Legislative Committee on Health Care

January 2005

Legislative Counsel Bureau

Bulletin No. 05-23

LEGISLATIVE COMMITTEE ON HEALTH CARE

BULLETIN NO. 05-23

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SUMMARY OF RECOMMENDATIONS

This summary presents the recommendations approved by the Legislative Committee on Health Care (*Nevada Revised Statutes* [NRS] 439B.200) at its August 4, 2004, meeting. The Committee submits the following proposals to the 73rd Session of the Nevada Legislature:

Emergency Mental Health Care in Clark County, Nevada

1. **Request legislation to appropriate funds for: (a) continued operation of mobile crisis teams; (b) staffing and operation of a renovated 28-bed facility; (c) recruitment of psychiatrists for the Division of Mental Health and Developmental Services, Nevada's Department of Human Resources (DHR); (d) the psychiatric residency program at the School of Medicine, University of Nevada, Reno; and (e) medical screening at the mental hospital in Clark County.**

Letters

The Committee authorized the chairwoman to send the following letters on behalf of the Committee:

2. **A letter to the administrator of the Division of Health Care Financing and Policy, DHR, concerning eligibility and services related to persons with disabilities, particularly as such issues relate to the care of children who are disabled;**

3. **A letter to the director of the DHR, with a copy to the administrator of the Division of Health Care Financing and Policy, urging the department to submit a bill draft request to address certain issues related to home care for persons who are disabled. The letter should urge the department to: (a) resolve issues related to NRS 629.091 and its existing limit to allow only persons with physical disabilities to self-direct their care; and (b) develop solutions that will allow a personal care assistant to administer medications in a home care setting.**

4. **A letter to the president of the Nevada Organization of Nurse Leaders urging the organization and its nurse executive members to open the lines of communication with nurses who provide direct patient care. The letter should encourage nurse managers to be receptive to requests for assistance from nurses who provide patient care when such nurses request assistance with their respective work loads during a shift.**

5. **A letter to the administrator of the Division of Health Care Financing and Policy, DHR, encouraging the division to resolve the issue of the late payment of Medicaid claims to providers.**

Statements of Support

The Committee directed staff to provide statements of support in the bulletin for the following issues:

6. **The establishment of a statewide office within the University and Community College System of Nevada (UCCSN) that would collect and analyze health workforce data. In conjunction with the establishment of the office, the Committee supports the suggestion by the UCCSN to create an advisory committee comprised of legislators, representatives of the state's licensing boards, individuals involved with education and training of health professionals in the state, and other stakeholders to direct the work of the office.**

7. **Consideration by administrators and managers of hospitals in Nevada to limit the ability of traveling nurses to be responsible for staffing assignments.**

8. **Recommendations made by the Governor's Strategic Plan for Rural Health Care Accountability Committee as such recommendations relate to: (a) health workforce data collection; (b) the establishment of a grant fund to support the development of services, equipment, and facilities that serve the needs of rural and frontier populations; (c) the development of a capital fund to support rural facility development, renovations, equipment, and start-up funding to support rural community needs; and (d) the development of primary care districts that may cross county and/or state boundaries for the purpose of addressing service area needs in rural and frontier Nevada.**

REPORT OF NEVADA'S LEGISLATIVE COMMITTEE ON HEALTH CARE TO THE 73rd SESSION OF THE NEVADA LEGISLATURE

I. INTRODUCTION

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

The Committee met six times, and three subcommittees of the Committee met a total of ten times. In addition, an advisory committee and a technical work group met a total of eight times. All public hearings were conducted through simultaneous videoconferences between Carson City and Las Vegas, Nevada.

At the sixth meeting, members conducted a work session at which they adopted one recommendation for legislation. The recommendation concerns emergency mental health care issues in Clark County, Nevada. In addition, members authorized the chairwoman to send four letters on behalf of the Committee, and members directed staff to address three specific points in the bulletin.

This bulletin provides background information addressing the Subcommittee to Study Staffing of the System for Delivery of Health Care in Nevada pursuant to Assembly Bill 313 (Chapter 410, *Statutes of Nevada 2003*). Activities of a second subcommittee, the Subcommittee to Study Current Challenges of Ensuring Adequate Health Care is Available to All Nevadans pursuant to Senate Bill 289 (Chapter 425, *Statutes of Nevada 2003*), were met by the Subcommittee to Study Health Insurance Expansion Options, which was authorized directly by the Committee. The report from this subcommittee is a separate bulletin. A third subcommittee established by the 2003 Legislature, the Subcommittee to Study Medical and Societal Costs and Impacts of Obesity pursuant to Senate Concurrent Resolution No. 13 (File No. 89, *Statutes of Nevada 2003*), has a separate bulletin.

This bulletin contains additional background information on the following topics:

1. Home children who are disabled;
2. Self-care for persons who are disabled;
3. Rural health care needs; and
4. Payments to Medicaid providers.

Assemblywoman Ellen M. Koivisto served as the Chairwoman of the Committee, and Senator Raymond D. Rawson served as the Vice Chairman. Other legislative members of the Committee during the 2003-2004 interim included:

Senator Bernice Matthews
Senator Barbara Cegavske
Assemblywoman Kathy McClain
Assemblyman Joseph Hardy, M.D.

Legislative Counsel Bureau staff services were provided by:

Marsheilah D. Lyons, Senior Research Analyst
Leslie K. Hamner, Principal Deputy Legislative Counsel
Kennedy, Senior Research Secretary

II. REVIEW OF COMMITTEE FUNCTIONS

The primary responsibilities of the Committee are established pursuant to NRS 439B.220 through 439B.240. These responsibilities include reviewing and evaluating the quality and effectiveness of programs for the prevention of illness, reviewing and comparing the costs of medical care among communities in Nevada with similar communities in other states, and analyzing the overall system of medical care in the state. In addition, members strive to avoid duplication of services and achieve the most efficient use of all available resources. The Committee also may review health insurance issues and may examine hospital-related issues, medical malpractice issues, and the health education system. See Appendix A for the statutes that govern the Committee.

Further, by statute, certain entities are required to submit reports to the Committee. They are:

- An annual report of the activities of the Bureau of Hospital Patients as required by NRS 223.575. This report provides information regarding the number of complaints received by the Bureau, the number and type of disputes heard, mediated, arbitrated or resolved through alternative means of dispute resolution by the Bureau Director and the outcome of the mediation, arbitration or alternative means of dispute resolution.

- An annual report of the activities and recommendations of the Advisory Committee on Traumatic Brain Injuries as required by NRS 426A.060. This report provides information on the programs for traumatic brain injury patients and statistics from the head trauma registry.

- A biennial report from Nevada's Department of Human Resources (DHR) regarding any laws or regulations that add to the cost of health care in the state as required by NRS 439A.083.

- A quarterly report from DHR concerning: (1) the progress of applying for a Medicaid waiver to extend coverage for prescription drugs to certain persons with disabilities; and (2) the establishment of a program in accordance with such a waiver as required by NRS 422.274 and NRS 422.2745.

III. DISCUSSION OF TESTIMONY AND RECOMMENDATIONS

A variety of issues were addressed at the meetings of the Committee. This section provides background information and discusses only those issues for which the Committee made recommendations. These issues relate to:

A. Emergency mental health care in Clark County, Nevada,

B. Children who are disabled and self-care for persons who are disabled;

C. Rural health care needs;

D. Payments to Medicaid providers; and

E. Staffing of the system for delivery of health care in Nevada.

A. EMERGENCY MENTAL HEALTH CARE IN CLARK COUNTY, NEVADA

According to testimony, lack of specialty care resources for individuals with mental illness exacerbate hospital emergency rooms capacity to accept increased patient loads without experiencing significant delays. Subsection 1(a) of NRS 433A.165 requires that before an allegedly mentally ill person may be transported to a public or private mental health facility, he must first be examined by a licensed physician, physician assistant, or an advanced practitioner of nursing to determine whether the person has a medical problem, other than a psychiatric problem, which requires immediate treatment. If it is determined that there is no medical problem, other than a psychiatric problem, the person may be transported to another appropriate medical facility. Testimony further indicated that the ability to transfer a patient from an emergency room to a mental health facility is hampered by extremely limited psychiatric emergency services and acute care psychiatric placement options.

In Nevada, the Division of Mental Health and Developmental Services (MHDS), DHR, is responsible for oversight and operation of the state-funded community mental health programs, inpatient programs, and mental health forensic services. To meet its responsibilities in southern Nevada, MHDS oversees the delivery of services made at Southern Nevada Adult Mental Health Services (SNAMHS). Services SNAMHS affords to adult clients include:

- inpatient services;

- medication clinic;

- geriatric services;
- contractual services;
- psychiatric emergency services;
- outpatient counseling;
- psychosocial rehabilitation;
- residential supports service coordination; and
- The Program for Assertive Community Treatment (PACT).

Testimony presented by a representative of emergency services listed the following areas which need to be addressed to improve the ability of MHDS to meet the needs of mental health patients in southern Nevada:

- To assist in making appropriate referrals for mentally ill patients that present in emergency rooms it was suggested that funding be continued for the pilot mobile crisis units established within MHDS. The mobile crisis units assist in coordinating psychiatric emergency services with local hospital emergency rooms. According to information provided by MHDS, the intent of the mobile crisis unit is to divert and triage mental health patients that may require less restrictive services out of the emergency rooms. The mobile crisis unit provides an immediate evaluation to determine whether the patient needs to be in the psychiatric observation unit or treated through an outpatient appointment.

- The SNAMHS has historically had a high vacancy rate in certain personnel positions, including psychiatrists, nurses, and mental health technicians. To alleviate this problem the representative stressed the need for an aggressive recruitment of psychiatric staff.

- In August 2004, the Interim Finance Committee appropriated $500,000 and allowed for the transfer of certain existing funds from within the MHDS 2005 budget categories to meet expenditure requirements to temporarily operate and staff an additional 28 inpatient beds for mental health patients in Clark County. This appropriation was made with the understanding that a supplemental apportion would be requested after the 2005 Legislature convened. Testimony indicated that continued financial support of this temporary facility is paramount to meeting the needs for mental health services in southern Nevada.

- To increase the number of psychiatrists in the community, testimony indicated that a psychiatric residency program at the University of Nevada, School of Medicine should be established in southern Nevada. According to testimony, currently the program only operates in northern Nevada.

- Finally, it was indicated that the requirement that individuals be medically cleared prior to being transferred to a mental health facility is the primary reason why many mental health patients are presented in emergency rooms. It was recommended that SNAMHS include a component that allowed for onsite medical screening. In this instance certain patients, who met specific criteria, would be transported directly to SNAMHS and medical screening would take place prior to making a mental health evaluation.

After deliberations on this topic, members of the Committee adopted the following recommendation:

Request legislation to appropriate funds for: (a) continued operation of mobile crisis teams; (b) staffing and operation of a renovated 28-bed facility; (c) recruitment of psychiatrists for the Division of Mental Health and Developmental Services, Nevada's Department of Human Resources (DHR); (d) the psychiatric residency program at the School of Medicine, University of Nevada, Reno; and (e) medical screening at the mental hospital in Clark County.

B. CERTAIN ISSUES RELATED TO HOME AND SELF DIRECTED CARE FOR CHILDREN AND OTHER PERSONS WITH DISABILITIES

Testimony indicated that recent cuts in Medicaid reimbursements and services, particularly as related to private duty nursing, greatly impacted a family caregiver's ability to maintain employment while keeping their disabled child in the home. Private duty nursing is an optional benefit under Federal Law Section 1905 (a) (8) of the Social Security Act. According to the Medicaid Services Manual Section 900, utilized by the Division of Health Care Financing and Policy (DHCFP), DHR:

> Private duty nursing . . . is an optional benefit offered under Nevada Medicaid State Plan. Private duty nursing provides more individual and continuous care than is available from a visiting nurse. The intent of private duty nursing is to assist the non-institutionalized recipient with complex direct skilled nursing care, to develop caregiver competencies through training and education, and to optimize recipient health status and outcomes. This benefit is not intended to replace care giving responsibilities of parents, guardians or other responsible parties, but to promote family-centered, community based care that enables the recipient to remain safely at home rather than in an acute or long-term care facility. Private duty nursing services may be provided, within program limitations, to a recipient in his/her home or in settings outside the home wherever normal life activities may take them. Service may be approved based on medical necessity, program criteria, utilization control measures and the availability of the state resources to meet recipient needs.

Testimony indicated that such items as requiring recertification every two months to determine the need for private duty nursing benefits, making school attendance an automatic reason to reduce the number of hours a recipient may utilize private duty nursing, and not allowing

providers such as certified nursing assistants (CNAs) and personal care assistants (PCAs) administer medication in a home care setting, greatly decrease benefit of using home health care options to keep the recipient in a home setting. Additionally it was indicated that support services such as a daycare center for children with special needs were not readily available. Finally, testimony indicated that there should be some ability for family caregivers who work to assist in paying for private duty nursing and other support services through the implementation of a sliding fee scale (See Appendix B).

A representative of DHCFP indicated that the purpose of recertification is not to revisit the issue of the patient's underlying diagnosis, but rather recertification is a federal tool to determine if a patient's skilled nursing care needs have changed. Additionally, federal constraints dictate how school attendance is counted in determining the numbers of hours a family can receive for skilled nursing services. Finally testimony provided by DHCFP, noted that sliding fee scales within the State Plan are illegal under Federal law. Lastly, further testimony provided by a representative of DHCFP noted that past efforts by the Division to create daycare centers for special needs children were consistently blocked by advocates for the disabled who do not want this population singled out.

With regard to allowing providers such as CNAs and PCAs to administer medication and possibly perform other skilled nursing duties in a home care setting, representatives of DHCFP noted that the Physically Disabled Waiver Program could allow a PCA to perform a variety of procedures. It was further noted that these limitations are directly related to the provisions of NRS 629, self-directed care for people receiving personal assistance services. Specifically, NRS 629.091 allows the health care provider, which could be a doctor, nurse, occupational therapist, or a physical therapist, to authorize a personal care attendant to perform certain services for the patient. These are services that the patient could perform himself under normal circumstances but due to their physical disability they are not able to perform the task. This section allows a personal care attendant for a patient with a physical disability to perform certain services for the patient under the patient's direction; however, this provision is not allowable for persons who may have a cognitive disability or a child under the age of 18, because they are deemed unable to self direct the care they receive. In these instances testimony indicated that a spouse, parent, or other personal care representative (responsible adult) could direct the care on a patient's behalf.

According to information provided, many in the skilled nursing community do not feel that this is self-directed care. If an appointed person is directing the care, rather than the patient, nursing tasks are being delegated to a person who is skilled/unskilled, by someone other than a nurse. Although the person directing the care and the unskilled person (PCA) are trained and taught how to perform just that certain procedure or treatment, this structure places two layers of unskilled support between a provider of health care and the patient. Advocates within the nursing community indicate that a health care provider has to feel comfortable that the person has the knowledge, skills, and abilities to actually perform the activity on the patient. In this scenario, a health care provider must also have a certain level of comfort with the appointed person's ability to direct the care. According to some in the nursing community, under current law an adult with certain physical limitations can tell a PCA to stop if they felt

something was wrong or if the procedure was not being done correctly, however if the suggested change is made, persons with certain cognitive disabilities and children will not be able to give this input. Another concern noted has to do with whether the person who is directing the care for the patient has to be present when the patient receives the care.

Following deliberation on these issues the Committee members recommended that letters be drafted to:

The administrator of the DHCFP, DHR, concerning eligibility and services related to persons with disabilities, particularly as such issues relate to the care of children who are disabled; and

The director of the DHR, with a copy to the administrator of the DHCFP, urging the department to submit a bill draft request to address certain issues related to home care for persons who are disabled. The letter should urge the department to: (a) resolve issues related to NRS 629.091 and its existing limit to allow only persons with physical disabilities to self-direct their care; and (b) develop solutions that will allow a PCA to administer medications in a home care setting.

C. RURAL HEALTH CARE NEEDS

The 2001 Session of the Nevada State Legislature passed A.B. 513 which mandated and funded the development of a Strategic Plan for Rural Health Care. That work was completed in October of 2002, and the final plan includes 11 goals, with many objectives and strategies intended to achieve those goals. Testimony presented by representatives of the Governor's Strategic Plan for Rural Health Care Accountability Committee indicated that one of the key recommendations in the plan was the creation of a mechanism to help ensure that the plan did not merely "sit on a shelf." Rather, the plan was to be viewed as the beginning of a process intended to actually result in improvements in the rural delivery system. To that end, the Governor created the Accountability Committee in November 2003 and charged it with oversight of the implementation of the plan and with updating it as needed.

Members of the Committee heard discussion regarding mechanisms to support practitioners who provide services in rural and frontier areas. Two specific possibilities presented the establishment of a fund that would support grants for the development of services for vulnerable rural and frontier populations, including limited operating capital, and funding for equipment and facilities; and the creation of a loan pool for capital needs for rural providers.

Testimony indicated that the grant pool is a way of providing an incentive for the development of services in rural Nevada. It was emphasized that the competition for providers and services is intense across the country and certainly in Nevada. Testimony indicated that this proposed program will make it easier for those wanting to serve in rural areas to do so. Testimony further noted that the grant pool is seed money, intended to get sustainable services off the ground. To qualify for these funds practitioners and others would have to demonstrate that they will serve an underserved or at-risk population, and that the service they propose to

develop would become self-sustaining in a reasonable amount of time. Additionally it was emphasized that many types of grantees could be eligible; including physicians, dentists, nurse practitioners, physical therapists, home health agencies, or those wanting to provide transportation or other services to the elderly. Grantees might be existing entities trying to expand services, or new entities trying to fill a need. An example provided indicated that an existing rural pharmacy might consider opening a limited pharmacy in a community that does not have one, if only the start up cost could be covered.

On a similar note, the Accountability Committee testified to the benefits of establishing a capital loan pool for rural practitioners. Testimony indicated that this pool would be intended to provide relatively easy access to capital for equipment and facilities needed by rural providers. The pool would be available to clinics, private practitioners, and others who use their loans to increase access to services for rural and frontier residents. Unlike the grant fund, there is an expectation that funds borrowed from the loan pool would be repaid with modest interest so that new loans can be made. Proponents indicated that a similar program managed by Nevada Rural Hospital Partners (NRHP) which offers funds for rural hospitals, works very well. It was emphasized that the program would provide a continuous, revolving resource with funds being loaned, paid back, and loaned again. Testimony indicated that the NRHP pool is approximately 15 years old and has never had a default. According to testimony, that pool started with $900,000, $500,000 of which was borrowed; that debt has been repaid and the pool now has $1.1 million dollars (See Appendix C).

Subsequently, Committee members agreed to support:

> **Recommendations made by the Governor's Strategic Plan for Rural Health Care Accountability Committee as such recommendations relate to: (a) health workforce data collection; (b) the establishment of a grant fund to support the development of services, equipment, and facilities that serve the needs of rural and frontier populations; (c) the development of a capital fund to support rural facility development, renovations, equipment, and start-up funding to support rural community needs; and (d) the development of primary care districts that may cross county and/or state boundaries for the purpose of addressing service area needs in rural and frontier Nevada.**

D. PAYMENTS TO CERTAIN MEDICAID PROVIDERS

Testimony indicated that the Medicaid Management Information System (MMIS), which began operations on October 1, 2003, was not meeting the expectation to provide ease in submitting and processing claims submitted by health care providers. Developed pursuant to A.B. 516 (Chapter 441, *Statutes of Nevada 2001*), the MMIS was designed to consolidate and automate Medicaid claims and payment processes and provide other health care management services. On October 1, 2002, First Health Services Corporation (FHSC) received the contract to implement this system. Testimony provided by hospitals, physicians, and other health care providers indicated concerns regarding delays, backlogs, errors, and confusion in the

processing and payment of Medicaid claims. Because of this situation, providers have experienced significant economic and administrative disruptions. Testimony further indicated that some providers found payment delays and uncertainties so onerous that they withdrew from participation in the Medicaid program.

Representatives of the DHCFP, DHR, confirmed that issues of concern exist related to the delay of Medicaid payments. However, DHCFP representatives indicated that several issues of concern have been resolved or are continually being monitored, including the following:

- Problems with Crossover Claims – Crossover claims are claims for individuals that are Medicare and Medicaid eligible. First Health Services Corporation is currently processing electronic Part B Medicare Crossovers.

- Limited Utilization of Electronic Data Interchange (EDI) – EDI is a method where electronic claims are transmitted directly to FHSC and processed the same day. Working toward the goal of moving from 5 percent of claims submitted electronically to a goal of 70 percent, the providers are offered automated, free submission software (PayerPath). Additionally, 27 EDI Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant transaction processing service centers (clearinghouses) are available.

- Eligibility Verification Systems (EVS) – To improve the two automated methods of eligibility verification (Web-based EVS and phone-based automated response unit), FHSC increased accessibility by adding additional Web agents, increasing the number of concurrent users from 10 to 200. Additionally, FHSC has added 14 additional phone lines to ensure adequate access at all times.

- Error Occurrences – The claim payment process is slowed down when a claim is submitted with errors. To address this issue, individual edits (error type notations) were reviewed to determine the best way to resolve future error occurrences. As a result of this review, certain edits are no longer at the top of the most frequent edits list. Additionally, to reduce the backlog, certain claims were manually reprocessed. Finally, providers are notified and continually educated regarding proper claim completion.

Testimony further indicated that although many corrections and modifications to MMIS have been made, full contract compliance had not yet been achieved.

As a result of testimony on this issue, the Committee recommended that a letter be drafted to:

The administrator of the DHCFP, DHR, encouraging the division to resolve the issue of the late payment of Medicaid claims to providers.

E. STAFFING FOR THE SYSTEM FOR DELIVERY OF HEALTH CARE IN NEVADA

Assembly Bill 313 (Chapter 410, *Statutes of Nevada* 2003) directed the Legislative Committee on Health Care, to appoint a subcommittee to conduct an interim study concerning staffing matters associated with Nevada's health care delivery system. The study was to include:

A. The use of certain established methodologies and models;

B. A comprehensive evaluation of the current requirements in Nevada for staffing of the system for the delivery of health care;

C. A comprehensive evaluation of the required methods of record keeping by medical facilities or other organizations that provide organized nursing services or statistics relating to staffing and patient care;

D. The identification of conditions under which nurses may refuse work assignments without jeopardizing the quality of patient care;

E. A survey of the staffing of the system for the delivery of health care in Nevada that is required by: (1) the Bureau of Licensure and Certification (BLC); (2) the Health Division; (3) the Joint Commission on Accreditation of Health Care Organizations; and (4) any other state or Federal law concerning medical facilities or other organization that provide organized nursing services;

F. A comprehensive evaluation of the practices of recruitment and retention of staff that are used by medical facilities and other organizations that provide nursing services;

G. Recommendations regarding staffing of the system for the delivery of health care in Nevada; and

H. A comprehensive evaluation of any disaster or emergency situations that would not be covered in any recommendations for the staffing of the system for the delivery of health care.

Further, the A.B. 313 Subcommittee was required to collaborate with a statewide advisory group consisting of members from higher education, along with certain health care associations and interest groups. This section briefly provides background regarding the recommendations from the Subcommittee adopted by the Legislative Committee on Health Care:

The A.B. 313 Subcommittee met three times and consisted of three members all of whom were members the Legislative Committee on Health Care. The Subcommittee heard formal presentations, staff reports, and public testimony regarding a system for the delivery of health care in Nevada (See Appendix D).

The following text summarizes key discussion points concerning the objectives. The objectives as noted above parallel the subsections of Section 1 as identified in A.B. 313 (i.e., Objective (a) is the same as Paragraph (a), Subsection 1, Section 1 of A.B. 313).

Objective (a)

Objective (a) required consideration of existing research concerning health workforce issues. This objective addressed general health workforce issues as well as issues specifically related to nurses.

General Health Workforce Issues

The following information is compiled from data presented by the Center for Health Workforce Studies (CHWS), School of Public Health, and State University of New York, New York. The data illustrates the following facts in relation to a nationwide shortage of health professionals:

Type of Health Professional	Rate of Shortage
Registered Nurses	86 percent
Pharmacists	68 percent
Certified Nurse Aides	66 percent
Home Health Aides	60 percent
Radiology Technologists	56 percent
Dentists	52 percent
Other	44 percent

Testimony further provided the following statistics concerning the percentage of hospitals that report more difficulty recruiting by profession for the periods 1999-2001.

Type of Health Professional	Rate of Difficulty Recruiting
Registered Nurses	82 percent
Imaging Technicians	68 percent
Pharmacists	53 percent
Lab Technicians	46 percent
Licensed Practical Nurses	40 percent
Billers/Coders	40 percent
Nursing Assistants	34 percent
Housekeeping Personnel	20 percent
Information Technology Technicians	13 percent

Testimony indicated the workforce directly impacts quality, cost, and access issues. Further, "system wide high turnover, difficulty recruiting, and worker dissatisfaction are signs of a systemic problem."

Citing Nevada's population growth rate it was noted that the state has an increasing number of persons over the age of 65, the highest rate of death due to firearms in the country in 1999, and was above the national rates of death due to cancer and heart disease. In addition, in 2000, Nevada had the fewest health workers per capita in the country (2,788 per 100,000 people versus 4,030 per 100,000 people nationally).

In terms of the distribution of the state's health workforce, the following points were made:

Where Employed	Nevada	U.S.
Offices and Clinics	42 percent	28 percent
Hospitals	33 percent	43 percent
Nursing and Personal Care Facilities	11 percent	17 percent
Home Health Services	5 percent	6 percent
Medial and Dental Laboratories	4 percent	2 percent
Other	5 percent	4 percent

Representatives of CHWS noted that in 2000, the median hourly wage of many of Nevada's health professionals was higher than the national average. The following table illustrates wages in Nevada compared to the United States:

Type of Professional	Nevada	U.S.
Registered Nurses	$24.25	$21.56
Licensed Practical Nurses	$16.27	$14.15
Pharmacists	$37.96	$34.11
Physical Therapists	$29.38	$26.35
Occupational Therapists	$25.99	$23.77
Radiologic Technologists	$20.05	$17.31

The following points discuss physicians in the state:

- There were over 3,200 active patient care physicians in Nevada in 2000.
- Nevada ranked 43rd among states in physicians per 100,000 population, with 159 physicians per capita in 2000, compared to the national rate of 198 physicians per capita.
- Nevada had 55 active primary care physicians per 100,000 population, compared to 69 per capita for the entire country.
- In 2000, Nevada graduated 53 new physicians.
- On a per capita basis, Nevada ranked 42nd among the 46 states with medical schools in graduates per capita in 2000.

In terms of nurses:

- There were more than 12,900 licensed R.N.s in Nevada in 2000.
- Nearly 80 percent of Nevada's licensed R.N.s in 2000 were employed in nursing.
- Nevada ranked last among states in R.N.s per 100,000 people with 514.4, compared to the national rate of 780.2.
- Nevada was among states with the lowest per capita rates of nurse practitioners, certified nurse midwives, and nurse anesthetists in the country.

Additionally, the following table illustrates the aging of selected professionals in the health workforce:

Type of Health Professional	Median Age		Percent Change
	1989	1999	
Dentists	40.7	44.0	3.3
Dietitians	38.8	40.0	1.7
Health Records Technologists and Technicians	35.3	40.3	5.0
Radiologic Technicians	34.3	38.0	3.7
Registered Nurses	37.3	42.7	5.4
Respiratory Therapists	32.3	38.0	5.7
Social Workers	38.7	40.3	1.7
Speech Therapists	35.7	40.7	5.0
Pharmacists	36.7	41.3	4.6
Total Civilian Labor Force	35.7	38.7	3.0

Further data concerning the diversity of the workforce was presented, and it was noted that the following workplace factors contribute to health workforce shortages:

- Physically and emotionally demanding work;
- Non-competitive wages and benefits;
- Poor job design and working conditions;
- Too much paperwork and lack of information systems; and
- Poorly trained managers.

The following responses to workforce shortages were specified.

- Expand the "pipeline" by implementing education and training strategies, which is a "supply side" strategy;
- Improve retention by using job related strategies, which is also a supply side strategy; and
- Reduce the number of people needed by improving productivity and reducing paperwork, which is a "demand side" strategy.

In addition, the following options as fulfilling the "supply side" strategy were noted:

- Scholarships and loan repayment;
- Grants for faculty, capacity expansion, or program start up;
- High school health careers awareness;
- Marketing health careers/public service announcements;
- Promote health provider and education partnerships; and
- Use Labor Department and other training funds.

The following points were further noted as being ways to increase supply by improving retention and job related strategies:

- Reimbursement support for higher wages/benefits;
- Support for career ladders;
- Best practices conferences on job design and retention;
- Prohibit mandatory overtime; and
- Mandate minimum staffing ratios.

In terms of modifying demand and improving productivity, the following strategies were noted:

- Study factors that promote efficient care;
- Conduct demonstrations and evaluation of job redesign;
- Conduct best practices conferences on efficient and productive care;
- Implement regulatory changes concerning scope of practice issues and use of workers;

- Modify health facility requirements and regulations; and
- Promote labor-saving technology.

Finally, the following other responses to health workforce shortages, were indicated:

- Develop better data collection and needs assessments;
- Establish task forces, commissions, and committees to discuss and make recommendations concerning the issues;
- Use immigration; and
- Provide support for the families and informal care givers of patients.

Considerations Related to Nursing

The following demonstrates data presented by the Center for California Health Workforce Studies (CCHWS), University of California, San Francisco, California. The CCHWS presented research related to nursing and quality of care. According to testimony presented by a representative of CCHWS, evidence suggests that an increase in nurse staffing is related to decreases in risk-adjusted mortality, nosocomial infection rates, thrombosis, and pulmonary complications in surgical patients, pressure ulcers, readmission rates, and failure to rescue. There is additional evidence that a higher ratio of registered nurses (R.N.s) to residents in long-term care facilities has positive effects for the patients.

Testimony further noted that high workload and poor staffing ratios are associated with nurse burnout, low job satisfaction, and increased nurse stress. Nurse stress is related to adverse patient events, nurse injuries, quality of care, and patient satisfaction.

It was emphasized that "no study identifies the 'ideal' staffing ratio," and there are limits to all of the research that has been done. Additional comments indicated that there are various ways in which staffing in medical facilities can be measured, and the following staffing statistics, highlighting that "Nevada's average staffing is above the national median" were noted:

State	Number of Hospitals	R.N. Hours Per Patient Day	R.N.+ Licensed Practical Nurse Hours Per Patient Day
New Mexico	60	9.14	11.15
Arizona	91	7.27	9.67
Oregon	68	7.47	8.14
Nevada	**32**	**6.05**	**7.31**
Colorado	83	6.13	7.02

State	Number of Hospitals	R.N. Hours Per Patient Day	R.N.+ Licensed Practical Nurse Hours Per Patient Day
California	488	5.91	7.02
Idaho	47	5.10	6.50
Montana	61	3.64	4.62
U.S.	**6,299**	**5.32**	**6.63**

The different approaches to staffing standards were discussed, which include the following types: (1) patient acuity/patient classification systems; (2) fixed ratios; (3) formula-based ratios; and (4) skill-mix requirements. It was further indicated that there are various problems with each type of system.

Finally, a representative of CCHWS indicated that the solution is more funding for hospitals and an increase in nurses within the labor market.

Nevada's Health Workforce Development and Education Issues

As part of its activities, the Subcommittee determined a need to consider education and training issues in Nevada. In meeting this activity, the Subcommittee received a presentation from representatives of the UCCSN. These representatives noted that an ad hoc Health Education Committee of the Board of Regents had been formed whose purpose was to:

1. Oversee the plan to double the capacity of the UCCSN's nursing programs;

2. Review and make recommendations concerning the School of Medicine's proposal to restructure its Practice Plans;

3. Consider and make recommendations concerning the development of an Academic Medical Center;

4. Review and make recommendations regarding existing health care programs in the UCCSN; and

5. Consider new programs and structures that may be needed to meet the state's needs.

The Health Education Committee also compiled a list of Health and Allied Health Programs by institution and degree level. The Health Education Committee will compare this list to employment data prepared by the Department of Employment, Training and Rehabilitation to better understand the training programs that should be provided by the UCCSN.

Objective (b)

Objective (b) sought to evaluate Nevada's current requirements for staffing the health care delivery system. Two presentations discussed this issue.

Staffing Standards in Nevada

Key points of the presentation concerning staffing standards in Nevada, were given by representatives of the BLC. They include the following bulleted points:

- Regulations governing staffing in medical facilities in Nevada were revised in 1999 after a 4-year discussion and review process. Members of the State Board of Health considered whether to require specific ratios for nurses to patients, but its members chose not to do so. One of the reasons given for not requiring specific ratios was the issue of hospital emergency room diversions. Consequently, existing regulations in Nevada for medical facilities do not require established ratios of nurses to patients. The standards are based on an acuity system that requires sufficient nursing staff to meet the needs of the patients.
- Citing components as established by the American Nurses Association, the state's acuity system requires facilities to consider: (a) the number of patients; (b) the levels of intensity of the patients for whom care is being provided; (c) the architecture and geography of the environment as well as available technology; and (d) the level of preparation and experience of the nurses on a particular unit.
- Skilled nursing facilities (SNFs), also known as "nursing homes" underwent a regulatory change in 1999. These facilities also are required to staff on an acuity basis, but the state's regulations require SNFs to have an R.N. on duty at least 8 consecutive hours per day, 7 days a week. Most SNFs choose to staff with an R.N. 24 hours per day, 7 days a week. The BLC may attempt to change the current regulatory standards for SNFs from 8 hours per day, 7 days per week to 24 hours per day, 7 days per week. Pursuant to federal regulations, SNFs are required to post the number of licensed and unlicensed nursing staff directly responsible for resident care.
- A patient's assessment ultimately determines whether care will be administered by a licensed practical nurse, R.N., or CNA.

Discussion before the Subcommittee indicated that there is a perception that facilities do not assess patients for acuity but rather assignments are made in another manner. Testimony indicated that the BLC will investigate such complaints through unannounced site visits and examinations of staffing requirements and managers' schedules. Further, the BLC is aware that some hospitals in Nevada cannot staff according to the established acuity standards. The BLC attempts to work with these facilities, and some of them may be sanctioned for noncompliance. However, the BLC has limited resources to enforce the acuity standards.

The general conclusion indicted that there is a lack of quality data concerning whether the acuity staffing requirements are being met by facilities in the state. In addition, there may be a lack of resources for enforcement of the standards.

Staffing Requirements of Joint Commission on Accreditation of Healthcare Organization (JCAHO) Accredited Facilities

Representatives of JCAHO testified regarding the standards for JCAHO accredited facilities. Testimony emphasized that JCAHO accreditation is a voluntary process. Additionally it was noted, the organization has changed its philosophy from one that encourages facilities to prepare for surveys to "one of continuous systematic and operational improvement focused on safe, high quality care, treatment, and services." Further, the JCAHO incorporates surveys, screenings, data and trend analysis, evaluation, et cetera, to assist its member organizations. These representatives noted that the essential connection between accreditation and quality improvement is an accurate system of accountability.

These presenters stated that staffing standards are complex, dynamic, and unique to each facility, and staffing ratios cannot be applied universally. Finally, they noted that hospital quality reports will be available to the public later in 2004 on JCAHO's Internet Web site. Information on this Web site will include hospital performance data in a variety of areas.

Representatives of JCAHO concluded their testimony by referencing a white paper titled *Health Care at the Crossroads: Strategies for Addressing the Evolving Nursing Crisis*, in which three recommendations are made and developed in the paper to address the nursing shortage. These recommendations are:

1. **Create Organizational Cultures of Retention**: Adopt the characteristics of "Magnet" hospitals to foster a workplace that empowers and is respectful of nursing staff. Provide management training, as well as support, to nurse executives. Positively transform nursing work through the use of information and ergonomic technologies. Set staffing levels based on nurse competency and skill mix relative to patient mix and acuity. Adopt zero-tolerance policies for abusive behaviors by health care practitioners. Diversify the nursing workforce to broaden the base of potential workers.

2. **Bolster the Nursing Educational Infrastructure**: Increase funding for nursing education, including endowments, scholarships and federal appropriations. Establish a standardized, post-graduate nursing residency program. Emphasize team-training in nursing education. Enhance support of nursing orientation, in-service, and continuing education in hospitals. Create nursing career ladders commensurate with educational level and experience.

3. **Establish Financial Incentives for Investing in Nursing**: Make new federal monies available for health care organizations to invest in nursing services. Condition continued receipt of these monies on achievement of quantifiable, evidence-based, and

standardized nursing sensitive goals. Align private payer and federal reimbursement incentives to reward effective nurse staffing.

Staffing Requirements in Other States

A representative of the National Conference of State Legislatures (NCSL) provided testimony concerning staffing requirements in other states and made the following relevant points:

- According to the 2000 National Sample Survey performed by the Federal government, the supply of nurses throughout the country varies considerably, and Nevada is more than 10 percent below average of employed nurses per 100,000 population. Nevada has 520 nurses per 100,000 patients as compared to the national average of 782 nurses per 100,000 patients. The nation's southwest region ranks consistently lower than the rest of the U.S.

- Most employers perceive newly licensed R.N.s as not fully prepared for basic practice setting tasks. In a 2001 Employer Survey conducted by the National Council of State Boards of Nursing, employers reported that 43 percent of R.N.s can adequately administer medication by common routes. Conversely, only 11 percent were able to respond adequately to emergency situations; 13 percent were able to supervise care provided by others; and 19 percent were able to perform psychomotor skills and recognize abnormal diagnostic lab findings. Further, employers perceive newly licensed R.N.s are not fully prepared for basic practice setting tasks. Finally, there is a significant turnover rate within the first two years of hire of Baccalaureate and associate degree nurses, but few employers have a preference for certain types of educational preparation when hiring new nurses.

- National hospital nurse vacancies in 2002 are on average 13 percent to 15 percent less than the 2001 vacancy rate. This is due to increased hiring of nurses aged 50 years or older and nurses who are trained overseas. National nursing home vacancies have risen sharply during this same time span.

- Thirty-seven states have enacted legislation that supplements minimum federal staffing standards for nursing homes; at least 15 states have enacted or considered limiting mandatory overtime; 11 states have strengthened R.N. supervisory responsibility for CNAs; and over 20 states have established statewide efforts concerning statewide nursing workforce commissions, including data centers.

- To address the nursing shortage and fully understand the problem and the needs and changes in supply and demand, states have enhanced their statewide data collection and analysis activities. States indicate that data collection efforts are relatively low-cost solutions to this issue.

- States have increased their efforts in regard to funding educational opportunities, and they are now considering workplace issues.

- Issues with staffing include: (1) patient acuity; (2) intensity and quality of patient care; (3) volume of care and demand for patient care staff; (4) appropriate supply and skill/degree mix of staff; (5) staff vacancy/turnover rate and wage competition; (6) the growing presence and power of nurse unions; (7) training capacity of area nursing schools and preparedness of graduates to "hit the ground running"; (8) staff costs and financial condition of health care institutions; (9) staff role in organizational decision-making; and (10) staff leadership capability and skills.

- Nurse job dissatisfaction due to poor working conditions is one part of why nurses are vacating the profession. There are other factors driving the exodus, including: (1) changes in the lifestyles and physical conditions of nurses; (2) desires to spend more time at home; (3) opportunities for salary changes and adjustments in other places; and (4) increasing requirements for retraining.

- Issues to consider in implementing nurse staffing ratios include: (1) outcomes of patient care; (2) availability of nurses to meet ratios; and (3) hiring a quality skill mix of R.N.s could result in shortages in other care giving staffing.

Objective (c)

Objective (c) was an evaluation of the required methods of record keeping by facilities. In discussing the types of presentations that would meet this objective, there was concern about records that are required to be kept and whether such records should be available to the public for review. The purpose of the review would be that the public is able to compare quality criteria between facilities. There is also a general concern that nurses, in particular, are overburdened by recordkeeping requirements, and the assessment of records might determine whether some records have outlived their usefulness.

In the presentation concerning staffing requirements in Nevada, the BLC's representative included information identifying medical records that must be kept by medical facilities. Notably, the types of records that must be kept are those records that are essential to assessing a patient, developing a care plan for a patient, and discharging the patient. The specific types of information required in a medical record of a patient for a hospital in the state are found at *Nevada Administrative Code (*NAC) 449.379, "Medical records." In particular, Subsection 8 of this regulation states:

> 8. All medical records must document the following information, as appropriate:
>
> (a) Evidence that a physical examination, including a history of the health of the patient, was performed on the patient not more than 7 days before or more than 48 hours after his admission into the hospital.
>
> (b) The diagnosis of the patient at the time of admission.
>
> (c) The results of all consultative evaluations of the patient and the appropriate findings by clinical and other staff involved in caring for the patient.

(d) Documentation of any complications suffered by the patient, infections acquired by the patient while in the hospital and unfavorable reactions by the patient to drugs and anesthesia administered to him.

(e) Properly executed informed consent for all procedures and treatments specified by the medical staff, or federal or state law, as requiring written patient consent.

(f) All orders of practitioners, nursing notes, reports of treatment, records of medication, radiology and laboratory reports, vital signs and other information necessary to monitor the condition of the patient.

(g) A discharge summary that includes a description of the outcome of the hospitalization, disposition of the case and the provisions for follow-up care that have been provided to the patient.

(h) The final diagnosis of the patient.

Although this information must be documented in the patient's medical record, the format of the actual paper records may vary between facilities, and this information is not reported in a systematic manner to any agency in the state.

Additionally, as noted in preceding text, staffing plans of facilities also are not standardized among facilities. Facilities are only required to have a staffing plan. When the BLC conducts surveys of facilities, the surveyor will request the facility's staffing plan and verify the requirements of the plan against the manager's reports. There is no established system in the state that tracks staffing ratios.

During a meeting of the Advisory Committee to the A.B. 313 Subcommittee, a representative of the BLC indicated that all facilities are required to keep records to demonstrate compliance with the NAC; however, facilities do not have to make their records public. Consequently, records that might provide details about deaths, infection rates, or other incidences at medical facilities are not available for the sake of comparing one facility to the next.

Nevada does have a Cost Containment Unit in the Division of Health Care Financing and Policy, DHR. This unit receives quarterly reports from Nevada hospitals that are available for public review. The data includes financial reports, utilization reports, selected audit reports, budget reports, and Medicare and Medicaid cost reports. Additionally, anyone can request patient discharge data from the unit's contractor, which is the Center for Health Information Analysis, University of Nevada, Las Vegas. There is a fee for data requests from these two entities.

Finally, at the final meeting of the A.B. 313 Subcommittee, there was a discussion about Pennsylvania's reporting system as it relates to hospital performance.

Objective (d)

The purpose of Objective (d) was to identify the conditions under which nurses may refuse work assignments without jeopardizing the quality of patient care. Lengthy testimony was provided to the A.B. 313 Subcommittee concerning this issue, and the discussion was largely a

debate as to whether a nurse who refuses an assignment would face retaliation or termination from his or her job for refusing the assignment. There also was general discussion about the consequences a nurse would face from the licensing board if he or she refused an assignment that jeopardized patient care. However, except for this discussion by the board, no specific criteria concerning the conditions under which a nurse could refuse an assignment were set forth in this regard.

A representative of the State Board of Nursing provided the following information as a guideline for nurses to use to ensure safe patient care and compliance with the *Nurse Practice Act*:

> **How can nurses protect their patients and protect their licenses?** Prevention and early intervention are always a place to start. Nurses should know the laws and regulations that govern their practice and clearly understand what constitutes a violation of the *Nurse Practice Act*. For example, nurses may be told that refusing to accept an assignment is "wrongful abandonment," but in fact, the *Nurse Practice Act* cites three conditions that must exist before such an action would be considered abandonment by the Board.
>
> Specifically, according to NAC 632.895(6):
>
> "An act of patient abandonment occurs if:
>
> (a) A licensee or holder of a certificate has been assigned and accepted a duty of care to a patient;
>
> (b) The licensee or holder of a certificate departed from the site of the assignment without ensuring that the patient was adequately cared for; and
>
> (c) As a result of the departure, the patient was in potential harm or actually harmed."
>
> **Evidence of all three conditions must be shown before the Board may consider disciplinary action against a nurse for patient abandonment.** (During fiscal year 2002-2003, one complaint met this legal requirement and resulted in disciplinary action against the nurse. The nurse left her shift after being on duty for a few hours, did not have permission to leave, and did not give [a] report on her patients to anyone before leaving. In other words, she met all three legal criteria for patient abandonment.)
>
> **Also, nurses may be disciplined if they accept assignments they are not competent to perform.** If they do, they may place the patient in danger, and they [a]re in violation of the *Nurse Practice Act* (NAC 632.890(4), assuming duties and responsibilities within the practice of nursing if competency is not maintained, or the standards of competence are not satisfied, or both.)

It should be noted that the Board has no jurisdiction over employment or contract issues. Well-intentioned nurses may feel like they [a]re in a "Catch 22," where if they practice in accordance with the law, they will keep their licenses but lose their jobs. Unfortunately, sometimes leaving a position is the only option. Here are some things to consider—

- Place patient safety and well-being first. Act in good faith.
- Know the laws and regulations that govern your practice.
- Build a defense for why an action (or act of omission) was unavoidable. Document carefully. Be able to demonstrate that the course of action was what would have been followed in a similar situation by a reasonable and prudent nurse with similar education and experience.
- Continue to advocate for safe nursing care for patients.

As noted in the opening paragraph of this section, the other discussion on this issue was a debate concerning whether a nurse would face retaliation or termination from his or her job if he or she chooses to refuse an assignment. Facilities with union protections have avenues in place for a nurse to document an unsafe assignment by using something called an "Assignment Despite Objection" form, but nurses who work at facilities without union representation do not have these options.

One presenter stated that the issue of refusing an assignment is directly related to the retention crisis as both are rooted in the problem of inadequate and dangerous short staffing. If a facility is not fully staffed with the appropriate mix of personnel, the remaining nurses must pick up the patient load without regard to their abilities to do so. This presenter noted that the current acuity system is inadequate, is ignored, and is not enforced.

The conclusion was that there are no avenues outside of the employment setting for a nurse to take his or her case if he or she is demoted, downgraded on an employment evaluation, denied a raise or promotion, or terminated from his or her position within a facility. Further, the current acuity system is inadequate and does not protect patients, and a new method of staffing medical facilities is required to ensure safe patient care.

Objective (e)

Objective (e) required that the study include a survey of the staffing of the system for the delivery of health care in Nevada that is required by the BLC, Health Division, the Joint Commission on Accreditation of Health Care Organizations, and any other state or Federal law concerning medical facilities or other organization that provide organized nursing services. The requirements of Objective (e) were met by the presentations made in Objective (b). Therefore, no additional testimony was provided specific to this objective.

Objective (f)

Objective (f) required an evaluation of the recruitment and retention practices of staff in medical facilities. Members of the A.B. 313 Subcommittee heard numerous presentations about recruitment and retention issues. These issues are discussed in subsequent text.

Recruitment Issues

In terms of recruitment issues, testimony indicted that there are many activities ongoing in Nevada to recruit health professionals, and a substantial sum of money is spent recruiting nurses to the state. In particular, many incentive programs are created to encourage students to train as nurses, including training programs while students are still in high school, and many scholarships and loan forgiveness programs exist for students to access. For nurses who have graduated, facilities offer various cash incentive programs, and they encourage nurses to continue their educations.

Finally, it was indicated that there is general support for the efforts to double the number of nurses who are trained in Nevada. This support is evidenced in a statement by the Advisory Committee to the A.B. 313 Subcommittee at its March 17, 2004, meeting.

Retention Issues

In terms of retention issues, however, testimony indicated that there are divergent opinions as to what activities and strategies should be undertaken to address this issue. There also are conflicting data concerning turnover rates at facilities in Nevada and whether current retention efforts are working in the state's facilities.

In dealing with the issue of strategies to retain nurses, the following data from a 2000 survey conducted by the Nevada Hospital Association, which illustrates why nurses leave Nevada hospitals was noted:

Reason Cited For Leaving	Percent
Moving/relocating	20 percent
Personal/family issues	20 percent
Other employment opportunities	15.7 percent
Staffing concerns	15.7 percent
Pay/benefits	11.4 percent
Retirement	8.6 percent
Offer from another facility	7.1 percent

Using this data, the following observations were made:

- It would be logical for this [S]ubcommittee to address nurse staffing as its primary area of attention relating to nurse retention. Increasing retention would increase staffing and increased staffing would encourage retention.

- Although the BLC maintains that there is an appropriate staffing system in place, acuity based staffing confidence of many nurses in this system is lagging. It was emphasized that many nurses believe that system is not being used, or is at best a paperwork exercise to satisfy state surveyors. It was argued that something more definitive and enforceable such as minimum staffing ratios is both desirable and necessary. Testimony indicated that this would provide for increased patient safety as well as increasing the satisfaction of bedside nurses in their work settings, thus enhancing nurse retention. It was further emphasized that the NCSL estimates that the cost of such a program would be a rise of less than 2 percent in per-hospital nursing expenditures.

Other testimony advocated for minimum staffing ratios as ways to retain nurses. Testimony cited current statistics of nursing graduates as well as license endorsements as evidence that there are enough nurses in the state, but these nurses simply choose not to practice in hospital settings in the state. Further, testimony cited a study titled "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction," which was published in the *Journal of the American Medical Association* (Vol. 288, No. 16, pp. 1987-1993, October 23/30 2002). This study had the following findings:

- After adjusting for patient and hospital characteristics, each additional patient per nurse was associated with a 7 percent (odds ratio, 1.07; 95 percent confidence interval, 1.03-1.12) increase in the likelihood of dying within 30 days of admission and a 7 percent (odds ratio, 1.07; 95 percent confidence level, 1.02-1.11) increase in the odds of failure-to-rescue.

- After adjusting for nurse and hospital characteristics, each additional patient per nurse was associated with a 23 percent (odds ratio, 1.23; 95 percent confidence interval, 1.13-1.34) increase in the odds of burnout and a 15 percent (odds ratio, 1.15; 95 percent confidence interval, 1.07-1.25) increase in the odds of job dissatisfaction.

These results formed the conclusion of the study, which is:

> In hospitals with high patient-to-nurse ratios, surgical patients experience higher risk-adjusted 30-day mortality and failure-to-rescue rates, and nurses are more likely to experience burnout and job dissatisfaction.

In discussing the study findings and conclusions, the authors made the following points:

> . . . all else being equal, substantial decreases in mortality rates could result from increasing registered nurse staffing, especially for patients who develop complications. (p. 1991)

> Our results suggest that the California hospital nurse staffing legislation represents a credible approach to reducing mortality and increasing nurse retention in hospital practice, if it can be successfully implemented. Moreover, our findings suggest that California officials were wise to reject ratios favored by hospital stakeholder groups of 10 patients to each nurse on medical and surgical general units in favor of more generous staffing

requirements of 5 to 6 patients per nurse. Our results do not directly indicate how many nurses are needed to care for patients or whether there is some maximum ratio of patients per nurse above which hospitals should not venture. Our major point is that there are detectable differences in risk-adjusted mortality and failure-to-rescue rates across hospitals with different registered nurse staffing ratios. (p. 1992)

Our results further indicate that nurses in hospitals with the highest patient-to-nurse ratios are more than twice as likely to experience job-related burnout and almost twice as likely to be dissatisfied with their jobs compared with nurses in the hospitals with the lowest ratios. This effect of staffing on job satisfaction and burnout suggests that improvements in nurse staffing in California hospitals resulting from the new legislation could be accompanied by declines in nurse turnover. We found that burnout and dissatisfaction predict nurses' intentions to leave their current jobs within a year. Although we do not know how many of the nurses who indicated intentions to leave their jobs actually did so, it seems reasonable to assume that the 4-fold difference in intentions across these 2 groups translated to at least a similar difference in nurse resignations. If recently published estimates of the costs of replacing a hospital medical and surgical general unit and a specialty nurse of $42,000 and $64,000, respectively, are correct, improving staffing may not only save patient lives and decrease nurse turnover but also reduce hospital costs. (p. 1992)

Our findings have important implications for [two] pressing issues: patient safety and the hospital nurse shortage. Our results document sizable and significant effects of registered nurse staffing on preventable deaths. The association of nurse staffing levels with the rescue of patients with life-threatening conditions suggests that nurses contribute importantly to surveillance, early detection, and timely interventions that save lives. The benefits of improved registered nurse staffing also extend to the larger numbers of hospitalized patients who are not at high risk for mortality but nevertheless are vulnerable to a wide range of unfavorable outcomes. Improving nurse staffing levels may reduce alarming turnover rates in hospitals by reducing burnout and job dissatisfaction, major precursors of job resignation. When taken together, the impacts of staffing on patient and nurse outcomes suggest that by investing in registered nurse staffing, hospitals may avert both preventable mortality and low nurse retention in hospital practice. (p. 1993)

Testimony concluded that the solution to bringing nurses back to hospitals is minimum nurse staffing ratios. Others testified making similar recommendations with the final speaker presenting on this issue stating:

When hospitals offer nurses good pay, good benefits, professional respect, and staffing ratios conducive to quality care, then more nurses will stay and the shortage will wither away.

Testimony provided noted that assignments at the beginning of a shift are more likely to be based on patient acuity and with a reasonable number of patients, but:

. . . reasonableness and safety fly out the window over the course of a nurse's shift. The patients are rolled in, assigned to a nurse in a flurry of activity, and questions of acuity are

left perhaps for the charge nurse to consider when she prepares her assignments for the next shift.

What can the [L]egislature do to protect patient safety at that moment in time, in the middle of a nurse's shift when that other patient is assigned, and when no single ratio or standard can possibly tell us what is the right thing to do?

For me, part of the answer must lie in respect for the professional judgment of the licensed nurse. We urgently need legislation that allows the nurse to refuse what he or she considers to be an unsafe assignment, and he or she must be able to do so without putting her job at risk.

Objective (g)

Objective (g) is simply a restatement of recommendations that have been made to the Subcommittee. Because one other criterion required study, this objective will be restated following discussion of the next objective.

Objective (h)

Objective (h) required a consideration of staffing during emergencies. In meeting this objective, the Subcommittee received a presentation and recommendations from the Director of Hospital Preparedness for the Nevada Hospital Association.

Notably, this speaker stated that staffing ratios are not feasible during medical emergencies and special circumstances such as terrorist acts or natural disasters. The speaker made the following three recommendations:

Exempt disaster and emergency situations from recommended staffing models because of the potential for local health care resources to be overwhelmed.

Require the Health Division in establishing staffing levels to evaluate the actual acuity and patient care requirements during a disaster or emergency with mass casualties, not just the number of patients alone.

Waive licensing requirements, various scopes of practices, and the use of nontraditional care centers during any large-scale, catastrophic event. (NOTE: NRS 632.340(3) allows for nursing assistance in the case of an emergency.)

Based on testimony presented on all of the areas discussed, members agreed to draft a letter:

To the president of the Nevada Organization of Nurse Leaders urging the organization and its nurse executive members to open the lines of communication with nurses who provide direct patient care. The letter should encourage nurse managers to be receptive to requests for assistance from nurses who provide patient care when such nurses request assistance with their respective work loads during a shift.

Additionally, the Committee agreed to support:

The establishment of a statewide office within the UCCSN that would collect and analyze health workforce data. In conjunction with the establishment of the office, the Committee supports the suggestion by the UCCSN to create an advisory committee comprised of legislators, representatives of the state's licensing boards, individuals involved with education and training of health professionals in the state, and other stakeholders to direct the work of the office.

Consideration by administrators and managers of hospitals in Nevada to limit the ability of traveling nurses to be responsible for staffing assignments.

IV. CONCLUSION

This report presents a summary of the bill draft that was requested by Committee members for discussion before the 2005 Nevada Legislature. In addition, the report provides information identifying certain other issues that were addressed during the interim. Persons wishing to have more specific information concerning these documents may find it useful to review the meeting minutes and exhibits for each of the meetings of the Committee.

VI. APPENDICES

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APPENDIX A

Nevada Revised Statutes 439B.200, Legislative Committee On Health Care

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

1. There is hereby established a Legislative Committee on Health Care consisting of three members of the Senate and three members of the Assembly, appointed by the Legislative Commission. The members must be appointed with appropriate regard for their experience with and knowledge of matters relating to health care.

2. No member of the Committee may:

(a) Have a financial interest in a health facility in this state;

(b) Be a member of a board of directors or trustees of a health facility in this state;

(c) Hold a position with a health facility in this state in which the Legislator exercises control over any policies established for the health facility; or

(d) Receive a salary or other compensation from a health facility in this state.

3. The provisions of subsection 2 do not:

(a) Prohibit a member of the Committee from selling goods which are not unique to the provision of health care to a health facility if the member primarily sells such goods to persons who are not involved in the provision of health care.

(b) Prohibit a member of the Legislature from serving as a member of the Committee if:

(1) The financial interest, membership on the board of directors or trustees, position held with the health facility or salary or other compensation received would not materially affect the independence of judgment of a reasonable person; and

(2) Serving on the Committee would not materially affect any financial interest he has in a health facility in a manner greater than that accruing to any other person who has a similar interest.

4. The Legislative Commission shall select the Chairman and Vice Chairman of the Committee from among the members of the Committee. Each such officer shall hold office for a term of 2 years commencing on July 1 of each odd-numbered year. The chairmanship of the Committee must alternate each biennium between the houses of the Legislature.

5. Any member of the Committee who does not return to the Legislature continues to serve until the next session of the Legislature convenes.

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

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

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

APPENDIX B

Self Directed Care Data Presented at the August 4, 2004, Work Session
of the Legislative Committee on Health Care
(Tab C of the Work Session Document)

NRS 629.081 Conditions under which person who observes rendering of care by practitioner of healing art is immune from civil action. A person who is present solely to improve his own personal skill or knowledge by observing the rendering of care by a practitioner of a healing art is immune from any civil action for damages arising from the alleged negligent rendering of that care if he does not participate in any way in the rendering of that care and is not compensated for that care.

(Added to NRS by 1985, 1891)

WEST PUBLISHING CO.
Physicians and Surgeons ⇐ 18.80(5).
WESTLAW Topic No. 299.

C.J.S. Physicians, Surgeons, and Other Health-Care Providers §§ 97 to 100, 121.

NRS 629.091 Personal assistant authorized to perform certain services for person with physical disability if approved by provider of health care; requirements.

1. Except as otherwise provided in subsection 4, a provider of health care may authorize a person to act as a personal assistant to perform specific medical, nursing or home health care services for a person with a physical disability without obtaining any license required for a provider of health care or his assistant to perform the service if:

(a) The services to be performed are services that a person without a physical disability usually and customarily would personally perform without the assistance of a provider of health care;

(b) The provider of health care determines that the personal assistant has the knowledge, skill and ability to perform the services competently;

(c) The provider of health care determines that the procedures involved in providing the services are simple and the performance of such procedures by the personal assistant does not pose a substantial risk to the person with a physical disability;

(d) The provider of health care determines that the condition of the person with a physical disability is stable and predictable; and

(e) The personal assistant agrees with the provider of health care to refer the person with a physical disability to the provider of health care if:

(1) The condition of the person with a physical disability changes or a new medical condition develops;

(2) The progress or condition of the person with a physical disability after the provision of the service is different than expected;

(3) An emergency situation develops; or

(4) Any other situation described by the provider of health care develops.

2. A provider of health care that authorizes a personal assistant to perform certain services shall note in the medical records of the person with a physical disability who receives such services:

(a) The specific services that he has authorized the personal assistant to perform; and

(b) That the requirements of this section have been satisfied.

3. After a provider of health care has authorized a personal assistant to perform specific services for a person with a physical disability, no further authorization or supervision by the provider is required for the continued provision of those services.

4. A personal assistant shall not:

(a) Perform services pursuant to this section for a person with a physical disability who resides in a medical facility.

(b) Perform any medical, nursing or home health care service for a person with a physical disability which is not specifically authorized by a provider of health care pursuant to subsection 1.

5. A provider of health care who determines in good faith that a personal assistant has complied with and meets the requirements of this section is not liable for civil damages as a result of any act or omission, not amounting to gross negligence, committed by him in making such a determination and is not liable for any act or omission of the personal assistant.

6. As used in this section:

(a) "Personal assistant" means a person who, under the direction of a person with a physical disability and for compensation, performs services for the person with a physical disability to help him maintain his independence, personal hygiene and safety.

(b) "Provider of health care" means a physician licensed pursuant to chapter 630, 630A or 633 of NRS, a dentist, a registered nurse, a licensed practical nurse, a physical therapist or an occupational therapist.

(Added to NRS by 1995, 749)

NRS 629.095 Commissioner of Insurance to develop standardized form for use by insurers and other entities to obtain information related to credentials of certain providers of health care.

1. Except as otherwise provided in subsection 2, the Commissioner of Insurance shall develop, prescribe for use and make available a single, standardized form for use by insurers, carriers, societies, corporations, health maintenance organizations and managed care organizations in obtaining any information related to the credentials of a provider of health care.

2. The provisions of subsection 1 do not prohibit the Commissioner of Insurance from developing, prescribing for use and making available:

(a) Appropriate variations of the form described in that subsection for use in different geographical regions of this state.

(b) Addenda or supplements to the form described in that subsection to address, until such time as a new form may be developed, prescribed for use and made available, any requirements newly imposed by the Federal Government, the State or one of its agencies, or a body that accredits hospitals, medical facilities or health care plans.

3. With respect to the form described in subsection 1, the Commissioner of Insurance shall:

(a) Hold public hearings to seek input regarding the development of the form;

(b) Develop the form in consideration of the input received pursuant to paragraph (a);

(c) Ensure that the form is developed in such a manner as to accommodate and reflect the different types of credentials applicable to different classes of providers of health care;

(d) Ensure that the form is developed in such a manner as to reflect standards of accreditation adopted by national organizations which accredit hospitals, medical facilities and health care plans; and

(e) Ensure that the form is developed to be used efficiently and is developed to be neither unduly long nor unduly voluminous.

4. As used in this section:

(a) "Carrier" has the meaning ascribed to it in NRS 689C.025.

(b) "Corporation" means a corporation operating pursuant to the provisions of chapter 695B of NRS.

Decision Tool – Logic and Methodology

The following considerations were used when determining the number of hours to apply to each category. All levels of skilled need were looked at in comparison to the number of hours previously allowed under the former utilization control method. Previously only maximum times were defined leaving it up to the discretion of the authorization nurse to determine where within the allowable parameters the individual recipient qualified. This tool provides some delineation when considering the household situation's influence on service utilization.

1. Elimination of the category for MR level of care. Care determined based on skilled need.
    1. Primary users of the MR category were recipients who would otherwise qualify as an SNL 1 or SNL 2. These individuals will now be determined appropriately, resulting in a reduction in costs.

2. A single level is authorized regardless of the licensure of the nurse.
    1. An individual who qualified for a particular level of care could receive more hours if the services were provided by an LPN as opposed to an RN. This is a violation of comparability as not all agencies can have enough LPNs to provide the services.

3. Maximum times where established in each category according to skilled nursing needs.
    1. A change in the methodology for determining NF level of care required that the PDN utilization control mechanism be independent and no longer tied directly to NF costs. Although the established limits are indirectly tied to the new rates.

    2. Limitations were established based on the previous methodology using cost neutrality when compared to the same level of care if the recipient were in a nursing facility.

4. All recipients are first determined under Factor I to establish the base authorization allowed.

5. Establishing availability and capability of the primary caregiver is a key factor pursuant to program policy.
    1. The Division recognizes that a two parent/caregiver home has fewer needs for skilled assistance than one with a single parent/caregiver. A 20% differential was applied in all categories to provide for the additional needs when only one caregiver is in the home.

6. Factor II and Factor III is applied to modify the base (established in Factor I) if the situation qualifies.
    1. Factor II: Capability of available caregivers. This Factor delineates the increase in allowable hours which can be considered within, but not to exceed, the maximum available hours for the specific Skilled Need category.

    2. Factor III: Attendance in school. Child appropriate for school must first access skilled care through School Based Services. A reduction in hours is applied to prevent any duplication of services.

PRIVATE DUTY NURSING SERVICES – DECISION TOOL

FACTOR I. Availability of Caregivers Living in Home

Household Situation and Resource Consideration	**INTENSITY OF CARE**		
"Unavailable" - Works or attends school either full-time (FT) or part-time (PT).	**Skilled Nursing Level 1**	**Skilled Nursing Level 2**	**Skilled Nursing Level 3**
a.) 2 or more caregivers; - Both unavailable * FT or PT. *No available /capable caregiver*	Not to exceed 20 hours per week.	Not to exceed 40 hours per week.	Not to exceed 56 hours per week.
b.) 2 or more caregivers; - 1 unavailable* FT or PT. *1 available /capable caregiver*	Not to exceed 10 hours per week.	Not to exceed 20 hours per week.	Not to exceed 28 hours per week. **
c.) 2 or more caregivers; - Neither unavailable* FT or PT *2 available / capable caregivers*	0 hours per week.	Not to exceed 12 hours per week.	Not to exceed 20 hours per week.
d.) 1 caregiver; - Unavailable* FT or PT. *No available / capable caregiver*	Not to exceed 24 hours per week.	Not to exceed 48 hours per week.	Not to exceed 67 hours per week.
e.) 1 caregiver; - Not unavailable* FT or PT. *1 available / capable caregiver*	Not to exceed 12 hours per week.	Not to exceed 24 ** hours per week.	Not to exceed 34 hours per week.

**** Up to ~~40~~ 56 hours per week may be allowed when overnight care is needed.**

FACTOR II: Capability of Caregiver

Household Situation and Resource Consideration	**INTENSITY OF CARE**		
Primary caregiver as identified in Factor I above. Verification required.	**Skilled Nursing Level 1**	**Skilled Nursing Level 2**	**Skilled Nursing Level 3**
a.) Available caregiver has health issues which inhibits their ability to provide any of the need ed care.	May allow an additional 2 hours per day. *NTE 25 total hours per week.*	May allow an additional 3 hours per day. *NTE 48 total hours per week.*	May allow an additional 4 hours per day. *NTE 67 total hours per week.*
b.) Available caregiver has moderate health issues which impacts their ability to provide all of the needed care.	May allow an additional 1 hour per day. *NTE 20 total hours per week.*	May allow an additional 2 hours per day. *NTE 40 total hours per week.*	May allow an additional 3 hours per day. *NTE 56 total hours per week.*

FACTOR III: Recipient's Participation in School

Household Situation and Resource Consideration	**INTENSITY OF CARE**		
Limitations imposed on the hours identified in Factor I above. Limitations imposed on all school aged recipients regardless of homebound status. ††	**Skilled Nursing Level 1**	**Skilled Nursing Level 2**	**Skilled Nursing Level 3**
a.) Recipient attends school 20 or more hours per week†	Reduce allowable hours by 2 hours per day. *NTE 14 hours per week*	Reduce allowable hours by 2 hours per day. *NTE 38 hours per week*	Reduce allowable hours by 2 hours per day. *NTE 57 hours per week*

† Includes hours attending school plus transportation time.

†† During planned breaks (i.e. summer vacation) of at least five consecutive school days, hours may be authorized pursuant to Factor I and II.

The following guide is used to determine the appropriate Skilled Nursing Level (SNL) category for the purposes of home health hourly services, also referred to as Private Duty Nursing (PDN). A similar guide is utilized for those recipients receiving intermittent home health care visits. This particular guide has been created for the sole purpose of this letter to illustrate the current procedure used in determining the applicable program limitations as it applies to Vincent and other recipients of hourly, or PDN, nursing services.

SNL I –

- In addition to nursing observation, at least 1 daily skilled nursing service provided by a home health care agency.

SNL II –

- In addition to nursing observation, 2 or more different daily skilled nursing services provided by a home health care agency.

SNL III –

- Ventilator dependent or 4 or more skilled nursing services daily provided by a home health care agency.

Some examples of what are typically determined to be "skilled nursing services" are provided below, however additional factors are always considered, such as the inherent complexity of the task being requested or the availability and capability of the legally responsible adult to perform the task. This is not intended to be an all-inclusive list, but is offered to illustrate the types of tasks that are considered "skilled nursing services."

- Sterile dressing changes/applications.
- Intravenous (IV) fluid administration of medications, total parenteral nutrition, hyperalimentation.
- Catheter insertion, irrigation, maintenance and care.
- Nasogastric, jejunostomy or gastrostomy tube feedings including tube and insertion site care.
- Trachestomy care, e.g. suctioning, care of endotracheal tube.
- Aseptic or clean wound irrigations or medication applications of ointment to abrasion, laceration, or skin tear. Including new ostomies (less than 60 days) and decubitus care for stage 2b or greater.

In addition to determining the appropriate Skilled Nursing Level category based, on the recipients needs, consideration is also given based on the most appropriate licensure level of the staff that will be required to complete the task, specifically if the nature of the task requires the skills of an R.N. as determined by the Nurse Practice Act. The following chart identifies the program limitations or "maximum allowable hours", for each Skilled Nursing Level (SNL) category, broken down by licensure of the staff.

	SNL I	SNL II	SNL III	MR
RN – Hourly (PDN)	NTE 24 hours /wk	NTE 30 hours /wk	NTE 45 hours /wk	**NTE 33 hours /wk**
LPN –Hourly (PDN)	NTE 32 hours /wk	NTE 41 hours /wk	NTE 61 hours /wk	**NTE 44 hours /wk**

900 PRIVATE DUTY NURSING

INTRODUCTION

Private duty nursing (PDN) is an optional benefit offered under Nevada Medicaid State Plan. Private duty nursing provides more individual and continuous care than is available from a visiting nurse. The intent of private duty nursing is to assist the non-institutionalized recipient with complex direct skilled nursing care, to develop caregiver competencies through training and education, and to optimize recipient health status and outcomes. This benefit is not intended to replace care giving responsibilities of parents, guardians or other responsible parties, but to promote family-centered, community based care that enables the recipient to remain safely at home rather than in an acute or long-term care facility. Private duty nursing services may be provided, within program limitations, to a recipient in his/her home or in settings outside the home wherever normal life activities may take them. Service may be approved based on medical necessity, program criteria, utilization control measures and the availability of the state resources to meet recipient needs.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up, with the exception of the four areas where Medicaid and Nevada Check Up policies differ as documented in Chapter 3700.

901 AUTHORITY

Federal Law Section 1905 (a) (8) of the Social Security Act
Private duty nursing is an optional benefit under Section 1905 (a) (8) of the Act.

42 CFR 440. 80 Private duty nursing services

Private duty nursing services mean nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility. These services are provided:

(a) By a registered nurse or a licensed practical nurse ;
(b) Under the directions of the recipient's physician: and
(c) At the State's option, to a recipient in one or more of the following locations:
    (1) His or her own home;
    (2) A hospital; or
    (3) A nursing facility

Nevada has opted to provide private duty nursing in the recipient's home.

902 DEFINITIONS

902.1 AUTHORIZATION NUMBERS

The assigned numbers issued by Nevada Medicaid's Quality Improvement Organization (QIO-like) or Nevada Medicaid home care staff for approved home health agency services. Authorization numbers are used for submitting claims to the Nevada Medicaid fiscal agent for reimbursement.

902.2 CAREGIVER

The legally responsible person (e.g. birthparents, adoptive parents, spouses, legal guardians paid foster parents) and/or other adults who are not (legally) responsible or paid to provide care, but who chooses to participate in providing care to a recipient.

902.3 COMPANION CARE

A service for individuals who spend time with another individual for friendly or social reasons.

902.4 CONCURRENT CARE

Concurrent care allows for the provision of PDN services by a single nurse to care for more than one recipient simultaneously in the recipient's residence.

902.5 EXPLANATION OF BENEFITS (EOB)

Statement from a third party payor/health plan to a beneficiary that lists the services that have been provided, the amount that was billed for each service, and the amount that was paid.

902.6 FULL TIME (F/T)

Working at least 30 hours per week for wages/salary, or attending school at least 30 hours per week.

902.7 IMMEDIATE RELATIVE

An immediate relative means as any of the following: 1) husband or wife, 2) natural or adoptive parent, child or sibling, 3) stepparent, stepchild, stepbrother or stepsister, 4) father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law, 5) grandparents or grandchild, 6) spouse of grandparent or grandchild. No reimbursement is made for services provided by an immediate relative.

902.8 INCAPABLE CAREGIVER

A caregiver who is unable to safely manage required care due to: 1) cognitive limitations (unable to learn care tasks, memory deficits), 2) documented physical limitations (unable to render care such as inability to lift patient), 3) significant health issues with health or emotional, as documented by the caregiver's treating physician, that prevents or interferes with the provision of care.

902.9 INHERENT COMPLEXITY

A service that by nature of its difficulty requires the skills of a trained professional to perform, monitor, or teach. This definition is used by HHA's to determine the need for skilled services and the type of provider.

902.10 INTERMITTENT SERVICES

Social Security Act section 1814(a)(2)(c) and 1835(a)(2)(a) defines intermittent as to skilled nursing and home health aide care that is either provided or needed on fewer than 7 days per week, or less than 8 hours each day for a period of 21 days or less and 28 or fewer hours each week.

902.11 PLAN OF CARE (POC)

The Plan of Care (POC) refers to the medical treatment plan established by the treating physician with the assistance of the home health care nurse.

The POC must contain all pertinent diagnoses, including the patient's mental status, the type of service, supplies, and equipment required, prognosis, rehabilitation potential, functional limitations, nutritional requirements all medications and treatments, instructions for timely discharge or referral and any additional pertinent to service provision.

902.12 PRIMARY DIAGNOSIS

The primary diagnosis is the diagnosis based on the condition that is most relevant to the current plan of care. Primary diagnosis is the first listed diagnosis for claims submission.

902.13 RESPITE

Respite is the short-term, temporary care provided to people with disabilities in order to allow responsible adults/primary care giver a break from the daily routine of providing care for the recipient. Respite is not covered under State Plan Services.

902.14 SITTERS

Sitters refer to individual services to watch/supervise a recipient in the absence of an LRA or primary caregiver.

902.15 UNAVAILABLE

Time constraints of primary caregivers, which limit their availability to provide care due to verified employment or attendance at school.

903 POLICY

903.1 POLICY STATEMENT

The private duty nursing benefit reimburses medically necessary and appropriate hourly nursing services by a registered nurse or licensed practical nurse. PDN may be authorized for recipients needing both a medical device to compensate for the loss of a vital body function and substantial and ongoing skilled nursing care to maintain the recipient at home. Service hours are determined based on skilled nursing need and are not related to diagnoses of mental illness (MI) or mental retardation (MR). Service hours take into consideration the availability and capability of legally responsible caregivers or other willing primary caregivers.

903.1A COVERAGE AND LIMITATIONS

1. PROGRAM ELIGIBILITY CRITERIA

a. The recipient has ongoing Medicaid eligibility for services;

b. The recipient's legally responsible adult or primary caregiver is unavailable or incapable of providing all necessary care;

c. The services have been determined to meet the medical criteria for private duty nursing; and

f. The service can be safely provided in the home setting.

2. COVERED SERVICES

a. PDN service may be approved for recipients who need more individual and continuous skilled nursing than can be provided in a skilled nurse visit through a home health agency, and whose care exceeds the scope of service that can be provided by home health aide or personal care aide (PCA).

b. PDN services may be approved for up to 16 hours per day for <u>new</u> ventilator dependent recipients for an eight week interval in the period immediately following discharge from the hospital.

c. PDN services may be approved for up to 12 hours per day for <u>new</u> tracheotomy recipients for an eight week interval in the period immediately following discharge from the hospital.

d. PDN services may be approved for recipients who are chronically ill who require extensive skilled nursing care to remain at home.

3. MEDICAL CRITERIA

PDN is considered medically necessary when a recipient requires the services of a licensed registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of an RN to perform skilled nursing (SN) interventions to maintain or improve the recipient's health status. Skilled nursing refers to assessments, judgments, intervention and evaluation of interventions which require the education, training and experience of a licensed nurse to complete. Services must be based on an assessment and supporting documentation that describes the complexity and intensity of the recipient's care and the frequency of SN interventions. Services must be provided under the direction of a physician and according to a signed plan of care.

a. The following criteria are used to establish the appropriate intensity of skilled nursing need (SNN) category.

1. SKILLED NURSING NEED CATEGORY 1

Limited to recipients who, in addition to skilled nursing observation, have at least one continuous skilled nursing need (as opposed to an intermittent need, such as wound care). An example of this category type recipient is the recipient who has a gastroscopy tube (g-tube) that receives nutritional feedings and medication administration through the tube, but who is unable to participate or direct his/her own care.

2. SKILLED NURSING NEED CATEGORY 2

Limited to the recipients that in addition to skilled nursing observation require 2 or more different skilled nursing interventions.

3. SKILLED NURSING NEED CATEGORY 3

Limited to recipients that are ventilator dependent at least 6 hours per day, or to recipients that, in addition to skilled nursing observation, have 4 or more different skilled nursing interventions daily*.

* Different skilled nursing intervention refers to distinct tasks that affect different body systems and require separate skilled nursing knowledge. For example, care for a tracheotomy and care for total parentural nutrition (TPN) would be considered two (2) different SNN tasks.

Related skilled nursing interventions are tasks that are an intrinsic component of the SN task. For example, suctioning is an integral part of tracheotomy care and would be considered one (1) SNN task.

Examples of what are typically determined to be "skilled nursing interventions" are identified below:

1. Ventilator care.
2. Tracheotomy with related suctioning and dressing changes;
3. Total parenteral nutrition (TPN);
4. Peritoneal dialysis;
5. Gastroscopy tube or nasogastric tube feedings, with related suctioning and administration of medication, are considered a SNN when associated with complex medical problems or with medical fragility of the recipient.
6. Complex medication administration – six or more medications on different frequency schedules or four or more medications requiring close monitoring of dosage and side effects.
7. Oxygen-unstable – continuous oxygen administration, in combination with a pulse oximeter and a documented need for observation and adjustments in the rate of oxygen administration.
8. Multiple sterile complex dressing change required at least BID. The dressing change must be separate from other SNN interventions such as changing a tracheotomy site dressing when associated with tracheotomy care.

Additional major procedures not listed here may be considered in determining the intensity of skilled nursing needed. The Nevada Medicaid Central Office or their designee should be contacted with information on what the procedure is and the amount of nursing skill time needed to perform this task.

b. DECISION GUIDE

The decision guide identifies the benefit limitations for individual recipients based upon the skilled nursing need intensity of care (SNN 1, SNN 2, and SNN 3) and the family/caregivers situation. Family situation includes the availability of caregivers in the home, the health status of caregivers and the recipient's attendance at school. The decision guide is Nevada Medicaid's tool used to determine the appropriate range of nursing hours that can be authorized under the Medicaid PDN benefit.

4. NON COVERED SERVICES

The following services are not covered benefits under PDN program and are therefore not reimbursable:

a. Services provided to recipients that are ineligible for Medicaid;

b. Services normally provided by a legally responsible adult or other willing and capable caregiver;

c. Services provided to a recipient who is a resident in a hospital, skilled nursing facility including a nursing facility for the mentally ill (NF/MI) or intermediate care facility for the mentally retarded (ICF/MR) or at institution for the treatment of mental health or chemical addiction.

d. Services rendered to recipients in pediatric and adult day centers.

e. Services rendered at school sites responsible for providing "school based health service" pursuant to IDEA §300.24.

f. Services provided to someone other than the intended recipient;

g. Services that Nevada Medicaid determines could reasonably be performed by the recipient;

h. Services provided without authorization;

i. Services that are not on the approved plan of care;

j. Service requests that exceed program limits;

k. Respite care that is intended to relieve a legally responsible adult or primary caregiver from the daily routine of providing care for the recipient;

l. Companion Care that is intended to provide friendly or social time with a recipient;

m. Sitters or services that are intended for individuals to watch or supervise a recipient in the absence of a legally responsible adult or primary caregiver and that provide no skilled care;

n. Homemaker services;

o. Medical Social Services (MSS);

p. Duplicative services, such as personal care services, that are provided during private duty nursing hours;

q. Travel time to and from the recipient's residence;

r. Transportation of the recipient by the private duty nurse to Medicaid reimbursable settings. PDN recipients may require immediate skilled nursing intervention. Such intervention would be precluded by the SN driving the vehicle.

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INTRODUCTION

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902.7 IMMEDIATE RELATIVE

An immediate relative means as any of the following: 1) husband or wife, 2) natural or adoptive parent, child or sibling, 3) stepparent, stepchild, stepbrother or stepsister, 4) father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law, 5) grandparents or grandchild, 6) spouse of grandparent or grandchild. No reimbursement is made for services provided by an immediate relative.

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A caregiver who is unable to safely manage required care due to: 1) cognitive limitations (unable to learn care tasks, memory deficits), 2) documented physical limitations (unable to render care such as inability to lift patient), 3) significant health issues with health or emotional, as documented by the caregiver's treating physician, that prevents or interferes with the provision of care.

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The primary diagnosis is the diagnosis based on the condition that is most relevant to the current plan of care. Primary diagnosis is the first listed diagnosis for claims submission.

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Sitters refer to individual services to watch/supervise a recipient in the absence of an LRA or primary caregiver.

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Time constraints of primary caregivers, which limit their availability to provide care due to verified employment or attendance at school.

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903.1 POLICY STATEMENT

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903.1A COVERAGE AND LIMITATIONS

1. PROGRAM ELIGIBILITY CRITERIA

a. The recipient has ongoing Medicaid eligibility for services;

b. The recipient's legally responsible adult or primary caregiver is unavailable or incapable of providing all necessary care;

c. The services have been determined to meet the medical criteria for private duty nursing; and

f. The service can be safely provided in the home setting.

2. COVERED SERVICES

a. PDN service may be approved for recipients who need more individual and continuous skilled nursing than can be provided in a skilled nurse visit through a home health agency, and whose care exceeds the scope of service that can be provided by home health aide or personal care aide (PCA).

b. PDN services may be approved for up to 16 hours per day for <u>new</u> ventilator dependent recipients for an eight week interval in the period immediately following discharge from the hospital.

c. PDN services may be approved for up to 12 hours per day for <u>new</u> tracheotomy recipients for an eight week interval in the period immediately following discharge from the hospital.

d. PDN services may be approved for recipients who are chronically ill who require extensive skilled nursing care to remain at home.

3. MEDICAL CRITERIA

PDN is considered medically necessary when a recipient requires the services of a licensed registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of an RN to perform skilled nursing (SN) interventions to maintain or improve the recipient's health status. Skilled nursing refers to assessments, judgments, intervention and evaluation of interventions which require the education, training and experience of a licensed nurse to complete. Services must be based on an assessment and supporting documentation that describes the complexity and intensity of the recipient's care and the frequency of SN interventions. Services must be provided under the direction of a physician and according to a signed plan of care.

a. The following criteria are used to establish the appropriate intensity of skilled nursing need (SNN) category.

1. SKILLED NURSING NEED CATEGORY 1

Limited to recipients who, in addition to skilled nursing observation, have at least one continuous skilled nursing need (as opposed to an intermittent need, such as wound care). An example of this category type recipient is the recipient who has a gastroscopy tube (g-tube) that receives nutritional feedings and medication administration through the tube, but who is unable to participate or direct his/her own care.

2. SKILLED NURSING NEED CATEGORY 2

Limited to the recipients that in addition to skilled nursing observation require 2 or more different skilled nursing interventions.

3. SKILLED NURSING NEED CATEGORY 3

Limited to recipients that are ventilator dependent at least 6 hours per day, or to recipients that, in addition to skilled nursing observation, have 4 or more different skilled nursing interventions daily*.

* Different skilled nursing intervention refers to distinct tasks that affect different body systems and require separate skilled nursing knowledge. For example, care for a tracheotomy and care for total parentural nutrition (TPN) would be considered two (2) different SNN tasks.

Related skilled nursing interventions are tasks that are an intrinsic component of the SN task. For example, suctioning is an integral part of tracheotomy care and would be considered one (1) SNN task.

Examples of what are typically determined to be "skilled nursing interventions" are identified below:

1. Ventilator care.
2. Tracheotomy with related suctioning and dressing changes;
3. Total parenteral nutrition (TPN);
4. Peritoneal dialysis;
5. Gastroscopy tube or nasogastric tube feedings, with related suctioning and administration of medication, are considered a SNN when associated with complex medical problems or with medical fragility of the recipient.
6. Complex medication administration – six or more medications on different frequency schedules or four or more medications requiring close monitoring of dosage and side effects.
7. Oxygen-unstable – continuous oxygen administration, in combination with a pulse oximeter and a documented need for observation and adjustments in the rate of oxygen administration.
8. Multiple sterile complex dressing change required at least BID. The dressing change must be separate from other SNN interventions such as changing a tracheotomy site dressing when associated with tracheotomy care.

Additional major procedures not listed here may be considered in determining the intensity of skilled nursing needed. The Nevada Medicaid Central Office or their designee should be contacted with information on what the procedure is and the amount of nursing skill time needed to perform this task.

b. DECISION GUIDE

The decision guide identifies the benefit limitations for individual recipients based upon the skilled nursing need intensity of care (SNN 1, SNN 2, and SNN 3) and the family/caregivers situation. Family situation includes the availability of caregivers in the home, the health status of caregivers and the recipient's attendance at school. The decision guide is Nevada Medicaid's tool used to determine the appropriate range of nursing hours that can be authorized under the Medicaid PDN benefit.

4. NON COVERED SERVICES

The following services are not covered benefits under PDN program and are therefore not reimbursable:

a. Services provided to recipients that are ineligible for Medicaid;

b. Services normally provided by a legally responsible adult or other willing and capable caregiver;

c. Services provided to a recipient who is a resident in a hospital, skilled nursing facility including a nursing facility for the mentally ill (NF/MI) or intermediate care facility for the mentally retarded (ICF/MR) or at institution for the treatment of mental health or chemical addiction.

d. Services rendered to recipients in pediatric and adult day centers.

e. Services rendered at school sites responsible for providing "school based health service" pursuant to IDEA §300.24.

f. Services provided to someone other than the intended recipient;

g. Services that Nevada Medicaid determines could reasonably be performed by the recipient;

h. Services provided without authorization;

i. Services that are not on the approved plan of care;

j. Service requests that exceed program limits;

k. Respite care that is intended to relieve a legally responsible adult or primary caregiver from the daily routine of providing care for the recipient;

l. Companion Care that is intended to provide friendly or social time with a recipient;

m. Sitters or services that are intended for individuals to watch or supervise a recipient in the absence of a legally responsible adult or primary caregiver and that provide no skilled care;

n. Homemaker services;

o. Medical Social Services (MSS);

p. Duplicative services, such as personal care services, that are provided during private duty nursing hours;

q. Travel time to and from the recipient's residence;

r. Transportation of the recipient by the private duty nurse to Medicaid reimbursable settings. PDN recipients may require immediate skilled nursing intervention. Such intervention would be precluded by the SN driving the vehicle.

APPENDIX C

Rural Health Data
Report Concerning the Activities and Recommendations of the Governor's Strategic Plan for Rural Health Care Accountability Committee
Presented at the August 4, 2004, Work Session
of the Legislative Committee on Health Care
(Exhibit F)

Exhibit F

Agenda Item No. VII.

REPORT CONCERNING THE ACTIVITIES AND RECOMMENDATIONS OF THE GOVERNOR'S STRATEGIC PLAN FOR RURAL HEALTH CARE ACCOUNTABILITY COMMITTEE

Presented by

Robin Keith, President
Nevada Rural Hospital Partners, and
Co-Chair of the Governor's Strategic Plan for
Rural Health Care Accountability Committee

TESTIMONY FOR THE LEGISLATIVE COMMITTEE ON HEALTH CARE
August 4, 2001
Presented by the Rural Health Strategic Plan Accountability Committee
Robin Keith, Co-Chair

INTRODUCTION AND BACKGROUND

Madam Chairman and members of the committee, my name is Robin Keith. I am here today as Co-Chairperson of the Rural Health Strategic Plan Accountability Committee, a group appointed by Governor Guinn. The 2001 session of the Nevada State Legislature passed AB 513 which mandated and funded the development of a Strategic Plan for Rural Health Care. That work was completed in October of 2002, and the final plan includes 11 goals, with many objectives and strategies intended to achieve those goals. One of the key recommendations in that plan was the creation of a mechanism to help ensure that the plan did not merely sit on a shelf. Rather, the plan was to be viewed as the beginning of a process intended to actually result in improvements in the rural delivery system. To that end, Governor Guinn created the Accountability Committee in November 2003. The committee is charged with oversight of the implementation of the plan, and with updating it as needed.

The committee was invited to develop recommendations for the upcoming budget and legislative session. To deal with the timeframe in which those recommendations had to be made, the committee has focused on identifying plan implementation activities, barriers, and issues that have regulatory, budgetary, and/or policy implications. The committee has met eight times since January and has approached the implementation issue by seeking input from groups and entities which have a role in delivering services and/or creating solutions to rural healthcare delivery issues. This process has involved listening to the reports both in terms of what is being done and what barriers are being encountered. To date, time has limited the number of entities we have been able to hear, and the committee plans to broaden its focus in coming months. So far, we have heard from the Bureau of Licensure and Certification, the Bureau of Family Health Services, the Bureau of Community Health Nursing, the Division of Child and Family Services, the Division of Mental Health and Developmental Services, the Division of Health Care Financing and Policy, the Bureau of Alcohol and Drug Abuse, and with numerous stakeholders in the rural telecommunications and telehealth network. The committee took the information presented by these groups and distilled it into common themes from which recommendations for consideration by the Department of Human Resources, the Legislature, and the Governor were developed. Caroline Ford Co-Chairs the committee with me; she and I met with Mr. Mike Willden, Director of the Department of Human Resources concerning committee recommendations appropriately considered by the Department. On Friday, I will meet with the Governor's staff to convey the committee's progress and to provide a list of recommendations for consideration by his office. Today, on behalf of the Accountability Committee, I am here with Gerald Ackerman, Director of the Northeastern Nevada Area Health Education Center, to request consideration by the Healthcare Committee of some specific recommendations. Time does not permit a full discussion of all of the committee's recommendations to. Instead, we have chosen to focus on those related to this committee, and to provide you with a complete list of all recommendations for your review as your time permits. Gerald will discuss the health care workforce, telehealth issues, and an issue related to the emergency medical system. I am going to talk with you briefly about the committee's recommendations concerning, infrastructure and financial stability.

Maintaining access means maintaining the infrastructure and the financial stability of the delivery system. I have never been involved in a session where there was sufficient money to do all that is

needed and this session will be no exception. Nevertheless, we have to talk about money because lack of it is a key barrier to the development of healthcare services in rural Nevada. The committee's financial recommendations include three which have been made to the Division of Human Resources. These are cost-based outpatient services in critical access hospitals, payment enhancements for rural practitioners, and Medicaid reimbursement for telehealth services. In addition, the committee requests that the Legislative Committee on Health Care consider bill draft requests that establish mechanisms to support practitioners who provide services in rural, and frontier areas. Two specific possibilities are included in the Accountability Task Force's recommendations. The first is the establishment of a fund that would support grants for the development of services for vulnerable rural and frontier populations, including limited operating capital, and funding for equipment and facilities. The second is the creation of a loan pool for capital needs for rural providers.

The grant pool is seen as a way of providing an incentive for the development of services in rural Nevada. The competition for providers and services is intense across the country and certainly in Nevada. This proposed program is intended to make it easier for those wanting to serve to do so. The grant pool is seed money, money intended to get sustainable services off the ground. Practitioners and others would have to demonstrate that they will serve an underserved or at-risk population, and that the service they propose to develop would become self-sustaining in a reasonable amount of time, two years for example. Many types of grantees could be eligible; examples include physicians, dentists, nurse practitioners, physical therapists, home health agencies, or those wanting to provide transportation or other services to the elderly. Grantees might be existing entities trying to expand services, or new entities trying to fill a need. Perhaps an existing rural pharmacy would consider opening a limited pharmacy in some community that doesn't have one, if only the start up cost could be covered. Although I have very limited expertise in the mechanics of getting this done, it seems the program might be logically attached to rural economic development programs.

On a similar note, the Accountability Committee requests that the Healthcare Committee consider a bill that would establish a capital loan pool for rural practitioners. This pool would be intended to provide relatively easy access to capital for equipment and facilities needed by rural providers. The pool would be available to clinics, private practitioners, and others who use their loans to increase access to services for rural and frontier residents. Unlike the grant fund, there is an expectation that funds borrowed from the loan pool would be repaid with modest interest so that new loans can be made. Some Healthcare Committee members are aware that Nevada Rural Hospital Partners has such a fund for rural hospitals and it works very well. The best part about it is that it is a continuous, revolving resource. Funds are loaned, paid back, and loaned again. The NRHP pool is now about 15 years old and has never had a default. That pool started with $900,000, $500,000 of which was borrowed. That debt has been repaid and the pool now has 1.1 million dollars in it, free and clear. This is a great example of a resource that has not been dissipated. Instead, it grows every year, continuing to benefit Nevada's small communities. Given the scarcity of funding, it seems very worthwhile to set up programs in such a way that the basic resource is conserved for the future.

New Mexico has loan pools for both hospitals and community based primary care centers. Their pools fund construction, equipment, land acquisition and planning. Originally funded with 5 million dollars by the New Mexico legislature, the program is administered by a state agency and the New Mexico Office of Rural Health. In view of the Accountability Task Force's recommendation for a grant pool, it was interesting to note in my conversation with New Mexico, that they feel that what their program lacks is a grant mechanism.

The committee deliberated on the issues related to coverage of the uninsured and the underinsured in rural Nevada. It is not within the charge of the Accountability Task Force to examine this complex issue in detail. However, the impact of compromised access to healthcare on the health of individuals and communities, and the fiscal burden left by inappropriate utilization of the healthcare system led to some general recommendations intended to help address improvement of access. These include:

- A request to the Healthcare Committee to consider proposals from the safety net providers to address the health care needs of the rural un- and under-insured. This is a recommendation that supports creation of the grant and loan pools discussed above; it is also intended as a statement of general support for other proposals the committee may consider on this topic, and

- To the extent that a single payer system might be considered, the committee received comment supportive of that concept.

Thank you for your time and attention. At this time, I'd like to turn to Gerald Ackerman to present the remainder of the Accountability Task Force's recommendations.

SUMMARY OF REQUESTS FOR CONSIDERATION BY THE
LEGISLATIVE COMMITTEE ON HEALTH CARE
Presented by the Governor's Accountability Task Force for the Rural Strategic Plan

Following is a list of recommendations for consideration by the Legislative Committee on Health Care. The list is a distillation of information gathered by the Governor's Accountability Task Force from multiple sources.

1. Request the Legislative Committee on Health Care support establishment of an Advisory Committee on Health Care Workforce.

2. Investigate/request the Legislative Committee on Health Care institute an assessment fee on either speeding tickets or motor vehicle registration to support establishment of a rural Trauma Network that will provide equipment; personnel support; services; training, and data collection/support.

3. Request the Health Care Committee establish a grant fund to support the development of services, equipment and/or facilities that serve the needs of vulnerable rural and frontier populations.

4. Request the Legislative Committee on Finance address the development of a capital fund to support rural facility development, renovations, equipment, and start-up funding to support rural community needs.

5. Request the Legislative Committee on Health Care to consider safety net proposals that address the health care needs of rural uninsured/underinsured.

6. Work with the Legislative Committee on Health Care to support efforts to investigate a Single Payer option for coverage in rural Nevada.

7. Request the Legislative Committee on Health Care investigate development of primary care districts that may cross county/state boundaries to address service area needs in rural and frontier Nevada.

Strategic Plan for Rural Health Care
Positions and Recommendations Re: Implementation of the Rural Health Care Strategic Plan

The following recommendations were distilled from testimony and discussions held by the Governor's Rural Health Plan Accountability Committee during the winter and spring of 2004. The Committee developed an approach to assess the recommendations as they impacted the development of health policy through the Department of Human Resources and the Legislative Committee on Health Care. The committee also assessed the development of specific legislative requests that could be made through the Department of Human Resources and the Legislative Committee on Health Care. The recommendations listed below are listed in two ways. First, by issue category, cross referenced to the eleven goals of the Strategic Plan for Rural Health Care, and second, by Strategic Plan goal.

The Committee re-emphasizes the focus within the Strategic Plan for Rural Health Care that emphasized a set of principles outlined on pages 128 – 130 that supported some basic tenants, for example: "Rural residents, like their urban counterparts, have a fundamental right to high quality and affordable health care", and ".....an understanding of the unique importance of health care to the rural community supports the need for funding/payment structures and public policy decisions that consistently support the delivery of rural health care services". These statements and the core principles should be applied in earnest when developing specific programs, policies and regulations for rural and frontier Nevada.

Health Care Workforce
The category of Health Care Workforce was the most frequently referenced and discussed topic of concern among all issue categories. Issues surrounding recruitment, retention, education, training, and supply/demand and serving the medically needy were identified topics in every presentation made by state agencies and other organizations, including the Committee membership. There are many recommendations in this category that explore meaningful ways that DHR, in particular, could initiate to bring focus, attention and problem solving to the many troubled areas.

- Request the Legislative Committee on Health Care support establishing an Advisory Committee on Health Care Workforce. (Goal II)

- Request the state to institute salary and/or benefit enhancements for state employees in the rural health workforce to address recruitment and retention. (Goal II)

- Request the DHR to develop an internal career ladder program to foster continuity, longevity within critical health professional vacancies throughout the multiple divisions that employ health professionals. (Goal II)

- Request DHR to establish an interagency health workforce workgroup partnership with public/private entities including UCCSN partners, to identify critical needs and develop strategic interventions to train, recruit and retain health professionals. (Goal III)

Telecommunications/Telehealth
The Committee received testimony from state and public agencies and held numerous discussions that emphasized the current and growing need to address the delivery of high quality health care to rural populations utilizing telecommunications, to increase access of health care services. The impact of telecommunications technology and information was so significant that the Committee scheduled a special meeting to bring together stakeholders and direct service providers to better define and understand the current delivery system and discuss the expansion of educational, administrative and clinical applications of telecommunications technology to rural and frontier Nevada. Recommendations from this special forum in conjunction with additional Committee input have produced significant strategic activities that warrant special attention in this document.

- Request the DHR support the Division of Health Care Policy and Finance budget that would provide payment for services delivered via Telemedicine. (Goal X)

- Request the DHR support the Division of Mental Health and Mental Retardation budget that addresses equipment and operational support for rural patient services via partnership with the University of Nevada School of Medicine-Center for Education and Health Services Outreach. (Goal X)

- Request the DHR support the Division of Health Care Policy and Finance analysis in addressing the regulations and/or certification of personal care aids to increase the availability of such persons to serve rural patients. (Goal X)

- Support state agency budgets that utilize and expand capacity for Telehealth and integrate consultation and referrals to in-state service providers (UNSOM, state agency and others) before out-of-state contractors are utilized. (Goal XI)

- Request the DHR institute a working group across divisions in partnership with rural service providers and the UNSOM-Center for Education and Health Services Outreach, to address integration and expansion of technology to support patient and community services. (Goal XI)

Access and Capacity

A variety of recommendations are clustered within this category that address issues of improving access to health care services and building the capacity to respond to identified needs. Often these activities are achieved through partnerships between private and public organizations. This Committee deliberated at length on addressing how to achieve improved integration of personnel and services to achieve cost efficiencies, expanded availability of services and support, and diffusion of resources into rural and frontier areas that are compromised in the access and availability of selected state health services.

Issues impacting the rural and frontier Emergency Medical Services system have long been compromised due to the volunteer nature of the numerous county ambulance services. The recruitment and retention of volunteer personnel, aging vehicles, problematic billing and collection systems, availability of training opportunities, county supported operating budgets and numerous other issues plague the EMS system's ability to respond to approximately 96,000 square miles of rural and frontier geography. The recommendations that follow support the stabilization and development of enhanced quality and performance of Nevada's rural Trauma Network.

- Request the DHR identify rural Nevada communities currently un-served or underserved by the Bureau of Alcohol and Drug Abuse, and identify potential contract providers for services in order that all rural Nevada communities are ensured of having an identified service provider within a reasonable distance. (Goal III)

- Investigate/request the Legislative Committee on Health Care to institute an assessment fee on either speeding tickets or motor vehicle registration to support establishment of a rural Trauma Network that will provide equipment; personnel support; services; training, and data collection/support. (Goal IV)

- Request the DHR support supplemental funding to the EMS Division to integrate data analysis of all collected run information by all licensed services, and provide rapid feedback of information to assist services in the improvement of patient care and response for Trauma. (Goal IV)

- Request the DHR consider a Bill Draft Request to address the potential for Emergency Medical Technicians (all levels) to address dispensing of pharmaceuticals as an expanded scope of practice. (Goal IV)

- Work with DHR to promote integration of personnel between Divisions that blends services and financing to achieve coordinated benefits and improved community services. (Goal IV)

- Work with DHR to address decentralization, integration of multi-division services and outreach of Division services to rural Nevada. (Goal IV)

- Request the DHR to accommodate enhanced funding within the Department to achieve parity and adequacy of services to all populations and communities. (Goal IV)

- Request the DHR to initiate funding for demonstration projects that address rural services integration. (Goal IV)

- Request the DHR to continue development of public agency partnerships and support innovations and community collaborations that result in local (rural) community infrastructure to provide public health and other preventive health services. (Goal V)

- Request the Health Care Committee establish a grant fund to support the development of services, equipment and/or facilities that serve the needs of vulnerable rural and frontier populations. (Goal X)

The Committee deliberated extensively on issues relative to the coverage of uninsured and underinsured rural Nevadans. The impact of compromised access to health care on the health of the individual and the community, and the fiscal burden left by inappropriate utilization of the health care system led to specific recommendations addressing improvement of access.

- Request the Legislative Committee on Health Care to consider safety net proposals that addresses the health care needs of rural uninsured/underinsured. (Goal VI)

- Work with the Legislative Committee on Health Care to support efforts on investigating a Single Payer option for coverage in rural Nevada. (Goal VI)

- Partner with the DHR and other public/private agencies that address Rural Health to integrate the needs/concerns of health system restructuring efforts. (Goal VI)

- Investigate the impact of limited access to a specialty provider network for rural and frontier populations. (Goal VI)

Fiscal Stabilization, Modeling and Infrastructure
Request the DHR appoint staff for rural health to specifically coordinate activities within the Department so that resources and benefits are maximized. Staff would address planning, integration, services and contracting to strengthen local communities, and further coordinate with the State Office of Rural Health; Goal I;

- Request the DHR appropriate funds to support rural data collection functions, outlined for the State Office of Rural Health as legislated in NRS 396.906, to address the strategic plan principle of "support collection of accurate and timely data to enhance effective decision making". (Goal I)

- Investigate partnership between DHR, UCCSN Health Profession training programs and other public/private partners to initiate a rural campaign of health promotion disease prevention targeted at employees and agency-specific audiences (Goal V)

- DHR to provide technical assistance to rural communities to explore models of health care delivery that address creation of health districts that serve public, preventive and primary health care (Goal V)

- Formulate a method to allocate and distribute funding to rural populations for programs identified within the Trust Fund for Healthy Nevada. (Goal VIII)

- Request the Legislative Committee on Finance to address the development of a capital fund to support rural facility development, renovations, equipment, and start-up funding to support rural community needs. (Goal VII)

- Request the Legislative Committee on Health Care to investigate development of primary care districts that may cross county/state boundaries to address service area needs in rural and frontier Nevada. (Goal VIII)

- Request the DHR to support the Division of Health Policy and Finance budget that would provide cost based payment for Critical Access Hospital outpatient services. (Goal IX)

- Request the DHR to support the Division of Health Policy and Finance budget that provides payment enhancements to practitioners (medical and dental) serving all rural and frontier Nevada communities. (Goal X)

Recommendations Listed by Goal

Goal I:

- Create an ongoing mechanism for planning and coordination of rural health care.

- Request the DHR appoint staff for rural health to specifically coordinate activities within the Department so that resources and benefits are maximized. Staff would address planning integration, services and contracting to strengthen local communities, and further coordinate with the State Office of Rural Health.

- Request the DHR appropriate funds to support rural data collection functions, outlined for the State Office of Rural Health as legislated in NRS 396.906, to address the strategic plan principle of "support collection of accurate and timely data to enhance effective decision making."

Goal II:

- Enhance rural physical health primary care

- Request the Legislative Committee on Health Care support establishing an Advisory Committee on Health Care Workforce.

- Request the state to institute salary and/or benefit enhancements for state employees in the rural health workforce to address recruitment and retention.

- Request the DHR to develop an internal career ladder program to foster continuity, longevity within critical health professional vacancies throughout the multiple divisions that employ health professionals.

Goal III:

- Create long-term viability in behavioral health, substance abuse, and support services

- Request DHR to establish an interagency health workforce workgroup partnership with public/private entities including UCCSN partners, to identify critical needs and develop strategic interventions to train, recruit and retain health professionals.

- Request the DHR identify rural Nevada communities currently unserved or underserved by the Bureau of Alcohol and Drug Abuse, and identify potential contract providers for services in order that all rural Nevada communities are ensured of having an identified service provider within a reasonable distance.

Goal IV:

- Improve service access and response capabilities

- Investigate/request the Legislative Committee on Health Care to institute an assessment fee on either speeding tickets or motor vehicle registration to support establishment of a rural Trauma Network that will provide equipment; personnel support; services; training, and data collection/support.

- Request the DHR support supplemental funding to the EMS Division to integrate data analysis of all collected run information by all licensed services, and provide rapid feedback of information to assist services in the improvement of patient care and response for Trauma.

- Request the DHR consider a Bill Draft Request to address the potential for Emergency Medical Technicians (all levels) to address dispensing of pharmaceuticals as and expanded scope of practice.

- Work with DHR to promote integration of personnel between Divisions that blends services and financing to achieve coordinated benefits and improved community services.

- Work with DHR to address decentralization, integration of multi-division services and outreach of Division services to rural Nevada.

- Request the DHR to accommodate enhanced funding within the Department to achieve parity and adequacy of services to all populations and communities.

- Request the DHR to initiate funding for demonstration projects that address rural services integration.

Goal V:

- Invest in public and preventative health for long-term benefits

- Request the DHR to continue development of public agency partnerships and support innovations and community collaborations that result in local (rural) community infrastructure to provide public health and other preventive health services.

- Investigate partnership between DHR, UCCSN Health Profession training programs and other public/private partners to initiate a rural campaign of health promotion disease prevention targeted at employees and agency-specific audiences.

- DHR to provide technical assistance to rural communities to explore models of health care delivery that address creation of health districts that serve public, preventive and primary health care.

Goal VI:

- Improve insurance coverage for uninsured and underinsured Nevadans

- Request the Legislative Committee on Health Care to consider safety net proposals that addresses the health care needs of rural uninsured/underinsured.

- Work with the Legislative Committee on Health Care to support efforts on investigating a Single Payer option for coverage in rural Nevada.

- Partner with the DHR and other public/private agencies that address Rural Health to integrate the needs/concerns of health system restructuring efforts.

- Investigate the impact of limited access to a specialty provider network for rural and frontier populations.

Goal VII:

- Develop adequate capital funding

- Request the Legislative Committee on Finance to address the development of a capital fund to support rural facility development, renovations, equipment, and start-up funding to support rural community needs.

Goal VIII:

- Develop adequate operational funding

- Formulate a method to allocate and distribute funding to rural populations for programs identified within the Trust Fund for Healthy Nevada.

- Request the Legislative Committee on Health Care to investigate development of primary care districts that may cross county/state boundaries to address service area needs in rural and frontier Nevada.

Goal IX:

- Ensure long-term viability of rural health care facilities

- Request the DHR to support the Division of Health Policy and Finance budget that would provide cost based payment for Critical Access Hospital outpatient services.

Goal X:

- Expand capacity to provide health care services within rural communities

- Request the DHR support the Division of Health Care Policy and Finance budget that would provide payment for services delivered via Telemedicine.

- Request the DHR support the Division of Mental Health and Mental Retardation budget that addresses equipment and operational support for rural patient services via partnership with the University of Nevada School of Medicine-Center for Education and Health Services Outreach.

- Request the DHR support the Division of Health Care Policy and Finance analysis in addressing the regulations and/or certification of personal care aids to increase the availability of such persons to serve rural patients.

- Request the DHR to support the Division of Health Policy and Finance budget that provides payment enhancements to practitioners (medical and dental) serving all rural and frontier Nevada communities.

- Request the Health Care Committee establish a grant fund to support the development of services, equipment and/or facilities that serve the needs of vulnerable rural and frontier populations.

Goal XI:

- Support maximum use of technology in rural communities

- Support state agency budgets that utilize and expand capacity for Telehealth and integrate consultation and referrals to in-state service providers (UNSOM, state agency and others) before out-of-state contractors are utilized.

- Request the DHR institute a working group across divisions in partnership with rural service providers and the UNSOM-Center for Education and Health Services Outreach, to address integration and expansion of technology to support patient and community services.

Appendix 1
WESTERN GOVERNORS ASSOCIATION POLICY RESOLUTION 04-03

Rural Health Improvements

June 22, 2004

Santa Fe, New Mexico

SPONSORS: Governors Owens, Napolitano, Richardson, and Johanns

A. BACKGROUND

1. About 54 million Americans currently live in rural areas, comprising approximately 20 percent of the U.S. population. These Americans can face daunting challenges in accessing quality and affordable healthcare. Geography, isolation, lack of public transportation, poverty and unemployment, lack of health insurance, and demographic and lifestyle factors can create access challenges unique from those experienced in most urban areas. Limited and/or weak economies contribute to the challenges of providing health care in many rural areas. Policy issues such as the healthcare workforce, Medicare and Medicaid coverage and reimbursement rates, federally designated underserved and frontier areas, infrastructure funding, and Emergency Medical Services (EMS) are some of the areas where government can act to make improvements in rural health care.

2. Despite the fact that 20 percent of Americans live in rural areas, in 1999, less than nine percent of physicians practiced there. Many rural areas experience chronic and critical physician shortages. In recent years, shortages of providers such as nurses, dentists, pharmacists, ancillary health and mental health professionals have also become more apparent. Recruitment and retention of all types of health care professionals is an ongoing problem for rural areas that see a lower volume of patients than urban areas, but still have to compete with urban areas, and with a global market, to maintain an adequate workforce. In addition, among other factors, the shift toward physician specialization means physicians are more likely to settle in an urban area where more specialty services are utilized

3. The elderly are disproportionately represented in rural areas. Approximately 18 percent of all rural residents are elderly. An estimated 8.7 million Medicare beneficiaries or roughly 22 percent of all beneficiaries live in rural areas. Medicare is therefore the dominant source of health care reimbursement for providers and for rural hospitals. Medicare accounts for approximately 47 percent of patient care in rural areas, compared to 36 percent in urban areas. Although the same standard of care is expected and delivered, Medicare payments to rural hospitals are below that of their urban counterparts thus threatening the viability of rural hospitals. Inequities built into Medicare rates that result in rural providers receiving smaller reimbursements than urban hospitals has been alleviated among hospitals designated as critical access hospitals (CAHs) as these hospitals are now receiving cost-reimbursement for their Medicare patient base. However, the larger rural hospitals using the Prospective Payment System (PPS) reimbursement system continue to suffer from the inequity that exists in the payment structure that reflects a rural-urban differential.

4. Rural areas in the West differ greatly from rural areas in the rest of the U.S. because they usually have very low population density and/or great distances to services. Many of these areas constitute America's 'frontier'. These vast, sparsely populated areas present additional challenges in providing and supporting a healthcare infrastructure. For example, in states with large frontier areas, federal program rules and regulations frequently make it very difficult to operate efficient programs because they do not consider the lack of infrastructure and other conditions such as isolation, distance and low population density. These areas therefore seek increased flexibility and cost savings from clinic innovations such as the Frontier Extended-Stay Clinics. Frontier areas also need to be well defined, and eligible for special consideration from federal programs. The Congress has asked The Department of Health and Human Services (DHHS) Health Resources Services Administration (HRSA), to adopt a definition of “frontier” based on the elements of the “Consensus Definition” developed by the Frontier Education Center and adopted by the National Rural Health Association.

5. Because many smaller rural communities have no health clinic, no hospital, and no physician, Emergency Medical Services (EMS) is often the residents’ entire safety net. EMS must be available 24 hours a day, every single day of the year. The vital nature of EMS and the state of constant readiness required, pose special challenges for rural communities such as adequate funding, recruitment, retention and training of personnel often volunteer, physician leadership, and modern communications and medical services equipment. In order to surmount these difficulties, many rural communities must develop innovative and flexible EMS programs that respond to the unique needs and circumstances of the area to be served. As to training of EMS personnel to maintain their skills, there is often a lack of adequate access to continuing education opportunities in remote areas. This situation is unlike, physicians that are often able to obtain continuing education through distance education.

6. Lack of access to mental health and substance abuse services have resulted in individuals in need of those services being treated in either the physical health care system or entering the system in crisis through law enforcement. Federal reimbursement policies which encourage the integration of mental health and primary care, adequate coverage in the public

and private sector for these services, co-location of mental and physical health programs, and the training of more mental health professionals for rural areas will lead to both reduced costs and improved outcomes.

7. Telemedicine offers a means to alleviate some of the difficulties faced in providing and receiving health care in rural and urban America. Western Governors have long supported and successfully advocated for reducing barriers to this promising use of technology. Barriers were identified and recommendations for surmounting them were made in a 1998 publication of the Western Governors' Association (WGA) entitled Telemedicine Action Update.

B. GOVERNORS' POLICY STATEMENT

1. Western Governors want rural areas to have an adequate and able workforce to deliver needed health care services. The governors call on the federal government to provide necessary funding for programs such as the National Health Service Corps (NHSC) that have a state-based component, and the Health Professions programs that help health professionals serve in rural and frontier areas. The governors call on the Congress to continue to reauthorize the NHSC and the Health Professions programs (Title VII and VIII of the Public Health Service Act), and to provide adequate funding and encourage program flexibility to assure dollars are used to support areas of greatest need, that they foster interdisciplinary training, and support the development of health professions training in and in collaboration with rural communities. In addition, the Congress should provide sufficient resources to assure that the numbers of health care educators, trainers, and programs exist to meet the needs. Additionally, because numerous programs rely on the federal Health Professional Shortage Area and Medically Underserved Area designations to allocate funding and services, care must be taken that any proposed changes in these designations does not have an adverse impact on rural and frontiers areas. To any extent possible, we also urge that the time used for processing designation applications be shortened.

2. Western Governors believe that rural health care providers should be paid fairly by Medicare in order to ensure access to health care for rural citizens. The governors applaud Congress and the Bush Administration for recent actions taken toward this end, and encourage the federal government to take further steps to ensure equity in Medicare reimbursement for urban and rural areas so that the benefits of health care are available to all Americans, regardless of where they live. The complexity and abundance of the paperwork required to participate in the Medicare program presents an even more significant challenge to smaller, lower volume, fragile rural health care systems. To every extent feasible, the paperwork and reporting requirements should be simplified.

3. Western Governors call on HRSA to implement and use the "Consensus Matrix" to define 'frontier' and obtain the consent of the governor in the determination of federally designated frontier areas. DHHS should develop the programmatic and reimbursement flexibility to allow clinic innovations such as Frontier Extended-Stay Clinics in frontier communities. Alaska, Hawaii, America Samoa, the Northern Mariana Islands and Guam face extraordinary geographic barriers in providing healthcare services and they should be designated for special consideration and adequate funding to overcome their frontier barriers.

4. Western governors call on EMS lead agencies at all levels of government to have a legislative mandate, expertise, flexibility, and resources to provide needed support and technical assistance in rural and frontier communities. Federal programs like the Rural Health Outreach Grants and the Rural Hospital Flexibility program need to continue to provide funds to states and communities to experiment with new programs, integration of services, and coalition building to develop new types of providers, facilities, and services. In addition, western governors request that state EMS directors examine and seek change in national rules to allow for appropriate distance learning opportunities for EMS personnel.

5. Western Governors believe in strengthening the existing health care system. Support for home health agencies, hospice, rural health clinics, emergency medical services, public health nursing, mental health and substance abuse treatment programs, and oral health services, critical access hospitals are partial solutions. These programs should be continued, enhanced, and supported. They should also allow, where feasible, state and local flexibility so that the unique needs of rural and frontier areas can be addressed. 6. Western Governors support the elimination of barriers to the use of telemedicine as outlined in the WGA's 1998 report. In particular, we request that the federal efforts to increase reimbursement for telemedicine consultations, to protect the privacy of patient identifiable medical information and to support rural health provider telecommunication costs with universal service funds continue. In particular, Western Governors support modifications to the Telecommunications Act or other legislative vehicles that would allow the Universal Services Discount program to be used to reimburse the cost of telemedicine equipment that makes access to health care possible to rural areas from distant sites.

7. Western Governors recognize the importance of HRSA grant support to states under the State Offices of Rural Health Program, Medicare Rural Hospital Flexibility Program, and Small Rural Hospital Improvement Program. These programs permit states to assess, plan and develop the critical rural health services infrastructure. Federal support for these efforts is particularly important to Western States. Western Governors call upon HRSA to make funding decisions that provide equitable funding of all states under these programs, and assure an adequate minimum funding level for all states. Adequate funding will assure that all states can undertake basic development activities. Western Governors also call upon HRSA to permit states the greatest flexibility in the implementation of their grant programs within the broad mission of entitling legislation. This flexibility is needed to assure that the programs can be tailored to meet the specific needs of each state.

C. GOVERNORS' MANAGEMENT DIRECTIVE

1. WGA will post this resolution on its web site to be used and referred to as necessary.
2. WGA will continue to assist the Governors by monitoring and reporting on further developments with regards to rural health.

This policy resolution was originally adopted by the Western Governors in 2001 as 01-06.

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APPENDIX D

Staffing System Data
Presented at the August 4, 2004, Work Session
of the Legislative Committee on Health Care

BACKGROUND REPORT AND DISCUSSION OF RECOMMENDATIONS INCLUDED IN THE WORK SESSION DOCUMENT

LEGISLATIVE COMMITTEE ON HEALTH CARE SUBCOMMITTEE TO STUDY STAFFING OF THE SYSTEM FOR DELIVERY OF HEALTH CARE IN NEVADA PURSUANT TO ASSEMBLY BILL 313 (CHAPTER 410, *STATUTES OF NEVADA 2003*)

April 13, 2004

The following report summarizes issues and recommendations that were discussed in relation to the A.B. 313 Subcommittee's study.

I. BACKGROUND

Assembly Bill 313 (Chapter 410, *Statutes of Nevada 2003*) required the Legislative Committee on Health Care (LCHC) to appoint a Subcommittee to conduct an interim study concerning staffing of the system for the delivery of health care in Nevada. The following persons were appointed to the Subcommittee at an October 29, 2003, meeting of the LCHC: Assemblywoman Ellen M. Koivisto, Chair; Senator Bernice Mathews; and Assemblyman Joe Hardy.

To satisfy the objectives of the study, the Subcommittee was required to collaborate with a statewide advisory group of persons. Assembly Bill 313 specified the organizations that were to have representation on an advisory group, and with the exception of two appointments made by the Subcommittee chair, the bill authorized these organizations to designate their representatives. Additionally, two other members were appointed in a nonvoting capacity. This group was officially designated as the "Legislative Committee on Health Care Subcommittee to Study Staffing of the System for Delivery of Health Care in Nevada Advisory Committee."

The following table identifies the organizations and their designees who made up the A.B. 313 Advisory Committee.

ORGANIZATION	DESIGNEE
A qualified peer review organization that is governed by Titles XI and XVIII of the Social Security Act	Deborah Huber Project Coordinator HealthInsight
Department of Human Resources (DHR), Health Division, Bureau of Licensure and Certification (BLC)	Diane S. Allen, R.N. Health Facilities Surveyor IV
Nevada Hospital Association	Nancy Bridges, R.N. Nurse Executive, and Chairwoman, Advisory Committee
Nevada Nurses Association	Wally Henkelman, M.S.N., R.N.
Nevada State Medical Association	Larry Matheis Executive Director, and Vice Chairman, Advisory Committee
State Board of Nursing	Debra Scott, R.N., M.S., A.P.N. Executive Director
University and Community College System of Nevada (UCCSN)	Dr. Patrick J. Ferrillo Dean School of Dentistry University of Nevada, Las Vegas
University of Nevada, Reno, School of Medicine, Center for Education and Health Services Outreach, Nevada Area Health Education Center Program	Caroline Ford Assistant Dean/Director
University of Nevada, Reno, School of Medicine, Nevada Office of Rural Health, Nevada Rural Hospital Flexibility Program	John Packham, Ph.D. Director
Two organizations that represent the interests of nursing. (Selected by the Chair of the Subcommittee.)	Anne Wagner, R.N. Service Employees International Union Dolores Delarwelle, R.N. Operating Engineers Local Union No. 3
NONVOTING MEMBERS	
Nevada Rural Hospital Partners	Robin Keith President
Nevada Organization of Nurse Leaders	Michele Nichols, R.N. President

II. IDENTIFICATION OF OBJECTIVES

Based on the requirements of the legislation, objectives of the study were set forth and adopted by the LCHC. The following discussion identifies the relevant objectives and illustrates how they were met.

REQUIRED CRITERIA	ACTIVITY TO MEET CRITERIA, INCLUDING RELEVANT DISCUSSION POINTS
(a) The use of established methods of analysis and technical models developed by the National Center for Health Workforce Analysis of the Bureau of Health Professions of the Health Resources and Services Administration of the United States Department of Health and Human Services and the Regional Centers for Health Workforce Studies located in: 1. The University of California at San Francisco; 2. The University of Illinois at Chicago; 3. The State University of New York at Albany; and 4. The University of Washington.	At the November 13, 2003, meeting of the A.B. 313 Advisory Committee, members discussed the relevance of "established methods of analysis and technical models." They agreed on the following points: • To have a presentation by Joanne Spetz, Ph.D., Associate Director, Center for California Health Workforce Studies, University of California, San Francisco, California. This presentation was made at the February 19, 2004, meeting of the Subcommittee. • To have a presentation concerning health workforce data produced by the State University of New York at Albany. This presentation was held at the January 21, 2004, meeting of the LCHC by Jean Moore, Deputy Director, Center for Health Workforce Studies, School of Public Health, State University of New York, New York. • To use as resources because of their research findings, the following publications: o *Keeping Patients Safe – Transforming the Work Environment of Nurses*, Institute of Medicine, January 2004. o *Nursing Staff in Hospitals and Nursing Homes: Is It Adequate?* Institute of Medicine, 1996.

REQUIRED CRITERIA	ACTIVITY TO MEET CRITERIA, INCLUDING RELEVANT DISCUSSION POINTS
	o "Hospital Nurse Staffing and Patient Mortality, Nurse Burn-out and Job Dissatisfaction," by Linda H. Aiken et. al., the *Journal of the American Medical Association* (October 23/30, 2002, Vol. 288, No. 16., pp. 1987-1993). o A report titled *Nursing, Staffing, and Patient Outcomes, and Hospitals,* which was a study headed by Jack Needleman. <u>Other Items for Consideration</u> Members recommended contacting the University of Washington's center because its research focuses on rural health issues. This presentation could not be coordinated within the timeframes of the study. Members also noted that the University of Illinois at Chicago had not produced a significant amount of workforce research; therefore, this center was not contacted for purposes of the study. Members further recommended contacting national professional associations connected with a variety of health profession occupations to determine their methodologies used for staffing ratios in different types of work environments. This issue was not pursued in meetings of the Subcommittee.
(b) A comprehensive evaluation of the current requirements in Nevada for staffing of the system for the delivery of health care.	In meeting this objective, the Advisory Committee members agreed that a presentation identifying Nevada's regulatory environment be held before the Subcommittee. They agreed that representatives of the BLC, Health Division, DHR, conduct the presentation. This presentation was held at the Subcommittee's January 8, 2004, meeting.

REQUIRED CRITERIA	ACTIVITY TO MEET CRITERIA, INCLUDING RELEVANT DISCUSSION POINTS
	To assess this issue in other states, a representative of the Primary Care Resource Center, National Conference of State Legislatures, made a presentation to the Subcommittee at the January 8, 2004, meeting. Representatives of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) also made a presentation for the purpose of examining staffing effectiveness, the impact of other disciplines on nursing staffing, and patient care. This presentation was held at the January 8, 2004, meeting of the Subcommittee.
(c) A comprehensive evaluation of the required methods of record keeping by medical facilities or other organizations that provide organized nursing services of statistics relating to staffing and patient care.	This objective was debated by the Advisory Committee members, and there were two record types that appeared to warrant discussion: 1. Identify the current records that are kept by medical facilities in Nevada as such records relate to staffing requirements; and 2. Identify methods by which consumers may access information about safety and quality concerns of medical facilities. Information in Item 1 was presented by representatives of the BLC at the Subcommittee's January 8, 2004, meeting. Two reports concerning quality measures were made to the Subcommittee at the April 13, 2004, meeting that discussed Item 2.
(d) The identification of conditions under which nurses may refuse work assignments without jeopardizing the quality of patient care.	Members of the Advisory Committee discussed this issue and agreed that the State Board of Nursing should make a presentation about the regulatory

REQUIRED CRITERIA	ACTIVITY TO MEET CRITERIA, INCLUDING RELEVANT DISCUSSION POINTS
	consequences a nurse may face if she refuses an assignment. Members also agreed that this issue should be discussed from the perspective of nurses and administrators. These presentations were held at the February 19, 2004, meeting of the Subcommittee. It appears, however, the conditions under which nurses may refuse work assignments have not been delineated. The debate around this issue has focused on the fact that nurses feel they are not in a position to refuse an assignment because they may face retaliation or termination by their employers if they do so.
(e) A survey of the staffing of the system for the delivery of health care in Nevada that is required by the BLC, Health Division, the JCAHO and any other state or federal law concerning medical facilities or other organizations that provide organized nursing services.	The Advisory Committee members agreed that this objective would be met in the presentation of Nevada's regulatory environment by representatives of the BLC, Health Division, DHR. This presentation was held at the Subcommittee's January 8, 2004, meeting.
(f) A comprehensive evaluation of the practices of recruitment and retention of staff that are used by medical facilities and other organizations that provide organized nursing services in Nevada.	The Advisory Committee members agreed that a comprehensive set of presenters should discuss the issues of recruitment and retention. Additionally, members agreed that representatives of the UCCSN should make a presentation concerning its education efforts across all health care disciplines trained in the system. The presentation by the UCCSN's representatives was held on January 8, 2004. The presentations concerning recruitment and retention were held on February 19, 2004.

REQUIRED CRITERIA	ACTIVITY TO MEET CRITERIA, INCLUDING RELEVANT DISCUSSION POINTS
(g) Recommendations regarding staffing of the system for the delivery of health care in Nevada.	Recommendations concerning staffing of the system for the delivery of health care in Nevada are noted throughout this document.
(h) A comprehensive evaluation of any disaster or emergency situations that would not be covered in any recommendations for the staffing of the system for the delivery of health care.	Members of the Advisory Committee suggested this issue be addressed by hearing from representatives of the Public Health Committee and Homeland Security Committee for the State of Nevada regarding disaster preparedness. They also recommended that the Subcommittee hear presentations concerning hospital emergency room diversions. At its February 19, 2004, meeting, the Subcommittee heard from the Director of Hospital Preparedness for the Nevada Hospital Association. The association is the state's grantee for federal emergency preparedness funding from the Health Resources and Services Administration, U.S. Department of Health and Human Services.

III. DISCUSSION OF OBJECTIVES

The following text summarizes key discussion points concerning the objectives. The objectives as noted above parallel the subsections of Section 1 as identified in A.B. 313 (i.e., Objective (a) is the same as Paragraph (a), Subsection 1, Section 1 of A.B. 313).

Objective (a)

Objective (a) required consideration of existing research concerning health workforce issues. This objective addressed general health workforce issues as well as issues specifically related to nurses.

General Health Workforce Issues

Data presented by Jean Moore, Deputy Director, Center for Health Workforce Studies, School of Public Health, State University of New York, New York, illustrates the following facts in relation to a nationwide shortage of health professionals:

TYPE OF HEALTH PROFESSIONAL	RATE OF SHORTAGE
Registered Nurses	86 percent
Pharmacists	68 percent
Certified Nurse Aides	66 percent
Home Health Aides	60 percent
Radiology Technologists	56 percent
Dentists	52 percent
Other	44 percent

Ms. Moore further provided the following statistics concerning the percent of hospitals that report more difficulty recruiting by profession for the periods 1999-2001.

TYPE OF HEALTH PROFESSIONAL	RATE OF DIFFICULTY RECRUITING
Registered Nurses	82 percent
Imaging Technicians	68 percent
Pharmacists	53 percent
Lab Technicians	46 percent
Licensed Practical Nurses	40 percent
Billers/Coders	40 percent
Nursing Assistants	34 percent
Housekeeping Personnel	20 percent
Information Technology Technicians	13 percent

Ms. Moore noted the workforce directly impacts quality, cost, and access issues. Further, "system wide high turnover, difficulty recruiting, and worker dissatisfaction are signs of a systemic problem."

Ms. Moore cited Nevada's population growth rate. In particular, she noted that the state has an increasing number of persons over the age of 65, the highest rate of death due to firearms in the country in 1999, and was above the national rates of death due to cancer and heart disease. In addition, in 2000, Nevada had the fewest health workers per capita in the country (2,788 per 100,000 people versus 4,030 per 100,000 people nationally).

In terms of the distribution of the state's health workforce, Ms. Moore made the following points:

WHERE EMPLOYED	NEVADA	U.S.
Offices and Clinics	42 percent	28 percent
Hospitals	33 percent	43 percent
Nursing and Personal Care Facilities	11 percent	17 percent
Home Health Services	5 percent	6 percent
Medial and Dental Laboratories	4 percent	2 percent
Other	5 percent	4 percent

Ms. Moore noted that in 2000, the median hourly wage of many of Nevada's health professionals was higher than the national average. The following table illustrates wages in Nevada compared to the U.S.:

TYPE OF PROFESSIONAL	NEVADA	U.S.
Registered Nurses	$24.25	$21.56
Licensed Practical Nurses	$16.27	$14.15
Pharmacists	$37.96	$34.11
Physical Therapists	$29.38	$26.35
Occupational Therapists	$25.99	$23.77
Radiologic Technologists	$20.05	$17.31

The following points discuss physicians in the state:

- There were over 3,200 active patient care physicians in Nevada in 2000.
- Nevada ranked 43rd among states in physicians per 100,000 population, with 159 physicians per capita in 2000, compared to the national rate of 198 physicians per capita.
- Nevada had 55 active primary care physicians per 100,000 population, compared to 69 per capita for the entire country.
- In 2000, Nevada graduated 53 new physicians.
- On a per capita basis, Nevada ranked 42nd among the 46 states with medical schools in graduates per capita in 2000.

In terms of nurses:

- There were more than 12,900 licensed R.N.s in Nevada in 2000.
- Nearly 80 percent of Nevada's licensed R.N.s in 2000 were employed in nursing.

- Nevada ranked last among states in R.N.s per 100,000 people with 514.4, compared to the national rate of 780.2.

- Nevada was among states with the lowest per capita rates of nurse practitioners, certified nurse midwives, and nurse anesthetists in the country.

Additionally, the following table illustrates the aging of selected professionals in the health workforce:

TYPE OF HEALTH PROFESSIONAL	Median Age		PERCENT CHANGE
	1989	1999	
Dentists	40.7	44.0	3.3
Dietitians	38.8	40.0	1.7
Health Records Technologists and Technicians	35.3	40.3	5.0
Radiologic Technicians	34.3	38.0	3.7
Registered Nurses	37.3	42.7	5.4
Respiratory Therapists	32.3	38.0	5.7
Social Workers	38.7	40.3	1.7
Speech Therapists	35.7	40.7	5.0
Pharmacists	36.7	41.3	4.6
Total Civilian Labor Force	35.7	38.7	3.0

Ms. Moore presented additional data concerning the diversity of the workforce, and she noted the following workplace factors contribute to health workforce shortages:

- Physically and emotionally demanding work;

- Non-competitive wages and benefits;

- Poor job design and working conditions;

- Too much paperwork and lack of information systems; and

- Poorly trained managers.

She indicated the following responses to workforce shortages.

- Expand the "pipeline" by implementing education and training strategies, which is a "supply side" strategy;

- Improve retention by using job related strategies, which is also a supply side strategy; and

- Reduce the number of people needed by improving productivity and reducing paperwork, which is a "demand side" strategy.

She noted the following options as fulfilling the "supply side" strategy:

- Scholarships and loan repayment;
- Grants for faculty, capacity expansion, or program start up;
- High school health careers awareness;
- Marketing health careers/public service announcements;
- Promote health provider and education partnerships; and
- Use Labor Department and other training funds.

She further noted the following points as being ways to increase supply by improving retention and job related strategies:

- Reimbursement support for higher wages/benefits;
- Support for career ladders;
- Best practices conferences on job design and retention;
- Prohibit mandatory overtime; and
- Mandate minimum staffing ratios.

In terms of modifying demand and improving productivity, Ms. Moore noted the following strategies:

- Study factors that promote efficient care;
- Conduct demonstrations and evaluation of job redesign;
- Conduct best practices conferences on efficient and productive care;
- Implement regulatory changes concerning scope of practice issues and use of workers;
- Modify health facility requirements and regulations; and
- Promote labor-saving technology.

Finally, Ms. Moore noted the following other responses to health workforce shortages:

- Develop better data collection and needs assessments;

- Establish task forces, commissions, and committees to discuss and make recommendations concerning the issues;

- Use immigration; and

- Provide support for the families and informal care givers of patients.

Considerations Related to Nursing

Joanne Spetz, Ph.D., Associate Director, Center for California Health Workforce Studies, University of California, San Francisco, California, discussed research related to nursing and quality of care. Ms. Spetz commented the evidence suggests that an increase in nurse staffing is related to decreases in risk-adjusted mortality, nosocomial infection rates, thrombosis and pulmonary complications in surgical patients, pressure ulcers, readmission rates, and failure to rescue. There is additional evidence that a higher ratio of R.N.s to residents in long-term care facilities has positive effects for the patients.

Dr. Spetz noted further that high workload and poor staffing ratios are associated with nurse burnout, low job satisfaction, and increased nurse stress. Nurse stress is related to adverse patient events, nurse injuries, quality of care, and patient satisfaction.

She stated that "no study identifies the 'ideal' staffing ratio," and there are limits to all of the research that has been done. She commented on the various ways in which to measure staffing in medical facilities, and she noted the following staffing statistics, highlighting that "Nevada's average staffing is above the national median":

State	Number of Hospitals	Registered Nurse (RN) Hours Per Patient Day	RN+ Licensed Practical Nurse Hours Per Patient Day
New Mexico	60	9.14	11.15
Arizona	91	7.27	9.67
Oregon	68	7.47	8.14
Nevada	**32**	**6.05**	**7.31**
Colorado	83	6.13	7.02
California	488	5.91	7.02
Idaho	47	5.10	6.50
Montana	61	3.64	4.62
U.S.	**6,299**	**5.32**	**6.63**

Dr. Spetz discussed the different approaches to staffing standards, which include the following types: patient acuity/patient classification systems; fixed ratios; formula-based ratios; and skill-mix requirements. She also discussed the problems with each type of system.

Concluding, Dr. Spetz said the solution is more funding for hospitals and an increase in nurses within the labor market.

Nevada's Health Workforce Development and Education Issues

As part of its activities, the Subcommittee determined a need to consider education and training issues in Nevada. In meeting this activity, the Subcommittee received a presentation from representatives of the UCCSN. These representatives noted that an ad hoc Health Education Committee of the Board of Regents had been formed whose purpose was to:

1. Oversee the plan to double the capacity of the UCCSN's nursing programs;

2. Review and make recommendations concerning the School of Medicine's proposal to restructure its Practice Plans;

3. Consider and make recommendations concerning the development of an Academic Medical Center;

4. Review and make recommendations regarding existing health care programs in the UCCSN; and

5. Consider new programs and structures that may be needed to meet the state's needs.

The Health Education Committee also compiled a list of Health and Allied Health Programs by institution and degree level. The task force members will compare this list to employment data prepared by the Department of Employment, Training and Rehabilitation to better understand the training programs that should be provided by the UCCSN.

Recommendations Concerning Health Workforce Issues

The preceding discussion illustrated the value of data and understanding what the state's workforce capabilities are in terms of the number of practitioners in the state and their ability to keep pace with the state's population. Because accurate, complete data is an essential piece of any discussion concerning health workforce issues, members of the Advisory Committee made the following recommendation to the Subcommittee in regard to health workforce issues:

> Consider a recommendation to establish a standing committee on health workforce. The committee should be comprised of legislators, regulators, individuals involved with education and training of health professionals in the state, and other stakeholders. The recommendation from the Subcommittee should leave the responsibility of further defining the composition and responsibilities for the committee up to the members of the Legislative Committee on Health Care.

Objective (b)

Objective (b) sought to evaluate Nevada's current requirements for staffing the health care delivery system. Two presentations discussed this issue.

Staffing Standards in Nevada

Key points of the presentation concerning staffing standards in Nevada, which was given by Diane S. Allen, R.N., Health Facilities Surveyor IV, and Jeannie Anspach, R.N., Health Facility Surveyor Supervisor, BLC, are:

- Regulations governing staffing in medical facilities in Nevada were revised in 1999 after a 4-year discussion and review process. Members of the State Board of Health considered whether to require specific ratios for nurses to patients, but its members chose not to do so. One of the reasons given for not requiring specific ratios was the issue of hospital emergency room diversions. Consequently, existing regulations in Nevada for medical facilities do not require established ratios of nurses to patients. The standards are based on an acuity system that requires sufficient nursing staff to meet the needs of the patients.
- Citing components as established by the American Nurses Association, the state's acuity system requires facilities to consider: (a) the number of patients; (b) the levels of intensity of the patients for whom care is being provided; (c) the architecture and geography of the environment as well as available technology; and (d) the level of preparation and experience of the nurses on a particular unit.
- Skilled nursing facilities (SNFs), also known as "nursing homes" underwent a regulatory change in 1999. These facilities also are required to staff on an acuity basis, but the state's regulations require SNFs to have an R.N. on duty at least 8 consecutive hours per day, 7 days a week. Most SNFs choose to staff with an R.N. 24 hours per day, 7 days a week. The BLC may attempt to change the current regulatory standards for SNFs from 8 hours per day, 7 days per week to 24 hours per day, 7 days per week. Pursuant to federal regulations, SNFs are required to post the number of licensed and unlicensed nursing staff directly responsible for resident care.
- A patient's assessment ultimately determines whether care will be administered by a licensed practical nurse, an R.N., or a certified nursing assistant.

Discussion before the Subcommittee indicated that there is a perception that facilities do not assess patients for acuity but rather assignments are made in another manner. Ms. Allen indicated that the BLC will investigate such complaints through unannounced site visits and examinations of staffing requirements and managers' schedules. Further, the BLC is aware that some hospitals in Nevada cannot staff according to the established acuity standards. The BLC attempts to work with these facilities, and some of them may be sanctioned for noncompliance. However, the BLC has limited resources to enforce the acuity standards.

There was a general conclusion that there is a lack of quality data concerning whether the acuity staffing requirements are being met by facilities in the state. In addition, there may be a lack of resources for enforcement of the standards.

Staffing Requirements of JCAHO Accredited Facilities

Noelle D. Brown, Associate Director, State Relations, and Carol Gilhooley, Director of Accreditation Process Improvement, JCAHO, discussed standards for JCAHO accredited facilities. They indicated that JCAHO accreditation is a voluntary process. The organization has changed its philosophy from one that encourages facilities to prepare for surveys to "one of continuous systematic and operational improvement focused on safe, high quality care, treatment, and services." Further, the JCAHO incorporates surveys, screenings, data and trend analysis, evaluation, et cetera, to assist its member organizations. These representatives noted that the essential connection between accreditation and quality improvement is an accurate system of accountability.

These presenters stated that staffing standards are complex, dynamic, and unique to each facility, and staffing ratios cannot be applied universally. Finally, they noted that hospital quality reports will be available to the public later in 2004 on JCAHO's Internet Web site. Information on this Web site will include hospital performance data in a variety of areas.

Ms. Brown and Ms. Gilhooley concluded their presentation by referencing a white paper titled *Health Care at the Crossroads: Strategies for Addressing the Evolving Nursing Crisis*, in which three recommendations are made and developed in the paper to address the nursing shortage. These recommendations are:

Create Organizational Cultures of Retention: Adopt the characteristics of "Magnet" hospitals to foster a workplace that empowers and is respectful of nursing staff. Provide management training, as well as support, to nurse executives. Positively transform nursing work through the use of information and ergonomic technologies. Set staffing levels based on nurse competency and skill mix relative to patient mix and acuity. Adopt zero-tolerance policies for abusive behaviors by health care practitioners. Diversify the nursing workforce to broaden the base of potential workers.

Bolster the Nursing Educational Infrastructure: Increase funding for nursing education, including endowments, scholarships and federal appropriations. Establish a standardized, post-graduate nursing residency program. Emphasize team-training in nursing education. Enhance support of nursing orientation, in-service, and continuing education in hospitals. Create nursing career ladders commensurate with educational level and experience.

Establish Financial Incentives for Investing in Nursing: Make new federal monies available for health care organizations to invest in nursing services. Condition continued receipt of these monies on achievement of quantifiable, evidence-based, and standardized nursing sensitive goals. Align private payer and federal reimbursement incentives to reward effective nurse staffing.

Staffing Requirements in Other States

The presentation concerning staffing requirements in other states was provided by Tim Henderson, Director, Primary Care Resource Center, National Conference of State Legislatures. Mr. Henderson made the following relevant points:

- According to the 2000 National Sample Survey performed by the Federal government, the supply of nurses throughout the country varies considerably, and Nevada is more than 10 percent below average of employed nurses per 100,000 population. Nevada has 520 nurses per 100,000 patients as compared to the national average of 782 nurses per 100,000 patients. The nation's southwest region ranks consistently lower than the rest of the U.S.

- Most employers perceive newly licensed R.N.s as not fully prepared for basic practice setting tasks. In a 2001 Employer Survey conducted by the National Council of State Boards of Nursing, employers reported that 43 percent of R.N.s can adequately administer medication by common routes. Conversely, only 11 percent were able to respond adequately to emergency situations; 13 percent were able to supervise care provided by others; and 19 percent were able to perform psychomotor skills and recognize abnormal diagnostic lab findings. Further, employers perceive newly licensed R.N.s are not fully prepared for basic practice setting tasks. Finally, there is a significant turnover rate within the first two years of hire of Baccalaureate and associate degree nurses, but few employers have a preference for certain types of educational preparation when hiring new nurses.

- National hospital nurse vacancies in 2002 are on average 13 percent to 15 percent less than the 2001 vacancy rate. This is due to increased hiring of nurses aged 50 years or older and nurses who are trained overseas. National nursing home vacancies have risen sharply during this same time span.

- Thirty-seven states have enacted legislation that supplements minimum federal staffing standards for nursing homes; at least 15 states have enacted or considered limiting mandatory overtime; 11 states have strengthened R.N. supervisory responsibility for certified nurse assistants; and over 20 states have established statewide efforts concerning statewide nursing workforce commissions, including data centers.

- To address the nursing shortage and fully understand the problem and the needs and changes in supply and demand, states have enhanced their statewide data collection and analysis activities. Mr. Henderson reported that data collection efforts are relatively low-cost solutions to this issue.

- States have increased their efforts in regard to funding educational opportunities, and they are now considering workplace issues.

- Issues with staffing include: (1) patient acuity; (2) intensity and quality of patient care; (3) volume of care and demand for patient care staff; (4) appropriate supply and skill/degree mix of staff; (5) staff vacancy/turnover rate and wage competition; (6) the growing presence and power of nurse unions; (7) training capacity of area nursing schools and preparedness of graduates to "hit the ground running"; (8) staff costs and financial condition of health care institutions; (9) staff role in organizational decision-making; and (10) staff leadership capability and skills.

- Nurse job dissatisfaction due to poor working conditions is one part of why nurses are vacating the profession. There are other factors driving the exodus, including: (1) changes in the lifestyles and physical conditions of nurses; (2) desires to spend more time at home; (3) opportunities for salary changes and adjustments in other places; and (4) increasing requirements for retraining.

- Issues to consider in implementing nurse staffing ratios include: (1) outcomes of patient care; (2) availability of nurses to meet ratios; and (3) hiring a quality skill mix of R.N.s could result in shortages in other care giving staffing.

Possible Recommendations Concerning Nevada's System of Staffing

Based on discussion concerning Nevada's system of staffing, the following recommendations might be considered:

> Require the Health Division, DHR, to develop a standardized staffing system for all medical facilities in the state and provide adequate financial resources to the division for enforcement of the standards.

Objective (c)

Objective (c) was an evaluation of the required methods of record keeping by facilities. In discussing the types of presentations that would meet this objective, there was concern about records that are required to be kept and whether such records should be available to the public for review. The purpose of the review would be that the public is able to compare quality criteria between facilities. There is also a general concern that nurses, in particular, are overburdened by recordkeeping requirements, and the assessment of records might determine whether some records have outlived their usefulness.

In the presentation concerning staffing requirements in Nevada, the BLC's representative, Ms. Allen, included information identifying medical records that must be kept by medical facilities. Notably, the types of records that must be kept are those records that are essential to assessing a patient, developing a care plan for a patient, and discharging the patient. The specific types of information required in a medical record of a patient for a hospital in the state are found at *Nevada Administrative Code (*NAC) 449.379, "Medical records." In particular, Subsection 8 of this regulation states:

8. All medical records must document the following information, as appropriate:

(a) Evidence that a physical examination, including a history of the health of the patient, was performed on the patient not more than 7 days before or more than 48 hours after his admission into the hospital.

(b) The diagnosis of the patient at the time of admission.

(c) The results of all consultative evaluations of the patient and the appropriate findings by clinical and other staff involved in caring for the patient.

(d) Documentation of any complications suffered by the patient, infections acquired by the patient while in the hospital and unfavorable reactions by the patient to drugs and anesthesia administered to him.

(e) Properly executed informed consent for all procedures and treatments specified by the medical staff, or federal or state law, as requiring written patient consent.

(f) All orders of practitioners, nursing notes, reports of treatment, records of medication, radiology and laboratory reports, vital signs and other information necessary to monitor the condition of the patient.

(g) A discharge summary that includes a description of the outcome of the hospitalization, disposition of the case and the provisions for follow-up care that have been provided to the patient.

(h) The final diagnosis of the patient.

Although this information must be documented in the patient's medical record, the format of the actual paper records may vary between facilities, and this information is not reported in a systematic manner to any agency in the state.

Additionally, as noted in preceding text, staffing plans of facilities also are not standardized among facilities. Facilities are only required to have a staffing plan. When the BLC conducts surveys of facilities, the surveyor will request the facility's staffing plan and verify the requirements of the plan against the manager's reports. There is no established system in the state that tracks staffing ratios.

During an Advisory Committee meeting, Ms. Allen stated that all facilities are required to keep records to demonstrate compliance with the NAC; however, facilities do not have to make their records public. Consequently, records that might provide details about deaths, infection rates, or other incidences at medical facilities are not available for the sake of comparing one facility to the next.

Nevada does have a Cost Containment Unit in the Division of Health Care Financing and Policy, DHR. This unit receives quarterly reports from Nevada hospitals that are available for public review. The data includes financial reports, utilization reports, selected audit reports, budget reports, and Medicare and Medicaid cost reports. Additionally, anyone can request patient discharge data from the unit's contractor, which is the Center for Health Information Analysis, University of Nevada, Las Vegas. There is a fee for data requests from these two entities.

Finally, at the final meeting of the Subcommittee, there will be a discussion about Pennsylvania's reporting system as it relates to hospital performance. Staff reviewed the Web site of the Pennsylvania Health Care Cost Containment Council, and the following recommendation considers the discussion that has occurred during two Advisory Committee meetings and the Subcommittee meetings as it relates to measuring hospital performance.

Possible Recommendation Concerning Records

A possible recommendation concerning the issue of records might be to:

> Require hospitals to report data concerning hospital-specific information about patients admitted for common medical procedures and treatments. Such information should include risk-adjusted measures of mortality, average lengths of hospitalization, length of stay outlier rates and ratings, readmission rates for any reason and for complication/infection, and regionally adjusted average hospital charges.

Objective (d)

The purpose of Objective (d) was to identify the conditions under which nurses may refuse work assignments without jeopardizing the quality of patient care. Lengthy testimony was provided to the Subcommittee concerning this issue, and the discussion was largely a debate as to whether a nurse who refuses an assignment would face retaliation or termination from his or her job for refusing the assignment. There also was general discussion about the consequences a nurse would face from the licensing board if he or she refused an assignment that jeopardized patient care. However, except for this discussion by the board, no specific criteria concerning the conditions under which a nurse could refuse an assignment were set forth in this regard.

A representative of the State Board of Nursing provided the following information as a guideline for nurses to use to ensure safe patient care and compliance with the *Nurse Practice Act*:

> **How can nurses protect their patients and protect their licenses?** Prevention and early intervention are always a place to start. Nurses should know the laws and regulations that govern their practice and clearly understand what constitutes a violation of the *Nurse Practice Act*. For example, nurses may be told that refusing to accept an assignment is "wrongful abandonment," but in fact, the *Nurse Practice Act* cites three conditions that must exist before such an action would be considered abandonment by the Board.
>
> Specifically, according to NAC 632.895(6):
>
> "An act of patient abandonment occurs if:
>
> (a) A licensee or holder of a certificate has been assigned and accepted a duty of care to a patient;

(b) The licensee or holder of a certificate departed from the site of the assignment without ensuring that the patient was adequately cared for; and

(c) As a result of the departure, the patient was in potential harm or actually harmed."

Evidence of all three conditions must be shown before the Board may consider disciplinary action against a nurse for patient abandonment. (During fiscal year 2002-2003, one complaint met this legal requirement and resulted in disciplinary action against the nurse. The nurse left her shift after being on duty for a few hours, did not have permission to leave, and did not give [a] report on her patients to anyone before leaving. In other words, she met all three legal criteria for patient abandonment.)

Also, nurses may be disciplined if they accept assignments they are not competent to perform. If they do, they may place the patient in danger, and they [a]re in violation of the *Nurse Practice Act* (NAC 632.890(4), assuming duties and responsibilities within the practice of nursing if competency is not maintained, or the standards of competence are not satisfied, or both.)

It should be noted that the Board has no jurisdiction over employment or contract issues. Well-intentioned nurses may feel like they [a]re in a "Catch 22," where if they practice in accordance with the law, they will keep their licenses but lose their jobs. Unfortunately, sometimes leaving a position is the only option. Here are some things to consider—

- Place patient safety and well-being first. Act in good faith.
- Know the laws and regulations that govern your practice.
- Build a defense for why an action (or act of omission) was unavoidable. Document carefully. Be able to demonstrate that the course of action was what would have been followed in a similar situation by a reasonable and prudent nurse with similar education and experience.
- Continue to advocate for safe nursing care for patients.

As noted in the opening paragraph of this section, the other discussion on this issue was a debate concerning whether a nurse would face retaliation or termination from his or her job if he or she chooses to refuse an assignment. Facilities with union protections have avenues in place for a nurse to document an unsafe assignment by using something called an "Assignment Despite Objection" form, but nurses who work at facilities without union representation do not have these options.

One presenter stated that the issue of refusing an assignment is directly related to the retention crisis as both are rooted in the problem of inadequate and dangerous short staffing. If a facility is not fully staffed with the appropriate mix of personnel, the remaining nurses must pick up the patient load without regard to their abilities to do so. This presenter noted that the current acuity system is inadequate, is ignored, and is not enforced.

The conclusion was that there are no avenues outside of the employment setting for a nurse to take his or her case if he or she is demoted, downgraded on an employment evaluation, denied a raise or promotion, or terminated from his or her position within a facility. Further, the current acuity system is inadequate and does not protect patients, and a new method of staffing medical facilities is required to ensure safe patient care.

Recommendations Concerning Refusal of a Work Assignment

Based on this discussion, the following recommendations might be considered by the Subcommittee:

> Prohibit employers of traveling nurses from requiring or otherwise authorizing traveling nurses to be responsible for staffing assignments. (This recommendation was offered because of a perception that traveling nurses do not have a commitment to a facility, and they do not consider the abilities of other nursing staff when they make assignments.)
>
> Implement a law that protects the jobs of nurses when they object to an assignment. The law should prevent an employer from retaliating against or terminating a nurse who objects to or refuses an assignment because the nurse is unable to perform the tasks required for care or because the nurse is unable to adequately care for a patient because of other patients for whom the nurse is responsible during a shift.
>
> Establish a system of penalties and adequately fund activities to enforce current acuity standards in Nevada's medical facilities.
>
> Mandate staffing ratios in medical facilities because the current acuity system does not protect patients.

Objective (e)

It appears that the requirements of Objective (e) were met by the presentations made in Objective (b). Therefore, no specific recommendations were made for this objective by either the Advisory Committee or during hearings of the Subcommittee.

Objective (f)

Objective (f) required an evaluation of the recruitment and retention practices of staff in medical facilities. Members of the Subcommittee heard numerous presentations about recruitment and retention issues. These issues are discussed in subsequent text.

Recruitment Issues

In terms of recruitment issues, discussion noted that there are many activities ongoing in Nevada to recruit health professionals, and a substantial sum of money is spent recruiting nurses to the state. In particular, many incentive programs are created to encourage students to train as nurses, including training programs while students are still in high school, and many scholarships and loan forgiveness programs exist for students to access. For nurses who have graduated, facilities offer various cash incentive programs, and they encourage nurses to continue their educations.

Finally, there is general support for the efforts to double the number of nurses who are trained in Nevada. This support is evidenced in a statement by the Advisory Committee at its March 17, 2004, meeting.

Retention Issues

In terms of retention issues, however, there are divergent opinions as to what activities and strategies should be undertaken to address this issue. There also are conflicting data concerning turnover rates at facilities in Nevada and whether current retention efforts are working in the state's facilities.

In dealing with the issue of strategies to retain nurses, one speaker noted the following data from a 2000 survey conducted by the Nevada Hospital Association, which illustrates why nurses leave Nevada hospitals:

REASON CITED FOR LEAVING	PERCENT
Moving/relocating	20 percent
Personal/family issues	20 percent
Other employment opportunities	15.7 percent
Staffing concerns	15.7 percent
Pay/benefits	11.4 percent
Retirement	8.6 percent
Offer from another facility	7.1 percent

Using this data, the speaker made the following observation:

> It would be logical for this [S]ubcommittee to address nurse staffing as its primary area of attention relating to nurse retention. Increasing retention would increase staffing and increased staffing would encourage retention.
>
> The Nevada Bureau of Licensure and Certification maintains that there is an appropriate staffing system in place, acuity based staffing. In my opinion, and the opinions of the many nurses with whom I interact, that system is not being used, or is at best a paperwork exercise to satisfy state surveyors. Something more definitive and enforceable such as minimum staffing ratios is both desirable and necessary. This would provide for increased patient safety as well as increasing the satisfaction of

> bedside nurses in their work settings, thus enhancing nurse retention. In spite of the scare tactics and worse case scenarios presented by some opponents of such an action, please note that the National Conference of State Legislatures estimates that the cost of such a program would be a rise of less than 2 [percent] in per-hospital nursing expenditures.

Other speakers again advocated for minimum staffing ratios as ways to retain nurses. One speaker in particular stated the following:

> . . . evidence will show that there is no nursing shortage – rather there is a shortage of nurses willing to work at the hospital bedside. . . [T]he primary reason my co-workers are leaving the bedside at such an alarming rate, well before retirement age, is because of our working conditions, mainly short staffing.

Although the premise made by this speaker is in dispute, this speaker cited current statistics of nursing graduates as well as license endorsements as evidence that there are enough nurses in the state, but these nurses simply choose not to practice in hospital settings in the state. Further, this speaker cited a study titled "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction," which was published in the *Journal of the American Medical Association* (Vol. 288, No. 16, pp. 1987-1993, October 23/30 2002). This study had the following findings:

- After adjusting for patient and hospital characteristics, each additional patient per nurse was associated with a 7 percent (odds ratio, 1.07; 95 percent confidence interval, 1.03-1.12) increase in the likelihood of dying within 30 days of admission and a 7 percent (odds ratio, 1.07; 95 percent confidence level, 1.02-1.11) increase in the odds of failure-to-rescue.

- After adjusting for nurse and hospital characteristics, each additional patient per nurse was associated with a 23 percent (odds ratio, 1.23; 95 percent confidence interval, 1.13-1.34) increase in the odds of burnout and a 15 percent (odds ratio, 1.15; 95 percent confidence interval, 1.07-1.25) increase in the odds of job dissatisfaction.

These results formed the conclusion of the study, which is:

> In hospitals with high patient-to-nurse ratios, surgical patients experience higher risk-adjusted 30-day mortality and failure-to-rescue rates, and nurses are more likely to experience burnout and job dissatisfaction.

In discussing the study findings and conclusions, the authors made the following points:

> . . . all else being equal, substantial decreases in mortality rates could result from increasing registered nurse staffing, especially for patients who develop complications. (p. 1991)

> Our results suggest that the California hospital nurse staffing legislation represents a credible approach to reducing mortality and increasing nurse retention in hospital practice, if it can be successfully implemented. Moreover, our findings suggest that California officials were wise to reject ratios favored by hospital stakeholder groups of 10 patients to each nurse on medical and surgical general units in favor of more generous staffing requirements of 5 to 6 patients per nurse. Our results do not directly indicate how many nurses are needed to care for patients or whether there is some maximum ratio of patients per nurse above which hospitals should not venture. Our major point is that there are detectable differences in risk-adjusted mortality and failure-to-rescue rates across hospitals with different registered nurse staffing ratios. (p. 1992)
>
> Our results further indicate that nurses in hospitals with the highest patient-to-nurse ratios are more than twice as likely to experience job-related burnout and almost twice as likely to be dissatisfied with their jobs compared with nurses in the hospitals with the lowest ratios. This effect of staffing on job satisfaction and burnout suggests that improvements in nurse staffing in California hospitals resulting from the new legislation could be accompanied by declines in nurse turnover. We found that burnout and dissatisfaction predict nurses' intentions to leave their current jobs within a year. Although we do not know how many of the nurses who indicated intentions to leave their jobs actually did so, it seems reasonable to assume that the 4-fold difference in intentions across these 2 groups translated to at least a similar difference in nurse resignations. If recently published estimates of the costs of replacing a hospital medical and surgical general unit and a specialty nurse of $42,000 and $64,000, respectively, are correct, improving staffing may not only save patient lives and decrease nurse turnover but also reduce hospital costs. (p. 1992)
>
> Our findings have important implications for [two] pressing issues: patient safety and the hospital nurse shortage. Our results document sizable and significant effects of registered nurse staffing on preventable deaths. The association of nurse staffing levels with the rescue of patients with life-threatening conditions suggests that nurses contribute importantly to surveillance, early detection, and timely interventions that save lives. The benefits of improved registered nurse staffing also extend to the larger numbers of hospitalized patients who are not at high risk for mortality but nevertheless are vulnerable to a wide range of unfavorable outcomes. Improving nurse staffing levels may reduce alarming turnover rates in hospitals by reducing burnout and job dissatisfaction, major precursors of job resignation. When taken together, the impacts of staffing on patient and nurse outcomes suggest that by investing in registered nurse staffing, hospitals may avert both preventable mortality and low nurse retention in hospital practice. (p. 1993)

This speaker concluded that the solution to bringing nurses back to hospitals is minimum nurse staffing ratios. Other speakers made similar recommendations with the final speaker on this issue stating:

> When hospitals offer nurses good pay, good benefits, professional respect, and staffing ratios conducive to quality care, then more nurses will stay and the shortage will wither away.

This speaker also noted that assignments at the beginning of a shift are more likely to be based on patient acuity and with a reasonable number of patients, but:

> . . . reasonableness and safety fly out the window over the course of a nurse's shift. The patients are rolled in, assigned to a nurse in a flurry of activity, and questions of acuity are left perhaps for the charge nurse to consider when she prepares her assignments for the next shift.
>
> What can the [L]egislature do to protect patient safety at that moment in time, in the middle of a nurse's shift when that other patient is assigned, and when no single ratio or standard can possibly tell us what is the right thing to do?
>
> For me, part of the answer must lie in respect for the professional judgment of the licensed nurse. We urgently need legislation that allows the nurse to refuse what he or she considers to be an unsafe assignment, and he or she must be able to do so without putting her job at risk.

Recommendations Concerning Recruitment and Retention Issues

Other than the suggestion to mandate nurse-to-patient ratios, it does not appear there are any specific recommendations related to recruitment and retention issues.

Objective (g)

Objective (g) is simply a restatement of recommendations that have been made to the Subcommittee. Because one other criterion required study, this objective will be restated following discussion of the next objective.

Objective (h)

Objective (h) required a consideration of staffing during emergencies. In meeting this objective, the Subcommittee received a presentation and recommendations from the Director of Hospital Preparedness for the Nevada Hospital Association.

Notably, this speaker stated that staffing ratios are not feasible during medical emergencies and special circumstances such as terrorist acts or natural disasters. The speaker made the following three recommendations:

> Exempt disaster and emergency situations from recommended staffing models because of the potential for local health care resources to be overwhelmed.
>
> Require the Health Division in establishing staffing levels to evaluate the actual acuity and patient care requirements during a disaster or emergency with mass casualties not just the number of patients alone.

Waive licensing requirements, various scopes of practices, and the use of nontraditional care centers during any large-scale, catastrophic event. (NOTE: *Nevada Revised Statutes* 632.340(3) allows for nursing assistance in the case of an emergency.)

IV. OTHER WORKPLACE ISSUES DISCUSSED DURING HEARINGS

Some speakers before the Subcommittee made recommendations that complement the work of the Subcommittee. This section includes their recommendations and summarizes their testimony.

One speaker provided examples of job stressors, discussed adversarial relationships between physicians and nurses, and submitted a list of ten suggestions to change the nurse status quo in Nevada, which include:

- Supporting initiatives to educate the public on the need for family involvement in the care of their hospitalized loved ones;
- Increasing cost-effective support for registered staff nurses;
- Computerizing hospital systems and including physicians in the process;
- Establishing zero tolerance hospital policies for abusive behaviors by anyone in the hospital workplace;
- Encouraging hospitals to contract directly with independent, self-employed R.N.s;
- Increasing workplace efficiency with regard to placement of vital equipment and supplies, et cetera;
- Investigating nursing schools in Nevada to determine failure rate statistics;
- Protecting workers from injury by using mechanical equipment to lift fallen patients;
- Incorporating shorter shifts; and
- Encouraging nurse entrepreneurship.

Another speaker noted the following problems with hospital work environments:

- Staff nurses report they are overworked and understaffed;
- There is a lack of trust between management and nurses;
- The 12-hour shifts are “debilitating, physically and mentally, to some staff nurses”;

- The use of higher paid agency nurses magnifies inequality in pay and staff nurses become resentful;
- Management reduces acuity scores, which results in inadequate staffing patterns, or inversely, makes staffing appear adequate; and
- Vague language in Nevada's *Nurse Practice Act* at NAC 632.222 suggests that an R.N. may delegate nursing care to other nurses and supervise other personnel, which "cannot ever be achieved."

This speaker made the following recommendations to address these issues:

- Improve working conditions by instituting staffing ratios;
- Prohibit hospitals from "loading" patients on staff nurses;
- Offer flexible shifts;
- Offer more extensive orientation and mentoring for new employees, new graduates, and recruits from other countries;
- Pay nurses better;
- Prohibit mandatory overtime and make it optional; and
- Remove the language "supervise other personnel" from the *Nurse Practice Act* at NAC 632.222(1) and NAC 632.230(3).

V. RECOMMENDATIONS

This section consolidates key recommendations that have been offered to the Subcommittee.

Objective (g)

As noted in preceding text, Objective (g) is a restatement of the recommendations that were put forth during meetings of the Subcommittee. Each of these recommendations has been assigned a number that the Subcommittee members may use if they choose to take action on a particular recommendation. These numbers correlate with the "Work Session Document."

1. Consider a recommendation to establish a standing committee on health workforce. The committee should be comprised of legislators, regulators, individuals involved with education and training of health professionals in the state, and other stakeholders. The recommendation from the Subcommittee should leave the responsibility of further defining the composition and responsibilities for the committee up to the members of the LCHC.

2. Require the Health Division, DHR, to develop a standardized staffing system for all medical facilities in the state and provide adequate financial resources to the division for enforcement of the standards.

3. Require hospitals to report data concerning hospital-specific information about patients admitted for common medical procedures and treatments. Such information should include risk-adjusted measures of mortality, average lengths of hospitalization, length of stay outlier rates and ratings, readmission rates for any reason and for complication/infection, and regionally adjusted average hospital charges.

4. Prohibit employers of traveling nurses from requiring or otherwise authorizing traveling nurses to be responsible for staffing assignments.

5. Implement a law that protects the jobs of nurses when they object to an assignment. The law should prevent an employer from retaliating against or terminating a nurse who objects to or refuses an assignment because the nurse is unable to perform the tasks required for care or because the nurse is unable to adequately care for a patient because of other patients for whom the nurse is responsible during a shift.

6. Establish a system of penalties and adequately fund activities to enforce current acuity standards in Nevada's medical facilities.

7. Mandate nurse staffing ratios in medical facilities in Nevada.

8. Exempt disaster and emergency situations from recommended staffing levels.

9. Require the Health Division in establishing staffing levels to evaluate the actual acuity and patient care requirements during a disaster or emergency with mass casualties not just the number of patients alone.

10. Waive licensing requirements, various scopes of practices, and the use of nontraditional care centers during any large-scale, catastrophic event. (NOTE: *Nevada Revised Statutes* 632.340(3) allows for nursing assistance in the case of an emergency.)

11. Prohibit hospitals from "loading" patients on staff nurses.

12. Require hospitals in Nevada to offer flexible shifts for nursing staff.

13. Require hospitals to have formal orientation and mentoring programs for new employees, new graduates, and recruits from other countries.

14. Prohibit mandatory overtime and make it optional for nurses in Nevada's medical facilities.

15. Remove the language "supervise other personnel" from the *Nurse Practice Act* at NAC 632.222(1) and NAC 632.230(3).

VI. CONCLUSION

This report summarizes the proceedings of two Advisory Committee meetings and two Subcommittee meetings. In addition, some of the recommendations contained in this report anticipate issues that will come up at the third and final meeting of the Subcommittee. The recommendations in this report are derived from debate during the hearings, and they may be changed based on input received during the final meeting of the Subcommittee. This report will be revised to accommodate the discussion at the third and final meeting of the Subcommittee and to accommodate the recommendations that were adopted by the Subcommittee, which will be forwarded to the members of the LCHC for their consideration.

MMW/k:Work Session Background.AB313.2003

University and Community College System of Nevada

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April 22, 2004

Assemblywoman Ellen Koivisto, Chair
Legislative Committee on Health Care
1147 Timber Ridge Court
Las Vegas, Nevada 89110-2545

Dear Ms. Koivisto:

I am writing in regards to discussions that I understand are taking place amongst members of the Legislative Committee on Health Care (*Nevada Revised Statutes* 439B.200) regarding a centralized agency for collecting and analyzing health care data for the state of Nevada. It is apparent that the need for an office in this state to collect health care workforce data and conduct meaningful analysis to determine if the state's higher education system is generating sufficient graduates in certain health care specialties is necessary at this time. I feel that such a function belongs within the University and Community College System of Nevada (UCCSN).

As you may be aware, during the 1997 Session of the Nevada Legislature, Senate Bill 385 (Chapter 427, *Statutes of Nevada 1997*) authorized the UCCSN to employ a health care program developer to study the role of the health science and allied health programs of the System in meeting the needs of the state as it related to education, training, and delivery of health care services. Unfortunately, after several years the funding for this position was discontinued and therefore the position was eliminated.

I believe that the UCCSN is the appropriate venue for the type of health care analysis office your committee is contemplating. I recommend that the Health Care Committee consider adopting a recommendation for consideration during the 2005 Session to create such an office located in the System Administration office of the UCCSN. The office would be responsible for collecting and analyzing health care data, developing policy, and working with the campuses in conducting program reviews and developing programs to meet health care workforce demands. Further, this office may coordinate an advisory council made up of representatives from UCCSN institutions to carry on dialogues and ensure that the campuses are developing the kind of programs that the Nevada marketplace for health care professionals demands.

Please consider this recommendation for discussion at your May 12, 2004, meeting. I would be happy to be present to articulate this concept to the committee as a whole. If you have any questions or need additional information, please feel free to contact me at 775-784-4901 or at 702-889-8426.

Sincerely,

Jane Nichols
Chancellor

JN/cmm

CC: UCCSN Board of Regents
UCCSN Presidents
Maria McDade Williams, Legislative Counsel Bureau

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April 29, 2004

MEMORANDUM

TO: ASSEMBLYWOMAN ELLEN M. KOIVISTO, CHAIR
LEGISLATIVE COMMITTEE ON HEALTH CARE

FROM: CAROLINE FORD
ASSISTANT DEAN/DIRECTOR
MEMBER, A.B. 313 ADVISORY COMMITTEE

SUBJECT: SUGGESTIONS RE: ADVISORY COMMITTEE ON HEALTH CARE WORKFORCE

Please allow me to provide the following clarification of the A.B. 313 Advisory Committee recommendation to support establishing an **Advisory Committee on Health Care Workforce**. An example that illustrates the legislature's ability to enact this approach is entitled "Legislative Committee for Local Government Taxes and Finance - Advisory Committee on Taxation."

This Advisory Committee's function would be to receive testimony, review health workforce analyses and make recommendations to the Health Care Committee to address policy, regulatory and education/training issues on a continuous basis throughout the interim sessions. In this manner, issues pertaining to the broad scope of health workforce do not appear before the Health Care Committee while in crisis, nor await action until each regular session; but are discussed, reviewed and strategies agreed upon that blend policy makers and stakeholders before they are placed on an agenda that competes for precious time allotted to testimony before the Health Care Committee.

This committee would be **advisory** to the Health Care Committee and be established to:

1. Review health workforce data presented by the Medical Education Council of Nevada and other Nevada health professions agencies, organizations and programs;
2. Make recommendations regarding specific qualitative and quantitative needs that pertain to outcomes of health workforce data;
3. Review supply and demand data;
4. Make recommendations to the Health Care Committee on regulatory barriers including licensing;
5. Make recommendations to the Health Care Committee on recruitment and retention strategies necessitating legislative action;
6. Make recommendations to the Health Care Committee regarding education and training programs within Nevada; and
7. Receive public comment and monitor Nevada's ongoing condition with supplying an adequate and qualified health care workforce to meet the needs of the citizens including special population and geographic considerations.

Possible Advisory Committee composition to be considered might include:

1. Two members appointed by the President Pro Tempore of the Senate, one from the membership of the Legislative Interim Standing Committee on Health Care during the immediately preceding session of the Legislature and one member from the Human Resources and Facilities Committee;
2. Two members appointed by the Speaker of the Assembly one from the membership of the Legislative Standing Committee on Health Care during the immediately preceding session of the Legislature and one member from the Health and Human Services Committee;
3. Ten members who are representative of various geographical areas of the State including rural areas, and are appointed for terms of 2 years:
    (a) One member of the Medical Education Council of Nevada (NRS 396.908) or the Executive Director of the Council, appointed by the Chair of the Council;
    (b) One member representing the Nevada Area Health Education Center Program (NRS 396.907) appointed by the Director;
    (c) Two members representing professional allied health organizations based in the State of Nevada that would be self nominated and be selected by the Legislative representatives of the Committee;
    (d) Two members representing educational programs and training of the UCCSN and appointed by the Board of Regents of UCCSN;
    (e) One member representing the hospital industry appointed by the Nevada Hospital Association (representation would rotate between rural and urban each term);
    (f) Two members representing health facilities and organizations (e.g. Long Term Care, Home Health, Tribal Clinics, Public Clinics, Private Clinical Practices, Pharmacy Practice etc.) self nominated and be selected by the Legislative representatives of the Committee; and
    (g) One member who directs the Nevada Department of Health Care Financing and Policy;
4. The members of the Advisory Committee are voting members of the Committee and would provide recommendations to the Legislative Committee on Health Care.

Health workforce data collection functions and analyses were authorized in July 2003 through NRS Chapter 396.908. In order to perform the analytical functions of the Medical Education Council, we would need to develop a budget to perform the tasks necessary to support their operations. A critical outcome of the analytic work is the power of the data for decision making in the state. The priorities for health workforce analyses can be closely coordinated with an established advisory body for Health Workforce and the Legislative Committee on Health Care.

In summary, establishing an **Advisory Committee on Health Workforce** would provide a conduit for information, data review and public testimony before specific recommendations are presented to the Health Care Committee.

I would be happy to discuss these issues further at your convenience. Thank you for your consideration of these suggestions.

Cc: Marla McDade Williams, Legislative Counsel Bureau

TALKING POINTS

EXHIBIT E

for delivery before the
Legislative Committee on Health Care
May 12, 2004

Prepared for
Dr. Richard Curry, Vice Chancellor
Office of Academic and Student Affairs

<<Introductions>>

I am here today representing the former Chancellor, Jane Nichols. As you are aware, Dr. Nichols recently resigned and the Board of Regents appointed Mr. Jim Rogers to serve as the interim Chancellor of the University and Community College System of Nevada (UCCSN).

Prior to her departure, the former Chancellor worked closely with members of the Board of Regents ad hoc Health Education Task Force in addressing matters related to health education programs in the UCCSN. In the course of its deliberations, it was brought to the attention of the Task Force that this Committee had discussed the need for a statewide office to collect and analyze health care workforce data. The Health Education Task Force also recognizes this need and fully endorses the creation of such an office. As you are aware, no such office currently exists to conduct the kind of meaningful analysis of health care workforce data that is needed to determine areas of deficiency in the marketplace. It was Dr. Nichols' vision that the System be a part of that solution by advocating for the creation of a health workforce center located in the UCCSN System Administration. If such a center were so located, it would serve as a true system-wide effort with likely collaboration from a variety of institutions.

During the 1997 Session of the Nevada Legislature, Senate Bill 385 authorized the UCCSN to employ a health care program developer to study the role of the health science and allied health programs of the System in meeting the needs of the state as it related to education, training, and delivery of health care services. Unfortunately, funding for this position was not renewed during the 1999 Session, and the position was eliminated. Re-establishing a health care workforce center in the UCCSN would enable the center to utilize the vast resources the campuses have to offer in terms of data collection, analysis, evaluation, and dissemination.

Going forward we would like to offer any services necessary to assist in the creation of this needed center. If you have any questions, I'd be happy to answer them now.

APPENDIX E

Suggested Legislation

The following Bill Draft Request will be available during the 2005 Legislative Session, or can be accessed after "Introduction" at the following Web site: http://www.leg.state.nv.us/73rd/BDRList/page.cfm?showAll=1.

BDR No. –725 Makes appropriation to support mental health services in Clark County.