# MINUTES OF THE SUBCOMMITTEE OF THE SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

**Seventy-sixth Session**
**April 4, 2011**

The subcommittee of the Senate Committee on Health and Human Services was called to order by Chair Sheila Leslie at 1:10 p.m. on Monday, April 4, 2011, in Room 2134 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to the Grant Sawyer State Office Building, Room 4412E, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

## SUBCOMMITTEE MEMBERS PRESENT:

Senator Sheila Leslie, Chair
Senator Ruben J. Kihuen
Senator Greg Brower

## STAFF MEMBERS PRESENT:

Marsheilah Lyons, Policy Analyst
Sandra Small, Committee Secretary

## OTHERS PRESENT:

Bill Welch, Nevada Hospital Association
Bobbette Bond, Health Services Coalition; Nevada Health Care Policy Group
Jay Kvam, Program Manager, Office of Epidemiology Sentinel Event Registry, Health Division, Department of Health and Human Services
Steve Winters
Marla McDade Williams, B.A., M.P.A., Deputy Administrator, Health Division, Department of Health and Human Services
Barry Gold, Director, Government Relations, AARP Nevada
Renny Ashleman, Nevada Health Care Association
Charles Duarte, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Robin Keith, Nevada Rural Hospital Partners Foundation
Graham Galloway, Nevada Justice Association

CHAIR LESLIE:
The sentinel events subcommittee intends to hear the issues on the bills scheduled today. The hearing will begin with Senate Bill (S.B.) 209.

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

MARSHEILAH LYONS (Policy Analyst):
This bill was introduced on behalf of the Legislative Committee on Health Care. Section 1 requires the Health Division (HD) of the Department of Health and Human Services (DHHS) to make annual reports available on its Website, the required reports being unexpected occurrences related to facility-acquired infection, death or serious physical or psychological injury. Section 2 of S.B. 209 requires the HD to report that information publicly in a format which allows comparisons between medical facilities. The information required to be placed on the Website is already required pursuant to State law.

BILL WELCH (Nevada Hospital Association):
The Nevada Hospital Association (NHA) supports S.B. 209 but recommends rather than using numbers as data is posted, a rate is used as indicated in the NHA "Outline of Proposed Amendments" (Exhibit C). When there is a significant difference in the size of hospitals and the complexity or scope of services, for instance, the University Medical Center compared to Boulder City Hospital, there will likely be more sentinel events in the larger facility. Using numbers may not provide the public with the appropriate information.

CHAIR LESLIE:
What do you mean by a "rate?"

MR. WELCH:
The NHA will be posting sentinel events live beginning April 8, 2011. We will be using a percentage of 1,000. The events will be represented as a percentage rate.

CHAIR LESLIE:
Where would you define the rate?

MR. WELCH:
The numerator would be whatever the categories are.

CHAIR LESLIE:
Would there be different definitions of rates?

MR. WELCH:
Yes. It would state the number per 1,000 as a percentage rather than a number of incidents.

CHAIR LESLIE:
Could both figures be presented?

MR. WELCH:
Both could be posted. The concern is a layperson looking at a whole number will not take the time to read and understand what the percentage means. Whoever posts the information would need to do a good job of explaining the variables if a whole number were to be used.

CHAIR LESLIE:
I understand your concern, but I believe the numbers could be posted side by side in a way a consumer could use both.

BOBBETTE BOND (Health Services Coalition; Nevada Health Care Policy Group):
The Health Services Coalition (HSC) and the Nevada Health Care Policy Group (NHCPG) support the idea of using both numbers and rates as you have suggested. Nevada consumers are just beginning to use these Websites. The State Website needs quite a bit of work to be consumer friendly. Consumers understand numbers, but it will take time to understand rates. In the short term, the use of rates only will be less useful. Would the rate be per 1,000 people, rate per 1,000 beds or rate per 1,000 bed days? We would like the rates expressed in a consistent manner for comparison purposes.

CHAIR LESLIE:
Can they all be done in the same way? Give me some examples.

MS. BOND:
For instance, if you are measuring central-line bloodstream infections, one would need to determine if the rate is for patients in all hospital beds, or every patient in the hospital, or every patient day in the hospital or just for people who had surgery.

CHAIR LESLIE:
Is this already determined in the national indicators?

JAY KVAM (Program Manager, Office of Epidemiology Sentinel Event Registry, Health Division, Department of Health and Human Services):
There are different ways rates can be calculated. For instance, when dealing with Ms. Bond's central-line example, if there were ten beds at a given facility, a rate can be generated based upon the number of patients treated. That rate may not take into account that the patient may be a resident of the facility for weeks or months, resulting in an elevated susceptibility. Another way to generate the rate is to look at patient days. A single patient staying for a week or more contributes more to the denominator than simply counting patients.

CHAIR LESLIE:
Do the national indicators come with established rates?

MR. KVAM:
There is an effort across the states to standardize these rates for the purpose of comparability. Some effort has been expended by the Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services (USDHHS). The National Quality Forum (NQF) does not have a formal methodology for generating rates. The NQF believes, using their definitions, these events are serious and preventable and should never occur.

CHAIR LESLIE:
The question is how to calculate the rates. Who should determine how the rate is expressed?

MR. KVAM:
In the absence of any formal definition in the statutes, we would consult with other statisticians and epidemiologists to determine the best method to use.

CHAIR LESLIE:
Would the hospitals have input?

MR. KVAM:
Their input would be welcome. We could acquire additional information from the hospitals using our own forms requesting representative figures.

MS. BOND:
The HSC and NHCPG want the numbers. If there is a nationally recognized and established quality indicator data set where the rates and risks are adjusted, such as AHRQ, we would prefer that to creating new data sets. We would like to work with the hospitals in the absence of an established rate. I do not want to chart new territory or use HD resources if rate setting is already available through the Centers for Medicare & Medicaid Services (CMS), USDHHS, the AHRQ, the NQF or The Joint Commission. There is a new data set hospitals help support, the Hospital Quality Alliance, which could be considered.

CHAIR LESLIE:
I agree with that approach.

MR. WELCH:
I will have staff available at the next workshop to address this issue.

CHAIR LESLIE:
We will have to come to a conclusion at the next workshop. Would you work with the interested parties?

MR. WELCH:
I will. We want something in Nevada that will compare nationally.

STEVE WINTERS:
The process needs to be simplified so the consumer understands what is happening. The hospitals are keeping these records somewhat secret. People need to know and be able to compare infection rates. The same percentage per capita should be used. People have a hard time navigating the Website. The State Board of Health, DHHS, has been unable to protect the public because they do not have the resources and there is no fair infection comparison. The rates should not be calculated just by the hospitals; how do we know they are telling the truth?

CHAIR LESLIE:
The subcommittee will now hear S.B. 264.

**SENATE BILL 264**: Revises provisions concerning the regulation of certain medical facilities. (BDR 40-15)

MR. WELCH:
The NHA worked with the HD on the language in this bill. There are similarities between S.B. 264 and S.B. 209: expression of rates and posting of sentinel events.

MARLA MCDADE WILLIAMS, B.A., M.P.A. (Deputy Administrator, Health Division, Department of Health and Human Services):
Section 1, page 2, of the HD's proposed amendment (Exhibit D) adds a definition of an adverse health event. The definition in S.B. 264 appears to combine definitions from the NQF and the AHRQ. The amendment proposes to use the NQF definition for serious reportable events in health care. As it relates to sentinel events, the AHRQ's health-care-associated infection definition is used. This change provides clear guidance as to what is reportable.

CHAIR LESLIE:
That is a better approach. Does it also include CMS, AHRQ, The Joint Commission and others involved in A.B. No. 146 of the 74th Session?

MS. WILLIAMS:
The *Nevada Revised Statutes* (NRS) have two separate systems for sentinel event reporting. The actual sentinel event report requirements are in NRS 439; NRS 439A contains the transparency and quality measures.

CHAIR LESLIE:
Is this definition broad enough to capture everything yet specific enough to regulate?

MS. WILLIAMS:
Yes.

CHAIR LESLIE:
Mr. Welch, do you agree?

MR. WELCH:
Yes.

MS. BOND:
The proposed amendment, Exhibit D, using the NQF definition, which contains 27 or 28 specific events, is too narrow for public reporting. The definition needs

to be broader. The HSC and NHCPG do not want to have two definitions. If we still have NQF, CMS, The Joint Commission and AHRQ on the Website, but in sentinel events where we have some AHRQ and NQF, there will continue to be trouble with the definition. I would like to work with the group to reach a compromise.

CHAIR LESLIE:
Could we have the same definition in both places?

MS. BOND:
If we could, that would be easier in the long term.

MS. WILLIAMS:
We have not determined what needs to be measured. If we cannot make it easier, we are comfortable with the current definition of sentinel events.

MR. WELCH:
We have tried to evolve the term "sentinel event" to include adverse health event, Exhibit C. Adverse health event is used nationally in many different contexts. An adverse health event may not be a sentinel event. We are attempting to make a distinction here to report sentinel events. To the extent adverse health event is used as a mechanism to refer to sentinel events, there should be specific parameters. If we post adverse health events, the terms need to be separated because it becomes a different reporting mechanism.

CHAIR LESLIE:
The three of you can discuss this section further.

MS. WILLIAMS:
The proposed amendment, Exhibit D, section 3, page 3, replaces the word "format" with "manner." The DHHS is not prepared to adopt the NQF and AHRQ forms which would require regulations.

CHAIR LESLIE:
There appears to be no objection to this change from Ms. Bond or Mr. Welch.

MS. WILLIAMS:
Section 3, page 3, lines 21 through 31, Exhibit D, proposes removing language relating to report format used by national organizations and is unnecessary under the current system.

CHAIR LESLIE:
Mr. Welch agrees with this change.

MS. BOND:
The AHRQ or CMS format is not an issue. We do not agree with the content. We want to finish the discussion of what is included in the report.

MS. WILLIAMS:
Section 5, line 7, page 4, Exhibit D, adds "expressed as a rate."

CHAIR LESLIE:
That is an issue to be worked on.

MS. WILLIAMS:
Section 5, lines 26 through 28, page 4, Exhibit D, proposes deleting the language related to 25 or more patients. Under the current reporting system that uses this language, of more than 100 facilities that could be reporting, only 38 meet the criteria. For purposes of sentinel events, the majority of the facilities eligible for reporting would be excluded.

CHAIR LESLIE:
We would not want that to happen. Why was the "25 or more" included in the bill?

MS. WILLIAMS:
That language is used in the National Healthcare Safety Network (NHSN).

MS. BOND:
We agree.

MR. WELCH:
We agree.

MS. WILLIAMS:
Section 5, subsection 3, paragraph (e), page 4, Exhibit D, eliminates certain facilities from reporting requirements. This is a policy decision to be made by the Legislature to protect possible disclosure based upon the facility size and events happening at any given facility.

CHAIR LESLIE:
Does the Health Insurance Portability and Accountability Act of 1996 (HIPAA) protect the patient?

MS. WILLIAMS:
We must adhere to HIPAA.

CHAIR LESLIE:
When would a patient's identity be at risk?

SENATOR BROWER:
If a facility is small, it would be easy for a person to ascertain who was a patient on any given day without seeing identified information.

MR. WELCH:
The NHA has a number of critical access hospitals, which means they have 25 care beds or less. Many of these hospitals run at a three or four census per day. If an event occurred and was reported, it would be hard to keep the individual patient's identity private.

CHAIR LESLIE:
Should the bill contain more defining language?

MR. WELCH:
We could work on it. If it were an infection, for instance, it may not be easy to identify the individual, but if it were a suicide, it would be hard to keep confidential. It would comply with HIPAA, but once it is posted on the State Website, a viewer could presume the patient's identity.

CHAIR LESLIE:
Are suicides reported as sentinel events?

MR. WELCH:
Yes, if they happen on the hospital premises.

MS. BOND:
If someone commits suicide in Caliente, for instance, everyone probably knows. By the time the incident is reported on an annual sentinel events registry, based upon the report only, a viewer would not be able to identify the patient. I do not understand the concern about this issue. I do want people's confidentiality protected.

MR. WELCH:
If need be, we can concede this issue. When we post the information, are we potentially violating patient confidentiality because it is being made public as the result of a hospital report? If it can be done in a way not in violation of HIPAA, we do not have an issue.

CHAIR LESLIE:
We need to discuss this issue further.

MS. WILLIAMS:
The event is reportable by the facility. We are trying to work with the publicly reported piece of this legislation.

MR. WELCH:
The NHA is proposing an implementation date in section 9, line 39, Exhibit D. Regulations developed by the DHHS require reporting hospital-acquired infections through the NHSN. A number of hospitals have been utilizing the NHSN system for many years. To keep the playing field equal, many of the hospitals were brought online and began posting data January 1, 2011. We want data publicly reported based upon identical time periods.

CHAIR LESLIE:
Is the date January 1, 2011?

MS. BOND:
The HSC and NHCPG would prefer the data become reportable at the time all facilities are required to report the information. The AHRQ and claims data have been available for four years. Not to lose trend, we would like to use what is

available when it is available, but we also want to be fair, so it should be used when everyone is included.

CHAIR LESLIE:
Mr. Welch, do you agree the date could be different for differing parts of the bill?

MR. WELCH:
Ms. Bond brings up a number of data sources which may or may not be included in this legislation. All hospitals were given up to January 1, 2011, to enroll. You do not just sign up for NHSN; there is an orientation process and training, all of which takes time.

MS. WILLIAMS:
If, for example, a facility were required to report all of its central-line bloodstream infections, and one or more hospitals had already been participating in the NHSN and reported those types of infections, Mr. Welch is saying the infection rates should not be publicly reported prior to implementation of the regulation.

CHAIR LESLIE:
Is January 1, 2011, the date information was required?

MR. KVAM:
The regulations were effective October 15, 2010. I will let you know the purpose of the January 1, 2011, date. The final report rolled into the system March 15, 2011.

CHAIR LESLIE:
Ms. Williams will let us know the date all facilities were ready to go.

MR. WELCH:
We will agree to whatever date is applicable to all hospitals

MS. WILLIAMS:
The DHHS proposes eliminating lines 16 through 31, section 15, page 10, Exhibit D, because it makes substantive changes to our current sentinel event system.

CHAIR LESLIE:
Are you proposing to leave in line 24, section 15, Exhibit D?

MR. WELCH:
Line 24 ties to section 16 regarding the regulations to be developed by the State Board of Health, DHHS.

The NHA is supportive of the concept of reporting readmissions. The subcommittee has received a copy of HealthInsight's "Hospital Readmissions: Background, Types, and Considerations" (Exhibit E). The NHA requests the use of a defined nationally recognized standard for what is being reported on readmissions. The CMS is the appropriate recognized guidance.

CHAIR LESLIE:
Is that what the NHA is recommending in section 16, line 12, page 10, Exhibit D?

MR. WELCH:
Yes.

MS. BOND:
We would support having readmissions reported based upon an established standard such as CMS.

CHAIR LESLIE:
Section 16, line 14, page 11, Exhibit D, replaces "preventable" with "unplanned."

MR. WELCH:
Unplanned is the word used by HealthInsight, Exhibit E. All readmissions could be posted, but there are four distinct types of readmissions. The NHA does not have a problem with posting those for which the hospital is responsible.

CHAIR LESLIE:
HealthInsight, Exhibit E, page 2, refers to the difficulty in retrieving the unplanned but preventable data. Does Joseph A. Greenway, Director, Center for Health Information Analysis (CHIA), University of Nevada, Las Vegas, have something to make the data accessible?

MR. WELCH:
Mr. Greenway testified to a software package that will help extract data. HealthInsight has performed a number of test runs utilizing the software but still has challenges with a complete reconciliation. It would be beneficial if Mr. Greenway and Deborah Huber spoke to the Committee about the software. The NHA wants to be sure what is being reported is appropriate.

CHAIR LESLIE:
Hopefully, Mr. Greenway will be able to speak with us. The NHA is not opposed to providing the data if it can be extracted.

MS. BOND:
The HSC and NHCPG prefer "preventable" readmissions. The hospital may not be responsible, but the event was preventable. There are a number of safety and quality issues related. If drill-down analysis is possible to determine those events were hospital caused, that would be great. "Preventable" does have a national definition. We are trying to get to like kind comparisons. I would like to hear from Mr. Greenway.

MR. WELCH:
HealthInsight is the peer review organization for CMS in Nevada. The document provided to the Committee, Exhibit E, is the CMS analysis of this issue. "Preventable unplanned" readmissions may be acceptable wording.

CHAIR LESLIE:
This field is evolving. I do not want to be too cautious just because we do not meet for two more years. Please attempt to come up with something reasonable and doable.

MR. WELCH:
The NHA recommends removal of section 17, lines 41 through 7, page 11, Exhibit D. This portion is limiting and would create difficulties because it identifies specific items. What the NHA is proposing allows the selection of one or more of those items.

SENATOR LESLIE:
I like that. Who would do the selecting?

MR. WELCH:
The HD would, hopefully based upon national standards.

MS. BOND:
Sections 15 and 16 impact section 17. In section 15, subsection 1, page 10, Exhibit D, the piece selected for deletion is related to section 1, the definition of an adverse health event. We need to wait to change section 15 until we have a complete definition of "adverse health event." In section 16, Exhibit D, the HSC and NHCPG propose lines 7 through 11, page 10, be deleted. We started with the reporting of 50 most frequent diagnostic related groups and 50 medical treatments for outpatients. So much has happened nationally with CMS, AHRQ, NQF and safety and quality indicators, we would like to keep the four reporting tools, but do not see a reason to limit reporting to the most frequent diagnosis-related groups which keeps us in regulation setting form. We recommend removing "The Department shall, by regulation:" in section 17, line 29, page 11, Exhibit D. As data sets are available and the State develops capacity for CMS NQF, AHRQ and The Joint Commission, if the software is available and there is a national indicator, we recommend the information be put online rather than establishing regulations which take time.

CHAIR LESLIE:
That is what I would like.

MR. WELCH:
We do not disagree, generally, with Ms. Bond's recommendation for section 16, lines 7 through 11. It may be difficult to report all of the different events which occur in a hospital on an outpatient basis; it will be significant. With respect to the inpatient functions, the NHA posts all the admissions and prices, not just the top 50. We would have to look at the practicability of posting the outpatient information.

MS. BOND:
Section 17 should be easier to implement without the regulation-setting process. We will work on this section.

MR. WELCH:
The NHA proposes deletion of section 17, subsection 1, paragraph (c), lines 17 through 19, page 12, Exhibit D. The hospitals do not always have the information if, for example, a patient is discharged from one hospital and

reenters another hospital. Mr. Greenway will be the best source to extract the data, not the hospitals.

MS. BOND:
We agree.

MR. WELCH:
Section 18, subsection 2, paragraph (e), page 12, Exhibit D, adds CMS so we have a nationally recognized standard.

CHAIR LESLIE:
This section also replaces "preventable" with "unplanned."

MS. BOND:
The HSC and NHCPG would like further discussion as to the usage of "preventable or unplanned" or "preventable and unplanned."

MR. WELCH:
Some hospitals have ambulatory surgery centers. A surgical center may not know if a patient is subsequently admitted to a hospital. Mr. Greenway is best prepared to report the information required in section 19, subsection 1, paragraph (c), lines 5 through 8, page 13, Exhibit D.

MS. BOND:
The HSC and NHCPG agree with the deletion of section 19, subsection 3, paragraph (c).

MR. WELCH:
That is the extent of the NHA's proposed amendment changes.

CHAIR LESLIE:
There are two or three issues requiring further discussion.

MS. BOND:
The HSC and NHCPG's issues are included in the proposed amendment, Exhibit D. If further issues arise, we will provide an addendum for the work session.

BARRY GOLD, (Director, Government Relations, AARP Nevada):
Having listened to the proposed amendments, the AARP supports the concept of S.B. 264. The term, whether it be sentinel event or adverse event, needs to be broad enough to include the information wanted by the public. More work needs to be done on the content of the report, which is more important than the format. If small facilities are not required to report, they will not report. Information should be timely. The word "preventable" needs to remain in S.B. 264 because people are interested in that information.

CHAIR LESLIE:
There is no further comment on S.B. 264. The subcommittee will hear discussion on S.B. 338.

**SENATE BILL 338**: Revises provisions relating to reports of certain medical and related facilities. (BDR 40-261)

MR. WELCH:
The NHA supports the concept of S.B. 338. The NHA has some proposed amendments to S.B. 338, Exhibit C, page 2. The NHA recommends adding the date all hospitals are required to report pursuant to the NHSN.

CHAIR LESLIE:
The NHA wants to add the appropriate beginning date for reporting?

MR. WELCH:
Yes. It may be either January 1, 2011, or October 15, 2010.

Section 2, subsection 2, paragraph (e), page 3 of the bill should add language requiring reports based upon CMS guidelines.

Section 3, subsection 1, paragraph (b), page 4 of S.B. 338 needs clarification. The measures of quality should be selected from this list or prioritized based upon those being studied on a national basis Otherwise, there would be hundreds of quality measures.

The NHA recommends removal of section 3, subsection 3, paragraph (c) because reporting takes place through the data Mr. Greenway receives.
The information in section 4, subsection 2, paragraph (d), lines 17 through 18, page 6 of S.B. 338 should be presented as an expressed rate.

CHAIR LESLIE:
Could the information be presented as a number and a rate? Were these changes discussed with Senator Shirley A. Breeden?

MR. WELCH:
The information could be expressed as a rate and a number. The NHA spoke with Senator Breeden last week. She acknowledged the NHA's recommendations.

RENNY ASHLEMAN (Nevada Health Care Association):
With respect to section 1, subsection 4, paragraph (b), lines 4 through 7, page 3 of the bill, the medical facilities should be compared to one another and the skilled-nursing facilities should be compared to one another. The consumer is not interested in how a nursing home compares to the University Medical Center.

CHAIR LESLIE:
Do some hospitals have skilled nursing?

MR. ASHLEMAN:
Yes, but you need to compare skilled nursing beds to skilled nursing beds.

We need to know if the nursing homes will be able to accomplish the requirements in S.B. 338 by October 1, 2011.

CHAIR LESLIE:
We will review section 2 as you suggest.

MS. BOND:
If the number 25 is removed from S.B. 264, section 5, subsection 3, to be consistent, it should also be removed in S.B. 338, section 1, subsection 2. The skilled nursing facility unit for the NHSN will probably not be ready before 2012. A reasonable implementation date should be used in the bill.

CHAIR LESLIE:
We will wait for input from Mr. Ashleman on the implementation date. What is your opinion on the 25 or more wording in this bill?

MR. ASHLEMAN:
Some of the facilities are very small. The small ones are financially burdened. I am comfortable with the 25 or more patients wording.

CHAIR LESLIE:
Mr. Gold's point is that if something bad happens, it does not matter where it happens; we should be working on prevention everywhere.

MR. ASHLEMAN:
I need to determine the administrative financial burden.

CHAIR LESLIE:
We could phase in the smaller facilities.

MR. GOLD:
Skilled nursing home information is needed to help people make decisions. I agree with the need for information on small facilities. The AARP would like the word "preventable" to remain in section 2, subsection 2, paragraph (e), line 36, page 3 of the bill.

CHARLES DUARTE (Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services):
Mr. Greenway will be able to tell you what is technically feasible, the time frame and the cost. Mr. Greenway will be available at the April 9, 2011, hearing.

CHAIR LESLIE:
We do want Mr. Greenway's input.

MR. WELCH:
Hospital reporting to NHSN is to be available February 1, 2011.

CHAIR LESLIE:
I would like all of the affected parties to discuss an implementation date.

MR. WINTERS:
Infections caught at health facilities are one of the nation's leading causes of preventable deaths. Mediocre hospital care in the Las Vegas Valley, as reported in the *Las Vegas Sun*, is evidenced by thousands of preventable injuries,

infections and deaths which can be traced to a few fundamental causes. The word is "preventable" not "unplanned." Senate Bill 209, sections 1 and 2, refer to confidentiality. The information needs to be public. The public and the taxpayers need to know, in laymen's terms, what is going on all of the time.

CHAIR LESLIE:
The discussion on S.B. 338 has concluded. The subcommittee will now hear S.B. 339.

**SENATE BILL 339**: Establishes provisions relating to the safety of patients in certain medical facilities. (BDR 40-662)

ROBIN KEITH (Nevada Rural Hospital Partners Foundation):
Mr. Ashleman, Ms. Bond, Ms. Williams and I met this morning to discuss this bill.

CHAIR LESLIE:
Between now and the next sentinel events subcommittee meeting, would you provide a mockup of your agreement? Today you could give us the highlights.

MS. KEITH:
We will do that.

Section 2 addresses informing the patient about infections in hospitals as the patient enters and leaves the hospital. We have conceptually agreed to this but need to work out the details.

The bill needs to clarify the definition of "medical facility." There are various points of view of what it means in the context of this bill. We understood from previous testimony that long-term care facilities were intended to be included.

MR. ASHLEMAN:
Traditionally, under definitions used, long-term care facilities are not included. There are differing opinions.

MS. KEITH:
How are adequate standards established and maintained for infection controls in hospitals? We are proposing a two-pronged approach from which a facility can choose. The purpose is to be sure, whichever choice is made, the standards

applied in hospitals are based on evidence. The first choice would be for a facility to adopt as its infection control policy the then current national guidelines appropriate for the facility's scope of service. The choice would be made from reputable infection control organizations such as the Association for Professionals in Infection Control and Epidemiology Inc. (APIC), the National Centers for Decease Control and Prevention or the World Health Organization. The other choice would be to develop and implement facility-specific infection control policies under the supervision of a certified infection preventionist.

CHAIR LESLIE:
The choice would be either a national organization's current guidelines or the alternate which would probably be chosen by a larger hospital.

MS. BOND:
The APIC is a solution for the rurals, but the urban hospitals would be held to both.

MS. KEITH:
Ms. Bond is correct. Science-based standards must be used. The choice would not necessarily be size-specific. The smaller facilities would probably not hire a certified preventionist. The larger facilities would not necessarily need to use the standards from national organizations if they had a certified preventionist.

CHAIR LESLIE:
A certified preventionist would likely use the national standards.

MS. KEITH:
There is no reason to preclude them from using the national standards. Small hospitals have benefitted from the HD's epidemiology team approach which should be codified in this bill.

Facility infection control officers would be required to complete a nationally recognized infection control training program such as the APIC's "Essentials of Infection Control Elimination" which is available online. The ratio of people having this training should be 1 person to 100 beds. Infection control officers bring a higher level of knowledge to the facility.

Facilities with 200 beds or more would be required to employ or contract with a certified infection preventionist who could be shared by all facilities with common ownership.

MS. BOND:
We need to make sure Senator Breeden supports these changes. The outstanding issues needing consideration are patient notification, public posting and whether the patient safety plans need a component which includes who is responsible for inspection control.

MR. GOLD:
Notification of hospital infections should be made upon admission and discharge as well as while the patient is in the hospital. Long term care should be included in S.B. 339. There should be someone in the hospital at all times to implement the safety policy.

GRAHAM GALLOWAY (Nevada Justice Association):
The Nevada Justice Association supports S.B. 339; however, we recommend the deletion of privilege and protection set forth in section 7, subsection 5, lines 39 through 41, page 5. If you are going to increase the dissemination of information on sentinel events, adverse health events and infections, this provision undercuts that concept and is unnecessary. The protection and privilege here is the privilege provided to a peer review committee at a hospital. The patient safety committee issues differ.

CHAIR LESLIE:
Are you recommending removal of a portion of existing law?

MR.GALLOWAY:
Correct.

CHAIR LESLIE:
We will take testimony on Mr. Galloway's point at the next meeting.

MS. WILLIAMS:
Full implementation on January 1, 2012, was discussed.

MR. WINTERS:
I support S.B. 339. These things are already being implemented elsewhere. As of 2009, Medicare will no longer pay for hospital-acquired injuries or infections. As of July 1, 2011, neither will Medicaid. If the patient safety issues are not addressed, fraud could become a problem.

CHAIR LESLIE:
The hearing on S.B. 339 is closed. The subcommittee will hear S.B. 340. This bill requires hospitals and surgical centers for ambulatory patients to report information related to physicians.

**SENATE BILL 340**: Revises provisions relating to programs to increase public awareness of health care information. (BDR 40-663)

MR. GOLD:
People need to know who their surgeon is and what he has done in the past.

MS. BOND:
The HSC and NHCPG support S.B. 340. The HSC recommends reporting, in addition to what is proposed in the bill, the 30-day mortality rate and the 30-day morbidity rate, as well as the urinary tract infections, the renal failure and the ventilator problems within 48 hours. Other specific issues should also be reported. We would like to talk with the stakeholders about adding this information as the capacity for reporting and the data is available.

CHAIR LESLIE:
Will you provide this information by next week?

MS. BOND:
Absolutely.

MR. DUARTE:
The fiscal note for this bill is primarily related to data collection and reporting requirements. Mr. Greenway estimates a 0.2 full-time equivalent person totaling $33,600 for the biennium will be needed. The cost of any new requirements should be considered.

MR. WELCH:
The DHHS is responsible for posting this information. Mr. Greenway has indicated he can extract the information from data already being collected. The NHA is neutral on S.B. 340.

CHAIR LESLIE:
The affected parties should prepare amendment mock-ups as soon as possible and send them to Ms. Lyons and the subcommittee before Monday.

MS. LYONS:
Legal counsel has requested statements of intent with amendment mock-ups. Intent is most helpful in drafting the language of a bill.

CHAIR LESLIE:
There being no further matters to come before the subcommittee, this meeting is adjourned at 3:02 p.m.

RESPECTFULLY SUBMITTED:

Sandra Small,
Committee Secretary

APPROVED BY:

Senator Sheila Leslie, Chair

DATE:

| EXHIBITS | | | |
|---|---|---|---|
| **Bill** | **Exhibit** | **Witness / Agency** | **Description** |
| | A | | Agenda |
| | B | | Attendance Roster |
| S.B. 209 S.B. 264 S.B. 338 | C | Bill Welch | NHA Outline of Proposed Amendments |
| S.B. 264 | D | Marla McDade Williams | Proposed Amendment |
| S.B. 264 | E | Bill Welch | HealthInsight's "Hospital Readmissions: Background, Types, and Considerations" |