MINUTES OF THE MEETING
OF THE
LEGISLATIVE SUBCOMMITTEE TO STUDY MEDICAL MALPRACTICE
July 22, 2002
Las Vegas, Nevada

The third and final meeting of the Legislative Subcommittee to Study Medical Malpractice was held on Monday, July 22, 2002, at 8:30 a.m., in Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada, and videoconferenced to Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. Pages 4 through 6 contain the "Meeting Notice and Agenda" for this meeting.

SUBCOMMITTEE MEMBERS PRESENT IN LAS VEGAS:

Assemblywoman Barbara E. Buckley, Chairwoman
Senator Dina Titus
Senator Randolph J. Townsend
Senator Mark E. Amodei
Assemblyman Lynn C. Hettrick

SUBCOMMITTEE MEMBER PRESENT IN CARSON CITY:

Assemblyman Bernie Anderson

OTHER LEGISLATORS PRESENT IN LAS VEGAS:

Senator Ann O'Connell
Assemblyman Douglas A. Bache
Assemblywoman Barbara K. Cegavske
Assemblywoman Christina R. Giunchigliani
Assemblywoman Ellen M. Koivisto

LEGISLATIVE COUNSEL BUREAU STAFF PRESENT:

Allison Combs, Principal Research Analyst
Vance A. Hughey, Principal Research Analyst
Risa B. Lang, Principal Deputy Legislative Counsel
Bonnie Borda Hoffecker, Senior Research Secretary

SPEAKERS PRESENT:

Charles Duarte, Medicaid Administrator, Division of Health Care Financing and Policy, Department of Human Resources, Carson City, Nevada
William R. Hale, Chief Executive Officer, University Medical Center of Southern Nevada, Las Vegas, Nevada
Curt Howell, Vice President of Program Management, NevadaCare, Las Vegas, Nevada
Deborah Huber, R.N., M.H.S.A., Project Coordinator, HealthInsight, Las Vegas, Nevada
Cheryl A. Hug-English, M.D., President, Board of Medical Examiners, Reno, Nevada
Richard J. Legarza, General Counsel, Board of Medical Examiners, Reno, Nevada
Larry D. Lessly, Executive Director, Board of Medical Examiners, Reno, Nevada
Mimi Marchev, Senior Policy Analyst, National Academy for State Health Policy, Portland, Maine
Lawrence P. Matheis, Executive Director, Nevada State Medical Association, Reno, Nevada
Todd Meek, President and Chief Executive Officer, NevadaCare, Las Vegas, Nevada
Dr. John M. Nowins, President, Clark County Obstetrics and Gynecology Society, and Member, Nevada Medical Liability Task Force, Las Vegas, Nevada
Kristie O'Neill, Concerned Citizen, Las Vegas, Nevada
Douglas A. Perednia, M.D., President/Chief Executive Officer, Kietra Corporation, Portland, Oregon
Charles Perry, Executive Director, Nevada Health Care Association, Las Vegas, Nevada
Jason Phillips, father of Brittany Phillips, a victim of medical malpractice, Las Vegas, Nevada
Jill Rosenthal, Project Manager, National Academy for State Health Policy, Portland, Maine
Kelly Simonson, Director, Medicaid Programs, Health Plan of Nevada, Las Vegas, Nevada
Marie Soldo, Executive Vice President, Government Affairs, Sierra Health Services, Las Vegas, Nevada
Paul A. Stewart, M.D., Secretary/Treasurer, Board of Medical Examiners, Las Vegas, Nevada
James S. Tate Jr., M.D., F.I.C.S., F.A.C.S., President, West-Crear Medical Society, Las Vegas, Nevada
John Yacenda, M.P.H., Ph.D., Chairman, Subcommittee to Study the Development of a System for Reporting Medical Errors (Assembly Concurrent Resolution No. 7 [File No. 77, *Statutes of Nevada 2001*]), Carson City, Nevada

R E V I S E D
MEETING NOTICE AND AGENDA

Name of Organization: Legislative Subcommittee to Study Medical Malpractice

Date and Time of Meeting: Monday, July 22, 2002
8:30 a.m.

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

Note: Some members of the subcommittee 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 4100
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. Opening Remarks

*II. Approval of Minutes of the May 13, 2002, Meeting

*III. Update on the Status of the Trauma Center at the University Medical Center of Southern Nevada

William R. Hale, Chief Executive Officer, University Medical Center of Southern Nevada

*IV. Prevention of Medical Malpractice: Procedures for Licensing and Disciplining Physicians

Cheryl A. Hug-English, M.D., President, Board of Medical Examiners
Jaculine C. Jones, Ed.D., Vice President, Board of Medical Examiners
Paul A. Stewart, M.D., Secretary/Treasurer, Board of Medical Examiners
Donald H. Baepler, Ph.D., D.Sc., Member, Board of Medical Examiners
Larry D. Lessly, Executive Director, Board of Medical Examiners
Richard J. Legarza, General Counsel, Board of Medical Examiners

*V. Prevention of Medical Malpractice: Reporting of Medical Errors

A. National Overview of the Medical Malpractice Crisis and Systems for Reporting Medical Errors

Mimi Marchev, Senior Policy Analyst, National Academy for State Health Policy
Jill Rosenthal, Project Manager, National Academy for State Health Policy

B. Report from the Legislative Committee on Health Care's Subcommittee to Study the Development of a System for Reporting Medical Errors

John Yacenda, M.P.H., Ph.D., Chairman

C. Discussion of Nevada Issues Relating to Medical Errors Reporting Legislation

Assemblywoman Ellen M. Koivisto

D. Systems for Tracking and Minimizing Medical Errors

Douglas A. Perednia, M.D., President/C.E.O., Kietra Corporation

*VI. Reimbursement of Physicians for Services: Impact on Ability to Pay for Medical Malpractice Coverage

A. Discussion of the Impact on Physicians

Dr. John M. Nowins, Clark County Obstetrics and Gynecology Society
Dr. Robert McBeath, Chairman, Nevada Medical Liability Physicians Task Force

B. Overview of State Role in Contract Oversight and Reimbursement for Medicaid Services

Charles Duarte, Medicaid Administrator, Division of Health Care Financing and Policy, Department of Human Resources

C. Discussion of Reimbursement Procedures of Health Maintenance Organizations in Southern Nevada

Todd Meek, President and CEO, NevadaCare
Curt Howell, Vice President of Program Management, NevadaCare
Marie Soldo, Executive Vice President, Government Affairs, Sierra Health Services, Inc.
Kelly Simonson, R.N., Director of Medicaid Programs, Sierra Health Services, Inc.

D. Overview of Laws in Other States Authorizing Physicians to Negotiate Collectively for Reimbursement for Services

Representative of the American Medical Association

*VII. Subcommittee Discussion of Potential Insurance Reforms to Address Medical Malpractice in Nevada

VIII. Public Testimony
*IX. Discussion of Future Meetings and Topics for Review

X. Adjournment

*Denotes items on which the subcommittee 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 Bonnie Hoffecker 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.

MODIFIED VERBATIM TRANSCRIPTION OF THE MEETING OF THE LEGISLATIVE SUBCOMMITTEE TO STUDY MEDICAL MALPRACTICE JULY 22, 2002

The following is a modified verbatim transcription of testimony given at the July 22, 2002, meeting of the Legislative Subcommittee to Study Medical Malpractice.

OPENING REMARKS

Chairwoman Buckley called the meeting to order and asked the secretary to call the roll. All members were present.

Chairwoman Buckley: We will move to Agenda Item III, "Update on the Status of the Trauma Center at the University Medical Center of Southern Nevada." I see a lot of faces in the audience who I think have been with us from the beginning, but in case there is anyone new joining us for the first time or anyone new with us listening on the Internet, I would just let you know that this is the third hearing of the Legislative Subcommittee to Study Medical Malpractice.

The first two hearings focused primarily on the situation, the crisis we are in. We listened to testimony from experts, a few from out of the state, many from in the state, and many in this room again with us today. We focused on—we heard testimony on caps on damages and fast tracking civil cases. We heard testimony on MICRA [California's Medical Injury Compensation Reform Act of 1975] and we heard from victims. We have had a wide array of hearings. Our third hearing was supposed to be devoted exclusively to the insurance industry, and that hearing was set for July 29, 2002.

A number of the insurance companies did not participate in our first two hearings despite being invited. We gave them 45 days notice and said, "We expect you to be here." We have had a good response rate, and so that hearing is still set right now for July 29, 2002. In light of the special session about to be called, we decided to add one hearing date and that is today. We kept the 29th, and at this point we are undecided whether we will actually begin the legislative session, adjourn and let this committee hear the testimony to get it into the record, or whether we will have them instead address the Legislature. That is still to be determined, but that hearing is still set because we are going to want to hear from the insurance industry regardless of what we do.

The agenda for today was supposed to be our last and that was to discuss prevention of medical errors. We heard from NCSL [National Conference of State Legislatures] who said that every state is looking at a four-prong approach to medical malpractice with, the first always being prevention, and that is why we are hearing from the Medical Board about licensing and discipline as well as prevention in terms of medical error reporting. The other issues with regard to reimbursements and those issues we also decided early on to put on one of our later agendas and instead of being later it's a little earlier. That is where the committee has been since the beginning.

With that, we will turn to our agenda today. Sorry, Mr. Hale, to make you stand during the remarks, but in case anybody was new, I wanted them to hear where the committee had been. I will also ask if you have any cell phones or beepers if you will turn them to the inaudible position as they are not permitted in the hearing room. With that, Mr. Hale.

UPDATE ON THE STATUS OF THE TRAUMA CENTER AT THE UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA

William R. Hale

Mr. Hale: Thank you, Madam Chair and members of the committee. For the record, my name is William R. Hale. I am the Chief Executive Officer of University Medical Center [UMC] of Southern Nevada. Sitting next to me on my left is Jaculine Taylor; she is my Chief Administrative Officer at UMC. Again, I want to thank you for allowing me to address the committee today regarding the UMC and what has occurred over the past several months.

First you will notice in your packet [Exhibit A] the chronology of the events that have occurred—actually began last February. I am going to give the committee a brief overview of the events and then go into the bill drafts we have drafted and we would like the committee to consider when they meet next week in Carson City. We started first noticing a problem in February of this year. We recognized that over 700 physicians were coming up for insurance renewal and that in the months of June and July alone, over 400 of those physicians would be coming due for their insurance. Starting in late May, we began to see an influx of resignations from the staff. We started to anticipate there could be problems staffing the trauma, emergency, and other areas of the hospital. In the matter of a month, over 124 physicians did resign from staff at UMC. Recognizing the fact that there seemed to be an issue there, the Board of Trustees of UMC as well as the Clark County Commission, acting as each other, did meet toward the end of June and gave myself the authority to do whatever I could to make sure the trauma center remained open. We then began negotiating with physicians to try to bring them to the table to see what their needs were and if there was any way that we could address their issues at our level. It was, frankly, very frustrating at that point to come to any type of consensus, and we were finally given the message that anything short of tort reform would not bring the physicians back to the table. It was very unfortunate but then on July 3, 2002, we were forced to close the trauma center as we did not have any orthopedic surgeons willing to take calls, and as a matter of fact, of 58 orthopedic surgeons on staff, 56 of them had resigned at that point.

After the closure on July 3, 2002, we were looking for any way to try and bring the center back open. We then engaged the chair of the Board of Trustees at UMC, Commissioner Erin Kenny, who in concert with the Governor met with the physician community and tried to reach some type of an understanding with the physicians about what their needs were et cetera and try to come to some point where the surgeons would be willing to come back to UMC. We proposed that the physicians, at least in the short run, become employees of the hospital. Under that, the employees would be covered

under the sovereign immunity cap. We had the Attorney General opinion stating that based on the terms of the contract that they feel very strongly that the physicians could be protected by the county under the immunity sovereign ability clauses in the *Nevada Revised Statutes*. They, therefore, at that point agreed to come back to the trauma center as temporary employees. The reality of it is that five of them signed the employment contract; at this time no others have signed that employment contract. Several others have requested and have come back to staff. The reality of it is that there is really one of the orthopedic surgeons covering three shifts a week, so he is being burnt out very quickly. We are able to maintain the trauma center opening, but it is very tenuous at this time. The majority of the orthopedic surgeons have not come back on staff so we still feel that we are in a very, very fragile condition at this point, and it wouldn't take much for us to have to close the trauma center once again. What I have included in here are two BDRs [Bill Draft Requests], and the reason I have included these is that when we were trying to figure out why the physicians were leaving and why UMC seemed to be the place where the physicians were so disconcerted and felt that there was a need for them to leave, time and time again it was pointed out to us that since we had sovereign immunity and they did not that they became the deep pocket. There were flyers sent out by various physicians who were talking about UMC being the deep pocket and telling the physicians to know where your liability is. So after some research we found that because of the joint statutes that talk about joint and several liability and the fact that we are the deep pocket, that physicians felt that it was not a good environment for them to practice in given the high risk nature of UMC and the types of patients that we take care of in our facility. We are requesting that the legislators as part of the package look at joint and several liability and, at least for public hospitals, the possibility of not having joint and several liability. I won't go into the specifics of that because I believe that the committee is fully aware of how joint and several liability works.

In addition to that, we are asking that we extend sovereign immunity to those physicians who provide indigent care at public facilities and provide emergency care at public facilities. Again, the physicians have for years taken care of these patients gratuitously, and one of the beautiful things about UMC is most of the physicians in the community did practice at UMC and, therefore, we provide the same level of care for any patient regardless of their ability to pay because the same standard for physicians at our hospital is likewise for other hospitals in our community. So we really feel that at this point, it is very difficult for us to go forward with the physicians knowing that we have a cap and they do not have a cap. We feel, regardless of what occurs with tort reform, that it is important to recognize the need for services for all people in our society and also provide the highest standard for care in our society of people. We feel that by extending the sovereign immunity to physicians who are providing care to emergency patients and/or indigent patients, this will relieve some of their concerns regarding the deep pocket and hopefully we will be able to continue to provide for that care.

I would hope that the committee and the Legislature, when they assemble next week, will take seriously our requirements and our needs going forward. Otherwise, we feel that the trauma center at UMC could be drastically reduced and/or eliminated if these other solutions are not found to the concerns of the physicians in our community. With that I would be happy to answer any questions.

Chairwoman Buckley: Thank you Mr. Hale. Any questions of the committee? Mr. Hale, from your research, on how many occasions have any doctors at the trauma center had to pay for a portion of UMC's negligence in a lawsuit?

Mr. Hale: I am unaware of any.

Chairwoman Buckley: Did the County Commission, in recommending the bill draft, or you or any of the surgeons consider instead suggesting that the Legislature consider Good Samaritan

immunity for the surgeons? Meaning, as long as a trauma surgeon does their work at UMC, and sees a trauma patient, that they should be absolutely immune from liability if they rendered the service in good faith if they did not bill, and they were acting as Good Samaritan for UMC indigent population. As long as their conduct was not grossly negligent. Because I am real concerned that if we pass a statute that says trauma surgeons are employees, there is a court that may not agree, and so we would not have accomplished anything. So, I am just wondering where that debate was and what their thoughts were on that item.

Mr. Hale: Yes, Madam Chair, it was talked about at length and most of the physicians do not want to be employees of UMC. The specialists—they are in the community and provide care in all of the hospitals and they are not really desiring of that. We do employ physicians but mainly in our urgent and primary care centers throughout the city. Again, the board did feel that it was important that we continue to provide the care for everyone and that certainly these surgeons had some type of need for that protection and that is why we have included in the BDR four emergency services that physicians would be covered under our sovereign immunity, and that could easily be turned into the Good Samaritan rule where they provide care on the street in an emergency. We felt in a public hospital, it would be appropriate to provide that care and be protected.

Chairwoman Buckley: Because, if the surgeons were going to obtain sovereign immunity, they would have to be considered employees under current law. So if physicians do not want to be considered employees, and in fact they are really not going to be employees, that really does not provide them much protection. We understand that they probably need some protection because no one wants the trauma center to close down. So you are not opposed to whichever way the Legislature goes on that item?

Mr. Hale: Not at all. I would encourage the Legislature to seriously think of that. Again, even if tort reform passes and the physicians get everything that they want, we still feel that in order to get them to come back to UMC and to provide the services, we are going to need something else. And, if we could move the Good Samaritan law or even contractor law in that direction, I think we would relieve their perceived problems. Whether they are real or not, it is perceived, and perception becomes reality as we all know. That is our big challenge is to try to bring them back and we feel those types of protections are warranted and needed by them to bring them back to the table with us.

Chairwoman Buckley: Thank you. Any other questions of the committee? Senator Townsend.

Senator Townsend: Thank you, Madam Chairman. I am particularly interested in your comment regarding a Good Samaritan law. Did you say that your board did debate that issue?

Mr. Hale: Yes, Senator, they did debate that issue. They did pass these two BDRs that I have in your package here [Exhibit A] and approved—the County Commission and the Board of Trustees of UMC both passed the BDRs to go forward in that direction.

Senator Townsend: Since this is the first time that I have seen this [packet of information], is there a portion of this that deals with the Good Samaritan law?

Mr. Hale: It does not directly reference the Good Samaritan law; it references the immune contractor statutes.

Senator Townsend: As you know, that is very much different than what our Chair asked you about. There is no fee involved; otherwise, you cannot qualify, is my understanding, Madame Chairman. It is a very much different defined issue. In other words, if a surgeon thinks that they would give five hours a week to the trauma center or whatever in exchange for immunity at no fee level but not have any contractual relationship other than a volunteer of five hours per week. For example, that is completely different than the sovereign

immunity statute with which we are discussing. And did you have that debate?

Mr. Hale: Yes, we did, and in the bill draft it talks about the physician waiving their rights to bill.

Chairwoman Buckley: The bill draft that we are discussing is in the "Medical Malpractice Crisis" handout of Mr. Hale, and the pages are not numbered. It is about half way back, and I think the Senator's questions emanate from the fact that on the second page of it you talk about indigent patients receiving gratuitous medical care and trying to put these services under the sovereign immunity cap of $50,000. It is kind of mixing up legal concepts. It is mixing up sovereign immunity, which goes with employee, and Good Samaritan by serving indigent patients at public hospitals. That is where the confusion is coming from I think. Assemblyman Anderson.

Assemblyman Anderson: I do not believe that I have the document to which you are referring, and, we just lost the link here for a while and we just came up a second ago.

Chairwoman Buckley: Thank you Assemblyman Anderson. We will have the document faxed up and the questions of the witnesses from both Senator Townsend and myself were trying to get at the wishes of the County Commission and their debate as to what they really wanted. Did they want trauma surgeons to be considered employees under the sovereign immunity cap or did they want surgeons to have more protections when serving indigents at the trauma center such as is provided in a Good Samaritan law.

Assemblyman Anderson: Whose bill draft is this?

Chairwoman Buckley: It is the County Commission's request. So we are trying to find out what their thinking was and their debate was in discussing this. Mr. Hale.

Mr. Hale: It is easy to get the Good Samaritan law and the physician immunity intertwined because they do relate basically with providing care, especially the indigents when it becomes a Good Samaritan law. When we were discussing this with our board, we made it very clear that our issues really were regarding indigent care as well as emergency care for everyone. Since when someone comes into our trauma center, for example, it does not matter what type of insurance they use; it is their emergency condition that really counts. We felt it was important to give them some type of protection given that they would not want to be employees of the hospital for various reasons whether they be financial or not. It was important that they have some level of comfort that when they did react to a situation requiring emergency services that they were protected and were not the deep pocket. That they be allowed to utilized the immune sovereignty that the hospital has in that type of a situation. Yes, the Good Samaritan law is one that talks about providing care to people on the street. We are talking about providing care in our facility for people in an emergency situation, as well as providing care to indigents. Again, many of the physicians have, for years, provided care to indigents for free basically and were not given the opportunity to be protected under the County's immunity. So that is the way these are drafted because of the County's immunity, and because of the fact that an immune contractors status is already in state statute that it could apply to these types of physicians, too.

Senator Townsend: I would like to follow up with that, thank you. Did your board debate the public policy issue whereby there may be multiple parties whose total responsibility is found to be 25 percent but there was 75 percent not found to be liable by anybody, and, that the 25 percent would pay the whole? Did they debate that versus trying to find a way to make sure that the patient recovered everything that had been awarded to them in a case? Did they debate how that works?

Mr. Hale: Yes, they did. The joint and several liability issue.

Senator Townsend: I understand that. What was their thinking as they went through that?

Mr. Hale: Well, their thinking again was how do we protect UMC and its physician base. It was felt that since the physician was being singled out as a deep pocket that these were some of the reasons why the physicians were leaving staff, and in order to maintain their viability on our staff, that we had to offer them some protection whereby they wouldn't become the deep pocket. If they are only 25 percent wrong for something happening, then they should only be responsible for 25 percent of the award. And so that's why, again, they did approve both of these BDRs that talk about joint and several liability.

Senator Townsend: They are saying then, the patient, based on a jury award, would come up short for the amount that was not found to be applicable to someone's liability. Is that what you're saying?

Mr. Hale: I'm saying their responsibility as the Board of Trustees for UMC is to keep the hospital open. Without physicians there, they could not do that, and, therefore, they feel that was the most important thing to do.

Senator Townsend: Did you debate then—this will be my last one, depending on his answer, of course—

Mr. Hale: I'll try to make it good then.

Senator Townsend: That's all right. We're just trying to understand what your board thought through. Did you have anyone from the insurance community there to help your board work through that issue of joint and several?

Mr. Hale: No, we did not.

Senator Townsend: Thank you.

Chairwoman Buckley: Any other questions of the committee? There are none. Thank you for your testimony.

Next on our agenda is prevention of medical malpractice. We'll skip IV and move to "Prevention of Medical Malpractice: Reporting of Medical Errors" as we're still waiting for a couple board members from the Board of Medical Examiners to arrive. You all are here? Okay, well, then we'll go to you.

Item No. IV, "Prevention of Medical Malpractice: Procedures for Licensing and Disciplining Physicians." And if you'll all give cards to the secretary so we can include you on our sign-in sheet, I would appreciate it. Good morning, and thank you for being with us today.

PREVENTION OF MEDICAL MALPRACTICE: PROCEDURES FOR LICENSING AND DISCIPLINING PHYSICIANS

Dr. Cheryl A. Hug-English, Larry D. Lessly, Dr. Paul A. Stewart, and Richard J. Legarza

Dr. Hug-English: I am Dr. Cheryl Hug-English, and I am the current President of the Nevada State Board of Medical Examiners, and we are here today to answer the committee's questions that you have regarding the functioning of the board. I have several people with me today. I have Mr. Larry Lessly, who is the Executive Director of the board; I have Mr. Dick Legarza, who is the attorney for the board; Dr. Paul Stewart, who is the Secretary-Treasurer and also chairs the Investigative Committee of the board; as well as Dr. Donald Baepler and Dr. Jaci Jones, who are nonphysician members of the board. Dr. Jaci Jones is our Vice President, and Dr. Baepler sits on our Investigative Committee.

It is our hope that we can help explain the functioning of our board. The board really has two purposes; to license and discipline physicians, physician's assistants, and. most recently, respiratory therapists. To help in our discussion what I would like to do is to first turn it over to Mr. Lessly to explain the process of licensing, and then to have Mr. Legarza go through our disciplinary process, and to then have Dr. Paul Stewart talk a little bit about how the investigative committee works. Dr. Baepler and Dr. Jones have some comments they would like to make as nonphysician members. At the end of that, if the committee has any further questions, we are happy to answer those as well. At this time then I will turn it over to Mr. Lessly.

Mr. Lessly: Thank you and good morning. My name is Larry Lessly, I am the Executive Director of the Nevada State Board of Medical Examiners. As Dr. Hug-English indicated to you, we do two things; we determine the initial and continuing competency of physicians, physician's assistants, and as of the last session of the Legislature, practitioners of respiratory care. To do that we need a lot of information and we get that information fairly readily in the licensing field. It does not come nearly as readily in the disciplinary field as it does with licensing and I think that those who are going to address the disciplinary issues can talk with you about that and some possible legislation to assist.

Let me simply run through the licensure process and I will be happy to answer any questions that you might have with respect to it. When an application is filed with the Nevada State Board of Medical Examiners for licensure to practice medicine, as a physician, physician assistants, or to practice respiratory care, the first thing we do is make an initial determination whether that physician, and I will talk about this from the standpoint of the physician, meets the statutory requirements for licensure. Assuming that the physician does, we then do what we call an original source investigation. That means we take really nothing from the physician other than his application for licensure. Everything else that comes to support that application comes from the original source. We get original source documents. Those are composed of several things—the first being actions against that physician by another licensing board in another state. We will inquire as to each and every state where the physician holds licensure; get a certificate of good standing from that state, and a report on any disciplinary action that has been taken against the physician in that state. That involves getting the legal documents, the judicial appeal documents, and an explanation from the physician—and that is an automatic appearance in front of our full board for a discussion of that issue. We look for criminal conduct on the part of the physician and we look for malpractice judgments or settlements that have occurred in other jurisdictions that come though primarily the Medical Board having jurisdiction over that physician where he was practicing in that state.

We then require that the applicant prove, which is a statutory requirement, that he has the authority to both remain and work in the United States. That involves the INS [United States Immigration and Naturalization Services] certification to us, passport review, that sort of thing. We then look at the applicant's licensure examination scores. Those come from a number of sources: the National Board of Medical Examiners, the United States Medical Licensing Exam, the Federation Licensing Exam, and the Canadian Licensing Exam. Proof of passage of those exams comes directly from those entities administering the exam.

For foreign medical graduates who have graduated from foreign medical schools but have completed their post graduate training in the United States or Canada, we require certification from the Educational Commission for Foreign Medical Graduates that in fact they have passed the examination of that entity allowing them to go into post graduate training. We then get direct verification from each and every medical specialty board the physician may be certified by. We then do a direct verification of the physician's medical education, meaning both a certificate indicating he graduated from a medical school and transcripts from that medical school. We then do state licensure

verifications to ensure that what he has told us is correct about where he has been licensed and when he was licensed. We get a direct verification from every hospital where the physician has had privileges in his entire practice. We are most concerned, however, about the previous ten years.

We then go to a computer data bank maintained by the Federation of State Medical Boards in Euless, Texas. That medical data bank contains any disciplinary action, and any type of administrative action taken against that physician in any state where the physician may be licensed, that come directly to us. We also then run that physician through the National Practitioner Data Bank for determination as to malpractice claims and for determinations as to any other administrative actions taken against that physician by any other medical board. Similar federal entity—the Health Care Integrity and Protection Data Bank is checked and then we check the American Medical Association Profile, which does something as far as verifying again a second source of verification of medical education specialty and certification.

Throughout this process we have an investigation going with respect to the physician. If there is anything in the application that would be grounds for denial of licensure, that physician is not administratively licensed. He is required to appear before the entire Board of Medical Examiners where he is questioned with respect to whatever aspect of the application troubled us. For instance, a physician may have adequate postgraduate education but we may see something back in his postgraduate education where he was placed on probation for a while. If it took longer than normal to complete postgraduate education, we would still require that physician to appear in front of the Medical Board to be questioned about his application.

Assuming that there are absolutely no problems with an application and it is squeaky clean there is nothing to investigate, there is nothing to indicate that there would be grounds for a denial of licensure, that physician can be licensed any day of the week that his file is completed. It requires a sign-off by the Secretary/Treasurer of the board, General Counsel, and me. If any one of us determines that the physician ought to meet the entire Medical Board—it only takes one—then that physician is scheduled for the next meeting of the full Medical Board for processing. When his application is complete and we have made a determination that he does not need to meet the Medical Board we have him complete a registration form which asks again those same questions that were on the application about any actions taken against him out of state, about any kind of malpractice. That is simply to verify, again, that nothing has changed since we started processing his application. We, at that point, also administer to him a jurisprudence exam, which is an exam specific to Nevada's Medical Practice Act, which he is required to pass before licensure. Assuming all of those things occur, it takes about 60 days to process it and the physician gets licensed. Assuming there is any type of problem at all, he goes to a quarterly meeting of the Board of Medical Examiners, he appears in person, he is questioned specifically by one member of the board, and all of the other members follow suit. That basically is the process, and I would be very happy to answer any questions you might have.

Chairwoman Buckley: Questions of the committee? Do you ever have occasions where a doctor is applying and has a number of medical malpractice suits from another jurisdiction?

Mr. Lessly: Certainly.

Chairwoman Buckley: And generally how does the board treat that? Is there a certain number where the board might…

Mr. Lessly: If he has malpractice suits from another jurisdiction he meets the entire board for a discussion of those suits or claims of those administrative actions taken against him by a licensing board for malpractice. In that situation the President [of the board] tries to

assign the questioning of that particular applicant to a board member who knows something about his specialty. We have the authority to use consultants in that specialty insofar as reviewing the actions against him. We require him to personally appear. We review all of the court settlement documents and he is questioned, physician-to-physician, with respect to the action.

Chairwoman Buckley: Have you ever denied a license to someone for…

Mr. Lessly: Sure.

Chairwoman Buckley: How many times?

Mr. Lessly: I have been there since 1983, I could not give you an estimate.

Chairwoman Buckley: Under 10, over 50?

Mr. Lessly: Probably 25, maybe, in all of those years. We tell the applicant up front if he has a serious problem with the application, a serious problem would be a pattern of malpractice or high settlement figures or judgments, we tell that applicant up front that those are grounds for denial of your application. In many instances we will make a staff recommendation to the board that the application be denied. The board is not bound by that.

Chairwoman Buckley: Is someone else going to do the presentation with regard to after doctors are already licensed so we will hold those questions?

Mr. Lessly: Yes, Madam.

Chairwoman Buckley: Okay, any other questions of this speaker on the initial process? I do not see any.

Dr. Hug-English: I will then ask Dick Legarza to come up and he will address the disciplinary procedures for the board.

Chairwoman Buckley: Thank you.

Dr. Hug-English: Dr. Stewart will start for us.

Chairwoman Buckley: Good morning.

Dr. Stewart: Good morning Madam. The way that the issues of discipline are handled by the board, information comes to us from many standpoints.

Chairwoman Buckley: Could you just state you name clearly for our secretary.

Dr. Stewart: Paul Stewart, M.D. We get information from many sources. Sometimes the information we get is early and timely and sometimes it is somewhat later. Their requirements for the physicians licensed in the State of Nevada, at large, to, if they believe that another physician is not practicing well or incapable of practicing, that they have an obligation to report to the board, that physician. That works well in the area of diversion. It has not worked well in the area of medical malpractice. There are requirements in the law that any hospital or clinic licensed in the state, if they believe that there is a problem with a physician, has a responsibility to inform the board of their worries and fears. That usually has been interpreted as when a final action by a hospital medical staff has been taken and that action lasts for longer than 30 days, i.e., reportable to the national data bank, the board is informed. There is a requirement that the insurance commission has that requires insurance companies to notify when there is a claim. That has been interpreted as when a claim is filed and finally adjudicated through the screening panel,

that if the screening panel has either no malpractice, yes malpractice, or unable to decide; the screening panel forwards the case to the board. There is a requirement that is very difficult to uphold; that the clerk of the county court, when any physician appears before them for any reason, whether it is a misdemeanor, whether it is a felony, whether it is medical malpractice, for whatever reason, that the board is informed of those issues.

We also have self-reporting. In regard to the diversion program, if a physician feels that he needs help either because of an alcohol or drug problem, or the tendency toward those, he can self-report and be placed in the diversion program. That is how we initially find that there are perhaps problems with a licensee. Once we are informed and decide that we really do have jurisdiction some of the complaints are: "My doctor was not nice to me," "My doctor did not spend enough time with me," or "I did not understand what my doctor was telling me." All of which we have no jurisdiction. If we feel we have jurisdiction over the physician we open a file, we request all of the medical records within a 20-day time frame. We have medical reviewers that review the case. If the medical reviewer finds any problem whatsoever we go to the opposite side of the state, Las Vegas cases are reviewed by Reno physicians, Reno cases are reviews by Las Vegas physicians, and rural cases are reviewed by either Reno or Las Vegas physicians. To define if there is a problem and if the problem rises to the level of the way malpractice was defined before October 1, 1997, which is one law that we operate under and after October 1, 1997, which is another law we operate under. Prior to 1997, October 1, we required evidence of, by law, gross and repeated malpractice. After 1997, October 1, the law states that we just need to find that there is evidence of malpractice so one case is enough. Before 1997, October 1, we needed repeated cases, which we defined as two cases. Once there is a case opened, the case is reviewed, and if we decide there really is a true issue, a reviewer from the opposite side of the state so there is no complaints of competition, jealously, or "I do not like this guy and I am out to get him." If the peer reviewer agrees that there is malpractice, we file a complaint from the investigative committee to the board. Hearings are taken, evidence is given, the board adjudicates and if found guilty sets a sanction for the physician. That is how the system worked before 1997 and now after 1997.

Chairwoman Buckley: Questions of the committee?

Mr. Legarza: My name is Dick Legarza, I am General Counsel for Nevada State Board of Medical Examiners. Ms. Combs sent me an electronic mail last week with a request from a member of the committee for some information about a period of time of five years or perhaps even longer of the notifications from the carriers which I have not prepared but we will be glad to do that. I just do not think we can do that. We are going to have to copy everything because everything is in alphabetical order and put in there. I do not know if we can separate five years out individually. So we will have to do each and every one. The other question was how many people we have licensed since the last report to you in January but the numbers of licenses and license applications that have been granted are running consistent with what you have in the annual reports that you have received from us over the years that are attached to the part that is in the handouts up there [Exhibit B]. I will get those numbers to you with respect to actual formal notice of physicians who have left the State of Nevada and notified us. I believe we have one that I was aware of before I left last week and I have been informed that has been the only additional one since I left.

One of the things that I had heard from talking with Ms. Combs was any suggestions that we may have with respect to any legislation that this committee can consider or recommend to the Legislature in the next session to assist us in disciplining physicians and proceeding with disciplinary matters with physicians. The Clerk of the Court for Clark County has corresponded with me in the past and we intend to meet to see if there is anything that we can work out between us to where she would get the information to

us in a timely manner. We get nothing from the courts, and, of course, the information from the courts is in our statute and we obviously have no jurisdiction over the courts. I do not know what you can do and I do not know what to suggest to you of what you can do to encourage those people to report to us. Clark County has a good on-line system on the Web and we can check there. We do not check there on a regular basis but when we get a physician that we are looking at we do check there. The information that is put up there is timely but then it gets rather dated after that point in time so it is hard to follow up on.

Insurance companies are very good about getting the information to us. The Medical Dental Screening Panel [MDSP] is very good about getting the information to us. We get the information from them in a timely manner under their statute that they are required to send to us, and we are in the process of working with them and giving an intergovernmental contract where they can get more of that information to us. The statute only requires them to send us the complaint of the plaintiff and any affidavits of the plaintiff at the MDSP. It does not require them to send us any medical records, response of the defendant physician, and any affidavits presented by the defendant physician. We are tentatively working on them sending that information to us, just getting it informally from them because they destroy it. Once we get the information then we are reinventing the wheel, if you will, by going out and contacting the hospitals, physicians, getting all of the medical records that they already have. So they are working with us with that.

With regard to the disciplinary area in malpractice things, the 1997 and post 1997 to show you how far things are running behind, post 1997 malpractice stuff has just started to come in over the last four to six months. Prior to that time it was pre October 1, 1997. Lawyers tend to file the MDSP right before the expiration of the statute of limitations. I do not know how backlogged the MDSP is, I have no clue, but the post-1997 medical malpractice stuff is just starting to come in. I have about nine of them on my desk right now where we have had peer reviews done on them. We do not get information from physicians. The statute says that a physician can in receiving grounds for a disciplinary action if a physician does not report to you of someone who has been violating. Well, how do I prosecute a physician? I guess I have to find the physician who did not report it and obviously have to prove it. At least when I have been there, there has been no formal complaint filed against a physician for not reporting malpractice or other violations of the Medical Practice Act by a physician to the board. We do get some from nurses but that is limited and I think there are reasons for that. The hospitals do not report that much. Dr. Stewart has told you their construction on when they should report. Of course we have the confidentiality statute under Chapter 49 ["Privileges," of *Nevada Revised Statutes* (NRS)] of the peer review process in the hospitals. Those two, the reporting to us and the peer review statute are at opposite ends of what should or needs to be done with respect to the confidentiality of peer reviews in hospitals, so we do not get much of that.

We may think that it may be possible that you might consider—I have looked, and I have not looked at length, but I have looked in the NRS and I cannot really find a quote unquote whistleblower protection thing for Registered Nurses, Advanced Practice Nurses, Physicians Assistants, Licensed Practice Nurses, other health care workers to encourage those people to report to the board. I do not think there is a specific whistleblower statute that I have found to encourage the other medical professionals to report to the board. We are the last ones to hear in many instances since we discipline physicians. I would be happy to answer any questions any member of the committee may have.

Chairwoman Buckley: Thank you. Senator Titus.

Senator Titus: Thank you. It is interesting you mentioned the whistleblower statute, that was a

provision of a bill I tried to get through two sessions ago, and it was a comprehensive nursing bill, and it fell by the wayside so maybe we need to readdress that. I wanted to talk a little bit more about the diversion part. Dr. Stewart concluded by saying then the board imposes sanctions. I would like to know what the whole range of sanctions are that you impose. I would like to discuss diversion and if it works well and if you have ever done any study comparing people in the diversion and how that connects to malpractice of people with certain problems are also involved in malpractice. Are the hospitals doing a very good job of finding those people and putting them in alternative programs, and what options do doctors have if they have been identified as somebody who needs those types of programs?

Mr. Legarza: The diversion program is funded by the board and several hospitals. We have a contract with the Nevada Physicians Assistants Foundation which is a nonprofit organization that has an Executive Director and a Medical Director and then has volunteer groups both in the north and in the south. Hospitals are good about contacting diversion. The policy of the Nevada State Board of Medical Examiners is, and has been, that if a person has a substance abuse problem, be it alcohol or drugs, that if that person participates in diversion voluntarily or even if the person is sent to diversion by the board, diversion tells that person what to do and that person is left alone by the Nevada State Board of Medical Examiners so long as that person complies with all of the requirements of diversion, such as going off to Talbott Marsh for weeks, months, some even years. Then comes back and participates with diversion, stays sober and practices medicine not being a danger to patients. If a person self reports or is reported by a hospital or someone else in health care, the Nevada State Board of Medical Examiners does not even know who they are. We stay away from that because there is no punishment the board wants associated with diversion. However, if the person does not comply with diversion the Nevada State Board of Medical Examiners are the first people to hear. This year the Nevada State Board of Medical Examiners has revoked the licenses of two physicians in the State of Nevada who decided they had a better idea of how to cure themselves. They had gone off the wagon and would not do what diversion asked them to do so they became, in the judgment of the Nevada State Board of Medical Examiners, a danger to the citizens of the state of Nevada. They can end up in the disciplinary process, and if it gets that far with someone who has been participating in it, they are revoked. We have revoked several physicians who simply, for whatever reason, did not stay straight and sober over the years. With regard to malpractice, the idea in committing malpractice in the practice of medicine, the idea of the existence of diversion is to try and get there before they harm the citizens of the state.

Senator Titus: Has there been any study of people who have gone into diversion and malpractice cases to see if these are the same people?

Mr. Legarza: Subsequent to diversion our experience has been, and I think the diversion people have told us, they have a 90 percent success rate. The 10 percent that are not successful, die. The 90 percent practice good, safe medicine. We have not, since I have been there, filed a complaint against a physician after diversion for a violation of the Medical Practice Act with respect to the practice of medicine, patient care. When the physician gets into diversion they have to sign a five-year contract with diversion. Diversion has the ability to extend that contract for more five-year terms as well.

Senator Titus: Dr. Stewart, when you talked about imposing sanctions, what are the different sanctions imposed other than taking someone's license?

Dr. Stewart: There are gradations of sanctions. There are 40 graduates of the diversion program who have been sober greater than five years and have ended their contract. There are currently 85 members of the program, north, south, and rural Nevada. The list of sanctions are listed by law, we can revoke a physician's license completely. We can suspend on terms and conditions, some of the terms and conditions are to get more

education in a field, eliminating a physician from practicing in one field. We can ask him to perform community service, fine him. Most of the things, if we do not revoke, revolve around increased education in a field whether it is ethics, or going back and learning how to do a procedure or not allowing him to do that procedure for a period of time until he gets expertise in training. Once we take away the right of somebody to do something we generally do not return that right to him.

Senator Titus: You gave a statistic on how many licenses are revoked, do you do these other sanctions very often?

Dr. Stewart: Of the ones we have dealt with finding from our definition of the word malpractice, not necessarily the court's definition or the screening panel's definition, we have taken away rights to perform surgery. We have taken away ability to do certain procedures. We have required continuing education above and beyond the 40 continuing medical education hours per every two for licensure. That is all public record.

Chairwoman Buckley: I would like to acknowledge that we have a couple of legislators who have joined us. Assemblyman Doug Bache and Assemblywoman Giunchigliani, thank you for joining us today. Senator Townsend.

Senator Townsend: Thank you. Let me go back to you doctor because the areas you are talking about are of great concern to all of us. Do you have any type of statistical evidence that shows us how many diversions have come to you and how many disciplinary actions have occurred, the time frames in which they occur, and the amount of times there were not disciplinary actions associated with someone's behavior?

Dr. Stewart: There is a public citizen—there is ranking of states based on what they describe as severe limitations of licenses. We average approximately 20 a year for the practicing physician population of 3,000 to 3,500. Diversion statistics do not appear in the public citizen listing of what we do. We have 110 listings of sanctions the board has taken since 1991. Ten years of sanctions posted on the Web for anybody to find. I cannot give you a number other than it has been averaging about 20 a year. This does not include the 85 in diversion and the 45 graduates of diversion.

Senator Townsend: If a licensee is in front of you and you decide and act appropriately that they should go into a diversion program, that is a discipline action by the board and subsequently is required to be public.

Mr. Legarza: No.

Senator Townsend: Why not?

Mr. Legarza: Because he has voluntarily gone into the diversion program. There is no formal complaint in that instance.

Senator Townsend: Why shouldn't that be changed to become public?

Mr. Legarza: Well, I do not know Senator. First of all, it is the overwhelming minority of those that are in diversion. No formal complaint is filed in that instance in order for it to be public of course we would have to file a formal complaint.

Senator Townsend: The goal of this committee is to find an atmosphere which all citizens can have the best medical care possible and deal with all these other issues that are auxiliary to that basic premise. Since the right to practice medicine is a privilege under our statutes, I think that since the seriousness with which medicine deals with peoples' lives, we would want to have the public to be as informed as possible as to the condition of the practitioner. If a practitioner looks you in the eye and sees that the hammer is going to come down and

then they voluntarily do something, then they can get around the public end of that and let me give you a for instance. The same as surrendering a license. If you are about ready to hand out severe disciplinary actions, a physician can surrender their license, and it is our understanding, that you do not pursue at that time any disciplinary actions.

Mr. Legarza: That is correct. Once the physician surrenders his license that physician is no longer practicing medicine in the State of Nevada. If there is a referral to diversion that physician, during the period of time while off in diversion, is not practicing medicine in the State of Nevada, and that physician will not be allowed to practice medicine in the State of Nevada, until diversion tells that physician that they in fact can practice medicine because they are now straight and sober. If the physician leaves the facility, then the physician is looking at a formal complaint. Your question is: "Do you have a bigger hammer over their head if you file a formal complaint?" and I think the answer of that question is, yes. The goal is to get that physician out of the practice of medicine before that physician hurts someone. These have not come to us, the ones that I have been involved with, after some bad event in patient care, it has been "the guy showed up drunk" or we get a report from the Substance Abuse Task Force and they will report to us about a physician self subscribing. Diversion program is sent out immediately to talk with that physician and there is a determination made. And, if the diversion program is convinced that there is probable cause to believe that the physician has in fact practiced medicine under the influence, that physician will do what the diversion program tells that physician to do or the diversion program will tell me about that physician and a formal complaint will in fact be filed. I am not arguing with you, Senator.

Senator Townsend: If a practitioner knows that there are serious sanctions about to be levied against he and his license and he surrenders his license, you believe at that point you lose jurisdiction over him; is that correct?

Mr. Legarza: No, I do not know that we lose jurisdiction over him, but he can no longer legally practice medicine in the State of Nevada. We have solved the problem by putting that physician out of the practice of medicine in the State of Nevada whether we proceed to have a formal hearing and have a determination made that the physician violated the Medical Practice Act and then the board decides that they're going to revoke that physician's license.

Senator Townsend: It is our understanding that physicians who are about to experience that and surrender their license, can then go to another jurisdiction with a clean record.

Mr. Legarza: That is not true Senator.

Dr. Hug-English: When a physician surrenders a license under investigation, that is a reportable offense. It does go to other jurisdictions and it is something that no physician does lightly. Because, if you go to get a license in Utah and have surrendered your license in Nevada, why you are being investigated; Utah is going to know that. It is truly a red flag for all medical boards including ours. When we get someone that has surrendered a license in another state, we are going to look at the physician very closely.

Senator Townsend: Do they all have the same reporting requirements of the surrendered license so that if someone is coming here having surrendered their license?

Mr. Legarza: Yes, Senator. The reporting requirements are the same for all of the licensing boards in the United States. If a physician surrenders their license while under investigation, that is a reportable offense. It is just like earlier, Mr. Lessly was addressing licensure and denial of licensure and the fact that physicians are told staff makes a recommendation for denial of licensure also during the licensing process, many physicians are told there is a chance you are not going to get a license or that your license will be revoked. Physicians will withdraw their application because denial of licensure is also a

reportable offense. If we deny a physician a license on an application, it is reportable, and if they surrender their license while under investigation, it is reportable. On a daily basis we work with licensing entities from other states and many times they already know about someone who we have under investigation that is licensed in their state as well since we are allowed to cooperate under our statute with other licensing boards. Surrender while under investigation is reportable and of course many physicians are licensed in multi-states, as you well know.

Senator Townsend: Last question, Madam Chairman. I appreciate your patience. Can you provided the statistics to us about providing appropriate disciplinary action to someone who in fact was found guilty of malpractice in a court setting.

Mr. Legarza: How many times have we provided appropriate discipline?

Senator Townsend: Whatever discipline it was. How many times have you disciplined someone based on a malpractice verdict?

Mr. Legarza: Informed by a court or informed by the MDSP? We have never disciplined…

Senator Townsend: Not a finding at the screening panel but an actual verdict.

Mr. Legarza: We have never been informed by any courts on actual verdicts.

Senator Townsend: So that means the answer is you have never disciplined anyone who was found guilty of malpractice, is that correct?

Mr. Legarza: No. That is not true.

Senator Townsend: That is what I just asked.

Mr. Legarza: We have disciplined people who have been found guilty of malpractice and we have disciplined for malpractice that have either been paid by the carrier prior to the filing of cause of action at the MDSP, have been paid by the carrier subsequent to a filing at the MDSP after we had been notified by the MDSP, or that have been paid as a settlement in a court of law or by judgment. By the time we get some of that information it is already down that path so yes, we have prosecuted people who have been found guilty, by juries, of medical malpractice. Remember, the malpractice situation is the one count of malpractice; the ability to prosecute on one count of malpractice is really new since 1997. We have only filed about 15 or so since that occurred after 1997. I have about 10 on my desk right now. There is more and more of those every day.

Senator Townsend: Are there cases where you do not file any potential disciplinary action on someone who is found guilty of malpractice?

Mr. Legarza: There are cases that the board has not filed a formal cause of action against a physician after there has been a determination by the MDSP that there is a reasonable probability of malpractice, yes.

Senator Townsend: Has there ever been a case where there was a subsequent court ruling that there was malpractice that you did not file disciplinary actions?

Mr. Legarza: Senator, not to my knowledge, but then once again, I do not know that there has or has not been because, once again, we are not in that reporting loop. We do not check to see how far it has gone in the court system since that has no bearing on how far we may or may not go with it. Our action is totally independent of anything that is happening in the court system. I am prosecuting one the 31st of July, which is in the court system. They are in the process of taking depositions in the court system. I do not know where that case is going to go but I do not really care because we are proceeding and we are

having the hearing starting the 31st of July and that is two counts of malpractice against a physician. Where that may or may not go in the court system, I do not know.

Dr. Stewart: Senator Townsend, you asked some questions that I need to add a little to. Diversion was set up by Dr. Jacobsen Sculley [phonetic spelling] in about 1984 or 1985 so there is a 17-year history of diversion theoretically working in the state. The reason that diversion is supposed to work is that you can get people to report that the doctor has problems. You can get wife and family, you can get hospitals, and sometimes you can get the doctor to admit that he has problems and that he needs help because it is separate from the board. Prior experience would suggest with the risk of loss of license, everybody keeps quiet. The family does not report, other doctors shy away from that individual and do not include them in their referral group or practice group. So the doctor, to be found, needs to have a place where he can go and get well. If the board has to intervene in that and it is public knowledge, lots of people will not report. That is just life.

Up until October 1997 when we had the mandate requiring gross malpractice and repeated malpractice before the board could act, the cases that we are now seeing, the cases that Ms. Buckley came and talked to the board about in March 2002, those cases are finally coming forward now. As Mr. Legarza explained, when the possibility of malpractice occurs, it generally takes 18 to 24 months to have a filing before the Medical Legal Screening Panel. We do not learn of that filing before the Medical Legal Screening Panel until they make a determination of yes, no, or unable to decide. The cases that are filed in 1997 that were adjudicated in late 1999 and early 2000, which are reported to us in the first and second quarters of 2000, are finally coming through peer review and through filings currently. The system is four and five years behind.

We need up-front reporting in my opinion. If a lawyer files a suit with the Medical Legal Screening Panel, I would think that the lawyer should notify the board. If a hospital does something for more than 24 hours with a physician, I think the hospital should notify the board. If an insurance company is notified that their insured is a defendant or is going to be sued in 90 days, I think the board should be notified. It would move us four and five years closer to the incidents. One of the incidents that went on was because after five years the X-ray to prove or disprove the doctor's malpractice was never found. We had to walk away from the case because we could not prove it. So we need to be there early and we do not need to be there after everyone has made their determinations. We have the requirement to make our determinations ourselves.

Assemblyman Anderson: Thank you, Madam Chair. Are there any instances where the Medical Board has moved forward where the medical screening panel has not recommended and the case was dropped and the Medical Licensing Board moved forward on its own because of other type of information that they felt they had?

Dr. Stewart: Yes sir, we get information from the public. We have a proactive radio and television advertisement campaign informing north, south, and rural individuals that they can find out about the qualifications of their doctor. If there has been any issues that the board has had with the doctor and we are able to give information over the phone to anyone who calls about the licensure history of the doctor.

There are approximately 800 complaints per year generated by the public. We look at each and every one of those complaints. Some of those are not in our jurisdiction such as: "He was not nice to me," "He overcharged me," or, "He did not explain what I had in a way that I could understand." We cannot deal with those because we do not have jurisdiction to deal with those. Of the 800, we open files on more than 400 of the complaints and then, over a period of three to six months, we go through and obtain the medical records of the patient from the doctor. We listen to the patient complaints and listen to the doctor's comments about the complaints and try and reach some decision on

what to do with the doctor if the doctor did something wrong. There may not be a malpractice claim filed and the doctor still may have sanctions applied against him for more education, not being allowed to do something in his practice until he gets the education and the training, and shows that he is capable of doing that. We have done that during my tenure more than five times.

Assemblyman Anderson: If a licensed physician in the state is subsequently found to be guilty of a medical error by a court, the Licensing Board does not take action except under its separate investigation of its own; is that correct?

Dr. Stewart: Yes. That is correct.

Assemblyman Anderson: Yet, if you come from another state, you do not take the information from a Medical Licensing Board from that state, but rather from a court action of gross medical negligence as outlined in NRS 630.165, "Application and affidavit for license; additional requirements; burden of proof. [Effective on the date of the repeal of the federal law requiring each state to establish procedures for withholding, suspending and restricting the professional, occupational and recreational licenses for child support arrearages and for noncompliance with certain processes relating to paternity or child support proceedings.]"

Dr. Stewart: If another state is described by a physician as having gross malpractice, we do not license him; we do not even send him an application for licensure.

Assemblyman Anderson: Is that determination made by the Medical Licensing Board of that state or is that determination made by a court of that state?

Dr. Stewart: It is a Licensing Board determination.

Assemblyman Anderson: If the a physician in another state has a medical malpractice case where he was found guilty and he moves to the State of Nevada, and that state which first licensed him, if that licensing board had not taken action, they would be under no obligation to tell you of that and, nor would you take that into consideration in your determination because it came from a court of law and not from a licensing board of the first state.

Dr. Stewart: No sir, I disagree. Let me explain what we do. If a doctor has been found guilty or settled a malpractice case for greater than $100,000; if that doctor applies for a license in the State of Nevada, he is required to appear in front of the entire board. The license is not given to him unless he can adequately explain his care of that patient.

If a doctor has been found guilty by another state medical board of gross or repeated malpractice he, by law, is not given a license.

Assemblyman Anderson: The $100,000 is the cap in effect for the determination as to whether it is reportable or not that has been set from the court standard. If it is less than the $100,000 cap, such as Nevada has a $50,000 cap, for those sovereign immunity question. If it were somebody who was a physician entirely within the state and it was an action of less than $50,000 or less than $100,000, then that would not be a question that you would have to take up. Is that correct?

Dr. Hug-English: I would like to clarify that on every applicant's application there is a question about malpractice. They have to answer that question and if they answer it and say "No," and we find out that they answered it incorrectly, that is almost a guarantee that they are not going to get a license. There are basically two different aspects. There is one way that we find out about malpractice from another state board but the second way is that basically each applicant is asked on their application. Now, they may answer that question and have had a $20,000 settlement on a case. What Dr. Stewart is saying is

that any case that the settlement has been greater than $100,000 automatically guarantees that the person will appear before the full board—to come before the board and answer questions about that particular case.

Assemblyman Anderson: Dr. Stewart, it appears in part that if you are coming into the state we have a higher standard to get your initial licensing than we do for somebody who may already be in the state but then ends up in a medical malpractice case. And, because of our reporting requirements, I guess listening to what your recommendations were, I am more concerned about this. They do not automatically come before you because they have already been found guilty in a court and they have agreed to or their insurance company has agreed to settle a malpractice suit, which is often the case. Those would not automatically be triggers for licensing investigation.

Dr. Stewart: Yes, they would be triggers.

Assemblyman Anderson: But it would be 10 years or four years after the fact.

Mr. Legarza: Mr. Anderson, your question talks about automatically triggered. A case ending up in the court system and having been settled in the court system and filed in the court system or having resulted in a jury verdict, we do not necessarily know about that particular action because the courts have not reported to us. If there is a settlement or if there is a medical malpractice matter that has been filed with the MDSP, those things are automatically triggered with us. Every one of those cases is in fact investigated so if a case is reported to us, the case is investigated. The carriers report them to us when they settle them. The MDSP reports to us when they make a finding on them. Cases are opened and cases are investigated in all of those instances. We do not, as a matter of course, open a case as a result of a jury verdict or a settlement in a court. The carrier will tell us about it. Once we hear about that then the case is opened and the case is investigated, but as a direct result of something that may happen in a courtroom, we do not know about that. I hope I have answered your question, sir.

Chairwoman Buckley: I think your question has been answered. I think the answer is what Mr. Anderson is not satisfied with but any further questions Assemblyman Anderson?

Assemblyman Anderson: No. Thank you very much Madam Chair.

Chairwoman Buckley: Senator Titus.

Senator Titus: Thank you. I just want to follow up on that because I find that appalling that it is five years before you can investigate somebody who has had these malpractice claims against them. Why have you not been coming to the Legislature sooner saying we need to be doing reporting up front. We have people out there who are slipping through the cracks. I wonder if these people who can move to other states, if the other states have similar recording requirements that we have and they look to Nevada and see nothing has been filed by our Medical Board against this doctor maybe it is not that bad. We are not only doing that here we are sending these people out further. What about that Dr. D'Ambrosio?

Mr. Legarza: Dr. Francis G. D'Ambrosio was licensed in the State of California before he was licensed in the State of Nevada. Dr. D'Ambrosio left the State of Nevada in year 2001, and went to California to practice medicine. Dr. D'Ambrosio's license was surrendered while under investigation in early 2002. The Nevada State Board of Medical Examiners has been working with the investigators and the licensing people in the State of California for about a year. They know everything we know about Dr. D'Ambrosio. I do not know if he is still practicing medicine there or not. I think he is. What they may or may not do I do not know but it's certainly grounds for disciplinary action for them to file disciplinary actions against him because he surrendered his license while under

investigation in the State of Nevada. There was nothing more we could do other than what we have done to help protect the citizens of the State of California with respect to that gentleman.

Senator Titus: How about all these other people in these five years that we have this back log that you are not investigating them because you are just now getting the reports from the court or MDSP, is that not scary to you?

Mr. Legarza: Yes. We do get information late and why we have not been down here complaining to you, I do not know. Maybe we should have been here sooner complaining to you. I do not think that we necessarily have a complaint about the MDSP. They have to live with what is filed with them and many times nothing is filed. The statute of limitations goes on forever some times. If you are a juvenile that statute of limitations runs until a certain period of time and when you discover the possible medical malpractice could be years down the road as well so there is years involved in the definition of when it occurred and how it occurred and when it can be filed. You are running behind the power curve for some period of time at any rate when you are talking about medical malpractice because many times it is not discovered and if it is not discovered that tolls the statute. As Dr. Stewart said, we could not even find a medical record, something that was important to our medical reviewers to give us a determination as to whether or not they felt there was medical malpractice. I think, by the nature of things of the legal system if you will, there is a time warp at any rate.

Assemblyman Hettrick: Thank you, Madam Chair. I think Dr. Stewart mentioned several instances where he thought there should be reporting directly rather than waiting for these cases to go on and finally come to conclusion before you hear something about it either at the level of the insurance company being notified or a lawsuit being filed. Why would it not make sense for us to say you folks should know this at the same time as anyone else if formally notified? Why should they not formally notify you? Why should this not be a concurrent investigation? Because, maybe you will find something that will not rise to the level of making it to the court case and finding of actual malpractice, but it would be something that you folks might decide would terminate a license. I do not see why we are waiting. I believe once this is filed somewhere and somebody has made a formal recognition that something is going on, I think you folks ought to be involved right then. If you have suggestions on what forms of notification would be sensible and meaningful to you, we would appreciate knowing that so we know all of the possible places we might gather the information that would make your job easier and much more timely.

Chairwoman Buckley: So, if we recommend legislation to make sure that you learn of all incidences of medical malpractice, at the soonest possible point by requiring reporting immediately; and, if we adopt some sort of whistleblower protections to require health care practitioners, doctors, and hospitals to report to you earlier, do you believe that we could prevent some instances of medical malpractice? Do you think that would assist you with your functions and duties?

Mr. Legarza: Absolutely.

Chairwoman Buckley: I think I know what one of our recommendations may be then. Any other questions from Mr. Anderson or the members in Las Vegas?

Dr. Hug-English: We do have Dr. Baepler and Dr. Jones if you would like to hear from them briefly if that is necessary, or if you feel you have gotten all of your questions answered.

Chairwoman Buckley: I have one more question. The issue about whether doctors are leaving Nevada and whose responsibility it is to track that. When you have difficult times, such as now, I think it has become evident that we would like good numbers about the number of

physicians coming in and the number of physicians leaving. If the Legislature asked you to find methods to determine that information and have it available for times like this, I assume you would be willing to do that as well.

Dr. Hug-English: Absolutely.

Chairwoman Buckley: Thank you, and thank you for your testimony today. I would like to go ahead and take someone out of order for public comment.

PUBLIC COMMENT

Jason Phillips

Mr. Phillips: A little background on what happened with my daughter is that she had a simple ear infection that, as it turns out, was being mistreated for three years by doctors so of course I had no idea. They kept giving her the same medication over and over again and they finally gave her a different kind. They said this medication may cause her to vomit, maybe even a lot. After she was on the medication for one day she starts throwing up. We called the doctor's office and the office said it was a new stronger medication than what we had given her before. The vomiting just kept getting worse and she started becoming lethargic the second day and we called back again. It was after hours. What we were told was that we had 24-hour nursing assistance available that we could call up any time, day or night, and be able to speak directly to a nurse. We called up and we told the person that the vomiting was getting really bad and she does not seem to want to move. We were told to take her off the medication and give her clear fluids and come see us at nine in the morning. As it turns out, the person that we spoke to was the cleaning lady for this physician's office.

What was actually causing the vomiting was the onset of spinal meningitis. Which luckily as soon as we did speak to the physician he looked right away and said what is going on here. I would like to note that she was born just like each and every one of us here. At the age of three, had a better vocabulary and better enunciation than her five-year-old brother.

What I am hearing today is that doctors are asking for more protection. My case is over and done. I am not waiting in the wings hoping no tort reform gets passed so maybe she would get more money. My case is over and done with and in my experience I find that the doctors are more than adequately protected. They are protected by their insurance companies so that they do not have to pay out-of-pocket the settlements. Even in these proceedings today I cannot mention the name of that doctor that did this and that is due to confidentiality laws I am assuming. The first time I went into the attorney's office that handled our case I did not say I want you to make this guy go broke. I said, "Can we sue him to get his license taken away?" and the attorney said, "No, we cannot. Those laws just do not exist." I asked if we could press criminal charges and he said, "No."

The doctors want more protection but it seems to me that they have all of the protection that they really need. They talk about a cap. Whatever the number is, try being in a position of waking up every single day for the rest of your child's life, dressing her, bathing her, feeding her, tying her shoes, and all of the little day-to-day functions that most children her age would be able to handle on her own but they have to be done for her. She was the victim. Do not feel sorry for me. But the doctors have so much protection and more protection is not necessary. What would be nice would be if the sanctions and things like that were public knowledge. The numbers may be but the names are not. Thank you.

Chairwoman Buckley: Thank you, and thank you for your testimony. Are there any questions? There are no questions. Thanks for being with us today. The next item on the agenda is the "Prevention of Medical Malpractice: Reporting of Medical Errors." We have some folks from the National Academy for State Health Policy first on our agenda. I think what we will do is take a five-minute break to allow the video to be set up as they will be hooking up with us through videoconference. We will be in recess for five minutes.

Before we start our next item I would like to go back to Agenda Item II, "Approval of the Minutes of the May 13, 2002."

APPROVAL OF MINUTES OF THE MAY 13, 2002, MEETING

SENATOR TOWNSEND MOVED FOR APPROVAL OF THE MINUTES OF THE SUBCOMMITTEE'S MEETING HELD ON MAY 13, 2002, IN LAS VEGAS, NEVADA. THE MOTION WAS SECONDED BY ASSEMBLYMAN HETTRICK AND PASSED UNANIMOUSLY.

PREVENTION OF MEDICAL MALPRACTICE: REPORTING OF MEDICAL ERRORS

Chairwoman Buckley: Now, we will go to Agenda Item V, "Prevention of Medical Malpractice: Reporting of Medical Errors." We are pleased to have a couple of experts to give us a national overview of medical malpractice crisis and systems for reporting medical errors. We have two very informative and knowledgeable people from the National Academy for State Health Policy. Thank you for joining us today via videoconference.

Mimi Marchev and Jill Rosenthal

Ms. Marchev: Chairwoman Buckley and committee, my name is Mimi Marchev, I am Senior Policy Analyst at the National Academy for State Health Policy and I am sitting next to my colleague Jill Rosenthal. Thank you for inviting us to speak before the committee. I hope next time we will have a chance to go out and visit your wonderful state.

We are going to present a brief overview of the medical malpractice crisis and when it is stated like that "the medical malpractice crisis" there are really two ways to look at it. As a crisis of medical error and medical malpractice, which Jill will address, and as a crisis of medical malpractice insurance which is the way it is presenting itself across the country, as a crisis that states are being forced to deal with in an immediate way.

As you know, this crisis has appeared before; this is the third time since the 1970s that we have been presented with this medical malpractice insurance crisis which is a sharp increase in the amount of insurance premiums, and in this case, it has been compounded by the fact that many companies are going out of business all together or pulling out of the medical malpractice insurance business which has created a crisis of availability as well as affordability. What seems to happen every time the crisis arises is there is an immediate polarization between, on the one side, with doctors and insurers and on the other side, trial lawyers and consumer groups. People such as yourselves are heavily lobbied to enact tort reform or to not enact tort reform.

It seems to me in looking at this, and sort of framing some of the issues, that the states really have multiple interests in the availability of affordable health care, i.e., that their doctors and hospitals have medical malpractice insurance to reduce errors and the incidence of medical malpractice, and, also to have a system in place that effectively and fairly deters medical malpractice and also compensates people who have been unfortunate enough to be injured through medical negligence.

As we looked at insurance premiums that are dramatically rising the questions that we

address here at the National Academy were why is that happening. On the one hand people claim that there has been a sharp increase in the number of medical malpractice cases and that the amounts being awarded have gone up. On the other hand, the blame is put on the insurance companies because of the price war of the 1990s and under pricing insurance.

What we have found in looking into this is that the empirical data is inconclusive. That some of the claims being made cannot be backed up with empirical data. There is some indication that the number of claims is going up slightly but we just weren't able to find any real hard data. I know from reading the newspaper that you went through that too and ordered a study to be done, and I did see that. It showed that in one county the numbers had gone up but when you see numbers like that you then have to go back and look at other factors that may affect that.

The big issue that seems to come up again each time this happens is tort reform. Another question we looked at was: "Does that work to remedy the rising premiums for medical malpractice insurance?" Again in looking through the research, there is not clear data that shows that tort reform in fact has acted effectively to reduce premiums or to stabilize them. There were many variations of tort reform passed in the 1970s when this happened and in the 1980s when this happened, and in some of those same states that enacted tort reform, you have rising medical malpractice premiums this time around.

The other questions to ask are: "Does tort reform cure the rising insurance premium prices?" and, "Does tort reform address the other issues that the states are interested in?" Making it more difficult for people to get into court or to reduce the number of damages does not address the issue of medical error. It certainly does not address the issue of deterring malpractice or compensating victims.

We look at them in an approach such as Pennsylvania's where the state, in an attempt to address the medical malpractice crisis from both those angles, the insurance premium crisis and medical errors, take a broad view, a comprehensive view and try to address it from all three fronts. From the insurance reform angle, patient safety and reporting of errors to collect data, and taking a hard look at the tort system as a way to meet the goals of deterrence and compensation. It seems to me that not only does tort reform not address the issue of pricing but also the tort system itself, the way it is does not address those issues of fairly compensating. We know that most people who are injured by medical negligence do not bring suit; it is an expensive and unyielding system. Of those people who do bring suit, only one-third of them ever achieve any amount of compensation.

What we would recommend, if anything, is a comprehensive approach to look at tort reform, medical error, and insurance reform. I see from your agenda that you certainly are taking that approach. I would like to turn this over to Jill to talk about medical errors and then we will be happy to answer as many questions as we can.

[Exhibit C is a handout provided by Ms. Marchev.]

Ms. Rosenthal: Thank you Chairwoman Buckley and committee members for inviting us. Ms. Marchev did mention the link between medical malpractice, at least how the medical malpractice crisis creates a chilling effect on efforts to improve patients safety. I would like to review for you what states are doing to address medical errors. I am sure you are all familiar with the groundbreaking report that the Institute of Medicine released in late 1999. That documented the significant human and financial cost of medical errors. The report documented that medical errors kill anywhere from 44,000 to 98,000 people a year, which is more than car accidents, breast cancer, and AIDS [Autoimmune Deficiency Syndrome] at a cost of anywhere between $17 and $29 billion a year.

The Institute of Medicine was clear to point out that the problems or causes of errors are mostly system problems. They are not problems with individual providers. The way to solve the problem is by looking at root causes and creating external pressure on the health care system to create safe systems of care and providing knowledge and tools to the health care industry to help them accomplish that.

There has been quite a bit of interest by the public on this issue and there is one poll awhile back that showed that most Americans do believe that providers should be reporting those errors. Among the Institute of Medicine's recommendations was to identify and learn from errors. Within that recommendation they recommended two different types of reporting systems for medical errors: mandatory systems and voluntary systems.

I think this has created some confusion in that we often hear about a debate between mandatory and voluntary systems. What the Institute of Medicine was really recommending was two complementary types of systems. Since they are intended for very distinct purposes. The idea of having these two types of systems is modeled on the aviation industry, which has both mandatory and voluntary reporting systems.

Mandatory systems were recommended to be created in all states to report only those small numbers of medical errors that result in serious injury or death. The purpose of mandatory reporting systems is to hold institutions accountable for those errors and what they mean by accountable is accountable for reporting those events and for identifying ways to correct the root causes.

The voluntary reporting systems are very different. The Institute of Medicine recommended that we promote those voluntary systems that already exist which are mostly national systems. They are intended for a larger number of medical errors being those that create very minimal harm or no harm at all in that they are caught before the error reaches the patient. The purpose of those systems is to identify system weaknesses and to track and trend data.

They are two quite distinct systems. The National Academy for State Health Policy has done a number of studies looking at those mandatory reporting systems that do exist and we have identified 19 mandatory reporting programs within 19 states that address hospital based errors. These 19 were identified through a report we did in early 2000, which identified 15 states that self reported having systems. Since then, a number of them have been added for a total of 19. Many of those systems were developed before the Institute of Medicine report made its recommendation, and for that reason, they are quite distinct. They collect different types of data and they have different types of definitions. They use the data in different ways. There are ongoing efforts in just about all of those states to continue to improve those systems.

What we have found since we studied the programs was that although there are many specific approaches that states have used, the states really do value those systems as an opportunity to provide a window into what is happening in hospitals in terms of patient safety. Part of what we found was that in many states most hospitals are deemed by the Joint Commission on Accreditation of Healthcare Organizations [JCAHO] and, as a result, many states are not doing annual or biannual surveys or licensure surveys of hospitals. As a result, the states do not have the opportunity to get into the hospitals as often as they would like and so the reporting systems presented another opportunity to really have a sense of what is happening within the hospitals.

Most of the states reported that under reporting of errors was a problem. We found this across the board. There is often an argument made that disclosure of data will discourage providers from reporting. What we found was that some of the systems protected the data very closely and in other states the data is disclosed to the public. We

found no difference in under reporting; it was problem in all kinds of systems. We also found that states are looking for opportunities to improve their data analysis and to find ways to focus more on improvement but they are facing resource shortages in most states. In most cases these reporting systems have been patched together with existing funds and existing staff so it has been somewhat of a struggle to find the resources to analyze the data to the extent that the states would like.

I want to talk a little bit about the use of the data from these systems and, as I mentioned earlier, the overriding reason for mandatory reporting is to hold health care facilities accountable for those errors that result in serious injury and in death. That accountability is achieved by investigating the event, providing expertise and resources to the facilities to make the corrections, and ensuring that those corrections are sustained over time so over time similar errors will not occur.

In addition to that focus on accountability, states are also looking at ways that they can provide education across facilities about those errors that they are tracking. As they have gained expertise and experience with their systems they have begun to track and trend the data and they have been providing feedback to the facilities in the form of newsletters or action alerts. In some cases hospitals or those institutions that report errors can actually compare their facility to a state average through a Web based system.

There has been continued interest in addressing medical errors across states. We have also been tracking state legislation to address medical errors. We have seen an increase in the number of bills reported, an increase of bills that have been enacted, and an increase in the number of states that have introduced legislation over the past three years. Those bills address a variety of means of addressing medical errors. Some of them have required studies and commissions to collect data on medical errors. A number of them have created reporting systems and we have also begun to track statewide patient safety coalitions. We have identified 17 states that have that type of coalition of which 12 are public–private partnerships.

I have included in a handout [Exhibit D] a list of the studies we have done on mandatory reporting. Many of them are available on our Web site: http://www.nashp.org/. They are also available to state government free of charge and we would be happy to provide those to you as well as additional information that you may have in the policy briefs that we provided [Exhibit D]. We are happy to answer questions and if there is anything that we can do for you to help you connect to other states or provide additional information on anything we discussed we would be happy to do that. Thank you.

Chairwoman Buckley: Thank you for your testimony. Questions of the committee? Assemblyman Hettrick.

Assemblyman Hettrick: Thank you, Madam Chair. For Ms. Marchev, please. You sent out to us, it is on a blue piece of paper [Exhibit C], it says "Agenda Item V. A. National Overview of the Medical Malpractice Crisis." And at the top of that you have kind of a summary of what is going on, and I was particularly interested in the last two sentences of that second paragraph where it says, ". . . a full and open disclosure of medical errors is seen as an essential step in addressing the issue of patient safety, doctors and hospitals resist reporting errors for fear of increased malpractice . . . ."—which you both have addressed to some degree—"The wave of the future may be seen in comprehensive legislative initiative in Pennsylvania, wherein tort and insurance reforms were combined with patient safety initiatives and reporting requirements."

We're, obviously, aware of the proposals in regard to tort reform, and we are somewhat aware of, at least the patient safety initiatives and reporting requirements, but what is included in that legislative initiative in Pennsylvania in regard to the insurance reform?

Ms. Marchev: Well, as I understand it, and I don't claim to be the expert on the Pennsylvania law, but

as I understand it, they did a couple of things. They changed their catastrophic fund, and they had a state-run catastrophic fund, which paid the amount of an award over the amount of the insurance policy. And they are privatizing that and, apparently, are going to close it out over time. Now, the doctors in Pennsylvania saw that catastrophic fund as an impediment, that it took a long time to go through it, that it was sort of inefficient, and they were the ones who proposed the privatizing of it, as I understand it.

The other thing that they did in terms of phasing it out was that they've lowered the amount of mandatory insurance from $1.2 million to $1 million, which they assume a lower rate. Some of the insurance reforms are really looking at lowering the rates, and they are phasing out the cap fund. And, do you know any more about that, Jill [Rosenthal]?

Ms. Rosenthal: I don't know too much specifically about the cap fund other than it was a fund created to provide malpractice insurance above and beyond a certain amount. But, I think part of what is interesting about this bill is that it does address both malpractice and patient safety within one bill. And from the study that we did previously, we found that a number of states actually did pass mandatory reporting bills in response to a malpractice crisis. They just didn't link it so closely into one bill like this.

Ms. Marchev: If I can just finish up on some of the other insurance pieces. The other thing they did in that bill was they limited the insurers liability to the coverage limit of the policy. And the other thing is, they are restricting the ability of insurance policies to cancel. Apparently, when this crisis hit and companies were folding and pulling out and not renewing policies, and I am sure you have faced some of the same thing in Nevada, it just creates a terrible situation where suddenly providers aren't covered. They also set up a joint underwriting to offer coverage to anyone who couldn't get coverage through the other means available.

Assemblyman Hettrick: All right. Thank you for that. Your last comment there, next to the last, limited liability to the coverage of the policy. Did they define what was included in the limit of the liability? In other words, are they counting payout or are they counting actual legal expense or fees and costs? What did they include in that?

Ms. Marchev: I don't know that, and I'd be happy to follow up on that.

Assemblyman Hettrick: That would be of some interest to me.

Ms. Marchev: Okay.

Assemblyman Hettrick: Just curiosity to see what they included; if they defined what the limit of coverage was included.

Ms. Marchev: Yes, and anything else while I am on the phone with Pennsylvania? I would be happy to ask any further questions.

Chairwoman Buckley: If I could follow up on that with regard to limiting liability to the cost of the coverage. I know as a practical matter that usually is what happens anyway, except in some very, very rare cases, but I think what the victims say that the benefit of having that is that the insurance company then, because of concern about their own bad faith, if there is an excess verdict over the policy limits, that's a tool to get the insurance company to pay rather than to have it go to a supreme court for a couple years. Is there anything in Pennsylvania or anywhere else that you know that did such a thing, limit it to the policy limits but had some sort of hammer to make sure there weren't unintended consequences by insurance companies then taking advantage of that?

Ms. Marchev: That is something I can look into, too, because I don't know that off the top of my head.

So the same issue, the limit of liability in terms of it being for the benefit of the victims.

Chairwoman Buckley: Are there any other questions of the committee? Assemblyman Anderson, I can't see you right now. Do you have any questions?

Assemblyman Anderson: No, thank you, Madam Chair.

Chairwoman Buckley: I don't think we have any questions, and we appreciate your participation, and we would love to receive that additional information from you.

Ms. Marchev: Yes, I will get back to you. If there is anything further, please contact us. I know Allison [Combs] has been in touch with us and has our e-mail, and we'd be happy to work with you as you attack this problem.

Chairwoman Buckley: We appreciate it very much, and it is always nice to have an impartial organization to turn to to get information, so thank you for your testimony and your time today.

Ms. Marchev: You are welcome. Thank you.

Chairwoman Buckley: Next on our agenda, I am going to break for just a minute and take somebody out of order who would like not to spend their entire day here. Ms. O'Neill, we would be happy to take you now if you would like to come forward.

PUBLIC TESTIMONY

Kristie O'Neill

Ms. O'Neill: Thank you, Chairwoman Buckley, and committee members. This is a very emotional subject for me. This issue personally affects me and my family. I'll try to just read as much as I can. My son and I almost lost our lives due to the carelessness and negligence of a doctor and hospital I put my trust in. My son was a full term, perfectly healthy baby before he was born. He suffered lack of oxygen at birth and now has cerebral palsy and seizure disorder. By the way, his name is Kevin, I'm sorry. He cannot walk. He cannot talk. He cannot sit or eat on his own. He has a feeding tube due to the fact that he cannot coordinate his swallow. He is three years old now, and it brings me to tears every time I think of how much he has suffered and how much he will suffer. This is my mom, Nancy Trudeau [phonetic]. I'll try to get through it; I am sorry.

Not just physically he suffers, but emotionally and socially. Because of what happened it has turned my life upside down. My entire family. I truly believe no one can completely understand what it's like to be a parent of a child with multiple disabilities unless you live it. I never before imagined what I would go through or see my child go through. I work for an early intervention program through the state, and I meet quite a few parents who have children with special needs. It is very difficult when your child has a genetic disorder or is born prematurely or with any kind of special need, but I feel it is extremely difficult because, for me anyway, because what happened to me and my son was completely preventable and was due to people not caring to do their job.

My son now sees six doctors on a routine basis. Most are wonderful doctors and have helped my son. And, I also take him to different therapies four times a week, and to say the least, he does not live like a typical three-year-old should. I don't believe doctors should have to pay such high insurance rates because insurance companies made bad investments. And, I also believe my son should not have to pay for bad investments and bad decisions made by other people, but he will for the rest of his life.

These facts should not affect my son. He is the victim. He is the one who suffers the most. Not the doctors or lawyers or insurance companies. It has been told to me that tort reform would only put a cap on suffering, that his medical and economic fees would be paid, and he would receive adequate care. And, this was from one of the legislators I've talked to. And, my opinion is he deserves much more than just adequate care. My son had no choice when he was born, and the doctor did, and he made a very bad choice. Why shouldn't the doctor in the hospital be held accountable? My son has to live with their decision for the rest of his life. I don't know how anyone could put a cap on suffering. It should be case-by-case. Everyone suffers differently. Besides, he's been suffering since his birth. For his entire life he will suffer, and when I calculate an award of about $250,000, if he lives to be an average life span, he would get about $2,000 a year, and this is after lawyers' fees. And, this is supposed to make him feel better about not being able to walk, talk, sit up, or eat?

I don't see the justice or the responsibility for what happened to him. I am sure you would agree with me, if he were your child. Thank you for taking your time for listening to me. It really means a great deal.

Chairwoman Buckley: We thank you for your testimony. We know how hard it was. Thank you. We'll move to Dr. Yacenda, a report from Legislative Committee on Health Care's Subcommittee to Study the Development of a System for Reporting Medical Errors.

REPORT FROM THE LEGISLATIVE COMMITTEE ON HEALTH CARE'S SUBCOMMITTEE TO STUDY THE DEVELOPMENT OF A SYSTEM FOR REPORTING MEDICAL ERRORS

John Yacenda, M.P.H., Ph.D.

Dr. Yacenda: Good morning, Chairman Buckley and members of the committee. For the record, I am John Yacenda, Chairman of the Legislative Committee on Health Care's Subcommittee to Study the Development of a System for Reporting Medical Errors.

It's very difficult, as I am sure you all imagine and everyone in this room, to follow with any testimony after that personal story. We have all been touched in different ways by those kinds of events, and it makes it particularly difficult for me presenting right now, and I will do it, of course, but having chaired this subcommittee trying to be very objective about the information that we received, and while there are stories that are painful to listen to and painful to observe, there are a lot of things that seem to be happening correctly, as well.

But, what I'll do, Madam Chairman, is I have an organized six-part presentation, not a lot of length, but necessary to give the complexion of the subcommittee. It is our charge, our research, our findings, our hearing process, and the scope of our testimony, our recommendations, and then a summary. I understand the committee has a copy of the final report.

The first section: The subcommittee's charge. Assembly Concurrent Resolution 7 of the [2001] Legislative Session directed the Legislative Committee on Health Care, through a subcommittee, to conduct an interim study concerning the development of a system for reporting medical errors. The subcommittee was charged with determining what constitutes medical errors, an outcome that is detrimental to a patient, and a medical error that causes an outcome that is detrimental to a patient. The subcommittee was also to evaluate systems for reporting medical errors, ensure that preventable medical errors are not systematically repeated, and encourage medical institutions to improve the safety of their patients.

Assembly Concurrent Resolution 7 also specifically charged the subcommittee to evaluate effective ways the system may impose mandatory reporting of medical errors;

methods for ensuring that information reported to the system remained confidential; that the system did not encourage blaming an individual medical professional for a medical error; and importantly, whether such a system should be established in Nevada.

Further, the subcommittee was to consider the proper use of information that is reported to the system; which health care entities should be required to report information concerning medical errors to the system; whether sanctions should be imposed on a medical professional who fails to comply with the reporting requirements of the system; and the relationship between medical errors and the licensing of medical professionals.

I need to say that, in a general sense, we as a subcommittee, did not in any way try to intrude into the licensing and statutory responsibilities of licensing boards in our research, but we did hear from the licensing boards.

Relative to our research, we used the Institute of Medicine's [IOM] [report] as required by A.C.R. 7 that was just reported to us by the National Academy for State Health Policy. The report, "To Err is Human: Building a Safer Health System," which was released in November 1999. The authors of this report stated that between 44,000 and 98,000 people each year die in hospitals from preventable medical errors. The report based its estimate on the number of deaths due to medical errors on the results of two large studies, one conducted in Colorado and Utah and the other in New York.

This study proposed several recommendations, three of which were a proposal to implement a national mandatory reporting system, beginning with hospitals; a recommendation that states establish a voluntary reporting system to collect information about near misses, so on and so forth; and a proposal for a comprehensive strategy to improve patient safety to create an environment that encourages organizations to identify errors, evaluate causes, and take appropriate actions to improve performance in the future.

In order to address the requirements of A.C.R. 7, the problem as identified in the Institute of Medicine report that led to the study had to be tested for its validity in Nevada because this study was about Nevada. And, we were charged to, along with other matters listed, study whether a reporting system should be established in Nevada. Evidence of a medical error problem in Nevada was approached from several different perspectives, including reports from the Nevada Department of Human Resources' [DHR] Health Division's Bureau of Licensure and Certification [BLC]; DHR's Medicaid Drug Utilization Review Board; and substantial testimony from Nevada's Professional Licensing Boards; and others I will soon mention.

First, the Institute of Medicine report. As noted on page 7 of our final report of the subcommittee, "At each meeting, the subcommittee heard from health care experts who dismissed the IOM report . . . as flawed." For one reason or another. The fact is that as good and compelling as it may sound and as great of press as it gets, bad science is not good nor does it shape effective public policy. For instance, the Institute of Medicine report was based on data from one study in New York that was performed on 1984 data and found that 3.7 percent of those admitted to the 51 New York hospitals studied experienced injuries caused by medical management. A Colorado and Utah study using 1992 data found this percentage to be 2.9 percent. Researchers then took these percentages and applied them, or extrapolated them, to the 33.6 million annual admissions to U.S. hospitals in 1997. Simply, they multiplied the numbers and they came up with the estimates of 44,000 to 98,000 deaths due to medical errors occurring in the United States.

Now, these estimates permitted researchers to proclaim preventable adverse events were a leading cause of death in the United States, even though for both studies combined, a total of only 45,000 medical records of patients who had already been discharged from

hospitals were reviewed. And of these, only a very small percentage of adverse events were identified.

A number of health care professionals and professional groups dispute the reliability of the Institute of Medicine report, while others tout its shocking numbers. But the scientific question is, and it remains, do these extrapolated numbers of deaths stay consistent when other doctors and researchers review the same charts and records? The answer is the numbers have not been consistent when scrutinized by other professionals. So as a matter of the Institute of Medicine data driving our concerns in Nevada, we found the report unsubstantial and unfounded.

Our findings. We found agreement that nurse staffing levels and long hours can contribute to medical errors, as well that a shortage of pharmacists and rushed prescriptions and unclear handwriting can lead to medication/medical errors. We learned that wrong site surgeries are easy to prevent and that intensivists, specially trained physicians, improve the survival of critically ill patients and actually decrease the cost of care.

Indeed, system failures in medical facilities lead to error, but we learned that these can and are corrected. We learned there are professionals who violate their practice codes and cause harm. And as the subcommittee heard earlier, there are established legal means of dealing with them. But two things we did not find: (1) We could not document a significant medical error problem in Nevada; and (2) We found no evidence that the institution of a mandatory reporting system would improve the safety of patients, one of the considerations of our charge.

The Bureau of Licensure and Certification complaint reports indicate that there are a very small number of substantiated complaints relative to medical care and hospitals. On average over the past five years—over the past five years—there were only 23.8 substantiated complaints per year, while there were an average of 148.2 complaints a year that were unsubstantiated. The Bureau of Licensure and Certification, as you know, is the state agency that licenses all medical facilities in Nevada.

Our hearing process and scope of testimony. In the process of collecting the broadest range of public and professional data on medical errors and the charge before the subcommittee, we held three meetings. At our first meeting, we focused on obtaining the definition of a medical error and a description of the current system for reporting medical errors from the following groups: the Bureau of Licensure and Certification; and the Division of Mental Health and Developmental Services, specifically their northern and southern adult mental health services. Additionally, we heard from the Board of Medical Examiners; the State Board of Osteopathic Medicine; the State Board of Nursing; Board of Dental Examiners of Nevada; and the State Board of Pharmacy. We also received testimony from the Services Employees International Union [SEIU], Nurse Alliance Local 1107, Nevada Nurses Association, Nevada Hospital Association, Nevada Pharmacy Alliance, and the Nevada State Medical Association. During public testimony at the first meeting of the subcommittee, we heard from only one person.

I would like to point out at the second meeting there was yet another attempt to gather public data on the extent of medical errors that occur in Nevada. We felt it was important to hear from the public, and a press release was broadly distributed prior to the meeting to encourage the public to come forward with their concerns and experiences with medical errors. Public testimony items were placed at the beginning and the end of the agenda. However, the subcommittee did not receive any public testimony at the beginning of the meeting, and though we heard from three people at the end of the meeting, none of the comments addressed any medical errors that occurred in our hospitals or other medical facilities.

At the second meeting, the subcommittee heard a presentation from the SEIU, Local 1107, and the Nevada Nurses Association concerning the current systems in hospitals for reporting medical errors from the perspective of nursing staff. Members of the Nevada Hospital Association also gave a presentation concerning hospital reporting systems, the Bureau of Licensure and Certification and Medicare patient standards, and how the hospital industry meets those standards. The Nevada Hospital Association report highlighted risk management programs, quality assurance activities, health care quality management practices, and community-wide patient safety initiatives.

Staff gave a presentation of comparative information requested from the six professional licensing boards with respect to their policies and statutory responsibilities for reporting medical errors. In summary, when a board receives information that might indicate a violation of professional standards the board has the authority to investigate, hold hearings, and impose discipline.

I think that, Chairman Buckley, your committee will hear today of some of the problems in that, some of the time delays, and we didn't investigate the details of the activities or operation of the licensing boards.

The National Conference of State Legislatures gave a presentation of state statutes concerning medical error reporting systems throughout the United States, highlighting states like New York, Massachusetts, and Florida. And staff also presented information on the components of a system for reporting medical errors.

Our recommendations. It is my understanding, Madam Chairman, that these recommendations will be heard at the August work session of the health committee [Legislative Committee on Health Care]. They have been presented, but they will be discussed in that work session.

The subcommittee held our work session on April 16 [2002], and the work session document is in the report [Exhibit E].

First, the subcommittee recommended that, through a letter, the Legislative Committee on Health Care urge the medical professional associations and organizations in the state to create an alliance for patient safety [NAPS]. Many other states have formed coalitions to study the issue of medical errors. A coalition is simply a forum for sharing information about the causes of medical errors and possible prevention strategies. I have used the Massachusetts coalition for prevention of medical errors as a model for NAPS. According to the National Academy for State Health Policy, this coalition was founded in 1997 by the Department of Public Health, the Massachusetts Association, and the Massachusetts Medical Society to develop and implement a statewide initiative to improve patient safety and minimize medical errors. For additional information on this recommendation, please turn to page 8 of the report for a brief overview of that coalition.

A report recently issued by the National Academy of State Health Policy indicates that there are 17 of these patient safety coalitions currently operating in the states, 12 of which are public/private partnerships.

Our second recommendation recommended increasing patient safety in medical facilities by providing information to patients regarding their rights while in a facility. Testimony indicated that medical facilities currently do not always provide the same information to patients. The information that would be provided to patients according to our recommendation would include a statement referencing the facility's mission to ensure a safe patient environment; a copy of the patient's rights provisions set forth in NRS; and the telephone numbers and addresses for: one, the facility's safety director; the BLC; the Joint Commission on Accreditation of Healthcare Organizations [JCAHO]; the

Office of Consumer Health Assistance; and the Office of the Governor. These contact points would help patients, and consumers and patients' families, readily address patient care and safety concerns.

A third recommendation of the subcommittee was to send a letter to the Department of Human Resources urging the department to require medical facilities that are not accredited by JCAHO to maintain a file of sentinel events as described by JCAHO. This file would be available to the licensure survey personnel at the time of on-site surveys. Staff of the BLC have indicated that it licenses roughly 289 medical facilities in the state of which only 44 are JCAHO accredited. So, the committee felt strongly that the recording of these records would be an important way to begin to level the reporting field for survey personnel. I should add that 80 percent of the hospital beds in Nevada are found in JCAHO-accredited hospitals.

Fourth. The recommendation was that DHR develop a statewide medical adverse event surveillance system. Based on testimony presented during the subcommittee's meetings, there is no state agency, program, or system in Nevada that identifies and tracks medical errors or adverse events. Therefore, there are no numbers or accurate reports reflecting the occurrence of medical errors, adverse events, or deaths due to medical errors. The surveillance system would identify and track adverse events occurring at hospitals and medical facilities. And the system would also be used to actively track adverse event occurrences, distribution, and trends. The ongoing collection, analysis, and dissemination of the data would provide for appropriate policy and program responses to the occurrence of adverse events based on Nevada-specific data and trended analyses.

The surveillance system proposed in this recommendation most closely resembles a traditional sentinel surveillance system that will cull its data on selected adverse events (as determined by regulation) from all existing sources of reported data and vital statistics on medical care and other data as provided in regulation. While there is currently much data available on adverse events and complaints, there is no central repository for this information.

In summary, Madam Chairman, based on Nevada's licensure requirements, the JCAHO accreditation standards, and hospital safety practices, it is evident that medical facilities in Nevada allocate considerable resources trying to prevent adverse outcomes and promote patient safety. Our professional licensing boards act to protect the public from incompetent and negligent health care professionals once these individuals are identified. Medical facilities adhere to federal or state quality assurance regulations that are designed to ensure that medical errors are identified, causes are evaluated, changes are implemented to prevent reoccurrences, and there is timely evaluation of the outcome of these changes. Yet, medical errors still occur.

We have made recommendations that take steps toward creating a body of knowledge about medical errors in Nevada through a surveillance system, an Internet-based registry, and other actions that promote a comprehensive strategy to improve patient safety by creating an environment that encourages organizations to identify errors; evaluate causes; and take appropriate actions to improve performances in the future; and further, to engage the public and private sectors and consumers in a constructive policy development dialogue.

Thank you, Chairman Buckley.

[Dr. Yacenda's prepared remarks appear as Exhibit F.]

Chairwoman Buckley: Thank you for your testimony. Are there questions of the committee? Assemblyman Anderson, I'll call on you first since I can't see you by screen. Do you have any questions?

Assemblyman Anderson: Thank you, Madam Chair. I found the report interesting. I am still kind of perusing it. I am concerned that if, in light of some of the testimony that we heard earlier from Mr. Legarza and the Dr. English that we may need to be a little more circumspect in terms of pursuing the reporting of medical error. I clearly want to make sure that we are, and I find it incredulous that we're not, and I want verification of this again, that we do not provide any whistle-blower protection for people who report medical error within a hospital. Or, do they follow that question here in the state in their determination?

Dr. Yacenda: Madam Chairman, through you to the Assemblyman. To my knowledge, we did not hear that there are any formal protections for professionals. Although, what we did hear was that there was a certain fear that some nurses particularly had in reporting events. But, we also heard to the contrary that reporting was encouraged and that there was no retribution. So, I think that probably the action that was recommended earlier about whistle-blower protections makes a lot of sense in the context of what we heard throughout the testimony.

Assemblyman Anderson: And second, and hopefully the last, one of the recommendations that your committee heard relative to the possibility that reportable error would be limited to a $50,000 cap. Did you see that as if the reportable error or the error was reported and then found not to be true and that you saw that as a protection for the person who made that legal statement? Or did you see that as if somebody voluntarily made a report of their own action that was reportable error? And, I am trying to draw the line between the action of somebody other than the person who is responsible and the actions of the person or the physician who might be responsible.

Dr. Yacenda: Madam Chairman to the Assemblyman. We are talking right now, Assemblyman, out of our particular study, but you brought up something that is very relevant to some of the discussion that we had and the testimony that we received. Any person in the State of Nevada, for that matter any person visiting a facility in the State of Nevada, or any person knowing of an activity in the State of Nevada that took place that they had question about, would be able to file that complaint with an appropriate agency in the state, and in most cases, with the Bureau of Licensure and Certification. And then the bureau is required to investigate that complaint. Depending on the severity of the event, there may be time lines that are required of that reporting.

The same is true of events that might be reported to the Joint Commission for the Accreditation of Healthcare Organizations, JCAHO as it's called. If a complaint is filed with JCAHO about a serious event that took place and the hospital, let's say an event happened at a hospital, and it was a serious event, a wrong site surgery, if that complaint was filed with JCAHO, and JCAHO hadn't heard that complaint filed to it by the hospital it accredited, then JCAHO triggers a series of demand root cause analysis and action plan to be filed by the hospital to JCAHO within a 45-day period, otherwise threatening their JCAHO accreditation. Of course, JCAHO accreditation is also tied to certain Medicare funding. So, there is a connection. There's a financial, unfortunately it drives the system, too. The health care system, there's a financial incentive that that hospital report events and it respond to events, because it has someone looking over it.

Assemblyman Anderson: My question, I think, was generated by, page 37 of your report [Exhibit E]. Again, I haven't had a chance to read the entire thing, but I noted that among the recommendations on page 37 was the recommendation number 22, which put the limiting of $50,000 in recoverable damages in actions in which errors have been reported in good faith. And, I was kind of curious as to who was going to be given that kind of protection if a physician, if it was envisioned or if you took testimony that if a physician reported it himself, would he then come under this cap as compared to there would be no cap available to him if it was reported by an outside group? And, that was more the nature of my inquiry.

Dr. Yacenda: Again, Madam Chairman, to the Assemblyman. The item 22, recommendation 22, was presented to the committee immediately prior to the work session, and it was listened to but was not considered in detail by the committee.

Assemblyman Anderson: Thank you very much, Madam Chair.

Chairwoman Buckley: Thank you. Senator Titus.

Senator Titus: Thank you, Madam Chairman. I am just looking over your list of recommendations and trying to match them up with some that I found in this, and I see in here there's one bill draft request for a mandatory medical error reporting system that includes a lot of different elements. And then there's another request for not developing a mandatory reporting system. And then I am looking at your last recommendation that says you want to, or your kind of summary that says you want to promote a comprehensive strategy that will create an environment that encourages organizations to identify errors. Now, I am wondering, does that mean that you want to do something that is going to encourage them to voluntarily to do this as opposed to mandating them to do this?

Dr. Yacenda: Madam Chairman, to the Senator. Actually, overall, we received eight recommendations that related to reporting systems. Two were for a mandatory reporting system; four were for a voluntary reporting system; and then two were against a mandatory reporting system. I was asked to chair the committee to be impartial and look as a scientist would look at the problem and the solution and look at the public policy, the implications. Without there being a pressing problem that was evident to us from all that we inquired, all that we tried to find out and determine without there being a pressing problem, what we did see is we knew some things were going on. Errors do occur. There are cases and there are sad cases; they are heart-rending. They are terrible, and there are tens of thousands of great things that happen. Wonderful things that happen, and they seem like miracles.

So, in weighing all that, we looked to what will help us create a better atmosphere of patient safety? So, it was a combination of looking at how do we get information about what's going on? And our surveillance systems in public health have a long history of being the most successful systems, and sometimes at very high cost and sometimes not. This particular model we recommend is a lower-cost model. They have been successful in controlling disease and preventing new disease and, ultimately, in leading to research for vaccines, and all. So, we took that approach so we would have an understanding of what's really going on with medical errors. At the same time, the corollary was bringing professional associations, organizations, and medical facilities together to talk about what they do. To talk about the problems they encounter. How they overcome them. How they prevent them. What the best practices are to prevent a circumstance. Some of the real simple, groundbreaking changes in practices, in system practices, related to wrong site surgeries. Right now, many surgeries will be, the part to be on which the surgery is going to take place will be marked with a very simple tag, or a marking pen. Simple things that seem like they don't make any sense in an operating room.

Senator Titus: It makes a lot of sense to me that they tag the right leg.

Dr. Yacenda: Well, what I am saying is that you would think that in an operating room with all the charts and everything set up that people would know automatically what's going on, but because it is an anxious environment and an intense environment that didn't always happen—so, that kind of change. Labeling vials in certain ways in operating rooms has created missed drug applications, missed injections. So, a lot of things like that are just system changes that take place, and those things are best generated by people who are in the trenches talking about it, working together, sharing their successes, and sharing their difficulties. Not in the atmosphere of litigation, but in the atmosphere of patient safety.

So, we leaned to that direction barring a major outcry of demonstration of error in the state.

Senator Titus: So, you don't think there are a lot of medical errors in Nevada?

Dr. Yacenda: Well, if there are, we can't find them.

Senator Titus: Then, why are we having this medical malpractice crisis?

Dr. Yacenda: Well, because the sense of medical errors has to do with what they consider preventable medical errors and a reporting system about those errors. We're talking about medical errors and a reporting system associated with somehow affecting medical errors and patient safety, not medical errors, per se, because we know that licensing boards take care of and hear complaints. We heard that the medical board gets 400 complaints a year.

Senator Titus: But we also heard that they were five years behind.

Dr. Yacenda: That's right, and I think that the legislation that this subcommittee is considering based on that testimony will be good for that board. And, I would recommend that the subcommittee look to all the board and look at their time lines. They may have the same circumstances with time, but those systems of licensing and, in a sense, policing medical professionals in all the professional boards, that's their duty, their statutory responsibility. And this is about a reporting system, somehow, that would help us better understand medical errors that do occur, or near misses that do occur, and how practices that people employ can actually be changed to prevent them or encourage what we think of as better patient safety.

Senator Titus: And, I don't argue with systemic changes that you're suggesting. I think those are fine, but it seems to me that you need more sunshine on the errors. You know, we have government in sunshine, shouldn't we have medicine in the sunshine, too? Isn't that an additional check on what's going on that would help to solve this crisis?

Dr. Yacenda: Well, I think that in knowing what I knew when I started the committee, I was very sure that we needed a reporting system because I read the testimony leading up to the concurrent resolution. But after studying from the boards, and literature, and reading, and the testimony, I was moved away from there. And, I think the subcommittee was moved away. In fact, at one point in time, the subcommittee would not consider voting on elements in a reporting system that I had before the subcommittee. There wasn't a mood in the subcommittee by that time to move there because we hadn't heard the information that would make you compelled to do that.

So, what we did learn, there's a lot of information that's currently collected in different places. The medical licensing boards have information, the Bureau of Licensure and Certification has information, JCAHO has information. By the way, all of the information that the Bureau of Licensure and Certification has is available for the public through a telephone call. The information that JCAHO has on all of the facilities that are accredited here is available on-line on their Web site. Hospitals are named, facilities are named, and Medicare has an on-line review of facilities as well, long-term care facilities. So, there's a lot of information.

A surveillance system with proper regulations, which would be the part where I would focus, would allow us to really put all that together and see what's going on.

Senator Titus: I think a clearinghouse would be a good idea. I am reminded a little bit of that country song, though, "I wish I didn't know now what I didn't know then." You know, it's kind of what I'm hearing.

Chairwoman Buckley: Thank you very much, and thank you for your testimony. Next we have Assemblywoman Ellen Koivisto who sponsored a medical errors bill in the 2001 Legislature and whose work led to the subcommittee in the first place.

DISCUSSION OF NEVADA ISSUES RELATING TO MEDICAL ERRORS REPORTING LEGISLATION

Assemblywoman Koivisto: Thank you Madam Chair, committee members. I am Ellen Koivisto, Assemblywoman, District 14, Clark County. Much of what I was going to testify to you, you heard from the ladies with the National Academy for State Health Policy, so I will be fairly brief.

I sat in on a couple of the hearings of the subcommittee to study the need for a medical errors reporting system. I'll go back to that later. About 16 percent more deaths a year can be attributed to medication errors than to work-related injuries, and I would think that the Nevada statistics would be fairly close to the norm. And, fear of becoming a victim of medical error can lead patients to delay obtaining medical care allowing their illnesses to become worse. I think that's certainly got to be a concern.

According to a national poll conducted by the National Patient Safety Foundation, 42 percent of respondents to the poll had been affected by a medical error, either personally or through a friend or relative. Thirty-two percent of respondents indicated that the error had a permanent negative effect on the patient's health. A survey conducted by the American Society of Health System Pharmacists found that 61 percent of Americans are very concerned about being given the wrong medicine. Fifty-eight percent are very concerned about being given two or more medicines that interact in a negative way. And 56 percent are very concerned about complications from a medical procedure.

When asked in still another survey about possible solutions to medical errors, 75 percent of respondents thought it would be most effective to keep health professionals with bad track records from providing care. And 69 percent thought the problem could be solved through better training of health professionals. In a national summit on medical errors and patient safety sponsored by the Federal Quality Interagency Coordination Task Force that was held in September of 2000, consumers were also part of the panels. The purpose of the consumer participation was to highlight the impact of errors on patients and their families and to better understand research that would be needed.

Testimony from the consumers' perspective was that the health care system is uncoordinated, confusing, and potentially dangerous. One of the consumer recommendations was to examine how consumers are informed of their responsibilities to report medical errors, and whether regulating agencies understand their own responsibilities to address such reports. And, further, to define the ethical responsibility and accountability of hospitals to patients who are victims of medical errors.

Some of the other recommendations from the summit were that research should not overemphasize inpatient care given the much larger number of patients treated in outpatient settings. The cumulative burden of outpatient errors is significantly greater. Identifying incentives, either positive or negative, financial or nonfinancial, that can drive health care providers to improve the quality of health care they deliver. And research to determine whether managed care poses special safety issues and to identify such issues if they exist. And research to determine how purchasers can assist consumers in identifying unsafe providers.

Further research is needed to evaluate the occurrence of medical errors in relation to the following variables: patient-nurse ratio; severity of illness; mortality/morbidity rates, and length of stay. The relationship between continuous hours worked by health care professionals and their ability to work safely and without errors. The relationship between work environment and patient safety by assessing work-related staff illness and

injury rates; overtime rates; staff satisfaction levels; flexibility of human resources policies and benefits packages; use of supplemental staffing, and compliance with federal, and state, and local regulations. Research to compare the efficacy in reducing medical errors of institutions that have enhanced monitoring and reporting systems versus institutions where continuous quality improvement principles have been implemented as part of the organization's culture.

Certainly, the testimony at the subcommittee hearing we heard what wonderful reporting is done in all the facilities in Nevada, and we need to define the extent to which medical devices contribute to medical errors with a special focus on technology-intensive medical specialties.

The key to reducing errors is to focus on systems. And you've heard this before today, the key is to focus on delivering care and not blame individuals. Research clearly shows that the majority of medical errors can be prevented. One of the landmark studies on medical errors indicated 70 percent of adverse events found in a review of 1,133 medical records were preventable. Six percent were potentially preventable, and 24 percent were not preventable.

A study released in 2000 based on a chart review of 15,000 medical records in Colorado and Utah found that 54 percent of surgical errors were preventable. The enhancement of patient safety encompasses three activities: preventing errors, making errors visible, and mitigating the effects of errors. We have to recognize that not all bad outcomes for patients are due to medical errors and that not all adverse events that are the result of medical care are, in fact, medical errors. Medical errors are adverse events that are preventable with our current state of medical knowledge. A near miss is an event or situation that could have resulted in an accident, injury, or illness but did not, either by chance or through timely intervention. There is as much to be learned from close calls as from incidents leading to actual harm.

In one study of intensive care units, the correct action was taken 99 percent of the time. Where I am going with this is that research done by the Agency for Health Care Research and Quality documents that the rate of health care errors is far higher than the rate of errors in other industries. In the study of intensive care units, the correction taken 99 percent of the time translated to 1.7 errors per day. One out of five of these errors was serious or potentially fatal. If performance levels even substantially better than those found in the ICU, for example a ten-fold reduction in errors, were applied to the airline and banking industries, it would equate to two dangerous landings a day at O'Hare airport and 32,000 checks deducted from the wrong account per hour. This is from a study by Lucian Leape in 1994.

Health care shares a number of characteristics with these other industries. They all rely on systems, which include the interaction of humans and technology to perform a number of functions leading to an outcome. However, health care is distinct in its complexity. For example, a patient in an ICU is the result of an average of 178 different activities performed a day that rely on the interaction of monitoring treatment and support systems. It was noted by Millenson in 1997 that many medical errors can be attributed to the simple fact that the knowledge base to effectively and safely deliver health care exceeds the storage capacity of the human brain. The work of federally-sponsored researchers illustrates the importance of focusing on the systems of health care delivery—and, again, its systems—to reduce medical errors.

Prescription and delivery of medications provides a dramatic example. It requires the completion of at least five interdependent steps: ordering, transcribing, dispensing, delivering, and administering. Inattention to system design leads to numerous opportunities for error. One study of adverse events showed that 78 percent of such events are due to system error. Because medical errors usually affect only a single patient at a time, they are treated as isolated incidents and little public attention is drawn

to these problems when compared with aviation incidents. Health care errors are also underreported due to liability and confidentiality concerns. These factors explain the ongoing and visibility of medical errors despite research documenting their high prevalence.

The professional culture may pose an even greater challenge than does complexity. The naming, blaming, and shaming approach to dealing with errors has hindered medical error reduction, yet it is the most commonly used approach to addressing errors in health care. It has driven the patient safety problem underground leading to an implicit conspiracy of silence where problems and close calls are not discussed due to fear of reprisal.

Health care workers are placed in systems and settings where errors are bound to happen. The systems are designed to achieve a particular set of goals, but inadvertently produce a certain level of errors. Health care workers are sometimes expected to work 24-hour shifts to ensure patients are cared for and have some continuity of care; although, it is known that overwork and fatigue lead to decreased mental concentration and alertness. They are expected to function in an environment that is not ergonomically designed for optimal work performance. They are expected to rely on their memories and deliver safe care without substantial investments in information technology or even the simple application of checklists.

They often deliver care through a set of complex processes; although, industry has shown that the probability of performing a task perfectly decreases as the number of steps in the process increases. Finally, they're expected to work in a climate where one error, even if not preventable, may mean a catastrophe or the end of a career. By not improving the systems in which medicine is practiced in the health care industry, as a whole, has not advocated a culture of safety and is not well organized to tackle the challenge of patient safety. Only when the entire industry is able to make patient safety and the reduction of errors its first priority will errors in medical practice be reduced. The fact that there has been very little success in reducing errors suggests that a general lack of awareness or alarm is a factor in this failure. The awareness of the problem and any subsequent solutions must be improved. Not only among physicians, nurses, pharmacists, dentists, and other health care providers but also among patients, policymakers, and many other stakeholders of the health care community.

A cultural change needs to occur that will enable health care providers and leaders, as well as the public, to talk about errors and recognize that they are, for the most part, a result of faulty systems and faulty system design, not of individual failures. A system, which supports learning from errors, is dependent upon reporting. Assurances of anonymity have been shown to enhance reporting in other industries. There will remain, however, instances where criminal or negligent acts demand proper disclosure. The legal issues will have to be examined carefully to determine the best mechanisms to promote learning form errors while protecting the public. Systems designed to facilitate quality improvement through error reduction can generate effective, useful reporting if those individuals who report are assured of confidentiality, protected from legal liability resulting form the report, and providing feedback from data from the system. Without feedback, they are not going to know how to make changes.

The public expects, and has a right to information that will demonstrate, the health care delivery system is as safe as possible. There is a need for data and information in support of efforts to learn why errors occur and what changes are effective in preventing errors. Both needs can only be met through the development of an effective data collection system. Further, accountability and learning will only be achieved if the data is analyzed and information is fed back to the users. Some characteristics necessary for a report system are: active leadership support must be ensured at all levels; reports must be accepted from all interested parties; reports are confidential and identifying

information has been removed—we heard all about the patient safety laws, or patient confidentiality laws—reports are used for prevention, not punishment; reports are analyzed by technically-expert peers from several perspectives; reporting is easy and it must capture the necessary details; and, again, reporters and interested communities receive timely feedback.

Consideration needs also to be given to including patient reporting to enable patients to report errors and adverse events using the same format so that the reports will work with the collection of activities from health care professionals and facilities. It's important to understand that individual performance issues are best addressed through credentialing, licensing, and other administrative mechanisms. However, safety reporting systems must not be a shield from necessary actions to address criminal activity or deliberately unsafe acts. The obligation to report these activities still exists, and mechanisms to address those issues should be improved.

Health professional licensing bodies should implement periodic reexamination and work with certifying and credentialing agencies to develop more effective methods to identify unsafe providers, and take action. I felt hearing the testimony this morning from the Board of Medical Examiners that there is something of a disconnect. That's certainly something that is a contributing factor. Unless the board's aware of situations in a timely manner, they are unable to deal with them.

Very simply, the purpose of a medical error's reporting system is to track errors to find out why they occur and take necessary steps to keep them from occurring again. We need to have a clear picture of what's actually happening, and the only way that will happen is if a system is set up to facilitate reporting to a central repository.

The state of Maine passed their bill in April of this year [2002]. One of the provisions of their bill is that reports are made to one person. A person was hired at their Department of Human Resources, what would be the same as our Department of Human Resources. They do not go to their licensing boards; they go to one person there. And, since we've heard that we don't have many medical errors here, we probably could get by with a half a person, a half an FTE [full-time employee].

The A.C.R. 7 subcommittee and its draft report said, "Currently," this is a quote from the report, "Currently, the Bureau of Licensure and Certification is unable to assess whether there is a medical errors problem in Nevada based on the information it currently collects." The draft report goes on to state, "There is no state agency, program, or system in Nevada that identifies and tracks medical errors and adverse events. Thus, there are no numbers or accurate reports reflecting the occurrence of medical errors, adverse events, or deaths due to medical errors."

A statement from the Veterans Administration Patient Safety Improvement Handbook sums it up:

> In order to take actions that will improve this situation, it is necessary to have a clear picture as to what is actually happening so that appropriate steps can be taken to prevent such occurrences. For this prevention effort to be effective, it is necessary to establish methods of gathering and analyzing data from the field that allows the formation of the most accurate picture possible. It is believed that only by viewing the health care continuum as a 'system' can truly meaningful improvements be made. A systems approach that emphasizes prevention, not punishment, as the preferred method to accomplish this goal will be used.

Chairwoman Buckley: So, I take it you're not in agreement with the recommendations of the interim committee. Would that be accurate?

Assemblywoman Koivisto: Yes.

Chairwoman Buckley: Okay. We thank you for that excellent testimony, a lot of very useful information in there. I don't see any questions of the committee. Thank you for being with us this morning. And, I would also like to acknowledge Senator Ann O'Connell has joined us. Thank you for being with us, Senator.

Chairwoman Buckley: Next on our agenda, Douglas Perednia, an M.D., President/C.E.O. of Kietra Corporation, who will talk about systems for tracking and minimizing medical errors. Thank you for traveling and being with us today.

SYSTEMS FOR TRACKING AND MINIMIZING MEDICAL ERRORS

Douglas A. Perednia, M.D.

Dr. Perednia: Madam Chairman and members of the committee. Thank you very much for having me here today. It is a pleasure to be here from Oregon. We are about 12 to 24 months behind Nevada in our malpractice problems. In Oregon this year, our malpractice insurance rates went up by about 35 percent across the board on January 1 [2002], and 20 percent across the board, July 1 [2002]. And, those are compounded rates. Those are after about 30 percent last year, 25 percent the year before that, and it's actually quite impressive to see these hearings, and all, because there is little or no recognition that there is a problem in Oregon yet.

I am here from Kietra Corporation as both a physician and a patient myself, and you should all have some diagrams, or figures, to follow along in some parts here [Exhibit G]. Kietra Corporation was founded entirely by individuals and physicians. And the reason we were founded was because it became very clear from our positions in practice, again both as physicians and patients, that there was no one representing the interests of physicians and patients in the medical marketplace.

Our mission is to reduce medical, financial, and personal risk for physicians and patients alike. And, the company was formed out of necessity. Malpractice is forcing clinicians out of practice in many states. That's certainly true in Oregon; we now have a shortage of virtually every type of physician, and that's only getting worse. It is important that the committee and everyone in Nevada understand that the financial interests of both medical malpractice insurance companies and trial lawyers are not, and never can be, the same as those of physicians and patients in your districts. I don't mean this to be judgmental; it's a simple statement of fact. Prior to becoming a physician I was trained as an economist and until, and unless, you realize that motivations are not the same, it's hard to understand this whole business. And because of what you're doing here, really, the futures of doctors and patients in every state are likely to be determined by what you do here.

Assemblyman Anderson: Madam Chairman.

Chairwoman Buckley: Yes, Assemblyman Anderson?

Assemblyman Anderson: I'm sorry. Has this been a piece of document that has been faxed?

Chairwoman Buckley: Yes, our secretary is doing it right now.

Dr. Perednia: Okay. Let me explain briefly why doctors and patients are on their own and give you some facts here. The first fact is that malpractice carriers can only exist if there are claims to support them. If there are no claims, there's no need for premiums and there's no need for insurance. And although claims are an expense item, carrier income

—the blood of life of an insurance company—is a function of return on invested reserves —not on claims and not on premiums. Carriers make money on the investment income generated between the time premiums are received and claims are paid. Depending upon where you are in the United States, that period on average varies between three to five years. In some places like Louisiana it's more like ten years.

So, insurance companies make their money on the float. Therefore, other things equal, carriers will do best financially when premiums, reserves, and claims are all stable but as high as the market will bear. And as you've seen now, the system breaks down only if prices are pushed so high that physicians can no longer absorb the cost. I can vouch for virtually every physician in the country when I say that none of us are taught anything about medical malpractice insurance in our training, and generally speaking, none of us know anything about it. And if you look at Figure 1 [Exhibit G], Figure 1 really represents what's easy to call the carrier paradox. This paradox is pointed out to me by an insurance company executive himself. Premiums are paid into loss reserves and then paid out as claims, and the income a carrier receives is a function of the investment income on those loss reserves.

I was actually talking to an insurance company executive, a president, in fact, who's also a physician, and I was bemoaning the fact that claims were increasing everywhere and that very few things were being done to capture that. And, to my surprise, he interceded and said, "Why are claims a problem?" And I said, "Well, gosh, if claims go up then you guys lose a lot of money." And he corrected me. He said, "Son," — I'm quoting verbatim here— "Son, you really don't understand our business, do you? We pay claims. And, in order to pay claims, we collect premiums. But our income comes from the investment income from our reserves."

Now, let's say our claims double. What do you think happens? Well, the insurance commissioner comes to me and says, "Son, your claims are going up. You need to double your reserves." So I triple my premiums, but I now earn twice as much money as I did before. "Son, that's my bonus money. Don't you mess with my bonus money." This is a true story, and I tell you as a real, and I tell you as a real shock to me. I've never heard anything like this before.

And, I would also like to point out the malpractice attorneys also do best when there are high, but stable, claim and dollar values. Some more facts. Plaintiff attorneys invest their own dollars in a given case in exchange for a 40 to 50 percent of gross awards. If there are no claims, there are no awards, and they have no business. In a very similar light, here, if there are no claims there is no insurance company, if there are no claims there are no malpractice trial lawyers. There's a bazaar situation coming up here in which the two major combatants in the struggle we see repeated across the United States are actually more similar than one would think. The patients who are the ones who are harmed actually receive less than 50 cents on every dollar awarded because expenses are deducted from their share of the award.

So, let's take a case of a poor patient who's been harmed and gets a $250,000 award. Half of that, about $125,000 goes to the plaintiff's attorney, and the average cost of bringing a malpractice case through trial in the United States is currently about $147,000. That means that plaintiff [patient] ends up with nothing. The insurance company's okay, and the trial lawyer's okay, but the patient's not.

If you look at Figure 2, plaintiff lawyers and health care. Now, again, if we have malpractice crisis come about where there's an increase in the number of claims and the numbers of dollars per case, then what you'll find is if we double the number of cases and increase the number of dollars per case, the actual revenue to the legal community goes up by a factor of four. So, the problem in a nutshell is that for doctors and patients, the best situation is one in which no errors occur, no harm results, and no

claims are filed. And if errors do occur, then the claims need to be paid promptly. That's the best possible case for the citizens of Nevada, and in fact, the world.

And the best case in Nevada occurs when patients and physicians are in the best possible position because, after all the principle here is that, we want to deliver health care and make patients better than when they came into the system. Unfortunately, this is the worst possible situation for companies on both sides of the current malpractice system. The key questions are: How do we reduce errors, claims, and costs? And, do we have the will to do so? Because, clearly, the factors that keep this system in place are all pretty much deeply rooted and very much the same. Deeply rooted and entrenched, and very much the same all over.

A little over three years ago, we started working with some of the pioneers of risk management in the United States. An example is Dr. George Thomasson, who is the recently retired vice president for risk management for Copic Insurance Company in Colorado. Copic Insurance is one of the so-called "bedpan" mutuals. I don't know if you've heard that term, but they are commercial carriers, and they are insurance companies that were formed by doctors usually as a result of the malpractice crisis that occurred in the late 70s and early 80s. And the physician-owned companies are commonly known as bedpan mutuals.

Copic has traditionally had one of the most aggressive risk management reduction programs in the world. They invented a large number of risk management things that are currently used today in many parts of the country. One of the first things they did was research into what causes claims. Now, as it turns out, technical errors, or technical failures, account for only about 10 percent of claims. One claim in ten. A technical failure is what we would commonly recognize as the doctor really screwed up. You took off the wrong leg. You operated on the wrong patient. You gave a medication that was totally inappropriate. You did your procedure wrong. Whatever.

It turns out that 90 percent of claims are actually the result of communication errors and system failures. To give you some examples: Communication errors are a problem where information didn't get from one place to another properly. One example is informed consent. When a patient is going to have a procedure, you need to tell the patient all the risks and benefits and alternatives in that procedure. But, they also have to hear you, and they also have to understand what you say. Another misunderstanding is a dose of a medication. Let's say, for example, you said to the patient, "Yea, take this medication three times a day." And the patient thought they were to take three pills once a day. There's a communication error, which could lead to a problem.

An example of system failure is when a test result is lost on its way to the lab, to the doctor, whatever. And, a good example of that are actually Pap smears in the United States. In the United States, the current standard of care is that when a woman gets a Pap smear, if the result of that Pap smear is normal, she never hears about it. If it is abnormal, she normally gets a letter. On the other hand, if you don't hear about the results of your Pap smear, there are really two possibilities. One is that it was normal, and the other is that it got lost. If it gets lost, that's almost a guarantee claim because there is no woman who should ever die of cervical cancer in this country. There is no reason for it, unless there's a system failure or somebody commits a technical error and says, "I am ignoring this result."

So, the question is, given these settings, can anything be done to reduce the risk of these kind of things happening. And the answer is unequivocally, yes, both in terms of the experience of Copic and the experience of all kinds of physicians all around the country. You can create and deploy programs that anticipate and prevent errors in communication and system failures. Technically, failures are harder, but not impossible, to correct. And risk management really does work.

Copic Insurance had a problem in Colorado where they had all these claims accruing to obstetricians and gynecologists for prenatal care, and they instituted a very simple intervention, which you should have there as Figure 3. This intervention is an ambulatory prenatal care flow sheet. What it is is simply a piece of paper with lines drawn on it. It's a pretty simple intervention. What it basically does is it reminds everybody involved that if I'm in week 12 to 16 of a pregnancy, it's time to do this, this, and this. When the patient comes in for my visit, I look at my flow sheet, and I check to see whether those are done or not, and if they are not done, I do them. And if they are done, then that's great. If there's a result that's abnormal, then I have an opportunity to record that and recognize it beforehand. This isn't really a system; it's simply an accurate way of recording.

Well, as a result of instituting this system, Copic, over a 12-year period, found that the number of claims filed against obstetricians for prenatal care fell by a factor of 30 from 126, and the control population to 4 in the intervention population. That's a factor 30 over an order of magnitude. Now, as a result of the drop of the factor of 30, they reduced their premiums for OBs by half. So, the obstetricians actually did much better. Not as well as the insurance company did, but they did much better. The patients did much better, and everybody was better off, and nobody was worse off. So, you might ask yourselves, in this case these types of risk management programs are really widespread, right? The answer is wrong. Most carriers spend little, if anything, on widespread and systemic risk reduction efforts. In fact, most carrier risk management programs consist of little more than occasional lectures.

In Oregon, if you attend one lecture every three years, you would get a 15 percent reduction in your malpractice premiums. That's risk management. Now, does that help you at midnight when you're seeing a patient, and you don't know what the blood pressure is because it wasn't recorded or whatever. No, it does absolutely nothing to reduce risk. There are very few carriers who actively work to anticipate practice problems and correct them perspectively. The problem is most carriers don't routinely collect the clinical data that's necessary to do this. Even fewer carriers reward clinicians and practices who invest in risk reduction measures on their own. So, even if I wanted to take my malpractice premiums and devote them entirely to risk management then I wouldn't be rewarded. I would not get a single penny less in premiums because I spent that money on my own. It's all a question of economics and incentives.

Now, think about this. Reducing risk reduces the size of the insurance pool required. If all these errors weren't happening, you would have a lot fewer cases, and you wouldn't need nearly as much in the way of premiums, or reserves. A successful risk reduction oriented insurance company may eventually put itself out of business. Where's the return on investment on that. This is one of the key problems in the system we have today. In fact, Copic Insurance, Kay Mason Howard who was the first president and chairman of Copic, he's a physician and orthopedic surgeon in Colorado. His avowed aim in Copic was to abolish the insurance company, to get it to a point where it didn't need to exist anymore. Unfortunately, he since retired, and it's not at all clear that the people who are now running the company share the same policies. They may, but you know what, companies have a life of their own.

Simple and inexpensive tools exist; they are created by doctors and patients. For example, in our company as doctors and patients we asked ourselves, "How can we duplicate the effective Copic's prenatal risk management intervention for multiple specialties and diagnoses simultaneously?" "How do we do this for everything?" And the answer was simpler than we actually thought. It turns out that if you have just a few pieces of information, that can go a long way towards serving as a starting point for physician-patient communication and reducing system failures. If we know only the age, the sex, the diagnoses, the medications, and the CPT codes—CPT codes are testing

procedures codes—for a given patient that tells us most of what we need to do to anticipate a problem before it occurs and prevent it.

So, how would that work? Well, we could anticipate and prevent trouble by educating the patient all about their diagnosis. If you know what's normal in the course of your illness, if something abnormal happens to you, then you can ask why. If you are a diabetic, and you know that most diabetics should get Hemoglobin A1c tests four times a year, and you've never had one, well that's the first chance you have to intervene on your own behalf. You can explain the medications test and procedures. One common question that comes up is, "If I have a medication, and I forget a dose, what do I do?" Well, normally, there's no opportunity to have anyone answer that question unless you call your pharmacist or you call the office, but there's not going to be anyone in the office after hours. So, most people don't call.

We can underscore the risks, the benefits, and the alternatives of procedures. We know from research that patients only remember 15 to 20 percent of everything they're told in an office visit. And, if there is a particularly severe problem involved, if you're talking about heart attacks, your children, potential for complications, an amputation, anything like that, you're going to remember even less, because the moment you were told you have cancer everything you're told from that point on goes out the window. You're thinking about your cancer. So, if you want to give patients information about their illnesses, it can't happen just in office visits. There has to be a system for providing that outside of the office.

We can also send messages to both patients and clinicians if something or someone appears to be headed for trouble, and we can identify doctors who don't' practice safely. In an example where if we have a doctor who happens to be getting a fair number of cases where their ear infections don't clear up, you might want to ask questions about how that physician is treating ear infections. If it turns out that patients keep coming back over and over and over again. So, we created, again, using private funding from physicians and patients, a system that does this in exactly this way. It's amazingly simple. It can be deployed in a way that doesn't interrupt any current clinic work flow.

The data needed, too, can be easily input either on paper or via computer, and it is inexpensive. The annual cost of the system that we've created ranges from about $1,200 to $4,500 per clinician per year depending upon how it's deployed and how fancy you want to get, but avoiding a single large claim would buy the system for every physician in the State of Nevada. And the same thing is true in Oregon; we've had claims already this year that would have paid for all of this. And patients and physicians both like it and use it.

Let me give you a very simple example, which is example one [Exhibit G]. The patient is placed on a medication that can cause liver damage. There are many of these. Methotrexate is a good example; it's used for rheumatoid arthritis and a lot of other things. Our risk management system notes the choice of the drug and expects to see a CPT code for a liver function test ordered in the next six to eight weeks. There are two very simple things; you have a diagnosis and a medication, you should expect to see a given test. There's no rocket science involved. If the liver function test is ordered in the time allotted, then nothing happens. If it's not ordered in the time allotted, we send a message to the patient and a message to the clinician and say, "We don't know, but there could be a problem. You guys ought to talk to one another because there are patients on a drug, which potentially causes liver problems. You may have gotten the test, and it just didn't get into the system, but if not, please just get together and see if it's appropriate."

And a second example is that studies show, as I mentioned before, that patients remember

only 15 to 20 percent of what they're told in the office. What we do based upon the information in a physician's practice management or medical records system is automatically create a secure customized Web site for every single patient in the physician's practice. Automatically. There's nothing required on the part of the patient or the physician to do this. The recommended procedure is described in detail in lay language. The patient is encouraged to write down specific questions, and these questions are automatically sent to the clinician and discussed at the next visit or before the procedure. Communication is better and less troubled than ever before. It's really a piece of cake to do it.

So, if you look at Figure 4, the way this works is pretty simple. A patient visit takes place. Somewhere in the physician's system, in order to get paid, they have to record the diagnosis and the CPT codes that they order or suggest for that patient. That's transmitted to a central server that says, "Oh, well let's put this information together to see what we can do to help prevent problems." The patient is sent an e-mail telling them to check their Web site, which is customized and secure especially for them, and the custom Web sites are created on the fly and updated as needed. Everything is done.

The implications for Nevada are that good doctors would become better. As you heard, it's not possible to remember everything that's necessary to provide good medicine or good health care. There's just too much to know, and so reminders are probably the easiest and best way to do this. On the other hand, bad doctors can be identified and held accountable for their actions. If you have a physician who's taking care of diabetics, and you never see a CPT code for a Hemoglobin A1c, that doctor is not taking very good care of their diabetics, and they ought to be singled out to have a talking to either by the insurance company or the board or by even their fellow physicians so that they know to change their ways.

Patients have a chance to play an active role in avoiding harmful elements and outcomes. Public health directly benefits, and more data is available in real time that it would allow us to rapidly detect problems. For example, if we knew that patients being prescribed Fen/Fen—which was taken off the market because it caused heart problems—if we knew that those patients on that drug suddenly had a larger number of ICD-9 codes associated with heart disease, because the side effect is rare, by gathering that data for all the physicians and all the patients in the state, we would know that the problem existed well ahead of any of the current reporting systems.

We can also dramatically reduce the cost of medical errors in both human and monetary terms. And, I would like to mention as a result of the testimony that's been presented earlier, there's a lot of talk about recording medical errors. Let's take the example of a Pap smear in which a Pap smear was normal, but the physician never saw it. Well, that's actually a medical error; it's a system failure. The physician should have seen that Pap smear, but you'll never find that recorded as a medical error because no one knows it occurred. And so, it's not possible just to get a handle on things by relying on reporting of medical errors. You have to look at system-wide practices and statistics based upon large numbers.

So, we created this company, small company. It does some of its things very logical, very rational, and we took it to carriers. We took it to dozens and dozens of malpractice carriers all over the country—bedpan mutuals, private insurers, public insurers—and the market has spoken. Most carriers don't care about reducing risk. Nevada should, and you all should. And your patients and constituents should. We've contacted dozens and dozens of carriers; only two have expressed interest, serious interest in any type of preemptive risk program. Some typical responses we've gotten are as follows: One carrier in the South, "What do we care what our doctors do?" A second one, "We want liability caps to solve this problem for us." Another carrier, "Risk management isn't where we're putting our effort right now; we don't see it as

producing a return on investment. Risk management is hard to quantify. It's like asking how many trees didn't fall? Our financial folks won't fund that because we don't know what it's worth." and then the final comment, "We don't like to ask our doctors to do anything if we can help it. They have enough problems already."

Required error reporting does nothing to help with preventive measures. So, I'd like to offer you some key conclusions from our experience in doing this, and I have to say that our experience has been hard won from actually being shocked by the responses we've gotten from both attorneys and carriers themselves. The first thing is the current tort-based model of medical malpractice management is inherently flawed. None of the incentives work properly to get the right thing done. It's now working well anywhere in the world. Basically, you have a ship which is sinking all over the country. Really, the best thing would be to get a new ship. Now, you can try to patch this one, but the best thing would be to get a new ship. The second thing is you cannot protect the health of Nevadans without dedicated risk management efforts. You just can't do it, and these have to be imposed and enforced by the state. There are no market incentives to make this happen, anywhere. And the market is the key factor in what's wrong, in what's right, in many parts of this economy.

No one else other than the state has the clout or the incentives necessary to do the right thing. Even physicians can't do the right thing. If you were to spend a bunch of money and put yourself out of business by launching risk prevention programs, you wouldn't be rewarded by your insurers; that's for sure. And the third thing is that we all have to agree that the objective here is to ensure that the citizens of Nevada and the United States systematically receive the highest quality health care possible. Malpractice policy isn't, or at least it shouldn't be, about crime and punishment. It's about preventing the problem and easing the punishment that patients suffer as result of untoward events.

Chairwoman Buckley: I'm sorry, excuse me. We're running a little short of time, so I'll ask the committee members to turn to pages 11 through 13 to read the conclusions, and because I don't want to cut short questions and answers, I'd like to open it up for that, if I could. Questions of the committee?

Assemblyman Hettrick: Thank you, Madam Chair. I think you've hit on the key what you just said a moment ago. While there would be an incentive to not have claims, the fact is the insurance company's not going to lower your premium. Especially if they don't run their own risk management program, so they're not going to lower your premium if you install it yourself as an M.D. At the same time as an M.D., I can see the reason why I might want to run a system like this. Individually, what would it cost if one M.D. said he wanted to do this? You said $1,200 to $4,500 for a group.

Dr. Perednia: This is per physician, on a per-physician basis, so it would cost anywhere from $1,200 to $4,500 per physician, per year.

Assemblyman Hettrick: Does this work also for hospitals?

Dr. Perednia: It can. It's not designed that way. It's designed for outpatient practices because many hospitals already have their own elaborate systems, but there's no reason it could not be implemented in hospitals.

Assemblyman Hettrick: What kind of training is necessary and time for, you say it's simple and easy to do. Is it another piece of paper to fill out with CPT codes and the like, or how is it done?

Dr. Perednia: Our training time required is about ten minutes for every physician involved. And, the way it works is we simply gather data about what happened in the course of a visit. Now, that data can come from many places, for example, from your billing records. And, if we simply interface with your billing system and download your diagnoses and

CPT codes, and if someone in your office would simply use a scannable form to write your prescriptions, you would have all the information we need in very easy format.

Assemblyman Hettrick: Do you have competition in this field?

Dr. Perednia: As far as I am aware, there is no one else who is doing anything remotely like this anywhere in the country.

Assemblyman Hettrick: That's a problem for a state level to mandate somebody to use a risk management system because there's no competition. We just heard about California's wonderful foray into taking ones provider, to do something totally different from this and on the theory that no one else could provide the same service, and they were getting a wonderful deal and then they found out that indeed they weren't. And that makes it very tough for state government. Any kind of pilot programs? Any kind of those types of things that you or your firm can provide or that kind of thing?

Dr. Perednia: Yes, Copic Insurance has agreed to pay to have this installed on a test basis in a number of their practices in Nevada. We're currently in selling systems in New Mexico: Elis Clinckis [phonetic], Del Norte, and in private practices in Oregon. Also, when I say that no one else is doing it, that's not that anyone couldn't do it, but simply that the financial incentives for doing this simply don't exist because there's no reason to have risk management in the current economic system.

Assemblyman Hettrick: So, theoretically, we would be able to obtain information from New Mexico and Oregon and other places over some period of time that would indicate whether or not their inquiries or actual claims were dropping?

Dr. Perednia: Yes, but this system is just recently created so that you probably won't have that information for at least another year.

Assemblyman Hettrick: What about—I guess the last one, Madam Chair—what about your company's ability? Let's say that by some stroke of genius on our part, we decided to implement this as a mandated risk management system in the State of Nevada. What would your company's ability be to install that for about 4,000 physicians statewide?

Dr. Perednia: It would take awhile, but since the system is so easy—it's Web based, which means that it's operated on a central server. You don't have to have computers installed everywhere. Probably within the course of one to two years it could be installed in every practice without a problem.

Chairwoman Buckley: Senator Titus.

Senator Titus: You've made a number of recommendations for us, I just wonder, are Oregon lawmakers doing these same kind of things or are any other legislators moving in this direction that we can look to if we don't want to make the same mistakes?

Dr. Perednia: Well, it's not come up in Oregon because the rates only recently have become painfully high. It will come up in about a year. I can pretty much guarantee it.

Senator Titus: There are a number of other states that may not be as bad as Nevada but are certainly approaching the level of crisis. Are you trying to peddle this there, too?

Dr. Perednia: No, actually, the reason we're primarily here is because there is an opportunity to do something before the crisis really gets out of hand. And, we're a brand new company. We've just discovered that the market in and of itself doesn't really support risk management, and so we'll be going to every state eventually, but pretty much one state at a time. We're a very small company.

Senator Titus: Well, you made some good points, and I appreciate it.

Chairwoman Buckley: Assemblyman Anderson.

Assemblyman Anderson: Thank you, Madam Chair. For me the big question is, is there anything that prohibits you from sharing your list with the state or with our medical boards of doctors who voluntarily went into such a program as this on their own?

Dr. Perednia: No, nothing at all.

Chairwoman Buckley: We thank you for your testimony. And with that, while we have one more speaker on this topic, but due to the lateness of the hour, I'm going to break for lunch. It is 12:45, and we'll come back at 1:15. That's 30 minutes. Thank you.

Chairwoman Buckley: I'd like to call the committee back to order. We're finishing our topic five, Prevention of Medical Malpractice: Reporting of Medical Errors, and we have one last speaker, Deborah Huber. We had planned with this item, at the request of Senator Rawson, was to hear from the chair of the committee and to hear from Assemblywoman Koivisto as the sponsor, but you had asked if you could at least say a few words to supplement. He didn't want me repeating all the testimony that they had already heard, but with all of your expertise, we're happy to have you.

Deborah Huber, R.N., M.H.S.A.

Ms. Huber: I appreciate it, Madam Chairman. Members of the Committee, thank you. My name is Deborah Huber. I'm a registered nurse and a project coordinator at HealthInsight and I thank you for the time and opportunity today. I've provided some written remarks and some more information about our company and so I won't go over those things right now. Basically, HealthInsight is the federally designated quality improvement organization for Nevada and Utah.

I'd like to start by telling a little story if you'll indulge me. It's not a health care story but I hope you'll see how it's related and I think it has something to do with something we can all relate to and that's construction on the I-15, not right here in Las Vegas but just up the road a piece. This is a true story.

Some recent and ongoing construction work finished not very long ago and this was a new intersection design and as you can imagine, billions of dollars were spent and people were sick and tired of having all the construction. So it opened to much fanfare and hoopla and the new design was that both the entrance ramp to the highway and the exit ramp to the highway were adjacent—so sort of an unusual sort of a thing. And, despite all the hoopla and fireworks and celebrations, when it opened, people drove the wrong way. Instead of going up the on ramp and getting on the highway, they ended up going up the exit ramp. Okay? Ultimately ending up going the wrong way on the 15. Okay? Like I said, billions of dollars, much hoopla, how does a thing like that happen? Particularly, because there were arrows, there were lights, there were things painted on the highway, you know, go this way, and yet people still made mistakes.

Well, so what do you think that they did? The first things out, well you call in Metro, right? And so within really just moments they gave 30 tickets and they thought well, we're going to run out of tickets pretty soon so they switched just to warnings and within two hours they gave 145 warnings. People just keep going the wrong way. So, finally, they had to stop and block it off and close it down.

So they went to the engineer and said, "Well how could this happen?" "We spent all this money and all that." And he said, "Well, you know, the design is really just

perfect. It's that people aren't paying attention." But hundreds of people were making the very same mistake. So was it just that they weren't paying attention or were there some other contextual things going on? Well, it might have had something to do that for the last year while the construction had been going on, this particular exit ramp had been used as an on ramp. So people had been trained to do this and had been doing it for the last year. The median itself, how they had to turn to go on correctly was very, very short. So, you didn't have to try very hard. In fact, it was pretty easy to do the wrong thing. And the design itself—I've never heard of that, that they're side by side—so, a very unfamiliar task for people.

So, since ticketing didn't work they decided to redesign this system a little bit and what they did was extend the median to make it easy to do the right thing, hard to do the wrong thing. Is it totally error free now? Probably not. Probably not. Somebody that tries really, really hard can go up the wrong way or somebody that doesn't drive that way very often. But it's probably better than it was and the point of this is why didn't the tickets work? Why didn't the tickets work? Were the drivers incompetent or didn't they care? It was an error and that's one of the things with the basic definition of an error. It's unintentional. I can't imagine any driver woke up that day and said, "Let's try something new. Let's go up an exit ramp here and see how that feels." So by nature, it was unintentional.

The other thing, what reason the punishment didn't work is that the guy behind didn't learn anything from it—"I got a ticket but 200 other people came right behind me." So there wasn't any learning from taking that approach and that's the problem with taking a punitive approach to any kind of an error, health care or otherwise. So the neat thing about this was when they discarded the punitive approach something happened and that was that the system could correct itself. Corrected itself, they made the redesign with the median. Well, how is that possible? Well, it was possible because they had information. They had information that was visible and information that people could use to understand the entire problem and then they could correct it, not just blame those individual drivers.

So, the reason I tell you this story is that given everything that we've heard and that we know, it would be easy to think that a mandatory reporting system for medical errors could be used to unmask [un]safe practitioners, hold them accountable, and remove them as a threat to patient safety. But is mandatory reporting really a useful solution? Both research and science tell us no. When an error happens it's a common belief, it's a common practice that accountability and blame should fall on the front line individuals where that sort of doctor-patient rubber meets the road, if you will. And this belief stems from a notion, a common notion, that bad outcomes result from personal inadequacies—"I didn't pay attention," "I didn't care," that sort of thing—and the reversal of that, that good doctors don't produce bad outcomes. That's the common notion.

Well, from our work at HealthInsight we've learned that although this is a common belief, it's also a misunderstanding of the true nature of error. Unfortunately, this misunderstanding is often used as a guiding principle for how we should deal then with error.

Now, it's important to differentiate that I'm not talking about situations where someone is intentionally harming a patient. You know, that's criminal behavior and there's other venues for that. What we're talking about is the everyday errors that everyday doctors and nurses make. So, if the meaningful improvement is truly what we're after, improvement in patient safety, then there has to be a better and a changed and revised understanding of human error and that would be one that would allow us to understand, believe, and act on the notion that caring, capable, competent people—that's good people, good doctors, without character flaws—can produce bad outcomes. A way that

will help us to recognize that errors are unintentional and not the lack of motivation or vigilance; a way that helps us understand that it's really the context in which the error occurs and not the individual that needs reexamination; and, a way to help understand error so that we can learn from it and not just punish those folks that commit errors.

Now some, I've heard it often, say that this is not possible or it's inappropriate, that it's a cop-out, that it's rationalization and that's often a popular view. But we found that this revised understanding is possible and that it's actually essential for patient safety and its merits are based in science and research just like the practice of medicine.

In addition, other non-health care industries have decades of experience utilizing a more scientific approach to managing human error. So there are models out there and we've heard about some of those earlier from the aviation industry in particular that we can replicate, that the Veterans Administration has replicated and is using very successfully now.

So, if we understand the true nature of error—that it has little to do with motivation and everything to do with context—then is there a way for reporting to be useful, a useful tool to improving patient safety? And as we've heard today, error reporting remains a complex endeavor because folks who are involved in adverse events or know about adverse events may hesitate to report their concerns because of reprisal, loss of license, loss of job. And so consequently, reporting can be driven underground, it inhibits reporting, but what we really lose is the information that we could use to learn from the errors and make sure they don't happen next time—really improve patient safety.

Now, some would argue that mandatory reporting is a way to rid the state of bad apples. Well, there's a couple of flaws with that thinking, frankly. First of all, bad apples don't cause the majority of errors. The majority of errors are caused by humans who are well-intended, well-trained, and competent, but part of a flawed system. And attempting to rid the state of bad apples by this mechanism isn't going to accomplish that goal and I suppose it could have the unfortunate side effect of forcing some good apples to leave our state, unintentionally.

Let me tell you just a quick personal story. My father's had several angioplasties over the last couple of years here in town and for the most part they've been successful until this last one when this doctor had a little problem. You know, they stick a tube up the groin and end up in the heart and the tube kinked in the heart. So, they needed to take that one out and put a new one in. In the course of taking the tube out they cut his artery in his groin. So instead of fixing his heart they had to take him for a two-hour surgery and have his artery fixed. Okay? So, my point is that to put this doctor's name on a Web site somewhere to say he committed this error, which he, you know, admitted freely and took full responsibility for, what purpose would we serve to enhance patients' safety by putting his name and credentials out there? You know, there clearly was some kind of equipment problem. We don't know if my dad had some, you know, change in his condition that they all had to think about or if there was some lack of communication in the cath lab or whatever. I don't see a point in the mandatory reporting of an error like that that's gonna really help our goal of patient safety.

The other thing is, how do you really make something mandatory? If people, even doctors, even nurses, health care professionals— remember they're first and foremost humans—if they know that by complying with a reporting law that they will face massive and certain negative consequences, even in a situation where medical complications are expected, like my dad's—I mean he's very high risk—and if they don't report, the consequences are uncertain. The likelihood is that people won't report, even doctors and nurses. And if they do report, we'll lose what we really need, which is that information that tells about what else was going on in the situation. That's how we can really learn.

Folks will find that the cost of reporting far outweighs the cost of not reporting. Over the last year, we've done a special study funded by Medicare on patient safety. In so doing we've talked to a lot of folks around the county and we've heard of hospitals that have gone to sort of a three strikes and you're out rule for the nurses that if you make three medication errors you lose your job. Well, what do you think happens? Nobody ever makes more than two mistakes. Okay? Driven underground. We lose that information that we could use.

So, as I understand it, the purpose of the tort system is really twofold. One is to compensate victims and then the other is to prevent further injury or the same kinds of things from happening again. And even though mandatory reporting seems like a viable solution, it won't help us reach either one of those goals.

But is there a way that a reporting system could enhance patient safety? And the answer to that is "Yes." A reporting system can play a useful role if it's used for learning, not for judgment. And you can tell the difference because judgment systems ask, "Who?" and learning systems ask, "Why, what, and how?" Judgment systems tend to micromanage the situations whereas learning systems try to find and fix those underlying causes. As we talked about earlier, learning systems and a good reporting system looks at the true nature of error—that is that it's unintentional—and acknowledge the intrinsic complexity of health care. A reporting system can be useful if it's voluntary and it has built-in protections for the reporters. A reporting system can help us if it replaces the culture of blame with redesigned systems that recognize human limitations, even doctors and nurses. A reporting system can play a useful role if it actively embraces the scientific principles and the safety lessons learned from non-health care industries. We don't have to reinvent the wheel. Of course, there's risks in proposing a system like this because some would argue we just need the names and the dates and to put those out there. But the solutions that focus on those kinds of data only really are a feel good, Band-Aid approach to a very complex problem. It could be politically expedient to choose that sort of a route, but it won't enhance patient safety because the real issues are very hard to get at. Of course, it is easier to affix blame than it is to fix the system, but placing blame doesn't really get us where we need to be.

I guess I'd just end by saying in the last few weeks and months we've all faced a situation where sound science was possible to use in a huge decision that affects all of us as Nevadans and we were all upset when that was not used as the criteria. And, I would say here, we have another chance, we have another chance as Nevadans in a situation that we are deciding, that we as Nevadans can choose to use sound science on another thing that will affect us in a long-reaching way. So, I would just ask that as you make these plans for Nevada not to go the easy way, the common way, and that your decision really requires a lot of exercise so that the intended results are what you want to have and that's an improved patient safety system. I thank you and would be more than happy to answer any questions you have.

[Exhibit H is a copy of Ms. Huber's prepared remarks.]

Chairwoman Buckley: Next on our agenda we have "Reimbursement of Physicians for Services: Impact on Ability to Pay for Medical Malpractice Coverage." When we first began our hearings we heard a lot of complaints about reimbursements and how that played a factor in this dilemma and so first, we'll talk about "Discussion of the Impact on Physicians." Dr. John Nowins.

REIMBURSEMENT OF PHYSICIANS FOR SERVICES: IMPACT ON ABILITY TO PAY FOR MEDICAL MALPRACTICE COVERAGE

DISCUSSION OF THE IMPACT ON PHYSICIANS

Dr. John M. Nowins

Dr. Nowins: Hello. Ladies and gentlemen of the Legislative Subcommittee to Study Medical Malpractice, I thank you for this opportunity to speak with you today. I'm Dr. John Nowins, President of the Clark County Obstetrics and Gynecology Society. I'm also a member of the Nevada Medical Liability Task Force. I've been asked to speak on the topic of reimbursement of physicians for their services and its impact on the ability to pay for professional liability insurance coverage in Clark County.

Today we are here to discuss the men and women who practice obstetrics and gynecology in Clark County; who have devoted their lives to their profession and their patients; who are available 24 hours a day, 7 days a week, 365 days of the year; who make thousands of complex medical and surgical decisions every day and every night; who deliver more than 2,000 babies a month in Clark County; who have witnessed patients who have recovered from supposedly irreversible illnesses, including patients with cancer; who work the emergency rooms all over the county; who in large measures give of themselves to help others; who take care of pregnant women for nine months, which includes over 14 office visits for prenatal care, hundreds of phone calls, and the delivery of a baby at any time of the day or the night, hospital rounds, post-op office visits, and finally, a postpartum office visit.

Something terrible has happened to our town. As a result, we stand to lose many of our excellent doctors. The medical liability insurance crisis stands to destroy the excellent health care system that we now have here in Clark County. It has taken more than a decade to achieve the great health care system that we now have. The crisis plans to reverse many of our achievements with devastating repercussions that will last for years to come.

As our community has grown into one of the fastest growing communities in the United States, this same growth has placed enormous demands on our health care system. Yes, Las Vegas area is home to roughly 1.5 million people and the destination of over 36 million tourists a year.

In response to these demands, we have had the extremely good fortune of being able to recruit high quality physicians and surgeons from all over the country in a short period of time. In fact, some of the best physicians and surgeons in the world now call Clark County their home. Unfortunately, despite our best efforts, this medical liability insurance crisis will cause many physicians and surgeons to leave town. As we speak, physician recruiting firms from all over the country are taking full advantage of this problem to move many of our best doctors out of Clark County and relocate them to other less hostile areas of the United States.

This is truly a crisis. The citizens of Clark County have come to expect that their medical and surgical needs would be met, no matter how complex, no matter what time of the day or the night, and no matter if they are elective or a full emergency. The people of Clark County could rest assured that their community was medically and surgically safe. Unfortunately, this will soon not be the case as we continue to lose our doctors.

<u>Reimbursement for Obstetricians and Gynecologists in Clark County</u>

On the topic of reimbursement for obstetricians and gynecologists in Clark County. As professional liability insurance carriers have left the Clark County market, the remaining few are either unwilling to write liability insurance for obstetrics or will do so at a great cost. In the year 2002, almost every obstetrician will face paying insurance premiums

over $100,000 per year, and many will pay over $200,000 per year. In most cases, we have seen over a 100 to 200 percent increase in premiums this year.

Although we are grateful to the Governor's NEIA, the Nevada Essential Insurance Association—otherwise known as the MLAN, Medical Liability Association of Nevada, we must understand that this is only a temporary fix. It has served as an essential service providing liability insurance to those who could not obtain it otherwise. Make no mistake, that even with MLAN insurance, obstetricians are still paying over a 100 percent increase in their premiums.

To put this in perspective, an obstetrician practicing 40 years ago in Clark County would pay approximately $320 per year for professional liability insurance. That same doctor could expect to get paid around $600 for the delivery of a baby. Now, 40 years later, in the year 2002, an obstetrician can expect to pay well over $100,000 for professional liability insurance and the average payment for the delivery of a baby ranges from $1,200 to $1,400 by most health insurance companies in Clark County.

Consider the impact of that overhead expense. If a physician receives approximately $1,300 per delivery, then 77 deliveries will need to be done before that portion of overhead is covered. Note that this excludes discussion of overhead costs like lease payments, employees' salaries and benefits, supplies, rent, et cetera.

In southern Nevada, continuing increases in malpractice premiums combined with progressive reductions and reimbursements for services are resulting in some of our best and most experienced physicians being forced to leave part or all of their practice, with the remaining doctors considering a future reduction of access to care. Physicians are expected to put the needs of the patient ahead of all other concerns, which we do. This commonly results in obstetricians not taking home a personal paycheck sometimes for months. We have shouldered this burden without complaint for many years. However, this trend is no longer a viable option. In fact, in the last six months, many of my obstetrical colleagues have had to resort to bankruptcy protection.

In the business of medicine there exist three variables that can be manipulated: volume of services rendered, cost to provide service, and reimbursement for services. In other words, number of patients treated, overhead, and payment. Physicians have been left with only one variable at their control and that's volume. This simply translates into more patients being seen in the same time frame or less time per patient. One may say, "So, this is just common business sense," until that individual becomes the patient who waits for more than an hour to see the doctor and gets four minutes of the doctor's time.

Obstetricians in southern Nevada are now delivering babies at below cost. Our accountants agree that delivering babies in southern Nevada is not a profitable business. In fact, most accountants discourage the practice of obstetrics for two reasons. Number one, insurance companies in southern Nevada have drained all the profits out of obstetrics and gynecology. Two, the present legal climate in southern Nevada has been unfavorable for physicians.

Managed Care

On the topic of managed care in particular. This is best stated by our President of the American College of Obstetricians and Gynecologists in Washington, D.C., Dr. Charles B. Hammond: "Managed care tangles have eroded patient trust." Dr. Hammond's words in describing the problems created by managed care plans, "The takeover of medicine by managed care is the most important factor in the deterioration of medicine as a profession and the erosion of trust between patients and their physicians. To meet their demands, we have added layers of employees just to code, bill, fight denials, and above all, meet compliance requirements or face civil or even criminal charges." Dr.

Hammond said, "The system is broken. It needs to be fixed."

In Clark County, obstetricians have not had a pay increase for most, if not all, managed care insurance companies since 1982. That's 20 years without a pay increase. Only in the last two to three months two payers have recently given OB/GYN [obstetric/gynecology] physicians a small pay increase. Most payers in Clark County pay far below Medicare rates. In fact, over the past ten years, OB/GYN physicians have experienced relentless pay cuts on most services from most managed care insurance companies in Clark County.

During the same period, the citizens of Clark County have experienced relentless increases in their health insurance premiums. In my own medical clinic, we experienced a 40 percent increase in health insurance premiums for myself and my employees. When I called the insurance company to find out the reason for this enormous increase, I was told—and they did not know I was a doctor when I called—that the reason was that the insurance company has to pay doctors a lot more money. This is an absolute falsehood. There has not been an increase to OB/GYN physicians by most, if not all, insurance companies in over 20 years. In fact, there have been plenty of pay cuts.

So, where is all the money going? Well, patients are paying more than ever before for health insurance. Their co-pays are going up. Their deductibles are going up. Their benefits are going down. The insurance companies dictate which hospital the patient can go to; how many days a patient can stay in the hospital; which surgeries, radiological tests they can or cannot have; which medications they can take—the tiered drug prescription plans, with co-pays commonly costing more than the actual cost of the medication; which doctors they are allowed to see. Every facet of their health care is scrutinized and analyzed by their health insurance companies, with doctors trying their best to make most of their patients' health care decisions. As to where all the money is going, all I can tell you is it's not going to the OB/GYN physicians of Clark County.

At the request of the Clark County OB/GYN Society, Tina Landskroener, Certified Professional Coder, Certified Health Care Compliance Consultant, and Certified Compliance Professional, and President/CEO [Chief Executive Officer], Proactive Health Care Services, was asked to conduct a survey of OB/GYN offices to determine the main problems with managed health care. Her findings were:

C The office's point of view. As managed care penetrated the health care industry, physicians' offices were required to add operational procedures to meet the health plan requirements:

- Added duties to verify insurance coverage on every patient at every visit. Before managed care, verification was done on new patients. Now patients change insurance coverage and benefits so frequently that verification must be done monthly at a minimum.

- Authorization is required for diagnostic and therapeutic testing, specialty consultation, and surgery. Therefore, additional staff is again required to obtain authorization and fax the necessary documents to the facilities and the health plan administrators.

- Billing departments are realizing an increase in correspondence from the payers because of authorization and prior authorization and approval and denial, denials due to ineligibility, and/or requests for additional information or more medical records.
- Collecting co-pays and co-insurance from patients is challenging when carriers or plans have different amounts for different services provided. For example,

one insurance company has different co-pays for each plan it offers. Usually, the beneficiary's identification card will note the co-pay amount, but when the explanation of benefits arrives the amount is different. Offices rely on the card information and it is not always accurate.

- Credentialing physicians in the plan has required many offices to employ more staff or to out source the process. In many cases, it takes a minimum of six months to fully credential a new physician on an entire insurance plan at a clinic. This process means that the new physician cannot see the patients within the plan, making it difficult to bill the practice.

C How about the consumer's point of view?

- Patients who are relatively healthy will not encounter too much difficulty in an HMO/PPO [health maintenance organization/preferred provider organization] plan because their needs for services are not great. But patients who have a number of medical problems often find it difficult to follow the plan's guidelines. Getting authorization for testing often takes too long to obtain, leaving the patient to suffer in pain while waiting for approval.

- Patients are required to change physicians when their attending physician is not on the plan they've chosen. This often means starting the preliminary work up all over again with a new provider. This again provides a delay in treatment and progress.

- Benefits are often capped. For example, one patient in an HMO plan ran out of her prescription benefits within the first four months of 2002 and was forced to another insurance. This meant changing specialists again.

- One Alzheimer's patient has been waiting three months for authorization to have a diagnostic examination of her stomach because the office staff at the physician's office could not get the necessary prior authorization from the HMO carrier. The patient's been suffering with abdominal discomfort for too long and this test will hopefully give the reason. These kinds of delays are common within the managed care arena.

C Quality of care. Physicians in general are greatly concerned about the quality of patient care when working under the restrictions of managed care medicine.

C Senate Bill 99 [Chapter 550, *Statutes of Nevada 2001*] can be viewed as evening the playing field for the physician since the insurance companies must notify receipt of a claim within 45 days or pay the physician interest for services. However, it has increased correspondence from the insurance companies—a letter stating they are in receipt of their claim and it is under review. Payment is still delayed and the billing department must now acknowledge another letter from the carrier.

Physicians can benefit from S.B. 99 if they watch the timely filing and payment of claims. This is difficult when the staff is already overworked with other projects and some offices will take another employee to oversee the contracts and match the reimbursements to the negotiated rates.

Improving S.B. 99 will only happen when physicians can hold the insurance companies accountable for the negotiated contract reimbursements. This will require constant auditing of the reimbursements received and challenging those accounts not paid according to contract.

Managed Care Medicaid Problems

On to managed care Medicaid problems. Managed care Medicaid was designed to decrease spiraling costs of health care to the State of Nevada. Its unintended consequence has been to decrease access and cause massive frustration among providers. In the current market of skyrocketing increases and professional liability premiums, the average provider needs to make approximately $2,300 or $2,800 just to break even for the delivery of a baby. That is at the current liability insurance rate, not taking into account future rate increases. Currently, managed care Medicaid pays approximately $1,200 to $1,300 for low-risk prenatal care and delivery when claims are actually paid. State Medicaid pays $1,800 to managed care Medicaid for each delivery with total OB care, hence the state is paying approximately $500 for delivery to managed care Medicaid or 27.8 percent of the total payment. Therefore, providers are dropping off or drastically limiting their access to the plans. This will, and is beginning to, limit providers and increase frustration. You cannot give 27.8 percent of the check to an entity not providing medical care.

It is clear to see how this would add frustration to our current market. You cannot add endless bureaucracy to easily identified medical conditions like pregnancy, which can't be faked. Why is prior authorization required? You cannot limit access to prenatal care, as this will only increase costs. Prenatal care is relatively cheap, even for hospitalization of a pregnant mother at a cost of $750 to $1,000 per day. Neonatal care, which becomes more frequent if there's poor prenatal care, costs $2,500 to $3,000 per day. This is further exacerbated as every maternal day prior to 34 weeks is 2 days in the NICU [neonatal intensive care unit] and every maternal day prior to 30 weeks is 3 days for the infant in the NICU—must be remembered that on an average, the high-risk OB specialist gets paid 3 cents for every insurance dollar; the neonatologist gets 17 cents —not to mention lifelong care for disability outside of the NICU for those affected infants.

Examples of limitation to care and access to care. One HMO Medicaid payer has limited all prenatal services to one perinatal group. This causes restrictions in high-risk pregnancy care. HMO Medicaid should not contract with only one doctor, one group of doctors for specific services since this limits patients' access to care. The Clark County OB/GYN Society with members numbering over 120 doctors represents the vast majority of obstetricians in southern Nevada. Many of these members have lodged repeated complaints concerning HMO Medicaid system. In addition, the Fax Network has conducted two surveys sponsored by the society, each further proving the dissatisfaction with the system. These are available upon request.

The HMO Medicaid system has caused problems. Many physicians have decided to limit or altogether drop their participation in the Baby Your Baby program, a state-run prenatal care program for the needy. Also, the quality of prenatal care for the disadvantaged has suffered.

The HMO Medicaid system has also created large amounts of unnecessary protocols and paperwork, such as prior authorizations for routine procedures or for pregnancy.

There is also the problem with claims allegedly being lost in the mailing process, causing a delay for nonpayment of claims, known as stale-dating claims. Not only are these problems a tedious process, but limit patient care and were not previously encountered in the state-run Medicaid program.

Even as of July 2002, obstetricians state that one HMO Medicaid plan still denies receiving claims by U.S. Mail. This results in physicians' offices resubmitting claims multiple times and still, doctors get stale-dated for no apparent reason. An appeals process then follows and even then most of these claims, whether they be deliveries for babies or surgeries or office visits, they don't get paid. They get stale-dated.

In Reno, patients and obstetricians are not forced to deal with the burden of mandatory HMO Medicaid and in turn receive greater reimbursement from regular Medicaid. Conversely, the lack of option in Clark County has caused many obstetricians from offering care to those who cannot afford it. This drop in medical access is reflected in the current survey of the *National Women's Law Review*. This is available upon request.

This state is on a course to soon become the worst state in the nation for first trimester prenatal care. Nevada ranked 47th in the year 2000 and fell to 49th in 2001. There's only one more spot lower. These problems cannot be corrected until state and federal officials finally acknowledge that problems exist with HMO Medicaid.

From a financial standpoint, investing in quality prenatal care is the most cost-effective way to spend tax dollars. By using this money to pay for treatment they will circumvent the disaster of the premature infant. When compared to the hospital stay for an extreme premature infant, an obstetrician's fee is miniscule. Dr. Kurlinski, a neonatologist and professor of pediatrics, states, "Critically ill micro-preemies on total life support can cost $5,000 to $10,000 per day of total charges and can exceed $1 million upon discharge from the hospital. In addition, many of these infants require lifelong, special care and lifetime financial assistance far exceeding their hospital bill."
The obstetricians of southern Nevada presently request an immediate exclusion from the mandatory HMO Medicaid program. The proposal would exclude prenatal care, high-risk care, delivery, postpartum care from HMO Medicaid and revert all such care to regular Medicaid. At the absolute least, make HMO Medicaid participation optional, giving patients and obstetricians in southern Nevada a choice. Obstetricians in southern Nevada willingly participate in the care of underprivileged pregnant patients requesting only fair and nondiscriminatory treatment. Patients and obstetricians in southern Nevada deserve the same rights afforded to those in the north and should not be forced under this system.

Finally, it is true. For obstetricians and gynecologists and all physicians in Clark County for that matter to pay the relentlessly increasing professional liability insurance premiums, managed health care companies will have to increase dramatically their reimbursements for physician services.

Concluding Remarks

In conclusion, there are many serious concerns about Clark County's managed care health system, especially the quality of health care afforded to our patients. I believe I speak for all the physicians of southern Nevada when I state our ultimate goal is to provide every patient that walks through our doors with the highest possible quality of care with physicians controlling health care decisions for their patients. Thank you very much.

[Exhibit I is a copy of Dr. Nowins' prepared remarks.]

Chairwoman Buckley: Thank you for your testimony. Are there questions of the committee? Dr. Nowins, when these complaints were brought with regard to the Medicaid managed care—where complaints were filed—can you tell us what reaction you received from the State of Nevada—the regulatory body—and whether any improvements resulted after those contacts?

Dr. Nowins: Yeah. Nothing. Nothing really happened. Pretty much every Assembly person, every Senator, Governor was notified.

Chairwoman Buckley: And was an investigation done by the regulatory body that you know of?

Dr. Nowins: That I don't know. I don't know.

Chairwoman Buckley: Well, we have them coming right after you so we will ask. Are there further questions? Assemblyman Anderson?

Assemblyman Anderson: No, I have no question. I noted that Mr. Duarte had come up to the podium and I presume that he was hoping to respond to the criticism although I don't think he understands maybe that we usually don't do that. If you wanted to direct your question to him he might be able to do that or maybe he's going to do that when he gives his own presentation.

Chairwoman Buckley: I'm going to go in order of the speakers and then we can take additional comments. Thank you. Thank you, Dr. Nowins.

Next on the agenda is "Overview of State Role in Contract Oversight and Reimbursement for Medicaid Services," Chuck Duarte, Medicaid Administrator, Division of Health Care Financing and Policy, Department of Human Resources.

OVERVIEW OF STATE ROLE IN CONTRACT OVERSIGHT AND REIMBURSEMENT FOR MEDICAID SERVICES

Charles Duarte

Mr. Duarte: Good afternoon Madam Chair, members of the committee. First of all, I'd like to apologize for not being there in person today. I had some scheduling problems. I do appreciate the opportunity to discuss the division's role in contract and quality oversight for our managed care program.

Managed care became a part of Nevada Medicaid in 1997 primarily because the state was interested in the budget certainty that that brought to the program at a time of escalating health care costs. It was also to put in place a system for improving access and quality of care.

The state Medicaid programs across the nation, including Nevada, are transforming themselves from passive, regulated bill payers in our fee-for-service system to more flexible purchasers of health care services for Medicaid consumers. Over 55 percent of Medicaid recipients are served through managed care programs nationwide. Long-standing problems in traditional fee-for-service Medicaid are being addressed and we're doing so as well.

Nevada Medicaid has put in place the elements of a good quality purchasing system and I'd like to point out the story that Ms. Huber from HealthInsight used in her testimony of a system that works is one that requires continuous quality improvement and I believe we have the components of that. It doesn't happen overnight, but when the components are in place you can begin to address the issues. Components such as negotiated performance goals, member satisfaction surveys, provider credentialing, independent quality reviews, data reporting, and consequences for underachievers. All of these are components of managed care and they're not available in the traditional fee-for-service Medicaid program.

With the advent of the Medicaid managed care program, the Division had for the first time the ability to ensure recipient access to quality health services. Prior to that point we did not. Through our contracts with HMOs, we have a single point of accountability to not only ensure appropriate access to care, but also for the first time, we can collect and monitor important health care quality data as well as information related to recipient satisfaction with their health plans and their health care.

Chairwoman Buckley: Mr. Duarte, may I interrupt for one second?

Mr. Duarte: Certainly.

Chairwoman Buckley: Most of the committee members, because they're either on Ways and Means and Commerce, I think what I might ask you to do is to skip your written testimony because I think everybody's kind of familiar with how we got into it and maybe ask you if you would mind addressing some of the concerns that we're hearing from the physician community that we also heard at our other hearings, maybe talk a little bit about what recently was done with the Governor, with your office to try to improve things and maybe just address why there's been such deep dissatisfaction and that doesn't seem to be getting much better. Would you mind just skipping to that?

Mr. Duarte: Certainly. We've been involved in discussions with the physician community since Dr. Robert Comeau began the Fax Network two years ago and I started with the division. I mean it wasn't a coincidence that those things happened but I just happened to come on board at the time when I think there were some issues surfacing that I think that Dr. Comeau rightly brought out and since then the OB/GYN Society has taken a role in raising these concerns.

The question, or I guess the statement from Dr. Nowins regarding problems with physician satisfaction in Clark County are well known to us and, in fact, have been brought to our attention and we have looked into a number of them. Back in the year 2000, in late 2000, actually in October, we instituted a contract action against one of the plans based on slow payment. We held enrollment in that health plan until the time that that was fixed and that was fixed within three months.

We've had concerns expressed to us by the OB/GYN Society regarding prior authorization policies, which prompted a review of both health plans' prior authorization policies to look at it with respect to community standards of care. We've done that as well and it's resulted in some changes in prior authorization policies at the HMO level.

We've been asked to look at reimbursement rates. We've done that. Those actions have resulted in an increase in reimbursement by one of the HMOs, which took effect June 1, 2002. Normally, we don't do that. Those are discussions that are held between a physician and the HMO. That's a contract between those two entities. But based on the level of concern that we heard, we did get involved.

I think the suggestion to subsidize physician payments through the Medicaid program is going to have an impact on the federal and state taxpayer. In my testimony I indicated that it costs us approximately $186 per month for the care of a recipient who what's called the TANF, Temporary Aid for Needy Family, recipient or a low-income child, it costs us approximately $186 per person per month in the fee-for-service program. That same family member or child in the Medicaid managed care program in Clark County costs us $160. Now, I know people say, "Well, you get what you pay for," but the bottom line is what we're paying for is coverage and if we were to increase the dollars that we pay out through our managed care program to a level that Dr. Nowins suggests is appropriate—and I'm not disputing the fact that their costs are going up—but if we're to subsidize that, that means that approximately 10 percent of the 74,000 recipients that we serve would not be able to be served through [the] Medicaid program. We'd have to find some way of financing that and my rough calculations were it would cost us about $14 million more.

So, we've made a decision as an agency, as a state to use managed care as a way of purchasing health care services more cost effectively in order to achieve a particular outcome and I think it's an outcome that we all want to see and that's to cover more low-income families with the same amount of state tax dollars that we have available to

us.

So, those types of decisions are decisions that the Legislature will have to make. If they're interested in eliminating the managed care program from Clark County then we'd have to come to you and request additional funding for the services to that same recipient population—not serving a single person more—but request more money to serve the same population.

We've been trying to work with our HMOs with respect to physician concerns and I believe that they're in the audience today and I think can more appropriately address the actions that they've taken as individual health plans to address concerns of physicians on their panels and I think I'd leave a lot of those detail discussions between physicians and HMOs to their presentation.

[Exhibit J is a copy of Mr. Duarte's prepared remarks.]

Chairwoman Buckley: Thank you and they are here and we will direct some questions to them as well. Additional questions of the committee? We thank you. Thank you for your testimony. Next we have Todd Meek and Curt Howell. Thanks for being with us today.

DISCUSSION OF REIMBURSEMENT PROCEDURES OF HEALTH MAINTENANCE ORGANIZATIONS IN SOUTHERN NEVADA

Todd Meek and Curt Howell

Mr. Meek: Thank you, Madam Chair. As you know, I'm Todd Meek. I'm President and CEO of NevadaCare. Curt Howell, who is to my left, is our Vice President of Program Management. We are pleased to be offered the opportunity to testify today before the Legislative Subcommittee to Study Medical Malpractice. NevadaCare offers this testimony to support an understanding of NevadaCare's reimbursement procedures and various issues surrounding the status of access to care in Nevada. And if I may be indulged, I'd like to spend just a few moments going through some history leading up to the current medical malpractice crisis and at that time I will ask Mr. Howell to make a few comments. So, Madam Chair, we will ask your permission to do that.

NevadaCare is a Nevada domiciled HMO, with subsidiaries in Iowa and Illinois. NevadaCare employs 225 individuals and is the second largest HMO in the State of Nevada providing quality health care to over 80,000 members via its 3,000 locally contracted providers. NevadaCare has been a partner with the State of Nevada since the beginning of Medicaid managed care in 1992.

Prior to being licensed as an HMO, NevadaCare operated as a primary care case management, or PCCM, health plan under the Medicaid managed care program. NevadaCare served as a contracted health plan providing coverage for all physician, laboratory, radiology, and pharmacy benefits.

NevadaCare and its subsidiaries have been performing HMO activities for a significant amount of time. During this time, the health plan has experienced significant growth in membership, employees, and geographic coverage. The health plan also experienced a significant growth in infrastructure, including a new technology platform, improved senior management depth, and procedural enhancements. Recently, the company moved into its new 40,000-square-foot home office in Summerlin, Nevada.

I would like to point out that NevadaCare has grown internally as well as externally through acquisition. In fact, three HMOs have left the state. NevadaCare was able to acquire the membership of those other HMOs which would have otherwise left the state.

The cost of Medical malpractice programs certainly remains an issue and is the driver to the discussions surrounding reimbursement rates for physicians and significantly one for one particular specialty, OB/GYN. NevadaCare believes this cost driver will ultimately push across all specialty lines and to primary care providers alike. The cost of doing business is, simply put, on the rise. And at this point I would like Mr. Howell, with Madam Chair's permission, to make a few comments.

Mr. Howell: For the purposes of this discussion, I think it's important that we look at basically two time periods: one, pre-crisis, and one, post-crisis or mid-crisis. With the medical malpractice crisis and resulting press coverage, it is imperative to understand the facts surrounding the reimbursement methodology to all physicians and in particular OB/GYNs. For purposes of this testimony, NevadaCare's focus is specifically Medicaid and commercial group insurance OB/GYN reimbursement.

Reimbursement. In recent days, NevadaCare's reimbursements have been discussed in public forums and have been held out by several individuals as the lowest of the low in the reimbursement spectrum. This is simply not true. As a matter of fact, in one local newspaper we were quoted as paying $900 for global payment. I think it's important to understand what a global payment is versus some of the other methodologies.

NevadaCare's proprietary fee schedules are set well within the standard for Nevada and in Attachments 2 through 4 you will see that some of the reimbursements that we do pay, the actual numbers are there on an EOB [explanation of benefits]. NevadaCare reimbursement levels paid for Medicaid and commercial business, and this is obviously for the pre-crisis time period up to May 31st of this year, the three levels are:

C Global – The reimbursement for all prenatal, delivery, and postpartum care;

C Delivery only – If somebody presents at an ER [emergency room] or a hospital, their physician isn't available, another physician delivers that baby, that's delivery only charge; and then the

C Cesarean section – The reimbursement for prenatal, C-section delivery, and postpartum care.

Please note, the physician reimbursement levels described above are for routine delivery of healthy babies. In addition, NevadaCare on a routine basis allows one to two ultrasounds, effectively increasing the global components by approximately $102.50 per procedure. Furthermore, high-risk prognoses are paid on a fee-for-service basement [basis] and Attachment 4A will detail what goes into a high-risk versus a normal delivery. And then, obviously, hospital reimbursements are outside of these, in addition to which on a commercial number there's going to be a number of co-pays that are also going to increase the reimbursement.

Mr. Meek: Madam Chair, if I may. As I said previously, the cost of business is certainly on the rise. NevadaCare understands this. In fact, we face it as well. The physicians in our community are facing rising professional liability coverages. Dr. Nowins' testimony that rates are increasing as high as 100 to 200 percent, we can certainly confirm that in our business. We received recently a 200 percent increase on our professional liability coverage that our company holds. So we certainly understand that the cost of insurance coverage, reinsurance, hospital rate increases, and even utilities all have an impact on the bottom line.

I think it is important to make one differentiation between the state Medicaid programs and commercial and I would like to do that for a moment.

In commercial programs, in that setting, flexibility exists to manage the escalating risk and costs. You can change benefits, you can raise premiums within a certain level, and contract cycles allow for adjustments over the course of the year and we also often refer to it as medical trend. We have contracts with our providers and contracts with our commercial members. NevadaCare will not breach its obligations to its commercial members or to its providers.

In the government setting it's a little different there. NevadaCare is a Medicaid contractor, has contractual obligations limiting its ability to manage risk. We can certainly not go in and change a benefit level, we cannot go to the state mid-contract year and ask for an increase to reimbursements. It's pretty much a locked and loaded scenario.

And yet, we have not been in a position where we have lowered reimbursements to physicians. There's been some testimony to that today. We have, in fact, increased over the years reimbursements to physicians and facilities and that at a time when we've actually experienced a significant reduction in the per member, per month revenues that we receive from the Medicaid program. Technically, we received a 2.9 percent total increase for the past four years, but our actual revenues fell as a result of changing participant mix. There are fewer babies being born. NevadaCare anticipates this trend to continue. At the same time, Medicaid has put us on notice that as of August 2002 we are to expect a reduction in our capitation payments.

Facing similar issues, a number of insurers have chosen to leave our state rather than present solutions to the various issues we face. NevadaCare chooses a different route. As an example, when the airline industry faced the tragedy of September 11th and the terrorist attacks, liability coverages, insurance coverage in general was very difficult if at all able to be found. What the airlines did is formed a means of self-insuring or creating insurance mechanisms that protected them and they kept flying. They managed through a crisis of tremendous proportions and we must do the same. We believe that NevadaCare has acted to be part of the solution.

As to the medical malpractice crisis in early 2002, we became aware of St. Paul's intended exit from the medical malpractice market in Nevada. We began a series of meetings with providers from many specialties to introduce Trean, Inc., an experienced medical malpractice insurance expert, to determine if a physician-owned mutual company could be developed and funded to provide a private sector solution to the impending medical malpractice crisis. These early facilitation meetings were successful and ultimately, Nevada Mutual Insurance Company was formed. Providers and local health facilities have financially contributed to this mutual.

Simultaneously, Governor Guinn's medical malpractice program also came on line, providing, at least in NevadaCare's opinion, a solid bridge solution to the need for choice and immediate access to coverage in the medical malpractice market.

I'd like Mr. Howell to speak to some of the reimbursement issues with respect to OB/GYN if that is acceptable.

Mr. Howell: I think it should be noted, we've heard a lot today about insurance companies and it should be noted that NevadaCare's a health insurance company and certainly is not a malpractice insurance carrier or participate in other forms of insurance.
While NevadaCare did not create the medical malpractice crisis, we were the first to offer a portion of the solution. NevadaCare increased its total OB package reimbursement by 25 percent, effective June 1, 2002, to our contracted OB/GYNs. At the same time, our company increased the autonomy of our contracted OB/GYNs with the intent to reduce their office administrative costs. Both commercial and Medicaid lines of business are benefiting. Costs are costs and patients are patients. We

understand that it really doesn't matter if it's a Medicaid patient or a commercial patient. It's still going to cost that physician to see that member and as such we raised it on all lines of business. Past and immediate future actions are evidenced in Attachment 10, which will really take you through all of the things that we have done.

Timely payment of claims. That's another area that was discussed today and I think it's important to understand where we are on reimbursement timeliness.

NevadaCare has worked diligently to achieve and maintain timely reimbursement of medical reimbursements. Attachment 11 evidences NevadaCare's claim reimbursement for the past 12 months showing approximately 95 percent of all claims are paid within 30 days of receipt. Those few claims falling outside the 30-day window include denied claims under appeal, or claims subject to third part liability. And for your edification, we've attached our process of what happens when a claim gets submitted to our organization.

Reducing the hassle factor. Now, this is something that is often mentioned in concert with managed care.

Finally, NevadaCare continues to reduce the hassle factor of managed care. As a stakeholder in the health care system, we wish to balance the issues of prior authorization requirements, best practices, and quality while addressing the requests of our physician partners to increase their autonomy and allow them to do what they have been trained to do.

Efforts made to date include:

C Implementation of EDI, or Electronic Data Interchange, allowing physicians to reduce the amount of their billing expense. If they can submit it electronically, it reduces it by a factor of several times. It costs about 30, 35 cents to submit electronically. It costs approximately $3 to submit on paper. So, we feel that that's one means that we have been able to reduce their expense.

C NevadaCare requires a 90-day claim submission window. However, in order to ease the administrative burden on our provider offices, effective October 1, 2001, NevadaCare eased its coordination of benefits claims submission window to 90 days from the date of service to 90 days from the date of the denied or paid explanation of benefits from the primary carrier.

C Effective July 1, 2001, NevadaCare raised its prior authorization dollar threshold from $250 to $400. This change excludes the vast number of diagnostic procedures requiring prior authorization, thus lowering providers' administrative costs.

C NevadaCare has implemented its Web-based provider site, allowing providers to access information regarding eligibility, claim status, and specific inquiries on line. Providers can now access information and ask specific question via a secure e-link to NevadaCare. Phone calls and hold times are thus greatly reduced.

C Regular educational sessions are held for providers and their office staff to obtain feedback and provide education on administrative rules and issues.

C NevadaCare in 2001 implemented new processes to speed reimbursement to all providers by eliminating manual processes and automating the generation of provider reimbursements and EOBs.

C And finally, as we mentioned, effective June 1, 2002, we increased our

reimbursement to OBs by 25 percent. This will result effectively in our population of an additional $1 million being paid out directly to the physicians in the State of Nevada.

Mr. Meek: And if I may add, that increase is both to the Medicaid population as well as to our commercial population. We understand the unique nature that the OB community is faced with. In our business we often talk in terms of the law of large numbers, which works to support most insurance concepts. Unfortunately, with the OB community, the more babies delivered, the higher cost of that insurance. It's an inverse relationship.

I would just like to close with a few comments regarding forging partnerships with providers.

Physicians not only drive the cost of health care but they also drive the quality of health care. For our system to work, managed care organizations, HMOs in general, should emphasize partnerships with physicians, including primary care and specialists.

There currently is a strain between HMOs and physicians over reimbursement, incentives, and control of patient care. We've heard a lot of that today. Closer links between the two are critical to dealing with the many issues that plague the current system. The dialogue should not be focused simply on reimbursement, but on what both parties are trying to accomplish in terms of care and how they define their visions for care. In essence, we must all pick our partners and compete.

As potential partners, there's much that both sides can bring to the table:

C How best to define and deliver quality of care.

C Resolving the issue of reimbursement incentives that are based on the quality of care.

C Linking HEDIS [Health Plan Employer Data and Information Set], the reporting standards, to physician practices so that physicians can see how other physicians in the community are engaging in practice and what are truly best outcomes.

C Timely communications so physicians see the impact of their behavior on those outcomes.

C Implementing prevention and wellness programs.

C Encouraging patient accountability and adherence.

C Applying evidenced-based medicine.

C Meeting community health needs.

C Defining specific services and how they will be reimbursed.

Finally, physicians have the potential to impact the direction and the cost of care. Physicians and their practices need to be more visionary and proactive rather than defensive and combative. Group practices need to take a very careful look at themselves to determine if they are doing things in a way that allows them to have influence on the system and to develop their practices so that other stakeholders see them as potential partners rather than adversaries.

And from that end, we can turn that mirror onto ourselves as well because insurers,

hospitals, and employers must accord physicians the respect of leaders and must be willing to enlist them in the process of defining care that can be delivered effectively and efficiently. And again, that goes back to that picking out partners and competing. Not everyone is pleased with managed care, there are a lot of conflicting discussions, a lot of conflicting interests out there, but we feel we need to work with our physician partners so that we can make this system work. Thank you.

[Exhibit K is a copy of the prepared remarks and attachments provided by Mr. Meek and Mr. Howell.]

Senator Titus: Thank you, gentlemen. Ms. Buckley had to step out for just a minute. Does anybody have any questions? Senator Townsend.

Senator Townsend: Thank you, Madam Chair. Gentlemen, I don't know whether you were here or not when an M.D. presented the whole issue of risk management. Were you here for that discussion on buying a software program for that?

Mr. Meek: Yes.

Senator Townsend: Could you reflect on that? Give us your ideas. What are you doing? If you're not doing anything, why aren't you doing anything, et cetera, et cetera? Since there's at least, there are multiple of us, Mr. Anderson included, who have dealt with the work comp issues for so long—that was such a primary area for us and it's proved to be very beneficial to the state, particularly those who benefited by not being injured, which is the most important thing. Could you reflect on that for us, please?

Mr. Meek: I would love to. It was a very interesting discussion. I'm not exactly sure what the processor, the software program that was discussed earlier entails. However, as a company we began looking I would say about eight to nine months ago with a system that may be somewhat different, but it basically utilized a hand held device—I believe the company's name is Well Links [phonetic spelling]—and it was a physician practice management tool that combined coordination of practice management software, you know, appointment keeping in a small PDA- [personal digital assistant] type device.

What peaked our interest in the program was that it had the ability to list formularies. We understand from meetings with a number of our providers that certainly, formularies are considered to be quite a pain. Every company has a different formulary. They change from time to time. This device allows that formulary for any health plan to be maintained by the physician at any given time so if there's a requirement or a need for a prescription drug that it is available on that device. It also has a unique feature—I believe it's a unique feature, I sound like I'm selling for this company but I'm not—that would allow what they call a virtual Pharm.D., which would indicate if there is a potential interaction or drug interaction with another type of medication. Say if you have someone who is on a maintenance medication and going in for a new problem or the existing problem, we are very excited about this.

It also allowed for in-office dispensing, whether or not that is the right way for a particular physician to go that is that physician's choice. But, in essence, the in-office dispensing component would allow the physician to sell most generic medications at an amount equal to or maybe a little bit more than their traditional co-payment, which would make it much more convenient for the patient, certainly for the physician, as well as the physician being able to increase their revenues. One of the things we're talking about here is the impact on the physicians' bottom line and this just seemed to be a win-win situation for everyone.

We introduced this to our network of providers. Unfortunately, our first foray into this was right as the med[ical] malpractice crisis was really beginning to bloom and we had a

very light turnout, but we anticipate to continue that path. So there are things out there. There are processes and programs available and it's certainly something to look at.

Assemblyman Hettrick: The Well Links program, how does it work in regard to the follow-up—the would be testing? Perhaps, the example given was a liver function test after six to eight weeks on certain drugs. Did it do that kind of thing?

Mr. Meek: I don't feel confident to testify to that. I'm not that comfortable with that element of this program, but the one point that goes somewhat to that that we found very attractive is the ability for the physician at the time of treatment if you're going on to either a medication or perhaps there's a lifestyle change that's requested or information about, "Well, I have Type II diabetes. What does that mean?" They can actually print out information on over 250 conditions right in their office and that's updated every six months by Well Links. So again, a good communication tool and when we heard a little earlier about folks saying that a lot of time you only retain 15 to 25 percent of what you've been told, this is a nice way to walk out of the office [of] your primary caregiver or your specialist and have a written document that says this is what you need to do.

Assemblyman Hettrick: Okay. How would you feel as an HMO then in regard to tests that would be recommended by a system like this where perhaps the printout document that you got from Well Links compared to whatever his follow-up was said that a test should be done in six to eight weeks, would you require preauthorization to do that kind of thing?

Mr. Meek: If we could link our systems, absolutely. If there's appropriate care that needs to be delivered that goes to the quality issue and the continuum of care that if someone is in for a particular ailment requiring treatment, if there's follow-up care that's part of what we need to do. In essence, an HMO is the medical home for a lot of these individuals. So, it's a good way to help coordinate that care and to remind folks that care is needed.

Another point on that would be the STORK [phonetic spelling] form that we use in our Medicaid program that we require that form to be completed by the physician, returned to us, to the health plan. Now, that's sometimes considered to be part of the hassle factor of managed care—"Why do I have to go through the hassle of completing this form?" But, on the flip side of that, it helps us monitor the care and make sure that that patient is receiving the appropriate prenatal care because they may change physicians, oftentimes they don't, but if that happens it allows us to track that care and make sure they get proper prenatal care.

Assemblyman Hettrick: But then does your company actually call somebody up and say, "We didn't get this form for a test and that you should perform that"?

Mr. Meek: Yes.

Assemblyman Hettrick: How much did Well Links cost for each physician?

Mr. Meek: If I recall, it was about $250 a month. They do most of their programs on a lease basis because the technology changes so quickly and I believe it was somewhere between $225 to $250 per month and the benefit to the physician group to have that additional expenditure was really the result of the ability to have in-office dispensing, which Well Links felt on a normal average physician dispensing practice somewhere between $15,000 to $20,000 per year per physician increase to revenue.

Assemblyman Hettrick: Well, I won't get into that part of it because I think then we have to start talking about investment and inventories and all kinds of things and whether or not that makes money and whether or not they add another liability factor and they're going to have to carry some more insurance for that and I think we'll stay out of that.

Mr. Meek: Absolutely. It opens up another can of worms.

Mr. Howell: Madam Chair, if it pleases the committee.

Chairwoman Buckley: Sure.

Mr. Howell: One other thing that we've undertaken this year. We've heard a lot today and the letters JCAHO [Joint Commission on Accreditation of Healthcare Organizations] and the accrediting body that they are. One thing that NevadaCare's undertaken this year is to receive our JCAHO accreditation. During this accreditation process there is a number of quality factors that are looked at, certainly credentialing. Are we making sure that the providers we have in our network are safe providers? Are we undertaking studies to see if we're impacting both the cost and the quality of care? Are asthma patients receiving the treatments that they should be receiving? All of these things are looked at during the process of the JCAHO accreditation audit and we will be undertaking that process this year. Our subsidiary in Iowa has already done that this year and very soon we'll be able to report what I think will be extraordinarily favorable results in Iowa and by November of this year we should have the same results coming out of Nevada. So, it's another step—certainly not a required or mandated step but one that we feel important to make sure that we are doing the right things and making sure that quality care's being administered to our population.

Assemblyman Anderson: Madam Chair.

Chairwoman Buckley: Assemblyman Anderson.

Assemblyman Anderson: Thank you. Does your corporation—and I really don't care which one of you answers this, but do you participate as part of the prompt payment laws from the Federal Government relative to this medical reimbursement question in terms of how they're processed? Do you only take them from patients or will you also take them from physicians in terms of reimbursement?

Mr. Meek: I will step to the plate on that. Our reimbursement is based upon the state requirement of prompt pay within 30 days. From a federal standpoint we are committed by contract with Medicaid to meet the payment requirements and we have certainly over the past I would say a year to two years have had scrutiny in that area. It's certainly a big issue. We have fought some ghosts there, particularly our company, from several years back. Our first acquisition was a company by the name of AMIL International and frankly, we probably bit off a little more at that time than we can chew. We fell behind somewhat in claim payments, but certainly for the past 12 to 18 months we have been under the 30-day payment rule.

Assemblyman Anderson: But up until this time that has not been the case because of some historic practices?

Mr. Meek: I'm referring now to 1999, about mid-'99, July '99 we ran into a situation where we had some claim backlog issues and we worked very diligently to—

Assemblyman Anderson: And now you're doing, 30 days is average turnaround?

Mr. Meek: Yes. In fact, part of our testimony—I apologize for not having this up to you—we go back for the past 12 months and basically chart out our turnaround time on claims and we have consistently been—

Assemblyman Anderson: They'll get it to me in a packet later on.

Mr. Meek: Okay—consistently paying claims within the 30-day time frame.

Assemblyman Anderson: Okay. One of the major complaints we continually hear from physicians is that is a major problem for them so the patient sees me today, the physician's office sends along a reimbursement form to you by the end of that week, then typically you would be able to make the payment back to him within the month?

Mr. Meek: Within 30 days from the date of receipt. That is correct.

Assemblyman Anderson: Okay. And what would you say your success rate is in making the 30-day?

Mr. Meek: I would say we're at 95 to 96 percent.

Assemblyman Anderson: I'm sorry. Madam Chair.

Chairwoman Buckley: Yes. Assemblyman Anderson?

Assemblyman Anderson: Does the complaint have to come from the patient for not having a late pay or can it come directly from the physician? And if they have a complaint—I guess I'm thinking about a recent event in my own medical life where my insurance company was a little late in paying my physician and sent me another form and apparently I had to do something. If the physician indicates that they haven't been paid and this was an authorized, you know, one of your physicians and that it's an authorized patient then can they re-remind you that you haven't paid or do you have to wait for the patient or the policyholder themselves to initiate the prompt payment request?

Mr. Meek: That can come from either the member or the physician's office.

Assemblyman Anderson: Okay. Thank you.

Chairwoman Buckley: Thank you. About a week and a half ago I spoke to the medical group administrators association here in Las Vegas and we talked about medical malpractice for about an hour and 45 minutes and when we got to the topic of reimbursement I asked how many —there were a few physicians but mostly heads of medical groups—I said, "How many people have problems with failure to comply with S.B. 99, not getting paid within 30 days?" And every hand in the audience went up and so I think that in the medical group and the medical practices there still is a great deal of concern about not getting timely reimbursed.

There is also a question about—that Assemblyman Anderson—about if you're filing a complaint with the Division of Insurance, "Can the patient file?" "Can the provider file?" With the Office of Consumer Health Assistance same thing, "Can either one file?" There were also questions about self-funded. "If you're under the federal jurisdiction and not the state jurisdiction can you file?" And I understood that the Insurance Commissioner does take those complaints. Ultimately, she may not have the regulatory authority to do the hearings, but she does take them. But there were some, I think, mix-ups where those weren't being taken for a little while.

So there was a great deal of concern and so I offered to perhaps next month after the Special Session to hold a forum for the medical group providers and the Insurance Commissioner's committed to attend. Valerie Rosalin with the Office of [for] Consumer Health Assistance offered to attend and Mr. Meek and NevadaCare has committed to attend and I'd invite all the members of this committee, if you still want to hear about medicine later in the month of August. It might be nice to get a nice cross section. Of course, it'd be without pay but a nice cross section maybe to just see if we can facilitate some more improvement in communications because you never know if the complaints are from things that happened two years ago but they're still really mad about them. But I will say that the level of dissatisfaction was pretty enormous and I think we could

just do a better job somehow to communicate so I offered to do that later next month and I appreciate very much you agreeing to attend and to try to help.

Mr. Meek: You're welcome.

Chairwoman Buckley: I don't see any more questions, so thank you very much. And for any provider in the audience I will have a time and date for you probably within the next week or so. Okay. Marie Soldo and Kelly Simonson. Thanks for joining us today.

Marie Soldo and Kelly Simonson

Ms. Soldo: Thank you for inviting us. I know it's been a long day. My name is Marie Soldo. I represent Sierra Health Services and Health Plan of Nevada. With me is Kelly Simonson. She's the Director of our Medicaid managed care program.

Health Plan has been contracting with the Division of Health Care Financing since 1997 for pregnant women and children, and since 1998 for the uninsured children's population. Today, we have about 33,600 patients as a combined membership in both programs.

The contract that we engage in is onerous, has a whole variety of provisions, and today what I thought we'd do just to give you some background is to concentrate on three areas—access, quality, and claims—and how we are performing.

I think one of the things that we have to do is meet a whole variety of quality standards that are built within the contract that were established by the [federal] Balanced Budget Act of 1997. We're subject to annual audits. We're scrutinized by outside audit teams that come into our offices. We prepare voluminous binders that we send to them in advance with all of our policies, procedures. They are able to read those in advance so that they can come to our offices prepared. Our most recent audit was completed in March of 2002 and I'm happy to say we've had a 98 percent score out of 100. I'm proud of this program because I helped pass this legislation—because if most of you will remember, there was a time when there was no access to care to this population. So, I don't feel like I need to defend it. I think we just need to explain it.

And I think some of the issues that I've been hearing today about lack of paying claims and all of that, I think some people really get confused between the managed care programs and the self-insured programs and oftentimes those two things get mixed up and when you meet with people from doctors' offices who are out there struggling and, unfortunately, this year I've had an opportunity to be a patient, so I see what's going on in the doctors' offices in a totally different way. It's hard for everyone, but there needs to be an identification of where the problems are coming from and not indicting managed care for all of those.

Our function in this role is to provide the state with those elements that it cannot do for itself. It cannot pay claims for itself. It doesn't have the infrastructure to do a quality assurance program. It doesn't have all of those pieces and so that's what it contracts with us to do.

Your fee-for-service program, which is the largest outlay of dollars by the state, has absolutely none of these audits, none of these quality programs. You cannot even make a comparison between what is going on with your most expensive population as with this population. So that is maybe something you'll care to look at going forward.

What I'd like to do is turn it over to Kelly. It's been a long day, so we'll kind of briefly go through it. We've put a lot of it in writing. If you have questions for us at the end of it, we'll just summarize the three areas and then we'd be happy to accept any questions you might have.

Ms. Simonson: Thank you, Marie. As Marie said, my name is Kelly Simonson. I'm the Director of the Medicaid Program for Health Plan of Nevada. I'd like to just go over briefly three aspects of our managed care Medicaid program.

The first is the quality program. Health Plan of Nevada has an extensive quality program, which Marie referenced. It's a combination of quality assurance activities and quality improvement activities. The goal of the program is to measure, monitor, and analyze the outcomes of care and services and to apply interventions that continuously improve the level of care and services to our members.

The scope of the program is multifaceted and includes health promotional activities; quality of care and quality of service monitoring; quality indicators; quality studies, which are conducted annually. In 2001, we conducted three clinical studies, which included childhood immunization rates, pediatric asthma, and high-risk obstetrics, and those were specific to the Medicaid program. In addition, the Medicaid members are also included in the studies that are conducted for all plan members and those include diabetes, mental health follow up after hospitalization, domestic violence, cervical cancer screening, adolescent immunizations, antibiotic awareness, dental exams, and member satisfaction with referral to a specialist.

We also submit quarterly and annual quality reports to the state. We have a high-risk pregnancy program, which provides high-risk obstetrical case management to pregnant women who are identified as at-risk or at high risk. We identify those members through team meetings with our Southwest medical providers, through questionnaires that we provide to the members when they've become enrolled—risk surveys.

The goal of the program is to obtain optimal health outcomes, decreased costs, and provide efficient customer service and family satisfaction. The OB team is staffed by registered nurses who are trained in obstetrics and they work collaberatively with the physician to manage the patient's care.

We also have a high-risk pediatric program that provides high-risk pediatric case management and coordinated health care services to children who are chronically ill and/or at risk. And again, this team is staffed by pediatric nurses and a medical social worker and they work with the pediatrician and the specialist who manage the patient's care.

The next aspect I'd like to talk about is claims.

All of our providers are contracted at the Medicaid fee schedule. In 2002, the obstetrical payments to our obstetricians were increased 40 percent and that was because that was an increase to the Medicaid fee schedule and that occurred on January 1, 2002, which means that the payment to an obstetrician for a vaginal delivery increased from $1,300 to $1,900, and for a Cesarean section increased to approximately $1,600 to $2,400 and that includes payment for the prenatal care with the delivery and the postpartum care.

As previously noted in some of the other testimony, we are contractually obligated to process 90 percent of our clean claims in 30 days and 99 percent in 90 days, and in 2001 we processed 94 percent of our claims in 30 days and that was noted in our annual audit conducted in March. For the first six months of 2002 we processed 90.71 percent of our clean claims in 30 days, and 99.99 percent in 60 days.

We have not had any providers leave our program due to the obstetrical payment issue.

Chairwoman Buckley: Could I ask a question?

Ms. Simonson: Sure.

Chairwoman Buckley: Is that even to date?

Ms. Soldo: We have two delivery systems fundamentally. We have a network of providers that we contract with and we have Southwest Medical, which has 13 full-time OB physicians. In the network, some of the OBs have contacted us and have indicated they want to renegotiate their contracts. Those are being handled on a case-by-case basis. There have been some terminations, all of which have added they want to negotiate their contracts. All of those are being handled on a case-by-case basis. But when you look at our requirements in terms of ratio—patient per doctor—we are far exceeding the requirement. I think we have 83 OB physicians available to the population that we serve and when you look at our population you can't look at 33,000 people. You have to look at those females that are from 13 to, I guess, 55 I think we look at and what that population is. So, I'm sorry, I didn't mean to go off on such a long explanation.

Chairwoman Buckley: And with some of the OBs who have indicated they might leave, do you feel like you might be hitting a crisis any time soon with regard to the number of OBs that you have to serve your members?

Ms. Soldo: I think we are engaging in additional recruitment. For Southwest there's no question that we're going to bring on more. We have more patients. Actually, we have more people selecting our health plan, not just on the Medicaid side but on the commercial side as well and it's relatively stable but it is something we have to continuously work on. We're going to work to keep our contracted network providers but we're also going to work to enhance our existing OB system.

Chairwoman Buckley: Thank you.

Ms. Simonson: The third aspect that I'd like to discuss is access to medical services. We are contractually required to provide 1 physician for every 1,500 members. Currently, our ratio of primary care providers to members is 1 to 63, specialists to members is 1 to 49, and obstetrical providers to female members is 1 to 186.

Our Medicaid and commercial members have access to the same physicians and other health care providers.

I'd like to just make one point on prior authorization that is not included in the information that you have. For obstetrical services, the prior authorization requirement is one phone call or one fax to Health Plan of Nevada and that includes all prenatal care, the delivery, and the postpartum services and the intent is notification so that we know who's delivering the baby and where because we have a contractual obligation to provide that information to the state. It would be nonsensical to deny obstetrical care. There's going to be a baby and it's in our best interest to make sure that that member gets care.

We require prior authorization for any service that is over $200 and that would be for each line of service that would be on the claim, not for the claim in total. So most diagnostic tests do not require prior authorization and if a primary care physician feels they need to refer to a specialist they can do that. It does not require prior authorization. They fill out the referral form and send it to the specialist and it suffices for the evaluation and two follow-up visits with the specialist. So, we feel that our prior authorization process is quite streamlined.

And that concludes our comments. We will feel happy to take any questions the committee has.

[Exhibit L is a copy of the prepared remarks of Ms. Soldo and Ms. Simonson.]

Chairwoman Buckley: Thank you very much for your testimony and I don't see any questions.

Ms. Simonson: Thank you.

Ms. Soldo: Thank you.

Chairwoman Buckley: I take that back. Assemblyman Hettrick.

Assemblyman Hettrick: Probably not a question. You know, I'm impressed. I look at the thing that you gave us and, of course, I see all of the numbers that you have and I guess the only thing I noted was that it says, "Member Satisfaction Survey conducted in 2001" and then it lists all of the members and I guess hearing the doctors and I think the Chairwoman's comment before was that it may go back a ways; and it may be from people who did this work before; and it may be from the impression they still have and a lot of things. But I think you ought to conduct the same survey with your providers and then it would be interesting to see what you had there and perhaps it might give you some places to go from a PR [public relations] standpoint to just improve their impression because, clearly, you do a lot of things very well and I think you could just benefit from some PR.

Ms. Simonson: Thank you. Every two years we do a provider survey and we did one last year and our results were significantly better than the one that was conducted two years prior. So, thank you.

Chairwoman Buckley: And I do want to add, at the forum not one person brought up HPN [Health Plan of Nevada] or Sierra [Health Services]. Thank you. Okay, with that, next on the agenda is "Overview of Laws in Other States Authorizing Physicians to Negotiate Collectively for Reimbursement for Services." A representative from the AMA [American Medical Association] was supposed to be here on this item, but we had some videoconferencing problems, so what I'll do is I'll just have Allison Combs maybe just spend a minute or two and just let the committee know what a couple other states are doing in this area. Oh, Scott, I think we're going to kick it off to you instead. We appreciate you being here today and pinch-hitting.

OVERVIEW OF LAWS IN OTHER STATES AUTHORIZING PHYSICIANS TO NEGOTIATE COLLECTIVELY FOR REIMBURSEMENT OF SERVICES

Scott Young

Mr. Young: Good afternoon Madam Chair and members of the committee. I'm Scott Young, Principal Research Analyst in the Research Division of the Legislature and I'll quickly state our standard disclaimer that we're nonpartisan staff and do not advocate, so we'll attempt just to present the results of our research.

We looked at this issue of whether or not physicians could organize, if you will, in order to negotiate with health plans and I want to differentiate two classes of physicians. Those who are clearly employees can negotiate without any antitrust implications because they're protected under the federal labor laws. An example that, if it still exists I think in California, Kaiser Permanente used to hire physicians and they were employees just as the nurses, the orderlies, and anyone else in the hospital system was. They would be allowed to negotiate collectively under the federal labor laws.

The other class of physicians would be the doctors, for instance, that have appeared here today who are really independent practitioners. There is a way that they can collectively negotiate and avoid antitrust implications and that's under what is called the State Action Doctrine. In a U.S. Supreme Court case in 1943, the court noted that the Sherman

Antitrust Act was aimed at the conduct of individuals and corporations and did not stop the states from sanctioning what would otherwise be anticompetitive behavior.

Over the years, the court has refined a test for when the State Action Doctrine can act as a shield against federal antitrust legislation and essentially there have to be two criteria that are met. One, the state must have a clearly defined policy of preferring a regulatory scheme over competition or free market systems and two, the state must remain actively involved in supervising those regulatory programs. They exist in some areas of utilities where the state may allow exclusive service territories. I've also seen examples in some of the cases where agricultural subsidy programs exist.

There are two states that have enacted legislation based upon the State Action Doctrine, specifically allowing physicians to negotiate with health plans. They're Texas and New Jersey. Texas adopted their statute in 1999 and New Jersey adopted theirs earlier this year.

In looking at the Texas statute and its implementation, and in talking with representatives of the attorney general's office in Texas, we've determined that the statute has not been utilized very much. There was one group of 11 physicians in Texas that met the requirements, formed a negotiating group, but were unsuccessful. And, the literature we reviewed indicates that it's largely because of some situations within the Texas statute itself.

Under the Texas approach, physicians must go to a third party negotiator. That third party negotiator must be approved by the attorney general and that's where the state action comes in. The state has first said, "In some instances we will allow physicians to engage in what would otherwise be anticompetitive behavior if it is determined that that would actually result in better outcomes for patients, physicians, and health plans." The continuing involvement of the state involves having the attorney general select or approve this third-party negotiator and then the attorney general must also approve any contracts that come out of the negotiations. So, the state must not just monitor what would otherwise be anticompetitive behavior under its enunciated state policy. It must actively be involved. Texas elected to do that through its attorney general.

The criticism that we have read of the Texas plan is that it's expensive. It's time-consuming. There's a lot of information that must be submitted to the attorney general's office. Some of it is felt by practitioners to be private or proprietary. And apparently, one of the largest drawbacks is that there are limitations on the size of the doctor group. For instance, no more than 10 percent of the physicians in a particular health plan's geographical service area can be represented. And, the doctors are specifically prohibited by statute from withholding services, striking, any kind of concerted activity like that. The third factor that's cited as being a weakness in the Texas approach is the health plan is not required to negotiate with the group and in talking to a representative from the attorney general's office in Texas, they said the physicians decided it was too costly, too time-consuming to go through the process and then be told that no one would negotiate with them.

When I spoke with representatives from the New Jersey attorney general's office, they indicated that their regulations, which they are currently working on, are similar to those in Texas. I asked them if they were aware of the problems that some people saw with the Texas approach and they said, no, they had not heard about that. So, I'm sure there will be people who will appear in their regulatory process and explain that.

But, so far, those are the two states that have actually enacted the statutes. About five other states have attempted to do so, but the bills have been unsuccessful. There was a bill introduced in 2001 in the Texas Legislature designed to correct some of the perceived deficiencies. It, however, did not pass. There was also one attempt in

Congress, in I believe 1999, by one of the California representatives, to introduce a bill that would have allowed physicians to have much the same protection that a union would have even though they were not employed. That also was unsuccessful.

So, the bottom line appears to be that there is a mechanism that a state can utilize in order to allow physicians to collectively negotiate, but the design of the program has a lot to do with whether or not it may ultimately be successful or be utilized by the physicians.

Chairwoman Buckley: Thank you. That was a very interesting topic to learn more about. Thank you very much. The next item on the agenda we had put in case any of the insurance companies could have rescheduled from the 29th [of July 2002] to today, which they were not able to do. And so, I'll just ask Allison Combs, if she would, to just discuss some of the questions we've asked them to provide by the 29th [of July 2002].

Ms. Combs: Thank you. There is a list of the proposed reforms that was sent to each of the insurance companies that were invited to attend and the list includes all the possible recommendations for insurance reforms that have been presented throughout the course of the committee through July 1 [2002]. And so far, at least five insurance companies have committed to attend to discuss these topics of reform that include rate approval issues, intervention in rate filings by interested parties, more public disclosure of underwriting decisions, discussion of confidentiality agreements and consent clauses, the issue of tail coverage and its high cost, claims-made policies versus occurrence-based policies, definitions of claims, business practices and holding companies accountable for certain business decisions. And then, there were also additional issues that had been brought forth in prior committee hearings, including limitations on time to trial, improvements in the medical malpractice screening process, and methods of encouraging settlements of meritorious cases. So, those are all issues that have been put before the insurance companies for discussion if that opportunity arises.
[Exhibit M is a copy of the document referenced by Ms. Combs.]

Chairwoman Buckley: And again, this was done before the call of the Special Session. This was done about 45 days ago just so we could put forward all of those questions that we had at our first two hearings and to get some responses. In particular, the one that I'm still curious about is the 125-delivery limit and how that has any basis from a risk analysis point of view and so, hopefully, we'll be able to get those in some manner on Monday [July 29, 2002]. Senator Townsend.

Senator Townsend: What is the best way for us to proceed? Mr. Anderson and the members of this committee are, I think, starting to feel comfortable that we've seen a great deal and want to proceed. This is a wonderful thing by the way, this recommendation in terms of how they can come up and approach us. I think this is very good. We heard some, I thought, very creative things that I know in discussing quietly here with Mr. Hettrick, some new things that I hadn't seen before. Can we get a lot of those down on paper where we can, as a committee, look at them and say, "Hey, this is something we ought to pursue further, or maybe offer in the Special Session, or have research done for the next Session" so that we can continue to—you know, we were all kind of hand picked for this thing and I'd like to make sure we all have an opportunity to present something whether it's collectively or individually. There's a lot of good stuff that's come to this committee and I'd like to be able to make sure we have an opportunity to do that.

Chairwoman Buckley: Right.

Senator Townsend: Have you heard at all about the timing of Monday [July 29, 2002]?

Chairwoman Buckley: I have not.

Senator Townsend: Okay.

Chairwoman Buckley: I plan on calling Marybel Batjer, Chief of Staff to Governor Guinn, to say, "What time are we starting on Monday, by the way?" so we can see what options we might have. I feel that this committee has come up with—just from my sense of everybody sitting here through our first three meetings—items that we feel are consensus and would help. I mean such as the fast tracking of medical malpractice cases to trial, as an example. I think that there was some consensus. We didn't discuss or vote, but that was just my sense. Today, eliminating the five-year lag time. I mean I think that's a no brainer. Some of the whistle-blower protections I think were very interesting and perhaps there'd be some consensus. If we had another week I think we'd be in good shape, but we haven't had time for Research [Division staff of the Legislative Counsel Bureau] to compile all of those and so what I might do is ask Research to do that and to ask both [Nevada State Assembly] Speaker [Richard D.] Perkins, you know, we could meet Monday [July 29, 2002] morning. I could recess right now today in case there is an opportunity for us to meet to have some consensus. I think, regardless, some of the ideas that we've uncovered in this hearing will end up in the bill drafts because I think we all agree that they'll be good for the state of health care in the State of Nevada.

So, to answer your question, I think what I'll do is I'll have staff attempt to compile those right away and maybe I'll recess at the call of the Chair at the end of this and then confer with the Governor's Office, with the rest of leadership, to see how we might accomplish this all, if that meets everyone's approval. Assemblyman Anderson, does that meet with your approval?

Assemblyman Anderson: You know, obviously, whatever you decide to do, Madam Chair, is going to meet with my approval.

Senator Townsend: Madam Chair, if I may.

Chairwoman Buckley: Senator Townsend.

Senator Townsend: My sense would be that we're on our way to a Special Session and probably the large issues that aren't consensus will be debated there and it would be, I think, unfortunate for the public if we did not as a committee assigned to do this, find all the things that aren't going to be talked about there that are probably consensus and get them into either a bill or one bill or a second bill and make sure that at least is signed into law at the end of whatever time period we have. And I think there's probably a lot more of that than most people think. There's probably more consensus than there isn't and that would, I think, would be very constructive. Because I know we're all about ready to, you know, give up an extra few days that none of us really planned on and try to be really good at what we're going to do, but I'd hate to miss out on something that the public deserves to have that everybody does agree on.

Chairwoman Buckley: So, why don't I do that, why don't I call us in recess at the call of the Chair and then what I'll ask Research to do is on those consensus items to not only draft them for our consideration but to have a draft go to the Legal [Division of the Legislative Counsel Bureau] to do the actual drafting so that on Monday we would actually—if we then approved it while normally we don't do that—put them on the same track so that we could actually have a bill draft and those drafted, especially for the consensus items. Okay. Well, let's do that then and we'll kind of figure out when we can do that. The great thing about recess is you just call it.

PUBLIC TESTIMONY

Chairwoman Buckley: Okay. Let's move on to public testimony and I'll start in northern Nevada. Is there anyone that would like to provide public testimony to us today?

Assemblyman Anderson: No. We're okay, Ms. Buckley. We're all ready to go. I don't see anybody. Nobody signed in and everything's fine.

Chairwoman Buckley: Okay. Thank you, Mr. Anderson. Is there anyone in Las Vegas that would like to provide public testimony? Mr. Matheis, doctor, pleased to have you on our first panel here, especially after waiting with us all day. Mr. Matheis.

Lawrence P. Matheis

Mr. Matheis: Larry Matheis, [Executive Director] Nevada State Medical Association [Reno, Nevada]. It's very late so all I want to do is just maybe a couple of items just to put on probably Allison's [Combs] work list because there were a couple items that were left, I think, with a little bit of confusion starting with the Board of Medical Examiners' discussion this morning.

One of those comes from a problem that I've mentioned before and that is the use of different terms or sometimes the same term with different meanings, different terms when they're really referring to other terms. I've mentioned that before with the use of the words "case" and "claims" to mean several different things that in terms of the medical liability cost issue, it is only about claims of those who are insured under the liability insurance policies that we're talking about in terms of both frequency and severity. It's those claims. Those claims may be wrapped up in cases filed before the medical legal screening panel, cases filed before the district courts. Those may not be the same cases, may not include the same participants. There may be cases that involve claims opened against physicians that result in them being named in the medical legal screening panel. The physicians may be dropped if a case goes forward. There may be no one there who, in fact, for whom there will be a claim being paid and there were several of those in those district court proceedings. So there is confusion there that only the frequency of claims being opened and closed, and especially those that are being closed with payment, payment to the plaintiff, are the only ones that affect the severity—how much is going out—and it's only the frequency—the number of times they have to open claims where there may or not even be a payment out in the end but where there will be costs associated to the claim being open and the research being done and whatever.

So, the frequency and the severity that's talked about has to be talked about only in terms of claims, but frequently there's a slipover and they're really referring to the number of cases that have been filed and to the settlement of cases and to the awards that are paid in those cases. And getting on a common definition is very important to understand specifically what you're going to tease out here in terms of public policies that will affect the issues related to claims against physicians and the payment of claims by the insurers because that's the immediate crisis at hand. There are bigger issues and these other things push it.

In the discussion this morning by the Board of Medical Examiners, you had the same problem now with a slightly different aspect to it. The term "malpractice" is used differently in their process, in the process of the findings of the medical legal screening panel, and obviously, in the findings of courts, and the interchangeability of the word because the word is used in different places and in different reports.

In fact, virtually every sanction I am aware of that the Board of Medical Examiners has taken against a physician, they do this process where they get a complaint, they explained that, they do an investigation, then if they, if there's a sufficient body of information there and they have jurisdiction they actually open then a case and when

they do that, if it goes to the point that they're recommending a sanction to the full board, they do an adjudication, they do a hearing, a mini-judicial hearing, at which there are findings issued and the board is deciding, first of all, whether there are findings that the doctor has done anything in the long list of grounds for action that the NRS 630 [Chapter 630, "Physicians, Physician Assistants and Practitioners of Respiratory Care," of *Nevada Revised Statutes*] provides for. And, if so, then they have a second phase in which they decide what sanctions to take as a result of issuing those findings.

I think in virtually every case that I can remember where they have sanctioned physicians it is because they have at least one finding of malpractice. Has nothing to do with the findings of a medical legal screening panel on whether there is a probability of medical malpractice and has definitely nothing to do with the standards of a court as to whether there has been a finding of medical negligence. The word is used but in different context and I think that was part of the communication problem that was going on.

And also, on the reporting issue to them, I think that also got into some confusion. When there is a settlement that has to be reported to them immediately. There's no five-year delay in that. That's where most claims of medical malpractice end up. They end up in settlement. The Board of Medical Examiners has that information. It's required to have that information, I think, within 90 days. They're also required right now to have a report from the physician that a claim has been—claim of medical malpractice, again in [NRS] 630.3062 ["Grounds for initiating disciplinary action or denying licensure: Failure to maintain proper medical records; altering medical records; making or causing false report; failure to allow inspection and copying of medical records; failure to report claim for malpractice or negligence; failure to report other person in violation of chapter or regulations"], claim of medical malpractice is used there. I think that's an imprecise use of it, but the physician is required within 90 days of a claim being filed reporting that to the Board of Medical Examiners and then within 90 days of the disposition of that claim reporting that.

So, again, the long time delay I think that they were talking about is from when a case is opened before the medical legal screening panel to when a finding of the panel and then when they receive the finding of the panel and that that may be as much as three or five years, I guess is what they were saying I'm not sure that's accurate from when the case was originally opened.

Same thing in terms of the district court process, although there I think they testified they weren't getting it at all. But the point would be that they wouldn't get it until there was a disposition of the case. However, that the case was filed is supposed to be reported to them already. So, again, I think you may want to just look at that and there was some confusion, I think, in the use of various terms. And I think I'll just leave it at that. I think that's sufficient.

Chairwoman Buckley: Thank you very much. Dr. Tate, thank you for spending the whole day with us. We appreciate you joining us again.

Dr. James S. Tate Jr.

Dr. Tate: You're welcome. For the record, my name is Dr. James Tate and I'm the President of the West-Crear Medical Society. There are a couple of things I also wanted to comment about.

Every time there's a finding of "probable" or "unsure" on the part of the medical legal screening panel, the board [Board of Medical Examiners] sends out a letter to the physician asking him to explain the circumstances. So, they are notified and that's not a five-year delay.

Secondly, anytime the board undertakes an investigation, which is I would say extremely loose in terms of when they decide or what they decide to do it over. Anyone who complains, it doesn't have to be the patient. It can be anybody who makes a complaint and they'll open an investigation. You're then required to send them all your input in terms of medical records and what your "treatment" plan was. The problem is that after they've done that investigation, you don't hear anything from them. So, as a physician you're left on the hook. I assume that if they haven't talked to you in the next ten years you're okay, but you don't know that. You don't have any idea that they've decided that, you know, unless they decide you're guilty. Then you go through the process.

A couple of other comments. I noticed that there were no D.O.s [doctors of osteopathy] or no representative from the D.O. board [State Board of Osteopathic Medicine]. I assume you are aware that there's a separate board for them and they don't come under the State Board of Medical Examiners. Let me make you aware of that. There are a significant number of D.O.s in the State of Nevada and I think you need to include them in that process. In fact, most of the emergency room physicians at University Medical Center are D.O.s, not M.D.s. Okay.

A comment on the reporting issue. While I don't have a problem with medical error reporting, I think making it public is, as most people have told you, is going to drive that process under ground because I doubt if you could agree what a medical error is in reality. A very difficult thing to define and it depends on—a lot of it is opinionated. I can tell you, when we have peer review processes within the hospital there will be battles over whether that person was right or wrong because there are different opinions. So, how do you classify that? You know, how do you classify whether that was really an error?

I found it interesting, bear with me, that the gentlemen who gave the report on the subcommittee authorized by, I guess, another subcommittee, there seemed to be some resistance to the findings and you have to be very careful. If you're going to really be objective, then you give someone a task and when they come back it may not be the answer you want but that's the answer you got. You can't then argue with them about the answer. So, you know, I think you have to keep that in mind.

The risk management system that was brought up I thought was a good idea. The only problem with that, I think, is that it only will work in your office and for those of us who have the kind of high-risk activities in hospitals it would not work because they already have those systems in place. Understand that we don't have a large office-based population. We're seeing patients who come in, you know, with injuries and so I don't believe it would work though I noted a lot of interest in it for family practice, primary care it might help, but for us I don't think it would.

If you're going to have injured parties come forward I think that's fine to get public participation. I think it should be evenhanded and you should have the folks who've had their lives saved or had good outcomes that should present too.
Finally, and I have mentioned this before, that you are only hearing from the trial lawyers association, which is the plaintiffs' side. You're not hearing from the defense lawyers who will give you a much different picture about the whole system that's broke. Right? I did talk to a prominent defense lawyer who I'm familiar with and she made several suggestions. If you don't mind, I'd like to just give them to you.

One, she suggests that you drop the medical legal screening panel all together. If you're not going to do that, then you should switch and have the northern end review the southern end and the southern end review the northern end so you make sure there is no bias.

You should tighten the standards for expert witnesses. Everything should be standard. A dermatologist shouldn't be able to testify against a trauma surgeon. Okay. And vise versa.

Again, I think that in order to make this as even as possible there needs to be some hearing on the part of the panel, hearing from the defense side on the part of the panel because one of the things she's very sensitive about is things like the judges who are all ex-plaintiff lawyers and the discovery commissioner, okay, who always rules in favor of the plaintiff. Okay? All right. Thank you very much.

Chairwoman Buckley: Thank you and I've heard a couple of those suggestions as well from defense lawyers and, Dr. Tate, we do have a question for you. Assemblyman Anderson.

Assemblyman Anderson: Dr. Tate, it's good to see you again.

Dr. Tate: Thank you.

Assemblyman Anderson: I feel badly that I am not there in the south where I have been able to set my calendar to in the past. Why do you think that the defense bar has stayed away from the previous meetings that we've had where we really had a, in the very, very beginning had a very, very open process and it's only been this one and the next one where we have become under the gun now to, because of the Special Session, that we have a narrower agenda that we are trying to finish. When we first started this we were thinking that we were going to be finishing in December [2002] and now, of course, we're moving a little bit on a different pace. Do you have a theory why the defense bar may have stayed away when physicians were here and where we heard those and the predominantly almost exclusively in the first two hearings?

Dr. Tate: I think one of the reasons is I don't know whether they got invited and, or were put on the agenda. I know they could've come for the public comment but you can ask some of their representatives and I'm sure they'd be happy to tell you. I think it may be that they have some concerns about publicly going after their colleagues. Okay? Some of them don't, some of them I'm sure do but I think if you invite, you know, some defense attorneys in and, you know, they come in and they tell the truth and their colleagues probably will have to back off. Now I can't speak for lawyers. That'd be the last thing I'd try to do.

Chairwoman Buckley: And just for the record. I've had numerous people contact me and ask to be placed on the agenda and I've tried to accommodate just about every person and I've not received any requests from any defense lawyers. And I think it might be because they're employed by the insurance companies and working for the doctors and so maybe they don't feel as comfortable speaking out publicly. I don't know. But I think you're right in that they offer a different perspective and we make the best decisions when we hear every single perspective. So, I think you've raised good points and we appreciate you being with us.

Dr. Tate: You're welcome. And let me just say that I have one who will come, but the problem is the notice is too short.

Chairwoman Buckley: Right. Yeah.

Dr. Tate: But she's even agreed to come up to Carson City if she can.

Chairwoman Buckley: Well, good. We'll take note of that.

Dr. Tate: One last thing.

Chairwoman Buckley: Sure.

Dr. Tate: And I'm surprised that the committee didn't pick up on this. About 50 percent of the physicians in the country are women yet everybody keeps saying him. Okay? So you at least ought to make them—just a suggestion.

Chairwoman Buckley: And a good one. Thank you. Is there anyone else that would like to provide—Mr. Perry—anyone else besides Mr. Perry for public testimony? Did someone else raise their hand? Okay then you'll be our last witness today.

Charles Perry

Mr. Perry: Good afternoon, Chairman Buckley and committee members. Thank you for the opportunity of letting me speak. I am Charles Perry. I'm the Executive Director of the Nevada Health Care Association. I represent the skilled nursing and intermediate care facilities here in the State of Nevada. Nursing homes, if you will, and I understand that nursing homes generally are not a real hot topic or necessarily very popular. I'd also like to say that I do appreciate the time and the care that you folks have taken in conducting these hearings and the information that you've taken and I certainly don't envy you the task that you have in front of you now as you try to put all of this stuff together and go forward with the Special Session that's coming up.

My only purpose in being here, I have spoken to a number of you individually in the past. We did come and speak before the Insurance Commissioner when they had that hearing here and spoken a couple of times, I believe, before the Legislative Health Care Committee and the only thing that I want to do is just basically make you aware and maybe reemphasize to you that the physician community is not the only segment of the provider community that's having a real problem with the escalating cost of liability insurance. And long-term care, of course, is known as general and professional liability and I believe that in the professional liability is where you do find your malpractice insurance cost.

We have very few independently owned and operated facilities in the State of Nevada. As a matter of fact, if I'm not very badly mistaken, we have four independent operators of long-term nursing care facilities in the state. The rest are operated by large, multinational chain organizations and their situation is little bit different than you'll find with the independently owned in the fact that they're generally self-insured and are able to spread their cost of their insurance over very large numbers of beds.

But we're looking at escalating costs of in the neighborhood of 300, 400, and 500 percent and a lot of it has just come about recently with the departure of the St. Paul Companies from the State of Nevada because several of our facilities did have coverage with St. Paul. One facility that I can refer—and I won't give anybody's names because they haven't authorized me to do so—but at one facility that was paying $181,000 a year in premium coverage just renewed the same coverage, the same identical policy with a different company because St. Paul is not here for $500,000. Another facility that was paying $121,000, I believe, $122,000, to get the same coverage that he had prior to his policy lapsing would have run $465,000 and so he really didn't have much of a choice except to look for different types of coverage. But, you know, we are a part of this community, we do provide a valuable service, I believe, and we're caught up in this and as you go forward with your deliberations I just would like to ask you to keep us in mind and to be aware of the fact that we're having problems too. I don't have any answers. I wish I did. I'll have to leave that up to you guys.

Chairwoman Buckley: We thank you for your testimony and we're hearing this across the board. I mean the convention center got hit with an incredibly large increase. [Nevada State]

Assemblyman [Harry] Mortenson sent us a letter saying he had a cleanup company business premium went from like $30,000 to $90,000 and just with the insurance companies taking such hits and with the market not getting any better. I think it's becoming a problem across the board to small businesses and it's one time where the market's not correcting itself fast enough I think for a lot of people who need it to. So, we thank you. Mr. Matheis, you had something else to add?

Lawrence P. Matheis

Mr. Matheis: Yeah. I apologize, Madam Chair. Larry Matheis, Nevada State Medical Association. There was a follow-up, another question from this morning from the Board of Medical Examiners and there was confusion again over terms that were used. I think there was an interchange ability of physicians who are impaired because of substance abuse and the board's diversion program. And I think that led when Senator Titus and Senator Townsend both sought information in how many cases where there were sanctions taken involved substance abuse. But you asked it in terms of how many involved those in diversion programs and those are two different things. That, in fact, I think that what you really need to do is I described their process of sanctioning and issuing findings is in how many cases where they sanctioned physicians did they have findings that there was substance abuse. I think you will find that that is a large number of the cases in which they had findings of malpractice against a physician and took a sanction. In most of those cases they also refer the physician to the foundation they use that does the diversion program. So, I think there was confusion on that. The diversion program is for [a] physician who there is no complaint against but there is concern that there is behavior which will lead to problems with patient care and if they agree to go into the diversion program there's no investigation because there's no actual complaint. However, if there's a complaint against a physician about malpractice or about anything else and it is related to substance abuse, they do follow up on that, that may be a matter of findings, and they may wind up not in a diversion program but actually being referred to the foundation that runs the diversion program. That, I think, was again an area where there was confusion because of the terms used.

Chairwoman Buckley: We'll follow up with some specific questions—"How many had malpractice cases as a result of substance abuse or alcohol? How many voluntarily reported, did well, and did they have any subsequent medical malpractice cases?"—to try to better answer the questions and get that data. So, thank you for that clarification.

DISCUSSION OF FUTURE MEETINGS AND TOPICS FOR REVIEW
ADJOURNMENT

Chairwoman Buckley: We thank all the members of the public for spending your day with us and we are in recess.

Chairwoman Buckley recessed the meeting at 3:50 p.m.

[Exhibit N is the "Attendance Record" for this meeting.]

Respectfully submitted,

_____

Bonnie Borda Hoffecker
Senior Research Secretary

_____

Gayle Nadeau
Senior Research Secretary

_____
Debby Richards
Manager of Office Services

_____
Allison Combs
Principal Research Analyst

APPROVED BY:

_____
Assemblywoman Barbara E. Buckley, Chairwoman

Date: _____

LIST OF EXHIBITS

Exhibit A is a booklet, titled *Medical Malpractice Crisis at University Medical Center of Southern Nevada,* which was provided by William R. Hale, Chief Executive Officer, University Medical Center, Las Vegas, Nevada.

Exhibit B is a document titled "Board of Medical Examiners," which was prepared by the Research Division, Nevada's Legislative Counsel Bureau. This exhibit also includes a letter dated May 9, 2002, to Allison Combs, Principal Research Analyst, Research Division, Nevada Legislative Counsel Bureau, from Maureen E. Lyons, Deputy Executive Director, Nevada State Board of Medical Examiners, which includes the following tables:

1. "Licensure/Population Statistics – Medical Doctors";

2. "Licensure Statistics – Medical Doctors"; and

3. "Rate of Nonfederal Physicians in 2000."

Exhibit C is a handout, titled "National Overview of Medical Malpractice Crisis—Statement of Mimi Marchev, Sr. Policy Analyst, National Academy for State Health Policy [NASHP; Portland, Maine] before the Nevada Legislative Subcommittee to Study Medical Malpractice, July 22, 2002," which was provided by Ms. Marchev.

Exhibit D, a packet of information provided by Jill Rosenthal, Project Manager, National Academy for State Health Policy, Portland, Maine, includes the following items:

1. A copy of a PowerPoint presentation, titled "State-Based Patient Safety Reporting Systems—Nevada Legislative Subcommittee to Study Medical Malpractice—Jill Rosenthal, MPH—National Academy for State Health Policy —July 22, 2002."

2. Three NASHP *News Briefs*:

   a. "State Mandatory Reporting of Medical Errors," February 2002;

   b. "Building state mandatory reporting systems for medical errors," November 2001; and

   c. "The Role of State Policymakers in Patient Safety," October 2001.

3. An *Issue Brief* titled "Medical Errors and Patient Safety," and dated April 8, 2002, by Stephanie Norris, Health

Policy Tracking Service, National Conference of State Legislatures.

Exhibit E is the *Report and Summary of Recommendations* of the Legislative Committee on Health Care's Subcommittee to Study the Development of a System for Reporting Medical Errors (Assembly Concurrent Resolution No. 7 [*Statutes of Nevada 2001*]), dated May 2002.

Exhibit F is a document, titled "Legislative Subcommittee to Study Medical Malpractice—Testimony by Dr. John Yacenda, Chairman—Legislative Committee on Health Care's Subcommittee to Study the Development of a System for Reporting Medical Errors—July 22, 2002," provided by Dr. Yacenda, Carson City, Nevada.

Exhibit G is a copy of a PowerPoint presentation, titled "Fixing the Problem: Identifying, Tracking, and Minimizing Medical Errors—Douglas A. Perednia, M.D., Kietra Corporation, Portland, Oregon."

Exhibit H is a document titled "Testimony Before the Legislative Subcommittee to Study Medical Malpractice—Deborah Huber RN, MHSA—*HealthInsight*—July 22, 2002."

Exhibit I is the prepared remarks of John M. Nowins, M.D., President, Clark County Obstetrics and Gynecology Society, Las Vegas, Nevada.

Exhibit J is a document, titled "Division of Health Care Financing and Policy—Testimony for the Legislative Subcommittee to Study Medical Malpractice—Room 4401, Grant Sawyer State Office Building—July 22, 2002, 9:00 a.m.," which was provided by Charles Duarte, Administrator, Division of Health Care Financing and Policy, Nevada's Department of Human Resources, Carson City, Nevada.

Exhibit K is a booklet, titled "NevadaCare, Inc.—Testimony for the Legislative Subcommittee to Study Medical Malpractice—Room 4401, Grant Sawyer State Office Building—July 22, 2002, 9:00 a.m.—Submitted by: Todd Meek, President/CEO and Curt Howell, Vice President Program Management," which contains the prepared remarks Mr. Meek and Mr. Howell and the attachments referenced in their presentation.

Exhibit L is a document titled, "Testimony before the Legislative Subcommittee to Study Medical Malpractice—July 22, 2002—Marie Soldo, Executive Vice President, Government Affairs, Sierra Health Services—Kelly Simonson, Director, Medicaid Programs, Health Plan of Nevada."

Exhibit M is a paper, titled "List of Proposed Reforms Relating to the Insurance Industry submitted for the Consideration of the Legislative Subcommittee to Study Medical Malpractice—Document Created for the Purposes of Discussion—July 29, 2002," which was provided by the subcommittee's staff.

Exhibit N 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. You may contact the library at 775/684-6825.