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

Seventy-Sixth Session
February 11, 2011

The Committee on Health and Human Services was called to order by Chair April Mastroluca at 1:33 p.m. on Friday, February 11, 2011, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4406 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 Pete Livermore
Assemblyman Mark Sherwood
Assemblywoman Debbie Smith

COMMITTEE MEMBERS ABSENT:

Assemblyman Scott Hammond (excused)

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

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

OTHERS PRESENT:

Marla McDade Williams, Deputy Administrator, Health Division, Department of Health and Human Services
Tracey Green, M.D., State Health Officer, Health Division, Department of Health and Human Services
Kathleen Silver, Chief Executive Officer, University Medical Center of Southern Nevada
John W. Griffin, representing Boyd Gaming Corporation
Lawrence P. Matheis, Executive Director, Nevada State Medical Association
Cheryl Hug-English, M.D., M.P.H., Dean, University of Nevada School of Medicine
Rick B. Thiriot, D.D.S., School of Dental Medicine, University of Nevada, Las Vegas
Darlene Stanton, Private Citizen, Yerington, Nevada
Wendy Simons, Chief, Bureau of Health Care Quality and Compliance, Health Division, Department of Health and Human Services
Bruce Arkell, representing Nevada Senior Advocates
LynnAnn Homnick, R.F.A., President, Southern Nevada Chapter, Coalition of Assisted Residential Environments
Larry Fry, representing Coalition of Assisted Residential Environments

Chair Mastroluca:
[Roll was called.] We will start with a presentation from the Health Division, Department of Health and Human Services.

Marla McDade Williams, Deputy Administrator, Health Division, Department of Health and Human Services:
It is my pleasure to introduce Dr. Tracey Green. She will be doing the presentation for the Division. Dr. Green has been the State Health Officer since July of 2009, so this is her first session. She came in after the end of the last session. Dr. Green is a board-certified family physician and an associate professor at the University of Nevada School of Medicine. She received her education at the University of Nevada, Reno (UNR), including her bachelor of

arts degree in Psychology and Biology and her doctor of medicine degree from the School of Medicine.

Tracey Green, M.D., State Health Officer, Health Division, Department of Health and Human Services:

I am here today to present a brief overview of the State Health Division. If there is interest for more in-depth information about the programs I will be covering, you can find it on our website, <www.health.nv.gov>. There are white papers on all of our programs.

If you will turn to page 1 (Exhibit C), the mission of the Health Division is to promote the health of Nevadans and visitors through its leadership in public health matters and enforcement. We take measures to prevent the spread of sickness and disease and we are guided by the State Board of Health. Primarily, public health for the division is population-based health. On page 2, you will see the ten essential services of public health, and I point these out because they do serve as our guide for all of our programs. On page 3, the slide wheel shows the three core functions of public health: assessment, policy development, and assurance. It also identifies which of the essential services I previously mentioned fall under each of the core functions of public health. As I go through my presentation, you will see how the activities within the Division fall in these three core functions, noting again that public health is population-based health. Page 4 is probably the key to the overview of the Health Division. Capitalized in green, you will see the four Bureaus with their functional roles and underneath are the general program overviews. Page 5 is our organizational chart and key contact list.

Now I will provide a brief overview of each of the Bureaus within the Division, so I will call your attention to page 6. On page 6, you will see that our Bureaus are divided by functional roles, those being regulatory, direct services, planning and data, and resource provision. Starting on page 7, the first Bureau, the regulatory bureau, is the Bureau of Health Care Quality and Compliance (HCQC). The Bureau is comprised of two sections: a Licensure and Certification section which includes licensing and certification of health facilities as well as medical labs, and also Radiological Health. The Bureau licenses over 30 different facility types encompassing over 1,100 different facilities. In addition, the Bureau licenses and certifies medical labs, laboratory directors, and laboratory personnel. The Bureau is also responsible for the licensing and regulation of sources of radiation, including x-rays and the Mammovan (mobile mammography unit), for example.

I would like to move to page 8. The direct services bureau is Public Health and Clinical Services. Nevada is unique in that we do not have health officers and

health departments in all of our counties. Through the Bureau of Public Health and Clinical Services, the state provides the essential public health services directly to the rural and frontier counties through both the Community Health Nursing program and the Environmental Health program. The Community Health Nursing essential public health services include adult and child immunizations, family planning, communicable disease treatment, and cancer screening, to name just a few. Environmental Health assures environmental safety in food establishments, in sanitary processing and disposal of waste, prevention of the spread of food- and environmental-borne disease, and emergency response in times of crisis. These two programs come together to make rural and frontier Nevada a safe and healthy place, and provide those essential public health services. In addition, Environmental Health has some statewide roles in state-run facilities in some of our larger urban counties. In addition to the clinical services, the Bureau also houses two statewide programs. The first is Early Intervention Services. This is the program that serves birth to 3-year-olds who are at risk for or have developmental delays. Early Intervention is guided by the acceptance of the U.S. Department of Education's Individuals with Disabilities Education Act (IDEA). As laid out by IDEA, the services within Early Intervention are determined through an individualized family service plan (IFSP). In 2010, Nevada Early Intervention had 4,734 referrals and we were able to treat 3,805 children. I am happy to say that we have a very small waiting list only in southern Nevada and we are moving toward eliminating all waiting lists across our state.

The other statewide program in the Bureau of Public Health and Clinical Services is that of Women, Infants, and Children (WIC). This is a 100 percent federally-funded program that is funded through the U.S. Department of Agriculture (USDA). It targets populations between the ages of zero and five. It focuses on nutrition and the nutrition risks that are posed by certain populations including pregnant women, postpartum and breastfeeding women, and infants and children aged zero to five.

Moving now to the third bureau, that of planning and data, this is the Bureau of Health Statistics, Planning, Epidemiology, and Response. Primarily, the goal for this Bureau is to analyze the data that we receive and to prepare us for public health emergencies. This is a very diverse bureau and I have listed some of the program heads that are within that Bureau. We have Public Health Preparedness, the Office of Vital Statistics, which is primarily our birth and death registry, the Office of Epidemiology, which looks at disease surveillance, investigating disease outbreaks, and initiating disease control activities. We also use the data collected in the Epidemiology Bureau to improve our health outcomes. We have the Emergency Medical Services program as well as the Health Planning and Primary Care Office and our health registries, including the

Medical Marijuana Program, the Statewide Cancer Registry, the Nevada Trauma Registry, and the Nevada Sentinel Events Registry.

The final bureau surrounds resources and provisions. It is the Bureau of Child, Family, and Community Wellness. This Bureau looks to assess children and families as a whole in Nevada, looking at education awareness, advocacy, policy, and leadership. The programs within that bureau are again diverse like those I have described. There is the Women and Children's Wellness program, which looks at injury prevention, rape prevention, children with special health care needs, maternal and child health and the Women's Health Connection, the immunization program, our chronic disease prevention and health promotion, HIV and AIDS with the Ryan White program, both looking at care and prevention, as well as school health and workplace wellness.

As you can see on page 13, this is the overview of our Health Division, and you can see that we cover quite a bit and many of our functional organizational models really highlight what the programs are within each of the bureaus. This is a very general overview, but I think you can see that our Division is very complex. During tough times we look to funding to improve health status, but it is often important to really look at policy and look at some of the improvements that we have made within our Division.

I would like to conclude my presentation by looking at some of the accomplishments and areas for growth in the Health Division. On page 14, I have listed some of the accomplishments within the Division over the last two years. For one, the Bureau of Child, Family, and Community Wellness has improved our immunization rates from 50th to 45th. We are looking at alternative resources for the provision of immunizations including targeting children in the school environment this year. In the public health preparedness arena, we have improved our Strategic National Stockpile rating from 34 to 89. This is a percentage out of 100, and we are especially proud of that score because this was the year of the H1N1 flu, when our stockpile was really called to arms.

The WIC program has also been one of the first to employ the Electronic Benefits Transfer (EBT) food delivery system. It is basically a card registry system so that our WIC clients are no longer separated with food stamps or food stamp booklets so that when they check out they now look like any other participant at the grocery store. Early Intervention Services has also begun to eliminate the need for a waiting list and we are looking at legislation from last year, which allowed us to have enough dollars to provide services and to reach our services out into the private sector as well. Right now we are happy to say

that about 30 percent of the early intervention services are a complement in the private sector to our state.

We also have the AIDS Drug Assistance Program (ADAP). Again, there is no waiting list on this program. We served 1,238 residents through ADAP and we have also increased our federal grant allotment by 13 percent. It is our goal to try to bring more dollars into our state.

I wanted to share some areas that the Division is looking at for growth and improvement. I am sure many of you have seen that the Commonwealth Fund examined states' performance on 20 key indicators of children's health care access, and unfortunately, we rated 51st overall and we rated 48th to 50th in most of the indices. We see this as a challenge to look at other alternatives for access in our state. You will be hearing some legislation this session about school-based health centers, and we are also looking at how we can combine services under one roof so that there is not a disrupted service for an entire family, putting WIC clinics in our community health clinics, and putting Medicaid establishing clinics within our community health services.

One of the other areas that was brought to our attention was the lag we have in the provision of services, primarily the medical assistant issue that will be coming to session, as well as our physician shortages in almost every county in our state, and our J-1 visa program. We continue to have few applicants and we are looking to understand how we can attract more applicants to our state.

We are also very much in the forefront with transparency and regulatory oversight, how we can improve the ratings system in our hospitals, and how we can minimize or reduce hospital-acquired infections. Finally, we are looking at budget reductions in ways that can keep funds in our state, and you will be seeing legislation to move newborn screening possibly back into our state and trying to keep dollars here.

In closing, I want to state that I am your State Health Officer and I am available to provide additional information, testimony, or if there are areas within our Division or areas in the health care realm on which you wish to consult me. On page 16 you will see contact information and the website address <www.health.nv.gov>, which is where you can find the white papers on all of our programs.

Chair Mastroluca:
Thank you very much, Dr. Green. I will say that some of the things that are going on in the Health Division are just fantastic. We are always so used to being at the bottom of the list and some of the improvements you have made,

especially in the area of immunizations, have been wonderful. Thank you very much for your work. We appreciate it.

Does the Committee have any questions for Dr. Green?

Assemblyman Hambrick:
I noticed that under AIDS prevention and treatment and rape prevention, part of that may involve young girls under the ages of 15 or 16 that are unfortunately involved in an activity that is potentially very dangerous to their health. Do you have any insight on dealing with this issue? I am talking about the victims of human trafficking in this state, some as young as the age of 11. I did not know whether the AIDS or the rape prevention may have played a small part of that. I am trying to find out what your agency's thought process is.

Tracey Green:
I think that is an excellent area of concern, and we are also concerned about it. We are looking at the incorporation in the mental health population of our younger women and how that may come into the trafficking picture. We are definitely looking at that and looking at how we can incorporate those younger women.

Assemblyman Livermore:
Thank you so much for your quick and easy-to-understand presentation. Can you tell me how you define what counties may be described as "rural" and what counties may be described as "frontier?"

Tracey Green:
First, because we have some counties that do not have health officers, the primary role for the Community Health Nursing program is the provision of public health services in those counties that are considered to be our rural counties without health officers. I do not know if I can tell you specifically which are considered frontier versus rural, but I can get you that information. There are three counties that have federally-qualified health centers: Elko, Eureka, and Storey Counties. So the public health essential services are provided through the federally-qualified health centers in those counties. The other 12 counties are the counties where we provide that public health service. I could specifically name them for you. I do not know if that is what you are interested in.

Assemblyman Livermore:
I am trying to put my county, which is Carson City, in this list, and I do not know if they are rural or frontier. They do have a public health board, and they do have a public health officer. Are they rural, frontier or urban?

Tracey Green:
They are urban. Washoe County, Clark County, and Carson City have health officers and they are considered the urban counties and the health officers provide the essential public health services within those counties.

Assemblywoman Pierce:
I think I have the same question. How many of the 15 counties have a permanent public health person in them?

Tracey Green:
There are three urban counties: Washoe, Clark, and Carson City. They are separate. There are 14 counties that are considered rural or frontier. Of those, three have federally-qualified health centers. So there are 11 other counties that we would be providing those essential services in.

Assemblywoman Pierce:
Of those 11, is there someone there permanently? Is it a permanent office?

Tracey Green:
It is a shared responsibility in many of the counties, so there is a designated day of the week for a couple of different services. We do share with the county as well, so the county does have some staff that is within their particular county. For example, in some of our smaller counties we have a community health nurse that comes in twice a week but the county also has some stable staff.

Chair Mastroluca:
Are there any other questions for Dr. Green? Thank you very much for your presentation; we appreciate it.

We will move on to Assembly Bill 29. I believe we have Kathleen Silver in Las Vegas speaking on behalf of University Medical Center of Southern Nevada (UMC).

Assembly Bill 29: Revises provisions governing county hospitals. (BDR 40-343)

Kathleen Silver, Chief Executive Officer, University Medical Center of Southern Nevada:
We are here today to talk to you about some provisions we would like to change in a fairly modest way to the current *Nevada Revised Statutes* (NRS). How would you best like me to go through them?

Chair Mastroluca:
If you would talk about what the changes mean and then if we need to delve into the actual language down to that detail, we can.

Kathleen Silver:
The first change proposed by A.B. 29 is on page 2, in section 1, subsection 3. This references the amount of money that has been previously set for the hospital to pay to members of the hospital advisory board. I think many of you know that within the past few months the Clark County Board of Commissioners actually appointed a hospital advisory board. Under the current version of NRS 450.175, the payment that is set for those advisory board members is $100 per month, which perhaps at the time this was written, was an adequate amount. We feel that to have someone to spend anywhere from 10 to 20 hours of volunteer time and being paid $100 is probably not in keeping with the times. We are suggesting that that amount could be fixed by the board of hospital trustees.

Chair Mastroluca:
Before you move on, for our new members, could you explain the difference between a board of hospital trustees versus a hospital advisory board?

Kathleen Silver:
In Las Vegas, the Board of Clark County Commissioners has been acting in the role of the hospital board of trustees. *Nevada Revised Statutes* 450.175 provides for the ability of a hospital advisory board to be appointed and after some discussion it was the belief of the Commissioners that perhaps being able to have another board to oversee part of the operations at UMC would be in our best interest, the idea being that the Clark County Commission is obviously quite busy running many things, UMC being just one of them. They oversee the airport, water reclamation, and many, many organizations within Clark County. The hospital advisory board is designed to be specifically oriented toward what is in the best interest of UMC.

Chair Mastroluca:
Thank you very much. Please continue.

Kathleen Silver:
The second proposed change is in section 2, subsection 1, and it is an addition of paragraph (a). We are asking that the hospital board of trustees may provide for a requirement that if you are to have staff privileges at UMC, that you have an affiliation with the University of Nevada School of Medicine or the University of Nevada, Las Vegas, School of Dental Medicine. This is actually designed to

provide more strategic alignment going forward for the hospital and our medical staff.

The second area, which is repetitive, is in section 3. It basically reiterates that the hospital board of trustees may organize a staff of physicians composed solely of physicians, podiatric physicians, and dentists who are affiliated with University of Nevada School of Medicine or the University of Nevada, Las Vegas, School of Dental Medicine. Again, this is the way that we can more closely align with the medical staff. Paragraphs (a), (b), and (c) of subsection 2 go into further detail or reiteration of that same statement.

Chair Mastroluca:
Are there concerns about having enough physicians to meet the qualifications that you set out?

Kathleen Silver:
That is one of our strategic initiatives going forward, to help the School of Medicine expand in many areas that we feel are going to be critical to the citizens of both Clark County and the State of Nevada. That would be one manner in which we think we could help them do that.

Chair Mastroluca:
Are there other questions from the Committee?

Assemblyman Sherwood:
The one thing that jumped out at me, and I think it is a great idea that we give you some oversight from professionals, but let us play the endgame through and say that UMC becomes a teaching hospital like so many other hospitals across the country. Would there be a financial obligation from the University of Nevada School of Medicine back to the hospital? Would it create kind of an unintended consequence whereby University of Nevada, Las Vegas (UNLV) or UNR is now on the hook for the costs associated with the hospital? Can we be assured that that would never happen?

Kathleen Silver:
As it stands right now, UMC operates completely separate from the University of Nevada School of Medicine and there is nothing being proposed right now other than a closer collaboration and the two of us working toward a strategic direction together, not a blended financial obligation in any way, shape, or form.

Right now the School presents UMC with a budget on an annual basis for what they are going to need to support the training programs, both for residents'

salary and benefits as well as some portion of the faculty members' salary support. It is dollars that we pay to the University; it is not the other way around.

Assemblyman Brooks:
I need a point of clarification. You have a board of hospital trustees and then you have hospital trustees? How does that work? The board is the Clark County Commissioners?

Kathleen Silver:
Yes, that is correct. Right now the Board of County Commissioners also serves as the board of hospital trustees. They have authority within NRS 450.175 to actually appoint a hospital advisory board with the intent that this other board would be directly responsible for UMC only as opposed to having multiple requirements of oversight with these other agencies.

Assemblyman Brooks:
In section 1, subsection 3 of A.B. 29, it says, "Members of the hospital advisory board may receive compensation for their services . . ." The original verbiage was "of no more than $100 per month." When you change that to say "in an amount fixed by the board of hospital trustees," what is the range that we are talking about?

Kathleen Silver:
The dollars that have been spoken of at this point have been in the range of $400 to $500 per month.

Assemblyman Brooks:
Would this language allow them to do more than that?

Kathleen Silver:
It would.

Chair Mastroluca:
In considering that amount, who is going to pay that additional fee and how is that going to be budgeted?

Kathleen Silver:
It is paid through hospital operations.

Chair Mastroluca:
You are going to be budgeting for that amount?

Kathleen Silver:
Yes, that is correct. It is in the hospital's budget.

Assemblywoman Pierce:
If this bill was passed, how many physicians do you have and how many physicians, podiatric physicians, and dentists do you have who are not now affiliated with University School of Medicine or School of Dentistry?

Kathleen Silver:
Right now we have over 1,300 independent physicians on UMC's medical staff. Of that, probably somewhere in the neighborhood of 120 to 140 are actually affiliated with the School of Medicine as School of Medicine employees or faculty members. We have a large number of community physicians who also have faculty appointments with the School of Medicine. I do not know exactly how many that is, but probably another 100 or so.

Assemblywoman Pierce:
So this would be a huge change.

Kathleen Silver:
It would be a significant change in terms of the way that UMC operates because of the 1,300 physicians, we probably have 300 that are active.

Assemblyman Livermore:
Could you tell me if the county commissioners could allow, throughout the state, for the election of hospital trustees independent of the board of county commissioners. Am I correct?

Kathleen Silver:
There is a provision within the NRS that would allow for a hospital district to be formed. That is not the case in this particular advisory board. This advisory board was appointed by the Clark County Commission. They were not elected.

Assemblyman Livermore:
How many advisors will there be and what is the definition of advisors? I am a member of a board of a not-for-profit facility. There are several committees that work within the hospital. Where would that begin and end?

Kathleen Silver:
It is in its infancy because this advisory board was only appointed a few months ago. They have 11 members and within their board structure they have two subcommittees. There is a finance committee and a patient care committee that meet separately. In the case of the advisory board, all of their activities, as

a duly-appointed board under the county commissioners, are subject to the open meeting laws and all the other requirements that go along with that.

Assemblyman Livermore:
I understand that. So you have 11 members of the advisory board. How many members of the finance board and how many members of the patient care board? Would they all be entitled to compensation?

Kathleen Silver:
There are currently eight members of the finance committee and there are four members on the patient care committee. Now there would be no expectation that there would be additional remuneration for serving on those committees, so we would be looking at the 11 board members in total as the fee per month.

Assemblyman Livermore:
That is fine. As long as what we are talking about is entered into the record because generally boards look at expertise when they decide to do something, whether it is a building expansion or a service expansion, somewhere advisors are added to the advisory board to serve their purpose. I just do not want to get into something where the legislation we are considering here could question whether someone is entitled to some payment or not entitled to a payment.

Kathleen Silver:
Right now everyone that serves on a subcommittee is part of the advisory board itself. So those 11 members are the same members of the two subcommittees. Anyone else who participates in the meeting is ex officio and would not be paid in this manner.

Chair Mastroluca:
Ms. Silver, go ahead and talk about your amendment.

Kathleen Silver:
Our amendment (Exhibit D) proposes a line to be added to section 2, subsection 1, paragraph (a), subparagraph (2) that reads, "To contract for the exclusive provision of services at University Medical Center." This was something we felt we needed to add later on as we looked back at the language of A.B. 29 because recognizing that there are certain areas of the hospital which are not necessarily ever going to be departments within the School of Medicine, specifically emergency medicine, although it is, right now, and radiology and pathology. You mostly see in acute care hospitals that those departments are exclusive, meaning you cannot just be a pathologist from somewhere else in the state and come and practice medicine within that department. It is very

standard within the health care industry for hospitals to exclusively contract in those departments.

Chair Mastroluca:
We have John Griffin and Larry Matheis in Carson City, and Rick Thiriot in Las Vegas.

John W. Griffin, representing Boyd Gaming Corporation:
Boyd Gaming is in support of UMC being allowed discretion in determining its provider privileges based on its business needs, and therefore is in support of A.B. 29.

Lawrence P. Matheis, Executive Director, Nevada State Medical Association:
We are always concerned about the future of University Medical Center. It has been an essential part of access in this state. If it becomes unstable or if it fails, the crisis that that would precipitate in southern Nevada would affect the entire state. We are also very strong supporters of the University of Nevada School of Medicine. Its growth is going to be essential if we are going to fill the physician workforce shortages that we have, build a greater capacity to provide residency training—medical residencies are where doctors do their specialty training—and to have fellowship capacity where they go on to more specialized levels. These are two important public institutions in the state and it is certainly prudent to look at ways to have synergy between the two. So I think the approach is a good one. We have questions and until we can get some clarification on what some of these things mean, we are just not sure that we are supporting this particular approach. We are dealing now not just with concepts, but with words and potentially with statute. I would like to put these questions on record and if we could meet with the proponents to get answers and make sure that we are comfortable with both the intent and that the intent is clear in statute.

On page 2, section 2, line 23, I have a question about the use of the word "may." "The board of hospital trustees may require a physician to affiliate with the University of Nevada School of Medicine or the University of Nevada, Las Vegas, School of Dental Medicine." Under what circumstances would the board exercise that authority? Is it by specialty? Using "may" rather than a more determinative approach raises the question of simply when would that be exercised? Under what circumstances? What are some examples of those circumstances? The more important question comes from language on line 24 of the proposed amendment, "To be affiliated with." What exactly does that mean? Affiliation is a very loose term that encompasses a whole range of relationships. Is it contemplated that these doctors would become adjunct faculty in the School of Medicine? Would they be on the faculty practice plan?

Would they be employees? Would they be in some contracted role? Would the University bill for the services provided by those doctors? Under what arrangements would the doctors then be compensated? Would the doctors be covered by the state's sovereign immunity cap under this arrangement? The doctors who are on staff at UMC but who are not employed by UMC or are employed by the School of Medicine right now do not have the sovereign immunity cap. They are covered by the usual medical liability rules. So the term "affiliation" is one that I think needs further refinement or definition of what it is limited to and what the affiliations could mean.

In section 3, subsection 2 of A.B. 29, presumably after this change in the staffing paneling occurs, then there is this other requirement for maintaining the affiliation in the future and meeting standards prescribed. In one place "standards" are used and in another place "regulations" are used. In section 3, subsection 2, line 9, regulations are prescribed by the board of trustees and on line 14 it talks about standards. So I think there needs to be clarification using the same language to mean the same thing. The more important issues really are to define the circumstances under which a doctor may be required to be in some affiliation with the School of Medicine or to be on staff at UMC and be available for the patients there, to define what "affiliation" means, and then to look at the broader implications of that. Once we get the clarity, I think we can look at the other thing.

As to the amendment, I think the comments that Ms. Silver made were useful in putting some idea of the contract that might be done that there is not a department at the School of Medicine to provide a position for those doctors. If that is the limit of what is being proposed in the amendment, I think that should be clarified and put in there. So if it is not, then it can be virtually any services provided in the hospital that could be contracted outside of this contemplated arrangement with the School of Medicine. If it is simply that it is limited to those specialties for which the School of Medicine would not have the department or the other capacity to provide those services, then I think that should be added into the amendment to clarify it.

Chair Mastroluca:
I look forward to seeing the amendment that you and Ms. Silver put together to solve both of your issues.

Lawrence Matheis:
Thank you, Madam Chair. I will certainly seek to meet with her and meet with the folks at the School of Medicine and I will report back to you on how our conversations go.

Cheryl Hug-English, M.D., M.P.H., Dean, University of Nevada School of Medicine:
The School is here to offer support for this bill, recognizing that UMC has been a valued partner for us in our core missions of teaching, research, as well as providing clinical service. We feel that the language in this bill is permissive, not prescriptive, with the identifier of "may," but also recognizes the desire of both UMC and the School of Medicine to develop in a more detailed and profound way to more of an academic medical center model. It allows for that to happen in the future. I think there have been some good things identified by Mr. Matheis as far as clarifications, but we do want to offer support for this bill.

Chair Mastroluca:
Does that also include the amendment?

Cheryl Hug-English:
As I am understanding the amendment, and I have to clarify that I did not see the amendment until coming in here today, so I would have to take a closer look at the language, but I believe the amendment is really allowing for the ability for the School to have kind of a first right of refusal if the School is able to provide contracted services, again recognizing that our primary partner in developing more of an academic medical center model would be UMC.

Assemblyman Sherwood:
The permissive rather than prescriptive . . . we are taking that from $100 to uncapped. Do you think you would be comfortable with putting a cap on how much someone would be paid? Based on the language, conceivably someone could be paid a million dollars for being on the board, right?

Cheryl Hug-English:
I think that the language I was referring to with the "may," reflected the medical staff, not the language for the board payment.

Assemblyman Sherwood:
It was probably a question for Ms. Silver, but since you are there and she is not . . .

Chair Mastroluca:
I think we will let her off the hook because I do not think this is the area she was prepared to speak about. We can either ask Ms. Silver or if someone from Clark County would like to address if there would be any interest in putting a cap on that amount.

Kathleen Silver:
Anything that is going to be put in there is going to be dictated by the amount of money that is available through the budget. While I can appreciate that there would be some level of concern that someone could be paid an exorbitant amount, given our financial situation, that is highly unlikely. If we get turned around to the point that we are extremely financially successful, then I think maybe that concern would come into play. Right now certainly we would not have the wherewithal or the financial ability to pay an exorbitant amount of money for the advisory board. If you feel more comfortable in putting a cap on it, our desire right now is just to move it from the $100.

Assemblyman Sherwood:
I would feel more comfortable. Tell us a number and let us put a cap on it just in case.

Kathleen Silver:
I would say that you could cap it quite safely at $1,000.

Chair Mastroluca:
Assemblyman Sherwood, if you would like to continue the conversation and propose an amendment when we get to work session, that would be excellent idea.

I wanted to point out that the $100 fee that is in there has been there since 1975. It has never been changed since the statute was enacted. That is something to keep in mind. There has been a little bit of inflation since then.

Assemblyman Livermore:
I serve as a governing board member and I have been serving for the past 15 years. Most advisory board members serve for the benefit of the health of the community and a lot of people serve for free. I currently receive a compensation or stipend of several hundred dollars a month, and that has been in place for the past four to five years. I know of no one in the Nevada area that receives any more than what is being recommended here of $1,000 per month. Those records are obtainable all over the place. You can do a survey of all of those records.

Chair Mastroluca:
Is there anyone else who would like to speak in favor of the bill?

Rick B. Thiriot, D.D.S., School of Dental Medicine, University of Nevada, Las Vegas:
I am speaking on behalf of Dean West. We are a new program. We have only been in business for eight years, and we are always looking for some way to increase our presence in the community and have better services for the people to allow for better general health. Partnering with UMC in the future is one of the things we are really looking forward to with our oral surgery programs and with our general dentists. We are strongly in favor of this bill and with the amendment. I just want to go on record to let you know that we are supportive.

Chair Mastroluca:
Are there any questions? Is there anyone in Carson City who would like to speak in favor of this bill? In Las Vegas? Is there anyone who would like to speak in opposition of this bill?

Darlene Stanton, Private Citizen, Yerington, Nevada:
I would like to voice my opinion about this. From what I read on here, I am not for this. I think it needs to be amended. The questions that were asked are very valid. Considering our financial feasibility at this time, $1,000 does not seem like a lot. However, it is my understanding that this is supposed to be something that you volunteer for because you care about it, not because you are going to get paid. I also understand that $100 is not very much. Again, you are there because you are volunteering, not to get paid. The other thing I did not feel comfortable with is this. It seems like if they are going to say the physicians, pediatric physicians, and dentists need to be affiliated, I am with the other guy. That is just too vague. What does affiliated mean? That opens a door for "good ol' boys." That does not make me comfortable. I think that it needs to be clarified. What does affiliated mean and if you are affiliated, does that limit us to physicians, doctors, dentists and so on that could be from another facility where they got their education? I am not saying that this is not a good education, but I am saying that we could limit ourselves to doctors and dentists and so on that could have an education that is beyond what we are getting here and limiting ourselves which is not really good. That is basically it.

Chair Mastroluca:
Is there anyone else who would like to speak against this bill? [There was no response.] We will close the hearing on A.B. 29. We will open the hearing on Assembly Bill 50.

Assembly Bill 50: Revises provisions relating to the licensure of medical and related health facilities. (BDR 40-445)

Assemblyman Livermore:
I do plan to abstain from this discussion mainly because I may have a conflict of interest.

Chair Mastroluca:
Please make sure that you take a few minutes to speak with our legal counsel and she can help you with that.

Marla McDade Williams, Deputy Administrator, Health Division, Department of Health and Human Services:
We are here to present Assembly Bill 50. This is a bill requested by the Health Division. We are going to have the Chief of the Bureau of Health Care Quality and Compliance (HCQC), Wendy Simons, go ahead and give testimony. Just for the members' benefit, Ms. Simons has been the Bureau Chief since August.

Wendy Simons, Chief, Bureau of Health Care Quality and Compliance, Health Division, Department of Health and Human Services:
I came from the private sector to the Bureau and am very pleased to be in the role I am in and to have the opportunity to present A.B. 50 to you today. By way of history [reading from prepared text (Exhibit E)], the Bureau licenses and regulates medical and other related facilities which basically encompass 30-plus provider types and over 1,100 facilities under Chapter 449 of the *Nevada Revised Statutes* (NRS) and the *Nevada Administrative Code* (NAC). These facilities include hospitals, nursing homes, hospice programs, home health agencies, surgery centers, personal care agencies, group care homes—also known as residential care facilities—adult day care centers, halfway houses, alcohol and drug abuse facilities, and many more.

In essence, A.B. 50 will:

- Authorize the Health Division to charge and collect the actual costs of investigating facilities that are operating without a license as required in NRS 449.249, NRS 449.2493 and NRS 449.2496.

- Require homes for individual residential care to meet licensing and operating requirements that are applicable to the "facility for the dependent" classification.

- Require the facilities for the care of adults during the day to pay licensure fees, removing them from their current exempt status.

- Authorize the Health Division to require the transfer of patients from a medical facility or facility for the dependent, at the expense of the facility, if the facility has exceeded its approved occupancy.

Before getting into the respective sections of A.B. 50, I would like to draw your attention to the repeal sections at the back of the bill. Although the bill appears to repeal the requirement for homes for individual residential care to be licensed, that is not what we are doing. When I discuss section 2, I will show how we ensure these facility types are still licensed and falling under the criteria.

Section 1 is related to unlicensed facility complaint investigations. The basic premise of it is charging and collecting fees from an unlicensed facility for the actual costs of the investigations when we are reported to have facilities operating without a license. Current law requires the Health Division to investigate unlicensed group homes, under subsection 4 of NRS 449.230, within 72 hours. These are homes that provide non-medical care and services in a residence. In addition, our Bureau conducts unlicensed facility complaint investigations of other facility types, which may include halfway houses, transitional living facilities, or the occasional unlicensed ambulatory surgical center, in order to ensure the health and public safety.

We also investigate whether facilities should be licensed as some type of medical facility, but we do not have a statutory requirement to conduct those investigations within 72 hours. In 2009, we worked with a number of different entities in Clark County on a case where it appeared that some type of surgical activity was being done in a store that actually sold vitamins. In this case, the store had gone through the appropriate process to be licensed as a business, but not as a medical facility.

In 2010 we investigated 96 unlicensed facility complaints, resulting in an increased workload for staff and an estimated cost to our Bureau and the Health Division in excess of $34,000. Of these 96, it is worth noting that we had 23 that were truly substantiated as unlicensed facilities. This averaged to a cost of about $1,478 to our Bureau per unlicensed facility.

Currently there are no provisions that allow the Health Division to recover these costs from these unlicensed facilities. This legislation will allow the Health Division to charge and collect fees from an unlicensed facility. This is similar to what we are implementing now for complaint investigations where the complaint was confirmed by an investigation. We will charge the facility for the actual costs to the Bureau of conducting the inspection or investigation of the facilities. I have also been asked to share with you that the billing for

these investigations will be at a rate determined through our budget approval process and it may change from year to year. Currently that rate is factored on 2010 data and is $82.01 per hour. We will be posting what those charges will be for the substantiated complaints on our website at <www.health.nv.gov/hcqc.htm> so that the public and the providers will have full understanding of what those hourly charges would be. Those charges would be similar for the unlicensed facilities.

Assemblywoman Smith:
I just wanted to clarify when you said that this is the same procedure that you have on the complaints on licensed facilities. So this mirrors what we did in the regulations with the Legislative Commission on the substantiated complaints?

Wendy Simons:
That is correct.

Assemblyman Brooks:
How many cases were there in total? You said that there were 23 substantiated. How many were in total?

Wendy Simons:
Ninety-six.

Assemblyman Brooks:
Does this mean that the facilities that have been investigated but are in compliance would also have to pay the bill of $82.01 per hour for being investigated?

Wendy Simons:
No. Only those that were found to be substantiated. The ones that were not substantiated were actually licensed and they were neighbor complaints or competitive complaints, but they actually operating with a license. They would not suffer that penalty.

I would like to call your attention to page 3, line 3 of A.B. 50, "homes for individual residential care." The beginning of section 2, where it says, "Facility for the dependent," outlines six classifications and now ascribes facilities for individual residential care into that section. Once again, homes for individual residential care are homes that care for two or fewer residents; that is usually in a homelike residence. The measure proposes classifying these entities as a "facility for the dependent" along with the other non-medical facilities. This change means they will continue to be licensed as they always have been, but they also will be subject to administrative penalties including paying monetary

fines for repeated noncompliance and for noncompliance that results in harm to a resident's health or safety. Even though we currently do not have the authority to apply administrative penalties, we do inspect them, we do identify violations, but there are no means to hold them accountable for the violations other than through issuing the inspection report or revoking or suspending their licenses. The intent for applying penalties is not to punish facilities but rather to promote quality health care in Nevada by assigning penalties that will encourage facilities to comply with the requirements. There are currently 156 such facilities in the state. The main issue with some of these facilities is that they are operating over census. About 50 percent of these homes have repeat deficiencies such as failure to assure criminal history checks for employees and health and TB-testing violations discovered during their inspections.

I would now like to call your attention to section 3. Section 3, subsection 2, addresses facilities for the care of adults during the day. With the exception of adult day care facilities, all facilities in our provider groups pay a fee to become licensed, and they pay an annual renewal fee. Adult day care facilities are exempt from this assessment in statute. Historically, these facilities accommodated the low-income and subsidized clients, and there were few in the state. In the recent past, there has been an increase in the number of adult day care facilities. We have 18 licensed and 5 in the pending license category. Although they do not pay fees, they are still inspected. Inspections average ten hours, and all of the other licensed providers are subsidizing their cost. The workload for adult day care facilities includes initial state licensure inspections, inspections every 18 months, and complaint investigations. In calendar year 2010 this resulted in over 200 hours of total work dedicated to these facility types. As you know, our Bureau is fee-funded and each provider industry supports its own regulation through the assessment of fees to the industry. This measure proposes to gain that balance of equal pay for licensure through our agency.

Section 6, subsection 1(c) basically discusses the transfer of patients if the facility exceeds its approved occupancy. When we are conducting routine inspections, we occasionally find a facility that has more residents than it is licensed to care for. When we find those situations, we need to assure safe and appropriate transfers to another facility, and we often partner with staff in the Aging and Disability Services Division, which is a sister agency to the Health Division in the state's Department of Health and Human Services. We jointly coordinate the transfer. Because HCQC is fully fee-supported, there are no means to recover the costs associated with transferring these patients. We want to make sure and have it be clear that it is the facility's responsibility to pay for these costs. Requiring facilities to transfer patients, at the expense of

the facility, to another licensed facility operating within its approved occupancy, will help ensure the safety of these patients and residents.

As Marla indicated, I have been with HCQC since August and I am so pleased to be serving in this capacity and being a benefit to the providers in the state. Some industries have their own associations but we have not had a lot of representation from the industries in partnering with the bureau. I am undertaking an initiative to establish relationships with the regulated industries, and have spoken to those who would be affected by this measure through our provider-based advisory groups that we have created. For the most part, the industries are supportive of these developments, but not all providers have had the opportunity to participate in the industry meetings that I have put together.

This concludes my presentation and I am open to any questions that the Committee may have.

Chair Mastroluca:
Are there any questions from the Committee?

Assemblywoman Benitez-Thompson:
I was wondering if you could quantify the costs of transferring a patient, because I think it might not be known to a lot of people that transferring, especially a medically-fragile patient, can actually be very expensive, even if the distance is not that great.

Wendy Simons:
I have not calculated those actual costs. I would be more than happy to quantify that and talk to my staff and see what costs those occurrences that we have had to mitigate and manage actually incurred to our agency. Remember that we partner with the Aging and Disability Services Division and I think that one of the greatest factors in the cost analysis is the amount of time that we spend on-site. For example, we were in a situation where we discovered an overcensus home for individual residential care not too long ago and staff had to stay an inordinate amount of time, resulting in overtime to assure that the overcensus folks were safely transferred. If you would like those statistics, I would be more than happy to meet with staff and pull those numbers for you.

Chair Mastroluca:
When you get those numbers, would you share them with our staff and then they can distribute them to all the members.

Wendy Simons:
Yes.

Assemblywoman Flores:
We had a conversation off-line about this and I wanted to ensure that it was reflected on the record. I had some concerns about the impact it would have on facilities that primarily serve a low-income population, low-income seniors, and others who utilize these types of services. I believe you said that whatever fees they would be assessed they were okay with, and they were not going to result in an excessive burden on these types of facilities that tend to serve a low-income population. Is that correct?

Wendy Simons:
Not being 100 percent certain about which provider sectors you are talking about, for the adult day cares, those costs based on our analysis would be less than $1,000 per year, probably in the $800 to $4,900 range. As far as accountability and perhaps sanctions for the homes for individual residential care now being considered, a "facility for the dependent," we always try to give all of those facilities every opportunity to correct. So there is not a fine or sanction applied to them at that point. They have due process with representation, and actually we seek the guidance of our legal counsel through the Office of the Attorney General, so we always try to take the softer approach initially. The actual sanctions will perhaps come for those who really choose to defy standards of care and not go to the level of operation that they should and then, yes, of course, there will be a financial impact.

Assemblyman Carrillo:
How often is an audit done on the occupancy of a home facility? Are they done without notification to the facility?

Wendy Simons:
Excellent question, thank you very much. The audits for facilities for the dependent—all facilities are currently running on an 18-month cycle. For residential care facilities for groups there is the statutory requirement that we do them no less than every 12 months. All of the other providers are an 18-month cycle. Everyone else is in the 12-month cycle on the state inspection side. These are unannounced inspections.

Chair Mastroluca:
Would you explain the process for determining the actual cost of the charge for doing these subsequent inspections?

Wendy Simons:
The methodology for the actual cost analysis is valid. It is based on actual time and effort of the total process entered into what we call a "670 methodology" into our database system where staff accounts for every 15 minutes that they are putting into any kind of workload. There is a little bit of preparation to go out for inspections. There is also the write-up time after the inspections. The cost of support staff is calculated into that as well—the administrative assistants. For example, I can speak with familiarity on the residential care side as that was my history and I operated a residential care facility and was inspected for 15 years or better. Then there is the preparation, inspection, and the time after, which in my instance—I behaved myself—was short. But other inspections run considerably longer.

Assemblywoman Pierce:
Why are we repealing these sections?

Wendy Simons:
I introduced that in testimony but I did not actually go through them point by point.

Assemblywoman Pierce:
The first one that says you have to have a license, is there somewhere else where it says that?

Chair Mastroluca:
We do not need to go through them point by point. If you could just find the section that she is questioning.

Wendy Simons:
We did an analysis comparison. In the analysis of A.B. 50 section 2, it is balanced and covered under the classification of a "facility for the dependent" under NRS 449.030 and NRS 449.037. We looked at all of the repealed sections in a mapped template and cross-matched them to assure that we would not be losing any of the accountability by repealing those sections. I would be more than happy to share that with the Committee.

Bruce Arkell, representing Nevada Senior Advocates:
I am representing a Nevada senior core association which is a group that essentially are providers as well as individual seniors. We are working with the personal care attendant industry with one of the committees that Wendy was talking about. We have proposed an amendment to this bill (Exhibit F) which we believe essentially closes the loop on the actual cost and how much you actually charge. Right now you have language in there that the only ones that

currently are required to pay the actual cost of the service are facilities for transitional living for released offenders. We are suggesting that you drop that language and then it would apply to essentially everyone that they license. That way it essentially closes the loop on what you are doing with the rest of the sections. With that I will take any questions you may have. We do support the bill, by the way.

Chair Mastroluca:
I can see where Mr. Arkell is coming from, but I am trying to understand because I believe that all of those facilities are covered without removing this language that he is asking for.

Marla McDade Williams:
I believe if you look at section 1 of A.B. 50, about line 8, the model that we use in the Health Division when we assess fees to the facility is to look at the actual cost that it takes to inspect individual facility types and again applying that per hour cost back to that time and effort to arrive at the cost. Our model is based on assessing industry types.

Chair Mastroluca:
What would be the advantage or consequence of removing this language from this section?

Marla McDade Williams:
This particular section, section 3, subsection 3, is specific to transitional living facilities for released offenders. If members recall, this is language that was enacted by the Legislature to ensure that this facility type, which is one of the facility types that provides care to persons who do not have a dependency but they are released from prison, were regulated at a minimal level. That is the intent of this language. If we are looking to do something different, this would probably not be the appropriate place to offer this type of amendment because it is limited to those transitional living facilities.

Bruce Arkell:
I went through the language too and I found that the first section says that. Basically what you get in section 3 on page 3, is that you are really talking about doing the same thing. It was not clear to me why you did that. I asked people in the Bureau why they did it and I was not getting an answer that was clear. Frankly, if in fact section 1 covers it, then you just strike section 3. If you are calling out one individual that says you are not going to charge them more than their actual cost, when you in fact say it above that you are not going to charge anyone but their actual cost, it is either redundant or there is something that I totally missed in reading this thing. It just struck me that you

need to bring those two sections into conformance with each other or you eliminate one or the other.

Chair Mastroluca:
I understand and appreciate that. I will say that one of the things I learned very quickly in law in working at the Legislature is that many things are redundant. I see your point. I will ask our legal counsel to look into that and we can continue the discussion.

Marla McDade Williams:
If I may offer one more point of clarification. When we assess our fees, we do not assess them so that we are making a profit off of any individual facility type. We do in practicality apply the actual costs to the industry type.

Chair Mastroluca:
Thank you very much. I appreciate that. I have someone in Las Vegas who wanted to speak?

LynnAnn Homnick, R.F.A., President, Southern Nevada Chapter, Coalition of Assisted Residential Environments:
By way of introduction, I am LynnAnn Homnick, Residential Facility Administrator of Silver Sky Assisted Living, also the President of the Southern Nevada Coalition of Assisted Residential Environments (CARE) Association presenting approximately 2,552 beds, and a member of the Assisted Living Advisory Council for HCQC. I am in total support of A.B. 50. During the last year, I have had over three occasions to testify before various committees such as the Nevada Legislature's Legislative Committee on Health Care, chaired by Senator Wiener, and the Nevada Legislature's Legislative Committee on Senior Citizens, Veterans and Adults with Special Needs, chaired by Assemblywoman McClain. On those occasions, I advocated for the HCQC to be able to recoup investigative and administrative fees incurred during investigations outside the normal survey process. The fees that are currently paid for licensure and renewals are gathered in order to finance HCQC through the normal course of their surveys throughout the year. Investigative costs and man-hour allotments for tracking unlicensed facilities and repeated complaints can drain the coffers quickly.

I believe that as a partner with HCQC it is imperative to support them in their quest to recoup from financial drain. Every provider is bound by regulations. The regulations clearly define how each facility type is to be run and they give us the guidelines for maintaining compliance. Each of us is also mandated to uphold these regulations through proper licensure and proper behavior.

Obviously, first and foremost is licensure. We owe our seniors the best that we can provide. Existing outside the parameters of licensing puts that fragile population at a greater risk. By having the oversight of HCQC, the standards are set and we can protect our elder population. That being said, I am here to support the passage of A.B. 50 and in support of fine-tuning language and finding all unlicensed entities that provide services to our seniors. They need to be held accountable for their actions. Thank you very much for hearing my testimony. I will take any questions.

Chair Mastroluca:
Are there any questions? Thank you. If you have a written copy of your testimony, would you please leave it with the secretary in Las Vegas and we can enter it into the record.

LynnAnn Homnick:
I will, Madam Chair.

I was asked to read testimony in support of A.B. 50 from Linn Thomé, another residential facility administrator (Exhibit G).

Chair Mastroluca:
If you would submit that to the secretary, we can make it a part of the record.

LynnAnn Homnick:
Thank you.

Chair Mastroluca:
Is there anyone else who would like to speak in favor of A.B. 50?

Larry Fry, representing Coalition of Assisted Residential Environments:
The CARE is an industry trade association. We mainly represent licensed adult group care facilities although we do have a few of the smaller homes for individual residential care as members as well. We hold workshops throughout the year. We exist to promote professional development among our operators including training and representation here at the Legislature.

We strongly support A.B. 50. It is simply a common sense measure that gives HCQC more tools and a little more leverage to more easily do their mandated job in making sure that unlicensed operators are held to account. Because we all bear those costs, since this Bureau is a fee-funded agency, we do pick up the cost of investigations for which we are not responsible for, so this does hold to account those that are responsible and we support it very strongly.

Chair Mastroluca:
Is there anyone else either in Las Vegas or Carson City that would like to speak in support of A.B. 50? Is there anyone that would like to speak against A.B. 50? [There were none.] Seeing none, we will close the hearing on A.B. 50.

We have one more piece of work to complete in Committee, and that is the introduction of Bill Draft Request (BDR) 18-179.

For those of you who have not had the opportunity to do this yet in Committee, we will be voting on whether we want this bill to go to the floor to be introduced so that it will come back to our Committee so that we can discuss it. This bill draft request makes various changes relating to the Office for Consumer Health Assistance. It basically talks about expanding the authority to adopt regulations, authorizing the director to appoint a designee, and some other matters.

May I have a motion to introduce?

BDR 18-179—Makes various changes relating to the Office for Consumer Health Assistance. (Later introduced as Assembly Bill 146.)

ASSEMBLYWOMAN PIERCE MOVED FOR COMMITTEE INTRODUCTION OF BDR 18-179.

ASSEMBLYMAN FRIERSON SECONDED THE MOTION.

THE MOTION PASSED. (ASSEMBLYMAN HAMMOND WAS ABSENT FOR THE VOTE.)

Chair Mastroluca:
Are there any members of the public that would like to comment either in Las Vegas or Carson City? [There were none.] The meeting adjourned [at 3:01 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: February 11, 2011 Time of Meeting: 1:33 p.m.

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
	C	Tracey Green, M.D., State Health Officer, Health Division, Department of Health and Human Services	Agency Overview
A.B. 29	D	Kathleen Silver, Chief Executive Officer, University Medical Center	Proposed Amendment
A.B. 50	E	Wendy Simons, Chief, Bureau of Health Care Quality and Compliance, Health Division, Department of Health and Human Services	Testimony
A.B. 50	F	Bruce Arkell, Nevada Senior Advocates	Amendment to A.B. 50
A.B. 50	G	LynnAnn Homnick	Letter from Linn Thomé