Did you say NACO has been part of this?

AMY HYNE-SUTHERLAND (Nevada Association of Counties):
Yes, we have been working with the sponsor to provide feedback on impacts to counties. They are considering what they want to accomplish with this bill and making sure that everybody understands the initial intent of the bill. The Nevada Association of Counties understands you want to respect that the remains should not be moved without the approval of a family member and things like that.

So, have all of the impacts to counties been taken out? No, and there will still be maintenance requirements that counties will need to work through. But they did work with us on getting provisions for historical sites, tombs, and making sure that wherever you have a historical cemetery, you will not have the same maintenance impacts. I can say we are neutral on this, but I would say we did not get to a place of no county impact. We did very much appreciate the sponsors working with us to mitigate the impact.

CHAIR DOÑATE:
Are there cases of graveyards or cemeteries that have not been designated as a historical site but have been around the community for a while?

MS. HYNE-SUTHERLAND:
Yes, I believe that there are county-owned cemeteries in the State that are not designated as historical markers but might be quite old and need significant adjustments for this bill.

CHAIR DOÑATE:
Perhaps after this hearing, we can talk about grandfathering those specifically. Obviously, the maintenance may be historically significant and perhaps it might even be an impediment of disrupting what has been there in terms of history.

SENATOR TITUS:
Exactly, because we have, in my valley, three cemeteries that are historical, but they do not have a designation as historical. And so, I have real concerns. The county owns them, and we have a cemetery maintenance group, and we do our best because I have relatives buried there. But I really worry about the potential impact on rural counties with those types of cemeteries.

MR. HASEEBULLAH:
I know we are up against a deadline, but what we can do in the next couple of days, based on all the provisions, we are happy to include a provision that would give counties the enabling authority to designate those specific cemeteries as historical sites. Then they would end up falling under the gambit of this, and we would not have to deal with those concerns. Certainly, that is not the intent behind this. Our view was that removing the civil liability provisions would have mitigated against all harm there, but we can make that clearer. Certainly, I think that should suffice for the remaining counties. I do not know that there's much more we could do beyond that in the way of language.

SENATOR TITUS:
Thank you so much.

CHAIR DOÑATE:
At this time, we close the bill hearing on A.B. 350 and move on to A.B. 360.

**ASSEMBLY BILL 360 (1st Reprint)**: Revises provisions relating to testing for sexually transmitted diseases. (BDR 40-745)

ASSEMBLYMEMBER HEATHER GOULDING (Assembly District No. 27):
I am honored to present A.B. 360 to you today. It is a critical piece of public health legislation designed to address the alarming rise in congenital syphilis in Nevada.

Congenital syphilis occurs when a syphilis infection is transmitted from a pregnant woman to her baby during pregnancy or birth. Assembly Bill 360 builds upon A.B. No. 192 of the 81st Session which passed in 2021. That bill required hospital emergency departments to test pregnant women for syphilis if they had not already received prenatal care. However, we have since learned that this testing is often not routinely conducted when pregnant patients visit the emergency room for reasons other than their pregnancy.

Assembly Bill 360 aims to close this gap. Increasing access to syphilis screening and treatment for pregnant women, specifically, those that are highest risk of congenital syphilis, those who have not received prenatal care. We are intervening with them at the place where they most frequently receive health care—in emergency rooms (ER). Today, I am joined by two distinguished physicians who bring firsthand insight to this issue. First, Dr. Nehal Naik, an ER

physician in Las Vegas, will speak to the practical need for this bill from the ER perspective. And Dr. Kris Deeter, Chair of Pediatrics, School of Medicine, University of Nevada, Reno and Renown Children's Hospital will discuss the tragic consequences that occur when syphilis is left untreated during pregnancy.

NEHAL NAIK (Elite Medical Center; Valley Health System):
I am a board-certified emergency physician, and I serve patients throughout the Las Vegas area. I am here to express my support for A.B. 360. Your colleagues in the other House heard from my colleagues in different specialties about the devastating effects of congenital syphilis. In Clark County alone, in 2022, there were 50 cases of congenital syphilis. Emergency departments [ER's] play a key role in this public health effort. Nationwide, about 21 percent to 58 percent of pregnant women use an emergency department at some point during their pregnancy. One study also showed that 50.8 percent of ER visits for pregnant women were in the first trimester. Particularly for Medicaid and uninsured patients, the use of ER care during pregnancy is notably higher.

I also serve as the medical director for Elite Medical Center, an emergency center that's an extension of Valley Hospital in Las Vegas. Due to its ease of access and ability to provide high-level emergency care, our ER frequently sees women in their first trimester. These facilities provide a perfect avenue to address congenital syphilis. This bill not only mandates testing but also ensures that every facility has the resources to quickly test for syphilis. It specifically addresses concerns within the ER of thoroughness and rapidity of our evaluation. It specifically states that serologic testing should be performed if results can be done reasonably before the patient leaves. Otherwise, a rapid point-of-care test can be used.

Assembly Bill 360 allows support for ER physicians to ensure that facilities have the resources they need to test and treat. For example, if a patient is otherwise in early syphilis without any severe findings, it is treatable by me. I can treat it with a shot of penicillin and encourage continued follow-up with the patient's obstetrician-gynecologist (OBGYN). If the patient does show with signs of late syphilis or any other further signs, treatment can be started in the ER and continued with the OBGYN. Our hospitals already communicate with the Southern Nevada Health District on communicable diseases including syphilis, which can help in coordinating with care.

This question of asking patients about pregnancy status and desire for syphilis screening can be incorporated into a nursing triage with a blood draw done early with an emergency department stay. We can do this quickly in the ER and address a key public health concern for our State.

The 2021 bill says I have to test and provide testing and potential treatment only for those who come in with potentially pregnancy-related symptoms. We're still missing a huge percentage of the population who may come in with other complaints. But if, in initial triage, she tells the doctor she is pregnant, this bill encourages and requires us to recommend other testing or ask if she wants testing for syphilis. And then [we can] explain what syphilis might do to the unborn baby. It can cause huge issues if you are positive. Now, some of my colleagues may say this is an undue burden and may make it harder for them to provide adequate emergency care. I think the amount of time is worth it to take the effort for what is right for the patient, and future Nevadans. The babies that are about to be born are so much more valuable than that short amount of time it takes in testing.

I frequently see patients who are pregnant in the ER and they often come with other pregnancy symptoms. They often come scared and confused, especially if they are having pregnancy-related symptoms. Many of them do not even know about congenital syphilis. Our physician group already helps treat patients at our main hospital sites where we have adequate testing and serological testing to quickly get the results to potentially treat. That being said, the test is not that quick. This bill requires that every facility have adequate testing so results come back before the patient leaves the facility. And that is an important piece for us—that we may be able to communicate afterwards if there's a positive test and let the health department know. If the patient only gets a letter or a phone call, that is not personal.

What I love about my job is that I can have that early conversation with the patient to let them know that there's something wrong, but we can treat it and then the patient gets the resources they need to make sure they have prenatal care and treatment throughout the pregnancy. Let's make Nevada safer and healthier and hope for healthy babies.

I am currently on paternity leave with a seven-week-old little girl and was able to ensure good prenatal care for her and my partner. I want to ensure the same for every Nevadan. So I urge you to support A.B. 360.

KRIS DEETER (Chair of Pediatrics, School of Medicine, University of Nevada, Reno; Renown Children's Hospital):
I am board-certified in both pediatric, critical care and general pediatrics. I am here today in support of A.B. 360 and would like to offer you the child's perspective, as most are unable to speak for themselves. I have been in practice for over 25 years, and I have personally witnessed the positive impact of prenatal screening and the treatment of diseases like syphilis. I have also seen the painful consequences for the baby when the mother does not receive prenatal screening.

You've heard about the possible consequences of misdiagnosis in syphilis, including stillbirth and prematurity. When a pregnant woman has syphilis, the infection can spread in utero before the child is born. Delayed diagnosis and treatment can lead to delayed persistent clinical features, including intellectual disability, skin rashes, hearing and visual deficits, severe anemia, meningitis, liver failure, splenomegaly and skeletal abnormalities. By default, we enroll all of our babies born with syphilis in our Nevada Early Education Program, Early Intervention Services because we assume that they are going to have intellectual disabilities and potentially autism and developmental delays from the start. It is the only default population that we actually slide straight into that program.

While awaiting lab confirmation of findings at birth, a baby has to go through an extensive workup. This is where the pain starts for the baby. They're taken from their mother soon after birth, held down in our new board lab. We then attempt to collect blood from them. You can picture a little chubby arm and a little tiny blood vessel. It is not easy, and it often requires multiple attempts. Then we have to do a spinal tap where one provider curls the baby up in fetal position, and the other provider pokes a needle in the base of the spine to collect fluid from around the spine and brain. They're then admitted to the neonatal unit for multiple X-rays, brain imaging, an eye exam, and a hearing exam. In order to protect them from further disability, we have to quickly start treatment.

While prenatal treatment for the pregnant mother could have been that one shot of Biocillin; for the baby, we have to place a deep IV line, often a PICC line [catheter used to medically deliver medications] so that it does not fall out during the treatment. We have to expose them to more X-rays to confirm placement of that line. And then we have to give them 10 days of IV penicillin

before they can go home for the first time to their family. As their doctor, my heart breaks for these littles, knowing all of this was preventable. As this is only their first week of life after diagnosis and treatment of syphilis, close monitoring is required with repeat blood draws every 2 to 3 months, repeat imaging, spinal taps, eye exams, etcetera. All of this could have been avoided with improved screening and prenatal care for young mothers.

Thank you for your attention to this matter and for prioritizing children in our State.

ASSEMBLYMEMBER GOULDING:
The core goal of A.B. 360 is to simply increase syphilis screening and treatment among high-risk pregnant women to protect babies from congenital syphilis. To highlight the main components of the bill, A.B. 360 requires that ER departments perform rapid or point-of-care syphilis testing for pregnant women during their ER visit, with some flexibility for providers regarding the specific test method. The bill accounts for clinical factors, whether the woman has been tested within the past three months and has a known history of syphilis. If the test is positive, treatment must be initiated during that same visit unless the patient declines.

If a woman refuses testing, that refusal must be clearly documented in her medical record. The bill ensures that Medicaid will reimburse providers for the rapid or point-of-care test. And importantly, the bill also requires hospitals and other medical facilities to adopt formal policies that guarantee syphilis testing and treatment protocols are in place and in alignment with best practices. These policies must ensure that testing is offered regardless of why a pregnant woman presents at the facility and that refusals are documented.

By ensuring pregnant women are screened and treated for syphilis, A.B. 360 will reduce preventable congenital syphilis cases. It will prevent infant deaths, and it will lower healthcare costs both in the neonatal period and for many years after in a child's life.

On behalf of the many lives that this bill stands to protect and improve, I respectfully request your support for A.B. 360.

SENATOR TITUS:
Well, thank you all for being here—I appreciate the bill. Doctors, thank you for being here. I saw cases when I did my neonatal intensive care unit training. It is pretty dramatic. Thank you for recognizing the rural areas and the smaller clinics in section 1, subsection 9 and acknowledging that. When you added the definition of the duly licensed physician throughout this bill, it says physician assistant, advanced practice registered nurse or physician. Do the nurse midwives have a separate title? Why would they not be added specifically or did you think you covered them with nurse?

ASSEMBLYMEMBER GOULDING:
My understanding is that they are covered. I am going to call a friend. Yes, they are covered within the definition.

SENATOR TITUS:
So, the nurse midwives are considered advanced practice registered nurses. All right. Thank you.

CHAIR DOÑATE:
I will open A.B. 360 up for support testimony. We have a letter of support posted on NELIS [Nevada Electronic Legislative Information System] from Rural Children's Mental Health Consortium (Exhibit J).

JEN HOWELL (Northern Nevada Public Health):
I am here to testify in support of A.B. 360. Nevada currently ranks sixth in the nation for congenital syphilis rates. Nevada's congenital syphilis rate is 232 cases per 100,000 live births. While the national rate is 105.87 cases per 100,000 live births. Washoe County is experiencing an increase in cases with Clark County having experienced increases during different time periods since 2005. Rural communities are also facing an increase in cases, with fewer resources and experience with syphilis than Washoe and Clark Counties.

The CDC has noted that congenital syphilis cases are sentinel health events that should be examined to identify where prevention, testing and treatment efforts broke down. Among maternal cases of congenital syphilis, many characteristic trends have been identified. These include polysubstance use with meth and fentanyl as the most commonly reported substances; unstable housing or being unhoused, justice system involvement; unplanned pregnancies; transactional sex involvement; missed opportunities of intervention in emergency departments,

where people are presenting for care for a variety of reasons; and lack of resources or health literacy needed to prove they could participate in prenatal care.

For example, from 2017 to 2022, 57.4 percent of maternal cases in Clark County had visits to the emergency room. Congenital syphilis and syphilis have had a tremendous impact on the health of Nevadans. It is crucial to advance interventions that allow for timely treatment, to prevent cases transmitted to babies and to reduce the burden of this preventable disease overall.

TIM MCFARREN (American College of Obstetricians and Gynecologists):
I am a board-certified OBGYN. During my career, I have had the privilege to deliver more than 5,000 babies and many times I am asked which ones I remember? Unfortunately, many I remember are the sad cases and this is what it is with congenital syphilis. When one presents a baby to the mother, knowing that the baby is blind and has multiple problems, it is something that no one can forget. It is knowing that this baby may not see, may not hear or may not walk. The emotional, physical and financial costs to the mother, to the family and society, are unmeasurable. And that is why this bill is so important. The only way to prevent congenital syphilis is by screening and early treatment and that is what this bill does. This bill will prevent congenital syphilis. I urge you to support A.B. 360.

IAN M. HARTSHORN (Nevada Faculty Alliance):
The Nevada Faculty Alliance supports A.B. 360. We support legislation that promotes and ensures public health and legislation that takes the advice of our colleagues in medical professional associations. We note that the Public Employees' Benefit Program has determined this bill will have no fiscal impact for them. Healthy children mean a healthier Nevada.

ALLISON HERZIK (Dignity Health-St. Rose Dominican):
Dignity Health has partnered with the focus program to integrate routine screening for several communicable diseases including HIV, hepatitis C and syphilis in our emergency rooms.

This program allows us to capture individuals who are not in routine primary care, screen and test them when indicated and if they are positive, provide linkage to care services to get them into the primary care system. We want to

thank Assemblymember Goulding for her work on this bill. We are in full support of A.B. 360.

SABRINA SCHNUR (Nevada Primary Care Association):
We are Nevada's federally qualified health centers, and we are in support of A.B. 360.

PATRICK KELLY (Nevada Hospital Association):
Due to the late hour, I will be brief: syphilis-bad; bill-good.

BLAYNE OSBORN (Nevada Rural Hospital Partners):
We too oppose syphilis and support this bill.

BRADLEY MAYER (Southern Nevada Health District):
I just want to share a few stats real quick and lend our support to Assemblymember Golding and this bill. In the last five years, Clark County had an average rate of 172 cases per 100,000 live births. Those cases have increased by 1,633 percent from 2014 to 2023. Although syphilis testing is required and we actually worked on a version of this bill a couple years ago, women who give birth to infants with congenital syphilis report no prenatal care and that is why this bill is important. A report of our 2024 surveillance data found that 56.9 percent of women with congenital syphilis had no prenatal care and 57.4 percent visited the ER at least once during pregnancy.

I think these stats and what is really going on out there necessitates the need for this bill.

CHAIR DOÑATE:
Can I ask a public health question? We have talked about making sure that folks are being tested for syphilis and so forth. Are there any other sites that we should consider as part of this that we are not capturing right now?

MS. HOWELL:
I think we captured where our main gap is and that is ERs for people who present for a variety of issues. It may not be for pregnancy-related issues, and that is where we have identified the biggest gap when we reviewed cases. Urgent caregivers do not have a designation that we could have included them in that.

JAMELLE NANCE (Children's Advocacy Alliance):
I am the early childhood policy director with the Children's Advocacy Alliance, and I am here speaking in strong support of A.B. 360. This bill strengthens health protection for pregnant people and their babies by ensuring timely accessible syphilis testing.

This legislation is critical because untreated syphilis during pregnancy can lead to stillbirths, birth defects and long-term health complications for newborns, as you heard today. Children who are exposed to syphilis during birth have high rates of medical and developmental delays. These delays can include in intellectual disability, visual and hearing impairments and other disorders that are alarming. For many of these children, the State will be covering these extensive services through Medicaid. And, fortunately, A.B. 360 mandates rapid point-of-care testing, ensuring that expectant mothers, especially those who have not received prenatal screenings, get tested and treated immediately. By requiring Medicaid and private insurers to cover these tests, A.B. 360 removes the financial barriers making screenings more accessible to low-income families and communities of color who face higher rates of congenital syphilis.

This bill is a public health win by promoting early intervention, preventing unnecessary infant death and reducing long-term healthcare costs. Ensuring that every baby has a healthy start in life is a shared responsibility. Please consider supporting A.B. 360. I have submitted written testimony (Exhibit K).

JACQUELYN NGUYEN (Nevada State Medical Association):
Nevada State Medical Association supports comprehensive, preventative care for all patients. The performance of a rapid test for syphilis at the point of contact for pregnant patients is important for early detection and treatment. We are in full support of A.B. 360.

CHAIR DOÑATE:
With no opposition testimony, we will take testimony in neutral.

NICOLE FLANGAS (Nevada Association of Health Plans):
While we appreciate the intent behind this legislation, it, along with many others, has mandates that come with unintended consequences, which can drive up costs for consumers and reduce plan flexibility. These increased costs will ultimately translate to higher out-of-pocket premiums and deductibles and out-of-pocket expenses for employers and individuals. Additionally, mandates

can limit consumer choice by requiring all policy holders pay for coverage that they may not want or need, reducing flexibility and plan options.

As an association, we remain committed to enhancing healthcare quality and accessibility and welcome the opportunity to continue to collaborate on policy solutions that align with the goals here, ensuring Nevadans have access to affordable, sustainable healthcare coverage.

ADAM PLAIN (Insurance Regulation Liaison, Division of Insurance, Nevada Department of Business and Industry):
The Division is neutral on A.B. 360. I did submit written testimony (Exhibit L) giving a more detailed breakdown. We want to note that while A.B. 360 does not actually touch the insurance code at all, there are four NRS chapters—89A, 695B, 695C, 695G—which do adopt NRS 442.010 explicitly by reference, so changes do affect insurance coverages.

CHAIR DOÑATE:
What is the effect if it is overturned federally?

MR. PLAIN:
That's a very astute question, Chair. I believe what you are referring to is *Braidwood v Kennedy* which was argued before the United States Supreme Court late last month

As it relates to A.B. 360, *Braidwood v. Kennedy* would have no effect directly. The statutes underlying the U.S. Preventive Services Task Force recommendations exist already. Those statutes and the insurance code already exist. So, if the United States Supreme Court were to rule in favor of the plaintiffs in Braidwood, in a variety of fashions, regardless of whether A.B. 360 passes or not, the State will have to deal with the fallout of the U.S. Preventive Services Task Force potentially being nullified.

SENATOR TITUS:
I just wanted to make sure—one of my frustrations sometimes with these mandates is that insurance companies say, oh yes, it is covered. It is a covered test and you are mandating that it is covered. But then they put it in the bundled fees for the care, say a pregnancy care. So ultimately somebody pays for it and it is not insurance companies.

I want to be clear that this bill—and in the initial description, it says it does—requires Medicaid to reimburse for the rapid test or the point-of-care separate from when they would be billing for care of a pregnant person.

ASSEMBLYMEMBER GOULDING:
Correct.

SENATOR TITUS:
But it does not mandate that insurance companies, if somebody comes in and they are insured, they [the insurance company] could say, well that is part of being pregnant. Because one of the articles that you left with me said they were all saying, "It is covered, but it is all bundled in a pregnancy delivery situation."

I just want to make sure that the reimbursements that you have obviously recognized with Medicaid, but what about the private insurance?

ASSEMBLYMEMBER GOULDING:
I am not an insurance expert, but I can get back to you with a more specific, response. What is important to know about this bill is that we are addressing an uninsured population. This was a huge collaborative effort with a large group of stakeholders—a very broad, large group of stakeholders—and we considered all of those possibilities. I can't answer right now, but I will get back to you on that. But the highest risk population that is going to the emergency room is not typically somebody who has insurance.

SENATOR TITUS:
Thank you for that. I just wanted to make sure we are holding some of the other insurance companies responsible too. I like the bill and, as a fiscal conservative, I think this makes fiscal sense, not to mention helping babies, but it also saves us money in the long run.

ASSEMBLYMEMBER GOULDING:
In short, A.B. 360 will save lives and reduce suffering, and I thank you for considering it.

CHAIR DOÑATE:
I will close the bill hearing on A.B. 360 and open the hearing on our final bill, which is A.B. 461.

**ASSEMBLY BILL 461 (1st Reprint)**: Revises provisions governing health care. (BDR 13-156)

ASSEMBLYMEMBER DAVID ORENTLICHER (Assembly District No. 20):
Professor Nina Kohn, who is the drafter of this model bill will be joining us. As background, A.B. 461 would enact the 2023 version of the Uniform Health Care Decisions Act (UHCDA). This is a model act from the Uniform Law Commission, which, if you are not familiar with it, is a not-for-profit organization that brings together judges, practicing lawyers, scholars and other experts, all lawyers, to develop model laws in areas where states regulate. It is desirable to have uniformity, so when you go from state to state, you do not have to change the law every time you cross the state boundary.

This one is for healthcare decisions, and it is important; we have a lot of people come to Nevada from other states and it would be good if they did not have to change the rules they have to follow. When doctors come from other states who are trained in California or Wisconsin, what they have learned about health care decisions should carry over to Nevada.

As I said, everybody who participates in the Uniform Law Commission, which includes myself, Assemblymember Shea M. Backus and some of our other colleagues, who are all lawyers. But all of these Acts get input from observers and advisers who do not need to be lawyers. Professor Kohn will talk about the different participants in this process who come from the healthcare setting and other relevant settings.

We already have a Uniform Act in statute that this is updating, but it goes back to the Act on the Rights of the Terminally Ill, drafted in 1985 and updated in 1989. The Act on the Rights of the Terminally Ill was then followed by the Uniform Health Care Decisions Act in 1993.

We have learned a lot in the past 40 years about health care, making healthcare decisions, and how to write good, advanced directives. So, the presentation (Exhibit M) shows that the 2023 version of the Act draws on 40 years of experience to improve on what we originally adopted in 1991. And it makes sure our laws reflect the lessons we have learned.

There's also a provision about a public awareness campaign, which I will talk about in a little more detail. This came from the Native Voters Alliance of

Nevada to provide information about the importance of planning for long-term care. It is an important area to plan for, but not everybody does.

What about making decisions for people who've lost their capacity? At some point, we all will lose our capacity to make healthcare decisions, and it is important to have good rules for doctors, families and patients to make sure that decisions are carried out appropriately both medically and ethically. One important way is an advance healthcare directive, a living will and a power of attorney. So that is an important way to provide instructions. Here's the kind of treatment I want or do not want, or here is an agent or surrogate I want to make decisions for me. And we adopted the model form two years ago.

The UHCDA also provides guidance for decisions for patients who do not complete an advance directive. I think we are up to more than half the public now, but still a lot of people do not complete these directives and decisions have to be made for them. So, this Act gives guidance on how to do that.

The UHCDA governs treatment to be provided. Do you get a ventilator at the end of life? And I want to be clear, it is not just about the end of life. The original Act was about terminally ill patients, but a lot of important decisions are made for people who do not have capacity when they are not at the end of life. This fills an important gap in our law. It is about medical treatment provided withheld or withdrawn. Nothing about this authorizes mercy killing, assisted suicide or euthanasia. We do have another bill that gets into that area. This does not.

And as I mentioned, Assemblymember Backus and I are members of the Uniform Law Commission. So, we have had very good input from Nevada on this model Act.

ANGEL HOOD (Intern to Assemblymember Orentlicher):
Sections 4 through 27 provide definitions for key terms; sections 28 through 31 address the capacity to make health decisions or give instructions for future decisions. People have the capacity when they understand, without limitation, the primary risks and benefits of the decision. People have capacity when they understand the nature and consequences of the decision. They are presumed to have capacity unless found otherwise by a court or a healthcare professional.

Section 32 recognizes a person's authority to give instructions for future care, either orally, in writing or by other means, including choice of doctor, hospital and surrogate decision-maker.

Section 33 recognizes a person's authority to formally appoint a surrogate decision-maker to make decisions in the event of incapacity, through a power of attorney form or other record that is signed by the person and a witness. These may include specific instructions for future care.

Sections 34 and 35 recognize a person's authority to create an advance healthcare directive specifically for mental health care. It also allows for clauses that waive the right to revoke the directive during specified psychiatric or psychological events.

Sections 36 through 38 recognize "default" surrogates if a person has not formally appointed one through a power of attorney.

ASSEMBLYMEMBER ORENTLICHER:
Section 39 addresses revocation of an advance directive, including automatic revocation upon divorce. It is important to have provisions about revoking and there's automatic revocation upon divorce, which is common with legal documents, especially financial ones when the presumption is that people probably do not want their ex-spouse [as their surrogate]. This can be waived if the person wants their ex-spouse to stay on as their surrogate.

Section 40 is important, especially in Nevada. If you create your advance directive in another state, it is valid if it complies with Nevada law or it complies with the other state's law. We do not force you to redo your advance directive. This bill would not force you to redo it when you come to Nevada.

Section 41 describes the fiduciary duties. We want to make sure the person who's either appointed as a surrogate or is the default surrogate for the patient who never got around to appointing one, acts responsibly for the patient. That means when they make decisions, it should be based on the instructions. If the patient left goals and preferences, but did not leave instructions, the fallback is what is in the patient's best interest, taking into account their medical condition, what their doctors recommend and so on.

In section 42, there are powers of attorney that take effect when they are written and signed like a financial power of attorney. But for a healthcare surrogate, it takes effect when the patient loses capacity; if the patient has capacity, you want the patient to decide. But once they lose capacity, surrogate kicks in. If the patient regains capacity, then they get to decide again.

In section 43, let's say you have a patient who has a long-term disability that required artificial ventilation, nutrition and hydration. They wanted help with their disability. The presumption is they would want the treatment continued unless they say otherwise.

Section 44 allows the appointment of co-agents: if you have two kids, you can make them both your agents.

Section 45 describes the duties of a healthcare professional to respect the patient's instructions of those surrogates and also to make sure they try to identify if there is a surrogate. There are exceptions for professional or institutional conscience. Some people are uncomfortable with drawing life-sustaining treatment and the standard in this Act and already in our law is not to force them to transfer to care that is not consistent with generally accepted healthcare standards. This is about patients choosing whether to follow their doctor's recommendations, not to dictate what doctors offer.

Section 47 is very important—good faith immunity for healthcare professionals. We do not want them to have to worry about liability if they carry out a patient's instructions. So, complying or not complying with surrogate decisions, if done in good faith, there will be no civil or criminal liability.

Again, as I mentioned before, section 51 is where it talks about, but does not authorize, mercy killing, assisted suicide or euthanasia. And if you do withdraw life-sustaining care, that is not a suicide or homicide, including for purposes of insurance or annuity death benefits.

Then we have a lot of sections that include conforming changes—in sections 53 through 59, 61 through 70 and 73 through 79. There is a conceptual amendment (Exhibit N) that Professor Kohn will discuss.

NINA KOHN (Professor, Syracuse College of Law):
I was the reporter for the Uniform Health Care Decisions Act. That Act was the product of a three-plus-years drafting process that benefited from very active participation by a large, broad and diverse group of experts, including experts representing healthcare providers, those with deep expertise in healthcare administration, hospital administration, palliative care, emergency medicine, and nursing, to name a few areas. We brought in disability rights leaders including the Autistic Self-Advocacy Network and people who represent older adults, including the ABA (American Bar Association), Commission on Law and Aging, and AARP.

We brought in lawyers who represent patients and lawyers who represent providers. We brought in mental health experts, including those who work with families and advocate passionately for mental health consumers. We brought in Physician Orders for Life-Sustaining Treatment (POLST) experts on organ donation. You name it. The list goes on and on. And together what we are trying to do is learn from the decades of experience with the first-generation Act—that's the one that Nevada has now—to create a law that would be better for patients, families and providers.

I am going to highlight a few of the ways that this Act would improve upon Nevada's current law. First, Nevada, like many states, currently puts patients and providers in an untenable position by not providing a clear standard of what level of capacity is needed to make or terminate an advance directive or what level of capacity a patient needs to make decisions for themselves. Similarly, Nevada currently provides no statutory guidance for what a provider should do if a patient objects to a surrogate making a decision for them or objects to a finding that they lack capacity. This is a really huge problem.

Let me just put it in perspective for you. Let's imagine that I create an advance directive and name my husband as my agent. But on the eve of a major surgery, I announced that he is the devil, and then I want this woman I met last week who has the voice of an angel, to be my surrogate instead. I present a signed advance directive to my doctor and my doctor looks at it and thinks "This does not smell right" and is kind of concerned about my grasp on reality. But can my doctor look to my husband to make decisions? Does he have to look to this newfound angel-voiced friend? Nevada's statutes are silent.

Similarly, imagine that I have long insisted that I want everything to be done. I want to be kept alive no matter what, but I am diagnosed with dementia, and I have an immediate reaction. I tear up my existing advance directive, and I write a new one saying I want no life-sustaining care. Which direction should the doctor follow? Nevada statute really does not provide much guidance. All it says is that I need to be of sound mind to make a binding declaration. Well, if I have a diagnosis of dementia, am I of sound mind? I have no idea. Or imagine that I have appointed my husband as my agent, but I still want to make decisions despite my dementia. My doctor says I lack capacity. I say "No, no—I can make decisions for myself." What now? Well again, the state statute is silent.

The new Act, by contrast, would require a second opinion on the issue of capacity and would require court involvement if the situation involves a decision to withdraw life-sustaining treatment.

Another key benefit of this Act is that it expands the default surrogate provisions currently in state law. So currently, as you know, the State allows a default surrogate to make a decision only for a terminally ill person. And what that means is that, when individuals have not appointed somebody as their agent, one of two things is going to happen. Either a decision is going to be made without any surrogate there to protect the patient's wishes and values, or you are going to need to initiate a guardianship proceeding and go through the expense of that proceeding—a proceeding that is likely going to strip the person of virtually all of their rights and is going to require the State to invest in ongoing monitoring. This bill effectively creates an important less-restrictive alternative to guardianship.

Section 41 states that a default surrogate is a fiduciary with clearly defined legal duties. And finally, I will note that the Act, including the optional form that you have already adopted, expands access to advance directives. It recognizes that many people are completing these on their own or without the assistance of an attorney.

SENATOR TITUS:
I was the one that had, two sessions ago I think, to build it to a mandate. April 16th is Healthcare Decisions Day here in Nevada. And I was able to get the POLST change from physicians to providers of what people's choices are. It has been an issue for me that has been really important that we have those discussions.

My question is regarding section 29, and it lists those who can determine whether an individual has capacity. That list includes a physician, licensed psychologist and an individual provided with training (it does not list what kind of training), a physician assistant, a registered nurse, social worker or a responsible health professional not otherwise mentioned. I have some concerns about that broad definition of someone who can determine capacity and am wondering if that is that language. Obviously, it is a new part of this bill. What was the prior language? Because we are not striking anything out, and where were we before this current recommendation? Maybe our own attorney could tell us who could determine capacity because it seems like this new wording is expanding it.

CHAIR DOÑATE:
Perhaps Ms. Kohn, if you can help us understand that, because I know you were part of the drafting of this nationally. I think there's also a concern that perhaps the definition is too broad in terms of who is considered a healthcare professional to be in this capacity. And so, if you can talk about some of the national conversation you have had, I think that would be helpful.

MS. KOHN:
In terms of the national conversation, part of the concern here was especially in rural communities—that there might not be anyone who fell into the category of physician or licensed psychologist available to make that determination in a situation in which it needs to be made in an urgent situation. By limiting what you see as the third part, at this so called lower-level people who also have training and expertise, would make it more viable to actually get those determinations made.

You are putting those additional requirements on those non-physician, non-psychologist people who are not physicians or psychologists. There's actually some conversation about limiting physicians to those physicians who have training and expertise in capacity assessment. We decided not to do that. But for this other group, the training and expertise is required, but it was very much a goal to try to make sure that we are meeting the needs of rural communities.

SENATOR TITUS:
Is there training available for other providers or other healthcare givers? Is there a formal training available to make sure this category even exists. I was 30-plus

years as a long-term care medical director. I have done lots of capacity evaluations. I was just looking at what that means or who would you be training? And are there formal programs? Are you talking about a nurse's aide? Are you talking about a legal aid person? Who did you have in mind? And what did the chapter have in mind with that?

MS. KOHN:
I have certainly been to capacity assessment trainings including ones through the Department of Justice. But I do think you correctly identify that there is a need potentially for more training. Part of what this does is sets forth what the capacity standard is. One of the challenges I admit I face sometimes in doing training is around capacity, or grounds for different systems. When I go in and talk about—well how would you assess capacity, or what would you look at? The State may actually not have a capacity standard. Once you put in the type of capacity standard—that this Act does—then it creates the possibility of actually training to it.

ASSEMBLYMEMBER ORENTLICHER:
On your question, what is existing statute? If I look at NRS 449A, a lot of the provisions refer to the physician or the advanced practice registered nurse. In some way, this is narrower because it is not just any advanced practice registered nurse. It is an advanced practice registered nurse who has the appropriate training and expertise. We have actually added some healthcare providers, but we have narrowed the role of the advanced practice registered nurse to try and have more balance. On one hand, we want to make sure you have access because not every community is going to have physicians who are licensed or a psychologist who is readily available. So we can draw on other providers, but making sure that they have the appropriate training. It is not automatic because of their degree. I think in some ways it narrows it from where we are now.

SENATOR TITUS:
I actually look at it just the opposite because of the way the paragraphs are broken out. In section 29, subsection 2, paragraph (a), subparagraphs (1), (2) and (3). and subparagraphs (I), (II) and (III), you list the physician assistant, advanced registered nurse, a clinical social worker (sic) … but then you add another section in subparagraph (4) a responsible healthcare professional not described in subparagraph (1), (2), or (3). So that's where I'm wondering, what

do you mean by that? Because that is a whole different section bouncing back out of subparagraphs (2) and (3).

ASSEMBLYMEMBER ORENTLICHER:
As I am reading this, a responsible healthcare provider is the person primarily responsible for the patient's care at the time. So again, it sounds like it might be a very broad range, but in fact, it should not be. But as I indicate, we are certainly happy to work through refinements and this is one of the areas where it sounds like we can clarify things and tighten things up. I am happy to have discussions to make sure we get this right.

SENATOR TAYLOR:
There are a lot of emails that are going around that may have different information. So I just want to have a little clarity on a few things. One of the concerns that I have is will it increase litigation and family conflicts as opposed to decrease it. Can you respond to that?

ASSEMBLYMEMBER ORENTLICHER:
I think one of the important points that Professor Kohn made was that we have all these questions that do not have spelled out answers in code. That is where you get litigation; where things are unclear and then doctors and hospitals do not know what their legal obligations are. That leads to the court spelling out answers to a lot of questions that come up regularly and this should do a lot to reduce litigation and give clarity to doctors. So they would not have to go to their lawyers and the lawyers would not have to take the issue to court.

SENATOR TAYLOR:
What do other states have? I know this is an update and I think you said what we have in statute is 40 years old or something like that. Are there other states that have taken on the same kind of effort to the extent that we have and, are we kind of out there? The information received is that there are only one or two others that have done it in this manner.

ASSEMBLYMEMBER ORENTLICHER:
This Act was just adopted in Fall, 2023. Delaware has adopted it; Utah just adopted it and enacted it I think two months ago. There are four other states that have introduced it this session. So, it is not surprising we do not have 20 states because it just was adopted. But as Professor Kohn indicated, given the careful vetting of this and the broad range of input, it ends up reflecting an

area that is an important breadth of consensus. You'll hear that the Nevada State Medical Association has questions, but the American Medical Association had representative participation in the Uniform Law Commission, which we will hear from. Stakeholders may have concerns, but we [have not] heard any concerns from the American Medical Association or the American Psychiatric Association. There are a lot of provisions that get debated and are controversial, but there was a very strong consensus around this Act by the time it was adopted.

PAULA LUNA (Deputy Director, Battle Born Progress):
We urge the support of A.B. 461. We are in dire need of strengthening our healthcare decision making. This bill will better inform and support our communities and, more importantly, would ease at least some of the burden during such a difficult time. We urge you to pass this important legislation.

TODD INGLESBY:
We want to thank the sponsor. We want to urge the committee to support A.B. 461. We think this helps clear up an old law and we think it is what families deserve and need, and we urge you to support this bill.

SUZANNE BRICE:
I am here in strong support of A.B. 461. It is every parent's fear that something will happen to our children, and we will not be there to help them. I am a mom to two adult children, and I also have a 13-year-old, and I am concerned about this. What if something happens to them or what if something happens to me and they are left not knowing what to do. Assembly Bill 461 gives us a way to prepare for the unthinkable. It allows me to make my healthcare wishes clear so that my kids do not have to make those decisions in a moment of crisis. It gives families clarity, direction, peace of mind when it matters most. This is not paperwork, it is protection. I support A.B. 461.

MATILDA MILLER (Native Voters Alliance, Nevada):
We are here in strong unwavering support of A.B. 461. When I was 18, I had to make too many life-or-death medical decisions for my dad while he was on a ventilator in the ICU for two months. I remember sitting at the student union. I was exhausted. I was in tears. I was jumping between 30 to 40 different web pages, and I was trying to figure out and understand what procedures the doctors were asking me to approve. And I kept asking myself, is this something that my dad would want? Am I doing the right thing? Can I carry this burden?

And I told myself that once my dad gets home, I never want to go through this again. Thankfully, my dad survived, but I am still carrying the trauma of the decisions that I had to make without guidance.

That moment did not just change me. It forced me into adulthood way before I was ready. Now, eight years later, my father is still facing the hardest battle of his life. We're trying to be as prepared as we can. But the truth is I still feel as lost as I did at 18.

I used to think that this was just something that happened to me, but it is not. I have spoken to my friends, my coworkers and volunteers who have all shared similar stories, where they were left confused. They were overwhelmed and unsure of how to navigate medical decisions for someone that they love dearly. They did not know what an advance directive is or what a medical power of attorney is, how it works or how to even create one. If you have ever had to care for a loved one and had to carry the weight of making medical choices for them, then you know how deeply personal this is. If you have ever wished for clarity, support or peace of mind during a medical crisis, this bill is for you too. We urge your support.

STEVEN TACKES: (Kaempfer Crowell):
I have submitted my opposition testimony in writing (Exhibit O).

JOHN MCCORMICK (Guardianship Commission):
I have submitted my opposition testimony in writing (Exhibit P).

WILLIAM VOY (Director, Pro Bono Services, Southern Nevada Senior Law Program):
We must respectfully oppose A.B. 461. I want to first thank the sponsors for bringing forth this legislation. I understand the intent was to make it easier to create healthcare powers of attorney and other forms of substitute decision making. But in practice, the legislation will have the opposite effect. This is a uniform act. There are some good provisions in this Act, which if adopted separately you would probably have no opposition. However, we currently have a very robust statutory framework. However, like most uniform acts that I have been involved with over the last 30 years, from an academic level, they look great, but from a boots-on-the-ground, practical application, they present challenges. One such challenge substantially affects our seniors that we advocate for.

Beginning last year when I came on board, we started a significant initiative to maximize the execution of healthcare powers of attorney. We use workshops at our office, and we have mobile workshops we give in the community in Southern Nevada and actually meet the folks there with pro bono attorneys and other staff members. We make sure those powers of attorney and advance directives get lodged in the lockbox in the Secretary of State's Office. This calendar year, we are scheduled to do about 1,000. If this bill is enacted, it will present a substantial challenge in our ability to do so. We hope to double that number in the next calendar year.

However, this bill will force our folks to come into the office one-on-one according to sections 29 and 42, and subsections 56 and 57. Section 28 will require us to fully document more than we already do currently as it relates to capacity. For example, the environment in which we do the mobile workshops is not conducive to being able to talk the client through that process. We can't gauge their capabilities at that time of execution. We will have to basically go back to square one on getting folks to get these things in place. As I said before, we have a robust statutory framework and some of the concerns are addressed in our current statutes.

MS. NGUYEN:
The Nevada State Medical Association recognizes that advanced care planning is a vital aspect of ensuring patients' treatment preferences are respected in the event that they are unable to communicate their wishes. We also support the standardization of healthcare decision-making across states so that there is clarity for patients and physicians. However, we do have concerns with some of the provisions of the underlying Act itself. We believe that the standards would determine what should be aligned with best practices in psychiatric assessment to ensure accuracy and consistency in evaluating a patient's decision-making ability.

We're also focused on section 29 of the bill. I want to emphasize the importance of prioritizing physician-led care, specifically ensuring that only appropriately trained or appropriately supervised professionals are authorized to rebut the presumption of capacity.

Finally, I may need some clarity regarding the conceptual amendment requiring due diligence and locating a designated agent. We want to ensure that this provision does not unintentionally impede physicians from delivering timely care

in emergency situations. At this time, we are in opposition but are committed to working with the bill sponsors to have the bill meet their intent while addressing our concerns.

JEFFREY LUSZECK (Solomon Dwiggins Freer & Steadman, LTD.):
I have practiced law in the Nevada for nearly 20 years and for 16 of those years practiced exclusively in probate trust, the power-of-attorney and guardianship law. I am in opposition to A.B. 461. I am extremely concerned with the implications A.B. 461 may have on our current healthcare power-of-attorney statutes, including NRS 162A and believe that it will unnecessarily increase litigation that will arise if enacted.

My concerns regarding A.B. 461 include but are not limited to the following: First, while I agree that Uniform Act can be helpful, Nevada already has a robust statutory scheme particularly Titles 12 and 13, that may be unintentionally impacted by adopting the Uniform Act. Second, A.B. 461 also seeks to enact 80 or so different statutes, some of which are definitions which appear to adopt the UHCDA in its totality. I have particular concerns with definitions set forth in sections 7, 10, 14 and 16, among others. Third, while people generally execute healthcare powers of attorney to avoid litigation, I believe the following areas appear to create a litigation landmine and will increase litigation specifically. I believe sections 28, 29 and 30 will create litigation regarding issues pertaining to an individual's capacity to create a healthcare power of attorney.

Sections 36 through 39 I believe will create litigation regarding definitions and default surrogates that can act as an agent under a healthcare power of attorney. Sections 41 to 43 dictate actions allowed by or not allowed by surrogates. Section 47 has the good-faith exceptions to civil or criminal liability, which was discussed previously. Section 48, while I generally agree that we do not want forged or falsified directives, the phrase "inducement" is extremely problematic for attorneys. It appears that an attorney could potentially be fined $25,000 if they do not disclose a copy of a healthcare power of attorney, even if their client instructs them not to do so. For those reasons and for others, I strongly oppose A.B. 461 and have submitted an opposition letter (Exhibit Q).

LEA CARTWRIGHT (Nevada Psychiatric Association):
On behalf of the Nevada Psychiatric Association, we would echo the comments you have heard previously, especially those from the Nevada State Medical Association. I would also add that the Nevada Psychiatric Association worked

diligently in 2017 on S.B. No. 50 of the 79th Session to create psychiatric advance directives. Those conversations took place over many, many months during the legislative session, especially to figure out capacity, competency, and all of those terms that were discussed earlier and we would ask that we retain our psychiatric advance directive portion of the law.

MR. NORMAN:
I just want to make sure that the opposition is noted.

DEBRA BOOKOUT (Directing Attorney, Guardianship Advocacy Project, Legal Aid Center of Southern Nevada):
Attorneys currently represent almost 3,000 adults in guardianship. We do have serious concerns with A.B. 461. The definition of "reasonably available" outlined in section 21, as it pertains to an agent or guardian being willing and able to act in a timely manner is one. It is our opinion that this definition is vague and highly subjective. And as such, it provides too many opportunities for a hospital to simply ignore a patient's lawfully executed healthcare power of attorney.

I want to offer a real-life example of what happens when hospitals have this much discretion regarding a named agent under a healthcare directive. Recently, we had a case in which a client named her long-term partner to be agent under her healthcare power of attorney. She went into the hospital with acute care needs, but then needed to be discharged to a setting that could assist with her lower level of care. The hospital was aware of an agent; however, they filed a petition for guardianship anyway. And when our attorney pointed out that she did not need a guardian because she had a named agent and suggested they dismiss it, the attorney for the hospital responded that they would not be withdrawing the petition because they preferred to work with the public guardian to find placement because they were more knowledgeable and had more connections. I quote them:

> For the average individual, had counsel not been appointed to represent her in the guardianship proceedings, our client may well have found herself in an unnecessary guardianship, despite having taken steps years prior to name an agent under a power of attorney and avoid guardianship.

If a hospital can simply ignore the healthcare directive of the patient when they are aware of a named agent who is willing and able to act, imagine what could happen if given only vague requirements to contact the agent. And when they do not, this bill would allow them to avoid all liability even with negative outcomes. Further, in that situation I just described, under this bill, rather than filing a petition for guardianship, the hospital could then have appointed a "default surrogate" under section 36—a person potentially unknown to the patient and possibly a hospital employee, by simply claiming that the named agent was "unable to exercise his authority." Based on the hospital's perception of his lack of knowledge as an average individual, the client's right to have a trusted named agent make decisions for her would simply be ignored by the hospital with no liability.

We should be encouraging more people to execute healthcare powers of attorney which is a means to avoid guardianship, and we should be making it easier to do so—not harder. We should also be requiring hospitals to honor all lawfully executed powers of attorney under any circumstance and take all necessary measures to contact a named agent and a patient's health care power of attorney. This bill does none of those things, and for these reasons and others, we oppose A.B. 461 and have submitted an opposition letter (Exhibit R).

SHAUNA BRENNAN (Attorney Advocacy Rights of Older Persons, Persons with a Disability, Intellectual Disability or a Related Condition; Aging and Disability Services Division, Nevada Department of Health and Human Services):

I am testifying in neutral because I do not lobby either side. I just want to make sure that this committee has been neutrally informed. I believe that many of the elements that have been discussed today are already in place, such as power of attorney and medical directive, of which you are aware. There are concerns that the Nevada stakeholders were not consulted. For example, the Guardianship Commission and Probate Bar have weighed in on this in writing, and also, they are in opposition. If you would please consider that.

Most importantly, I am concerned about the patient's rights and due process, which many of the aspects of this proposed bill overlook. The rights of the patient are possibly inconsistent with my reading, inconsistent with Nevada provisions regarding least-restrictive alternatives to guardianship, power of attorney, shared decision-making and the guardianship orders.

I would draw your attention to section 46, subsection 2, which I do not believe was amended. The last reading said that the health care decision made by these agents can prevail over the decision of the guardian—that is in direct conflict with our guardianship law. And I would ask you to take this and other provisions under consideration.

ASSEMBLYMEMBER ORENTLICHER:
It's true only two states have enacted the Uniform Health Care Decisions Act, as I mentioned, but it was only passed in 2023, and several states have adopted different provisions. I mentioned earlier that this is based on 40 years of experience with what has happened clinically, what kind of directives work—not what have states done. There are states that have the kind of default surrogate provision that is in this and that they have had for years, and it has worked well and has not created the kinds of problems that some of the opposition is worried about.

I think it was Mr. Voy who said this creates new legal obligations—no, it clarifies existing legal obligations. So, lawyers and providers know what to do and do not have to go to court. This will reduce the need to go to court. There's some misreading—section 72 does not require the use of the model form. It is just presented as an option. Other forms are perfectly fine.

If it is important to say it more clearly, we will say it more clearly, but this does not change what they do and it does not change the Senior Law Project's ability to go out and do their programs for seniors to fill out advance directives. This makes it no more burdensome. All it does is just make things clearer for everybody involved.

Let me know what you would like tightened up, and I will continue to work with them and tighten things up.

CHAIR DOÑATE:
We received three letters of support (Exhibit S) and four letters of opposition (Exhibit T). I will close the hearing on A.B. 461 and we will move on to our last agenda item, public comment. Hearing no public comment and having no further business for the Senate Committee on Health and Human Services, we are adjourned at 6:23 p.m.

RESPECTFULLY SUBMITTED:

Donna Crawford-Kennedy,
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. 60 | C | 4 | Destini Cooper | Work Session Documents |
| A.B. 244 | D | 4 | Destini Cooper | Work Session Documents |
| A.B. 368 | E | 10 | Assemblymember Max Carter | Conceptual Amendment |
| A.B. 368 | F | 15 | Jodi Collins | Support Letter |
| A.B. 368 | G | 18 | Chair Doñate | Support Letter<br>Ryley Svendsen |
| A.B. 368 | H | 18 | Chair Doñate | Support Letter<br>Robert Collins |
| A.B. 350 | I | 19 | Kaylah Maese, ACLU Nevada | Conceptual Amendment |
| A.B. 360 | J | 30 | Chair Doñate | Support Letter<br>Nevada Rural Children's Mental Health Consortium |
| A.B. 360 | K | 33 | Jamelle Nance / Children’s Advocacy Alliance | Support Testimony |
| A.B. 360 | L | 34 | Adam Plain/ Department of Business and Industry | Neutral Testimony |
| A.B. 461 | M | 36 | Assemblymember David Orentlicher | Presentation |
| A.B. 461 | N | 39 | Assemblymember David Orentlicher | Conceptual Amendment |
| A.B. 461 | O | 46 | Steven Tackes/ Kaempfer-Crowell | Opposition Testimony |

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|---|---|---|---|---|
| A.B. 461 | P | 46 | John McCormick/ Guardianship Commission | Opposition Testimony |
| A.B. 461 | Q | 48 | Jeffrey Luszeck/Solomon et al. | Opposition Testimony |
| A.B. 461 | R | 50 | Debra Bookout/ Guardianship Advocacy Project | Opposition Letter |
| A.B. 461 | S | 52 | Chair Doñate | Three Support Letters |
| A.B. 461 | T | 52 | Chair Doñate | Four Opposition Letters |