MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND EDUCATION

Seventy-fifth Session
February 4, 2009

The Senate Committee on Health and Education was called to order by Chair Valerie Wiener at 3:15 p.m. on Wednesday, February 4, 2009, in Room 2149 of the Legislative Building, Carson City, 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 Maurice E. Washington
Senator Barbara K. Cegavske
Senator Dennis Nolan

STAFF MEMBERS PRESENT:

Marsheilah D. Lyons, Committee Policy Analyst
Mindy Martini, Committee Policy Analyst
Sara Partida, Committee Counsel
Betty Ihfe, Committee Secretary

OTHERS PRESENT:

Michael J. Willden, Director, Department of Health and Human Services
Richard Whitley, M.S., Administrator, Health Division, Department of Health and Human Services
Marla L. McDade Williams, MPA, Bureau Chief, Bureau of Licensure and Certification, Health Division, Department of Health and Human Services
Maria D. Canfield, M.S., CHP, Bureau Chief, Bureau of Child, Family and Community Wellness, Health Division, Department of Health and Human Services
Tami M. Chartraw, MPA, HA, Health Program Manager; Immunization Program Manager, Bureau of Child, Family and Community Wellness, Health Division, Department of Health and Human Services

Ihsan Azzam, M.D., M.P.H., State Epidemiologist, Health Division, Department of Health and Human Services
Kareen Masters, Deputy Director, Administrative Services, Department of Health and Human Services
Jack Mayes, Executive Director, Nevada Disability Advocacy and Law Center
Larry Matheis, Executive Director, Nevada State Medical Association
Tracey Green, M.D., Physician-of-Record, Health Division, Department of Health and Human Services
Keith L. Lee, Legislative Counsel, State Board of Medical Examiners
Pam Beal, Executive Director, Southern Nevada Immunization Coalition
Cari Rovig, MBA, Statewide Executive Director, Northern Nevada Immunization Coalition

CHAIR WIENER:
The Senate Committee on Health and Education oversees a broad spectrum of issues related to health, human services, K-12 and higher education. Among the nine Senate policy committees, last Session this Committee received the third largest number of measures referred for processing. In the State's General Fund budget, the Department of Health and Human Services (DHHS) receives 32.4 percent. The Department of Education receives 34.6 percent and the Nevada System of Higher Education receives an additional 19.3 percent, which combined, totals 53.9 percent for education. The measures over which this Committee has jurisdiction in terms of the State's budget, if they were to come to policy first, would affect 86.3 percent of the State's budget. That is the impact the issues that come before this Committee have on the people of our State. The mission we have on this Committee is to address the challenges before us and accomplish great things to benefit the people of Nevada.

Today after an overview of the Committee Brief, we will hear two presentations from DHHS concerning infection control practices and immunization practices in Nevada. Following those presentations, we will consider Senate Bill (S.B.) 23 and Senate Bill (S.B.) 54.

MARSHEILAH D. LYONS (Committee Policy Analyst):
The document, "Committee Brief Senate Committee on Health and Education 2009 Legislative Session" (Exhibit C, original is on file in the Research Library), provides background information and summarizes issues relating to the Senate Committee on Health and Education. Page 1 of Exhibit C defines the jurisdiction of the Committee. As stipulated in the *Nevada Revised Statutes* (NRS), this

Committee oversees general health and human services, education, libraries, museums and historic preservation. The Committee also oversees the privileges and benefits relating to veterans, public welfare, mental health and mental retardation, some public health and safety issues, and food and other commodities issues. A number of measures may have policy impacts on health and human services and education issues; however, they may not be referred to this Committee.

During the 2007 Legislative Session, this Committee considered a total of 114 measures: 71 Senate measures and 44 Assembly measures. Of those measures, 70 percent were passed or adopted by both houses.

MINDY MARTINI (Committee Policy Analyst):
On page 3 of Exhibit C, there is a list and summary of elementary and secondary education reports from the 2007-2009 biennium. The higher education summary is on page 4 of Exhibit C. The mandated list of education reports from the biennium is on pages 25 through 29 of Exhibit C.

The significant education issues for this Session begin on page 4 of Exhibit C. The foremost issue is the funding of education and higher education. On page 5 of Exhibit C is a list of the programs that have been eliminated or reduced during the current biennium based upon the reductions to education. Other significant issues are the governance of education, charter schools, and school and campus safety.

Beginning on pages 14 through 21 of Exhibit C, there is a list of education contacts and Website links for your reference. On page 22 of Exhibit C, there is a glossary of acronyms and selected terms to assist you in identifying the numerous acronyms used in education.

SENATOR WASHINGTON:
Could we have an overview of how the formula works for higher education concerning the funding of capital improvements and projects, and how the colleges, the salaries and benefits of the professors are being funded? I would also like to know what impact the 36-percent reduction is going to have on higher education and whether it is a reduction in their overall budget or whether it is a reduction in their growth plans?

CHAIR WIENER:
Since we are hearing a presentation concerning the status of higher education during our Committee meeting on Monday, February 9, we could ask for that information then.

SENATOR WASHINGTON:
I would like to have this information from the Senate Committee on Finance before hearing that presentation.

CHAIR WIENER:
That is fine.

MS. LYONS:
The Legislative Committee on Health Care oversees the health issues during the interim. The listing on page 9 of Exhibit C highlights some of the key health and human services reports produced during the period. Each of these studies produced a bulletin that is available to you in hard copy and on the Internet. The measures from the Legislative Committee on Health Care Subcommittee to Review the Laws and Regulations Governing Providers of Health Care, the Use of Lasers and Intense Pulsed Light Therapy, and the Use of Injections of Cosmetic Substances will most likely be referred to the Senate Committee on Commerce and Labor. This Committee can expect to process the study relating to senior citizens and veterans as well as the study on the placement of children in foster care.

The significant health issues for this Session begin at the bottom of page 9 of Exhibit C and continue through page 13 of Exhibit C. Those issues are "Access to Health Care," "Placement of Children in Foster Care" and the "Hepatitis C Investigation." Other State and federal issues include long-term care and assisted living, immunization, cost and quality of health care, pharmacy benefit and cost of the Medicaid program, development of the health-care workforce and access to mental health care and services.

The list for contacts in the health and human services field is on pages 17 through 20 of Exhibit C, and the statutorily required list of reports is on page 30 of Exhibit C. To facilitate the work of the Committee and move the measures along, we have included the deadlines for this 120-day Session.

CHAIR WIENER:
We will be having a joint hearing on the hepatitis C and infection-control issue with the Assembly Committee on Health and Human Services on Saturday, February 21, 2009, in Las Vegas. We will be hearing about the proposed legislation produced during the interim. The hearing will be videoconferenced.

SENATOR WASHINGTON:
Could we have an update on the status of the transparency program?

MS. LYONS:
We have a recent update from the U.S. Department of Health and Human Services, and we will distribute it to all the members of the Committee.

CHAIR WIENER:
There is a copy of the "Senate Committee on Health and Education Rules for the 2009 Session" (Exhibit D) before you for your review. If there are no concerns or questions, I will entertain a motion to adopt the rules.

> SENATOR WOODHOUSE MOVED TO ADOPT THE SENATE COMMITTEE ON HEALTH AND EDUCATION RULES FOR THE 2009 SESSION.
>
> SENATOR HORSFORD SECONDED THE MOTION.
>
> THE MOTION PASSED UNANIMOUSLY.

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MICHAEL J. WILLDEN (Director, Department of Health and Human Services):
In my eight years as director of DHHS, I would say the hepatitis C situation in Las Vegas is the most serious issue I have seen in my tenure. The staff has dissected the issue and has worked diligently to find solutions to the problem. We certainly recognize the seriousness of the immunization issue and the concerns about funding that program.

We have prepared two documents for you for our presentations today. The first is "Infection Control Practices in Nevada" (Exhibit E, original is on file in the Research Library), and the second is "Bureau of Child, Family and Community Wellness Immunization Program" (Exhibit F, original is on file in the Research Library).

RICHARD WHITLEY, M.S. (Administrator, Health Division, Department of Health and Human Services):
I will speak about health-care associated infections and specifically about the hepatitis C outbreak as it relates to ambulatory surgery centers. To establish a framework, I will begin with the licensure and certification of health facilities. Facilities are regulated by the federal government, our State government and the national accrediting bodies.

Under the tab "Overview" on page 6 of Exhibit E, the chart shows the frequency at which health facilities are surveyed. Only the residential facilities for groups are required under Nevada statute to be inspected annually. Assisted-living facilities are required by regulation to be inspected every three years. I would note that there is currently no State statute or regulation requiring any periodicity of inspection of ambulatory surgery centers.

The inspection frequency for all other types of facilities is determined by the Centers for Medicare and Medicaid Services (CMS). The CMS has a contract with the State. They prioritize inspections by tiers or levels of priority by facility types. In spite of what has occurred in Nevada, and in other states, ambulatory surgery centers remain a Tier 4, the least priority, of facilities that are inspected as stated in our contract with CMS.

The third system that surveys facilities is comprised of the national accrediting bodies. All the entities delegated by CMS and authorized to accredit health facilities are listed on pages 18 and 19 of Exhibit E. These functions are intended to protect the public's health and assure quality of care; however, there is a lack of communication between many of the organizations and the entities that make up the health-care system.

Under the tab "Disease Surveillance" on page 20 of Exhibit E, you will find a report from the Centers for Disease Control and Prevention (CDC) on how the hepatitis C virus was identified and linked to the endoscopy center in Las Vegas. An example of what worked well in the system was when the Southern Nevada Health District's (SNHD) epidemiology and disease investigation teams identified the disease, notified the patients and linked the outbreak to a specific source in a timely manner. Most medical errors come about as a result of failure on the part of an individual, an organization or between organizations.

MR. WHITLEY:
Under the tab "Patient Safety" on page 32 of Exhibit E, the bubble diagram illustrates the extensiveness of the components of the health-care system and where the State Board of Health could intervene and respond. There is no umbrella organization or entity that ties all this together. The biggest challenge we continue to face is the breakdown of communication between organizations. This is often due to limitations in the policies and procedures within each agency or entity. On page 33 of Exhibit E, that bubble diagram depicts the regulatory issues we identified from DHHS's perspective. We have not had the policies or procedures that would allow us to take action when it has been needed, nor have we had the formal communications established between agencies for reporting and responding.

The DHHS uses this document, Exhibit E, as its core source to identify what is needed to improve our performance. Under the tab "Recommendations/Status Update" on page 76 of Exhibit E, we put those needs into three categories. They are the internal policy and procedures, existing statutes and missing statutory authority to take action to improve the public's health and safety. One crucial clarification needed for the Health Division is for it to be authorized to issue a cease and desist order to a facility for a specific procedure. Another clarification needed is to strengthen the penalties and sanctions for noncompliance.

One of the things that did work well during the hepatitis C outbreak was when Governor Jim Gibbons immediately signed emergency regulations putting all facilities on notice about the reuse of syringes in multidose vials and about following the manufacturer's directions. Emergency regulations were made permanent through the State Board of Health. We have the authority to inspect all facility types with a frequency of 18 months. Internally, the areas where we can perform much better are by responding to complaints and by filling all vacant inspector positions.

SENATOR NOLAN:
With the new requirements for inspections, how long has that been in effect? Will you have to hire additional staff that was not budgeted in the last cycle in order to accomplish all these inspections?

MR. WHITLEY:
We have filled our vacant positions, and we have not hired any additional staff for our current workload. We are fully staffed for the first time in years and have built an enhancement into our budget for 12 new positions to achieve the periodicity of 18-month investigations.

SENATOR NOLAN:
In your inspections of the hepatitis C exposures, have your investigators found any other substantive violations by clinics or similar practices to the one that created the recent hepatitis C issue?

MR. WHITLEY:
As a result of the identification of hepatitis C in the endoscopy center, the staff inspected all ambulatory surgery centers. Under the tab "Infection Control" on page 74 of Exhibit E, out of approximately 50 facilities, 49 percent of them had some kind of deficiency in infection-control practices. On page 75 of Exhibit E, those deficiencies are identified. The biggest and continuing deficiency is related to sterilization and disinfection. In this survey, 15 facilities were cited for some infraction in those areas.

CHAIR WIENER:
As you pursued the information in the sites, did you gather information on the number of people who might have been exposed to those unsafe practices?

MR. WHITLEY:
Since the Health Division has worked in collaboration and consultation with CDC in each of these incidents, the risk did not require patients to be notified. The nation has learned from what has happened in Nevada. The CDC has taken an interest in and has invested resources to assist us in retooling our inspection process. They are creating a standardized approach to looking at infection control issues and creating a toolbox for other states to use.

We are seeing a culture change in the health-care system within the last six months, and for the first time, facilities are beginning to self-report deficiencies. If surgery centers believe they may have had a breach in their infection-control practice or if they have questions, they are contacting us. There is no penalty for self-reporting. After they self-report, we confirm that the corrections have been made. We want to incentivize that approach. That is

preferable to an issue being identified through a complaint by a consumer or through the regular inspection process.

SENATOR HORSFORD:
My concern is the life and safety evaluation of each incident. How do we strike a balance between regulatory oversight and the self-reporting process?

MR. WHITLEY:
We are improving what we do internally. Historically for sterilization and disinfection, the practice of our inspectors was to determine if policies and procedures were in place. They did not observe those practices and procedures to see if the directions of the manufacturer were being followed. We are putting in place self-attestation, so the facilities will have to attest that the staff has been adequately trained by the manufacturer in how to operate and clean the equipment. Then the process will be demonstrated for our inspectors. This will provide that balance to protect the life and safety and improve the quality of care for patients.

SENATOR HORSFORD:
What else are you doing beyond inspections to help improve the public's confidence that the regulatory environment and structure is in place to ensure safety at all levels?

MR. WHITLEY:
We have collected data, but we have never produced an annual report breaking the facilities out by type, identifying what we find in inspections or by what we have received in complaints. We get approximately 1,100 complaints a year reported by health professionals and by consumers. Our intention now is to analyze the data and make recommendations for improvement. We have already begun working on that report for hospitals and ambulatory surgery centers.

Improvements can be made by using the standardization tools and by sharing information through the associations to which most of the facilities belong. We have authority through regulations to take action when appropriate, and we can approach the Legislature for measures when we deem that necessary.

SENATOR CEGAVSKE:
Why does it take so long for physicians or facilities to be notified about discrepancies?

MR. WHITLEY:
We have received only self-reporting instances that are occurring now. I have not received any reports from recent past infractions or from previous years.

SENATOR CEGAVSKE:
Did any federal regulations come down as a result of what has happened in Nevada?

MR. WHITLEY:
Surprisingly, they have not. The CMS has not changed their priorities of going into surgery centers even in other states where there have been similar incidents. It remains their least priority for inspection.

MARLA L. MCDADE WILLIAMS, MPA (Bureau Chief, Bureau of Licensure and Certification, Health Division, Department of Health and Human Services):
In August, we began posting on our Website the "Statements of Deficiency" in our findings for facilities. We will be linking that information to our database, so the results of the inspections will be able to be identified.

SENATOR NOLAN:
In regard to the number of centers in which you found deficiencies, was the reason no notifications were made because the deficiencies were not considered to be a threat to any individual?

MR. WHITLEY:
That is correct. As an example, one facility that self-reported did not have their autoclave calibrated at the number of minutes the manufacturer recommended. They were under-autoclaving. One policy and procedure we have put in place is the state health officer and the state epidemiologist are to be notified about anything related to infection control. When equipment is involved, there is also a consultation with the manufacturer.

I recommend this entire document, Exhibit E, to you as it contains much information we believe will be of assistance to you in your deliberations.

CHAIR WIENER:
As we have an ongoing concern and interest in this situation, I encourage you to provide us with any updates you receive or any information you develop as we proceed through this process.

MS. WILLIAMS:
We have arranged for the Joint Commission, an independent not-for-profit organization that accredits and certifies health-care organizations and programs, to be at the Legislative Building on February 11, 2009. The agenda is on the handout, "A Discussion of the Health Care Accreditation Process by the Joint Commission" (Exhibit G). Meetings with individual representatives can be scheduled at your request.

MARIA D. CANFIELD, M.S., CHP (Bureau Chief, Bureau of Child, Family and Community Wellness, Health Division, Department of Health and Human Services):
The second part of DHHS's presentation concerns the Nevada State Immunization Program (NSIP). The goals of the program are to reduce the incidence of vaccine-preventable disease, to improve the capacity for a comprehensive, culturally appropriate and systematic approach and to improve immunization coverage levels.

TAMI M. CHARTRAW, MPA, HA (Health Program Manager; Immunization Program Manager, Bureau of Child, Family and Community Wellness, Health Division, Department of Health and Human Services):
My written testimony (Exhibit H) will focus on four primary areas. Those areas are an overview of the program, immunization rates, vaccine finance and transition for the vaccine supply for the children's program. The NSIP has administered the Vaccines for Children program (VFC) since its inception in 1994. The VFC program is a federal entitlement program to provide free vaccines to children who meet certain criteria.

The NSIP is also responsible for nine program components. Those components are listed on page 1 under the tab "Program Overview" of Exhibit F. One critical part of the strategy to increase Nevada's childhood immunization coverage rates is Nevada's WebIZ. WebIZ is the State's confidential, population-based immunization registry. Registries have proven to improve the quality of health care for children by providing critical tools to ensure that all children receive the required immunizations at the right time. As required by law, Nevada immunization providers must report vaccines administered to the Immunization Registry beginning July 1, 2009.

You will find a summary of the immunization rates on page 1 under the tab "IZ Rates Overview" of Exhibit F. Immunization coverage rates are a means of

estimating up-to-date immunization status in a specific age group. The chart in the middle of the page shows the trend line for Nevada and for the nation. Under that same tab, the diagram on page 4 of Exhibit F illustrates the major factors impacting rates. It should be noted that one factor not shown by research to impact rates is the State's vaccine supply policy. For example, until January of this year, Nevada provided most vaccines to all children regardless of eligibility status. Yet, our rates remained low.

MS. CHARTRAW:
Financing for vaccines in Nevada comes primarily from three sources: The federal VFC, the Public Health Service Act, section 317 vaccine funding (317) and the State Children's Health Insurance Program known as SCHIP. Under the tab "Vaccination Financing" on page 2 of Exhibit F, there are two graphs that depict the level of 317 and VFC funding over the past few years. The level of 317 funding has remained fairly level over the years with a sharp increase in 2007 due to the change in distribution methods. Although VFC funding has trended upward over the years, this merely reflects the increased number of eligible patients plus the increased cost of vaccines.

Also under that same tab on page 3 of Exhibit F, the pie chart at the top of the page shows the relative percentages for Nevada in terms of sources of funding. You will note that 87 percent of our vaccine funding comes from the VFC program. The pie chart below shows how the patient eligibility status breaks out in Nevada. For VFC patients only 48 percent of the provider profile reports they are VFC children. Compare that with 87 percent of the federal funding coming from the VFC program, but only 48 percent is eligible for VFC. This demonstrates that we have been using federal funds for privately insured children.

Under the tab "VFC Transition Overview" on page 1 of Exhibit F, you will find an overview of the change in policy that occurred on January 1, 2009. Vaccine supply policy refers to the way a state supplies state and federally funded pediatric vaccines. Nevada changed its vaccine policy to what is known as "VFC Only" plus Nevada Check Up. This change meant that privately insured children, formerly eligible for State-supplied vaccine, were no longer eligible. It did not change the other categories of eligible children.

This transition in policy from when the state provided free vaccine to all children regardless of insurance status to VFC eligible and Nevada Check Up children

received State-supplied vaccines beginning in May 2008 and culminated in the change effective January 1, 2009. This transition was communicated to parents, providers, health insurance plans and other stakeholders through a variety of methods beginning in May 2008.

As with any major policy shift, there have been a number of challenges along the way. Some of these are illustrated in the bubble diagram under the tab "VFC Transition Overview" on page 3 of Exhibit F. The smaller bubbles show reimbursement coverage, parent out-of-pocket expense and private purchase of vaccine. The larger bubbles highlight the various groups or mechanisms with the ability to affect the degree to which these challenges continue to produce obstacles in Nevada. For historical context and more detailed information on the vaccine supply transition, under the same tab, I direct you to pages 4 through 9 of Exhibit F. There you will find a chronology of decisions and communications on the transition as of January 30, 2009.

The NSIP is working hard to address its many challenges, and we are confident that by utilizing strategies proven to work in other areas of the nation, Nevada's immunization-coverage levels will continue to increase. The program is committed to working with all of our partners to implement these strategies and reduce the incidence of vaccine-preventable disease.

SENATOR CEGAVSKE:
Physicians are required to meet several sets of standards for several entities and to document compliance differently for each entity. For instance, refrigerating the vaccines is not uniform for the entities. If vaccines become outdated, the physician bears the cost of that loss as there is no reimbursement for that loss of investment.

The insurance companies and the uninsured also complicate the issue. The dilemma is the federal government said Nevada should not be paying to vaccinate all children. The hospitals and others tell us if we do not vaccinate all children, we will have outbreaks of diseases. Insurance companies apparently pay for vaccines in some instances and not in others. To add to the situation, parents are being bombarded with information for and against immunizing their children. Was this discussed during the interim?

MS. LYONS:
There was only limited discussion on this during the interim. Some of the changes happened after the interim Legislative Committee on Health Care had completed most of it work.

SENATOR CEGAVSKE:
When I asked the SNHD if Nevada had been challenged by the federal government for paying for all children's immunizations, they told me, "No." Should the federal government receive this updated information? Do you have to make some decisions as an agency?

MS. CHARTRAW:
The primary decision was to shift from what was known as "Universal Select," which is providing vaccines to children regardless of status, to one of VFC Only. To address having all children continue to be immunized, we are putting two plans together: one which would include and the other one which would not include any funding from the proposed federal stimulus package.

SENATOR CEGAVSKE:
Since there is no reimbursement for physicians, some of them have made the decision not to give vaccinations in their offices. The SNHD can only vaccinate those who meet the eligibility requirements. Where else can the children get vaccinations?

MS. CHARTRAW:
There are only a few physicians who have chosen to no longer administer privately purchased vaccines. The two refrigerators you mentioned refer to the private stock versus the public stock. The insured children who are not eligible to receive the VFC vaccine would have the option to go to the SNHD.

SENATOR CEGAVSKE:
Do you think there are only a few physicians who have chosen not to do this?

MS. CHARTRAW:
We are in the reenrollment process that takes place every January in which the VFC providers send us a new enrollment form if they choose to participate in the program. Out of 300 physicians, approximately 12 have not enrolled. We will have updated numbers probably by the middle of the month.

SENATOR CEGAVSKE:
The indication I have received shows there will be many more who will not reenroll.

MS. CHARTRAW:
To anticipate some of the need for the underinsured children, we introduced a program through the Nevada Health Centers called the "Delegation of Authority." That is where the health centers delegate their federally qualified health center authority to the State. We, in turn, delegate the authority to private providers. That way, anyone who wanted to apply to be deputized to have that authority can still see the underinsured patients in their medical home.

SENATOR CEGAVSKE:
Why was Nevada the only state that vaccinated everyone, even those who are covered by insurance?

MS. CHARTRAW:
Nevada was not the only state doing universal vaccinations, although the trend is toward VFC. Under the tab "VFC Transition Overview" on page 19 of Exhibit F, note there are 8 states that are Universal, 9 states that are Universal Select. The vast majority are VFC and underinsured. The states that are Universal and Universal Select are primarily funded through general fund monies.

SENATOR CEGAVSKE:
That makes the difference. Nevada did not use the General Fund. We were the only state that used all federal dollars while the other states used matching funds.

CHAIR WIENER:
With the shift in policy from Universal, I have several concerns in terms of public policy. Would those who have some level of insurance have access at health districts or would they be referred or rereferred to their private-practice providers? Carrying a supply of vaccines, which is a perishable commodity, in inventory is a challenging business practice. Gauging which dosages of which medicines the providers will need to have on hand is a guessing game for them no matter how well they know their patient load.

My concern is that those who are insured may become the population that creates the gravest concern in terms of public health and inoculations. It is ironic that those who are conscientious about getting health insurance might be the ones who are being put at the greatest risk in terms of the lack of opportunity to access immunization. This Committee will continue to look at options to create affordability and access, so the immunization program can succeed.

IHSAN AZZAM M.D., M.P.H. (State Epidemiologist, Health Division, Department of Health and Human Services):
I begin my prepared testimony (Exhibit I) with the following statistic: According to the 2008 National Immunization Survey (NIS), Nevada has seen marginal increases in immunization rates. Compared to the national average, our State continues to rank last; however, our incidence of vaccine-preventable diseases (VPD) does not correlate to this low immunization rate.

Under the tab "VPD Overview" on page 4 of Exhibit F, many decades of medical research have shown a well-established relationship between the incidence rate of a VPD and the immunization rate for that disease. This relation is an "inverse relation," which means when the immunization rate goes up, the incidence rate of that specific VPD is expected to go down and vice versa.

Still under the tab "VDP Overview" on pages 7 through 9 of Exhibit F, note the graphs numbered 5, 7 and 9. They indicate in spite of such low immunization figures revealed by the NIS, Nevada's incidence rate of VPD has been and continues to be significantly lower than several states with the highest immunization rates in the nation, such as New Hampshire, Hawaii, Minnesota and Nebraska.

According to the NIS, Nevada has ranked below the national immunization average since 1994; however, it is reassuring that our rates of VPD did not manifest any increases. Contrary to all expectations, our rates continue to decline and are significantly below the national VPD average.

Population- or community-based immunizations are contributing the most to what is referred to as "Herd Immunity." Herd Immunity offers one plausible explanation because the protective effect of mass immunization extends beyond specific immunized individuals to benefit unimmunized and underimmunized individuals and groups. This indirect or "collective" immunity index, or

Herd Immunity, provides protection even to those who are not themselves immunized.

CHAIR WIENER:
Is there predictability at what percentage of the immunized population the Herd Immunity does not protect?

DR. AZZAM:
The national target is 90 percent without either defining the biological agent or the susceptible host. It does depend on the agent as every biological agent has its own level of Herd Immunity.

CHAIR WIENER:
Are there any of the infectious diseases where we are at risk?

DR. AZZAM:
Our VPD incidence data indicates that we are not at risk. Since we were ranked in 1994, we have been consistently below states with large rates of immunization. Those are set even beyond the national target rate set for Herd Immunity.

The most recent "Kindergarten Immunization Survey" from 2007-2008 revealed that 96 percent of children enrolled in Nevada's public kindergartens were immunized. Additionally, Nevada children are being properly immunized by school age but not by ages 19 to 35 months.

The problem we are facing in our State is not the result of a general lack of immunization, but rather it is due to a significant delay in vaccinating our children ages 19 to 35 months. This delay contributes to the low rates revealed by NIS. However, it is good to know that our children, including those who were unimmunized or underimmunized at ages 19 to 35 months, are being properly immunized by school age. The "Catch Up" program, where vaccinations are given before entry to school, has helped with increasing our Herd Immunity.

CHAIR WIENER:
Perhaps this is an anomaly since no one can seem to explain the rankings. As you suggested, they might not accurately represent what is going on in our State. Do I understand correctly that we are low in the immunizations yet low in

the diseases we are attempting to immunize against? Should we anticipate a shift since we are changing from the Universal immunization policy?

DR. AZZAM:
As a matter of fact, we have ranked last in the nation under Universal Select since 1994. There is no doubt in my mind that the Universal Select was not the cause of the VFC Only. I think the cause is lack of access and lack of availability of health-care providers. If you look at multiple performance measures in the states, Nevada is among the lowest eight states in the nation in the number of pediatricians. Nevada also has the lowest rates of nurses per capita.

CHAIR WIENER:
Besides the lack of providers and the concern about some providers withdrawing because of the shift in policy, would that not exacerbate the concern or have an impact on future statistics?

DR. AZZAM:
While we have not received all the enrollment forms, so far only 5 percent of the providers have not submitted their reenrollment.

CHAIR WIENER:
How many have you received?

MS. CHARTRAW:
As of January 30, 2009, we have received 192 of 316. That is roughly two-thirds.

DR. AZZAM:
I believe vaccinations are the single most important primary disease prevention medical tool ever invented. Ultimately, the goal of the vaccine is to reach a high enough number of the population to prevent the transmission of the disease and eventually eliminate the disease. We must improve our immunization rates for children ages 19 to 35 months old. We are working to accomplish that while we still want to enjoy some of the lowest VPD rates in the nation.

SENATOR CEGAVSKE:
How are you drawing your statistics?

MS. CHARTRAW:
The data we have now is from a variety of sources. It is primarily from the NIS, but we are also beginning to use the Immunization Registry. We are working on improving our methods of looking at our coverage levels.

SENATOR CEGAVSKE:
Who fills out the survey?

MS. CHARTRAW:
In a telephone survey of 250 households conducted through the CDC. They ask those they contact about their immunization record. Then, those responses are verified with the providers that the immunization information is correct. The CDC develops a coverage level for the State. We are doing a retrospective study in Clark County with kindergarten children to determine their vaccination records beginning at 2 years of age and forward.

SENATOR CEGAVSKE:
My concern is how your statistics are being gathered and the accuracy of those responses. Have you been able to determine who is insured, underinsured and uninsured? Physicians seem to be most concerned about liability issues in immunizing the underserved population.

DR. AZZAM:
The data we are reporting has come from the CDC. That is why we are concerned when people who do not know our large State with its relatively small population conduct the surveys. Surely, the validity of the data is very low. I see the only value of this type of survey is to rank the states.

SENATOR CEGAVSKE:
How do you plan to determine the information? I still would like to know why we included every child in the State. Why are we the only state that did it that way? Why did we use all the federal dollars to do it, and who made the decision to do it that way?

CHAIR WIENER:
I would like to know the history on this as well. I expect we will have that information the next time we consider this issue.

I open the hearing on S.B. 23.

SENATE BILL 23: Revises provisions governing certain organizational matters within the Department of Health and Human Services. (BDR 18-328)

KAREEN MASTERS (Deputy Director, Administrative Services, Department of Health and Human Services):
During my prepared testimony (Exhibit J), I will present the rationale for modifying the appointment process for the administrator of the Division of Mental Health and Developmental Services (MHDS) and remove the requirement for the Commission on Mental Health and Developmental Services to review the credentials of certain key staff members in the MHDS and the Division of Child and Family Services. I will also address why doing this would provide greater flexibility to the administrators of each division to appoint the staff necessary for the operation of division facilities.

The proposed change would make the method of appointment consistent with that used for other division administrators and streamline the recruitment and appointment process. In removing the requirement from the Commission, this change would allow each administrator to identify the qualifications that are most critical for his or her respective deputy administrators to possess. Additional changes requested in S.B. 23 provide the latitude to the respective division administrators to appoint or designate staff to carry out division operations or to delegate that responsibility to agency heads.

CHAIR WIENER:
What is the history as to why this position was segregated from the others?

MR. WILLDEN:
My assumption is that when DHHS was created in the 1960s, MHDS was a separate track. The Mental Health Commission had a strong policy role. As DHHS developed over time, six divisions and six administrators were created and, for whatever reason, MHDS was still outside the organizational structure.

There are three positions outside of the scope now: The MHDS administrator, the State Public Defender and the executive director of the Nevada Indian Commission. The MHDS administrator is the only one about whom I have a concern.

JACK MAYES (Executive Director, Nevada Disability Advocacy and Law Center):
The Nevada Disability Advocacy and Law Center is a federally mandated, nonprofit organization to protect and advocate for persons with disabilities. Approximately 60 percent of our budget focuses on mental health and developmental disability areas.

A few years ago, I found myself in a situation in a meeting with the director of DHHS and the previous director of MHDS. I thought it weird that the director of DHHS, whom I thought was the decision maker, could not override the director of MHDS, whom I thought was his employee. As a result of that, we ended up in litigation. I would encourage you to clear up these areas of responsibility.

CHAIR WIENER:
I close the hearing on S.B. 23, and open the hearing on S.B. 54.

SENATE BILL 54: Revises the qualifications of the State Health Officer. (BDR 40-336)

MR. WHITLEY:
I am providing written testimony (Exhibit K) in support of S.B. 54, which our agency has brought forward, to revise the qualifications of the State Health Officer (SHO). This position has been vacant for three of the past ten years. The Health Division has experienced recruitment challenges each time the position has become vacant.

In 2002, a highly qualified, board-certified, family-practice physician, licensed in four other states, could not be hired because he was unable to obtain his Nevada medical license due to statutory licensing requirements for medical residency. During 2007, we experienced difficulties in recruiting individuals with public health qualifications. The two top candidates declined the position citing salary and limitations on outside employment as reasons.

In our handout, "State Health Officer Position, Nevada State Health Division" (Exhibit L), there is a description of the role and duties of the position. We contend that S.B. 54 would enhance and provide options for the Health Division to attract, recruit and retain qualified physicians for this critical, key position for our State.

LARRY MATHEIS (Executive Director, Nevada State Medical Association):
In 2002, the completely qualified physician about whom Mr. Whitley referred was absolutely stymied by the unbending, inflexible Board of Medical Examiners, so the position remained vacant. When the hepatitis C outbreak occurred in Las Vegas, the position of SHO was still vacant. Governor Jim Gibbons appointed Mary Guinan, M.D., Ph.D., who had served as SHO previously, to serve as the SHO in the interim. She is filling the position full time now.

This SHO position requires a licensed physician. The SHO is the top public health physician in our State government. It is equivalent to the Office of the Surgeon General at the federal level. The SHO practices medicine, and whether it is population-based medicine or it is individual medicine, it is the practice of medicine. It is very important that specific standard be kept in the position description. The SHO has to be able to understand the population-based health issues and also has to be able to understand how those translate into individual medical issues.

In S.B. 54, my concern comes with the last word "or" on page 1, line 8 and continuing to page 2, line 1. "A physician or administrative physician ... ." is not a licensed physician. That wording opens the possibility the SHO would never have to be a licensed physician in Nevada. I agree with broadening the expansion of the position except for the possibility that a physician who is not licensed might end up permanently as the SHO.

SENATOR CEGAVSKE:
Do you have an objection to the SHO being licensed to practice medicine in another state?

MR. MATHEIS:
The Legislature has changed the rules over the last several sessions to allow for actively licensed physicians who have no professional problems to be able to get expedited licensing in Nevada. That is perfectly fine.

MR. WILLDEN:
The bill is meaningless to us if we delete everything after the "or." Our intent is that someone does not have to be licensed in the State to be the SHO. We believe an administrative physician without being licensed in the State can be an appropriate health officer. We see this throughout the nation.

SENATOR NOLAN:
I understand the need for the person in the position to have a fairly current perspective on practices and medicine on which they would be making determinations. The administrative role of the position does not include visiting patients and reviewing charts; however, would the person have to be familiar with the physicians and their roles?

MR. MATHEIS:
Yes, he or she would.

SENATOR NOLAN:
Are there Continuing Education Units (CEUs) involved in maintaining licensure in Nevada? Would the administrative physician have to meet those requirements, that operating in an administrative capacity, he or she might find onerous?

MR. WILLDEN:
I do not know the answer, but I will get back to you with that information. We do contract with licensed medical physicians where CEUs are required, such as in our rural health clinics. Former SHO Brad Lee performed the administrative functions, but he did not do the oversight of the clinical work.

SENATOR NOLAN:
The question pertaining to this position is, "Does the individual in this position need to maintain a license or can he or she perform the duties adequately without one?"

TRACEY GREEN, M.D. (Physician-of-Record, Health Division, Department of Health and Human Services):
I am a board-certified family physician and the Physician-of-Record for the Health Division since 1998. Since that date, we have had three SHOs. When the position became vacant again, I began serving as acting SHO. "I am also, for reference, one of those persons who declined the position due to stipulations for outside employment."

Yes, there are CEU requirements to maintain both the administrative and nonadministrative positions. The role of the SHO is to enforce laws and regulations in regard to public health. My role has always been to supervise the actual clinical public health portion of the State. I do not think the SHO needs to

be an active medical physician, but instead can be an administrative person with the public-health skills especially in regard to populations.

CHAIR WIENER:
With the previous applicants, could these people ever have been licensed in Nevada?

MR. WILLDEN:
Generally, yes, if they have been licensed elsewhere, but they must meet the Nevada licensing standards.

CHAIR WIENER:
Do you know how many states have doctoral degree level public health or related-field SHOs?

MR. WILLDEN:
We have some candidates locally who meet the definition we have described here. We may also have to look at the money issue at some point.

MR. WHITLEY:
Seventeen states required a master's degree or higher in public health.

CHAIR WIENER:
Do those states have a physician or administrative physician who also has a master's degree, or does the person just have a degree in public health?

MR. WHITLEY:
It was the addition of the public-health component.

CHAIR WIENER:
How many states require the physician or the administrative physician to be licensed in that state?

MR. WHITLEY:
From the 2006 report, 11 states did not require licensure in that state as a physician. As in S.B. 54, they require the person to be a medical doctor (M.D.) or a doctor of osteopathy (D.O.), but the person did not have to meet licensure requirements in their state.

SENATOR NOLAN:
How do we ensure the competency of the individual who is seeking this position, and how do we know they are up to date in modern medical practices?

MR. MATHEIS:
In 2002, DHHS asked the State to create an administrative license category for physicians. The Nevada State Medical Association supported that. That action requires the administrative physician to be licensed. Do you want to go back to the NRS and take that requirement out for the administrative category? If not, the person would be illegally practicing medicine. Perhaps the Board of Medical Examiners should implement the tools they already have to license certain quality physicians, especially in specialized fields like public health.

For the safety of the people of Nevada and to instill confidence in the people of Nevada, when the SHO, the highest ranking medical officer in the State, makes a statement, they need to know it is a pronouncement by a licensed Nevada physician. I understand the tactical frustration in filling this position, but we do have to think strategically. In a time of crisis, I would hope those 11 states will revisit their decision.

DR. GREEN:
I think it should not be the degree, but the applicant that should determine the best person for the position. It should not be whether you have an M.D. or D.O. degree, but whether you are qualified and have the experience we need for the SHO position.

KEITH L. LEE (Legislative Counsel, State Board of Medical Examiners):
The Medical Board has no position on S.B. 54. If you decide that the SHO serving in an administrative capacity need not be a licensed physician, so be it. Let me caution you, however, that you would need to narrowly define the scope of the responsibilities of the SHO. Whoever fills that position, if he or she is not a licensed physician, the scope has to be narrowly defined so that person is not in violation of the Federation of State Medical Boards of the U.S. Medical Practice Act, April 2003, for practicing medicine without a license.

The Board of Medical Examiners applied the law we were given. We have worked to change the law to provide for administrative physicians. We also put in NRS 630.1605 which is licensure by endorsement. We are issuing licenses rather broadly, using a lot of discretion, and we are granting those quite rapidly.

CHAIR WIENER:
Does the licensure by endorsement make it more streamlined for a physician licensed in another state to be licensed in Nevada?

MR. LEE:
Yes, it does. The administrative-physician position is a rather easily granted license. There were certain criteria established, but there is no discretion within the criteria. We are asking for that discretion.

SENATOR NOLAN:
Perhaps we can ask the Health Division to provide this Committee with those responsibilities which can be identified as practicing medicine? In lieu of having a license in the State, the responsibilities would have to be succinctly identified. If that is the case, someone else would have to fill in for those things that are considered the practice of medicine.

CHAIR WIENER:
Mr. Willden, as long as there is not a scope issue, will you and the other stakeholders develop something which would avoid a violation of practicing medicine without a license and yet ensure that person could participate in the administrative duties?

MR. WILLDEN:
I am happy to work with the others to accomplish that.

SENATOR WASHINGTON:
What you are asking is for more flexibility to hire the best applicant for that position, is that correct?

MR. WILLDEN:
That is correct. It has been frustrating losing two really qualified candidates. I could not get either of them through the licensing process.

SENATOR WASHINGTON:
You need discretion and flexibility to fill this position, especially with the stonewalls you have faced, do you not?

MR. WILLDEN:
We do have a Physician-of-Record who is also the SHO.

CHAIR WIENER:
This Committee would like to see the options. I close the hearing on S.B. 54.

PAM BEAL (Executive Director, Southern Nevada Immunization Coalition):
In my written testimony (Exhibit M), I will express how proactive the Southern Nevada Immunization Coalition (SNIC) has been in communicating with its 100-plus members and partners in the Las Vegas Valley regarding the NSIP transition to VFC Only.

One of SNIC's most important strategies was to reach out and communicate with the various health plans and employers. This included communicating with the Health Services Coalition (HSC). The HSC is a nonprofit coalition in southern Nevada. It includes labor and management representing over 20 separate entities and approximately 350,000 individuals. As a result of our outreach efforts, the NSIP was asked by the HSC to make a presentation about the transition to VFC.

Our Coalition acknowledges the NSIP for doing an outstanding job communicating with key stakeholders, both traditional and nontraditional, about the transition to VFC Only.

CARI ROVIG, MBA (Statewide Executive Director, Northern Nevada Immunization Coalition):
I may veer some from my written testimony, "Improving Children's Immunization" (Exhibit N) but I want to tell you about the progress of the Nevada Immunization Coalition.

As you saw in the Health Division's document, Exhibit F, under the tab "IZ Program Overview" page 2, the Immunization Community Coalitions are a link to the community. There have been many questions over the years regarding Nevada's old and often confusing vaccine system. While there has been some concern about the transition to VFC Only, many partners across our State have come together to move Nevada's vaccine system forward and improve it. This improved vaccine system more effectively uses our resources to identify pockets of need and protects all children.

CHAIR WIENER:
There being no other issues before us today, this meeting of the Senate Committee on Health and Education is adjourned at 6:12 p.m.

RESPECTFULLY SUBMITTED:

Betty Ihfe,
Committee Secretary

APPROVED BY:

Senator Valerie Wiener, Chair

DATE: