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

Seventy-Fifth Session
March 3, 2009

The Committee on Health and Human Services Subcommittee was called to order by Chair Joseph Hardy at 3:08 p.m. on Tuesday, March 3, 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).

SUBCOMMITTEE MEMBERS PRESENT:

Assemblyman Joseph Hardy, Chair
Assemblyman Mo Denis
Assemblywoman Ellen B. Spiegel

SUBCOMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Assemblyman Paul Aizley, Clark County Assembly District 41

STAFF MEMBERS PRESENT:

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

OTHERS PRESENT:

Jesse Wadhams, Reno, Nevada, representing West Hills Hospital, Reno, Nevada
Robin Keith, President, Nevada Rural Hospital Partners, Reno, Nevada
Michael Alonso, Reno, Nevada, representing West Hills Hospital, Reno, Nevada
Rebecca Gasca, Public Advocate, American Civil Liberties Union of Nevada, Reno, Nevada
Lesley Dickson, M.D., Nevada Psychiatric Association, Las Vegas, Nevada
Harold Cook, Ph.D., Administrator, Division of Mental Health and Developmental Services, Department of Health and Human Services
Dan Musgrove, Las Vegas, Nevada, representing West Care of Nevada, Las Vegas, Nevada
Bill Welch, President/CEO, Nevada Hospital Association, Reno, Nevada
Gary Milliken, Las Vegas, Nevada, representing American Medical Response; MedicWest Ambulance, Las Vegas, Nevada
Patricia Moore, R.N., representing University Medical Center; Service Employees International Union Nevada, Las Vegas, Nevada
Lynn P. Bigley, Esq., Nevada Disability Advocacy and Law Center, Sparks, Nevada
Mary Smith, R.N., representing Service Employees International Union Nevada, Henderson, Nevada

Chair Hardy:
[Roll called.] We are videoconferencing this to Las Vegas, and we are faxing to them one of the documents on Assembly Bill 6 that we will be considering.

Assembly Bill 6: Revises provisions governing certain emergency admissions to mental health facilities and hospitals. (BDR 39-211)

This Subcommittee has been called to further consider Assembly Bill 6, which was originally heard by the full Committee on February 25. I will start by suggesting that the reason we have this Subcommittee is to determine how we can make sure allegedly mentally ill patients get into the right facility and out of the emergency room.

With me today on the Subcommittee are Assemblyman Mo Denis and Assemblywoman Ellen Spiegel, and we welcome our colleague in the audience, Assemblyman Paul Aizley.

I will make this fairly informal. May I see a show of hands of how many have a copy of A.B. 6 and a copy of the amendment presented by the Nevada Psychiatric Association (Exhibit C)? We have had people sign in as neutral, but the good thing about this bill is that no one signed in for it, which brings us to the question of why we are here. What I would like to do is take the prerogative of the chair and come down to use the easel. We are going to have somewhat of a participatory workshop atmosphere. We are going to look at section 1 of A.B. 6.

Jesse Wadhams, Reno, Nevada, representing West Hills Hospital, Reno, Nevada:
The amendment (Exhibit C) submitted by Lesley Dickson and the Nevada Psychiatric Association dealing with section 1, we felt, was a good start.

Chair Hardy:
Jesse Wadhams is going to read it aloud for us.

Jesse Wadhams:
[Mr. Wadhams read from the amendment (Exhibit C).]

Robin Keith, President, Nevada Rural Hospital Partners, Reno, Nevada:
My issue with this amendment is in the word "admitted," because emergency room patients are not admitted, and that is who we are trying to deal with.

Chair Hardy:
Mr. Wadhams, did it say "admitted?"

Jesse Wadhams:
Yes, the language says "admitted."

Michael Alonso, Reno, Nevada, representing West Hills Hospital, Reno, Nevada:
The language we are talking about that Mr. Wadhams read was "admitted pursuant to *Nevada Revised Statutes* (NRS) 433A.160." That is the involuntary commitment. Do you have a problem with that?

Robin Keith:
As you point out, the fact that this refers to NRS 433A.160 negates the problem that I spoke of in this instance. However, we will still have to deal

with the question of how we handle these patients in hospital emergency rooms, in section 5.

Rebecca Gasca, Public Advocate, American Civil Liberties Union of Nevada, Reno, Nevada:
We have concerns about the first sentence following the amendment language proposed by Dr. Zuchowski, which would delete "the administrative officer of a facility" and only include "a licensed physician who is on the medical staff." We propose that the "administrative officer of a facility" be put back in, and in addition to a licensed physician, that a psychiatrist or psychologist on the staff of the facility be able to issue the certificates under the requirement of NRS 433A.160. In addition, we feel that it is a constitutional requirement that the word "shall" be put back in, instead of "may," as suggested by Dr. Zuchowski. Particularly because committing an individual is the essence of true deprivation of liberty, if a physician or psychologist or psychiatrist deems that person not to be a danger to himself or others, or he does not fall into the criteria for involuntary hospitalization, then, constitutionally, a hospital or psychiatric facility must release that person, so that necessitates the word "shall" instead of "may." Later on in the amendment, in addition to the staff physician, a psychiatrist or a psychologist should be the person to issue that certificate.

Jesse Wadhams:
On the issue of "shall" versus "may," we are simply setting up a situation where we are going to have two physicians—one who says the person is a clear and present danger to self and others, and one who says the person is not—and we are immediately giving more
credence to one than the other. So we are setting up an issue where there will be two doctors with opposing opinions.

Assemblywoman Spiegel:
My question comes down to the original amended language where it crossed out the "administrative officer of the facility." Why was that done, was it because the administrative officer might not have the technical expertise to make that determination, and thereby shift the liability burden? Or was there some other reason that might help me make some better sense of it?

Lesley Dickson, M.D., Nevada Psychiatric Association, Las Vegas, Nevada:
We took out "administrative officer" because that is not the way hospitals work. Doctors make decisions in emergency rooms, one does not try to find an administrative officer—and I am not even sure who that would be—to try to decide whether or not to release a patient or admit a patient, or take any kind of action with a patient. Administrators are in the background, not out in the front

end making clinical decisions. I never understood why that was put in the bill in the first place. Second, one of the things people need to remember is that psychiatrists are licensed physicians; so to say "licensed physicians or psychiatrists" is redundant. Third, we want the person to be on the staff of the facility so that they are actually operating within the bylaws of that particular facility.

Chair Hardy:
Did that address your question?

Rebecca Gasca:
I understand the concern about the "administrative officer of a facility" and appreciate the explanation put forward. The concerns largely stem from the acute medical reasons that would be put forward to determine that an individual is not a threat to themselves. If that language will not be added back in, then I still have concerns that if the psychologist is determining that a person is not posing a threat to themselves, they should still be able to file that same certificate. The doctor did not touch on that. As to the comment about the conflicting doctors' certificates that would be filed as to whether or not the patient was a threat, there would need to be additional language crafted in this bill to address that. The true deprivation of liberty is holding an individual, and if a doctor says that the individual does not need to be held, then that is plainly unconstitutional.

Michael Alonso:
I guess the issue, getting back to "shall" and "may," as we discussed in the full meeting before the Committee, is that you would hope that physicians and caregivers, would be having a discussion in the best interests of the patient to try to get the issue resolved, and when you make things mandatory, or you have the certificate language be the concern that we have as the hospital, you get caught in the middle. I still think the majority of these get resolved by the clinicians who have a discussion, and hopefully that what is done is in the best interests of the patient. When you put the language "shall" in there, we still have the issue of liability. We are being put in a position where we are moving someone out who, a professional tells us, is still a danger to himself or others. If everyone agrees, we do not have an issue, because at that point we cannot hold them anymore. So the issue is, if they do not agree, and that circumstance can arise the way this is written, then we do have an issue, and to whom do we listen to at that point? If we listen to the physician who says the patient is a clear and present danger to themselves or others, the American Civil Liberties Union (ACLU) wants to come in and file a lawsuit against us. If we listen to the other person, then Bill Bradley and the Nevada Trial Lawyers Association will be filing a lawsuit against us.

That is the issue, and I believe that "may" works because at the end of the day, one wants physicians or others who have an expertise in this area making a decision that is in the best interests of the patient.

Chair Hardy:
Hospitals have physicians on staff, but I do not know that psychologists are "on staff" to admit or discharge from the hospital. At West Hills that may exist. But the actual physician who holds the liability insurance is the one with the power of the pen to discharge or to admit. So the physician is the one that makes the determination, not the administrative officer, not the psychologist, not the family therapist, not the social worker. It is the physician who has the ability to admit. Having said that, is there an exception that I am not aware of in hospitals in Nevada?

Lesley Dickson:
I agree with you, absolutely. The physician is the one who holds all the power, but more importantly, all the liability. Therefore, the physician needs to be the one making the decisions. The psychologists, I agree, currently do not have admitting privileges or discharge privileges in the State of Nevada. Where the psychologists enter into this issue is that they also get involved in the evaluation of the patient for the court documents, not for the hospital documents.

Chair Hardy:
When someone has been admitted on a 72-hour hold status because they may be a danger to themselves or others, there is generally a team evaluation. The emergency room physician, or the attending physician, takes into consideration the team's recommendation and the supporting documentation and is either comfortable with discharging the patient or with continuing to go through the court process to keep him longer. It would be unusual for the emergency room physician to singularly make the decision to keep or to discharge the patient.

Rebecca Gasca:
This section does not just cover a hospital; it also covers mental health facilities. Is that also the case in those facilities, that there is one charging physician who has sole responsibility of admittance and release?

Michael Alonso:
In the case of West Hills, it is a licensed hospital. I imagine it would be the case for the state facilities as well, as they are licensed as hospitals.

Harold Cook, Ph.D., Administrator, Division of Mental Health and Developmental Services, Department of Health and Human Services:
That is the case for state facilities, too. We have the two licensed, joint commission, certified hospitals and we function the same way as West Hills.

Chair Hardy:
And is it the physician who admits and discharges?

Harold Cook:
Yes it is.

Rebecca Gasca:
The problem, then, still would lie in the language as submitted by Dr. Zuchowski, in the replacement of "shall" with "may." In the case that the "administrative officer of a facility" and the "psychiatrist" or "psychologist" are not reintroduced into the bill, then a licensed physician cannot just consider releasing a person. A person would be constitutionally required to release, and therefore, the word "shall" must be reentered into this section.

Harold Cook:
This is a tough issue. In my experience, and I would bet that as a practical matter, very few physicians are going to keep someone in a facility based on an assessment that they are no longer a danger to themselves or others. I can speak from personal experience within Mental Health and Development Services (MHDS), as soon as an individual is deemed no longer a threat to themselves or others they are discharged, whether they are on a court commit or an emergency commitment. I would expect that to be the same in emergency rooms around the state. Having said that, it is not so much the language that dictates that this must be done in MHDS facilities, but we do have courts that monitor our activities fairly closely, and if we violate that provision of NRS, we get our hands slapped. [Dr. Cook provided written testimony (Exhibit D).]

Assemblywoman Spiegel:
Are there instances where someone would not be released under those circumstances where they have gone through an evaluation?

Harold Cook:
There would be some cases where someone may choose to go on a voluntary status, and we may choose to allow that to happen. Just because someone is no longer a danger to themselves or others, does not mean that they could not continue to benefit from hospitalization. So, if it is our opinion that they could continue to benefit, and if they voluntarily agree to that, then we would keep them.

Chair Hardy:
If I were the emergency room physician and I had evaluated a patient and asked questions regarding self-harm, to the point where he said, "yes, I have every intention of killing myself," then later, the team came in and asked the same question, and the patient said, "no," I would be the one liable and I would not release him. I would go through the court process so he would not be released. That is the backup for the physician. The physician has the liability and the responsibility ultimately to discharge or not, and that is where I would come back to "may," because, as we know, sometimes people do not tell the truth when they are trying to get something.

Rebecca Gasca:
I really appreciate the Assemblywoman's question because it did bring up a perfect situation in which there may be an exception made to the "shall," and in that case I would suggest putting that into the language so that it reads, "shall, perhaps, unless a person has asked to be voluntarily committed, release a person admitted pursuant to...." As the doctor said, in those instances in which a physician deems that this person is not posing a threat to themselves or others, then they should be released. They have a duty to do so, and we would agree, so there should not be a problem otherwise, with that one exception, for having "shall" be put into this section.

Chair Hardy:
Are there any other questions or observations on section 1?

Lesley Dickson:
I am okay with section 1. I do not have a strong opinion on "shall" versus "may." Dr. Thienhaus actually wrote that, and I am not sure why he did. I think "may" is better than "shall," but I am not going to make a big deal of it. [Ms. Dickson provided written testimony that contained an amendment (Exhibit E).]

Chair Hardy:
In section 2, on the mock-up amendment, Alzheimer's disease was crossed out as being too specific, and "dementia, delirium" was put in at section 2, mid-paragraph of subsection 1. Are there any questions or comments? [None.] Then, subsection 2 of section 2, "next preceding" was crossed out and "previous" was put in before "30 days." Any questions on that? [None.] Then, subsection 3 of section 2, again "previous" inserted instead of "next preceding." Questions? [None.] Next, amend section 3, subsection 2, paragraph (a) by removing "within that period." Any questions?

Next, section 3, subsection 3, "The written petition must be filed on or before the close of the court's business day on the date of expiration."

Dan Musgrove, Las Vegas, Nevada, representing West Care Hospital, Las Vegas, Nevada:
I think we probably need to talk about section 3, subsection 2, paragraph (b), which refers again to the "administrative officer." We cleared that up in the previous section, and we should probably go with the language that we adopted in section 1.

Chair Hardy:
Is there any disagreement on that? It certainly would be consistent to do what Mr. Musgrove has suggested. Does anyone have any objection to that? [None.]

Were there any problems with section 3? [None.] Regarding section 4, the mock-up changes section 4, subsection 2, paragraph (a) to use the word "have" instead of "has," and clarifies some words following that so that it reads "have been completed, if such examinations are required..." Are there any questions on those changes? [None.] Section 4, subsection 2, paragraph (b) "immediately upon receipt by the administrative officer..." is being deleted, as it is the same thing as previously, unless there are any objections. [None.] And subsection 3, "The written petition must be filed..."; are there any problems with that? [None.] Section 5, reinstate the word "transported" versus "admitted." Does anyone have any comment about that word change?

Lesley Dickson:
I am going to defer to others on this issue.

Bill Welch, President/CEO, Nevada Hospital Association, Reno, Nevada:
We would request that the proposed language of "admitted" be continued in the legislation as it moves forward. Our issue with that term is that for years we have tried to work with the mental health facilities, the emergency medical services (EMS), and the acute care hospitals in trying to insure that patients are able to be transported to the most appropriate setting for their health care needs, whether for mental health services or acute care services. The way the law has been interpreted in the past is that, if the patient is presented with alleged mental health issues, they are not able to be transported to a mental health facility for evaluation; they must first be transported to a hospital ER, based upon the interpretation of current law, for a medical evaluation. The data suggests that 93 to 97 percent of patients presented for medical clearances do not need medical care; what they need is mental health services, but they have to go through an ER first. This language is permissive; it does not mandate that

a mental health facility must have medical screening capabilities. When we tried to work on this in the past, we were advised that there was no need to have those discussions since the law prohibits that. What we would like to do is to create a legal environment where we can begin to have those discussions so that a patient can be transported to the proper location.

When a patient presents himself voluntarily to a mental health facility and the facility does not do medical screening, the facility can contact an ambulance service and have that patient immediately transported to an acute care hospital for evaluation. Conversely, if the patient is presented to an acute care hospital for a medical clearance, once they receive that medical clearance, they are held in that hospital ER until a mental health facility will accept that patient. That can sometimes take days. So it works just the opposite if they are presented to an acute care hospital versus if they are presented to a mental health facility. Again, I emphasize, this is permissive language, and it does not mandate a mental health facility must do medical screening, but would allow for that to occur if a mental health facility chose to do that. We request that "admitted" be the language that continues to be considered as this legislation is processed.

Dan Musgrove:
I represent several parties, including WestCare and others, and I also speak as an individual who has been involved in this process along with Mr. Welch and Dr. Hardy, and many others who have been, working on the problem of the emergency room overcrowding. This is a very important first step for us in moving toward a front door for these folks, to determine the right level of mental health care. As Mr. Welch said, we have found over the years, and now have statistics to substantiate this, that only about 3 percent of mental health patients actually need the medical portion of this process. But they do need the mental health services at many different levels, from the most restrictive or to just getting them back on their meds and back out in the community with their support systems. We appreciate that the Committee brought this forward, but this one word—"transport" versus "admit"—has always been our stumbling block, and we certainly hope the Committee yields some discretion in allowing this to go forward. It is very important for this process to move forward.

Harold Cook:
This is a tough issue, and I can appreciate the cumbersome nature of the current process which creates difficulties for medical facilities and it creates a delay in mental health treatment for many people. Having said that, just as a practical matter, I do not know how we would respond if patients started to be transported to our two mental health facilities. We do not have the staff or the resources to do medical clearance, except on a very occasional basis. In fact, for security reasons, the facility in southern Nevada was constructed so that

only one patient at a time can be admitted; only one ambulance at a time can come into the ambulance bay. The patient is removed, brought into the facility, the ambulance is backed out, and only then can another ambulance take its place. If ambulances started bringing in people to be medically cleared, I could see huge traffic jams in that facility. It is somewhat less burdensome in northern Nevada, but it is basically the same thing: we do not have the capacity. So, to make the language permissive is fine, but how do we allow facilities which do not have the capacity to do medical clearance opt out of that process until at some point in the future, perhaps, when they achieve that capacity?

Originally when I got this bill it was recommended to me that I attach a fiscal note. I have a fiscal note which is roughly $2.5 million a year for both facilities. I chose not to attach the fiscal note in the hope that perhaps we could work out some language that would allow for a change in the procedure, again, to benefit facilities and patients but, at the same time, recognize the fact that the state does not have the capacity to engage in medical clearances wholeheartedly.

Bill Welch:
In response to Dr. Cook's comments, I would suggest that ambulances pick up patients every day, both in the north and in the south. Ambulances will transport the patient to the setting that is most appropriate to deliver the care the patient needs. The emergency medical technicians (EMTs) are trained to evaluate patients, they also have a registry at the EMS dispatch as to where they should or can take a patient, and I would suggest that we could easily develop regulations or criteria which the mental health hospitals, just like every acute care hospital, are required to communicate to the dispatch services as to what capabilities or services are available. I think by regulation we could address this so we could insure that an EMS transport is not arbitrarily showing up at a state mental health facility if that facility has opted not to participate in providing medical screening.

I think we could handle this by regulation, because I certainly appreciate Dr. Cook's comments, and I do not want to put the state in a difficult position in dealing with medical screenings if they are not capable of handling that. However, at some future time, there may be facilities in this state that would want to do that and under current law that is not a consideration. Accordingly, we would like to create an environment where we can begin to develop those in the future.

Assemblyman Denis:
How long does it normally take to process an individual?

Harold Cook:
It can take from a few minutes to an hour and one-half, depending upon the behavior exhibited by the individual. Sometimes these individuals are combative, resistive, and so on. If everything goes smoothly, if the flow is easily handled, then it could take as little as 15 minutes, but that would be the least amount of time, and half an hour would be more representative.

Assemblyman Denis:
Would it make a difference if you did not have that particular physical limitation? I am assuming that the ambulance has to stay in that bay until you have cleared the patient, then you can pull the ambulance out?

Harold Cook:
The ambulance has to remain there until such time as the patient is transferred to the custody of the facility staff. There are procedures and paperwork necessary to get the patient out of the ambulance and into the facility and that hand-off can sometimes take a little bit of time. The ambulance staff is involved in the hand-off.

Bill Welch:
I want to respond to Assemblyman Denis. I think you raise a very good point. Part of the reason we considered this was due to the amount of time the ambulances were being held at the acute care hospitals waiting to transfer the patients from the ambulance to the hospital. In fact, we passed legislation in the 73rd Session and it sunset in 2007, so we continued that legislation in the 74th Session, to insure that we were tracking the prompt turnaround of the ambulance services and setting the standard of 30 minutes or less. Part of that issue has been making sure that we are getting our ambulances out, and not having them held up at our hospital ERs. However, although the patient is transferred to the hospital, as long as they are in the ER, they are not considered admitted to the facility; and they could be in the ER for hours depending upon the mix of patients who are there at the same time. We have to triage those patients and take care of the ones determined to be the most critically in need of care. Patients being presented for a mental health evaluation may not be seen for an hour or two hours, or more. Our objective was to make sure patients were getting to a location that would allow them to get the care quickly.

Assemblyman Denis:
In that situation, do the ambulance personnel stay, or do they drop off and go?

Bill Welch:
Once they are brought to the hospital and transferred to the hospital, the ambulance is then released. Thereafter, the patient is put into triage for an initial assessment and then put into the "float" of prioritization of care.

Gary Milliken, Las Vegas, Nevada, representing American Medical Response; MedicWest Ambulance, Las Vegas, Nevada:
I agree with everything Mr. Welch has stated. There are times when ambulances with mental health patients wait up to three hours before the patient is accepted into the emergency room. That is a procedure we set up many years ago when we started these discussions about wait time, where the hospital has to accept that patient before our ambulance can leave.

Chair Hardy:
Can a patient walk in to one of the state mental health hospitals and say, "I am here to be admitted?"

Harold Cook:
People can walk into the facilities and ask to be hospitalized. They would be evaluated by clinicians, and, if deemed to be a danger to themselves or others, then we, unfortunately, do what everyone else does; we initiate the Legal 2000 and call an ambulance for a transport to an emergency room to do a medical clearance.

Chair Hardy:
Do you do that on each and every patient that walks in?

Harold Cook:
We do that on 99.5 percent of the patients. If it is an existing patient of the MHDS and we have his medical history, and if we have a physician who is not otherwise occupied, we will in that very rare case do a medical clearance ourselves.

Chair Hardy:
And the same question for the private hospitals, can a patient walk in and say, "I am here to be admitted?"

Bill Welch:
Yes. In talking with the CEOs of the private mental health facilities on a regular basis, I am told they have mental health patients who present themselves and they follow a similar policy to what Dr. Cook described. The facility will call an ambulance, if the patient is not able to be transported by their family member or other person, for transport to an acute care hospital for medical clearance so

that they can then be transported back to the mental health hospital to be admitted.

Chair Hardy:
Does the initial evaluation they had in the mental hospital allow them to flip right back that same day to the mental hospital if they are medically cleared?

Bill Welch:
Not necessarily. It depends upon how quickly we can process them through our ER. It also would depend upon our ability to contact an ambulance to pick up that patient and transport them, and since it is non-emergent, we get put into a rotation with the ambulance services. It is not an immediate pick up. If they are presented at one of these hospitals and there is a perceived need for medical care, the ambulance will be dispatched immediately. In our case, when it is a transfer from an acute care hospital ER to a mental health facility, it is on a rotation.

Chair Hardy:
So, no matter what we do, we are still going to the ER?

Bill Welch:
Under current law, that is correct.

Chair Hardy:
Is that by law or by reality of medical clearance?

Bill Welch:
That is based upon the interpretation of the existing law that states a patient cannot be transported to a mental health facility until they have been medically cleared.

Chair Hardy:
But they are already there?

Bill Welch:
That is correct.

Chair Hardy:
Does anybody else do Catch-22's here?

Harold Cook:
In a circumstance where a patient presents at a mental health facility, nobody has transported them so I think that language is obviated at that point. The

practical matter, though, is they present at a mental health facility which does not have the capability to do the medical clearance, so then they have to be transported elsewhere for the medical clearance, and then transported back. It is not so much a Catch-22 as it is a merry-go-round.

Chair Hardy:
Do we need to change the law to say it is not necessary for medical clearance to be done before admission to a mental health hospital, pending the evaluation of somebody who is comfortable with that patient?

Harold Cook:
I think that would create a lot of problems that we do not want to address at this point.

Bill Welch:
Chair Hardy, I agree with Dr. Cook. However, it may be appropriate that we evaluate what is required for a medical screening, because it varies from state to state, and I know there are a number of states that have more extensive medical clearance requirements and many that have less. So evaluating medical clearance may be appropriate, but it is important to have medical clearance done.

Assemblyman Denis:
What is required to do the medical clearance? Who can do that?

Harold Cook:
Medical clearance has to be done by a physician, but I believe the law was changed a couple of years ago to allow mid-level practitioners as well. However, as a practical matter, only physicians are doing them. Medical clearance is done to screen out the possibility that no medical reason exists which could be the cause of the symptoms exhibited, and that it truly is a psychiatric diagnosis.

Assemblywoman Spiegel:
Is special equipment needed to do a medical clearance, or is it a matter of just bringing a qualified physician to a state hospital to provide that service?

Harold Cook:
Generally speaking, it is a relatively simple procedure. It usually requires a blood test and some minimal lab work, nothing complex, unless the lab work results in some finding which necessitates additional evaluations.

Assemblywoman Spiegel:
Do you have an on-site lab or do you send work out? What I am trying to find out is if there is a way that we may be able to help cut through some of the redundancy and merry-go-round activity in a simple way, and to reach the goal of treating patients who need it as quickly as possible without crowding ERs and engaging in processes that are not necessary.

Harold Cook:
The potential fiscal note that I have does call for some additional lab capability. The primary cost is the staff required; medical technologists, phlebotomists, and others, because one cannot just have the resources to do the testing without the staff. In addition, there is the practical issue of not having the space in either facility to do that. We have space to keep people for psychiatric evaluation and assessment, but we do not have an emergency room setting in which to perform medical clearance.

Bill Welch:
A stat lab would be sufficient and would take limited equipment, and a minimal X-ray capability would probably be needed. But if the patient would require a greater diagnostic evaluation than what those tools could provide, that patient does need to be transported to a medical acute care facility. Dr. Cook is correct. The greatest part of the cost would be for a nurse practitioner qualified to do a medical clearance evaluation, or who could be credentialed to work in a hospital setting. Also required would be a lab technologist and an X-ray technician. Capital expenditures should not be significant.

Assemblyman Denis:
Do we know what percentage of the folks who come in that require basic medical and are cleared quickly, as opposed to those who actually have medical problems?

Bill Welch:
Two different studies over the last two interims showed that 97 percent of the patients do not need medical care. Two interims ago the study showed that it was 93 percent.

Assemblyman Denis:
Then approximately 93 percent would only require the basic lab and perhaps X-ray?

Bill Welch:
They would all need the evaluation, but only 7 percent would need something beyond that.

Assemblyman Denis:
They would need to be treated, but 93 percent do not need any medical treatment, and they would be transported?

Bill Welch:
Yes. That is correct.

Lesley Dickson:
The main problem is primarily logistics. The Nevada Psychiatric Association takes the position that a good medical clearance does not necessarily require everything for every patient; a good physician, or advanced practice nurse, or physician's assistant can determine what is needed. Some of the problems that have been alluded to are these: 1.) If the clearances were switched over to being done at Southern Nevada Adult Mental Health, there would be thousands of patients to tend to. That 7 percent does not sound like very many until you multiply it by the thousands of patients that number represents; 2.) Given the location of Southern Nevada Adult Mental Health Services, on Charleston and Jones, you know that any patient who was being transported to a hospital from there would probably go to University Medical Center (UMC), which is probably the last thing UMC want to hear. So that is a problem because UMC would be getting all those patients rather than all the other hospitals.

Dr. Cook talked about the numbers. We are talking about a significant number of people who generally present during the daytime hours, but a few present in the evening, and some at night. What Dr. Cook did not mention was staffing; not only would he need some technicians to do clearance, he would need to run that place 24 hours a day, 7 days a week, and it would considerably change the staffing pattern of both the internist and psychiatrist on staff. Another point that came out was that we spent all that time last summer putting a plan together only to be told there was not the money for it.

I think I heard that some people in the neighborhood of Southern Nevada Adult Mental Health Services were not really thrilled with the hundreds of people being brought to that location every week. One of the things that I see as a problem is that now we are distributing these patients among 13 or 14 hospitals in Clark County. More of them tend to be at UMC, Sunrise, Valley, and Desert Springs Hospital, but some are out in the periphery. If we were to start bringing them all to Charleston and Jones for medical clearance and psych evaluation, and we know that about 75 percent of them are not going to be admitted, we are going to have all these people now at that location, some of them 30 miles from home. And then we have the problem of getting them all back. Once a patient is psychiatrically and medically cleared, the ambulances are no longer involved, and I see that as a logistic problem also. We suddenly have a lot of

people in one place that need lots of things, even if they do not need to be legally committed to the psychiatric hospital.

Assemblywoman Spiegel:
Dr. Dickson, did you say that 75 percent of the people wind up being released?

Lesley Dickson:
The patients brought in on the initial Legal 2000 form are put in the observation unit, then the ones who are actually admitted as regular in-patients, I am told, is 25 percent of the original number. So 75 percent do not get admitted. I cannot speak for the situation in northern Nevada.

Harold Cook:
Dr. Dickson's statistics are accurate. The majority of people admitted to the psychiatric observation unit subsequent to a medical clearance are discharged from that unit within the 72-hour time limit of the legal hold. I know that a number of patients are discharged from the legal hold at the emergency room level, as well, so the percentage of patients actually admitted to the in-patient facility is relatively small, as compared to the total number of people put on a legal hold.

Dr. Dickson was also talking about some resistance by the local community to bringing a whole bunch of people to the mental health facility in Las Vegas for medical clearance. There has been discussion over the last several years about creating a medical clearance unit on the grounds of the Southern Nevada Adult Mental Health Services and the City of Las Vegas has weighed in and indicated that they would not like to have those thousands of people brought to that location for that purpose, because of the problems that Dr. Dickson alluded to. Many of those individuals would be released off the Legal 2000, and once they are released, they are no longer a medical problem, but how do they get back to their communities? The community did not want to have all of these folks there. Having said that, my position is that if the language is changed, Southern Nevada Adult Mental Health still does not have the capability to do medical clearance. So if people are brought there for medical clearance, we are going to have to put them in another ambulance and ship them somewhere else for that.

Patricia Moore, R.N., University Medical Center; Service Employees International Union Nevada, Las Vegas, Nevada:
I am a 27-year employee of University Medical Center (UMC), and a registered nurse in the pediatric intensive care unit. I do not have an opinion on the bill either way, but what I want to say is that children are unique to the mental health situation in Nevada. Children cannot be Legal 2000, so parents can bring

their children to the private mental health facility for evaluation and the same thing is going to happen. If they need a medical evaluation, they are going to go to a hospital. I am not in the political arena or part of any association, although I am a member of and secretary for the local Service Employees International Union (SEIU), and as other services at UMC, I truly believe that the private sector is reluctant to provide the necessary evaluations. I know that if the emergency room is presented with an ambulance with a patient, they will see that patient. But taking all these patients to the public facility is not the answer either. With more people losing their jobs and losing insurance, the emergency rooms are going to be more backed up with medical problems, and the mental health problems are only going to make that worse. Insured patients and uninsured patients are going to stand in the same line. It is my fear that patients will die in the emergency room because there just are not enough beds. I think the private sector hospitals could reflect the same thing. Uninsured patients are no different than insured patients when it comes to the emergency room. They all need care, and whoever is the sickest goes in first.

You spoke of providing the dollars to take care of mental health patients and to have them evaluated in the public sector. There are not dollars enough to do that, with all the budget cuts in the state and county. Having experienced that with a family member in the state system, there just is no way they can do it. I am not exaggerating when I say that it could take two to three hours sitting in the waiting room at the mental hospital until the patient can be evaluated. I think there needs to be some way to streamline the medical process, just as they do in the juvenile justice detention or county detention; have a nurse practitioner see them. It does not have to be the long wait, as in an urgent care facility.

I want to point out, specifically, that in the pediatric cases of children who lash out in their homes, against their parents or siblings, or at school, are always brought to UMC, because they are minors and are usually at risk of harming themselves or others. The problem then becomes that we do not have that many pediatric beds at UMC, so usually every day we have up to four patients in the pediatric unit who are awaiting mental health beds. They are taking up acute care beds. We have had one or two patients who have been there for two months at a time because there is no place for them to go. It is a great drain on the county, on the taxpayers, and I do not know what the solution is but I wish there was more money for the mental health system. There is no parity between medical care and mental health care in this state, and I think that is standard across the country. There needs to be more parity and more facilities to take care of the mental health patients.

Chair Hardy:
It has become clear to me that there is a consensus: we do not agree. Does anyone have any problems with the bill language as it relates to medical facilities, petitioning the court, the 7 days, the notification, and the mental illness?

Lynne P. Bigley, Esq., Nevada Disability Advocacy and Law Center, Sparks, Nevada:
In the section that allows the facility to petition to advise the court that medical treatment requires the person to be held longer than the 72 hours, there is no reference to any attendant right to hearing. I do not believe a petition without a right to a hearing would be sufficient, constitutionally. Perhaps there needs to be some reference to NRS 433A.220, which requires a hearing to be set within 5 business days once a petition is filed. Additionally, the language allows for the petition to be filed sometime after the 72 hours. I think for purposes of being consistent with the other provisions and amendments that are being proposed, that the petition would necessarily have to be filed by the expiration of the close of that business day. Those are just some general comments.

Also, if there is a petition filed and a right to hearing, there is an attendant right to have representation. Obviously, the public defender's offices in northern Nevada, Washoe County, and Clark County, are in the business of representing folks in the commitment process, so, I do not know if they are aware of it, but I will certainly bring it to their attention to the extent that these revisions are going forward.

Mary Smith, R.N., representing Service Employees International Union Nevada, Henderson, Nevada:
The petitions are usually placed at the 48-hour period before the 72-hour hold has expired. They do have a set court date at Southern Nevada Adult Mental Health, usually on Tuesdays and Fridays at 1:30 p.m. in the afternoon. They do have physicians there at the mental health court also representing the people, so they do have a set date and time when they are put on that petition.

Lynne P. Bigley:
I may be misreading it, but this section is carving out something different than a petition for a mental health hold. This is about these folks who need to be held because their medical treatment requires them to be held beyond the 72 hours. Again, I think for any change in the statute like this would necessarily have to reference NRS 433A.220 and the attendant right to hearing.

Mary Smith:
I do not know what it is up here in Washoe County, but in Clark County we are holding people three to five days, sometimes seven. At any given time, even though they expanded Southern Nevada Adult Mental Health with extra beds, we still have 70 to 80 people sitting in the ERs. So that 72 hours is always exceeded on a daily basis.

Lynne P. Bigley:
I concur. That is a problem, and I do not know if any of these changes are addressing that. I am assuming that petitions are not necessarily being filed within 72 hours from the point that the person is actually detained.

Chair Hardy:
Are there any other questions regarding section 5?

Lesley Dickson:
Just to clarify why we have proposed this part of the amendment, I think Dr. Zuchowski expressed it last week also, is that there is a group of patients who are not medically cleared; therefore, you cannot file the petition because you have not medically cleared the patient to finish the Legal 2000 form. At the same time, we are trying to make sure these people are not lost in the shuffle of a busy hospital, going from an ICU to a regular medical floor, waiting for their medical condition to improve. This was aimed at that patient, like Dr. Zuchowski said, the one who may be comatose, may be suffering from a serious gunshot wound, or actually may be suffering from a serious pneumonia. The Legal 2000 petition cannot officially be filed because the Legal 2000 certificate cannot be completed.

Chair Hardy:
Thank you for that clarification. Now we get to the exciting part of the hearing where we get to vote. [Chair Hardy had a series of possibilities on a large easel in the front of the room. He distributed colored "dots" to each participant and instructed them to vote on their choice, as illustrated on the accompanying exhibit (Exhibit E). For example, section 1, "shall" or "may;" "licensed M.D." or "more" and for section 5, "transport" or "admit;" "medical clearance" or "concern." The results were as follows: 13 in favor of "may" and 14 in favor of "licensed M.D." for section 1. For section 5, the vote was 10 for "admit" and 1 for "transport;" and only 1 vote each for "medical clearance" and "concern."]

This is not necessarily how this is going to come down, but this is how we feel.

The licensed M.D. is the one who would discharge. "Admit" wins over the "transport" language, and there are some concerns on "medical clearance," albeit not a consensus. Are there any other viewpoints? [None.]

Amber Joiner, Committee Policy Analyst:
Do you want to take a motion?

Chair Hardy:
I want to take a motion on making a recommendation to the full committee.

Assemblywoman Spiegel:
I move that we take the recommendations from the flip chart and incorporate those into some revised language and present them back to the Committee.

Assemblyman Denis:
I second that. And I have a question. Are these recommendations the same as the recommendations from the Nevada Psychiatric Association?

[General brief discussion occurred during which no one had his microphone on.]

Assemblywoman Spiegel:
Let me modify my motion. I move that we take the recommendations from the flip chart and also incorporate the rest of the language that was presented by Dr. Lesley Dickson, in section 2, 3, and 4, that we corrected as we went through it, and consolidate that into some revised language and present back to the Committee.

Assemblyman Denis:
I second that. Does that mean that we are going to clarify the language, and it is going to come back to a Subcommittee, or are we taking it back to the full Committee with the revised language and have the discussion?

Chair Hardy:
I would recommend that the motion is to forward this to the Committee with the language that we will have to clarify. Do you have enough to go on, Amber?

Amber Joiner:
Yes.

Chair Hardy:
[The vote was taken and the motion passed.] Is there any public comment? [None.] The hearing is closed on A.B. 6. Meeting adjourned. [at 4:37 p.m.]

RESPECTFULLY SUBMITTED:

Darlene Rubin
Committee Secretary

APPROVED BY:

Assemblyman Joseph Hardy, Chair

DATE:

EXHIBITS

Committee Name: Subcommittee on Health and Human Services

Date: March 3, 2009 Time of Meeting: 3 p.m.

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
AB 6	C	Lesley Dickson	Amendment
AB 6	D	Harold Cook	Testimony
AB 6	E	Chair Hardy	Photo of voting sheet