MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND EDUCATION

Seventy-fifth Session
April 13, 2009

The Senate Committee on Health and Education was called to order by Chair Valerie Wiener at 3:25 p.m. on Monday, April 13, 2009, in Room 2149 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to the Grant Sawyer State Office Building, Room 4412, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

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

COMMITTEE MEMBERS ABSENT:

Senator Maurice E. Washington (Excused)

GUEST LEGISLATORS PRESENT:

Assemblyman Joseph (Joe) P. Hardy, Assembly District No. 20
Assemblyman John Oceguera, Assembly District No. 16
Assemblyman Bonnie Parnell, Assembly District No. 40

STAFF MEMBERS PRESENT:

Marsheilah D. Lyons, Committee Policy Analyst
Laura Adler, Committee Secretary

OTHERS PRESENT:

Christine Wood, RDH, BS, Chronic and Communicable Disease Manager, Bureau of Child, Family and Community Wellness, Health Division, Department of Health and Human Services
Robert H. Talley, D.D.S., Executive Director, Nevada Dental Association
Bobbette Bond, M.P.H., Executive Director, Nevada Health Care Policy Group, LLC
Wendy St. Cyr, Dental Hygienist, Nevada Dental Association
R. Michael Sanders, D.D.S., Professor and Interim Chair of Clinical Sciences, University of Nevada, Las Vegas School of Dental Medicine
Tom Ray, General Counsel, University of Nevada School of Medicine; State Public Health Laboratory
Keith Zupnik, M.D., Project Coordinator, Southern Nevada Health District Childhood Lead Poisoning Prevention Program
Lawrence Sands, D.O., Chief Health Officer, Southern Nevada Health District
Jo Malay, Section Manager, Early Childhood Wellness, Health Division, Department of Health and Human Services
Kevin C. Barker, Las Vegas Police Protective Association
Richard Gilbert, Contracts Manager, Department of Public Safety

CHAIR WIENER:
We will open this hearing with A.B. 136.

ASSEMBLY BILL 136: Establishes the State Program for Oral Health. (BDR 40-861)

ASSEMBLYMAN BONNIE PARNELL (Assembly District No. 40):
I am excited to bring this bill before the Committee. I have prepared my testimony to make sure I cover all the points (Exhibit C).

CHAIR WIENER:
On page 4, lines 28–31, it mentions applying for waivers from the federal government. Could you give an example of the kind of waiver you had in mind?

CHRISTINE WOOD, RDH, BS (Chronic and Communicable Disease Manager, Bureau of Child, Family and Community Wellness, Health Division, Department of Health and Human Services):
I was not part of writing the language of the bill, so I am not sure what the intent was here. Currently, I am not aware that there would be a need for any waiver. I am wondering if that paragraph was added in the event that in the future there might be a need for such a thing.

ASSEMBLYMAN PARNELL:
That may have been put in as enabling language in case the opportunity arose.

MS. WOOD:
I have prepared testimony providing background on this bill (Exhibit D).

CHAIR WIENER:
Thank you for including that last portion about statutory authority, because in your remarks you had in this fiscal year information about the divisions and receipt of money and the number of members. That sounds so much like the bill before, but this is codifying what has become a practice to ensure the integrity of the program continues under statute rather than under division practice.

SENATOR CEGAVSKE:
The fiscal note says zero on both sides. I wanted to make sure there was not any change.

ASSEMBLYMAN PARNELL:
This is one of those great bills that has a zero fiscal note and is still allowed to do great things.

CHAIR WIENER:
That is why we have gifts, grants and donations provisions.

ROBERT H. TALLEY, D.D.S. (Executive Director, Nevada Dental Association):
I have prepared testimony in support of A.B. 136 (Exhibit E).

BOBBETTE BOND, M.P.H. (Executive Director, Nevada Health Care Policy Group, LLC):
I am in support of the State Program for Oral Health being codified. It has been a long time coming. There has been so much effort in this State to create a

better educational and prevention environment for the children. I started working on behalf of oral health a decade ago, and talked a little about that in the fluoridation testimony last week. This effort has coalesced all the stakeholders and moved forward. Nevada had a serious shortage of dentists and dental access ten years ago. The laws in this State were changed to allow more dentists to come in. Those additional dentists performed more work for the underserved, for community coalitions and for all the children who have gotten health care through the "Day One" program that Christine Wood helped organize, and the Nevada Dental Association was key in creating. Insurance companies developed the self-funded plan for many children in Nevada, and we appreciate the work the coalition has done. One of the partners in the coalition is the Nevada State Office of Rural Health. Caroline Ford, Director, Nevada State Office of Rural Health, could not be here today so she submitted a letter of support for A.B. 136 (Exhibit F). She has been a key stakeholder in working on filling dental shortages in rural areas and working with Western Interstate Commission for Higher Education to get more dental training in Nevada, and locating dental equipment to rural areas. All that has flowed through this coalition was put together without an actual office. We are here in support of the program being codified to keep it moving forward and to create the stability it needs for this growing State.

WENDY ST. CYR (Dental Hygienist, Nevada Dental Association):
The Nevada Dental Association is in favor of A.B. 136 for all the reasons that have already been stated. I applaud Nevada for its forward thinking on oral health.

R. MICHAEL SANDERS, D.D.S. (Professor and Interim Chair of Clinical Sciences, University of Nevada, Las Vegas School of Dental Medicine):
The School of Dental Medicine is indebted to the oral health program in this State for the richness of our curriculum. We have a uniqueness in the country among dental-education facilities in that our students are committed to service work, to community activities and to outreach within the State. Much of that educational process is facilitated by the state oral health program. I have consulted for a number of years with them on our curriculum and activities we generate. We take the position that this is a significantly important function to codify.

SENATOR CEGAVSKE MOVED TO DO PASS A.B. 136.

SENATOR WOODHOUSE SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR WIENER:
We will open the hearing on A.B. 137.

ASSEMBLY BILL 137 (1st Reprint): Revises provisions governing branch laboratories of the State Hygienic Laboratory. (BDR 40-201)

ASSEMBLYMAN JOSEPH (JOE) P. HARDY, (Assembly District No. 20):
This bill had its genesis out of the need for a statewide designation of a laboratory in southern Nevada to interface with the Centers for Disease Control and Prevention (CDC) and other nationwide laboratories so we could have equal footing in gathering information and sharing expertise. What this bill does is codify the concept that the University of Nevada School of Medicine can designate, establish or maintain a branch laboratory. The bill requires a public agency that operates or controls such branch laboratory to enter into a cooperative agreement concerning the branch laboratory.

That sounds simple, and it was, until the attorneys had to write the language; that is why it took so long. The good news is the language is fairly straightforward. The basic part is in section 1, subsection 6. The bill also recognizes that we changed the name of the State laboratory from the State Hygienic Laboratory to the State Public Health Laboratory, so it is better described.

TOM RAY (General Counsel, University of Nevada School of Medicine; State Public Health Laboratory):
I am here to endorse the State Public Health Laboratory in support of this legislation.

SENATOR WOODHOUSE MOVED TO DO PASS A.B. 137.

SENATOR CEGAVSKE SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR WIENER:
We will now open the hearing on A.B. 219.

ASSEMBLY BILL 219: Enacts provisions governing certain blood tests for children. (BDR 40-682)

ASSEMBLYMAN HARDY:
This bill came out of a yeoman's task of looking at lead exposure and lead poisoning with a lead task force in southern Nevada, working diligently to prevent and protect children from lead exposure. Inasmuch as the treatment for lead poisoning is problematic, it is critical that we prevent lead poisoning, and that is how the genesis of the bill came about.

Senator Horsford and I served on the interim Legislative Committee on Health Care. We started looking at how many bills we were going to be able to bring to this Committee. I volunteered to the Chair of the interim Legislative Committee on Health Care that I would reserve a bill draft request for this purpose, and Senator Horsford graciously said he would come with me, and we are here with the bill to protect the children.

It is problematic trying to figure out how to fund things. When a health-care provider, a doctor, does an early and periodic screening diagnostic treatment service for a child, the doctor can order a lead test. The bill encourages health-care providers to do exactly that. Then we have the opportunity to look at this as a means of data collection to access the exposure rate to lead, and perhaps even identify the areas that are most challenging for us to make sure that we protect our children.

CHAIR WIENER:
On page 2, you address the specific patient reaching 12 and 24 months of age or before the child is age 6. Is this the preferred time frame to capture this information or make this diagnosis? Is there is still something that could be done to help create healthier children who have been exposed to lead once you capture this information at those ages? Is that why these ages are cited?

ASSEMBLYMAN HARDY:
The earlier you catch it, the better off the child is. As the child becomes a toddler and starts chewing toys or picking up flakes of lead-based paint, that is when the child is most vulnerable to being exposed to lead. The earlier we find it, the better. That is why you want to do testing at 12 and 24 months. Likewise, certainly before they are age 6. Once you have lead in you, it is very difficult to reverse it, so the earlier the lead is found, the better off you are.

CHAIR WIENER:
I am looking at 12 and 24 months, and then I am seeing age 6. I was wondering about that span after 24 months; going from 2 years to 6 years is quite far.

ASSEMBLYMAN HARDY:
One of the problems with the early screening is how often we do it. If you have done it already at 12 and 24 months, you have a bit of a feel for where you are, but, if they have not had it done, they should have it done by age 6. It is not so much that you cannot, but that we would want you to do it to be sure where we are by age 6; after age 6 the child is probably not going to be as exposed.

CHAIR WIENER:
That is stated in this order. It certainly shows a preference as to when the tests would be given. Could you tell us what Title 42 of the USC, section 1396 is?

ASSEMBLYMAN HARDY:
That is one of the many reasons I brought Dr. Zupnik with me.

CHAIR WIENER:
Then we will ask him. The bill mentions a sample of blood from a vein. The language might say a blood test; it is obvious there is a reason for that to be put into statute. Could you explain that?

ASSEMBLYMAN HARDY:
If the person has a capillary blood test, like a finger stick, you use the tiny capillary tubes to get the blood. The blood test not using the capillary but confirmed by a sample of blood from a vein would be more specific and sensitive as to the exact amount of lead.

CHAIR WIENER:
Would it be possible then that if we did not do it using a vein we might not be able to catch the lead level?

ASSEMBLYMAN HARDY:
You would probably be able to catch it no matter how you do it. You would probably want as tight a control as you could get with the vein sample to find out exactly. You would be able to have some kind of idea where you are; you would want to know exactly. We are trying to find out how good we are doing at lowering it or if the lead level is going up. So, you want the information as accurate as possible. If you ever do vein sampling from children, you will recognize that sometimes a capillary tube is easier to do.

SENATOR CEGAVSKE:
It is not a mandate.

ASSEMBLYMAN HARDY:
Right.

SENATOR CEGAVSKE:
It is information that, hopefully, they will get to the patients. Let us say I have a company that insures all of us. That provider will somehow disseminate information to all of us who belong to that health program, and they will tell any of the new parents or people with children up to age 6 that they should be tested. Do you know the cost of each test?

ASSEMBLYMAN HARDY:
I do not know the exact cost of the test. It may vary from insurance to insurance or laboratory to laboratory. We tried to massage this as best we could. This bill is one of several iterations attempting to get through the difficulty of trying to require every single person to get the test. In the process of having what we call the early screening and periodic screening tests, there is a lengthy Medicaid form to fill out that is helpful, but there is also a blood count check for anemia in certain stages that the person is in.

SENATOR CEGAVSKE:
Do you want every child to be tested or are you looking for a category of child? My daughter-in-law told me a notice had been sent out about some toys from China and the amount of lead they contain. A lot of parents do not know about

the lead problem. Would any child be susceptible to lead just based on everyday occurrences or is there more? The stories we are used to hearing involve paint chips. Kids eat paint chips and that causes so much damage to those children. I am looking at what area or what root cause you are trying to get to or is this something you think is so widespread that we need to test every child. I am trying to grasp what you are looking for.

ASSEMBLYMAN HARDY:
You have asked all of the global questions. Every child should be checked. Every child could be exposed. Every child could have opportunities to chew on toys that are lead-based. A child in a particular geographic area may be more exposed because the age of the home and the repainting over the painting. A child who is in an old crib could be exposed to lead-based paint on the crib. That was one of the most common things we saw in the past. There is an interest in finding out how every child is, but we recognize we are not going to be able to accomplish that. This bill is, if I may, the watered-down version in trying to start this process.

SENATOR CEGAVSKE:
On page 2, lines 22-24, "... Each qualified laboratory that conducts a blood test for the presence of lead in a child who is under 18 years of age shall, as soon as practicable after conducting the test, submit a report ... ." This report goes into the health authority of the State Board of Health that they would keep track. Is the report only if it is positive or do you keep the reports of those who take the blood test and do not test positive? Do you want both or are you going after only the positive one?

ASSEMBLYMAN HARDY:
We are looking for the presence of lead, and that is our concern. Obviously, in some of these things, the Health Division, for instance, gets the bill so they know how many lab tests are done, and thus with the report know how many lab tests are positive. They will be able to see what the percentage is.

SENATOR CEGAVSKE:
That is what I was looking for. I did not want you to leave that out when it says just the presence of lead, because I would like us to see, for example, 2,000 children were tested and "X" amount tested positive. There is a lot of information garnered from knowing that. The other thing is you said you were with Senator Horsford in an interim committee meeting. Was there any

discussion about what we need to do, not only as a State, but as a nation, about these imported products that are not regulated and have lead contained in them? Was there any conversation about that at all, because that to me is a huge concern that we should be looking at?

ASSEMBLYMAN HARDY:
Yes, we had those kinds of conversations and, yes, the conversations we had were not nearly as in depth as what Dr. Zupnik and his group will have found and discussed. The whole task force met all the time. I was always getting invitations to attend, and they met as much as we do, it seems. They were very involved with this. The whole community was involved.

SENATOR CEGAVSKE:
If there is a report from that committee, I would like to know if there was anything expounded on which we could suggest to our State officials, and in writing to our Congressional Delegation. The other concern was that you are mostly going towards those who have insurance. What about those who do not have insurance? What happens? Can they go in and ask at the Health Division to be tested for lead? What does that cost?

ASSEMBLYMAN HARDY:
Obviously, if there is a child who is not insured, then if they qualify for Medicaid, that covers them. If they qualify for Nevada Checkup, that should cover them. If they are in between, then that whole process is more of a voluntary kind of thing.

SENATOR CEGAVSKE:
But we do not know the cost. That is what I am looking for. If you are not covered, you cannot get Medicaid and you are in between, what would it cost you to have that done?

ASSEMBLYMAN HARDY:
I do not have that answer. I would not be surprised if Dr. Zupnik does. I did want to say, in answer to a previous question, Dr. Zupnik will probably state something about the fact that we have a portable lead tester. One of the other sources of lead is candy. Basically, there is some lead in water and that is used in the manufacture of some candies. You will see a poster warning about these candies you get at Halloween or at some stores. We suggest you do not eat them or buy them. That is one of the sources of lead as well as lead exposure.

Hopefully, the theory would be that as we get data and get a more uniform and larger sampling of children and learning where they are getting the lead, we will be able to not only identify the individual, but look at groups and target those groups for education.

SENATOR CEGAVSKE:
On the "reaches 12 and 24 months," is that and/or, or both at 1 and 2 years of age? Do you want them tested twice and then at age 6? Would there be three times?

ASSEMBLYMAN HARDY:
There is an "or" between the 12 and 24 months and we would like to add 12 "and" 24 months or at least by age 6.

CHAIR WIENER:
On page 2, line 9, I read, "Reaches 12 and 24 months," and the "or."

KEITH ZUPNIK, M.D. (Project Coordinator, Southern Nevada Health District Childhood Lead Poisoning Prevention Program):
To make sure I adequately cover this important subject, I have prepared testimony in support of A.B. 219 (Exhibit G).

SENATOR NOLAN:
We are getting more sophisticated in our ability to do examinations for minute traces of different substances in the body. A lot of work is being done on lead. Scanning and imaging systems detect metals and deposits in different organs such as the thyroid and you can see where concentrations are, not just in blood levels. I am sure blood tests are the best way to get at this problem, given today's level of sophistication in medicine, but will we find ourselves looking to change this in statute somewhere down the road to accommodate changes? Maybe—I answered my own question—maybe we will when something better comes along.

ASSEMBLYMAN HARDY:
Technology is interesting, it progresses, but in this particular case we do not have a treatment. We have a treatment called chelation which in and of itself is almost as bad, if not worse, than the issue of having lead in your body. The issue is at what level do you do treatment? If I were to have hope on this issue, it would not be so much the measuring of how much lead as to what we could

do with the treatment. If I were to come back here someday, it would be to say, "Wow, we have figured out how to get lead out of the body." That would be my hope. Realistically, we have looked at the same level of ability to measure for a long time. I do not know that we are going to be able to have that technology breakthrough on measuring how much lead is in the body. As you point out, you can start looking at biopsies and checking organs, I do not know if you want to go there, even if we had a better technology, on little children, unless the lead level was so high that it would behoove us to do something for treatment. It is the treatment that is going to be the speed-bump phase. So, we really do want to practice prevention.

CHAIR WIENER:
Dr. Zupnik, you were going to address the 12 and 24 months of age issue. The CDC has been intensively studying this subject for many years. Their study finds that children, because of their hand-to-mouth behavior which is normal in infants and up through the toddler age, are the children most likely to ingest lead and have these problems. The 12 and 24 months is essential, and the safety catch of 6 years is if you have not had it done, then certainly it should be done before the age of 6. By the time children reach age 6, they should stop putting as many things in their mouths. Although, I am sure we have all seen many adults chewing on pens and various items, and those items could have lead in them.

SENATOR CEGAVSKE:
My question was about the cost. We were talking about people coming to the local health district and they do not have insurance and cannot get Medicaid, what would be the cost to have this test at age 12 months and 24 months?

DR. ZUPNIK:
If they do not have any health care coverage?

SENATOR CEGAVSKE:
That is correct.

DR. ZUPNIK:
Would you want to know our basic cost or would you want to know the cost to the individual? If somebody was indigent and did not have the funds, we would do the test for them at no charge. I would say the average cost for a lead test is about $20.

SENATOR CEGAVSKE:
I am trying to find out what you would charge somebody who does not qualify for any of the Medicare or Medicaid programs. They do not have insurance, they walk in and say they would like to have a test done for lead. What would you charge that family for that child? Not what it costs you, but what would you charge?

LAWRENCE SANDS, D.O. (Chief Health Officer, Southern Nevada Health District):
We do have fee schedules for various services. Unfortunately, I do not have that one off the top of my head, but I can get that to you. I want to go on record in support of A.B. 219.

Dr. Zupnik has been our lead on this project in the Health District, and we have been working together with the State Health Division as well as other partners in the community that have been involved with the childhood lead poison prevention project since its beginning. As Dr. Zupnik indicated in his testimony, this is an important piece of legislation for us to have in place so we can begin building that infrastructure to identify children who have been exposed to lead. Not only to make sure they get the care and services they need if they have been exposed to lead, and particularly at very high levels, but also that it is one of the best ways for us to identify sources of lead in the community.

Back East, much of the childhood lead-poisoning problems have to do with lead-based paint. There are many more older homes in urban areas where it is much more common for children to be exposed to lead-based paint. Here in the West, we do not see that quite as much because the homes are much newer. There has not been as much need to use lead-based paint for the moisture protection as there is back East and in the Midwest. Our problems have to do more with nontraditional sources such as household items, folk remedies containing lead, candies, lead in toys and other products that children may come in contact with. Because of that, it is important for us to be able to effectively protect children in southern Nevada as well as all of Nevada. We need to have a system to ensure children are getting screened at the appropriate ages. We need to make sure health professionals are following proper guidelines and then have a way to report that information to health authorities who are interested in tracking lead exposure in children in communities so they can assess the burden of the disease in the community as well as identify and eliminate sources so lead in the community can no longer harm children.

SENATOR CEGAVSKE:
I would still like to find out the cost as soon as you can get that to us. Are the tests available now? Is this something that you are already doing? How many children are you doing on a monthly or yearly basis, if you have those statistics?

DR. ZUPNIK:
As mentioned before, we screen several hundred children a month. It varies from month to month. I do not think we properly answered you when you asked about the cost. We have a machine that is U.S. Food and Drug Administration approved. The cost of the machine to do lead testing through a finger stick, a capillary draw, is approximately $2,000. If a patient comes to the health district for our particular program and they do not have any means to pay for the test, we will absorb the cost of that test. Once you have invested in and own that machine, you can literally do thousands of tests and all that is needed is certain supplies to support testing. So, for a few dollars cost, we are able to offer lead testing to the public. If they do have coverage through insurance, whether it is publically funded or private insurance, then we bill their insurance company for that fee. If they have no means of insurance, we are still able to do that test. In fact, we take that machine into the community to do tests for Head Start, for health fairs and for faith-based events. If there are children who do not have any means of paying for that test, we absorb the cost of the supplies to conduct that particular test on the child, which is just a few dollars.

SENATOR CEGAVSKE:
I may not be making myself clear. I am asking about the person who falls between the lines of having insurance, qualifying for any public assistance, making too much money to qualify for any of the free programs, but cannot afford health coverage. If I walked in there and I make $30,000 a year and have no health care, what are you going to charge me to have that test? What are you doing now, for instance? That is what I am curious about. Do the insurance companies cover lead testing right now or at all? Is that something that is covered?

DR. ZUPNIK:
Yes.

DR. SANDS:
The coverage may vary from health plan to health plan, but they do cover the test. How they reimburse the physician is another issue. Medicare and Nevada Checkup do cover for lead testing through the programs we do, such as the healthy child examinations and examinations for Head Start.

SENATOR CEGAVSKE:
How many other states do something similar to this?

CHAIR WIENER:
I heard mention of a sliding scale earlier. If you could also give us an estimate of how many children might fall into that calculation, that might be helpful too.

DR. SANDS:
I cannot give you an exact number, but we have studied the legislation from many states. It does vary from very explicit requirements of having children screened by health professionals at 12 and 24 months of age to requirements of reporting and tracking, etc. We looked at the legislation from different states to come before you with what we thought would work best in Nevada. Again, this is a starting point to give us a chance to build the infrastructure needed and allow us to get the information we need in order to determine how much further we need to go with this in Nevada.

SENATOR CEGAVSKE:
Do you track any of it now? Do you keep any records of anything now that you are collecting from people? You said there are 200 children a month you are testing through Head Start. Do you keep any statistics now?

DR. ZUPNIK:
In our Office of Epidemiology we have a surveillance coordinator who keeps track of all the statistics and can tabulate whatever type of statistic one may wish to conclude from those numbers collected. The answer to your question is yes, we have ongoing surveillance.

SENATOR CEGAVSKE:
Could those numbers be used in the report we are going to be doing from now on? Would you be able to use the history that you have collected so far? Would that be put in the report so we can look over a long period of time?

DR. ZUPNIK:
We can, if you would like the up-to-date statistics. We have developed a pamphlet called the "Interim Report," which describes the lead program in detail. I thought we had handed it out to everyone here, but if you did not get one, we can get you a copy and any particular statistics you would like to know. Every month, we report our latest statistics to our local board of health and we could give you a copy of that report. If you would like, we can provide you with any information.

SENATOR CEGAVSKE:
The copy is fine, but what I was looking for is for you being able to use the history of the data that you have collected to move forward with what we are doing.

DR. SANDS:
If I understand your question, yes. In other words, could we build on what we currently have with the data that comes in as a result of this legislation if it were to pass?

SENATOR CEGAVSKE:
You got it.

DR. SANDS:
Absolutely, that will help. One of the biggest challenges has been expanding the amount of children who are getting tested according to the current guidelines. There have been great improvements over the last couple of years, but there is still a long way for us to go to get a much more complete picture of what lead exposure looks like in Nevada.

CHAIR WIENER:
Dr. Zupnik, in his testimony, stated that in southern Nevada the 20,000 children screened with a blood level test showed that one in four children have some level of lead in their blood. That is certainly a baseline and you can go from there with the more specific information you have.

JO MALAY (Section Manager, Early Childhood Wellness, Health Division, Department of Health and Human Services):
The Health Division is neutral on A.B. 219 which would enact provisions governing blood lead tests for children. The bill provides for a reporting

requirement on blood lead testing to local health authorities. The fiscal note is about the regulation, development and adoption by the State Board of Health. The fiscal note is for staff to work with Southern Nevada Health District in developing the language, then go to the State Board of Health to work through that language.

DR. SANDS:
I want to confirm for Senator Cegavske and the members that I did get a confirmation of the fee we charge for a lead test at the Southern Nevada Health District, and that would be $20. Mind you, in most cases where there is an inability to pay, we are able to waive that fee so that we would not deny service to anybody who needed it.

CHAIR WIENER:
Seeing no one else who wants to come forward, we will close the hearing on A.B. 219 and open the hearing on A.B. 16.

ASSEMBLY BILL 16 (1st Reprint): Provides for the disclosure of certain information to an emergency response employee concerning possible exposure to an infectious disease. (BDR 40-600)

ASSEMBLYMAN JOHN OCEGUERA (Assembly District No. 16):
This bill provides that if an emergency responder such as an emergency medical technician or a firefighter provides help to someone who is found to be carrying an infectious disease, that the responder will be notified of the exposure. I would like to emphasize exactly how important the passage of this bill is. Currently, doctors, nurses and other medical personnel already enjoy these protections and notifications. You might be surprised to find out that this notification procedure is not already in use for emergency responders. Actually, the federal law provided emergency responders with that protection under the Ryan White Care Act passed in 1990, and then reauthorized several times. In 2006, for some reason unbeknownst to me and most of the people who worked on it—we can find no good reason—the provision providing that emergency responders to be notified was taken out. There is now an effort to restore that provision to the federal legislation; however, many states have tried to take care of it on their own.

First the bill requires that the employer of an emergency responder designate at least one employee to be the point person for the employer to coordinate the

communication between the emergency responder and medical facilities. Next, the bill provides that a victim of an emergency transported by an emergency response employee to a medical facility and the facility determines that the victim has an airborne infectious disease, the medical facility must notify the person designated by the emergency responder's employer within 48 hours. The bill also outlines the procedure so that if emergency responders think they have been exposed to a disease, they can request information about the victim to find out if they have been exposed. I have a letter from CDC that has ruled that sharing of this type of sensitive patient information is not a violation of the Health Insurance Portability and Accountability Act of 1997 because of the continuity of care. There is no spending required under this bill, no fiscal note.

Last Session I proposed legislation that is a companion piece to this bill that enables the emergency responder to get this information by court order. This bill would make it two different ways to get this information.

SENATOR NOLAN:
I was surprised to hear the Ryan White Care Act provisions were repealed. I was an infectious disease officer for Mercy Ambulance and received a lot of that information. I understand what you are trying to do. I am in complete agreement with this bill. I am shocked that we are not doing this now. In some cases, it is not a health-care facility that makes the determination that the deceased actually had a blood-borne pathogen or an infectious disease. Quite often, if they arrive in critical condition, patients are in cardiac arrest and the doctor stops resuscitative efforts early on. The hospital may not have some of the pathological examinations early on. They call the coroner's office and that victim may be out of the hospital emergency room within an hour and then have a postmortem examination conducted the next morning. It is the medical examiner who is conducting that postmortem who would make an early determination that this person may have had some infectious disease. I made a quick effort to contact the Clark County coroner and Mike Murphy was not available. What I asked Assemblyman Oceguera and the other people supporting A.B. 16 is that we look at including the medical coroner/medical examiner offices in this bill, because they might be the first person to determine the victim had an infectious disease, and they could notify the provider right away. The coroner and medical examiner are offices in Washoe County and Clark County and are one and the same, so you have the medical examiners who are physicians that actually conduct the autopsies.

CHAIR WIENER:
Based on what Senator Nolan said about blood-borne pathogens, I want to understand the difference. On page 2, line 26, it has "airborne infectious disease." Does this cover both blood-borne and airborne diseases?

SENATOR NOLAN:
In my reading of the bill, in sections 4 and 5, it talks about what the exposure is, "a person becoming infected with an infectious disease," then in section 5, "by a living organism or other pathogen." The way I read it, it talks about any infectious disease.

CHAIR WIENER:
The reason I ask is when we specify that the victim has an airborne infectious disease and make that specific reference, then by exclusion, because blood-borne is not there, to me, it is not a consideration and we are excluding it. Maybe there is another way to say it that captures the meaning. Maybe the victim has an infectious disease as described in section 5.

ASSEMBLYMAN OCEGUERA:
Let me go back to the coroner conversation. I think we did work on that the last Session or the Session before on notification from the coroner's office. I am sure that Mr. McAllister, on behalf of the Professional Fire Fighters of Nevada, had a bill that talked about the coroner, because there were issues exactly like Senator Nolan described. The other thing is that in the rural areas, it may not be the medical examiner, it may be a mortician. As I recall, we did work on something that covered those things. On an infectious disease that is blood-borne, it is easier to report that kind of exposure because you either had blood on you, you stuck a needle in your leg, you did those kinds of things, so that type of reporting situation is much easier to take care of than an airborne exposure. You do not often know that there was an airborne exposure. You know if you were sneezed on, thrown up on or stuck a needle in your hand. There are other methods to take care of those incidents.

CHAIR WIENER:
Our Committee Counsel suggested that clarity could benefit the people you want to serve. There may be an instance where, in chaos, something might happen and you might not be as aware. You know better than the rest of us because you have confronted that as a firefighter. For clarity, it would make it for sure. That is what we will do, make sure we include blood-borne as well.

SENATOR NOLAN:
The wording on page 5, section 12, states, "The provisions of sections 2 to 12, inclusive, of this act must not be construed to ..." and then in subsection 3 it says, "Require or authorize a medical facility, designated officer or emergency response employee to disclose the identity of or identifying information about a victim." Do we also want to include the employee who is potentially exposed? Normally you would not disclose that information. I know that under the Ryan White Care Act there are a lot of confidentiality rules that were built in place for infectious disease officers not to disclose any information regarding somebody, an employee, who may have had a possible exposure. If the Ryan White Care Act is gone, then maybe those provisions are gone too. I know that when I was told about somebody who was potentially exposed, I could not tell anybody other than their immediate supervisor and discuss with the physician who was treating him the situation of the employee. A lot of times you had to pull those who were potentially exposed off active duty until they went through tests to determine if there was a legitimate exposure.

ASSEMBLYMAN OCEGUERA:
That is a good point. We are concentrating on the patient's confidentiality and that may be something we missed concerning the employee's confidentiality.

KEVIN C. BARKER (Las Vegas Police Protective Association):
The Las Vegas Police Protective Association supports A.B. 16 as important legislation in that it protects firefighters, paramedic personnel and other first responders including peace officers. The bill allows for the disclosure of information to potential exposure of infectious disease to first responders and law enforcement personnel.

RICHARD GILBERT (Contracts Manager, Department of Public Safety):
The Department of Public Safety supports this important bill. Among other things, we would like to see the inclusion of the words "peace officer" as a portion of the amendments we have proposed included in all the emergency response employee definitions (Exhibit H). There was not much thought given to all the emergency response personnel in the listings in the bill.

As to the questions of airborne versus other potential infectious diseases, our amendment proposes to strike the word "airborne" from section 7, subsections 1 and 2 and subsection 4, paragraph (a), and to remove subsection 5 entirely,

which then would mean that all infectious diseases would be included under this important legislation.

ASSEMBLYMAN OCEGUERA:
On the Assembly side, I did testify that, with legal counsel advising me, emergency-response employee did, in fact, cover the peace officer in lines 10 and 11, on page 2, where is says, "... or other person who, in the course of his professional duties, responds to emergencies in this State." I believe that covers it, but you feel the need to clarify that. I have not seen this amendment and will look at it quickly.

MR. BARKER:
We are in concurrence with Assemblyman Oceguera's interpretation that the verbiage stated in section 3 to include "other person who," qualifies peace officers in that category.

CHAIR WIENER:
We will have Committee Counsel look at it as well. We will also have counsel look at the recommendations for airborne.

SENATOR NOLAN:
I want to be sure Assemblyman Oceguera is satisfied with crafting an amendment that would include the confidentiality of employees.

ASSEMBLYMAN OCEGUERA:
That would be fine.

SENATOR NOLAN:
If it is alright with Senator Horsford, I will follow up with the Clark County coroner's office to get information on notification, and also check with the Washoe County coroner and medical examiner to see if there is anything on the books, and then add something to the amendment.

SENATOR CEGAVSKE:
I would like to know if Mr. Gilbert brought these amendments to the Assembly when the bill was in committee.

MR. GILBERT:
No. We were not able to check on this until this past week, so we did not bring this to the Assembly.

SENATOR CEGAVSKE:
Did you testify in the Assembly?

MR. GILBERT:
No, Ma'am.

SENATOR CEGAVSKE:
You did not know about the bill?

MR. GILBERT:
I did not know.

CHAIR WIENER:
We will close the hearing on A.B. 16. There being no other business before the Committee, we are adjourned at 4:46 p.m.

RESPECTFULLY SUBMITTED:

Laura Adler,
Committee Secretary

APPROVED BY:

Senator Valerie Wiener, Chair

DATE: