MINUTES OF THE JOINT MEETING
OF THE
ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES
AND THE
SENATE COMMITTEE ON HEALTH AND EDUCATION

Seventy-Fifth Session
February 21, 2009

The Joint Assembly Committee on Health and Human Services and the Senate Committee on Health and Education was called to order by Chair Debbie Smith at 8:16 a.m. on Saturday, February 21, 2009, in Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. The meeting was videoconferenced to Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, 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).

ASSEMBLY COMMITTEE MEMBERS PRESENT:

Assemblywoman Debbie Smith, Chairwoman
Assemblywoman Peggy Pierce, Vice Chair
Assemblyman Ty Cobb
Assemblyman John Hambrick
Assemblywoman Sheila Leslie
Assemblywoman April Mastroluca
Assemblywoman Bonnie Parnell
Assemblywoman Ellen B. Spiegel
Assemblyman Lynn D. Stewart

SENATE COMMITTEE MEMBERS PRESENT:

Senator Valerie Wiener, Chair
Senator Joyce Woodhouse, Vice Chair
Senator Steven A. Horsford
Senator Shirley A. Breeden
Senator Maurice E. Washington
Senator Barbara K. Cegavske
Senator Dennis Nolan

COMMITTEE MEMBERS ABSENT:

Assemblyman Mo Denis (excused)
Assemblyman Joseph (Joe) P. Hardy (excused)

GUEST LEGISLATORS PRESENT:

Assemblyman John Oceguera, Clark County Assembly District No. 16

STAFF MEMBERS PRESENT:

Kristin Roberts, Committee Counsel
Sara Partida, Committee Counsel
Amber Joiner, Committee Policy Analyst
Marsheilah Lyons, Committee Policy Analyst
Melinda Martini, Committee Policy Analyst
Chris Kanowitz, Committee Secretary
Shauna Kirk, Committee Secretary
Olivia Lloyd, Committee Assistant

OTHERS PRESENT:

Martha Drohobyczer, CNM, MSN, President, Nevada Nurses Association, District Three, Las Vegas, Nevada
Debra Scott, M.S., R.N., A.P.N., F.R.E., Executive Director, State Board of Nursing
Stacy Shaffer, Political Director, Service Employees International Union, Local 1107, Las Vegas, Nevada
James Wadhams, representing Nevada Hospital Association, Las Vegas, Nevada
Bill M. Welch, President/CEO, Nevada Hospital Association, Reno, Nevada
Lawrence P. Matheis, Executive Director, Nevada State Medical Association, Reno, Nevada
Mary Wherry, R.N., M.S., Deputy Administrator, Health Division, Department of Health and Human Services
Bobbette Bond, representing the Health Care Services Coalition, Las Vegas, Nevada; Nevada Health Care Policy Group, North Las Vegas, Nevada
Darla Leibel-Burrow, Executive Director, Nevada Hepatitis C Task Force, Reno, Nevada
Paul Schubert, Health Facilities Surveyor IV, Bureau of Health Care Quality and Compliance, Las Vegas, Nevada

Kathleen Kelly, Executive Director, Board of Dental Examiners of Nevada, Las Vegas, Nevada
Marla McDade Williams, Bureau Chief, Bureau of Health Care Quality and Compliance, Carson City, Nevada
Timothy Cummings, representing Epiphany Surgical Solutions LLC; Surgery Center of Southern Nevada, Las Vegas, Nevada
Ronald M. Kline, Secretary, Nevada State Medical Association, Las Vegas, Nevada
Brian Labus, Senior Epidemiologist, Southern Nevada Health District, Las Vegas, Nevada
Sandy Curl, Director, Nevada Hepatitis C Task Force, Carson City, Nevada
Tom Townsend, Private Citizen, Las Vegas, Nevada
Gwen Martin, Private Citizen, Las Vegas, Nevada
Richard Whitley, M.S., Administrator, Health Division, Department of Health and Human Services
Lawrence Sands, D.O., M.P.H., Chief Health Officer, Southern Nevada Health District, Las Vegas, Nevada
Jeanette Belz, Reno, Nevada, representing Nevada Academy of Ophthalmology, Denver, Colorado
John Stolebarger, representing the Nevada Hepatitis C Task Force, Reno, Nevada
Michael Ciccolo, M.D., Private Citizen, Las Vegas, Nevada
Kelly Kogut, M.D., Private Citizen, Las Vegas, Nevada

Chairwoman Smith:
[Roll called.] I would like to welcome everyone to the hearing this morning here in Las Vegas. We are video conferencing to the Legislative Building in Carson City.

We will hear testimony on four bills today that are related to the hepatitis C exposure that was investigated last year, beginning in December of 2007, and continuing into 2008. I know there were several hearings during that time. Although we do have several new committee members on this joint committee, we had a briefing prior to this hearing earlier in the week so that the committee members were updated, and I hope that many of you followed that discussion as well. We have one additional bill at the end of the agenda on a different topic, but it is related to Clark County, so we wanted to hear the bill as we were hearing testimony in Las Vegas. There will be no action taken on bills today.

I know that there are other issues that have been related to the hepatitis C issue, such as liability and malpractice. That is not part of our discussion today, and not part of any of the bills we are hearing. I am aware that the Assembly Committee on Judiciary is introducing at least one piece of legislation, so there will be opportunities at another time to discuss legislation in that regard.

Senator Wiener:
As we work together jointly, there is a synergy in the legislative effort to address these issues, and we appreciate being included in this joint effort to process very important policy considerations that address a very profound public need.

Chairwoman Smith:
I am going to open the hearing on our fist bill, which is Assembly Bill 10. This bill is a direct outcome of the hepatitis C exposure. The Interim Committee on Health Care sponsored this bill, and the chair of the Interim Committee, Assemblywoman Leslie, will present the legislation.

Assemblywoman Leslie:
With your indulgence Madam Chair, I would like to make some opening remarks before I present the first bill. During the interim, we have a joint committee made up of three Senators and three Assembly members who work on various topics related to health care. The Chairmanship alternates between the Senate and the Assembly, and it happened to be the Assembly's turn, so I chaired the committee.

Typically, we work on a variety of health care issues, such as lead poisoning prevention and access to health care concerns, but then December 2007 came, and that was when the investigation began on the hepatitis C crisis. Very quickly our committee's work was refocused, almost entirely, on that investigation. Over 40,000 people here in Las Vegas were affected and were notified that they might have been exposed to hepatitis C through a routine procedure at the endoscopy center. The committee responded by quickly scheduling hearings, which was to help the public and the Legislature understand the depth and the scope of the crisis. Those of us who were there will probably never forget that meeting when hundreds of people testified about their fears and frustrations regarding how the system did not respond adequately. I hope that everyone will agree that these bills address all concerns. We understood that the public health system in Nevada depends upon the public trust; and the public trust was seriously eroded by this crisis.

The Interim Committee on Health Care continued to schedule meetings throughout the year, to delve more into the reasons behind the crisis, and redevelop the legislative response, which will be covered in the first bill today.

Assembly Bill 10: Prohibits retaliation or discrimination against registered nurses, licensed practical nurses and nursing assistants who report certain information relating to the safety of patients. (BDR 40-219)

Assemblywoman Sheila Leslie, Washoe County Assembly District No. 27:
This is the whistleblower protection bill. You should all have an outline of the bill (Exhibit C). I would note that we had a lot of testimony about why practices were not reported immediately, and there was a feeling among many of the people who testified, nurses in particular, that there was not sufficient protection in our existing laws to prevent retaliation; nurses and other health professionals felt that they could not make a complaint without fear of losing their jobs. We asked the Nevada Nurses Association to try and document how widespread this fear was, and to see if it truly was a problem. They were unable to obtain hard documentation, but anecdotally, it was reported that the non-reporting by nurses of abuse in Nevada was often due to fear of losing their employment, and so much of the language in A.B. 10 came from the Nevada Nurses Association as their recommendation for changing existing statutory law to better assist Nevada health care providers with reporting these abusive practices. They believe that these suggestions will strengthen and clarify existing Nevada whistleblower law.

Martha Drohobyczer, CNM, MSN, President, Nevada Nurses Association, District Three, Las Vegas, Nevada:
I am presenting testimony prepared by Dr. Lisa Black; member of the Nevada Nurses Association Legislative Committee. [Read prepared testimony (Exhibit D).] You should all have a copy of the study conducted by the Nevada Nurses Association (Exhibit E).

Assemblywoman Spiegel:
You had mentioned that 18 states currently have whistleblower laws in effect. By any chance, do you have any data on what the average penalty and what the average fine is for violations?

Martha Drohobyczer:
I am sorry; I do not have that information.

Assemblyman Hambrick:
When, in your opinion, does the fear of retaliation outweigh the necessity to report an incident? I am looking from the point of view of personal responsibility; at some point each and every one of us must take personal responsibility without any excuses, so when does one outweigh the other?

Martha Drohobyczer:
As health care providers and registered nurses, we are obligated to report anything that is unsafe for our patients. That is an obligation with the Nevada State Board of Nursing and it is a professional obligation. We would say there is no excuse not to report; it is their responsibility, regardless of whether or not there is fear of losing a job or if there is fear of sanctions. We do not endorse that as an excuse.

Assemblyman Cobb:
What is the current law in existence, in statute, for requiring the health care worker to provide this information to the appropriate authorities, and is there anything in A.B. 10 that addresses that requirement to, in essence, act as a whistleblower?

Debra Scott, M.S., R.N., A.P.N., F.R.E., Executive Director, State Board of Nursing:
All of our staff, registered nurses (RNs), licensed practical nurses (LPNs) and certified nursing assistants (CNAs) are all mandated reporters, based on the Nurse Practice Act.

Assemblyman Cobb:
Is the Nurse Practice Act part of the *Nevada Revised Statutes* (NRS) or is it a regulation from a board?

Debra Scott:
The Nurse Practice Act consists of the NRS 632 and *Nevada Administrative Code* (NAC) 632, so the Nurse Practice Act is in statute.

Assemblywoman Pierce:
Is this language substantially like the other 18 states? Are there a lot of similarities between the laws in the other 18 states?

Martha Drohobyczer:
I do not have the exact language of all 18 states, but they are fairly similar in that they protect against any retaliation related to reporting.

Assemblyman Stewart:
In your survey, was there actually any firing reported among the participants, or was there any knowledge of other nurses being fired, and did you record what the retaliation was when it took place?

Martha Drohobyczer:
In the report, the retaliation sometimes could be moving a nurse from day shift to night shift, changing days off, or making the work environment uncomfortable. Nurses have been terminated, but I do want to emphasize that the report did state that nurses had reported in the past, and there was no retaliation. For the majority of nurses there has been no retaliation, but the nurses knew of situations in which there was retaliation.

Assemblyman Stewart:
Is there a record of how many nurses were fired?

Martha Drohobyczer:
I do not believe that our survey included people who were actually terminated.

Senator Wiener:
Can you help me understand what the threshold might be for a sentinel event, so we have a sense of what environment we would have in terms of reporting? Is there a definition, or something in practice?

Martha Drohobyczer:
Usually that is a situation where a patient might die, or there could be great bodily harm or infection.

Assemblywoman Mastroluca:
Is there standard whistleblower language in the NRS, or is this very similar to the kinds of fines and penalties that we would see for other whistleblowers in other areas?

Sara Partida, Committee Legal Counsel:
With regard to this bill, you will notice that part of the language is being added to an existing whistleblower protection, and the fines and the penalties have been patterned after other provisions in the NRS.

Senator Washington:
Nevada Revised Statutes 449.205, is that the whistleblower statute?

Sara Partida:
That is correct, that is the current whistleblower law. The new language is added as part of that existing law.

Senator Washington:
The language states that there are some punitive damages, if facts warrant it. I guess the facts that are warranted are determined by the court. Who can file the court injunction; the nurse or the actual facility that is being reported?

Sara Partida:
The employee who is being retaliated against would be the one filing the suit in court.

Senator Washington:
What is the standard for determining retaliation?

Sara Partida:
Retaliation is defined in NRS 449.205, subsection (4), paragraph (b). There are approximately ten actions listed there that would constitute a retaliation.

Senator Washington:
In Section 2 of the bill, we have now constituted fines, which constitute civil penalties. Are those penalties determined by the court or by the Attorney General's office?

Sara Partida:
I believe that is still up to the court to determine the amount of that penalty, but you will also see in that section that the Attorney General or any District Attorney of the state may recover the penalty in a civil action.

Senator Washington:
So this is actually new language in the current NRS?

Sara Partida:
That is correct.

Chairwoman Smith:
We will continue testimony on A.B. 10.

Stacy Shaffer, Political Director, Service Employees International Union, Local 1107, Las Vegas, Nevada:
We are in support of A.B. 10. We represent over 17,500 employees, and we are the health care union here in Nevada. In May of last year, a Service Employees International Union (SEIU) member testified before the Interim Committee on Health Care, and shared her personal experience of losing her job for speaking out against unsafe practices. Due to the lack of teeth in the current legislation, her case dragged on for more than two years before she was found to have been illegally fired. The single largest obstacle in getting health care professionals to report unsafe practices is the fear of retaliation. Health care professionals must feel that they will be protected if they file a report, and they must know that they have a course of action if they are retaliated against by their employer. This legislation provides the depth needed to protect health care professionals who come forward to report unsafe practices. The SEIU is happy to support A.B. 10.

Debra Scott:
I am here to testify in favor of A.B. 10. [Read prepared testimony (Exhibit F).]

Assemblywoman Leslie:
On page 13 of the study (Exhibit E), regarding the participant's perception of retaliation experiences, there is a series of questions, and one is "Do you know of a nurse who has experienced retaliation after having reported the actions of another staff nurse?" and 57.6 percent said yes. Same question, reporting the actions of a nursing supervisor, 68.4 percent said yes. Same question, reporting the actions of a physician, 68.4 percent said yes. So, while they are mandated reporters, it does seem that there is a serious perception, or reality, that nurses who do report and experience retaliation, and the percentage goes up when it is a supervisor or a physician. When we had nurses come and testify, they gave us some specific examples, and we asked again and again why the nurses did not report, and we never got a satisfactory answer about why they did not report the unsafe practices that they saw. Some people might say that we do not need this law because health care professionals are mandated to report, and so they should report, but at the same time, it seems that retaliation is fairly widespread.

Martha Drohobyczer:
In addition to the fear of retaliation, on page 11 of the study, 37.6 percent of participants said that they thought nothing would come of the report. That is quite a large number of nurses who feel that maybe nothing would happen with their report. After they report so many times or know of other staff nurses who report and nothing happens, maybe they lose interest in reporting. Also, I am

sure that the severity of the situation would play a part in their decision to report. I do want to emphasize that a lot of nurses feel that even if they report something, nothing will happen.

Assemblywoman Leslie:
Is it your view that if we pass A.B. 10, that nurses will be more likely to report?

Martha Drohobyczer:
I think nurses would feel more protected. Sometimes when we talk about retaliation, we think of retaliation occurring specifically on that particular job, but there are nurses that fear that if they left that job after reporting, that information and retaliation may even follow them to another worksite. That is a great fear. Nurses usually can obtain other employment, but there is fear that somehow that information will get to another employer, or when they have references that are checked, information might be leaked, which would lead to them being blackballed and having to move to find employment. That is a fear that I have heard spoken by many nurses.

Assemblywoman Leslie:
I think that is a very salient point in terms of the hepatitis C investigation too, because those were Nurse Anesthetists, and that is a highly specialized nurse; there are not many of them and not many opportunities for them to practice, and so that is a reason given in some of the testimony why they did not report the unsafe practices that they saw. My mom is an R.N. by the way, so I know there is that nurse-doctor relationship, and I think that is what struck me with this data, because the higher you go in the medical food chain, the harder it might be to report. So a Nurse Anesthetist who reports a physician, as in this case, could very rightly fear that they would never be able to work in Nevada again.

Martha Drohobyczer:
Even staff nurses report that they feel the information would follow them to other worksites, or that they would just not be employed.

Senator Washington:
I personally believe in personal responsibility. I think what has been alluded to by my colleague is that the nurses had some responsibility in this matter as well, knowing that there were certain sentinel events that were taking place within the ambulatory center that were copious and scrupulous at best, which they failed to report. And because of the nurses' lack of sense of responsibility, and their failure to report, some or several have contracted hepatitis C. That does not excuse them because they have fear that there may be some

retaliation. I think the NRS explicitly provides certain protection for those individuals to report those events that are taking place. I skimmed your report, and I looked at page 11, in which you indicated that there was a fear of some retaliation, and there were some nurses who felt that their reports would be of no concern, which I find appalling. That is not an excuse. So therefore, I think we should make this piece of legislation reflective of all persons who are responsible. I know there are other bills we are going to look at, but in this particular piece of legislation, I think it would be incumbent upon us to ensure the safety of the public and those patients receiving medical care, that we have some provisions in this legislation that will speak to the fact that those nurses who failed to report a sentinel event, especially one of this nature, have some responsibility as well. I do not know how we do that; maybe we make sure that if they fail to report it, there is a redacting of their licensing. Something needs to be done, because I do not think they should be off the hook, and the blame placed primarily on the owners, operators, or doctors of those facilities. The nurses have a responsibility, but this bill gives them a way out, and your report gives them an excuse. Maybe we ought to put in the bill that all sentinel events that are reported should be recorded, notarized or noted, and that we should keep track of those reports, and somehow keep the identity of the nurse who reported confidential, so that it is not open to everybody. At least we would get an idea of what is being reported and what is not being reported, and we as legislators can act appropriately, and all those that work within the health industry can act appropriately to those sentinel events. I am going to propose language in this bill that is going to hold the nurses within those particular facilities responsible and accountable for their job. I just do not want this to be one-sided.

Chairwoman Smith:
I am assuming that there is already that provision elsewhere that holds nurses accountable and responsible. Could you respond to that Ms. Scott?

Debra Scott:
In our *Nevada Administrative Code* 632.890, subsection 15; it is unprofessional conduct and a basis for discipline for a nurse to fail to report the gross negligence of a licensee or a holder of a certificate in the performance of their duties. This does not extend to the facility or to the physicians, so I think the nurse is partially held responsible, but I agree with maybe making it even broader, based on what Senator Washington is saying. We do have something in law that will hold nurses responsible for not reporting another licensee with the Nevada State Board of Nursing, but nothing in law for not reporting facilities or physicians.

Senator Washington:
I appreciate your comments regarding the NAC, but the NAC is not the NRS. I want to make sure it is in statute, that they are held responsible.

Senator Cegavske:
Did any reports happen at all? Did somebody report, but no action was taken? I did not sit on the interim committee, so my colleague from the north may have that answer. My other question is, is this legislation trying to get nurses off the hook for not reporting?

Martha Drohobyczer:
I want to emphasize that our study was not conducted so that we could find excuses for nurses not to report. It was conducted so that we could have some data to find out why they were not reporting. Again, this is part of professional conduct; nurses should always put patient safety first, whether we would lose a job, have change in job assignment, or even if we thought that we would not be able to get a job within the confines of where we live. We are not trying to excuse any nurse or health care provider for not reporting. There is a personal responsibility.

Senator Cegavske:
Do we know of any reports that were filed, and yet nothing happened as a result?

Chairwoman Smith:
I would like Ms. Scott to bring us up-to-date on what happened with the nurses who were involved with the hepatitis C case. What was their responsibility and what has happened with those licenses?

Debra Scott:
We are still in the process of investigating. We have six Certified Registered Nurse Anesthetists whose licenses are still surrendered; they are not practicing in Nevada. We also have complaints open on 22 other nurses, who may or may not have been in a position to report, and the bottom line for their investigations is the failure to report. As I am sure you will be hearing later on, the documents that we need for investigation have not been forthcoming, and so we are working very diligently with other agencies, including the health district, the Board of Medical Examiners, and the Bureau of Licensure and Certification, to get those documents, but at this point those licensee investigations are still pending.

Chairwoman Smith:
Just to clarify, the Nurse Anesthetist's licenses were surrendered voluntarily, they were not revoked?

Debra Scott:
Correct. As soon as we contacted them, they voluntarily surrendered their licenses, pending the investigation, and those licenses continue to be surrendered at this time.

Senator Cegavske:
Did reports happen? Does anybody know if somebody actually made reports, but no action was taken?

Chairwoman Smith:
So your question is, was reporting made prior to this investigation coming to light?

Senator Cegavske:
Correct. If any nurses came forward at all, was action taken on their reports?

Debra Scott:
Not only do we have the information based on the surveys done by several different entities, but we also have complaints based on reports from employees of those clinics where the misconduct occurred. Investigation is still in place, and we continue to investigate based on the information that we have available to us. So the answer is yes, people were reported and we continue to investigate, and hopefully we will be able to, in the near future, come to some decision so that the board can make a decision about disciplining or not. It is still pending.

Senator Cegavske:
Did the nurses at the time know the appropriate place to file the complaint? Was that information in your survey? Are the nurses trained how to report and who to go to?

Martha Drohobyczer:
I believe that all the nurses knew where they could report. The nurses knew to go up the chain of command to report either to a supervisor, and if that supervisor could not help them, to then go further. There was not an issue with not knowing where or how to make the complaint.

Debra Scott:
That is my experience too.

Stacy Shaffer:
From talking to our nurses, we found this was the case as well. Many of the nurses were confused about where they could go, especially if they felt that the reporting needed to be done outside of the facility, so something our union has taken up is educating the nurses about where they can go to report and what that process looks like. We felt that when we were looking at the recommendations back in May, that was a big piece; continued education.

Assemblyman Hambrick:
My colleagues from the upper house have asked and received answers on some of these questions, but from my standpoint, the nurses happen to be the target of opportunity. Any licensed or certified professional in anything connected to health care needs to be asked these same questions. Nurses are not being targeted. Whether you are an M.D. or a CNA, they all have to stand up and have personal responsibility, and hopefully the M.D.s will be in those seats at some point and have to answer these questions. Please do not ever think that we are targeting the nursing profession; you are far too valuable.

Assemblywoman Pierce:
How much staff do you have to perform this investigation that you have been speaking of?

Debra Scott:
I believe we have adequate staff to do the investigations. It is not about staffing time or resources, it is about being able to get the documents that we need to review to be able to prove or disprove misconduct on the part of the nurses.

Senator Horsford:
Just for the public's information, the bills that we are hearing today are the first in a series of bills based on the jurisdiction of this Committee. There are a number of other bills that go before other committees, particularly around the regulatory licensing structure for some of these boards. So, please just be aware that these are not the only matters that are being considered as part of our legislative response to the Hepatitis C issue.

Chairwoman Smith:
Ms. Scott, will you clarify for the Committee, how nurses are given information about reporting?

Debra Scott:
There are many avenues from which nurses receive information, and let me just list some of them for you. Our staff of 22 gives presentations at every nursing program throughout the state, every time that program graduates students. Those students, at that point, receive information about reporting and their responsibility in reporting and how to report. On our website, there is a link to show exactly how to report and what to report. Just recently, I sent out a magazine that goes out quarterly, and it included two different articles on a nurse's responsibility to report and how to report. We take phone calls, and a live person answers the phone, and we give that information daily. There is a lot of information out there about reporting, and the Nurse Practice Act itself shows that nurses are mandated to report, and that they are mandated to report other nurses to the Nevada State Board of Nursing, so I believe that nurses know when they are supposed to be reporting, and in this situation, they chose not to. That is the part that is most troubling for me.

Chairwoman Smith:
Is there anyone to testify on A.B. 10?

James Wadhams, representing Nevada Hospital Association, Las Vegas, Nevada:
This is important legislation, and I think some of the legislators' questions have helped focus on the broader aspects of this issue. Nurses are an absolutely critical component of the health care system, and in the facilities of the Nevada Hospital Association. We have just a couple of comments (Exhibit G), and they are more of a technical nature. I think in the drafting, there was a reference that needs to be clarified. The issue that we are trying to prevent here is retaliation or discrimination, and I think the drafter referred not to the definition, but to subparts of the definition. If you look at page 5 of the bill, lines 6 and 7, we think that the language should read "if any action to retaliate or discriminate is taken against an employee..." And what the drafter did is refer to subparagraph 1 of paragraph (b) of subsection 4. We simply think that it should be reference to "retaliate or discriminate" which is a defined term. If you look at page 4 of the bill, lines 4-24 really are the embodiment of that definition, so we are just suggesting that it is just a simple editorial reference to the statutory definition for "retaliate or discriminate."

Chairwoman Smith:
Actually, that strengthens the bill.

James Wadhams:
We believe so. The other aspect, which I noted from Martha Drohobyczer's testimony in which she referenced the concern about willful conduct, is that in the bill, on page 3, line 13, it does not say "the willful conduct" of a registered nurse, it simply is "the conduct," and I am not sure if that is a distinction that the Committee cares about, but for those of us who represent people in such matters, that phrasing could make a significant difference in a legal matter. The reason I raise that issue is because what I sense the Committee is attempting to do is to make sure that it is clear that the responsibility to put patient care and safety first and foremost is underscored. Also, on page 3, line 17 and line 22, I am a little concerned about the word "concerns." I would suggest that from a due process standpoint, the Committee may want legal staff to work on words that are a bit more precise, so that we do not trigger problems both for the complaining person or persons or the person or persons being complained about. We should not have something as amorphous as "concerns"; it should specify clinical, patient safety, health care related concerns. I would also note, and this has been referenced by several questions from committee members, we do have a whistleblower statute that has been previously supported by the Nevada Hospital Association which I sense that the Committee wants to clarify and strengthen, and we are comfortable with that as long as some of these subtle issues are considered.

Bill M. Welch, President/CEO, Nevada Hospital Association, Reno, Nevada:
The hospital community does support ensuring that provisions are in law that protect the patients and ensure that they have access to quality care. We also support ensuring the rights of the employees and the professionals who are providing that care should a circumstance occur that is not appropriate. One of the things that I heard during the testimony is that it seems there is a lot of effort to ensure that an individual understands who they would report to. It seems to me that part of the initiative should also be about ensuring that the employees understand their rights.

Assemblywoman Leslie:
With regard to the "concerns" issue, you are correct; "concerns" can mean anything. What is your specific suggestion for clarifying that language?

James Wadhams:
We are really talking about clinical concerns, safety concerns, and medical concerns. It will be helpful, during this process, if we make it clear that this legislation is not for social judgment but for professional judgment.

Assemblywoman Leslie:
I think the way it is drafted, the concerns are addressed in the language following the word "concerns": "concerns regarding patients who may be exposed," "concerns regarding the medical facility," et cetera. I think we can take a look at it, but I think we are on the same page.

Chairwoman Smith:
I would ask, Mr. Wadhams, that you leave us any suggestions that you have about this language.

Senator Horsford:
Regarding workers understanding their rights, beyond what the representative from the SEIU said, what is it that the hospitals do to educate the employees as to their rights, and with this bill, what more do you think will be able to be done with that law to make sure that the people understand those procedures and their rights?

Bill Welch:
Hospitals go through an employer orientation with all new employees, and there are periodic educational opportunities that are made available. I think that needs to continue. As I look at this bill, I think that the bill is trying to encompass a broader range of employment environments, other than just the hospital setting. The issues that arose this last summer were not in a hospital setting, but in another type of setting that may not have had the same types of protections and/or systems in place to ensure that their employees understood the process for filing a concern as well as what their rights are. I do not know that law can speak to that, but certainly, all of the various professions have a responsibility to do that. As I look at this bill, I do not know if you are encompassing all the types of situations that you are trying to cover. For example, in Assembly Bill 123, Senate Bill 70, and some of the others, you may want to look at your definition of "facility." That might help bring in some of the other organizations or entities that need to have accountability as well.

James Wadhams:
This law has applied to hospitals for four or five years. We think that explanation of these rights to employees is critical, and what I sense the Committee is trying to do is to make sure that this is broadened now so it is not just in the acute care facilities or the licensed hospital facilities, but that it is in all health care venues. So the education of employees may be an issue that you may want to take up more specifically, either in this bill or one of the other bills that will come up.

Chairwoman Smith:
I think this might be an issue that we may refer to the licensing boards, as far as the employee rights go, to ensure that their members are duly educated and notified about their rights.

Lawrence P. Matheis, Executive Director, Nevada State Medical Association, Reno, Nevada:
We had supported this in the Legislative Committee on Health Care during the interim, and I want to make sure that we were on record for supporting it. The anti-retaliation provisions in the law, both in terms of hospitals and in the two physician licensing acts, have been there for some time. It became clear during the interim that they were not believed to be sufficient to protect the employees or other health professionals who report important information. This bill tries to clarify that there really is protection and tries to add to those protections, so that is worthwhile. There is an obligation in all the professional statutes for physicians to report if they observe things. It is a sanction against them if they are found not to have reported, as well as protections for reporting. I believe there was some testimony during the interim, and certainly some media stories during the interim, about physicians who had previously been associated with some of the clinics, and who had made reports to no avail. This is important both symbolically and statutorily, that professionals are expected to report when they observe something that may put patients at risk, that there are protections for those actions, and that there are consequences for not reporting as well. Fear of retaliation should not be a prohibition on making sure that the system is working for patients.

Chairwoman Smith:
Is there anyone else to testify on A.B. 10?

Mary Wherry, R.N., M.S., Deputy Administrator, Health Division, Department of Health and Human Services:
We would like to note that this bill changes the statutory language of NRS 449, and from some of the discussion that has already occurred, I think that it is important to note that we believe this change occurs in NRS 449 because the majority of RNs and CNAs practice in facilities that are regulated. There is a huge body of literature around the fact that women make up 94 percent to 96 percent of the profession of nursing. They tend to be an oppressed group, and they practice in a patriarchal setting. We believe that is why this law exists; most nurses are not comfortable coming forward because they tend to be caretakers, and not quite as assertive. We would like to note that regarding the education piece, if this bill is passed, we will educate and train our surveyors to use any opportunity they have to educate staff and the facilities about rights

and the process of reporting. We will also look at policies and procedures that those facilities have with regard to how they may educate their staff about the whistle blowing protection that will hopefully exist in law.

Bobbette Bond, representing the Health Care Services Coalition, Las Vegas, Nevada; Nevada Health Care Policy Group, North Las Vegas, Nevada:
We had, between our 23 organizations within the Health Care Services Coalition, thousands of patients who had to be contacted and tested for Hepatitis C. When we had our own roundtable about what would be the best solution for this crisis, one of the first things that the Coalition came up with was to not only protect the consumer by helping them understand how to complain about something that they saw that they thought was not safe, but also to help protect the workers at these facilities. I think this legislation goes a long way to providing some protection, and I hope that when it is implemented, that the facilities really provide avenues for people to understand the process to complain. Protecting the workers helps protect the patients.

Darla Leibel-Burrow, Executive Director, Nevada Hepatitis C Task Force, Reno, Nevada:
I have spoken with some of the nurses who were involved at this particular health clinic, and their biggest fear was retaliation. They feared they would be fired, mistreated, or blackballed. They want to abide by the Hippocratic Oath that they take to do no harm, but at the same time, they have families and children and their own lives to worry about also. What do they do if they cannot get a job? We need to make sure that we make a broader protection ring so that they will no longer fear reporting, even if it is reporting anonymously.

Chairwoman Smith:
Is there anyone else to testify on Assembly Bill 10? Seeing none, I will close the hearing on A.B. 10 and open the hearing on the Assembly Bill 123. We are going out of order from the agenda since Assembly Bill 123 and Senate Bill 70 are very similar, so we will hear those together.

Assembly Bill 123: Revises provisions governing certain offices of physicians and related facilities and surgical centers for ambulatory patients. (BDR 40-215)

Assemblywoman Sheila Leslie, Washoe County Assembly District No. 27:
Again members, you should have a bill summary on your desk that you can refer to (Exhibit H). Assembly Bill 123 came about due to the testimony that we heard about the lack of inspections. If you recall, the newspaper accounts during the Hepatitis C crisis reported a great variety of time periods between when certain facilities were inspected. We discovered that ambulatory surgical centers actually fell out of the inspection process all together and were not accredited. Basically there was no specific requirement for when these facilities had to be inspected, and so they were so low on the priority list that often they were not inspected for a long period of time.

Also, we discovered that in more recent years, there were a lot more of these same surgical procedures being performed on an out-patient basis in individual physician offices, and there was great concern that these were not being regulated in any way. The interim committee strongly believed that we needed to safeguard patient safety, no matter where the procedure was being performed; if you have a colonoscopy in an endoscopy center, you should be protected; in the hospital, you should be protected; and if you have that same procedure in a physician's office, you should be protected.

This bill is fairly dramatic by requiring the Division of Health to inspect annually. We had quite a debate on the interim committee whether annually was right, or every six months, or every two years, and we settled on annually. That will certainly be a topic of debate as we work through the bill. We are also requiring accreditation, which you will see in the bill summary. There are some very well known national groups that accredit, and they specialize in different kinds of offices; some specialize in accrediting doctor's offices, others hospitals and ambulatory surgical centers, and there was pretty widespread agreement on the concept of accreditation.

The new aspect of the bill is in regard to how we inspect doctor's offices. We settled on doing doctor's offices where anesthesia is administered in the three levels of sedation. We felt that would cover the kind of patient safety concerns that emerged from the hepatitis C crisis, in terms of reusing needles, et cetera. The bill drafters have come up with the idea of requiring permits for doctor's offices that choose to do this level of surgical procedure. Again, it is not that we are saying that doctors are less careful in their offices than they would be in a hospital, but rather we need to make sure that patients are safe, whether they have the same procedure in a doctor's office that they might have in an ambulatory center or hospital. It is more about the level of sedation and the procedure being performed rather than where it is being performed.

Senator Washington:
I would say that my colleague, Ms. Leslie, did a good job in explaining this bill. It does have several concepts, and I think they were flushed out, debated, and agreed upon that these areas were important for the health, welfare, and safety of patients who were receiving certain procedures, whether they were in an ambulatory center or in a doctor's office. I think we put in some safeguards that would also protect the professionals who are providing these services. I think this is a good bill.

Mary Wherry, R.N., M.S., Deputy Administrator, Health Division, Department of Health and Human Services:
I have Paul Schubert to my left and Marla McDade Williams is available in Carson City to answer any questions that I may not have answers for.

[Read prepared testimony (Exhibit I).]

Chairwoman Smith:
Would you clarify the dentist versus physician issue?

Mary Wherry:
My experience has been referring to them as "dually-boarded," so you may have a dentist who is both an M.D. and a D.D.S.; they are licensed as both professionals. I think it is clear in both A.B. 123 and Senate Bill 70 that only physicians in NRS 630 and NRS 633 are to be covered by this practice of being dually-boarded. The Board of Dental Examiners of Nevada regulates conscious sedation or deep anesthesia practices in those dental offices. So if they are regulating those dentists, but those dentists also are licensed as an M.D., I believe our challenge with the way the law is written would be are we required, because the dentist is an M.D. or D.O., to regulate the office where they are performing the deep anesthesia, even though the Dental Board has already regulated it?

Chairwoman Smith:
How many dually-boarded professionals would you say we have?

Mary Wherry:
We would have to contact the boards to get that information, but I would say a handful.

Chairwoman Smith:
I was amazed when I realized that dental offices have already been covered but physician offices were not, even though similar types of procedures involving anesthesia are being offered.

Assemblyman Stewart:
I understand that the fees that are assessed here will take care of the additional inspectors or additional amount of money that is needed. Is that correct?

Mary Wherry:
That is correct.

Assemblyman Stewart:
I assume you already do some unannounced inspections. Do you have trouble going into an office unannounced? For example, maybe the doctor is not there that day or for some reason the doctor is at the hospital, and you have to keep going back multiple times. Is that a problem at all?

Paul Schubert, Health Facilities Surveyor IV, Bureau of Health Care Quality and Compliance, Las Vegas, Nevada:
When we do unannounced inspections, and all of them are unannounced, and the physician is not there or those persons who are necessary for certain activity in the facility are not there, we go ahead and start the inspection and conduct that portion of it that we can. If there are any questions that we need answered or any documents that we need specifically from those individuals who are not there, we go ahead and make arrangements to either return to the facility or to obtain that information through the people who are at the facility.

Assemblyman Stewart:
Once the inspection has been made, how soon is the follow-up? Do you give them a certain amount of time to comply with any deficiencies?

Paul Schubert:
Even if we need to return to the facility or we need additional information, that is just a continuation of the inspection process. We try to accomplish that entire process within a matter of days, not weeks or months. Once we have concluded the inspection, then we generate a report that goes to the facility identifying any deficiencies that they have, and then the facility must respond to us within ten days after receiving that report.

Assemblywoman Leslie:
I am still thinking about the dentists, because I found that so interesting. Is the level of inspection and regulation that the Dental Board is doing equal to what we are proposing?

Mary Wherry:
There probably is some discrepancy.

Assemblywoman Leslie:
I want to make sure that they are equal, and if they are and we can work it out so that we are satisfied, I guess we could just exempt dually-boarded professionals. There is no reason to do it twice, but I do want to make sure we are getting the same caliber of inspections.

Mary Wherry:
I am not absolutely sure that there are not other dually-boarded physicians, for example a podiatrist. I do not know, because that is not my area of expertise. The Boards would possibly have the information as to whether or not they have physicians under NRS 630 and NRS 633 that are dually-boarded.

Chairwoman Smith:
We will have our staff figure out that piece. I realize that this is not the Ways and Means Committee, but I would like to ask, since we had the discussion about what it would cost to do this, and it is paid for by fees, what do you do for the ramp-up cost to get started before you have collected the fees?

Mary Wherry:
We have some money in reserve that we would use to start the business. Obviously, based on the roll-out dates that are proposed in the statute, we would have to ramp-up pretty quickly with developing our regulations and taking them through that rule-making process.

Kathleen Kelly, Executive Director, Board of Dental Examiners of Nevada, Las Vegas, Nevada:
We do have regulations through *Nevada Administrative Code* 631 that address the administration of anesthesia. Also our statutes are the statutes used for defining conscious sedation, deep sedation, and general anesthesia. Regarding our inspection process, we do permit both the site (the facility) as well as the individual who is administering the anesthesia. The site is inspected and there are specific, defined issues that the inspectors look at through regulation. The inspection of the physical facility, the equipment that is required, or the emergency drugs that are required to be present is a different inspection than

evaluating the administrator, and how they administer the medications. We inspect a site for conscious sedation, not by the method, but by achieving the level of sedation. We inspect pediatric dental offices because they will typically administer an oral medication for conscious sedation to their patients. We inspect every five years, but we can re-inspect any time. Once the permit is issued, the permit holder has consented to the Board's inspections at any time. If we were to receive a complaint that proved to have validity, that individual could lose his permit. So we go into a site every five years, we reevaluate an administrator every five years, but the law does allow us to do that at any time. With respect to the dual licensure, it affects oral and maxillofacial surgeons only at this point. They can be dual degreed, for example M.D., D.D.S.; some are licensed with the Medical Board in addition to the Dental Board, but there are others who are only licensed with the Medical Board, and not with the Dental Board. Those who are licensed with our Board have received permits for themselves as administrators as well as for their sites. Again, that is for any level of sedation which is conscious sedation, deep sedation, and general anesthesia.

Chairwoman Smith:
This legislation requires the inspection to be focused on infection control practices. Is that the same with the Dental Board's inspection?

Kathleen Kelly:
All licensees of our Board are required to follow the guidelines for infection control procedures, whether they are administering anesthesia in those three levels or not. Our inspectors do not specifically look for infection control in all aspects, but they do evaluate the individual who is administering the anesthesia drugs in terms of whether they have followed appropriate techniques and procedures for administration.

Chairwoman Smith:
So it sounds like that is another area that we may want to compare and make sure that we have similar practices in effect for both inspections.

Kathleen Kelly:
Many times we talk about accreditation, and there are very specific standards to achieve that level of accreditation that may or may not specifically be addressed in our regulations. I think our Board would certainly consider suggestions to strengthen the regulations if that were necessary to achieve the same level of accreditation in all areas that the term "accreditation" implies. I do not know that our inspections are exactly the same as what is employed by other entities that perform inspections.

Assemblywoman Mastroluca:
Regarding accreditation, what kinds of accreditation would you be looking for? Being accredited by a nationally recognized organization that is approved by the Board sounds like it could be too broad. Does it depend on the type of practice you are looking at?

Mary Wherry:
The Health Division would not decide what accrediting body would be used. The Joint Commission accredits physician offices, and there are four accrediting bodies that accredit ambulatory surgery centers. So it is really up to the facility to discern which accrediting body they want to apply to and be accredited by. It would be up to the accrediting body what their standards are, specific to the scope of practice that those clinicians practice under.

Assemblywoman Mastroluca:
Do you know what the average cost for accreditation is? Is it a yearly rate? How much does it run?

Mary Wherry:
An ambulatory surgery center that performs up to 5,000 procedures a year will pay an initial cost of $4,025. If they perform more than 5,000 procedures a year, it is $5,300 for the initial survey by the Joint Commission. The annual fee ranges anywhere from $1,870 to $3,065 based on the number of procedures. The initial cost of accrediting by the Accreditation Association for Ambulatory Health Care seems to be based on the number of procedures, and is $4,725 and six months later, another $4,725.

Assemblywoman Mastroluca:
I am trying to find a balance between patient safety and cost effectiveness for the physician. My fear is that we might make this cost prohibitive for a physician to perform a procedure that could be done relatively simply and quickly in his office, rather than taking up space in our overcrowded hospitals. If we have physicians who are performing these procedures, for example a biopsy, who are saying they will not do them anymore because it is too costly for the accreditation and the licensing, that would force patients to go to an outpatient surgery center, which could become overcrowded. I do not have an answer, but I can see both sides and I am just trying to find that balance.

Assemblywoman Spiegel:
Similar to the question that Assemblywoman Mastroluca just asked about the costs associated with accreditation, how does that compare with the dental field and how do the costs for the inspections and accreditations compare?

Kathleen Kelly:
The costs would be significantly different. The application fee for a dentist applying for a site permit is $350. A dentist applying for an administrator permit is also $350. If the individual is applying for both permits, because it is the dentist's site and they are also the administrator, it is a one time fee of $350; they are not charged separately. The re-inspection fee is $250. The inspectors and evaluators are licensed Nevada dentists that hold the same level permit, or higher, for what they are inspecting or evaluating. They are individuals appointed by our Board, and they are their own committee of anesthesia evaluators. There is a renewal cost; every two years, it costs $100 to renew the permits and that includes both the administrator permit and one site permit. We do have dentists who have multiple sites. Every two years, it costs $100 to renew a permit for each additional site.

Assemblywoman Mastroluca:
Existing law requires a physician who is using conscious sedation, deep sedation, or general anesthesia to fill out a form from the Board of Medical Examiners. That form is extremely simple and it really only asks you how many times a physician performed a procedure. Will that form still be required with these new regulations? Can we combine them? It seems that one group is asking for information for one reason, and another group is asking for information for another reason, and so can we combine them?

Mary Wherry:
My understanding is that we would only be able to identify the practices that do the deep sedation based on what data the Boards collect. We would have to be in consistent, regular communication with both of the Boards to determine who we would need to work within the permitting process. It is really at the onus of the clinician.

Assemblywoman Leslie:
Could you explain this concept of "permitting" the physicians? I know that it is different from anything you have done in terms of annual inspections, and how would it work? You said they just have to self-identify, so if the bill is passed, how are we going to roll that out?

Mary Wherry:
I am going to speak to my knowledge. Under section 8 of A.B. 123, it says that an office of a physician or a facility that provides health care must obtain a permit. Then it goes on to say that if a physician operates at more than one facility, he must obtain a permit for each location. If you go on through the bill, it says that an office that provides health care must submit to the Division of

Health on a form prescribed by the Division of Health, and be accompanied by the appropriate fee and application for a permit. I read this to mean that the office is the one that needs to initiate. We would probably question if we are getting data from the two boards that there are 235 practices, and we have only had applications from 20. We would probably become curious as to why we have not received applications from the other businesses.

Marla McDade Williams, Bureau Chief, Bureau of Health Care Quality and Compliance, Carson City, Nevada:
I would add that it is very difficult to get a newly required permittee or licensee to come in for whatever the law requires. It takes us on average two years before we are able to communicate very clearly with the provider community that there is a requirement they need to adhere to. What we end up doing is drawing a line in the sand, issuing a cease and desist to all of those providers who have not come forward, and turning them over to the Attorney General's office as an unlicensed facility. Those come with a whole set of fines when we have to get to that point.

Chairwoman Smith:
I guess it seems obvious that this is another point; that we need to work with the licensure boards to make sure that everyone is well aware of their responsibilities, especially if we have a big change such as this one.

Senator Horsford:
I am supportive of these provisions. I would like to note that the Assembly Majority Leader, Assemblyman John Oceguera, is in the audience. I do think that there might be an opportunity to align some of these licensing requirements with the business portal concept that Assemblyman Oceguera and the Secretary of State are pursuing. We need it all to connect between licenses, taxes, and requirements by the Board.

Chairwoman Smith:
When I looked at all of this, I was very surprised how little communication we had between agencies or divisions, whether state or local. I was amazed at how much of a problem that was. If we can accomplish better communication, the public will be much better served.

Assemblywoman Leslie:
Is there a concern that doctors will refuse to do these procedures? My opinion is that if they cannot be done safely, then they should not perform them at all.

Mary Wherry:
I have not heard anything about that. It seems like it would be a natural potential.

Marla McDade Williams:
I have not heard any specific concerns, but I think where there would be contention is when the fees are applied to the physicians.

Chairwoman Smith:
Is there any other testimony in support of A.B. 123?

Timothy Cummings, representing Epiphany Surgical Solutions LLC; Surgery Center of Southern Nevada, Las Vegas, Nevada:
We are here in support of A.B. 123 and S.B. 70. I represent an ambulatory surgery center, and I was pained to hear about what happened last year and that it happened in an ambulatory surgery center and that no one came forward from the ambulatory surgery side to put legislation forward or to support this legislation. Speaking to our physician partners and our staff, they are clearly in support of these bills.

Chairwoman Smith:
How will this legislation impact your center?

Timothy Cummings:
We do not expect that much of an impact. We already are accredited with the Accreditation Association for Ambulatory Health Care. For our physician partners, some of them will have to seek accreditation for procedures that they currently do in their office. They have indicated that they are willing to pursue that accreditation or to bring those procedures to an ambulatory surgery center that does have accreditation.

Lawrence P. Matheis, Executive Director, Nevada State Medical Association, Reno, Nevada:
Since the committees are likely to be looking at this group of issues together, you should also consider Assembly Bill 125, which also proposes national accreditation of ambulatory surgery centers.

The purpose of these bills is to ensure that ambulatory practices have effective infection control, primarily safe injection practices. That is why we support this bill. In the last couple of years, we have seen that injection practices have not always lived up to the standards that they should. We need to reapply the proper education and understanding of injection practices, what is safe and

what is not, and what cannot be waived for any reason. We are doing that as part of a national effort with the Centers for Disease Control and Prevention (CDC), the U.S. Food and Drug Administration (FDA), and other national organizations. We will be testing educational materials here in Nevada over the next few months that will then be adapted and will become part of a national injection safety campaign. There are a lot of parallel activities happening, and it is necessary because we want to be redundant; we want everyone in the health professions to hear the same message from a lot of different settings and groups so that it sinks in.

Regarding the parts of the bills that deal with the ambulatory surgery centers, I do not think there are any problems with requiring national accreditation and requiring national inspections. In A.B. 123, the requirements are specifically to focus on the infection control practices and policies of the centers. We really want to make sure everybody has that as a high priority, and the other issues will be addressed as appropriate. I think that part of the bill is straightforward. The only question is how frequently should full inspections occur? The national accreditation is important symbolically and also because it means there is an additional group looking. However, remember that one of the centers involved in the hepatitis C outbreak was nationally accredited. So there is no assurance, but it adds an additional layer of protection for the public, and I think everybody can agree that is a wise step to take, given what we have experienced.

Regarding the issue on how best to regulate ambulatory practices that are not licensed, or not certified, or there is no oversight, the professionals who work there are licensed and certified, so how do we add that oversight function? The question is if these problems are occurring in offices where there is oversight, what is happening in the offices without oversight? The public confidence needs to be restored to believe that practices are doing the proper things.

The next question is how do we determine which practices to look at? You do not want to create a regulatory scheme that will allow the Health Division to frequently go into every place where some kind of medical care is being delivered. It would be impractical. What we are talking about is going from no oversight to some effective means of looking at practices where there might be infection issues. The use of the levels of sedation as a threshold—there is nothing new or magical about that. When the federal government created ambulatory surgery centers, it was done according to medical procedures. The reason was simply because Medicare was paying more than it wanted to pay to have procedures done in a hospital setting and so it set up a separate fee schedule for certain procedures if they were done in an ambulatory surgery center, and the states had to scramble to license ambulatory surgery centers

that were created. There are a lot of different ways of approaching this, but the sedation level is what the states are beginning to look at, either for requiring accreditation or doing inspections. We have used this model for four years in terms of requiring physicians to report if their practice does engage in any of these three levels of sedation. This is related to the 235 practices that were indicated in previous testimony. That is really 235 physicians, and I am not sure exactly how many settings are involved.

The primary concern that has been raised is really in two areas; we want to try to get steps ahead to really look at ambulatory centers for safety issues and we want to take a step toward oversight of those ambulatory centers. We want to be able to come back to the Legislature in two years and show that we have been effective; the state has been able to adopt and implement regulations and guidelines; we have been able to go into facilities; permits have been issued; and any problems have been identified and fixed. The question is how to focus this in such a way that we have a successful start up.

One of the issues is, because other states are also now beginning to go into this area, these national accrediting bodies that have not had to do many office practices may suddenly be inundated with requests. The Board of Health has been directed to adopt regulations by October 1, 2009, providing for which accrediting bodies will be accepted as certifying these practices, and that by October 1, 2010, the practice would receive a permit. My only suggestion is to allow in the language of the bill, for the State Board of Health to be flexible with regard to granting extensions in the event that the national accrediting bodies are not able to schedule all of these reviews. I am not saying to change the timeline or to change the expectation, but you may want a built-in hedge just in case it takes longer to implement this new law. The same thing regarding the state permit; it would be contingent on the state having the resources to be able to go out and inspect facilities after they have had the national accrediting body approve them. Again, I think you may just want to allow flexibility for the State Board of Health in the event that they cannot meet a particular target date, as long as they are on the right path. After all, these would not be in the control of the physician practices, it would be in control of other factors. That is the only thing that we would advise.

The second issue really addresses whether or not this is too large a net for regulating office practices for the first time. Regarding the three levels of sedation, everyone that I have talked to agrees that deep sedation and general anesthesia should definitely be a qualifier. There is a fairly wide variety of opinions regarding the lowest level, conscious sedation. In fact, when the Legislature adopted the reporting requirement in 2005, the

American Society of Anesthesiologists, which came up with the definitions of the three categories of sedation, had an exception to it, which has guided the reporting requirement. The exception is "the administration of medication to a patient to relieve the patient's anxiety or pain, if the medication is not given in a dosage that is sufficient to induce in a patient, a controlled state of depressed consciousness or unconsciousness, similar to general anesthesia, deep sedation, or conscious sedation." So it is an exception because at that conscious sedation level, it allows procedures, breast biopsies for example, to be a little less painful, and it reduces the anxiety of the patient. It is those practices that just do the conscious sedation that are the ones most likely to have this cost benefit problem facing them. We would certainly encourage you to continue to have that exception in the statute about what is being regulated, as well as what you have received in terms of the reporting; the reporting has already made that exception. You may want to consider staging the implementation, and to start with deep sedation and general anesthesia, and continue to monitor how much conscious sedation is being done, and then look at adding that down the road.

We also agree with continuing mandated reporting to the licensing boards, and that those boards should report what they find to the Health Division. At some point down the road, you may want to rethink to whom the reporting should be done. For now, since we have had three or four reports to the two physician licensing boards, you probably want to keep that in place at least through this transition period, and then reevaluate it in the next legislative session.

Chairwoman Smith:
I have Ron Kline signed in with amendments. Are there actually amendments?

Ronald M. Kline, Secretary, Nevada State Medical Association, Las Vegas, Nevada:
[Answered inaudibly.]

Chairwoman Smith:
Mr. Kline stated that the amendments were the ones Mr. Matheis offered. I wanted to make sure there was not something in writing that the committee did not have. If you will work with our staff, Mr. Matheis, to have some suggestions in writing about your association's thoughts on the bill, that would be helpful.

Assemblywoman Spiegel:
Are there infectious issues that exist with regard to conscious sedation, and if so, what are they?

Lawrence P. Matheis:
What we are really talking about, for the most part, are blood-borne pathogen infections. There are a lot of different kinds of infections that can be obtained, but the hepatitis C outbreak raised the concern that we had a generation ago about HIV/AIDS. What we are talking about are blood-borne pathogens, which have higher incidences of causing illness. That requires injection practices, and that is why the Committee is looking at injection safety. With the deep sedation level and the general anesthesia, the procedures are more complex, and it may require multiple types of injections during the procedure and following the procedure. Again, I think this is taking steps forward by looking where there is most likely to be a potential for a problem, focus on those areas, make sure there are not problems there, and then to expand out. Eventually what you want is to make sure that every health care practice is following the appropriate infection safety standards, especially when it comes to injection safety. There is no easy way to capture how to define the settings; the ones the American Society of Anesthesiologists offered have been used in a handful of states. Again, it is a surrogate way of trying to identify where activities may occur that may have higher risk. It will not be perfect, but it is a way to start.

Assemblywoman Spiegel:
So if I understand correctly, conscious sedation does not involve a procedure that would result in blood-borne pathogens, so it could be administered in a safer manner than other forms of sedation?

Lawrence P. Matheis:
No, I cannot say that. Anytime there is an injection, or anytime there is a possibility of blood-to-blood transmission, it is possible to spread a blood-borne pathogen. What we are trying to do here, I think, is to try to begin to move towards additional regulation and oversight and to look at the areas where you would expect that the greater risks are associated.

Assemblywoman Leslie:
What was the level of sedation used in the endoscopy centers where the problems began?

Lawrence P. Matheis:
I think it was deep sedation, but I do not know for certain.

Paul Schubert:
The level of sedation that was used was conscious sedation at those endoscopy centers.

Assemblywoman Leslie:
Well, that would seem to contradict your answer, Mr. Matheis, if that is true.

Lawrence P. Matheis:
That was how the Health Division advised me, but we can clarify that information later.

Chairwoman Smith:
We will get that information to the committee members after this hearing.

Assemblywoman Leslie:
Regarding accreditation versus inspection, you said accreditation in lieu of inspection, and then you rightly pointed out that the problems we saw occurred in at least one ambulatory surgery center that was accredited. We had a lot of testimony during the interim about what accreditation does and what it does not do, and I was wondering what your thoughts were about also requiring inspections. Please clarify that, because after I heard all the testimony during the interim, I was convinced that we definitely wanted accreditation.

Lawrence P. Matheis:
I think the issue is a practical one. I think that if the focus of the annual inspections is infection control and injection safety, that is probably doable. If the expectation is a full facility inspection, that may be difficult annually. There are different levels of inspections. I think that the Health Division has been doing these multiple level inspections, and I think there is a sentinel effect that you have anytime you have officials coming in and looking at a facility.

Assemblywoman Leslie:
Having looked pretty deeply at the State Division of Health's plan, I think they have a good plan for doing focused surveys, and then if they see something that is wrong, they would go in and do a full-blown survey. I think they have a practical plan that makes sense.

Lawrence P. Matheis:
I agree with you, Ms. Leslie. I think the approach that has been taken in the last year, with the total revamping of the Health Division's efforts in this area, is now a national standard. We have been proposing and working with Senator Reid to have the Centers for Medicare and Medicaid Services (CMS), because they pay for the certification of facilities, require all states to use the same kind of inspection in facilities that they are certifying. As horrible as hepatitis C outbreak is, I think that some lessons are coming forth that are going to make the health care system in Nevada and in the country better.

Assemblywoman Leslie:
Does CMS have accrediting agencies that they accept for physician offices?

Lawrence P. Matheis:
I am not sure.

Senator Cegavske:
I have not heard anyone bring this up, but I think it is important to at least throw it out on the table. We received an email from a practice in Reno. They perform breast biopsies and are afraid that if this legislation is passed, they will not be able to do the conscious sedation any longer, which they are worried will increase the time between discovery and diagnosis, increase discomfort, and increase patient and insurance costs on necessary testing. They think it has unintended negative impacts, and again I do not know anything about the woman who wrote this email or the surgical center. I just want to see if there is anyone who has information on her concerns.

Chairwoman Smith:
This really does relate to Mr. Matheis' testimony, and I think we really do need to get the answer about what level of sedation was being used at the centers because that will certainly help us in trying to decide how to proceed with that language.

Darla Leibel-Burrow, Executive Director, Nevada Hepatitis C Task Force, Reno, Nevada:
Our own investigations of what happened in that specific set of clinics showed that procedures that were suppose to be under deep sedation were not, because they reused the vials to sedate other patients. It is supposed to be one vial for multiple use on the same patient, and these clinics had used vials up to six times on six different patients. So, depending on how much the body needs to sedate, the clinics were not necessarily giving patients all of what they needed. There were patients who were not completely sedated at the time of their procedure. They were sedated enough to where they did not feel the pain, but they were not completely sedated to avoid discomfort. If they need to keep injecting you to keep you sedated, they are supposed to use that one vial.

Chairwoman Smith:
We will get the official answer from our staff as well. I would note, from the presentation we had earlier this week, that you may not need to use one whole vial per patient, but you are not supposed to reuse the vial on anyone else.

Senator Nolan:
I think you are correct. Having been a health care provider in the past, and using multi-dose vials, there are really two issues: one being that you have a multi-dose vial that is only supposed to be used on one patient, and the other being how much medication is actually needed in any situation to sedate the patient. It is always a physician's call, as to what level of sedation is required in some patients, based upon a patient's individual circumstances; some people may have medical conditions that would predispose them to problems if you deeply sedated them, and other people may have a high tolerance for pain that may not require as much sedation. I do not know if the testimony from the last witness was accurate or if I misunderstood it.

Brian Labus, Senior Epidemiologist, Southern Nevada Health District, Las Vegas, Nevada:
I would agree with Senator Nolan. There are two issues here: how much medication do you need to sedate the person, and where do you get it from. There are vials that are licensed for use on multiple patients where you can get a large amount and then use it to give the correct amount to many patients. There are other vials that are licensed that no matter how much is in that vial, it is for use on one patient. Now the medication that they are talking about here came in 10cc vials, 20cc vials, and 50cc vials. Different vials would be appropriate, depending on the situation. If you had a long surgery that went on for several hours, you may use several 50cc vials, but if you had a short procedure, you could use a smaller vial. Whatever the case is, a vial is used for one patient, but has nothing to do with how much they were actually given. So the question about people not being completely sedated really is a separate issue than the issue of reusing of the vials.

Chairwoman Smith:
Thank you for clarifying that. It appears that we are probably going to have a much more complex answer to the original question, whether conscious sedation was used or deep sedation, because there are multiple procedures performed in these clinics.

Brian Labus:
In this case, there are basically two procedures performed in the clinics, so using the endoscopy center as an example is probably not a good one because there was one very specific type of procedure. For the other surgical centers, that answer does become more complicated.

Chairwoman Smith:
That was my point. In this legislation we are talking about everyone, not just the clinics that were impacted by the hepatitis C exposure. Thank you for clarifying that.

Senator Nolan:
My understanding is that from your investigations, it appears as though the direct infection of those patients who had contracted the hepatitis C were from the reuse of needles. I never heard whether they had been reusing needles or not sterilizing the scopes that were also used, which also is a potential for contamination, maybe even more of a direct potential if they were not being sterilized properly.

Brian Labus:
We evaluated all the different procedures they did at the clinic and ruled out all the other sources of infection. We looked at the scope cleaning procedure, which appeared to be adequate. The patients were having procedures performed using different types of scopes and we did not have the same scope used on a number of people, so we ruled that one out rather quickly. A recent article from the CDC about 33 hepatitis outbreaks that have occurred over the last ten years found that it is mainly the injection practices and not the scopes. In discussing it with the people who wrote the article, they said that when people find it is the scopes, a lot of times it is because they have not looked into the injection safety issue deep enough; they did not do a complete investigation, and they just concluded that it was likely the scopes because those are going from patient to patient. We were able to rule scopes out, as well as a number of other things, at the clinic. What we were left with was the injection safety issue.

Chairwoman Smith:
We do have the update that was provided by the health district that we can provide as well.

Ronald M. Kline:
I am a pediatric blood and cancer physician in southern Nevada, and I use conscious sedation extensively in my office to decrease the pain and anxiety that is caused by a variety of painful procedures that are part of treating cancer in children. I am here to speak in favor of A.B. 123 with the amendment that Mr. Matheis suggested, that we remove conscious sedation from this legislation. I, and the physicians I represent, are concerned that some of the regulations in this legislation may cause our patients to experience more pain and anxiety than is necessary. Let me be clear, the Nevada State Medical

Association has no objection to this legislation as it applies to ambulatory surgery centers. These are large, busy, multi-million dollar facilities that can afford the additional cost of national accreditation and yearly licensing fees. Rather, our concern is that for smaller physician offices, the thousands of dollars in yearly licensing and accreditation fees may force us, in the face of increased costs and declining reimbursements, to discontinue the use of conscious sedation, and deprive our patients of the adequate control of their pain and anxiety.

I would also add that when we were speaking of the dental practices and their licensing, that was on an every five-year basis; this legislation refers to a yearly basis. Lest I forget, and I got lost in all the fees and other things that were being discussed, when we spoke about the dental licensing fees for dentists who were doing conscious sedation, the Committee heard numbers like $250 and $300 every year, every two years, every five years. When you heard about accreditation for medical facilities, the Committee heard numbers like $3,000, $4,000, and $5,000. If the Health Division has suggested an $880,000 budget per biennium to license 250 physician offices performing conscious sedation, that works out to roughly $2,000 per year on top of the accreditation fees.

Let me be specific about our concerns. In my office, a child with cancer will undergo two types of procedures. One that we call bone marrow aspiration and biopsy, and the other is lumbar puncture with the injection of chemotherapy. During the bone marrow aspiration and biopsy, we insert a five inch needle, which is approximately 1/8 of an inch in diameter, in the back of the hip to obtain a core of bone that contains bone marrow. We then insert a second needle, of similar size, into the hip again and aspirate bone marrow into a syringe. As barbaric as that sounds, there is no other way to accurately diagnose leukemia and accurately measure its response to chemotherapy. We also perform lumbar punctures where we insert a 3 1/2 inch needle into the space between the backbones in the lower back to obtain spinal fluid for measurement and to inject chemotherapy into the spinal fluid that circulates around the brain. Without this procedure, leukemia can escape the effects of chemotherapy and recur in the brain and spinal chord. During that 3 1/2 year course of treatment for a child with leukemia, he will undergo four bone marrow aspirations and biopsies and 17 lumbar punctures. In my office these are done using conscious sedation. The children experience no pain during the procedure and are not anxious prior to the procedure, since they have no previous recollection of anything uncomfortable. The medicines block the pain, as well as the short-term memory associated with the event. The children remember coming into the room and lying on the bed, but nothing after. Please compare this to the way these procedures were performed in the 1970s and 1980s. I

have spoken to several adults who were treated for cancer as children. They described to me the experience of being held down by several nurses while the physician inserted needles into their back and spine as quickly as they could. The children of the 70s and 80s were told to imagine being at the beach, which we call guided imagery, which was their only comfort while undergoing these very painful procedures. Whenever I think of this, it reminds me of the limb amputations of the Civil War, when the best physicians were the ones who could saw off a leg or arm the fastest. Please do not force us to return Nevada medicine to the 1970s.

My partner and I perform approximately 100 conscious sedations per year and have done so for the last eight years with no serious adverse events. Our nurses are experienced in providing conscious sedation, and we have the proper equipment to monitor these children during sedation and in the recovery phase. We also have emergency equipment and medicines in case of any adverse event. We strongly feel that adequate pain control is part of being a good and caring physician. Furthermore, I am unaware that there is a significant problem with adverse events associated with conscious sedations. For at least the last two years, I, and other physicians in Nevada who provide conscious sedation, have submitted forms to the Board of Medical Examiners describing the number of conscious sedation procedures we have performed and any sentinel events associated with them. The Committee should easily be able to ascertain whether there is a significant problem with adverse events during conscious sedation, and I believe Mr. Matheis referred to three or four, over the last several years. I would also remind the Committee that based on the findings of the Southern Nevada Health District, the much publicized problems in ambulatory surgery centers did not involve problems with sedation, but rather problems with injection practices, which this legislation only indirectly addresses.

We are deeply concerned about costs associated with each physician office in complying with the requirements of this legislation. This legislation will make it financially impossible for us to continue to provide services to our patients. If physicians choose not to administer conscious sedation in their offices, then a more expensive alternative will be to perform these procedures in hospitals, and I believe Senator Cegavske and Assemblywoman Mastroluca referred to this. A breast surgeon, who was part of our discussion on this legislation, told us that she performs breast biopsies in her office under conscious sedation. She stated that if this legislation passes as currently written, she would simply admit all of her patients to the hospital for their procedures; a vast and more expensive process that will drive up medical costs in general and Medicaid costs in

particular. Our office would likely do the same thing for some procedures, while performing other procedures without conscious sedation.

Lastly, we feel that bureaucratic delays may impede our ability to provide conscious sedation, even if our office chooses to pay for it. If, for example, there were delays in the national accrediting process or the state yearly permitting process, then our office would be legally unable to provide these services until the state finally issued a permit. Given the lack of staff in the State Division of Health and the unlikelihood of increasing staff, and given the current budget constraints, we feel this is a real possibility. Our recommendation to the Committee is that the bill be amended so as to remove the requirement for accreditation and yearly permitting in physician offices providing only conscious sedation. Accreditation and permitting would still be required for all ambulatory surgery centers and for physician offices that perform deep sedation and general anesthesia.

We believe that this minor amendment will continue to allow the vast majority of physicians to provide pain and anxiety-free procedures with state-of-the-art technology, while still providing adequate oversight to the larger, high-volume centers, as well as offices administering higher risk sedation. We know that the Committee has put forward this legislation with the best of intentions, but sometimes the law of unintended consequences intervenes. Physicians are not afraid of, or opposed to, inspections of their offices, but are deeply concerned that the costs involved in this process, which will inevitably be passed on to them, are so significant as to make it financially impossible to provide the level of care we wish to provide. We hope the Committee will find the right balance between assuring the safety of Nevadans and not imposing unnecessary costs that will limit the access of these same Nevadans to appropriate, pain-free care.

Senator Nolan:
I think that you said something in your testimony that is really key to what we are doing here. The issue before us is really the result of poor injection practices that federal laws and state laws already address. Apparently we have an individual who chose to forego all those federal and state laws that were designed to protect individuals and to do one particular practice, reusing needles that should never have been reused. In the case of your practice, where you are doing lumbar punctures and bone marrow aspirations, are those procedures performed with individualized packages that come sealed, are used once, and then disposed of in their entirety afterwards, or do you actually re-sterilize needles and reuse them?

Ronald M. Kline:
Let me begin by saying that I am an interim member of the Medical Board on the issue of ambulatory surgery centers, so I would not want to improperly imply anything that would say that I have come to any conclusion until I have the information on the investigation. Speaking about my office in particular, everything we use is disposable and is used once and thrown away.

Senator Nolan:
Somehow we have focused exclusively on endoscopy centers because there were different levels of sedation, whether deep sedation or conscious sedation, and that somehow the needles that were reused were associated with those particular procedures. In your case, where you might be performing a lumbar puncture, it is a couple of injections of an anesthetic around the site, and then you are inserting the lumbar needle, and it is a one time, one package thing. My point is, I do not know how we got over to the deep sedation issue when the problem is more with the individual practice.

Ronald M. Kline:
I agree with you 100 percent. If you are trying to address safe injection practices, then this legislation only indirectly addresses that issue. As Mr. Matheis pointed out, you can receive a Botox injection or an allergy injection and the same issues that were reported by the Southern Nevada Health District can occur without any issue of sedation. So if you are trying to speak to safe injection practices, then that requires different legislation.

Senator Washington:
Maybe this is a question for staff. After listening to your testimony, I think you have some valid concerns, and maybe we heard those concerns during the interim, but we were not really conscious of it. Let me ask you this question, because I think you have a legitimate concern, is there a way to remove conscious sedation from doctor's offices, based on the use within those offices, and to take a serious look at injection procedures, so that we really capture what we are trying to accomplish?

Ronald M. Kline:
You simply remove conscious sedation from the types of sedation that require annual permitting and national accreditation. I think if you are trying to address the issue of safe injection practices, you have an enormous issue on your hands because basically every physician office is using needles and injection in some way or another. You have gone from 250 practices providing some form of sedation, to 4,000 physicians in Nevada, presumably most if not all, providing some form of sedation.

Senator Washington:
That is impossible. So let me retract my question. I guess what I am asking is, based on conscious sedation and its different uses within the scope of different practices, is there a way to categorize those practices so that we are only looking at conscious sedation practices that are relevant to this issue? In other words, not Botox, but practices like biopsies.

Ronald M. Kline:
Well, I think one other way to approach this issue would be to find the practices that perform certain kinds of procedures that require reporting and accreditation, as opposed to the type of sedation. There really is a continuum between conscious sedation, deep sedation, and general anesthesia, so it is hard sometimes when we ask of the endoscopy center whether a procedure is conscious sedation, deep sedation, or general anesthesia. It depends on how much medicine you use.

Senator Washington:
When we were crafting the bill, we were looking at a method by which we could certify, inspect, and license these facilities and deep sedation, conscious sedation, and general anesthesia were the levels that we looked at. We did not take into account the type of practices that you do, and I see where there could be a concern if we just lump everybody into these three categories. Personally, I do not want to amend the bill to take out conscious sedation, but I do not want to needlessly harm practices.

Ronald M. Kline:
Just to emphasize, all the physicians who have been involved in looking at this legislation understand the good will of the Committee in crafting this bill. The problem is that you have a 30,000 foot view of the problem, and we are the soldiers on the ground who are dealing with the issue.

Chairwoman Smith:
I think the issue that cannot be resolved here today in the bill is to figure out the differences in sedation. Mr. Labus, would you clarify for us why the injection practice became the issue that we are trying to solve. It seems that we have gotten off track from what we are trying to accomplish in this bill, so maybe you can provide some insight for us.

Brian Labus:
The issue that we found in the endoscopy center was an injection safety issue. It so happened that the injection safety is related to anesthesia. That is why I think both issues are coming up. In the outbreaks that have happened in the

ambulatory surgery centers, the injection safety issues have typically occurred related to anesthesia. Trying to determine where that injection safety issue ends, and where it becomes an issue of anesthesia, is the difficult part facing the Committee. I think the real focus is on safe injection practices, no matter what type of procedure is actually occurring.

Senator Nolan:
In the early 1980s, I participated in providing input on the blood-borne pathogen standards that were eventually developed, and I administered those for our company. Were the practices just clear violations of the county ordinances and the federal standards regarding blood-borne pathogens? In other words, if this clinic had followed those procedures, would these outbreaks have occurred?

Brian Labus:
I am not an expert in what those requirements are. What I can say is that the FDA licenses those particular medications for use on a single patient only, and that is the first federal regulation to look at. Had they not reused the vials, even if they had reused the syringes, there would not have been potential for transmission from patient to patient. There were two practices that, when put together, led to that transmission of disease. So had they either followed the law and used the vials for just one patient and then discarded them, or even if they had ignored the law and used those as multi-use vials in violation of the labeling, but used them correctly, there would not have been potential for disease transmission from patient to patient.

Senator Nolan:
So to put things in perspective, we had a health care provider who failed to follow the federal regulations. It sounds as if we have those federal regulations and standards in place and, if they had been followed, would have prevented this outbreak. I think the legislation that we are looking at brings up the question of how do we ensure that those people are following those practices? How do we do it without destroying the 99.9 percent of the medical practitioners who are out there and are following the regulations?

Brian Labus:
I would like to add one thing about the Occupational Safety and Health Administration (OSHA) standards. The OSHA generally focuses on the protection of the workers, and so the OSHA standards, in terms of patient-to-patient protection, would not be the same issue. There are other basic standards of practice to prevent one patient from being exposed to the blood of another patient. So, I do not think this would fall under OSHA; there is probably some other area, either regulations or standards of practice, in which

that particular issue falls. While there have not been other outbreaks like this in Nevada, there have been outbreaks like this around the country. Nevada is by no means unique. We are not the first place to have an outbreak and, unfortunately, we are not the last place to have an outbreak. Even after the public announcement of our outbreak, we have had problems reported in other states. This is not an issue specific to just Nevada, it is a general issue of providing injections in a safe manner so that these problems do not continue to occur. We have the largest outbreak, but we are not unique.

Senator Nolan:
It sounds like we agree; there are procedures in place, that had they been followed, this would not have occurred. What we are all collectively trying to do is make sure that this does not happen again, without penalizing those health care providers who have consistently followed those regulations.

Senator Horsford:
Mr. Labus, I do not know if you have the final investigative report done, but I would like to receive a copy of it if it is available. I want to respectfully disagree with my colleague, Senator Nolan. We heard from hundreds of people who lost all confidence because of those who were not following regulations, but instances when they felt that the practice was more prevalent. It was only because one was caught that this issue was ever brought to anyone's attention. I feel that the issue is more about raising the bar for health care in Nevada and to set the industry standard by which anyone who wants to meet that standard can practice. If individuals choose not to meet that standard, then they do not share our same values to have the best quality health care system that we can have. I just want to make sure that we focus the attention back on the fact that 50,000 people's lives were put at risk and we would not have known it unless someone had not gotten caught. We need a system that works when someone is not watching. I agree with Senator Nolan that there are a lot of good, quality doctors, nurses, and health care providers who dedicate their lives to this work, and they agree that we should raise the bar, set it high, and they will meet it. For those who do not, maybe they should not be in this profession. That is the debate that we began to have in the interim and I hope that is the debate that we will continue to have as these bills are considered over the next few weeks.

Senator Nolan:
I do not disagree with anything you have just said. I think we are on the same page. My only comment would be that with regards to the bills that are before the Committee, there is nothing proposed in this legislation that considers the federal requirements regarding the use of syringes and injection practices.

There is nothing that we have that makes those any more onerous than they already are. In other words, there are standard practices that have already been established, and none of the bills in front of us say that we are going to take those practices and make them tougher. What they do say is that we want to make sure everybody is following those federal standards. I absolutely agree that we need to make sure that people are reaching those standards. I just think that we need to do it in a fair and equitable way, and in a way that does not harm the practices of good providers.

Assemblywoman Pierce:
With regards to the discussion about taking out this one kind of sedation, Dr. Kline, you yourself said that these levels were a continuum, which suggests that you cannot take out one, that it is a matter of how much you use. This means the procedure is the same, which means that you cannot actually break out one. The other thing is, I appreciate your allusion to the Civil War, but I am still not hearing that what this bill requires in terms of an increase in fees is so onerous that any sensible person would choose not to have a procedure. I also appreciate your comment about our "30,000 foot view" but in the last ten years, I have been a big consumer of health care, and I do not want to take a chance; I will go find the money to pay for my procedure.

Chairwoman Smith:
I think we understand where the concerns are and what we need to do in moving this bill forward. We will certainly take all the information we have heard today and work with staff to compile everything we need to come up with a good resolution, again keeping in mind that it is our job, at that level, to protect the citizens of this state and make sure that we are delivering the best health care in this state.

I am going to close the hearing on A.B. 123. We are going to take a brief recess, and then we will hear testimony on Senate Bill 70.

[Committee in recess at 11:29 a.m.]

I would like to call the meeting back to order [at 11:41 a.m.] and open the hearing on S.B. 70. As I previously stated, this measure is very similar to A.B. 123, so we are hearing these bills together. The measure was sponsored by the Senate Committee on Health and Education, and I am going to ask Senator Horsford to present the bill.

Senate Bill 70: Requires certain offices of physicians and related facilities to obtain a permit under certain circumstances and requires annual inspections of surgical centers for ambulatory patients. (BDR 40-169)

Senator Steven A. Horsford, Clark County Senatorial District No. 4:
First and foremost, let me restate that the Centers for Medicare and Medicaid Services (CMS) recommend the surveyor inspection of qualified ambulatory surgery centers occur once every six years. This timeline is considered a recommendation and what I view as the minimum, because these facilities fall within the CMS fourth tier priority. Therefore, the inspections are not federally mandated, and there is no fine or penalty if they are not inspected at that rate. So, S.B. 70, along with A.B. 123, works to address that issue from a state level by requiring the annual inspection. Before I go through the sections of the bill (Exhibit J), I do have a proposed language change that was submitted by Andy North with St. Rose Dominican Hospitals (Exhibit K).

Senate Bill 70 revises the provisions for certain physician offices, related facilities, and surgery centers. Sections 2 through 7 of the bill ascribe definitions to various words and terms used throughout the legislation, and that is specifically related to the amendment that I have from Mr. Andy North. They feel that "surgical center" is not defined in the bill or referred to in the definition and they suggest that be clarified in the language. Sections 8 through 10 of the bill requires offices of physicians or other facilities providing health care that are not licensed as a medical facility by the Health Division of the Department of Health and Human Services, to obtain a permit. This relates to the general anesthesia, conscious sedation, and deep sedation. Section 11 of the bill requires the Health Division to conduct annual, unannounced inspections of those offices and facilities. Section 12 of the bill prescribes the sanctions which the Health Division may impose for a violation. Section 13 of the bill requires the State Board of Health to prescribe regulations to carry out the provisions of sections 3 through 13 of this bill, including the fees for the issuance and renewal of permits. The regulations adopted by the State Board of Health are subject to review by the Legislative Committee on Health Care. Section 14 of the bill requires the Health Division to conduct annual, unannounced inspections of surgical centers for ambulatory patients. Finally, sections 19 and 22 of the bill requires the State Board of Medical Examiners and the State Board of Osteopathic Medicine to forward to the Health Division such reports stating the number and types of surgeries requiring conscious sedation, deep sedation, or general anesthesia performed by the holder of a license at an office or other center. The provisions of this bill would become effective upon passage and approval on October 1, 2009.

Just to restate some of the reasons these provisions came forth, this bill is to raise the bar and create an industry standard that the health care industry is able to meet, and ultimately to restore the public's confidence that we are improving health care throughout the State of Nevada.

Chairwoman Smith:
I would also remind the Committee of the chart that we were provided that shows the differences between the two bills (Exhibit L), and certainly as we work on the bills in both the Assembly and Senate, we will take those differences under consideration and figure out how we can meld this concept into one good bill.

Senator Cegavske:
A question came up as you were talking, Senator Horsford, and what came to my mind was that because injections done at our county health centers, do we have any provisions of who would regulate, or are you just looking at surgical procedures? I am concerned about vaccines, injections, and any needle use, so who would be checking on the counties?

Senator Horsford:
That is not something that is addressed in this bill so we would need to discuss that further. Maybe with some of the officials who are here today, we can discuss appropriate language that addresses that issue.

Senator Washington:
There were some concerns that A.B. 123 versus S.B. 70 might be overreaching, and so I would like to hear Senator Horsford's comments regarding the sedation levels that we discussed in the last bill.

Senator Horsford:
I am not an expert in these areas. I believe that what we are trying to do is expand the regulatory requirements for a broader set of facilities. We are trying to better ensure that we are preventing future problems. If we put things into law that no one is checking, or has the resources to check, then it is not useful; it does not help the public's confidence. I think that Mr. Whitley and Ms. Wherry have discussed that we need a proper regulatory structure, both at the local and state level, to ensure that whatever ultimate legislation we pass will be enforced. Otherwise, it will become very apparent that it is not enforced and some people will go back to bad habits that got us into this situation in the first place.

Senator Washington:
I appreciate the comments of Senator Horsford in regards to his bill, S.B. 70. I am not opposed to making sure that the regulatory process is in place and that it is comprehensive enough to achieve the intent and goals of both bills. However, in light of the comments from the doctors and health care professionals who brought up legitimate concerns, especially about those procedures that are practiced in doctors offices, we need to make sure that we are not too far-reaching and that we do not make it cost prohibitive. It will be an interesting discussion as we move forward.

Chairwoman Smith:
Is there anyone who would like to testify on S.B. 70?

Sandy Curl, Director, Nevada Hepatitis C Task Force, Carson City, Nevada:
One of the things that I am concerned about is that in a lot of ambulatory surgery centers, before you have a procedure, you are tested for HIV/AIDS, but there is not a hepatitis C test prior to any of these services. I would like that to be added to this legislation; that a test for hepatitis C be added to the tests that are given prior to surgery, so that everybody knows ahead of time if a patient has hepatitis C.

Mary Wherry, R.N., M.S., Deputy Administrator, Health Division, Department of Health and Human Services:
I would like to note that our testimony for A.B. 123 is the same for S.B. 70 (Exhibit M). I would like to note that A.B. 123 has broader reaching language than S.B. 70.

Chairwoman Smith:
We clearly understand that we need to define ambulatory surgery centers in S.B. 70.

Assemblywoman Spiegel:
During the subsequent testimony during the hearing on A.B. 123, it was made clear that there is a huge disparity between accrediting and regulating doctor's offices and dentist's offices. Do you have any insight into what is causing that disparity?

Mary Wherry:
The costs of the accreditation process and surveys are based on the amount of time it takes to perform the survey. We based our projections of cost on the focused infection control surveys. One of the things that you have to take into consideration is that the Dental Board is only looking at a certain aspect when

they do their review or validation prior to permitting their dentists. Our review would be more expansive; not just looking at the anesthesia process but the infection control process also. That is how we defined our costs. Just for clarification, we are guessing that the cost for accreditation would probably be half of what the Joint Commission charges for ambulatory surgery centers because of the amount of time it would take to go through the practice and observe what it is that they do.

Senator Nolan:
What is the projected cost per facility?

Mary Wherry:
There is a fiscal note for $884,806. That is adding the 235 physician offices together with the 53 ambulatory surgery centers. We are estimating that the cost per facility is somewhere between $2,000 and $3,000.

Senator Nolan:
Is that $2,000 to $3,000 per review?

Mary Wherry:
That would be the cost of the annual fee.

Chairwoman Smith:
What may be helpful is for the Committee to be provided with the total cost to the facility with this legislation versus what they currently pay.

Mary Wherry:
Some of these would be a range based on the number of procedures the facility performs. Is that acceptable?

Chairwoman Smith:
Absolutely. I think if we can just get a snapshot of what type of cost we are talking about, that would be helpful.

Lawrence P. Matheis, Executive Director, Nevada State Medical Association, Reno, Nevada:
[Mr. Matheis requested his comments for A.B. 123 be entered for S.B. 70.]

Since the committees are likely to be looking at this group of issues together, you should also consider Assembly Bill 125, which also proposes national accreditation of ambulatory surgery centers.

The purpose of these bills is to ensure that ambulatory practices have effective infection control, primarily safe injection practices. That is why we support this bill. In the last couple of years, we have seen that injection practices have not always lived up to the standards that they should. We need to reapply the proper education and understanding of injection practices, what is safe and what is not, and what cannot be waived for any reason. We are doing that as part of a national effort with the Centers for Disease Control and Prevention (CDC), the FDA, and other national organizations. We will be testing educational materials here in Nevada over the next few months that will then be adapted and will become part of a national injection safety campaign. There are a lot of parallel activities happening, and it is necessary because we want to be redundant; we want everyone in the health professions to hear the same message from a lot of different settings and groups so that it sinks in.

Regarding the parts of the bills that deal with the ambulatory surgery centers, I do not think there are any problems with requiring national accreditation and national inspections. In S.B. 70, the requirements are specifically to focus on the infection control practices and policies of the centers. We really want to make sure that everybody has that as a high priority, and the other issues will be addressed as appropriate. I think that part of the bill is straightforward. The only question is how frequently should full inspections occur? The national accreditation is important symbolically and also because it means there is an additional group looking. However, remember that one of the centers involved in the hepatitis C outbreak was nationally accredited. So there is no assurance, but it adds an additional layer of protection for the public, and I think that everybody can agree that is a wise step to take, given what we have experienced.

Regarding the issue on how best to regulate ambulatory practices that are not licensed, or not certified, or there is no oversight, the professionals who work there are licensed and certified, so how do we add that oversight function? The question is if these problems are occurring in offices where there is oversight, what is happening in the offices without oversight? The public confidence needs to be restored to believe that practices are doing the proper things.

The next question is how do we determine which practices to look at? You do not want to create a regulatory scheme that will allow the Health Division to frequently go into every place where some kind of medical care is being delivered. It would be impractical. What we are talking about is going from no oversight to some effective means of looking at practices where there might be infection issues. The use of the levels of sedation as a threshold—there is nothing new or magical about that. When the federal government created

ambulatory surgery centers, it was done according to medical procedures. The reason was simply because Medicare was paying more than it wanted to pay to have procedures done in a hospital setting and so it set up a separate fee schedule for certain procedures if they were done in an ambulatory surgery center, and the states had to scramble to license ambulatory surgery centers that were created. There are a lot of different ways of approaching this, but the sedation level is what the states are beginning to look at, either for requiring accreditation or doing inspections. We have used this model for four years in terms of requiring physicians to report if their practice does engage in any of these three levels of sedation. This is related to the 235 practices that were indicated in previous testimony. That is really 235 physicians, and I am not sure exactly how many settings are involved.

The primary concern that has been raised is really in two areas; we want to try to get steps ahead to really look at ambulatory centers for safety issues and we want to take a step toward oversight of those ambulatory centers. We want to be able to come back to the Legislature in two years and show that we have been effective; the state has been able to adopt and implement regulations and guidelines; we have been able to go into facilities; permits have been issued; and any problems have been identified and fixed. The question is how to focus this in such a way that we have a successful start up.

One of the issues is, because other states are also now beginning to go into this area, these national accrediting bodies that have not had to do many office practices may suddenly be inundated with requests. The Board of Health has been directed to adopt regulations by October 1, 2009, providing for which accrediting bodies will be accepted as certifying these practices, and that by October 1, 2010, the practice would receive a permit. My only suggestion is to allow in the language of the bill, for the State Board of Health to be flexible with regard to granting extensions in the event that the national accrediting bodies are not able to schedule all of these reviews. I am not saying to change the timeline or to change the expectation, but you may want a built-in hedge just in case it takes longer to implement this new law. The same thing regarding the state permit; it would be contingent on the state having the resources to be able to go out and inspect facilities after they have had the national accrediting body approve them. Again, I think you may just want to allow flexibility for the State Board of Health in the event that they cannot meet a particular target date, as long as they are on the right path. After all, these would not be in the control of the physician practices, it would be in control of other factors. That is the only thing that we would advise.

The second issue really addresses whether or not this is too large a net for regulating office practices for the first time. Regarding the three levels of sedation, everyone that I have talked to agrees that deep sedation and general anesthesia should definitely be a qualifier. There is a fairly wide variety of opinions regarding the lowest level, conscious sedation. In fact, when the Legislature adopted the reporting requirement in 2005, the American Society of Anesthesiologists, which came up with the definitions of the three categories of sedation, had an exception to it, which has guided the reporting requirement. The exception is "the administration of medication to a patient to relieve the patient's anxiety or pain, if the medication is not given in a dosage that is sufficient to induce in a patient, a controlled state of depressed consciousness or unconsciousness, similar to general anesthesia, deep sedation, or conscious sedation." So it is an exception because at that conscious sedation level, it allows procedures, breast biopsies for example, to be a little less painful, and it reduces the anxiety of the patient. It is those practices that just do the conscious sedation that are the ones most likely to have this cost benefit problem facing them. We would certainly encourage you to continue to have that exception in the statute about what is being regulated, as well as what you have received in terms of the reporting; the reporting has already made that exception. You may want to consider staging the implementation, and to start with deep sedation and general anesthesia, and continue to monitor how much conscious sedation is being done, and then look at adding that down the road.

We also agree with continuing mandated reporting to the licensing boards, and that those boards should report what they find to the Health Division. At some point down the road, you may want to rethink to whom the reporting should be done. For now, since we have had three or four reports to the two physician licensing boards, you probably want to keep that in place at least through this transition period, and then reevaluate it in the next legislative session.

Senator Cegavske:
One of the biggest concerns that I have heard from constituents is regarding how they are being notified.

Chairwoman Smith:
I think that question is more suitable for our last bill, because much of it relates to patient records.

Mary Wherry:
I think someone made this point during the hearing on A.B. 123. If the A.B. 206 language is put in place, then much of that language would have an effect on A.B. 123 and S.B. 70, if they are in law as well. That is something

we would have to take into consideration when we reevaluate the impact because our evaluations have been based on current practice, not potential future.

Chairwoman Smith:
Thank you, and I guess as is often the case, we need to look across the spectrum. Is there anyone else who would like to offer testimony on S.B. 70?

Tom Townsend, Private Citizen, Las Vegas, Nevada:
I am sure that the bills that you are working on will be helpful and appreciated. I am here to talk about some people who are going to be left uncovered the way things stand now. Regarding my experiences with the hepatitis C outbreak, in particular the statute of limitations in these cases, when a person is diagnosed with hepatitis C, they have no way of knowing who is responsible in many cases...

Chairwoman Smith:
Mr. Townsend, I am sorry but I need to interrupt you. I had previously indicated that we need to limit testimony to the specifics of this bill. However, I welcome your testimony, so if you could wait until we get to public comment, that is where your testimony is appropriate. I have to limit testimony to the merits of the bill, and I am sorry to inconvenience you.

Gwen Martin, Private Citizen, Las Vegas, Nevada:
I am one of the eight original patients who was diagnosed with hepatitis C. I am speaking to you because a medical clinic decided to expose their patients to deadly diseases like hepatitis C, hepatitis B, and HIV. I am speaking to you because from the doctors and nurses, to the people charged with overseeing these practices, there was a total breakdown in patient safety. I am speaking to you because those responsible for our safety as patients turned a blind eye to the practices of medical clinics that placed the lives of its patients in jeopardy.

I am one of the 40,000 people who were subjected to the medical clinic's outrageous practices. Unfortunately, I am also one of hundreds who contracted hepatitis C because of those outrageous practices. My life and the lives of my loved ones have changed dramatically in a way that I cannot describe. I feel violated in the most personal way. I trusted my health care providers and those who work for them to ensure my health, safety, and life. I went in for an endoscopic procedure and left with hepatitis C. This should not happen anywhere, especially in the United States of America. Our health care system broke down.

While I applaud the agencies that exposed the clinic's practices, and I applaud the committee members for looking into these practices and proposing laws to try and prevent future outbreaks, I caution you to remember that this is a story impacting real people, and that this is about responsibility and accountability. I trust you all will take whatever just steps are necessary and appropriate to do your best to make sure that this never happens again to anyone. The entities charged with running and supporting our health care system, from doctors to drug companies to HMOs, take on a special responsibility. That responsibility is to further the best interests of the patient, and make them better, not worse. In Las Vegas, many people neglected their responsibilities, and 40,000 people were exposed to hepatitis C, hepatitis B, and HIV. I did not even understand what hepatitis C was before this happened; unfortunately I do now. It is a devastating virus that attacks the liver and is life threatening. There is only one treatment, Interferon, which has horrific and debilitating side-effects, and the treatment often does not work. I cannot express the utter fear when thinking of what will happen to those of us with hepatitis C if this treatment does not work. Having hepatitis C has forever changed my life. It is a disease which robs you of your energy, vitality, and health. The stigma of having a disease like hepatitis C, and having to reveal it every time you go to a new doctor or dentist, or worrying about infecting someone if you get a cut or a nosebleed, is something none of us bargained for or deserve. We all deserve to receive care and treatment with dignity and respect.

Now I found that my rights are severely limited under medical malpractice laws. I have been made a victim of our health care system twice...

Chairwoman Smith:
Ms. Martin, I will have to ask you to limit that testimony. If you want to talk about that issue, you will have to do so under public comment.

Gwen Martin:
The only way we can truly protect our health care system, and the public, is to hold those people and entities who contributed to this catastrophe accountable for what they have done. Thank you for hearing my story and for your efforts to help make a real change.

Chairwoman Smith:
We appreciate you sharing your story with us. It must be very difficult, but we appreciate your courage and that you are willing to help us to make these decisions to help protect the public in the future. Is there further testimony on S.B. 70? [There was no response.] Seeing none, I will close the hearing on

S.B. 70 and open the hearing on Assembly Bill 206 and ask Mr. Whitley to come to the table.

Assembly Bill 206: Revises provisions relating to public health. (BDR 40-858)

Richard Whitley, M.S., Administrator, Health Division, Department of Health and Human Services:
I serve as the Administrator of the Health Division, and I am here to introduce a measure that was requested as a result of the 2008 hepatitis C crisis. [Read prepared testimony (Exhibit N).]

Chairwoman Smith:
It seems that this bill is the one that gets to the heart of all of the experiences the patients had. I would think that this would be a bill of great interest to everyone in trying to prevent further breakdown.

Richard Whitley:
I think this bill transitions nicely from the discussions about the previous bills regarding the infrastructure that is needed to take these actions. Although this bill has many components to it, each one is directly tied to our experience as a state agency regulating the health care facilities, and the challenges we faced in conducting the investigation, notifying patients, and taking swift and appropriate action.

Assemblywoman Leslie:
Where are we going to send the consumers if the Office for Consumer Health Assistance is gone, as it has been zeroed out in the Governor's budget. If that decision is not reversed, where would you suggest that we send the consumer complaints?

Richard Whitley:
You will probably send them to me. One of the things that we have done, in changing our practices in response to this crisis, is to actually reorganize how we handle complaints. We have restructured so that we can be timelier in getting back to consumers. I do not have a specific answer about the Office for Consumer Health Assistance other than we get referrals from them, and we likewise make referrals. If the Office for Consumer Health Assistance was to go away, we would fill that gap to the best of our ability.

Assemblywoman Leslie:
What is the advantage in having the complaints go to the Office for Consumer Health Assistance?

Marla McDade Williams, Bureau Chief, Bureau of Health Care Quality and Compliance, Carson City, Nevada:
I think one of the primary reasons that we have a high level of interaction with the Office for Consumer Health Assistance is because they deal with the billing issues. When we do our investigations, we do not deal with billing issues for consumers.

Assemblywoman Leslie:
I guess that is what I was looking for. I know the Health Division does not send the complaints, but there is a specific role for the Office for Consumer Health Assistance. I am concerned that if we get rid of that office, these issues will not be handled with the same degree that they would otherwise.

Senator Horsford:
I think that this is a very important bill. I have some technical questions, particularly regarding the medical records portion in section 20 of the bill. First, in section 20, line 42, I have a question about summarily suspend versus any other actions that you guys may take, because the threshold is different. I do have a question regarding local coordination, since the local entity had initiated the investigation previously, how would the provisions of this bill change that? On page nine, subsection 2 (a) and (b), my question there is under what conditions would the medical records be released to another entity? For example, I understand law enforcement, but another agency such as the Board of Medical Examiners? What if their goal is not the same as the goal of your agency in releasing those records? Finally, could you talk about what specific capabilities or special training the Health Division will undertake to be able to secure and maintain these medical records in the event that they need to do that?

Chairwoman Smith:
Perhaps, Mr. Labus or Dr. Sands, you can answer these questions?

Brian Labus, Senior Epidemiologist, Southern Nevada Health District, Las Vegas, Nevada:
This portion of the bill actually refers to what the Health Division is doing, so I cannot answer most of those questions, and some questions may be better answered by Dr. Sands. What I can say is that this is a little different from what we dealt with in the endoscopy center. The issue around medical records

in the endoscopy center had to do with records that were taken by law enforcement as part of a criminal investigation. I believe the intent of this section is to provide provisions that ensure we are making those records available to people. That is my understanding of the intent of the bill, but I will have to defer to the Health Division.

Chairwoman Smith:
Just to clarify, the reason I asked you and Dr. Sands to comment was because the discussion we had in our last committee meeting was really about the frustration of not having adequate access to records so you could properly notify those patients, and the records being incomplete. That was why I thought you might just talk about the experience that you had and how difficult it made that process.

Brian Labus:
That is really a separate issue than what we are talking about here. Our ability to get information from the records is one thing related to our investigation. In this case, the purpose of this language is to make sure that we do not have the situation where somebody has the records locked up and the patients cannot get to their records. It is not an issue for me, as an agency, trying to get those records for an investigation, but it would be an issue for the patients of that clinic if some agency has closed the clinic, and the patients do not have access to those records. My experiences with incorrect information and incomplete records, et cetera, is really very different from the intent of this section of the bill.

Marla McDade Williams:
In terms of actually assuming control of the medical records, the provisions are specific to those facilities we regulate. The bill is broader in granting the local health authorities certain power to shut down a practice or a facility that is not currently licensed by the Health Division. From our perspective, what we would do is contract with a medical records company. We would close the facility and then bring that company in to actually control the records so that the records are out of the control of the facility owners and operators, are under the official control of the Health Division through its contractor, and available to anyone who needs to access the records. There would be mechanisms in place for the company to know where the records are.

Senator Horsford:
On that specific point, though, if the first standard is to maintain confidentiality, then there has to be some conditions. I understand the centralizing of the records, but there would have to be standards by which those records would be

made available, and I need to understand better how that process would work. Is the language in this bill adequate enough? First and foremost is to protect the confidentiality of those records. Secondly, what are the conditions by which the records are released? Also, please address the issue of suspending the license of a medical facility because that is the first step that would allow you to be able to take the medical records. There was a lot of dispute, and still is, around the standard for suspension of a license.

Marla McDade Williams:
When we make a decision to suspend a license, it is because an immediate action needs to be taken. We would suspend the license and use the window that is provided in this bill to get a hearing to determine whether or not that suspension is going to be permanent and their license revoked. The standard for confidentiality of the medical records falls back to existing statutes, and that the existing authorities are within existing law for someone to access those records.

Senator Nolan:
Is the threshold for the closure of a facility—which I assume is a significant event, since you are displacing workers and potentially destroying the practice of a medical operation—a probable cause situation?

Richard Whitley:
The threat is if a situation is an immediate jeopardy to a consumer in the facility. To actually issue the "cease and desist" would be systemic. When we inspect a facility and we identify an issue while we are there, the facility is made to correct the issue while we are there. If they do not, that is when we would take the action to "cease and desist" the operation of the facility and suspend their license which would initiate the process of taking control of the medical records.

Senator Nolan:
With regards to the medical records, in the medical world you have the Health Insurance Portability and Accountability Act (HIPAA) which protects the identity of a patient and their medical records. However, when you go into a criminal investigation, you have to turn those records over to the District Attorney's Office. I do not know if the HIPAA laws apply to those records that have been released for a potentially criminal investigation. My concern is that perhaps a box of records that is turned over may be from a clinic that deals with HIV infected patients, which will be scrutinized by the District Attorney's Office, and who knows where those end up. I respect your answer

that this issue falls within the current statutes, but I would feel more comfortable if we knew what those statutes were.

Assemblywoman Mastroluca:
Section 17, subsection 1, paragraph (a) says "a written order directing the provider of health care...to cease and desist...", which is something you have discussed. Paragraph (b) says "take any other action to reduce or eliminate the harm to the health, safety, or welfare of the public." Can you give me an example of what that would be and how it would be different from a "cease and desist" order?

Richard Whitley:
That could include notification of patients or to take any action on issues we might find while we are in the facility. I think the hepatitis C transmission is the issue we are most familiar with, but we were trying to be broad in terms of thinking of other issues that could occur where we would need to have more authority. For many of these items, such as the medical records, I think we are going to need to go to the Board of Health and develop regulations to spell out more of the details. What we did not have was the authority to take action previously. Although much of this language is broad, including the provision that you just spoke of, I think that what we need to do is spell out in more detail, with regulations, how to go about implementing this. What we were seeking was the authority to take action.

Assemblywoman Mastroluca:
I am very concerned about the breadth of that. I would really like to see some scenarios or examples of what would go beyond a "cease and desist" that you would want the authority to do.

Marla McDade Williams:
This section is the one that grants authority to local health authorities that previously did not have specific authority to stop a practice. For example, if a physician office is currently not licensed by anyone in the state other than their local business license, the local health authority would have the power, under this section, to take action in addition to any Health Division action. That is how I understand this section of the bill. So "take any other action" would mean they could pull the practice's business license or the health authority could work with the Board of Medical Examiners to accelerate stopping that practice.

Chairwoman Smith:
I would ask legal staff to respond because of the broad nature of this section. Although the Health Division can always set regulations, would it be appropriate to specify that they set regulations that would go through a public process because it is so new and broad?

Kristin Roberts, Committee Legal Counsel:
We can certainly do anything that the Committee would like us to do in that regard. If you want to add a provision specific to this section about the adoption of regulations, we can do that.

Chairwoman Smith:
I just was not sure if it is common or if it makes sense, since they already have the authority, that we would actually need to put this in another statute.

Kristin Roberts:
It is not uncommon, so we can do it. If you want to set parameters on those regulations, we can also do that in the language.

Assemblyman Hambrick:
As we look at this, I see that we are dealing with two issues. One is absolutely a health care issue, but as we start looking at the practicality of the situation, we are also dealing with a legal issue with criminality. Both the Clark County District Attorney and the federal authorities are looking at two separate issues inside the same problem. The federal authorities are looking at the billing issues. We should try to separate that issue because both the county and the federal authorities can deal with the billing issue. The health care issue is where we can bring in HIPAA, and there are methods and manners in which to deal with that. I think it would be easier to try and separate the purely health care aspects that we are looking at, from the purely legal or criminal aspects of the situation. They are both unspeakably horrible, but they are going down different tracks.

Chairwoman Smith:
I would ask staff to address Senator Nolan's and Assemblyman Hambrick's questions and perhaps give us some information regarding the HIPAA provision. Since those medical records go into places that do not normally have HIPAA authorization, we need to find out what the responsibilities of those various offices are regarding HIPAA.

Senator Wiener:
The Senate Committee on Judiciary is currently processing legislation regarding dual sovereignty. We are going to take a look at that as well because one may preclude the other. We are looking at a bill right now that deals with federal to local jurisdictions.

Senator Washington:
I do have a question regarding the change in administrations at the federal level. The federal stimulus legislation requires all medical records to become electronic records (e-records). What cause and effect is that going to have on this piece of legislation that we are considering as we move to this e-record era?

Richard Whitley:
When we originally tried to address this issue in our bill, we were responding to the paper records that were taken by law enforcement. Patients were having difficulty accessing their records and we saw that as a role that the agency that regulates health facilities could be involved in. I think if medical records do all become electronic, that changes the need for this. I do not know how that will be implemented until that stimulus package rolls out, and we see the impact that it has on the electronic medical records.

Senator Washington:
This is not out of the norm. The UnitedHealthCare has made efforts to move towards e-records. We passed a bill last session regarding the HIPAA standards and the transporting of these records. I do not know if your department has addressed that issue, but it would be nice if you could report back to the Committee and give us your foresight regarding how you might address this issue.

Regarding the Centers for Medicare and Medicaid Services (CMS), I imagine that a lot of these patients were on Medicaid. Has CMS weighed in on this particular legislation that we are considering now?

Richard Whitley:
The CMS has not changed the priority of inspecting ambulatory surgery centers since the crisis, but they have not weighed in on the proposed bill either, and they continue to have a contract with the state to inspect facilities.

Senator Washington:
I understand where they are regarding inspections. I am concerned more about confiscation and the security of medical records. Some of these patients are on Medicaid and we do not want to get caught in between CMS and the state in

trying to secure these records and procure them for investigation purposes. It might be to our advantage to at least check in and see where CMS is regarding the confiscation of medical records.

Richard Whitley:
I think in addressing both of your questions, it was our intent that what we would do if this bill passed is to work through the Purchasing Division and make a request for information. We know from what happened with the endoscopy center and the patient charts that there were several companies that came forward saying that in a crisis or in an emergency they come in and take over medical records. What we would do, which we have done as fairly common practice in state government, is work through the Purchasing Division and put out a request for information, to find out what vendors out there are available to us. We certainly can control that request for information by assuring that they comply with all of the HIPAA and CMS regulations.

Senator Washington:
I appreciate that. I am just concerned with CMS's regulations, not so much the vendor.

Marla McDade Williams:
The action of CMS against a facility is often to terminate their Medicare participation. The investigations of any criminal activity, such as Medicare fraud and Medicaid fraud, go through the Office of the Inspector General, and in Nevada, through the Attorney General's Medicaid Fraud Unit. At least in that respect I do not think this bill is changing how the Attorney General would have access to those records, and CMS's prerogative is not to shut down the facility, it is to terminate their Medicare participation so that the facility cannot bill Medicare or Medicaid.

Senator Washington:
Section 21 of the bill deals with imposing sanctions of $1,000 and not more than $10,000 for each patient who is harmed or at risk in these medical facilities. I am curious if we are treading into an area that deals with medical malpractice. I know there is some legislation being considered that repeals tort reform, and I am just curious if the insurance industry has weighed in on this particular section of the bill because there could be a potential conflict.

Kristin Roberts:
I do not feel comfortable responding to that right now. I will have to look into that.

Chairwoman Smith:
This is similar to one of the bills that we talked about earlier, whether this type of fee assessed on a violation is similar to other fees in other statutes, and therefore would be more common practice and not something that is directly related to malpractice. We will get an opinion on that.

Senator Washington:
Section 24 of the bill refers to the Director of the Office for Consumer Health Assistance. There are some patients who have contacted my office who have said that the process is slow and cumbersome as far as who to report problems to, or how to obtain information after contracting hepatitis C. Are you going to have procedures in place that are simplified so patients who have contracted hepatitis C from one of these ambulatory surgery centers may move through the process expeditiously and quickly to get results?

Richard Whitley:
On the issue related to the disease investigation, I would defer to the Southern Nevada Health District.

Lawrence Sands, D.O., M.P.H., Chief Health Officer, Southern Nevada Health District, Las Vegas, Nevada:
If Senator Washington would not mind restating the question, we can try to respond.

Senator Washington:
I received calls and emails in my office regarding the process and the procedure as far as obtaining information and direction to dealing with their contraction of hepatitis C. Some consumers have complained that the process is too long and cumbersome, so I am just wondering if in section 24 of the bill, as you develop the process and the procedures, is there going to be some way to expedite the issue so those patients are not lingering for so long?

Lawrence Sands:
If I understand correctly, you are talking about the complaint process. One of the recommendations that we came forward with during the interim was for consumers to have one interface for complaints, since the complaint process is so cumbersome and complicated, and there are different procedures depending on which professional board you go through. We wanted the consumers to have one place to go to for complaints. We thought that should be the Office for Consumer Health Assistance, at the local level, because we regularly get complaints from consumers about medical facilities, individual providers, and other areas that we have no authority to regulate. Unless the consumers bring

something forward that gives us the authority to investigate infectious disease outbreaks, we have to refer those to the appropriate regulatory agency, whether it is the Bureau of Health Care Quality and Compliance or to the appropriate licensing board. This kind of intermediary can work with consumers to navigate the system. However, for it to be successful, it has to be bi-directional. Once they put something into the system, there has to be a way for them to get something out of the system.

Assemblyman Cobb:
My understanding is that your concept for the role of the Office for Consumer Health Assistance is to take the complaint from the individual and then forward it to your division, correct?

Richard Whitley:
That is what happens now if the complaint is about a facility. The complaint is referred to us from the Office for Consumer Health Assistance.

Assemblyman Cobb:
But you are the people who actually handle the complaint?

Richard Whitley:
Yes, correct.

Assemblyman Cobb:
So if the Office for Consumer Health Assistance were not in existence, that consumer complaint is forwarded to your office, and because a level of bureaucracy is eliminated, that complaint is directly handled by your division?

Richard Whitley:
In answer to your question, I would say yes. We tried to put on our website an algorithm of how consumers could navigate the complexity of the system. So yes, most of our complaints do come directly to us.

Assemblywoman Mastroluca:
Just to clarify regarding the complaints that you receive, do you get every complaint that pertains to you or do you sometimes get complaints that need to be re-referred? Having the Office for Consumer Health Assistance ensures that the correct entities get the correct complaints, and it cuts down on the amount of people a patient has to deal with when trying to get an answer, correct?

Richard Whitley:
From an agency perspective, the more resources that are available to refer to are an asset. We have become more knowledgeable about how to respond. What I have instructed my staff to do is to answer the questions of consumers. The biggest complaint that we get about government is that it refers people a lot. With specialization and expertise, a person may need to follow several referrals before finding an agency that will actually be helpful. So, to the degree that I have been able to, we have tried to be as comprehensive as possible, regardless of what the consumer is calling for. Our authority may only be with facilities, but if we can answer a question and be one stop, then that is what we will do.

Marla McDade Williams:
We often get a situation, for example an ambulatory surgery center complaint, but it is also a complaint against a doctor or a nurse who work in that facility. What we do is take the complaint against the facility itself, and we forward the complaint to the Board of Medical Examiners, and we will forward a complaint on behalf of a consumer to the Board of Nursing. What we have more trouble doing is responding to the consumer about the status of their complaint with the Board of Medical Examiners or with the Board of Nursing. We can respond as to the status of our health facilities, but when it is referred out, it is much more difficult for us to even assist the consumer because we do not have the information regarding the status of their complaint. I think that section 24 of the bill is designed for that consumer to have some means to have someone help them navigate all those systems. Right now we can handle the health facilities side, but when it comes to status updates for those others, it is out of our realm.

Chairwoman Smith:
Other questions? [There was no response.] I do not see any. We have quite a bit of work to do between this bill, the next bill, and public comments. We will take another break.

[Committee in recess at 12:55 p.m.]

I would like to call the meeting back to order [at 1:15 p.m.]. We will now take public testimony on A.B. 206.

Lawrence Sands:
I want to thank you all for having these hearings today. All this legislation is a very important part of regaining the public trust and confidence in the health

system here in Nevada, and particularly here in southern Nevada. [Read prepared testimony (Exhibit O).

Senator Washington:
Can you talk more about the changes to section 14 of the bill that you are suggesting?

Lawrence Sands:
We are recommending expanding section 14 so that the funds collected in the sanction funds could potentially be used to defray the cost of an investigation and the response in case the facilities are not able to recoup the cost, or in case we find a situation that does not actually involve a health care provider or facility, but may be some other entity that is not addressed here specifically.

Lawrence P. Matheis, Executive Director, Nevada State Medical Association, Reno, Nevada:
We support A.B. 206. This is one of the numerous bills that really comes out of the range of the investigation by the Legislative Committee on Health Care. I think Senator Horsford's comments and Assemblywoman Leslie's comments are important in order to keep focus for both committees. At some point it is going to be necessary to make sure that all of the various bills that address the gaps that were found, or the need for clarity of authority, will not create an inadvertent problem at the end of the session. Usually we do not have this many bills to deal with one issue. Assembly Bill 206 addresses the specific problems that the Health Division identified during its work, but you may want to also consider A.B. 112, which looks at the declaration for a public health emergency and how the various agencies that have authority are able to coordinate or are required to coordinate. They are different aspects of the same issues that are being addressed here. I think one thing that we all saw during the hepatitis C outbreak was that many of our state systems were not prepared for facing that kind of emergency.

Chairwoman Smith:
I would note that we had Assembly Bill 112 on the agenda, but in the interests of time, we decided to confine the hearing to the bills that were similar in nature. I think A.B. 125 was mentioned earlier, but Assemblywoman Heidi Gansert was not able to be here to present the bill, so that is why we were unable to hear that bill today.

Bobbette Bond, representing the Health Care Services Coalition, Las Vegas, Nevada; Nevada Health Care Policy Group, North Las Vegas, Nevada
I want to support what Dr. Sands said about expanding the content of the definition of "infectious disease" to some other categories.

I would like to talk about sentinel events because both A.B. 10 and A.B. 206 reference them. The Health Care Services Coalition has been very involved in patient protection and improving health care quality, and we followed the sentinel events registry for some time. We have some concerns that new legislation is being proposed which embeds the current sentinel events content and processes. We would like to have the section in the *Nevada Revised Statutes* (NRS), which created the sentinel events registry and is referenced in this legislation, to be reviewed as part of the A.B. 206 work session. Since the legislation was created in 2002, NRS 439.835 has been difficult to implement. We feel that subsections 1, 2, and 3 have not really been successful, and so we would like to request the Committee and the stakeholders to work more effectively on sentinel events language and processes as part of the discussions. We are not sure whether the language that is proposed in A.B. 206 is going to address our concerns; we are very glad that there is effort to move the sentinel events registry to something that has some teeth in it, but we are not sure that the Board of Health is going to implement it in a way that our concerns are addressed.

James Wadhams, representing Nevada Hospital Association, Las Vegas, Nevada:
We also support this bill. We have not had a great deal of time to look at it, but I believe that some of the questions that I have heard Committee members raise deal not so much with the concept of the bill, but the detailed process. I think some of these questions really raise important issues when we are dealing with broader rights than simply the quality of health care. Now we have rights to privacy and rights to due process and we are happy to help work on those concepts.

Chairwoman Smith:
Thank you for offering to work with us to refine this legislation. I will close the hearing on A.B. 206 and open the hearing on Assembly Bill 196. The bill was sponsored by Assemblywoman Leslie and she will present the bill.

Assembly Bill 196: Revises provisions relating to the licensure of facilities for refractive surgery. (BDR 40-813)

Assemblywoman Sheila Leslie, Washoe County Assembly District No. 27:
For those of you who live in Las Vegas, I am sure that the words "Valley Eye Care" ring a bell and the name Dr. Vikas Jain may also, yet I use the word "doctor" loosely. Valley Eye Care faced several malpractice lawsuits from patients who went to the center to improve their eyesight, but are now legally blind. According to their complaints, victims charge that this doctor took part in either their pre-operative or post-operative care. These are procedures, according to the lawsuits, that only a licensed doctor should perform. His license was permanently revoked by the Ohio Medical Board in November 2005. The finding was that he damaged more than 20 patients there. Dr. Jain was also the subject of an ABC News Primetime special on negligent eye care. The lawsuits also allege that surgeon Dr. Stella Chou allowed Dr. Jain to do pre-operative tests, while knowing that he was not licensed to perform them. In late October 2008, after months of investigations, the Health Division took action and ordered Valley Eye Care to stop LASIK surgeries because they were an unlicensed facility. The Health Division found that they performed nothing but LASIK procedures, and therefore according to statute, Valley Eye Care needed to be licensed as a refractive laser surgery center. The Attorney General's Office, the Nevada Board of Medical Examiners, and the Nevada Optometry Board also conducted investigations. In November 2008, the Nevada Attorney General, on behalf of the Board of Medical Examiners, filed for restraining orders and injunctions against the physicians associated with Valley Eye Care and an injunction against the practice of medicine at the facility.

So A.B. 196 is really designed to zero in on a very specific problem. We have had a lot of testimony this morning about system-wide problems regarding licensing and regulation, and this bill is really focusing on these "eye mills" where they are doing a lot of laser eye surgery, but they are not licensed. Assembly Bill 196 has four basic concepts, and you have a full explanation of the bill at your desks (Exhibit P). The first is to ensure that all surgical treatments for refractive errors of the eye are performed by a licensed ophthalmologist. The bill defines pre- and post-operative care. It ensures that the surgeon is available for post-operative care or has arranged for coverage for said care by another ophthalmologist. Finally, it gives the Health Division the ability to issue a "cease and desist" order when they believe that a facility for refractive laser surgery is operating without a license, and it gives a court the authority to impose a civil penalty of up to $10,000 for the first offense and between $10,000 and $20,000 for the second offense.

The bill codifies into law an exemption for ophthalmologists who provide surgical services in addition to procedures to treat refractive errors of the eye, and it requires these ophthalmologists to file an affidavit with the state attesting that they provide these additional surgical procedures. Some people have said that it looks like a loophole, but remember that all this is in existing regulation; we are just now putting it into statute. The purpose of the bill is to target doctors who come into our state, for example, on a Thursday night, perform the surgery on Friday, and then they leave. If there is a problem, they leave the patient behind with that problem and no where to go to get help. That is the basic concept behind the bill.

Richard Whitley, Administrator, Health Division, Department of Health and Human Services:
I would just add that normally, to address a problem, we need to have a broad focus. In contrast, this has a narrow focus because we know what the problem is. This proposed legislation does not overregulate, and it also helps the Health Division in clarifying our role and giving us clear authority.

Chairwoman Smith:
This bill is the direct result of a case when a doctor flew into Nevada, performed the surgery, and flew out. The patient had an emergency and did not have a doctor available, and then the doctor who was contacted was afraid to take the case because he had not treated the patient. If I remember correctly, that is how it all started, and the pre- and post-operative care is a very important piece of this legislation because somebody has to be responsible for the patient.

Assemblywoman Mastroluca:
The bill mentions the surgical center being licensed. If the surgical center is licensed and the surgeon is licensed, the same situation can still occur where the surgeon can fly in on Thursday, fly out on Friday, and over the weekend, there is no care. Where is the provision that ensures that someone is in charge of that care?

Richard Whitley:
If you look at section 6 of the bill, it identifies the types of procedures that facilities perform under the definition of "surgical treatment for a refractive error of the eye." You are correct about the licensure of the ophthalmologist and the facility, but the language in this bill strengthens that by addressing the business component, as well. If you do more than one type of procedure, you are required to have more oversight. That is based on what we experienced and observed with the facility here in Las Vegas. Currently we only have two facilities licensed to provide these services under the existing statute. It affects

a narrow group, but when harm is done, it affects a great number of people. The way it is written addresses that issue by singling out facilities that only perform one type of procedure. What we found is that people would set up a shop and only perform one type of procedure. We also found that many of these facilities would advertise that they perform several procedures, but were in fact not providing them. There is also the piece about the post-operative care. We probably should not have to say "follow manufacturer's directions" or "provide post-operative care" but this, again, responds to a real issue that was experienced, so that detail is in here to address what the actual experience was.

Assemblywoman Mastroluca:
I am looking at section 7 of the bill. There really is not a licensing procedure specifically for a refractive surgery center? Is that somewhere else in the bill and I am not seeing it?

Marla McDade Williams:
Nevada law currently contains provisions for a refractive center for surgery to be licensed. However if you are an ophthalmologist, and you have a comprehensive practice in addition to doing LASIK surgery, you do not have to be licensed as a medical facility, as a refractive surgery center, or as an ambulatory surgery center. That is existing law. What this bill does is add pre-operative and post-operative care to the existing law to ensure that there are standards in place. Does that make sense?

Assemblywoman Mastroluca:
That makes sense. Now a bigger question is, if I am an ophthalmologist and I buy a laser that I found on sale on eBay, I can start doing surgery because I do not have to be licensed due to the fact that I am an ophthalmologist?

Marla McDade Williams:
That is the point that this bill is addressing. If you have a center for refractive surgery, you still are required to be licensed. There is no longer the argument that just because you are a licensed ophthalmologist, you can escape licensure.

Assemblyman Hambrick:
When I first moved to this state a number of years ago, I was surprised that an individual graduating from medical school and getting a medical license could be an ophthalmologist on Monday and be a proctologist on Friday. They can do basically anything they want to once they have their medical license. Regarding the issuance of licenses for particular clinics, whether it is ophthalmology or LASIK surgery, is there a way that we can put into law that these licensees for these businesses have to be board certified? Rather than just calling them

ophthalmologists, we could call them board certified ophthalmologists. It may give a little more protection to patients. I would hate to have to go through a brain surgery, only to have foot surgery from the same doctor three days later. It would be nice to have some board certification language in some of these statutes.

Chairwoman Smith:
I suppose that is a bigger issue, and it is also one that is taken up in the licensing bills that are related to these issues.

Kristin Roberts:
I think that is something that we will have to look into as well.

Chairwoman Smith:
Is there anyone else to testify?

Jeanette Belz, Reno, Nevada, representing Nevada Academy of Ophthalmology, Denver, Colorado:
I was here back in 2001, when this was originally put into statute, and hopefully my testimony will help clarify a few issues.

[Read prepared testimony (Exhibit Q).]

If I could just point out section 3 of the bill to Assemblyman Hambrick, the definition of ophthalmologist here "means a physician who is qualified to perform laser surgery or intense pulsed light therapy on the globe of the eye pursuant to NRS 630.371 or 633.693." Those were added to statute last session. Hopefully that can give some comfort to Assemblyman Hambrick.

The Nevada Academy of Ophthalmology stands in favor of these safeguards that are being put forward for patients. I thank you for your time.

Lawrence P. Matheis, Executive Director, Nevada State Medical Association, Reno, Nevada:
We support this bill. The original law was to stop some horrible practices that were happening around 2000 and 2001. This bill simply updates the existing law to identify new abuses and to stop them.

Chairwoman Smith:
I do not see anyone else coming forward, so I will close the hearing on A.B. 196. That brings us to public comment. Please come forward if you have comments.

Darla Leibel-Burrow, Executive Director, Nevada Hepatitis C Task Force, Reno, Nevada:
I do not want anyone to forget the patients who are involved, as you consider these bills. We are living, breathing examples of the patients. For how long we will be living and breathing, we do not know. What concerns me about these bills is that we have not been clear on who is supposed to monitor these facilities and how often. If we are only going to examine these clinics on a five-year basis, that leaves a wide open area for infractions to happen, with no one monitoring. I am in favor of Mr. Whitley's bill because it is trying to handle a situation that happened recently. Please do not forget the patients; the patients are who we are here to protect.

Chairwoman Smith:
I just want to comment that the five-year discussion was about the dental offices, and I would imagine that we will be revisiting all of those bills to see if we can get some similarity.

John Stolebarger, representing the Nevada Hepatitis C Task Force, Reno, Nevada:
I agree with everything the Committee is trying to do. I have a letter that I would like to read to you from an 11-year-old girl. Her name is Brittany Parham and she is from Chester, Virginia. [Read letter (Exhibit R).] I got to meet her last year. In addition, I had the opportunity to go to Kentucky to visit seven people who have hepatitis C. Five of those people got their hepatitis C from medical practices. On a personal note, the lady who helped get me started in advocacy passed away this morning. Thank you.

Sandy Curl, Director, Nevada Hepatitis C Task Force, Carson City, Nevada:
I have run a support group for people with hepatitis C for the last six years. The hardest part of my job is when people call me who have been diagnosed with this disease and ask me how they can get help. Even with everything that is in these bills, we need more help. We need to give people a place to go to get treatment. Some people cannot get onto Medicaid. The hardest part for me is having to refer people to the health department. With all the budget cuts that we are seeing, we need to look at this disease in a different light. [Presented (Exhibit S).] We would like to see people who are diagnosed with hepatitis C have access to early treatment and be able to get onto Medicaid, even if just for

the time that they need treatment. The pharmaceutical companies will donate the drugs, but we need the doctors and the help from everyone to overcome this epidemic in our state.

Michael Ciccolo, M.D., Private Citizen, Las Vegas, Nevada:
I would like to apologize to the Senators who have already heard my presentation and will have to hear it again, but I appreciate the opportunity to speak to the Assembly members. [Read prepared testimony (Exhibit T).]

Kelly Kogut, M.D., Private Citizen, Las Vegas, Nevada:
I wear many hats as a board certified general surgeon and pediatric surgeon, small business owner, wife and mother, and a member of the Las Vegas community. [Read prepared testimony (Exhibit U).]

Chairwoman Smith:
I appreciate you sharing your story with us. I can assure you that our joint money committees are doing everything in our power to try to make things better and do what is right in this state so that we can provide the best care as possible to our citizens. Is there anyone else who would like to provide comment during this public comment period? [There was no response.] I will close public comment.

I want to thank you all for your endurance and attention. I want to thank all of our staff for doing everything to get us ready for this meeting, and I want to thank the Las Vegas staff. I especially want to thank the public for your input. When we scheduled this meeting we thought we would have many more people, but I am really an optimist, and I would like to think that the reason we did not have more in attendance is because the Interim Committee did such great work making opportunities available to the public and so carefully drafting legislation to address those concerns. I think because of that, the public was not here in huge numbers. I want to make sure that the Committee knows that we personally notified over 500 people of this hearing today; people who had followed this issue throughout the interim. We hope that the bills we are working on will answer the concerns of those 500, and the other 59,500 or more, who were affected by this.

Senator Wiener:
On behalf of the Senate Committee on Health and Education, I want to express our appreciation for inviting us to meet jointly and allowing us to participate with a piece of our legislation as well. I appreciate the participation of not only those of us who are elected to serve, but also those who have come here today because of the impact of the issues we discussed today. This is a profound

issue that has affected so many people, many of whom we will never meet, but certainly many will be impacted by the work we are doing today. I am so thrilled to be a listener and to observe the extraordinary commitment we have, and thrilled to know that the process will continue to move forward with those who have the energy, the intelligence, and not only the head, but the heart, to do the good work. Thank you for allowing us to participate.

Chairwoman Smith:
You are very welcome. This meeting is adjourned [at 2:17 p.m.].

RESPECTFULLY SUBMITTED:

_____
Chris Kanowitz
Committee Secretary

APPROVED BY:

_____
Assemblywoman Debbie Smith, Chair

DATE: _____

_____
Senator Valerie Wiener, Chair

DATE: _____

EXHIBITS

Committee Name: Assembly Committee on Health and Human Services/Senate Committee on Health and Education

Date: February 21, 2009 Time of Meeting: 8:16 a.m.

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance roster
A.B. 10	**C**	Amber Joiner	Outline of A.B. 10
A.B. 10	**D**	Lisa Black	Testimony
A.B. 10	**E**	Lisa Black	Patient Advocacy Activities of Registered Nurses
A.B. 10	**F**	Debra Scott	Testimony
A.B. 10	**G**	James Wadhams	Amendments
A.B. 123	**H**	Amber Joiner	Outline of A.B. 123
A.B. 123	**I**	Mary Wherry	Testimony
S.B. 70	**J**	Marsheilah Lyons	Outline of S.B. 70
S.B. 70	**K**	Andy North	Amendment
A.B. 123 & S.B. 70	**L**	Mary Wherry	Side by side comparison of A.B. 123 and S.B. 70
S.B. 70	**M**	Marla McDade Williams	Testimony
A.B. 206	**N**	Richard Whitley	Testimony
A.B. 206	**O**	Lawrence K. Sands	Testimony
A.B. 196	**P**	Amber Joiner	Outline of A.B. 196

A.B. 196	**Q**	Jeanette Belz	Testimony
	R	Brittany Parham	Letter
	S	Sandy Curl	Testimony
	T	Michael Ciccolo	Testimony
	U	Kelly Kogut	Testimony