MINUTES OF THE
SENATE COMMITTEE ON HUMAN RESOURCES AND EDUCATION

Seventy-third Session
March 7, 2005

The Senate Committee on Human Resources and Education was called to order by Chair Maurice E. Washington at 1:35 p.m. on Monday, March 7, 2005, in Room 2135 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to the Grant Sawyer State Office Building, Room 4412, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file at the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Maurice E. Washington, Chair
Senator Barbara K. Cegavske, Vice Chair
Senator Dennis Nolan
Senator Joe Heck
Senator Bernice Mathews
Senator Valerie Wiener
Senator Steven Horsford

GUEST LEGISLATORS PRESENT:

Senator Randolph J. Townsend, Washoe County Senatorial District No. 4

STAFF MEMBERS PRESENT:

Leslie K. Hamner, Committee Counsel
Marsheilah D. Lyons, Committee Policy Analyst
Cynthia Cook, Committee Secretary

OTHERS PRESENT:

Carlos Brandenburg, Ph.D., Administrator, Division of Mental Health and Developmental Services, Department of Human Resources
Alexander Haartz, M.P.H., Administrator, Administration, Health Division, Department of Human Resources
Lawrence Sands, Community Health Services Director, Clark County Health District
Erin McMullen, Hospital Corporation of America
Brian Rogers, Vice president for Operations, Southwest Ambulance Nevada

Steven E. Kramer, American Medical Response
Randy Howell, City of Henderson
Bill Welch, Nevada Hospital Association
Dan Musgrove, Clark County
Raymond McAllister, Professional Firefighters of Nevada
J. Mike Myers, Assistant Chief, Emergency Medical Services, Office of the Fire Chief, City of Las Vegas Fire and Rescue Operations
Robert Forbiss
Ann Lynch, Hospital Corporation of America

CHAIR WASHINGTON:
We will open the meeting with testimony from Senator Townsend, who will review Senate Bill (S.B.) 21.

SENATE BILL 21: Revises provisions governing individualized plans of services for clients of certain facilities that provide services to persons who are mentally ill or mentally retarded or have related conditions. (BDR 39-280)

SENATOR RANDOLPH J. TOWNSEND (Washoe County Senatorial District No. 4):
The bill before you is the result of my serving on President Bush's New Freedom Commission on Mental Health. The 72nd Legislative Session saw the Nevada Mental Health Plan Implementation Commission Subcommittee to Continue Work of the Commission that came out of my service on the President's Commission. It included Dr. Carlos Brandenburg, almost every state agency leader, and Assemblywoman Sheila Leslie. The two of us represented the Legislature and the agency leaders represented their respective areas in order to pick and choose what we brought to you. There were 230 suggestions from consumers, family members and other affected parties, the judiciary, social services, law enforcement and business. We narrowed the proposals to just over 20, and one of those is before you today. Senate Bill 21 deals specifically with the development of an individualized written plan for mental health or mental retardation. Wording is added, on page 2, line 8, "Be developed with the input and participation of the client." The President's Commission found the more involvement a client had in his or her treatment the greater the potential for success. A cornerstone of the Commission was the term recovery. A person receiving services is in recovery and hopefully always believes in recovery. The greatest chance for success is for the client to have ownership in his or her plan.

CARLOS BRANDENBURG, PH.D. (Administrator, Division of Mental Health and Developmental Services, Department of Human Resources):
I am here to provide testimony on S.B. 21 which would change *Nevada Revised Statute* (NRS) 433 to mandate treatment plans for individuals with mental illness or developmental disabilities be developed with the active input and participation of the individuals being served. Senate Bill 21 would implement a major provision of President Bush's Mental Health Commission and the Nevada Mental Health Plan Implementation Commission recommendations. The provision stipulates that mental health care is consumer- and family-driven. Currently, individuals with serious mental illness typically have limited influences over their care. Passage of the bill will mandate greater consumer participation in treatment planning with a greater chance of success.

SENATOR CEGAVSKE:
Can a guardian participate if the client is unable to?

DR. BRANDENBURG:
Basically, the way the law is currently written, either the patient or the patient's guardian or the person designated by the court or statute can participate.

SENATOR CEGAVSKE:
Then we are all right by simply saying client?

DR. BRANDENBURG:
We would not object to strengthening the current language to include others.

SENATOR TOWNSEND:
Family members are often the personal infrastructure to which people react best. When it is the family member or guardian who participates you do not have the same level of success, but it is still higher than no participation.

LESLIE HAMNER (Committee Counsel):
It would be better to amend the bill in order to include family members or guardians.

SENATOR CEGAVSKE MOVED TO AMEND AND DO PASS AS AMENDED S.B. 21.

SENATOR NOLAN SECONDED THE MOTION.

THE MOTION CARRIED. (SENATOR WIENER WAS ABSENT FOR THE VOTE.)

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CHAIR WASHINGTON:
We will open the hearing on S.B. 120.

SENATE BILL 120: Transfers responsibility to establish program concerning treatment of trauma. (BDR 40-885)

SENATOR JOE HECK (CLARK COUNTY SENATORIAL DISTRICT NO.7):
Before I proceed, I have been advised by the Legislative Counsel Bureau that I should disclose that I am a contract consultant to the Clark County Health District. I will receive no benefit from this bill in the independent judgment of a reasonable person. I have been advised I may materially participate and vote on this bill and a written disclosure will be filed with the director of the Legislative Counsel Bureau.

This bill will transfer the responsibility to establish a program for the treatment of trauma from the State Board of Health to a county or district board of health in counties with a population of 400,000 or more. Pre-hospital care is that portion of medical care that takes place from the time a 911 emergency call is received for an ill or injured person, and it continues until that person is delivered to an emergency department. Prior to 1993, the State Board of Health was the sole body that promulgated regulations in the furtherance of the statutes. In 1993, the Legislature granted regulatory authority over Emergency Medical Services (EMS) to the county or district board of health in counties with populations of 100,000 or more. The provision was amended in 1995 to counties with populations of 400,000 or more. Currently, it applies to Clark County. The State Board of Health retained regulatory authority over the portion of EMS dealing with the pre-hospital treatment and transport of patients with trauma. The reason for this proposal is due to the changing health care environment in Clark County. Before February 2005, Clark County had just one trauma center, University Medical Center (UMC). Subsequently, the Health Division, Department of Human Resources, has granted trauma center designation to Sunrise Hospital and Medical Center. We expect the Siena Campus of Saint Rose Dominican Hospital will also receive designation. The evolution of trauma care in southern Nevada requires the ability to rapidly

respond to system changes to insure provision of the best possible trauma care, in an integrated manner, to residents and visitors in Clark County and the surrounding area.

Currently, all decisions concerning trauma must be made by the State Board of Health, which is a more time-consuming process than making decisions locally. Initially, it was also the primary reason the regulatory authority over EMS was transferred to Clark County. In the past year, Clark County has requested two variances from the State Board of Health concerning trauma. These variances would not be necessary if this legislation was in place. As an example, when Sunrise Hospital and Medical Center was becoming a trauma center, a decision was needed regarding patients delivery to a trauma center based on the geographic origin of the call. The goal was to provide Sunrise Hospital and Medical Center with an adequate number of patients to build their capacity without overwhelming them, while ensuring the decrease of trauma patients to UMC would not adversely impact their ability to remain a viable Level One Trauma Center. The initial boundaries were drawn based on volume projections. The State Board of Health granted a variance to Clark County to enact these boundaries. As actual experience increases with the volume, or as St. Rose comes online, the boundaries may need to be redrawn. The requirement of coming to the State Board of Health each time the boundaries need changing to maintain the overall system makes the process lengthy and does not permit timely adaptation to ensure maximum efficiency. This proposed transfer of authority would in no way affect the regulatory process or requirement for the hospital portion of trauma care. The Clark County District Board of Health has 12 years of experience regulating EMS in southern Nevada. The EMS system in southern Nevada is a nationally recognized model of a high-performance system due to the collaborative working relationship among Clark County Health District, the fire departments and private providers. The transfer of authority over the pre-hospital treatment and transport of patients with trauma will ensure the system can respond to the fastest growing county in the State, maintain its recognition and, most importantly, saves the lives of victims of trauma. There is one technical amendment to the bill (Exhibit C).

SENATOR CEGAVSKE:
In Exhibit C, the language "in the county" has been deleted. Would you please explain?

SENATOR HECK:
Initial discussions with the State Board of Health and the EMS providers indicated a problem with the draft language in the bill. They indicated that saying the board shall establish a program in the county would add confusion. The word board itself is defined in statute as either the Health Board or the local board in counties with a population greater than 400,000.

SENATOR CEGAVSKE:
You could make it specific to a particular county.

SENATOR HECK:
The language was deleted because there was no reason for it. My initial request to the bill drafters was to have them drop the phrase State Board of Health. In *Nevada Revised Statute* (NRS) 450B, board is defined as two entities: the State Health Board or the local health board in Clark County.

CHAIR WASHINGTON:
I believe Mr. Haartz can clarify the reason for change.

SENATOR HECK:
The definition of board is spelled out in NRS 450B.

ALEXANDER HAARTZ, M.P.H. (Administrator, Administration, Health Division, Department of Human Resources):
Senator Heck is correct, the definition of board is accurate and this would simplify the language.

SENATOR MATHEWS:
The population of Washoe County is under 400,000 as of today. Would this proposal only apply to Clark County?

MR. HAARTZ:
That is correct.

SENATOR MATHEWS:
My concern is that Washoe County is so close to 400,000 in population that this proposal will affect them within months.

MR. HAARTZ:
There are several references throughout NRS concerning a county population of 400,000 or greater. The figure is based on the census. When the census is taken in 2010, probably every NRS reference will need to be amended.

SENATOR MATHEWS:
I think Washoe County residents need to have a voice in how this will affect them.

SENATOR HECK:
The 400,000 figure is referred to in NRS 450B. Washoe County is not affected by this currently, because it would already pertain to their EMS.

MR. HAARTZ:
Senate Bill 120 would transfer the authority of the State Board of Health to establish a program for the treatment of trauma victims to each county or district health board in counties with a population greater than 400,000. The Health Division views this bill as consistent with its position of encouraging Clark County Health District to assume the responsibility of managing trauma victims at the local level. I would note, for the record, the one drawback associated with S.B. 120 is that it eliminates the flexibility that currently exists and would require a statutory change if Clark County determined that it either no longer wanted or could not perform this responsibility.

CHAIR WASHINGTON:
I assume the county has agreed to this bill.

MR. HAARTZ:
Yes. There are representatives from the Clark County Health District here to testify.

SENATOR CEGAVSKE:
Do the 16 counties, not including Clark County, agree with the language in the bill?

SENATOR HECK:
That is correct. When the first change was made in 1993, Washoe County established their authority. Two years later Washoe County came back to the Legislature and requested the population figure be raised.

CHAIR WASHINGTON:
I believe that answers Senator Mathew's concern. As Washoe County approaches the 400,000 population figure they will have to consider allowing the State Board of Health to continue to oversee the treatment of trauma victims or exercise the option to be responsible themselves.

LAWRENCE SANDS (Community Health Services Director, Clark County Health District):
I am here to support S.B. 120. The Clark County Health District willingly accepts the responsibility as we believe decisions regarding pre-hospital care in the county need to be made by the organizations providing the medical care. By placing the decisions with the District we will be able to provide a more timely response to the changing needs and contingencies of the Clark County emergency medical system. Additionally, the legislation will alleviate the need for the district to request variances from the State Health Division. We understand there may be a fiscal impact upon the District; we do not intend to request relief for this responsibility any time in the near future. The District has taken the responsibility seriously, and we willingly accept this commitment.

ERIN MCMULLEN (Hospital Corporation of America):
I will read testimony from Dr. Michael Metzler who is a trauma surgeon at Sunrise Hospital (Exhibit D).

CHAIR WASHINGTON:
We will close the hearing on S.B. 120. We will hold the bill until we hear from Washoe County.

We will open the hearing on Bill Draft Request (BDR) 40-1321. We will ask staff for a review of some of the options.

BILL DRAFT REQUEST 40-1321: Makes various changes concerning diversion of patients from hospitals. (Later introduced as Senate Bill 458.)

MARSHEILAH D. LYONS (Committee Policy Analyst):
One option is to amend the provisions of NRS related to EMS to include language that provides a specific time in which the regular staff of the hospital or other advanced medical facility shall assume responsibility for care of a patient from licensed attendants involved in the transport. Additionally, to authorize the assessment of an administrative fine or fee to be charged to the

hospital in certain cases if the specific transfer time is not met. Regulations related to this matter will provide exceptions by which a hospital that is unable to accept a patient in a timely manner may be exempt from the administrative fine or fee.

Another option is to amend the provision of NRS related to EMS. It would allow certain EMS personnel to refer patients to nonemergency transportation and delivered to an urgent care or other appropriate medical facility. In these circumstances, patients that request an ambulance transport will be assessed by certain EMS personnel. If it is determined the patient does not meet the criteria for an emergency, the EMS personnel will provide the patient with information to contact a nonemergency-transportation service to transport the patient to another health facility, such as an urgent care facility or community health clinic. Prior to implementation of this proposal, federal legislation such as the Emergency Medical Treatment and Active Labor Act must be reviewed to assure compliance.

Another option is to require a formal review of the wait times for the transfer of care from the ambulance provider to appropriate staff at hospitals. The review should include an assessment of calls to determine what percentages were for nonemergency transports. It should also include information regarding organized efforts made by area hospitals to address the wait times for EMS and emergency rooms (ERs). It is presumed that several other legislative measures that seek to develop capacity in addressing the needs of certain patients with drug and alcohol addiction or mental illness will alleviate some of the hospital overcrowding and therefore EMS wait times. As presented, this proposal seeks to gauge those improvements and provide time to develop a more comprehensive solution to the EMS concerns.

CHAIR WASHINGTON:
These are conceptual ideas. Most of the members of the Committee have worked with the problem of hospitals diverting patients to other ERs for an extensive period of time. Our intent is to find a solution to the problems that have plagued southern Nevada.

BRIAN ROGERS (Vice President for Operations, Southwest Ambulance Group):
We have been working on the problem of diverting patients since 1992 through the Clark County Health District. We have come up with many scenarios to try to divert patients to where they would receive the best care. Currently, all the

hospitals have long wait times, so trying to divert patients has no advantage. The Abaris Group, consultants for EMS and other health-care-related issues, performed a study in Clark County in 1999. They said this was probably one of the worst situations they had seen. They made several suggestions. Since then there have been discussions about who can work in an ER within the hospitals and what that person could do. We are hoping for a bill to permit the use of other professionals including paramedics and emergency medical technicians (EMTs) to function in hospital ERs under the supervision of a registered nurse. Currently, we do not feel we are providing the best service. We are a nationally known, high-performance EMS system. We would like to continue being one of the best. We have situations where we are working on cardiac-arrest patients on ambulance gurneys in the hospitals. If you go back 8 or 9 years, the whole call from initiation until drop-off took 40 minutes. That time has probably tripled. There are open beds in a lot of the ERs, but they are not staffed. We acknowledge the effort of the hospitals, and we have been working with them closely. At this time, we have to step up and do what is right for the person who dials 911. We think that person needs help more than a person sitting in a hospital waiting room. We acknowledge the mental health issue, but we believe overcrowding was here before and will be here after the mental health issue goes away.

STEVEN E. KRAMER (American Medical Response):
Seriously ill patients entering the ER are held from one to eight hours. The ambulance companies are looking for relief to get the ambulances out on the road and have the hospitals take over the patient care. It is beyond the scope of the EMT to provide in-hospital care. We would like to recommend alternative sites such as urgent care facilities or freestanding clinics. Any one of the services, including the fire services, has about 75 percent of their resources waiting in the hospitals for an amount of time greater than an hour. When we are working inside the hospital, we are working outside of our protocol. We will continue to do what we can to help the situation.

RANDY HOWELL (City of Henderson):
I hope you keep in mind the prime issue is being able to deliver the patient to the hospital and get them off of our gurneys in a reasonable period of time. The definition of reasonable transfer of care should be set at 15 minutes.

SENATOR CEGAVSKE:
To what capacity are the urgent care facilities being utilized?

MR. KRAMER:
We cannot transport to the urgent care facilities. We can advise those who call that the ERs are crowded and they can be helped at the urgent care center.

SENATOR CEGAVSKE:
Have you had a discussion with the taxicab companies for nonemergencies?

MR. ROGERS:
I was informed by the Clark County Health District that nonemergency taxicab transport probably is not a viable option. Patients are required to be with certified EMTs.

SENATOR CEGAVSKE:
I have concerns with an administrative fine or fee.

CHAIR WASHINGTON:
These are all proposals that are under consideration. There are some issues concerning federal legislation for compliance. The EMTs can offer the patient alternatives to the ER, and it is then their choice.

SENATOR NOLAN:
I believe the national average for response, treatment, transport and off-load into an ER is 30 minutes. The suggested time frame of 15 minutes is the amount of time expected to transfer a patient.

MR. KRAMER:
Yes, that is correct. When I first began 20 years ago, the system was to walk into the hospital with the patient, give the nurse a report and transfer the patient. I do not know why we cannot return to that system. Being able to come into a hospital, wait 15 minutes and then transfer the patient is more than reasonable.

SENATOR NOLAN:
Are there any fines based upon performance with respect to EMS?

MR. ROGERS:
Yes. If we do not respond to a call with a life-threatening emergency within 8 minutes and 59 seconds or if we do not respond to a nonlife-threatening emergency within 12 minutes and 59 seconds, we are fined $11.71 per minute.

The fines are administered by the Administrative Oversight Committee which consists of an interlocal agreement among Henderson, Las Vegas and Clark County.

SENATOR NOLAN:
How long have discussions been going on between EMS providers and hospitals?

MR. ROGERS:
I believe a divert committee was formed in 1992 to try to alleviate overcrowding in individual hospitals. When all the hospitals became overcrowded, the divert system was no longer functional.

SENATOR HORSFORD:
Are you saying we went from bad to worse with hospital divert?

MR. ROGERS:
We spend more time inside a hospital rather than being available to help people.

SENATOR HORSFORD:
You testified some ERs are understaffed. Can you elaborate on that statement?

MR. ROGERS:
Every day at certain hospitals, depending upon their staffing levels, there may be beds that we cannot use. It is a system-wide issue.

SENATOR HORSFORD:
Are there agencies that oversee the lack of staffing or capacity of ERs?

MR. ROGERS:
Not to my knowledge. We have not known where to go in order to get relief from the hospitals.

SENATOR HORSFORD:
I hope the Committee might be open to putting some additional proposals on the table.

CHAIR WASHINGTON:
Could you report to staff those companies that have been fined within the past two years?

MR. ROGERS:
We will report on those companies that have been fined, broken down by month.

BILL WELCH (Nevada Hospital Association):
For the record, the hospitals are very concerned about the issues before you today. The hospitals staff their ERs to the extent they have personnel available. The hospitals spend money to recruit staff, and they spend millions of dollars to recruit support staff to help supplement the workforce. We initiated the plan to double the University and Community College System of Nevada (UCCSN) nursing program, which was accomplished during the 72nd Legislative Session. The hospital industry funds scholarships and underwrites the overhead of the seven nursing programs at UCCSN. We must make sure we have staff that is cross trained to work multiple departments. Nurses are shifted to help alleviate the stress at a particular point. We need to look at what is causing the ERs to be overcrowded. On any given day, mental health patients comprise between 20 and 30 percent of the ER capacity. Once a patient is in our system we are not able to transfer until there is a plan for their care. There has been a 39-percent increase in Medicaid utilization of ERs from 2003 to 2004. Medicaid recipients are coming to the ER for primary care. The State needs to develop plans to solicit the private sector of the health care delivery system on an outpatient basis to be more responsive and willing to treat Medicaid patients. The hospitals are the largest provider for the uninsured patients in the State.

CHAIR WASHINGTON:
Are these patients who transport themselves to the ER?

MR. WELCH:
That is correct. We need to look at all of the uninsured. We are considering a Health Insurance Portability and Accountability Act of 1996 (HIPAA) waiver. Hospitals are the only 365 days a year, 24 hours a day, 7 days a week (365/24/7) medical facilities available.

CHAIR WASHINGTON:
Please explain the HIPAA waiver.

MR. WELCH:
The HIPAA waiver is a proposal that is coming before the Legislature to allow the State to go to the federal government to create an uninsured pool of monies to help provide insurance for certain individuals. It would increase the eligibility and income criteria for expectant mothers. It would provide small employers with 50 employees or less with a subsidy to offer health insurance. It is a federal waiver program, and there would be a federal match for funds if the waiver is approved.

SENATOR MATHEWS:
Is the increase in Medicaid patients in the ERs because of slow payments from Medicaid?

MR. WELCH:
The transitions within the Medicaid system, the new intermediary and the changes in fee schedules have compounded the payment problem. We support the physician providers and other outpatient providers for having what they believe is the appropriate reimbursement rates to encourage them to see Medicaid clients on an outpatient basis. It is a complex problem, and I do not think there is any one answer. There has been a concerted effort to relieve those problems. We have seen an improvement recently in claims processing.

Ambulances are one source of delivery of patients to the ER. Most of the patients arrive by their own means. We are required by the federal Emergency Medical Treatments and Active Labor Act (EMTALA) to take every patient. Even with the changes in EMTALA to help relieve this problem, we still must do a medical screening of every patient. In certain cases, we can then try to refer the patient to another location. We triage all patients who go to the ER in order to facilitate the most critically injured or ill through the system as quickly as possible. We must come up with solutions to help relieve the overcrowding in the ERs. I look at a fine as a punitive action meaning somebody has done something wrong. I am not sure how hospitals that have ERs at maximum capacity are doing anything wrong. I do not understand the fine. I was not aware of the ambulance fines. If they are facing the same challenges as the hospitals, I do not believe they should be fined.

SENATOR NOLAN:
I am aware the hospitals and the Hospital Association support the nursing programs. You referred to the fact the hospitals seem to see the nursing shortages as the problem. Do the hospitals have staffing levels that cannot be met?

MR. WELCH:
The hospitals are accountable to the Bureau of Licensure and Certification, Health Division, Department of Human Resources. Each hospital must have a staffing plan. If the plan cannot be met, then the facility needs to downsize to the point it can meet a staffing plan. Staffing cannot be arbitrarily changed.

SENATOR NOLAN:
The staffing plans are usually based upon the number of treatment beds available in the ER and the nature of the treatment to be provided. Is that accurate?

MR. WELCH:
That is a part of how hospitals staff. There is also the acuity of the patient, the qualification of the personnel and available beds to consider.

SENATOR NOLAN:
On any given day, an overcrowded emergency room might have six or eight patients on gurneys up against walls that paramedics are attending. Since those are temporary spots, I do not believe they are figured into the staffing plans for the ER. If the hospitals are allowing paramedics to attend to six or eight patients on hallway beds, then we should be looking at having such staff underneath the hospital roof.

MR. WELCH:
The hospitals are licensed for a specific number of beds. There was a proposal made in 2002 to permit hospitals to hire paramedics or EMTs to tend patients transported to the ER, thus enabling ambulances to more quickly return to the field. However, the Nurse Practice Act clearly defines who a nurse can supervise. If we utilize other individuals who are not governed by the Nurse Practice Act, then they must be directly accountable to and work under the supervision of a physician. We ended up with a job description that was so diluted it was of little value. Do we license this person as a paramedic or as spelled out in the job description? If we were going to utilize them in the ER, we

could not recognize them as a paramedic. We would be required to recognize them as this new category so they could fall under the supervision of the nursing personnel.

SENATOR NOLAN:
There was recognition by the hospitals concerning the need for additional staff in the ER to attend patients in the hallway. Somehow the solution fell through the cracks and the hospitals were not able to provide these individuals, but they did not add any additional nurses. Paramedics were still treating people in the hallways.

MR. WELCH:
That is correct. I would be remiss if I left the impression the hospitals are not actively trying to recruit nursing personnel. The nursing program at UCCSN will graduate between 600 and 700 students when the first cycle is complete. The estimate made in 2000 of the growth and attrition of new nurses has become inadequate. We are continually falling behind the curve. Many hospitals are paying for instructors so they can go beyond the UCCSN program. Nevada has the worst nursing shortage in the country.

SENATOR HORSFORD:
I heard you say earlier that the hospitals are adequately staffing the emergency rooms.

MR. WELCH:
The hospitals are staffing to capacity, but there are going to be days when staff members call in sick or there is an influx of acute admissions. They work within their staffing plans to be most effective in the use of the workforce.

SENATOR HORSFORD:
Is that the same as fully staffing the ER?

MR. WELCH:
On any given day, I would be surprised if we do not have vacancies in nursing personnel.

SENATOR HORSFORD:
Has the industry explored the impact of providing adequate pay or other benefits to the nurses we have now? Based on research I have seen, Nevada

has licensed nurses who are not working. Some of the reasons given are work conditions, pay and a stressful environment. I am wondering if the industry would direct some focus on these issues.

MR. WELCH:
The hospital industry has looked at the issues you raised, and there will always be varying opinions. The industry has found Nevada salaries to be in the top 25th percentile in the western United States and the top 60th percentile across the United States. Our staffing ratios were higher across the board than more than two-thirds of the surrounding areas. Nevada has recruited more nurses than California, and California has implemented regulations to address staffing issues. We need to keep in mind that the hospital is the only provider of health care services that is open 365/24/7. However, the health care industry has diversified over the past 15 to 20 years. We now have outpatient surgical and diagnostic centers. Insurance companies drive how and when a patient can be admitted and discharged.

CHAIR WASHINGTON:
Perhaps, Mr. Musgrove can review the use of urgent care centers.

DAN MUSGROVE (Clark County):
The UMC has 11 urgent care centers across the valley, Laughlin and Boulder City. I believe there are other providers in Las Vegas who would need to be considered a part of this matter. Some UMC facilities were closed based on revenue issues, and some hours were changed. These are limited-care facilities and are not fully staffed, but they can handle some emergency accidents and injuries.

RAYMOND MCALLISTER (Professional Firefighters of Nevada):
Hospitals are not the only 365/24/7 health care providers. The people who run fire departments and private ambulance companies provide care 365/24/7. The hospitals have their jobs and we have our jobs. It seems we are mixing the jobs. Federal guidelines say that once a patient is within 250 feet of the door of an emergency room, the patient is the responsibility of the hospital. We are finding the hospital has the responsibility, and the firefighters and paramedics are providing the care. Federal guidelines also state that once a patient is in the hospital they cannot be transferred if the hospital is full, and the hospital must take responsibility in a reasonable and timely fashion. We have not found a definition of reasonable and timely. We believe it is between

15 and 30 minutes. The hospital administrators might think it is one hour or six hours. In Clark County, the taxpayers passed a bond issue to purchase more equipment and hire more manpower to provide adequate service. One private ambulance company has reported losses of $5 million to $10 million a year because of wait times. This example is a subsidy to the hospitals. The majority of the hospitals in southern Nevada have been reporting record profits. There are new hospitals and new trauma centers opening. The hospitals have the ability to open new beds, offer new services and post record profits, but they cannot adequately allow the private companies and publicly funded fire departments to get out of the ER in a reasonable time. The two equations do not compute. We are aware of the nursing shortage. As a fire captain, I hear information on a firsthand basis from the paramedics who transport patients on a daily basis. Hospitals are treating patients while they are on our gurneys, but they are letting our medics monitor those patients. It is not unusual for a nurse to give medication to a patient on a gurney in the hallway of a hospital and allow the paramedic to monitor the care of the patient. The paramedic may not know what the medication is, since paramedics are not trained to the level of nurses. There are no urgent care centers in the Las Vegas area that are open 24 hours a day. A partial solution may be to use urgent care centers, but that will not solve the entire problem. The Pahrump Fire Department has three ambulances. For ambulances to be tied up in an emergency room puts the town at great risk.

SENATOR HORSFORD:
We are hearing a lot about the causes of overcrowding in ERs. Are the Medicaid patients being transported to the ER or are they walk-ins?

MR. WELCH:
There is a 39-percent increase in Medicaid usage of the ERs. We see the Medicaid patients using the ER for primary care.

SENATOR HORSFORD:
Please provide the Committee a report showing the usage of the ERs and the hospital by the targeted population.

MR. WELCH:
I can provide that information. I would like to apologize to the EMS, because they too are 365/24/7.

Facilities are expanded because of the increased demand for services. As hospitals expand, it helps to relieve pressure on the ER. Additional beds are available to move patients from the ER to inpatient services.

SENATOR WIENER:
Perhaps, if there is a cost-effective way, we could persuade some of the facilities to stay open 24 hours.

MR. MCALLISTER:
Urgent care facilities open at 9 a.m. and close at 7:30 p.m.

SENATOR WIENER:
What kind of demand is placed on the ER during those hours?

MR. MCALLISTER:
There are problems that will come to light when you explore the use of urgent care facilities as a solution. We are not allowed to refer a patient to a specific facility; we can explain they can go by private transport to an urgent care facility. Many are Medicaid patients, and they do not have transport. We are required to take them to a hospital at that time. The first question a patient is asked at an urgent care facility is if there is insurance.

CHAIR WASHINGTON:
Are you telling us the urgent care facility can deny care?

MR. MCALLISTER:
If the patient has Medicaid, they must be treated. If the patient does not have insurance and is not considered critical, care can be denied.

CHAIR WASHINGTON:
If the urgent care facility is owned or operated by the county, care must be provided.

SENATOR HECK:
I have worked in this field for 27 years. I now oversee the direction of the Clark County EMS system. I am also an ER physician. It does not take a statutory change to allow EMS providers to transport to an urgent care facility. That is under the purview of the Clark County Health District. We have looked at encouraging urgent care centers to participate in this system and none of

them is agreeable. If they participate, they must take all patients. The uninsured and underinsured are disincentives for those organizations. Urgent care facilities that are owned by the UMC are mandated to provide care to all patients. A patient in an urgent care facility which closes at 7:30 p.m. must be transported to an ER. It then becomes two EMS transports.

CHAIR WASHINGTON:
Is it possible to mandate the urgent care facilities to remain open for 24 hours?

SENATOR HECK:
With appropriate staffing and funding, that could work. The facilities may have to apply for licensure as an independent center for emergency care, which is the other type of facility in statute that would allow them to receive EMS patients. The quality assurance of that process would be extremely onerous.

CHAIR WASHINGTON:
If a patient calls 911, the EMT would be required to determine whether to deliver the patient to the hospital or an urgent care facility. Continuity of care must be considered. There could be transport, staffing and payment issues with this proposal.

SENATOR HECK:
The final decision is with the patient.

J. MIKE MYERS (Assistant Chief, Emergency Medical Services, Office of the Fire Chief, City of Las Vegas Fire and Rescue Operations):
We are concerned about seriously ill patients being treated in the hallways of the hospitals. Overcrowding is the issue, and the thought is that nonurgent patients are clogging the ERs. The American College of Emergency Physicians maintains there is no evidence that nonurgent use of the ER is responsible for hospital overcrowding. The report contends that overcrowding is in the waiting room rather than in the treatment area. I believe this is important. Urgent care facilities are no less crowded than the ER, and there may be a four-hour wait. It would be helpful if we could come in the back door and unload our nonurgent patients directly to the waiting room. Please assist us to take critical patients off the gurneys and move them into the ER so they can receive appropriate care.

ROBERT FORBISS:
I was involved in EMS for 30 years, and I have been on the board of directors of two of the major hospitals in this community. These complicated issues must be addressed this Legislative Session. The fact we have ambulances and paramedics tied up with patients in the ER for hours is a disservice to the system and the patient. Today, the ER is a holding tank, and keeping it staffed is difficult. The problem is not just the problem of the ER. Frequently, there are no other beds available for transfer of the patient from the ER. Management must work constantly with doctors to figure out ways to move patients out of the hospital to make more beds available.

SENATOR MATHEWS:
I believe some nurses who work in ERs need to be represented in the meeting scheduled for tomorrow.

CHAIR WASHINGTON:
We will ask staff to invite a nurse to attend the work session scheduled for tomorrow. We will now open discussion on the Subcommittee Report on Mental Health Issues, and we will review the memorandum prepared by staff (Exhibit E). We are looking for language to be included in BDR 38-1322.

BILL DRAFT REQUEST 38-1322: Makes various changes concerning mental health services. (Later introduced as Senate Bill 405.)

MS. LYONS:
There was not a recommendation regarding the development of long-term psychiatric beds. There was a general recommendation for the Legislature to continue to look at the number of beds being developed in southern Nevada.

CHAIR WASHINGTON:
The first provision to be drafted for the bill would be to add 40 beds to the new psychiatric hospital that was approved by the 2003 Legislature at a cost of $11 million.

SENATOR WIENER:
Since there is already a bill before the Senate Committee on Finance for this provision, if we add it to BDR 38-1322, it will require a fiscal note and need to be re-referred to the Senate Committee on Finance.

CHAIR WASHINGTON:
This entire proposal will trigger a fiscal note. We are adding the language in order to codify the fact that we are in agreement.

MS. LYONS:
The next issue the subcommittee reviewed was short-term acute psychiatric beds as described on page 2 of Exhibit E.

CHAIR WASHINGTON:
There was also a recommendation from Senator Horsford.

MS. LYONS:
The recommendation Senator Horsford suggested was to require local hospitals to provide a percentage of psychiatric beds in order to address the lack of beds for the mentally ill.

SENATOR HORSFORD:
The subcommittee received information that 133 psychiatric beds were lost over the last 4 years that had been provided by general hospitals in Las Vegas. I would like a requirement that the hospitals provide some beds within the existing structure.

MR. WELCH:
I would like to point out that the loss of 110 beds was the result of the closure of one facility. There has been an expansion of psychiatric services in the acute care hospitals. Hospitals representatives have heard Dr. Brandenburg testify about the shortage of licensed health care psychiatric workers and the difficulty he has in recruiting sufficient staff for the state mental health facilities. The hospitals would have to compete for those personnel. For each hospital to have psychiatric beds would further dilute the availability of human resources. Because of licensure requirements, it would take a hospital 6 to 12 months to provide some mental health beds. I have had contact with the hospitals in Clark County in an attempt to solicit some beds they thought could be put back into the system. At this point, I have not been able to find any hospital that has the capacity to do that. There is one facility that is going to open 20 geriatric psychiatric beds within the next 90 to 180 days. I am trying to see if they would be willing to have those beds come online as a full adult psychiatric service, but I cannot commit for them.

SENATOR HECK:
Mr. Welch has summarized the likelihood of hospitals providing psychiatric beds. The closure of Charter Hospital accounted for the loss of 110 psychiatric beds. With presumptive eligibility to enable people to be qualified for Supplemental Security Income (SSI) faster and increasing the reimbursement rate, it would be highly unlikely that a hospital would have a psychiatric unit open by the time the new psychiatric hospitals are complete.

SENATOR HORSFORD:
The way it sounds in this proposal is the new mental health hospitals and the triage centers are going to solve all the problems. A part of the overall solution is to have the hospitals as a part of the equation, and should be considered.

MS. LYONS:
Mr. Welch's testimony about psychiatric beds indicated low-reimbursement rates from Medicaid and processing time for disability-applications determination were two major issues that discouraged hospitals from providing those services.

MR. WELCH:
Currently, we have one of the lowest-reimbursement rates for adult psychiatric services in the region. As we build new hospitals, we have demand for other services and we try to direct the resources for those services. Dealing with presumptive eligibility is problematic as it takes 18 months before a hospital knows if it will be reimbursed for services. The freestanding psychiatric facilities representatives have indicated the rate needs to be between $550 and $570 per day. Monte Vista Hospital management is willing to add 10 psychiatric beds, if their rates were increased from $490 per patient-day to $550 to $570 per patient-day. To set up a distinct part of an acute care hospital for psychiatric services would cost $720 to $740 per patient-day.

SENATOR HORSFORD:
I have an issue with the proposal from Monte Vista Hospital about which I asked Michael J. Willden, Director, Department of Human Resources. These proposals are not apples-to-apples comparisons. These are proposals based upon meetings Mr. Willden had with individuals and the priorities at that time. We need to ask all the providers the same questions.

CHAIR WASHINGTON:
That is addressed in the second bullet on page 3 of Exhibit E. I agree with you, but the issue before us now is the increase of the reimbursement rates.

> SENATOR CEGAVSKE MOVED TO INCLUDE LANGUAGE TO ASSIST LEGAL DIVISION STAFF ESTABLISH WORDING IN BDR 38-1322 WITH THE RECOMMENDATION TO REVIEW AND INCREASE THE REIMBURSEMENT THROUGH NEVADA MEDICAID FOR INPATIENT PSYCHIATRIC SERVICES.
>
> SENATOR HECK SECONDED THE MOTION.
>
> THE MOTION CARRIED UNANIMOUSLY.

* * * * *

CHAIR WASHINGTON:
We will go to the second recommendation on page 3 of Exhibit E**.**

SENATOR HECK:
Monte Vista Hospital is the only facility able to provide 10 beds tomorrow at the rate of $550 per patient-day. They are able to set them aside immediately.

SENATOR MATHEWS:
I will not vote for a bill that contains the name of a specific institution.

SENATOR HECK:
We would not put the name in the bill. We would issue a request for proposal (RFP).

CHAIR WASHINGTON:
The language will state a contract will go out for an RFP for an additional 10 short-term acute psychiatric beds.

SENATOR CEGAVSKE:
I would not put a number in the language.

CHAIR WASHINGTON:
We will leave the number of beds out of the language.

SENATOR CEGAVSKE MOVED TO INCLUDE LANGUAGE TO ASSIST LEGAL DIVISION STAFF ESTABLISH WORDING IN BDR 38-1322 WITH THE RECOMMENDATION TO IMMEDIATELY CONTRACT WITH A SHORT-TERM ACUTE PSYCHIATRIC SERVICES FACILITY TO PROVIDE ADDITIONAL BED SPACE.

SENATOR HECK SECONDED THE MOTION.

SENATOR MATHEWS:
I would like the "A" removed. Having it there sounds as though we are dealing with just one institution.

CHAIR WASHINGTON:
We will have the "A" removed. Please amend the motion.

SENATOR CEGAVSKE MOVED TO INCLUDE LANGUAGE TO ASSIST LEGAL DIVISION STAFF ESTABLISH WORDING IN BDR 38-1322 WITH THE RECOMMENDATION TO IMMEDIATELY CONTRACT WITH SHORT-TERM ACUTE PSYCHIATRIC SERVICES FACILITIES TO PROVIDE ADDITIONAL BED SPACE.

SENATOR HECK SECONDED THE MOTION.

THE MOTION CARRIED. (SENATOR HORSFORD VOTED NO.)

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SENATOR HORSFORD:
For the record, I am voting no because part of the contracting with acute psychiatric services could be with the hospitals. The wording here assumes we will not be doing that.

CHAIR WASHINGTON:
Recommendation number 3 is on page 3 of Exhibit E.

SENATOR CEGAVSKE MOVED TO INCLUDE LANGUAGE TO ASSIST LEGAL DIVISION STAFF ESTABLISH WORDING IN BDR 38-1322 WITH THE RECOMMENDATION TO IMPLEMENT PRESUMPTIVE DISABILITY

DETERMINATION PENDING SUPPLEMENTAL SECURITY INCOME ACTION.

SENATOR NOLAN SECONDED THE MOTION.

SENATOR NOLAN:
When we have a presumptive-disability determination, we are assuming the person has a disability. The patient may not qualify for SSI. What happens if they are denied? How are the costs recaptured?

CHAIR WASHINGTON:
This is a state option; the State would make the payments.

SENATOR HECK:
If it is ultimately approved to allocate $10 million in general funds to the Medicaid budget for this provision for the purpose of paying for mental health services, who are we paying? Now there is no bed space and we are looking at 12 to 18 months for new beds to be in place.

MS. LYONS:
This proposal was brought forward as a way to entice the industry back into the business of providing mental health services.

SENATOR HECK:
Mr. Welch, do you believe this carrot might entice the acute-care medical facilities to put in psychiatric services?

MR. WELCH:
I cannot speak for the individual hospitals. This major concern has been discussed for 36 months, and I believe this is a part of the long-term solution.

SENATOR HECK:
Does this proposal allow the $10 million to be used for any Medicaid patient or specifically for mental health patients?

CHAIR WASHINGTON:
This is specifically for mental health patients.

SENATOR HECK:
Then, I would recommend we amend the reference to be exclusive to mental health patients.

MS. HAMNER:
I will need to get clarification on whether the language can be specific to mental health patients.

CHAIR WASHINGTON:
Ms. Hamner, what do you suggest we do in order to assure this applies exclusively to mental health?

MS. HAMNER:
We can draft this to state "to the extent authorized by federal law."

CHAIR WASHINGTON:
Will the motion need to be amended?

MS. LYONS:
It is my understanding the Committee is voting to implement a presumptive-eligibility determination pending SSI actions for patients diagnosed with a mental illness, so far as it is allowable in federal law.

THE MOTION CARRIED UNANIMOUSLY.

* * * * *

CHAIR WASHINGTON:
We will look at proposal number 4 on page 3 of Exhibit E.

SENATOR HECK:
This goes directly to the question Senator Horsford raised about proposals we have received. We are in the process of crafting an RFP format so instead of having three different vendors tell us what they want, we tell them what we want. We can compare as apples-to-apples.

SENATOR HORSFORD:
I was supportive of medical clearance. After doing more research and listening to the EMS providers today, I am not supportive. It is $12 million for between 40 to 50 beds. Mr. Welch has indicated the industry has very little incentive to work with this population. Rather than putting this money into a limited-focus provider, I would be more supportive to having the money go to help individuals receive the services they need within the existing structure.

SENATOR CEGAVSKE:
I believe this should be put in as worded. I do not know if we still need 40 to 60 beds. Are we required to put in a number?

SENATOR HECK:
When I met with Purchasing Division, Department of Administration, they requested the RFP specify a single number. When an RFP is submitted, the bidder can put in a lower number which will be evaluated.

SENATOR CEGAVSKE:
This is language that will be going into a bill. I will move we adopt the language as it is written on page 3.

SENATOR MATHEWS:
Are we looking for a proposal or other appropriate mechanism?

CHAIR WASHINGTON:
We are looking for an RFP.

MS. LYONS:
I included that language in the document because I was not sure what the mechanism would be.

> SENATOR CEGAVSKE MOVED TO INCLUDE LANGUAGE TO ASSIST LEGAL DIVISION STAFF ESTABLISH WORDING IN BDR 38-1322 THE RECOMMENDATION TO DEVELOP A REQUEST FOR PROPOSAL WHICH OUTLINES NEVADA'S NEED FOR SERVICES AND EXPECTATION OF VENDORS INTERESTED IN PROVIDING 40 TO 60 SHORT-TERM ACUTE PSYCHIATRIC INPATIENT BEDS WITH A MEDICAL CLEARANCE COMPONENT.

SENATOR NOLAN SECONDED THE MOTION.

THE MOTION CARRIED. (SENATOR HORSFORD VOTED NO.)

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MS. LYONS:
Pages 3 and 4 of Exhibit E describe proposals concerning community triage centers (CTC). According to testimony, a plan for the immediate continuation of CTC is included in Assembly Bill (A.B.) 40.

ASSEMBLY BILL 40: Makes various changes concerning community triage centers. (BDR 40-905)

CHAIR WASHINGTON:
I will entertain a motion for the inclusion of statutory language that makes the State's contribution, one-third of the total cost, contingent upon continued financial support by local governments as described on page 3 of Exhibit E.

SENATOR CEGAVSKE:
During the 72nd Session, the State did not give a one-third contribution. The local governments contributed their one-third. The language in A.B. 40 will reimburse WestCare Community Triage Center (WestCare) for services they provided.

CHAIR WASHINGTON:
The proposal is to create statutory language that would make the State contribute one-third of the total cost for CTC.

SENATOR CEGAVSKE:
We have not heard whether the local governments are going to continue to provide this care.

MR. MUSGROVE:
The contingency has always been whether the State will fund its one-third. I believe some of the hospitals have maintained this should be the responsibility of the State entirely. We have a memorandum of understanding (MOU) in place that expires on June 30, 2005. There is language in the MOU to allow the hospitals to leave if the State does not fund its portion. I believe we have a hard negotiation going forward in July to keep all of the local governments as well as

the hospitals involved if the State does not contribute. Clark County will continue to fund triage. We are awaiting approval by the State for this model of triage.

CHAIR WASHINGTON:
We are hoping the State is willing to step up to the plate. We would like to hear from the private facilities.

MR. WELCH:
The hospitals have indicated they will step away if the State does not participate. The hospitals have been participating as a partner for the past two and one-half years with the understanding the State would be a part of the funding mechanism. Some hospitals are reluctant to go forward under any circumstances. Other hospitals are willing to consider the proposal.

CHAIR WASHINGTON:
The language will state funding is to be one-third from the State, one-third from the county and one-third from private facilities.

MR. MUSGROVE:
Las Vegas has been committed. When the funding formula is changed for some of the local governments, there will be additional participation.

CHAIR WASHINGTON:
We are working on this in order to push the State to commit funding for this proposal.

SENATOR HORSFORD:
If the State is funding one-third and the local government is funding one-third, that means two-thirds is coming from the taxpayers. The State is doing its share in all of the other proposals that have been outlined. I support A.B. 40 and I hope the State does contribute. If this is a community problem, where is the partnership from the private sector if the taxpayers are contributing two-thirds of the funding?

MR. WELCH:
The hospital industry has contributed $2.5 million in support of the triage centers. I cannot speak for the hospitals, but I hope it is clear that the hospital community, as a whole, has been a partner in this initiative over the last

two and one-half years. We should note that hospitals care for many psychiatric patients in the ER for which there is no reimbursement. I believe the cost of those services should be recognized as a contribution to help address this issue.

SENATOR HORSFORD:
Is the care for psychiatric patients in the ER reimbursed to the hospitals through the disproportionate-share funds?

MR. WELCH:
There are only two hospitals that receive disproportionate-share funds in Clark County.

CHAIR WASHINGTON:
There is a bill coming forward to address disproportionate-share funding.

SENATOR HORSFORD:
Hospitals benefit when mental health patients are not clogging the ER. We have a responsibility to meet the needs of the taxpayers. We need to meet a level of balance on some of these initiatives.

MR. WELCH:
I believe the hospital community has been in support of most of the initiatives. There are various components about which the industry has expressed reservations. We have testified in support of A.B. 40 and a number of other pieces of legislation. It was suggested the profits of the hospitals have skyrocketed. We have provided data to the Assembly that shows the industry as a whole has had a profit, but the profitability has been down. The hospital community reinvests for expansion of facilities and services. The uninsured population cost of services has been $785 million over the past 5 years.

CHAIR WASHINGTON:
Is there a motion for the recommendation on page 3 of Exhibit E concerning statutory language?

SENATOR HORSFORD:
Would the committee consider having the funding be defined as 50 percent public, state or local, and 50 percent private?

CHAIR WASHINGTON:
Which entity would be responsible for the 50-percent public funding?

SENATOR HORSFORD:
That would require negotiations between the county and State. It will also depend on each entity's ability to pay.

SENATOR HECK:
Mental health care is actually a responsibility of the State. That it is in statute. The fact that local governments and private hospitals have stepped up when the State has stepped back is a testament to their willingness to help. The parties could say the State should fund 100 percent of the program. I concur with the language as it is written as long as there is continued cooperation from the local and private sector.

SENATOR HORSFORD MOVED TO INCLUDE LANGUAGE TO ASSIST LEGAL DIVISION STAFF ESTABLISH WORDING IN BDR 38-1322 WITH THE RECOMMENDATION TO INCLUDE STATUTORY LANGUAGE THAT WOULD MAKE THE STATE AND LOCAL GOVERNMENT CONTRIBUTION ONE-HALF FOR THE SUPPORT OF COMMUNITY TRIAGE CENTERS.

SENATOR MATHEWS SECONDED THE MOTION.

THE MOTION FAILED. (SENATORS WASHINGTON, CEGAVSKE, NOLAN, HECK AND WIENER VOTED NO.)

* * * * *

SENATOR HECK MOVED TO INCLUDE LANGUAGE TO ASSIST LEGAL DIVISION STAFF ESTABLISH WORDING IN BDR 38-1322 WITH THE RECOMMENDATION TO INCLUDE STATUTORY LANGUAGE THAT WOULD MAKE THE STATE'S CONTRIBUTION ONE-THIRD FOR THE SUPPORT OF COMMUNITY TRIAGE CENTERS.

SENATOR NOLAN SECONDED THE MOTION.

THE MOTION CARRIED. (SENATOR HORSFORD VOTED NO.)

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CHAIR WASHINGTON:
The next recommendation on the bottom of page 3 of Exhibit E was requested by Michael J. Willden, Director, Department of Human Resources.

SENATOR MATHEWS:
I have the same concern I have expressed in the past. We should not be appropriating funds to a private entity. An RFP should be issued.

CHAIR WASHINGTON:
The appropriation makes up for funding that was committed but not delivered to WestCare during the 72nd Legislative Session.

MS. LYONS:
My understanding is not that the Legislature made a commitment, but there was an acknowledgement. The one-third share from the State was not paid, and this is an effort to reimburse the facility for existing services.

SENATOR MATHEWS:
I do not remember committing to any one vendor during the 72nd Legislative Session. I thought this went out to bid. If it did not, that is another issue.

MR. MUSGROVE:
The idea of a community triage center was not a WestCare idea. This was a community-based idea that was proposed to the UMC. WestCare was the only entity in the community able to provide the care. The costs in an initial funding formula were shared among local governments and the hospitals. The full Legislature did not have the opportunity to vote on the measure. During the interim, Mr. Willden came to the Interim Finance Committee's Subcommittee on Community Triage Center. There were some discretionary funds he wanted to use for the community triage center concept. Because the Legislature had not approved of triage, the Interim Finance Committee would not approve payment. There will be an RFP issued for future services.

> SENATOR HECK MOVED TO INCLUDE LANGUAGE TO ASSIST LEGAL DIVISION STAFF ESTABLISH WORDING IN BDR 38-1322 WITH THE RECOMMENDATION FOR CONTINUED FUNDING FOR CLARK COUNTY COMMUNITY TRIAGE CENTER.
>
> SENATOR NOLAN SECONDED THE MOTION.

SENATOR WIENER:
I would like to state for the record I am an unpaid member of a technical advisory board at WestCare.

MS. HAMNER:
That is probably all right. It would need to be disclosed as you have done.

THE MOTION CARRIED. (SENATOR MATHEWS WAS ABSENT FOR THE VOTE)

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CHAIR WASHINGTON:
The next proposal is on page 4 of Exhibit E.

MS. LYONS:
The State's contribution for this proposal would be after the amount provided by the Bureau of Alcohol and Drug Abuse (BADA), Department of Human Resources has been subtracted.

MR. MUSGROVE:
If there is an RFP issued and it is less than $2.7 million, the amounts would be adjusted.

SENATOR WIENER:
Is the reference to A.B. 40 to pay for triage services henceforth? Or does this include reimbursement for the services provided by WestCare through June 30, 2005?

MR. MUSGROVE:
That is correct.

SENATOR HORSFORD:
Can we be provided with the procurement process used for the WestCare contract?

MS. LYONS:
If I am not mistaken, the State had no contract.

SENATOR HORSFORD:
According to A.B. 40, WestCare will be paid $500,000 for services through June 2005. What was the procurement process?

MR. MUSGROVE:
There is an existing MOU in place that has all of the local governments and hospitals as signatories. The intent of A.B. 40 is to give some relief to the local governments and private hospitals who have funded the triage center during the past year.

CHAIR WASHINGTON:
Are you saying there was no contract, just an MOU between the county and the BADA?

MR. MUSGROVE:
No. The BADA process was a grant application that WestCare made through the Department of Human Resources. That is the only money WestCare has been receiving for triage. I am sure the Department of Human Resources can provide the amount of the BADA grant.

SENATOR HORSFORD:
As I understand it, that is a separate amount from the one-third contribution by the State for the last year.

MR. MUSGROVE:
No, it is just a flat appropriation to show good faith that the State believes in triage. It really is some reversionary money that they are hoping to use to fund triage.

SENATOR HORSFORD:
I would like to have further clarification. I do not feel my question is being answered. If there was a contract for services that WestCare entered into with the county, then there would have been a list of the scope of services with payment for those services.

MR. MUSGROVE:
I can provide that.

SENATOR HORSFORD:
If the State is now going to contribute a share, even though it is late, I would like to know what the procurement process was for that contract or MOU with WestCare.

MR. MUSGROVE:
I can provide the scope of services, the budget and the MOU to you.

SENATOR HORSFORD:
I want to make sure for the ongoing funding that we truly have a formal competitive-bid process. What we did last time was more of an amendment to an existing MOU and other providers did not have an opportunity to bid.

MR. MUSGROVE:
You have my commitment on behalf of Clark County.

CHAIR WASHINGTON:
The final discussion is on page 4 of Exhibit E regarding support services for the mentally ill. We will take one vote on all of the proposals.

MS. LYONS:
These items came up in discussion related to mental health patients who return to the ER because they were unable to access certain services. The section acknowledges A.B. 41 and the appropriation it makes of $2 million over the biennium to the mental health courts in Clark County.

ASSEMBLY BILL 41: Makes appropriation for support of Mental Health Court in Clark County. (BDR S-812)

CHAIR WASHINGTON:
These recommendations would go to the Legislative Committee on Health Care. We are asking that Committee to review these recommendations.

SENATOR HECK MOVED TO ACCEPT THE RECOMMENDATIONS CONCERNING SUPPORT SERVICES FOR THE MENTALLY ILL BE CONSIDERED BY THE LEGISLATIVE COMMITTEE ON HEALTH CARE.

SENATOR CEGAVSKE SECONDED THE MOTION.

SENATOR WIENER:
Are we asking for a better-defined scope of activity for this Committee?

CHAIR WASHINGTON:
That is correct.

SENATOR HORSFORD:
I thought the purpose of the Senate Subcommittee on Human Resources and Education on Mental Health Issues was to analyze and assess these issues. I have a problem putting these issues into an interim study for further review. Why would we not make a commitment to fund the mental health court or any of the other quality-of-life issues?

CHAIR WASHINGTON:
It is not an interim committee; it is an ongoing statutory committee which basically deals with health issues. Mental health issues are a part of that committee. They will provide recommendations to this Committee and the Assembly Committee on Health and Human Services.

SENATOR HORSFORD:
We are going to wait and allow a committee to review some of the most-promising practices that can actually help people through prevention and family support. I find it offensive that the subcommittee that was charged to study these issues does not recommend them in a bill to be passed this Legislative Session.

CHAIR WASHINGTON:
Governor Guinn did provide for many of these issues in his budget.

SENATOR CEGAVSKE:
We were trying to address the immediate crisis by dealing with issues to get us over the next 18 months. We lost funding in the early 1990s and it has taken a long time to return to where we were.

SENATOR HORSFORD:
I hope we do not pretend we have accomplished very much, because we have not. Those items that are going to be reviewed by the Legislative Committee on Health Care are actually things that can prevent people from getting to the point where they become more stressed.

CHAIR WASHINGTON:
I would like to thank the members of the subcommittee for all of their work.

SENATOR MATHEWS:
I want to explain why I am in favor of the RFP process. An audit of the university system indicated there was a great deal of money spent because people did not follow the RFP bidding process. It is important we do not bypass that step.

THE MOTION CARRIED. (SENATOR HORSFORD VOTED NO.)

* * * * *

ANN LYNCH (Hospital Corporation of America):
We will be partners throughout this entire process with you, and we appreciate all that you are doing.

CHAIR WASHINGTON:
There being no other issues before us today, this meeting of the Senate Committee on Human Resources and Education will now adjourn at 5:20 p.m.

RESPECTFULLY SUBMITTED:

_____
Cynthia Cook,
Committee Secretary

APPROVED BY:

_____
Senator Maurice E. Washington, Chair

DATE:_____