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

Seventy-Sixth Session
May 11, 2011

The Committee on Health and Human Services was called to order by Chair April Mastroluca at 6:05 p.m. on Wednesday, May 11, 2011, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/76th2011/committees/. In addition, copies of the audio record may be purchased through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

COMMITTEE MEMBERS PRESENT:

Assemblywoman April Mastroluca, Chair
Assemblywoman Peggy Pierce, Vice Chair
Assemblyman Elliot T. Anderson
Assemblywoman Teresa Benitez-Thompson
Assemblyman Steven Brooks
Assemblyman Richard Carrillo
Assemblywoman Lucy Flores
Assemblyman Jason Frierson
Assemblyman Pete Goicoechea
Assemblyman John Hambrick
Assemblyman Scott Hammond
Assemblyman Pete Livermore
Assemblyman Mark Sherwood
Assemblywoman Debbie Smith

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Senator Valerie Wiener, Clark County Senatorial District No. 3
Senator Sheila Leslie, Washoe County Senatorial District No. 1
Senator Shirley A. Breeden, Clark County Senatorial District No. 5

STAFF MEMBERS PRESENT:

Kirsten Coulombe, Committee Policy Analyst
Risa Lang, Committee Counsel
Linda Whimple, Committee Secretary
Olivia Lloyd, Committee Assistant

OTHERS PRESENT:

Tracey Green, M.D., State Health Officer, Health Division, Department of Health and Human Services
Jay Kvam, M.S.P.H., Program Manager, Sentinel Event Registry, Office of Epidemiology, Health Division, Department of Health and Human Services
Bobbette Bond, representing Health Services Coalition; and Director of Public Policy, Culinary Health Fund
Bill M. Welch, President/CEO, Nevada Hospital Association
Leslie Johnstone, Executive Director, Health Services Coalition
Michael Ginsburg, Southern Nevada Director, Progressive Leadership Alliance of Nevada
Barry Gold, Director, Government Relations, AARP Nevada
Joseph Greenway, Director, Center for Health Information Analysis, University of Nevada, Las Vegas
Charles Duarte, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Wendy Simons, Chief, Bureau of Health Care Quality and Compliance, Health Division, Department of Health and Human Services
Amber Joiner, Director of Governmental Relations, Nevada State Medical Association
D. Taylor, Secretary-Treasurer, Culinary Workers Union Local 226
Kenny Adamson, Private Citizen, Las Vegas, Nevada
Rusty McAllister, President, Professional Fire Fighters of Nevada
Yvanna Cancela, Political Director, Culinary Workers Union Local 226
Steve Winters, Private Citizen, Reno, Nevada
Denise Selleck Davis, C.A.E., Executive Director, Nevada Osteopathic Medical Association
Joan Hall, President, Nevada Rural Hospital Partners

Chair Mastroluca:
[Roll was called.] We have a lot of information to cover, and I know that we have a lot of people who are anxious to get to other things. We will move as quickly yet efficiently as possible.

We will start with Senate Bill 209. Good evening, Senator Weiner.

Senate Bill 209: Revises provisions relating to reports of sentinel events and related information reported by certain medical facilities. (BDR 40-193)

Senator Valerie Wiener, Clark County Senatorial District No. 3:
I appreciate your willingness to hear Senate Bill 209, which deals with sentinel events. To give you a little bit of background, during the last session I chaired the Senate Committee on Health and Education, and in the interim I chaired the Legislative Committee on Health Care. This is one of the measures that was very important to our Committee. During the work session it was the consolidation of two bill draft requests merged into one.

Senate Bill 209 expands the amount of information that is available to the public. We have been in an era over the past couple of legislative sessions, and I think this is a phenomenal way to go in creating the greatest transparency probably in the history of our state. Senate Bill 209 is all about health care transparency, seeing what is out there, and making choices. This allows the public to go to a website that our state Health Division is engaged with and determine what is going on in the hospitals in their area or statewide.

There are two parts to the bill. In the bill itself you will see the definition of a sentinel event—because this is what this bill is all about—and hospital-acquired health conditions. This applies to hospitals that average 25 or more patients during each business day so that we at least know we are comparing hospitals of some size and not to hit the rural hospitals disproportionately. This measure would authorize the Health Division to access information that is submitted to the website by the Division of Healthcare Quality Promotion of the Centers for Disease Control and Prevention (CDC). This is an Internet-based surveillance system.

Senate Bill 209 builds on legislation that we did last legislative session, which allowed the Health Division to give aggregate information about sentinel events, but S.B. 209 takes it to the next step and allows facility-specific information to be posted so people can be comparison shoppers for their health care when it is not an emergent situation. This legislation authorizes the Health Division to access information that is submitted to this surveillance system and it requires those hospitals that I just mentioned by size to provide consent to the

Health Division to include that information on a website in facility-based fashion. There are reports that are prepared and people are allowed to compare somewhat apples to apples so that they understand what is going on.

This is a real breakthrough for the people who live in the state of Nevada; they can go to a place and determine, based on the information that is posted, where they might want to get their medical care. Again, not emergent care, because you go where they take you sometimes. If you get to make that choice, that is something else. This allows that level of transparency where we can actually determine, based on information that is provided for the first time in a facility-based manner, what is going on, and we can make choices about our health care. This is about transparency, learning about sentinel events, and what is going on in those facilities.

Chair Mastroluca:
That was pretty straightforward.

Senator Wiener:
I have Dr. Green, who is the State Health Officer, and who is certainly engaged in this. If she came forward, she could answer more specific questions you may have.

Chair Mastroluca:
Good evening, Dr. Green; it is nice to see you again.

Tracey Green, M.D., State Health Officer, Health Division, Department of Health and Human Services:
I am here to present on S.B. 209. As Senator Wiener described, this would allow the Division to use the Sentinel Event Registry to publish the information by individual facility. Currently this information is aggregated so as not to disclose the facility reporting the sentinel event. It is already posted, so this would allow us to do it on a facility-specific basis. In addition, this would enhance the ability for transparency in government and for reporting this health information. It is something that we are able to do at the Division as well.

Assemblyman Livermore:
As a patient, if you are researching information, generally you are going to consult a physician of some type based on what your needs are, such as orthopedic or vascular. Will this information have both facility and physician combined together, or will it be two different sites? I think a patient probably needs to look at both of them, not just the facility, but also the physician who is going to perform the service.

Tracey Green:
At this time, no, it would not have physicians. There are other bills that would also continue to remove the physician's name. This would be specifically by facility.

Assemblyman Livermore:
We had the issue of the sentinel events earlier today and the list of information was there. Do you believe it is a whole measurement and that someone can make a very good and informed decision without having both criteria?

Tracey Green:
I think this is a continuum and that we are moving in the direction of more transparency, and I think it is a good move.

Assemblyman Livermore:
So it is a first step.

Tracey Green:
First step, yes.

Senator Wiener:
The surveillance system from the CDC is charged with collecting data on hospital-acquired infections. This bill requires facilities to give the Health Division permission to utilize this information in a facility-specific manner. It is interesting wording, but that is what is required. It requires them to give us permission to use the information. It is hospital related because that is where the infections are acquired.

Assemblyman Sherwood:
The bill seems to be straightforward, and certainly that would be great information to have. My concern is that there is a concept of self-reporting. I know the intent, and I have spoken with supporters of the bill. The intent is not to impugn the doctors, put them on the defensive, or open themselves up to liability. We have been building on past legislation, and the next logical step would be to identify the actual health care workers and the actual event. Now it turns into, "We are trying to make health care better, but because we did this, as a hospital, and we were honest about it, we did not cook our books, and we reported the right way . . ." Now I can see in two, four, or six years that we revisit this and then we use the information against the best players. The best players will accurately report the events. They will not interpret them a different way, correct? So what incentive do we have for the hospital to actually report, do the right thing, and limit infections instead of reporting, doing the right thing, and then getting burned on the liability side?

Jay Kvam, M.S.P.H., Program Manager, Sentinel Event Registry, Office of Epidemiology, Health Division, Department of Health and Human Services:

In response to your question, I would say that the Health Division considers sentinel events very seriously in terms of protecting the confidentiality and a lot of the details of those records. The real intent is a collaboration between the facility and the Health Division in identifying issues that are not just one-offs, might not have just occurred one time but point to underlying conditions that we can both engage with and really rectify. It is those kinds of things that we are interested in. As you mentioned, it is not to impugn the integrity or the qualifications of any individual practitioner, but rather to improve the quality that a given facility provides. These issues highlight areas where, through standards of practice or science-based approaches, we can really solve the issue at that given facility. Knowing that information and allowing us to engage with them in that manner will enable us to prevent those things from recurring. So as they come in, we expect to improve on them so that the patients and hospitals are served through that process.

Assemblyman Hammond:

I have questions based on the testimony I read from the Senate when you debated this bill. Earlier today we heard some testimony from Dr. Green about sentinel events and what they are. I want to first make sure I know that we have a consensus on what that definition is so that when we have different people reporting, they are not reporting different numbers or different events. That would be my first question. Second, one of the concerns you raised was making comparisons, weights, and taking a look at a hospital with 40 beds. If it was filled the whole year and they had one major outbreak, how do you compare that with a larger hospital? Have you had further discussions on that issue and what did you resolve?

Senator Wiener:

The sentinel event is defined statutorily in this bill. For these reports and this measure, ". . . an unexpected occurrence involving facility-acquired infection, death or serious physical or psychological injury or the risk thereof." That is defined in this bill. One of the concerns were the rural areas, and during our interim committee work, Dr. Hardy was very concerned about a facility in a rural area that has a 20-bed capacity, and they have two or three incidents, but that could be significant in a 20-bed hospital. The bill requires an average of 25 patients per day occupancy per year to even qualify for inclusion in this. In terms of putting the data together, I cannot get so specific on it because I have never seen the reports that come out of the surveillance that is done by the CDC. That is what this wonderful expert to my right would be working on. We want to ensure that the information is meaningful and customer friendly.

That is what the Health Division will ensure so that the comparisons are real comparisons and not weighted so that they are disproportionate and not representative of what is going on in the hospitals.

Assemblyman Hammond:
So you are fairly comfortable and confident right now that what you have here is going to make sure there is equal measurement. Just following up with the definition, the last part of the definition is where I am sketchy. I think you said psychological . . .

Senator Wiener:
". . . infection, death or serious physical or psychological injury . . ."

Assemblyman Hammond:
That is the one I am worried about the interpretation of. Who is going to interpret what is psychological, what is not, or maybe even some of the other ones. Are you proposing perhaps that we are going to have regulations in this later on? How is that going to be determined?

Senator Wiener:
If I may turn it over to the experts here, I would appreciate Dr. Green or Mr. Kvam responding.

Jay Kvam:
For the time being, we do not have any further guidance on what qualifies as a psychological sentinel event, but those have been historically very low amongst the sentinel events that we record. The qualification needs to be of a serious nature, either a serious physical or a serious psychological injury that has implications for permanent or lasting loss to an individual.

Assemblyman Hambrick:
We had a very good presentation this afternoon, but my question deals more with the proactive versus reactive nature of this bill. In the algorithm that you provided us earlier today, there are only two instances that were two-stage. If something happened, then there was a second question. "Did the event result in actual injury? Yes." Then it moves to the second stage, "Was there a risk of injury due to the event? Yes." So if the answer is yes, it moves to a second stage. My question deals with the second stage on both these areas. "Was the injury of a serious nature?" "Yes, sentinel event; no, not a sentinel event." Hang onto that just for a moment. "Would the injury have been of a serious nature?" "Yes, sentinel; no, non-sentinel." With my background in law enforcement, we always asked the next question. If it went to the second stage, is that being picked up somewhere?

This bill, by and large, is of a reactive nature. I believe that in order to do a better job or the best job that we can, we also have to be proactive. If we do discover something in the health care facility that may have caused a problem, and if it is repetitive but it never causes injury, it may never get reported. Are there other processes within the community that they are picking these things up, like a hospital inspection? Walking up to the edge and never falling off is great, but if you do that 10 times, we have to know why we are walking up to the edge to avoid the 11th time when we do go off the edge.

Tracey Green:
There are other mechanisms for identifying the issues you are describing such as the 18-month and/or annualized inspections that we do on every facility. Complaints are another way to discover or identify issues. So I think there are mechanisms to pick up some of those. The sentinel event registry is a way in which we can then take the final step and then create a database and present data that we can then use for education and for change in health care. So I think the answer to the question is, yes, there are other mechanisms that look at that first step.

Assemblywoman Benitez-Thompson:
I am looking to get a better understanding of the surveillance data and how it is collected. When we are talking about the system that is already established, we are literally talking about surveillance cameras in there and then people go back and review that data. How is the data collected?

Jay Kvam:
Essentially when a health care practitioner or the patient safety officer at one of these medical facilities believes a sentinel event may have occurred, they fill out a report which is then either mailed or faxed to us. That initiates the processes of us registering that event in our data. It also triggers us to follow up with that facility to ensure that they complete an investigation of the event. We also collect the information. I would also dovetail this into what Assemblyman Hambrick mentioned earlier about what is done in regards to these sentinel events. When one is indicated, it begins a root-cause analysis at that facility where they investigate what is going on and they report back on any kind of systemic things that might be going on. They include that in the reports to us, and they also take action on it within the facility.

Assemblywoman Benitez-Thompson:
I should clarify. I was looking for the 30,000-foot view to help me understand the language in section 2, the "Internet-based surveillance system established by the Division of Healthcare Quality Promotion of the Centers for Disease Control and Prevention . . ." I believe that in Senator Wiener's testimony she

talked about how we look at aggregate data right now, and part of what this would do would allow us to drill down and look at facility by facility. I was wondering for that surveillance system and the data we collect, how does the CDC go about doing that?

Jay Kvam:
You are right. There are two different systems in this bill. One is sentinel events; the other one is what you are referring to, which is the Internet-based one maintained by CDC. For one, the facilities directly login via the Internet to report that information. It then goes into databases that are stored and maintained by the CDC. The Health Division has access to that information, when a facility grants that level of access, so that we can look at what is going on within the facility and potentially in the future. Currently we aggregate those returns.

Assemblywoman Benitez-Thompson:
So for all of the facilities that right now the state is collecting in, you would want all of those facilities—for us to drill down to look at it by facility name, not aggregate—on all the ones that the CDC currently collects data on?

Tracey Green:
Yes, the information is currently provided to us as a facility, but we present it as an aggregate. We are interested in moving forward to be able to do it on a facility-specific basis.

Senator Wiener:
For clarification, in subsection 3 of section 2 where it says, ". . . medical facility that participates in the . . . surveillance system shall . . ." This mandates that they authorize the Health Division and give them permission to use that facility-specific data.

Assemblyman Livermore:
In section 2, the bill reads, "Each medical facility which provided medical services and care to an average of 25 or more patients during each business day . . ." Are you talking about inpatient or outpatient or a combination thereof?

Jay Kvam:
We actually specified those guidelines in regulation, and they differ for hospitals, ambulatory surgery centers, and other facility types. So for hospitals, for instance, it is inpatient. For other facility types, it is patients served in a given day. Those are averages that are calculated over the course of a year.

Assemblyman Livermore:
I think it is quite confusing here. If I am someone on the opposite side that is going to have to get that information, I am going to ask for a definition. I do not see it within this bill. Any definition of what the words literally mean, although I do not have *Nevada Revised Statutes* (NRS) 439.847. Hopefully it is embedded.

Chair Mastroluca:
I believe that is current language in the NRS. I understand your question and it is a very valid question, but I just want to make sure you understand that language currently exists, I believe, in the statute.

Assemblyman Livermore:
Below that in section 3, subsection 1(b) it says, "Include, for each surgical center for ambulatory patients in this State, the total number of patients discharged and the average billed charges . . . ." So if a surgery center does in-and-out surgery—less than 23 hours—is that declared as an inpatient?

Jay Kvam:
There are no inpatients whatsoever at ambulatory surgery centers because it is an outpatient procedure.

Assemblyman Livermore:
Sierra Surgery Hospital is an inpatient facility that does both—inpatient and outpatient. It is a three-day stay hospital.

Jay Kvam:
You are correct that there are facilities that do multiple services. They include surgeries. Dedicated ambulatory surgery centers, however, would not do that, but that is a correct assessment of a facility.

Assemblyman Livermore:
Thank you for that information. I do not mean to be argumentative, but I am reading the bill in the purity that it is, and I do not see it specifically spelled out.

Assemblywoman Benitez-Thompson:
I am looking at the CDC website for the Division of Healthcare Quality Promotion, and a lot of this data is still hard to find. As a consumer, I get that in theory this would make it easier for us to shop and compare, but I do not know if I am missing a step in how this data actually gets into consumer hands.

Tracey Green:
We would gather that data and then, in our annual report, present it in a way in which we hope would be much clearer.

Chair Mastroluca:
Are there any other questions? [There were none.]

Did you have a specific order you wanted to proceed, Senator, or shall I just go down the list?

Senator Wiener:
I think I would like to stay for a while to see if you have any additional questions in general or maybe about what happened during the process of moving this bill through the interim and to this session.

Bobbette Bond, representing Health Services Coalition; and Director of Public Policy, Culinary Health Fund:
I have not presented the Health Services Coalition very much in this Committee, but it represents 260,000 lives in southern Nevada in 24 different self-funded plans. The Culinary Health Fund represents about 50,000 lives. We are very supportive of the move towards transparency in health care and distribution of data to the consumer level. We have worked on transparency in several different arenas. The Coalition is very focused on it in a campaign we call "Better." In addition to what Senator Wiener was saying about publicizing the data, it gives consumers a better idea about what is going on inside the hospitals.

One of the main reasons this has been such a push nationally, not just in Nevada, but all over the country, is because adverse health events, readmissions, hospital-acquired infections, and sentinel events are becoming publicly reported. Once the data is available, hospitals really compete with each other to make their numbers look good publicly, and it has an impact on improving quality quickly and affordably without more regulations to try to keep pushing down more tightly on hospitals. The hospitals want to do the right thing. The hospitals are trying, things happen, but the more that it is publicized and the more people can see it in areas where it has happened, the more the quality is improved and the numbers get better, and that is why we are so supportive of it. We are very supportive of the bill, and I will take any questions.

Bill M. Welch, President/CEO, Nevada Hospital Association:
We are here to speak in support of S.B. 209. We have worked with the interim Legislative Committee on Health Care on this legislation. We also worked with

the original legislation process in 2007—I believe that was Assembly Bill No. 146 of the 74th Session. I would like to say for the record that the Nevada Hospital Association has been very proactive in its transparency website. It established a website in 2006 that has continued to evolve. Recently we put out a press release that we have added to our website sentinel events by facility and by type, and I believe we have been live with that for about 30 days. We are also transitioning the infection rate information to our website as well. We are supportive of this legislation.

Chair Mastroluca:
Mr. Welch, would you like to promote your website?

Bill M. Welch:
There is a link on the Nevada Hospital Association website.

Chair Mastroluca:
What is the web address?

Bill M. Welch:
It is <www.nvha.net>. That will take you to all of the various sites we have linked, including our quality measurements.

Assemblyman Hammond:
I believe this or another bill is actually going to create a website so that all of the information will go there. What is going to happen to your website? Right now, are you using the definition of sentinel event as contained in these bills?

Bill M. Welch:
Our website will continue. We initiated our website in 2006. Since that time the state has developed their own website as required by A.B. No. 146 of the 74th Session. We think it is still relevant for us to demonstrate our proactive willingness to be transparent with what happens in our facilities and will continue to maintain our website. The information that will be posted on our website should be the same information that will be posted on the state's website. We should note that the state does have their website up already and has been up for at least the last couple of years that I am aware of. They will not be creating a new website for that information; it will just be adding another page to their website which would provide sentinel event information. The sentinel events that we are reporting to the state is the sentinel event information we are posting on our website, so it should be the same. We report that information based upon the NRS requirements as well as the regulations that the Division has developed for helping to facilitate the reporting of sentinel events. I think Dr. Green talked about that; I was not able to be here for her

presentation earlier today. They have had an algorithm and developed very specific criteria. They have modified it as of the first of the year and I understand they are in the process of developing their algorithm to help ensure consistency in that reporting.

Assemblyman Hammond:
Are you getting full cooperation from all of the hospitals that are in your organization, or is it not mandatory?

Bill M. Welch:
We are a voluntary association, so it is voluntary for them to participate in this website. We represent more than 95 percent of the hospitals in the state of Nevada. The state hospitals are not members of the Hospital Association. They are not allowed to be part of a trade association. We have a couple of specialty hospitals that are not members, but 90 to 95 percent of the hospitals in the state are members. All of our member hospitals have endorsed and are participating in providing the information.

Leslie Johnstone, Executive Director, Health Services Coalition:
I want to quickly reiterate our support of S.B. 209. We think it makes consumers more informed and it also makes the self-funded plans that we represent more informed. Thank you.

Michael Ginsburg, Southern Nevada Director, Progressive Leadership Alliance of Nevada:
The Progressive Leadership Alliance of Nevada (PLAN) is in support of all three bills this evening.

Barry Gold, Director, Government Relations, AARP Nevada:
In a recent AARP survey of 50-plus Nevadans, their top three concerns had to do with health issues. [He read from written testimony (Exhibit C).] The National Quality Forum published a list of 28 unambiguous, serious, preventable, and adverse events sometimes referred to as "never events." In Nevada statutes we know these types of events are referred to as "sentinel events" and are unexpected occurrences involving facility-acquired infection, death, serious physical or psychological injury or risk. Federal and state governments should require a health care facility to report the occurrence of these events, and policymakers should require the facility-specific report be publicly disseminated.

Senate Bill 209 would let the public know about the sentinel events that occur in hospitals and medical facilities. Currently, facilities that care for more than 25 people a day are required to report these to the state, but the information is

shared in summary only with no details by individual facilities. Senate Bill 209 requires the facilities that submit these reports on the website to provide consent to the Health Division to identify the facility they occur in. That is the current problem. They do not specifically list what hospital or medical facility the events happened in. How can this information be helpful to Nevadans if they do not know where they happen?

This bill also requires that "The information must be reported in a manner that allows a person to compare the information for the medical facilities." This will solve that problem. You and I would now be able to compare facilities and know what is happening in each one. Consumers will have the information they need to make the best choices for their health care. Senate Bill 209 requires hospitals and medical facilities to consent to identify the individual facilities that are reporting sentinel events and the Health Division to post the annual reports so consumers can compare facilities. This will achieve that. This bill will provide essential access to information that helps consumers. On behalf of our 305,000 members across the state, AARP Nevada supports S.B. 209 and urges the Committee to pass it.

Assemblyman Hammond:
You mentioned at the very beginning of your testimony about a survey you conducted of 50-plus—I imagine you mean 50-plus in age—I want to know more about the information you received from that. Did you include that in your testimony? The survey where we can find it? I am curious as to how many people you surveyed, over what period of time, and did you have a lot of open-ended questions, or were they specific: "Do you support or not?" I would like to see if there are any open-ended answers that would be interesting to read.

Barry Gold:
I would be glad to provide that survey. I do not have the information with me, but I can provide the information of the full survey, which has some great information about the problems and needs of 50-plus Nevadans. It is one of the first times that we surveyed not just AARP members, but 50-plus Nevadans across the state. I would be glad to provide that information to the members of the Committee.

Chair Mastroluca:
Is there anyone else who would like to testify on S.B. 209, either in support, opposition, or neutral? [There was no response.] Is there anyone in Las Vegas on S.B. 209? [There was no response.] We will close the hearing on S.B. 209.

We will open the hearing on Senate Bill 264 (1st Reprint) and invite Senator Leslie up.

Senate Bill 264 (1st Reprint): Revises provisions concerning the regulation of certain medical facilities. (BDR 40-15)

Senator Sheila Leslie, Washoe County Senatorial District No. 1:
I am here today on Senate Bill 264 (R1). I know you just heard S.B. 209, so hopefully a lot of the questions have been answered. As you heard from your discussion with the previous bill and certainly if you have read a newspaper in Las Vegas or northern Nevada in the last year, you already know that Nevada is behind many other states regarding the public reporting of health care quality information at the facility level. We know that public reporting is an essential element in both patient education and safety improvement. This bill is intended to supplement what is currently in statute and help fill the holes that still remain in our health care quality and transparency reporting. Senate Bill 264 (R1) has several components that were identified by the *Las Vegas Sun* series "Do No Harm," as well as input from constituents with loved ones receiving health care in discussions with our state agencies about current capacity.

I do not know if Senator Wiener told you in the Senate Committee on Health and Human Services, we had a subcommittee that I chaired, and we worked very hard on five related bills. You are hearing three of them tonight. We met several times. We took hours of testimony from many of the parties you have already heard from, so these bills were worked. I know that in some cases—and I am going to present a technical amendment myself—there is still a little bit more work that needs to be done, but I hope the Committee appreciates that everyone has worked very hard on these bills. I want to thank the Nevada Hospital Association, the Health Services Coalition from southern Nevada, and all the advocates that we heard from. They put in a lot of time and I think we have a good work product.

In the interest of time, and especially since you just heard S.B. 209, I think I will skip most of my remarks about why this is needed, because I think you probably heard enough testimony on that. One thing that is in this bill which is a little different that I put in on behalf of the Health Division was to let them use the fine money that they generate and use it for training purposes. I think that was a really good provision.

Madam Chair, if you would like, I can go to the amendment and explain what the cleanup provisions are. In my mind, these are technical issues. With all the people who worked on this bill, I do not know how we missed some of this

stuff. There were a lot of changes and a lot of different parts of the bill, so I will go through them (Exhibit D).

The first change in the amendment is in section 5, subsection 3(f). You can see we are deleting lines 19 through 21. That was just an error. We had a lot of discussion on this bill about effective dates, and they were all negotiated. This section should not have even been put in there because they already have to report sentinel events.

The next change is on the fifth page in section 9, subsection 4(b), line 24. We want to make sure that the information has to be reported as both a number and a rate. We had a lot of discussion about that. We all agreed that it would be reported as a number and a rate.

Chair Mastroluca:
Senator, would you please explain about a number and a rate?

Senator Leslie:
Yes. We really want to make this data very accessible to the consumer. We want it to be reported as a whole number, how many incidents there were in a particular medical error, but we also want a rate. Maybe you are lucky enough to have health insurance that lets you choose which hospital you want. I do not. I think most of us do not. We go where we are told to go. But if you do, or if you are uninsured and you have the ability to pick your hospital, this would enable you to go to a website, look up your diagnostic code, and you can see what the medical error rate is in your hospital. To be fair, we thought, it should not just be a whole number. It should also be the rate of medical error. This bill lets you see it both as a number and a rate, and it just got left out of the section.

Chair Mastroluca:
Because this is a technical amendment, I am wondering if our legal staff feels that it is enough complete information to verify that that is what you are looking for.

Senator Leslie:
We can certainly consult our legal counsel, who is also our legal counsel in the Senate. There are so many other people, and I believe that everyone agrees with this, but I can be wrong.

Chair Mastroluca:
I do not disagree with the information; I just want to make sure that it is clear in statute that the number of instances as well as the rate is what we are looking for.

Assemblywoman Pierce:
I think I am still not clear what you mean by "rate."

Senator Leslie:
A percentage. A rate per certain amount of patients. I do want to make the point that the federal government is requiring us to report this information. More and more we as consumers are going to be getting this information, and we just want to make sure that for our Nevada hospitals it is available to consumers.

The next technical amendment is in section 16, subsection 2(c). Again, this is just saying that these measures of quality need to be expressed as both a number and a rate.

The next one is in section 16, subsection 2(f) on line 34. There we had rate but we did not have a number, so we are asking to add a number and a rate.

The next one is in section 20, subsection 1, paragraph (a), subparagraph (1). We are taking out "50 most frequent" on lines 10 and 11. That is leftover language from a bill we worked on four years ago, and at that time we wanted to limit it to the 50 most diagnosis-related groups for inpatients. We are well past that data now nationally. More than 50 have to be reported now, so we are ready to take that out. Everyone has agreed to that; we just did not get it out in this particular area. If you keep reading, you will notice that we are leaving it in for 50 medical treatments for outpatients, and that is because that data has not been sufficiently developed yet. Four years from now we may be back and say, "We are ready to not limit it." If this data is being reported federally, we do not want to be limited by our own legislation. If the data is ready to go up on the website, we want it to go up. We want to have access to it. So this is matching up the language in another part of the bill.

Finally, a very small technical amendment further down on line 20 in subparagraph (2). Instead of saying ". . . for which the patient originally received treatment at the hospital;" we would like it to say "a hospital." Those are my suggested amendments. We have representatives here who are much more able to answer any technical questions your Committee has, but I would be happy to try.

Assemblyman Hammond:
You said that the word "rate" is already being applied by federal regulations or standards, one of those two. Am I correct in saying that?

Senator Leslie:
I think it is a little different—and we can have them confirm this—but my understanding of rate is that for every data set that we have to report, there is an established rate for that particular data set. So the rate may differ by the medical error. It may be one error per 100,000 for a certain thing, and it may be a different rate.

Assemblyman Hammond:
So this language that you are proposing is not mirroring the language that we have in federal statute or regulations?

Senator Leslie:
It is referencing that, because it is saying a rate, and all of the federal data that is reported is by a rate.

Assemblyman Livermore:
Are you referring to Diagnosis Related Groups (DRG), which is the rate schedule?

Senator Leslie:
Apparently I am not. But perhaps Mr. Greenway in Las Vegas can give us a better explanation of rate. I think that is important, so let us get it from the expert.

Joseph Greenway, Director, Center for Health Information Analysis, University of Nevada, Las Vegas:
As Senator Leslie described, the rate is not referring to the DRG rate. Say if you were looking at drugs, you might want to say for one thousand times a drug was prescribed, you had one incident. That would be a rate of one of per thousand. You might have a rate of one instance per 1,000 bed days of a facility. So the rate would be whatever is most appropriate for the measure of quality that is being displayed.

Chair Mastroluca:
Are there any further questions for Senator Leslie? [There was no response.]

Senator, did you have an order that you wanted to go in?

Senator Leslie:
I would have the Health Services Coalition and the hospitals come up, because they worked on it together, and I was really happy with the process this time.

Bobbette Bond, representing Health Services Coalition; and Director of Public Policy, Culinary Health Fund:
I am going to represent the Culinary Health Fund because I saw in the last bill that Leslie Johnstone was to represent the Coalition, so she should have the chance to do that and I do not want to speak for her.

We are very in favor of the transparency elements of S.B. 264 (R1), and we are also very appreciative that this bill has been brought forward in a comprehensive way. I know you have heard the presentation this afternoon about sentinel events. There are really three different data streams in this bill that are all being brought together to move forward on transparency, so the way the bill turned out is great. I am very grateful that the hospitals have taken a great attitude about disclosure on these issues.

What S.B. 264 (R1) is going to do is allow the sentinel events data that you just saw in Senate Bill 209 to be publicly posted. It is also going to have the National Healthcare Safety Network data about infections that you heard a little bit about to be publicly posted. The third set of data—which Joseph Greenway can talk more about if you have questions—is the claims data that come into the website that Assemblyman Hammond was asking about, which is used to post quality indicators for the hospitals in this state. This bill will allow that quality indicator data set to be expanded and more robust and publicly reported by hospitals, and it will help us build the state website, which is <nevadacomparecare.net>. That has been up and running for about two years, and they are now working on some of the more consumer friendly pieces. We see this all moving together into a comprehensive disclosure and transparency tool to take us into the next era of hospital quality. That was a long way of saying that we support the bill.

Bill M. Welch, President/CEO, Nevada Hospital Association:
The Nevada Hospital Association is in support of S.B. 264 (R1), including the technical amendments being provided today. I will not repeat the testimony I provided on S.B. 209 other than to say on this particular bill I would just like to point out <www.nvha.net> again.

We have had our pricing transparency up since 2007, we have been posting 100 percent of our inpatient data since that point in time, and we are just in the process of going live with our outpatient pricing information. I believe the state is in the process of developing theirs, and we will be able to move forward on

theirs shortly as well. So again, we are in support of S.B. 264 (R1) as represented today.

Assemblywoman Benitez-Thompson:
I have a question on section 5, subsection 3 where it talks about the information that each medical facility is supposed to report. Also on line 17 in subsection (e), could you give me an example of what it would be when it says, "Not be reported for a medical facility if reporting the data would risk identifying a patient . . ."? Could you give me example of an instance where you would not report something because it would identify a patient?

Bill M. Welch:
As we have testified, in many rural communities, even though they may have, on average, a 25-patient daily census, they are small communities and may only have had one incident. Depending on how you would represent that, it could cause to become public who that individual patient was and how. So it is trying to protect the patient's privacy. It is not trying to prevent the information from being provided publicly; it is just trying to make sure the patient's information—unless they choose to make it public—is kept confidential.

If I may, Madam Chair, one of the questions was about the rate versus number or both. The reason we asked for rate—the Nevada Hospital Association website presents it as a rate, and on the sentinel events we are doing it based upon a thousand patient days. We talked a little about small hospitals versus large hospitals, but you also have hospitals within a community, as Senator Leslie indicated. We have four hospitals here in northern Nevada, so I will pick on those four hospitals. You have Northern Nevada Medical Center, Saint Mary's Regional Medical Center, Renown Regional Medical Center, and Renown South Meadows Medical Center. They are different in size, scope of services, and complexity. One is a level II trauma center and the others are not. There are going to be different volume numbers and different risks. If you just compare hospital to hospital by number, you might look at—I will pick on Renown Regional Medical Center because they are behind me—they are the largest hospital, and they are a trauma center. You might see that they had 50 sentinel events and then you will look at another hospital like Northern Nevada Medical Center which is a 100-bed facility that only had 10. You might say, "Well, this hospital is better than this hospital," because you are just looking at numbers. So we are trying to make sure that the rate will help balance it for the consumer.

Chair Mastroluca:
Thank you for that explanation, Mr. Welch. That helps.

Are there further questions from the Committee? [There were none.]

Leslie Johnstone, Executive Director, Health Services Coalition:
I would like to indicate our strong support for S.B. 264 (R1) including the technical amendment presented by Senator Leslie. The Health Services Coalition was actually one of the primary financial supporters of Nevada Compare Care, so to the degree that this bill would bolster the information that is included on that website, we are very supportive. Thank you.

Chair Mastroluca:
Thank you very much. Are there any questions for Ms. Johnstone? [There were none.]

Barry Gold, Director, Government Relations, AARP Nevada:
We strongly support this bill. You heard me talk about the sentinel events and how important it is to report those. This bill also contains potentially preventable readmissions. We did not survey our members or any 50-plus Nevadans on this, but I think it would be pretty safe to say that no one wants to go to the hospital. No one wants to have to go back to the hospital after they are discharged for something they did not have to go back for. I think this bill requiring the reporting of these potentially preventable readmissions is a really important step in informing the public on what is going on, and also to look at what is happening in those facilities with these potentially preventable readmissions and doing something to stop them. We think that is another really great component and we strongly support the bill. Thank you.

Chair Mastroluca:
Thank you very much. Are there any questions for Mr. Gold? [There were none.]

Mr. Duarte, are you actually coming up in support of the bill?

Charles Duarte, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services:
I am sorry, Madam Chair, I am neutral on this bill. I just wanted to make sure the Committee knows there is a fiscal note. I also wanted to make sure that Joseph Greenway—if he is still down in Las Vegas and if there are any questions about the note—has an opportunity to explain it.

By way of background, the Division maintains a contract with the Center for Health Information Analysis (CHIA) at University of Nevada, Las Vegas (UNLV)

that runs the Nevada Compare Care website for us, as well as performs many other reporting functions. As a part of their work, they are going to need to be able to do some additional programming, particularly to do electronic data capture off of claims information for potentially preventable hospital readmissions. As a part of that, Mr. Greenway has estimated that CHIA will need about $67,200 over the biennium for the services of a 0.4 full-time equivalent (FTE) programmer. He has this down to the point FTE estimate. So if there are any questions about that, you can either ask me or Mr. Greenway.

Assemblywoman Smith:
Did the amendment create the fiscal note? The fiscal note attached to the bill is zero.

Charles Duarte:
The fiscal note has been there for some time as an unsolicited fiscal note. As a result of that, I do not believe it gets posted on the Nevada Electronic Legislative Information System, but it should be available to the Committee. We presented this information to the Senate Committee on Health and Human Services when the bill was being heard then.

Assemblywoman Smith:
None of that changed?

Charles Duarte:
None of that has changed with the amendment.

Chair Mastroluca:
We will look for that and get the information to the Committee.

Assemblyman Brooks:
My question was the same thing. On my paperwork it says it will have no fiscal impact on the Health Division since it is within the existing scope of duties. It is the exact same thing as my colleague questioned you about.

Charles Duarte:
For clarification purposes, the provisions of this bill that result in the fiscal note are the result of the effect on the Health Division. It is specifically on the requirements in *Nevada Revised Statutes* (NRS) Chapter 439 that have CHIA putting up the website and hospital information. To complete the work that is required in here, particularly about potentially preventable hospital readmissions, Mr. Greenway is going to have to do some programming and report development. That is where the costs come in.

Assemblyman Hammond:
You said the numbers so quickly, and I want to make sure I have the numbers. Would you give me the numbers again? I think you said, "Each biennium." Is it recurring or is it one time?

Charles Duarte:
It is a recurring amount of money that Mr. Greenway is going to need to run this. It is $67,200 for the biennium.

Chair Mastroluca:
Are there any other questions for Mr. Duarte? [There were none.] Is there anyone else who would like to testify in support of S.B. 264 (R1), either in Las Vegas or Carson City? [There was no response.] Is there anyone opposed to S.B. 264 (R1)? [There was no response.] Is there anyone else neutral on S.B. 264 (R1)?

Wendy Simons, Chief, Bureau of Health Care Quality and Compliance, Health Division, Department of Health and Human Services:
I have a very brief contribution to the discussion, which is pertinent to the language of sections 21, 22, 24, and 25. This will now broaden how monies that are collected through administrative sanction process can be used to protect the health, safety, well-being, and property of patients and residents in licensed facilities. This will give the Health Division the flexibility it needs to best protect health and safety of patients and residents. For example, health care associated infections have been identified as an area of improvement in licensed facilities. The monies could then be used to carry out, for example, an infection control and prevention campaign for all facilities, whereas it is currently facility specific, or to help individual facilities improve the quality of care in their facilities. The Health Division has the structure in place to carry out the provisions of this bill as amended. I am happy to answer any questions.

Chair Mastroluca:
Thank you very much. Are there any questions from the Committee? [There were none.] Is there anyone else who would like to testify on S.B. 264 (R1)? [There was no response.] Seeing none, we will close the hearing on S.B. 264 (R1). We will move to Senate Bill 339 (1st Reprint).

Senate Bill 339 (1st Reprint): Establishes provisions relating to the safety of patients in certain medical facilities. (BDR 40-662)

Senator Shirley A. Breeden, Clark County Senatorial District No. 5:
Senate Bill 339 (R1) is a bill which is an effort to reduce infections, especially facility-acquired infections, for patients. Each of these components is very

critical to implementing systems and procedures that lead to better outcomes for all patients. There is data showing that reducing infections in a medical facility by a mere 6 percent is that breakeven point for a hospital. That is, the expense that goes into a quality infection prevention and control program is covered if only 6 percent of a facility's infections are prevented. Anything beyond 6 percent results in direct cost savings to facilities. Wherever patient care is provided, adherence to infection prevention guidelines is needed to ensure that all care is safe care. This measure seeks to: (1) educate patients about health care associated infections, (2) establish trained infection control staff for every medical facility in the state, and (3) update the patient safety plans with information related to hospital-acquired infections.

A lot of work has gone into S.B. 339 (R1) and I would like to publicly thank all of the stakeholders who were involved in this. In fact, you have the latest conceptual amendment that is hot off the press. The stakeholders involved were the Health Services Coalition, Nevada Hospital Association, Nevada Rural Hospital Partners, Nevada Osteopathic Medical Association, and the Nevada State Medical Association. Of course, without all of these partners, the bill would not be here before you.

Madam Chair, if it is acceptable to you, would you like me to go through each section and give you a brief summary, or do you want to skip to the conceptual amendment? What would you prefer?

Chair Mastroluca:
Would you mind doing a brief description of each section?

Senator Breeden:
Section 2 of the bill requires each medical facility to provide patients with information relating to facility-acquired infections, and to post in public areas of the facility directions for reporting facility-acquired infections. Section 2 also requires that hospitals develop protocols for informing patients who are found to have an infection whether facility-acquired or not. Lines 3 through 5 on page 3 protect from liability those who provide this information. I will come back to section 2 in more detail when we discuss the proposed amendment.

Section 3 of the bill requires medical facilities to designate a certified infection preventionist as the infection control officer for the facility in any hospital with at least 175 beds. In addition, hospitals are required to ensure a ratio of at least one trained infection control personnel employee for every 100 occupied beds in the hospital, and outlines the training requirements. Finally, section 3 continues the Health Division's education and technical assistance support regarding infection prevention and control.

Section 4.5 of the bill is removed in the proposed amendment, and we can explain that at the end.

Section 5 requires that the patient safety plans now submitted to the Health Division of the Department of Health and Human Services will be posted publicly on the Internet website maintained by the department.

Section 6 requires that the existing patient safety plan be updated annually and that it include an infection control program and policy, and what the components of the policy include, giving facilities a choice between two options, or a combination of those two options. Also included is a designation of who is responsible for infection control at all times in the facility.

Section 7 revises existing statutes to carry out the provisions of the bill as it relates to the infection control officer and the patient safety committee. Madam Chair, that is a brief overview of the first reprint of the bill.

Chair Mastroluca:
Now you are going to go through the amendment?

Senator Breeden:
Yes. The hospitals, the Health Services Coalition, and as I mentioned, others worked on the conceptual amendment before you (Exhibit E). A couple of issues were not resolved in S.B. 339 (R1) that are addressed in this amendment, and additional changes have been made to ensure that this bill does not create a fiscal impact on the state.

The conceptual amendment addresses an issue that arose in the Senate regarding who is responsible for ensuring that a patient is informed if they have an infection. There was testimony that patients do not always know they have an infection, and it was unclear in the language if a patient would always be informed, by whom, and when. Section 2, subsection 1(c) has therefore been expanded to specifically state in statute that the patient will be informed within a reasonable time frame of five days. How this happens is left to each hospital and the hospital medical staff through the development of the medical facility protocols. This ensures the patient is informed but gives the providers the flexibility they requested to determine how. Specifically, item 1 of the proposed amendment adds some specific requirements to be included in the medical facility protocols about patient notification including the time frame. Item two adds a new *Nevada Revised Statutes* (NRS) provision that . . .

Chair Mastroluca:
Senator, I am sorry, can we go back to item 1? I am confused about the time frame. I am confused about setting a hard time frame. Is that reasonable, is it enough time, not enough time?

Senator Breeden:
Are you talking about the development of the protocols or informing?

Chair Mastroluca:
The notification within five days.

Senator Breeden:
The five days was actually at my request, and the reason for that is once the "infection" has been confirmed, they have five days in which to notify the patient. Depending on the infection, you could be dead in ten days. So we compromised—that was my request.

Chair Mastroluca:
Is five days too long?

Senator Breeden:
I will let the experts answer that.

Amber Joiner, Director of Governmental Relations, Nevada State Medical Association:
Setting a specific time frame was also a concern for our members, the physicians, because there are some cultures that take more than five days to come back and confirm. With the language in this amendment saying that the clock starts once we have a confirmed infection alleviated some of our concerns. You will notice that there has been language added that says that unless it is "determined, on the basis of medical judgment . . . not to be in the best interest of the patient . . . ." With that caveat, we can go along with the specific time frame. The reason for that is, according to medical ethics, there are situations where if a patient is suicidal, for example, or if they are incoherent, you may need to delay the notification beyond five days. That is where medical judgment is really crucial.

As far as your question about whether fewer days as needed, we actually anticipate that five is the far outside extreme. What we are basically saying is that if you have not been informed within five days of receiving a confirmation and you do not have other medical conditions that would prevent you from being able to comprehend and use that information, five is the maximum. Should it be less than that? The protocols can actually determine less

than that. Honestly, we have heard extreme examples, but for the most part people find out right away that they have an infection because the doctors are administering antibiotics to them and explaining to them, "Well, you have spiked a fever, we think you have an infection, we are going to give you this particular antibiotic." So in most cases people are finding out much sooner than within five days. In fact, usually it is right when the infection is confirmed and the treatment begins. So with this five-day limit, we think that it will actually be much sooner than that in most cases, but that is the outside limit.

Bobbette Bond, representing Health Services Coalition; and Director of Public Policy, Culinary Health Fund:
We think five days is a little long. Five days is longer than what is really required based on the new language. We had five days in there before we clarified that it is five days from confirmation of the diagnosis. I think that once the diagnosis is confirmed, having five days before patients can be sure they are going to hear about their diagnosis of infection seems a little long to us, but in the interest of compromise, that is where we are.

Assemblyman Anderson:
Ms. Joiner, I am glad to hear you think that is the outside window. I understand that maybe there are some situations where you said suicide prevention, maybe language to say "as soon as practicable but not later than five days." Would that be something that would be acceptable?

Amber Joiner:
There will be cases that need to go beyond five days because of the mental health of the patient. It would help to add language, "unless it is detrimental to the mental or physical health of the patient." That is basically what we are getting at. There are cases where patients need to be stabilized mentally before they can be told. I am not sure I answered your question, but there are cases. That is why the medical judgment exception is in there. It is very few cases. Another example is a coma. It does not help a patient at the end of five days to have the physician stand at their bedside and tell them they have an infection if they are not able to comprehend it. There are going to be cases where more than five days is needed, but they are rare, and that is why that language is in there for the medical judgment exception.

Assemblyman Anderson:
I understand. If we put, "as soon as the diagnosis is known," we still have the medical judgment protocol in there. Would that not cover it if you had to go beyond as soon as you knew about it? Let us say you have the medical judgment exception in there. That would basically cover you as much as you

have to if you have a situation like mental health. Why not put a little less than five days? That is the question I am trying to get at.

Amber Joiner:
We were offered five days from the sponsor. We have not considered other time frames because they were not brought up before, so I would have to go back to my members. It just has not been taken to them.

Assemblyman Anderson:
I am sorry to put you on the spot. I understand that you need to go back. I am just throwing out ideas.

Assemblywoman Pierce:
I had concerns about those two points. It seems to me that the vast majority of people do not spend five days in a hospital. Every time I have been in a hospital they were trying to shove me out the door just as soon as I could. That seems a long time. I understand if someone is suicidal or in a coma. The language seems expansive for those possibilities.

Chair Mastroluca:
Based on the question that Mr. Anderson and I had, maybe we can look at something more along the lines of, "as soon as practical but not later than five days" to show the urgency. That is how I am looking at it. I do not doubt that any medical professional would wait one minute longer than necessary, but just to show the intent of the urgency, I think that it would be something that would be helpful.

What would "medical professionals or their designees" constitute?

Amber Joiner:
That was at our request this morning. It is purely related to the fact that there will be a protocol and we envision that the protocol will establish a sort of hierarchy of the order of the professionals who will inform the patients. You might have the treating physician, the attending physician, the physician's assistant, and it would go in that order. The reason we thought "designee" was important was because every hospital is going to have a different hierarchy depending on the personnel they have. Some of the smaller hospitals might not have as many people who could notify. The "designee" part is important because if the physician is out of the hospital, on vacation, and the protocol says, "in this order these people shall notify," we need to be able to have a designee, such as an infection control nurse, social worker, or someone who is on the premises who can immediately give the information to the patient and their family. It would rarely happen, but our physicians are able to designate

people to do things for them. In case that person who they want to designate—who is in the room with the family at the time—is not in the protocol, we thought they should be able to designate someone to do that.

Chair Mastroluca:
Thank you. That makes perfect sense.

Senator Breeden:
Section 2 adds a new NRS provision that specifically requires that each patient or their designee be informed that they have an infection. It also lists the five-day requirement of when the provider has confirmed diagnosis for the patient. Finally, it addresses a concern by the Nevada State Medical Association of the requirement that includes an exemption if there is some unusual or extenuating circumstance when it would not be in the best interest of the patient to inform them.

Chair Mastroluca:
I recognize Ms. Joiner made a comment about if the patient were incoherent for some reason, obviously you cannot tell them, but since it does specify guardian or other authorized person, generally I believe that when you are dealing with someone who is incoherent such as in a coma, someone is authorized to get that information if they are available. I want to make sure that we are getting as much information to as many people as possible, and not putting any roadblocks in the way, for the doctors or for the patient.

Amber Joiner:
We definitely discussed that, and unfortunately we cannot legislate for 100 percent of the people. We came up with the reality that indigent people show up at the hospital and do not have people designated to take that information for them, and at the point that they are incoherent or suicidal, we need to have that exception.

I am happy to take your proposal about saying something such as "as soon as practical but no later than five days" back to my members. I think making something like that more specific could work.

Bobbette Bond, representing Health Services Coalition; and Director of Public Policy, Culinary Health Fund:
On this issue with the protocols, we did not get a chance to confer with Senator Breeden on this section before this was brought to the group. We still have a concern about the language, "the basis of medical judgment as set forth in the protocols, not to be in the best interest of the patient." We would really like that to be tighter. We would like something in the protocols to state what

situations there would be, because to your point, we said exactly what you just said. There is always a way to inform the patient, family, or designee. If they do not have one, they do not have one. But if they do have one, there is a way to inform them. I would like it on the record that we have a concern about how loose the protocol language is right now about the exception.

Chair Mastroluca:
But you are in support of the amendment?

Bobbette Bond:
In the interest of compromise.

Chair Mastroluca:
Just wanted to make sure we are on the same page. Thank you, Ms. Bond.

Senator Breeden:
Item 3 of the proposed conceptual amendment adds a date when these protocols should be completed. It was based on input received by the hospitals in what they thought was a reasonable time frame for them. You will see that we came up with the date of October 1, 2011 because we thought it was urgent, so we are looking at 90 days ourselves.

Chair Mastroluca:
It is reasonable to all parties to be able to put together the protocol and have all of it?

Senator Breeden:
Yes.

Amber Joiner:
We did not have a concern with that. I know the hospitals may be able to adjust that later since it is their . . .

Chair Mastroluca:
They are on here. I have an official nod from Mr. Welch on it.

Senator Breeden:
I would like to expand on it. Ninety days was Mr. Welch's suggestion and I said, "Great. October 1, 2011." That is how we came up with that date.

Item 4 reverts the bill to the original definition of a medical facility which includes only the hospitals. The addition of other types of facilities such as skilled nursing, ambulatory surgical centers, and obstetric centers were added to

make the bill as complete as possible; however, it has been determined that this will increase the cost for the state. We needed to protect the state from additional funding issues, so that is why we went back to the original definition.

Chair Mastroluca:
It would exclude skilled nursing facilities and different groups like that. We want to do that?

Senator Breeden:
That was our original intent, yes.

Item 5 is a technical correction. It was the intent of the parties to agree that infection control staff "shall" versus "may" be trained using one of the two processes or a combination of two. We just did not catch that.

Chair Mastroluca:
Are there questions from the Committee on the amendment as a whole? [There were none.]

Bobbette Bond:
I just want to say that we are glad we got this far in the bill and we are going to accept this amendment, but we would prefer that there was language that explained instead of the protocol what kind of exceptions there would be for when it would not be in the best interest of the patient to be notified that they have an infection. Thank you.

Chair Mastroluca:
I understand your point. My concern is that it would become a very long list. I think that it is worth you having a conversation with the rest of the group, but I do not know that you are going to be able to come up with that specific answer at this time.

Amber Joiner:
I just had a statement of support for the measure and also for the amendment. I would like to sincerely thank Senator Breeden for addressing her concerns in this bill. It has been a long day today. All along we have supported S.B. 339 (R1). We support the first reprint with or without the amendment, and we definitely support this latest version of the amendment. We think it is more specific, it designates hospital personnel, and we agree that patients should absolutely be informed when they have infections. We support hospital-acquired infection transparency. We support quality health care. I am pleased that we were able to come to these agreements on this amendment.

To address the situation about how specific the protocol should be regarding the types of situations, I appreciate your comments about how cumbersome that would become. That has been our concern all day. We have had a very lengthy conversation. The World Health Organization identifies over 12,000 conditions, and when you combine them, it is an infinite combination. There is really no practical way for a staff protocol—which is a by-law or list—to list all of the possible conditions that might make someone incapable of understanding their medical condition. We have tried to come up with language regarding if it would be detrimental to the mental or physical health, all kinds of combinations. We sympathize with that. We just think it is not practical to list specific conditions. We appreciate your understanding of that. But overall we support the bill and amendment. Thank you.

Chair Mastroluca:
Are there any questions from the Committee? [There were none.] Thank you for all the work on this amendment. I think it brings everyone to the same page and I really appreciate the time that you have spent. Thank you very much, Senator.

Senator Breeden:
Thank you. It has been a long three months, but it is a good bill.

Michael Ginsburg, Southern Nevada Director, Progressive Leadership Alliance of Nevada:
We are in support of all three of these bills, but in the interest of time we will only speak on this one. In my capacity as the Southern Nevada Director, one of my responsibilities is health care advocacy and organizing. I also have an extensive background in health care, working the greater part of the last two decades as a biomedical researcher and as a clinical laboratory manager. I also continue to volunteer for the Clark County Health District's Medical Reserve Corps to respond to community disasters such as outbreaks of communicable and infectious diseases.

The Progressive Leadership Alliance of Nevada feels that this is an excellent bill that will do a great deal of good to protect patients as well as the public, and to help instill more confidence in our state's medical facilities. We feel that sections 2 and 3 are more than generous in ensuring that facilities will not suffer any undue burdens from this law, especially when weighed against patient and public safety. In fact, in my duties as a researcher, when no patient contact was made, our laboratory always had an infection control officer for the protection of our own employees due to work being done with certain pathogens. Again, in my capacity as a clinical laboratory manager where we had fewer than 100 patients per month in an outpatient setting, we also had an

infection control officer at all times. We think that this is not only a reasonable expectation for medical facilities, it is absolutely the right thing to do for patient safety.

As for the amendment, we are not particularly thrilled with the removal of the intermediate care and skilled nursing facilities, especially considering the number of demerits those facilities receive from the Health Division. We are not crazy about that, but we feel it is an excellent bill and we do look forward to seeing it become law. Thank you.

Chair Mastroluca:
Are there any questions from the Committee for Mr. Ginsburg? [There were none.] Thank you very much for your testimony and for waiting for us. I really appreciate it.

Leslie Johnstone, Executive Director, Health Services Coalition:
I would like to also express our support for S.B. 339 (R1) along with the amendments that were presented today. You can get a sense just listening to the discussion of the work that went on today to reach an agreement on the amendment, even with the compromises that had to be put in place.

I would like to emphasize one aspect of the importance of this kind of bill in that we are not just talking about notification of the patient, but we are also speaking to the education of the caregivers, the family, and the general public that that patient will be exposed to. The sooner that information about any kind of infection is known, the patient can care for themselves as well as protect spreading of that infection. Thank you.

Chair Mastroluca:
Thank you very much, Ms. Johnstone. Are there any questions? [There were none.]

D. Taylor, Secretary-Treasurer, Culinary Workers Union Local 226:
I want to note that I am very thankful to Senator Breeden for taking the issue of expanding infection control resources. I must say sitting in the audience here, I am not quite sure about the amendment that has been presented. I hear stories all the time about what occurs in the hospital with infections, and I would encourage this entire Committee, if you have not done so yet, to read Marshall Allen's "Do No Harm" series last year. After that series came out, members and their families came out of the woodwork to me. It was unbelievable. I am concerned on this amendment that it is not used so patients and their families are not informed. I think that is a very, very important fundamental right. I never would have thought I would have to be speaking on

that issue after that series came out. In that series—I am sure many of you read—that is what occurred. If there is an exemption for the doctors that it is not in the best interest of the patient or their families to know, I hope that is very, very few times and very, very far in between. I think if you have come this far on a good piece of legislation to have an amendment that would appear to be not informing the patients or their families in a very quick way, I think that we would fall just short of the goal line, which would be a real tragedy. I hope when you are looking at this amendment, you can figure out how it works so it does not happen very often and is very, very rare.

Chair Mastroluca:
Are there any questions from the Committee? [There were none.] Is there anyone else in Las Vegas who wishes to testify on S.B. 339 (R1)?

Kenny Adamson, Private Citizen, Las Vegas, Nevada:
I am here for my father, Charles Adamson. He was a pretty vibrant person. About a year and a half ago you could not keep him at home. He was always doing something. It got to the point where he could not go up and down stairs. So he had to make a choice of whether or not to have surgery, because both of his knees were in bad shape. He had arthritis pretty bad. He decided to have surgery. They took him to Sunrise Hospital; my sisters were all there pretty much most of the time. For three hours there were feces on the floor. They kept telling the nurse and kept telling the people to clean it up and no one cleaned it up. This started some time in February. He stayed in the hospital for about three weeks.

He went to a rehabilitation facility and there was another gentleman in the other bed. When I went in to see my father, he told me that this guy had laid in his own waste for three hours and his daughters had come in. When they saw that, they pulled him out. They were supposed to use this thing on my dad's knee every so often—I cannot remember what it was—but they had not done it once the whole time he was there until we went in and asked them about it. He was in there probably about a week to two weeks—I am not sure—and he went home. He went home and started getting sick. He progressively got worse and worse and he was losing weight. He could not eat and could not do much of anything. He was sitting on the couch and all of a sudden he just fell over. He was lucky that night because his sister was there. She called the ambulance, and they took him to the hospital. This time it was Southern Hills Hospital. They said that they could not really find anything wrong with him, either, and he was in there for about two or three weeks. They really did not find anything, so they finally sent him back home. About two weeks later he goes home and when he went home he said he was in pain as soon as he got home. He could not eat, and still does not eat. He has a

hard time swallowing, has a hard time doing anything. He ended up going to St. Rose Dominican Hospital the third time. If you go into St. Rose, it looks like a pretty clean hospital. At least they came up with something that said he had some type of a staph infection. This is probably six months that went by when they finally decided to tell anyone that he might have a staph infection. They just wanted to pump him up with antibiotics. He went from 180 pounds to 135 pounds.

Today I have a call that hospice is going to see him tomorrow. He looks like a shriveled up prune. This is less than a year and I put it back on doctors, on someone, because I cannot see anyone losing that much life in such a short period. To tell someone they have to wait a week—if you can tell someone in three days, you should tell them. It does not matter when you find out, you should tell them, unless they are in a coma or something they cannot be told. But when someone should be told, you should not have a limit on when you tell someone, "Hey, you might have a really bad sickness." This has hurt me pretty bad. I should have had my sisters come up here. They probably would have acted a lot more different than me. That is all I have to say.

Chair Mastroluca:
Mr. Adamson, thank you very much. I cannot even imagine how difficult it was for you to share that story, and I am so sorry for what your father is going through now, and what your family is dealing with. I appreciate you taking the time to come down and wait to tell your personal story, because that has an impact on all of us. Please extend our concern to your family. Thank you.

Rusty McAllister, President, Professional Fire Fighters of Nevada:
Today I am representing the Las Vegas Firefighters Health and Welfare Trust fund along with the Clark County Firefighters Union 1908 Security Fund. As two small trust funds representing about 1,300 firefighters and their families, we certainly are in support of this legislation. Anything that can be done to improve the safety standards within our hospital system provides a certain level of protection for our members, reduces the cost for our trust fund by not having readmits and having to have treatment that is not needed. So with that, Madam Chair, we are in support of S.B. 339 (R1).

Yvanna Cancela, Political Director, Culinary Workers Union Local 226:
I want to reiterate how important it is to not allow for the exemptions portion of this to become something that allows patients to slip through the cracks. When we talk about the 12,000 conditions, that number gets thrown out, and I hope it does not stick, because we are not talking about 12,000 different diseases. We are talking about specific infections that should not be exempt based on

broad-based language that will allow doctors to shift out of what is necessary in order for patients to get the best care.

Chair Mastroluca:
Ms. Cancela, are you in support of the bill as amended?

Yvanna Cancela:
Yes, we are in support of the bill in favor of compromise, but just want to throw that out there. It is important to know that there should be protocols that should be followed as the exemptions portion gets considered.

Barry Gold, Director, Government Relations, AARP Nevada:
The topic of facility- or hospital-acquired infections has gotten everyone's attention and has been in the news. [He read from written testimony (Exhibit F).] These stories are horrific to read. Imagine what it would be like to live one of these stories. These are preventable. We have read about studies and procedures that some facilities have put in place that have reduced the incidence of these dreaded hospital-acquired infections to zero or almost zero. We have also heard about friends and neighbors who are afraid to have needed medical procedures done for fear of getting one of these horrible infections. Providing information for patients will help everyone have a better understanding of the problem, how to prevent it, how to recognize it, who to report it to, and to begin to stop it.

This bill requires an infection control officer or someone designated in patient safety plans that will help develop procedures to fix this problem and build trust with patients. They will know what the facility is doing to protect them, and know there is a designated employee who is overseeing this issue. We must have language in the bill that says patients will be timely notified that they have an infection. AARP was involved a little bit, perhaps more peripherally in the amendment process, and I have to admit I feel just a little bit like Rodney Dangerfield, having not been mentioned, but most of them did the lion's share, and they did talk to me about that and asked what patients thought about it and what would be important. I would concur with the concerns that Ms. Bobbette Bond had about not making those exceptions be too broad because people could slip through the cracks, and we definitely concur with the comments that the Committee made on the timeliness with language something like, "up until five days." These are things that should happen right away when practical. We would agree with some of that language.

We must make our hospitals and medical facilities safe places without the fear of getting something worse than what you came in for. AARP members have said they want to stay healthy. So on behalf of our thousands and

thousands and thousands of members across the state, AARP Nevada supports S.B. 339 (R1) strongly, and urges this Committee to pass it to protect families from the life altering pain and suffering that can result from facility-acquired infections.

Steve Winters, Private Citizen, Reno, Nevada:
Many of you might know that my mother died on June 24 of multiple hospital infections; in fact, she is the poster child for sentinel events. I am in support of S.B. 339 (R1). My condolences to Mr. Adamson for the suffering he is going through.

This is a picture of my mother on May 25 with my brother when she was getting better. [He held up a picture.] I had medical power of attorney the entire time. This is her with me a couple of days before they transferred her. [He held up another picture.] I want you to take a really good look at this. [He held up a picture.] This is her before she died, and that was three weeks later. This is what sentinel events do. This is what happens when families do not know about what is going on.

I would like to play this tape. It is very short. Some of you have heard it; some of you have not. Those of you who have heard it, I apologize, but it is important. [He played an audio recording of two voice messages.]

My mother had five hospital-acquired infections when they transferred her on May 28th, so when the hospital discharge nurse called, she had five infections. I was unaware of all but one urinary tract infection, and I questioned them about that, and she was supposed to be fine. But when they put her to work at the rehab, the infections had time to blossom, since they were making her run up and down the stairs and go to the bathroom and do all those things, which eventually resulted in her death. The autopsy report, which I paid for myself, listed in excess of ten hospital-acquired infections. I should have known about that on May 28 when they transferred her because I could have made different decisions. But because I did not know, and I did not know timely, I let them transfer her and that resulted in her death.

The Board of Health, in their mission statement, says, “The Board is dedicated to ensuring that both residents and visitors of our state can be active in an environment where good sanitation is practiced and there is a minimum risk of contracting disease and experiencing disability and unintentional injury.” Well, you know what? They believe that one. Not happening. Did not happen here. If you look everywhere, you can see it all over the place. Here is an article from November 2010 in *USA Today* entitled, “Hospital Care Fatal for Some Medicare Patients.” Well, that is because it is not being paid close enough attention.

This bill will at least attempt that. You are the only protection the consumer has. It is not the Joint Commission. It is not the Bureau of Health Care Quality and Compliance. They are certainly very good at what they do, but they are understaffed. It is certainly not HealthInsight. It is you, the regulators, that pass the bills that save people from experiencing what my mom experienced. I am here before you instead of in jail because it was about 30 seconds before the attending doctor was going to get strangled to death when I found out what happened. I spent nine hours with my mom in an intensive care unit and the only way I ever found out about what infections she had was when I came home and saw this story on the 11 o'clock news about NAP1 *Clostridium difficile*. This was on May 30, the day my mom was terminal. There is no cure. There is no antibiotic that will touch it. You are a goner if you have it. So to keep that information from the public is criminal.

I am in support of the bill—it needs to be passed. But the five days is critical for someone to live. During that five days, an infection can develop that is beyond repair. When I finally found out what was going on, it was too late. I had to look at my mom, and I had been telling her she was going to come home and she was going to be healthy and everything was going to be fine, and I was going to take her—because she lived with me and my wife—and then I was lying to her, telling her, "Yeah, Mom, you are going to come home." She looked at me and she just looked away. She knew that was not going to happen. For me to describe what she went through—it is indescribable. I cannot. But one thing to consider here is we are all going to be in a hospital. Sooner or later, if you do not think so, hide and watch. It is going to be your turn. If we do not pass these things correctly and we do not start really paying attention to infection, and we do not start doing the things that need to be done, you are going to end up in that same situation if you are not careful. Thank you.

Chair Mastroluca:
Thank you very much, Mr. Winters. Please accept our condolences on the loss of your mother. I appreciate you taking the time.

Denise Selleck Davis, C.A.E., Executive Director, Nevada Osteopathic Medical Association:
That is a very difficult testimony to follow, and our condolences to you, as no patient or their family should ever have to go through this type of situation.

One of the reasons we came to five days is that we started out with, "in a timely fashion." It was felt that this was a very difficult thing to try to quantify, and it did vary from patient to patient. I am more than happy to take Mr. Anderson's suggestion back to my group. What we were trying to come up

with was an outside time frame, but I think something underneath is very legitimate. I do not foresee that the group I represent would have any difficulty in that at all. We would be delighted to take that back to them and I anticipate a positive outcome.

As far as medical judgment is concerned, one of the things we want every one of you to understand is that our physicians' goal is to see to it that you are healthy, remain healthy, and if not, that you get healthy. That is why they went into medicine in the first place. Their goal is not to have patients admitted to the hospital. There is no bonus paid for everyone they put into the hospital. There are no additional monies every time you are sick. There is no financial benefit for them to see to it that you do not improve. In fact, they went into medicine with a pure heart and the idea of making you, their patient, better.

They also wish to treat each and every patient as an individual, and give each the due that he has coming as a patient of a physician being treated to his needs at that moment. Sometimes your need cannot be prescribed in a cookbook fashion and listed in a protocol. Sometimes your needs are individual, different, and unique. Every one of us would like to be considered unique. For that reason, we occasionally have to allow a physician to use his best medical judgment.

Now in the case of things going wrong in hospitals, there are committees and organizations that physicians have to answer to. It is not as though they are allowed to make a rash decision and walk away scot-free. Again, their goal is to make sure that you, as a patient, continue to thrive. So what we ask is that in the rare cases when a patient might need to have that information withheld, that it is allowed to be so. We could paint you a dozen scenarios, and we did that over coffee on the first floor while we waited for this, so that we could give you suggestions of what might happen. But they are things that we have made up, and scenarios that we played out in our own minds. There are cases when patients need to have that information withheld, or cannot accept the information as it is given to them. Not every patient comes with a caregiver, would that they did, because if every patient had an advocate, every patient would do better. So there is not always someone to pass that information on to. Occasionally that information has to be withheld long enough to confer with a better expert in that situation. There are better experts on some of these really awful infections that have arisen. For those of us who have grown up in the world of antibiotics, we anticipate that every infection will be cured. There was a time when penicillin was the golden bullet for every infection, but it is not the case anymore. It is something that all of us are going to have to deal with.

We ask that you do allow that within these protocols there are occasions when physicians will have to use their best medical judgment—which is, by the way, why you hired them and chose them and why you continue to trust them and allow them to have the time that they need to deal with the patient individually. We support this bill, we support transparency, and we support what this body is trying to do, and we support this amendment. Thank you.

Chair Mastroluca:
May I offer an alternative?

Denise Selleck Davis:
Absolutely.

Chair Mastroluca:
What if it was, "when not in the best interest of the patient and there is no legal guardian or person authorized to receive the information?"

Denise Selleck Davis:
I would have to take that back to my group, but I do not anticipate a lot of issues.

Assemblywoman Pierce:
I am not too comforted by that. There used to be a time when they did not tell people they had cancer. That was not serving anyone. That was serving the doctors. It is a hard thing to tell someone, and they did not want to. You and I are old enough to know that a lot of things did not used to get told to people, especially women, because we were women. I am not comforted. You know how it used to be. Some of that stuff still goes on. I would still like to see this tightened up.

Chair Mastroluca:
Are there any further comments or questions from the Committee? [There were none.]

Bill M. Welch, President/CEO, Nevada Hospital Association:
I am here to speak in support of S.B. 339 (R1) as well as the proposed compromised amendment that has been presented to you today. We have appreciated working with the sponsor of this bill and all of the concerned parties. That is all I have to say; I do not want to repeat what has already been testified to. We are in support of the bill as well as the proposed amendments today.

Chair Mastroluca:
At this late hour, I say thank you. I appreciate it.

Joan Hall, President, Nevada Rural Hospital Partners:
We would also like to express our appreciation to Senator Breeden and to the work group that worked on this. We are also willing to tighten that time frame.

Chair Mastroluca:
Are there any questions? [There were none.] Is there anyone else who would like to testify in support of S.B. 339 (R1)? [There was no response.] Is there anyone in opposition of S.B. 339 (R1), either in Las Vegas or Carson City?

Tracey Green, M.D., State Health Officer, Health Division, Department of Health and Human Services:
I want to put on record one clarification on the amendment. Section 4.5 would leave current statute intact, which are subsections 1, 2, 3, and 4, and would remove subsections 5 and 6. That is my only addition.

Chair Mastroluca:
Would you tell us why?

Tracey Green:
If we were to add that, it would increase our workload by approximately 100 percent, which would also increase and put a fiscal note on the bill.

Chair Mastroluca:
Are there any questions from the Committee for Dr. Green? [There were none.] Is there anyone else who would like to testify on S.B. 339 (R1)? [There was no response.]

Senator Breeden, did you have any closing comments?

Senator Breeden:
I know it is late and I appreciate your time. Again, I appreciate all of the stakeholders. It was a lot of work.

I would like to share with the Committee—and I see Mr. Adamson has left, but Mr. Winters is here. I, too, had a very similar situation with my dad during the last legislative session. He weighed 165 pounds, and when he left the hospital for the second time he weighed 130 pounds. This bill is to protect every citizen in the state of Nevada. Thank you.

Chair Mastroluca:
Thank you, Senator Breeden.

With that, I will close the hearing on S.B. 339 (R1). Is there anyone here for public comment? [There was no response.] Thank you very much, Committee, for being here at this late hour. I appreciate your attention and the time you gave to these topics. They are obviously very serious and very important, and I wanted to make sure that we had plenty of time to go through them carefully and not feel rushed by having another committee back up to us.

To those of you who attended this evening, thank you very much. I know some of you may have missed something else that you would have rather gone to, but we appreciate your time and we appreciate the work that you did to bring these bills to the point where they are now. Thank you very much.

The meeting is adjourned [at 8:14 p.m.].

RESPECTFULLY SUBMITTED:

_____
Linda Whimple
Committee Secretary

APPROVED BY:

_____
Assemblywoman April Mastroluca, Chair

DATE: _____

EXHIBITS

Committee Name: Committee on Health and Human Services

Date: May 11, 2011 **Time of Meeting: 6:05 p.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
S.B. 209	C	Barry Gold	Testimony
S.B. 264 (R1)	D	Senator Sheila Leslie	Proposed Amendment
S.B. 339 (R1)	E	Senator Shirley A. Breeden	Conceptual Amendment
S.B. 339 (R1)	F	Barry Gold	Testimony