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

Seventy-Sixth Session
March 16, 2011

The Committee on Health and Human Services was called to order by Chair April Mastroluca at 1:39 p.m. on Wednesday, March 16, 2011, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, 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 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:

Assemblyman Steven Brooks (excused)

GUEST LEGISLATORS PRESENT:

Assemblyman John Oceguera, Clark County Assembly District No. 16

STAFF MEMBERS PRESENT:

Allison Combs, Committee Policy Analyst
Kirsten Coulombe, Committee Policy Analyst
Risa Lang, Committee Counsel
Mitzi Nelson, Committee Secretary
Olivia Lloyd, Committee Assistant

OTHERS PRESENT:

Luana J. Ritch, Ph.D., Chief, Bureau of Health Statistics, Planning, Epidemiology, and Response, Health Division, Department of Health and Human Services
Patrick Irwin, Program Manager, Emergency Medical Systems, Health Division, Department of Health and Human Services
Michael Schwartz, Member, Committee on Emergency Medical Services, Health Division, Department of Health and Human Services; and Battalion Chief, North Lake Tahoe Fire District
Jim Gubbels, R.N., B.S.N., Chief Administrative Officer, Regional Emergency Medical Services Authority
Rusty McAllister, President, Professional Fire Fighters of Nevada
Barry Gold, Director, Government Relations, AARP Nevada
Darla Burrow, Executive Director, Nevada Hepatitis C Task Force
John Pappageorge, representing Health Services Coalition
Robin Keith, Vice President, Government Relations, Nevada Rural Hospital Partners
James L. Wadhams, representing Nevada Hospital Association

Chair Mastroluca:
[Roll was called.] This afternoon we have a full agenda. We will begin with Assembly Bill 51.

Assembly Bill 51: Revises provisions relating to certain providers of emergency medical services. (BDR 40-447)

Luana J. Ritch, Ph.D., Chief, Bureau of Health Statistics, Planning, Epidemiology, and Response, Health Division, Department of Health and Human Services:
Emergency Medical Services (EMS) is one of the programs for which I am responsible. With me today is Mr. Patrick Irwin, who joined the Health Division in November as the EMS Program Manager. He supervises our EMS program. We are here today to present A.B. 51, which was requested by the

Health Division to standardize language between *Nevada Revised Statutes* (NRS) Chapter 450B and the *National EMS Education Standards* released by the National Highway, Traffic, and Safety Administration (NHTSA) in 2009. The changes addressed in the Health Division's request include standards for training and names used to designate various levels of pre-hospital care providers. Standard terms for EMS personnel allow responders to be recognized with a common title and a base scope of training that is uniform within all states. This also allows EMS personnel to be deployed across state borders in times of natural disasters or other such events. Assembly Bill 51 also provides authority to use and manage certificate fees, including the ability to carry those funds forward year to year for training purposes.

The Health Division recently had a change in leadership in the EMS program. After Mr. Irwin was brought on board, we were able to meet with many of the stakeholders in the EMS community to receive their input on the bill. We are very grateful to these stakeholders who embraced the bill and took the opportunity to go further in improving the statute. One of the people who will be speaking today, Chief Schwartz, from North Lake Tahoe Fire Protection District representing the Nevada Fire Chiefs Association, has some changes that he would like to bring forward. We are in support of those changes. We will work with the Committee to submit these changes in the proper format.

We also would like to mention that there is a fiscal note attached to the bill which would have a zero fiscal impact. Although we will have to adopt new regulations to accompany the changes made by the bill, the cost will be funded by a federal grant that we have received for EMS children's activities. I would be happy to answer any questions.

Chair Mastroluca:
I noticed that the word "volunteer" has been removed in section 11, on page 5, and again in section 16, on page 7. Can you tell me why?

Luana J. Ritch:
These sections address the entire EMS community. When the statutes were originally established, the majority of fire departments that provided EMS in Nevada utilized volunteers. Now that we have grown up as a state and our EMS system has developed, we have individuals who are working both in the volunteer and in the paid service sector. They often work together on the same scene. Modernizing the language to recognize that new environment helps to ensure that we are recognizing everyone at the same level.

Chair Mastroluca:
In section 21, subsection 1, paragraph (b), the bill references a nationally recognized training organization. Does that mean that the training is standardized, there is only one in the country, and everyone will be using the same program?

Patrick Irwin, Program Manager, Emergency Medical Systems, Health Division, Department of Health and Human Services:
That is absolutely correct. This training will allow our certifications to be recognized in other states in a mutual aid environment. The names, terms, and scope of certification will all match across the nation.

Assemblyman Goicoechea:
I believe Utah uses a state certification process, rather than the national certification. Is that correct?

Patrick Irwin:
That is correct. While Utah currently uses a state certification process, I have spoken with Paul Patrick, Bureau Director of Utah's Emergency Medical Services and Preparedness agency, and he has informed me that they are also considering joining the national registry.

Assemblyman Goicoechea:
This is an issue in some of the rural areas. Some of the other legislators and I, who have attended meetings in the past, have seen a push in some of the smaller communities to adopt a state certification rather than the national registry. These communities were considering patterning their programs after Utah's program. I understand the concern about having a one-size-fits-all program when you need to cross state lines. However, this concern continues to be an issue in the rural areas. I know you are very aware that other bills are being proposed that attempt to address the inconsistencies across state lines.

Chair Mastroluca:
Are there any other questions?

Assemblyman Sherwood:
You mentioned that there is a fiscal note that will be paid for by a grant. What happens when the grant goes away?

Luana J. Ritch:
The fiscal note is for the expenses that will be incurred to adopt the new regulations. It is a one-time expense and effort. In this case, we are hoping to adopt the new regulations during this biennium.

Assemblyman Sherwood:
When we strike the word "an emergency medical technician" (EMT) from all the language, it appears that EMS services would then fall to a firefighter or an attendant. We would be derelict if we did not bring up the fact that it would most likely be a fairly expensive proposition to require firefighters to undergo an extra level of training, when they may or may not be performing the service. Anything that will make it more expensive to perform the service will be a difficult sell in today's environment.

Luana J. Ritch:
The bill does not remove language, it replaces language. The current national standard terminology is basic EMT, advanced EMT, and paramedic. Nevada's language does not have the word "paramedic" included in the existing statute. The current terminology used in Nevada for the same levels of training is basic EMT, intermediate EMT, and advanced EMT. This bill changes that language to reflect the national standard of terminology for the three levels of expertise.

Assemblyman Sherwood:
I am reading the bill at section 18, subsection 1 which shows a strikethrough of the term "an emergency medical technician" with no replacement terminology. It looks like the only alternative would be a firefighter. Can you help me out with this example?

Patrick Irwin:
That title is being removed from that section. The process recognizes that an EMT holds an attendant's license, which is required to drive an ambulance. We have to have two licensed attendants on every ambulance. That person may be a firefighter or work for an ambulance service; there are multiple classifications of employees that may have that role. The language here is for cleanup purposes only.

Assemblyman Sherwood:
I just heard testimony that we were replacing a word and additional testimony that we are removing a word. It looks like we have fewer, more expensive options.

Luana J. Ritch:
We have cleanup language throughout the bill; this is one of those cases. The intent of the bill does not require any additional level of skill or care. The bill changes the current language to be standardized such that, when we say a person is a "basic EMT," everyone across the country will know the meaning of the term. The skill set and the training requirements for a basic EMT,

an advanced EMT, and paramedic will be understood. The language changes within the bill should not have any impact on the cost of care.

Assemblywoman Flores:
It was kind of confusing to go through the bill and find that in some areas the language used is "paramedic," while in others you were striking the terminology "EMT" and replacing it with "paramedic." In other sections you used the terminology "EMT," "paramedics," and "attendant." It is somewhat difficult to figure out what is being done because many terms are being replaced or stricken. My greatest area of concern with this is in section 2, where the term "emergency medical technicians" is replaced with the word "paramedics." I found out that, for training purposes, in order to reach the paramedic level you must first become an EMT. Is that true? So, first you are an EMT and then you can become a paramedic. The way I read this provision is that the most highly trained personnel, the paramedic, must be used in the particular situation outlined in this section. That concerns me because it appears that lower level EMTs would no longer be able to be used for these services.

Luana J. Ritch:
Madam Chair, would you like Mr. Irwin to go through the bill section by section to answer these questions? The bill and the statute flow in a way where it addresses different levels of EMT personnel in different sections of the bill. That contributes to some of the confusion.

Chair Mastroluca:
I hesitate to do that because of the length of the bill. We do have other bills to hear today. Could you address the question Ms. Flores asked? Afterwards, if Ms. Flores or the Committee has other questions, we will revisit that idea. I would like to avoid going through the bill section by section.

Patrick Irwin:
The terminology "advanced emergency technician" is being replaced in this section to reflect the national standard terminology of "paramedic." In the past, if you crossed the state line, reported to an incident command site, and stated you were an "advanced EMT," you would not be allowed to work to the scope of a paramedic because that term is not recognized. The change in this section generalizes the term so that a Nevada EMT who is qualified to work as a paramedic will be recognized as such. It does not change anything else at all. The steps to reach the various levels described by the new language also do not change. It simply changes the terminology that is placed on the EMT certificates. The bill does not change the situations where a paramedic must be used rather than a lesser certification. Nothing changes in the cities and counties as far as which personnel can perform what service.

Chair Mastroluca:
I would like to verify that the certificate to which you refer is defined in section 4. Is that correct?

Patrick Irwin:
The differences between a certification and a license are defined throughout the entire process, as well as within in the *Nevada Administrative Code.*

Assemblywoman Flores:
To be clear, section 2, which outlines a particular area of the state, allows a paramedic, lower level EMT, or other licensed personnel to be used?

Patrick Irwin:
That is absolutely correct. The agency that hires the EMT sets the particular standard that is required.

Assemblyman Goicoechea:
I know you have to have a Certificate of Need (CON) to establish an air ambulance, but that requirement has not been established for a ground ambulance. We have some turf wars out in the rural areas. We should probably incorporate a statute that requires a CON, either in this bill or in the regulations, prior to establishing an ambulance service.

Luana J. Ritch:
We would be very happy to work with you to discuss the new realities of Certificates of Need. Federal case law has superseded Nevada's state laws in requiring a CON for air ambulances. I administer the CON program as well, so I would be happy to speak with you regarding this issue.

Assemblyman Goicoechea:
As I read the bill, it looked like this issue might fit into section 15 of A.B. 51. It appears to be a catch-all bill.

Chair Mastroluca:
Are there any other questions? [There was no response.]

Michael Schwartz, Member, Committee on Emergency Medical Services, Health Division, Department of Health and Human Services; and Battalion Chief, North Lake Tahoe Fire District:
Because we knew the changes in terminology used throughout the bill created some conflicts, the Nevada Fire Chiefs Association has been working with the Committee on Emergency Medical Services. These groups worked together to develop a consensus and we have a proposed amendment that was not posted

to the Nevada Electronic Legislative Information System (NELIS). The amendment was reviewed by Emergency Medical Services and the EMS Committee, which advises the director of the EMS program and has also been thoroughly brought through all the fire departments. Many of the issues you have discussed today have been worked out in the consensus groups from both the EMS and the fire department side. We would like to have this amendment considered in the future. Unless you have questions for me regarding A.B. 51, that is all I have to add.

Chair Mastroluca:
Is there anyone who would like to speak in support of A.B. 51?

Jim Gubbels, R.N., B.S.N., Chief Administrative Officer, Regional Emergency Medical Services Authority:
The Regional Emergency Medical Services Authority (REMSA) has worked with the EMS Committee to provide amendments to A.B. 51. We would like to address the Committee when those amendments are heard.

Chair Mastroluca:
Is there anyone else who would like to speak in support of A.B. 51? Would anyone like to speak in opposition to this bill? [There were none.] Is there anyone who would anyone like to speak as neutral to the bill?

Rusty McAllister, President, Professional Fire Fighters of Nevada:
I signed in as neutral on this bill and I would like to be sure that there is a clarification from the Health Division regarding section 5, where it states that money generated from licensure or certification would go to the state. I want to be sure that section does not include money collected in Clark County. The generation of licensure and certifications in Clark County is used to pay for two positions that help run the Office of Emergency Medical Services and Trauma System there. We would like to make sure that money stays in Clark County where it is being generated. Another concern brought to me by one of the fire departments in northern Nevada—not by their chief—is that the bill allows the money to be used to provide grants to volunteers. The concern was that three volunteer fire departments are already trained using money from the budget of a northern Nevada fire department. That department did not wish to turn their certification money over to the state to provide grants. I do not know if this section covers a widespread basis or a significant amount of money. Certainly the amount of revenue that is generated in Clark County from all the fire departments and private ambulance companies is significant; it is enough to fund the positions within the Southern Nevada Health District. We would like to make sure that the revenue is going to stay in place. I would be happy to answer any questions.

Assemblyman Sherwood:
Nevada currently has a "Cadillac" EMT service that is both public and private. However, many other municipalities have needed to make their EMT services 100 percent private. Hypothetically, if Nevada ever had to go private with these services, would this bill limit the access of private EMT services? Would it not have any effect at all?

Rusty McAllister:
The way I read the bill, it would have no effect at all. I have noted some of the questions asked by the Committee today and I would like to simplify the discussion if I can. Currently there are three EMT levels recognized by the State of Nevada: basic, intermediate, and advanced. The qualifications of an advanced EMT are the same as those of a paramedic. The bill's intent is to substitute the word "paramedic" in every location that currently says "advanced emergency medical technician." Likewise, each use of the term "emergency medical technician intermediate" would be replaced with "advanced emergency medical technician." It is a title change as opposed to a change in job description.

Assemblyman Sherwood:
For clarification, when the term "emergency medical technician" is struck from a paragraph that appears to be attached to the services of a firefighter and then EMT services become 100 percent privatized, would this not create a problem? I see what they have said that they are saying, but it does not actually say that. In a couple of places they strike the term "emergency medical technician" without providing replacement terminology. I just want to make sure that everyone is on the same page that, if the state or a county privatized their EMT services, we would not be putting ourselves in the corner due to the cleanup language. If you are comfortable with the wording, that is all the assurance I need.

Rusty McAllister:
I am comfortable with the language. I do not believe that the sponsors of the bill have any intention or desire to cut EMTs who are employed by private ambulance companies out of work or jobs. I also do not believe that they have any desire whatsoever to cut the fire department, which provides first responder service throughout Nevada, out of business either.

Chair Mastroluca:
Are there any other questions?

Assemblyman Goicoechea:
Is there a difference between an advanced EMT and a paramedic in the way we have looked at them today? Are there going to be different educational requirements?

Rusty McAllister:
There is not going to be a different standard. The current terminology used in Nevada for paramedic is "advanced emergency medical technician." The bill changes that terminology to match the national standard of "paramedic." An advanced EMT who currently works in Nevada is a paramedic. The term "advanced emergency medical technician" will be moved down to replace Nevada's current terminology of "intermediate emergency medical technician." It is a title change.

Assemblyman Goicoechea:
Thank you for putting that on the record.

Assemblyman Livermore:
Is this change of wording reflected anywhere in any collective bargaining agreement that might impact a local municipality by requiring higher pay grades?

Rusty McAllister:
Not to my knowledge. We did not write this bill.

Assemblyman Livermore:
I realize that, but you know, the devil is in the detail. I want to make sure that the change will not eventually affect a collective bargaining agreement.

Rusty McAllister:
The only contracts that I know of within fire departments are incentives for maintaining EMT certification.

Assemblyman Livermore:
Would the new terminology cause a higher pay grade to be required? I am not aware of all the collective bargaining agreements that may apply and I am sure you are not either. Evidently, pay grades in the fire service are dependent upon the job level that you perform. I want to make sure that changing to the new terminology does not trigger unintentional pay grade advancements.

Rusty McAllister:
To my knowledge, it does not. Departments that employ advanced EMTs pay them at the same rate as the classification or job description of a paramedic.

Chair Mastroluca:
Does anyone else have questions?

Patrick Irwin:
Would you like me to answer the questions posed by Mr. McAllister or would you prefer for me to speak with him directly?

Chair Mastroluca:
Answer those with him directly and then work together to bring back an amendment, if there is one we need to consider. Is there anyone else who would like to speak regarding A.B. 51? [There was no response.] I will close the hearing on A.B. 51. I will now open the hearing on Assembly Bill 280, which deals with the adoption of patient safety checklists.

Assembly Bill 280: Requires the adoption of patient safety checklists at certain medical facilities. (BDR 40-517)

Assemblyman John Oceguera, Clark County Assembly District No. 16:
I am here to present A.B. 280, the patient protection checklist bill. As you can see on the second slide (Exhibit C), the problem is that the mortality rate in America's hospitals from hospital-acquired infections is nearly 200,000 patients per year. A recent study said that 48,000 people die a year in U.S. hospitals from pneumonia and blood-borne infections, which are both very preventable. Research also shows that those same 48,000 deaths cost hospitals $8.1 billion. If you compare that to the aviation industry, in 2010, there was one accident for every 1.6 million flights. Over 2 billion people flew safely on over 36 million flights. The obvious analogy is that pilots, who work in a very dangerous profession with a lot of lives at risk, use a checklist to ensure that basic steps are taken before, during, and after each flight. There is a sample checklist provided on page 4 of the handout showing the steps a pilot would take before starting the engine, after starting the engine, on taxi, and upon takeoff. While the checklist is pretty simple, it ensures that the pilot goes through each and every required procedure.

In existing law, medical facilities have to adopt a patient safety plan and establish patient safety committees. Assembly Bill 280 will require patient safety committees to adopt and annually review safety checklists to further protect patients. Included in the handout is an example for a checklist that is used during heart surgery. For instance, we can look at some of the basics. You want to make sure that you have the right patient by confirming his identity. You confirm the site. Are you operating on the right arm or the left arm? You confirm that you are doing the right procedure. You confirm that the patient has given his consent to the procedure. Does the patient have any

known allergies? If so, what are they? It may seem simple, but these are some of the errors that occur.

Do checklists work? Infection rates in Michigan hospitals were significantly decreased by using a checklist that was designed by Johns Hopkins University researchers. Blood-borne infections from central lines used for IV access were previously thought to be inevitable. When the checklist procedure was put into place, these infections dropped to almost zero and the number of ventilator-associated pneumonia cases dropped by almost 70 percent. Those are pretty impressive results. In 2010, the *New England Journal of Medicine* published a study that found hospitals that use checklists to prevent errors involving surgical patients, dramatically reduced complications and in-hospital deaths. From 2007 to 2009, 6 hospitals in the Netherlands used 11 surgical care checklists, which covered items such as: making sure blood was available during surgery, double-checking that surgeons were operating on the correct site, ensuring proper medications were being given, and confirming when a patient should be allowed to eat again. A comparison of about 7,600 patients found that checklists reduced complications by one-third and in-hospital deaths were cut in half.

We also believe that this process will reduce costs. Using, and periodically updating, checklists can not only improve quality of care but may also reduce the cost of care. The World Health Organization surgical safety checklist is associated with an annual cost saving of more than $103,000 for a hospital that performs 4,000 non-cardiac operations, or about $26 per operation performed. The cost savings equate to about $8,600 for every complication averted. If at least five major complications were prevented with the use of a checklist, we believe that hospitals would achieve cost savings within the same year of implementation. Obviously, not only the hospitals will save money. It would also be reasonable to expect that additional savings would accrue from the payors as well. In short, I think A.B. 280 accomplishes four goals: it is simple and low-cost, it helps to prevent complications, it will save lives, and it will reduce costs. I would be happy to answer questions on A.B. 280.

Chair Mastroluca:
Thank you very much, Assemblyman Oceguera. With the issues surrounding health care in Nevada, it sounds like the time has come to consider this issue. Who would create the checklists?

Assemblyman Oceguera:
All medical facilities are mandated by law to have a patient safety committee and each hospital must adopt a patient safety plan within their respective committees. We are requiring that the patient safety committee create the

checklists. We are not dictating how the creation would be administered; each individual hospital or facility can determine how they will create the checklist.

Chair Mastroluca:
Would the medical facilities included be hospitals, obstetric centers, surgical centers, or centers providing emergency medical care?

Assemblyman Oceguera:
A medical facility is defined in *Nevada Revised Statutes* (NRS) Chapter 439, I believe. I do not have the definition in front of me.

Chair Mastroluca:
I do, I was cheating.

Assemblyman Oceguera:
So, it was a rhetorical question?

Chair Mastroluca:
It was a rhetorical question. I am glad you picked up on that. Are there any questions for Assemblyman Oceguera regarding A.B. 280?

Assemblyman Livermore:
The Joint Commission inspects hospitals, and most hospitals of 100 beds or more also have a quality assurance department. How does that fit with the patient care committee? Are they separate entities?

Assemblyman Oceguera:
It seems to me that the patient safety committee could delegate this task however they see fit. I am not trying to say how they should accomplish it, whether through the Joint Commission or otherwise. I do not want to restrain or limit how it is done; I just want to see it done.

Chair Mastroluca:
Are there any other questions? [There were none.] Assemblyman Oceguera, do you have a preference in the order of speakers?

Assemblyman Oceguera:
I do not have a preference of order, but I believe there are a few people here who want to testify in favor of the bill.

Barry Gold, Director, Government Relations, AARP Nevada:
AARP is a nonprofit, nonpartisan social welfare organization with a membership that helps people aged 50-plus have independence, choice, and control in ways

that are beneficial and affordable to them and society as a whole. Safety is a critical component of quality and should be a core attribute of the health care system. [Mr. Gold continued to read from prepared testimony (Exhibit D). Supplemental dialogue has been added for clarity.] The Patient Safety and Quality Improvement Act of 2005 authorized a system for hospitals, doctors, and other health professionals to voluntarily report information to patient safety organizations on a privileged and confidential basis. The data is used to analyze events that compromise patient safety. AARP Nevada, on behalf of our 304,000 members across the state, supports A.B. 280 and urges the Committee to pass it.

Chair Mastroluca:
Are there any questions?

Assemblyman Anderson:
Do you think checklists might also help bring down the costs of medical malpractice insurance due to a reduction in hospital errors? Will it help the doctors as well?

Barry Gold:
I am neither an attorney nor well-versed in malpractice law. However, from a common-sense perspective—if you use patient safety checklists, you do not have medical errors, and patients do not sue—what will that do for the malpractice claims and payments?

Assemblyman Sherwood:
Thank you, Assemblyman Anderson, for introducing that line of questioning. For the record, I support checklists and think they are a great idea. The one thing that gives me pause is confidentiality. If the checklist is not confidential and the information can be used against hospitals for malpractice suits, that would be a concern. We want to keep costs down. As you have testified and per your understanding, are the checklists confidential and not able to be used against hospitals who utilize them?

Barry Gold:
Again, I am speaking outside the scope of my area of expertise, as I am not a malpractice attorney. I was referring to the Patient Safety and Quality Improvement Act of 2005, which collected data from professionals who voluntarily reported information to patient safety organizations. That information was privileged and confidential. I am not sure exactly how this patient safety checklist would be administered. It would be organized and written by the patient safety committees within each medical facility. I did not

see how confidentiality would be handled outlined within the bill. I am not equipped to comment about that.

Chair Mastroluca:
I will try and save you. Section 3 of the bill specifically states, "Any report, document and any other information compiled or disseminated pursuant to the provisions of NRS 439.800 to 439.890, inclusive, and section 1 of this act is not admissible in evidence in any administrative or legal proceeding conducted in this State."

Assemblyman Sherwood:
We will not be here in ten sessions. Can we go on record as saying there will be no scope creep with this bill? Who could be against a checklist?

Barry Gold:
I would agree that patient safety checklists sound like an ideal way to stop preventable medical errors, improve patient outcomes, and save costs.

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

Darla Burrow, Executive Director, Nevada Hepatitis C Task Force:
The Nevada Hepatitis C Task Force supports this bill because it will help with the many steps needed to prevent further spread of this terrible disease.

Chair Mastroluca:
Are there any questions?

Assemblyman Hambrick:
I have a comment. I agree with you. The sad part is that there is no checklist anywhere in the world that could have prevented what happened in Clark County. It was not caused by the lack of a checklist; it was pure greed.

Darla Burrow:
I agree. I am one of the victims of hepatitis C and I recently went through a liver transplant. I do not want anyone else to have to live the way I lived. If this disease can be prevented by just a little check mark on a sheet of paper, we need to do it.

John Pappageorge, representing Health Services Coalition:
I just learned that this bill was being presented to the Committee today. I have a few very short notes. We strongly support A.B. 280. This bill improves patient safety, which we do support. We would be happy to provide any

assistance necessary to craft this bill into its final form. We understand that there is still a little work that may be done on this bill. In any case, patient safety is extremely important. Many of you may know that I recently just spent almost a month in the hospital. During that time, a few things happened that I wondered about. A checklist might have been very helpful, not for a lawsuit, but for my own personal safety. I think this is a great idea and it should happen. I would be happy to answer any questions.

Chair Mastroluca:
Are there any questions? [There was no response.]

Robin Keith, Vice President, Government Relations, Nevada Rural Hospital Partners:
I am here to support the intent of A.B. 280 and to offer insight into how we might approach the issues that are highlighted in the bill. We are very sincere in our desire to do this well. The rural hospitals are actively working on, are very interested in, and are funding improvement in the quality of care. The bill addresses three particular aspects of patient care: patient identification, hand washing, and what is described in the bill as "recognized protocols." It proposes to address these issues through the use of checklists. While there is certainly a role for checklists in hospitals and they are used frequently under many different kinds of circumstances, we do not believe that checklists are the most effective way to approach these three issues.

Checklists can become a mechanical process that has a high potential for becoming a kind of rote activity. They can easily turn into an "autopilot" type of activity. If a person is not performing the correct behavior responsibly, there is little to prevent that person from checking the box anyway. The root of the issue here is that humans do not always do what they are supposed to do. We do not believe that checklists will effectively solve the problem in these particular instances. Instead, I would like to offer some alternative suggestions and examples.

With respect to patient identification, I have spoken to two representatives . . .

Chair Mastroluca:
Ms. Keith, could you clarify if you are in support of the bill?

Robin Keith:
We are absolutely in support of this bill. We believe we have these problems and they should be addressed. We are not convinced that checklists are necessarily the best solution, but we appreciate the bill and are totally in

support. We just think the bill needs a little work. Maybe that is enough for me to say. Do you want me to speak more specifically about this?

Chair Mastroluca:
I think you might want to take your issues up with the sponsor of the bill.

Robin Keith:
I would be happy to do that.

Chair Mastroluca:
Are there any questions? [There was no response.]

James L. Wadhams, representing Nevada Hospital Association:
I am appearing in place of Bill Welch, who is in another meeting right now. I will be very brief. We are in support of the bill. Mr. Welch gave me a list of the checklists currently operating in hospitals, which I am happy to leave with the secretary (Exhibit E). There are about 40 checklists already in existence. Checklists are very important and need to be implemented. I want to make sure the Committee, as they move forward on this bill, has the benefit of seeing that checklists are already currently in place. Assemblyman Oceguera may be addressing a composite or element of that idea. We are here to support that effort and are willing to work with it.

Chair Mastroluca:
Would anyone else like to speak in support of A.B. 280? [There was no response.] Is there anyone who would like to speak in opposition to A.B. 280? [There was no response.] Is there anyone who would like to speak as neutral to A.B. 280?

Luana J. Ritch, Ph.D., Chief, Bureau of Health Statistics, Planning, Epidemiology, and Response, Health Division, Department of Health and Human Services:
Ms. Williams is currently attending another committee meeting. Public safety checklists have been used successfully by medical personnel to improve the quality of care of patients. The state Health Division is supportive of efforts to improve patient care. The concept of a simple checklist is intended to create independent redundancies to monitor whether patients receive the care processes they should. [Ms. Ritch continued to read from prepared testimony from Marla McDade Williams, Deputy Administrator, Health Division, Department of Health and Human Services (Exhibit F).]

Chair Mastroluca:
Are there any questions? Is there anyone else who would like to speak on A.B. 280? [There were none.] I will close the hearing on A.B. 280. Is there anyone here who would like to participate in public comment? [There was no response.]

This meeting is adjourned [at 2:35 p.m.].

RESPECTFULLY SUBMITTED:

_____
Mitzi Nelson
Committee Secretary

APPROVED BY:

_____
Assemblywoman April Mastroluca, Chair

DATE: _____

EXHIBITS

Committee Name: Committee on Health and Human Services

Date: March 16, 2011 Time of Meeting: 1:39 p.m.

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
A.B. 280	C	Assemblyman John Oceguera	PowerPoint on Patient Protection Checklists
A.B. 280	D	Barry Gold	Testimony
A.B. 280	E	James L. Wadhams	Sample of Some of the Checklists Utilized by our Hospitals
A.B. 280	F	Luana Ritch	Testimony from Marla McDade Williams