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

Seventy-Fifth Session
February 11, 2009

The Committee on Health and Human Services was called to order by Chair Debbie Smith at 1:37 p.m. on Wednesday, February 11, 2009, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4406 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/75th2009/committees/. In addition, copies of the audio record may be purchased through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

COMMITTEE MEMBERS PRESENT:

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

GUEST LEGISLATORS PRESENT:

Assemblyman John Oceguera, Clark County Assembly District No.16

STAFF MEMBERS PRESENT:

Brenda Erdoes, Legislative Counsel
Amber Joiner, Committee Policy Analyst

Darlene Rubin, Committee Secretary
Chris Kanowitz, Committee Secretary
Olivia Lloyd, Committee Assistant

OTHERS PRESENT:

Tami M. Chartraw, MBA, Manager, Nevada State Immunization Program, Department of Health and Human Services
Pam Forest, M.D., Health Program Specialist, Nevada State Immunization Program, Department of Health and Human Services
Cari Rovig, MBA, Statewide Executive Director, Nevada Immunization Coalition, Reno, Nevada
Erin McMullen, representing Regional Emergency Medical Services Authority, Las Vegas, Nevada
Les Lee Shell, Administrator, Departmental Administrative Services, Clark County, Las Vegas, Nevada
Jason Meilleur, Special Operations Manager, American Medical Response, Las Vegas, Nevada
Melissa Stephenson, Infection Control Nurse, Clark County Fire Department, Las Vegas, Nevada
Rusty McAllister, President, Professional Fire Fighters of Nevada, Las Vegas, Nevada
David F. Kallas, Director of Government Affairs, representing Las Vegas Police Protective Association and the Southern Nevada Conference of Police and Sheriffs, Las Vegas, Nevada
Bill Welch, President, Nevada Hospital Association, Reno, Nevada
Graham Galloway, representing Nevada Justice Association, Reno, Nevada

Chairwoman Smith:
[Roll called.] Our first item is a presentation regarding immunization practices in Nevada and following that we will open the hearing on Assembly Bill 16.

Tami M. Chartraw, MBA, Manager, Nevada State Immunization Program, Department of Health and Human Services:
I would like to note that we provided an immunization update to your colleagues in the Senate Health and Education Committee on February 4, 2009.

I would like to open with an overview of the Nevada State Immunization Program. It will consist of four primary areas of focus: The Immunization Program overview, immunization rates and vaccine-preventable disease, vaccine finance and the Vaccines for Children (VFC) Program transition, and strategies for improving immunization coverage rates. You may refer to certain graphs

and documents in your presentation booklets (Exhibit C). I will give you the document page number that I am referencing as you go through the presentation.

Tab 1, Immunization Program Overview: The Immunization Program in Nevada has administered the Vaccines for Children program (VFC) since its inception in 1994. The VFC program is a federal entitlement to provide free vaccines for children who meet the following eligibility criteria as of January 1, 2009. They must be Medicaid-eligible, or Alaskan Native or American Indian, uninsured, or under-insured when receiving vaccines in a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC). In addition, children enrolled in Nevada Check Up are also eligible for state-supplied vaccinations. The Immunization Program is also responsible for the following program components: adolescent and adult immunizations, education, information, training and partnerships, epidemiology and surveillance, immunization information systems, perinatal Hepatitis B prevention, population assessment, provider quality assurance, and vaccine accountability and management.

I would like to highlight a critical part of the strategy to increase Nevada's childhood immunization coverage rates: Nevada WebIZ. WebIZ is the State's confidential population-based immunization registry. Registries are proven to improve the quality of health care for children by providing critical tools to insure that all children receive the required immunizations at the right time. As passed into law in the 2007 Legislative Session, Nevada immunization providers must report vaccines administered to the Immunization Registry beginning in July 1, 2009.

I would like to thank this Committee specifically for its efforts in 2007 in passing Assembly Bill 410 of the 74th Legislative Session, and especially to Assemblywoman Leslie for her vision and support of our statewide registry, WebIZ. Since the time that A.B. 410 of the 74th Legislative Session was passed, we have increased the number of providers and clinics in the registry to 541, the number of users to over 2,000, and the number of records in the registry to 1.3 million. In 2008, we trained 774 new users, and just during the month of January we added another 100. I draw your attention to the WebIZ newsletter on the back of Tab 1, on pages 3-6.

Next I will describe immunization coverage rates and the information they provide. A summary of this information is contained in Tab 2, beginning on page 7.

Immunization coverage rates are a means of estimating up-to-date immunization status in a specific age group. Immunization rates identify groups at risk of

contracting vaccine preventable diseases, stimulate efforts to increase coverage rates, and evaluate the effectiveness of immunization strategies. The chart in the middle of page 7 shows the trend lines for Nevada's immunization rates as well as national rates. It is no secret that Nevada's immunization coverage rates could be improved. There are a number of factors that impact immunization rates. Please refer to the diagram on page 10 that illustrates the major factors impacting rates. For example, looking at the circle in the middle, you see the phrase "Immunization Rates." The gray circles on the inner circle describe the factors that impact those rates and the green outer circles describe those groups or entities that have influence over these factors.

In summary, Nevada does have the lowest rank nationally for children 19 to 35 months old with a 63 percent immunization coverage rate. By the time these children reach kindergarten age, however, 96 percent will be up to date on vaccinations required by statute for school entrance. We also think the rates will continue to improve for younger children as well, as new child care vaccination requirements went into effect last year. The primary factors that influence rates in Nevada are access to health care and record scattering. It should be noted that one factor not shown by research to impact rates is a state vaccine supply policy. For example, until January 2009, Nevada provided most vaccines to all children regardless of eligibility status, yet our rates remained low. To illustrate, page 11 of the booklet shows the top ten states by immunization coverage rates. The top ten states have different vaccine supply policies, but something they all appear to have in common is that they have passed mandatory vaccination coverage statutes.

The last tab in the booklet contains an overview describing vaccine-preventable disease in Nevada. Commonly held wisdom would suggest that if a state had low immunization rates, the incidence of vaccine-preventable disease would be high. That is not the case, however, in Nevada. Research indicates that while our immunization rates are low over the past few years so, too, has been the incidence of vaccine-preventable disease. I emphasize, however, that the absence or low incidence of vaccine-preventable disease does not mean that Nevadans are less at risk. Outbreaks of measles and mumps have occurred in other states, for example, in Iowa, among highly-vaccinated populations. Just because we have not experienced significant sustained increases in vaccine-preventable disease, does not mean that we should take our eye off the ball. Increasing immunization coverage rates is and will remain our top priority.

Tab 3, page 12, discusses vaccination finance. Financing for vaccines in Nevada comes primarily from three sources: the federal Vaccines for Children Program (VFC), an entitlement-based program providing free vaccines for children that meet the eligibility requirements described earlier; Section 317

funding, a discretionary source of vaccine funding that is subject to Congressional appropriation; and the State Children's Health Insurance Program (SCHIP). Children enrolled in Nevada Check Up are eligible for state-supplied vaccine funded through a combination of State General Fund and matching SCHIP funds.

On Page 13, two charts depict the section 317 and VFC funding level over the past few years. The level of 317 funding has remained fairly level over the years with a sharp increase in 2007 to fund the change in distribution methods. Although VFC funding has trended upward over the years, this merely reflects the increased number of eligible patients plus the increased cost of vaccines.

On page 14, the top chart shows the relative percentages for Nevada in terms of sources of funding. In federal Fiscal Year 2008, VFC funds accounted for 87 percent of our vaccine funding. Contrast that with the bottom chart which shows the patient eligibility category as reported by VFC providers. It is important to note that our providers reported that only 48 percent of their patients are VFC-eligible, this despite receiving 87 percent of our funding from the VFC Program. What this demonstrates is that we have been using federal funds to vaccinate privately-insured children.

Chairwoman Smith:
In the economic stimulus package that was passed today, the immunization funding had been taken out. Do you know how that came out in the conference?

Tami Chartraw:
I do not know.

Chairwoman Smith:
It was in the House version, but taken out in the Senate version.

Tami Chartraw:
That is correct.

In Tab 4, VFC Transition, there is an overview of the change in policy on page 17. Vaccine supply policy refers to the way that a state supplies state and federally-funded pediatric vaccines. As I mentioned earlier, as of January 1, 2009, Nevada changed its vaccine supply policy to what is known as VFC-only plus Nevada Check Up. This change means that privately-insured children formerly eligible for state-supplied vaccine are no longer eligible. It did not, however, change the other categories of children eligible highlighted earlier in this presentation. Why was the change in vaccine supply necessary? There

were a number of reasons that led to this decision: First, the increased number of vaccines and costs, as recommended by the Advisory Council on Immunization Practices; second, a significant decrease in the level of federal funding for vaccines; third, a growing population; and fourth, the policy decision that federal dollars should not subsidize private insurance to pay for vaccinations.

This transition in policy from that in which the state provided free vaccine to all children regardless of insurance status, to that in which only VFC-eligible and Nevada Check Up kids receive free vaccine started in May 2008, and culminated in the change effective January 1, 2009. As with any major policy shift, there have been a number of challenges along the way. Some of these are illustrated in the diagram on page 19. The challenges include financial barriers to the private purchase of vaccine by providers, vaccine reimbursement coverage rates, and parent out-of-pocket expense by those providers choosing not to bill private insurance. For historical context and more detailed information on the vaccine supply transition, please refer to the documents contained on pages 20 to 36. There you will also find a chronology of decisions in communications on the transition.

The State Immunization Program is working very hard to address many challenges but is very confident that by utilizing strategies proven to work in other areas of the country, Nevada's immunization coverage levels will continue to increase. The program is also committed to working with all of our partners to implement these strategies and to reduce the incidence of vaccine-preventable disease. Some of these strategies include: Working to identify barriers to health care access and target interventions to increase access for Nevada's children, particularly in rural areas; updating state vaccination requirements for day care, schools, and colleges to align with the American Council on Immunization Practices Guidelines; partnering with Clark County Schools and the Southern Nevada Health District, and the Centers for Disease Control (CDC), to obtain and analyze data on un-and under-immunized children in Nevada's population center; increased provider use of WebIZ so that historical data is included and record scattering is minimized; and last, as we heard from providers all over the state, promote maximization of public dollars by insuring first dollar coverage of all recommended childhood vaccines and full reimbursement to providers for the actual cost of each vaccine and their administration.

Assemblywoman Parnell:
On page 17 of the section you just covered—the VFC transition overview—in that first paragraph, do I understand correctly that if you are privately insured you cannot even get access to the VFC?

Tami Chartraw:
That is correct. The VFC is a federal entitlement program specifically for Medicaid kids and the uninsured. If you have private insurance, you have a pay source—your insurer—to pay for those vaccines.

Assemblywoman Parnell:
And those vaccines would be as readily available to those children as any other group of children?

Tami Chartraw:
Yes, assuming that the doctor, in their medical home, privately purchases those vaccines. That has been somewhat of an issue. The doctors are making a transition in order to purchase an inventory.

Assemblywoman Parnell:
Has that private insurance access been an issue in the last couple of years?

Tami Chartraw:
No. It has been an issue probably just in the last month since we made the change on January 1, 2009.

Chairwoman Smith:
Can they go to the Health Department and pay if they have private insurance?

Tami Chartraw:
Yes, they can go and pay.

Chairwoman Smith:
Is an honor system in place when they are asked if they have private insurance?

Tami Chartraw:
Yes. Providers are asked to screen for eligibility, but there is no requirement to produce income, so they do not get that documentation.

Assemblyman Hardy:
Do all insurances cover for immunizations?

Tami Chartraw:
Most cover for immunizations, but not all. We have many underinsured in the state, and I think Cari Rovig, who is speaking next, may have more data on that.

Assemblyman Hardy:
There is a difference between uninsured and underinsured; underinsured means that it is not completely covered. In one city there are hundreds of dollars worth of immunizations that the insurance will probably not cover completely. The privately insured person is still in a difficult position. I do not see the immunization rate going up.

Tami Chartraw:
If the doctor privately purchases the vaccine, they can give the vaccinations in their medical home and then just bill insurance. If the children are underinsured, we have introduced something called "delegation of authority." The facility is deputized as a Federally Qualified Health Center that enables those underinsured children to stay in their medical home. We have offered that to all of our VFC providers.

Assemblyman Hardy:
Are you saying that the underinsured, because the immunizations are not covered completely, will still be able to get the immunizations with the VFC?

Tami Chartraw:
That is correct.

Assemblyman Stewart:
I have had a significant number of email over the last six months about vaccines as a possible cause of autism. I want to be very clear that you are completely confident the vaccinations are safe. There is no safety issue in any of the vaccines?

Tami Chartraw:
That is correct.

Assemblyman Stewart:
Regarding the cervical cancer vaccination, has there been enough testing on that to make sure it is safe?

Pam Forest, M.D., Health Program Specialist, Nevada State Immunization Program, Department of Health and Human Services:
Before the human papillomavirus vaccine was released by the FDA, there were thousands of doses that were administered to females to check for its safety.

Assemblyman Stewart:
Have we done enough testing to know if it is effective?

Pam Forest:
There are two companies that produce the vaccine, and we have been reassured that it is effective for the majority of the types of viruses that cause cervical cancer.

Assemblyman Stewart:
You said that the cost of vaccinations has increased. Is that because of the new vaccinations that are now required?

Pam Forest:
That is correct.

Chairwoman Smith:
I want to go back to the private pay, underinsured issue. If I have insurance, but my plan pays only $20 for a vaccination, is my insurance billed the $20 and it complements the VFC? How does that work?

Tami Chartraw:
If your insurance partially covers the vaccine, you are not considered underinsured. Once you have met your deductible, however, you are considered underinsured. They can still bill the insurance, as would be done in a well-child visit. There is a lot of detail on "underinsured" in the presentation booklet (Exhibit C).

Chairwoman Smith:
Those are the kinds of questions that people bring up in the community.

Assemblyman Hardy:
Do we have regular pediatrician or family practice doctors who are buying the vaccine, who can testify as to their reimbursement rates, and the opportunity they have to recoup their costs?

Cari Rovig, MBA, Statewide Executive Director, Nevada Immunization Coalition Reno, Nevada:
I need to clarify that Nevada provided some vaccines to all children, so children who were insured received some vaccines from the state. However, a provider would have to bill for a number of vaccines. The majority of our insurance companies that we have been partnering with over the years are doing a good job of reimbursing. A lot of it has to do with how physicians contracted with an insurance company, and how they bill and code for vaccine. So there are some providers who have been doing very well. There are even providers who will say they are making money vaccinating kids. There are others, however, who are struggling, and we are hoping to continue working to improve that. There

are insurance companies such as St. Mary's Health Plans, United Health Care, and certain plans where we have a little more control within the State of Nevada. They also are required to report Healthcare Effectiveness Data and Information Set (HEDIS) rates, and so forth. Those plans typically reimburse fairly well. Where we struggle somewhat is for the Employment Retirement Income Security Act (ERISA) based plan or self-insured plans. Most of those kids end up being underinsured and then again are covered with VFC vaccine.

Assemblyman Hardy:
Have you seen a reduction in the numbers for providers who have vaccines for children who have private insurance?

Tami Chartraw:
As of yesterday, we are in the reenrollment process for VFC providers which happens every year in January. We have seen 21 providers out of approximately 300 leave the program. Of those 21, 16 stated that they do not see Medicaid children. There were 2 who left for other reasons. Primarily, it is because they just do not have the patient base to support getting state-supplied vaccines.

Chairwoman Smith:
Ms. Rovig, Did you have a separate presentation you would like to give?

Cari Rovig:
Yes, thank you. I will build on Ms. Chartraw's presentation, and you may refer to the handout I gave you (Exhibit D). I have more information on vaccines and vaccine-preventable diseases, as well as some information on the public-private partnership of the Immunization Coalitions and additional strategies we are working through in Nevada.

Vaccines are perhaps the greatest medical accomplishment ever. Vaccines have prevented more disease and death than any other program in history. Therefore, ensuring the timely immunization of our children is paramount not only to our children but to our communities as a whole. Although we do not see the disease outbreaks of years past in our communities, no disease is more than a plane ride away. Polio still exists in Africa, diphtheria in the former Soviet Union, and even in the United States, the viruses and bacteria that cause diseases like whooping cough are still circulating, and we have seen outbreaks across our nation.

In Nevada we have visitors coming by the thousands, probably millions. They come from across the nation and around the world to vacation, gamble, and ski.

Even though our disease rates are low, an outbreak is merely a plane flight away from us. We are not letting our guard down.

The cost-benefit analysis by the CDC shows that every dollar spent on immunization saves $6.30 in direct medical costs; an aggregate savings of approximately $10.5 billion. There are also indirect costs to society—missed work, death, disability—and for every dollar spent on immunization in that regard it saves approximately $18.40; an aggregate savings of $42 billion. The cost analysis shows there is a huge benefit in prevention through immunization in addition to reducing disease and death.

Some data hits closer to home. There are mothers like me who have lost children to preventable diseases like whooping cough and meningitis right here in the United States. No child should have to suffer from one of these diseases simply because they were not immunized on time. We have the impetus to immunize all children on time.

Nevada has ranked lower in the nation due to a number of complex factors. However, it does not mean that in Nevada we are doing a poor job. On the contrary, we have doctors that are very dedicated to vaccinations, we have a proactive State Immunization Program, as well as our public health districts, and partners throughout the state all dedicated to preventing vaccine-preventable diseases. Contained in your materials is information on the Immunization Coalitions in Nevada. We are a diverse public-private partnership of individuals and organizations all committed to improving and protecting the health of Nevadans. The Immunization Coalitions could be called the state's "link to the community" because we not only work with the community—doctors, organizations, parents—we also mobilize the community. What is truly most amazing is how we have mobilized major competitors throughout our state to work together: major health systems, vaccine companies, and insurance companies partnering with us; all have come together to work on this issue.

Additionally, we are trying to get the word out to parents through community education. One of our products is our "Protect and Immunize Nevada's Kids" (PINK) Program. It is a portfolio that goes out to every single birthing hospital in Nevada, so we reach 40,000 families having babies in Nevada every year to promote immunizations, infant safety, and health. We give them a place to keep the baby's immunization record, birth certificate, et cetera. That is free to all parents and unique to Nevada.

We work to increase access; we have a lot of partners who have come together and go into the school districts to give on-site vaccinations. For healthcare providers, the world of vaccinations changes weekly. There were many new

vaccinations in the past few years, which have increased the costs, mostly related to preteens; such as the tetanus, diphtheria and pertussis (Tdap) vaccine, human papillomavirus (HPV), and the meningitis vaccine. We provide education on vaccinations, on the giving of vaccines, and strategies to improve patient care. Some pediatric practices have been very successful with the insurance companies. The insurance companies are working with providers in the community to teach them how to contract better with insurance companies, and appropriately bill and code to insure they are being reimbursed for these vaccines. We have also brought in some purchasing groups across the nation for our providers.

We advocate for pro-immunization issues, and all of the partners I have mentioned work together to keep Nevada's daycare, school, and college vaccine requirements up to date. Nevada is one of the lead states to implement the seventh grade Tdap mandate. There are many great things going on, and it is not for lack of effort that the CDC has a lower ranking for our childhood rates.

How you can help as leaders: The key is to support funding for community outreach and education on vaccinations, and work to increase the number of doctors in Nevada. We are one of the fastest growing states in the nation and sometimes our infrastructure does not keep up. Finally, you can help by supporting immunization access not only for children's vaccines, but for teen and adult vaccines as well.

Assemblywoman Mastroluca:
Regarding the Nevada WebIZ, is the registry limited to children who receive their vaccines through VFC, or is it for every child in Nevada? It would be a great thing if it was for every child because, as a parent, I am always struggling to find vaccination records.

Tami Chartraw:
Yes, it is for every child, and for every person in the State of Nevada, but it is mandated as of July 2009 for every child. Therefore, every vaccination administered after that date must be reported to the registry.

Assemblywoman Mastroluca:
Is that something the school district will have access to?

Tami Chartraw:
Absolutely, currently many do have that access.

Assemblywoman Parnell:
What has been the success with the meningitis vaccine that our university students were encouraged to get? Also, how is it being promoted?

Tami Chartraw:
I do not have those numbers, but I would be glad to find out for you.

Assemblywoman Parnell:
We tried a number of years ago to list that vaccine as an admission requirement, and I believe we succeeded in a previous legislative session, so I would like to see how that is moving along. It is a frightening disease for college students across this country.

Cari Rovig:
That actually was implemented by the Board of Health. We would like to see it include preteens as well because that is where it is truly recommended. Currently, it is only required for freshmen students living in the dorms, so there was some specific wording to that requirement. The coalitions are working with the colleges to promote the vaccinations. We have information about meningitis, HPV, and tetanus that is sent home at the high school level. We had a community collaboration meeting yesterday to look at how we can improve informing the community.

Assemblyman Stewart:
All of this bad news is depressing, but I am cheered up by the Tdap information. How does Nevada rate in disseminating that information?

Cari Rovig:
Nevada was one of the lead states to implement that mandate. I do not know what our Tdap rates are.

Assemblyman Stewart:
We go from 63 percent to 95 percent in kindergarten, is that correct? So we still have about 5 percent who are not vaccinated. Have the unvaccinated been identified; are they the homeschooled, or others?

Cari Rovig:
We do not have information on that. We have day care requirements, so most of the kids in day care can be identified as being up-to-date.

Tami Chartraw:
We are trying to gather that information. The Clark County School District Study is a kindergarten retrospective that is currently underway. We are asking, for example, are the unvaccinated children born outside the state, and what demographic areas and zip codes are they in? We are trying to fill in the gaps. In terms of our Hepatitis B vaccine Birth Dose, we are thirteenth in the nation.

Assemblywoman Leslie:
The one I want to see changed in the next two years is where Nevada is fifty-first in the nation for 2-year-olds, so I do not have to leave here feeling like a failure. Assemblywoman Mastroluca may be interested to know the reason I sponsored Assembly Bill No. 410 of the 74th Legislative Session was because my college-aged daughter needed her vaccination records. Trying to find those records by the time a child is in college is really difficult. It is nice to give new parents those packets for recording that information; however, I could not find mine. We now have a registry in the budget. We lost it during a round of the budget cuts, but now it is back. It was my understanding that a parent who needed that information could type in her secret code at the Website and be able to get a print-out. Could someone describe, if it goes through this time, what more the registry will be able to offer parents?

Tami Chartraw:
The "parent interface" is one of the things that we are looking at. However, with limited dollars, we have set a higher priority on the interface between the provider records and the system, because we have heard from many providers that dual data entry is problematic, and we really want to get those histories into the registry. We are currently doing a pilot project with Southwest Medical Associates, a large provider, to exchange records electronically through something called Health Language 7 (HL-7), a set of standards. Other states have introduced the parent interface, and that is a very important function. If we get the stimulus dollars, that would be something we would love to look at. If the Committee is interested, we had a great demonstration of WebIZ during the 74th Legislative Session, and we would be happy to provide that again.

Assemblywoman Leslie:
I doubt Nevada is actually fifty-first in the nation, but perhaps we are fortieth. We have never had a registry—we were the last state in the nation to get one. I am convinced that once we do get it going that our ranking might be better. When is the national ranking done?

Tami Chartraw:
The ranking comes out in August of every year, so we should have our new data after that. This year we are requesting in our grant a cross-match of the

National Immunization Survey to our registry to determine if our numbers are valid. By the way, the National Immunization Survey, through Centers for Disease Control (CDC), is where we get our ranking. I do not have hard data, however, I see so many records that are incomplete; families come from other states, the parents have lost the records, and so the children are revaccinated. When I address record scattering I really feel that our rates are probably higher, but the record keeping is inadequate and the registry is a good strategy to address that.

Chairwoman Smith:
You had adult immunization on your list. Does that mean adults who need to be immunized for childhood illnesses, or do adults have access to that? I am thinking of chicken pox.

Tami Chartraw:
There are adult immunizations, for example, for pneumonia and flu. There is a new vaccine for shingles for the elderly population. It would be to allow for those who did not receive vaccinations during childhood to become up-to-date.

Chairwoman Smith:
If I have not had chicken pox can I be vaccinated against that?

Tami Chartraw:
Yes.

Assemblyman Stewart:
Have you looked into the illegal population moving in and out as a source of that 4 percent?

Pam Forest:
Do you mean kindergartners?

Assemblyman Stewart:
Is it possible that people who are here illegally are afraid to be immunized because of immigration problems?

Pam Forest:
I reviewed the kindergartner records last year and found that the 4 percent who were not immunized were those children who had medical indications; they had allergies, for example, or their parents had elected to take a religious waiver.

Assemblyman Stewart:
How effective is that religious waiver; how does that work?

Pam Forest:
Each county is different. The school board determines the waiver process.

Chairwoman Smith:
That was very informative and well presented. Thank you all for being here.

We will now open the hearing on Assembly Bill 16.

Assembly Bill 16: Provides for the disclosure of certain information to an emergency response employee concerning possible exposure to an infectious disease. (BDR 40-600)

John Oceguera, Clark County Assembly District No. 16:
Assembly Bill 16 provides that if an emergency responder, such as an emergency medical technician (EMT), fire fighter, or police officer renders help to someone who is found to be carrying an infectious disease, the responder will be notified of that exposure. It is important to emphasize just how significant is the passage of this bill. Currently, doctors, nurses, and other medical personnel in hospitals enjoy those protections and notifications, but you might be surprised to learn that the notification procedures in this bill are not already in law for emergency responders. At one time, federal law provided emergency responders with protections through the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. That was a comprehensive HIV-AIDS bill passed in 1990. Since then, the act has been reauthorized several times, but during the 2006 reauthorization, provisions providing notification to emergency response personnel were removed. To reiterate, between 1990 and 2006, providing notification was the law.

According to an interview with a member of the congressional staff, when the decision was made to delete the provisions protecting emergency responders, staff basically did not understand the purpose of the emergency response provisions. They unintentionally made it more difficult for emergency responders to obtain critical information about their exposure to infectious disease. By passing A.B. 16 we will make sure that the protections are restored in Nevada.

Basically, the bill requires that employers of emergency responders designate an officer to be the point person for that employer and coordinate the communication between the emergency responders and medical facilities. There is an amendment (Exhibit E) forthcoming that states more than one person may be named. It also provides that if a victim of an emergency is transported by emergency response employees to a medical facility, and the facility determines that the victim has an airborne infectious disease, the

medical facility must notify the point person within 48 hours. It also outlines the procedure so that if the emergency responder thinks he has been exposed to a disease, he can request information about the victim to find out if he has indeed been exposed.

I think these professionals courageously face exposure to infectious diseases in their daily work and they deserve the protections that this bill provides. We are not creating any new liability here. One of the questions that came up earlier today was about Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule concerns. There is a HIPAA requirement, but there is also a countermanding CDC rule making this an exception in this case.

Chairwoman Smith:
Several states have adopted this language, is that correct?

Assemblyman Oceguera:
I believe this mimics the federal Ryan White CARE Act in Nevada legalese.

Chairwoman Smith:
But other states have been adopting this to clarify this very issue, is that correct?

Assemblyman Oceguera:
That is correct.

Assemblyman Hardy:
I think this is critical. It may explain why I was giving CPR when the EMTs were standing around one time. When I trailed the ambulance to the hospital, I asked what does he [the victim] have? It is critical for people who may need to give CPR to be able to know of any illness so they will not hesitate to give it. I support and commend you for bringing this forward.

Assemblywoman Pierce:
In section 7 of the bill, it states "airborne infectious disease," and then goes on in section 8 to mention only "infectious disease." Why is that?

Assemblyman Oceguera:
In section 7, subsection 5, it says "as used in this section, 'airborne infectious disease' means an infectious disease transmitted from person to person by an aerosol, including, without limitation, tuberculosis." Also, at the beginning of section 7, under subsection 1, it references *Nevada Revised Statutes* (NRS) 441A.195, regarding exposure to various viruses. The two chapters appear to tie in, and I certainly think that there is room there to say

"communicable disease" so that it is a little broader without broadening it too far. I would be open to some language like that.

Assemblywoman Pierce:
One part of your bill mentions obtaining a court order that has to do with specific diseases which are spelled out. Another section of your bill is about a medical facility notifying an officer about airborne disease. Then it talks about the employee requesting the officer to talk to the medical facility. It was unclear whether everything was covered in every way.

Assemblyman Oceguera:
Legal Counsel is here today, and perhaps she has an answer to that question.

Brenda Erdoes, Legislative Counsel:
The reason it is set up this way is because it is actually replacing the Ryan White CARE Act, and that is how that act was set up. But section 7 states very specifically something the hospital or the facility must communicate to the EMT if those specific diseases are there. Section 8 is a little broader and it is what the EMT can ask for if he or she determines there is an issue for him or her. But those are tests that are already done. The hospital would have determined that there was an airborne respiratory disease, or some kind of airborne disease, and they then would have a duty to let the EMT know. Under (a) it is any kind of communicable disease that the EMT is worried about, but it would still just cover tests that had already been done. The court-ordered procedure is a completely separate thing because the court then would order a test be performed. That is where the difference is.

Assemblywoman Pierce:
In section 3 of 9, does the request to any medical facility include the coroner?

Assemblyman Oceguera:
Yes.

Chairwoman Smith:
I had the same note on my bill, but when I went back and referenced the other statute, what I realized was that regardless of one saying airborne and one not saying it, the other statute refers to that list of diseases. It is the same in both sections in that regard.

Assemblyman Hardy:
Could this apply to other people who are not EMTs but people who are Good Samaritans delivering CPR? Do they have the ability to find out what they were exposed to?

Assemblyman Oceguera:
I need to defer to Legal Counsel on that one also because this bill specifically talks about responders to emergencies in this state.

Brenda Erdoes:
The answer is "sort of." Under the definition that is in section 3 it would include a volunteer attendant and it also would include anybody in the course of his professional duties. Therefore, a doctor who is in Good Samaritan mode would be included. As far as I can ascertain, that is where the "sort of" comes in. Someone like me, who is not a medical professional and not a volunteer for any program, could not make use of this; and that makes sense if you look at the whole concept because I would not have a designated person to follow through with the inquiries and the whole scheme does not work at that point.

Assemblyman Hardy:
Could I, as a physician who hears about somebody who has rescued another and is curious about what happened, become the designee of the person that I assign to be a volunteer for me?

Brenda Erdoes:
I think that would actually be a reach. Because you are trying to fit under an exception that the CDC has made to a HIPAA Privacy Rule requirement, I would be concerned about saying "yes," as much as I might want to.

Assemblyman Hardy:
I am bringing this up for a purpose. There are people who we give masks and protective equipment to when they do CPR. The person nearest to a victim needs to be the one to administer CPR. In a sudden death situation, where the first symptom is death, how do we protect that person giving CPR?

Assemblyman Denis:
I am reminded of Assembly Bill 294 of the 74th Legislative Session that I authored. It dealt with communicable diseases, and I think it included police officers and some others. If there was a death, they could petition to find out what the victim died from. How does this bill tie in to that?

Assemblyman Oceguera:
Because the coroner was not included in the language, it was becoming difficult for first responders if the person died. Some of this language came from the 73rd or 74th Legislative Session, when we added the ability to get the records from the coroner when a death occurred. One could be exposed to a communicable disease or a blood-borne pathogen at the scene of an accident for example, and the person was already deceased.

Assemblyman Hambrick:
Does HIPAA follow death? I thought HIPAA stopped at death.

Brenda Erdoes:
I would be happy to look that up for you.

Chairwoman Smith:
We have several people who have signed in to testify. Mr. Oceguera, in case you have to leave, I want to make sure you acknowledge there is an amendment. I am sure that will be presented.

Assemblyman Oceguera:
Yes. That is fine.

Erin McMullen, representing Regional Emergency Medical Services Authority, Las Vegas, Nevada:
Regional Emergency Medical Services Authority (REMSA), a nonprofit and under a county franchise, is the sole provider of emergency services transportation in Washoe County. They also provide air and ground transportation emergency services throughout rural parts of the state. We are in support of this bill.

Les Lee Shell, Administrator, Administrative Services, Clark County, Las Vegas, Nevada:
We are here in support of A.B. 16. The amendment you have is from Clark County (Exhibit E). We want to make sure that in case that first designated person for contact is not available, we would have a backup person. We get a number of calls at all hours, and we want to make sure that we have multiple people who would be able to respond to calls in a timely manner.

Chairwoman Smith:
So the amendment includes the designee or that person's designee?

Les Lee Shell:
Yes. The amended language (Exhibit E) we submitted is the person or designee. We obviously would not want to have a cadre of people who would have to be contacted. It would be the primary person with a backup.

Chairwoman Smith:
I am going to change focus to Las Vegas to hear from those individuals waiting to testify.

Jason Meilleur, Special Operations Manager, American Medical Response, Las Vegas, Nevada:

I am representing more than 700 Emergency Medical Technicians (EMT) and paramedics who are currently employed in southern Nevada by American Medical Response and our sister company MedicWest Ambulance. We are in support of A.B. 16. Such legislation is necessary to help protect the many emergency responders who face the risk of exposure to infectious disease during every patient encounter. As pointed out by Mr. Oceguera, the Ryan White CARE Act enacted in August 1990 and subsequently reauthorized three times, most recently in December 2006, provided for medical facilities to notify responders of a potential exposure. However, in the last reauthorization, the particular language allowing for notification was excluded from the legislation.

As a result, many health care facilities are now reluctant or are directly refusing to provide information to the emergency responders about a potential exposure to infectious disease. Such actions can have dire consequences as emergency responders continue their daily routine interacting with patients, coworkers, and family members, unaware that they may have been exposed to infectious disease. A.B. 16 will allow medical facilities and emergency responders to exchange information which will provide for timely notification and appropriate testing of personnel that will help mitigate a disease should an employee truly be exposed to infectious disease. This piece of legislation creates no fiscal impact on the state and therefore should be easy to enact. However, the financial and emotional impact on the emergency responders who continue with their profession and lives not knowing whether they may have been exposed to infectious disease cannot adequately be measured.

Melissa Stephenson, Infection Control Nurse, Clark County Fire Department, Las Vegas, Nevada:

We have 770 Emergency Medical Service (EMS) workers out in the field, around the clock, and there are a couple of issues to which I would like to speak. First, HIPAA does not follow a person into death. Once a person expires, the HIPAA law also expires, so that is one issue that should be cleared up regarding the coroner. However, two years ago the mandate that the coroner should be covered was an excellent move. Over the past four years, I have had difficulty trying to gather information for my very dedicated EMS staff.

Second, concerning the bystanders, situations happen other than sudden death. Dr. Hardy, I do totally support your thinking that our bystanders also need to be covered, and that is something that should be looked at in the future. For the same reason, emergency responders need to be covered. They sometimes are first at the scene at an auto accident, or even out at Red Rock when a climber falls. There have been times over the past four and one-half years that those

people have come to me trying to find out results concerning their source victim who went to one of the 13 hospitals in the valley. In terms of A.B. 16, we cannot leave the men and women in the field of emergency response uncovered. They need to find out that their source patient is clean of infectious disease and they are safe to return to their families.

Chairwoman Smith:
We will return to the witnesses in Carson City.

Rusty McAllister, President, Professional Fire Fighters of Nevada, Las Vegas, Nevada:
We are in support of A.B. 16. To address some of Assemblyman Hambrick's concerns mentioned earlier, I know that several years ago we worked on a piece of legislation that dealt with this about requesting a blood test from a deceased person. There were restrictions about requesting blood tests because a family had rights about whether or not blood could be drawn and the results made known. That was the reason we passed legislation years ago stating that if we needed to do so, we could get an expedited court order to have blood drawn and tested, even if the family refused.

Assemblyman Hardy:
Does the request for a court order include a Good Samaritan citizen who is a non-professional?

Rusty McAllister:
I do not believe it does. The Good Samaritan citizen, if he is not performing in a professional capacity, is not covered. There is no provision in law that says specifically that a Good Samaritan has the ability to request test results. Good Samaritans were also not included in the law passed several years ago that allows a request for an expedited court order.

David F. Kallas, Director of Government Affairs, representing Las Vegas Police Protective Association and the Southern Nevada Conference of Police and Sheriffs, Las Vegas, Nevada:
We are in support of A.B. 16.

Bill Welch, President, Nevada Hospital Association, Reno, Nevada:
We are in support of A.B. 16. I was the one who raised the question about HIPAA on behalf of the hospital community. I would like to get a copy of the Legal Counsel's information that Assemblyman Oceguera referred to regarding HIPAA and CDC. I think that is the reluctance the hospitals have, and as long as there is that assurance there, we support this legislation.

Chairwoman Smith:
Is there anyone else to speak in support? [None.] Anyone who wishes to speak in opposition? [None.] Anyone neutral?

Graham Galloway, representing Nevada Justice Association, Reno, Nevada:
We do support this bill, although there are a couple of issues of concern. Assemblyman Oceguera's bill is meritorious, and I do not want anything I say here today to be construed as opposition to the bill. I do think with a little fine tuning this bill would be perfect.

My first concern is in the enforcement of the bill. If for some reason someone does not comply with the mandates or requirements, what redress or recourse does the emergency responder have? The bill speaks to NRS 441A.195; and unfortunately, the language does not match up with the two provisions, with the proposed bill, or the existing statute. The proposed bill talks about airborne diseases and infectious diseases. The existing statute talks about communicable diseases and contagious diseases. The existing statute permits a responder to petition the court for testing when there has been exposure to bodily fluids and blood. The proposed legislation only talks about airborne diseases. The proposed legislation does not permit or at least does not specifically affirmatively permit an emergency responder to petition the court for testing. If you are going to provide these individuals the protection for which this legislation is designed, it should be clearer. They should have the opportunity to petition the court for testing beyond the particular diseases set forth in the existing statute. The existing statute, as I read it, permits testing only for AIDS, Hepatitis B, Hepatitis C, and tuberculosis. So if someone is exposed to Severe Acute Respiratory Syndrome (SARS), for example, they would not be able to petition the court. There is a gap in the legislation proposed and the existing statute. Expanding the language would be more beneficial to the emergency responders.

The second concern is subsection 1 of section 12 that reads "nothing in this proposed legislation should be construed as authorizing a cause of action in a civil matter." If that is put in there to say that this legislation does not authorize a new cause of action, then it would not be a concern for us. But if it is intended to eliminate or abrogate any other existing rights or recourse that emergency responders have, then it would be a problem for us.

A third concern, that was not a concern until raised by Assemblyman Hardy, is this issue of the Good Samaritan, and I hope that would be addressed in a future bill. If you are going to give the emergency responders this type of protection, a Good Samaritan ought to have that too.

Chairwoman Smith:
This sort of nudged away from the neutral area, so I am assuming that you are going to work with Assemblyman Oceguera on your concerns and try to come to some satisfactory outcomes on this bill.

Graham Galloway:
Yes, that it is correct. We have spoken, and I think we can reach an understanding and agreement. We are neutral because it is hard to say we support something when we have some concerns, but essentially this is a great bill.

Chairwoman Smith:
Thank you. I will ask all the parties who have concerns to work with Assemblyman Oceguera so we can get this bill processed. Is there anyone else who would like to speak on this bill? This is your last opportunity. [None.] We will now close the hearing on A.B. 16.

Meeting adjourned at 2:57 p.m.

RESPECTFULLY SUBMITTED:

_____
Darlene Rubin
Committee Secretary

APPROVED BY:

_____
Assemblywoman Debbie Smith, Chairwoman

DATE: _____

EXHIBITS

Committee Name: Committee on Health and Human Services

Date: February 11, 2009 Time of Meeting: 1:30 p.m.

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Sign-in Sheets
	C	Tami M. Chartraw, Manager, Nevada State Immunization Program, Department of Health and Human Services	Presentation of the Nevada State Health Division
	D	Cari Rovig, Statewide Executive Director, Northern Nevada Immunization Coalition, Reno, Nevada	Written testimony
A.B. 16	E	Les Lee Shell, Administrator, Departmental Administrative Services Administrator, Clark County, Nevada	Proposed Amendment