# Legislative Committee on Health Care

## Bulletin No. 13-18

*Legislative Counsel Bureau*

## January 2013

# LEGISLATIVE COMMITTEE ON HEALTH CARE

## BULLETIN NO. 13-18

**JANUARY 2013**

## TABLE OF CONTENTS

SUMMARY OF RECOMMENDATIONS

## LEGISLATIVE COMMITTEE ON HEALTH CARE

*Nevada Revised Statutes* 439B.200

This summary presents the recommendations approved by the Legislative Committee on Health Care (LCHC) (*Nevada Revised Statutes* [NRS] 439B.200) at its August 29, 2012, meeting. The LCHC submits the following recommendations and bill draft requests (BDRs) to the 77th Session of the Nevada Legislature:

## CHILDREN'S MENTAL HEALTH SERVICES IN NEVADA

1. Send a letter to Nevada's Congressional Delegation regarding access to care for certain children who have access to care through a variety of governmental entities such as Medicaid, child welfare, and juvenile justice. The letter will:

    a. Inform the Delegation of the Institution for Mental Diseases (IMD) exclusion that disallows group homes of 16 beds or more from being reimbursed through Medicaid and the impact of this federal regulatory hindrance on Nevada. Specifically, this prohibition is not allowing medically necessary behavioral health services to be reimbursed in a delivery model that is in the least restrictive, most normative setting for the child. The goal of the Division of Health Care Financing and Policy, Department of Health and Human Services (DHHS), is to develop funding models that are innovative and within the community setting.

    b. Request that the Delegation advocate for the IMD exclusion regulation to be reconsidered by the Centers for Medicare and Medicaid Services (CMS) by considering the severity of the mental disease rather than the existence of a mental disease in combination with the bed count (i.e., 16 beds or more). This will place more emphasis on the acuity of the child instead of the facility.

    Because of these prohibitions in current federal regulation, these facilities have been mistaken for the more traditional higher level of care psychiatric hospitals and psychiatric residential treatment facilities.

2. Send a letter to the Director of the DHHS and the Executive Director of the Silver State Health Insurance Exchange. The letter will:

    a. Encourage the development of a mechanism for Children's Mental Health Consortiums (NRS 433B.333) to provide input into State implementation of the federal health reform initiative to ensure that targeted case management and service

delivery for children with serious emotional disturbance is provided with a family-driven, individualized, wraparound approach.

b. Request that the appropriate Director consider the viability of pursuing the following proposals, which were presented by the Children's Mental Health Consortiums:

(1) Include the following as essential health benefits to be covered for children with serious emotional disturbance under benchmark plans for Medicaid, health insurance exchanges, and other plans: family-to-family support, mentoring, mental health consultation, mobile crisis intervention, and respite care.

(2) Build in reimbursement incentives for use of evidence-based practices in case management and direct services.

(3) Build family navigators into the essential benefits package to provide outreach and navigation to assist families of children with serious emotional disturbance in choosing the best benefits package.

(4) Develop a mechanism/legislation for reinvesting savings from health care reform's increased federal financial participation into community-based services.

(5) Submit to the CMS a Medicaid State plan amendment for review and approval to establish a 1915(i) Home and Community Based Services waiver, in an effort to increase the capacity of Medicaid mental health service providers to deliver in-home services and supports, and decrease the need for out-of-home care.

## PRESCRIPTION DRUG ABUSE AND THE PRESCRIPTION DRUG MONITORING PROGRAM IN NEVADA

3. Send a letter to Nevada's Congressional Delegation related to prescription drugs. The letter will: (a) emphasize the impact of prescription drug abuse, misuse, and diversion in Nevada; and (b) encourage the development of policies that recognize the impact of prescription drug advertising, promotion, and marketing to health care professionals and direct-to-consumer on excessive or unnecessary prescription drug use.

4. Include a statement in the Committee's final report: (a) emphasizing the Committee's support for the efforts of the Substance Abuse Working Group within the Office of the Attorney General (Assembly Bill 61 [Chapter 89, *Statutes of Nevada 2011*]) and the Prescription Controlled Substance Abuse Prevention Task Force; and (b) recognizing their accomplishments related to addressing substance abuse issues and challenges in the State of Nevada.

5. Send a letter to the DHHS encouraging collaboration with the United States Drug Enforcement Administration, Nevada Statewide Coalition Partnership, and other entities as appropriate, to provide for safe and available destruction and disposal of medications; including the creation of safe disposal sites in each county in Nevada.

6. Send a letter to the DHHS encouraging collaboration with the Nevada Statewide Coalition Partnership, and other entities, as appropriate, to develop consumer education related to prescription medications. The letter will encourage the development of:

    a. A media campaign that teaches consumers how to work with their health care professionals around prescription drugs, including how to store, keep, and use their prescriptions; and

    b. Training information for consumers on safe handling, storage, et cetera, along with education on potential for abuse and misuse.

7. Send a letter to the Chairs of the Senate Committee on Judiciary and the Assembly Committee on Judiciary forwarding the record concerning the LCHC discussion regarding penalties for trafficking prescription medications and request that the respective committees work with law enforcement and other interested parties to address concerns and penalties related to trafficking schedule III, IV, and V controlled substances.

## CANCER DRUG DONATION PROGRAM

8. Send a letter to the following medical and related groups: the Clark County Medical Society, the Washoe County Medical Society, the Nevada Nurses Association, the Nevada Osteopathic Medical Association, the Nevada State Medical Association, the Nevada Pharmacist Association, the Nevada Society of Health-System Pharmacists, the Retail Association of Nevada, and other relevant groups. The letter will: (a) emphasize the Committee's strong support for the Cancer Drug Donation Program; (b) highlight the cost of prescriptions for the treatment of cancer and the availability of unused medication; and (c) encourage the groups to educate their members about the program in an effort to make them more knowledgeable and comfortable referring individuals who may benefit.

9. Amend NRS 457.460 to allow dispensing practitioners (physicians and osteopathic physicians) to dispense donated cancer drugs through the Cancer Drug Donation Program. **(BDR 40–500)**

## STANDARDIZING LANGUAGE IN CHAPTER 450B, "EMERGENCY MEDICAL SERVICES," OF THE *NEVADA REVISED STATUTES* TO CONFORM TO THE *NATIONAL EMERGENCY MEDICAL SERVICES EDUCATION STANDARDS* RELEASED BY THE NATIONAL HIGHWAY TRAFFIC SAFETY ADMINISTRATION IN 2009

10. Amend Chapter 450B of the NRS to**:**

    a. Remove all references to "advanced emergency medical technician" (currently defined at NRS 450B.025) in the NRS and change the term to "paramedic."

    b. Remove all references to "intermediate emergency medical technician" (currently defined at NRS 450B.085) in the NRS and change to "advanced emergency medical technician." **(BDR 40–501)**

## UNLICENSED HEALTH CARE IN NEVADA

11. Amend the NRS to provide consistent practices, and authority to address the unlicensed practice of health care and related issues to the following health care professional licensing boards: Board of Examiners for Audiology and Speech Pathology (NRS 637B.100); Chiropractic Physicians' Board of Nevada (NRS 634.020); State Board of Cosmetology (NRS 644.030); Board of Dental Examiners of Nevada (NRS 631.120); Board of Hearing Aid Specialists (NRS 637A.030); Board of Examiners for Long-Term Care Administrators (NRS 654.050); Board of Homeopathic Medical Examiners (NRS 630A.100); Board of Medical Examiners (NRS 630.003); State Board of Nursing (NRS 632.020); Board of Occupational Therapy (NRS 640A.080); Board of Dispensing Opticians (NRS 637.030); Nevada State Board of Optometry (NRS 636.030); State Board of Oriental Medicine (NRS 634A.030); State Board of Osteopathic Medicine (NRS 633.181); State Board of Pharmacy (NRS 639.020); State Board of Physical Therapy Examiners (NRS 640.030); and State Board of Podiatry (NRS 635.020).

    a. Specifically:

        (1) Make unlicensed practice a category D felony;

        (2) Authorize each board to cite and fine any unlicensed person who performs an act that requires a license or represents themself to be licensed;

        (3) Authorize each board to seek an injunction from the district court prohibiting unlawful conduct;

        (4) Authorize each board to write and enforce a cease and desist letter;

(5) Authorize each board to enter any premises where a licensed person practices the profession or where an unlicensed person performs activities that require licensure; and

(6) Authorize each board to investigate based on an anonymous complaint unless the lack of identity of the complainant would make processing the complaint impossible or unfair to the subject of the complaint.

b. Amend NRS 179.121 to include the felony for unlicensed practice, in each chapter referenced, as a crime for which all personal property used in the crime is subject to forfeiture. **(BDR 54–502)**

12. Amend the chapters for each board referenced in Recommendation No. 11 to:

a. Require each board to refer all substantiated violations to the proper entity for prosecution and to take all lawful and necessary actions to discontinue the unlawful practice; and

b. Allow each board to combine resources and work collaboratively with any other listed board to investigate unlicensed practice. **(BDR 54–502 and BDR 54–503)**

13. Amend Chapter 200, "Crimes Against the Person," of the NRS to:

a. Provide that the performance of a health care procedure without a license that results in:

(1) Substantial bodily harm is a category C felony for the first offense and a category B felony for a subsequent offense.

(2) Death is a category B felony and the sentence not be suspended nor probation granted.

b. Provide that the performance of a surgical procedure without a license that results in:

(1) No substantial bodily harm is a category C felony for the first offense and a category B felony for a subsequent offense.

(2) Substantial bodily harm is a category B felony.

(3) Death is a category B felony and the sentence may not be suspended nor probation granted.

c. Ensure that a person who is legally authorized to perform a health care procedure without a license is not subject to these offenses for performing any procedure that they are legally authorized to perform. **(BDR 15–504)**

## PROPOSALS RELATING TO CHILDREN IN THE CARE OF CERTAIN GOVERNMENTAL ENTITIES

14. Amend Chapter 432B, "Protection of Children From Abuse and Neglect," of the NRS to:

a. Require each agency which provides child welfare services to:

(1) Collect certain information concerning the actions of persons legally responsible (PLRs) for the psychiatric care of a child, including data on the number of medical evaluations attended by the PLR, the number of medications approved or denied by the PLR, and the number of second opinions requested by the PLR; and

(2) Provide the information collected to the Division of Child and Family Services (DCFS) of the DHHS.

b. Require the DCFS to:

(1) Submit a report annually to the LCHC containing the information gathered in Item 14a;

(2) Adopt regulations establishing a limit on the number of children for whom a person may be nominated as a person legally responsible for psychiatric care;

(3) Establish a standardized training curriculum that must be completed by a person before they may be nominated as a person legally responsible for the psychiatric care of a child and must be provided online; and

(4) Ensure that children in foster care receive age-appropriate information about any psychotropic medication that they are prescribed before they begin taking the medication. The information must notify them about the risks and benefits of the medication, including any side effects of taking the medication, the potential impact of taking the medication on future employment, and any other issues related to the use of the psychotropic medication. If the child objects to the medication, the objection must be noted in the child's record with the Division. **(BDR 38–505)**

c. Amend Chapter 432B of the NRS to allow a child to be placed with fictive kin even if the record indicates that a previous instance of child abuse or neglect was

substantiated, if a case plan was established and subsequently completed. **(BDR 38–506)**

## PROPOSALS RELATING TO THE USE OF EPINEPHRINE AUTO-INJECTORS AT SCHOOLS IN NEVADA

15. Amend the NRS as follows:

    a. Provide authority for each public or private school or institution of higher education to:

        (1) Stock epinephrine auto-injectors for use in emergencies, regardless of whether the student has been previously diagnosed with an allergy;

        (2) Accept gifts, grants, and donations to stock epinephrine auto-injectors;

        (3) Provide food allergy training to food service workers and other school personnel and develop a comprehensive anaphylaxis action plan that enables students, teachers, and school employees to:

            i. Understand the risk of anaphylaxis;

            ii. Avoid their allergic triggers;

            iii. Recognize the signs and symptoms;

            iv. Be prepared with access to epinephrine auto-injectors (two doses); and

            v. Know to seek emergency medical care following administration of treatment.

    b. Authorize physicians to write a prescription for an epinephrine auto-injector for an entity, such as a school, in addition to a natural person.

    c. Allow a school nurse or any other trained school employee to administer an epinephrine auto-injector to a person at the school or a school function when the nurse or trained employee believes that the person is experiencing anaphylaxis.

    d. Extend Good Samaritan protections to schools, school nurses, and trained school employees who administer or allow the administration of an epinephrine auto-injector to a person when acting in good faith in an emergency. **(BDR –513)**

## PATIENT-CENTERED MEDICAL HOMES

16. Draft a resolution encouraging the DHHS and the Commissioner of Insurance to work with health care providers and insurers to:

    a. Develop a patient-centered medical home model of care; and

    b. Adopt payment models that allow for the implementation of this model of care. **(BDR R–507)**

# REPORT TO THE 77TH SESSION OF THE NEVADA LEGISLATURE BY THE LEGISLATIVE COMMITTEE ON HEALTH CARE

## I. INTRODUCTION

The Legislative Committee on Health Care (LCHC), in compliance with *Nevada Revised Statutes* (NRS) 439B.200 through 439B.240, oversees a broad spectrum of issues related to the quality, access, and cost of health care for all Nevadans. The LCHC was established in 1987 to provide continuous oversight of matters relating to health care.

The LCHC for the 2011–2012 Interim was composed of six members. The members of the LCHC were as follows:

Assemblywoman April Mastroluca, Chair
Senator Valerie Wiener, Vice Chair
Senator Shirley A. Breeden
Senator Joseph (Joe) P. Hardy, M.D.
Assemblywoman Maggie Carlton
Assemblyman Cresent Hardy

The following Legislative Counsel Bureau staff members provided support for the LCHC:

Marsheilah D. Lyons, Supervising Principal Research Analyst
Kirsten Coulombe, Senior Research Analyst
Roger McClellan, Health Care Policy Specialist
Lisa Gardner, Senior Research Secretary
Anne Vorderbruggen, Senior Research Secretary
Risa B. Lang, Chief Deputy Legislative Counsel
Asher Killian, Senior Deputy Legislative Counsel

The LCHC held a total of eight meetings, including a work session. All public hearings were conducted through simultaneous videoconferencing between legislative meeting rooms at the Grant Sawyer State Office Building in Las Vegas, Nevada, and the Legislative Building in Carson City, Nevada. The summaries of testimony and exhibits are available online at: http://www.leg.state.nv.us/Interim/76th2011/Committee/StatCom/HealthCare/?ID=11.

## II. REVIEW OF COMMITTEE FUNCTIONS

The primary responsibilities of the LCHC include: (a) reviewing and evaluating the quality and effectiveness of programs for the prevention of illness; (b) reviewing and comparing the costs of medical care among communities in Nevada with similar communities in other states; and (c) analyzing the overall system of medical care in the State. In addition, members strive to promote a health care system that avoids duplication of services and achieves the most efficient use of all available resources. The LCHC may also review health insurance issues, as

well as examine hospital-related issues, medical malpractice issues, and the health education system.

Further, certain entities are required by statute to submit reports to the LCHC, including:

- A report of the activities and operations of the Division of Health Care Financing and Policy, Department of Health and Human Services (DHHS), concerning the review of health care costs. The report must be submitted on or before October 1 of each year as required by NRS 449.520.

- An annual report concerning the review of the health and health needs of the residents of this State and a system to rank the health problems of the residents of this State, including, without limitation, the specific health problems that are endemic to urban and rural communities, and the allocations of money from the Fund for a Healthy Nevada pursuant to NRS 439.630 to determine whether the allocations reflect the needs of this State and the residents of this State.

- A quarterly report, as required by NRS 450B.795, from the State Board of Health regarding its findings in the study concerning the cause of excessive waiting time for a person to receive emergency services and care from a hospital after being transported to the hospital by a provider of emergency medical services.

## III. DISCUSSION OF TESTIMONY AND RECOMMENDATIONS FOR THE STATE OF NEVADA

A variety of issues were addressed at the meetings of the LCHC. This document constitutes a report of the Committee's activities during the 2011–2012 Interim, provides background information, and discusses only those issues for which the LCHC made recommendations. These issues relate to:

A. Children's mental health services in Nevada;

B. Nevada's Cancer Drug Donation Program;

C. Prescription drug abuse and the prescription drug monitoring program in Nevada;

D. Chapter 450B, "Emergency Medical Services," of the *Nevada Revised Statutes*;

E. Unlicensed health care in Nevada;

F. Children in the care of certain governmental entities;

G. The use of epinephrine auto-injectors at schools in Nevada; and

H. Patient-centered medical homes.

At the Committee's eighth meeting, the members conducted a work session at which they adopted 12 recommendations to be included in 9 bill draft requests (BDRs). The BDRs concern: (1) the Cancer Drug Donation Program; (2) emergency medical services personnel classifications; (3) health care professional licensing boards' authority to address unlicensed practice; (4) health care professional licensing boards' authority to combine resources and collaborate to address unlicensed practice; (5) criminal penalties for performing certain health care procedures without a license; (6) reporting requirements and revisions related to certain child welfare services and persons legally responsible; (7) guidelines for placement of certain children with fictive kin; (8) use of epinephrine auto-injectors in emergencies in public or private schools or institutions of higher education; and (9) developing a patient-centered medical home model of care. In addition, members authorized the Chair to send seven letters on behalf of the LCHC. Lastly, pursuant to Assembly Concurrent Resolution No. 10 (File No. 42, *Statutes of Nevada 2011*), the LCHC appointed a Task Force to Develop a State Plan to Address Alzheimer's Disease.

## A. CHILDREN'S MENTAL HEALTH SERVICES IN NEVADA

The LCHC heard testimony that the eligibility for Medicaid payment for mental health services for certain children was being threatened under a federal rule called the exclusion for institutions for mental disease (IMD). An IMD is defined as a facility with 17 or more beds, primarily to provide mental health services. Although the rule has been in place since 1965, the Centers for Medicare and Medicaid Services (CMS) recently began reviewing facilities that meet certain criteria for classification as an IMD in various states. The exclusion was meant to assure that infrastructure that had been funded primarily through state dollars for mental health hospitals would not be subsidized by federal dollars, and to ensure that community-based models would be utilized for services as opposed to the large mental health institutions that were in existence at the time the rule was implemented. According to testimony, the DHHS notified CMS that Nevada has over 400 children receiving services through Medicaid while living in facilities with more than 16 beds. The DHHS also shared its concern about the ability to find placements for the children if CMS orders the State to discontinue coverage. The LCHC heard testimony regarding the need to develop smaller facilities in the State and an overarching need to provide adequate funding and programming for the children's mental health system in Nevada.

In an effort to address the immediate challenge, the LCHC agreed to:

**Send a letter to Nevada's Congressional Delegation regarding access to care for certain children who have access to care through a variety of governmental entities such as Medicaid, child welfare, and juvenile justice. The letter will:**

**a. Inform the Delegation of the institution for mental disease (IMD) exclusion that disallows group homes of 16 beds or more from being reimbursed through Medicaid and the impact of this federal regulatory hindrance on Nevada. Specifically, this prohibition is not allowing medically necessary behavioral health**

**services to be reimbursed in a delivery model that is in the least restrictive, most normative setting for the child. The goal of the Division of Health Care Financing and Policy, Department of Health and Human Services (DHHS), is to develop funding models that are innovative and within the community setting.**

**b. Request that the Delegation advocate for the IMD exclusion regulation to be reconsidered by the Centers for Medicare and Medicaid Services (CMS) by considering the severity of the mental disease rather than the existence of a mental disease in combination with the bed count (i.e., 16 beds or more). This will place more emphasis on the acuity of the child instead of the facility.**

Because of these prohibitions in current federal regulation, these facilities have been mistaken for the more traditional higher level of care psychiatric hospitals and psychiatric residential treatment facilities.

The LCHC received testimony from the Children's Mental Health Consortia (NRS 433B.333), representing Washoe County, Clark County, and rural Nevada. The Consortia expressed concern for the implementation of the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act (referred to as the Affordable Care Act [ACA]). Specifically, the Consortia requested that they be included in the State's selection of an essential health benefits benchmark plan so that the needs of children with serious emotional disturbance are not overlooked. Essential health benefits are a set of health care service categories that must be covered by certain health plans pursuant to the ACA, beginning in 2014. In addition, the Consortia expressed an interest in ensuring that revisions to Medicaid also consider the unique needs of this population.

To convey these concerns and interests, the LCHC agreed to:

**Send a letter to the Director of the DHHS and the Executive Director of the Silver State Health Insurance Exchange. The letter will:**

**a. Encourage the development of a mechanism for Children's Mental Health Consortiums (NRS 433B.333) to provide input into State implementation of the federal health reform initiative to ensure that targeted case management and service delivery for children with serious emotional disturbance is provided with a family-driven, individualized, wraparound approach.**

**b. Request that the appropriate Director consider the viability of pursuing the following proposals, which were presented by the Children's Mental Health Consortiums:**

**(1) Include the following as essential health benefits to be covered for children with serious emotional disturbance under benchmark plans for Medicaid, health**

**insurance exchanges, and other plans: family-to-family support, mentoring, mental health consultation, mobile crisis intervention, and respite care.**

**(2) Build in reimbursement incentives for use of evidence-based practices in case management and direct services.**

**(3) Build family navigators into the essential benefits package to provide outreach and navigation to assist families of children with serious emotional disturbance in choosing the best benefits package.**

**(4) Develop a mechanism/legislation for reinvesting savings from health care reform's increased federal financial participation into community-based services.**

**(5) Submit to the CMS a Medicaid State plan amendment for review and approval to establish a 1915(i) Home and Community Based Services waiver, in an effort to increase the capacity of Medicaid mental health service providers to deliver in-home services and supports, and decrease the need for out-of-home care.**

## B. NEVADA'S CANCER DRUG DONATION PROGRAM

The 2009 Session of the Nevada Legislature enacted the Cancer Drug Donation Program (NRS 457.450). The program allows participating pharmacies to accept certain cancer medications used in the course of cancer treatment that were dispensed by a Nevada pharmacy. The drugs may be redispensed to Nevada residents who are currently being treated for cancer. Participation in the program is voluntary and any pharmacy that chooses to participate may elect to quit at any time. The medications accepted by the participating pharmacy can be redispensed to participating cancer patients who are Nevada residents and have, in conjunction with their physician, signed up to be a part of the program.

Testimony presented to the Committee recognized that very few pharmacies have elected to participate and a limited number of cancer patients have taken advantage of the program. Presenters indicated that a lack of funding limited the opportunities to educate physicians, pharmacies, other medical providers, and cancer patients about the program's availability.

The Committee was encouraged to consider revising the program by: expanding the types of drugs that could be donated to include therapeutic medications; authorizing dispensing practitioners to redispense donated drugs in addition to pharmacies; and establishing State-run pharmacies, rather than going through retail pharmacies.

Following deliberation on these recommendations, the Committee agreed to:

1. **Send a letter to the following medical and related groups: the Clark County Medical Society, the Washoe County Medical Society, the Nevada Nurses Association, the Nevada Osteopathic Medical Association, the Nevada State**

**Medical Association, the Nevada Pharmacist Association, the Nevada Society of Health-System Pharmacists, the Retail Association of Nevada, and other relevant groups. The letter will: (a) emphasize the Committee's strong support for the Cancer Drug Donation Program; (b) highlight the cost of prescriptions for the treatment of cancer and the availability of unused medication; and (c) encourage the groups to educate their members about the program in an effort to make them more knowledgeable and comfortable referring individuals who may benefit.**

2. **Amend NRS 457.460 to allow dispensing practitioners (physicians and osteopathic physicians) to dispense donated cancer drugs through the Cancer Drug Donation Program. (BDR 40–500)**

## C. PRESCRIPTION DRUG ABUSE AND THE PRESCRIPTION DRUG MONITORING PROGRAM IN NEVADA

In the midst of national concern over illicit drug use and abuse, prescription drug abuse has been identified as the fastest growing drug problem in the United States. Nearly all prescription drugs involved in overdoses are originally prescribed by a physician (rather than, for example, being stolen from pharmacies).[i]

The LCHC heard historical information related to the development of our current "drug culture" and the prevalence of prescription drug abuse at a national and local level. According to testimony, based on the amount of drugs consumed per 100,000 people, Nevada ranks nationally at number 2 for hydrocodone and oxycodone consumption, number 4 for methadone consumption, number 7 for codeine consumption, and number 17 for meperidine (Demerol). In 2008, Nevada pharmacies filled 26 million prescriptions for alprazolam (Xanax), with a total approximate population of 3 million.

According to testimony, to prevent the diversion of prescription drugs after the prescriptions are dispensed, many states across the nation implemented prescription drug monitoring programs (PDMPs). Nevada's PDMP was established in 1995 and is one of the oldest programs in the nation. Prescription drug monitoring programs maintain statewide electronic databases of prescriptions dispensed for controlled substances (i.e., prescription drugs of abuse that are subject to stricter government regulation). Information collected by PDMPs may be used to support access to and legitimate medical use of controlled substances; identify or prevent drug abuse and diversion; facilitate the identification of prescription drug-addicted individuals and enable intervention and treatment; outline drug use and abuse trends to inform public health initiatives; or educate individuals about prescription drug use, abuse, and diversion as well as about PDMPs. [ii]

The LCHC also heard testimony regarding the need to implement more environmentally responsible prescription drug disposal programs to help decrease the supply of unused prescription drugs in the home. The LCHC heard testimony regarding the impact of "direct-to-consumer (DTC) advertising." Direct-to-consumer advertising refers to any

marketing or advertising of prescription drugs that is targeted specifically to consumers, rather than to physicians, pharmacists, or other health professionals. For decades, prescription drug makers promoted their products exclusively to health care professionals, who were expected to interpret drug information for their patients. Beginning in the early 1990s, some drug manufacturers began targeting consumers due, in part, to the aging baby boomers and to an increase in the number of patients participating in their own health care decisions. Since then, DTC advertising has become a popular promotional tool.[iii] Health care providers and various advocacy groups have expressed concern about the impact of DTC advertising on the use and possibly abuse of prescription drugs.

Finally, representatives from law enforcement expressed concerns regarding statutes that address trafficking prescription medications. Specifically, the Committee heard appeals to:

- Authorize and possibly require the use of electronic prescribing of schedule II drugs to limit and better track prescription fraud;

- Encourage prosecution by increasing the penalty for selling prescription drugs so that the penalties more accurately match current penalties for the sale and trafficking of illicit drugs; and

- Consider the potency of the prescribed drug when establishing specific weight thresholds that determine the appropriate penalty.

After hearing testimony regarding these issues, the LCHC agreed to:

1. **Send a letter to Nevada's Congressional Delegation related to prescription drugs. The letter will: (a) emphasize the impact of prescription drug abuse, misuse, and diversion in Nevada; and (b) encourage the development of policies that recognize the impact of prescription drug advertising, promotion, and marketing to health care professionals and direct-to-consumer on excessive or unnecessary prescription drug use.**

2. **Include a statement in the Committee's final report: (a) emphasizing the Committee's support for the efforts of the Substance Abuse Working Group within the Office of the Attorney General (Assembly Bill 61 [Chapter 89, *Statutes of Nevada 2011*]) and the Prescription Controlled Substance Abuse Prevention Task Force; and (b) recognizing their accomplishments related to addressing substance abuse issues and challenges in the State of Nevada.**

3. **Send a letter to the DHHS encouraging collaboration with the United States Drug Enforcement Administration, Nevada Statewide Coalition Partnership, and other entities as appropriate, to provide for safe and available destruction and disposal of medications; including the creation of safe disposal sites in each county in Nevada.**

4. **Send a letter to the DHHS encouraging collaboration with the Nevada Statewide Coalition Partnership, and other entities, as appropriate, to develop consumer education related to prescription medications. The letter will encourage the development of:**

   a. **A media campaign that teaches consumers how to work with their health care professionals around prescription drugs, including how to store, keep, and use their prescriptions; and**

   b. **Training information for consumers on safe handling, storage, et cetera, along with education on potential for abuse and misuse.**

5. **Send a letter to the Chairs of the Senate Committee on Judiciary and the Assembly Committee on Judiciary forwarding the record concerning the LCHC discussion regarding penalties for trafficking prescription medications and request that the respective committees work with law enforcement and other interested parties to address concerns and penalties related to trafficking schedule III, IV, and V controlled substances.**

## D. CHAPTER 450B, "EMERGENCY MEDICAL SERVICES," OF THE *NEVADA REVISED STATUTES*

Testimony indicated that in February 2009, a reassessment of emergency medical services (EMS) in the State of Nevada was conducted. The first assessment was completed in 1991. In addition to other key findings, the reassessment pointed out that the nomenclature and titles of emergency medical service providers was inconsistent with the national standards. To address these inconsistencies and allow for continued reciprocity with other states, DHHS proposed A.B. 51 for consideration by the 2011 Legislature; however, the measure failed. Testimony from the session indicates that additional time was needed to address the industry's concerns prior to implementing changes. At the direction of the Committee, DHHS worked during the interim to address many of the stated concerns and to develop a proposal with input from a broad spectrum of interested parties.

Recognizing the importance of establishing national standards and reciprocity, the Committee approved the following action:

**Amend Chapter 450B of the NRS to:**

a. **Remove all references to "advanced emergency medical technician" (currently defined at NRS 450B.025) in the NRS and change the term to "paramedic."**

b. **Remove all references to "intermediate emergency medical technician" (currently defined at NRS 450B.085) in the NRS and change to "advanced emergency medical technician." (BDR 40–501)**

## E. UNLICENSED HEALTH CARE IN NEVADA

Representatives of DHHS testified that Nevada has seen a sharp rise in services provided by unlicensed people. During testimony, specific examples were provided of situations where people became ill or died as a result of procedures being performed by unlicensed people with no sterile practices and using equipment illegal in the United States. The Health Division, DHHS, and the Office of the Attorney General, with key stakeholders and community members, created a task force to produce a strategic plan and an action plan to increase enforcement and awareness of the problem of unlicensed health care providers. In Nevada, a significant number of illegal surgeries, other unlicensed health care, and incident reports, including death, occur primarily in the Hispanic community. Therefore, education in the Hispanic community would be the initial focus of the action plan. The plan titled "Responding to Unlicensed Health Care in Nevada: A Plan for Action" was presented to the Committee and is available at the Office of the Attorney General's website at: http://ag.state.nv.us/issue/unlicensed/ActionPlanFinal.pdf.

A representative from the Office of the Attorney General indicated that various criminal justice agencies across the State collaborated to review ways to improve the criminal justice system's response to unlicensed health care, including developing better lines of communication between the various State and local agencies that may have jurisdiction over unlicensed activity. A recommendation from the Office of the Attorney General was presented to stiffen criminal penalties when unlicensed activity results in serious injury or death.

Through testimony, the Committee learned that each health care professional licensing board has a statute that addresses unlawful acts and provides a penalty. However, the penalties for unlicensed practice varies, ranging from a category D felony, a gross misdemeanor, or a misdemeanor. In addition, nothing in the criminal statutes specifically addresses a situation that results from a botched procedure by someone who is unlicensed. Further testimony indicated that the authority to pursue someone who is unlicensed varies among the health care professional licensing boards. The Committee was encouraged to consider the creation of a new criminal statute with criminal penalties and to provide the health care licensing boards with consistent authority to investigate and pursue the prosecution of someone who has been reported to them as operating or performing medical procedures without a license.

The Committee received seven recommendations contained in a letter jointly submitted by the State Board of Cosmetology, Board of Dental Examiners of Nevada, Board of Medical Examiners, State Board of Nursing, State Board of Osteopathic Medicine, and State Board of Pharmacy. Following are the seven recommendations:

1. The unlicensed practice of the health care professions should be considered a category D felony, and law enforcement agencies should be given the authority to seize the property, drugs, and assets used in the crime for purposes of forfeiture.

2. Med spas or similar entities should be required to be licensed through the Health Division if dangerous drugs or controlled substances are present.

3. Each board should have the authority to cite and fine those who represent themselves as licensed practitioners when they are not duly licensed or perform acts that require them to be licensed.

4. Each board should have the authority to seek from the district court an injunction prohibiting unlawful conduct.

5. Each board should have the authority to write and enforce a cease and desist letter.

6. Each board should have the authority to enter the premises where an individual licensed by that board is practicing.

7. Each board should have the authority to investigate based on an anonymous complaint.

After holding multiple hearings on the topic and receiving input from a variety of interested parties, including health care professional licensing boards, health care professional associations, advocates, law enforcement, and prosecutors, the Committee agreed to:

1. **Amend the NRS to provide consistent practices, and authority to address the unlicensed practice of health care and related issues to the following health care professional licensing boards: Board of Examiners for Audiology and Speech Pathology (NRS 637B.100); Chiropractic Physicians' Board of Nevada (NRS 634.020); State Board of Cosmetology (NRS 644.030); Board of Dental Examiners of Nevada (NRS 631.120); Board of Hearing Aid Specialists (NRS 637A.030); Board of Examiners for Long-Term Care Administrators (NRS 654.050); Board of Homeopathic Medical Examiners (NRS 630A.100); Board of Medical Examiners (NRS 630.003); State Board of Nursing (NRS 632.020); Board of Occupational Therapy (NRS 640A.080); Board of Dispensing Opticians (NRS 637.030); Nevada State Board of Optometry (NRS 636.030); State Board of Oriental Medicine (NRS 634A.030); State Board of Osteopathic Medicine (NRS 633.181); State Board of Pharmacy (NRS 639.020); State Board of Physical Therapy Examiners (NRS 640.030); and State Board of Podiatry (NRS 635.020).**

    a. **Specifically:**

        (1) **Make unlicensed practice a category D felony;**

        (2) **Authorize each board to cite and fine any unlicensed person who performs an act that requires a license or represents themself to be licensed;**

**(3) Authorize each board to seek an injunction from the district court prohibiting unlawful conduct;**

**(4) Authorize each board to write and enforce a cease and desist letter;**

**(5) Authorize each board to enter any premises where a licensed person practices the profession or where an unlicensed person performs activities that require licensure; and**

**(6) Authorize each board to investigate based on an anonymous complaint unless the lack of identity of the complainant would make processing the complaint impossible or unfair to the subject of the complaint.**

**2. Amend NRS 179.121 to include the felony for unlicensed practice, in each chapter referenced, as a crime for which all personal property used in the crime is subject to forfeiture. (BDR 54–502)**

**3. Amend the chapters for each board referenced in No. 1 to:**

**a. Require each board to refer all substantiated violations to the proper entity for prosecution and to take all lawful and necessary actions to discontinue the unlawful practice; and**

**b. Allow each board to combine resources and work collaboratively with any other listed board to investigate unlicensed practice. (BDR 54–502 and BDR 54–503)**

**4. Amend Chapter 200, "Crimes Against the Person," of the NRS to:**

**a. Provide that the performance of a health care procedure without a license that results in:**

**(1) Substantial bodily harm is a category C felony for the first offense and a category B felony for a subsequent offense.**

**(2) Death is a category B felony and the sentence not be suspended nor probation granted.**

**b. Provide that the performance of a surgical procedure without a license that results in:**

**(1) No substantial bodily harm is a category C felony for the first offense and a category B felony for a subsequent offense.**

**(2) Substantial bodily harm is a category B felony.**

**(3) Death is a category B felony and the sentence may not be suspended nor probation granted.**

**c. Ensure that a person who is legally authorized to perform a health care procedure without a license is not subject to these offenses for performing any procedure that they are legally authorized to perform. (BDR 15–504)**

## F. CHILDREN IN THE CARE OF CERTAIN GOVERNMENTAL ENTITIES

The Committee heard testimony regarding children's mental health services in Nevada. A variety of information was provided, including:

- The definition of children's mental health (behavioral health) in Nevada;
- The oversight of children's mental health in Nevada;
- The Commission on Mental Health and Developmental Services;
- Mental health consortiums in Clark and Washoe Counties and rural Nevada;
- Community stakeholders involved in children's mental health;
- Funding sources for children's mental health;
- Children's mental health providers in Nevada;
- The number of children served in Fiscal Year 2011;
- Early childhood mental health;
- Children's clinical services outpatient services;
- Wraparound services in Nevada;
- Outpatient psychiatric services;
- Treatment homes;
- The most common identified problems at admission;
- The ages and custody status of the children served; and
- The survey results of the children and families who received the services.

Advocates expressed concerns with the quality of mental health services being received by children in foster care. The following concerns were specified before the Committee and shared in writing with the DHHS:

1. Overuse and inappropriate use of psychotropic medications;

2. Concerns about a haphazard and failed system of record keeping;

3. A lack of quality community-based mental health services and appropriate community-based placements for children with emotional disturbances;

4. Overreliance on residential treatment centers;

5. Substandard treatment at State facilities;

6. Higher level of care homes that seem more interested in billing for children in their care rather than ensuring that they achieve permanency; and

7. A dysfunctional system with a large number of participants that appear to be interested in profiting from services to children.

Advocates called attention to Senate Bill 371 (Chapter 444, *Statutes of Nevada 2011*), which was intended to make a person legally responsible for: understanding the medications that are given to children; making sure informed consent is provided; and ensuring that the adverse effects are recognized and dealt with. Testimony indicated that since the implementation of S.B. 371, several challenges have arisen that may need further revision. Examples were provided of instances in which a limited number of staff were required to fill the role of a person legally responsible (PLR), because some children do not have parents or anyone legally close to them to become the PLR. The PLRs are required to attend the initial evaluations for their clients, as well as the monthly reviews, which is an almost impossible task for the PLRs with a large number of clients.

Recommendations were presented to improve the role of the persons legally responsible by reviewing relevant data related to PLRs, providing consistent quality training, and setting up certain parameters. In addition, emphasis was placed on rethinking options for placement of children in large facilities by expanding the opportunities for children to be placed with fictive kin and family members who may have minor flaws or blemishes.

After holding multiple hearings on this topic, the Committee agreed to:

**Amend Chapter 432B, "Protection of Children From Abuse and Neglect," of the NRS to:**

**a. Require each agency which provides child welfare services to:**

**(1) Collect certain information concerning the actions of persons legally responsible (PLRs) for the psychiatric care of a child, including data on the number of medical evaluations attended by the PLR, the number of medications approved or denied by the PLR, and the number of second opinions requested by the PLR; and**

**(2) Provide the information collected to the Division of Child and Family Services (DCFS) of the DHHS.**

**b. Require the DCFS to:**

**(1) Submit a report annually to the LCHC containing the information gathered in Item a;**

**(2) Adopt regulations establishing a limit on the number of children for whom a person may be nominated as a person legally responsible for psychiatric care;**

**(3) Establish a standardized training curriculum that must be completed by a person before they may be nominated as a person legally responsible for the psychiatric care of a child and must be provided online; and**

**(4) Ensure that children in foster care receive age-appropriate information about any psychotropic medication that they are prescribed before they begin taking the medication. The information must notify them about the risks and benefits of the medication, including any side effects of taking the medication, the potential impact of taking the medication on future employment, and any other issues related to the use of the psychotropic medication. If the child objects to the medication, the objection must be noted in the child's record with the Division. (BDR 38–505)**

**c. Amend Chapter 432B of the NRS to allow a child to be placed with fictive kin even if the record indicates that a previous instance of child abuse or neglect was substantiated, if a case plan was established and subsequently completed. (BDR 38–506)**

## G. THE USE OF EPINEPHRINE AUTO-INJECTORS AT SCHOOLS IN NEVADA

According to the American Academy of Pediatrics, about 1 in 25 school-age children have food allergies. With the prevalence of food allergies, also come the dangers of life-threatening allergic reactions, or anaphylaxis. The most common and immediate treatment for anaphylactic shock is epinephrine administered through an auto-injector. As it relates to students at school, current law in Nevada allows schools to give prescription medicines (including epinephrine) only when prescribed by a doctor, supplied by a parent, and listed on the student's medical plan. Epinephrine pens are not allowed to be stocked by schools for use by a child who may have an allergic reaction but does not have a diagnosis on record and, therefore, does not have a personally prescribed pen.

The Committee heard testimony regarding how other states have addressed the issue of anaphylactic emergencies in schools. The Committee was encouraged to request legislation

regarding emergency anaphylactic shock treatment at schools and that the measure include the following:

- That school nurses and other trained school personnel be authorized to administer an epinephrine auto-injector to an individual at school or at a school function when the nurse or designated, trained personnel believe that the individual is experiencing anaphylaxis.

- That school systems, school nurses, and trained personnel have Good Samaritan protection when acting in good faith in an emergency.

- That schools have authority to stock epinephrine auto-injectors for use in emergencies regardless of whether the student has been previously diagnosed.

- That physicians be given authority to write a prescription for an entity such as a school and not just for individuals.

- That schools make food allergy awareness training available to food service workers and other school personnel, if possible.

The Committee considered the percentage of children who experience anaphylaxis at school, the training that would be required, and the cost and shelf life of epinephrine auto-injectors. In addition, the Committee heard testimony from pharmaceutical representatives, school nurses, parent organizations, and school administration.

Following deliberations on the issue, the Committee agreed to amend the NRS as follows:

**a. Provide authority for each public or private school or institution of higher education to:**

**(1) Stock epinephrine auto-injectors for use in emergencies, regardless of whether the student has been previously diagnosed with an allergy;**

**(2) Accept gifts, grants, and donations to stock epinephrine auto-injectors;**

**(3) Provide food allergy training to food service workers and other school personnel and develop a comprehensive anaphylaxis action plan that enables students, teachers, and school employees to:**

**i. Understand the risk of anaphylaxis;**

**ii. Avoid their allergic triggers;**

**iii. Recognize the signs and symptoms;**

**iv. Be prepared with access to epinephrine auto-injectors (two doses); and**

**v. Know to seek emergency medical care following administration of treatment.**

**b. Authorize physicians to write a prescription for an epinephrine auto-injector for an entity, such as a school, in addition to a natural person.**

**c. Allow a school nurse or any other trained school employee to administer an epinephrine auto-injector to a person at the school or a school function when the nurse or trained employee believes that the person is experiencing anaphylaxis.**

**d. Extend Good Samaritan protections to schools, school nurses, and trained school employees who administer or allow the administration of an epinephrine auto-injector to a person when acting in good faith in an emergency. (BDR –513)**

## H. PATIENT-CENTERED MEDICAL HOMES

The Patient-Centered Medical Home (PCMH) is a health care setting that facilitates partnerships between individual patients and their personal physicians, and, when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchanges, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.[iv]

The Committee heard from several different PCMH health care systems. Witnesses noted that there are working models of PCMHs in 47 states and the first champions of change in those states were leaders in business who were looking for a better way to use their health care dollars to keep their work force healthy. Emphasis was placed on the benefit of a team-based concept, which allows the primary care physician to focus on the patient and tailor the care to the patient's particular needs. For example, the leading cause of death in the United States is coronary artery disease and four of the six cardiac risk factors are related to obesity. In a PCMH system, middle-level providers in the practice spend time educating, instructing, coaching, encouraging, and giving the patients the proper tools and resources necessary to reeducate a patient to adopt healthy behaviors and manage their illness. In addition, the electronic medical records system serves as an important element of the PCMH because it allows the physician to track and manage chronic diseases more precisely.

Presenters urged the Committee to recognize the value of a PCMH and to adopt the PCMH as the model to deliver better health care. The Committee was encouraged to: (1) adopt a functional definition of the PCMH; (2) authorize a State agency to lead a multistakeholder collaborative to guide Nevada's transformation to a PCMH; and (3) allow public and private payers to adopt a payment system that is more aligned with higher quality medical care that demonstrates improved patient health care outcomes.

To begin the establishment of a PCMH system in Nevada, the Committee agreed to:

**Draft a resolution encouraging the DHHS and the Commissioner of Insurance to work with health care providers and insurers to:**

**a. Develop a patient-centered medical home model of care; and**

**b. Adopt payment models that allow for the implementation of this model of care. (BDR R–507)**

## IV. LEGISLATIVE COMMITTEE ON HEALTH CARE'S TASK FORCE TO DEVELOP A STATE PLAN TO ADDRESS ALZHEIMER'S DISEASE

Assembly Concurrent Resolution No. 10 directed the Legislative Committee on Health Care to create a Task Force to develop a State Plan to address Alzheimer's disease and submit a report of the findings and plan developed by the Task Force and any recommendations for legislation to the 77th Session of the Legislature.

The Committee appointed the following members to the Task Force:

- Senator Valerie Wiener, Chair
- Charles Bernick, M.D., Associate Medical Director, Cleveland Clinic Lou Ruvo Center for Brain Health
- Albert Chavez, Ed.S., CFLE, Regional Director, Southern Nevada Region, Desert Southwest Chapter, Alzheimer's Association
- Virginia (Gini) L. Cunningham, M.Ed., Volunteer and Support Group Facilitator, Humboldt Volunteer Hospice and Alzheimer's Association in Northern Nevada
- Ruth Gay, M.S., Director, Public Policy and Advocacy, East Bay Office Site Director, Northern California and Northern Nevada Chapter, Alzheimer's Association
- Sandra Owens, L.C.S.W., Ph.D., Associate Professor, School of Social Work, University of Nevada, Las Vegas
- Wendy Simons, Chief, Bureau of Health Care Quality and Compliance, Department of Health and Human Services

In addition, each Task Force member designated two people who could serve as an alternate if the member was not able to attend a meeting. The names of the alternates are available on the Task Force's webpage at: http://www.leg.state.nv.us/Interim/76th2011/Committee/StatCom/Alzheimers/?ID=73.

Experts in medicine, nursing, psychology, public policy, social work, and related disciplines were called to provide testimony. The Task Force gathered information about existing services and gaps and made recommendations for the State Plan.

Three working groups were created to meet and provide input in the following areas: (1) Access to Services; (2) Quality of Care and Regulation; and (3) Impact on the State, Safety, and Independence.

The Task Force met five times between June and October 2012. All public hearings were conducted through simultaneous videoconferences between legislative meeting rooms at the Grant Sawyer State Office Building and the Legislative Building. In addition, each meeting provided time for public comment. Caregivers, educators, health care professionals, working groups, and other members of the public provided input and recommendations to the Task Force for consideration. At the fourth meeting, members adopted several recommendations and goals for inclusion in the State Plan. At the fifth meeting, members conducted a work session in which they adopted the State Plan and recommendations for legislation.

In collaboration with the Chair for the Assembly Committee on Health and Human Services and the Chair for the Senate Committee on Health and Human Services, the Task Force requested the following bill draft requests:

**BDR 40–546** **Assembly Committee on Health and Human Services**
Creates the Task Force on Alzheimer's Disease in the Department of Health and Human Services.

**BDR 54–549** **Senate Committee on Health and Human Services**
Makes changes related to advanced practitioners of nursing.

**BDR 40–550** **Senate Committee on Health and Human Services**
Revises provisions related to eligibility for services for persons with Alzheimer's disease.

The State Plan and the Summary Minutes and related exhibits for each Task Force meeting are available on the Task Force's webpage, at the address listed above.

## V. CONCLUSION

This report presents a summary of the bill drafts requested by the LCHC members for discussion before the 2013 Nevada Legislature. In addition, this document provides information identifying certain other issues that were addressed during the 2011–2012 Interim. Persons wishing to have information that is more specific concerning these issues may find it useful to review the Summary Minutes and related exhibits for each LCHC meeting at: http://www.leg.state.nv.us/Interim/76th2011/Committee/StatCom/HealthCare/?ID=11.

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[i] Kristin M. Finklea, Erin Bagalman, Lisa N. Sacco. *Prescription Drug Monitoring Programs*, Congressional Research Services, July 10, 2012.

[ii] Kristin M. Finklea, Erin Bagalman, Lisa N. Sacco. *Prescription Drug Monitoring Programs*, Congressional Research Services, July 10, 2012.

[iii] "The Impact of Direct-to-Consumer Advertising," U.S. Food and Drug Administration, U.S. Department of Health and Human Services, August, 19, 2011.

[iv] http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx

## VI. APPENDICES

## APPENDIX A

*Nevada Revised Statutes* 439B.200

**NRS 439B.200 Creation; appointment of and restrictions on members; officers; terms of members; vacancies; annual reports.**

1. There is hereby established a Legislative Committee on Health Care consisting of three members of the Senate and three members of the Assembly, appointed by the Legislative Commission. The members must be appointed with appropriate regard for their experience with and knowledge of matters relating to health care.
2. No member of the Committee may:
   (a) Have a financial interest in a health facility in this State;
   (b) Be a member of a board of directors or trustees of a health facility in this State;
   (c) Hold a position with a health facility in this State in which the Legislator exercises control over any policies established for the health facility; or
   (d) Receive a salary or other compensation from a health facility in this State.
3. The provisions of subsection 2 do not:
   (a) Prohibit a member of the Committee from selling goods which are not unique to the provision of health care to a health facility if the member primarily sells such goods to persons who are not involved in the provision of health care.
   (b) Prohibit a member of the Legislature from serving as a member of the Committee if:
      (1) The financial interest, membership on the board of directors or trustees, position held with the health facility or salary or other compensation received would not materially affect the independence of judgment of a reasonable person; and
      (2) Serving on the Committee would not materially affect any financial interest the member has in a health facility in a manner greater than that accruing to any other person who has a similar interest.

4. The Legislative Commission shall review and approve the budget and work program for the Committee and any changes to the budget or work program. The Legislative Commission shall select the Chair and Vice Chair of the Committee from among the members of the Committee. Each such officer shall hold office for a term of 2 years commencing on July 1 of each odd-numbered year. The office of the Chair of the Committee must alternate each biennium between the houses of the Legislature.

5. Any member of the Committee who does not become a candidate for reelection or who is defeated for reelection continues to serve after the general election until the next regular or special session of the Legislature convenes.

6. Vacancies on the Committee must be filled in the same manner as original appointments.

7. The Committee shall report annually to the Legislative Commission concerning its activities and any recommendations.

(Added to NRS by 1987, 863; A 1989, 1841; 1991, 2333; 1993, 2590; 2009, 1154, 1568)

## APPENDIX B

Status of Bill Draft Requests From the 2009–2010 Interim

# STATUS OF BILL DRAFT REQUESTS
# FROM THE 2009-2010 INTERIM

| BDR | Summary | Bill | Status |
|---|---|---|---|
| 34-188 | Establishes a statewide school wellness policy. | A.B. 547 | Failed |
| 40-189 | Prescribes provisions relating to medical assistants. | S.B. 388 | Failed |
| 40-190 | Revises provisions relating to controlled substances. | S.B. 114 | Chapter 102, *Statutes of Nevada 2011* |
| 34-191 | Revises provisions relating to school nutrition programs. | A.B. 137 | Vetoed |
| 40-192 | Establishes provisions governing payment for provision of certain services and care and reports relating to those services and care. | S.B. 115 | Vetoed |
| 40-193 | Revises provisions relating to reports of sentinel events and related events. | S.B. 209 | Chapter 186, *Statutes of Nevada 2011* |
| 54-194 | Revises provisions governing licensure of certain physicians. | S.B. 117 | Chapter 199, *Statutes of Nevada 2011* |

## APPENDIX C

Suggested Legislation

**The following Bill Draft Requests will be available during the 2013 Legislative Session, or can be accessed after "Introduction" at the following website:** http://leg.state.nv.us/Session/77th2013/BDRList/page.cfm?showAll=1**.**

| | |
|---|---|
| BDR 40–500 | Allows physicians to dispense drugs donated for use in the Cancer Drug Donation Program. |
| BDR 40–501 | Revises provisions relating to certain providers of emergency medical services. |
| BDR 54–502 | Revises provisions governing the unlicensed practice of certain health-related professions. |
| BDR 54–503 | Revises provisions relating to enforcement authority of certain health-related licensing boards. |
| BDR 15–504 | Creates specific crimes for performing certain medical procedures without a license. |
| BDR 38–505 | Revises provisions concerning persons legally responsible for the psychiatric care of a child who is in the custody of an agency which provides child welfare services. |
| BDR 38–506 | Revises provisions relating to the placement of a foster child with fictive kin. |
| BDR R–507 | _CR: Encourages the Department of Health and Human Services and the Insurance Commissioner to work with health care providers and insurers to develop a patient-centered medical home model of care. |
| BDR –513 | Authorizes schools and institutions of higher education to obtain and administer epinephrine. |