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

Seventy-Fifth Session
March 25, 2009

The Committee on Health and Human Services was called to order by Chair Debbie Smith at 1:53 p.m. on Wednesday, March 25, 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 Joseph (Joe) P. Hardy
Assemblywoman Sheila Leslie
Assemblywoman April Mastroluca
Assemblywoman Bonnie Parnell
Assemblywoman Ellen B. Spiegel
Assemblyman Lynn D. Stewart

COMMITTEE MEMBERS ABSENT:

Assemblyman John Hambrick (Excused)

GUEST LEGISLATORS PRESENT:

Assemblywoman Ellen Koivisto, Clark County Assembly District No. 14

STAFF MEMBERS PRESENT:

Kristin Roberts, Committee Counsel
Amber Joiner, Committee Policy Analyst
Darlene Rubin, Committee Secretary

OTHERS PRESENT:

Mary Wherry, Deputy Administrator, Health Division, Department of Health and Human Services
Stacy Shaffer, Political Director, Service Employees International Union, Local 1107, Las Vegas, Nevada
Alfredo Serrano, Registered Nurse, Vice President, Sunrise Hospital; Member, Service Employees International Union, Local 1107, Las Vegas, Nevada
May Chevez, Registered Nurse, University Medical Center, Las Vegas, Nevada; Member, Service Employees International Union, Local 1107, Las Vegas, Nevada
Marvel Bramwell, Registered Nurse, Renown Medical Center, Reno, Nevada; Executive Board Member, Service Employees International Union, Local 1107, Las Vegas, Nevada
Mike Ward, Research Director, Service Employees International Union, Local 1107, Las Vegas, Nevada
Renee Ruiz, Henderson, Nevada, representing Certified Nurses Association of Nevada, Henderson, Nevada
Toni Dobbins, Registered Nurse, Saint Mary's Hospital, Reno, Nevada; Member, California Nurses Association/National Nurses Organizing Committee, Oakland, California
Carrie Carter, Registered Nurse, St. Rose Dominican Hospital, Las Vegas, Nevada
Hedy Dumpel, Chief Nursing Director, Practice and Patient Advocacy, California Nurses Association/National Nurses Organizing Committee, Oakland, California
Bill Welch, President and CEO, Nevada Hospital Association, Reno, Nevada
Betty Razor, President, Nevada Nurses Association, Reno, Nevada
Robin Keith, President, Nevada Rural Hospital Partners, Reno, Nevada
Margaret Covelli, President, Nevada Organization of Nurse Leaders, Henderson, Nevada

Chairwoman Smith:
[Roll called. Protocol on testifying before the Committee.]

We will begin with our work session today, and we will start with Assembly Bill 107.

Assembly Bill 107: Creates the Advisory Committee for the Prevention and Treatment of Stroke within the Health Division of the Department of Health and Human Services. (BDR 40-208)

Amber Joiner, Committee Policy Analyst:
[Introduced work session document (Exhibit C).] Assembly Bill 107 was sponsored by Assemblyman Oceguera and heard on March 2. It creates the Advisory Committee for the Prevention and Treatment of Stroke within the Health Division of the Department of Health and Human Services. This measure requires the Advisory Committee to make recommendations to the Health Division for the establishment of a comprehensive plan for the prevention of stroke, heart disease, and other vascular disease in Nevada, and it requires submission of an annual report of its activities to the Division.

The first amendment that was offered is by the sponsor, Assemblyman Oceguera. He proposes several changes, which are laid out in the mock-up attached to the work session document. On page 1 of the mock-up, the only change on that page would be to change the name of the Advisory Committee to the "Advisory Committee for the Prevention and Treatment of Stroke and Heart Disease." On page 2, you will see that "and Heart Disease" continues throughout. In addition to that, section 8 would change some of the qualifications for the members. The neurologist would need to be board-certified. In section 8, subsection 2, paragraph (b), a board-certified cardiologist would be added who is experienced in treating victims of heart disease and heart attacks, instead of a person who works in an emergency room.

Under paragraph (g), a representative from a school of public health of the Nevada System of Higher Education would be removed under the amendment. On line 41, a person who is a survivor of heart disease rather than a stroke would be appointed by the Speaker of the Assembly.

On page 3, starting on line 5 in subsection 4, you will see that the expert in chronic disease appointed by the administrator of the Health Division would not be reappointed. In section 9, the provision was made to clarify that it is only to the extent that money is available from any source that the Advisory Committee would do its work.

On line 41, you will see a deletion. That concept was not deleted entirely, because you will see it on the next page. It was thought that it would be more effective to make it its own section. So on page 4, lines 11 through 14, it very clearly states that "In making the recommendations required by paragraph (c) of subsection 1, the Committee shall not consider or address any issue concerning the transfer of a patient."

Additionally, there was another amendment offered in writing during the original hearing. You will see it behind the mock-up, which is Amendment B, by the Nevada System of Higher Education. They proposed the following amendment: that there would be a technical correction for the name of the school from which a member would be appointed. A school of public health technically does not exist within the Nevada System of Higher Education so the name would be changed to "a School of Community Health Sciences." The second part of their amendment would be to add that the appointment of the representative from the School of Community Health Sciences would be made in consultation with the Chair of the Board of Regents.

You will notice that these amendments directly conflict. Final action to amend this measure requires a choice between either Amendment A(2)(c) or Amendment B because both relate to the Advisory Committee member representing the Nevada System of Higher Education. There was no testimony in opposition to this measure.

Chairwoman Smith:
From the work done by the sponsor of the bill, Assemblyman Oceguera, and others who had testified and had concerns about the bill, the mock-up that is presented is the sponsor's preference.

Assemblyman Hardy:
Does section 9 on page 3, lines 16 and 17, do away with the fiscal note?

Chairwoman Smith:
I do not know if it does away with the fiscal note, but I think it clearly states that the Advisory Committee will not be functional unless they have the money available. I guess the fiscal note would still exist because that would be the cost of the Advisory Committee.

Assemblywoman Leslie:
Why does the sponsor want to delete the representative from the Nevada System of Higher Education? It looks like from their amendment they want to be represented. I just do not recall any discussion on that point.

Chairwoman Smith:
I do not have the answer to that as that resulted from the negotiations that took place regarding this bill. I checked with the sponsor as recently as about a half an hour ago to make sure everybody was satisfied. Am I stating it correctly—if the bill states that the Advisory Committee would function if there was money available, the fiscal note would not technically go away because it still indicates how much it would cost to run the Advisory Committee? Is that correct?

Mary Wherry, Deputy Administrator, Health Division, Department of Health and Human Services:
That is correct. In our original testimony, what the staff spoke to was that the cost incurred by the Health Division would be $245,474 for the biennium, which would include support of one full-time employee and the Advisory Committee activities.

Chairwoman Smith:
So the fiscal note is there, and the bill states that the money would have to be available for the Advisory Committee to be functional.

Mary Wherry:
Correct. We are very interested in seeing a committee like this come to fruition and do believe that it would help us qualify for future federal funding opportunities. The challenge is that we do not have any fat or pork in our agency at this point in time to free up resources to send out notices, to abide by the Open Meeting Law, to set up the accommodations, to do all the communication, to do the minutes, and to provide all the support that is necessary to appropriately staff a committee. And if anybody needs accommodations for disabilities or transportation, we just would not be able to cover that.

Assemblyman Cobb:
I have in my notes from the testimony that the real requirement for receiving grant funds is that we have a stroke plan on the books and that we do not necessarily have to have a government program or government employees attached to it. I know the American Heart Association already has a committee working on this issue. I do not know all of the ins and outs of the interaction with the Ways and Means Committee regarding this bill, but I would hate to hold this up by making it a requirement that this be a government program.

Maybe we should just encourage the American Heart Association to move forward with their already ongoing efforts to establish a stroke plan so they can start receiving grant funds. Then we are not hog-tied by the $250,000 fiscal note.

Mary Wherry:
I would not disagree with you at all. We would be more than happy to participate on a committee and to do what we could. We are always seeking grant opportunities. We would do what we could to help draft a grant application if an opportunity came forward. We would be committed to doing what we could with the resources we have if the private sector or nonprofits were able to pull together some of their own resources. We would be available with whatever expertise and experience we have to offer in these types of chronic disease program management opportunities.

Assemblyman Hardy:
Has the state been invited to the table by the private sector American Heart Association to be involved with this very same thing?

Mary Wherry:
To my understanding, Chris Wood, who is our new chronic disease coordinator, has been working with Mr. Roller. We had funds from last session for a vascular committee, and that was part of what we gave up in the first round of budget cuts. There has been a little bit of background and momentum in this direction, but it has come down to our availability of resources to really devote more of our time and attention to help them pull this together.

Chairwoman Smith:
I think we know from messages we were receiving, particularly at the beginning of the session, that this is very important to the American Heart Association in moving their agenda forward. If there is no other discussion, I will accept a motion to amend and do pass.

> ASSEMBLYWOMAN SPIEGEL MOVED TO AMEND AND DO PASS ASSEMBLY BILL 107, INCLUDING AMENDMENT A.
>
> ASSEMBLYWOMAN MASTROLUCA SECONDED THE MOTION.

Assemblyman Hardy:
We have to make sure that we are clear that this does not obligate the state to come up with any money as it is written, other than to accept and use funds as they become available.

Assemblyman Stewart:
I am a "yes" with the option to change my vote.

Assemblyman Cobb:
I am going to make the same disclosure, the concept being that I think we already have this available to us in the private sector. I would encourage the Health Division to work closely with those individuals who are experts at this and just keep moving forward without having to have a fiscal note attached to it or slowing down the process because the American Heart Association is already moving forward on this.

Assemblyman Hardy:
I want to be sure that we do not put another $250,000 hole in the budget.

> THE MOTION PASSED. (ASSEMBLYMAN HAMBRICK WAS ABSENT FOR THE VOTE. ASSEMBLYMEN COBB AND STEWART RESERVED THE RIGHT TO CHANGE THEIR VOTES ON THE FLOOR.)

Assembly Bill 337: Creates the Office of Statewide Coordinator for Children Who Are Endangered by Drug Exposure in the Office of the Attorney General and makes various other changes concerning children who are endangered by drug exposure. (BDR 38-593)

Amber Joiner, Committee Policy Analyst:
[Read from work session document (Exhibit D).]

Chairwoman Smith:
We just heard this bill and a lot of testimony on it. There was obviously a lot of concern about the judicial aspect of the bill. There also is a sizeable fiscal note. I suggested to the sponsor that we move this bill with no recommendation to Ways and Means so that it would be declared exempt, and there would be the rest of the session to resolve any issues. If they cannot be resolved, then whatever happens to it would happen in that committee. It seemed to me that it does not make a lot of sense to hold on to it here when it would receive more time for work in Ways and Means. If the sponsor likes that idea, I think that would be a good resolution.

Assemblywoman Leslie:
I think that is a good idea. I spoke with the Attorney General last night and they have lawyers working with the public defenders' offices and the American Civil Liberties Union (ACLU) to try to come up with some acceptable language in the first part. Regarding the second amendment, nobody wants

affordable health care for children more than I do, but I am not sure this is the right bill to put it in. I would like the first part of the amendment on comprehensive drug and alcohol treatment too, but that is not really what the bill is about. The issue of making sure we do not criminalize pregnant women absolutely will be addressed in the legal language. I am fine if the Committee wants to move it to Ways and Means.

Chairwoman Smith:
Is everyone clear? I will take a motion.

> ASSEMBLYMAN STEWART MOVED TO REPORT ASSEMBLY BILL 337 WITHOUT RECOMMENDATION AND TO REREFER THE BILL TO THE COMMITTEE ON WAYS AND MEANS.
>
> ASSEMBLYMAN DENIS SECONDED THE MOTION.
>
> THE MOTION PASSED. (ASSEMBLYMAN HAMBRICK WAS ABSENT FOR THE VOTE.)

Chairwoman Smith:
I will open the hearing on Assembly Bill 121.

Assembly Bill 121: Makes various changes concerning health care facilities that employ nurses. (BDR 40-492)

Assemblywoman Ellen Koivisto, Clark County Assembly District No. 14:
For those of you who have served on this Committee in the past, this bill has been before you a number of times with my name on it. I have an amendment to the bill (Exhibit E). The amendment takes out specific numbers. The question is how many nurses is enough. Anyone who has dealt with health care issues certainly has read or heard the statistics that the lack of enough nurses in a unit can cause infections, pneumonia, et cetera. If you do not have enough bedside nurses that they are able to spend time with patients, we have problems. Many nurses will tell you that if you have a family member going to a hospital, make sure you have someone who can spend time and be there because the nurses do not always have the time. I am sure we have all seen those situations.

This year—and a lot of the information I am using is from the National Conference of State Legislatures—at least nine states are considering legislation that would require hospitals to meet specific nurse-to-patient ratios. Advocates want to follow the lead of California. It has taken me ten years of working on this to get it through my head that we cannot pass legislation from

this Legislature that specifies numbers. This is not California, nor would we want it to be.

Section 1 says that Chapter 449 of the *Nevada Revised Statutes* (NRS) is being amended by adding the provisions of sections 2 through 28 of this bill. Sections 2 through 11 are definitions. When you get to section 13 on page 3 of the bill, from section 13, subsection 1, down to lines 32 and 33, those will be deleted. The amendment will redesignate the paragraphs, too. Section 14 is what is in the amendment. Subsection 1 of section 14 is amended to remove specific ratios. Subsection 2 remains, which states that a nurse administrator or supervisor who is not a direct-care nurse must not be included in the calculation of nurse-to-patient ratios. Subsection 3 remains unchanged. Subsection 4, on line 24 of page 5, the word "following" is removed. Lines 27 through 30 are deleted.

Chairwoman Smith:
Lines 27 through 30? I do not see that on your document. I just want to make sure it is clear.

Assemblywoman Koivisto:
In subsection 5, it is changed to redesignate paragraph (a) as subsection 5 by removing the language ahead of the paragraph. Lines 31 and 32 will be deleted, too. [Read from proposed amendment (Exhibit E).]

Section 15 remains intact to line 19. Paragraph (a) of subsection 2 of that section will be replaced by my proposed language. [Read from proposed amendment (Exhibit E).] The rest of the bill stays the same. It deals with licensure and nurses. On page 7, it deals with nurses being assigned for purposes of compliance with the staffing level if the nurse is appropriately licensed for assignment to that unit or clinical area, and the nurse has had prior orientation before working in that area. One of the complaints that I have heard over the years from nurses is that they are taken from the area where they work and are familiar with the processes and put into another unit, and that can cause difficulties.

Chairwoman Smith:
This takes the numbers out of the bill and requires everything to be required at the hospital level.

Assemblywoman Koivisto:
Yes, it requires labor management committees to meet and establish the ratios.

Assemblyman Hardy:
Obviously this would change your fiscal note.

Assemblywoman Koivisto:
It probably would.

Assemblyman Hardy:
We will have to look into it.

Assemblywoman Koivisto:
I believe the fiscal note came from the Labor Commissioner.

Chairwoman Smith:
There is also a sizeable fiscal note for the state hospitals. We will discuss that after we figure out the entire amendment.

Stacy Shaffer, Political Director, Service Employees International Union, Local 1107, Las Vegas, Nevada:
We did have an opportunity to speak with the sponsor, Assemblywoman Koivisto, earlier today. Unfortunately, we have not had an opportunity to present the amendment to our executive board, which is our standard process. If it pleases the Chair, our members would like to speak on the importance of nurse-to-patient ratios.

Alfredo Serrano, Registered Nurse, Vice President-Sunrise Hospital, Member, Service Employees International Union, Local 1107, Las Vegas, Nevada:
[Read from prepared testimony (Exhibit F).]

May Chevez, Registered Nurse, University Medical Center, Las Vegas, Nevada; Member, Service Employees International Union, Local 1107, Las Vegas, Nevada:
[Read from prepared testimony (Exhibit G).]

Marvel Bramwell, Registered Nurse, Renown Medical Center, Reno, Nevada; Executive Board Member, Service Employees International Union, Local 1107, Las Vegas, Nevada:
[Read from prepared testimony (Exhibit H).]

Chairwoman Smith:
Since you have all been in the field for a number of years, I was wondering if you could tell the Committee if you think that the conditions have changed since we have been talking about this issue for over the last four sessions. It has been a number of sessions since we have had a staffing bill, and I just

wonder if things have improved because this has been discussed often and in the forefront of health care discussions.

Alfredo Serrano:
I believe things have changed just recently with the economic crisis and that was used as a reason to decrease staff by sending nurses home when a patient went home, resulting in not having any padding on the staff. Every nurse, during every minute of the day, is running. I think just recently it may have taken a turn for the worse.

Chairwoman Smith:
Had it improved until then, do you think?

Alfredo Serrano:
It was improving until just recently.

Chairwoman Smith:
Well, we certainly see this economy affecting us everywhere. We feel it in every committee room, and in every budget hearing we see the ramifications of the bad economy.

Marvel Bramwell:
I just want to point out that when we went into negotiations, safe staffing ratios was our number one concern, and we really fought hard for that. We are very proud of it.

Mike Ward, Research Director, Service Employees International Union, Local 1107, Las Vegas, Nevada:
Today you are probably going to hear many doomsday scenarios about what happened to California hospitals when nurse-to-patient ratios were implemented on January 1, 2004. In preparation for this, we took a look at data from California's Office of Statewide Planning and Development and the California Hospital Association to gain a better understanding of California's hospitals before and after the implementation of ratios. We sought to answer the following questions: Did hospitals close after the implementation of ratios? If so, what were the reasons for hospital closure? What has been the impact in hospital operations and financial performance since the implementation?

On the first chart of my handout [Slide 2 of (Exhibit I)], hospitals did close after the implementation of nurse-to-patient ratios, but at a slower pace than in previous years. Between 1996 and 2003, the years before ratios were implemented, an average of approximately nine hospitals closed every year in California. The ratios were implemented on January 1, 2004, and between 2004 and 2008, less than four hospitals closed per year.

On the next slide, the hospitals did not close as a result of the ratios. All of the facilities were experiencing financial distress. All of the facilities that closed in 2004 had negative operating margins in at least two of the previous three years.

On the next slide, we see the same trend for hospitals that closed in 2005. All of the facilities were experiencing financial distress and all had negative operating margins prior to closure.

The next slide shows California hospital operating profits before and after ratios. The average California hospital is more profitable today than before the implementation of ratios. The average California hospital had a net operating revenue per adjusted patient day of -$9.34 from 1998 to 2003 compared to $4.19 from 2004 to 2007. While we see that net operating revenue per patient day dipped slightly in 2004, it has since recovered. The next slide shows Nevada hospital operating profit. By comparison, the average Nevada hospital's net operating revenue per patient day is $41.50 since 2003. They are in much better shape financially than the average California hospital.

On the next slide is California hospital employee expenses before and after the implementation of ratios. We expected to find that increasing the number of registered nurses at the bedside would drive hospital expenses. We found, however, that total expenses grew an average of 8.4 percent per year between 1998 and 2003 but only 7.2 percent after. Total operating expenses grew 8 percent versus 6.7 percent after. The last slide shows registered nurse (RN) productive hours as a percentage of total productive hours.

We should also note that there is an impact on quality and patient outcomes. The RNs show a greater percentage of productive hours per patient day than they did prior to the implementation of ratios. Repeated studies, such as Aiken's groundbreaking study, have shown that more nursing hours lead to better patient outcomes.

In closing, many people here would have you believe that implementing mandatory nurse-to-patient ratios will bankrupt hospitals in Nevada. This is simply untrue. I urge you to consider the legislation before you and pass A.B. 121.

Chairwoman Smith:
It does seem a little bit counterintuitive. Anecdotally, can you explain why you do not believe expenses go up when the staffing ratios are implemented?

Mike Ward:
The reasons we have for expenses growing have nothing to do with salaries, but more with professional fees of physicians, insurance, and so forth. We also found that necessary supplies tended to increase. There is a concern that in some instances ancillary staff was reduced at the same time nurse-to-patient ratios were implemented.

Assemblyman Hardy:
What ancillary services were decreased?

Mike Ward:
We did find that licensed practical nurse (LPN) and certified nursing assistant (CNA) hours were reduced since ratios were implemented.

Assemblyman Hardy:
Is that ancillary or is that just different kinds of nurses?

Mike Ward:
That is considered ancillary.

Renee Ruiz, Henderson, Nevada, representing Certified Nurses Association of Nevada, Henderson, Nevada:
We will speak to the bill as it is written, as we have not had a moment to review the amendments presented by Assemblywoman Koivisto. We applaud the intent of A.B. 121 in establishing real nurse-to-patient ratios for all hospitals in Nevada. There is, however, a small amendment to section 14 that we wish to propose. I believe I have made the language available to the Chair and to Assemblywoman Koivisto. We have also presented the amendment to the Service Employees International Union (SEIU).

Chairwoman Smith:
We will make copies of the amendment available, although I do not know if it is still pertinent considering the sponsor's amendment.

Toni Dobbins, Registered Nurse, Saint Mary's Hospital, Reno, Nevada; Member, California Nurses Association/National Nurses Organizing Committee, Oakland, California:
I have been an RN for about five years. We have RN-to-patient staffing ratios in our contracts with California Nurses Association/National Nurses Organizing Committee (CNA/NNOC) and Catholic Healthcare West (CHW), which is the organization that owns Saint Mary's now. Let me tell you what it is like for a patient and an RN when there are not clearly defined and state mandated RN-to-patient ratios. I was once working in our critical care area. It was busy, which is commonplace in the emergency room. I was assigned four rooms and assigned a newly graduated nurse as well. Within a very short time, I had four patients: one with severe abdominal pain and altered mental status, a patient complaining of heart palpitations whose heart rate would dip into the 30s, a patient with a possible gastrointestinal bleed, and a patient with new onset chest pain, all of whom arrived within a very short period of time of each other.

Although I needed and requested help to stabilize and begin medications, assess my patients, and supervise the new RN, no one was available to assist, as staffing was low for the acuity needs, and my fellow nurses were just as busy. A short time later, my patient with severe abdominal pains stopped breathing and her heart rate slowed. We were successful in stabilizing her but, because no one was available to take over primary care of my three other patients, I continued to provide care for them as well, but they had to wait.

I believe that on days where RN-to-patient ratios are appropriate to the acuity level needed, adequate care is provided with positive outcomes. On days such as I described, three equally deserving critically ill patients had to wait for their care. If we do not act and pass adequate legislation for safe RN-to-patient ratios, it could be my or your family member who has to wait. I have heard administrators say that RN-to-patient ratios are not law, so we do not have to comply. The safe ratios are proven to save lives. But, in Nevada, the health care and hospital industry is balking at the proven evidence of this, causing our patients to suffer, and we lose RNs due to unsafe working conditions so the hospitals can increase their bottom line. I can personally tell you that I have seen lives saved when hospitals are staffed appropriately. The RNs know their patients. We know what it takes to care for our patients, and we are the ones at the bedside.

I ask you to help us care for you and your families. It is our obligation as RNs to advocate for our patients. That is why I am here, to advocate for all patients and RNs in Nevada. It is most important for the health and welfare of our state that real RN-to-patient ratios are put into law. We may not be California, but we have the opportunity to learn from them and be better.

Carrie Carter, Registered Nurse, St. Rose Dominican Hospital, Las Vegas, Nevada:
I have practiced all across the country and now find myself in Nevada trying to bring up patient care issues and be an advocate for our patients and bring the standards up to California's. I currently work at the gastrointestinal unit and same-day surgery center at St. Rose Dominican Hospital, Siena Campus, in Las Vegas.
I want to explain what a typical day looks like for an RN on a gastrointestinal unit. My day starts with reviewing my schedule and seeing that I have the responsibility of recovering 30 patients in four hours. If you look at the numbers, that is 7.5 patients each hour that another nurse and I have to "recover," which means coming out of an induction agent medication.

I find that management sets the tone of "move fast, not safe." Reimbursements by Medicare have increased 17 percent. So in my unit alone, if we kept the same numbers as last year, my unit would profit $200,000, not counting if we increased our numbers. Management is encouraged by the upper-level management to cut staffing to ensure large bonuses for them. It entails our patients' health and safety being put at risk.

I am a firm believer in nurse-to-patient ratios all across the country. I believe that each family member would agree with you. Every day I walk into the hospital, I try to provide the best care that I can for my patients, and I take on a sincere duty to keep my patients safe, as do my coworkers and other hospital staff. I do feel it is my duty to put the needs of the patients first, not the budget. I know budgets are important in these tough economic times, but let me assure you that we still have to take care of patients no matter what the budget is. They will still come into our emergency room bleeding because they could not afford the medicine that they need. They are still going to need surgery whether they have insurance or not. I work at a Catholic nonprofit hospital that must take care of patients whether they have insurance or not. We do not ask them if they have Medicare, Medicaid, Blue Cross, or Blue Shield. We say that they have come to a safe place where we want to care for them so they can return back to work, back to families, and back to homes.

I appreciate the time and the energy all of our nurses give in caring for our patients, no matter what background. I appreciate the time that you have given to listen to us. We hope you will take what we have to say into consideration.

Hedy Dumpel, Chief Nursing Director, Practice and Patient Advocacy, California Nurses Association/National Nurses Organizing Committee, Oakland, California:

One thing that needs to be very clear is that we as an organization strongly support mandated, uniform, specific, and numerical RN-to-patient ratios, and for that reason we strongly oppose the amendments that are in front of you.

There has been quite a bit of testimony today that eloquently describes the concerns that registered nurses have in the State of Nevada with respect to safe, therapeutic, and effective patient care in the state's hospitals. I want to give you some data from studies, some of which you have already heard today. The higher the number of patients assigned to registered nurses, the higher the rate of mortality and the higher the rate of failure to rescue. It is also shown that the higher the number of registered nurses, the higher the likelihood that registered nurses can monitor the patient's condition to recognize subtle changes and to engage in early intervention that saves lives. Studies have also shown that the more patients assigned to a registered nurse, the higher the rate of burnout and job dissatisfaction, and the higher the rate of exodus of registered nurses from acute care facilities. This has been the case in the state of California, where there was an exodus from the hospitals as a result of oppressive working conditions and an excessive patient workload. Based on the surveys that were done by our Board of Registered Nursing, since the implementation of the ratios in 2005, registered nurses have come back to the bedside and they have come back to the hospitals. As a matter of fact, there are now more than 100,000 additional RN licenses that have been issued by the California Board of Registered Nursing. It is an indication that ratios work and that the hospitals have not lost money and have not closed as a direct result of the ratios. They have made money, our vacancy rate is down, and it is working. Whatever doom and gloom you have heard of in California, it is not there.

Chairwoman Smith:

I want to clarify with Ms. Ruiz because I thought you were supportive of the bill as amended. Do you need to clarify that position? I just heard Ms. Dumpel say that you are opposed to the bill.

Renee Ruiz:
We support the bill as written. Ms. Dumpel was addressing the amendments that were presented today by Assemblywoman Koivisto.

Bill Welch, President and CEO, Nevada Hospital Association, Reno, Nevada:
I am here to oppose A.B. 121 as it was introduced. I am providing you written testimony that supports my arguments as submitted (Exhibit J). However, understanding that the sponsor of the bill has presented an amendment, we would like an opportunity to review and consider the amendment, and that certainly could modify our position.

I disagree with a number of the comments and agree with a number of the comments. Patients are in a hospital for nursing care after they receive their initial care from a physician. Nurses are a very critical component for patient outcomes. There are many studies that would disagree with the data that was presented today. I have presented to you some of those findings. We have developed a white paper that researched a multitude of studies across the nation with regard to mandatory numerical staffing ratios, including California, which has taken the lead in establishing mandatory numerical staffing ratios. The financial conclusions that Mr. Ward came to, not having seen his data nor having the opportunity to consider his analysis, are difficult for me to respond to. However, the California Hospital Association and its members have a different perspective than what Mr. Ward presented.
I would also disagree with his projected image that Nevada hospitals are doing well financially. We have presented a lot of testimony on many different bills with regard to the financial status of Nevada's hospitals.

As one of the previous speakers stated, who better than a nurse to know what is appropriate and needed for nurses? We believe that an artificial numbering system does not take into consideration the nurse's knowledge, understanding, and experience on how to best staff and ensure that patients receive their care.

With respect to the proposed amendment, we have been working with the Nevada Nurses Association, the Nurse Organization and Nurse Leaders, the Nevada Rural Hospital Partners, and the members of the Nevada Hospital Association to try to come up with some language. We have been trying to build consensus, and we believe we are close to achieving that with those organizations on several issues in the bill.

There are aspects of A.B. 121 that we are supportive of and receptive to. We do agree that a staffing committee is appropriate. Many of our hospitals already have staffing committees that have equal representation, if not more, of bedside registered nurses than of management. We are receptive to the concept, and we just need to work with the sponsor of the bill to come up with what that language should look like. We do agree it should be put into law that each hospital must have a committee with a minimum of 50 percent of bedside nurses and up to 50 percent of management. That committee would be responsible for developing a staffing plan. All hospitals today must have a staffing plan. That is a condition of licensure. That staffing plan is available to the Bureau of Licensure and Certification—I understand that they have a new name, but I do not recall the new name. That oversight agency has the ability to come in, review the plan, go to the floor, and ensure that the plan is being implemented. A nurse at a hospital has the opportunity to submit an anonymous complaint to the Bureau of Licensure and Certification. The Bureau then has a responsibility to evaluate the validity of the complaint, and if they believe it is valid, they have the responsibility to come in and investigate that complaint.

We support the idea that a committee be created in all hospitals that would have an equal representation of bedside registered nurses and management.

Chairwoman Smith:
One question I have—and we do not need an answer today, but you might want to explore this for us and get an answer to the Committee—is about the comment made by one of the nurses, that in the current economic situation, we are seeing ratios diminished because of the financial conditions that the hospitals are in. I do have a concern about that.

Bill Welch:
I would be happy to do that. Hospitals have been reducing staff as a result of the economy. They first tried to reduce in nonpatient areas. Utilization of our hospitals has also been on the decline because of the growing number of uninsured. Many people are putting off their health care needs. It is possible that there have been reductions, but I would certainly look into this and will report back to you.

Betty Razor, President, Nevada Nurses Association, Reno, Nevada:
We have been working diligently with the Hospital Association and other organizations to try to come up with some language that we felt would be more appropriate for the changes in the original bill. The amendment that has been presented right now has given us a little bit of thought as to where we are

going to go from this point. We request some more time to be able to present our amendments accordingly.

We have found that the ratios, which have created some angst and disturbance, create logistical challenges within the system for maintaining ratios on a 24/7 timeframe. You cannot take a break unless you find someone to cover for you. That means that you have to find a nurse from somewhere to come in and assume your duties while you go to lunch or even go to the bathroom. That has become a great issue and has sometimes created a lot of animosity between management and staff. One of the studies from the California HealthCare Foundation found that the issue was critical. They did find that it did not increase the quality of care during the timeframe that they studied, which was from 2004 to 2007.

As for the Nevada Nurses Association, we prefer that you have flexibility, and that nurses be part of the challenge to come up with a nurse-to-patient ratio that has flexibility without the dictates of numbers.

Chairwoman Smith:
You certainly will have an opportunity to continue working with Assemblywoman Koivisto and others to develop your opinions and thoughts on this amendment.

Robin Keith, President, Nevada Rural Hospital Partners, Reno, Nevada:
I refer you to section 28 on page 11 of the original bill. Depending on the proposed amendment from Assemblywoman Koivisto today, the number may actually change. Section 28 was intended to exclude the small rural hospitals in the state from the provisions of the bill as originally written. I am assuming that the same language would apply in the amendment. I am proposing an amendment today. It is intended to deal with the fact that we accidentally captured in this bill the hospital in Incline Village, which is in Washoe County, and two small hospitals in Clark County, the one in Boulder City and the one in Mesquite. By adding language in section 28 that specifically excludes hospitals with fewer than 50 acute beds, I think we accomplish that. We are working with the Hospital Association and others trying to reach an amendment that we can all agree on and where this will not even be an issue, but we are not there yet.

Chairwoman Smith:
I have your amendment but the Committee does not have it, because we were not sure where the bill was going. We will certainly have that in the mix and the parties can address that. I am assuming that the sponsor is open to that. The sponsor is nodding her head in the affirmative.

Margaret Covelli, President, Nevada Organization of Nurse Leaders, Henderson, Nevada:
Our organization represents all nursing leaders, from frontline managers to executives in hospitals, specialty hospitals, long-term care facilities, home health and hospice, and outpatient care facilities. Our mission is to advance the profession of nursing and to ensure access to care for the citizens and visitors of Nevada. We are here to let you know we opposed A.B. 121 as it was introduced. However, now that an amendment has been proposed, we would like to be offered time to work with the Nevada Nurses Association, the Nevada Hospital Association, and Nevada Rural Hospital Partners on this amendment.

Chairwoman Smith:
I will close the hearing on A.B. 121.

Is there any public comment? [None.] Meeting adjourned [at 3:18 p.m.].

RESPECTFULLY SUBMITTED:

Darlene Rubin
Recording Secretary

RESPECTFULLY SUBMITTED:

Sean McDonald
Transcribing Secretary

APPROVED BY:

Assemblywoman Debbie Smith, Chair

DATE:

EXHIBITS

Committee Name: Committee on Health and Human Services

Date: March 25, 2009 Time of Meeting: 1:53 p.m.

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
A.B. 107	C	Amber Joiner, Committee Policy Analyst	Work session document
A.B. 337	D	Amber Joiner	Work session document
A.B. 121	E	Assemblywoman Ellen Koivisto	Proposed amendment
A.B. 121	F	Alfredo Serrano	Prepared testimony
A.B. 121	G	May Chevez	Prepared testimony
A.B. 121	H	Marvel Bramwell	Prepared testimony
A.B. 121	I	Mike Ward	Prepared testimony
A.B. 121	J	Bill Welch	Prepared testimony