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

Seventy-Third Session
May 18, 2005

The Committee on Health and Human Services was called to order at 1:39 p.m., on Wednesday, May 18, 2005. Chairwoman Sheila Leslie presided in Room 3138 of the Legislative Building, Carson City, Nevada, and, via simultaneous videoconference, in Room 4406 of the Grant Sawyer State Office Building, Las Vegas, Nevada. Exhibit A is the Agenda. All exhibits are available and on file at the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Ms. Sheila Leslie, Chairwoman
Ms. Kathy McClain, Vice Chairwoman
Mrs. Sharron Angle
Ms. Susan Gerhardt
Mr. Joe Hardy
Mr. William Horne
Mrs. Ellen Koivisto
Mr. Garn Mabey
Ms. Bonnie Parnell
Ms. Peggy Pierce
Ms. Valerie Weber

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Senator Dennis Nolan, Clark County Senatorial District No. 9
Senator Dina Titus, Clark County Senatorial District No. 7
Senator Maurice Washington, Washoe County Senatorial District No. 2

STAFF MEMBERS PRESENT:

Barbara Dimmitt, Committee Policy Analyst
Joe Bushek, Committee Attaché

OTHERS PRESENT:

- Randy Howell, EMS Division Chief, Paramedic Program, Henderson Fire Department, Henderson, Nevada
- Brian Rogers, Vice President, Operations, Southwest Ambulance, Las Vegas, Nevada
- Rusty McAllister, Vice President, Professional Fire Fighters of Nevada
- Steven Kramer, Administrative Supervisor, American Medical Response, Las Vegas, Nevada
- Bradford Lee, State Health Officer, Health Division, Department of Human Resources, State of Nevada
- Stephanie Beck, Coordinator, Emergency Medical Services, District Health Department, Washoe County, Nevada
- Bill Welch, President, Nevada Hospital Association, Las Vegas, Nevada
- John MacNab, Management Analyst IV, Division of Health Care Financing and Policy, Department of Human Resources, State of Nevada
- Bob Ostrovsky, Legislative Advocate, representing North Vista Hospital, North Las Vegas, Nevada
- Michael Alastuey, Legislative Advocate, representing University Medical Center of Southern Nevada and Clark County, Nevada
- Trudy Larson, Assistant Chancellor, Board of Regents, University and Community College System of Nevada (UCCSN)
- Colleen Lawrence, Chief, Program Services, Division of Health Care Financing & Policy, Department of Human Resources, State of Nevada
- Mary Wherry, Deputy Administrator, Division of Health Care Financing & Policy, Department of Human Resources, State of Nevada
- Dave Noble, Assistant Staff Counsel, Public Utilities Commission of Nevada
- Craig Steele, Manager, Safety and Quality Assurance Division, Public Utilities Commission of Nevada
- Jeanette Belz, Legislative Advocate, representing the Associated General Contractors of America, Nevada Chapter
- Robin Keith, President, Nevada Rural Hospital Partners Foundation, Reno, Nevada
- Ann Lynch, Legislative Advocate, representing Sunrise Hospital, Las Vegas, Nevada

Chairwoman Leslie:
[Meeting called to order. Roll called.] We are going to open the hearing on S.B. 458.

Senate Bill 458 (1st Reprint): Makes various changes concerning time within which person who is transported to hospital is transferred to place in hospital where he can receive services. (BDR 40-1321)

Senator Dennis Nolan, Clark County Senatorial District No. 9:
This was introduced as an emergency bill in the Senate. It was brought to our attention by nearly all of the emergency medical service (EMS) providers in southern Nevada after the session had started and our bill allocations had been depleted. After an explanation of the issue, the Senate Majority Leader granted an emergency bill.

The issue that has been ongoing in southern Nevada for years—even when I was a paramedic—is overcrowding in emergency rooms. The problem has increased so much in recent years that the EMS providers who bring patients in on gurneys are often left standing in the hallway without treating them for hours. This has a serious domino effect on the ability of emergency medical service providers to maintain good response times in the community. Ultimately, it will have an effect—in fact, it probably already has, but we just don't have the numbers on that—on increased morbidity and mortality rates in southern Nevada due to the delayed response times for EMS personnel.

This bill received a lot discussion in the Senate. Ultimately, the policy issue is that we cannot continue to have firefighters and paramedics standing in the hallways for hours treating patients—not only because of the concern for quality patient care in our community, where people are sometimes left strapped to a backboard, but what if they have to use the restroom? We cannot have problems in the hallways. EMS personnel are treating patients who should long ago have been received by the hospitals and beds found for them. Some of the hospitals have actually designated permanent bed spots in the hallways. My contention in the Senate was that if they can designate a permanent bed spot for a gurney in the hallway, only to have EMS staff treat those people, then they can put a slightly wider hospital bed there and transfer that patient to the hospital bed.

Senate Bill 458 before you is a compromise. Due to time constraints and the complexity of the problem, I think what you have before you is the best bill we could get. This puts a time limit on how long the hospitals have in which to receive the transfer of a patient from the EMS crew to a hospital bed. It sets that time limit at 30 minutes.

Chairwoman Leslie:
Let me make sure I understand the bill as amended. On page 2, you are asking the Health Division to adopt regulations about this. Don't regulations exist now?

Senator Nolan:
With regard to time allowed for the transfer of patients, there are none. In the past, the language in statute was "a reasonable amount of time." This bill qualifies what that reasonable amount of time is.

Chairwoman Leslie:
This goes beyond current regulations? [Senator Nolan replied in the affirmative.] There is no penalty as the bill is amended, but a report would be collected and given to the Legislative Committee on Health Care. Is that correct?

Senator Nolan:
There was quite a bit of discussion about whose purview this should fall into, whether it was the State Health Division or the Clark County Health Department. As it was finally amended, it ultimately falls to the State Health Division. They may permit the Health District to assume the role of keeping records on compliance with the time limit established.

Chairwoman Leslie:
Somehow it has to get to the Legislative Committee on Health Care, because on page 5, it says that is the group that has to submit a final report.

Senator Nolan:
Yes. The Health District would assume that role, because they currently have charge of the emergency medical services and are already collecting response-time data and outcome data.

The testimony from the Clark County Health District was that this would be a task they were capable of doing. It would only require a little extra manpower, and they were willing and able to do it. Ultimately, the information they compile would be provided to the State Health Division, who would review it and pass it on to the Legislature.

Chairwoman Leslie:
I see that in paragraph 9. I am confused about paragraph 8, which looks like it is directed specifically at Washoe County. Do you want to explain that or wait for the experts to testify?

Senator Nolan:
There will be an amendment that the Washoe County District Health Department has asked for, which would allow them to opt out of this particular provision. Their emergency rooms are pretty full, but their situation is not at the crisis level as it is in Clark County.

Assemblyman Horne:
How is this going to work? We get a report, and then we adopt the regulations? You said the regulations aren't already in place, but we will adopt them. One concern is the overcrowding of mental health patients. I don't want this to become a situation where we have a regulation in place—so we have to put the patients somewhere—but have not solved the problem.

Senator Nolan:
This will complement what we have tried to do with regard to the mental health issue, which is part of this overall problem. So many of those people are transported to the hospital by ambulance, and then personnel and resources are needed to attend to them in the hallways. This will, even in mental health situations, require the hospitals to process those people who need help more quickly.

Assemblywoman Koivisto:
In prior sessions, emergency personnel were authorized in legislation at that time to attend to the people in the hospital. There is nothing in this bill that addresses a staffing issue. What if there isn't staff at the emergency room to handle these patients in 30 minutes? What do the EMS personnel do? Do they just slide them off onto a gurney or onto a bed and leave them?

Senator Nolan:
There are a number of laws in place that would prohibit medical providers from abandoning the patient, which is what it would constitute if they had not officially transferred the patient to the care of the hospital. They would stay and continue to attend the patient until they make that orderly transfer. Within the bill, there is a provision that deals with reporting when the 30-minute timeframe is exceeded. That, and the reason for that, would become part of the data provided to the Health District and eventually back to the Legislature.

The first part of your question addressed a standard of care with the emergency providers being able to provide care. Until they actually formally transfer that care to the hospital, they can still provide treatment in the hallway to the level that they are authorized by law and trained to do. In some cases, those patients may be seen by someone who could give more advanced care.

[Senator Nolan, continued.] Staffing is an issue with this, as you will hear from the hospitals today. We contemplated a number of different solutions in our deliberations, including the hiring of contract paramedics. That would be up to the hospitals to implement. Currently, under the statutes and regulations in both counties, paramedics can do standby work. You see them at concerts, rodeos, and other events. They are actually on contract and paid by those events to be there to provide medical care. Hospitals can do the same thing.

The problem is that the paramedics who are going into the hospitals now are on duty. If they get locked up tending to patients, they cannot respond to calls in the community. If they have to stay too long, they have to call in overtime crews. However, they won't abandon patients; they will stay with them and continue to provide the level of care that they are trained to do until the patient is transferred.

Assemblywoman Koivisto:
That answered my question, but I am still concerned that we are addressing only part of the problem and maybe creating another problem.

Senator Nolan:
This is not an easy issue. The people in Clark County have struggled with this for years. Now, it is at an absolute crisis point, and something has to be done. There are responsibilities on both sides of this issue, but we ultimately want to ensure that people are treated properly and receive appropriate care in an appropriate timeframe. It will require the hospitals having difficulties to be more creative in recruiting and staffing techniques. They may even have to bring contract people in to provide care in emergency rooms.

Chairwoman Leslie:
As amended, the focus of the bill is on studying the problem. The extra work for the hospitals involves keeping data concerning when the patient got there, when the patient was actually seen, et cetera.

Senator Nolan:
The crux of the bill really is the time limit. It goes beyond the study. Yes, we are going to study the problem and see how the hospitals have done in complying, but ultimately, the main purpose of the bill is to have those hospitals assume care of those patients within the 30-minute timeframe.

Chairwoman Leslie:
But if they don't, as Mrs. Koivisto pointed out, they are not going to abandon those patients, and there is no penalty if they are not able to do this. Is that right?

Senator Nolan:
There would be a penalty if the paramedics abandon the patient. That is already in federal and state law. There is no penalty if the hospital goes over the 30 minutes. There are really no teeth in this bill to force compliance. The hospital industry did go on record and commit to our Committee that they would give a good-faith effort in trying to see this happen.

Assemblyman Hardy:
When you get done in two years and all the reports are complied, we will find that we don't have enough hospitals, ER [emergency room] beds, nurses, or respiratory therapists, and we have to do more. Is there something else we are going to find out? This is my hypothesis.

Senator Nolan:
At the rate that the community is growing, that is a very realistic outcome. I see southern Nevada—and Washoe County right on our heels—struggling with some incredible population growth issues. It is very reasonable that what you predicted may happen. Something that prevents us from getting really creative in staffing—using physician extenders, nurse extenders, et cetera—is turf wars. At that point, we're just going to have to get creative and start allowing other staffing options.

Chairwoman Leslie:
At least, if this bill passes, we'll understand the problem more.

Assemblywoman Gerhardt:
When we collect all this information, will we be collecting information on the reason the person was brought to the hospital? Obviously, if you have a cardiac patient, we would hope that would be taken care in less than 30 minutes. If something is less life-threatening, we can expect a longer time period to process them because of triage. When we get this information, are we going to have that piece of the puzzle so we can look at that as well?

Senator Nolan:
That should be part of it, but I don't know that it was specifically mentioned in the bill. We talked about identifying excessive time and the reason for that time, such as a staffing shortage. It is very important to make sure that the reason the person was transported to the hospital, as well as the outcome, be put in there.

Assemblywoman Gerhardt:
That is an important component. [Senator Nolan agreed.]

Randy Howell, EMS Division Chief, Paramedic Program, Henderson Fire Department, Henderson, Nevada:
I am speaking for my agency, as well as the valleywide EMS group in Las Vegas. We have seen an increase in our wait times over the past 10 years, but in the last two years, it has become critical. One of the questions asked was, "Will this put more pressure on the hospitals?" We have exhausted every avenue locally to try to get relief. We will transport a patient to a hospital and basically be held hostage. There are cases of our personnel having to tend to patients for up to 12 hours on an ambulance gurney until they can get the patient transferred onto a hospital bed.

We are caught in the middle. We have a responsibility to our community to respond where there is no medical care in residential areas. Many of our resources are tied up sitting in an emergency ward waiting for a transfer of care. Our original intent was to figure out a solution to getting units turned around. We sat down with the Nevada Hospital Association (NHA) and, through our discussions, came up with this bill to get our units turned around more quickly and to find out the cause.

I believe Assemblyman Hardy hit the nail on the head. I don't think we are going to learn much more than we already know: there are not enough nurses, not enough space, et cetera. We are caught in the middle. We have a responsibility to our citizens to try to get an emergency apparatus to the scene of a call and render care. When we are tied up in the hospitals, it makes it very difficult for us to meet the national standard of response times. When someone is in cardiac arrest, brain death occurs within 4 to 6 minutes. We want to meet the needs of our community. That is where our difficulty is.

This bill isn't exactly what we had in mind, but I think it will work; it is a step in the right direction. We had good cooperation in talks with the Nevada Hospital Association, but ultimately, we would like to be able to walk into an ER, give a report, and transfer the patient to a bed. We don't want a maximum wait time of 30 minutes; we want a zero drop time. Nineteen years ago, that was the way it was in Clark County, but it has progressively gotten worse. If we don't do something now to curtail this, five years from now, the norm will be a one- or two-hour wait. We aren't averaging 12 hours now, but there are times when we are waiting 12 hours. Unless we do something, we are going to cripple our emergency response system in Clark County.

Chairwoman Leslie:
You presented that well. Are you keeping track of this now? You said there was one case where you had to wait up to 12 hours. Are you doing some internal

analysis for what your average wait time is and what your maximum out time is? Is 12 hours the worst it's ever been?

Randy Howell:
We do keep track of those statistics. Part of the reason for this study is that there isn't an agreement between the local hospitals and our agencies as to what the time is. They track it and come up with a wait time of 22 minutes; we track it and come up with 88 minutes. Hopefully, this study will get us on the same page, looking at the same information. That will be a big positive step.

Chairwoman Leslie:
So, everybody will be doing it the same way, according to the regulations.

Assemblywoman Koivisto:
In another committee earlier this week, I heard that the ambulance services often end up picking up people who really aren't emergencies, but just want a ride to the hospital. Can you comment on that? How do you deal with that? Do you have to give them a ride?

Randy Howell:
If somebody wants to be transported by ambulance to the hospital, we are committed to do so. Locally, we have worked with the Clark County Health District to put a protocol in place that allows us to take those patients directly to the waiting room. We give the hospital 20 minutes to place the patient. If, after 20 minutes, they haven't placed that patient, and the patient meets certain criteria—for example, they can sit up and their vital signs are stable—then we can place them in the waiting room. That has been helpful in getting our units out of the hospital.

Assemblyman Mabey:
I am an OB-GYN [obstetrician-gynecologist]. I was on the labor and delivery area, and an ambulance brought in a young lady in early labor. About 30 seconds later, eight or nine people showed up. I asked her, "Why did you take the ambulance?" She said, "There wasn't room enough for me in the car, so I called the ambulance."

Randy Howell:
A lot of times, people will call the ambulance because they think it's faster. They don't want to wait in the waiting room. This protocol has helped to eliminate the people who think they will get treated faster if they come in by ambulance. They get sent right to the waiting room, so it discourages them from calling an ambulance and absorbing a bill.

Brian Rogers, Vice President of Operations, Southwest Ambulance, Las Vegas, Nevada:

I have been a paramedic in southern Nevada for 17 years. We brought this bill to the Legislature because we really had exhausted all possibilities in our local areas. We worked with the Health District and with people within the hospitals, and we could not find a solution.

I have been sitting on the so-called "divert committee" since 1993. We would say, "These emergency rooms are open, and if they close, then these other ERs are open." That didn't work anymore. We then made a color system, which isn't working either. We have tried many different ways to get patients to the right place for quick treatment. At this point, there is no more redirecting patients. Wherever you go, it is going to be busy.

You talk about the types of patients we bring in and whether they can wait 45 minutes or an hour. Our theory has always been that it is not the patient we are bringing in right now that we're worried about. Even if we left that patient in a waiting room at a hospital, they are better off than the next patient who dials 911 and doesn't have an ambulance available. We don't know if that's going to be a cardiac arrest, and if you're not there in 4 to 6 minutes, the patient has real problems. It doesn't really matter what is wrong with the patient we are bringing in. Our problem is getting ambulances back on the streets. There are many days when ambulances spend more time inside a hospital than outside taking care of the customers we are bound to serve.

Please, don't put this off. We finally put a bill together that would allow some accurate information to be gathered so that next session you can make better decisions on this issue. We have talked about it at the local level many times, and they always ask if they can have more information. The longer we wait to do this, the worse the situation will get.

There is no easy solution. The hospitals are overwhelmed; we are overwhelmed. We have gone from 42 ambulances on the street at any one time to over 80 ambulances. Yes, there has been a population increase, but not to that extent. We are just trying to mitigate the circumstances any way we can.

As a valleywide EMS group, some of the things we hope to see come out of this bill are:

- Decreased wait times
- Increased communications between EMS and the hospital administration, which can't help but better the system
- A huge buy-in by State and local health divisions and departments
- Frequent reporting to the Interim Committee on Health Care

[Brian Rogers, continued.] Nobody wants to report that we're not doing well, so we're all going to try our best to report back that it is going well. All of that, ultimately, will lead to patients being admitted more quickly.

We are in the middle of a franchise negotiation in southern Nevada. We sit and argue over 10 or 15 seconds. That argument can last for several months, yet we can spend hours delaying responses in hospitals. Our goal, as well as that of the hospitals, is to serve all of us as a community. The only way we can do that is to have our ambulances and fire department rescue units back on the street to respond to the next patient. That is what we are trying to get everyone to understand. It is not the patient on the bed; it's the next person who calls 911, who is at home by himself having a medical emergency. Someone has to be available to get there. A couple of weeks ago, there were some calls that no one responded to after 25 minutes. As a community, that is not acceptable.

Chairwoman Leslie:
No one wants to be that person. You outlined the problem very well.

Rusty McAllister, Vice President, Professional Fire Fighters of Nevada:
We also played a part in negotiating this legislation. We worked with the Nevada Hospital Association in this effort in good faith. There are a couple of points that need to be mentioned related to this bill, which may even answer some of Dr. Hardy's questions.

One of the major intents, other than being able to get our ambulances out of the hospitals within 30 minutes—we realize that's not going to happen on a regular basis, especially at this point in time—is to have properly documented check-in and check-out times. That should be equal across all hospitals. There will be a specified procedure for us to check a patient into the ER. Once that care is transferred over to the hospital, that will also be documented in the same way. There will be no disagreement between the hospitals and the emergency service providers about how that was done and what the timeframes were.

Our hope is that, by having that as a starting point and by creating this data that we can track, we should see some things happen here in southern Nevada in the very near future, if this Legislature's goals come to fruition.

The Legislature is in the process of approving money for a mental health triage center. That will allow us to take patients that meet the criteria to that triage center and drop them off there, rather than to the hospital emergency rooms. That should show some form of decline in the wait times. We are also looking at opening up 190 new mental health beds in southern Nevada before the next legislative session begins. That, too, should produce a decline in the wait times,

but if not, we need to know why. St. Rose is opening another hospital shortly that will give us another ER, which will add more emergency beds to the system. That, too, should affect the wait times in some manner. We should be able to track that.

[Rusty McAllister, continued.] This bill will also track offload times. In southern Nevada, we have a color code system for hospital offload or wait times. Black is the worst, meaning at least an hour wait time to have a patient offloaded. I have a status report summary from January 1, 2004, to May 11, 2005, on the percentage of time hospitals are in the black. This will help us track or identify why some hospitals are very rarely in the black and other ones are constantly in the black. The vast majority of the hospitals are in the black between 13 and 19 percent of the time. Three or four hospitals in southern Nevada range from 45 percent to 71 percent of the time in the black. There has to be a reason why some of the hospitals are only 15 or 20 percent of the time in the black area and others are continually in the black 70 or more percent of the time. We hope this data that is collected will help identify why. Maybe the hospitals that are doing very well are doing something different and the ones that aren't doing so well need to adopt that policy. It's been our understanding that one of the hospitals has a nurse working in the emergency room who acts as a "traffic cop," moving people and keeping track of things. When that position is staffed, the wait time for ambulance crews is 20 minutes. When it's not staffed, the wait time is more than an hour. Those are the things we hope to identify. We want to be able to think outside the box and get creative so our ambulance crews get out of there.

Assemblywoman Parnell:
I don't see in the bill any exception for a disaster, such as a multi-vehicle accident. I'm thinking of a hospital like Carson-Tahoe, where we would have ambulances arriving and Care Flights coming in, yet we just have one small hospital. It worries me that there is no exception language.

Rusty McAllister:
There is no specific language in the bill. However, in southern Nevada, we do have a procedure in which a hospital emergency room can close by claiming an internal disaster. An internal disaster could be claimed in the event of a major disaster in the Las Vegas Valley, such as a multi-car/multi-victim accident, a bus rollover, or a hazardous materials incident. In that event, they have the ability to claim an internal disaster and close their emergency room. If that were the case, we would be able to see they had an emergency room disaster that caused them to shut down and for their times being excessive. Barring that, though, we should not have a problem.

[Rusty McAllister, continued.] There are no penalties associated with this bill as it stands. We worked in good faith with the hospitals to come up with something we all could agree on. This is a good step in that direction.

Chairwoman Leslie:
Are rural hospitals included in this? It looks like Washoe County has an option to opt in or out. What about Carson City or the smaller counties?

Rusty McAllister:
When the bill was originally drafted, it was an "opt-out." Everyone was included unless they purposely opted out. The Health Division said that would put a huge fiscal note on the bill, because it would have to be done statewide. The problem is mainly in Clark County, so the bill was changed to an "opt-in" as opposed to an "opt-out."

Chairwoman Leslie:
How is Carson City affected?

Rusty McAllister:
Carson City could opt in if they chose to.

Chairwoman Leslie:
We can take a look at that.

Steven Kramer, Administrative Supervisor, American Medical Response (AMR), Las Vegas, Nevada:
This condition has been going for longer than six years, but over the past four to six years, we have made dramatic changes to assist the hospitals with the problems they were facing, such as the shortage of nurses. Both AMR and Southwest Ambulance have placed paramedics and EMTs [emergency medical technicians] in the hospitals. We divided the city geographically, and each took an equal load of hospitals. We've placed people there to watch numerous patients from both entities, whether it be private entities or even the fire department.

When they came in the door, they would give their report to the triage nurse and, at that point, transfer control of the patient to one of our staff members. We have been doing that, and it is still ongoing with staff that we have. Unfortunately, we don't have the staffing to put them in all of the hospitals, but we continue to do that on a daily basis. We pay for these crews to be in those hospitals, so we can get our crews turned around and back on the streets as quickly as possible. Unfortunately, at the end of the six-year mark, we can no longer do this; we need that staff out on the road.

[Steven Kramer, continued.] We talked about a shortage of staff at the hospitals. Anywhere from 50 to 75 percent of our ambulances available for the road can be held up in the hospitals just waiting to offload their patients. That creates a staffing shortage and puts a strain on our units and their ability to respond to calls. I cannot, as a member of management, try to up staff for something that may happen that day or may happen at a specific hour. This bill should help us identify specific problem areas and make the hospitals look more closely at the ones that are doing a very good job. Hospitals also would have to look at ways to decrease their percentages of being in the black.

Senator Maurice Washington, Washoe County Senatorial District No. 2:
I don't know what testimony you've heard on what we call the "divert" bill. The stakeholders and the Senate Human Resources and Education Committee worked very diligently to put together a bill that would be apropos to all of them.

We have dealt with this issue in several sessions. The 30 minutes is a national standard. They have indicated they are willing to meet the reporting requirements that go to the Health Division. The bill only is applicable to a county that has a population of more than 400,000, which is only Clark County. We are very appreciative of the work all the stakeholders have done on this bill, and hopefully, we will get an idea of what the situation really is in Clark County and will be able to put together a comprehensive plan that will be best for patient access and quality of care.

I strongly urge you to support and pass this bill out of your Committee. This is one of three bills that cannot stand alone. They are like a three-legged stool, and this is the first leg.

Bradford Lee, State Health Officer, Health Division, Department of Human Resources, State of Nevada:
We did testify on this bill before, and as it was originally written, there was a significant fiscal note attached. However, with all the parties working together, we no longer have the fiscal note. We are neutral on this bill.

Chairwoman Leslie:
I noticed that the bill becomes effective upon passage for the purpose of adopting regulations. Can those be adopted by October 1, when the rest of the bill would go into effect?

Bradford Lee:
It is my understanding that, as it currently sits, S.B. 458 requires Clark County to adopt regulations that would be uniform for Clark County, so that all the players have the same rules to play by in measuring times, when it starts, when it stops, and what any definitional issues might be. Those would be the regulations required.

Chairwoman Leslie:
This is where I am confused. On page 2, it states that the Health Division shall adopt regulations. Are you saying that Clark County District Health is going to do it? You are going to adopt their regulations?

Bradford Lee:
That is my understanding of it. For the purposes of this study, we are going to go with whatever they come up with, because they are, essentially, the only ones doing it in the state.

Chairwoman Leslie:
But the bill does give you the authority to adopt regulations.

Bradford Lee:
Yes, it does, but we discussed this with Clark County and anticipated that this study would be in Clark County only.

Stephanie Beck, Coordinator, Emergency Medical Services, Washoe County District Health Department, Washoe County, Nevada:
I am here to testify on behalf of the Washoe County District Board of Health. The Board of Health supports S.B. 458 with the following proposed amendment: the board respectfully requests that Section 2, subsection 8, be deleted (Exhibit B). This section would allow the Nevada State Health Division to require Washoe County, and Washoe County only, to participate in this study of the waiting times for persons transported to a hospital, even if all parties in Washoe County do not feel such a study is warranted.

The Board of Health works closely with the Nevada State Health Division and would anticipate that, if they had information regarding excessive wait times in our health district, they would contact us so we could approach the local area hospitals and EMS agencies to coordinate community participation in such a study on a voluntary basis. Staff has had several recent discussions with the hospitals and EMS transport agencies. The consensus is that currently, there are not excessive wait times at our hospitals in Washoe County.

[Stephanie Beck, continued.] The District Health Officer, Barbara Hunt, discussed S.B. 458 with the Nevada State Health Division Administrator, Alex Haartz, and he has no objection to deleting this section of the bill.

Chairwoman Leslie:
The way you read it now, you would have to do it?

Stephanie Beck:
We can opt out and not do it. If we wanted to do the study, all of us would have to agree in writing and provide that information and our data to the State Health Division, but at the same point, if we don't want to, the State Health Division could force us to.

Chairwoman Leslie:
That is how you interpret this section? [Ms. Beck responded in the affirmative.]

Senator Washington:
Madam Chair, that is not correct. I respectfully disagree with the county. It is an "opt-in" provision. The county has to opt in, and everyone in the health district has to agree to opt in to the study. Every county within the state also has the option to opt in. Everyone is out except for Clark County.

Chairwoman Leslie:
Would you object to deleting that section, Senator?

Senator Washington:
I would object to it, due to the fact that, if there is a problem dealing with divert or time limits, it does give the Health District some options to take a look at, assess, and determine that it might be good for a certain county or district to actually begin reporting to see how long the wait time or divert is, and if it exceeds 30 minutes, et cetera. It does give the State some leeway to exercise some options.

Chairwoman Leslie:
The way it is now written, they can opt in if they want to. However, if they don't want to and the Health Division thinks they should, it gives the Health Division the opportunity to make them do it? [Senator Washington responded in the affirmative.]

Stephanie Beck:
If that is the Committee's pleasure, the District Board of Health would request that it be the State Board of Health that does that and not the Health Division. That would give us a chance to review the issue in front of a public body.

Chairwoman Leslie:
Is it, in Clark County, the District Health that gets to decide? [Senator Washington replied in the negative.] It would have to be consistent in both places? [Senator Washington responded in the affirmative.]

Bill Welch, President, Nevada Hospital Association (NHA), Las Vegas, Nevada:
The Nevada Hospital Association has worked collaboratively with the proponents of this legislation and is in support of the legislation. With respect to Assemblyman Horne's comments, we agree that this does not get to all of the issues, but what it does provide is a consistency in how we are going to collect data. Much data has been presented from individual components of the health care industry's perspective, but not necessarily in a consensus format.

This reporting mechanism gives us a specific set standard time and how it will be measured. As has been testified, there have been varying opinions on how that time is measured, not only between the hospitals and the ambulance services, but also from one ambulance service to another and from one hospital to another. This bill sets a specific manner in which we will measure it. This also sets a specific form and process in which the data will be collected and analyzed. Both parties involved in the transport and receiving of the patient—the ambulance attendant and the hospital—will be signing off on these forms.

With respect to Assemblywoman Koivisto's question, she is correct. There was legislation passed in the prior session to develop a mechanism for us to utilize EMS staff in the hospital. We worked diligently on that. The way the infrastructure of the hospital works, with nursing supervisors and the management of various areas of the hospital, we had to work with the State Board of Nursing. By the time we finished defining a job description that would allow a nurse-manager to supervise and delegate, it diminished what the intent had been. Ultimately, that did not prove to be the benefit we had hoped it would be.

With respect to using paramedics in the hospital, we can do that under current law, but they have to work under the direct supervision of a physician. They cannot work under the supervision of a nurse-manager or nurse-supervisor. That certainly creates a challenge.

I would be remiss if I didn't state that we understand and agree that there are some significant wait times. However, only 30 to 40 percent of our ER patients come in from ambulance transport; the balance comes in by other means. Along with those patients who are transported to us, 10 to 15 percent of them are true emergency patients. A lesser percentage of them are urgent patients, and

even fewer than that are primary care patients who need transportation to get to the hospitals.

[Bill Welch, continued.] I want to assure this Committee, and agree with Assemblywoman Gerhardt, that a patient's condition should be analyzed here. My research shows that the patients who are truly coming in a 911 emergent state are being immediately received into the hospital. There are other categories there are some extraordinary wait times. Hopefully, this will help relieve that process. We are here to support the bill.

Chairwoman Leslie:
Is it your impression that all the hospitals are onboard with this and will fully cooperate in the study, or do they see this as just one more effort to attack them? It is only going to work if they are going to cooperate.

Bill Welch:
I worked diligently with the hospital community to bring consensus to the language that is in this legislation. I, as their representative, do not have the authority to sign off on policy decisions. I have to go before the membership to get their approval to testify in support of any legislation.

We have discussed this throughout the membership of the Nevada Hospital Association. I have made my commitment to the Senate Health Committee and to the proponents of this legislation that, through the Association, we will do everything in our power to bring all parties to the table to collaborate on this resolution.

Chairwoman Leslie:
I know you act in good faith. Maybe, Senator Washington, when we have our Legislative Committee on Health, we can get quarterly reports and updates to see how things are going. If there are problems, we will know about them sooner, rather than waiting a whole year to learn about them. We would ask you to do that. [Senator Washington agreed.]

Bill Welch:
This will help us all. There are a lot of issues that we think we know. These issues will either be confirmed or not. It will help us develop a roadmap for the legislation that we have been talking about, developing a community health plan.

Chairwoman Leslie:
Yes, I see this as a companion piece to what we've been talking about all session. When the new resources come online, as Rusty mentioned, that should

make a difference. If it doesn't, we have a bigger problem than we think we have. We will have to analyze the data that comes in, and that will help us identify other gaps that may really be causing the problem.

[Chairwoman Leslie, continued.] Is there anyone else who needs to testify for or against this bill? Not seeing any, we will close the hearing on S.B. 458 and take up S.B. 281.

Senate Bill 281 (1st Reprint): Requires Division of Health Care Financing and Policy of Department of Human Resources to determine certain information concerning uncompensated care percentage for certain hospitals. (BDR 38-42)

Senator Maurice Washington, Washoe County Senatorial District No. 2:
Senate Bill 281 is the second leg of this three-legged stool. The third leg deals with the mental health issue. As we've grappled with these issues, we're trying to come up with a comprehensive health policy and trying diligently to ensure access and quality of patient care. We came up with S.B. 281. This is an issue we have grappled with in session after session. We call it the DSH [disproportionate share] bill. These are payments made by the feds to match Medicaid funds. We hope this is a solution that will answer the migration of the demographics within the county, those accessing our ERs, and uncompensated care.

The bill actually looks at the overall operating revenue, which is part of A.B. 342, and the uncompensated care for those patients coming into, or accessing, the ERs. It comes up with an arithmetical formula to give a percentage based on the IGT [intergovernmental transfer fund]. It looks at those percentages, and if you are at 2 percent or above, you are eligible for the DSH funding. The problem is that as our suburban areas grow, those accessing our ERs are usually migrating with those pockets of growth, and certain hospitals are receiving more uncompensated care patients than other hospitals. This looks at those percentages and allows the Division of Health Care Financing and Policy (DHCFP) to allocate those funds based on the demographics of uncompensated care patients who are accessing those emergency rooms.

Chairwoman Leslie:
This is the shortest DSH bill I've seen. This, then, doesn't really deal with changing the formula. It has the DHCFP defining what "uncompensated" is.

Senator Washington:
It doesn't even have to define what uncompensated care is, because it is already defined. It keeps UMC [University Medical Center of Southern Nevada] whole and the IGT whole. It looks at the percentages of the overall operating budget and the uncompensated care, and it arithmetically comes up with a formula for the percentage, which we currently use. As those percentages shift from hospital to hospital based on demographics, the DSH money follows those uncompensated patients.

Chairwoman Leslie:
Does it actually change the amount of money each hospital is going to get?

Senator Washington:
Yes. It could change it by the percentage, absolutely. When we ran the numbers, we found that although we had assumed Sunrise Hospital was getting a large portion of the uncompensated care in their ERs, it was not them, but the old Valley Hospital. They get more of the uncompensated care than any other hospital in Clark County.

Chairwoman Leslie:
Are you counting Medicaid and Medicare as uncompensated care? [Senator Washington responded in the negative.]

Assemblyman Hardy:
So, I have a bag of money that is going to UMC and Valley Hospital. We are going to keep UMC whole but take part of that money out of the bag and give it to another hospital going forward?

Senator Washington:
Yes, based on the demographics and access to the ERs. It is based on the formula that we currently use. We are not changing the formula at all. It is the same formula that we use for DSH already. What changes is the percentage. One hospital may have a percent more or less than another. That money would follow based on the percentage of uncompensated patients who are actually accessing the hospitals' ERs.

Assemblyman Hardy:
You mean, keep their demographically adjusted percentage whole but not necessarily the amount of money?

Senator Washington:
Correct. DHCFP would make that determination based on percentage. It is done biannually, as opposed to whenever the Legislature decides it wants to involve itself with DSH again.

Assemblyman Hardy:
They would get a variable amount of money, but their percentage would be appropriately calculated demographically.

Senator Washington:
Correct. Hopefully, we never have to revisit this issue again.

Assemblywoman Koivisto:
Senator Washington, it is my recollection that Valley Hospital currently gets no DSH money. Believe me, they don't.

Senator Washington:
I could be wrong; don't take my word on that. I do know there is a hospital that does receive more indigent or uncompensated patients than Sunrise does. I don't have my list, or I would quote it accurately.

Assemblywoman Koivisto:
My question is, since they are getting no DSH money now, and UMC is going to be kept whole, who is going to give up some of their DSH money to Valley Hospital?

Senator Washington:
It would be based on the demographics, based on the arithmetical formula that we currently use for DSH. As those percentages shift and change—hypothetically, let's say the cutoff point is 2 percent—if Valley is getting 3 percent of the uncompensated care, they would get, based on the formula, their share of DSH. If Sunrise is at 4 percent, then they would get their share based on that 4 percent. It could vary based on the demographics and the migration of the population within a given geographic or county location.

Assemblywoman Koivisto:
The concern is whether hospitals like North Vista in North Las Vegas are going to lose some of their DSH money. There is a big pocket of uncompensated care there.

Senator Washington:
It depends on where the cutoff is and where they fall in that arithmetical formula in their percentage of uncompensated care. They could lose or they

could gain, depending on the migration of the population or the uncompensated care within that geographic location.

Assemblywoman Koivisto:
I really think we need to see some charts or something showing us how this is going to work.

Senator Washington:
We have worked on this with all the hospitals. It was agreed upon. We haven't changed the formula we currently use. The only thing we don't do that this bill allows us to do is require that the hospitals report to the Division itself, biannually, their operating costs and uncompensated care. It kicks in the formula, and the percentages will change based on the demographics or the migration of people within the geographic location of that hospital, as well as whatever the cutoff is. That pot of DSH money will follow the uncompensated care patients. That is what the money is going to do: follow the patient.

Chairwoman Leslie:
Maybe we can get the Division to help us out. Senator, what Mrs. Koivisto is after is very reasonable. We want to see how this is going to play out. If there is only so much money, we want to know who gets what. What is it in this bill that is going to change what each hospital actually gets?

Senator Washington:
I understand what you are saying. We are not changing the money, because that is set.

Chairwoman Leslie:
If everyone is on board with this, then there are no winners or losers. Is everything going to stay the same for every hospital?

Senator Washington:
Of course it won't stay the same, because the population shifts. Currently, in Clark County, Sunrise receives a large portion of uncompensated care patients who access their ER for medical services. North Vista may receive a larger portion of uncompensated care patients in their ER. If they receive more than Sunrise, naturally, they will get more money based on the percentage. If that percentage goes up at Sunrise and they get more patients, then their share of DSH will go up. You go across the board like that with every hospital in Clark County.

Chairwoman Leslie:
We are not so concerned about where it is going up as much as where it is going down. We are going to hear some screaming as they lose revenues.

Senator Washington:
There is a cutoff point.

Chairwoman Leslie:
Why don't we hear from our staff people here? Maybe they can help us out.

John MacNab, Management Analyst IV, Division of Health Care Financing and Policy, Department of Human Resources, State of Nevada:
In general, we remain neutral on this bill, since there is no fiscal impact on the Division. Senator Washington is correct. The way DSH is set up currently, it is in pools. The uncompensated care percentage is used to distribute excess funds in those pools above the guarantees for each pool. It shouldn't change anything substantially.

Assemblywoman Koivisto:
Senator, you keep referring to ER uncompensated care. Is this a change, or does this refer to all uncompensated care?

Senator Washington:
It is all uncompensated care.

Bob Ostrovsky, Legislative Advocate, representing North Vista Hospital, North Las Vegas, Nevada:
North Vista Hospital used to be Lake Mead Hospital, which is currently one of the recipients of DSH funding. Our understanding of this bill is that the purpose of the language that was created was to get better data, which would allow not only the Division, but also the Legislature, to make more informed decisions regarding future funding. As I read the bill, I don't see any automatic triggers that would change the distribution that is established under the fund. The funding mechanism that is there has triggers in it. As hospitals qualify, they would get funding. I don't think this changes the trigger; it just provides additional information to the Division to help do an analysis of the data.

The legislation does not make any substantial change; therefore, we support the language as it exists. It protects the DSH monies appropriated for this biennium to North Vista Hospital and to UMC. The extent that it changes in future years is dependent upon the formula that currently exists in law, which this Legislature passed in the last legislative session. There was a fairly contentious argument, but we came up with a good solution.

Chairwoman Leslie:
That is helpful. We might draw the Committee's attention to page 2, where it says that the Division is also going to report this information back to the Legislative Commission on Interim Finance and the Legislative Committee on Health Care. We will all have a chance to take a look at it.

Michael Alastuey, Legislative Advocate, representing University Medical Center of Southern Nevada and Clark County, Nevada:
As I understand it, there was discussion on what S.B. 281 does. The language of the bill provides for reporting only. It does not address or change the existing formula allocation. For future legislative considerations, the reports that would be generated for your review would be available for your consideration. It is our understanding, on reading the bill in its first reprint, that this does not change the formula, numbers, or parameters; does not name hospitals that are not now named; and does not provide any change in percentage, decimal factor, or any other mathematics.

Chairwoman Leslie:
That was the root of our concern. There are no winners or losers in this. Everything stays the same. We just get more information. [Mr. Alastuey responded in the affirmative.] Okay, that's what we really wanted someone to say. Are there any other questions or anyone else who would like to testify on this bill? We will close the hearing on S.B. 281 and move to S.B. 410.

Senate Bill 410: Exempts University and Community College System of Nevada from requirement to purchase prescription drugs, pharmaceutical services, or medical supplies and related services through Purchasing Division of Department of Administration. (BDR 27-156)

Trudy Larson, Assistant Chancellor, Board of Regents, University and Community College System of Nevada (UCCSN):
We submitted this bill as a housekeeping bill. Basically, the substance of the changes proposed is in Section 3, subsection 4. This removes language that included the UCCSN as a using agency for purposes of purchasing prescription drugs, pharmaceutical services, or medical supplies. For all other purchases, the UCCSN is exempt. We would like to request that all of our purchasing—including prescription drugs, pharmaceutical services, medical supplies, and related services—be excluded from the pool along with all the rest of our purchases. This also has efficiency and effectiveness aspects, in that our medical school is probably the biggest user purchasing these items. They have excellent contracts that make them very efficient in the use of money.

Chairwoman Leslie:
Don't we get a better price if we all go in together? If you have the best contracts, why isn't the State piggybacking on yours for our prescriptions?

Trudy Larson:
That is an excellent place to look and see if we can help. We are such a large purchaser, at least through our School of Medicine. We have a lot of chemotherapeutic agents. It may be that our purchases are very specific and may not generalize to the rest of the agencies. We would like the ability to be excluded to do this the same as the rest of our purchases.

Chairwoman Leslie:
You are not excluded now?

Trudy Larson:
No. We are excluded from everything else except this. It was basically an oversight. We were kept in as a using agency just for these purchases. We would like to have all our purchases, including these, exempted to be consistent in terms of our purchasing. We may opt in as other exempted agencies do; that is in Section 4 of the bill.

Chairwoman Leslie:
Does the purchasing department agree with you? [Ms. Larson answered in the affirmative.] Are there any questions for Ms. Larson?

Assemblywoman Koivisto:
Did we not hear this bill before; hasn't this come up before?

Trudy Larson:
From my understanding, this was overlooked.

Assemblyman Horne:
Would exempting you allow you to get these items more cheaply?

Trudy Larson:
Because of the nature of the pharmaceutical supplies required, particularly for the School of Medicine, our turnaround time is extremely rapid. We are able to negotiate for particular rates that are advantageous to us. We would like the ability to do that more within the parameters of the rest of our purchasing, which is excluded. That would bring these particular supplies within the rest of the purchasing for the system.

Assemblyman Horne:
I know it brings the rest of your purchases in line with your system, but how does it benefit you?

Trudy Larson:
There are actually two purposes to this. The first is that it brings consistency to the purchasing for the entire system, so that all the services then will be excluded. The second is that, particularly for the School of Medicine and their clinical endeavors, this provides some opportunity, in specific areas, for them to negotiate some excellent rates.

Assemblywoman Koivisto:
Is it also not possible that State purchasing is limited by a formulary, and the School of Medicine, because they are a school of medicine, cannot be bound by that formulary, and it would be very limiting for your mission?

Trudy Larson:
I am not aware that it has been a significant issue. That doesn't mean it isn't on some of the specific medications that are used. Clearly, formulary use does have limitations. Many of the pharmaceuticals are for some of our specialty areas—chemotherapeutics come to mind as one of the mainstays—so it may be likely that this does allow more flexibility, particularly within the context of our researchers using more cutting-edge protocols.

Assemblyman Mabey:
As a physician or medical student, we prescribe a medication and then the prescription is filled at a pharmacy. Except for research, I don't see why the School of Medicine would be purchasing medications.

Trudy Larson:
Not only is this for prescription drugs and pharmaceutical services, but it includes medical supplies and related services. In our clinics, that is big. We do have limited pharmaceuticals that we purchase, and they primarily have to do with chemotherapeutic agents, but this also includes medical supplies, and we go through lots of those in our clinical settings.

Assemblyman Mabey:
Why do you buy those? Why does the medical school have to purchase the medication and the supplies? When a patient comes to me, I don't sell them a medication or give them a knee brace and charge them for that. I am curious why the School of Medicine wouldn't do the same.

Trudy Larson:
Again, these are limited areas. It is primarily for the chemotherapeutics on the prescription side. However, we have lots of the medical supplies within our clinical endeavors, for shots and other things. Those are fairly extensive. We do have very large clinics, both north and south, and the overhead is basically paid through the practice plan. All of our purchasing does go through the system.

Chairwoman Leslie:
We do have State hospitals, too, like the mental health hospitals, which purchase a lot of the same things. I would hope that you are coordinating purchasing with them so we can get the best rates by volume. I assume that you are doing that, but maybe I shouldn't assume that, since the system is separate and apart.

Trudy Larson:
I hadn't actually thought about that, but Senator Raggio said the same thing. It did get me thinking. Since we have excellent cooperation with many of our State agencies and hospitals, and many of our faculty members provide services, I think that is really a good place to look for some efficiencies.

Chairwoman Leslie:
We would encourage you to do that. We are pinching every penny in the money committees. We want to make sure we are getting the absolute best price possible. We don't want to be like the federal government, saying, "Don't negotiate drug prices." We want you to negotiate.

Is there anyone else who wishes to testify on this bill? We will close the hearing on S.B. 410 and move to S.B. 420.

Senate Bill 420 (1st Reprint): Authorizes Drug Use Review Board to hold closed meetings for certain purposes. (BDR 19-172)

Colleen Lawrence, Chief of Program Services, Division of Health Care Financing and Policy, Department of Human Resources, State of Nevada:
I am here to introduce a second amendment to the rewrite of S.B. 420. The purpose of this proposed amendment is to prevent disclosure of closed meetings of the Drug Use Review (DUR) Board. Actually, I will walk you through it. My testimony (Exhibit C) is more narrative, and you will have an actual copy of the amendment (Exhibit D).

[Colleen Lawrence, continued.] We have S.B. 420 that the Division has introduced. The last amendment was accepted off the original bill. We also have S.B. 267, which is coming in for a different purpose on the Open Meeting Law. After we put our amendment in, S.B. 267 added its own amendment, which put in different language. Our amendment stays consistent with our original bill and excludes us from what S.B. 267 is entering. This is definitely just a housekeeping amendment.

Chairwoman Leslie:
The crucial issue is, why you should be excluded?

Colleen Lawrence:
We have to have closed-meeting DUR boards because of federal law. We are required to do drug use review investigation on physicians' prescribing patterns and on recipients. In our original bill, we testified that it is a HIPAA [Health Insurance Portability and Accountability Act of 1996] violation, because there is specific patient information being released, including diagnosis and types of medication. That is why our original bill had excluded us.

The amendment was accepted and passed. At the same time, S.B. 267 came in, addressing the Board of Regents and all the other Open Meeting Law issues that were going on. This, again, clarifies that and adds that we will continue to be excluded, including S.B. 267, Section 2, subsections 4 and 5, and Section 3, subsection 2.

Chairwoman Leslie:
Back to my original question. I just want to understand why you think you should be excluded from the Open Meeting Law? Is it because a patient's name is openly discussed?

Colleen Lawrence:
Let me clarify that. It is not excluded from the Open Meeting Law; we are underneath that. It is to allow us to have closed sessions to talk about specific information that is specific to retrospective drug use review. It is looking at claims data that has already been dispensed. Our original amendment in our bill said that this would not make any policy decisions behind closed doors; we just do not want to talk about drug history and claims utilization in an open forum. This is just concerned with our closed sessions, exempting us from noticing the person that is being discussed in a public setting, to protect the physician and the recipient.

Chairwoman Leslie:
Is there something in the bill about when you would call a closed session and when you would not?

Colleen Lawrence:
Section 1, subsection 2 says that we will close the meeting as required by and stated in 42 U.S.C. [*United States Code*]. That code is specific to the retro drug use review board on fraud for Nevada Medicaid. The only time we can close a session is when it is based upon a retro review of claims payment for Nevada Medicaid.

Chairwoman Leslie:
We have something that says "Amendment 2" (Exhibit D); is that yours? [Ms. Lawrence answered in the affirmative.] This is the one you have been talking about. What does it do?

Colleen Lawrence:
Our bill already excludes us from notifying recipients or anybody who is being discussed in a closed session, because it could eventually be a referral to our Medicaid Fraud Control Unit. Senate Bill 267, Section 2, subsections 4 and 5 say that we have to notify the person we are reviewing and talks about whether we are to take an administrative action. We were clear in our piece that ours is a referral to another body. Ours is not administrative action in a closed session. It is just to look at the claims processing and the drug utilization during the DUR Board. So, we are exempt from that area.

The second piece of it is Section 3, subsection 2 of S.B. 267, which goes back to where, in our original bill, we were already excluded from this. We just wanted to clarify that we remain excluded from this provision. This covers the notifying of the person and that the person may decide to have the meeting as an open meeting. Because we do have HIPAA information, we do not want to give the ability to have it an open meeting.

Chairwoman Leslie:
Shouldn't you be doing these amendments in S.B. 267? Do you have that in Government Affairs? Is that where you've heard it?

Mary Wherry, Deputy Administrator, Division of Health Care Financing and Policy, Department of Human Resources, State of Nevada:
In S.B. 420, Section 1, subsection 2, what we're asking to do is on page 2, line 7. We would be asking to add S.B. 267—Section 2, subsections 4 and 5—so that we're referencing, in S.B. 420, the S.B. 267 language.

Chairwoman Leslie:
Do we have that language on this amendment (Exhibit D)?

Mary Wherry:
That is the language that is on the amendment page, where it says "2"; that is the entirety of Section 2 of S.B. 267.

Chairwoman Leslie:
That is what you want to amend?

Mary Wherry:
Exactly. If I may give a concrete example for a recipient, one of things we had planned to do with our MMIS [Medical Management Information System], which we can do at the point of sale, is to track recipients who may go to multiple providers and get OxyContin [oxycodone hydrochloride] prescriptions, and then they may go to multiple pharmacies to get them filled. If we needed to, we would use the DUR Board, in closed session, to talk about putting this person into a lock-in program, where they have to go to one physician and one pharmacy, and we would not honor or pay for anything else. That would be a very confidential matter. There are times when a provider may have unusual practice patterns. The DUR Board, in a closed session, would discuss those practice patterns and decide whether or not we need to do something with that particular provider.

Assemblyman Hardy:
If S.B. 267 changed in some way because we dealt with that today, would we have to revisit this bill, or are you saying to take the language from S.B. 267 and put it in here, regardless of what S.B. 267 ends up looking like?

Colleen Lawrence:
That is my understanding. We had nine bills to start with; we are now down to two. This was intended to help LCB [Legislative Counsel Bureau] staff understand what our intent was for S.B. 420. As S.B. 267 was rewritten, we still wanted to stay with our original intent. I have not seen what S.B. 267 did today. We can continue to work with the LCB staff to make sure that our intent stays as it is. My understanding is that this was done in S.B. 420 to stay on the line of our intent.

Chairwoman Leslie:
To rephrase what I think you said, you want this language regardless of what happens to S.B. 267? If that bill goes away, if it doesn't pass at all, would you still want this language? You still need it, right? [Ms. Lawrence answered in the affirmative.]

Assemblywoman Parnell:
Section 1 says, "...may hold a closed meeting to consider the character, alleged misconduct, professional confidence," et cetera. Isn't that what you're going to be doing when you want to have this closed meeting? In a sense, aren't you covered by existing language?

Colleen Lawrence:
Yes, we are with the "may hold." What we don't want, and are trying to be excluded from, is the posting of the meeting and putting that person's name on the actual posting. That's what the amendment of S.B. 267 changed. Our intent is the same as "may hold," but it is the posting issue.

Assemblywoman Parnell:
We spent about three hours this morning discussing opening meetings. It is a little difficult to come in this afternoon after hours of discussion of meetings being as open to the public and transparent as possible, and then take that same bill and deliberate closing a meeting. I have a little difficulty merging those two. I don't know that this is the best bill to put this in.

Chairwoman Leslie:
That is a good point. Just forget about S.B. 267. We are very sensitive in this Legislature about closing meetings. We don't like to do that. What we need from you is specific language. You made a decent argument about a person's name. I don't think the public needs access to the name of somebody who needs to be reined in on prescription drug abuse. If that's really what you're getting at, then what is the best language to make sure we accomplish that?

Colleen Lawrence:
The first section does allow us to have the closed session, along with Section 2, and we agree with that piece of it. Regardless of S.B. 267, would you like language in that first section just talking about the posting for our closed session only?

Chairwoman Leslie:
We want to know from you what amendment to this bill would meet your needs without referencing any other bill in this session.

Mary Wherry:
What we can commit to is to rewrite what our recommendation would be. It would be to delete any reference to S.B. 267 and make sure that the language embraced in S.B. 420 protects the providers or recipients who would be discussed in closed session, whether it is in regard to the posting of the open meeting or the actual discussion in the meeting.

Chairwoman Leslie:
There are ways to do that. As for a deadline, our last work session is this Friday at 1:30 p.m. Our staff would like to have this by tomorrow to prepare our final work session document.

Is there anyone else who like to testify for or against this bill? Seeing none, we will close the hearing on S.B. 420. The next bill we should consider moving out is Dr. Larson's bill. We did not hear any opposition to it. It is pretty straightforward. Is the Committee comfortable with Senate Bill 410?

> ASSEMBLYWOMAN KOIVISTO MOVED TO DO PASS SENATE BILL 410.
>
> ASSEMBLYMAN MABEY SECONDED THE MOTION.
>
> THE MOTION CARRIED. (Assemblywoman McClain was not present for the vote.)

Chairwoman Leslie:
We will open the work session with the PUC [Public Utilities Commission of Nevada] bill, S.B. 146. Ms. Dimmitt will give an overview. It is behind Tab A in the Work Session Document (Exhibit E).

Senate Bill 146 (1st Reprint): Makes various changes concerning detection and marking of subsurface installations. (BDR 40-654)

Barbara Dimmitt, Committee Policy Analyst, Legislative Counsel Bureau:
Senate Bill 146, first reprint, has to do with ways of marking and detecting subsurface installations. We heard testimony about that on May 16, 2005. The issues of contention involved the mechanism for identifying the criterion colors for marking certain subsurface installations. The issue appears to have been whether the criteria should be identified in specific statute or in regulation. Mark Sullivan of the Nevada Chapter of the Associated General Contractors provided an amendment, which is on yellow paper behind Tab A (Exhibit E), and it is an older amendment. There is a new amendment (Exhibit F).

[Barbara Dimmitt, continued.] Essentially, the difference between these two amendments is that Mr. Sullivan has put the specific colors and designations back into the bill. In addition to that, in the new amendment, he added some more colors and designations. These were additional changes in the American Public Works Association's criteria that had not been included in the previous law. What he did was basically update it. For the purpose of your deliberations, this doesn't make a great deal of difference.

In an attempt to deal with the issue of whether or not there should be an incorporation by reference, Ms. McClain asked me to check into that and contact the Legal Division to find out why the amendment did not just refer to the American Public Works Association's standards. Scott Wasserman said that was because it would be unlawful delegation of authority to incorporate some other private entity's standards. There would have to be either a specific citation for those standards, or it would have to be more general.

Dave Noble of the Public Utilities Commission of Nevada had submitted an additional amendment in response to this entire issue. One of the concerns was that giving the PUC the authority to regulate, without any criteria to limit that, might mean they would do things that were not according to national standards. On page 2 of their amendment, which is on blue paper behind Tab A (Exhibit E), they added the wording that says that the operator shall use the national standards for identifying criterion colors that are set forth in regulations of the PUC. If it were to be adopted by the Committee, the Legal Division might make some adjustments to this language, but that was the PUC's attempt to satisfy the Committee's request for something that incorporated national standards. There were no other amendments submitted.

Chairwoman Leslie:
I designated Dr. Hardy as an informal subcommittee, since he had the most interest in this bill. I did provide him a copy with the amendments for study before the meeting. I told him he could take a stab at it and see if the parties agree. If we're going to run into a roadblock, I've asked him to head up a subcommittee of one, unless there's someone on the Committee who would like to join him. He was willing to sit down with the parties tomorrow to hash out the color scheme if necessary.

Assemblyman Hardy:
I don't know if this is a solution as much as an observation. You have received a proposed amendment from Mark Sullivan that replaces the yellow copy in the Work Session Document (Exhibit E). In reviewing this document, I looked at Mr. Sullivan's amendment and noted the last paragraph, which, in bold type, talks about a statement from Craig Steele of the PUC that Mr. Sullivan's

amendment before the Health and Human Services Committee on March 16 was not consistent with the national standard, because it excluded language on reclaimed water. Mr. Sullivan's sentence at the end, "To remedy that situation, I suggest that subsection 4 be modified to read as follows," illustrates what is more in line with regulation than it would be with codification with statute.

[Assemblyman Hardy, continued.] If we look at the color indicators, there are going to be other things that have other colors. My personal feeling is that we need to look at those other things that have other colors—more in the line with regulation—that can be adapted to "national standards" easier than we can by statute. I was looking at this to probably come down upon the side of regulating rather than statute. For instance, on the blue sheet with Dave Noble's email to us, NRS [*Nevada Revised Statutes*] 455.133 used to have 5 colors; now there are 8 colors in APWA [American Public Works Association], and then we have to add an "O" to make sure we actually have the "FO" for fiberoptic. All those things seem more transitory, and that's why I agree with our Committee Counsel, Leslie Hamner, who said, "Typically, it is easier to change a regulation than a statute, and we could have the PUC adopt regulations to address any problems."

The PUC was forthcoming in their email in suggesting that the operator shall use the "national standards" for identifying criterion colors set forth in the regulations of the PUC for the markings. That is what I would side with. I suspect there is someone who has problems with that, but I don't see them in the room.

Chairwoman Leslie:
Will the representatives for AGC [Association of General Contractors] and the PUC come to the table? What do you think of Dr. Hardy's suggestion?

Dave Noble, Assistant Staff Counsel, Public Utilities Commission of Nevada:
We like the suggestion, since it incorporates our proposed change.

Craig Steele, Manager, Safety and Quality Assurance Division, Public Utilities Commission of Nevada:
I am here for moral support.

Jeanette Belz, Legislative Advocate, representing the Associated General Contractors of America, Nevada Chapter:
I'm not sure I quite understand the Legal Division's issue with not being able to reference a national organization and that it is somehow unlawful.

Chairwoman Leslie:
That is correct. We don't like to do that.

Jeanette Belz:
I only bring that up because I worked on a crane bill this morning where they comply with standards of the American Society of Mechanical Engineers (ASME), and that is referred in the bill. Why is it okay in that one and not in this one?

Chairwoman Leslie:
In the PUC amendment, there are two mentioned, the American Public Works Association and Common Ground Alliance. We had testimony before, which said that there is even another one. It may not be as clear as with the crane bill. I just know that our attorneys discourage us from naming them, because if the name changes, we have to revise all the statutes. I think that is their objection.

Jeanette Belz:
Understood. Our original concern was that this was all laid out in statute, and here was an attempt to change how fiberoptic cable was classified. Disrupting fiberoptic cable is extremely expensive and has far-reaching ramifications. We were arguing that in statute. Now I guess we would have to argue that in regulation. That is the issue.

Chairwoman Leslie:
Basically, that is it. On the theory from Dr. Hardy that in regulation, you do not have to wait 2 years to come before the Legislature—which barely understands what you're talking about—to change anything, you would be better off doing it in regulation. Regulations can change much more easily than changing the statute and reeducating the Legislature. Could you live with this suggestion?

Jeanette Belz:
I have been living with it for about five minutes.

Chairwoman Leslie:
Dr. Hardy has agreed that he can hold a subcommittee on this topic at 11:30 a.m. tomorrow. We'll give Dr. Hardy a chance to sit down and meet with everybody at the conference table in my office tomorrow.

Assemblywoman Parnell:
Since I will not be in that subcommittee meeting, I want to put this on the record. In Section 6, it says, "The operator shall use the identifying criteria and colors set forth in the regulations of the PUC." That's where I have a problem. I don't have any problem with the PUC abiding by regulations, standard

regulations, or something that refers to a bigger national standard. However, when I read it's just the criteria established by the PUC, that could be something very contrary to national standards. I believe that's the concern of Jeanette, Mr. [John] Madole, and Mr. Sullivan. I want that to be communicated for the meeting in the morning.

Assemblyman Hardy:
Are you asking for the national standards? Does that language make you feel more comfortable?

Assemblywoman Parnell:
Yes, national standards would be fine. We don't have to identify a particular set of standards, as in Mr. Noble's email, but there should be something broader than just giving it to the PUC.

Assemblyman Hardy:
I would be using that suggestion and putting national standards in there. [Assemblywoman Parnell concurred.]

Chairwoman Leslie:
We look forward to your subcommittee report on Friday. We will close the hearing on S.B. 146 and go to S.B. 155.

Senate Bill 155: Requires hospitals to provide patients with certain information regarding Bureau for Hospital Patients. (BDR 40-1254)

Barbara Dimmitt, Committee Policy Analyst, Legislative Counsel Bureau:
This bill, as written, requires hospitals, upon admission of a patient, to provide that patient or his legal representative written information explaining the existence of the Bureau for Hospital Patients within the Office of Consumer Health Assistance, explaining the services provided, and how to contact the Bureau to get assistance.

We received testimony in support of the bill from the Bureau for Hospital Patients and did not receive testimony in opposition. We have a conceptual amendment, which is under Tab B of the Work Session Document (Exhibit E). It proposes two new subsections to the bill. One requires every hospital to provide written disclosure upon a patient's release of the discount available under statute, NRS 439B.260; the payment arrangements required to access that discount; and information on any other discounts that the hospital might provide through its charity care policies. In addition, the second subdivision that's added

requires every hospital to post signs in its waiting rooms, written in clearly stated language in Spanish and English, describing the charity care policies available and how to get more information about them.

Senator Dina Titus, Clark County Senatorial District No. 7:
The amendment is nothing new, and this is the perfect vehicle to add this. The original bill has to do with notifying patients of assistance that is available to them through a State program if they run into problems. This carries that a step further and says that if the hospital also has a plan for any discount or payment over time, patients should be notified of that as well. There are programs available that people are not aware of, so they don't take advantage of them.

In December 2003, in response to a lot of bad publicity—people going bankrupt trying to pay their hospital charges—the American Hospital Association issued a statement of principles and guidelines relating to billing and collection practices. It called upon hospitals to provide financial counseling to patients; to have clear, written policies; and to help patients determine whether they qualify for any the special programs to help them figure out how they might be able to pay their bills. It also asked hospitals to sign a confirmation of commitment that showed they were working on this kind of policy. Many hospitals did that, but many people did not know of their existence.

A study came out last week that showed that, indeed, people did not know hospitals had these plans available. This would be a good way to inform patients of how the State can help them and whether their hospital has any of these provisions. The public will realize that these programs are available.

We'd also like to present a slight adjustment to the amendment from the small hospitals, which makes perfect sense.

Robin Keith, President, Nevada Rural Hospital Partners Foundation, Reno, Nevada:
We are in support of the bill. We would be happy to provide the notification to our patients. Our issue is on the second page of S.B. 155, Section 4, where it says, "Every hospital shall, upon the patient's release, provide a written disclosure approved by the Director which sets forth: (a) the discount available under NRS 439B.260..." That statute, I believe, applies only to major hospitals. In small settings, what we would be required to do is give a notice saying that, if you were at Sunrise Hospital, you would be entitled to X, Y, and Z. I would hope that the Committee would consider fixing that by inserting language after (a) that said, "If required by NRS 439B.260, the discount available under that section ..." or however LCB would want to word that.

Chairwoman Leslie:
I want to thank the Senator for allowing us to amend her bill in Committee. If this looks familiar, we have seen it before in A.B. 353, which we passed out of Committee. In the Senate, we ended up compromising A.B. 353, A.B. 342, and A.B. 322 into one bill, A.B. 342. In doing so, we felt that this language fit better with Senator Titus' bill, and she and everybody agreed that this would be the appropriate place to put it.

Assemblyman Mabey:
Why wouldn't you want to have this for small hospitals? Why wouldn't you want them to know about the discounts available?

Robin Keith:
We do want to notify them, and we would want to comply with the other requirements in S.B. 155 about posting our charity care and our discount policies. That particular statute, NRS 439B.260, specifically applies only to major facilities. We would be distributing an announcement that does not apply to us.

Assemblyman Mabey:
It says in both English and Spanish. What about Chinese or another language? Why Spanish?

Robin Keith:
I don't know specifically why. My guess would be that Spanish is a language more commonly spoken in Nevada than many other languages.

Senator Titus:
You do it one piece at a time. Spanish is the next dominant language in Nevada. Next time, we could add others. It would be great if we could do it in every language, but this is the practical second step.

Chairwoman Leslie:
I agree; I think other languages have a long way to go before they get up to the level of Spanish.

Assemblyman Mabey:
I think it would be better if it was just in English and everybody learned English.

Chairwoman Leslie:
Everyone is in the process of learning English, but in the meantime, we have to provide the information about their health care and how to get assistance.

ASSEMBLYMAN HARDY MOVED TO AMEND AND DO PASS SENATE BILL 155 WITH THE AMENDMENT AS REQUESTED.

ASSEMBLYMAN HORNE SECONDED THE MOTION.

Chairwoman Leslie:
Is there any further discussion?

Ann Lynch, Legislative Advocate, representing Sunrise Hospital, Las Vegas, Nevada:
I am not objecting strongly to most of this bill, except that this is going to add costs to health care. I want to remind everyone that every time you add a requirement, you have added to the cost of health care. This is not something we can just run off. It is going to take someone to do this. My concern is giving it to every patient who is discharged, because not every patient is going to find this valuable or helpful, and it could even be confusing to people who don't need charity care.

Chairwoman Leslie:
A lot of people don't know that they are going to need it. They have insurance, and then they find out their insurance doesn't pay. They don't know they need the Bureau of Health Care Financing. I think the cost for this is minimal.

Ann Lynch:
Yes, it is minimal, but added to the 16 other things that have been added this year, it is not minimal. We get criticized because our health care costs are high, but every time the Legislature is in session, we get more health care costs. It gets harder and harder. The hospital and social workers know, upon admission, which patients have health care plans, which don't, and who they will be working with. They usually work with these people from the beginning. They are prepared to help these people with these plans. We don't need to provide this to 700 people when only 30 of them need it.

Chairwoman Leslie:
Any more discussion?

Assemblyman Hardy:
If we gave this to the applicable patients, but the hospital has a patient fall through the cracks who should have received this information because they didn't realize they didn't have the appropriate insurance in place, the hospital

would then give them the extra amount of time as if they hadn't been notified. That gets even more complicated.

Chairwoman Leslie:
I know that health care changes, sometimes monthly. It is hard to keep up with what coverage you have or don't have. Is everybody ready to vote?

THE MOTION CARRIED UNANIMOUSLY.

Chairwoman Leslie:
We are adjourned [at 3:44 p.m.].

RESPECTFULLY SUBMITTED:

Joe Bushek
Recording Attaché

James S. Cassimus
Transcribing Attaché

APPROVED BY:

Assemblywoman Sheila Leslie, Chairman

DATE:

EXHIBITS

Committee Name: Committee on Health and Human Services

Date: May 18, 2005 **Time of Meeting: 1:39 p.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
S.B. 458	B	Stephanie Beck, Washoe County District Health Department	Written testimony and an amendment
S.B. 420	C	Colleen Lawrence, Division of Health Care Financing and Policy	Testimony and narrative
S.B. 420	D	Colleen Lawrence, Division of Health Care Financing and Policy	Amendment
S.B. 146 S.B. 155 S.B. 296 S.B. 354 S.B. 396	E	Barbara Dimmitt, Legislative Counsel Bureau	Work Session Document
S.B. 146	F	Barbara Dimmitt, Legislative Counsel Bureau	Proposed amendment submitted by Mark Sullivan, Associated General Contractors