MINUTES OF THE MEETING
OF THE
LEGISLATIVE COMMITTEE ON HEALTH CARE
(*Nevada Revised Statutes* 439B.200)
October 28, 2002
Las Vegas, Nevada

The ninth meeting of the Legislative Committee on Health Care for the 2001-2002 interim was held on Monday, October 28, 2002, at 10 a.m., in Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada, and videoconferenced to Room 2135 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. Pages 2 through 4 contain the "Meeting Notice and Agenda" for this meeting.

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:

Senator Raymond D. Rawson, Chairman
Assemblywoman Ellen M. Koivisto, Vice Chairwoman
Senator Maurice E. Washington

COMMITTEE MEMBERS PRESENT IN CARSON CITY:

Senator Bernice Mathews
Assemblywoman Bonnie L. Parnell

COMMITTEE MEMBER ABSENT:

Assemblywoman Merle A. Berman

OTHER LEGISLATOR PRESENT:

Assemblywoman Barbara K. Cegavske

LEGISLATIVE COUNSEL BUREAU STAFF PRESENT:

Marsheilah D. Lyons, Senior Research Analyst
Leslie K. Hamner, Principal Deputy Legislative Counsel
Susan Furlong Reil, Principal Research Secretary
Gayle Nadeau, Senior Research Secretary

MEETING NOTICE AND AGENDA

Name of Organization: Legislative Committee on Health Care

(*Nevada Revised Statutes* [NRS] 439B.200)

Date and Time of Meeting: Monday, October 28, 2002
10 a.m.

Place of Meeting: Grant Sawyer State Office Building
Room 4401
555 East Washington Avenue
Las Vegas, Nevada

Note: Some members of the committee may be attending the meeting and other persons may observe the meeting and provide testimony through a simultaneous videoconference conducted at the following location:

Legislative Building
Room 2135
401 South Carson Street
Carson City, Nevada

If you cannot attend the meeting, you can listen to it live over the Internet. The address for the legislative Web site is http://www.leg.state.nv.us. For audio broadcasts, click on the link "Listen to Meetings Live on the Internet."

A G E N D A

I. Introductions and Opening Remarks
Senator Raymond D. Rawson, Chairman

*II. Approval of Minutes From the August 20, 2002, Meeting

*III. Presentation Concerning the Four Strategic Plans of Nevada's Department of Human Resources (DHR) Developed Pursuant to Assembly Bill 513 (Chapter 541, *Statutes of Nevada 2001*) Regarding Senior Services, Rural Health, Persons With Disabilities, and Provider Rates
Michael J. Willden, Director, DHR
Task Force Chairpersons and Coordinators

*IV. Presentation Regarding the Impact of Senate Bill 483 (Chapter 291, *Statutes of Nevada 2001*) Concerning the Licensure of Certain Mobile Units and the State Board of Health's Regulations Adopted Pursuant Thereto (Legislative Counsel Bureau [LCB] File No. R063-02) on Services Provided by Certain Mobile Medical Facilities
Janice C. Pine, Director, Governmental Relations, St. Mary's Health Network

*V. Presentation Regarding Proposals to Develop Additional Inpatient Psychiatric Care and Other Mental Health Services for Individuals With Mental Illnesses
Kathryn Landreth, Chairwoman, Southern Nevada Mental Health Coalition
Janelle L. Kraft, Co-Chairwoman, Southern Nevada Regional Planning Coalition's Task Force on Emergency Room Overcrowding

*VI. Presentation Concerning Placement Options for Providing Inpatient Psychiatric Care and Other Mental Health Services to Individuals With Mental Illnesses
Thomas Maher, Chief Executive Officer, Montevista Hospital

*VII. Presentation Regarding Proposals to Address the Affordability of Medical Malpractice Insurance for Obstetricians and Gynecologists and to Improve Access

to Such Care
Terry Murphy, Facilitator, Clark County OB/GYN Task Force

*VIII. Presentation Regarding the Proposal Submitted by EP&P Consulting, Inc. to Perform a Study of Potential Opportunities for Nevada to Maximize Federal Funding for Certain Indigent Health Care Services
Senator Raymond D. Rawson, Chairman

*IX. Presentation Regarding the Draft of a Bill That Updates Existing Laws to Address Public Health Issues Related to the Detection and Control of Certain Diseases
Leslie K. Hamner, Principal Deputy Legislative Counsel, Legal Division, LCB

*X. Consideration of Health Care Regulations Pursuant to NRS 439B.225
Leslie K. Hamner, Principal Deputy Legislative Counsel, Legal Division, LCB

A. LCB File No. R050-02 State Board of Health (Adopted)
B. LCB File No. R052-02 State Board of Health (Adopted)
C. LCB File No. R053-02 State Board of Health (Adopted)
D. LCB File No. R057-02 State Board of Osteopathic Medicine (Adopted)
E. LCB File No. R063-02 State Board of Health (Adopted)
F. LCB File No. R068-02 State Board of Pharmacy (Adopted)
G. LCB File No. R077-02 Board of Psychological Examiners (Adopted)
H. LCB File No. R079-02 Board of Examiners for Social Workers (Revised Proposed)
I. LCB File No. R111-02 State Board of Physical Therapy Examiners (Revised Proposed)
J. LCB File No. R119-02 State Board of Pharmacy (Adopted)

XI. Public Testimony

*XII. Work Session—Discussion and Action Regarding Recommendations Related to: the Study of Programs and Funding for the Treatment of Medicaid, Indigent, and Other Low-Income Patients Conducted Pursuant to Senate Bill 377 (Chapter 598, *Statutes of Nevada 2001*); the Four Strategic Plans of DHR Developed Pursuant to Assembly Bill 513 (Chapter 541, *Statutes of Nevada 2001*) Regarding Senior Services, Rural Health, Persons With Disabilities, and Provider Rates; Placement Options for Providing Inpatient Psychiatric Care and Other Mental Health Services to Individuals With Mental Illnesses; and Mobile Medical Facilities

The Work Session Document is available on the Nevada Legislature's Web site (www.leg.state.nv.us) at the committee home page or it may be obtained by contacting Marsheilah D. Lyons, Senior Research Analyst, Research Division, Legislative Counsel Bureau, at (775) 684-6825.

XIII. Adjournment

*Denotes items on which the committee may take action.

Note: We are pleased to make reasonable accommodations for members of the public who are disabled and wish to attend the meeting. If special arrangements for the meeting are necessary, please notify the Research Division of the Legislative Counsel Bureau, in writing, at the Legislative Building, 401 South Carson Street, Carson City, Nevada 89701-4747, or call Susan Furlong Reil or Gayle Nadeau at (775) 684-6825 as soon as possible.

Notice of this meeting was posted in the following Carson City, Nevada, locations: Blasdel Building, 209 East Musser Street; Capitol Press Corps, Basement, Capitol Building; City Hall, 201 North Carson Street; Legislative Building, 401 South Carson Street; and Nevada State Library, 100 Stewart Street. Notice of this meeting was faxed for posting to the following Las Vegas, Nevada, locations: Clark County Office, 500 South Grand Central Parkway; and Grant Sawyer State Office Building, 555 East Washington Avenue. Notice of this meeting was posted on the Internet through the Nevada Legislature's Web site at www.leg.state.nv.us.

INTRODUCTION AND OPENING REMARKS

Chairman Rawson called the meeting to order at 10:17 a.m. and directed the secretary to call roll. All committee members attended the meeting except Assemblywoman Berman. Chairman Rawson invited Assemblywoman Barbara K. Cegvaske to join the committee at the dais and to participate in discussion of the issues.

The agenda items before the committee were heard out of order to accommodate the schedules of the witnesses. Further, the recommendations contained in the Work Session Document (Exhibit A) were considered individually as each topic was discussed. The recommendations contained in the Work Session Document (Exhibit A) appear below in italics and precede the actions of the committee.

APPROVAL OF MINUTES FROM THE AUGUST 20, 2002, MEETING

Chairman Rawson announced he would accept a motion for approval of the minutes of the committee's August 20, 2002, meeting.

ASSEMBLYWOMAN KOIVISTO MOVED FOR APPROVAL OF THE MINUTES OF THE COMMITTEE'S MEETING HELD ON AUGUST 20, 2002, IN LAS VEGAS, NEVADA. THE MOTION WAS SECONDED BY SENATOR MATHEWS AND PASSED UNANIMOUSLY.

PRESENTATION REGARDING PROPOSALS TO ADDRESS THE AFFORDABILITY OF MEDICAL MALPRACTICE INSURANCE FOR OBSTETRICIANS AND GYNECOLOGISTS AND TO IMPROVE ACCESS TO SUCH CARE

Chairman Rawson noted that while the 18th Special Session of the Nevada Legislature addressed the availability of affordable medical malpractice insurance coverage, it might be some time before the effects of the legislative actions taken will be evident. Despite the Legislature's recent efforts, this issue continues to significantly impact the provision of care in certain specialty fields including obstetrics and gynecology (OB/GYN), pediatric anesthesia, and pediatric cardiology. Continuing, Chairman Rawson stressed the importance of developing positive solutions to the challenges facing the health care community. He pointed out that if women are unable to secure OB/GYN care through private practitioners, they might be forced to seek care through hospital emergency rooms. Chairman Rawson reported he had recently attended meetings of the Clark County OB/GYN Task Force. He asked the Task Force's facilitator, Terry Murphy, to report on the group's progress.

Terry Murphy

Terry Murphy, Facilitator, Clark County OB/GYN Task Force, Las Vegas, explained the Task Force was appointed by the Board of Trustees of University Medical Center of Southern Nevada (UMC) to develop and evaluate potential solutions to the lack of affordable medical malpractice insurance for OB/GYNs that might not have been considered by the 18th Special Session of the Legislature. She indicated the recommendations of the Task Force had not yet been presented to UMC's Board of Trustees due to time constraints. Ms. Murphy prefaced her remarks by noting that in her role as the group's facilitator, she was providing information for the committee's consideration, and she did not advocate or oppose any of the potential solutions offered.

Ms. Murphy provided the committee with an outline of topics discussed by the Task Force (Exhibit B). She explained that in identifying potential solutions, the Task Force participants attempted to determine whether the recommended goals were long- or short-term in nature. Further, each suggested recommendation was ranked from 1 to 10, with items at the lower end of the spectrum more likely to be supported by interested parties.

Topics discussed by the Task Force included the following:

- Creating a liability compensation fund similar to that established in Maine to provide coverage for typical high-

risk outcomes;

- Providing in-state training for OB/GYNs;
- Establishing a subsidy with a sunset provision as other reforms become effective;
- Requiring physicians who utilize such a subsidy to increase their participation in state-funded health care programs such as Baby Your Baby and Medicaid, thereby reducing Nevada's health care burden;
- Expanding the capacity of the University of Nevada School of Medicine (UNSOM);
- Creating incentives for physicians to remain in Nevada;
- Raising the cigarette tax and earmarking the revenue for health care;
- Increasing property taxes to fund a subsidy;
- Developing a plan to stem the departure of insurers from the Nevada market;
- Establishing a state system of self-insurance;
- Increasing the role of midwives by utilizing a tiering system to encourage prenatal care;
- Implementing a prenatal care public awareness campaign, including information on the Baby Your Baby program; and
- Accelerating the Medicaid eligibility process.

Ms. Murphy indicated the Task Force recognized that if a subsidy were created to address the needs of OB/GYNs, other industries or specialties within the health care field might also seek to establish similar mechanisms.

Continuing, Ms. Murphy reported the Task Force was asked to identify and monitor certain data so that information is available to the 2003 Legislature as it considers the affordability of medical malpractice insurance for OB/GYNs and patient access to such care. She indicated a list of data points would be provided to the committee. Chairman Rawson acknowledged the need for reliable data to determine more accurately the breadth of health care provider shortages.

Caroline Ford, M.P.H.

Caroline Ford, M.P.H., Assistant Dean/Director, University of Nevada School of Medicine (UNSOM), Center for Education and Health Services Outreach, Reno, Nevada, provided the committee with a draft proposal to expand the UNSOM's Rural Obstetrical Access Program (Exhibit C). Ms. Ford summarized the background of the existing program and discussed impediments to providing obstetrical care in Nevada's rural areas. She also reviewed the details of the proposal and the suggested methodology for integrating the enhanced obstetrical program within the current rural-based program. Ms. Ford covered the following points:

- The UNSOM's Rural Obstetrical Access Program was first authorized in 1991. The program was originally intended to subsidize the differential cost of malpractice insurance for family practitioners delivering prenatal care and for OB/GYN physicians. Before operations could commence, however, budget reductions forced closure of the program.
- In 1995, the Legislature appropriated $75,000 per year for the Rural Obstetrical Access Program. All applications for program grants were required to include plans to provide: (1) community-based prenatal care; (2) prenatal services to low-income and uninsured women; and (3) improved health care for pregnant women in counties or communities served by clinics or rural practitioners. The Rural Obstetrical Access Program began operating in Fiscal Year (FY) 1996 with eight practitioners.

- During the 1999 Session, the Rural Obstetrical Access Program was expanded to provide additional education and skill enhancement for practitioners and routine and subspecialty obstetrical consultation through telemedicine. In addition, the program expanded prenatal services to rural communities that previously had no access to such care. Further, some resources were used to ease the burden of uncompensated care on rural practices.

- As of the most recent FY, the program assisted in providing coverage for 17 practitioners, or 65 percent of all those who practice in frontier and rural Nevada. In five communities, the Rural Obstetrical Access Program provided coverage for all medical practitioners.

- The UNSOM conducted a survey of physicians the previous week to determine their future plans with regard to obstetrical care. A decrease in number of practitioners providing obstetrical care will hamper the state's efforts to ensure access to OB/GYN services.

- Factors contributing to the decline in Nevada's obstetrical workforce include practitioner age, declining reimbursements, medical malpractice insurance costs, physician turnover, and increasing levels of uncompensated care.

- In addition, recruitment of OB/GYN physicians and family practitioners that provide obstetrical services is difficult. For instance, a replacement has not yet been secured for a physician in Churchill County, Nevada, who plans to discontinue the practice of medicine within the next few months. If a replacement is not found, only two physicians will be available to serve a community that is currently experiencing a leukemia cluster.

- The UNSOM has forecasted about 4 percent of the workforce delivering obstetrical care will discontinue such services within the next six months because of the medical malpractice insurance crisis.

- For the year ending June 30, 2002, the UNSOM Rural Obstetrical Access Program received requests totaling approximately $900,000 for an appropriation of $150,000. The largest proportionate request was for uncompensated care.

- Because OB/GYNs expect to provide care within their specialty, they usually assume the cost of medical malpractice insurance and seek to maintain the viability of their practices in other ways. Such practitioners typically approach the UNSOM for assistance with uncompensated care costs of patients without Medicaid or other insurance coverage. In contrast, family practitioners that provide obstetrical services often seek assistance with the differential cost of medical malpractice insurance rather than with the uncompensated care burden.

- To address health professions development, the proposal provides for an increase in OB/GYN residents and associated faculty. These additional staff would enable the UNSOM to expand its direct clinical services in Las Vegas and rural areas of the state and to begin offering obstetrical care in Reno.

Senator Washington asked what efforts are made to encourage students to enter the UNSOM's OB/GYN program. He also inquired about the UNSOM's primary geographic recruitment area and questioned whether tuition reimbursement is offered as an incentive. Ms. Ford explained that as a community-based school of medicine, the UNSOM's curriculum in primary care is intently focused. Approximately 48 percent to 53 percent of the school's graduates enter practice settings in primary care, well above the national average. Ms. Ford reported that about eight years ago, the UNSOM began an initiative to increase its recruitment of generalist physicians including practitioners in the fields of family medicine, internal medicine, OB/GYN, and pediatrics. Students are exposed to practitioners and practice sites to entice them into these fields. However, the current crisis in the delivery of OB/GYN services is not conducive to these recruitment efforts.

Continuing, Ms. Ford indicated the UNSOM's efforts to attract people to Nevada and to specific practice sites within the state include participation in a national network. In addition, through its Nevada Health Service Corps program, the UNSOM provides loan repayment funds for persons that choose to enter primary care professions and are willing to practice in areas designated as medically underserved. While the school has participated in community scholarship programs over the years, it lacks the necessary funds to offer such an incentive at this time. Ms. Ford noted that the UNSOM focuses its efforts on physician retention. The school strives to build a relationship between the medical

students and the communities in which their training takes place with the anticipation that following graduation, the physician will serve the area in which he or she trained. She also pointed out that given the number of years students must train before they are able to practice medicine, scholarship programs offer a less attractive incentive tool. Ms. Ford asserted rural areas are unable to compete with the bonus incentives offered by urban facilities, particularly in the nursing field, making recruitment of practitioners more difficult.

Assemblywoman Cegavske asked if the UNSOM was involved in the Western Interstate Commission for Higher Education (WICHE) program, and if so, how many openings were available for health care professionals. She noted one of the issues raised during the 2001 Session was the fact that the WICHE program still maintained openings for physical therapists even though a school had been opened in Las Vegas. Ms. Cegavske suggested this topic could be revisited during the 2003 Session.

Responding, Ms. Ford reported the UNSOM participates in the health care access portion of the WICHE program. Currently, WICHE and the UNSOM together provide matching funds to students participating in the scholarship portion of WICHE. Upon graduation, the students are assigned to provide care in a community designated as medically underserved, and the UNSOM provides assistance through the loan repayment program. Chairman Rawson indicated a report on the current WICHE allocation could be obtained.

Ms. Ford suggested consideration be given to incentivizing students to train in Nevada programs and to provide care in areas of need. For example, policies could be established in a manner that would guide profession choices and the geographic areas served by practitioners.

Continuing her review of the UNSOM's proposal, Ms. Ford made the following remarks:

- As part of its clinical services expansion plan, the UNSOM has submitted a proposal to the Office of the Governor that would not only provide additional personnel but also utilize community physicians. By contracting with community health centers, private practitioners could provide obstetrical services to clinic patients. Deliveries performed for clinic patients would not be counted in the physician's number of adjusted deliveries for purposes of determining his or her medical malpractice insurance premiums. Further, participating practitioners would be protected under federal tort law with regard to care provided to clinic patients.

- Establishing a partnership with community physicians is another component of the proposal. The proposed budget would provide a medical malpractice insurance subsidy for 25 OB/GYNs; 10 family practitioners; and 20 family nurse practitioners, certified nurse midwives, or physician assistants. The amount of the subsidy offset would be proportionate to the true cost of medical malpractice insurance.

- Eligibility criteria would need to be established if the Legislature chose to approve such a medical malpractice insurance subsidy. For example, a practitioner would receive a certain subsidy if at least 30 percent of his or her practice included prenatal or obstetrical patients who were: (1) Medicaid eligible; (2) participants in a sliding fee scale program; (3) underinsured or uninsured. Physicians whose practices included a higher percentage of medically underserved patients might be eligible for a higher subsidy.

- A medical malpractice subsidy alone will not maintain the viability of clinics and private practices that offer obstetrical care. Therefore, the proposal also recommends the creation of an uncompensated care fund to assist with uncompensated care costs.

- Data collection and analysis is a key element of the proposal. Information could be collected regarding the impact of the health care crisis, e.g., financial costs and health care outcomes.

Senator Washington questioned whether the data collection would include tracking of medical malpractice complaints filed, outcomes of adjudicated cases, and the affect of such claims on the insurance industry. Ms. Ford indicated a variety of data could be collected that would enable the Legislature to make informed appropriation and policy decisions, and she offered to add these items to the narrative description of information to be collected.

Continuing, Ms. Ford explained that as data collection and analysis are key elements of the proposal, the associated costs were included in the program's operating expense. She pointed out the importance of understanding fluctuations

and migrations within the health care field to measure the effectiveness of intervention strategies. Utilizing federal funds, a part-time program manager position was added to assist with rural outreach efforts, explore alternative interventions for communities, and monitor patient outcomes.

Chairman Rawson suggested the committee request the drafting of a bill encompassing the concepts set forth in the UNSOM's proposal to expand its Rural Obstetrical Access Program for consideration by the 2003 Legislature. He pointed out that while a medical malpractice subsidy would offer a short-term solution to the health care crisis, in the long term, steps must be taken to ensure the continued availability of obstetrical practitioners. Acknowledging revenue concerns, Chairman Rawson pointed out that if a bill draft request (BDR) is not prepared, further discussion of the issue cannot occur. Senator Washington proposed that the bill include provisions that would encourage minorities to pursue careers in the health care field. In addition, Assemblywoman Cegavske recommended the list of data to be collected include information on public health programs such as Healthy Kids and Nevada Check Up to determine their impact, health outcomes, and utilization levels.

SENATOR WASHINGTON MOVED THAT THE COMMITTEE REQUEST THE DRAFTING OF A BILL ENCOMPASSING THE PROVISIONS SET FORTH IN THE UNIVERSITY OF NEVADA SCHOOL OF MEDICINE'S PROPOSAL TO EXPAND ITS RURAL OBSTETRICAL ACCESS PROGRAM AND THAT SUCH BILL INCLUDE PROVISIONS TO ENCOURAGE MINORITIES TO PURSUE CAREERS IN THE HEALTH CARE FIELD; AND FURTHER, THAT THE LIST OF DATA TO BE COLLECTED UNDER THE PROPOSED PROGRAM INCLUDE INFORMATION ON PUBLIC HEALTH PROGRAMS SUCH AS HEALTHY KIDS AND NEVADA CHECK UP. THE MOTION WAS SECONDED BY ASSEMBLYWOMAN KOIVISTO AND PASSED UNANIMOUSLY.

Chairman Rawson indicated he would work with Ms. Murphy and Ms. Ford on the bill draft and invited the participation of interested committee members.

PRESENTATION CONCERNING THE FOUR STRATEGIC PLANS OF NEVADA'S DEPARTMENT OF HUMAN RESOURCES (DHR) DEVELOPED PURSUANT TO ASSEMBLY BILL 513 (CHAPTER 541, *STATUTES OF NEVADA 2001*) REGARDING SENIOR SERVICES, RURAL HEALTH, PERSONS WITH DISABILITIES, AND PROVIDER RATES

1. *Request the drafting of a resolution or letter expressing support for the four strategic plans related to senior services, rural health, persons with disabilities, and provider rates developed pursuant to Assembly Bill 513 (Chapter 541, Statutes of Nevada 2001).*

   (Proposed by Senator Raymond D. Rawson, Chairman, Legislative Committee on Health Care)

Michael J. Willden

Michael J. Willden, Director, Nevada's Department of Human Resources (DHR), Carson City, provided the committee with the following documents:

1. Strategic Plan for People With Disabilities dated October 2002 (Exhibit D);

2. Strategic Plan for Provider Rates dated October 2002 (Exhibit E);

3. Strategic Plan for Rural Health Care dated October 2002 (Exhibit F);

4. Strategic Plan for Senior Services dated October 2002 (Exhibit G);

5. Executive Summary, Strategic Plan for People With Disabilities dated October 2002 (Exhibit H);

6. Executive Summary, Strategic Plan for Provider Rates dated October 2002 (Exhibit I);

7. Executive Summary, Strategic Plan for Rural Health Care dated October 2002 (Exhibit J); and

8. Executive Summary, Strategic Plan for Senior Services dated October 2002 (Exhibit K).

Mr. Willden reported the four strategic plans developed pursuant to Assembly Bill 513 (Chapter 541, *Statutes of Nevada 2001*), which "makes an appropriation to Department of Human Resources for development of long-term strategic plan concerning health care needs of citizens of Nevada," are the product of hundreds of hours of work by consumers, providers, staff, and other interested parties. Minutes of the meetings of the steering committee, task forces, and subcommittees involved in this effort together with the strategic plans are available on DHR's Web site.

Continuing, Mr. Willden indicated the 2001 Legislature appropriated $800,000 for development of the strategic plans. Because DHR was able to access Medicaid and other funds, it expects to return $130,000 to $150,00 of that appropriation. Mr. Willden emphasized the strategic plans establish a foundation for addressing the needs of people with disabilities, provider rates, rural health care, and senior services. The DHR will attempt to ensure steps are taken to implement recommended actions contained in the plans. He cautioned that the value of these planning tools will diminish if steps are not taken to implement the recommended actions.

Mr. Willden reported that for those recommendations where adequate information was available—e.g., additional services for disabled persons and waiting lists—a funding request was included in the agency request phase of the Executive Budget. He noted key issues not yet discussed with Governor Kenny C. Guinn include *Olmstead* (*Olmstead v. L.C.*, 138F.3d 893 (1999)) concerns, organization, suggested Medicaid waivers, and other recommended programs, particularly pertaining to accessibility and data retention. The strategic plans will be presented to the Governor and his staff on October 30, 2002. Thereafter, more direction may become available as to items that might be included in the Governor's recommendation phase of the Executive Budget.

Chairman Rawson complimented and thanked Mr. Willden on his leadership throughout the endeavor. Mr. Willden acknowledged the efforts of consumers, providers, staff, and other interested parties in developing the strategic plans.

Senator Washington indicated he had been approached by imaging center operators regarding service reimbursement levels. He was advised that some centers might be forced to close if reimbursements are not increased to cover operating costs. Acknowledging that the service reimbursement level is in part a federal issue, Senator Washington asked Mr. Willden to consider the concerns of the imaging center operators and to offer suggestions that might mitigate the current situation. Mr. Willden noted that DHR utilizes a number of pay sources and indicated he would review the reimbursement rates.

As a member of the steering committee formed to facilitate the strategic planning process, Assemblywoman Parnell thanked Mr. Willden for his direction and leadership. Ms. Parnell expressed concern regarding the best manner in which to present the necessary BDRs and the funds needed to implement the measures outlined in the strategic plans.

STRATEGIC PLAN FOR PEOPLE WITH DISABILITIES

Thomas B. Pierce, Ph.D. and Donny Loux

Thomas B. Pierce, Ph.D., Chair, Department of Special Education, University of Nevada Las Vegas (UNLV), and member, Nevada Task Force on Disability, Las Vegas, provided the committee with an overview of the findings and recommendations of the Nevada Task Force on Disability (Exhibit L). Dr. Pierce reported that in 1999, people with disabilities and their advocates testified before the Legislative Committee on Health Care regarding the need to develop a statewide *Olmstead* plan. After the publication of the U.S. Supreme Court's *Olmstead* decision in 2000, states learned that they were required to provide community-based services for people with disabilities who would otherwise be institutionalized. The 2001 Legislature appropriated $150,000 to develop a long-term strategic plan to address this issue.

Continuing, Dr. Pierce explained that the Nevada Task Force on Disability was charged with developing a strategic plan for people with disabilities that would meet the following five principles of the *Olmstead* decision: (1) comprehensive assessment and planning; (2) community capacity; (3) information and choice; (4) quality assurance

and infrastructure; and (5) stakeholder partnerships. These principles are imbedded throughout the plan. The firm of Tony Records and Associates, a national expert and consultant to the federal Office of Civil Rights for the past two years, trained the Nevada Task Force on Disability in *Olmstead* issues. In addition, the Nevada Task Force on Disability was assigned a special technical assistance group to assist with issues surrounding *Olmstead*.

Dr. Pierce presented the Nevada Task Force on Disability's recommendations as follows:

1. Develop a rider to the Medicaid budgets based on the Texas model of "money follows the person" for adults and children assessed to be in unnecessarily restrictive residential environments as has been recommended to all governors by U.S. Department of Health and Human Services Director Tommy Thompson.

2. Ensure that the waiting list for services critical to community integration and avoidance of segregated service environments move at a reasonable pace, not to exceed 90 days. Those services are identified as home- and community-based services, medication clinics, personal assistance for children and adults with disabilities at or at risk of institutionalization, and treatment for mental illness.

3. Utilize as a continuous allotment source the 10 percent portion of tobacco settlement funds designated to address the needs of disabled persons to provide: (a) home and environmental medications and assistive technology to allow community access, independent living, or return from institutional care; (b) permanent funding for the state's Positive Behavioral Supports Program at a level that at a minimum supports adequate training and service delivery to 1,500 families of children afflicted with autism or brain injury as well as others in need of such interventions; and (c) respite within 90 days of application for families providing primary care to a severely disabled family member.

4. Establish by legislative resolution, renewed at each session of the Legislature, that effective July 2003, critical health, mental health, nutrition, and personal assistance services to adults and children with disabilities, poor children, and frail seniors are exempted from budget reductions during economic downturns.

5. Develop a statewide single point of entry for accessible, affordable, basic dental and health care in all counties and on all reservations, offering specialized disability services through collaboration of the UNLV School of Dentistry, federally qualified health centers, and tribal health services.

6. Utilize the State Disability Consortium to develop and implement uniform statewide quality assurance measures in all state programs serving people with disabilities to assure service provision in the most integrated setting appropriate to the individual in need; consistently solicit consumer perspectives for program improvements; and evaluate and report impact, outcome, and consumer satisfaction. Outcomes would be reported biennially to the Legislative Commission's Subcommittee to Study State Program for Providing Services to Persons With Disabilities.

Assemblywoman Koivisto commented she had been studying the number of children in Nevada afflicted with autism and questioned the accuracy of the information contained in the Strategic Plan for People With Disabilities. Dr. Pierce explained that because of the influx of people moving to Nevada, the Nevada Task Force on Disability did not attempt to determine the exact number of children in Nevada afflicted with autism. For this reason, the plan provides for a biennial report on people with disabilities to the Legislative Commission's Subcommittee to Study State Program for Providing Services to Persons With Disabilities. It is the position of the Nevada Task Force on Disability that the numbers provided in the Strategic Plan for People With Disabilities are adequate for the current legislative session.

Donny Loux, Chief, Office of Community Based-Services, Rehabilitation Division, Nevada's Department of Employment, Training and Rehabilitation (DETR), Carson City, clarified that the Nevada Task Force on Disability's recommendations were structured to allow programs such as Medicaid, Independent Living Services, and Vocational Rehabilitation to buy services from the Positive Behavioral Supports Program—provided it is permanently funded—thereby allowing growth in the program.

Assemblywoman Cegavske observed the strategic plan indicated 125 Nevadans with disabilities live out of state. She questioned if these persons are all adults and whether a cost analysis for placing them in out-of-state facilities was available. She also asked if the out-of-state residential schools in which Nevada students have been placed are geographically close enough to allow parents to visit their children. Dr. Pierce indicated both adults and children

with disabilities have been placed out-of-state facilities. He reported the majority of these children are living in Utah facilities and offered to provide Ms. Cegavske with specific numbers at a later date.

Mr. Willden indicated he could provide detailed cost data regarding the out-of-state placements. He pointed out the state will be unable to comply with *Olmstead* until it returns these disabled persons to Nevada. Continuing, Mr. Willden reported most of Nevada youth living in juvenile correction facilities are placed in states as far away as Tennessee. He asserted the majority of these youth could be returned to Nevada to receive education and treatment at a premium of approximately 25 percent. Because many facilities in other states experience lower labor and placement costs, a disabled juvenile can be placed in out-of-state facilities for $120 per day while care in Nevada historically costs approximately $140 to $150 per day.

Chairman Rawson asked if a resolution or letter expressing the committee's support for the four strategic plans would be adequate. Mr. Willden indicated a resolution would be appropriate. He acknowledged that funding of some of the specific components would be difficult and recognized not all of the recommendations would be addressed in the upcoming biennium. For this reason, DHR is attempting to prioritize the recommendations.

ASSEMBLYWOMAN KOIVISTO MOVED THAT THE COMMITTEE REQUEST THE DRAFTING OF A RESOLUTION EXPRESSING SUPPORT FOR THE STRATEGIC PLAN FOR PEOPLE WITH DISABILITIES DEVELOPED PURSUANT TO ASSEMBLY BILL 513 (CHAPTER 541, *STATUTES OF NEVADA 2001*). THE MOTION WAS SECONDED BY ASSEMBLYWOMAN PARNELL AND PASSED UNANIMOUSLY.

Dr. Pierce asked that the committee request the drafting of a bill specifying that the 10 percent portion of tobacco settlement funds designated to address the needs of disabled persons be utilized as a continuous allotment source to provide: (1) home and environmental medications and assistive technology to allow community access, independent living, or return from institutional care; (2) permanent funding of the state's Positive Behavioral Supports Program; and (3) respite for families providing primary care to a severely disabled family member.

Chairman Rawson disclosed he serves as Chairman of the Task Force for the Fund for a Healthy Nevada (NRS 439.625), which is responsible for allocation of tobacco settlement funds. Senator Washington indicated it was his understanding the allocation of such funds would not impact other programs. Chairman Rawson confirmed that because the funds are currently designated to address the needs of disabled persons, such an allocation would not affect other groups competing for funds. He observed the disability community has determined the funds would best be utilized by directing them to certain services.

SENATOR WASHINGTON MOVED THE RESOLUTION INCLUDE LANGUAGE URGING THE CONTINUOUS ALLOTMENT OF 10 PERCENT OF THE TOBACCO SETTLEMENT FUNDS THAT ARE DESIGNATED TO ADDRESS THE NEEDS OF DISABLED PERSONS BE UTILIZED AS A CONTINUOUS ALLOTMENT SOURCE TO PROVIDE: (1) HOME AND ENVIRONMENTAL MODIFICATIONS AND ASSISTIVE TECHNOLOGY TO ALLOW COMMUNITY ACCESS, INDEPENDENT LIVING, OR RETURN FROM INSTITUTIONAL CARE; (2) PERMANENT FUNDING OF THE STATE'S POSITIVE BEHAVIORAL SUPPORTS PROGRAM; AND (3) RESPITE FOR FAMILIES PROVIDING PRIMARY CARE TO A SEVERELY DISABLED FAMILY MEMBER. THE MOTION WAS SECONDED BY ASSEMBLYWOMAN KOIVISTO AND CARRIED UNANIMOUSLY.

STRATEGIC PLAN FOR PROVIDER RATES

Charles Duarte and Edward Guthrie

Charles Duarte, Administrator, Division of Health Care Financing and Policy (DHCFP), DHR, Carson City, provided the committee with a copy of a Microsoft PowerPoint presentation titled "Summary of Provider Rates Task Force Recommendations" (Exhibit M).

Edward Guthrie, Executive Director, Opportunity Village, and Chairman, Strategic Plan for Provider Rates, Las Vegas, reported the Provider Rates Task Force reviewed multiple rates for 36 services over a nine-month period. Mr. Guthrie provided the committee with background information, reviewed priority areas, and explained the Task Force's analysis process, covering the following points:

- The Provider Rates Task Force was charged with developing a strategic plan for the rates paid for services, specifically focusing on:

  1. The need for standardized rate methodologies across programs, e.g., for similar services in different programs;

  2. Inclusion of stakeholders in the rate-setting process; and

  3. Creation of methodologies that include mechanisms for regular adjustments to rates.

- Areas identified for study were limited because of the large number of services. The 36 services addressed by the Provider Rates Task Force related to:

  1. Community support services for disabled persons;

  2. Adults and children with mental illness; or

  3. Elderly persons.

- Priority areas established by the Provider Rates Task Force were based on a letter of intent from Senator William J. Raggio and Assemblyman Morse Arberry Jr. and communications from other legislators. Senator Raggio and Assemblyman Arberry specifically requested priority be given to the study of rates for community training services and supported living arrangements for people with developmental disabilities and mental retardation. The Provider Rates Task Force submitted its report regarding these two services on July 15, 2002.

- An independent model was used to develop a rate for community training centers of $7.16 per person per hour for a six-hour day, with a ratio of one staff person to five clients. Clients are provided services in community training centers under four different staff-to-client ratios: 1 to 1, 1 to 2, 1 to 5, and 1 to 8. The proposed rates for the 1 to 1, 1 to 2, and 1 to 8 staff-to-client ratios were calculated by multiplying the hourly rate for the 1 to 5 ratio by 5 and dividing the product by 8, 2, or 1.

- For supported living arrangement services, the Provider Rates Task Force also used an independent model to establish a proposed rate of $20.75 per person per hour for up to 16 hours of service, with a proposed rate of $6.56 for any hours of service in excess of 16 hours per day, which would essentially cover sleep time. In addition, a rate of $42.74 per hour was proposed for nursing services.

Chairman Rawson asked if a comparison of current and proposed rates was available. Mr. Guthrie reported that using the independent model rate of $7.16 per hour for a staff-to-client ratio of 5 to 1, the proposed community training center daily rate would be $42 to $43 per day as compared to the current rate of a approximately $32 per day. He was unable to provide a comparison for supported living arrangements.

Mr. Duarte directed the committee's attention to the summary chart of rates contained on pages 1 through 6 of the Executive Summary, Strategic Plan for Provider Rates (Exhibit I), which outlines the methodology used to determine rates and the current and proposed rates for each of the 36 services evaluated.

Continuing his remarks, Mr. Guthrie covered the following points:

- Additional areas identified as priorities by the Legislature included:

  1. Services to persons with autism;

2. Targeted case management; and

3. Personal assistance services for people with disabilities.

On August 15, 2002, the Provider Rates Task Force submitted its report on these and the remaining services identified for study.

- Remaining areas studied by the Provider Rates Task Force were classified as:

1. Fiscal intermediary services;

2. Home- and community-based services to seniors and people with disabilities;

3. Adult and children mental health rehabilitative services; and

4. Therapies, e.g., physical therapy, speech therapy.

- The Provider Rate Task Force utilized a five-part method of analysis in its study of provider rates:

1. Stakeholder input was received from state personnel, county agencies, clients and their families, provider agencies, and other interested parties. In addition, public comment periods were provided at each Provider Rate Task Force session.

2. A comparison of intrastate rates was conducted to ensure that appropriate justification exists in those instances where different rates are charged for similar services, such as differentials in case manager qualifications or responsibilities. For example, the differences between services provided through an adult day care program for seniors and a community training center for people with mental retardation and developmental disabilities are not significant. Adult day care programs for seniors currently receive $40 per day while community training centers for persons with mental retardation and developmental disabilities receive slight more than $32 per day for the same service. The Provider Rates Task Force had similar concerns with respect to case management, and at the direction of the Legislature, it studied rates for such services.

3. The Provider Rates Task Force also performed a survey of service rates charged in 17 other states. States chosen for study are either demographically similar or geographically border Nevada and thus compete for service providers. In conducting the survey, the Provider Rates Task Force learned the average hourly rate for community training centers in other states is $10.08, or more than $60 per day, as compared to $32 per day currently paid for the same services in Nevada.

4. Cost collection was another area of analysis, with a wide range of responses among the various services. For example, 70 percent of the state's community training centers and 90 percent of supported living arrangement programs provided information while little response was received from other service providers. The cost collection survey revealed the average hourly cost of community training centers is over $9 per hour, or $54 per day, compared to the current rate of $32 per day.

5. Through the cooperative efforts of the DHCFP and service providers, an independent model was developed to reflect the benefits, wages, and administrative and programmatic costs associated with service delivery. The Provider Rates Task Force considers the independent model a valuable tool for the Legislature to set and analyze rates both now and in the future.

Mr. Duarte explained the study was conducted in two phases: (1) analyzing priority areas as identified by the Legislature; and (2) evaluating other services. He outlined the Provider Rates Task Force's findings and recommendations with respect to services not identified as priority areas by the Legislature, covering the following points:

- At the request of the Provider Rates Task Force, the Nevada Medicaid Office, DHCFP, developed a home- and community-based waiver program specific to individuals with autism, including an array of behavioral and support services. The recommendations for the proposed waiver program are based on the estimate of the Task

Force for People With Disabilities that approximately 300 children could immediately benefit from such a program. The Provider Rates Task Force also recommended:

1. A pilot program for adolescents;

2. A pilot program for rural areas;

3. Involvement of the University of Nevada Reno (UNR), UNLV, and the Special Children's Clinic in the program; and

4. Inclusion of appropriate support services in the Medicaid State Plan.

- Because of potential impacts to legislative mandates such as Assembly Bill 1 (Chapter 1, *Statutes of Nevada 2002 Special Session*), which "provides for integration of state and local child welfare services," discussion of targeted case management and the array of groups served through this mechanism generated some controversy. The Provider Rate Task Force's recommendations included the following:

  1. Improved standardization of Medicaid program policies;

  2. Standardization of the rate-setting process for public agencies such as state and county entities that provide targeted case management to certain groups in Medicaid;

  3. Development of standards for claiming and reporting services;

  4. With respect to targeted case management services, development of outcome and performance measures, e.g., require that a child in a target group receiving case management be facilitated in accessing appropriate medical and social services whenever such services are rendered and payment is made;

  5. Development of a per person, per month rate;

  6. Allowing the private sector to provide case management services for lower levels of care; and

  7. Utilization of a level of care system for individuals who are chronically mentally ill, such as seriously emotionally disturbed children and acutely mentally ill adults. A similar system exists for adolescents and children to ensure a child who meets certain clinical criteria receives the appropriate level of service.

- Through an independent model, it was recommended that agency providers of personal care aid services be reimbursed at a rate of $18.50 per hour and individual providers at an hourly rate of $15.50. It is important to note that these rates are likely more appropriate to Medicaid, although DETR offers a personal care aid services program. Further, the recommended rates would likely require modification to allow for the manner in which the agencies budget for services.

- The Provider Rates Task Force also recommended that a statewide fiscal intermediary waiver program be established to allow Medicaid programs to provide funds to a client through a fiscal agent of the recipient. With the assistance of the fiscal agent, the recipient could then chose and pay for needed services. Fiscal intermediary services would primarily benefit disabled persons.

- Home- and community-based service rates were also evaluated, including adult day health care, assisted living, and supported employment. Because group residential care is being phased out, a rate was not provided for this service.

- Also analyzed were adult and child mental health services involving rehabilitative assistance provided through the Medicaid State Plan. Children's community-based service rates analyzed included attendant care, day treatment, intensive community-based care, mobile crisis and therapeutic foster care services, parent and family support, rehabilitation partial care programs, rehabilitation skills training, and residential care. Adult community-based service rates considered included independent living, psychosocial rehabilitation, and other services. A rural add-on for mental health services is recommended to compensate for distances traveled.

- The Provider Rate Task Force's recommendations relative to adult and child mental health services are consistent with the provisions of A.B. 1 of the 2002 Special Session. They are also consistent with the proposal for a new model of care delivery for adult and child mental health currently being developed by the Division of Child and Family Services, DHR; the Nevada Medicaid Office; and the DMHDS for consideration by the Director of DHR within the next couple of weeks.

Chairman Rawson indicated the committee had initially received complaints that the provider rate study appeared to favor community training centers. Responding, Mr. Guthrie explained that community training centers were the first service analyzed by the Provider Rate Task Force. Establishing a methodology for evaluating the community training centers and other services was a significant undertaking, and the Provider Rate Task Force experienced a learning curve during this period. Mr. Guthrie reported the Provider Rate Task Force also encountered a number of obstacles. The state's data systems were unable to provide needed information. He noted that Mr. Willden and others are working to improve the state's data system. In addition, because service providers do not maintain cost data in the same manner, analysis was sometimes difficult. Mr. Guthrie offered the following recommendations to address these issues:

- Require service providers to maintain cost data in a more uniform manner to facilitate future analysis and comparison of information.

- Provide that rates be reevaluated at least every five years. Further, establish an independent third-party inflationary index to rebase rates during the interim years. Service rates were last rebased 14 years ago.

Mr. Duarte agreed that a significant portion of the Provider Rates Task Force's learning curve was expended developing the methodologies for community training centers and supported living arrangements. He also pointed out the legislative letter of intent identified these two services as priority areas of study with a specified report deadline of May 15, 2002. The majority of time expended by the Provider Rates Task Force in evaluating rates pertained to home- and community-based services.

Chairman Rawson asked if a resolution or letter expressing the committee's support of the four strategic plans would be adequate. Mr. Willden indicated a resolution would be appropriate. Referencing pages 1 through 6 of Exhibit I, Mr. Willden reminded the committee of the budgetary issues associated with the Provider Rates Task Force recommendations.

STRATEGIC PLAN FOR RURAL HEALTH CARE

Robin Keith

Robin Keith, President, Nevada Rural Hospital Project, and Chairperson, Rural Health Care Task Force, Reno, provided the committee with a copy of a Microsoft PowerPoint presentation titled "Rural Strategic Plan" (Exhibit N). Ms. Keith reviewed the background of the study and

discussed the findings and recommendations of the Rural Health Care Task Force, covering the following points:

- Public hearings were held throughout the state in accordance with the provisions of A.B. 513 to ensure interested persons had an opportunity to provide input. Approximately 200 individuals were involved in stakeholder meetings, and key interviews were held with 32 people with particular interest in rural health care. In addition, written opinion surveys were received from 253 rural residents, and a variety of experts provided direct comment.

- In preparation for developing a strategic plan, the Rural Health Care Task Force identified changes that had occurred in the health care delivery system over the past 20 years. It also defined certain underlying principles upon which to construct the plan. These underlying principles included:

    1. Utilizing the current infrastructure;

    2. Facilitating local control;

3. Enhancing flexibility of the workforce;

4. Facilitating statewide resource allocation that is fair to rural areas;

5. Investing in prevention;

6. Enhancing efficiency and coordination to avoid waste and duplication;

7. Supporting data collection and coordination to enhance decision making;

8. Adopting a public policy that promotes a consistently supportive approach to rural health care; and

9. Supporting tax base reform.

- Rural Nevada's vast distances, low population density, and rapidly growing and aging population present a difficult health care environment. It is estimated that by 2015, health-related expenditures for rural Nevadans over the age of 65 will increase from the current level of 24 percent of total health care expenditures to 36 percent. This will significantly affect the ability of rural areas to care for their senior citizens.

- The rate of underinsured and uninsured persons in Nevada is among the highest in the nation.

- With the assistance of its consultant, the Rural Health Care Task Force established several proposed access standards as follows:

  1. Primary Care—At least 90 percent of rural Nevadans be able to access primary care within one hour as compared to the current 78 percent that meet this standard.

  2. Behavioral Care—At least 90 percent of rural Nevadans be able to access behavioral care within one hour as compared to the current 81 percent that meet this standard.

  3. Secondary Services (Hospitals)—At least 90 percent of rural Nevadans be able to access secondary services as compared to the current 61 percent that meet this standard.

  4. Tertiary Services—At least 90 percent of rural Nevadans be able to access tertiary services within a one-hour drive as compared to the current 33 percent that meet this standard.

- Key issues relative to the provision of adequate health care in rural Nevada include the following:

  1. Limited physical and financial access;

  2. Lack of affordable insurance coverage;

  3. Financially unstable facilities, both in terms of capital and operating revenue;

  4. The growing demand for and cost of long-term care;

  5. Emergency medical systems which face issues regarding capital, coordination, funding, and staffing;

  6. Lack of sufficient behavioral health services and inadequate access and transportation to such care;

  7. Workforce shortages, including designated health personnel shortages in all 15 rural Nevada counties;

  8. Inadequate dental, obstetric, and specialty services;

  9. The absence of public health officials at the local level;

10. A need for continued development and use of telemedicine and telecommunications;

11. Lack of transportation;

12. Inadequate preventive health care;

13. Availability, accuracy, and coordination of data, which was a significant obstacle for the Rural Health Plan Task Force; and

14. The need for state, local, and public support to ensure the financial viability of the rural health care system.

- The Rural Health Plan Task Force views the broad policy statement contained in its Strategic Plan (Exhibit J, page 3) as vital to the provision of quality health care services to rural Nevadans. The policy statement asserts that:

  1. Rural residents have the same right to health care as their urban counterparts;

  2. The great majority of Nevadans should have reasonable access to quality health care;

  3. Sustaining a viable rural health care system is impossible without the commitment of public resources; and

  4. Poor or good health in rural Nevada costs or benefits all Nevadans.

  The policy statement is intended to provide a consistently supportive context in which to discuss rural health care.

- Rural health care is an important segment of Nevada's economy, generating approximately 4,700 jobs and $145 million in annual income.

- The Rural Health Care Task Force noted consistent setbacks to gains in the rural health care delivery system, referred to as "right hand/left hand."

- A total of 11 goals, 43 objectives, and approximately 170 actions steps were established. The goals were divided into the following four categories:

  1. Planning and coordination;

  2. Service delivery;

  3. Sustaining financial viability; and

  4. Infrastructure development.

- Planning and coordination are central to a meaningful effort to improve rural Nevada's health care delivery system. The Rural Health Care Task Force recommends the creation of a quasi-governmental advisory board to coordinate this effort. The advisory board's membership should consist of persons with expertise in the health care field who possess strong decision-making skills.

- In conducting the rural health care study, the Task Force was unable to obtain good data upon which to base decisions and make recommendations. It is important that Nevada maintain health care data in a consistent manner to support sound decision-making. While a great deal of data exists, Nevada lacks a central source for coordination and analysis. The Rural Health Care Task Force recommends that a central data repository be established within the Office of Rural Health.

Concluding her remarks, Ms. Keith reiterated the importance of establishing an advisory board and a central point for the collection, collation, and analysis of data. She noted that the Executive Summary, Strategic Plan for Rural Health Care (Exhibit J) did not contain a list of the 170 action steps identified by the Task Force and indicated copies would

be provided to each legislator.

Chairman Rawson observed the committee had authorized a bill draft earlier in the meeting that addressed some of the issues raised by the Rural Health Care Task Force. He suggested Ms. Keith work with Ms. Ford, previously identified on page 7 of these minutes, to ensure a coordinated effort.

ASSEMBLYWOMAN KOIVISTO MOVED THAT THE COMMITTEE REQUEST THE DRAFTING OF A RESOLUTION EXPRESSING SUPPORT FOR THE STRATEGIC PLANS FOR PROVIDER RATES AND RURAL HEALTH CARE DEVELOPED PURSUANT TO ASSEMBLY BILL 513 (CHAPTER 541, *STATUTES OF NEVADA 2001*). THE MOTION WAS SECONDED BY ASSEMBLYWOMAN PARNELL AND PASSED. SENATOR WASHINGTON WAS ABSENT FOR THE VOTE.

SENIOR SERVICES STRATEGIC PLAN

Susan Rhodes, L.A.S.W.

Susan Rhodes, L.A.S.W., Social Work Supervisor, Clark County Social Services, and Chairwoman, Senior Services Task Force, Las Vegas, provided by committee with a copy of a Microsoft PowerPoint presentation outlining the findings of the Senior Services Task Force (Exhibit O).

Ms. Rhodes reviewed the Senior Services Task Force's recommended objectives, implementation strategies, and long-term goals, covering the following points:

- Membership of the Senior Services Task Force included persons from both rural and urban areas of the state.

- To gather public input, the Senior Services Task Force conducted focus group meetings throughout the state. It also established a Web site that allowed interested parties to provide comment. Through the Clark County Senior Advocate Program, the Task Force learned of the types of direct services needed by seniors. Further, the Task Force published a survey in *Senior Spectrum*, a newspaper that is distributed statewide. A total of over 2,000 Nevadans provided input to the Task Force.

- The vision statement adopted by the Senior Services Task Force states that all seniors in Nevada are knowledgeable, secure, respected, and able to make choices toward health, hope, and happiness. It also provides that seniors should have maximum independence, direct their own care, and be fully engaged in living their lives. Further, it envisions a balanced, quality care system that is equally available to every senior with all types of services readily available.

- Six strategies guided the course of the Senior Services Strategic Plan:

  1. Implement an information campaign to educate and empower seniors and their caregivers;

  2. Encourage private sector initiatives in expanded preventive health programs, long-term care insurance, health care integration, and housing and transportation services;

  3. Establish a single point of entry system, a consistent theme of all four strategic plans;

  4. Expand and retain a qualified workforce by addressing reimbursement rates and career incentives in the long-term care field;

  5. Shift seniors from institutional care to home- and community-based care;

  6. Establish a reliable data analysis and collection system, which will lead to improved plan accountability.

- To coordinate implementation of the plan and ensure accountability, the Senior Services Task Force recommends

the appointment of a subcommittee of the Commission on Aging and quarterly tracking of all strategies.

- Six primary objectives were identified by the Senior Services Task Force:

1. Ensure more Nevada seniors live in the setting of their choice and receive needed support to maintain their independence and health. Suggested strategies to implement this objective include:

   a. Adopting a statewide policy that calls for a shift to home- and community-based services as opposed to the current institutional-based settings;

   b. Establishing an integrated data system;

   c. Providing more assisted living options for persons afflicted with Alzheimer's disease and related cognitive impairments;

   d. Supplying fully accessible housing units with integrated and wraparound services, thereby diverting entry of certain seniors into nursing homes.

   The Senior Services Task Force's goals are to complete the following by June 30, 2010:

   - Ensure that 60 percent of Nevada seniors receiving publicly funded long-term care services are being cared for at home. Currently, approximately 85 percent of long-term care is provided in an institution, with the remaining 15 percent provided in a home- or community-based setting.

   - Decrease by 15 percent from the baseline year 2000 the hospital admission rate and average length of stay. Baseline years and baseline data represent the most recent years for which the Senior Services Task Force was able to quantify its results.

   - Ensure that no Nevadans with Alzheimer's disease and related cognitive impairments are placed in out-of-state facilities due to a lack of appropriate care in Nevada.

2. Ensure more Nevada seniors engage in the occupation of life. Suggested strategies to implement this objective include:

   a. Promoting out-of-home respite options;

   b. Increasing the availability of assistive and adaptive devices; and

   c. Providing for flexible respite care options.

   The Senior Services Task Force's goal with respect to this objective is to ensure that 1,200 Nevada senior caregivers are able to use at least one formal respite care option by June 30, 2010.

3. Ensure improved health outcomes for Nevada seniors. Suggested strategies to implement this objective include:

   a. Educating seniors and their caregivers;

   b. Expanding the current Senior Rx Program and existing medication management programs; and

   c. Providing a comprehensive oral health strategy.

   The Senior Services Task Force's goals are to complete the following by June 30, 2010:

   - Decrease the percentage of severely disabled seniors aged 75 and older from the baseline year of 1997;

- Expand senior participation in the Senior RX program to 10,124; and

- Decrease the number of hospital admissions for seniors in medication management programs.

4. Ensure more Nevada seniors live in homes that are safe, fully accessible, and affordable. Suggested strategies to implement this objective include:

   a. Ensuring newly constructed homes for seniors are fully accessible;

   b. Encouraging low-interest bond financing;

   c. Identifying funding for heating and air conditioning repairs;

   d. Retrofitting existing senior housing units to be fully accessible; and

   e. Including in Medicaid waiver conditions an allowance for repairs and modifications to maintain seniors in their homes rather than placing them in institutional settings.

   The Senior Services Task Force's goals with respect to this objective are to ensure that by June 30, 2010:

   - Housing and utility expenses comprise no more than 30 percent of income for 290,000 Nevada seniors; and

   - Seven hundred seniors live in fully accessible publicly funded housing units.

5. Ensure more disabled and frail Nevada seniors receive adequate transportation services. The majority of questionnaire respondents cited transportation as a significant issue. Suggested strategies to implement this objective include:

   a. Conducting an independent study of Nevada transit programs; and

   b. Requiring that all existing providers of transit services become eligible for Medicaid reimbursement.

   The Senior Services Task Force's goal with respect to this objective is to ensure that by June 30, 2010, approximately 19,300 frail Nevada seniors are receiving adequate transportation services.

6. Ensure more Nevada seniors receive needed benefits, services, and supports. Suggested strategies to implement this objective include:

   a. Establishing a single point-of-entry system;

   b. Examining the roles and responsibilities of state and county agencies and identifying opportunities to work cooperatively to provide improved services to seniors;

   c. Adopting the recommendations of the Personal Assistance Services Advisory Council.

   The Senior Services Task Force's goals with respect to this objective are to ensure that by June 30, 2010:

   - Approximately 85,000 Nevadans are able to use a single point-of-entry system to gain information and access to services;

   - Care management and planning is provided to 9,120 seniors; and

   - Personal assistance and homemaker services are utilized by approximately 10,650 low-income seniors.

Assemblywoman Cegavske asked if any seniors had voiced concern regarding difficulties in obtaining long-term care insurance coverage. Ms. Rhodes reported the Senior Services Task Force discussed long-term care insurance at length and received input from some seniors on the topic. She noted that as a person ages, the cost of long-term care insurance becomes increasing prohibitive. Most seniors who expressed an interest in purchasing long-term care insurance could not afford the cost. Ms. Rhodes pointed out the Senior Services Task Force included in its recommendations further study of long-term care insurance.

Continuing, Ms. Cegavske indicated that she had been approached by some constituents who are concerned about their ability to provide for their future care. She also heard from persons who had been forced to sell their homes and belongings. Ms. Cegavske suggested that Minnesota's approach to long-term care be explored.

Chairman Rawson reported he has been working with a group that is examining the retirement benefits people can expect to receive in the next 30 to 50 years in various states. The group is attempting to determine whether such benefits will be sufficient to cover long-term care expenses. He complimented the Senior Services Task Force for establishing long-term goals to address the issue. In his view, the process of ensuring people receive long-term care benefits could begin by providing coverage to public employees. He noted that the cost to provide long-term care insurance to state employees was estimated at approximately $150 per employee per year, in large part because the group as a whole spans a wide range of ages. He argued that in the long term, providing such benefits would offer cost savings to the state in lower Medicaid costs.

ASSEMBLYWOMAN KOIVISTO MOVED THAT THE COMMITTEE REQUEST THE DRAFTING OF A RESOLUTION EXPRESSING SUPPORT FOR THE STRATEGIC PLAN FOR SENIOR SERVICES DEVELOPED PURSUANT TO ASSEMBLY BILL 513 (CHAPTER 541, *STATUTES OF NEVADA 2001*). THE MOTION WAS SECONDED BY ASSEMBLYWOMAN PARNELL AND PASSED. SENATOR WASHINGTON WAS ABSENT FOR THE VOTE.

PRESENTATION REGARDING THE IMPACT OF SENATE BILL 483 (CHAPTER 291, *STATUTES OF NEVADA 2001*) CONCERNING THE LICENSURE OF CERTAIN MOBILE UNITS AND THE STATE BOARD OF HEALTH'S REGULATIONS ADOPTED PURSUANT THERETO (LEGISLATIVE COUNSEL BUREAU [LCB] FILE NO. R063-02) ON SERVICES PROVIDED BY CERTAIN MOBILE MEDICAL FACILITIES

2. ***Request the drafting of a bill exempting certain mobile medical facilities that are operated by medical facilities accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association from licensure by the State Board of Health.***

   (Proposed by Janice C. Pine, Director, Governmental Relations, Saint Mary's Health Network)

Janice C. Pine

Janice C. Pine, Director, Governmental Relations, St. Mary's Health Network, Reno, reported that Senate Bill 483 (Chapter 291, *Statutes of Nevada 2001*), which "requires state board of health to license mobile medical facilities and facilities for refractive laser surgery," was originally introduced at the request of a podiatrist who sought to perform certain procedures in rural areas of southern Nevada. It was St. Mary's understanding that its Mobile Outreach Program would be exempt from the legislation. After the bill passed, it was determined that St. Mary's Mobile Outreach Program was subject to the provisions of the bill and would be required to comply with associated regulations. Ms. Pine explained an attempt was made to address this issue through a variance to the regulations, and she complimented staff of the Bureau of Licensure and Certification, Health Division, DHR for their efforts. However, it appears legislative action will be required to resolve the matter.

Continuing, Ms. Pine covered the following points:

- St. Mary's Regional Medical Center is accredited by the Joint Committee on Accreditation of Healthcare Organizations (JCAHO) as a tertiary care center. Its Mobile Outreach Program is part of St. Mary's Mission Services Division and was specifically designed to provide certain services to underserved populations of Washoe County, Nevada, and of outlying rural areas in northern Nevada. All aspects of the Mobile Outreach Program are subject to inspection in the JCAHO accreditation process.

- During the past year, St. Mary's dental and medical programs visited more than 126 sites in Washoe County and rural northern Nevada counties and served more than 16,000 northern Nevada residents. Medical services provided through the Mobile Outreach Program are preventive in nature and are considered basic primary care.

- Currently, the Mobile Outreach Program is funded entirely by donations and grants; however, St. Mary's is exploring the possibility of utilizing Medicaid, Medicare, and county indigent funds in the future.

- St. Mary's presently operates three mobile units, two dental and one medical. Ronald McDonald House Charities recently awarded St. Mary's funding for a fourth van, or mobile unit, which will probably incorporate both dental and medical services.

- Mobile units visiting underserved areas often provide dental as well as medical services. The regulations required under S.B. 483 would not allow for this flexibility unless St. Mary's underwent a rigorous process, including obtaining variances as well as licensing a dental van as a medical unit. The medical services provided by the Mobile Outreach Program are similar to those typically offered at county and health fairs and at shopping centers.

- Requiring St. Mary's Health Network's Mobile Outreach Program to comply with the regulations required under S.B. 483 would present a number of obstacles to its mission of providing dental and health services to people who lack the access and means to obtain medical care elsewhere, including the following:

  1. Flexibility—Because dental offices are not included in the definition of medical facilities, they are not subject to the regulations required under S.B. 483. However, if such mobile units are used for medical purposes such as providing immunizations or counseling services, they will be subject to the regulations required under S.B. 483.

  2. Record Keeping— Record keeping must comply with standards of practice. In addition, it must meet JCAHO standards and serum provider requirements. Physically maintaining patient records, which would be required by the regulations developed pursuant to S.B. 483 would present certain problems.

     St. Mary's works in partnership with Washoe County on several of its programs. For instance, it shares responsibilities with Washoe County's child and adult protective services staff as well as the Washoe County District Health Department's community health nurses. The Washoe County District Health Department maintains all immunization and well-child records while St. Mary's is responsible for maintaining patient records on seniors who receive services. Mobile health records are kept by those providing the service in the vans, which in some instances might be Washoe County's District Health Department or its child and adult protective services staff.

Concluding her remarks, Ms. Pine stated St. Mary's Health Network's goal is to maintain the current level of service it provides through its Mobile Outreach Program. She pointed out that under the regulations required by S.B. 483, St. Mary's mobile outreach units are treated as medical facilities within a medical facility, creating an unnecessary layer of regulatory review. Ms. Pine requested that the committee sponsor a bill to remove its Mobile Outreach Program from S.B. 483, noting this might be accomplished by exempting all such outreach mobile units that are operated by an appropriately accredited medical facility. Assemblywoman Cegavske asked that the committee also extend this exemption to First Lady Dema Guinn's Mammovan.

Chairman Rawson observed that certain mobile units in southern Nevada provide preventive services. In addition, some mobile dental units currently do not undergo an accreditation process. He cautioned that any bill introduced to provide exemptions to such mobile units not create additional issues.

Continuing, Chairman Rawson noted the committee had limited bill drafts remaining, and he asked that staff consolidate as many issues as possible.

SENATOR MATHEWS MOVED THAT THE COMMITTEE REQUEST THE DRAFTING OF A BILL TO EXEMPT CERTAIN MOBILE OUTREACH UNITS FROM THE PROVISIONS OF SENATE BILL 483 OF THE 2001 SESSION, WITH THE INTENT THAT SUCH MOBILE UNITS BE ABLE TO PROVIDE SERVICES WITHOUT EXCESSIVE REGULATION. THE MOTION WAS SECONDED BY ASSEMBLYWOMAN KOIVISTO AND PASSED. SENATOR WASHINGTON WAS ABSENT FOR THE VOTE.

PRESENTATION REGARDING PROPOSALS TO DEVELOP ADDITIONAL INPATIENT PSYCHIATRIC CARE AND OTHER MENTAL HEALTH SERVICES FOR INDIVIDUALS WITH MENTAL ILLNESSES

Chairman Rawson reported that in discussing issues relative to emergency room diversions, concerns were expressed regarding the need for additional inpatient psychiatric care and overall mental health services. He noted testimony and recommendations related to this topic were also presented to the Legislative Commission's Subcommittee to Study Suicide Prevention (NRS 218.682). In a letter dated October 22, 2002, Senator Ann O'Connell, Chairwoman of the Legislative Commission's Subcommittee to Study Suicide Prevention, requested that the Legislative Committee on Health Care consider certain recommendations presented to the suicide prevention subcommittee (Exhibit P).

Continuing, Chairman Rawson announced that Carlos Brandenburg, Director, DMHDS, reported to committee staff that several of the items suggested by the Legislative Commission's

Subcommittee to Study Suicide Prevention have been included in DHR's budget and submitted to Governor Kenny C. Guinn for consideration. Items requested include funding for:

1. Construction of a new facility to increase available inpatient and observation bed space;

2. Expansion of the current capacity of the adult mental health facility in Clark County from 68 to 77 beds;

3. An increase in the number of psychiatric observation beds from 16 to 26;

4. Mobile psychiatric assessment teams that would operate 24 hours per day, seven days per week;

5. Expansion of the program for assertive community treatment, thus providing more support to individuals with mental illness who are not institutionalized; and

6. Increased community placement of individuals with sufficient support services.

Kathryn Landreth and Janelle L. Kraft

Kathryn Landreth, Chief, Office of Policy and Planning, Las Vegas Metropolitan Police Department, and Chairwoman, Southern Nevada Mental Health Coalition, and Janelle L. Kraft, Budget Director, Office of Finance, Las Vegas Metropolitan Police Department, and Co-Chairwoman, Southern Nevada Regional Planning Coalition's Task Force on Emergency Room Overcrowding (also known as the Chronic Public Inebriate [CPI] Task Force), both of Las Vegas, provided the committee with the following documents:

1. Mental Health Crisis Recommendations Submitted by the Southern Nevada Mental Health Coalition and the Chronic Public Inebriate Task Force (Exhibit Q); and

2. Psychiatric Tracking Totals (Exhibit R).

Ms. Kraft prefaced her remarks by noting that her purpose in testifying before the committee was to discuss certain needs not currently being met in southern Nevada and to support the efforts of the DMHDS and the mental health

community to increase funding of CPI and mental health services. Ms. Kraft covered the following points:

- The CPI Task Force has identified the housing of public inebriates and chronically mentally ill persons in hospital emergency departments as the most significant contributing factor to emergency room overcrowding. Many of these persons have co-occurring disorders and suffer from alcohol and drug abuse as well as mental illness.

- Emergency responders are required by law to transport public inebriates and mentally ill persons to hospital emergency rooms for full medical clearance. Such individuals sometimes remain in hospital emergency room beds for extended periods of time until they become sober or can be transferred to a mental health treatment center, if appropriate. In the meantime, rescue personnel and police must wait hours in hospital emergency rooms for these patients.

- Most CPIs and mentally ill persons are indigent and are released from hospital emergency rooms without receiving any follow-up care or treatment. These individuals continue to cycle through the criminal justice and health care systems.

Referencing Exhibit Q, Ms. Landreth reviewed statistics in support of the recommendations of the CPI Task Force and the Southern Nevada Mental Health Coalition, covering the following points:

- Southern Nevada public entities adversely affected by the lack of community mental health resources include ambulance companies, fire departments, hospitals, and law enforcement agencies.

- The cost of detoxification services varies widely, from $1,500 per visit for treatment at a hospital emergency department to $130 per day for care received at WestCare.

- A comparison of the number of CPIs presenting for treatment in southern Nevada's hospital emergency rooms over a three-year period showed an increase of 1,739 patients between 1999 and 2001. The cost of providing treatment to such patients rose from $3,075,764 in 1999 to $7,045,021 in 2001.

- Similarly, a comparison of the volume of psychiatric patients in crisis presenting for treatment at southern Nevada hospital emergency rooms more than doubled, from 3,253 in 1999 to 6,864 in 2001. Typically, these patients are taken to hospital emergency rooms as part of the process by which a person is certified to be a danger to himself or to others.

- Exhibit R provides a summary of the number of patients recently held in southern Nevada hospital emergency department beds over a three-week period while awaiting admission to a mental hospital. Such psychiatric patients typically do not receive mental health treatment while awaiting transfer.

- The estimated cost of care provided to psychiatric patients presenting at hospital emergency departments has increased significantly in the past three years, from $3,330,356 in 1999 to $9,292,976 in 2001.

- Currently, a patient must be medically cleared before being admitted to Southern Nevada Adult Mental Health Services (SNAMHS), DMHDS. Such medical clearance is usually performed at a hospital emergency room. This process creates a significant transportation expense. At present, the annual cost of transporting people to hospital emergency rooms for medical clearance and then to SNAMHS is approximately $1.7 million. Ambulance companies are able to recover only about 15 percent of this expense.

Chairman Rawson questioned whether the referenced costs shown in Exhibit Q had been paid by UMC and other hospitals or if they represent unrecovered expenses. Ms. Landreth explained that the Clark County Public Health Department assisted in gathering the statistics. It is her understanding the figures shown represent the estimated cost to hospitals of holding CPI and mentally ill patients for which reimbursement is not received. She noted the hospitals have established an estimate of the cost to occupy one of their emergency beds and one of their regular hospital beds. Continuing, Chairman Rawson commented that legislators and candidates for public office receive a great deal of information, especially during the campaign season. For instance, he heard UMC's loss was $40 million. However, because Medicaid payments are sometimes issued 100 days beyond schedule, several million dollars might be deducted from the projected loss. He asserted such issues must be recognized and addressed.

Ms. Landreth noted that placing CPIs and mentally ill patients in hospital emergency room beds is the most expensive care provided. She expressed a desire to offer lower cost alternatives to meet the needs of such persons. Continuing her presentation, Ms. Landreth covered the following additional points:

- Estimated annual unrecovered costs for holding CPI and mentally ill patients is $16 million.

- A significant number of persons afflicted with mental health problems enter the criminal justice system. While the crimes they commit justify their arrests, incarceration may not deter them from reoffending. Exhibit Q provides a conservative annual estimate of the jail costs associated with housing mentally ill persons whose crimes arise from their mental illness. Examples of such offenses include occasional harassment, petty theft as a crime of survival, and trespass.

- Las Vegas Fire & Rescue responded to a total of approximately 6,800 overdose and suicide calls in 2001. In addition, a two-month survey recently conducted by the Las Vegas Metropolitan Police Department revealed the Department had responded to over 350 suicide attempt calls in one month.

Ms. Kraft reviewed the recommendations of the CPI Task Force and the Southern Nevada Mental Health Coalition as follows:

1. Establish a crisis triage center to evaluate persons in crisis regardless of the initial assessment, e.g., alcohol abuse, dementia, drug misuse, or epileptic seizures. Responders such as fire personnel, law enforcement officials, and paramedics currently spend a significant amount of time in the field performing assessments and determining where to transport persons in crisis. WestCare has offered the use of its facility located at Martin Luther King Boulevard and Alta in Las Vegas to serve as a crisis triage center. Identified funding sources for the center include local governments, hospitals, and federal and state grant funds that WestCare currently receives. Local governments have been asked to pay one-third of the cost of funding the center, or about $1.2 million; formal requests to the individual boards will be presented in November 2002.

Chairman Rawson observed that it appeared creation of a crisis triage center was already being pursued and asked how the committee might support this endeavor. Ms. Kraft noted the committee's earlier approval of a BDR to appropriate $681,000 toward funding of the center was adequate.

Continuing, Ms. Kraft offered the following recommendation:

2. Develop a mechanism to provide permanent long-term funding, such as increasing the tax on the sale of liquor, to support CPI and mental health services. The Governor's Task Force on Tax Policy was recently asked to consider increasing the alcohol tax. Preliminary research indicates only a small portion of the tax revenue from liquor sales is currently used to fund CPI and mental health services. An increased portion of the liquor tax revenues should be designated to fund such services.

Chairman Rawson observed that tax committees view earmarking of funds as poor tax policy. Acknowledging the relationship between alcohol and CPIs, Chairman Rawson suggested a portion of liquor tax revenue should be dedicated to funding mental health services and should not be used solely to address the General Fund shortfall. Continuing, he noted the committee could express its support for allocation of a certain percentage of liquor tax revenues to fund CPI and mental health services by sending a letter. In the alternative, the committee could add its support for allocation of a certain percentage of liquor tax revenues to fund CPI and mental health services to the resolution expressing support for the four strategic plans developed pursuant to A.B. 513. Chairman Rawson pointed out that a significant portion of hospital costs is associated with lifestyle choices such as liquor and tobacco use. In his view, a portion of the funds generated from the sale of such items should be used to develop relief.

ASSEMBLYWOMAN KOIVISTO MOVED THAT THE DRAFT RESOLUTION PREVIOUSLY REQUESTED BY THE COMMITTEE TO EXPRESS ITS SUPPORT FOR THE FOUR STRATEGIC PLANS DEVELOPED PURSUANT TO ASSEMBLY BILL 513 (CHAPTER 541, *STATUTES OF NEVADA 2001*) ALSO CONVEY THE COMMITTEE'S SUPPORT FOR ESTABLISHING PERMANENT, LONG-TERM FUNDING FOR CHRONIC PUBLIC INEBRIATE

AND MENTAL HEALTH SERVICES, INCLUDING CONSIDERATION OF THE POTENTIAL ALLOCATION OF A CERTAIN PERCENTAGE OF LIQUOR TAX REVENUE TO FUND SUCH SERVICES. THE MOTION WAS SECONDED BY ASSEMBLYWOMAN PARNELL AND PASSED. SENATOR WASHINGTON WAS ABSENT FOR THE VOTE.

Ms. Landreth continued the review of the CPI Task Force and the Southern Nevada Mental Health Coalition's recommendations as follows:

3. Amend *Nevada Revised Statutes* (NRS) 433A.330, "Transportation to mental health facility," to authorize paramedics to transport patients who meet specific criteria directly to the state mental hospital or other qualified facility for treatment. According to Ms. Landreth, Nevada statute currently requires that a person be medically cleared at a hospital emergency room before he or she can be transferred to a mental health facility in Nevada. It is her understanding that at the time this requirement was adopted, hospitals possessed the resources necessary to carry out this task. She noted that circumstances have changed over the years, and hospitals now struggle to fulfill their obligation. To address this issue, Ms. Landreth asked that the committee request a bill draft to authorize a medical evaluation to take place at a facility other than a hospital emergency room.

Chairman Rawson pointed out that if the medical clearance requirement were removed from statute, mentally ill patients who exhibit symptoms of a disease or an illness might be placed in a mental institution without first receiving proper medical care. He noted that if the committee decided to request a bill draft to address this issue, a thorough discussion of the topic would ensue during the 2003 Session.

Ms. Landreth explained the CPI Task Force did not envision that people would be transported to mental health facilities without consideration for their medical care. The CPI Task Force has developed an effective algorithm to assist emergency responders in determining whether a person must be medically cleared in a hospital ER before being transported to a mental health facility. First responders would be trained to administer certain tests to determine whether the patient requires medical clearance. For example, if the patient passed certain screening tests, he or she would be transported to a facility that accepts CPIs. Continuing, Ms. Landreth pointed out that the receiving institution is always free to determine whether the patient can be safely maintained at the facility without the necessity of obtaining medical clearance from a hospital emergency department. She suggested similar screening tests could be developed for mentally ill persons. Authorizing the use of this mechanism would allow the transportation of patients directly to the crisis triage center so that they receive appropriate treatment in a timely manner.

Senator Rawson questioned why medical clearances have not been conducted at sites other than hospital emergency rooms in the past. Ms. Landreth indicated it is her understanding that liability is an issue of concern for the state mental hospital. While liability is also of concern to the Clark County Detention Center, the Detention Center does not require medical screening for mentally ill persons. Ms. Landreth emphasized that the effectiveness of the proposed crisis triage center would be seriously undermined if first responders were not allowed to transport CPIs and mentally ill persons who pass certain medical screening tests directly to WestCare.

Chairman Rawson expressed a willingness to consider the issue during the 2003 Session. In his view, the recommendation is worthy of discussion. He cautioned, however, that the necessary resources may not be available to support the recommendation. Further, the state may oppose the recommendation. Chairman Rawson asked if Ms. Kraft and Ms. Landreth had prepared draft language for a bill. Responding, Ms. Kraft indicated they did not draft specific language to address this issue. The CPI Task Force and the Southern Nevada Mental Health Coalition envisioned some type of medical evaluation being conducted at a facility other than a hospital emergency room. She indicated that if the committee authorized a bill draft, she would make available hospital representatives and paramedics to assist with the language. Chairman Rawson indicated the committee may need to seek permission of the Legislative Commission for additional bill drafts.

ASSEMBLYWOMAN KOIVISTO MOVED THAT THE COMMITTEE REQUEST THE DRAFTING OF A BILL TO AUTHORIZE THE MEDICAL EVALUATION OF A CHRONIC PUBLIC INEBRIATE OR MENTALLY ILL PERSON TO BE CONDUCTED AT A FACILITY OTHER THAN A HOSPITAL EMERGENCY ROOM. THE MOTION WAS SECONDED BY SENATOR MATHEWS AND PASSED. SENATOR WASHINGTON WAS ABSENT FOR

THE VOTE.

Ms. Landreth stated it was her understanding the following CPI Task Force and the Southern Nevada Mental Health Coalition recommendations have been included in the Executive Branch's legislative requests: (1) funding of mobile crisis units; (2) additional crisis observation beds; (3) an increased number of inpatient acute care beds at SNAMHS; (4) coordinated case management; and (5) Program for Assertive Community Treatment (PACT) services.

Continuing, Ms. Landreth reviewed additional recommendations of the CPI Task Force and the Southern Nevada Mental Health Coalition as follows:

4. Amend the provisions of NRS 458.270, "Procedure for placing person in civil protective custody" to include persons with substance abuse issues or mental illness. Currently, NRS 458.270 applies only to persons who are under the influence of alcohol. Civil protective custody benefits should be extended to all persons who may present a danger to themselves or others or are unable to care for themselves due to mental illness or abuse of certain substances. A bill draft would be necessary to accomplish this goal.

Chairman Rawson reiterated that the committee might need to seek permission of the Legislative Commission for additional bill drafts.

ASSEMBLYWOMAN KOIVISTO MOVED THAT THE COMMITTEE REQUEST THE DRAFTING OF A BILL TO EXPAND THE PROVISIONS OF NRS 458.270 TO INCLUDE PERSONS WHO MAY PRESENT A DANGER TO THEMSELVES OR TO OTHERS OR WHO ARE UNABLE TO CARE FOR THEMSELVES DUE TO MENTAL ILLNESS OR ABUSE OF CERTAIN SUBSTANCES. THE MOTION WAS SECONDED BY SENATOR MATHEWS AND PASSED. SENATOR WASHINGTON WAS ABSENT FOR THE VOTE.

5. Provide funding for a mental health court system in Nevada. Statute currently authorizes the creation of mental health courts, and a successful pilot project in presently operating in Washoe County, Nevada, without funding. Mental health courts would offer a means of identifying persons entering the criminal justice system as a result of mental health issues. Such courts could utilize the same principles used by drug courts to keep persons from reoffending. An appropriation was requested to fund mental health courts in Clark County and Washoe County.

Chairman Rawson asked what amount was being sought to fund mental health courts in Clark and Washoe Counties. Ms. Landreth indicated she lacked the expertise necessary to provide a dollar amount; however, one funding option discussed was to increase a court fine or some court-related fee by about $5. She noted that Assemblywoman Sheila D. Leslie had proposed a specific amount to fund a mental health court. Ms. Landreth requested that the committee consider increasing a fee by a nominal amount and using the additional revenue collected to fund the proposed mental health courts. She suggested the mental health courts could then operate at whatever level of funding is received.

Continuing, Chairman Rawson questioned whether Assemblywoman Leslie has requested a bill draft to address funding of mental health courts. Ms. Kraft stated it was her understanding Assemblywoman Leslie had requested a bill draft that would provide funding for mental health courts in both Clark and Washoe County. Chairman Rawson pointed out that if a bill draft had already been requested to address the issue, there would be no need to authorize another measure on the same topic.

Richard L. Siegel

Richard L. Siegel, Ph.D., Professor of Political Science, UNR; President, American Civil Liberties Union (ACLU) of Nevada; and a member of the Steering Committee for the ACLU's Human Services Network, Reno, endorsed the recommendations of the CPI Task Force and the Southern Nevada Mental Health Coalition to promote mental health services. He reported the ACLU is particularly supportive of the effort to fund mental health courts in both northern and southern Nevada.

Steven Dempsey

Steven Dempsey, a private citizen, Las Vegas, stated that he is a health care professional with a law degree. He

related that a woman was held against her will for two or three days at an area hospital, and once space was available, transferred to WestCare. He expressed concern that if more mental health beds are made available, facilities may hold people against their will in an attempt to secure added revenue.

Senator Rawson acknowledged Mr. Dempsey's concerns and assured him that care would be taken in drafting the bill to ensure incentives are not created that would result in the loss of individuals' rights without adequate safeguards or due process.

Chairman Rawson indicated he would accept a motion to send a letter to Assemblywoman Leslie in support of her bill draft to fund mental health courts.

ASSEMBLYWOMAN KOIVISTO MOVED THAT THE COMMITTEE SEND A LETTER TO ASSEMBLYWOMAN SHEILA D. LESLIE EXPRESSING SUPPORT FOR HER BILL DRAFT TO FUND SPECIALTY COURTS, PARTICULARLY MENTAL HEALTH COURTS. THE MOTION WAS SECONDED BY ASSEMBLYWOMAN PARNELL AND PASSED. SENATOR WASHINGTON WAS ABSENT FOR THE VOTE.

PRESENTATION CONCERNING PLACEMENT OPTIONS FOR PROVIDING INPATIENT PSYCHIATRIC CARE AND OTHER MENTAL HEALTH SERVICES TO INDIVIDUALS WITH MENTAL ILLNESSES

3. *Request the drafting of a bill directing Nevada's Department of Human Resources to study the feasibility, and if appropriate, to develop a proposal for outsourcing certain inpatient psychiatric care and mental health services provided to individuals awaiting placement in a state facility.*

   (Proposed by Thomas Maher, Chief Executive Officer, Montevista Hospital)

Thomas Maher

Thomas Maher, Chief Executive Officer, Montevista Hospital, Las Vegas, and a member of the Nevada Hospital Association's (NHA's) Board of Directors, appeared at the direction of the NHA. Mr. Maher provided the committee with a written copy of his remarks together with a document titled "Clark County Acute Care Hospitals: ER Psychiatric Cases, January 1, 2002, to October 6, 2002" (Exhibit S). He discussed placement options for providing inpatient psychiatric care and other mental health services to individuals with mental illness that would alleviate the overcrowding of southern Nevada's emergency room departments, covering the following points:

- Other than SNAMHS, Montevista Hospital is the only freestanding psychiatric hospital in southern Nevada.
- The NHA and Montevista Hospital share the goal of SNAMHS to provide access to mental health services for those in need and to relieve the overcrowding of hospital emergency departments.
- There is consensus among the various groups studying overcrowding of hospital emergency departments that an increasing number of mentally ill patients are presenting at such sites needing psychiatric services. According to recent research, an average of 22 mentally ill patients waited for placement in emergency departments each day during the first nine months of 2002. Recent reports for the weeks prior to October 17, 2002, indicate the number of such mentally ill patients awaiting placement in a mental health facility has risen to 36 per day.
- Many psychiatric patients who present for treatment at hospital emergency departments occupy a bed for up to several days while awaiting placement at a mental health facility. As a result, persons with serious medical conditions must wait for increasingly long periods of time to be treated or triaged to the appropriate level of care.
- For each psychiatric patient occupying an emergency department bed, an average of seven medical patients could be seen.
- Another issue that contributes to hospital emergency department overcrowding is the placement of mentally ill

patients on a 72-hour hold as authorized by statute. There is disagreement as to when the 72 hours of detainment begins, e.g., upon admission to a mental health facility or upon placement of physical restraints. Depending upon the demand for psychiatric services, a mentally ill patient might spend several days in a hospital emergency department in physical restraints before being admitted to SNAMHS.

- Southern Nevada Adult Mental Health Services needs additional resources to meet the growing demand for services. The Governor has suggested using $15 million from prison funds to build a new state mental health facility. However, such a facility would cost significantly more to build. Further, the annual operating budget of the new hospital could be between $7 million to $10 million, depending on the size of the facility. In addition, nurses and physicians would need to be retained to provide patient care.

- Outsourcing mental health services to private providers offers a viable solution to ameliorating hospital emergency room overcrowding and is routinely utilized in other markets. Such arrangements are typically governed under a per diem agreement where the facility is paid a daily rate that includes physician services. If mental health services were outsourced, patients could be treated and released in accordance with state criteria or transferred to a government facility once space becomes available.

- Montevista Hospital has available bed space, physicians, and staff to help reduce overcrowding in southern Nevada's hospital emergency rooms. Utilizing surplus local private resources such as those available at Montevista Hospital would significantly reduce hospital emergency room overcrowding and alleviate the demands being placed on SNAMHS.

Referencing other area mental health facilities, Assemblywoman Cegavske mentioned she had been informed that the Willow Springs Center would be closing in April 2003 and questioned whether Mr. Maher's proposal would address treatment of adolescents needing psychiatric care. She also asked what services are provided by Mohave Mental Health Services. Mr. Maher indicated it is his understanding that Willow Springs Center's children's intermediate program will be closing. He noted that Montevista Hospital's proposal could be generalized to all populations.

Chairman Rawson asked Mr. Maher to provide a comparison between the bed day costs for Montevista Hospital and SNAMHS. Mr. Maher prefaced his response by noting that he did not have official information on the cost of a bed day at SNAMHS. Based on a conversation with Jonna Triggs, Ed.D., Agency Director, SNAMHS, it is his understanding that SNAMHS's direct costs are approximately $360 to $380 per patient day. Mr. Maher reported that given the same census, Montevista Hospital's bed day costs would be comparable to those of SNAMHS. Currently, Montevista Hospital provides treatment to an average of 55 patients per day at a daily cost of approximately $425 to $435 per patient. However, economies of scale could be achieved with a higher census, thus lowering the cost per bed day.

Chairman Rawson observed that DHR could authorize placement of mentally ill patients in a private facility without the necessity of changing the law. He asked Mr. Maher what action he was seeking from the committee. Mr. Maher indicated that having no knowledge of SNAMHS's budget line items, he was asking for the committee's support in approving additional resources to alleviate hospital emergency department overcrowding.

Michael J. Willden

Mr. Willden, previously identified on page 12 of these minutes, reported the reduction in services at the Willow Springs Center is part of the overall 3 percent budget reductions approved over the past month. The 56-bed facility currently operates close to capacity, and it was his recollection that 12 of the beds would be closed effective April 1, 2003. The reduction specifically relates to the youngest children in Willow Springs' program. An attempt will be made to provide services to the children affected by the reduction in a community-based setting.

Continuing, Mr. Willden outlined specific recommendations included in DHR's budget requests to the Governor:

1. Construction of a new mental hospital in southern Nevada with: (a) 30 beds in the observation unit; and (b) 120 inpatient beds with expandability for another 30 beds. It is his understanding the proposed new mental hospital is a priority capital improvement project.

   The proposed new mental hospital is a long-term project that would likely require at least two years to complete.

In the meantime, SNAMHS has 20 beds in its observation unit and 68 inpatient beds. The DHR has requested that the Governor consider fully staffing to the facility's licensed capacity—an addition of approximately ten beds—while the new mental hospital is being built. If capacity issues arise, it might be possible to contract with a private provider.

2. Creation of an additional PACT team.

3. Establishment of a mobile crisis team.

Chairman Rawson questioned whether DHR anticipated restoring services at Willow Springs Center in the future or if it planned to explore alternate means of treatment. Mr. Willden explained that Willow Springs Center contains five different units. Staff recommended closure of the unit that serves the youngest age group, indicating an attempt would be made to provide services to these children in a community-based setting. Chairman Rawson expressed concern about the planned reduction in services and indicated he would closely monitor the situation. He noted that as the Legislature returns funds to the budget, agencies will be asked what items should be funded.

David A. Rosin

David A. Rosin, M.D., State Medical Program Director, DMHDS, DHR, Carson City, explained that Mojave Adult, Child, and Family Services is primarily an outpatient treatment program that provides care mostly to Medicaid and some Medicare clients. In southern Nevada, Medicaid clients requiring hospitalization currently utilize SNAMHS or Lake Mead Hospital, which is a Medicaid provider. Because of reimbursement issues, such patients cannot utilize Montevista Hospital. Facilities that accept senior citizens covered by Medicare include SNAMHS, Lake Mead Hospital, and Valley Hospital. He noted that Montevista Hospital opted out of the Medicare program some months ago.

PRESENTATION REGARDING THE PROPOSAL SUBMITTED BY EP&P CONSULTING, INC. TO PERFORM A STUDY OF POTENTIAL OPPORTUNITIES FOR NEVADA TO MAXIMIZE FEDERAL FUNDING FOR CERTAIN INDIGENT HEALTH CARE SERVICES

Chairman Rawson reported that Senate Bill 377 (Chapter 598, *Statutes of Nevada 2001*), which "revises provisions governing payment of hospitals for treating disproportionate share of Medicaid patients, indigent patients or other low-income patients," required the committee to explore alternative methodologies for providing funding for the provision of medical care to Medicaid patients, indigent patients, and other low-income patients, including the possibility of increasing revenue from other sources. At the committee's August 20, 2002, meeting, Peter Burns, Senior Consultant, EP&P Consulting, Inc. (EP&P), discussed the potential for maximizing federal funding using county dollars (Exhibit T). Mr. Burns indicated approximately $46 million in county funds allocated to cover indigent health care expenses is unmatched by federal funding sources.

Thereafter, the committee requested that EP&P provide an estimate of the cost to continue its study of the potential for maximizing federal funds. Chairman Rawson announced that EP&P had quoted a price of $39,000 to perform a more in-depth study on this topic. Because only $15,000 remains in the committee's budget, several potential partners were approached to determine possible funding sources for the remaining $24,000. Chairman Rawson reported that the committee has received commitments from several hospitals that are members of the NHA and from the Nevada Association of Counties (NACO) to fund the remaining $24,000 needed to conduct the study.

Chairman Rawson indicated he would accept a motion to: (1) pay EP&P $15,000 for the balance remaining on its current contract; (2) enter into a contract with EP&P in the amount of $39,000 to develop a proposal for leveraging local funds with an expansion through a Medicaid waiver; and (3) pay EP&P $15,000 to conduct an in-depth study of the potential for maximizing federal funds and accept $24,000 from various hospitals of the NHA and NACO to fund the balance of the contract. To ensure fair distribution of potential additional funding, Chairman Rawson envisioned that any waiver program designed to maximize federal revenue would provide that funds follow the patient. Further, a distribution formula would be required. Chairman Rawson stated that the financial contributions of NHA members and NACO would not unduly influence the study; however, these parties would stand to benefit should a plan be developed which ultimately leads to increased health care revenue through federal funds maximization.

Mike Alastuey

Mike Alastuey, Las Vegas, appearing on behalf of UMC, requested that UMC be allowed to participate in efforts to maximize federal funding.

ASSEMBLYWOMAN KOIVISTO MOVED THAT THE COMMITTEE: (1) PAY EP&P $15,000 FOR THE BALANCE REMAINING ON ITS CURRENT CONTRACT; (2) ENTER INTO A CONTRACT WITH EP&P IN THE AMOUNT OF $39,000 TO DEVELOP A PROPOSAL FOR LEVERAGING LOCAL FUNDS WITH AN EXPANSION THROUGH A MEDICAID WAIVER; AND (3) PAY EP&P $15,000 FROM THE CURRENT COMMITTEE BUDGET TOWARD SUCH A STUDY AND ACCEPT A TOTAL OF $24,000 FROM VARIOUS HOSPITALS OF THE NHA AND FROM NACO TO FUND THE BALANCE OF THE CONTRACT. THE MOTION WAS SECONDED BY ASSEMBLYWOMAN PARNELL AND PASSED. SENATOR WASHINGTON WAS ABSENT FOR THE VOTE.

Chairman Rawson asked that staff monitor the progress of the funds maximization study and keep him advised of any new developments. Further, he directed that the study be conducted in a manner that allows for input from interested parties.

PRESENTATION REGARDING THE DRAFT OF A BILL THAT UPDATES EXISTING LAWS TO ADDRESS PUBLIC HEALTH ISSUES RELATED TO THE DETECTION AND CONTROL OF CERTAIN DISEASES

Leslie K. Hamner

Leslie K. Hamner, Principal Deputy Legislative Counsel, Legal Division, Legislative Counsel Bureau, Carson City, provided the committee with the following documents:

1. Bill Draft Request of the Legislative Committee on Health Care to Update Existing Laws to Address Public Health Issues Related to the Detection and Control of Certain Diseases (Exhibit U); and

2. A draft of the bill designated as BDR 40-677 (Exhibit V).

Ms. Hamner reported that the draft bill had been reviewed by Randal L. Munn, Deputy Attorney General, Human Resources Division, Office of the Attorney General, and indicated she would be working with Mr. Munn to address his concerns.

Continuing, Ms. Hamner reviewed the bill draft that proposes to update existing laws to address public health issues related to the detection and control of certain diseases, covering the following points:

- At its August 20, 2002, meeting, the Legislative Committee on Health Care requested the drafting of a bill to make various changes to Nevada statute to address certain public health issues.

- The Legislative Committee on Health Care requested that the bill draft:

  1. Authorize certain agencies and officers of the state and local governments to quarantine and isolate a group of persons as suggested by Randall L. Todd, Dr.P.H., State Epidemiologist, Health Division;

  2. Include various due process protections patterned after those set forth in Chapter 433A of NRS, "Admission to Mental Health Facilities, Hospitalization and Sealing of Records," for certain persons who are isolated or quarantined as suggested by Randal L. Munn, Deputy Attorney General, Human Resources Division, Office of the Attorney General; and

3. Require the State Board of Health to develop a syndromic reporting and active surveillance system to monitor public health during certain major events and when appropriate and necessary as suggested by Dr. Todd.

- Sections 27, 28, 30, and 31 of the draft include provisions authorizing a local board of health and a health authority to isolate or quarantine a group of persons.

- The provisions which set forth the procedures that must be followed when a person with a communicable or infectious disease is isolated or quarantined in a medical facility are contained in sections 2 through 26 of the draft and are modeled after those in NRS 433A.145, "Restrictions on change of status from voluntary client to emergency admission," through 433A.330. Mr. Munn has suggested that these provisions should be amended to include all persons who are isolated or quarantined, regardless of where the isolation or quarantine takes place.

- Section 7 of the draft prohibits a medical facility from changing the status of a person who has been voluntarily isolated or quarantined in the facility to an emergency isolation or quarantine unless the facility has received certain documentation. This section further provides that a person whose status has changed to emergency isolation or quarantine must not be detained in excess of 48 hours after the change in status is made unless within that period of time, a petition for the involuntary court-ordered isolation or quarantine of the person is filed.

- The draft provides in Section 8 that a person who is alleged to have a communicable or infectious disease may be detained in a medical facility under an emergency isolation or quarantine for testing, examination, observation, and treatment upon application for such isolation or quarantine. It further provides that a person admitted to a medical facility under an emergency isolation or quarantine must be released within 72 hours from the time of his admission unless a written petition for the involuntary court-ordered isolation is filed within that time or the person's status is changed to voluntary isolation or quarantine.

- Section 9 of the draft authorizes a health authority or a physician, licensed physician assistant, or registered nurse to apply for the emergency isolation or quarantine of a person who is alleged to have a communicable or infectious disease. Also authorized to apply for emergency isolation or quarantine are the spouse, parent, adult child, or legal guardian of the person who is alleged to have a communicable or infectious disease. These persons may apply to a district court for an order requiring a peace officer to take an allegedly ill person into custody and have the person transported to a medical facility to allow the applicant for the order to apply for the emergency isolation or quarantine.

- The draft requires in Section 12 that within 24 hours after the admission of a person alleged to have a communicable or infectious disease, the administrative officer of a medical facility must provide notice of such emergency isolation or quarantine to the spouse or legal guardian of a person alleged to have a communicable or infectious disease.

- Section 13 of the draft provides that a proceeding for an involuntary court-ordered isolation or quarantine of a person must be commenced by a spouse, parent, adult child, legal guardian, health authority, physician, licensed physician assistant, registered nurse, or any officer authorized to make arrests in this state by that party filing a petition with the clerk of the district court of the county where the person to be isolated or quarantined resides. In addition, Section 13 provides that if the person to be treated is a minor and the petitioner is a person other than the parent or guardian of that minor, the petition must include a statement signed by the parent or guardian that he or she does not object to the filing of the petition.

- Youth petitions filed for the involuntary court-ordered isolation or quarantine of a person must include a petition executed by a health authority, physician, licensed physician assistant, or registered nurse stating that the individual making application has examined the person to be isolated or quarantined, there is a reasonable degree of certainty that the person examined suffers from a contagious or infectious disease, and the person alleged to suffer from a contagious or infectious disease likely poses an immediate threat to the health of the public. In addition, the individual making application must state that in his or her opinion, executing the petition for the involuntary isolation or quarantine of the person is necessary to prevent the person from immediately threatening the health of the public.

- Other provisions of the draft require the clerk of the district court to immediately transmit a petition for such

involuntary court-ordered isolation or quarantine to the appropriate district judge, who must then set the matter to be heard within five judicial days after the petition was received. The court must give notice of the petition and any details of the proceedings to the subject of the petition; his or her attorney, if known; the petitioners; and the administrative officer of the medical facility where the person is detained.

- The draft requires in Section 17 that the court, after the filing of the petition for isolation or quarantine, promptly cause two or more physicians or licensed physician assistants to examine the person to be isolated or quarantined.

- Section 20 authorizes a person who is alleged to have a communicable or infectious disease to retain counsel to represent him in any proceedings before the district court. If the person fails to obtain counsel, the court must advise him of his right to an attorney and appoint counsel.

- The court is required to hear and consider all relevant testimony in such proceedings in accordance with Section 21. Section 22 provides that the person with respect to whom the proceedings are held has the right to be present, either by live telephonic conference or videoconference, but does not have the right to be physically present during the proceedings.

- Section 24 of the draft provides that if the district court finds, after the hearings, that there is not clear and convincing evidence that the person with respect to whom the hearing was held has a communicable or infectious disease or is likely to present an immediate threat to the health of the public, the court must enter its findings, and the person must not be involuntarily detained in the medical facility. In contrast, if the court finds that there is clear and convincing evidence that the person has a communicable or infectious disease and because of that disease is likely to pose an immediate threat to the health of the public, the court may order the involuntary isolation or quarantine of the person. Such isolation or quarantine expires at the end of six months if it is not terminated previously by the Health Division, the local board of health, a health authority, or the medical director of the health care facility.

- The third element of the committee's request is contained in Section 29 of the draft, which requires the State Board of Health to develop a system for syndromic reporting and active surveillance to monitor public health in Nevada during major events or when determined appropriate and necessary by a health authority and to adopt regulations concerning the system.

Randall L. Todd, Dr.P.H.

Randall L. Todd, Dr.P.H., State Epidemiologist, Health Division, Carson City, suggested the proposed legislation be viewed from two perspectives: (1) its affect on day-to-day business operations; and (2) its application in a worst-case scenario. Dr. Todd shared his views regarding the proposed draft legislation and suggested that the committee consider certain fundamental issues, covering the following points:

- The draft appears to contemplate that isolation or quarantine would only take place in a medical facility as defined in state law. Currently, the majority of isolations relate to tuberculosis. Of these tuberculosis isolations—which number under a hundred statewide each year—most require the afflicted person to remain at home for a couple of weeks. If the draft bill were to pass, state health authorities would be required to isolate such individuals in a medical facility rather than in their own homes.

- Viewed from a worst-case scenario, situations could occur following a bioterrorism attack where it might be impractical to isolate affected persons at a medical facility. Rather than transporting people to a licensed medical facility, in certain instances it might be more appropriate to isolate or quarantine at a hotel or other location and to bring medical services to that setting.

- The draft bill does not appear to differentiate between quarantine and isolation and refers repeatedly to evidence of infection with a communicable disease and evidence of contagiousness of that disease. While this might be an appropriate measure for isolation purposes, it would not be an effective standard for quarantine where health officials are seeking evidence of exposure and/or lack of immunity to a certain disease that would represent a threat to the public health.

- The language presently contained in Chapter 439 of NRS, "Administration of Public Health," provides that local boards of health can establish isolation hospitals and quarantine stations and appoint quarantine officers. However, empowering local boards of health to file applications for emergency isolation and quarantine might be problematic in rural parts of the state. Oftentimes a local board of health will consist of a county commissioner, a local physician, and a sheriff. Such boards typically do not govern agencies and in practice would not be the appropriate entity to seek isolation or quarantine. Chapter 441A of NRS, "Communicable Diseases," which currently addresses isolations and quarantines with respect to certain diseases, specifies that the "health authority" has responsibility for isolations and quarantines. The term "health authority" might be more appropriate than "local boards of health" in the draft bill.

- Further, the draft bill contemplates allowing physicians, physician assistants, and registered nurses to initiate an isolation and quarantine procedure but does not require that they notify a local or state health authority. Allowing the initiation of isolation and quarantine procedures outside the official public health infrastructure would be problematic.

- The draft bill also provides that once a person is isolated or quarantined in a medical facility, the medical facility could decide to discharge the person without contacting public health authorities.

- While some of the due process provisions of the bill are appropriate when applied to a mental health situation, they would hamper disease control efforts in the event of a public health emergency. For instance, it would be inappropriate to allow parental objection to negate a quarantine or isolation order relative to a communicable disease. Likewise, allowing friends or relatives to accompany a person to a testing site could promote disease transmission.

- As written, the due process provisions relative to mass quarantine and isolation would be burdensome in a major public health emergency. For instance, if it became necessary to issue a thousand isolation or quarantine orders within the matter of days, the due process procedures set forth in the bill would overwhelm the courts and health authorities.

Randal R. Munn

Randal R. Munn, Deputy Attorney General, Human Resources Division, Office of the Attorney General, Carson City, observed a delicate balance is necessary in applying due process to public health. It is unclear what stance the courts would take in the event of a public health emergency that required invocation of state police power. Mr. Munn shared the concern expressed by Dr. Todd that in the event of a mass public health event, the courts and health authorities would not be able to meet due process requirements. He pointed out that other legal issues would arise if due process requirements during public health emergencies were set forth in statute and officials were unable to meet those standards.

Mr. Munn indicated the concerns raised are of a mechanical nature, and he offered to continue working with the committee on the draft bill.

Chairman Rawson pointed out that while no additional committee meetings would be held in 2002, certain concerns should be addressed before the bill draft is finalized. He asserted that civil liberties are important, even during a catastrophic event. Chairman Rawson asked that the committee authorize him to work with the Office of the Attorney General, representatives of Clark and Washoe Counties, Dr. Todd, and other interested parties to address the issues raised and to finalize the bill draft. Once introduced, the bill will be heard in both houses of the Legislature, and there will be adequate time for interested parties to express their concerns.

Assemblywoman Parnell expressed concern regarding the provisions of Section 9. She asked that in the final bill draft, terms such as "personal observation" and "likely possess" be avoided in favor of language such as "probable cause."

Dr. Siegel, previously identified on page 41 of these minutes, recognized the threat of bioterrorism and acknowledged the need of authorities to address public health emergencies in a practical manner that respects civil liberties and constitutional rights. He asserted much

work remains to be done on the bill draft and suggested a working group of interested parties meet to address areas of concern, including the following:

- Throughout the bill, reference is made to isolation and quarantine of groups. However, the bill contains no language providing due process for groups. Further, United States case law has never addressed due process requirements for groups.

- Due process provisions that are useful in a mental health context may not be effective in addressing public health emergencies. For example, while treatment review for a mental health patient might only be required every six months, this standard would not be effective in monitoring the condition of a person with an infectious disease.

- Historically, forced treatment has rarely been allowed outside of the mental health arena. People of sound mind have a right to die in their own homes without treatment so long as they do not present a grave threat to themselves or others.

- Terms of notification should also be reviewed.

- The bill draft does not provide for use of the least restrictive environment, which is an important concept of law. Isolation or quarantine outside of a person's home should be required only when absolutely necessary.

Chairman Rawson acknowledged Dr. Siegel's concerns, reiterating that he had asked the committee's permission to form a working group to address these and other issues before submitting the final bill draft to the Legislature.

Janine Hansen

Janine Hansen, President, Nevada Eagle Forum, Sparks, Nevada, shared Dr. Siegel's concerns regarding terms of notification, treatment of groups of persons rather than individuals, and use of the least restrictive environments for isolation. Ms. Hansen highlighted other areas of concern regarding the proposed bill draft as follows:

- Prior versions of the bill draft provided medical and religious exemptions. These exemptions have been omitted from the current bill draft.

- The bill fails to protect patient confidentiality in that it does not prohibit the sharing of medical data and records with the federal government.

- Allowing law enforcement officers to take people into custody without a court order or warrant is of particular concern.

There being no objection, Chairman Rawson indicated he would work with the Office of the Attorney General, representatives of Clark and Washoe Counties, Dr. Todd, Ms. Hansen, Dr. Siegel, and other interested parties to address the concerns and issues raised and to finalize the bill draft.

WORK SESSION—DISCUSSION AND ACTION REGARDING RECOMMENDATIONS RELATED TO: THE STUDY OF PROGRAMS AND FUNDING FOR THE TREATMENT OF MEDICAID, INDIGENT, AND OTHER LOW-INCOME PATIENTS CONDUCTED PURSUANT TO SENATE BILL 377 (CHAPTER 598, *STATUTES OF NEVADA 2001*)

3. *Request the drafting of a bill amending sections 422.380 through 422.390 of the NRS, which currently authorize payment to certain hospitals for treatment of indigent patients, to revise the methodology and distribution of disproportionate share hospital (DSH) payments and intergovernmental transfers as outlined in the "Report on Indigent Care Costs and Disproportionate Share" developed pursuant to Senate Bill 377 (Chapter 598, Statutes of Nevada 2001).*

   (Recommendations included in "Report on Indigent Care Costs and Disproportionate Share" prepared by EP&P

Consulting, Inc.)

Assemblywoman Parnell reported that Carson-Tahoe Hospital and other rural hospitals have requested that prior to the 2003 Session, DHR conduct an audit of the information used by EP&P Consulting, Inc. in preparing its Report on Indigent Care Costs and Disproportionate Share, which was provided to the committee at its August 20, 2002, meeting. It is her understanding that EP&P's report is difficult to read, and the information compiled is in many instances incorrect.

Chairman Rawson indicated a bill draft will be needed if the Legislature is to address the issue of indigent care costs and disproportionate share payments during the 2003 Session. He pointed out that by the time the 2003 Session convenes, EP&P will have completed its study of federal funds maximization. The results of this study may significantly affect the Legislature's action on this issue. Chairman Rawson asked that the committee authorize the bill draft with the understanding that the figures contained in the Report on Indigent Care Costs and Disproportionate Share would be verified and, if necessary, updated.

ASSEMBLYWOMAN PARNELL MOVED THAT THE COMMITTEE REQUEST A BILL DRAFT TO AMEND SECTIONS 422.380 THROUGH 422.390 OF NRS, WHICH CURRENTLY AUTHORIZE PAYMENT TO CERTAIN HOSPITALS FOR TREATMENT OF INDIGENT PATIENTS, TO REVISE THE METHODOLOGY AND DISTRIBUTION OF DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS AND INTERGOVERNMENTAL TRANSFERS AS OUTLINED IN THE "REPORT ON INDIGENT CARE COSTS AND DISPROPORTIONATE SHARE" DEVELOPED PURSUANT TO SENATE BILL 377 (CHAPTER 598, STATUTES OF NEVADA 2001), WITH THE UNDERSTANDING THAT THE FIGURES CONTAINED IN SAID REPORT WILL BE VERIFIED AND, IF NECESSARY, UPDATED. THE MOTION WAS SECONDED BY ASSEMBLYWOMAN KOIVISTO AND PASSED. SENATOR WASHINGTON WAS ABSENT FOR THE VOTE.

Assemblywoman Cegavske suggested that the resolution approved by the committee supporting the four strategic plans of DHR also include a recommendation that a study be conducted regarding the over diagnosis of children with attention deficit disorder and attention deficit hyperactivity disorder, including a review of national findings. She noted this issue has received national and state recognition. As the committee lacked a quorum, Chairman Rawson indicated he would submit the item as a recommendation of the chairman.

PUBLIC TESTIMONY

Jeanette K. Belz

Jeanette K. Belz, J.K. Belz & Associates, Reno, appearing on behalf of the Nevada Ophthalmological Society, provided the committee with a packet of information consisting of the following documents (Exhibit W):

1. A letter dated October 16, 2002, to the committee from the Nevada Ophthalmological Society;

2. Proposed Regulation of the Nevada State Board of Optometry, LCB File No. R197-01, dated January 9, 2002;

3. Revised Proposed Regulation of the Nevada State Board of Optometry, LCB File No. R049-02, dated August 2, 2002;

4. *Nevada Revised Statutes* 233B.063, "Submission to legislative counsel of proposal to adopt, amend or repeal permanent regulation; duties of legislative counsel; adoption of temporary regulation"; and

5. Assembly Bill 432 (Chapter 404, *Statutes of Nevada 1999*), which "revises provisions governing practice of optometry."

Ms. Belz indicated the Nevada State Board of Optometry planned to take action on the proposed regulations at its

November 8, 2002, meeting. She explained that in accordance with NRS 233B.063, because the hearing was being conducted after August 1 in an even-numbered year, any regulations adopted by the Board would be considered temporary and therefore would not be subject to the normal review process, which includes legislative scrutiny.

Continuing, Ms. Belz reported Board staff indicated that consideration of LCB File No. 197-01 dated January 9, 2002, was delayed so it could be considered at the same time as another proposed regulation. She pointed out that the second regulation being considered by the Board—LCB File No. 049-2—is dated one day after commencement of the time frame within which the Board may adopt temporary regulations. Ms. Belz suggested the Nevada State Board of Optometry might have intentionally postponed action on the proposed regulations until after August 1, 2002, to circumvent legislative and public review.

Of particular concern to the Nevada Ophthalmological Society are certain provisions of the proposed regulation contained in LCB File No. R197-01. Ms. Belz summarized the Society's position and its concerns as follows:

- Citing patient confidentiality, the Board seeks to amend *Nevada Administrative Code* (NAC) 636.280(4)(b) by eliminating the requirement that an optometrist provide the names of the 15 patients he treated for glaucoma, in conjunction with an ophthalmologist. It is the Nevada Ophthalmological Society's position treatment details must be provided to the Board to meet the statutory requirement set forth in A.B. 432. By using a pseudonym such at "Patient 1," the Board could review information on the types of patients who received care and the treatments provided while maintaining patient confidentiality. The language suggested by the Board is inadequate in that it would only require a statement that treatment was provided.

- Assembly Bill 432 requires that an optometrist must treat 15 glaucoma patients, in conjunction with an ophthalmologist, for at least one year, as one of the conditions to becoming certified to provide treatment. The proposed regulation seeks to change the treatment period from one year to 12 months and provides that such care need not be provided for 12 consecutive months. This provision is beyond the intent of the original legislation.

Weldon Havins, M.D.

Weldon Havins, M.D., an ophthalmologist, Las Vegas, spoke on behalf of the Clark County Medical Society. Dr. Havins explained the ophthalmologic standard of care for glaucoma patients includes examination of afflicted individuals once every four months during the first year of treatment. He pointed out the regulation proposed in LCB File No. R197-01 would eliminate this requirement.

Jeanette K. Belz

Continuing her remarks, Ms. Belz summarized additional provisions of the proposed regulations contained in LCB File Nos. R197-01 and R049-02 of concern to the Nevada Ophthalmological Society, covering the following points:

- Subsection 2 of NAC 636.290, "Consultation with and referral to ophthalmologist; records," requires a consulting ophthalmologist to agree or comment on a course of treatment recommended by an optometrist within 30 days. The proposed regulation contained in LCB File No. R197-01 would eliminate the time frame within which a consulting ophthalmologist must agree or comment on an optometrist's recommended treatment. The Nevada Ophthalmological Society is of the opinion the elimination of this time frame is inappropriate.

- With respect to the proposed regulation contained in LCB File No. R049-02, the Nevada Ophthalmological Society recommends the language contained in subsection (1)(c) of section 1 be changed to read "Any follow-up examination that is deemed necessary by the optometrist." Because optometrists are not medical doctors, the language suggested by the Society is more appropriate than that currently set forth in the proposed regulation.

- Further, the meaning of subsection 7 of section 1 of LCB File No. R049-02 is unclear as the fitting of the lens is incorporated into the patient's prescription.

Referencing subsection 2 of section 1 of LCB File No. R049-02, Dr. Havins pointed out that the fee for writing a spectacle prescription is not always a covered expense. For instance, if there were no change of spectacles, Medicare and other insurers that follow Medicare's guidelines would not pay for this service. In such an instance, the patient

would be forced to pay for the prescription out of his or her own pocket.

Chairman Rawson reported the committee's legal counsel had advised him that proposed regulations of the Nevada State Optometry Board, unless temporary, are usually reviewed by the Legislative Commission, not the Legislative Committee on Health Care. He acknowledged that as the proposed regulations under discussion would be temporary, the Legislative Commission would most likely not review them. Continuing, Chairman Rawson indicated the committee would share the Nevada Ophthalmological Society's concerns with the Chairman of the Nevada State Board of Optometry and urge an amicable resolution of the issues. He pointed out that if the parties are unable to resolve the matter, the issues could be addressed by the Legislative Commission at its December 2002 meeting or by the 2003 Legislature.

Marietta Nelson, M.D.

Marietta Nelson, M.D., Nevada Ophthalmological Society, Las Vegas, noted that A.B. 432 was a carefully crafted compromise between ophthalmologists and optometrists. In her view, it would be inappropriate to change the intent of this legislation.

Steven Dempsey

Mr. Dempsey, previously identified on page 42 of these minutes, shared his views regarding government and the health care industry. Mr. Dempsey is of the opinion that a health care crisis does not exist in the United States. Referencing the book *None Dare Call It Conspiracy*, he urged the committee to determine who would benefit financially from deceiving the public. Mr. Dempsey questioned the ability of government to solve problems and advocated the careful selection of experts to provide guidance. He also he urged individuals to refrain from unquestioningly following the lead of others.

Referencing the concerns voiced by Mr. Dempsey earlier in the meeting that if mental health bed spaces are increased, facilities might hold people against their will in an attempt to secure additional revenue, Chairman Rawson assured Mr. Dempsey that the Senate Committee on Judiciary would consider such issues.

Elizabeth Gilbertson

Elizabeth Gilbertson, Director of Strategic Planning, Culinary Health Fund, and Chairwoman, Health Services Purchasing Coalition, Las Vegas, reported the Culinary Union has closely followed the DSH issue and disseminated reports to interested parties in the organization. Ms. Gilbertson requested that the Culinary Union be informed of any new data that might be considered which could impact the development of a BDR regarding future DSH fund distribution.

Chairman Rawson acknowledged that an attempt to access additional health care funds of $45 million to $48 million would likely affect the distribution formula. He indicated the Culinary Union would be added to the mailing list of persons and entities interested in receiving such information.

Christopher Thompson

Christopher Thompson, Senior Analyst, Center for Health Information Analysis, University of Nevada, Las Vegas, of Carson City, reported he met with Carson-Tahoe Hospital officials the prior week regarding correction of information supplied to EP&P for the DSH distribution study. He reminded the committee that at its August 20, 2002, meeting, EP&P had reported experiencing some difficulty with the data received from the hospitals, particularly those operating in rural areas of the state.

Continuing, Mr. Thompson asserted correction of the data supplied by Carson-Tahoe Hospital would not significantly affect DSH distribution except within the individual pools, particularly the rural private hospital pool, or impact any of the primary conclusions of the study. He indicated he would consult with Mr. Duarte, previously identified on page 17 of these minutes, regarding the possibility of scheduling a meeting among the rural hospitals to review their data and provide updated information to the 2003 Legislature.

ADJOURNMENT

There being no further business, the meeting was adjourned at 2:57 p.m.

Exhibit X is the "Attendance Record" for this meeting.

Respectfully submitted,

_____
Susan Furlong Reil
Principal Research Secretary

_____
Marsheilah D. Lyons
Senior Research Analyst

APPROVED BY:

_____
Senator Raymond D. Rawson, Chairman

Date:_____

LIST OF EXHIBITS

Exhibit A is the Work Session Document dated October 28, 2002, provided by Marsheilah D. Lyons, Senior Research Analyst, Research Division, Legislative Counsel Bureau, Carson City, Nevada.

Exhibit B is an outline of topics discussed by the Clark County OB/GYN Task Force, provided by Terry Murphy, Facilitator, Clark County OB/GYN Task Force, Las Vegas, Nevada.

Exhibit C is document titled "Obstetrical Access Program, Draft," provided by Caroline Ford, M.P.H., Assistant Dean/Director, University of Nevada School of Medicine, Center for Education and Health Services Outreach, Reno, Nevada.

Exhibit D is a document dated October 2002 titled "Strategic Plan for People With Disabilities," provided by Michael J. Willden, Director, Nevada's Department of Human Resources (DHR), Carson City, Nevada.

Exhibit E is a document dated October 2002 titled "Strategic Plan for Provider Rates," provided by Michael J. Willden, Director, DHR, Carson City, Nevada.

Exhibit F is a document dated October 2002 titled "Strategic Plan for Rural Health Care," provided by Michael J. Willden, Director, DHR, Carson City, Nevada.

Exhibit G is a document dated October 2002 titled "Strategic Plan for Senior Services," provided by Michael J. Willden, Director, DHR, Carson City, Nevada.

Exhibit H is a document dated October 2002 titled "Executive Summary, Strategic Plan for People With Disabilities," provided by Michael J. Willden, Director, DHR, Carson City, Nevada.

Exhibit I is a document dated October 2002 titled "Executive Summary, Strategic Plan for Provider Rates," provided by Michael J. Willden, Director, DHR, Carson City, Nevada.

Exhibit J is a document dated October 2002 titled "Executive Summary, Strategic Plan for Rural Health Care," provided by Michael J. Willden, Director, DHR, Carson City, Nevada.

Exhibit K is a document dated October 2002 titled "Executive Summary, Strategic Plan for Senior Services," provided by Michael J. Willden, Director, DHR, Carson City, Nevada.

Exhibit L is a document titled "Recommendations of the Nevada Task Force on Disability to the Legislative Committee on Health Care," provided by Thomas B. Pierce, Ph.D., Chair, Department of Special Education, University of Nevada Las Vegas, Las Vegas, Nevada.

Exhibit M is a copy of a Microsoft PowerPoint presentation dated September 20, 2002, titled "Summary of Provider Rates Task Force Recommendations," provided by Charles Duarte, Administrator, Division of Health Care Financing and Policy, DHR, Carson City, Nevada.

Exhibit N is a copy of a Microsoft PowerPoint presentation titled "Rural Strategic Plan," provided by Robin Keith, President, Nevada Rural Hospital Project, Reno, and Chairperson, Task Force for Rural Health Care.

Exhibit O is a copy of a Microsoft PowerPoint presentation regarding the recommendations of the Senior Services Task Force, provided by Susan Rhodes, L.A.S.W., Social Work Supervisor, Clark County Social Services, Las Vegas, Nevada.

Exhibit P is a letter dated October 22, 2002, from Senator Ann O'Connell, Chairwoman, Legislative Commission's Subcommittee to Study Suicide Prevention, to the Legislative Committee on Health Care, provided by Senator Raymond D. Rawson, Chairman, Legislative Committee on Health Care, Las Vegas, Nevada.

Exhibit Q is a document dated July 2002 titled "Mental Health Crisis Recommendations Submitted by the Southern Nevada Mental Health Coalition and the Chronic Public Inebriate Task Force," provided by Kathryn Landreth, Chief, Office of Policy and Planning, Las Vegas Metropolitan Police Department, and Chairwoman, Southern Nevada Mental Health Coalition, and Janelle L. Kraft, Budget Director, Office of Finance, Las Vegas Metropolitan Police Department, and Co-Chairwoman, Southern Nevada Regional Planning Coalition's Task Force on Emergency Room Overcrowding (also known as the Chronic Public Inebriate [CPI] Task Force), both of Las Vegas, Nevada.

Exhibit R is a document titled "Psychiatric Tracking Totals," provided by Kathryn Landreth, Chief, Office of Policy and Planning, Las Vegas Metropolitan Police Department, and Chairwoman, Southern Nevada Mental Health Coalition, and Janelle L. Kraft, Budget Director, Office of Finance, Las Vegas Metropolitan Police Department, and Co-Chairwoman, Southern Nevada Regional Planning Coalition's Task Force on Emergency Room Overcrowding (also known as the Chronic Public Inebriate [CPI] Task Force), both of Las Vegas, Nevada.

Exhibit S is a written copy of the remarks of Thomas Maher, Chief Executive Officer, Montevista Hospital, Las Vegas, together with a document titled "Clark County Acute Care Hospitals: ER Psychiatric Cases, January 1, 2002, to October 6, 2002," provided by Mr. Maher.

Exhibit T is a copy of a Microsoft PowerPoint presentation titled "Report on Indigent Care Costs and Disproportionate Share," dated August 20, 2002, provided by Senator Raymond D. Rawson, Chairman, Legislative Committee on Health Care, Las Vegas, Nevada.

Exhibit U is a document titled "Bill Draft Request of the Legislative Committee on Health Care to Update Existing Laws to Address Public Health Issues Related to the Detection and Control of Certain Diseases," provided by Leslie M. Hamner, Principal Deputy Legislative Counsel, Legal Division, Legislative Counsel Bureau (LCB), Carson City, Nevada.

Exhibit V is a draft of BDR 40-677 requested by the Legislative Committee on Health Care, which proposes to make various changes concerning public health laws, provided by Leslie M. Hamner, Principal Deputy Legislative Counsel, Legal Division, LCB, Carson City, Nevada.

Exhibit W is a packet of information consisting of the following documents:

1. A letter dated October 16, 2002, to the Legislative Committee on Health Care from the Nevada Ophthalmological Society;

2. Proposed Regulation of the Nevada State Board of Optometry, LCB File No. R197-01, dated January 9, 2002;

3. Revised Proposed Regulation of the Nevada State Board of Optometry, LCB File No. R049-02, dated August 2, 2002;

4. *Nevada Revised Statutes* 233B.063, "Submission to legislative counsel of proposal to adopt, amend or repeal permanent regulation; duties of legislative counsel; adoption of temporary regulation"; and

5. Assembly Bill 432 (Chapter 404, *Statutes of Nevada 1999*).

This information was provided by Jeanette K. Belz, J.K. Belz & Associates, Reno, Nevada.

Exhibit X is the "Attendance Record" for this meeting.

Copies of the materials distributed in the meeting are on file in the Research Library of the Legislative Counsel Bureau, Carson City, Nevada. You may contact the Library at (775) 684-6827.