MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-Fifth Session
May 6, 2009

The Committee on Health and Human Services was called to order by Chair Debbie Smith at 1:46 p.m. on Wednesday, May 6, 2009, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/75th2009/committees/. In addition, copies of the audio record may be purchased through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

COMMITTEE MEMBERS PRESENT:

Assemblywoman Debbie Smith, Chairwoman
Assemblywoman Peggy Pierce, Vice Chair
Assemblyman Ty Cobb
Assemblyman Mo Denis
Assemblyman John Hambrick
Assemblyman Joseph (Joe) P. Hardy
Assemblywoman Sheila Leslie
Assemblywoman April Mastroluca
Assemblywoman Bonnie Parnell
Assemblywoman Ellen B. Spiegel
Assemblyman Lynn D. Stewart

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Senator Shirley Breeden, Clark County Senatorial District No. 5
Senator Maggie Carlton, Clark County Senatorial District No. 2
Senator Mike McGinness, Central Nevada Senatorial District

Senator David Parks, Clark County Senatorial District No. 7
Senator Maurice Washington, Washoe County Senatorial District No. 2

STAFF MEMBERS PRESENT:

Amber Joiner, Committee Policy Analyst
Darlene Rubin, Committee Secretary
Olivia Lloyd, Committee Assistant

OTHERS PRESENT:

Mary Liveratti, Deputy Director, Programs, Department of Health and Human Services
Jan Crandy, Chair, Strategic Plan Accountability Committee, Department of Health and Human Services
Mary Walker, Minden, Nevada, representing the Carson City and Douglas County
Bob Crowell, Mayor, Carson City, Nevada
Nancy McDermott, Chair, Board of County Commissioners, Douglas County, Minden, Nevada
Bryan Gresh, representing Southern Nevada Health District, Las Vegas, Nevada
Lawrence Sands, D.O., Chief Health Officer, Southern Nevada Health District, Las Vegas, Nevada
Janine Hansen, President, Eagle Forum, Elko, Nevada
David Schuman, Chairman, Nevada Committee for Full Statehood, Minden, Nevada
Luana Ritch, Ph.D., Chief, Bureau of Health Statistics, Planning, and Emergency Response, Health Division, Department of Health and Human Services
Stacy Shaffer, Political Director, Service Employees International Union Nevada, Las Vegas, Nevada
Carl Heard, M.D., Chief Medical Officer, Nevada Health Centers, Inc., Las Vegas, Nevada
Lynn O'Mara, M.B.A., Health Planning Program Manager, Health Division, Department of Health and Human Services
Christine Roden, Manager, Primary Care Office, Health Division, Department of Health and Human Services
Lawrence Matheis, Executive Director, Nevada State Medical Association, Reno, Nevada
Bobbette Bond, M.P.H., Executive Director, Nevada Health Care Policy Group, North Las Vegas, Nevada, representing the Health Services Coalition, Las Vegas, Nevada

Marla McDade Williams, Chief, Bureau of Health Care Quality and Compliance Nonstatutory, Health Division, Department of Health and Human Services
Garrett Weir, representing HCA Sunrise Hospital, Las Vegas, Nevada
Robin Keith, representing Nevada Rural Hospital Partners Foundation, Reno, Nevada

Chairwoman Smith:
[Roll called. The Chair reminded Committee members, witnesses, and members of the audience of Committee rules and protocol.]

We have four bills that we are going to hear today and I am going to begin by opening the hearing on Senate Bill 79 (1st Reprint) regarding boards and commissions under the Department of Health and Human Services.

Senate Bill 79 (1st Reprint): Revises provisions governing various commissions, boards and committees relating to health. (BDR 38-327)

Mary Liveratti, Deputy Director, Programs, Department of Health and Human Services:
[Provided handout of outline of testimony (Exhibit C).]

This is an agency-requested bill. In the last year, we have had an opportunity to look at how we do business. The main intent of this bill is to streamline our systems and combine some boards to be more efficient.

What this bill does is consolidate certain boards, streamline the appointment process, improve coordination, and enhance communication among boards. The three main areas that we are dealing with are: our Office of Disability Services, health boards and committees, and the Commission on Mental Health and Developmental Services. We currently have 55 boards and commissions under our Department. That was part of the impetus for us to go forward with this.

First, the bill creates a new Commission on Services for Persons with Disabilities. Right now, our Office of Disability Services has eight different boards that they oversee, and that office is very small with only 20 people. We intend to create a new division, the Division of Aging and Disability Services. Our Aging Services Division already has a Commission on Aging Services. We would like to create this Commission on Services for Persons with Disabilities that would parallel the current Commission on Aging Services, and then this bill would incorporate three existing boards into subcommittees under this new Commission. Those three subcommittees would be the Subcommittee on Communication Services for Persons who are Deaf or Hard of Hearing and

Persons with Speech Disabilities, Subcommittee on Personal Assistance for Persons with Severe Functional Disabilities, and Subcommittee on Traumatic Brain Injuries. We would also, under this Commission, incorporate the Strategic Plan for Persons with Disabilities Accountability Committee, which is actually appointed by an executive order, but they would be meshed in with this new Commission so that there would be better coordination between all of the groups working on disability services.

The second major part of the bill is changing the appointment process for a number of health committees from the Governor to the State Board of Health. It is our hope that by doing this the State Board of Health will facilitate better communication among these health committees, and have a more coordinated system. The boards that would be affected are the Advisory Committee to the Office of Minority Health, the Advisory Board on Maternal and Child Health, and the Committee on Emergency Medical Services. We are also proposing to do away with our Task Force on Prostate Cancer and the Task Force on Cervical Cancer because we have a more comprehensive cancer council that would take over those duties and responsibilities.

The third area is the responsibilities of the Commission on Mental Health and Development Services. Right now, under statute, we have three consortia for Children's Mental Health Services, located in the north, south, and rural areas. Every year they come up with recommendations for children's mental health services. In the bill, we propose they send their reports to our Commission on Mental Health and Developmental Services to facilitate better coordination.

We will be adding co-occurring disorders as an area of responsibility under our Commission on Mental Health and Developmental Services. We feel that is an area of their responsibility, but we would like to have it in statute along with mental health, mental retardation, and related disorders. We also have some enabling language under that Commission so they can create subcommittees as needed. Per our statutes, our commissions and boards have the ability to have subcommittees. We did get advice, not a legal opinion, that we probably do not need this, but Director Willden wanted to have that enabling language added to be consistent with the other statutes.

Assemblyman Stewart:
We are consolidating some and eliminating others? Are we going to reduce the number of employees?

Mary Liveratti:
No. We are not reducing any employees. It is mainly just streamlining. Part of the problem with 55 boards and commissions is that we do not have staff assigned to the commissions. There are no full-time equivalency (FTE) position numbers that come with them, so we absorb them every time new boards and commissions are added. By streamlining, we are hoping to be more efficient with the FTEs that we have.

Assemblyman Stewart:
So, you will be able to do more with what you have.

Mary Liveratti:
Right.

Chairwoman Smith:
There is no fiscal note, right?

Mary Liveratti:
There is no fiscal note. We have trouble staffing all of these boards and commissions and that is a consideration. Every time there is a board or commission meeting, it creates more work for us to support the board and enable them to do the important work that they need to do. Sometimes we obtain grants and use that money to contract for services to help with minutes and travel logistics for the board members. In the last year, we have taken a hard look at our workforce. Between vacancies and state problems, this was an area that we spent a lot of time on and felt it would be an improved process that would enhance communication between our boards and our divisions.

Chairwoman Smith:
Our members have expressed concern when other bills have come before us that create another job for you. I would like to see the system streamlined and more efficient and effective for the staff.

Assemblyman Hambrick:
I am more visual than conceptual, so, would it be possible for the Department to give us today's organizational chart and what the organizational chart would look like should the legislation pass? I think it would help all of us to understand.

Mary Liveratti:
I would be happy to provide that.

Assemblyman Hambrick:
I would like to see what you want to do.

Chairwoman Smith:
That is a good idea.

Jan Crandy, Chair, Strategic Plan Accountability Committee, Department of Health and Human Services:
Our Committee supports this bill. Some of the members are open to transitioning onto the Commission, and we will do whatever we can. We will be dissolving, and some members will become part of the Commission.

Chairwoman Smith:
I will close the hearing on S.B. 79 (R1).

We will now open the hearing on Senate Bill 278 (1st Reprint). This is Senator McGinness's bill, which requires the Legislative Committee on Health Care to study certain issues concerning the provision of public health. Senator McGinness has indicated that Mary Walker will present the bill.

Senate Bill 278 (1st Reprint): Requiring the Legislative Committee on Health Care to study certain issues concerning the provision of public health. (BDR S-1061)

Mary Walker, Minden, Nevada, representing the Carson City and Douglas County:
With me today are Carson City's Mayor, Bob Crowell, and the Douglas County Board of Commissioners' Chairwoman, Nancy McDermott, and they will explain the bill.

Bob Crowell, Mayor, Carson City, Nevada:
The original Senate Bill 278 was requested by both Carson City and Douglas County, and they unanimously supported it. We still support S.B. 278 (R1) as amended. The original bill would have created legislation to allow for the creation of regional health districts by counties that are adjoining. Carson City and Douglas County are interested in forming regional public health services. The bill discusses both public health services and mental health services.

The Senate believed it was a wise policy to look at provisions of regional health, but they had concerns about the funding and some of the services that we were talking about. We were asking that state-provided services be transferred down to the local jurisdictions for provision by the regional health district. For that reason, they asked that this be studied further through the standing Committee on Health Care during the interim. We fully support doing that. We have been advised, even though there was a fiscal note on the original bill, that there is no fiscal note associated with it at this juncture because it goes to the standing Legislative Committee on Health Care. Both Carson City and Douglas County stand ready to provide technical assistance to the standing Legislative Committee in their deliberations should you see fit to pass this legislation.

Carson City, as many of you know, already has a health district that is operating well, yet we are still interested in looking further at the rendition of public health and mental health services in our area. We are particularly interested in engaging in regional cooperation with our neighboring counties so we can gain economies of scale for the provision of public health services between our counties. Carson City sees a lot of patients and citizens from the surrounding counties. We see them in our health services facilities and, unfortunately, we also see them in our justice facilities. If given the opportunity, we would like to work with the interim Legislative Committee on Health Care to determine what public health services we can provide more efficiently and effectively on a regional basis for the benefit of those needing those services.

Nancy McDermott, Chair, Board of County Commissioners, Douglas County, Minden, Nevada:

We believe that this legislation would enable the analysis and study of how to integrate public health and mental health services. A regional cooperation has great merit. The Department of Health and Human Services has worked with us and is supportive. We believe this is good policy. Forty-seven states integrate services regionally and there are only three states that centralize them: South Carolina, Alaska, and Nevada. We believe that most of the services for public health and mental health, et cetera, are delivered at the local level and not at the centralized state level.

We already have some examples of cooperation in a regional aspect with our Carson Water Subconservancy District that has been here for over 20 years now. We in the rurals work together because one county alone does not have the population numbers to allow us to do the things that Clark County and Washoe County are able to do. One of the things that the Department of Health has told us is that we cannot go for grants unless we are a regional health district. We do not have the numbers, so we may miss out on funding that

could come to our regional facility. We think that, in doing regional projects, we will be able to have an economy of scale and to deliver services that the state provides, but in a more economical and efficient manner to our citizens who need it. One of the serendipitous aspects of a regional health district, at least for Douglas County, is that we would like to require, in ordinance, denitrification systems for ensuring clean water. The problem is who will monitor it? The state is not able to do it, but we do not have a health district to provide that type of environmental service. That is just one of the things that could come out of this regional health district.

Mary Walker:
For the last year, we have worked with the Department of Health and Human Services. A couple of the things that we have discovered are: public health services in the United States—as far as we know—are all done by counties, not by the state. Currently, the State of Nevada provides public health services for 14 of the rural counties, while Carson City, Clark County, and Washoe County provide those services themselves. When you look at mental health, what we have discovered is that there are only three states in the United States—and this is coming from the federal Department of Health and Human Services' staff—where the state provides the clinical mental health services. However, it is very common that the state provides the mental health hospital services.

If the study moves forward, we believe it could be a pathway for a very efficient and effective service delivery system for rural Nevada regarding both public health and mental health services. What they do in other states is to integrate the public and mental health services so that it is a one-stop shop. If you have mental illness, frequently you also have physical problems. Under our current state system, patients go to the Health Division for physical problems, inoculations, and other health issues, then go somewhere else for mental health services. If you would combine services, you not only can have your community health nurse provide inoculations and other physical needs, but she could also provide the medication for mental health needs. People will not slip through the cracks like they do today.

Why are we looking at this? The major reason, as the Mayor and the Chairwoman have discussed, is that the Governor's budget cuts have started to affect mental health. Many people from rural Nevada have started to move to Carson City and Douglas County because the hospitals and services are here. Some of these people are ending up in our jails, in our juvenile facilities, in our justice system, and in our emergency rooms, so we are already paying for services for these people. However, when we pay for them in those facilities,

we are talking about several times the cost than if we were providing them clinical services.

Regarding this study, we think that it really is a good way to go. It may be new to Nevada, but there are 47 other states that provide services in that manner. I think there is a lot we can learn from them, and we offer our services to the interim Committee to do a lot of the legwork in cooperation with the Department of Health and Human Services. I think it could be a pathway to a new and much better service delivery system in rural Nevada.

Assemblywoman Parnell:
This is another example of what a shame it is that this bill could not go through in its original form because of the budget situation. The idea of regionalization makes providing services more efficient. One thing that is true in our state is that it allows you to address the needs of the people in your region. We know that the northeastern part of the state is very different from Clark County. Carson City and Douglas, Lyon, and Storey Counties are all different from Washoe County, and the people who live in those communities are the ones who understand these specific needs. So, while I support the bill as is, I think it is a shame that we could not give you the opportunity to try it.

Assemblyman Hambrick:
I am in agreement with my colleague from Carson City. I like this piece of legislation. Given the optimum time frame—I realize the report comes back to us next session—do you feel that the study could be completed and be referred to and reviewed by interim committees prior to the beginning of the 76th Session for potential tweaking? Then, when we come back into session, we could hit the ground running. Do you think that is possible?

Mary Walker:
Yes, I do, because we have been working on this for a year. We have already done a lot of the work regarding what the needs would be, what types of services we could potentially transfer, as well as looking at different states and what they do. There is a lot of work left to do, but we believe this is a very important step forward to serving our communities' needs.

Assemblyman Hambrick:
I concur.

Assemblyman Stewart:
Would this potentially save the state money since you would be able to apply for grants from the federal government? Have other areas of the state like the eastern counties expressed interest in this as well?

Mary Walker:
You will see in this legislation under section 31, subsection 1, paragraph (b), there were people from Clark County who were interested in having the same type of integrated health, mental health, and social services, so they are part of the bill as far as the study. It is a new concept to the other rural areas, and I think Carson and Douglas would potentially be a pilot program.

Regarding saving the state money, the other states that I have looked at take the federal grant dollars that go to the state, and the state dollars, and transfer them to the counties. The counties match the federal and state dollars to provide services. Where I see this really benefiting the state would be in 2011, since we are going to study this over the interim.

Putting the money back into rural mental health care would be a good example that you could use as a tax effort on a community-based level to match the state and federal dollars. We would basically take what is termed an anemic rural mental health budget and, instead of you trying to find the money to enhance those services, we would take the federal dollars and match it with our local dollars, and we would enhance services. That is what they do in other communities; it is a partnership.

As Chairwoman McDermott correctly stated, Carson and Douglas by themselves would not be eligible for certain federal grants because we do not have the population or the caseload numbers. But, if we consolidated and had a regional health district, that would give us the population and the caseload in the health problem areas to give us enough numbers to get more federal grants. I believe it is a very efficient and effective manner of providing those health services.

Chairwoman Smith:
Senator McGinness and Senator Washington are here as the sponsors of the bill and they are offering up an amendment.

Senator Mike McGinness, Central Nevada Senatorial District:
Obviously, the bill has changed. This is a good opportunity to take a look at it, and I support Senator Washington's amendment.

Senator Maurice Washington, Washoe County Senatorial District No. 2:
The bill as you see it now deals with two subjects: the integration of services provided by Clark County, and the formation and study of creating a rural regional health district. With that, some providers have come to me and asked if they might be able to amend the bill to include those who provide prevention

treatment for alcohol and substance abuse. In developing the regional concept, once again based on Mr. Hambrick's theme...

Chairwoman Smith:
If I may interrupt you for just a moment, I need to let the Committee members know that you all have the amendment (Exhibit D) at your desk.

Senator Washington:
...and assist the feasibility study within the Legislative Committee on Health Care, establishing regional centers that provide services for the prevention and treatment of alcohol and substance abuse. That is the entire amendment.

Chairwoman Smith:
That is pretty straightforward.

This is an area that we have to do something about. This will give us an opportunity to figure out what that something is.

Senator Washington:
We have done a number of things over the past years dealing with Child Protective Services to juvenile services, so this is just one step in the evolution of trying to decentralize some of the services that we provide for the state, and allow the regions to handle those services in a more comprehensive way.

Assemblyman Stewart:
Do we have anyone from Clark County who can comment on their part of this bill?

Senator David Parks, Clark County Senatorial District No. 7:
It is my understanding that portions of Senate Bill 322, introduced in the Senate Health and Education Committee, were merged into S.B. 278. Senate Bill 322 was requested to potentially help establish more efficient, effective, and client-focused service delivery. While the bill was not passed, a portion of the intent of the bill was added to Amendment 298 on S.B. 278 (R1). That part indicated a study of the feasibility of consolidating or integrating certain public health and social services provided in a county whose population was 400,000 or more. In the bill as you received it, section 31, subsection 1, paragraph (b) lists the 13 services that were intended to be part of an interim study.

Assemblyman Stewart:
Can you tell me how things are being done now in Clark County? Would they have to build a new facility or just bring people into the current facility for different services? Can you explain in more detail how that would work, please?

Senator Parks:
Currently in Clark County, there is the Southern Nevada Health District, as well as the Clark County Department of Social Services. They are across the street from each other. Senate Bill 322 was a by-request bill that I was asked to carry and submit. The hope was that, in these tough times, we would be able to better utilize services by looking at the integration of services to avoid any degree of duplication. The intent was to be family focused and community based.

Assemblyman Stewart:
So, some of the health offices would be moved into the welfare area, or vice versa?

Senator Parks:
The situation is that space is a rare commodity in both the Clark County Department of Social Services and the Southern Nevada Health District. The Health District has been in a building that should have been condemned some time ago. Efforts have been made by the Southern Nevada Health District to build a new facility on its existing site, as well as to expand their residential applications—which would be similar to what the Clark County Social Services Department is doing. They are decentralizing many of their services out into the community where the services are in demand.

Bryan Gresh, representing Southern Nevada Health District, Las Vegas, Nevada:
I will leave this to the Chief Health Officer of the District, Dr. Larry Sands, who can answer any of the Committee's questions.

Lawrence Sands, D.O., Chief Health Officer, Southern Nevada Health District, Las Vegas, Nevada:
The Southern Nevada Health District has a main building that is located centrally in what is considered the medical district in Las Vegas. It is by the University Medical Center, and is within convenient distance to the county government center and city and state offices. That central building is over 40 years old. For its age, it is very well maintained, but it was not designed for current technology and seismic standards. We have developed a space plan for a replacement facility, but that does not replace ongoing efforts to locate community public health centers to provide services. Much of that

depends on the availability of resources and the services provided within the health district, such as disease investigation, epidemiology, and many of our core public health promotion programs. The centers are largely administrative areas, so they can be located almost any where. They do not have a client service delivery end in many cases, but we do have things such as our community health nursing programs—such as immunizations—as well as providing health cards. We have pushed those services out into the community with other preventive health services that are client driven. We continually look for ways to get services delivered in the community, and opportunities to partner with other agencies that have facilities available for delivering services. We are always interested in exploring collaborations and partnerships that get services out to the people.

Chairwoman Smith:
I see that you signed in against the bill. Is that correct?

Lawrence Sands:
I signed in opposition to the provisions of the bill that would specifically impact counties whose population is 400,000 or more. I support what Carson City and Douglas County are trying to do. We have concerns about just that one provision that would impact our health district.

Assemblyman Stewart:
How are we going to consolidate, or integrate, the social services and the health services? Will this be possible with the limited building space we have now, or will this depend on the construction of a new facility near your present facility?

Lawrence Sands:
With or without consolidation, there is a tremendous need for new facilities for the Health District. It is not just physical consolidation, but it is programmatic consolidation that is being proposed. The mission of the public health services is much different from the mission of Social Services. Social Services are more one-on-one client focused, whereas public health services focus on community health and population-based services. The last part of the program integration would be more challenging because of the differences in the missions of the programs.

Assemblyman Hambrick:
I understand that we are looking at counties of 400,000 or more, but would Boulder City or the City of Henderson have any input? I believe Boulder City has a city hospital, but do you consider them part of the county health services program?

Lawrence Sands:
Part of the issue is that our mission as a public health agency is much different from the University Medical Center, where they are a health care delivery organization. They are there to provide care and treatment for people who are injured or sick. Our focus is on providing services that protect the health—and improve the health—of the whole community. We try to be there before the people are ill or injured. Each of the jurisdictions within the Clark County government, and all of the incorporated cities, are represented on the Southern Nevada District Board of Health. They all have input into public health policy.

Assemblywoman Mastroluca:
Was the fiscal note removed with the amendment?

Chairwoman Smith:
I believe that is what we heard in the testimony. Yes.

Janine Hansen, President, Eagle Forum, Elko, Nevada:
We testified against the original bill. I do not have a problem with the study or with the regional health districts. My concern is that when this study is done, it will be based on the original bill, which we had some issues with.

On page 2, lines 34 through 37 of the bill, it talks about the composition and authority of a health district, and the manner in which it may be financed. Those were the areas of concern in the original bill: it was a fundamental violation of our representative form of government. Nonelected and appointed people were raising taxes, above the tax cap and without a vote of the people. Assuming that this may be part of the study, we wanted to go on record and express our concerns about the way it might be financed.

Our other concern is that, in the original bill, if there is a health district made up of several counties, each county would have only one vote in raising taxes or making decisions. There would be no way for a taxpayer to object to what the health district was doing. They would not really be represented. My main concern is the fundamental violation of our representative form of government where nonelected people can raise our taxes.

Chairwoman Smith:
So your concerns are answered in the reprint, correct?

Janine Hansen:
Yes, those original concerns were taken care of in this, but our concerns continue because we anticipate that the original bill will be the basis of the study. They will probably look at some of those original concepts. We heard testimony from Mary Walker and others that they had already done a lot of work, and it resulted in that bill, so these same ideas will be coming forth in the study.

Chairwoman Smith:
So the good news for you would be that, in the study, you will have an opportunity to contribute and further testify.

Janine Hansen:
Right, so we want it on the record that we do not want this fundamental violation of our representative form of government, by having unelected people raising taxes.

David Schuman, Chairman, Nevada Committee for Full Statehood, Minden, Nevada:
I will start on line 36 of page 2, which says, "The manner in which such a health district may be financed." For the counties under 100,000, they should strongly consider financing the study's cost out of the state welfare budget, and not the county budget, since most of what I read in the original bill is of a welfare nature.

Going on, the original bill had one doctor and several non-doctors on each of these governing boards. You need to put as many doctors on the Board as those who are not doctors, since we are making medical decisions. Either that, or give the doctor a voting power equal to one more than all of the non-doctors on the Board.

Further, I see that they are specifically targeting senior citizens like me, but I have no desire for this. I strongly suggest that this study take a poll of people over 65 and ask them if they would rather have these boards and be taxed, or not have the boards and not get taxed. Universally, and without exception, when you combine government and medicine, you get a lower standard of medicine. During the interim, I strongly suggest that this Committee go to London for six months and see what mixing government and medicine does. How will the health boards keep the National Coordinator of Health Information Technology and his employees out of the health district facilities? The National Coordinator of Health Information Technology is a new position created by the federal government. The Coordinator will assign someone to visit with you and your doctor and sit there as you are treated and make

recommendations whether your doctor is correctly treating you according to his standards. He will ask if this is a wise expenditure of funds, particularly for people my age. When you reach a certain age, it is not worth it, even if you are paying the bill privately. It is an expenditure of national resources and we should let these old folks die. I have seen the bill that was passed with the stimulus bill.

Chairwoman Smith:
At this time, I am going to turn the gavel over to the Vice Chair.

Vice Chair Pierce:
Dr. Sands, would you like to begin, please?

Lawrence Sands:
I am here to testify in opposition to the provisions of S.B. 278 (R1) that would specifically impact counties whose population in about 400,000 or more. [Read from written testimony (Exhibit E).]

Assemblyman Hardy:
In the way of disclosure, I am on the Southern Nevada Health District, but on sabbatical. I was not there when this was discussed. Is the chair of the Southern Nevada Health District Board still former Assemblywoman Chris Giunchigliani and is she opposed to being put into this, as am I?

Lawrence Sands:
The consensus of the Board was to oppose this. Commissioner Giunchigliani was not part of that discussion when this issue was on the agenda.

Assemblyman Hardy:
Did that answer my question? I did not ask if it was voted on; I asked about a specific name and a specific stand.

Lawrence Sands:
She did support the original bill. I am not sure what her position is on the new bill.

Assemblyman Hardy:
For the record, I still have a problem, as Dr. Sands mentioned, while diluting the public health issues with this.

Vice Chair Pierce:
Was this voted on by the Board of the Southern Nevada Health District?

Lawrence Sands:
Yes. This was put on the agenda for discussion in one of our monthly Board of Health meetings. The vote of the members present at that time was unanimous to oppose the original bill.

Assemblywoman Parnell:
I want to know how important it is for you all to keep the "over 400,000" language in S.B. 278 (R1). Would someone respond to that, please?

Bob Crowell:
We are essentially neutral on anything over 400,000. Our interest is clearly under 100,000.

Luana Ritch, Ph.D., Chief, Bureau of Health Statistics, Planning, and Emergency Response, Health Division, Department of Health and Human Services:
The Health Division is neutral on this bill. We worked with the parties that were involved with looking at the option of health districts for our rural communities. As amended, it proposes a study of how best to provide public health services in Nevada. This is probably long overdue. In our history of providing population-based public health services in Nevada, we have over 110 years of organized public health services, but at present, we have health districts only in Clark County, Carson City, and Washoe County. That leaves approximately 12 to 13 percent of our state's population not covered by a locally or regionally controlled and directed public health agency. This does create a disparity.

In our rural counties, for the most part, we have appointed part-time health officers. Some of those health officers are extremely competent. I point to Dr. Titus in Lyon County as an example. In some of the counties, the county health officers are Health Division employees, community health nurses who are stationed in those counties. In some counties, it is a county employee with no public health knowledge who serves as that county's health officer. There is a lack of local control of services when you do not have regionalization or local county health districts. You do not have the ability to prioritize local services, your food, your water, your environmental health, disease control, or chronic disease prevention. You also do not have the ability to respond to novel public health threats that may suddenly emerge just in that region or community. It has to percolate up to the attention of the State Health Division in order to be addressed, prioritized, and have resources committed to it.

My experience over the last 13 days, particularly with the emergence of the novel H1N1 influenza virus, has convinced me more than ever that we need to look at how we are providing health services for this significant population. The Health Division is committed to providing support to that study in the interim

through our health planning programs, particularly to support the efforts of the interim Legislative Committee on Health Care.

Stacy Shaffer, Political Director, Service Employees International Union Nevada, Las Vegas, Nevada:
We represent nearly 18,000 health care workers and public sector workers in the state, and that includes the employees of the Southern Nevada Health District. We would like to go on record saying that we support S.B. 278 (R1). We were in support of the original bill, S.B. 322. For the record, our members are in support of this legislation.

Carl Heard, M.D., Chief Medical Officer, Nevada Health Centers, Inc., Las Vegas, Nevada:
I am here today to relate my strong support for S.B. 278 (R1). I spent five years as County Health Officer here in Carson City, and about ten years on the Mental Health Task Force. In fact, the Nevada Health Centers is pursuing the development of mental health services locally. Having a standing public health oriented dialogue here locally would be a great asset to this community and the region. It may provide lessons that could be acted upon in other rural communities in which we work. We are neutral on the position of the larger counties or Clark County.

Vice Chair Pierce:
I am closing the hearing on S.B. 278 (R1).

Next, we will open the hearing on Senate Bill 229 (1st Reprint), which establishes the Physician Visa Waiver Program in the Health Division of the Department of Health and Human Services.

Senate Bill 229 (1st Reprint): Establishes the Physician Visa Waiver Program in the Health Division of the Department of Health and Human Services. (BDR 40-368)

This bill is sponsored by Senator Carlton, but there will be a presentation first by the Health Division.

Lynn O'Mara, M.B.A., Health Planning Program Manager, Health Division, Department of Health and Human Services:
The Physician Visa Waiver Program came to public scrutiny in September 2007 with the *Las Vegas Sun*'s investigative report entitled "Indentured Doctors." At that time, the program was under the management and supervision of a different agency within the Health Division. After taking a look at where it

might be better placed, it was returned under the Bureau of Health Planning and Statistics, and Dr. Luana Ritch and I developed a corrective action plan.

One of the first steps since January of 2008 was to address the deficiencies that were identified in that series. You have in front of you a resource document (Exhibit F) that provides an update to information presented to the Legislative Committee on Health Care regarding the program, its deficiencies, and corrective actions. There is additional information to provide a more current status of the program as to what we have accomplished in the last year or so.

The J-1 Visa Waivers are issued to foreign-born physicians who are willing to serve in health-professional shortage areas. These are federally designated areas that the Primary Care Office works with the federal Department of Health and Human Services to get designated. We, as a nation, have a shortage of physicians, and in Nevada it is probably greater than every other state. These foreign-born physicians, who are here under J-1 Visas for their medical residencies or fellowships, usually decide they would like to stay in the United States and work toward permanent residency. One method for them to do that is to get a waiver that allows them to stay without having to go back to their home country for two years. In doing that, they agree to work in our underserved areas—those are designated in both rural and urban areas—and that includes Las Vegas. They agree to serve for three to five years and at the end of that period they are eligible for permanent residency. The federal government caps the waivers at 30 per state per federal fiscal year. Also, when an employer applies for a J-1 Visa Waiver for one of those physicians, they have to prove that it does not displace an American-born physician. That is prohibited by the program. [Written testimony was provided (Exhibit G), but not read.]

The role of the State Health Division in this program is merely administration and oversight. That is where one of the major deficiencies was. We were not doing the site visits that were required, and we were not monitoring what happened to the physicians after they received their J-1 Visas. Several actions that we have taken appear to be undertaken only in Nevada, and I am very proud that we are taking the lead on this. We are the only state to have a transparent process.

Senator Carlton, along with Larry Matheis, who is here today from the Nevada State Medical Association, and Dr. Carl Heard are part of the Health Division's Primary Care Advisory Council. That Council follows the open meeting law and through that we have been able to refine the process and be sure that the employers and the physicians are in compliance with the program. We have done our best to balance the rights and responsibilities of both sides to

achieve what I call a "triple win." It is a win for the employer, a win for the physician, and most importantly it is a win for the patients since they are getting access to care that they would not otherwise have.

We are also partnered with the State Board of Medical Examiners to streamline the process. One of the most critical improvements was getting these physicians, once they went through the process and got their waiver and license, to begin work within 60 days versus the original 150, and again, getting much needed access to primary care into those underserved communities. We are also working with the Division of Health Care Financing and Policy, both for compliance—we can monitor the Medicaid billing and services data to ensure that these physicians are seeing Medicaid patients as required—as well as ensuring they are in an underserved area. In addition, we are now starting to look at how we can use it to do needs assessments, so we will know what kind of physicians are needed by the state and target them for recruitment and retention. We do have a good retention rate in this state.

Borrowing from our sister agency of Health Care Quality and Compliance, we are issuing letters of deficiency when site visits are done and we find an employer not in compliance. They are required to give us a corrective action plan, and, if it is a critical issue, we will do follow-up visits as often as necessary and within budget.

Finally, balancing the rights and responsibilities of the employers and physicians helps to ensure that these physicians are not being abused. We know that we are not the only state experiencing these problems; however, other states seem to be hesitant about acknowledging them. In your packet (Exhibit F), you will have information that provides you with more detail about the program analysis that we did, as well as some additional information regarding health professional shortage areas, how they are designated, and other related information to the program.

Senator Maggie Carlton, Clark County Senatorial District No. 2:
I am a member of the Primary Care Advisory Council. When those articles hit the paper, and there was a flurry of them in southern Nevada, we were trying to figure out how to address these problems. In my other life working for the Great Basin Primary Care Association—and being one of the folks who deals with addressing the issues of the underserved and uninsured—I got very involved in this issue and participated with the Council both in the personality of my real life and the personality of my legislative life. What you have before you in this bill is the final endeavor without legislative action to address the problems and concerns that arose. We can only do so much without your permission, so I offered to bring a bill draft for the Council because I believe in

the things that they are trying to do and address when it comes to the J-1 Visa doctors. They are very valuable to the State of Nevada, especially to our underserved areas, and whatever we can do to address these concerns I have committed to help them address.

Assemblyman Hambrick:
I realize who administers the program, and I am familiar with that group, so have they been brought into this, and do they have their fingerprints on the program for oversight? I am talking about the U.S. Immigration and Customs Enforcement (ICE).

Lynn O'Mara:
We have finally been working with them and have gotten some good contacts. They have had some reorganization and, as a result of the study requested by Senators Reid and Conrad, they have been much more in touch with the states than they have been in the past. It is our understanding that they will be looking at their regulations, possibly as early as federal Fiscal Year 2010. We have pointed out some of the gray areas that have confused us, and they have assured us that they will be redoing their regulations. In Nevada, we hope to participate in that process.

Vice Chair Pierce:
The bill requires the adoption of regulations, but I do not see a fiscal note that was on some other bills that adopt regulations.

Lynn O'Mara:
That is because we were able to include those costs in our federal Health Resources and Service Administration (HRSA) Primary Care Office Grant. We are allowed to use some of those dollars for the funding of this program, which is largely an unfunded mandate. They permitted us to put some money in for that process.

Vice Chair Pierce:
What is that grant?

Lynn O'Mara:
It is the HRSA Primary Care Office Grant, which each state has.

Vice Chair Pierce:
Section 12 provides for penalties for a physician who violates the provisions of the program, and those will be provided for in regulation. Would one of the penalties be revoking the visa?

Lynn O'Mara:
The state does not have the power to do that; however, if there were an issue such as that, we would have to notify ICE and they would make that determination.

Assemblyman Hardy:
I get a little uncomfortable when someone says, "They allow us to use some of the grant money." I do not know what you mean by "some." Is it all counted or what is "some"?

Christine Roden, Manager, Primary Care Office, Health Division, Department of Health and Human Services:
We submit a grant proposal each year. We get about $210,000 from the federal government to do Health Professional Shortage Area designation, and to provide oversight to the J-1 Visa Waiver physicians. I asked for $10,000 to be used for the development of regulations and we were approved to use those funds for that purpose in state Fiscal Year 2010.

Assemblyman Hardy:
Does that completely fund it or is there still some dangling need for more money?

Christine Roden:
I believe that will completely fund the regulations. We did ask for some fees within this bill and that will provide for site visits and orientation.

Assemblyman Hardy:
Would those be new fees or fees that are already in the Governor's budget?

Lynn O'Mara:
When Senator Carlton developed the bill, she let us know that she was proposing a small fee, but it was too late to include it in the Governor's budget.

To also answer your question a little more specifically about the regulation costs, as a rule for the Health Division, it costs approximately $8,000 to develop and implement new regulations. We asked for a little more than that in our grant because we are not exactly sure what this is going to cost, but it is roughly around $8,000.

Assemblyman Stewart:
Can you give us a rough idea what the track record has been on foreign physicians? Have we had many problems overall?

Christine Roden:
We have 41 J-1 physicians working in the state right now. They provide about 240,000 medical services a year, which is very impressive. I did the site visits; they are 96 percent complete. We had seven physicians who were not working in their designated area. The agency returned a corrective action plan and corrected the situation. A lot of this is miscommunication, sometimes by their immigration attorneys. I plan to correct that with an orientation program starting in July. About 70 percent of the physicians' offices did not have a sign posted saying they would provide care to the underserved, which is a requirement of our program. They have all submitted corrective action plans indicating those signs will be posted. The next time I go out, if the sign is not posted, it is possible the Health Division will withdraw support for that placement. The physicians and the employers both know that they have to provide care to those underserved. Those were the major critical deficiencies: not being in the correct designated area, and not having a sign posted stating they were providing care to the underserved.

Assemblyman Stewart:
Do we have a record of the physicians once they are here and complete the program? Do they stay here for the most part or do they move on to other areas? Do we have statistics?

Christine Roden:
We do; we have an 89 percent retention rate of these physicians. It is very impressive. We work very hard in our office to make sure that we stay in contact with them. Every six months, we require an affidavit from them that they are doing the right thing and staying where they are supposed to be. Many of them stay for an additional two years in the National Interest Waiver Program. About 30 percent stay for a total of five years in an underserved area rather than three.

Assemblyman Stewart:
Right now, the state has to fund your visits. Is that correct?

Christine Roden:
Yes, that is correct.

Assemblyman Stewart:
What is the average cost for a visit for inspection and could we charge the doctor a fee for this?

Christine Roden:
It costs about $300 to do a site visit, especially if it is in rural Nevada. I had to go to Wendover, so that was a couple of days. When I go to Las Vegas, I try to see two or three physicians a day. Some are in Laughlin, which takes about six hours, round trip. I estimate that the cost would be about $300 a visit. Some of the visits had to be repeated because there were critical deficiencies identified; however, the fee that we are asking for—the $500 fee from all new applicants—will be shared between the employer and the physician. That fee should cover those site visits for us. We still have about $5,000 that we get from the federal government to conduct site visits because we also look at the National Health Scholarship Corps. We check on those too, so we try to combine a lot of different activities when we are out doing site visits.

Assemblyman Hambrick:
The J-1 physician, when I was involved, was terrified at the prospect of committing a violation because it was an absolute bar for them ever coming back if they got deported.

Lawrence Matheis, Executive Director, Nevada State Medical Association, Reno, Nevada:
We support this bill. It is, as Senator Carlton explained, the last step in responding to what was more than just a media story in southern Nevada. It really was a critical failure of an important system. Our health professional workforce shortages are serious and they are not going to get better if we have trouble recruiting. We are already seeing that our training opportunities are limited and probably could be more limited given the current economic difficulties in the Nevada System of Higher Education (NSHE). We have some physicians from the private sector training, but for the most part, we have to recruit. We have to recruit people who are trained elsewhere, whether they are doctors trained all the way through their medical education elsewhere in the United States, or J-1 Visa Waiver physicians who started their training in some other country, came to the United States for their residency training, and now are looking for a place to settle. Last fall, when the *Las Vegas Sun* stories were reported, revealing that there were serious problems within the program in Nevada, it made the national and international news. It was very difficult for Nevada to establish a reputation as a place to which these physicians would want to come.

The Legislative Committee on Health Care did good work in the interim trying to deal with this issue, and they have taken it very seriously. We proposed a number of regulatory changes and those were done. We also proposed opening up the process of the Advisory Council and making sure that things are done in

the light of day because past decisions were not always ones that would have been made if they had to be done publicly.

I think we have turned Nevada's reputation around through this. The bill makes it clear where the lines of authority are, and closes loopholes. If things do not go well, there will be resources and authority to make sure they do. I think this is a worthwhile bill and a worthwhile project. We are getting calls from other states regarding the substitute programs we put into place to respond to these issues, and they are now being viewed as models they want to adopt. Every state has this problem; these programs were on automatic pilot for many years. They were located in rural areas, which has changed in the last seven or eight years, but it is clear that the oversight did not go along with it. Nevada has taken what was an unfortunate set of incidents and turned it around, creating something that will actually benefit the state and the participants in these programs in the future.

Carl Heard, M.D., Chief Medical Officer, Nevada Health Centers, Inc., Las Vegas, Nevada:
I am here very strongly in favor of S.B. 229 (R1). In particular, it is probably the lifeblood of the rural health services of our state to have these foreign medical graduates available to our population. It is a remarkably important program. About 25 percent of all physicians in the country are actually coming from other countries to work in the United States. I think that is a strong recognition of the health care practice environment here in the United States and the importance of Nevada public health. Nevada is positioning itself as the most desirable state in the nation to come and work in if you are a foreign physician. It is a huge asset to Nevada Health Centers, and these rules help clarify things. The Advisory Committee has had some very meaningful and valuable results.

Lynn O'Mara:
We have two J-1 Visa Waiver physicians employed by the state in our psychiatric hospitals: one in the north and one in the south. We now have two more applications requesting to hire two more waiver physicians for the southern facility.

Assemblyman Hambrick:
Since you mentioned mental health, are you recruiting a specific specialty?

Lynn O'Mara:
Mental health professionals are considered part of the health professional shortage designation group that is permitted to request a waiver. Right now, we cannot fill all of our 30 slots—we have 30 employers—so we are open to

anyone who will fill these slots. We are hoping in the future to have more competition for these slots, but for now we will work with whoever has the need for us to help recruit and bring those physicians in.

Vice Chair Pierce:
We will close the hearing on S.B. 229 (R1).

We will open the hearing on Senate Bill 319 (1st Reprint).

Senate Bill 319 (1st Reprint): Revises provisions governing certain reports of sentinel events and related events. (BDR 40-828)

This bill is sponsored by Senator Breeden.

Senator Shirley Breeden, Clark County Senatorial District No. 5:
[Senator Breeden read from prepared testimony (Exhibit H).]

Bobbette Bond, M.P.H., Executive Director, Nevada Health Care Policy Group, North Las Vegas, Nevada, representing the Health Services Coalition, Las Vegas, Nevada:
We are speaking in strong support of S.B. 319 (R1) and we really appreciate Senator Breeden and the Senate addressing in more detail some of the sentinel event issues that have been happening in the State of Nevada. Without repeating things that Senator Breeden just said, we feel this bill will make progress on some key issues. First of all, it will help give the incentive to facilities to report and investigate their sentinel events. The sentinel event legislation has been on the books since 2002, but the hospitals have not been completely filling out the reports or reporting everything because there was no process to do it or for doing an evaluation of an event once it was put in the log. We think clarifying the reporting and investigating of sentinel events will help, and we hope that the companion bill that came out of here, Assembly Bill 206, will provide some teeth in the sentinel event legislation that we think will further support S.B. 319 (R1)'s efforts. We feel they are collaborative and will work well together.

There were things in S.B. 319 (R1) that we took out because they were duplicated in A.B. 206. We think this bill is going to increase attention and activity around hospital-acquired infections in an affordable and collaborative way with the state and give them the ability to coordinate a statewide effort. Coordination, eliminating fragmentation, and letting all of the hospitals know that they have one set of things they have to do, is easier for them and it also contributes to the national dialogue on this topic and helps Nevada join what is going on nationally. There are 19 hospitals that are currently involved in the

Center for Disease Control (CDC) website that Senator Breeden just talked about and is in S.B. 319 (R1), and there are 2,000 hospitals nationally that are participating. This gets Nevada into the loop and it is a pre-set process, a smart way to go.

We are very excited to close the loopholes that currently exist between the sentinel events and the Health Division. Sentinel events have to be reported to three boards, but there is no process to get the information from them to the Health Division. This is one of the issues that was identified during the hepatitis outbreak. Communication holes needed to be closed, so this bill is the one that closes them. When the Doctor of Osteopathic Board, the Medical Board, and the Nursing Board get sentinel event issues, they need to provide them to the state. We are supportive of that.

Finally, in the legislation, we had originally wanted to start a huge near-miss program. However, after our conversations with the hospitals, we scaled back and are trying to collaborate on a way that we can make progress without causing them undue burden. A near-miss event is an event that would cause serious harm to a patient, but is averted, often because staff action has intervened to stop something bad from happening. Attention to near-miss events can facilitate identification of existing risks and safeguards that help prevent or mitigate severity of an incident. So, in short, this is a streamlined approach to get the most bang for the buck on safety by looking at incidents that nearly happened. It is the best way to provide consistent training to prevent them from happening in the future.

My last comment is about the unique identifier. We are very frustrated that nationally, and in the State of Nevada, we can no longer use social security numbers as identifiers. Removing social security numbers from claim forms is great for patient privacy, but it is terrible for tracking patients. When there is no social security number on forms to link a patient between different databases, it is going to impact our quality indicators and our data going forward. You cannot link two different hospital admissions in two different facilities to one patient, or to a stay in a hospital resulting in a death certificate. This is a national problem, so we are trying to figure out, with the Division's help, a way to create a unique identifier to follow patients. When they are readmitted to a different facility for the same course of illness, we want to be able to find the records. We have a hole in the system right now, so we need to find a solution.

Assemblywoman Parnell:
With President Obama's push for the electronic medical records, are they tackling the issue of how we track patients without using the social security number? It seems the solution will have to come from the national level, so that

things run smoothly and we can identify the patient. Do you know if that is part of the administration's plan?

Bobbette Bond:
I know that finding the solution has been part of the discussions in all of the information technology (IT) committee meetings. I have not heard a proposed solution from anyone yet, and you are right, it is hard for Nevada to address this when it is a national problem. Even if we figure it out in Nevada, someone could be readmitted in California. That is the same problem that we are having with immunizations: kids get two sets because they are not in a registry from one state to another so they have to start over. It is the same problem, so we are very frustrated. The intention was good to remove social security numbers, but this is the consequence.

Assemblyman Stewart:
Is it possible to use Kim Wallin's eXtensible Business Reporting Language (XBRL) program on this with the bar code?

Bobbette Bond:
I do not know. That is a good idea.

Assemblyman Stewart:
I suggest you talk to Ms. Wallin.

[Vice Chair Pierce recessed the meeting. Following the recess, Chairwoman Smith reassumed the chair.]

Chairwoman Smith:
I am resuming the hearing.

Bobbette Bond:
I want to clarify for the Health Services Coalition my comments about sentinel events reporting by the hospitals. I want to ensure that it is not interpreted that the hospitals are not reporting sentinel events. What I was trying to say was the sentinel events reporting program has not been as fluid, as organized, and as structured as it might. I am not saying they are intentionally not reporting events. I think that the intent in A.B. 206 and the intention of S.B. 319 (R1) will help strengthen the sentinel events program in general, and we will get some consistent expectations and rules in place that will help. That is what I meant to say.

Marla McDade Williams, Chief, Bureau of Health Care Quality and Compliance Nonstatutory, Health Division, Department of Health and Human Services:
I am here today on behalf of S.B. 319 (R1). The Joint Commission currently requires Nevada hospitals that are accredited by the Joint Commission to analyze sentinel events that occur. This would codify that existing relationship. I would also like to say, as Bobbette Bond noted, facilities are reporting sentinel events in Nevada as required. Although the numbers are small, the provisions in A.B. 206 would allow penalties for facilities that are not reporting. Putting those items together will ensure that the system is stronger than it is now.

We support the use of the National Health and Safety Network Reporting System that has been developed by the CDC. This reporting is not directly related to sentinel events. It is an established system that reports infection related data, and 19 states currently require the state to use that system to report their infection incidents. Many of the states require facilities to give them access to the data so the states can do their own analysis of the information. Reporting through the existing surveillance system is a cost savings to the medical facilities and the state. Providers will have access to consistent technical assistance and will benefit from an established peer group among the other states currently using this system. It has additional benefits of modules that can be targeted in the future for certain issues, such as dialysis. It is my understanding that approximately 10 to 12 hospitals in Nevada are currently participating in this reporting system in some manner.

In terms of the analysis of the data and the reports that are required by the bill, the Health Division has proposed adding a biostatistician to the Bureau that would be available to analyze all of the Bureau's data. If this position is supported by the Legislature through the budget process, the work required in this bill can be absorbed into the function of the biostatistician position.

Chairwoman Smith:
Where do we stand with the fiscal note?

Marla McDade Williams:
I do not believe that the Health Division would have a fiscal note as there is no related impact on the Health Division.

Chairwoman Smith:
It would be $180 for regulations.

Marla McDade Williams:
I do not believe there are any provisions in the bill that require regulations. They may have been amended out.

Chairwoman Smith:
We will follow up on that. I am trying to keep as many things as we can out of Ways and Means.

Assemblyman Stewart:
So, there are approximately 12 hospitals in Nevada that are currently using some part of the system. And how many total hospitals do we have?

Marla McDade Williams:
There are approximately 60 hospitals licensed in Nevada. When we license a psychiatric facility, it is licensed as a hospital, so there are 60 hospitals, but not all are general hospitals.

Assemblyman Stewart:
Do we know which hospitals are using the system now?

Marla McDade Williams:
I do not know. I know that Renown Hospital is a longtime user of the system, but I do not know the names of the newer ones.

Assemblyman Stewart:
Are they mostly in cities or in the rural areas, or do we know that?

Marla McDade Williams:
It could be a combination of both, but I am not sure. The facilities are allowed to participate confidentially, and they do not have to release that information.

Assemblyman Stewart:
So how do you know there are 12?

Marla McDade Williams:
Health Insight has been working with facilities and I believe they testified on the Senate side that they were currently working with 10 to 12 hospitals to bring them in.

Assemblyman Cobb:
Does the Health Division currently prepare reports of sentinel events and annual summaries of reports?

Marla McDade Williams:
We are currently required to produce a report of the aggregate data, but I believe the numbers were so small that the report has not been prepared.

Assemblyman Cobb:
The bill does require that you do something new, right?

Marla McDade Williams:
Correct.

Assemblyman Cobb:
There is no cost for having to do all of these new reports and summaries and such?

Marla McDade Williams:
Because we have the existing staff, it would be absorbed into their existing functions for sentinel events. The data analysis piece through the National Healthcare Safety Network (NHSN) is a new function, but in our budget, we proposed the position that would absorb that function. That position's function is all data analysis.

Assemblyman Cobb:
So the fiscal note is in the Executive Budget?

Marla McDade Williams:
The fiscal note was primarily for regulations development, which I believe has been taken out of this bill because the regulations are already in place.

Assemblyman Cobb:
Right, but that position that you just mentioned is in the Executive Budget?

Marla McDade Williams:
The sentinel events position is, yes.

Garrett Weir, representing HCA Sunrise Hospital, Las Vegas, Nevada:
We would like to express our support for this bill in its current form.

Assemblyman Stewart:
Are you one of the hospitals that are currently doing this?

Garrett Weir:
Yes, we are.

Assemblyman Stewart:
So this would not be an additional burden to you?

Garrett Weir:
No, it would not.

Robin Keith, representing Nevada Rural Hospital Partners Foundation, Reno, Nevada:
I am speaking today for Nevada Rural Hospital Partners (NRHP) and for the Nevada Hospital Association. On their behalf, I would like to thank Ms. Bond for clarifying the fact that the hospitals are actively reporting their sentinel events and have been since the inception of the legislation that created it.

I would like to thank Senator Breeden for making it so all of the stakeholders could come together about this bill and participate in crafting the amendment.

Assemblyman Stewart:
Is this going to cause any burden on the rural hospitals?

Robin Keith:
I do not believe so. Currently, the Joint Commission and Centers for Medicare and Medicaid Services (CMS) require that when a sentinel event occurs, a hospital do an investigation. As Ms. McDade Williams pointed out, this codifies an existing requirement. Also, in section 4 of the bill, where it talks about facilities participating with the CMS national database and website, that only applies to hospitals that have an average of 25 or more patients during each business day. By virtue of that language, the really small hospitals in the state are exempt from participation in this database. The reason for that is that their numbers are statistically insignificant, so we appreciate that they were relieved from that administrative burden.

Assemblyman Stewart:
Do you know which 12 hospitals are currently involved?

Robin Keith:
I am sorry, but I do not know.

Assemblyman Hambrick:
How many sentinel events have there been? Are we talking a miniscule amount? I am trying to get a sense because if there is a fiscal impact I would like to know.

Marla McDade Williams:
I will provide that information to you. I do not know what the number is offhand—I am guessing less than 50—but I will provide that for you.

Chairwoman Smith:
I will close the hearing on S.B. 319 (R1).

The meeting is adjourned [at 3:54 p.m.].

RESPECTFULLY SUBMITTED:

Darlene Rubin
Recording Secretary

RESPECTFULLY SUBMITTED:

Karyn Werner
Transcribing Secretary

APPROVED BY:

Assemblywoman Debbie Smith, Chair

DATE:

EXHIBITS

Committee Name: Committee on Health and Human Services

Date: May 6, 2009 **Time of Meeting: 1:46 p.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
S.B. 79 (R1)	C	Mary Liveratti	Handout of outline of testimony
S.B. 278 (R1)	D	Senator Maurice Washington	Proposed amendment mock-up
S.B. 278 (R1)	E	Lawrence Sands	Written testimony
S.B. 229 (R1)	F	Lynn O'Mara	Resource document that provides an update
S.B. 229 (R1)	G	Lynn O'Mara	Information on J-1 Visa Waivers
S.B. 319 (R1)	H	Senator Shirley Breeden	Written testimony