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

Seventy-sixth Session
April 12, 2011

The subcommittee of the Senate Committee on Health and Human Services was called to order by Chair Sheila Leslie at 11:12 a.m. on Tuesday, April 12, 2011, in Room 2135 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to the Grant Sawyer State Office Building, Room 4412, 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
Joseph A. Greenway, Director, Center for Health Information Analysis, University of Nevada, Las Vegas
Bobbette Bond, Health Services Coalition; Nevada Health Care Policy Group
Marla McDade Williams, B.A., M.P.A., Deputy Administrator, Health Division, Department of Health and Human Services
Robin Keith, Nevada Rural Hospital Partners Foundation
Renny Ashleman, Nevada Health Care Association
Graham Galloway, Nevada Justice Association
Bill Bradley, Nevada Justice Association
Steve Winters
Charles Duarte, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services

CHAIR LESLIE:
The sentinel events subcommittee is charged with hearing five transparency bills today. We will first hear Senate Bill (S.B.) 209. The only issue with this bill is the rate.

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

BILL WELCH (Nevada Hospital Association):
The Nevada Hospital Association (NHA) proposed an amendment to specify that events be expressed as a rate rather than a raw number. We are now recommending the information be expressed as a rate and a number. The Centers for Medicare & Medicaid Services, national Centers for Disease Control and Prevention, The Leapfrog Group and other organizations typically represent these events as a rate rather than a whole number. Bobbette Bond and I have agreed to disagree on this issue. If it is going to be a number, the NHA recommends first showing the rate as it balances the comparison between all hospitals and allows the consumer to make informed decisions. Using numbers only does not provide a fair comparison of larger to smaller facilities. The NHA suggests a consumer could click on the rate to see the number and an explanation.

CHAIR LESLIE:
That may be a good compromise. The first thing a consumer would see is the rate. To gain further information one would click on the rate.

MR. WELCH:
That is the NHA's recommendation.

JOSEPH A. GREENWAY (Director, Center for Health Information Analysis, University of Nevada, Las Vegas):
I agree with Mr. Welch. The rate is important for understanding the quality of care between hospitals, both large and small. It is possible, and I like the idea, to click on the rate to get additional information.

BOBBETTE BOND (Health Services Coalition; Nevada Health Care Policy Group):
The Health Services Coalition (HSC) and Nevada Health Care Policy Group (NHCPG) spoke with Mr. Greenway, Center for Health Information Analysis

(CHIA) about options. The HSC and NHCPG believe consumers need both a rate and a whole number. The best solution is to use both.

CHAIR LESLIE:
Is the presentation of the rate and number, as Mr. Welch suggests, acceptable?

MS. BOND:
The State Website is difficult to use. If Mr. Greenway can make the process easy with an easy click, it could work. It sounds as though it could be one or two additional clicks. It is difficult to get to those steps on the Website. We were hoping to make it as easy as possible.

MR. GREENWAY:
If the Website displays both the number and the rate with an additional click to explain further what the numbers do and do not mean, would that be an acceptable compromise?

MR. WELCH:
The argument against that suggestion is similar to Ms. Bond's problem with additional clicks. There is an informational explanation on the Website. The Website could provide additional information on an individual hospital by simply requiring a click on the rate.

MARLA MCDADE WILLIAMS, B.A., M.P.A. (Deputy Administrator, Health Division, Department of Health and Human Services):
Senate Bill 209 originated in the Legislative Committee on Health Care and is specific to what is reported through the National Healthcare Safety Network (NHSN). The bill clarifies the language so the Department of Health and Human Services (DHHS) can report the information. The NHA wanted a report date included in this bill.

MR. WELCH:
It may be appropriate to have the date, October 15, 2010, referenced in this bill. The law and regulations use that date. There was communication giving the hospitals until February 1, 2011, due to difficulties signing up with NHSN. Most of the hospitals were diligent in signing, but were not able to complete the training timely. Most hospitals did not go live until the first of the year.

MS. WILLIAMS:
The regulations became effective October 15, 2010. The DHHS has sole access to the data from each hospital. The DHHS produces a report that is transmitted to the transparency Website.

CHAIR LESLIE:
Are you suggesting the date be added to S.B. 209?

MS. WILLIAMS:
I defer to the Chair. The date has been suggested in other bills. Since S.B. 209 deals only with NHSN, it would make sense to amend the date into this bill and remove the provisions in the other bill, if there is an intent to consolidate bills.

CHAIR LESLIE:
There is no intent to consolidate bills.

MR. WELCH:
The NHA concurs with separate bills and with adding the date.

CHAIR LESLIE:
The consensus of the subcommittee is a recommendation to the Senate Committee on Health and Human Services to amend and do pass S.B. 209. The amendment will add an October 15, 2010, effective date and include the rate and whole number.

CHAIR LESLIE:
The subcommittee will 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):
A number of stakeholder meetings were held involving the hospitals, culinary, AARP, DHHS, long-term health-care parties and Senator Shirley A. Breeden. The resulting conceptual amendment for S.B. 339 (Exhibit C), which I will read, has been provided to the subcommittee. The changes to section 2, including an addition providing for immunity, are shown on page 1 of the conceptual amendment, Exhibit C. The immunity addition is an attempt to protect against

lawsuits in situations such as when a patient is received with an infection which appears to have been acquired in a different facility.

The conceptual amendment suggests removal of all requirements for certified infection preventionists, pages 2 through 4, Exhibit C, because infection preventionists are expensive and scarce. As shown on those pages, we propose to replace those portions of the bill with a requirement that certain facilities have either a certified infection preventionist or a designated infection control officer.

A new section proposed to be added to the bill will require facility infection control policies, page 3, Exhibit C. We want hospital policies to be science based and based upon authoritative sources.

A new section requiring the Health Division to continue its current level of facility support for infection control and prevention is recommended, page 4, Exhibit C.

Confusion exists in the bill regarding the definition of medical facilities. Recommendations for additions to the definition are shown in the conceptual amendment, section 4, page 4, Exhibit C.

The conceptual amendment recommends posting patient safety plans on the DHHS Website, section 5, pages 4 and 5, Exhibit C.

In the conceptual amendment, section 6, page 5, Exhibit C, a requirement is added to designate in the safety plan a person responsible at all times for infection control.

The effective dates for S.B. 339 are recommended in the conceptual amendment, page 6, Exhibit C.

RENNY ASHLEMAN (Nevada Health Care Association):
The Nevada Health Care Association was part of the working group and is in accordance with the conceptual amendment.

MS. BOND:
The HSC and NHCPG agree with the conceptual amendment.

CHAIR LESLIE:
Are there any questions regarding the immunity provisions?

GRAHAM GALLOWAY (Nevada Justice Association):
Generally, the Nevada Justice Association (NJA) supports S.B. 339. The increased collection of information and dissemination of the information are worthy goals. The NJA has two concerns. The privilege contained in section 7, subsection 5, lines 39 through 41, page 5 of S.B. 339 gives the patient safety committee (PSC) the peer review privilege already embodied in the *Nevada Revised Statutes*. The NJA does not believe this is necessary or appropriate. If the goal is to provide the public with more information regarding infections, this section undercuts that goal. If this section renders the proceedings of the PSC privileged, then no one would be permitted to look into what has transpired at those committee meetings.

The NJA did not participate in the development of the conceptual amendment. A new section is proposed providing immunity for the disclosing facility from third-party lawsuits, page 1, Exhibit C. It is unclear why immunity is necessary. If information about an infection is being disclosed to a patient, how would a suit result? If the information is truthful and accurate, there is no basis for a lawsuit. If immunity is provided, the goal of accuracy is undercut. The NJA is opposed to this proposed new section.

CHAIR LESLIE:
Why is the immunity section needed?

MR. ASHLEMAN:
A statement made that a problem or disease was acquired at another facility would be the result of an in-house investigation. It is unlikely an in-house committee would reach a conclusion if it opens the possibility of a suit. The objective is to be free to disclose an opinion.

CHAIR LESLIE:
The worry is a facility would be sued because the patient was told of acquiring the problem at a different facility.

MR. GALLOWAY:
It appears there is a desire to point the finger at another facility but not take responsibility for that action.

MR. ASHLEMAN:
It would be better to remove the immunity recommendation in the conceptual amendment if the burden on the hospitals is 100 percent accuracy.

CHAIR LESLIE:
I can see both sides of this issue.

SENATOR BROWER:
I would like to see the actual language providing immunity. The concept language makes sense to me.

CHAIR LESLIE:
We need to decide if the immunity section should be added to the bill.

MR. ASHLEMAN:
The suggestion in the concept language is that it be stated whether the infection was acquired at the reporting medical facility. If that is all that is being told to anyone, there probably is not a liability problem. That is not the same as saying where the problem was acquired.

CHAIR LESLIE:
We will report both sides of this issue to the full Senate Committee on Health and Human Services.

MR. WELCH:
We need to be careful about changing existing law. The PSC is responsible for the review of specific patient detailed information which would be included in the minutes. The PSC also reviews sentinel events. There are specific provisions in the law for the discoverability of that information. With the proposed changes to section 5, page 4, Exhibit C, the PSC would need to be restructured.

CHAIR LESLIE:
This is not the time to change existing law. There should be a full hearing on this issue.

SENATOR BROWER:
My concern is the effect it would have on the discussions at the PSC meetings.

BILL BRADLEY (Nevada Justice Association):
There is a peer review committee (PRC) at every hospital. That is where reviews occur which are entirely privileged, and should be so they can get to the root cause analysis. The NJA does not have a problem with the PRC maintaining that privilege. I do not understand why the PSC and the PRC need privilege.

CHAIR LESLIE:
That issue needs to be discussed in a different context, not today, because it is beyond the scope of S.B. 339.

MR. BRADLEY:
If the family does not receive a sentinel report, there still is secrecy.

CHAIR LESLIE:
The conceptual amendment includes protocols for informing a patient of infection, page 1, section 2, subsection 1, paragraph (c), Exhibit C.

STEVE WINTERS:
My mother died with ten hospital-acquired infections. None of the infections were documented when she entered the hospital. It was documented when the infections were acquired. Where the infection is acquired should be documented and should be public information, especially for the family and patient.

CHAIR LESLIE:
The protocol is for how the patient would be informed.

MR. WINTERS:
If the family has power of attorney (POA) and the patient is unconscious, the family must be involved.

MS. KEITH:
The intent is to inform the patient or the patient's representative.

MS. BOND:
The HSC and NHCPG want something in the bill ensuring the patient is notified of a hospital-acquired infection. Extending the notification to the family is acceptable if it does not put the bill at risk.

MR. BRADLEY:
It takes two weeks to acquire a legal guardianship. Upon admission to a hospital, a patient has the ability to designate someone with whom to share patient information. If the person is designated on a form, there should be no need for additional legal maneuvering to inform the designated representative. Guardianships and POAs do not happen quickly.

MR. ASHLEMAN:
The term on the hospital form is "designated representative."

CHAIR LESLIE:
The conceptual amendment requires certain facilities have a certified infection preventionist either employed or contracted.

MR. WINTERS:
The Nevada Rural Partners Foundation recommends a certified infection preventionist on a part-time basis and states it would be expensive. I do not believe a hospital infectionist is too expensive. Medicare pays to treat many infections. A hospital infectionist available at all times could save the hospitals money. Someone should be in every intensive care unit 24 hours a day.

CHAIR LESLIE:
The subcommittee could recommend that the Senate Committee on Health and Human Services have additional discussion on the immunity issue in S.B. 339.

MARSHEILAH LYONS (Policy Analyst):
The subcommittee wants to clarify the immunity provision and include a designated representative for patient notification.

CHAIR LESLIE:
That is correct. The subcommittee will now hear S.B. 338.

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

MR. GREENWAY:
I have submitted two recommended changes to S.B. 338 (Exhibit D). In addition to rates, I recommend incident counts be added, section 2, subsection 2, paragraph (e), page 3, Exhibit D. As it relates to posting numbers and rates, I

assume whatever goes into S.B. 209 will also be in S.B. 338. My second recommendation is that where readmissions are mentioned in the bill, it be preceded by the words "potentially preventable." Mr. Welch, Ms. Bond and I came to a consensus on this wording and the need for a definition. Potentially preventable readmission should be defined within the text of the bill as I have indicated, Exhibit D.

CHAIR LESLIE:
The rate issue was discussed in S.B. 209 and does not require further discussion. Potentially preventable readmission would be defined within the text of the bill as an "unplanned readmission within no more than 30 days of the initial admission, clinically related and preventable."

MR. WELCH:
The NHA concurs with Mr. Greenway's recommended language.

MS. BOND:
The HSC and NHCPG concur with Mr. Greenway's recommended language.

CHAIR LESLIE:
I also like this language.

CHARLES DUARTE (Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services):
I would like Mr. Greenway, at some point, to discuss the fiscal impact of the modified bills.

MS. BOND:
Mr. Greenway, Mr. Welch and I developed the mock-up amendment to S.B. 338 (Exhibit E). The date for facility reporting would be inserted in section 1, lines 31 and 35, page 2, Exhibit E. The date should be when all hospitals are able to report.

MR. WELCH:
Ms. Williams stated October 15, 2010, is required in existing law. The intent is there would not be a noncompliance violation because hospitals were not able to log in or receive NHSN training by that date.

MS. WILLIAMS:
There should be some recognition that a new provider is being added to the NHSN reporting system. We are adding skilled nursing facilities. The deadline for the skilled nursing facilities to come online is January 1, 2012.

CHAIR LESLIE:
Should the skilled nursing date be added to S.B. 338?

MS. WILLIAMS:
January 1, 2012, should be the bill's implementation date. Sections 5 and 6, page 6, Exhibit E, give an effective date of October 1, 2011, which is an aggressive date the DHHS may not be able to meet.

MS. BOND:
I agree with the January 1, 2012, effective date.

MR. WELCH:
I agree with the January 1, 2012, effective date.

MS. BOND:
The amendment, page 2, subsection 4, paragraph (b), line 1, Exhibit E, changes "may" to "shall."

We are in agreement that the readmissions changes recommended in the mock-up, section 2, subsection 2, paragraph (e), lines 34 through 38, page 3, Exhibit E, can be replaced with the language recommended by Mr. Greenway, Exhibit D.

Section 3, subsection 1, paragraph (c), page 4, Exhibit E, is removed because the hospital will not have the information.

Mr. Greenway does not believe the DHHS is ready to provide the outpatient information required in section 4, subsection 1, paragraph (a), subparagraph (2), line 17, page 5, Exhibit E.

Section 4, subsection 2, paragraph (d), line 18, page 6, Exhibit E, adds the requested rate and number language as discussed in S.B. 209.

CHAIR LESLIE:
The rate and number discussion can apply to all bills and will be discussed in the full Senate Committee on Health and Human Services.

We will close the discussion on S.B. 338 and open the discussion on S.B. 340.

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

MR. GREENWAY:
I am recommending the deletion of "principal surgical procedure and secondary," section 2, subsection 2, paragraph (e), lines 17 and 18, page 3 of S.B. 340, leaving in "procedure." We have no way of determining principal from secondary surgical procedure in outpatient data.

CHAIR LESLIE:
Since there is no disagreement, the subcommittee will accept Mr. Greenway's proposed change to S.B. 340 and make that recommendation to the full Senate Committee on Health and Human Services.

The subcommittee will hear discussion on S.B. 264.

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

MR. GREENWAY:
I have provided the subcommittee with my recommended changes related to readmissions in S.B. 264 (Exhibit F).

MS. BOND:
Mr. Welch, Chris Bosse of Renown Health and I reviewed S.B. 264. The subcommittee has been provided with intent language and an amendment mock-up (Exhibit G).

CHAIR LESLIE:
We should focus on the intent since the bill drafters will have to rewrite the bill.

MS. BOND:
The definition of sentinel event would be revised, item 1, Exhibit G. There has been a definition of sentinel events on the books for a long time. We are fine with either the existing definition or the proposed definition. The suggested definition change was to tighten up what would be reportable because the existing definition of sentinel events refers to something that is unexpected and something with a risk thereof. Ms. Williams should make the determination on which definition to use.

MR. WELCH:
I agree with Ms. Bond's comments. The NHA would like to use the term "sentinel events" because adverse health event takes on a multitude of definitions. We can accept either the existing definition of sentinel events or the one in the proposed amendment, page 1, Exhibit G.

CHAIR LESLIE:
What is the difference between the sentinel event definition we have in existing law and what is in the mock-up amendment?

MS. WILLIAMS:
The difference is unexpected and a risk thereof.

MS. BOND:
The intent of the proposed amendment is to get rid of the ambiguity of unexpected and risk thereof, but you lose the nationally recognized definition of sentinel event. The definition in the *Nevada Revised Statutes* is nationally recognized and comparable to other states.

CHAIR LESLIE:
Which definition would the DHHS prefer?

MS. WILLIAMS:
The DHHS and the facilities struggle with the ambiguity when trying to comply. The proposed amendment removes the ambiguity. The DHHS can implement either definition. Removing unexpected and the risk thereof from the definition is a policy decision.

SENATOR BROWER:
I am comfortable with the definition in the proposed amendment, item 1, Exhibit G. Where did the term "sentinel event" come from?

MS. WILLIAMS:
The Legislature looked at a variety of ways sentinel event information was reported. It is a combination of definitions in use at the time. The intent of sentinel is to allow you to make a decision and determine if there is a need to respond to the event. It is a trigger to let others know of the event.

MR. WELCH:
Sentinel event is a nationally recognized term.

CHAIR LESLIE:
The proposed amendment's definition appears to be more precise. Does Nevada need a better definition than what is commonly used?

SENATOR BROWER:
Is the national trend toward a different definition or a different term? We should use whatever is most common.

MS. BOND:
The bill was created in two parts. The first was to get rid of sentinel event and go to the words "adverse health event." We have backed off that idea. The question now is whether the definition of sentinel event should be more precise or whether we should retain the definition used for at least the last 20 years.

SENATOR BROWER:
Is the definition in the proposed amendment the new one?

MS. BOND:
Yes.

CHAIR LESLIE:
The old definition appears in the bill's digest. The problem lies with the words "unexpected" and "risk thereof." Is the problem with defining what is expected and what is unexpected?

MS. WILLIAMS:
Yes. As of 2009, there are tools available to implement whatever definition is in place. There is a hearing and appeal process if someone disagrees with the DHHS's decision.

SENATOR BROWER:
The proposal is to eliminate "or risk thereof."

MS. BOND:
We would eliminate "unexpected" and "or the risk thereof." By definition, a sentinel event is unexpected.

SENATOR BROWER:
Would removing "or the risk thereof" unreasonably narrow the scope? It would not account for a near miss.

MS. WILLIAMS:
That is correct.

SENATOR BROWER:
The policy decision is whether or not we want to include near misses.

MR. WELCH:
The NHA proposed the original definition of sentinel event because it is specific and clear. Since 2009, if a hospital does not comply, the DHHS has the ability to enforce and apply penalties. The language in the proposed amendment was received from DHHS when we were trying to build a consensus.

CHAIR LESLIE:
We should try the nationally recognized definition of sentinel event for two years. If it does not work, we can look at it again.

SENATOR BROWER:
I would defer to Ms. Williams.

MS. WILLIAMS:
The DHHS is comfortable with Senator Leslie's suggestion of waiting for two years to see how the definition works.

MS. BOND:
With the decision to use the existing definition of sentinel event, items 2 and 3 are no longer needed, page 1, Exhibit G. We may not need the recommendation to clarify what is now being reported, item 4, page 1, Exhibit G. Since the DHHS has regulations in place, I am fine with not implementing this part of the proposed amendment.

MR. WELCH:
I agree to the use of the existing definition.

CHAIR LESLIE:
We do not need the clarifying language recommended in item 4, Exhibit G.

MS. BOND:
The proposed amendment includes a requirement to post health-care information by rate and number for sentinel events by facility, item 5, page 1, Exhibit G.

CHAIR LESLIE:
We have accepted the rate and number recommendation and will discuss with the full Senate Committee on Health and Human Services how they would be displayed.

MS. BOND:
The proposed amendment removes the restriction of 50 inpatient procedures for public reporting, item 6, page 1, Exhibit G. The technology, data and capacity are beyond that number. We have not included outpatients because the data is not ready.

MR. WELCH:
The NHA concurs.

MR. GREENWAY:
I concur.

MS. BOND:
The proposed amendment, item 7, page 1, Exhibit G, recommends future quality indicators be posted publically when the State has the capacity available as long as the quality indicators are based upon the four national data sets already in statute. The process has been that anytime a new data set is posted, it is

screened by the hospitals; they can validate that the data is accurate before it goes live. Regulation setting has been a barrier.

MR. WELCH:
The NHA agrees as long as the quality indicators are based on available data and are driven by the nationally recognized organizations. If every indicator is required, as stated in the original bill, it would not be feasible to provide hundreds of postings.

MR. DUARTE:
We need to be sure not to exceed CHIA's capacity to publish the information. I like the proposed language. The bill could be permissive. If the DHHS is going to request new information from providers, new regulations may be needed.

MR. GREENWAY:
The collection of additional information is the most expensive part of any project. There would be a fiscal impact, and additional regulations would be required.

MS. BOND:
The inpatient hospital data is in a separate section of statute than the section for ambulatory center data. This proposed amendment could be limited to inpatient and hospital-based data to avoid new regulations.

MR. GREENWAY:
I would like to include the ambulatory surgical center and the outpatient data. The information is being collected, and there are indicators being developed for these data sets. I would like to post the data as the national standards are developed. Generating new indicators based upon existing data would not have a fiscal impact.

CHAIR LESLIE:
Will making the bill permissive give the State the ability to proceed without further regulation?

MS. BOND:
The language should be clear that regulations are not needed for these postings unless new data is collected. We will work on clarifying the language.

Item 8, page 1, Exhibit G, of the proposed amendment omits the specific adverse events listed in section 17 of S.B. 264.

MR. WELCH:
The NHA wants to make sure the readmission language used in S.B. 388 is also used in S.B. 264.

MS. BOND:
The HSC and NHCPG agree. The readmissions and effective date recommendations in the proposed amendment, items 9 through 14, page 1, Exhibit G, have been addressed in the discussion on S.B. 388.

If hospitals have a long trend and have been using the NHSN for a long time and are showing success, they can voluntarily have that data posted.

CHAIR LESLIE:
Does the voluntary posting need to be in statute?

MS. BOND:
No.

MR. WELCH:
The NHA does not have an issue as long as it is voluntary.

MS. WILLIAMS:
If it is not in the statute, the DHHS would not have the authority even if the hospital consented.

CHAIR LESLIE:
I do not see why we would not allow a hospital to post the information if they choose to do so.

MS. BOND:
The proposed amendment omits the 25 average daily census for medical facilities reporting to the NHSN, item 15, page 1, Exhibit G. The HSC and NHCPG are neutral on this proposal.

MR. WELCH:
The NHA conceded to this request. The NHA's concern is if the data cell is too small and is posted, it will be easy to identify an incident.

CHAIR LESLIE:
I would like to include it if the facilities are willing and able. We should err on the side of transparency. It should not matter what facility you are in; if something happens, it should be addressed.

MS. BOND:
Section 5, subsection 3, paragraph (e), page 5, Exhibit G, recommends new language to protect patient identity.

MR. WELCH:
To the extent this recommendation protects patient identity because the data cells are too small, the NHA supports this change.

MS. KEITH:
The proposed change to section 17, subsection 1, paragraph (a), subparagraph (2), line 8, page 12, Exhibit G, relates to the ability of the DHHS to regulate measures of quality for hospitals. The words "prescribe a reasonable number of" have been deleted. The Nevada Rural Hospital Partners Foundation does not want to open the door to a requirement that hospitals report on hundreds of quality measures. It is burdensome for a hospital to abstract a chart manually to get to a quality measure.

MS. BOND:
There was no intent to require new data or information from the hospitals. It would always be within the content of the claims data and what is developed through quality indicators already in statute.

MR. DUARTE:
The DHHS will update fiscal notes as Mr. Greenway reports on costs associated with S.B. 264, S.B. 340 and S.B. 338.

CHAIR LESLIE:
The subcommittee is comfortable with presenting these recommendations to the full Senate Committee on Health and Human Services.

MR. GREENWAY:
A 0.4 full time equivalent requirement (FTE) of $67,200 for the biennium is needed for implementation of S.B. 338. The same is required for S.B. 264. There is duplication in S.B. 338 and S.B. 264. If both bills are passed, the requirement would not be 0.8 FTE; the requirement would be 0.4 FTE because of the duplication. There will be a 0.2 FTE requirement of $33,600 for the biennium to implement S.B. 340.

CHAIR LESLIE:
These recommendations will be discussed in the full Senate Committee on Health and Human Services. There being no further business, this meeting is adjourned at 12:56 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. 339	C	Robin Keith	Expanded Conceptual Amendment
S.B. 338	D	Joseph A. Greenway	Written Testimony
S.B. 338	E	Bobbette Bond	Mock-up Amendment
S.B. 264	F	Joseph A. Greenway	Simplified Version of his SB264 Amendment
S.B. 264	G	Bobbette Bond	Mock-up Amendment