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

Seventy-Fifth Session
March 16, 2009

The Committee on Health and Human Services was called to order by Chair Debbie Smith at 1:44 p.m. on Monday, March 16, 2009, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/75th2009/committees/. In addition, copies of the audio record may be purchased through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

COMMITTEE MEMBERS PRESENT:

Assemblywoman Debbie Smith, 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

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

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

OTHERS PRESENT:

Bill Welch, President and CEO, Nevada Hospital Association, Reno, Nevada
Robin Keith, President, Nevada Rural Hospital Partners, Reno, Nevada
R. Keith Schwer, Executive Director, Nevada KIDS COUNT, Las Vegas, Nevada
Renny Ashleman, Las Vegas, Nevada, representing Nevada Health Care Association, Las Vegas, Nevada
Charles Perry, Executive Director, Nevada Health Care Association, Las Vegas, Nevada
Lynda Mathis, Lead Clinical Consultant, LTC Systems, Conway, Arkansas
Debra Scott, Executive Director, State Board of Nursing
Keith Lyons, Las Vegas, Nevada, representing Nevada Justice Association, Carson City, Nevada
Steven Zuchowski, MD, Nevada Psychiatric Association, Reno, Nevada
Betty Razor, President, Nevada Nurses Association, Reno, Nevada
Stacy Shaffer, Political Director, Service Employees International Union, Local 1107, Las Vegas, Nevada
Bobbette Bond, Las Vegas, Nevada, representing Health Services Coalition, Las Vegas, Nevada

Chairwoman Smith:
[Roll called.] We have three presentations and one bill to hear.

Our first presentation is from the Nevada Hospital Association.

Bill Welch, President and CEO, Nevada Hospital Association, Reno, Nevada:
We were contacted a week and a half ago by your staff and were asked if we would be willing to present some of the challenges facing the hospital industry today. This is what my presentation is based on today. I have handed out a copy of the presentation (Exhibit C). I will try to move through it rather quickly and will give you an overview of the hospitals and what they represent. I will also go over some of our financial challenges, work force challenges, mental health challenges, and what we think needs to be done. Our solutions are certainly going to be driven by economics. I hope as you move forward and

resources become available, if they become available, we will be kept in consideration.

The first thing I would like to cover is on the third slide and is about understanding the impact of Nevada's hospitals. We have 61 hospitals in the State of Nevada, two of those are veteran hospitals and three are state hospitals. We have 36 acute care hospitals, 15 being rural and 2 being urban. We have eight long term acute care facilities, 11 psychiatric facilities with 3 being state facilities and the rest private, and we have 6 rehabilitation facilities in the State of Nevada.

These hospitals, directly or indirectly, affect 50,000 jobs in the State of Nevada. The hospitals pay out in excess of $3 billion in payroll per year. We are paying $19 million in direct taxes. Our 16 largest hospitals, based upon legislation passed in 2005, reported that they have over 100 beds and are providing over $600 million in community benefits. That is an annual report that we submit to the Nevada Department of Health and Human Services (DHHS) each year.

We gave one of the Assembly Finance Committees a handout to provide an overview of the financial situation of the hospital community, and I have included it in this PowerPoint presentation. I will go over each of them on an individual basis, but I want to show how they all flow together. First, we will go over uncompensated care and second, we will look at the shifting of cost or the population for which we were able to collect our costs of providing services. You will see what is happening by looking at the hospitals' operating margins and, ultimately, how the decline of the financial liability of the hospital community is affecting access to service.

The next slide goes into the uncompensated cost of health care services. This is probably one of the greatest challenges that we are dealing with today. In 2007, our uncompensated costs for our hospitals in the State of Nevada exceeded $714 million annually. Because of the economic strife facing the state, this last summer there was a special session. The special session called for a five percent reduction in reimbursement rates on the Medicaid program to the hospitals. This affected us by an additional $19 million. There was an Indigent Accident Fund (IAF) supplemental fund sweep that was taken in the special session in December, which cut an additional $25 million from the hospitals for the cost of those who have had a catastrophic medical encounter and do not qualify for Medicare, Medicaid, or any other payment sources.

The proposed budget that is before you is carrying forward the $25 million annual IAF supplemental sweep. It is also carrying forward the original

five percent rate reduction, as well as an additional five percent rate reduction. We are looking at an additional $54 million just in these budget cuts, which we need to add to the $714 million of uncompensated costs of health care in Nevada's hospitals.

Unemployment is growing rapidly in this state. As unemployment grows, so does our uninsured. Our unemployment has almost doubled in the last four years. With the projected impact of the unemployed on the hospitals, we are looking at an additional $368 million that we would anticipate during 2009 in costs for uncompensated health care. By the time 2010 comes around, we are expecting that hospitals will be absorbing in excess of $1 billion in costs for uncompensated health care.

The next slide will show you what some of this means, and what this causes. The areas in red on this slide are areas that do not pay for the cost of health care services. These are the patients that we treat that do not pay for cost of health care. The uninsured, and those without Medicaid, Medicare, or other governmental assistance programs represent 67 percent of our population, which leaves only 33 percent of the population who are treated in the hospitals paying the cost of health care service. And what does this mean? We are trying to reduce our operating expenses, and you have seen reports in the newspaper of how our hospitals have had to have layoffs and how we have clipped expenses in a number of areas. In the end, this total cost of uncompensated care—to the extent that we cannot absorb it through a reduction in operating expenses at the hospital—becomes a shift to the population that is paying the cost of health care services. In simple terms, it is three-to-one. For every $1 in uncompensated cost, one-third of the population that is paying health care will have to pay $3. Every time we have something that reduces the number of patients or the ability of patients to pay the cost, there will be a cost-shift.

Going back to 2001, the hospital industry was working at a 4.40 percent operating margin. By the end of 2007, we were operating at a less than one quarter percent operating margin. Through December 2008, the hospital industry in Nevada is now operating at a negative 1.75 percent operating margin. More than 50 percent of the hospitals in Nevada are now operating at a deficit margin. We have half a dozen public hospitals in rural Nevada, and we have one urban public hospital. In the past, it has been suggested that it is because of the public hospitals that we are showing this deficit.

Assemblywoman Leslie:
Can you provide us a list? I would like to see and compare where the hospitals are that are having these problems.

Bill Welch:
Yes, we can provide you with that data. I can tell you that the majority of the hospitals that are operating at a loss are urban hospitals.

As the hospitals are sliding into a deficit operating margin, you can see that there are 10 specific services that have been listed by the hospitals that have had to be reduced or closed altogether as a result of the deficits that we are now dealing with.

I want to go back to the cost of uncompensated care. These were services that were reduced as a result of the five percent rate reduction. This did not factor in the $25 million that we are going to lose this June. Even though those funds were cut in December, the way the funds of the IAF supplement are repaid, we will not have received those payments until June of this year. That $25 million hit has not been felt on the hospitals yet. Part of that $25 million IAF supplement would have been realized in November, but the bulk of it, $22 million, is not going to be realized by the hospitals until this June. As was discussed during the special session in December, we were going to be able to roll the bills from the current year into next year, but now we are talking about continuing the IAF supplement sweep into the future. We are going to see a significant impact in June based upon a cut that has already been authorized by legislation in December. This also does not include the additional five percent rate reduction, which was presented in the state budget.

The next area of significant challenge for the hospitals is where we rank with workforce. We rank 47th in the nation in availability of physicians. We are not making progress in the gap. We are recruiting and training more physicians into the state, but as hard as we are trying to make progress toward this, the population is growing faster than our ability to recruit or produce enough physicians in this state. In 1996, we were almost at an even keel, but that margin is growing, and by the year 2014, we are going to have serious challenges in trying to ensure we have adequate physicians available for the public. A similar situation is occurring in nursing. We have been behind in nursing for years. Even though we are graduating more nurses, trying to recruit more nurses and even gaining nurses in this state, we cannot keep pace with the growth of the population. Hospitals put out over $22 million a year in graduate medical education. These are direct expenses they put out. We are being offset on those expenses by reimbursement of only $3.1 million. There is a big disparity in how much we put out versus what we are receiving. I do not

know how our hospitals are going to be able to continue to absorb those kinds of costs as we see the financial plight of the hospitals grow. There is some indirect offset that we do receive, approximately $6 million, but we have not been able to identify the complete indirect expenses that have been incurred. I raise this issue because in a lot of the discussions, it is pointed out that we get $3.1 million in direct reimbursement, but we also get a lot in indirect reimbursement. Even with the indirect expenses added in, the indirect and direct expenses do not offset our direct expenses for graduate medical education in this state. We are in the process of trying to identify what are the indirect expenses.

We have made a commitment to grow the graduate medical education program in this state, and you have seen a number of the hospitals step up. There are four hospitals in this state that are currently involved in graduate medical education. There is Renown in the north, University Medical Center (UMC) in the south, Sunrise, and Valley hospitals. Renown, UMC, and Sunrise are capped. Any additions to graduate medical education in those facilities will be 100 percent out-of-pocket based upon federal capping. Valley hospital has one more year to add additional slots, and I know that they are working to do that. At that point in time, they will also be capped out and any graduate medical education cost beyond that at those four hospitals will be absorbed 100 percent by the facility.

We are spending millions of dollars in nursing recruitment, and we spend millions of dollars in supporting the schools training programs in the state, both with scholarships as well as supporting the direct overhead of the various programs. We continue to fall behind in that particular area.

The next area is mental health. I provided you a slide that comes from the Division of Mental Health and Developmental Services. We have a bunch of different data from the various hospitals. We have been tracking the numbers who are held in the emergency room (ER), but I think this slide tells the story by itself. You can see that there are some 232,000 individuals needing service. Nevada is able to provide service to about 24,000 of those, leaving 89 percent of the mental health population to try to find help as best they can. The areas those fall in will be the ERs. You are seeing in the budgets this session the closure or reduction of many mental health services, and that is causing significant concern to us. A few years ago there was an emergency called in Clark County because we had so many mental health patients backing up in our hospital ERs. We are gradually going to find ourselves slipping back into that arena. That is not where mental health individuals should be receiving their health care services.

On the next slide, "unfunded mandates" is probably not the best term, but I understand that every piece of legislation needs to have its opportunity. The only thing I ask you, as you consider legislation going forward, is to think about the financial challenges that the hospital community is already challenged with, and think about the workforce shortages that we are already challenged with. If legislation needs to be moved forward, then I hope the funding to offset the increased burden and costs associated with that legislation comes forward with it.

Madam Chair, I know the funding challenges the Legislature has, and unfortunately, all of the solutions to the problems that we have are going to require funding at some level. We need to fund Medicaid, and we hope the stimulus monies that were designated for Nevada for Medicaid go to Medicaid and are not used to offset other programs. We ask you to be aware when those from the university system present cuts to you, and to ask where they plan to make those cuts. Hopefully there will be a priority system in place so we do not see cuts as we have heard suggested to the School of Medicine and nursing programs. We cannot afford cuts in those areas within our educational system. We cannot afford any more cuts in mental health delivery services in this state. We are in last place in most of these categories, and we cannot deal with that.

Chairwoman Smith:
I have a couple of questions before we move on. Your slide that has the pie chart about how the problems drive the cost-shift has reminded me that the insured category is not really paying the cost of care. They are very similar to Medicare or other government programs because most of those are paying some kind of contracted rate, correct?

Bill Welch:
Most payers are under some sort of contracted reduction off the bill of charges. They do cover the costs and have helped pick up the costs of these other categories that cannot pay the cost of health care service.

Chairwoman Smith:
It may be that the uninsured who pay their bills are probably the ones with the biggest disadvantage because they pay more of an actual rate than anyone else.

Bill Welch:
That would be less than one percent, but you are absolutely correct. We do have laws in the State of Nevada that do require us to give a 30 percent discount on the self-pay patients if they make arrangements to pay their bills.

Chairwoman Smith:
Regarding the physician and nursing shortage, I remember from the statistics a couple sessions ago, we have a lot of nurses who are licensed but are not practicing. Do you know if that is still the case? I am assuming we do not have a problem like that in the physician area, correct?

Bill Welch:
There are some physicians who have retired but maintain their active licenses, and they do donate some time. There are a few physicians in this state who have elected not to practice medicine full time any longer but have maintained their license. The majority of them are practicing medicine at some level. The same occurs with nursing, and Debra Scott can provide you with better data. As we have looked at this, there are 28,000 licensed health care professionals in the State of Nevada. I would say that hospitals are employing around 50 percent of the licensed nurses in the State of Nevada. Most of those are practicing in the nursing profession, but medicine is no longer primarily delivered in a hospital setting. Health care is being delivered in all of the outpatient surgical centers, outpatient diagnostic centers, and there are many settings in which a nurse has the opportunity to practice her profession and not work in a hospital setting. The last fulltime employment (FTE) count that we had this last summer said that we are employing just under 10,000 registered nurses in the hospitals. The majority of those nurses are working, but they are not working in the hospital because there are many other opportunities. We are the only entity where we have the staff 24 hours, 365 days a year, and it is challenging for us.

Chairwoman Smith:
I am sure we will hear those statistics on another day, so I will not put Debra on the spot today. Mr. Welch, you will get the information to the Committee that Assemblywoman Leslie asked for?

Bill Welch:
Yes.

Chairwoman Smith:
Next, we have Robin Keith presenting on behalf of the Nevada Rural Hospital Partners.

Robin Keith, President, Nevada Rural Hospital Partners, Reno, Nevada:
I do not plan on repeating what Mr. Welch has said but rather build on it. I have provided a presentation to the Committee (Exhibit D), which will give you some context about rural hospitals and health care and talk about the challenges we face and some important policy questions.

To give you an overview of Nevada's rural hospitals, there are 15 of them serving about 350,000 people. The residents live in an area about the size of Colorado. It is as if we took the population of Carson City, Reno, and Sparks, and spread it around Colorado, and that is the service area these hospitals take care of. In the system, we have about 500 acute and long term beds.

[Spoke from prepared testimony.]

At this point, I would like to digress a little bit from the presentation to address the question that Assemblywoman Leslie asked about profit margins in specific hospitals. Ten of Nevada's rural hospitals are designated as critical care hospitals, and that is a federal program that was designed between 8 to 10 years ago to stabilize the nation's rural hospitals and bring them to a greater financial stability. The way that is done is that critical access hospitals are paid more by the Medicare program than non-critical access hospitals. That program has done a lot to stabilize not only Nevada's rural hospitals, but the rural hospitals across the country. Look at the pie graph that Mr. Welch provided (Exhibit C), which shows the distribution of who is paying the bills and who is not. When you look at the Medicare segment, it shows Medicare as accounting for 35 percent of the patient load in the state. It goes on to show that Medicare pays 81 percent of what it costs to deliver Medicare service in most hospitals. In critical access hospitals, Medicare pays 100 percent of costs, and when we look at the list of who has a better profit margin, you will find that the critical access hospitals are doing better because their costs are being paid. They are a great illustration of what it would mean to the health of our delivery system if the government programs paid their share of the cost.

I will now go back to the prepared presentation. The size of a rural hospital is a challenge for us because we have a small workforce. We have 2 lab techs, not 20, and 2 radiology techs, not 20. If we lose one, we have lost 50 percent of our workforce.

Another challenge related to size has to do with management. The management of a small hospital is responsible for the entire regulatory burden that applies to large hospitals. We have to comply with the Health Insurance Portability and Accountability Act (HIPAA), Centers for Medicare and Medicaid Services (CMS), Occupational Safety and Health Administration (OSHA), and Emergency Medical Treatment and Active Labor Act (EMTALA).

We have a small staff, yet we have a responsibility to our communities to take care of what they need when they need it. We never know what is going to walk through the door of the ER. It might be something really simple, for example, Johnny has the sniffles, or it might be the result of a horrendous

accident on Interstate 80 resulting in people with burns and major trauma. Our physicians and nurses have to be competent generalists, and that is a hard thing to be these days in medicine. Everything is so specialized, and the body of knowledge is so great. It is a real challenge to be ready on any given day for anything that comes through the door.

The next challenge has to do with growing demand. That demand comes from population growth, the aging of our population, and advances in technology and treatment.

The next challenge I want to mention is the upfront cost of shifting to electronic health records in the face of coming penalties. You have all heard testimony about the stimulus package, and we are very happy about the money that is going to be flowing to help hospitals convert to electronic records, but if you have looked at that program, it is a program of incentives. Basically, you have to put out the cash upfront to get this done, and then you can recover it later. We will manage to do that, but it will be a challenge. We will manage to do it because we have to do it. If we do not get it done by 2015, penalties ensue, and if we do not get it done by 2015, we will have lost an incredible opportunity.

Finding enough qualified health care professionals is a huge challenge in rural Nevada as well as in urban Nevada. We face some special issues such as geographic isolation and lifestyle. A person must want to live in some of those small, remote communities, and it is sometimes hard to recruit into them.

I do understand the challenges that you are faced with, and I am hopeful that we will not undo some of the progress that we have made in growing the nursing programs in the community colleges. The need is great.

I am going to skip ahead to page 12 of my summary of what this system looks like. [Spoke from prepared testimony (Exhibit D).]

Assemblywoman Pierce:
What rural counties do not have a hospital?

Robin Keith:
Esmeralda, Eureka, and Storey Counties do not have a hospital.

Assemblyman Stewart:
What is the population definition of a rural hospital?

Robin Keith:
There are a number of definitions, and I am going to put disclaimers on this because I am not sure I can quote them accurately. There are definitions based on density, so a frontier hospital has fewer than four persons per square mile. There are other definitions that have to do with proximity to urban centers, and they are much more about where this community is located. For example, Fallon might be quasi rural because it is not as far away as Ely is. Boulder City is a better example of that. I cannot give you just one. It depends on which program and which agency is doing the defining.

Assemblyman Stewart:
Are Boulder City and Mesquite considered rural hospitals?

Robin Keith:
They are. Mesquite, by virtue of distance, is more rural than Boulder City. Boulder City has qualified for the critical access program under a special section of that program that allows hospitals like Boulder City to participate, where they have a distinct population base.

Assemblyman Stewart:
It would be helpful for us to have a map of where they are located.

Robin Keith:
I would be happy to provide that.

Chairwoman Smith:
Is there a report that shows the profits gained by urban and rural hospitals?

Robin Keith:
Yes, if you are thinking of the quarterly reports.

Bill Welch:
Yes, all of the hospitals are required to submit data to the state through the Nevada Hospital Quarterly Reports. That report would not identify the hospitals as to whether they are rural or urban, but we could go through that list and categorize them for you.

Chairwoman Smith:
Thank you. You will probably put everything in one place rather than providing several lists.

Assemblywoman Spiegel:
I had read a lot about the challenges associated with the J-1 Visa program, and I was wondering if (a) any of those have gotten resolved and if (b) the program is actually helping address some of the challenges you are facing?

Robin Keith:
Yes and no. The program has undergone a massive overhaul in the last couple of years, and I think that has been very positive. The state has done a lot to try to make that work smoothly. Several years ago, the federal regulations changed and made it possible for specialists to practice in urban areas. That is probably a good thing in some ways because urban areas have underserved populations too. When the change occurred, the rural hospitals lost our edge. Many of the J-1 physicians would prefer to be in urban settings. It is much harder for us to recruit them, but we have a few.

Assemblywoman Leslie:
On page 11, you skipped the rural emergency medical services (EMS). Could you give us an update on the little bit of money we were able to give last time, what happened, and what the need still is?

Robin Keith:
Rural EMS is a very difficult area. Most rural communities cannot afford to actually pay for EMS services, so they rely on volunteer services. The volunteers have to give their own time, they have to pay for their own training, and they have to give up their own businesses sometimes in order to be a rural EMS provider. I am thinking of a woman in Eureka who owned a store. She was a volunteer because she thought it was an important thing to do. She was also the only person working in her store, so when the siren went off, she locked her doors and went. The volunteers give up a lot to do this, and it is increasingly difficult to recruit people into this service. I think the downturn in the economy is exacerbating that program because people are now working more than one job or looking after their children's children so that more family members can go to work. They just have less time to devote to this kind of thing.

During the last session, funds were allocated to help rural communities replace their ambulances or do other kinds of things that would help stabilize rural EMS. Unfortunately, that funding was not applied to those programs and was taken back into the state budget. That need still remains. I told Mr. Raggio, the Chairman of Senate Finance at the time, that the need was $16 million to replace the ambulances that were out there. We have ambulances with 250,000 miles on them.

Assemblywoman Leslie:
I remember when the Legislative Committee on Health Care met in Elko, and we had a list. Is there a current list? That need is not going away, and those ambulances are just getting more and more miles on them. I go to rural Nevada a lot, and it is miles away from the nearest hospital; it is difficult to think that the ambulance might break down while transporting someone. We have heard horror stories about an ambulance breaking down and equipment that was old and falling apart. It is very discouraging to me that this small amount of money did not get out there. Is there a list of equipment needs or what the priorities are now so we can know?

Robin Keith:
I am sorry to say that the list has not been updated, although I am sure we could do that. We would certainly be happy to provide that same list, knowing that it is even worse at this point. It seems so hopeless, and it is a huge problem. I go out to rural Nevada a lot too, and I think about how we have visitors who cross our state constantly through the rural areas.

Assemblywoman Leslie:
It is shameful that we do not provide at least a basic medical safety net throughout our state for our tourists if not for the people who live here and travel here. I would appreciate it if you could give me that list again.

Assemblyman Hambrick:
The problems we are talking about today seem to be across the board. If we instead address each problem individually, whether it is lack of physicians or lack of nurses, would the problem cascade and make the next one easier to solve? You could then tell a physician that he or she has enough nurses.

Robin Keith:
That is an interesting question. If I thought about this for quite a while, I might have a different answer than I am going to give you now. Maybe I could come to see you when I think this through. What comes to my mind now is that we might end up with two or three cascades. If we solved the problem of the cost-shift, and if we were actually paying what it costs to deliver the service and everyone was paying his or her share, that solves an enormous number of problems. That cascades down into our ability to compete better with the rest of the nation for health care professionals. It translates into the equipment that is needed to make sure that our physicians have what they need to do their job. It probably translates, to some degree, into an ability to provide the level of quality that would bring the health status in our state to something we could be proud of, rather than something we are always ashamed of. Another cascade probably has to do with state funding of our education system and our ability to

generate the physicians and nurses we need. We need everything, including lab techs, radiology techs, pharmacists, and pharmacy techs. We need certified nurses' aids. We do not generate nearly enough within our state to solve that problem.

Chairwoman Smith:
In a previous life, I was an x-ray technician in a rural hospital, and I absolutely know the challenges and what the people in those environments have to do to make things work. It is just incredible. It was long enough ago that we did not have a lot of the challenges we have now with regulation and meeting federal requirements. I am very sympathetic for what the people are faced with in our rural counties when they are trying to deliver medical care.

Our last presentation today is from Executive Director, R. Keith Schwer, from Nevada KIDS COUNT. He is in Las Vegas, and he is going to give us a piece of their KIDS COUNT report on the qualitative study of high school dropouts in Nevada.

R. Keith Schwer, Executive Director, Nevada KIDS COUNT, Las Vegas, Nevada:
I will take a few moments to note that we have our recent Nevada KIDS COUNT data book we just completed. I would note that there are more than 650,000 youth and children in our state, and they make up the highest percentage of native Nevadans, and they will inherit the future. The materials we have given you include my comparison of the 2007 and 2008 findings. Generally, we find that the status of children has remained fairly the same. There are no surprises, but I would add one additional point. We know the significantly rising unemployment rate in our state and the implication of that for children, and the percentage of children in poverty is continuing to rise, even though we do not have the latest data for you. We have the latest data on the unemployment rate, but not the percentage of children in poverty.

As the Chairwoman noted, my task this afternoon is to summarize some of the material findings that we have gathered in addition to our KIDS COUNT data book. The KIDS COUNT data book does include what we think is the best available data on the health of children. My task here is to talk a little bit about one of our major challenges in the area of education and, in particular, to talk about basic research we have done here in Nevada on what is referred to as the "silent epidemic," the drop-out rate.

With financial support from citizens in the State of Nevada as well as from the Annie E. Casey Foundation, we have been able to take a second look at the status of children by focusing in on what children and youth are telling us about their experiences and the reasons they have dropped out of school. I have

given this to you in two pieces. One is a PowerPoint handout in paper (Exhibit E), but I have also included one of our bulletins of our research findings (Exhibit F). It is a brief on Nevadans' reasons for dropping out of school, and the recommendations for change coming from the youth. In particular, we recently were able to carry on a conversation with 63 students who dropped out and were trying to come back to get their degree. Some of the primary findings were that there was no significant difference between the drop-out rate of nonimmigrant and immigrant children. There has been quite a bit of discussion within our state and elsewhere that perhaps the rapid rise of immigrants into our state might be a significant factor for our problems. After our discussion with young people, we found that there was no significant difference in the factors that compelled students to drop out.

One of the more interesting points, at least from my perspective, was that none of the youth blamed anybody other than themselves. There was a high degree of responsibility, where they could have easily blamed others including parents, schools, or their community. However, they did not, and that was somewhat heartening in the sense that the attitude that was expressed was one of taking charge of their lives.

What we are left with is a complex problem. The causes for our drop-out rate and the high drop-out rate nationally are many, and they can be due to personal reasons, family, schools, and communities. There is not just one simple solution. What it tells us is that as we go forward in our KIDS COUNT effort to monitor the status of children and provide you with the best possible data, we are going to have to broaden our base in order to be more effective.

In conclusion, I would say that our children and youth are facing many challenges, and because of this, we too face challenges as we go forward.

Chairwoman Smith:
I have a question about your data as far as what you used in determining numbers of dropouts. We are at odds about high school graduation rates as an example because we do not have a consistent tracking mechanism, so I wonder what source you used for your data.

R. Keith Schwer:
We are reporting the state's number in our data and following the state's definition. You are absolutely right that there is a wide range of definitions that are used. In the Nevada KIDS COUNT book, we use the state definition. In the national KIDS COUNT book that is compiled on a state-by-state basis, they use a different method and are currently making efforts to standardize those methods. I would suggest that even if we come to a standardized method of

looking at the drop-out rate, there will still be need for different perspectives so these different definitions may well prove useful. I think the bottom line to keep in mind is that irrespective of which drop-out rate definition we use, our state does not do very well.

Chairwoman Smith:
You are certainly right about that. Whichever number we use, the numbers are not good. We need to get to the bottom of why kids are leaving.

We will now open the hearing on Assembly Bill 106.

Assembly Bill 106: Provides for the regulation of certified medication aides. (BDR 54-288)

Renny Ashleman, Las Vegas, Nevada, representing Nevada Health Care Association, Las Vegas, Nevada:
I am going to present the substance of the bill and how it changes law. We will have other people speak to the need for the bill. I am passing out the second redraft of Assembly Bill 106 (Exhibit G). You had an earlier redraft from me. This does not have any substantive changes as far as policy is concerned. With the assistance of the State Board of Nursing, we inadvertently dropped some paragraphs of existing law. We did not have them bracketed because we were not trying to omit them.

Section 1 gives four definitions. [Spoke from document.]

There have been concerns with the earlier bill and with the bill we brought last year about the role of the registered nurse. I think this goes a long way to clarify that and any tightening that needs to be done can be done by the Board.

On page 1, the detail qualifications are contained in section 1 and require that a person submit evidence, is qualified, and duly certified. Subsection 2 states, "The use of medication aides-certified in skilled nursing and intermediate care facilities shall be at the discretion of the skilled nursing facility and intermediate care facility." The facilities do not need to use these individuals, and in fact, initially we anticipated relatively few would until more experience was gained in this area. If they are going to use medication aides-certified, "the facility shall notify the Board in a manner prescribed by the Board."

Subsection 4 is a critical item of interest to other personnel. "The use of medication aides-certified shall not replace other licensed nursing or healthcare personnel." There is no danger of this costing anybody their job and not even

other aides. This is an additional person to assist in a particular area in the facility.

The qualifications are outlined in subsection 5. [Spoke from document.]

This is more important than immediately meets the eye because it has been found that when you look into medication errors, the single biggest error is that people do not properly read the instructions they have been given, whether it is a patient or nursing personnel of all levels and grades.

[Spoke from document.] Our nursing aids currently take 75 hours of training, and this is an additional 100 hours of training. The minimum by national standards is 130 to 140 hours.

[Spoke from document.] As you recall, our definition of "supervision" requires that the nurse actually be on duty and physically present at the time.

We have a list of administrations they can make in section 1, subsection 10, "except as otherwise proscribed by regulation." That limitation is intended to apply through paragraphs (a) through (g).

Subsection 11 states that the administered medication "shall not include controlled substances." Under subsection 12, there are a series of restrictions on various things they can do. Some of them are obvious, like not being able to administer certain kinds of substances. [Spoke from document.] We are proposing rather tight controls on this.

The next significant section addresses the Advisory Committee on Nursing Assistants, where we add to the Advisory Committee a medication aides-certified.

The next section administers some definitions and prescribes things like the salary the Advisory Committee gets. Section 6 adds the medication aides-certified to the people that the Board can provide regulations for. Section 7 bridges over existing law, but we add the words "medication aides-certified."

Chairwoman Smith:
In section 4, the Advisory Committee has the last appointee being a medication aide-certified, but how are they supposed to help develop this if they wait on the Committee?

Renny Ashleman:
The Advisory Committee is an ongoing committee. You cannot have a new category on the Committee until you have created the Committee, but, thereafter, there would be an Advisory Committee to advise the Nursing Board. This adds a person to that committee. I do not know if we need a tweaking of the drafting process or not, but that is the intention.

Sections 7 and 8 allow the Board to accept gifts to carry out duties. The sections give direction as to the supervision and annual reports to the Board on these employees and requires that the Board give validation before the listed occupations can be hired.

As far as the substance, those are the primary changes that I want to bring to your attention. It has to do with the policy that is involved in this.

Charles Perry, Executive Director, Nevada Health Care Association, Las Vegas, Nevada:
Many of you were present two years ago when we presented another bill that sought to do the same thing that we are asking to do with A.B. 106. In the interim that has transpired since the 2007 session, we retained consultants who went to several of the other states where medication aides-certified have been in use for some time. We asked them to look at a number of things, including what the authorities in those states thought about the effectiveness of the program and any weaknesses they might have determined. We asked them to look into the educational component of the other states. In particular, we asked them to look at the states of Arkansas and Missouri because they both have educational programs that have been accepted and almost adopted by the National Council of State Boards of Nursing as model-type programs. We did all of this in a effort to answer many of the questions that came up during the last session so we could put those questions to rest and come up with a better program.

As Mr. Ashleman just said, we did not come up with this as a method to cost anyone their job. We are not trying to replace anybody with the use of these medication aides-certified.

Long-term care is a very specialized subset of the overall health care delivery system, and what we are trying to do is devise any way we can to provide a better level of care to people. We also want to try to do what we can to help further the interest of people who work in our facilities to continue their education and develop a career ladder. That is essentially what our purpose is today.

Renny Ashleman:
Before we have Lynda Mathis come up and talk about how these work in practice and what she sees to be the advantages, I would like to express my thanks. We have been working with the Nursing Board on these matters, and they have assisted us greatly with these amendments. I do not want to presume in any way to speak for them or how they feel about the bill at this particular period of time, but their cooperation and technical assistance was exemplary.

With that, we will have Lynda Mathis come up. She has been instrumental, and she will tell you more about the Arkansas system, which is widely reviewed as probably the best model in the country. Primarily, she is here to tell you of some of the advantages and disadvantages of that system.

Assemblywoman Pierce:
This second redraft stops at section 10. Does that mean that the rest of the bill, as we have it, is left the way we had it originally?

Renny Ashleman:
This is intended to be a replacement for A.B. 106. The section numbers are due to the way we approached this, and it is not relevant or comparable.

Chairwoman Smith:
Let us clarify because the second redraft is short one section from the first redraft. Is that intentional?

Renny Ashleman:
That was existing law that inadvertently got picked up and repeated in the second redraft.

Chairwoman Smith:
It really should stop at section 10 as the section redraft does.

Renny Ashleman:
That is correct. This has not been done in the appropriate style where we would relate to the existing law and show you where it would fit in. I apologize for that. By the time we were done, there was not enough time to put it into that form, so we thought it would be easier on staff if we just gave you a redraft of the bill.

Lynda Mathis, Lead Clinical Consultant, LTC Systems, Conway, Arkansas:
I am a registered nurse, and I have practiced in Louisiana, Arkansas, Oklahoma, and Nevada. My first experience with what we are now going to call

medication aides-certified was in 1983. I worked in a 230 bed facility where I was the director of nursing, but I supervised non-licensed assistant personnel who gave medications. Nurses supervised that process but were not actively involved in the delivery of the oral medication. At that time, medication errors were not of any greater significance than they are today. I was fortunate enough after that job to be a state licensing and certification surveyor for the State of Louisiana for 10 years. During that time of my nursing career, I surveyed hospitals, nursing homes, home health agencies, hospice agencies, and all kinds of health care providers. Part of those survey processes included doing medical passes to ascertain what the rate of medication errors were. Once again, there was not a statistically significant variance between what the practice determination was of the caregiver who administered medications as opposed to registered nurses only administering medications.

In the State of Oklahoma, we also had certified medication assistants in use for many years, back into the 1970's, both in long-term care facilities for our elderly as well as for our mentally challenged clients. Once again, it was my experience as a director of nursing and as a nurse consultant that the incidence of medication administration errors was not significantly different no matter who the caregivers were who administered medications.

I have been in Arkansas since 2002, and I am very active in working with long-term care, and I am on some subcommittees with the Board of Nursing. When this potential came up in 2004, we went through the processes that you have been going through for the past several years, and in 2006, we got the legislation passed that made medication aides-certified possible in the state of Arkansas. We graduated our first classes within 11 months of that date, and about 10 percent of the facilities in our state utilize medication aides-certified. We have a total of 239 nursing homes in the state of Arkansas, and we have 23 who are regularly using medication aides-certified staff. They range from large facilities, up to 200 beds, down to facilities that may be as small as 60 beds.

Before I flew out here yesterday, I had contact with the chief of pharmacy surveyor for the State of Arkansas, and he and I have agreed to disagree on many issues, but John Tipton keeps me up to date on what I need to know, and he said that in his experience in the past two years since we have been using medication aides-certified in the State of Arkansas, there is no appreciable difference in the medication error rate. As an entity whose major purpose is to protect the citizenry, I know that is very important to you. What it has done by increasing the ability to give care has also been a positive factor. With the medication aides-certified able to give medications in their reasonably constituted form to residents who are less fragile, it has empowered the nurse

to be able to give more complex medication in more complex care settings including IV therapy; therapy that includes iodine and subcutaneous injections, as well as specialty inhaled medications; and providing more time at that resident's bedside and better increasing the potential for a positive outcome. Our legislation states it is required to have at least a year's experience as a Certified Nursing Assistant (CNA). That is up to the facility if they decide to have in practice a longer period of time and to more ably select and choose those dependable staff members who they have seen to have appreciable talent and skills. One of the things that we are finding is that a CNA who is diligent and dependable and works to become a medication aide-certified is the same person who is interested in going to licensed practical nurse (LPN) school and eventually to become a registered nurse (RN). It has become a career ladder that we strongly encourage among our facilities in Arkansas. We strongly endorse the creation of that degree of nurse extender for the State of Nevada.

Chairwoman Smith:
It looks like from the chart that you gave us (Exhibit H) that virtually every state has either done this or has pending legislation.

Lynda Mathis:
Currently, there are 38 states that have medication aides-certified in facilities of some kind.

Chairwoman Smith:
All the remaining states are considering legislation. Is that correct?

Renny Ashleman:
All but a handful are considering legislation. That is an older chart; as you see, Nevada is listed as blank even though it is a consideration state. I think there may be half a dozen at most that are either not considering it or do not already have it. They are not all in our setting. Some of them are in different settings, but in general, it is typical for them to be in our setting.

This would be set up in the community colleges, and it is our intention to pay for the education process. That is not strictly the matter for this bill, but it is a necessary accompanying part.

Chairwoman Smith:
It is, and it does help us decide if it stays here or moves on. I was looking at the fiscal note during your testimony.

Renny Ashleman:
There will be two fiscal elements with one being the Nursing Board, and the other one would be the education aspect.

Debra Scott, Executive Director, State Board of Nursing:
We have been discussing medication aides-certified specifically for the past two years. During the last session, we were directed by the Committee and the Chair of the Committee, Assemblywoman Leslie at the time, to really look at this concept of medication aide-certified. For the last two years, we have put medication aides-certified on our CNA Advisory Committee agenda, which meets quarterly. Those have been public meetings for the last two years where this has actually been an issue and item on our agendas.

We have taken a lot of time and effort educating ourselves and the public about what this might mean if we had medication aides-certified in Nevada. We have had many discussions about that, and through this process, we have come to consider that this may be something that may be helpful for nursing in Nevada.

As was said earlier, the National Council of State Boards of Nursing has put together a model curriculum. They have a model practice act that would show Nevada how to put medication aides-certified into our law and had those components of the program accepted at their delegate assembly at the last meeting. There is also now a textbook by Mosby, which is a nursing textbook publisher, that is specifically for medication aides-certified.

I will let you know that we have been working very closely with Mr. Ashleman and Mr. Perry. We had some concerns with the initial bill we saw, and we have worked through at least two sessions with them, looking at what safeguards we might be able to put in place. With the safeguards that have been presented to you in amendment form, our Board voted to support the regulation of medication aides-certified as described previously by Mr. Ashleman.

You have before you a list of the rationale for our Board wanting to support this bill (Exhibit I). I will not go over them, but I do want to say that the process itself has been an eye opener for us, and as nurses, this is something that we definitely want to look at and consider. Is this a safe thing for the citizens of Nevada? With the safeguards in place, we have come to the conclusion at this point that this would be a safe alternative to have in our long-term care setting. We want to be sensitive to the concerns of those who will testify in opposition to A.B. 106. Our intent, should this bill pass, would be to include all of the stake holders in the promulgation of regulations so we can address those concerns.

Chairwoman Smith:
Did those same stake holders participate in your quarterly meetings when you were reviewing this concept?

Debra Scott:
Many of them did, yes.

Chairwoman Smith:
What about errors? Who tracks those, and how are they reported? Where is the transparency in that regard?

Debra Scott:
At this point, that would be something that would be tracked through the hospitals, and I think someone else would be better able to answer that question. We would get information about medication errors when there was patient harm, and we would follow up on that. Reporting is a different responsibility.

Lynda Mathis:
Every long-term care facility that is certified by the federal government is required under their quality assurance and assessment process to have a methodology for identifying and correcting, when possible, medication errors. That includes counseling for the nurse or the individual who was involved and communication with the physician immediately upon the discovery of any incident. The incidents and the remedial actions would be tracked, as you would in any other organizations' quality assurance program. Further, the public is free to complain at any time to the state agency, and if there is any complaint, the state agency will come to the facility and do a full investigation. Their findings are available to the public. Also associated with the findings are punitive actions for the individuals involved who may have committed a medication error. There is a system already in place which addresses the caregivers who are giving medication. It would then be up to the individual facilities to add to their policy the procedures consistent with new legislation. They would still be subject to the same punitive outcomes as any other caregiver who is administering medication or care.

Chairwoman Smith:
It seems that in an area that is brand new, you would want to make sure that your reporting and transparency are at the absolute highest bar.

Lynda Mathis:
I agree, and in addition, the facilities that have begun to use this new worker have developed orientation programs that are above and beyond what would be

their usual orientation program for a CNA. For instance, I know of many facilities that have direct observation of the individuals until they show competence, and they are subject to periodic reevaluation by observing a med pass. Once again, this is a regular part of ongoing care and quality assurance and assessment process.

Renny Ashleman:
I had assumed that these were automatically reported to the Nursing Board as they are to some other boards. Let me survey the information that we report. We are actually supervised by three different kinds of agencies, one federal and two different state agencies. I will submit for your staff an amendment to make sure that copies of that material go the Nursing Board.

Chairwoman Smith:
My question is where do I, as a member of the public, see that information?

Renny Ashleman:
Those are public records. They are available at Medicaid offices and the Bureau of Licensures offices. The federal government publishes reports quarterly on these matters by nursing home name and what their certification is. There is widespread public availability. The important thing to do here is to make sure that all of this information is carried over to the Board.

Lynda Mathis:
Today, any of you are free to go onto the Centers for Medicare and Medicaid Services (CMS) website and go to nursing homes to compare and choose the name of the facility you would like to observe. You will have full information available on the most recent survey information, including deficient practices that resulted in a medication error of greater than five percent or a medication of a significant circumstance, such as something that could cause potential harm or did actually cause harm to an elder. That is on the federal website. In addition, when you speak to the Board of Nursing, the Nurse Practice Act in every state states that if a nurse is aware of a failed practice that results in or could result in harm to someone in her care, she is under duty to report it to the Board.

Assemblyman Hardy:
We keep using the word Board, and I want to make sure that the nurse is reporting to the State Board of Nursing and not to the State Board of Pharmacy. Is that correct?

Debra Scott:
The medication aides-certified would be regulated by the State Board of Nursing as are the LPNs and RNs. At this point, that is what the State Board of Nursing would like to have happen should you decide to have medication aides-certified. The State Board of Nursing would be the board that would be regulating these providers.

Assemblywoman Spiegel:
Ms. Scott, I have a question about the fiscal note you put together for this. How many medication aides-certified have been put into the fiscal note?

Debra Scott:
It depends on which state you talk to as far as numbers are concerned. With the support that we hear is coming from the Long Term Care Association or the Nevada Hospital Association, we anticipate that there will be many, but that is not what the fiscal note is based on. That is for starting the program, such as approving schools and getting curriculum in place and setting up the new regulations.

Assemblywoman Spiegel:
It is not based on the staff required to review the applications and review the conduct of the medication aides-certified?

Debra Scott:
That is part of it, but not the majority of it. We have approximately 5,000 CNAs in Nevada, and we have approximately five times as many nurses as CNAs, although, when we look at discipline, the group of 5,000 CNAs has almost as much discipline as the 25,000 nurses. There may be more investigations than we are anticipating.

Assemblywoman Spiegel:
Will having a curriculum and education program that is being taken from another state reduce the fiscal impact?

Debra Scott:
It may.

Renny Ashleman:
Our initial expectation is that it would be a relatively small number of these people. We are really thinking that as few as half a dozen and no more than three dozen in the initial couple of years of the program. It will take us a year of so to even get the program going. The numbers may climb, but we can only do this when we have an RN on duty, and it only pays to do it when you have a

fairly large facility. I do not think there would be a great many in the State of Nevada the way the law is being set up.

Assemblywoman Pierce:
We have the smallest government in the country. It seems to me the thing we most likely will not be doing is oversight. I have real concerns about oversight.

Keith Lyons, Las Vegas, Nevada, representing Nevada Justice Association, Carson City, Nevada:
We have some serious concerns as to patient safety. In particular, we have concerns over the training and oversight. One of the issues that was raised by one of the assemblywomen was the issue of our ability to do oversight. The other problem is the enacting statute allows the Board to create regulations, and the regulations may allow the medication aides-certified to go to different facilities other than large facilities, which would increase the danger with patient safety. Furthermore, we have had enough problems in this state with issues relating to facilities not properly maintaining records or equipment. I think expanding responsibility to somebody who is in a fairly low paying job with minimal training to provide any type of medication leads to tremendous risk for patients. Those are our concerns.

Steven Zuchowski, MD, Nevada Psychiatric Association, Reno, Nevada:
We want to emphasize the point that the administration of medication is an assessment. It does involve an assessment every single time a person is administered, even with a relatively benign oral medication. There is something that goes on between a professional and a patient that cannot be covered in 100 hours of training. I have an example for you from the last couple weeks in my practice. I am a practicing psychiatrist in Reno, and I got a phone call in mid-afternoon from an RN at the hospital who said, "I have a feeling that Mr. so and so is having a little bit of lithium toxicity." Lithium is one of the noncontrolled substances that we prescribe quite often in psychiatry. I said you might be right. It was very mild, and it was a suspicion and not an obvious toxicity meaning a matter of a tremor and acting a little "funny." That is the nature of the interaction of doctor and professional and saying that I am going to trust you on this. I ordered the medication held, which is what the nurse wanted me to do, and I ordered a lithium level for the following morning. Lithium is toxic above 1.2 in the blood. This patient came back with a lithium level of 1.6, which is above the toxic level. A couple of extra doses of lithium may have put that patient into severe toxicity that possibly could have resulted in irreversible damage to the central nervous system. This is an example of where two professionals discuss an assessment of the patient. I emphasize that lithium is not a controlled substance, and we can substitute other medications for lithium in this respect.

The other less compelling point I want to make is regarding supervision and how supervision, as described in the redraft is somewhat a myth in that the nurse will undoubtedly go off and do other things that he or she is busy with. The medication aide-certified is going to be administering medications. I fear "supervision" will be a matter of who we blame when something goes wrong. It will not be a matter of whether this nurse was actually helping or ensuring that there would not be medication errors, but there would be blame toward the nurse who was off doing an IV, saying that she should have somehow prevented this error. This does not seem to add up in our eyes.

Finally, a related point is the issue of medication errors. As a practicing psychiatrist who works in an inpatient setting, I can tell you that medication errors are vastly underreported. I am also chief of staff of a private psychiatric hospital in Reno so I get to see things from both sides. I work on the front lines, and I see situations that inevitably resulted from a medication error. People admit it one-to-one and say that there was a problem, and the patient says that he got a blue pill instead of a yellow one. I go to the chief of staff meetings and everyone sort of congratulates themselves and says we have a medication error rate of .01. I know for a fact that it is vastly underreported. The error reporting system is almost completely dependent upon self report, meaning the person administering the wrong medication has to admit it and fill out a form and say "oops, I made a mistake." You can imagine that the vast majority of people will have some concern about that. I realize the Nurse Practice Act requires that of people, and that is good, but it is also human nature to want to sweep it under the rug. I think this responsibility belongs in the hands of a professional, and that professional is the nurse. They have a profession to uphold, and they have the professionalism that it takes to admit that they have made a mistake and there has been an error. Obviously, if somebody has a severe side effect or interaction, that error is going to come to light anyway, but the vast majority of the time that is not the case. The patient may feel a little strange or may have a little nausea or vomiting but would not necessarily be able to trace it back to the medication error that may have occurred.

The numbers that I see quoted are not reassuring to me. I do not think it reflects the reality of what happens in the trenches of medical care.

Chairwoman Smith:
You are speaking on behalf of the Association I assume?

Keith Lyons:
That is correct.

Chairwoman Smith:
As a psychiatrist, you commonly have patients in nursing homes?

Keith Lyons:
I would not say commonly. I have a number of patients in nursing homes but not very commonly.

Betty Razor, President, representing Nevada Nurses Association, Reno, Nevada:
[Spoke from prepared written testimony (Exhibit J and Exhibit K).]

Stacy Shaffer, Political Director, Service Employees International Union, Local 1107, Las Vegas, Nevada:
I am here in opposition of A.B. 106. We have many of the same concerns that have already been addressed. First of all, this bill is not a solution to the nursing shortage. We believe that instead of allowing RNs more time at the bedside, the legislation will add additional responsibility to an already full workload. If you look at the legislation as it is written, the definition of "supervision" means active oversight. Again, we feel that this will increase the workload to RNs.

Secondly, the administration of medication is not a simple, mechanical process. As was stated earlier, there are concerns with drug interaction, which increases with the number of medications a patient may be taking. A nurse has to be able to evaluate and monitor a patient before, during, and after administering medications. Something that raised a red flag was where Ms. Scott stated that CNAs are currently receiving discipline five times as much as RNs are. I wonder what that would mean for the administration of medication?

One of the main issues that was raised last session when we were opposed to the same language was the issue of medication errors. We feel that what we have not heard here today is conclusive evidence that more errors will not occur with less skilled, educated, and trained CNAs administering medication. I think that was an important topic, and I do not think we have delved into that enough.

Lastly, although the legislation addresses a long-term care setting, it is my understanding that the bill would allow the use of medication aides-certified at the discretion of the facility as it is stated in section 1, subsection 2. This would also include acute-care facilities, and this would allow them to use medication aides-certified if this legislation is passed. That is something we absolutely would not be comfortable with.

Bobbette Bond, Las Vegas, Nevada, representing Health Services Coalition, Las Vegas, Nevada:
My very brief issue is in reference to the quality concerns we would have with any kind of initiative that is not carefully tracked, transparent, and reported to the state. I think what has happened in the last year with issues you would have thought would be reported and visible is that they were not, and it has been surprising and of great concern. It has put us all on high alert, including the Coalition. The Coalition puts substantial efforts into improving quality through transparency and to try to monitor quality. In response to one of the witnesses who was talking about Nursing Home Compare online through CMS, out of the 48 nursing homes listed on Nursing Home Compare, 25 of them are reporting their quality indicators as poor or very poor. That is more than half as having quality issues that would raise concerns about reporting. If this legislation is to move forward, we would want something to be built into it to ensure statewide transparency and reporting to the state in a way that we could carefully monitor the change. I do not think you will pick it up from CMS, and I think those indicators are too global, too late in reporting, and they would not track a new initiative going into place like this. We would hope for some state oversight.

Assemblyman Hardy:
On our Nursing Home Compare website, if they are reporting poor or semi-poor, is that not self reporting?

Bobbette Bond:
I think it is great that Nursing Home Compare is picking up that there are quality indicator problems. I think those quality indicator programs are pretty global and do not pick up a lot of finite things. They have no indicator to report that a new initiative has been put into place that is reporting higher medical errors, and I think medical errors are a serious enough concern already that they deserve special attention.

Assemblyman Hardy:
Are those not self reported? Does this not show that they are reporting themselves not doing as well as they would like to or expect to be doing?

Bobbette Bond:
I am not sure if they are self reporters. I know that there is a set of quality indicators required by CMS, but I am happy to research that and get back to you.

Assemblywoman Leslie:
Is it Nevada Compare Care? We have to get the name right. It just went live today. You found this going live on the website today?

Bobbette Bond:
I am very excited about Nevada Compare Care too, but this is not it. I am talking about the CMS website that compares nursing homes in Nevada.

Assemblywoman Leslie:
Is this information on Nevada Compare Care?

Bobbette Bond:
No, but it should be.

Assemblywoman Leslie:
It should be. That is the sort of information that I would hope is on our Nevada Compare Care website.

Renny Ashleman:
The discretion of the statement was simply an error. There is a definition that says "skilled nursing facility," which is in the definition of "facility." There is no possibility of this being confused with acute-care hospitals. That is in the statutory material that we have supplied so the speaker who was concerned with that did not have the definition of "facility" up.

We have supplied you with voluminous studies on the error rate and supervision by academics, practical application, state boards, and special experimental studies funded by the industry (Exhibit L). There is about every kind of study you can think of in there, and the experience of those studies is overwhelming that this does not increase the error rate. The indication that it has been adopted nationwide and is being considered by practically every state in the nation that has not already adopted it speaks for the fact that it does not have the problems that people may think would occur. The facts are that it has not been true. The studies all show that the statistical error rate is not meaningful between RNs and these particular aides. When compared to LPNs, they are somewhat superior, and that is in the literature I supplied to you and your staff. There is ample evidence available along those notes.

People do fear change, but we are not asking you to experiment, to do something that has not been studied, or do something that the overwhelming majority of the country is not already doing. I do agree with the need for transparency, and I previously promised this Committee that I will check out

how the reporting mechanisms interact to make certain that it is given to the State Board of Nursing. We will supply you with the information on that.

Chairwoman Smith:
We appreciate that. I think there is general concern being expressed because not every other state is in the situation that we are in, having just come off of the Hepatitis C crisis and the reporting problems that we experienced in regard to boards and licensing. However, we will let you continue doing your research and working with the Committee.

Renny Ashleman:
I think that we found, with regards to the Hepatitis C crisis, we had an area that was practically not regulated at all. We are, in fact, a heavily regulated industry.

Chairwoman Smith:
I understand that, and I think you understand my point that we are just in an odd situation.

Renny Ashleman:
I would not have picked this year with those headlines to begin this process if I had the choice.

Chairwoman Smith:
We will close the hearing on A.B. 106.

I do not think we will be able to do the work session today because we are bumping up against another committee, but I would like to go ahead and have Assemblywoman Pierce give us the Subcommittee report from Assembly Bill 76 and Assembly Bill 83 (Exhibit M). We will be able to go to the work session at another time.

Assembly Bill 76: Revises provisions governing the placement of children who are in the custody of an agency which provides child welfare services. (BDR 38-332)

Assemblywoman Peggy Pierce, Clark County Assembly District No. 3:
We had the Subcommittee meeting on March 5 at 3:30 p.m., and it was attended by myself, Assemblywoman April Mastroluca, and Assemblyman Joe Hardy. On A.B. 76, we considered a revised amendment offered by the Nevada Division of Child and Family Services (DCFS). In addition to the amendments offered during their original testimony, they added an amendment to address the concerns raised by a representative of the

Clark County Department of Family Services concerning the word "voluntary." No other amendments were proposed, and there was no testimony in opposition to the measure. Our recommendation to the full Committee was to amend and do pass.

On A.B. 83, DCFS testified at the first hearing that they reviewed the bill and found that they already had the authority to do what they needed to do. The Subcommittee recommendation on A.B. 83 is that the Committee take no further action.

Chairwoman Smith:
Thank you for participating in that Subcommittee.

[Meeting adjourned at 3:47 p.m.]

RESPECTFULLY SUBMITTED:

_____
Chris Kanowitz
Recording Secretary

_____
Julie Kellen
Transcribing Secretary

APPROVED BY:

_____
Assemblywoman Debbie Smith, Chair

DATE: _____

EXHIBITS

Committee Name: Committee on Health and Human Services

Date: March 16, 2009 Time of Meeting: 1:44 p.m.

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance sheets.
	C	Bill Welch	PowerPoint presentation.
	D	Robin Keith	Presentation on rural hospitals.
	E	R. Keith Schwer	PowerPoint presentation.
	F	R. Keith Schwer	KIDS COUNT bulletin.
A.B. 106	G	Renny Ashleman	Second Redraft handout.
A.B. 106	H	Lynda Mathis	Chart.
A.B. 106	I	Debra Scott	List of rationale.
A.B. 106	J	Betty Razor	Written testimony.
A.B. 106	K	Betty Razor	Bulleted points.
A.B. 106	L	Renny Ashleman	Redraft and supporting exhibits handout.
A.B. 76 and A.B. 83	M	Assemblywoman Peggy Pierce	Subcommittee report.