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

Seventy-Fifth Session
May 13, 2009

The Committee on Health and Human Services was called to order by Chair Debbie Smith at 1:49 p.m. on Wednesday, May 13, 2009, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/75th2009/committees/. In addition, copies of the audio record may be purchased through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

COMMITTEE MEMBERS PRESENT:

Assemblywoman Debbie Smith, Chair
Assemblywoman Peggy Pierce, Vice Chair
Assemblyman Ty Cobb
Assemblyman Mo Denis
Assemblyman John Hambrick
Assemblyman Joseph (Joe) P. Hardy
Assemblywoman Sheila Leslie
Assemblywoman April Mastroluca
Assemblywoman Bonnie Parnell
Assemblywoman Ellen B. Spiegel
Assemblyman Lynn D. Stewart

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Senator Dennis Nolan, Clark County Senatorial District No. 9
Senator Barbara Cegavske, Clark County Senatorial District No. 8
Senator Shirley A. Breeden, Clark County Senatorial District No. 5
Senator David R. Parks, Clark County Senatorial District No. 7

STAFF MEMBERS PRESENT:

Amber Joiner, Committee Policy Analyst
Darlene Rubin, Committee Secretary
Chris Kanowitz, Committee Secretary
Olivia Lloyd, Committee Assistant

OTHERS PRESENT:

Colonel Christian Benjamin, Commander, Mike O'Callaghan Federal Hospital, Nellis Air Force Base, Nevada
Christopher Roller, Director of Advocacy, American Heart Association, Las Vegas, Nevada
Matthew Williams, Intern to Senator Dennis Nolan, Las Vegas, Nevada
Joni Eastley, Chair, Nye County Board of Commissioners, Tonopah, Nevada
Patti Chipman, Pahrump, Nevada, representing Nye County, Tonopah, Nevada
Joseph L. Pollock, Deputy Director, Frontier and Rural Health Program, Health Division, Department of Health and Human Services
Robert Sack, Division Director, Environmental Health Services Division, Washoe County District Health Department, Reno, Nevada
Leo M. Drozdoff, Administrator, Division of Environmental Protection, Department of Conservation and Natural Resources
Wes Henderson, Government Affairs Coordinator, Nevada Association of Counties, Carson City, Nevada
Matt Alberto, Deputy Chief, Investigations, Department of Public Safety
Lillian Mandel, Private Citizen, Las Vegas, Nevada
Renny Ashleman, representing Nevada Health Care Association, Las Vegas, Nevada
Thomas D. Morton, Director, Department of Family Services, Clark County, Las Vegas, Nevada
Donna Coleman, Children's Advocate, Las Vegas, Nevada
Ann Lynch, representing HCA Sunrise Hospital, Las Vegas, Nevada
Lisa Corrado, Redevelopment Project Manager, City of Henderson, Nevada

Jennifer Stoll-Hadayia, M.P.A., Public Health Program Manager, District Health Department, Washoe County, Reno, Nevada
Liz MacMenamin, Director of Government Affairs, Retail Association of Nevada, Carson City, Nevada

Chairwoman Smith:
[Roll called. Introductory remarks.] This is our last regularly scheduled meeting before we have second Committee passage, so we have a busy agenda with several bills to hear and also some work session bills to take care of this afternoon. We will go out of agenda order to accommodate Senator Nolan who has some guests who need to leave.

I will open the hearing on Senate Bill 302. This bill is sponsored by Senator Nolan.

Senate Bill 302: Authorizes certain agreements for the provision of medical care in certain hospitals. (BDR 40-982)

Senator Dennis Nolan, Clark County Senatorial District No. 9:
Thank you for the opportunity to present Senate Bill 302. This is a bill that I am bringing at the request of Michael O'Callahan Federal Hospital, located at Nellis Air Force Base (AFB), Las Vegas, Nevada, and also on behalf of University Medical Center (UMC), Las Vegas. Colonel Christian Benjamin, who is the Commander at the hospital, will testify following me. Dr. Dale Carrison, also of Las Vegas, has authorized me to make a few comments on his behalf. This bill would allow the hospitals to enter into agreements with the military installations in the state, including Nellis AFB, Hawthorne Army Depot, and the Naval Air Station in Fallon, to have the physicians from those bases be able to work and train under the direction of physicians and medical directors at the county hospitals. There are two significant advantages. First, having licensed physicians from the military bases work and train at University Medical Center's Trauma Center and at the county hospital in Washoe County greatly benefits the military. It gives those physicians, many of whom are new, the volume and the diversity of medical calls and patient care that just does not exist on the base and the opportunity to practice and hone their skills, especially prior to going into the combat theatre. Second, it benefits the county hospitals by having additional licensed physicians in the emergency rooms working alongside the medical directors and providing an extra set of professional hands, eyes, and ears. Perhaps Colonel Benjamin would like to add his testimony.

Colonel Christian Benjamin, Commander, Mike O'Callaghan Federal Hospital, Nellis Air Force Base, Nevada:

Thank you for the opportunity to testify today on this important bill. I am the Commander of the Mike O'Callaghan Federal Hospital at the Nellis Air Force Base, a joint venture Veterans Administration/Department of Defense (VA/DoD) 104-bed hospital with specialists from all the various surgical and medical backgrounds.

I would like to applaud Senator Nolan and his colleagues for their efforts in creating a cooperative environment between the Air Force and the county and state entities and all the work they have done to make this bill come this far. Although federal statute allows for the portability of state medical licenses for Department of Defense medical officers, it does stipulate that it would occur at authorized locations within the scope of federal duties and in coordination with state licensing boards. Senate Bill 302 would allow a hospital in the state to enter into an agreement with the Armed Forces which would define the conditions of this cooperation, specifying both the scope and the location to honor out-of-state licenses for military physicians. This would enable UMC and the Air Force to forge an agreement to place military physicians in the UMC Trauma Center to hone their skills prior to going to Afghanistan or Iraq. The benefit to the Armed Forces is clear. Experience in a Level 1 trauma center prior to deploying to a combat zone assures that they will be prepared to handle the level of combat injuries they will face. There have been similar programs in Cincinnati and Baltimore, which have been very successful. Through such programs, combat medicine has made substantial progress. Today we enjoy the lowest died-of-wounds rate in the history of warfare. A soldier today, if he can make it to the first line of medical care in a combat theatre, has a 99 percent chance of survival, which is a phenomenal rate when compared to rates as low as 40 to 70 percent within the last century. It is all due to the advances in trauma care, both on the military side as well as on the civilian side, and it is a real tribute to their cooperation.

I had some experience with this personally in 2006. I was the Commander of a combat hospital in Baghdad, and we were there only a week or so when we got hit with five critically wounded combat participants, all of whom required critical surgery. Our surgeons and our emergency medicine nurses and doctors had the experience of the type of training that S.B. 302 would allow us to have at Nellis Air Force Base, and I think because they had that level of training their performance was outstanding and the outcomes were very favorable. Combat environment does not afford us the luxury of trying to spin up teams once they get into theatre. The price of lack of currency is simply too high.

The benefits of S.B. 302 to the citizens of Nevada are also significant. An agreement between the Air Force and UMC would provide fully-trained and certified military physicians with out-of-state licenses to work in the UMC free of charge. We would provide them to UMC on a rotating basis and essentially set it up so that we would always have somebody filling one of the roles on their team. In addition, the experiences that they bring back from the war zone would also add to the academic environment in which UMC has an important role. The collaboration between military medicine in the civilian sector has a long history of successes. Techniques and discoveries from Vietnam, World War II, and Korea have gone a long way toward advancing civilian medical care at the same time that advances in the civilian sector today save lives in the combat zone. Thank you for allowing me the opportunity to testify today on this critical legislation.

Chairwoman Smith:
Thank you, sir, for being here with us today. What a great partnership this could be. I spent just a short while in the UMC Trauma Center before the session started; I witnessed one trauma case that came in and was totally blown away by what I saw. I cannot imagine a better learning opportunity for both the hospital and the doctor.

Assemblyman Hambrick:
How many of the physicians will be coming from military schools and how many from civilian schools?

Colonel Benjamin:
Essentially what we would do is put together a memorandum of agreement which would state that our physicians, only at Nellis AFB, who are the only ones I can speak for, would do rotations at UMC. We would not open it up at this point to physicians coming from other places like Bethesda Naval Hospital, Walter Reed Army Medical Center, or Wilford Hall Medical Center. It would just involve the Air Force physicians at Nellis AFB. It is probably also important that I point out that the physicians at Nellis AFB are fully-credentialed surgeons. They have already been through all their training, perhaps even at Bethesda Naval Hospital, and they are on staff with us. Those would be the only ones included in the memorandum.

Assemblyman Hambrick:
Would they have general subspecialties or would they be primarily surgeons?

Colonel Benjamin:
Primarily we are working with surgeons, orthopedic surgeons to some degree, although we know our general surgeons are the ones who really need the

experience at UMC. Most of the cases that a general surgeon handles are fairly straightforward until you get into the trauma realm, and, as Madame Chair saw at UMC, a Level 1 trauma center draws some very significant kinds of cases that you really do not see at other hospitals. Our emergency medicine physicians would also gain a lot by being part of a team in a Level 1 trauma center.

Assemblyman Hambrick:
I agree, Madame Chair, this is a great bill.

Assemblyman Cobb:
I just wanted to thank you for your service and tell you that the work all of you do is incredible. In fact, a buddy of mine was patched up at that hospital where I assume you worked, in Baghdad, in the green zone; he took three AK-47 rounds to the chest, and you guys "pulled him through." I appreciate very much the work you do.

Assemblyman Hardy:
I think the concept is great. What about staff privileges, liability, and peer review? Will that be addressed in some way in that memorandum of understanding?

Colonel Benjamin:
We are addressing all of those items in our meetings with the UMC staff. It was interesting that it was the state license that was probably our biggest obstacle; hopefully, with this bill we can get past that. We have solutions for all those other areas.

Assemblyman Hardy:
Was there a reason why we did not put a population cap in this or recognize that it would only happen in counties greater than 400,000?

Senator Nolan:
The intention was—and we discussed it with Fallon Naval Air Station as well—that we wanted to do this with Washoe County, and they were in support of it. The impetus for the bill came out of Nellis AFB and their need. Fallon Naval Air Station is in a very low-population area, but Washoe Medical Center is in a higher population center, and we would have to make accommodations for the two different population caps, so we just decided it was better left unstated. That way, any military installation that had a memorandum of understanding with a hospital under these provisions would be able to do it.

Assemblyman Hardy:
In looking at the bill I did not see a trauma center referenced as much as a hospital. Is that purposeful as well?

Senator Nolan:
Yes. And I think it was because of the definition that was currently in federal law with regards to a licensed facility—the term the federal government used—and I think that just by using "hospital" as opposed to "Level 1 trauma center" it affords them the opportunity in the future to explore other opportunities. It seemed to mirror the federal language, so that is how the bill drafter put it together.

Assemblyman Hardy:
So potentially it could be used with any hospital and with any part of the state, recognizing that the physician would have to have some kind of staff privileges and peer review, so you have a double layer of looking at these people?

Colonel Benjamin:
I believe that is correct.

Assemblyman Hambrick:
On the average, what would be the duration of deployment at Nellis for these physicians?

Colonel Benjamin:
Right now, the Air Force is rotating on six-month rotations every two years. The way the schedule would be set up is that a physician prepares to deploy and starts going down to UMC to do trauma activity more frequently as his deployment approaches. He deploys for six months, comes back, and maybe he is not sent down to UMC for awhile. As he prepares for his next tour, the process repeats.

Chairwoman Smith:
Are there any further questions? [There was none.] I am going to wait until we are through with all of our bills today. Thank you for your testimony, Colonel Benjamin, and, on behalf of our Committee, thank you for your service.

Senator Nolan:
I do not know if there was anyone from UMC in Las Vegas.

Chairwoman Smith:
I did not see anyone signed in. If anyone wants to testify on this bill, please come forward. [There were none.] Is there anyone here present who wishes to

testify in support, opposition, or neutral? [There were none.] We will close the hearing on S.B. 302.

Senator Nolan, you are also the cosponsor of Senate Bill 244 (1st Reprint). We will go ahead and hear that bill, then we will catch Senator Cegavske's bills. I will open the hearing on S.B. 244 (R1). This bill is sponsored jointly by Senator Nolan and Senator Cegavske.

Senate Bill 244 (1st Reprint): Revises provisions governing automated external defibrillators. (BDR 40-277)

Senator Barbara Cegavske, Clark County Senatorial District No. 8:
Most of you know that every day in the United States more than 1,200 people die from cardiac arrest before they reach a hospital. In most cases, sudden cardiac arrest is due to ventricular defibrillation, a rapid, irregular, twitching of the ventricles of the heart. If the electric shock can be delivered within one minute of its onset, the life can usually be saved. The automated external defibrillators (AEDs) are becoming increasingly common in airports, airplanes, schools, and other public places. What this bill seeks to do is to increase the accessibility of these life-saving devices by helping to keep track of where AEDs are located and increasing the number of them available in public locations such as schools, medical facilities, and health clubs.

Senate Bill 244 (R1) would require the Health Division of the Department of Health and Human Services to establish and maintain, within the limitations of available funding, a database containing information concerning AEDs and to make that information available to each agency and facility that employs an emergency medical dispatcher in our state. An emergency medical dispatcher is authorized to disclose the information in the database to any person for the purpose of providing emergency medical care. The measure requires a manufacturer that sells an AED for commercial use in the state to provide certain information to the purchaser in writing and authorizes the owner of an AED to register the defibrillator with the Health Division. The bill also authorizes the board of trustees of each school district as well as medical facilities and health clubs to provide for the placement of AEDs in certain locations.

Senator Dennis Nolan, Clark County Senatorial District No. 9:
The AEDs can be seen around airports in little white boxes, and we walk by them without really noticing. It is important when you vote on something that you know what you are dealing with. [Senator Nolan displayed an AED.] This is an AED like we have in this building. If someone were to collapse right now, any of you could use it to save a life. Many think we have to wait until

emergency medical services (EMS) arrive, but that is not the case. These boxes are available for use by the public at many locations; anyone can open up the box and follow the picture instructions inside. One does not have to be trained to use it. The AED comes with a set of pads that are placed on a bare chest, one above the right side and the other under the apex, or armpit. Then push a button and it "talks" the user through the process and then analyzes the person's heart rhythm. If the person is in ventricular defibrillation it will send the shock. It is that easy. That is why these AEDs are so prevalent and why we are putting them everywhere. As a paramedic, if I got to a cardiac arrest in four to six minutes after the person fell, for me to defibrillate with one shock and hope that the person would come back would be a real wish. It usually does not happen; we would end up shocking someone four or five times and doing other things as well as medication before we could get a heart started again. But if someone were shocked with the AED within the first two minutes, their chance of survival is increased by about 70 percent.

This bill is about creating a registry so that we know where these devices are located. If someone falls and there is a 911 call, whoever calls in will be told by the operator that there is an AED located, for instance, in the office next door, and to retrieve it and follow the instructions. That is one component of the bill. Christopher Roller will discuss the other component shortly.

Chairwoman Smith:
What happens if I collapse, and someone uses it, and that is not what I needed?

Senator Nolan:
It is a smart machine. It will only shock you if you are in the rhythm that indicates defibrillation is needed. It has to be a ventricular defibrillation in order for the AED to respond. There is one rhythm when the heart is just quivering.

Chairwoman Smith:
So, by being hooked up the AED senses that?

Senator Nolan:
It senses that, and it will say that it is going to shock, then "delivering shock, stand clear." Or, it will say, "shock not advised."

Assemblywoman Spiegel:
The intent of this is fabulous, but I do have a question about where the bill talks about the people who have these for commercial use. If somebody has one in their office, maybe because they have a history of heart problems, but it is not really commercial use in the true sense, would that go into the database? How would that work? Also, what happens if the AED is in a nonprofit place?

Senator Nolan:
My understanding is that if someone has an AED—which many people with cardiac problems now have because they are becoming less expensive; around $1,000—they are not required to register. However, in commercial buildings, public buildings, airports, et cetera, they are required to register the AED. They are so required for two reasons: one, so the EMS dispatcher will know where they are and can direct people to use them, and, two, because these also have a shelf life and the batteries need to be replaced periodically, about every two to three years. If the manufacturers are able to track them, then they can notify the owners.

Assemblywoman Mastroluca:
Is this similar to legislation in other states requiring the registration of these machines?

Assemblyman Stewart:
I know there is no fiscal note on this, but it seems to me we could work out something where they could do this for very little or nothing. Has any effort been made to do that?

Senator Nolan:
Not with regards to creating a registry. There is nothing that I know of where a piece of equipment is being registered. But this is such a unique piece of equipment. The EMS dispatchers at 911 dispatch centers are trained to give prearrival instructions, so if someone goes down they can ask the pertinent questions and give the appropriate instructions, but before they could tell someone to use an AED, they would have to know where one was located nearby. In some cases, people do not know what an AED is. Perhaps the American Heart Association could tell what other states are contemplating in this regard, but nothing like what this bill proposes has been done previously. It is such a unique piece of life-saving equipment that is now available to the public, where previously it was available only to health care providers.

Assemblyman Stewart:
It seems like it would be relatively easy to set up a database and maybe charge a small fee or just have the machines registered. If there was a fiscal note, would it be a huge amount?

Senator Nolan:
I do not think it would be. Christopher Roller may be able to tell us how many AEDs are placed in Nevada now. It was just a couple of years ago that AEDs would rarely be seen, now we can see them everywhere. If one was to register the AED for a fee, I do not think the cost would be too great.

Christopher Roller, Director of Advocacy, American Heart Association, Las Vegas, Nevada:
I would like to answer a couple questions posed. First, to Assemblywoman Mastroluca's question, registries have been created over the past decade in several other states: Arizona, Nebraska, New Hampshire, North Dakota, Tennessee, Utah, and West Virginia have created them statewide, but they have also been created in a multitude of cities and counties across the country. They have been proven to work and be effective in other places. To Assemblyman Stewart's question, the costs—and this comes from my discussions with the Nevada State Health Division—for initial start-up would be anywhere from $35,000 to $50,000, with a $6,000 to $9,000 annual cost for upkeep and maintenance of the database. The American Heart Association is searching for grant money from private sources to be able to, at the very least, provide the start-up costs to the Health Division for this database. Then, hopefully within the possible grant we are able to secure, we will be able to provide at least a few years of the annual costs.

I want to point out a section of the bill, mentioned by one of the Committee members, about the requirement for registration of these devices. Please refer to section 3 of the bill where it states it is the requirement on the manufacturer to notify the Health Division when one of these devices is purchased as to where it will be placed. It is an option for the purchaser to notify about that placement, so people who are purchasing them for their homes for "commercial use" do have that option to have them registered, but it is not a requirement. There is a possible civil penalty for the manufacturers if they do not provide that information. Hopefully, I was able to answer the questions that came up previously.

I also want to point out that I had provided a handout for the Committee, a fact sheet (Exhibit C) about the AEDs, which contains some very good information.
[Mr. Roller also provided written testimony (Exhibit D).]

Chairwoman Smith:
I am surprised that we do not see a fiscal note or any cost attached to this if we are requiring their staff to do a database and deal with a penalty, so we can have some discussion about that.

Assemblyman Hambrick:
Senator Nolan emphasized that he knew where an AED was located outside the hearing room. Are the AEDs going to be on a global positioning system (GPS), or when they are placed and registered, does the location then become known?

Senator Nolan:
They are just placed, and the location would be registered. It is not inconceivable that in the future there might be a GPS locator on the device. For now, however, it would be on a registry.

Senator Cegavske:
On page 3, lines 30 and 31 of the amended version, it does not say that the database would be put together but that we are enabling them to apply for and accept gifts to establish and maintain the database.

Chairwoman Smith:
I still think this is odd because, in any other bill we see where the state is required to do anything, there is a fiscal note. We have all of these bills that have fees in them, and until the fees are collected you have to have ramp up costs and plan who is going to do what and how they are going to do it. I am just surprised; I do not think I have ever seen anything where we are asking them to take on a task but we do not really see how they will do it.

Senator Cegavske:
We changed the description, so instead of "requiring" we are "authorizing," and that is on page 1, line 6.

Christopher Roller:
There is not a specific date by which the Health Division is required to create the database. I believe it just says when funding is available or upon the availability of funds. That is why there is not a fiscal note attached.

Assemblyman Hardy:
We have come a long way because we are calling the event "sudden cardiac arrest" instead of "sudden death." The first symptom one has with sudden death is death. This would preclude that from happening.

Senator Nolan:
I would like to introduce Matthew Williams, who is my intern and a student at the University of Nevada, Las Vegas. All of our interns are required to find one bill on which they wish to testify, and he chose this one. That does not preclude you from asking him questions; make him appreciate the full process.

Chairwoman Smith:
I will tell you that my intern's one day to testify ended up with him having to be in class, so he wrote up this great testimony, and I agreed to give it on his behalf. He told his instructor that he needed to step out of the room for a minute so he could get on his laptop and listen to me giving his testimony.

His instructor turned the tables on him and made the entire class log on so everybody could watch it taking place.

Matthew Williams, Intern to Senator Dennis Nolan, Las Vegas, Nevada:
I want to underscore the importance of having this database, as proposed in S.B. 244 (R1). The database allows for emergency personnel to know where AEDs are located and, also important, where they are not located. By that I mean, there may be areas where several cardiac-related events occur—for instance, if there were multiple records of ambulance calls to a certain neighborhood where a number of aged people lived—and there was no AED in the area. It would behoove us to place an AED in that area. This bill would help us know areas where we might want to do that.

Assemblywoman Parnell:
It is amazing to think that in nursing homes and senior centers only 4 percent have access to one of these AEDs. Going along with what Mr. Williams said about a pattern of cardiac-related events, we have a number of people living in senior complexes in this state. For example, in mobile home parks, if there is a recreation center, that would be a perfect location for an AED. The bill could really open the door to a lot of possibilities beyond this initial registry, and that is an exciting prospect.

Chairwoman Smith:
Senators, we received a note from Senate staff that the Health Division asked that language be added to the bill. Where the bill says "the maintenance of the database" for those fees, they wanted "or other activities specified by the Health Division" added there. Had you previously agreed to that?

Senator Cegavske:
We do not have a problem with that. They have been very good to work with. I had not heard that before but do not have a problem with it.

Chairwoman Smith:
So if we have a work session we can amend that then?

Senator Cegavske:
Yes.

Chairwoman Smith:
Is there anyone who would like to testify against this bill? [There were none.] I will close the hearing on S.B. 244 (R1). We will open the hearing on Senate Bill 60 (1st Reprint) on behalf of Nye County.

Senate Bill 60 (1st Reprint): Revises provisions governing buildings and other property that has been used in crimes involving methamphetamine or certain other substances. (BDR 40-542)

Joni Eastley, Chair, Nye County Board of Commissioners, Tonopah, Nevada:
As a little background history on how this bill came about, Nye County has made ample use of the Environmental Protection Act (EPA) Brownfields Funding on various projects throughout the county and has done so very successfully. We found out last year that EPA was expanding the program to provide for grants for cleanup on properties that had been contaminated by methamphetamines. We want to take advantage of expanding our grant opportunities through the Brownfields Program, but we found out pretty quickly that while the funds were available to us, current legislation did not allow us an avenue for certifying that the properties that we were able to remediate were in fact clean. In the larger counties, there were health district regulations that would assist in determining whether or not a property was actually clean. When we looked on our own behalf, there were no state regulations or guidelines for a county of our size, and we did not have a health district to fall back on, so we introduced this bill to clarify the regulations and provide for agency identification of remediated or cleaned properties.

Patti Chipman, Pahrump, Nevada, representing Nye County, Tonopah, Nevada:
We worked with EPA, the state Health Division, and many agencies on this. We have one amendment (Exhibit E) that we presented along with the bill that would totally delete sections 5 and 6, which would allow the Clark County and Washoe County Health Districts to recoup any fees if they have to come in and clean up. It turns out there was a jurisdictional issue and there are other bills that allow them to use that. Therefore, the easiest way for this was just to delete those two sections.

Vice Chair Pierce:
Do we have anything on that in writing?

Patti Chipman:
You should have a mock-up (Exhibit E).

Vice Chair Pierce:
Are there are questions for Ms. Eastley or Ms. Chipman? [There were none.]

Joseph L. Pollock, Deputy Director, Frontier and Rural Health Program, Health Division, Department of Health and Human Services:
As written, S.B. 60 (R1) requires the State Board of Health to be the governmental entity in counties with populations less than 400,000 and

to be responsible for determining if a building that was used for the manufacture of a controlled substance is safe for habitation. To make this determination, the Board of Health shall receive verification that all materials and substances involving methamphetamine have been removed from or remediated on the property by an entity certified or licensed to do so. Since Health Division staff will not be conducting the actual inspections, the Health Division anticipates meeting the requirements of the bill utilizing staff and existing work programs. Consequently, there will be no fiscal impact on the Health Division.

Vice Chair Pierce:
I am confused about how this is going to work.

Joseph Pollock:
It is my understanding that the Nevada Division of Environmental Protection will actually be drafting the regulations. The actual inspections of the buildings will be conducted by an entity that has been certified by those regulations, which will specify who those entities are. They will certify to the Health Division that the buildings are safe for habitation, and then we will go from there.

Vice Chair Pierce:
Does the state get notified that a building needs remediation?

Robert Sack, Division Director, Environmental Health Services Division, Washoe County District Health Department, Reno, Nevada:
The way we anticipate this working, this ends up being a partnership between law enforcement, the state, the Division of Environmental Protection, and the local health authorities. Depending upon the jurisdiction, it might be within a health district or within the Frontier and Rural Health Program's jurisdiction. Basically, law enforcement would find a methamphetamine lab, perform its legal duties, notify the local health authority that they have located a lab, and turn it over to us. Before the building could be occupied again, we would require that an assessment be done and the building be cleaned up, and we would request certification that it is acceptable to occupy.

Vice Chair Pierce:
Proof that the building has been cleaned would come from the county?

Robert Sack:
That is correct.

Assemblywoman Parnell:
I need someone to tell me what is wrong with the way it is working now.

Robert Sack:
Law enforcement finds these labs. In the past, there were a great many of them, although there are not so many right now because of the methodology they are using. They have almost had to walk away from some of them because there is no requirement that an assessment be done inside the buildings. They end up as property rented to tenants who have no idea that the property may be contaminated. In some of our health districts, and in some cases, we had a better handle on that with law enforcement; however, in the rural areas we have not. We have been working with the State Division of Environmental Protection for a number of years to try to get a mechanism to adopt some standards for doing assessment and cleanup, but it is very haphazard and it is a real liability.

Assemblywoman Mastroluca:
Are you saying that you do not currently say that a home is a public nuisance if it has been a site for drug-making activity? It is my understanding that existing law says that you have control over whether it can be considered habitable, but what you just said makes it sound like you do not.

Robert Sack:
We do not have that authority now. We use the powers of the health officer somewhat, which are very generalized and broad, but we have to have more proof than just a notification from law enforcement, because it is very difficult to get inside a house. The notification from law enforcement would be enough for us to at least require that a risk assessment be done. By the time they notify us, they have already conducted an extensive investigation and know a drug lab was located there.

Assemblywoman Mastroluca:
So you do not deem a building unsafe for habitation?

Robert Sack:
We do not.

Assemblyman Hardy:
If I understand this correctly, it may not have a fiscal note but it sounds like somebody from the county is going to pay for this, or is it just a private inspector that the owner pays for and then the county and state sign off?

Robert Sack:
It would stay pretty much at the local level. We would require that homeowner to have the assessment done. If that showed there was a problem associated with contamination from a methamphetamine lab, they would be required to do

a cleanup and submit a report of the work done, and then we would say there was no further risk and the property was now habitable. That contractor assessment and cleanup would be done, we believe, under the Certified Environmental Contractors, a consultant program under the auspices of the Nevada Division of Environmental Protection. Those pieces are already in place, including our field staff who are already out there working, but this bill would give us a much better mechanism to be able to deal with them more effectively.

Assemblyman Hardy:
So the government does not pay anything, the homeowner is the one who is going to pay for it?

Robert Sack:
That is correct.

Leo M. Drozdoff, Administrator, Division of Environmental Protection, Department of Conservation and Natural Resources:
We obviously support the bill. We were approached by Nye County and then other local governments, and as Mr. Sack and others said, the role of the Division of Environmental Protection will be to adopt regulations which will establish these cleanup standards that they can use for the work they described.

Assemblyman Hardy:
So the fiscal note would be $8,000 or $10,000 to develop regulations, and we would get a list?

Leo Drozdoff:
We did not put a fiscal note on the bill. As Mr. Sack said, this has been an issue that the local governments have been struggling with for quite a number of years. I view the work that we do as everchanging, and this seems to be an area where there will be a little bit of cost associated with developing the regulations, but we accommodate that in developing budgets. We deal with issues as they arise at any time, and that is why we opted not to put a fiscal note on it.

Vice Chair Pierce:
Is there anyone else who wants to come forward in support of S.B. 60 (R1)?

Wes Henderson, Government Affairs Coordinator, Nevada Association of Counties, Carson City, Nevada:
We thank Nye County for bringing this bill forward. Methamphetamine, unfortunately, is not restricted to Nye County; it is a problem in all 17 counties of the state. This bill will give all the counties another tool to clean up the aftereffects of methamphetamine manufacture. The way I understand this, through the EPA Brownfields Funding, if there is a mechanism to certify that a house which has been used for the production of methamphetamine or other dangerous drugs has been cleaned up and is safe to be occupied again, and if there are standards created through a state agency, then money is available from the EPA to pay for both the site inspection and the cleanup of the property.

Matt Alberto, Deputy Chief, Investigations, Department of Public Safety:
As the law enforcement entity that is involved in a lot of the drug enforcement throughout the state, we would also like to add our support for this bill. Quite often, as was previously described, law enforcement comes across clandestine drug labs. They may not be methamphetamine, because there are several other types of synthetic drugs manufactured illicitly that create hazards and hazardous waste sites when they are finished. When we find these, typically our task would be to notify the local health agency, but, unfortunately, there were never standards in place for them to actually be able to regulate how the hazards were cleaned up. There have been several instances that I am familiar with where the owners would make an attempt to clean it up by themselves. They may even bring in an environmental technician to run some tests. Unfortunately, the tests were not the proper type, and while they would maybe do an air sample and deem the area to be safe, those of us who have worked in labs would tell them no, it was not safe. There are residuals that are soaked into the drywall, wood, and the rest of the structure that have to be physically removed.

This bill would allow the EPA to develop these regulations that mandate how a person can test to guarantee and ensure the safety of the public. A lot of these private homes, motor homes, and mobile homes end up being re-rented to people who are unaware and are subjected to the hazards from these residual contaminants. As far as the law enforcement aspect, as previously stated, we would support any bill that would help us to further the safety of individuals who happen to cross these sites—even days, weeks, and years after the site has been cleaned out by our officers.

Vice Chair Pierce:
Is there anyone who wishes to speak in opposition to S.B. 60 (R1)? [There were none.] I will close the hearing on S.B. 60 (R1). I will open the hearing on Senate Bill 290 (1st Reprint).

Senate Bill 290 (1st Reprint): Authorizes patients of certain facilities to install electronic surveillance devices in the room of the patient. (BDR 40-852)

Senator Barbara Cegavske, Clark County Senatorial District No. 8:
I would like to introduce Cici Kilgore. She is the young lady I have chosen to be in Senator Weiner's Legislative Youth Forum, and I invited her to come up for the day. I had several great applicants from Las Vegas whom I interviewed by phone and by reading their applications, but Cici's stuck out. This young lady is absolutely incredible; she is a ninth grade honor student at Palo Verde. Please welcome Cici, and thank you for allowing me to talk about her. She is Assemblyman Hambrick's constituent as well.

I am here on S. B. 290 (R1). It is the goal in Nevada and across the nation to make sure that as many seniors and persons with disabilities are able to live as independently as possible. However, there is a small segment of this population whose needs are best addressed through services that are provided in a hospice, long-term care, or group home setting, and those individuals are usually the frailest. According to a recent news article, more than 4,700 people aged 60 or over were victims of abuse last year in Nevada alone. Unfortunately, sometimes this abuse is committed while an individual is a resident of one of the types of facilities already mentioned. Recognizing that a number of safeguards are in place to protect patients of hospice, long-term care, or group home facilities, I believe that this measure will provide added safeguards. Many of you know that my mother is an Alzheimer's patient in the State of Minnesota, and I am only able to see her twice a year. One evening something serious happened to her hand, which led to a year of surgeries, and to this date we do not know what it was. She was playing the piano but is no longer able to play due to that accident.

The capability of monitoring from a remote location provides an additional sense of security to the facility, the patients, and the families. Although my mother would not know she was being monitored, we would be able to see her from a distance. There are six of us, most a lot closer than I, and we all take turns going to see her. Senate Bill 290 (1st Reprint) does seek to allow for such monitoring in a way that respects the rights of each patient, resident, or their guardian, and the facility. This bill establishes the right of a patient, or a person authorized to act on behalf of a patient, who resides in a facility for hospice care, a facility for intermediate care, a facility for skilled nursing, or

a residential facility for groups, to install and operate a monitoring device in the room of that patient. The measure also prescribes the required waivers that must be obtained from the patient, or the person authorized to act on his or her behalf, who is installing the device and from each patient who also resides in the room, or a person authorized to act on the patient's behalf. The bill requires that the monitoring devices be installed in a manner that is safe for the resident, employees, and visitors to the room; that the monitoring device be installed in compliance with all applicable regulations and codes; and that all monitoring be conducted in plain view. Finally, the measure sets forth the conditions under which a video recording from such a monitoring device may be admitted into evidence in a civil or criminal court action or in an administrative proceeding.

In the Senate we had two concerns, but we worked the amendments and thought we had it finished. However, Renny Ashleman told me this morning that his client still has a concern, which I will let him explain to you. I do not know that anything we do would make them feel any better. I do believe in this measure. We currently have the availability to watch children in schools—they allow monitoring so parents at work can see their kids. I also know of a couple of doggie day care centers that allow owners to see their dogs. When I looked at this bill I thought it made so much sense, and being so far away, being able to watch my mother would give me a sense of security.

I ask that you look at this legislation as one that, in my opinion, is a safeguard. I did not think about the issue of having more than one patient in a room, because my mother is in a private room, and I was glad when Renny Ashleman mentioned that to me. There are certain residential areas where there is more than one person per room; that was a big concern, and I understand that issue. But I think the safeguards, the amendments we did with Renny Ashleman and others, were effective, and the bill passed out of the Senate. Mr. Ashleman will discuss his client's concerns. Also, the lady who inspired me to sponsor this bill is in Las Vegas, and I hope she will testify next.

Assemblywoman Leslie:
Did you say if this is being done in any other states?

Senator Cegavske:
If you give me a minute I will look back, because I do not remember if we looked into that. However, I believe the witness in Las Vegas has that information.

Assemblyman Denis:
I just want to be clear that currently the laws do not allow monitoring?

Senator Cegavske:
I believe that if I went into a facility and said I would like to do this, I might be allowed to if I followed their regulations and codes. I have not tried it. I have to ask Legal to verify that.

Assemblyman Denis:
This is obviously a one-way communication, but had you thought about having a two-way communication? Does this bill have that possibility?

Senator Cegavske:
That capability exists with computers using WebCams. In my case, because of my mother's condition, I thought it might scare her if I started talking to her and she did not know where the voice was coming from, so I had not thought about doing it that way. I can talk to her on the phone for very short periods of time. Because of her severe injury and the fact that no one knew what had happened, I was really looking at being able to turn on my computer or television to monitor her room to see if everything was alright. There might be people who would want the two-way communication, and maybe that would be something to consider.

Assemblyman Denis:
Is this video and audio or just video?

Senator Cegavske:
Just video. The wording in the bill says "video." Again, I think that would all be included, perhaps as part of a contract in combination with their regulations and codes, between the family member and the facility.

Lillian Mandel, Private Citizen, Las Vegas, Nevada:
My mother is in a nursing home; she was abused twice in July of last year. The first time, an astute nurse was able to go into the room when she heard that my mother's voice stopped abruptly and found that a diaper was shoved in her mouth. The facility took care of everything, reporting the incident to appropriate agencies, the fines, and so on. Then, a couple of nights later, another certified nursing assistant (CNA) came in the room and threatened my mother, saying they were sending her away because she got her friend fired. I reported that to the administrator of the facility, they checked it out, and it was a "he said, she said." I realized then that I had to do something. I pressed charges with the first incident; she pleaded guilty, got 60 days in jail, and she could no longer work with any facility. I also found out that the same person also abused other people in another facility and that just the week before she had abused a man who had a stroke. Another CNA saw it and reported it to a nurse. The nurse did not report it, but because of my actions, all of this

came out and that nurse was fired. I realized that I needed some kind of camera in my mother's room to protect her, or any other person in a similar situation, and that is why I feel so strongly about this bill.

I checked online and found "granny cams," and a dozen legislators have proposed "granny cam" legislation. Earlier this year, New Mexico joined Texas in allowing nursing home residents and their representatives to install monitoring cameras in their rooms. I feel this is very important; and, hopefully, nursing homes in the future will do this instead of paying out large sums for abuse cases, as often seen in the media. That money could be better spent protecting seniors because one day it could be one of us in there.

Renny Ashleman, representing Nevada Health Care Association, Las Vegas, Nevada:

The Senator was absolutely correct. She was extremely cooperative in working with us. When we did the amendments, we did not take all of the categories into account that perhaps we should have. For example, I do not know what we are going to do with a wanderer. We try to prevent that, but by definition probably most of them are not able to give consent by seeing a sign on a door. The Health Insurance Portability and Accountability Act of 1997 (HIPAA) and a number of other privacy acts, both state, federal, and regulatory that we are under, are not very forgiving of violations of privacy, even though there might be little we can do to prevent it. I do not know what we do with guests that go from one room to another and another to visit, which happens fairly often in these facilities. A number of these patients are ambulatory and they visit one another. Roommates change; even if you had a proper consent from one roommate, almost all nursing home patients, or at least a large percentage of them, are housed two persons to a room. That is the common set up. When that happens, supposedly we would turn off those monitoring devices, but I do not know who is responsible for doing that. Some of these things are probably addressable, but many are not. We do not know what happens if the equipment is damaged or stolen. The equipment is in our facility, but it is not ours, and we would have the burden of trying to protect it, which is a concern, although that could probably be handled by amendment.

Directing your attention to page 3, line 30, subsection 6—if a patient lacks the mental capacity to consent. Who decides that and how do we decide it? We know certain kinds of medical conditions would clearly put them into one category, but other kinds put them in a grey area. Is it our expense to have them evaluated? What happens under HIPAA if we guess wrong? What happens if that ability to consent changes over time? These are concerns that we have. The bill and the amendments I drafted depended on there being a guardian, attorney-in-fact, or other legal representative for the patient. Many

patients do not have a guardian or representative, and many do not have families who are local or who are interested in these problems. That is unfortunate, but it is true. Who bears the expense, then, in giving them proper representation? It cannot be the party that wants the monitor, because if the guardian was paid by that party, there would be a conflict. It should not be the facility's burden. Somebody has to do it, but under federal privacy law if this were done, I cannot imagine anyone who would be willing to consent because of the danger to them of being sued by friends, relatives, et cetera. These are just some of the things that struck me as problematic upon review.

Assemblyman Hambrick:
Going back to the privacy question, if the camera is focused only on the patient with whom we are concerned, and I take it these are not wide-angle cameras, is it your testimony that these patients stay in the same location in the room—a given bed for months—so the camera would not be changed very often, would it?

Renny Ashleman:
They do not typically reassign beds, although it does happen. However, these folks visit each other. I do not know anything about these cameras or whether they are wide-angle. There is a provision in the bill where, if the person who is consenting wants the camera pointed away from him, it could be done, so that indicates to me that in general they would be set up to take in the entire room. We tried initially to address some of these things, but it is my judgment that we really have not, in the time we have had available, had the ability to sufficiently address all of the concerns to satisfy my clients as to their liability, their proper role, and who bears the various costs.

Assemblyman Hambrick:
I am familiar with the term "reasonable expectation of privacy," and going back to the wanderers, they do not have an expectation of privacy when they leave their little area and start wandering. Whether they know they are doing that or not, there is no expectation of privacy once they leave their universe. Do you still see that as a problem?

Renny Ashleman:
Actually, reasonable expectation of privacy is not the law that governs here; HIPAA and other strictures which require that we protect their privacy without any limitations are what govern here. That is part of the problem. It might not be just a reasonable expectation of the wanderer but of their family.

Assemblyman Denis:
Do you know of anyone currently that has this type of a set up?

Renny Ashleman:
I do not. It is quite possible that one could put together a voluntary legal system that would work in the room of a private patient; I would not rule that out. There are one or two states that permit it, but I do not know how it is working out. Our national association has surveyed that situation and has advised us that they do not believe these are desirable situations from our liability standpoint.

Assemblyman Denis:
My other concern is how would someone know that the system was on or off?

Senator Cegavske:
The ones I have seen have a blinking red light; it is constantly on, and the blinking is to make one aware that it is on.

Assemblyman Denis:
Do you anticipate that the facility would provide the service, or would a family member provide it? You mentioned the lap top which could have a wireless card.

Senator Cegavske:
All of this is on the family or person who asked to have the monitor put in. If I request the monitor, I am responsible for it if anything happens to it. That is what we tried to make clear in this bill. We are trying not to put anything on the facility owners. I totally understand the HIPAA, and that is what we thought we had finalized.

Chairwoman Smith:
I absolutely understand the passion behind a bill like this. Your personal experience is one that we would all absolutely dread to have happen to a family member. I just do not think we are there yet. It is one thing to have a video camera in your home, the "nanny cam" situation, when you have only your surroundings to worry about. I am concerned though when we are involving other people's space and facilities. I appreciate your passion and how important the safety of all of our loved ones is, but I think there is still a lot that would need to be worked out on an issue like this.

We will close the hearing on S.B. 290 (R1) and open the hearing on Senate Bill 293 (1st Reprint).

Senate Bill 293 (1st Reprint): Establishes procedures for authorizing the administration of certain medication for children in the custody of certain agencies. (BDR 38-701)

Senator Barbara Cegavske, Clark County Senatorial District No. 8:
Senate Bill 293 (1st Reprint) requires child welfare agencies to obtain the consent of a parent or guardian of a child in custody of the agency before authorizing the administration of psychotropic medications. If the parent or guardian does not respond to a request for consent to administer the medication within five days, the agency may authorize the administration of the medication. In cases where the parent or guardian denies the request for consent for medication, the child welfare agency may authorize administration of the medication to the child unless the child is less than six years of age or the child is being prescribed more than five medications. In instances where the child welfare agency believes that a psychotropic medication must be administered to a child and an authority is not provided, the agency may file a petition with a court of competent jurisdiction for an order authorizing administration of that medication. For accountability purposes, this measure requires the Division of Child and Family Services (DCFS) to review the policies and procedures relating to the prescription and administration of psychotropic medication to children in the custody of child welfare agencies and report its findings to the Legislative Committee on Health Care and the mental health consortiums on or before July 1, 2010.

According to the Child Welfare League of America, children in foster care are at a higher risk for physical and mental health issues stemming either from the maltreatment that led to their placement or from their preexisting health condition and long-term service needs. Despite the dismal fact that anywhere between 50 percent and 80 percent of children in foster care experience moderate to severe mental health and behavioral problems, findings from the Federal Child and Family Services Review (CFSR) reveal that the mental health needs of these vulnerable children are often not met. Many states, including Nevada, have committed to better address the mental health needs of children and families in their child welfare systems. There is a growing concern about the use of psychotropic medications with children, partly because very few of these medications have been approved by the United States Food and Drug Administration (FDA) for treating mental health disorders in children. Studies have shown that children involved with the child welfare system are three to four times more likely than others to have Medicaid recipients receive these medications. Although some extreme situations certainly warrant the use of these psychotropic medications on children, the prescriptions and administration of those medications must be monitored closely.

The measure seeks to greatly improve the monitoring of the practice in Nevada, so as I urge your support I would like to give you a little background about the bill in our House. In the Senate, as we heard, this bill has changed since its original drafting in that we had discussions with Tom Morton, Director of

the Department of Family Services in Clark County, who has been wonderful to work with. I appreciate that he and the others came forward to help us on this issue. Donna Coleman brought the issue to me originally because of her persistence in trying to find resolution to an ever-increasing problem that we have: the overmedication of children in foster care. What we learned is that we do not have anybody in charge of this area. To a certain extent, we have somebody who oversees some of the facilities but not the foster care area of which we are speaking. Mr. Morton and Ms. Coleman will certainly give you more background and information. There is no accountability for the treatment, and that is something we have to straighten out. Unfortunately this bill does not address all the issues that have been brought forward, and unfortunately, too, we cannot do it in a short period of time.

What we are asking is that the Interim Committee on Health—and I am looking at Assemblywoman Leslie because she is a staunch advocate, and I know her passion for this because I have had the pleasure of working with her on committees—assist in putting together a system of accountability with the help of Mr. Morton and Dr. Norton Roitman, who was unable to appear today, who have agreed to help with whatever we do. We do not have leadership at the state level in this arena, and this area is not addressed. At the state level they are under the DCFS and Rural Adults, those are the two different areas, but the kids do not have an area. They are not recognized, and we are not taking care of them. One of the issues is that some of these kids are on more than five medications, and they are combinations. If you went to a pharmacist, he may say to you that you cannot combine these two or three drugs, but we do not have anyone looking at that on behalf of children. We originally wanted to have this as something that judges looked at, but the judges told us they did not have the capability or knowledge to know if those drugs can be combined or not. We can certainly ask to have the child re-reviewed. These are some of the issues we are struggling with—regulations and policy. I ask that the two speakers in Las Vegas go ahead with their testimony, as they will be able to amplify what I have talked about. I believe this is an issue that we can take care of, but I think we need the time in the interim to do it correctly. There seems to be agreement from those who have come forward that what we have done to this point, what has been amended, will help. But we still have to carry this on. We need to make this one of our priorities in the interim.

Thomas D. Morton, Director, Department of Family Services, Clark County, Las Vegas, Nevada:

More than a year ago, I first encountered this issue in a meeting with a number of youth who are in foster care in Clark County. They began to describe to me their experiences with psychotropic medications and the frustrations they had. In particular, the concern that stood out was that

there were instances in which medications were being used to manage behavior and behavior was not being treated. In fact, I raised this issue in the Court Improvement Project (CIP) Steering Committee at the time Justice Maupin was Chair. In the presence of Assemblywoman Buckley, I talked about my concern about the use of psychotropic medications throughout the child welfare system. Assemblywoman Buckley then requested information from Mr. Michael Willden.

That information revealed that, of the approximately 500 kids in treatment foster care, 49 percent were being treated with psychotropic medications, but only about 20 percent of those kids were currently and concomitantly receiving therapy. That tends to reinforce the perception that drugs are being used to manage behavior rather than as part of a treatment regimen. Particularly concerning was that 86 children under the age of six were on psychotropic medications, according to the data. When I did an internal review in Clark County, I found more than 50 kids under the age of six on psychotropic medications. Part of the concern here is that, at that time, there was no internal policy in Clark County, nor statewide policy, nor specific legislative guidance in terms of the approval and review of the use of psychotropic medications for children in foster care.

I am aware that there are two actual bills before the Assembly and the Senate, one introduced by Assemblywoman Mastroluca, which I believe is A.B. 347, and this one introduced by Senator Cegavske. Both of them contain a provision to establish statewide regulations. I think that is a very important step that we must take, because we must clarify as a state what our expectations are in regard to the care and protection of children in our custody. I mentioned that there are 500 child welfare children in treatment foster care; there are actually a total of 900 in this state. The remaining 400 are a mix of private placements by parents and children placed by juvenile justice agencies.

When I originally testified in response to this bill, I said that there were a number of concerns that are not addressed by this bill that relate to the use and misuse of psychotropic medications. On the other hand, I do believe that any step we can take to extend protections to this group of children is important, and certainly in that regard I would urge the adoption of statewide policies in regard to the review and approval of these medications. This bill proposes to go a bit further by requiring judicial review of a certain set of cases, and those would include any child under the age of six, as well as any child of any age in the custody of a child welfare agency who is receiving more than five psychotropic medications. I believe the bill can and will work. I have talked with Judge Ritchie and Judge Steel in Clark County, and both officers of the judiciary agree with the scope of the language of the bill, and they endorse

and will support this. Recently, a seven-year-old child in Florida hanged himself. He was a foster child, a child on a cocktail of psychotropic medications that were approved by a judge. Therefore, as we move forward I think we need to implement guidance in relation to this that ensures that there are adequate supports available to the court and the child welfare agency. I am not implying a fiscal note on this bill, please do not misinterpret me, but we need to be careful that the right kind of expertise is available to both the court and the child welfare agency as we implement this legislation, if passed.

To summarize, I believe this is a very important problem, and to build on what Senator Cegavske said, I know the Legislature is extremely limited by the current economy and resources available in the state today. But, overall, I think the child mental health system in Nevada is extremely fragmented in terms of its accountability. I asked someone the other day, when a child and family team meeting occurs and there is a treatment plan developed, who is accountable for implementing that plan? It is not clear that the child welfare agency is, because my staff does not have clinical expertise in mental health. It is not that the Wraparound in Nevada worker is, nor is it clear that the treatment foster care agency case manager is, but somebody should be. Ultimately, I would say the treatment of very vulnerable children who are severely emotionally disturbed should not be like the office coffee pot in which anybody could, and somebody should, but nobody did.

Assemblyman Stewart:
Mr. Morton, thank you for all the good work you do in Clark County, we appreciate your being there. So, right now we have a hodge-podge of who is authorizing the medication, and there is no direct authority, is that correct?

Thomas Morton:
This is partially true. I should have commented that there are a couple of important things in the bill: for instance, it clarifies the responsibility of the child welfare agency to seek informed consent of the parent. For most of the children in my care, the parental rights are still intact, and I believe parents should have a role in at least being informed and reviewing any authorization of such medications to their children. But the way it is now, it is not clear who can authorize. Or, alternatively, I could say it appears clear that my case managers can authorize these medications, but the case managers are not adequately trained or equipped with information from consultations to let them know whether they should say yes or no. They are not going to question a physician's opinion. And there is also a range of use of these medications that occurs outside of a psychiatric context. A foster parent can take a child to a pediatrician, complain about a behavior—the child is hyperactive, the child does not sleep, et cetera—a pediatrician can write a prescription, and that

foster parent can begin giving the medication to the child. There is an expectation that they notify us, but it does not always occur. I think the rigor and the structure around the use of these medications is significantly deficient right now.

Senator Cegavske:
I wanted to apologize to my colleague, Assemblywoman April Mastroluca. We both had similar bills, and she did such a good job of putting them side-by-side for us in the Senate. What we talked to Chairwoman Smith about was amending the language from the Assembly bill into the Senate bill, so we have to make sure that we have her name on it. Staff tells me that if we do not ask for that in any amendment it would not happen, so I want to be sure that is done.

Assemblywoman Mastroluca:
Based on the research that the Senator has done and the research that I have done, we can all acknowledge that it is an issue we need to deal with. I appreciate her willingness to work together to amend this language, and I think that adding it into part of the interim study is going to be critical. There is a lot of work to be done and that time is going to be very valuable.

Donna Coleman, Children's Advocate, Las Vegas, Nevada:
First, I think Mr. Morton hit all the points that I wanted to cover very well. Basically, my problem with this is, again, the word "accountability"—informed consent. Unless the child is in a hospital where there is a guardianship ordered by the court, most of these children's only legal guardian is still their parents. At some point they will probably be reunited with these parents, and yet the parents are not given the opportunity to give informed consent on medicating their children. In too many cases the caseworker is not at the table either. I also worry that too many of these children are getting drugs instead of counseling in order to preserve placements.

About the judges, I want to make one thing clear. This bill does not try to make judges, doctors. What they really want is for the judge to do the same thing that a parent would do—ask questions such as why is this needed and what are the alternatives?

Senator Cegavske:
I want to thank Donna Coleman again. She brought this to my attention, and there is not a better advocate for children in Clark County. She does an incredible job with dignity and respect, and I am grateful to her for all she has done and for coming on such short notice.

Assemblyman Stewart:
I, too, would like to thank Ms. Coleman for the great job that she does. She has helped me on a bill, and she is a great advocate for the children of Clark County and the State of Nevada.

Chairwoman Smith:
I wanted to lend my support to this issue and thank both the sponsors. I know that a lot of work has gone into working out the language in these bills and a lot of the staff time with the agencies was spent on trying to craft some language that works. I think adding it to the interim committee's scope of work is a great idea. In our hearing we heard testimony about a young person who had been on 17 different medications, which is just dreadful. The other thing I want to mention is that the Court Improvement Project (CIP) is also looking at this issue, thanks to one of the staff members from Legal Aid, and I think some good work will come out of that as well. Between the bills, the interim committee looking at it, and the CIP, I think we will see some great change in this area.

Is there anyone else who wants to speak in support, opposition, or neutral on this bill? [There were none.] I will close the hearing on S.B. 293 (R1). I will open the hearing on Senate Bill 325 (1st Reprint).

Senate Bill 325 (1st Reprint): Authorizes hospitals to establish a program concerning methicillin-resistant Staphylococcus aureus. (BDR S-42)

Senator Barbara Cegavske, Clark County Senatorial District No. 8:
I thank the Chair for allowing me to present all of these bills in one meeting.

Senate Bill 325 (1st Reprint) authorizes each hospital in the state to establish a methicillin-resistant Staphylococcus aureus (MRSA) Infection Control Program to identify patients with MRSA infection, isolate such patients, enforce hand-washing policies, and work with the Nevada Hospital Association to develop a method to report information about such infections. The bill further encourages the Nevada Hospital Association, in cooperation with the Health Division of the Department of Health and Human Services and hospitals, to develop a model for reporting cases of MRSA infection. If the Nevada Hospital Association develops a model for reporting on or before January 1, 2011, the Nevada Hospital Association shall submit a written report to the Director of the Legislative Counsel Bureau (LCB) for transmission to the next regular session of the Legislature concerning the model adopted. This measure would be effective on October 1, 2009.

What we are trying to do is encourage the hospitals to start this. We had mandated it in the Senate in the original language. We talked to them, and

because everyone is struggling with the economy, we asked them to work on a plan to identify the patients and isolate them, to enforce the hand-washing policy, and to develop the model for reporting. Those items are so critical for us, especially with the epidemic of swine flu, so the more we can do to bring awareness to this serious issue, the better. I was amazed when I heard the number of deaths that have occurred from MRSA. It is something we need to address, and I hope this Committee will embrace it. I hope my good friend Ann Lynch from Sunrise Hospital, who helped me with my revision on this, will be the next speaker. I appreciate your support on this measure.

Ann Lynch, representing HCA Sunrise Hospital, Las Vegas, Nevada:
All of our hospitals currently enforce the hand-washing, isolation, and identification policies. To my knowledge, all the hospitals in Clark County and statewide are very progressive in the enforcement of these policies and have been for some time. Staph infection is the greatest fear that any hospital has. The problem we have run into, however, is in trying to report it. Each hospital does collect data for information for its infection control committee. I have spoken to the Nevada Hospital Association, and its patient safety committee, made up of nurses in each of the facilities throughout the state, is going to take this on at their workplace. I have also spoken to the Department of Health, and they are going to join in that effort. We would hope by the deadline we will have a plan that is workable and a databank, so that we can take a good look at the cases of staph throughout the state and develop prevention practices that can be adopted. This is a difficult task, but we are more than anxious to do it because our concern is the safety and protection of our patients and fellow citizens.

Chairwoman Smith:
This issue became very important to me several months ago when my three-year-old granddaughter had a case of MRSA. What started as a little dot about the size of a pencil head two days later had grown, and she was instantly hospitalized and had emergency surgery. One hears about these things, but it is difficult to understand until it is a personal experience. It was very scary. The aftermath, too, is frightening and a really big issue. I think in our endeavors to provide better care and be more transparent, we must know what is going on out there so that we can see the data. It is so important to stay on top of this everchanging infection.

Assemblywoman Pierce:
Is there anyone else who wishes to speak in support of or opposition to this bill, or as neutral? [There were none.} I will close the hearing on S.B. 325 (R1) and will turn the meeting back to the Chair.

Chairwoman Smith:
I think we will take a break in order to gather up some information for the work session. We will stand in recess [at 3:52 p.m.].

Let us reconvene [4:26 p.m.].

We are going to a work session on some bills that we have previously heard plus some of those we heard today. We will go out of order to accommodate some Senators who were kind enough to come and participate in the work session. Let us discuss Senate Bill 137 (1st Reprint) first. The mock-up is being distributed (Exhibit G).

Senate Bill 137 (1st Reprint): Provides for the placement of recycling containers in certain locations. (BDR 40-741)

Amber Joiner, Committee Policy Analyst:
Senate Bill 137 (1st Reprint), sponsored by Senator Breeden, was heard on April 29, 2009. [Ms. Joiner read from the work session document and mentioned that Clark County had proposed a two-part amendment during the hearing (Exhibit F).] There was no testimony in opposition to this measure.

Chairwoman Smith:
I know there was some concern about whether the existing apartment complexes and condominiums would be able to deal with this, and I know there was some concern in our hearings about the penalties and uncertainty about what those penalties would be. This amendment (Exhibit G) has been suggested to delete the regulations from the Environmental Commission, I think primarily because there is not a real close connection between the Environmental Commission and the local governments who are the ones who negotiate the franchise agreements and the agreements for the collection of materials. Also, on page 5, in addition to the revised plan for the construction of new complexes, it adds major renovations, so if a complex is going to have at least 50 percent of its property renovated, they would have to fall into this requirement to include provisions for the placement of recycling containers on their grounds. I think the local governments have indicated that 50 percent is a typical threshold for them where they already do certain types of plan checks and have certain requirements, so that would be a likely nexus for them. It leaves the University System in as in the original bill.
Senator Breeden, perhaps you want to come to the table and indicate whether you can support this. I know that you prefer your original version, and I had indicated that we can keep working and see if we can come up with more suitable language, but I would really like to be able to move this bill.

Senator Shirley A. Breeden, Clark County Senatorial District No. 5:
I would like to move the bill as well and, yes and no. I agree with it, but only because constituents came to me who currently live in apartments. I was sharing with Assemblyman Hambrick that I have talked to Republic Services and, if this measure is passed with the amendment as proposed, they have a pilot project, and I may be able to work with the constituent and the landlord where they live and see how we can help them in some way to get some data. I would be supportive of this measure's moving forward. Thank you for your help.

Chairwoman Smith:
We will keep working on it. It is a great concept. I think there was just some concern in the original bill about whether these existing complexes can all handle what is being asked of them, and if there is some way we can phase it in or have some other plans in place, we will do so. As I committed to you, we will keep working on it, but I do want to move this bill today.

Senator Breeden:
Thank you, and this is a good start.

Chairwoman Smith:
It is actually a big start, and I think you have done a very good thing here getting this issue moving forward.

Assemblyman Hardy:
In Clark County it is a problem because we have so many different levels of trying to get things done. I want to make sure somebody from Clark County somewhere along the line said that this is not going to further slow down projects that are already being slowed down.

Chairwoman Smith:
As far as I know, all the local governments of the major counties were contacted on this amendment to make sure this made sense.

Lisa Corrado, Redevelopment Project Manager, City of Henderson, Nevada:
We actually jointly submitted that amendment with Clark County, so I do not know if there is anything I can do to help.

Chairwoman Smith:
We were actually talking about this new amendment, not your amendment. Had you been consulted on the amendment we are talking about (Exhibit G) that takes the Environmental Commission out?

Lisa Corrado:
Not formally. I do not have a copy of it, but we talked about it with the county and looked into different ways to capture some of those existing structures, and that 50 percent replacement value came up as an option. So if that is acceptable to the sponsor and the Committee, then that is something that would allow us to catch some projects when they come in. For example, if there is damage to the structure from flooding or fire and they come back in, that gives us an opportunity to check that; otherwise, we may not be able to.

Chairwoman Smith:
So it adds another big level for local government to be able to capture these existing properties into the system.

Assemblyman Hardy:
Along that same line of the mock-up amendment, I want to make sure that our intent still allows a city or a county to use their planning commission in that process after they make the regulations. That way we do not have to go to the county commission, necessarily, if the planning commission has seen it.

Chairwoman Smith:
In section 11, on page 5, it indicates the same language, but that is where it adds the major renovation regarding the governing body.

Assemblyman Hardy:
And that is the governing body being the commission, but sometimes they use the planning commission?

Chairwoman Smith:
We can double check that with Legal to see that it is sufficient. That was the intent when the original bill was presented.

Assemblyman Stewart:
Has the fiscal note to the state been removed?

Senator Breeden:
Yes, the fiscal note was with the State Environmental Commission for the development of the regulations.

Chairwoman Smith:
Dr. Hardy, to go back to your question, the amendment that was worked on between Clark County and Henderson addresses your issue of the planning commission, and that would stay as proposed. Is there any further discussion? [There were none.]

I would entertain a motion to amend with the amendment presented today in the work session document (Exhibit G).

> ASSEMBLYWOMAN PIERCE MOVED TO AMEND AND DO PASS SENATE BILL 137 (1st REPRINT) WITH THE AMENDMENT PRESENTED TODAY IN THE WORK SESSION DOCUMENT.
>
> ASSEMBLYMAN HARDY SECONDED THE MOTION.
>
> THE MOTION PASSED UNANIMOUSLY.

Ms. Pierce, will you do the floor statement on this one.

Since we still have Senator Parks here, let us move on to Senate Bill 305 (1st Reprint) (Exhibit H).

Senate Bill 305 (1st Reprint): Makes various changes concerning dispensing a medication and providing a prescription for the sexual partner of a person diagnosed with a sexually transmitted disease. (BDR 40-845)

I had some concerns about this bill being a little bit too loose with being able to give the medication to the diagnosed person without any information about the partner. In talking to Committee Members, I felt there was general concern about that. I think we have worked out some really good language that, hopefully, the Committee can work with. I will ask Senator Parks or Jennifer Stoll-Hadayia to speak, and then we can offer a conceptual amendment.

Senator David R. Parks, Clark County Senatorial District No. 7:
Since I am not an expert in this area, I will happily ask Jennifer Stoll-Hadayia to speak about the bill.

Jennifer Stoll-Hadayia, M.P.A., Public Health Program Manager, District Health Department, Washoe County, Nevada:
The goal of expedited partner therapy overall is to increase the number of potential contacts to a sexually transmitted disease (STD) who are treated. The conceptual amendment we were discussing earlier today would still allow for that to happen, it would simply happen through a different process. Instead of allowing a provider of health care to simply administer an extra dose of medication or write a prescription without the contact's information, the conceptual amendment would allow for a provider of health care to give a diagnosed contact instructions to give to his partners or potential partners, who would then present to a local health district or another type of public health

provider. At that point, we could provide what is commonly referred to as presumptive treatment—which is someone who feels or knows they have potentially been exposed to an STD pending a positive test. That is currently a practice allowable in public health once we have confirmed contacts to a positive case. The conceptual amendment would simply allow that confirmed case to provide instructions to his contacts who would then present to us, and we could presumptively treat them.

What that means is that contacts could come straight to a local health department, like the Washoe County Health District, and receive presumptive treatment that would reduce barriers to them getting treated. It would allow immediate treatment for them, and it would prevent transmission in the meantime. So though it is not expedited partner therapy (EPT) in the strictest sense, in the way the bill is currently written, this conceptual amendment would still allow for us to reduce barriers to contacts getting treated that would result in more contacts being treated, which is the overall goal of EPT.

Assemblyman Hardy:
If I diagnose and treat a patient for an STD, and the patient has a partner, I can write down the diagnosis and test results and he can take it to his partner who, in turn, can take it to a health district in the state. The health district can treat that patient presumptively without having to make the appointment with the health district, because they have already, in essence, opened that presumptive treatment door.

Jennifer Stoll-Hadayia:
Should this legislation be written in that manner then, yes, we would be able to presumptively treat that contact without having issued a test on that contact. The bill as currently written requires the State Board of Health to provide protocols for that process, so obviously those protocols would further elaborate on the process you just described. The clinician, in his judgment at the time he is providing treatment to that contact, might decide to treat for other things at the same time, but that process would allow them to receive treatment. Local health departments, certainly my own, have on-site pharmacies so that treatment could happen immediately without waiting for test results because that person has already been exposed to someone who has been tested.

Assemblyman Hardy:
We have other providers who treat people, federally-qualified clinics, and if those clinics could be encouraged about this opportunity, the same kind of thing may happen. I mention this because, from a liability standpoint, when you are a physician and write treatment for somebody you do not know, you have a certain potential incurred liability. The advantage the federally-qualified clinic or

health district has is that they have some federal protection that allows them to get away with treating somebody without having the huge liability risk hanging over them. The obvious advantage, too, is that people get treated sooner and decrease the risk of passing disease along. I think this is probably a good thing to do if we can make it broad enough.

Chairwoman Smith:
One of the pieces of discomfort for me was just giving medication to someone without going through a pharmacy. So, we could also add a provision that if there is not an on-site pharmacy, the person would be given a prescription and not the drugs. That way, it would have to go to a pharmacist who could ask about drug allergies or contraindicative medications.

Assemblyman Hambrick:
I have a concern if there are multiple partners on both sides. Where do we stop with this?

Jennifer Stoll-Hadayia:
Expedited partner therapy originated as a practice to help address what you are describing. In the field we often call it the "ping-ponging" effect, where people simply give an STD back and forth to each other. Expedited partner therapy was meant to stop that, and that is where it has had some of its greatest impact. An individual who has tested positive for Chlamydia and gonorrhea, the two STDs for which this is recommended at this time, has been able to give his partner that instruction to present to the health department, or to a federally-qualified health clinic, and the partner is treated, and that "ping-ponging" will stop. It will be the clinician's judgment on how many of the instructions to give to the positive case based on their risk assessment of the case and how many partners he has. Then, once presumptive treatment occurs, the ideal is at least that potential case is no longer transmitting that STD to other partners they may be involved with.

Chairwoman Smith:
I think this is a good resolution to the bill. It really gives the providers and the patients some expanded opportunities and keeps the risk a little more limited. Dr. Hardy, would you like to articulate that conceptual amendment and make the motion?

Assemblyman Hardy:
Yes, I would. And before I do that, I would even like to pay tribute to our wonderful Chair who came up with this brilliant idea and made this work so well.

The conceptual amendment would allow presumptive treatment to a person who has had a known exposure to an STD that has been diagnosed either in the public health or private health arena. The provider would be able to write a note that could be taken to the public health facility, such as Southern Nevada Health District or Washoe County Health District, and/or any other federally-qualified clinic that voluntarily chooses to participate in this, so that the exposed person would be able to receive presumptive treatment, and any other treatment based on any other specific questions that may have come up with the screening that the public health or federally-qualified clinic would do; recognizing that the treatment would require a prescription to be given to the person with the caveat that a pharmacist would ensure there is no drug-drug interaction and/or allergy before treating that person.

> ASSEMBLYMAN HARDY MOVED TO AMEND AND DO PASS SENATE BILL 305 (1st REPRINT) WITH THE CONCEPTUAL AMENDMENT.
>
> ASSEMBLYWOMAN PARNELL SECONDED THE MOTION.

Chairwoman Smith:
As we have done in the past, you will have an opportunity to look at any language before it goes to the floor, so everyone will have a comfort level. Jennifer, will you be willing to work with our Legal staff, since you understand what it is we are trying to accomplish, and help us with the language? Our Legal staff wants to know if the name would remain confidential or if the name would have to be listed on the note that would be written at the public health facility.

Assemblyman Hardy:
I will look to Jennifer on this, but the physician who writes the note will be writing it to his/her patient, not to the partner. That note is under the control of the patient until the patient gives it to the partner. Coincidentally, with a positive Chlamydia or gonorrhea test result, the health district, whether local or state, will get the results of that test, since it is a reportable disease. They are going to make a phone call to a contact, explain that the contact has been exposed to someone who had an STD, and offer that person a confidential treatment. This bill will facilitate and expedite the treatment, which in turn will reduce "ping-ponging."

Jennifer Stoll-Hadayia:
That was articulated perfectly. What that also helps the public health community do is expedite the identification and notification of contacts, which

is a very time- and labor-intensive process. If contacts are coming to us voluntarily, that is even better and will help with our limited resources as well.

Senator Parks:
I just want to make sure that we did leave in there that the Health Division would submit the regulations to the Board of Health for them to adopt.

Chairwoman Smith:
Absolutely. I think all of that is still intact; it is just the flow of information or treatment that we are worried about.

THE MOTION PASSED UNANIMOUSLY.

Let us go to Senate Bill 17 (2nd Reprint) in the work session document (Exhibit I).

Senate Bill 17 (2nd Reprint): Revises provisions governing health care records. (BDR 54-607)

This bill is also a little problematic, but we will try to work through the issues. There is also a new amendment (Exhibit J). Please come to the table, and we will try to resolve some of the issues we have. There is just a very slight change in this amendment, and Amber Joiner will go over where we are with you. That is one just received that we did not know about. Amber will go through the amendments, and then we can ask some questions and try to clarify. I think we will probably have to make some changes to get everyone comfortable with this.

Amber Joiner, Committee Policy Analyst:
Senate Bill 17 (2nd Reprint), sponsored by Senator Wiener, was heard on May 11, 2009. [Ms. Joiner read from the work session document (Exhibit I). There were two amendments proposed.]

The amendment (Exhibit J) just received replaces letter A of the work session document, so you will want to look at the most recent mock-up. I just received this, and I believe the only change is on page 2, line 32. The original mock-up, Proposed Amendment No. 4876 (Exhibit I), used the word "record," and the new one, Proposed Amendment No. 4943 (Exhibit J), uses "data"; however, I believe the reason for that would best be answered by Liz MacMenamin. The second amendment, Proposed Amendment No. 4885 (Exhibit I), was based on discussion during testimony and among members. It clarifies that upon attaining 25 years of age, a person's records may be destroyed if they are more

than seven years old. That mock-up is in the work session document. There was no testimony in opposition to this measure.

Chairwoman Smith:
Let us clarify that the amendment you just received, Proposed Amendment No. 4943 (Exhibit J), that says "prepared for Senator Wiener," replaces the other one from Senator Wiener, so get rid of that one, Proposed Amendment No. 4876 (Exhibit I). Then we have the second one that clarifies the age of 25 years, Proposed Amendment No. 4885 (Exhibit I). We had a discussion last night concerning the in-pharmacy clinics and a lack of comfort from the Committee that the in-pharmacy would somehow be exempted from recordkeeping. Liz, do you want to address that issue?

Liz MacMenamin, Director of Government Affairs, Retail Association of Nevada, Carson City, Nevada:
I understand the concern. These medical clinics right now are required by federal law to maintain these records. They do have them within the clinic. There is also a doctor that oversees the clinics; it is a contractual agreement. He also has access to those records, but a nurse practitioner is the one that provides the service within these pharmacies. The Nursing Board also has the regulatory authority over these entities. Right now, if you come into one of these clinics, it is for a non-life-threatening, simple, and uncomplicated illness or treatment, and often it is for only one visit. They are very limited in space and cannot maintain a large volume of records, but they are, by federal law, required to keep the mandatory five-years-worth of records.

One of the things we spoke to Senator Wiener about was the problem with these clinics trying to maintain records from newborn to 18 years plus 5 or 7 years, her requirement under this bill, and she said that as far as she could tell, the doctor still had the records and they are available. When the patient leaves the clinic he has a copy of his record so that he can follow-up with his primary health provider; that is always recommended by the clinic. Senator Wiener agreed that the records are to be kept by the in-pharmacy clinics for the federally-mandated five years.

Chairwoman Smith:
I am not sure if I am reading this correctly. To me, it looks like a clinic operating within a pharmacy is exempted from everything. I am not sure if that was the intention since it is listed in several of the sections.

Assemblywoman Spiegel:
The language at the top of page 2 was added and says that the records relating to the prescriptions issued by the providers of health care are retained by those providers. I think that covered it, because I spoke to someone who explained to me that the physician who oversees the clinic is required to keep the records. It is not that they need to keep them in the clinic in the pharmacy, but they just need to keep them.

Chairwoman Smith:
The issue is whether we are comfortable with the provider keeping them. Four or five places in the amendment says, "a provider of health care other than a pharmacy governed or a retail clinic operating within the physical facility of a pharmacy shall not," so they have been exempted in several locations, and I am just trying to figure that out.

Liz MacMenamin:
The intent was never to remove them from having to keep records for the federally-mandated length of time.

Chairwoman Smith:
Maybe what we need to do is get to where we want it to be, pass that, and have it drafted.

Assemblywoman Spiegel:
An ancillary issue for me is that I think the patient perceives that he went to the doctor at Walgreen's. They do not necessarily have the doctor's name and might have difficulty going back to find that doctor a few years later if that doctor is not still overseeing that clinic. I am wondering if there could be some provision where even just a list in the clinic could state the doctors' names and the time frames when they oversaw the clinic.

Chairwoman Smith:
But that is the case in any clinic—a doctor once seen by a patient might have moved on. The problem, I guess, is in other clinics those records remain behind, but in these clinics the records are in a doctor's office. The idea here is that in these clinics the records would be kept on-site for five years, and then with the provider in accordance with the law.

Assemblywoman Pierce:
Unless we have already designated what we are calling in this bill a retail clinic as some kind of lesser clinic in *Nevada Revised Statutes* (NRS), regardless of how we may think people should use these clinics, lots of people go to clinics. That may be the only medical care they ever get. So, unless we have already

fenced off these clinics in Walgreen's from all other clinics, and already done that in NRS, I am not comfortable doing that now. Whatever we are saying in this bill to all the other clinics in this state has to apply to these clinics, unless we are going to create another category of clinics. Also, be sure that Walgreen's is telling people that these are not real clinics, like other clinics one goes to, and that these are in a different category and only have to follow certain rules.

Liz MacMenamin:
I understand your concern on that, and we had some questions because, right now, the doctor oversees the nurse practitioner who provides the services to the patient. It is more like a satellite of the doctor's office. They may be called "Take Care Health Clinics," but they are actually in Nevada law, as well as in other states.

Chairwoman Smith:
It occurs to me that this probably is not the only instance of that type of clinic where a nurse practitioner or a physician assistant runs the clinic under the supervision of a doctor. Probably the in-pharmacy retail clinics or pharmacy-clinics are not the only places where that is happening.

Assemblywoman Parnell:
I am going along with Ms. Pierce. I could not support this unless I had a very clean definition. I think what we are missing is the definition of a retail clinic. I understand what you are saying, but when I look at the word "clinic," and I am thinking "medical," it may be something else. I would not be comfortable unless part of this bill referred back to the definition of the term that we are using within the bill language.

Assemblyman Hardy:
Regardless of what is written down at this point, I would make sure that the records of a visit are safe, secure, and available to the patient, as well as to the nurse practitioner and/or physician assistant and the supervising doctor. Therefore, we have to determine where the records are kept, that they are maintained for the federally-mandated five years, and the retail clinic definition. I think there was a start on that on page 3, lines 9 through 11 of the mock-up, where it talks about a provider of health care other than a pharmacy, governed pursuant to NRS Chapter 639, or retail clinic operating within the same physical facility as a retail pharmacy. This gets to what our question was the other day; just because it is called a retail clinic, it is not actually in the pharmacy; it is next door to the pharmacy. The supervising doctor is important for the patient to know because that would be where the ultimate repository of the records and the liability lies. On page 1, line 17, and page 2, lines 1 and 2, I read that

as meaning the records pertaining to prescriptions. So the pharmacist, in my view, does not need to keep the records of the health care. The pharmacist needs to keep the records of the prescriptions, just as they are mandated to do now. The pharmacist is different from the pharmacy, if we think of the pharmacy as the drug store, the retail establishment. I would like to see those types of clarifications to make it clean.

Assemblyman Stewart:
I think we need to look at the purpose of these clinics. They are to provide quick, inexpensive care, and I think if we regulate them too much we will drive them out of business and they will no longer perform this very-much-needed care. They need to be safe and so on, but these clinics are for treatment of minor medical conditions and are where a person can go near his neighborhood. Perhaps he does not have transportation or the ability to get to a hospital or a doctor, but in a clinic he can get inexpensive medical care quickly, and I think that is the purpose of these clinics.

Liz MacMenamin:
Mr. Stewart is absolutely correct. That is exactly what these clinics are for. To Dr. Hardy, whom I greatly respect, I want to respond that these records are maintained in the clinics according to federal law. The doctor also has access to them, and there are postings in the clinic as to who the doctor-supervisor is.

Assemblywoman Mastroluca:
The records are kept for five years pursuant to federal requirement?

Liz MacMenamin
Yes.

Assemblywoman Mastroluca:
And why are we saying seven years in this bill?

Assemblyman Hambrick:
Are these clinics owned by someone outside the building?

Liz MacMenamin:
Most of them are. Some of the entities are owned by another entity, like CVS Pharmacy.

Assemblyman Hambrick:
I am not sure where the problem is. So long as the records are stored someplace identifiable, and eventually go back to a parent organization, there may not be a problem.

Chairwoman Smith:
Unfortunately, I think we have gotten bogged down on something that is a side issue. I still have an issue with the fact that there are undoubtedly other clinics in the same circumstance as the clinics in the retail pharmacy. I cannot imagine that there are not other satellite clinics that operate the same way with a physician assistant or a nurse practitioner running the clinic under the supervision of a doctor, who is back in the main office, and this would not encompass those people, so I have a little bit of heartburn over that.

Liz MacMenamin:
There probably are those other clinics, but they would be regulated the same way as this entity is that is spoken of in this bill—through the medical board, because of the doctor's license, and the nursing board. I spoke to Carolyn Cramer with the State Board of Pharmacy and was told these entities are governed and regulated by those two boards. There is not a separate board for clinics; they are regulated by the licensee boards.

Chairwoman Smith:
I understand that. What I am saying is the retail clinics would have one provision saying that they could continue doing what they are doing. The other satellite clinics, which may be in exactly the same circumstance, would be operating under the provisions of this new law. I am not sure I would feel comfortable differentiating between them. I think Ms. Pierce is right that we have not created a provision in statute for this one type of clinic which would encompass others as well. I do not know how we get to that, but, again, it is almost a side issue to the bigger point here, which is to provide information to patients about where their records are and how to obtain them. We have gotten bogged down on the number of years and now on the retail clinics.

Liz MacMenamin:
The people who visit these clinics for care leave with copies of their records.

Chairwoman Smith:
Maybe that is the solution. It should say that in this type of clinic the patients are provided with a copy of their medical records. Not just a quick bill, but an actual copy of their records for that day.

Assemblyman Hardy:
In my practice we do electronic medical records. I hit "print," the computer prints out the office visit, and I give it to the patient because it is helpful to get what you have been told or what the plan is. It is not limited to the retail clinic. One of the problems with giving a copy of the record to the patient,

without assurance that there is a copy retained, is the liability issue when somebody asks what happened to that patient. All of these clinics should be using electronic records so the information is always retained; there is not enough room to keep charts in those places. The electronic record can be accessed by the supervising doctor, and the patient can get a copy.

Chairwoman Smith:
That makes sense, and I think that is what I said. Obviously, the clinic or the doctor is always going to retain the actual record.

Assemblywoman Spiegel:
Dr. Hardy, do you know if some of the clinics at the schools, like the one at Basic High School, are run in a similar fashion? It is overseen by Dr. Joel Bauer, but is there a nurse practitioner there? If it is run in a similar fashion, we have to be cognizant that as we are setting policy: we are saying that the records would have to go with the patients. Are we giving medical records to high school students and hoping they are giving them to their parents?

Assemblyman Hardy:
I would be a little reluctant to count on giving a medical record to a patient and having that be the semi-sole source of medical information, because there will be times where the patient will be asking for their medical records for insurance purposes as well as documentation in changing physicians. In fact, Ms. MacMenamin and I got to tour a clinic such as this, and the charismatic, wonderful nurse practitioner and/or physician's assistant has a certain following of people who are treated for diabetes and high blood pressure. Those health issues lead to other problems, so it is not just episodic care that is given, but critically important care is given for diabetes and high blood pressure and other chronic problems. It is not limited to minor ailments; in fact one does not know that it is minor sometimes until you have seen the person diagnosed.

Chairwoman Smith:
I think the issue before us is what we do about the language on the retail clinic within the pharmacy facility. Dr. Hardy, did you have a comment?

Assemblyman Hardy:
It almost seems like we are spending a lot of time trying to rescue something that does not need to be rescued. It sounds like the clinics are doing what they are supposed to do: protecting the health and welfare of the patient and the record, and I am trying to figure out where we are going with all of this. It seems like wherever we go we are already doing it and doing a good job.

Chairwoman Smith:
So, what would your motion be if that were the case?

Assemblyman Hardy:
I would probably move to the next bill.

Chairwoman Smith:
Let us pass on it for right now. Everybody can ponder it for a few minutes. Let us go on to Senate Bill 340 (1st Reprint), which is the last bill in the work session document (Exhibit K).

Senate Bill 340 (1st Reprint): Revises provisions governing the allocation of certain money from the Fund for a Healthy Nevada. (BDR 40-1133)

Amber Joiner, Committee Policy Analyst:
This bill is sponsored by the Senate Committee on Health and Education and was heard on May 12, 2009. [Ms. Joiner read from the work session document (Exhibit K).] There were no amendments proposed in writing and no testimony in opposition.

This morning we received an email from Jennifer Stoll-Hadayia at the Washoe County Health District, and she provided what was requested during the hearing, which is a list of the current grantees. She also provided us with an executive summary of the National Association of County and City Health Officials relative to the local issue that was being discussed.

> ASSEMBLYMAN COBB MOVED TO DO PASS SENATE BILL 340 (1st REPRINT).
>
> ASSEMBLYMAN HARDY SECONDED THE MOTION.

Chairwoman Smith:
Ms. Stoll-Hadayia, I would like to say thank you for providing the information that you did for us. That was very helpful.

> THE MOTION PASSED UNANIMOUSLY.

Ms. Joiner, can you walk us through the bills we had today.

Amber Joiner, Committee Policy Analyst:
I will spare you the summaries since you just heard them.

Senate Bill 60 (1st Reprint) was sponsored on behalf of Nye County and there was one amendment proposed. You have the amendment before you. It entirely strikes sections 5 and 6.

> ASSEMBLYWOMAN PARNELL MOVED TO AMEND AND DO PASS SENATE BILL 60 (1st REPRINT).
>
> ASSEMBLYMAN STEWART SECONDED THE MOTION.
>
> THE MOTION PASSED UNANIMOUSLY.

Amber Joiner, Committee Policy Analyst:
Senate Bill 244 (1st Reprint) is a bill relating to automated external defibrillators (AEDs) sponsored by Senator Cegavske. There was one amendment proposed, and that was relayed to us by the Senate staff. It was an oversight on their side relating to the Health Division's request to allow the funds to be spent in other areas.

> ASSEMBLYMAN HARDY MOVED TO AMEND AND DO PASS SENATE BILL 244 (1st REPRINT).
>
> ASSEMBLYMAN COBB SECONDED THE MOTION.
>
> THE MOTION PASSED UNANIMOUSLY.

Chairwoman Smith:
Mr. Cobb, would you do that floor statement on S.B. 244 (R1), please.

Amber Joiner, Committee Policy Analyst:
The next measure is Senate Bill 293 (1st Reprint), also sponsored by Senator Cegavske, relating to medication for children in the custody of agencies. I believe there was one verbal amendment provided.

Chairwoman Smith:
This was heard today from Senator Cegavske, and the suggestion was that we amend the bill to strike the current language, amend the language from Assembly Bill 364 that has already passed both Houses dealing with the same subject, and add the language that we would ask the Legislative Committee on Health Care to study this issue or to consider this issue. That was an agreement from Senator Cegavske.

ASSEMBLYWOMAN PARNELL MOVED TO AMEND AND DO PASS SENATE BILL 293 (1st REPRINT).

ASSEMBLYWOMAN MASTROLUCA SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

Let us go to Senate Bill 302, which is the bill Senator Nolan brought us regarding military physicians. No amendments were offered, and there was no testimony in opposition to this measure.

ASSEMBLYMAN HAMBRICK MOVED TO DO PASS SENATE BILL 302.

ASSEMBLYMAN STEWART SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

Next is Senate Bill 325 (1st Reprint), which is the bill that you heard from Senator Cegavske and Mrs. Lynch regarding MRSA and hospitals developing programs with regard to MRSA reporting of incidents.

ASSEMBLYWOMAN MASTROLUCA MOVED TO DO PASS SENATE BILL 325 (1st REPRINT).

ASSEMBLYMAN DENIS SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

Let us return to Senate Bill 17 (2nd Reprint). As I mentioned earlier, the intent of the bill is really about notification and posting of information and also about some kids' records. We seem to be hung up on the seven-year issue because that changes the amount of retention time and its effect on these small clinics, and that is what varies from federal regulation. We could amend the bill to put it back to the federal requirement of five years but keep the posting information and the disclosure information. Does that make sense? I hate to let this bill go, but we are not going to get this bill out of here as we have dissent on the small-clinic issue, and we just do not have time to fix that.

Liz MacMenamin:
It is not my bill, so of course the policy is this Committee's, but I would ask that we look at the problem with keeping the children's records.

Chairwoman Smith:
Whether it is five years, you still have the children's issue. We are not going to get this bill passed unless we do that. If we do it and can try to work something out in conference committee, that is one possibility. That is my suggestion: We leave the disclosure information, take it back to five years, and allow you all the opportunity to work with the sponsor as it goes back to the Senate to try to resolve your issues. I understand that issue because in those small environments keeping those records for 23 years is a long time, but that would allow some opportunity to try to resolve it. We have the conceptual amendment and the data change in the one amendment from Senator Wiener. Conceptually you are taking the language back to five years and you are taking out the retail pharmacy clinic information. Ms. Leslie, is that what you agreed to? I am saying that B from the work session document would be included with 25, and that will be an issue that we know we could continue to work on.

Liz MacMenamin:
And the pharmacies are exempted out of this. Pharmacies are not a part of the bill any longer?

Chairwoman Smith:
If you do not have a retail clinic it is not an issue for you any longer, is that what you are saying?

Liz MacMenamin:
All pharmacies are exempted, period. The pharmacy and the records within them are not part of this bill, because they are only kept for two years within the pharmacy.

Chairwoman Smith:
Because you have another provision in statute regarding pharmacies?

> ASSEMBLYWOMAN LESLIE MOVED TO AMEND AND DO PASS SENATE BILL 17 (2nd REPRINT) AS DISCUSSED AND AGREED UPON.
>
> ASSEMBLYWOMAN MASTROLUCA SECONDED THE MOTION.

Discussion?

Assemblyman Hambrick:
There is a typo on page 2, lines 34 and 41, there are two number 4s. Very minor.

Chairwoman Smith:
Okay, so that is on the record so our staff can correct it. Are we ready for a vote? The motion is that we take out the seven-year language, so we are back to the current federal law, and that takes out the issue of the retail clinic. They no longer have an issue in that regard. You still have the 25-year issue—or 23 years if it is taken back 5 years. You still have the issue of the children, with the understanding that those who are concerned about it can continue working on it with the bill sponsor. Again, you will see the language before it goes to the floor so everyone has a comfort level.

THE MOTION PASSED UNANIMOUSLY.

Thank you all for your hard work. It was a long session, I appreciate your good work, and it was not easy, either. The meeting is adjourned [at 5:32 p.m.]

RESPECTFULLY SUBMITTED:

Darlene Rubin
Committee Secretary

APPROVED BY:

Assemblywoman Debbie Smith, Chair

DATE:

EXHIBITS

Committee Name: Committee on Health and Human Services

Date: May 13, 2009 **Time of Meeting: 1:49 p.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
S.B. 244	C	Christopher Roller	Fact Sheet
S.B. 244	D	Christopher Roller	Testimony
S.B. 60	E	Patti Chipman	Amendment
S.B. 137 (R1)	F	Amber Joiner	Work session document and amendment
S.B. 137 (R1)	G	Chairwoman Smith	Mock-up
S.B. 305 (R1)	H	Amber Joiner	Work session document
S.B. 17 (R1)	I	Amber Joiner	Work session document and mock-ups
S.B. 17 (R2)	J	Amber Joiner	Mock-up
S.B. 340 (R1)	K	Amber Joiner	Work session document