MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON COMMERCE AND LABOR

Seventy-Seventh Session
May 8, 2013

The Committee on Commerce and Labor was called to order by Chairman David P. Bobzien at 1:38 p.m. on Wednesday, May 8, 2013, in Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at nelis.leg.state.nv.us/77th2013. 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:

Assemblyman David P. Bobzien, Chairman
Assemblywoman Marilyn K. Kirkpatrick, Vice Chairwoman
Assemblywoman Irene Bustamante Adams
Assemblywoman Maggie Carlton
Assemblyman Skip Daly
Assemblywoman Olivia Diaz
Assemblyman John Ellison
Assemblyman Jason Frierson
Assemblyman Tom Grady
Assemblyman Ira Hansen
Assemblyman Cresent Hardy
Assemblyman James W. Healey
Assemblyman William C. Horne
Assemblyman Pete Livermore
Assemblyman James Ohrenschall

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Senator Justin Jones, Clark County Senatorial District No. 9
Senator Barbara Cegavske, Clark County Senatorial District No. 8
Senator Joseph Hardy, Clark County Senatorial District No. 12

STAFF MEMBERS PRESENT:

Kelly Richard, Committee Policy Analyst
Matt Mundy, Committee Counsel
Leslie Danihel, Committee Manager
Julie Kellen, Committee Secretary
Olivia Lloyd, Committee Assistant

OTHERS PRESENT:

John D'Angelo, Chief Executive Officer, Banner Churchill Community Hospital, Fallon, Nevada
Robert Groves, Senior Medical Director, Clinical Performance, Banner Health, Phoenix, Arizona
Alfredo Alonso, representing Banner Health
Lawrence Matheis, representing Nevada State Medical Association
Joan Hall, President, Nevada Rural Hospital Partners
Keith Lee, representing Board of Medical Examiners
Bill Welch, President and Chief Executive Officer, Nevada Hospital Association
Liz MacMenamin, Vice President, Government Affairs, Retail Association of Nevada
Kam Gandhi, Pharmacist, Albertsons and Savon, Las Vegas, Nevada
Elisa Cafferata, President and Chief Executive Officer, Nevada Advocates for Planned Parenthood Affiliates
S. Paul Edwards, General Counsel, State Board of Pharmacy
J. David Wuest, Deputy Secretary and Inspector, State Board of Pharmacy
Michael Edwards, Physician, Las Vegas, Nevada
Gregory Juhl, President, Nevada Chapter, American College of Emergency Physicians
Linda Gray Murphy, representing American Board of Physician Specialties
Denise Selleck Davis, Executive Director, Nevada Osteopathic Medical Association
James Overland, Sr., President, Nevada Chiropractic Association
Tiffany Stevens, Executive Director, Tennessee Chiropractic Association
Marlene Lockard, representing Nevada Chiropractic Association

Roper Dollarhide, Vice President, Nevada Chiropractic Association
Joseph Nicola, Chiropractic Physician, Las Vegas, Nevada
Derek Day, Chiropractic Physician, Anthem Chiropractic, Henderson, Nevada
Annette Zaro, Chiropractic Physician, Las Vegas, Nevada
Stephanie Youngblood, Board Member, International Chiropractic Association
Benjamin Lurie, Vice President, Chiropractic Physicians' Board of Nevada
Gary Landry, Executive Director, State Board of Cosmetology
Frederick Olmstead, General Counsel, State Board of Nursing
Paula Berkley, representing Board of Occupational Therapy; State Board of Physical Therapy Examiners
Neena Laxalt, representing Board of Dispensing Opticians
Rodney Moore, Operational Manager, Carson City Beauty Academy, Carson City, Nevada
Richard Moreira, Private Citizen, Carson City, Nevada
Dennis Wood, General Counsel, Marinello Schools of Beauty, Beverly Hills, California
Joyce Mikesell, representing International Academy of Style, Reno, Nevada
Sandy Dunham, Owner, Academy of Hair Design, Las Vegas, Nevada
RoseAnn Perea, representing Supercuts, Las Vegas, Nevada
Kristie Chiles, Regional Executive Director, Euphoria Institute, Las Vegas, Nevada
Helen Foley, representing Marriage and Family Therapy Association of Nevada
Vance K. Farrow, Industry Specialist, Health Care, Governor's Office of Economic Development

Chairman Bobzien:
[Roll was called.] We are going to begin our business this afternoon with Senate Bill 327 (2nd Reprint). I will invite our colleague Senator Jones to the table.

Senate Bill 327 (2nd Reprint): Revises provisions relating to health care professions. (BDR 54-772)

Senator Justin Jones, Clark County Senatorial District No. 9:
I appreciate the opportunity to present Senate Bill 327 (2nd Reprint). Telemedicine is the practice of using secure videoconferencing technology to enable long-distance medical care between a patient and a health care provider. In Nevada, we are not able to fully utilize the telemedicine system developed

because of certain restrictions and limitations. Senate Bill 327 (2nd Reprint) seeks to address those barriers.

As we consider the health care workforce shortage in Nevada and across the nation, the increased use of telemedicine can only help our efforts to provide quality care to a broad range of individuals no matter where they may reside.

I am honored to be here today with representatives of Banner Health and others to present the measure in detail and provide a section-by-section overview of the bill. First is John D'Angelo, who is head of the hospital in Fallon. He will be addressing this.

John D'Angelo, Chief Executive Officer, Banner Churchill Community Hospital, Fallon, Nevada:

Before introducing our main speaker, Dr. Robert Groves, I would like to provide you with some background on Banner Health and Banner Churchill Community Hospital. [Read from written testimony (Exhibit C).]

Banner Health is striving to transform from a clinical delivery organization to a clinical quality organization performing at the highest level. [Continued to read from written testimony (Exhibit C).]

In 2012, Banner Health was named as one of the top five largest health systems in the country based on clinical performance by Truven Health Analytics, which is a health care provider of information and solutions to improve the cost, quality, safety, and customer satisfaction of health care. Banner Health has achieved this distinction in three out of the past four years. [Continued to read from written testimony (Exhibit C).]

Robert Groves, Senior Medical Director, Clinical Performance, Banner Health, Phoenix, Arizona:

My goal today is to present some background on why this transition is necessary and the way we deliver health care to give you some insights into how it has worked in some other systems. I will give you an overview of how the system works because it is more complex than just telemedicine. I will show you some outcomes for Banner Health, of which we are quite proud. We would like to continue to provide that service, and we would also like to be able to provide it to our colleagues in Fallon.

[A PowerPoint presentation was shown (Exhibit D).] This is what the iCare system looks like from behind the camera, as we call it. You will see there is a gentleman with six computer screens in front of him. What he has access to is real-time, firsthand information on all of the vital signs that are streaming

from that patient's bed, as well as all of the data in the electronic medical record, and with one of those, you will see he has the ability, with a high-resolution pan-tilt zoom camera, to be in the room virtually with that patient at a moment's notice.

There are many reasons why this change makes sense. I think most of you are familiar with some of the challenges we have going forward in health care, so I will spend a lot of time here. We have a rapidly aging population, which will require and consume more resources, including critical care. Nursing demand has continued to outstrip nursing availability. The demand for intensivists, or intensive-care physicians, is in the same situation nationally and in the Western states. Historically, we also have a double standard of care. There was a recent article in the *CHEST Journal*, the publication for physicians who practice lung diseases and critical-care medicine and surgery, that suggested that if you are admitted after hours, you do not fare as well as patients who are admitted during the day. One of our solutions for Banner is to provide the support after hours. I would submit to you that historically there is also a double standard in some of our rural facilities throughout our system, and probably throughout the country, in that the availability of cognitive expertise in a broad specialty has also been wanting. This is a solution that can help us address that problem so we have a single standard of care across the country.

The other thing I would like to point out is that physicians have been practicing telemedicine for quite some time. We have used an inferior tool called the telephone, but it is not unusual for a physician to get secondhand information in the middle of the night, try to make decisions based on that secondhand information, and give orders that will be implemented by the nurses at the bedside. This system allows us to have much more information, to have it firsthand, and to be virtually in the room at the time we are making those difficult decisions. Historically, the nursing surveillance has been the primary means to identify patients who are at risk. Physician contact has not been a simple process either. Knowing which physician is on call and getting them to call back in a reasonable amount of time takes a lot of time. That time can be very valuable in terms of preserving patient function and saving their lives. Once the physician does give orders to implement an intervention, if he is on call, many times he is unaware of what happens subsequently unless the nurse calls him again.

The other component of this particular system is a sophisticated set of computer algorithms that are constantly scanning the data from every single patient, identifying those patients who are getting out of bounds, and notifying

us immediately so we can look in on them and hopefully interrupt those adverse trends before they become a problem.

Obviously, it is a lot more than technology. Technology is just a tool. Physicians and nurses are the ones who practice medicine. What this technology does is allow us to expand the scope and make distance far more irrelevant for certain parts of the care-delivery process.

These are the components of the iCare system. We have two-way audio and video communication, decision support, and a surveillance algorithm built into the computer system. We can view X-rays and vitals in real time. We are tightly connected with the care team at the bedside. We are literally an added layer of support, designed not to replace anybody at the bedside but to support them to the best of our ability. What we do is respond to requests for help from the bedside. Rather than encountering points of failure and delay, as shown in that cheese diagram you saw on slide 5 (Exhibit D), if the other caregivers want a consultation, all they have to do is push a button. Within moments, we can be there with them in the room with the same firsthand information to discuss the case. We proactively manage care. As I told you, we have a surveillance system, and that allows us to identify those adverse trends earlier than we would otherwise, or even earlier than the bedside would. We can then intervene to prevent them from becoming adverse outcomes. We want to ensure "evidence-based practice" to make sure those things we all agree, as physicians, should be done on every patient are done on every patient. We also want to collect accurate data, and we want to measure ourselves and benchmark our performance so we can continuously improve it.

We have implemented this system in our rural facilities. Slide 9 shows a 25-bed facility in Page, Arizona (Exhibit D). Next is a 25-bed facility in rural Colorado, in a place called Brush. In both of those facilities, they are extremely happy to have us there to support what they do every day. The physicians, who are primarily family practice and internal medicine, with an occasional specialist, really appreciate the opportunity to have that level of expert advice at any time for any patient in their intensive care unit (ICU). The nurses deeply appreciate the moment's notice availability of a physician.

When this bill was designed, we did not limit it to the iCare platform. This is a bill that will allow multiple uses across the state of Nevada. Those services include: (1) TeleStroke, which has been a proven technology winner for saving patients' lives and preserving brain function; (2) trauma triage, which was first demonstrated by our colleagues in Tucson to be a very valuable asset in determining which patients need to go to a higher level of care; (3) telepsychiatry, which has been successful at Banner Health; and

(4) specialty call coverage, which will also be an option. Because of this bill, it will allow Nevada to have all of those things available. It is not Banner-centric; it is state-centric.

Let me show you some of the outcomes we have achieved with this system (Exhibit D). The chart on slide 12 shows ICU days saved beyond predicted since we began implementing this program and covers 2007 to present. As you will see, there were about 30,000 ICU days that were saved after the implementation of this system. Estimated savings from that length-of-stay reduction is about $83 million just for 2012. Patients are in the ICU for a much shorter period of time. We believe the reason for that is we are able to identify adverse trends and interrupt them before they become adverse outcomes. While we have driven down length of stay, which you can see on the top graph on slide 14 (Exhibit D), we have also dramatically reduced mortality at the same time across that same system of critical-care patients. Over 2,000 people were saved beyond predicted in 2012 alone, as shown on slide 15. They are out, walking around because they came to a facility that had this level of expertise and surveillance. We use APACHE II scores to measure ourselves; APACHE stands for Acute Physiology and Chronic Health Evaluation. This is the most respected severity adjustment tool in the United States for critical-care patients. Right now, our mortality is 50 percent better than that tool would predict based on patient physiology and diagnosis when they enter our system.

The bottom line is that with this system, we are able to do a number of things that very few bills that come before you can do. We are offering to reduce cost, improve patient care, and improve patient outcomes, and it will not cost the State a dime. I really do believe that one of the solutions to bending the cost curve in health care is telemedicine. Banner is proud to compare ourselves against 40 other systems that leverage an electronic, tele-ICU tool in the country. For five of the last six quarters, we have been number one in length of stay, and for the last six years, number one in quality. That is rated against 40 systems over 250 hospitals nationwide.

Chairman Bobzien:
Do we have any questions?

Assemblyman Healey:
Thank you for the very informative presentation. Looking at slide 15, which shows lives saved beyond predicted, can you explain how you come to that number of 2,003? That number is very impressive. What do you use to calculate it? Where are those 2,003 lives, or are those systemwide?

Robert Groves:
I would be happy to address that. The severity adjustment tool we use is a system that is called APACHE II. It is a system that is nationwide and not limited to this particular tool. Any ICU that wishes to can measure themselves using this system based on physiology; in other words, the patient's labs, X-rays, past medical history, diagnosis, and where they came from. Where they came from means was this an emergency admission from surgery on somebody who came from home through the emergency department, et cetera. All of those factors are built into an algorithm, and that algorithm is run on patients as they are admitted to the ICU. Based on that algorithm, a validated prediction is made as to how long that patient will stay in the hospital and what their chances of dying are. For any individual patient, it is not accurate enough for us to guide medical decision making, but if we look at a population of patients, it is very accurate in making the predictions it is designed to do. I think the coefficient of correlation is very high. I believe it is in the high 70s or low 80s. What that means is when a prediction is made on that population, it is very likely to be accurate if you take all comers across the country in a validated set. When you see 2,003 lives saved beyond predicted, that means when that population of patients was admitted to Banner facilities systemwide in 2012, that APACHE algorithm would have predicted 2,003 more deaths than actually occurred in 2012 at Banner Health critical-care units.

Assemblyman Healey:
Thank you for that. I caught most of that not being a doctor, a scientist, or even strong in math. Out of those 2,003 patients, do you know how many were here in Nevada?

[Assemblywoman Kirkpatrick assumed the Chair.]

Robert Groves:
I cannot answer that question for you. It would be a small percentage because a small percentage of our business is here in Nevada. We have one 40-bed facility. That has never stopped us from wanting to provide the highest level of care. We believe we can provide the same level of care regardless of facility size. I do not have the specific breakdown on exactly how many of those lives were here in Nevada.

Assemblyman Livermore:
Thank you for the information you have provided here. I have a couple of concerns about this. I served on a board of directors at a hospital system for many years. When we did this, we did it with radiologists ad hoc, and all of those people had to be credentialed through a local facility. Are you planning on doing this in a hospital setting? Your presentation was about ICU beds.

Robert Groves:
That is a great question. For Banner specifically, our plans are to implement the same tele-ICU program in Fallon, at Banner Churchill, that we have implemented everywhere else that gave us these numbers.

With regard to the bill itself, it was designed not to be Banner-centric but to allow telemedicine practice more broadly in the state of Nevada. If you are asking about our plans, the plans are to bring Nevada up to the same standard that every place else in Banner is operating under now with the use of this system.

First of all, I want to reiterate that this is in addition to whatever level of care is already at the bedside. This does not change nursing ratios or the number of hospitalists or intensivists that are at the bedside. We use this system even in places that have 24-7 in-house intensivists. The next question is why. The reason is that we have found it improves quality outcomes and reduces cost, even in those facilities that are well-served with physicians. I will take you back to that cheese slide (Exhibit D) for the reason we think that is true. Most of the time, particularly in smaller facilities, they are unable to afford to keep critical-care doctors in the house 24-7. That is a highly subspecialized field. Even in those that can, doctors are typically kept very busy being reactive and solving problems that are laid before them. They may be occupied for an hour or more doing a procedure on a critically ill patient. The rest of the patients in that unit may continue to have problems during that time period. This allows somebody to be able to address that problem instantly instead of waiting for that doctor to be available or to respond.

The other differentiating features are the surveillance tool and the algorithms that are built into the computer to constantly look at patient parameters and identify patients who are out of bounds. The computers are actually better at identifying that than human beings are. I will give you a quick example. Let us say a patient comes into the hospital with a gastrointestinal bleed—in other words, his or her stomach is bleeding from an ulcer—and his or her heart rate is initially in the 60s, which is normal. But if over four hours it creeps up to 90, human beings are not very good at recognizing that difference. They see that as a normal heart rate both times. The computer will send an alert to us saying there has been a significant change over this period of time, so you might want to check and make sure this patient is okay. The program's proactive nature and the intentional redundancy—it is designed not to replace but to support the service already in place—is how and why we do it.

Vice Chairwoman Kirkpatrick:
I have a couple questions on sections within the bill. The thing I am most concerned about is the reference to outside of the United States. I envision somebody outside of the country telling me how my stomach issue is going to be resolved. On page 6, section 5 of the bill, it says that in order to do all of this, you have to go before the board. How do you ensure the people outside of the United States continue with these qualifications?

Alfredo Alonso, representing Banner Health:
The way we drafted the bill was to actually keep in place everything the statute has today. In each section, from section 1 through almost the end of the bill, dealing with the advanced practitioners of nursing, the doctors of osteopathic medicine (D.O.) and the physicians each has this ability to do telemedicine. We do not change anything in the chapter. Your doctor is a Nevada-licensed doctor with jurisdiction in the state of Nevada. We made sure that was the case. It was an amendment to make sure that clarification was indeed there. The section you referred to, section 5, allows the Board of Medical Examiners to approve temporary licenses for doctors, whether it be for teaching or other items. Basically what each of those sections does is allow for those individuals to be approved by the Board. Once they are approved, they would be able to partake in telemedicine as well. The goal is to not change anything that is currently in statute.

Senator Jones:
I want to direct your attention to section 10. This was something that was of concern in the Senate. We made sure that if you have a doctor who is at a facility, as Banner has in Israel, and is providing services via videoconference to residents in Nevada, the doctor must be licensed in the state of Nevada. Under section 10, they are subject to the jurisdiction of the courts of Nevada. If anything were to go wrong, they are subject to the licensing board and the courts here.

Vice Chairwoman Kirkpatrick:
That alleviates some of my concern. Are there any other questions?

Assemblywoman Bustamante Adams:
Mr. Alonso, if they have to be licensed in Nevada, could you help remind me what the licensing fee is in Nevada? How much of the economics is actually staying in Nevada if a doctor is located outside of the country?

Alfredo Alonso:
Again, the goal here is to have telemedicine, whether you are talking about Banner or someone else, and allow for the care to improve within the state.

Our state is so rural that I think the applications are endless. In cases where, perhaps, a patient needs to go outside of the state for care, you could foresee a situation where that patient ultimately spends the majority of their time at home, communicating with their doctor, and only needs to travel when necessary for one-on-one care. That could alleviate a lot of concern with patients having to go back and forth, especially for younger patients who have to leave home to travel to a children's hospital. The applications are endless.

I believe Mr. Lee with the State Board of Medical Examiners is here. He could probably tell you more information on the fees themselves.

What we foresee with this bill, and the reason it was written broadly, is not just to take care of Banner's issue, but to look to the future of medicine. We have a lack of doctors, and even if we doubled them, there would still be a shortage situation. I think rural counties and specialty types of practices can be assisted tremendously with this practice.

Senator Jones:
In January, I spent some time at University Medical Center of Southern Nevada (UMC) in Las Vegas with a neurosurgeon and asked him about this particular issue and how to better serve the rural areas. This was one of the areas he thought would be very beneficial. If you have someone coming to UMC, a level one trauma center, and the person has surgery, there needs to be follow-up care. If they are coming in from a rural area of the state, they can get some of that aftercare via videoconference instead of having to come into Las Vegas. There is not an issue in that regard with people leaving the state or providing care from another state.

Robert Groves:
The fees we pay for licensure are exactly the same. Nevada is one of the most difficult states in the Union to get a license to practice medicine. We pay the same fees and go through the same process to provide this service. That goes down to the facility level. We have to be on the medical staff and meet all of the requirements for being on the medical staff.

The physicians who are licensed, no matter where they are, are licensed in every state in which we practice. They must be, and we like it that way. They have to maintain privileges in every state in which we practice.

Vice Chairwoman Kirkpatrick:
Are there any further questions?

Assemblyman Ohrenschall:
I have a couple of questions. In section 7, at the bottom of page 7, regarding the provision for service of process via email, is that being done in other jurisdictions? That is something I have not seen before.

Alfredo Alonso:
That was an amendment on the Senate side that came from the Board of Medical Examiners. I believe their intent was to find an electronic means of contacting doctors. It makes it easier for them to contact them for various reasons, whether it be disciplinary or otherwise. We did not have a problem with it, and that is why it is in the bill.

Assemblyman Ohrenschall:
Would that be used primarily for physicians abroad, or would that be used for everyone who is practicing telemedicine?

Alfredo Alonso:
I do not know for sure. I think Mr. Lee could answer that question. I would assume they would be able to use it here as well. It is the mode of communication these days.

Assemblyman Ohrenschall:
I have a similar question with section 13 with the telepharmacy. If a telepharmacy is established, then you could have the pharmacist be in Israel or another country and there would just be a dispensing technician at the pharmacy location, correct? I am on page 13, lines 9 through 24.

Alfredo Alonso:
Initially, the language read to where you could have foreseen a pharmacy being located elsewhere. I do not believe this language allows for that anymore. In fact, we worked with the Board to make sure that the actual pharmacy would be located in Nevada. The doctors would have a provision of calling in that prescription, and that is really where the clarification needed to be.

Initially, with physical contact, you could not do that with telemedicine. This allows for someone to call in or send in a prescription from outside of the state. Again, as Dr. Groves indicated, if you are in an ICU unit, and that doctor has walked away and something happens to an individual in that ICU unit, the doctor in Phoenix, or wherever the remote location is, would need to be able to provide that prescription.

[Chairman Bobzien reassumed the Chair.]

Assemblyman Ohrenschall:
There will still be a pharmacist at the pharmacy. We are not saying the pharmacist would be abroad.

Alfredo Alonso:
No.

Chairman Bobzien:
Are there additional questions?

Assemblywoman Bustamante Adams:
I have a question about your slide presentation (Exhibit D). It has to do with the technician on slide 2 and the evolution of health care workers. Do you see that being more focused on technology and not necessarily on health care? With the evolution of the individuals involved in health care, is that going to be displacing any of the current staff members?

Robert Groves:
Right now, health care is changing dramatically, as you all know. That change is outside of telemedicine. I think there is a lot of effort put into allowing every caregiver to work at the top of their ability with training and licensing, but that is independent of telemedicine. That will happen regardless of what happens with telemedicine.

In terms of displacement, this does not displace anyone. The nursing team that is behind the camera is in addition to the nursing team at the bedside. There are no respiratory therapists or anything like that behind the camera. It is conceivable that some roles would be able to provide service from behind the camera, but when you are talking about the people in the delivering facility for telemedicine, it is about cognitive skills that can be delivered through that process. The hands-on stuff has to remain at the bedside and will remain at the bedside. How that is distributed at the bedside is going to change regardless of what telemedicine does.

Assemblywoman Carlton:
Along the lines of the out-of-country issue, was there any thought or discussion about how we discipline someone who is not within our jurisdiction? I understand that suspension is easy. You yank the ticket. We have had some serious incidents with doctors in southern Nevada lately, and I would not want to have to tell my constituent that a doctor they had a problem with was in another country, and we had no way to deal with what issue had arisen.

Senator Jones:
I appreciate the question. That was the intent of section 10. It is to make it clear that if a doctor or other health care professional is providing this care from a different country, they are not only subject to the licensing boards where they can get their ticket pulled, but also subject to the jurisdiction of the State of Nevada for purposes of our court system. I do not think that was something that was in our law before. I appreciate the Nevada Justice Association bringing that up. Anytime a doctor provides care, he or she could flee the jurisdiction and evade the courts. I think that risk is inherent in our system. We are not going to solve every problem, but I think under these circumstances, there is no greater risk than there is now of a doctor providing care in our state as opposed to providing it from a different country.

Assemblywoman Carlton:
I hope you considered that concern a serious one.

Senator Jones:
Absolutely.

Assemblywoman Carlton:
I do not know if this is an extraditable offense. I guess it would depend on the level of harm.

Senator Jones:
Correct.

Assemblywoman Carlton:
I have no problem with telemedicine within the United States, but when we get outside of our borders, there are issues. People have concerns. It is bad enough when you call to get service on your cell phone and talk to somebody in another country. If my constituents have to talk to somebody in another country for their health care, there might even be greater concern. I want to make sure it is addressed.

Senator Jones:
I appreciate that 100 percent. I want to provide one perspective that I do not think Dr. Groves went over in his presentation here that he did on the Senate side. One of the advantages of telemedicine is that we have people who are working long hours in our facilities. Frequently they are tired because they are there at 1 a.m. or 2 a.m., and if you are in Israel, it is daytime there. If they are the ones behind a camera looking at a patient, they are hopefully more alert than someone who is at a facility at 2 a.m. in Nevada. Obviously, that is not to resolve your concern with people practicing from jurisdictions outside the

United States. I think it is something to consider in today's era of providing care 24-7. There may be advantages to having people in different time zones who can provide that additional level of care.

Robert Groves:
To expand on that, your concern is a legitimate one. There are multiple models around the country of exactly this going on right now. This means out-of-country services being provided. I want to give you a bit of background specifically on Banner. The physicians who are providing the service to us from Israel are dual citizens and who were trained in the United States who choose to live in Israel. They previously spent six months a year in the United States practicing and then going back to Israel to live with their families. This is a very conservative model of that strategy. There are less conservative models out there. I am sure it is a national concern. Banner has successfully implemented this strategy in all of the other states with the exception of Alaska. We are in the process of rolling this strategy into California soon. It is a model that has worked and I think can work. Your concern is a legitimate one, but I think that it is unlikely that the transition towards variations of that model are going to slow down in the near future. For the physicians from Israel, we actually recaptured resources for the United States that were lost for half the year. We feel pretty good with the model Banner is using to support our iCare program.

Assemblyman Livermore:
When an ambulance picks you up, they hook you up to a telemetry unit or other device. The unit we had was actually functioning out of Australia. All of those things about licensing and whatnot I am familiar with. Where is the setting? Is this in a hospital, or is this is a warehouse someplace? Where would you have this location?

Robert Groves:
We have a location in Los Angeles, California, that is in an office building. We have one in Mesa, Arizona, and that is the primary location and is the largest by far. It is an outbuilding on the Banner Desert Medical Center campus. We also have one in Tel Aviv, Israel, that is in an office building.

Assemblyman Livermore:
How do you keep all these staff on the line so when a call comes they can address it?

Robert Groves:
It is a shift. For 12 hours at night, there are three intensivists who are sitting at that console. It is kind of like air traffic control. They are constantly vigilant

to identify adverse trends, help support the people at the bedside, and provide consultation.

Chairman Bobzien:
Do we have additional questions? Senator, do we have other people testifying in support today whom you want to have called up?

Senator Jones:
No, that is everybody I have.

Chairman Bobzien:
Is there anyone else wishing to come to the table in support of S.B. 327 (R2)?

Lawrence Matheis, representing Nevada State Medical Association:
We had opposed the original bill. They cleared it up, and we do support the current bill for the reasons that were given by the proponents.

Joan Hall, President, Nevada Rural Hospital Partners:
We urge your support of S.B. 327 (R2). Telemedicine is very important for rural Nevada hospitals to be able to meet adequacy of network. To Assemblyman Livermore's comment about the teleradiology, those radiologists are currently practicing in Nevada, and they are in Australia. To Assemblywoman Carlton's question about that and the liability of that, the rural hospitals have used this system, and there have been no malpractice with any of those providers.

Not all telemedicine is as elaborate as the system that Banner is proposing to use. Some of it is much simpler. I want to stress that all of it has to meet Centers for Medicare and Medicaid Services regulations, Food and Drug Administration (FDA) regulations for the equipment, and Health Insurance Portability and Accountability Act (HIPAA) regulations for patient privacy. All positions have to be credentialed and privileged in the originating side, wherever that side is. They must have gone through the medical staff process. That should alleviate some of the fears I have heard.

For the rurals, this is very important for a patient who may have had a stroke in Ely and there is only a three-hour window to get that lifesaving drug. They could use TeleStroke specialists in Utah or in Reno and save lives. Long-term care patients in Battle Mountain can be seen via the telepsych process. Patients in Caliente with recent joint replacements can see their specialists via telemedicine.

Chairman Bobzien:
We will have everyone stay at the table, and once we have heard from all of the panelists, we will open it up to questions.

Keith Lee, representing Board of Medical Examiners:
We have worked with Mr. Alonso and Banner representatives during the interim on this particular piece of legislation. We fully endorse it. For a number of years, the Board of Medical Examiners has recognized the concept of telemedicine. From the presentation you have seen, this bill takes it to an entirely different level from what we have been using in this state for a number of years. We see this as a very valuable tool for the rendering of health care in this state. We have enjoyed working with Mr. Alonso and Banner on this and urge your support of it.

Bill Welch, President and Chief Executive Officer, Nevada Hospital Association:
We are here to endorse and support this legislation. As a past chief executive officer of a rural hospital, and somebody who has lived out in rural Nevada for many years, without repeating some of the testimony that has been provided, I see a number of benefits. As we look at the growth of the demand on the health care system as a result of the Affordable Care Act (ACA), the baby boomers hitting the system will be needing more access to health care services. At the same time we see the workforce not keeping pace as far as availability of physicians and other health care professionals. We see this as an opportunity to ensure that we can continue to provide that access to health care.

Years ago, many specialists traveled through rural Nevada to provide diagnostic evaluations. Beyond the services that have been presented to you today, we see this as a vehicle that will ensure—as these specialists can no longer travel through rural Nevada to provide these diagnostic clinical evaluations—these patients will still have access to the service without having to take time away from home, and time away from their jobs, to travel to an urban setting to get this care. It will be under a controlled environment, as has been described. We see this as very essential in ensuring we are able to meet the needs of the patients of the future.

From an economic standpoint, I would like to add to the comments that have been made. We see this as an economic opportunity for rural Nevada as these patients are able to be maintained locally. This helps support the health care delivery system in that community. In most of the rural communities, the health care delivery system is the largest economic engine. We see this as an economic boon of sorts. Certainly, this is a support to the economic viability of the health care delivery system in the rural communities.

Chairman Bobzien:
Do we have questions for the panel?

Assemblyman Ellison:
Mr. Welch, this looks like a great system and will be able to help in rural areas. I think it will eventually be able to help in larger hospitals. How will this come into play costwise? It will be passed onto patients. The initial amount for the system has got to be a lot of money.

Bill Welch:
There is a cost. Joan Hall could probably provide a more thorough answer. There are grant opportunities we are pursuing for the hospitals. We are working closely with a number of the urban providers who are trying to outreach into the rural communities. The University of Nevada School of Medicine is also trying to outreach into the communities. As far as the broadband network, we are trying to look at financial resources to help expand the capability for the transmission for these services. There will certainly be a cost to the community. The cost is going to be greater if they do not do it. They will not be able to meet the essential needs they are required to, and patients will ultimately leave the community. Doing nothing is going to be more costly to that community. While there is a cost associated with this, we look for grant opportunities to help offset that cost, but at the end of the day, it will be an investment that will be well worth it.

Chairman Bobzien:
Do we have additional questions?

Assemblyman Grady:
Ms. Hall, when you were with South Lyon Medical Center in Yerington, you got in on the infancy of this with training nurses. Although the cost is there, it saved our hospital a lot of money by keeping the people at home. Could you talk about that for a couple of minutes?

Joan Hall:
We used the same equipment for education as we would use when a patient and a doctor had an encounter. With that system you were talking about, we trained nurses throughout rural Nevada and in western Nevada communities via the televideo equipment.

To Assemblyman Ellison's question, the equipment itself is very expensive, and when you get into the stethoscopes, otoscopes, ophthalmoscopes, ultrasounds, and other devices you can buy, they do have to be FDA-approved. They are very expensive. Medicare and Medicaid recognizes this as a reimbursable

service to the distant site specialists and pay them as if they were seeing the patient in an office. This will sound facetious, but they pay the rural originating site $20 for the visit. Obviously, that does not cover the cost of the equipment, but as Mr. Welch said, we are looking for grants. We work with the School of Medicine through the Nevada Office of Rural Health, and we have received many grants and try to equip as many hospitals as possible.

Chairman Bobzien:
Are there additional questions for the panel?

Assemblywoman Carlton:
In your opening statement, to give comfort to people, you talked about doing telemedicine, but you have not done it with a doctor outside the United States, and that is where the concerns have come from.

Joan Hall:
We do telemedicine. We do teleradiology with physicians who are in Australia now. They have to be licensed in Nevada. They have to be credentialed at each hospital, but they are in Australia. They are awake when our doctors are asleep and vice versa. It provides real-time support, and I think we have used that service for maybe ten years now. Nevada Rural Hospital Partners also has a liability cooperative, which is an insurance product. We have not had any liability issues with those providers.

Assemblywoman Carlton:
Is radiology basically reading the films?

Joan Hall:
Yes, it is reading the films.

Assemblywoman Carlton:
That is disclosed to the patients when they get their results.

Joan Hall:
Yes.

Chairman Bobzien:
Are there any further questions?

Assemblywoman Bustamante Adams:
Mr. Lee, for the doctors who are outside Nevada and maybe even outside the United States, how invested are they economically in our state? How much is the license fee?

Keith Lee:
The initial application fee is $600. Every person who applies for licensure by the Board of Medical Examiners pays the $600 application fee. If he or she is then licensed, it is an $800 biennial fee. It is a license fee and is essentially $400 a year once he or she has been licensed, but we collect it biennially.

Assemblywoman Bustamante Adams:
Does malpractice insurance have to be based with a Nevada-centered company?

Keith Lee:
I do not know. We at the Board of Medical Examiners do not monitor and are not responsible for that. I am sure there is a Nevada-based medical malpractice company, but I do not know if every doctor uses it. There is certainly no requirement that I know of that a doctor who carries malpractice insurance be licensed with a Nevada malpractice carrier.

Assemblywoman Bustamante Adams:
The investment of somebody living outside Nevada is $400 a year.

Keith Lee:
At least with respect to the Board of Medical Examiners, yes.

Joan Hall:
I would like to follow up a little bit on that. From a rural perspective, the economic investment with telemedicine is great for rural hospitals. Those doctors who may be in Reno, Australia, or wherever they are order tests that are then performed in our local hospitals. If the patient from Ely had to travel to Utah, that money leaves the state. The Ely hospital would be able to do those diagnostic tests. For rural hospitals, there is a positive economic impact. There is an economic benefit for both patients and rural facilities.

Bill Welch:
I would like to emphasize that while I understand the concern with regard to physicians outside of the United States, that would not necessarily be the predominance of the telemedicine services being provided. There may be outlying communities of Nevada that would be linked into neighboring states, but most of the telemedicine services will be delivered within the health care delivery system of the state of Nevada, although certainly not all of it. You have been given several examples today of physicians in Australia or Israel who are providing services. Much of the telemedicine services that will be provided to help meet the needs of the patients in the future will be services that are provided from Reno, Las Vegas, or possibly neighboring cities like Salt Lake City. We have given a couple of examples of telemedicine that are

being delivered outside the state, but I think you will find the predominance of the telemedicine services would be services delivered from physicians who are based in Nevada.

Assemblyman Frierson:
I am struggling as well with this notion of liability and culpability. I recognize that it rarely happens and apparently has not happened, at least in the radiology area, but all it takes is one time. Are you saying the benefits of access to health care outweigh the potential cost of somebody making a mistake who is not subject to either civil or criminal culpability within the state of Nevada? Obviously, that would be primarily abroad and not domestically.

Joan Hall:
That has been a concern of everyone. I go to the fact that these doctors have to be credentialed and privileged at each hospital. If a hospital determined that they did not want overseas physicians or out-of-state physicians, then those doctors would not have that privilege. It is up to the hospital.

Assemblyman Frierson:
That is prospective, and I think the concern is what happens after there is a problem, if there is ever a problem. I apologize if this has been addressed; in going through this, is there anything that ties their practice or license where they are to their conduct in telemedicine, so there is at least some type of consequence or ability for Nevada to be in contact with the licensing body they are under for any type of response for a problem?

Keith Lee:
Let me take a shot at that. If we take disciplinary action against a doctor in the state of Nevada, that is what we would call a reportable event that goes to the National Practitioners DataBank. Every other jurisdiction in which that particular physician is licensed is then subject to discipline in that particular jurisdiction. Generally speaking, when one state takes disciplinary action against a physician who is licensed in a number of states, all the other states then open a complaint and will at least pursue disciplinary action against that person. That is the hammer we have. Even though, at least to my knowledge, other countries do not participate in the National Practitioners DataBank, that person's license is at risk. If that person's license is at risk in Nevada, obviously his or her privileges in facilities in Nevada are also at risk.

I might also indicate that we have made a provision in here, and Senator Jones referred to it, to adopt what we think is a long-arm statute that submits the Nevada-licensed physician located in a foreign country to the jurisdictions of the court of this state. If that person commits malpractice, that person is subject

to the jurisdiction of this state through this particular bill. That was the purpose of doing that so that physician would be subject to the jurisdiction and laws of the State of Nevada.

Assemblyman Frierson:
I remember Senator Jones mentioned that such provisions were in section 10.

Bill Welch:
I would also like to point out that all of our hospitals in Nevada require these physicians to be licensed in Nevada, and they have to be credentialed and privileged at each of the individual hospitals. The hospitals are also requiring physicians to maintain a certain level of medical malpractice insurance so if there is a liability situation that occurs, there is some assurance there is an ability for the patient to recover.

Chairman Bobzien:
Thank you, Mr. Welch, and thank you, Mr. Lee, for the information on the National Practitioners DataBank and how that comes into play.

Assemblywoman Carlton:
We do not require every doctor in the state to carry medical malpractice insurance. Under this, if they were to participate, would they have to carry medical malpractice insurance? We are setting up a separate standard for the doctors under this licensing provision. I am confused because I am seeing heads nod no, but Mr. Welch said if they have privileges at the hospital, the hospital requires them to carry medical malpractice insurance. I am trying to figure out how this works.

Keith Lee:
At least *Nevada Revised Statutes* (NRS) Chapter 630, which governs allopathic physicians, does not require them, as a condition of licensure or renewal licensure, to carry malpractice insurance. As a practical matter, as Mr. Welch has indicated, if that person wished to practice at any hospital and be credentialed at that hospital—and almost every physician is even though he or she may have an office outside of the hospital—that is the requirement. Mr. Matheis may be able to give further enlightenment on that.

Assemblywoman Carlton:
I am not sure what the levels are currently, but I want to make sure that these people will have medical malpractice insurance. Why bring them to court otherwise?

Chairman Bobzien:
I seem to recall this conversation from an earlier bill this session. Mr. Matheis, do you have any comment to that?

Lawrence Matheis:
Only that the physicians who would be dealing with telemedicine are on staff at the hospital. They fall under those rules. Any doctor in the state who is on staff at a hospital is bound by the hospital's rules regarding obtaining insurance. It is the same thing with all of the health plans.

Assemblywoman Carlton:
Do all hospitals now require medical malpractice insurance? I remember a few years ago, it was not 100 percent.

Joan Hall:
All rural hospitals do: $1 million limit per claim and $3 million per policy year, or $2 million and $6 million.

Assemblywoman Carlton:
Thank you.

Bill Welch:
Yes, the liability coverage would go up from what Joan Hall just represented. All of our hospitals do require the physicians on their staff who are licensed and privileged at that hospital, whether they are from outside the United States, or outside or within Nevada, to maintain medical malpractice insurance. There is not a different standard.

Chairman Bobzien:
Are there any final questions for the panel? [There were none.] Ms. MacMenamin, I see you getting up, but this is the bill you have an amendment on (Exhibit E). According to our rules this session, if you have an amendment, you must sign in as opposed. I will call you up in opposition. Do we have anyone else wishing to come to the table in support of S.B. 327 (R2)? [There was no one.] Let us move to opposition of S.B. 327 (R2).

Liz MacMenamin, Vice President, Government Affairs, Retail Association of Nevada:
We very much support this bill, but according to the bill, I will come forward in opposition. We thank Senator Jones for this bill. We have seen the face of health care changing and evolving over the time I have been with the Association. We think this is the future of health care. We were very involved

when this body implemented telepharmacy last session, and we thank this body for being open-minded enough to come forward and move into the future.

We would also like this body to consider current statutes that do not take into consideration the change in current technology within the industry we represent, which is pharmacy. *Nevada Revised Statutes* 639.2392 requires a refill record of the prescription to be kept either in a book or on the original prescription at the time of the refill. Today, many pharmacies have the technological ability to record this electronic signature within the system they have. We ask you to look at our amendment (Exhibit E), which would add this technological change to the records.

The other change we were looking for is in regard to NRS 639.2396, which would allow a patient to obtain a 90-day supply of his or her maintenance medications. One of the most important maintenance medications I was thinking about and discussed with someone earlier was birth control pills. Right now, if your doctor writes for a year's worth of birth control pills, you can only get a month at a time. With this change in the language, you could go to your pharmacy and get a three-month supply if, and only if, your health care plan allows it. Please understand that the amendment you are looking at is permissive language only. If your health care plan will not allow this, we are not mandating that this be done. This is purely good public policy for the patients out there. It is a work flow issue within a pharmacy. We are not, and will not, ask health plans to change. This is a contractual agreement within the health care plan. We are not looking at changing that.

Also joining us today in Las Vegas is Dr. Kam Gandhi, who is a practicing pharmacist.

Chairman Bobzien:
Do we have any questions on the amendment (Exhibit E)?

Assemblywoman Carlton:
In section 3, not having it apply to the different health care plans and keeping in mind that with the Affordable Care Act (ACA) next year, most people will have health insurance through some sort of plan. Who will this end up applying to?

Liz MacMenamin:
At this point in time, there are quite a few plans out there that will allow this to happen. I am not sure how the ACA is going to impact it. It may change how that is handled. It is a contractual agreement. Some plans will never allow a 90-day fill. Some plans allow a mail-order 90-day fill but not at a pharmacy.

That is why section 3 is there. We do not want to change that. It will apply to many cash patients who come in. My plan allows for a 90-day fill if the pharmacist applies his professional judgment to it. There are plans out there that will allow this. I think that is one thing we will look at down the road as well. There may be people who are written out of it through the health exchange.

Assemblywoman Carlton:
To be clear, this would be the same provision we heard earlier this year that did not make it through a previous Assembly bill. If you did fill this, the copays would still apply. If I had a $20 copay for a 30-day supply, it would be $60 for the 90-day supply, even though we are just filling one bottle. That money does not go to the pharmacy but to the health plans to help cover the cost. Basically, the pharmacy is passed through. One of the concerns I had was in regard to budgeting and figuring out how you are going to do these things. If you had a significant portion of your patient list decide to do this, all of a sudden you have triple the payment on a drug you are figuring out, and there could be a financial impact on the back end. Actuarially, you would never really be able to know where that dollar amount would fall because you would never know how many of your patients are going to show up and ask for 90 days instead of 30. Whoever the insurer is would end up having a 90-day bill to the company rather than the 30-day bill. The financial impact on the back end would not be any greater than it would have been over a year, but it is frontloaded.

[Assemblyman Frierson assumed the Chair.]

Liz MacMenamin:
I would say that may be true, but I think marginally, if you look at it, and after discussing it with Dr. Gandhi, the pharmacy will be losing money. There is a payment to the pharmacy for filling that is up-front. The pharmacy will only be getting one fill charge at this point in time. One of the reasons we looked at this was not because we would be losing money but because it is a good policy for our patients. Not everybody is going to want their 90-day refill. I would not necessarily go in and pay my copay for three months' worth of the prescription I have. Somebody else may, and that will be their choice. Maybe I need to go back to the $20. That money does go to the pharmacy, but it goes to the pharmacy as the cost of the drug itself. It is not a cost to the insurance company. I think that is a conversation we had earlier on. Your reasoning for monthly budgeting for a health insurance company may change some. I am not sure how, though, because that is not my expertise. I will try to find that answer for you if I can.

Acting Chairman Frierson:
Are there any other questions? Did you mention whether or not the sponsor indicated support of the amendment (Exhibit E)?

Liz MacMenamin:
I spoke to Senator Jones, and we talked about bringing this forward. He was okay with bringing it initially as long as none of the stakeholders involved were opposed to it.

Acting Chairman Frierson:
Senator Jones is here. Mr. Bobzien will allow him to address that at some point. Are there any other questions?

Assemblywoman Diaz:
I would like to hear from the pharmacist, so he can answer Mrs. Carlton's questions.

[Chairman Bobzien reassumed the Chair.]

Kam Gandhi, Pharmacist, Albertsons and Savon, Las Vegas, Nevada:
Can you restate the question please?

Assemblywoman Diaz:
I think we are trying to grapple with the difference between the pharmacies filling a 30-day prescription versus a 90-day fill. How does that impact insurance carriers, pharmacies, consumers, et cetera?

Kam Gandhi:
The difference right now is that each month we fill a prescription, we get a dispensing fee. If you are filling prescriptions three months in a row, you are getting three dispensing fees. The pharmacy as a retail organization is accepting that dispensing fee loss. If you are filling it for 90 days, you are actually foregoing two dispensing fees. The retail industry, the community pharmacies, are accepting that loss for two reasons, and those are patient convenience and better health for the patient. It is proven that if you get a 90-day supply versus a month-to-month fill, compliance and adherence to the product and medication is increased. That is the whole purpose behind this.

Assemblywoman Diaz:
You are saying the pharmacy will forego two dispensing fees. If I recall my health care plan, when I mail order, I do not get the mail order for the 90 days at the price of 30. If my copay is $30 for 30 days, I would have to pay $60 for

90 days. Is it accurate to say that you forgo two dispensing fees? Is it dependent on your plan or the pharmacy?

Kam Gandhi:
Mail order and retail have a completely different model. Mail order has the benefit of charging two copays versus three. In our organization, as far as retail, we would have to charge the patient three copays to fill the 90-day supply. We would get the initial dispensing fee for that one time we fill it, so we do forgo the other two. I cannot speak on behalf of mail order because they have different rules and guidelines. There is definitely a differentiator.

Assemblywoman Diaz:
If I go to the pharmacy, and I fill a medication, a maintenance drug, for 90 days, I only pay the 30-day copay, and you dispense 90 days' worth, correct?

Kam Gandhi:
No, the dispensing fee is paid by the insurance company. In the example, the copay was $20. You would pay $20 for each month, so if you got a 90-day supply, you would be responsible for $60. The insurance company reimburses the pharmacy for dispensing that medication. If we are only dispensing it one time to the patient for a 90-day supply, we are not filling it month two and month three, so we are forgoing the insurance company reimbursing us for those dispensing fees.

Assemblywoman Diaz:
The price remains the same for the consumer, but there is a cost saving on the insurance end.

Kam Gandhi:
Correct.

Chairman Bobzien:
Are there additional questions? [There were none.]

Elisa Cafferata, President and Chief Executive Officer, Nevada Advocates for Planned Parenthood Affiliates:
I am not opposing this bill. We are here in support of the bill as it is written because of the reasons stated, and we are also supportive of the amendment, especially the concept of patients being able to get a 90-day supply of birth control. As you know, it is a very time-sensitive prescription, so it is better for clients to be able to get 90 days' worth and use it consistently. To clarify, under the ACA, birth control is available as a preventative prescription without

additional copays. That issue would not come up for birth control prescriptions but may for some other maintenance drugs.

Chairman Bobzien:
Are there any questions for Ms. Cafferata? [There were none.] Is there anyone else wishing to speak in opposition to the measure? [There was no one.] Is there anyone wishing to speak as neutral?

S. Paul Edwards, General Counsel, State Board of Pharmacy:
I did not initially come here to speak on this bill. However, there are a couple of things I think are worth mentioning for your consideration. We do not necessarily oppose the bill, but I think there are some things that should be considered. Telemedicine is already available under existing law. It is widely used. Generally, it requires involvement of an in-state practitioner to be at the patient's side. There is that physical examination requirement. This bill would eliminate that. I understand that under Banner's model, which I think is a good model, there is a practitioner present. However, at the other end of the spectrum, there will be practitioners who will take advantage of that and there will not be a practitioner present. You will have somebody on the telephone talking to a doctor out of state or out of the country, and this bill would allow that. I say that understanding that I do not believe Banner's model would allow that, but this bill would.

A second point is that Nevada pharmacies can currently fill prescriptions written by out-of-state doctors as long as they have a controlled substance registration in their current state and have a Drug Enforcement Administration (DEA) number. I appreciate that an amendment was made because originally, when this bill was presented, it allowed for out-of-state and even out-of-country dispensing. It would have allowed a doctor to talk to a patient by telephone, write a prescription, fill that prescription, and send it from out of state or out of the country. That has been removed, and we appreciate that. However, we still have concern.

While Banner is on the good end of the spectrum, as a regulatory body we do have to look at the other end of the spectrum. This would be the doctors who would go around the system and who would use a telephone or Skype to see a patient in a very cursory manner and prescribe controlled substances. The reason this concerns us is that Las Vegas is currently number one on the DEA's list for prescription drug abuse. It used to be Florida, with us as number two. We heard just this week that Las Vegas is now number one. This bill opens the door to doctors who would take advantage of the rules, or not practice the utmost standard of care, to make that problem worse. This has the potential of increasing the amount of illegal prescription drugs on the street.

While we do not necessarily oppose the bill, it is something to be concerned about, particularly when we are talking about doctors from other states or outside the country where it may be difficult to discipline or reach out and get ahold of them.

A final point is that this is being presented as a bill that will make doctors and practitioners more available to Nevada citizens, and I believe that is true. However, by opening the door, it also increases competition for Nevada physicians. All of a sudden, but also will not only have competition with the people in their own city or state, they will be faced with competition from around the country and around the world. There may not be incentives for doctors who actually live here to stay here. You may find that some doctors choose to leave the state but maintain practices here because they can do so by telemedicine.

I bring up those concerns because I think they hit the other end of the spectrum. Everything that Banner talks about is physicians who are credentialed with a hospital, this being done in a hospital setting, and controls put in place by a hospital. This bill does not require those controls. This bill does allow a physician in another country who is licensed here to get on the telephone, talk to a patient, and be their doctor without the careful controls that Banner suggested. Those are the points we want to make this body aware of and hope you think about as you consider the policy concerns and the approach to passing this additional telemedicine bill.

Chairman Bobzien:
This was neutral testimony?

Paul Edwards:
Yes. These are points we hope you will consider. The Board of Pharmacy is not opposing this bill.

J. David Wuest, Deputy Secretary and Inspector, State Board of Pharmacy:
Everything that was presented in front of you today we are supportive of. We are supportive of this bill. On the other side, we see the diversion and other things that can happen. I think what Mr. Edwards is trying to tell you is that there is a potential for it to swing too far to the other side.

Chairman Bobzien:
Are there any questions?

Assemblyman Ohrenschall:
Do you know if other jurisdictions are allowing doctors to try to call in prescription from out of state or from abroad? If so, how is that working? Have there been problems?

David Wuest:
In the past two weeks, I have received calls from my counterparts in Colorado and New Hampshire about a physician in Las Vegas whose patient is physically presenting to pharmacies in those states. My question is, what is our physician doing giving this patient a prescription? To answer your question directly, I think other states do allow this telemedicine. We already have some rules for telemedicine, but when it is a physician on a phone in a different state or country giving a patient a narcotic, it is far from what is presented today. It can be an issue.

Assemblyman Ohrenschall:
Do you have a concern that this bill could allow that to happen?

David Wuest:
I think the testimony that has been presented to you today is for a hospital-based system, and I think that is very well used in this system. The concern is that the way the bill sits right now, a physician in Tel Aviv, Israel, can get on the phone with a patient outside of a hospital setting, and outside of the malpractice insurance, and he or she can call in a prescription the patient can get filled. It is the narcotic use we are concerned about.

Paul Edwards:
If I can add to that, many of those physicians have patients who are cash-pay. They would not have any of the controls that would come into place through Medicare, Medicaid, or any of those programs. They are doing it by cash. The suggestion that some of the existing rules would prevent those things on a cash-pay patient who is looking to get drugs in a nefarious way would not be affected by federal or state regulations.

Assemblywoman Carlton:
When I read the bill, and knowing where it was coming from, I really thought this was hospital centered. If it is not, I think that is something we need to talk about. I know the issues other states have had. Florida is a perfect example with the pill-mill doctors. I would hate to see us put something out that would allow the doctor to be out of the country and have that jurisdiction. When I went through this, everything to me said, hospital, hospital, so I had no idea we were talking about outside the hospital because that was most of the testimony we had.

David Wuest:
The way I read it is that it is outside the hospital as well. If this was all inside the hospital, I think that would be an excellent setting for it.

Assemblyman Livermore:
Along that same line, what I thought I heard in the presentation was an iCare system that took care of hospitalized patients who were in critical care. I think somewhere along the line, the hospital must have some ability to discharge a patient, and that would generally happen with an on-staff physician in a hospital. At that point in time, that is when prescriptions are written. I did not hear in the presentation that they would be discharging patients.

David Wuest:
I heard in the testimony this would be useful when they discharge the patient. I think that would be very appropriate, and the Board of Pharmacy would support that. When you have that partly closed system, it is the hospital pharmacist following up on a hospital activity. Our biggest concern is when there are two people who do not know each other, meeting in the night and getting a controlled substance. They said they may use it for a discharge on a patient and follow up with a specialist. From our perspective, that would be very appropriate. The concern is where there is really no relationship.

Assemblyman Livermore:
I did not hear that from Banner Health. It may have been in there. Maybe they can address that when they come back up to wrap up the bill. I understand your concerns, and you are right to be concerned. I thought it was a service provided to critically ill people who needed that attention immediately. I think that is where telemedicine could benefit. I want to echo your concerns if that is the case.

Paul Edwards:
Keep in mind there are two things to be kept distinct here. This body is not being asked to approve the iCare system. It is being asked to approve a bill that is much broader and within which the iCare system would play a role on one end of the spectrum. It leaves the door wide open at the other end of the spectrum. While the iCare system may be very cautious and address those considerations within a hospital setting, iCare is not what is being approved. It is an entire bill where the testimony has been intentionally left very broad and open. Unfortunately, leaving it broad and open can allow for bad actors.

Assemblyman Healey:
I appreciate your testimony today. Were these concerns you just presented to us discussed with the bill sponsor on the Senate side?

Paul Edwards:
Through our lobbyists and through their lobbyists, we have discussed this. I testified to this on the Senate side. As I indicated, the bill sponsor has been good to remove some provisions we thought were really bad that would have allowed dispensing from outside the country. It would have allowed a dispensing practitioner to send drugs from any state or any country via UPS or FedEx to the patient. It would go around the FDA, DEA, and other regulatory bodies. That part has been removed, and we thank Senator Jones for that.

The other concerns were raised, and we present these as things we would like the members to consider and realize in passing a very broad, open bill, it does open the door to more than just one hospital system's program.

Assemblyman Healey:
Mr. Edwards, if these were raised with the sponsor, and by your testimony, you said other issues were brought up and changed as a result, I take it that he was not willing to take these into consideration. Is that correct?

Paul Edwards:
I cannot say he was not willing to take these into consideration. It was us working through our lobbyists and their lobbyists. I am not sure I can answer that completely other than the issues were raised.

Chairman Bobzien:
Are there any further questions?

Assemblywoman Carlton:
Who represented you in these discussions?

Paul Edwards:
We are represented by Michael and Fred Hillerby.

Assemblywoman Carlton:
We know them very well. I was just making sure I understood who all the players were.

Chairman Bobzien:
Any final questions? [There were none.] Last chance for neutral testimony on S.B. 327 (R2). [There was no one.] Senator Jones, would you like to say some final remarks?

Senator Jones:
I would like to thank the Committee for their consideration of this bill. I think telemedicine is something currently in statute. The purpose of this bill is to streamline it and bring it up to date. In response to Assemblyman Frierson's questions with regard to jurisdiction of the courts, that is in section 4, subsection 1, paragraph (e), subparagraph (2) and also in section 10, subsection 1, paragraph (b), which relates to both doctors and osteopathic physicians.

With regard to the retailer's amendment, I was okay with it. In the Senate, it was deemed by the Counsel as nongermane. I understand there has been reconsideration of that. If that works out, I am fine with the amendment.

I guess that brings us to the Board of Pharmacy. There were concerns raised by Mr. Edwards at the Senate hearing for the first time. He had never bothered to raise those concerns with me prior to the hearing. I talked to him afterwards and said I did not appreciate he did that. He apologized, and we worked with him. I believed we resolved the concerns he had. I will express my extreme displeasure with the fact that he did the same thing here in the Assembly.

Chairman Bobzien:
We just provide the wrap-up to the bill sponsor. We will close the hearing on S.B. 327 (R2). We will open the hearing on Senate Bill 211 (1st Reprint).

Senate Bill 211 (1st Reprint): Requires certain health care practitioners to communicate certain information to the public. (BDR 54-14)

Senator Barbara Cegavske, Clark County Senatorial District No. 8:
I am here today to introduce Senate Bill 211 (1st Reprint). This measure requires that advertisement for health care services include certain information to the public. In today's health care environment, patients are bombarded with advertisements and claims regarding different health care services that are provided by different health care professionals and by both physicians and nonphysicians. I believe that health care practitioners must be truthful in how they market themselves and their services. However, the Internet and other forms of communication create an almost limitless ability for anyone to say anything. This bill promotes truth in advertising among health care practitioners by ensuring that any advertisements they have do not promote services beyond what they are legally permitted to provide.

In an effort to help provide increased clarity and transparency for Nevada's patients, S.B. 211 (R1) also helps ensure patients know the education, training, and licensure of their health care provider. When health care practitioners wear

name tags during patient encounters, the tags must clearly identify the type of license they hold. Health care practitioners will also have to display their education, training, and licensure in their offices.

This measure does not increase or limit anyone's scope of practice. Instead, it increases transparency of health care practitioners' qualifications for patients so that patients can clearly see and make informed decisions about who provides their care.

I would like to walk you through the highlights of this bill. In section 1, subsection 1, paragraph (a), it requires that advertisements for health care services identify the type of license held by each health care practitioner in that ad, and it must not include any deceptive or misleading information regarding a health care practitioner. Section 1, subsection 1, paragraph (b) requires a health care practitioner to communicate his or her specific licensure to all current and prospective patients by conspicuously displaying in each office he or she practices a written patient disclosure statement that clearly identifies the type of license he or she holds. If the health care practitioner wears a name tag, his or her license is included on the tag.

Section 1, subsection 1, paragraph (d) prohibits health care practitioners who are physicians or osteopathic physicians from using the term board-certified unless the board is a specialty certifying board of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) or meets their criteria. Section 1, subsection 1, paragraph (f) provides that a health care practitioner who violates any advertising or patient disclosure requirements is subject to professional discipline.

Finally, section 1, subsection 2 exempts from these provisions veterinarians or other persons licensed by the Nevada State Board of Veterinary Medical Examiners. It also exempts a person "who works in or is licensed to operate, conduct, issue a report from or maintain a medical laboratory . . . unless the person provides services directly to a patient or the public." It also exempts advertising for health care services or a health care practitioner who provides service in certain health care facilities.

I want to thank you for your time and attention, and I urge your support of this worthwhile legislation. If I might, I would like to go to Dr. Michael Edwards in Las Vegas and come back to our panel here to testify.

Chairman Bobzien:
Senator, could you submit your remarks to our staff so we have a record?

Senator Cegavske:
You can have these when I am gone.

Chairman Bobzien:
Perfect. We will head down to Las Vegas.

Michael Edwards, Physician, Las Vegas, Nevada:
Thank you for the opportunity to provide further comment on S.B. 211 (R1). The language we are discussing today will help to provide clarity and transparency for the citizens in Nevada who may seek out health care services from any type of health care professional. Senate Bill 211 (R1) would require all health care practitioners to disclose their license type and additionally places the requirements on the physicians' use of the term board-certified in advertising efforts. There are many credentialing bodies that exist with varying levels of certifying requirements. However, it is important to note that the Board of Medical Examiners recognizes only the boards under the purview of the American Board of Medical Specialties (ABMS) as do most state boards across the country. Mr. Cooper, the executive director of the State Board of Medical Examiners, refers to the ABMS as the gold standard.

This bill does not place restrictions on the current scope of practice of any health care practitioners in Nevada. It simply increases transparency of the health care practitioner's qualifications for Nevada patients so they can clearly see and make their own informed decisions about who provides health care to them and their families. These commonsense measures are aimed to help alleviate what is known as the "white coat confusion" that exists in the health care setting today. Currently, we know that patients often confuse medical doctors with nonphysician providers, and they may not know the various medical specialists or physicians. I was a registered nurse prior to going to medical school, and I was commonly called doctor by patients, whom I had to correct. A recent telephone survey conducted by the American Medical Association (AMA) of 852 adults nationwide yielded that 67 percent of respondents believed that podiatrists were medical doctors when they are not. The same AMA survey revealed that only 32 percent of respondents believed that laryngologists are physicians when most certainly they are.

The citizens of Nevada deserve to know precisely what type of health care professional is treating them, whether it be a physician, nurse, medical assistant, or technician. Uninformed choices could, unfortunately, lead to unintended consequences that could be avoided. This is what makes passage of this legislation so important. Along those same lines, it only makes sense that patients be informed of the specific training and credentials of their treating provider.

If you are licensed to practice medicine in Nevada, you are virtually unrestricted in terms of how you choose to focus your practice and the specialized care you provide. This legislation would not change that, and as stated, it is not intended to limit any provider's scope of practice. This bill serves to provide clear parameters for the use of stating you are board-certified, which we know the public considers to have significant meaning and importance when it comes to distinguishing the credentials of providers, even if the citizen cannot put their finger on how that is true. The "name your board" provision of this amendment would require the physicians using the term board-certified to do so only in conjunction with making clear the full name of the approved ABMS certifying board. Simply stating one is board-certified alone is not enough for a patient to understand the type of training his or her provider has. As an example, I am board-certified in plastic surgery and also in general surgery. If I decided to open a LASIK clinic in downtown Carson City today, I could advertise that I was a board-certified surgeon without ever making the qualification that my certificate is, in fact, not in ophthalmology. Requiring physicians to disclose the ABMS board from which they received their certificate simply provides additional transparency and clarity, enabling prospective patients to discern the credentials of training of the physicians from whom they receive care.

This legislation is founded on the notion that patients and the public should be confident that medical and health care advertising is clear and informative—not muddy, misleading, or confusing. As stated earlier, less than half the respondents felt confident that health care professionals only advertise and provide services for which they are properly trained. In garnering the public's trust, in medical advertising in particular, patients must be able to uniformly rely on physicians' appropriate use of the board-certified designation. The citizens of Nevada deserve to be sure they are gauging physicians who have the requisite education and training necessary to provide the specialty care they are seeking, and S.B. 211 (R1) will do that.

Chairman Bobzien:
We will come back up to Carson City.

Gregory Juhl, President, Nevada Chapter, American College of Emergency Physicians:
I am in support of S.B. 211 (R1) as presented, without amendments.

Lawrence Matheis, representing Nevada State Medical Association:
We do support this. You will recognize that this was part of a bill you heard and processed earlier. Our reason for supporting this language is the same as it was when we testified previously. Transparency about the rules of the health professional is a growing set of urgent policy needs, as we are going

to have increasing use of integrated delivery systems. We think this is a version we can support.

Chairman Bobzien:
Are there any questions for the bill sponsor and witnesses? Senator, do you have anyone else you wish to come forward?

Senator Cegavske:
This is all that I had planned.

Chairman Bobzien:
Is there anyone else wishing to testify in favor of S.B. 211 (R1)? [There was no one.] Is there anyone wishing to testify opposed to S.B. 211 (R1)?

Linda Gray Murphy, representing American Board of Physician Specialties:
I have provided the Committee with a packet (Exhibit F). We are here in opposition of the bill, not because we do not believe what it is going to do is a good idea. We are a board-certifying entity and believe physicians should disclose their board certification. In that part, we are not opposed to the bill.

We are asking for the bill to be amended where it specifies that the American Board of Medical Specialties or the American Osteopathic Association (AOA) be the only two boards to be recognized. We are asking for the American Board of Physician Specialties (ABPS) be recognized as well. We are much smaller than ABMS and AOA, but that does not necessarily mean we do not do just as good of a job.

The American Board of Medical Specialties often refers to itself as the gold standard. That would be similar to me calling myself Princess. You cannot go around determining that you are the gold standard. Someone else needs to make that determination. As of today, no one has done that. The American Board of Physician Specialties hired a third party, Castle Worldwide—you will find a summary from them in the packet (Exhibit F)—to look over how we tested and conducted our board examinations to determine if we met the standards of ABMS or any of the other board-certifying entities. They found that we met or exceeded their qualifications. Just because we are smaller and the competition does not mean we should be cut out of being recognized.

I lobby in many states for them, and it is always the same argument that ABMS is the gold standard and should therefore be the only one. When you do that, you have, in essence, told a nonprofit organization they can determine what board certification in your state can be. That is what this bill does. It creates

a monopoly and limits access to only ABMS as calling itself board-certified if you are a medical doctor (M.D.).

We certify M.D.s and D.O.s, and we feel we have an extremely good program. We are very rigorous; we do not want bad physicians practicing. As someone who sits through medical board meetings throughout the United States, I am going to tell you the majority of physicians who are brought before medical boards are ABMS board-certified. In the state of Oklahoma, the medical board recently attempted to do something similar to what is going to happen here in saying that if you are not ABMS-certified, you must be ABMS-certified. We found that was creating a monopoly. The attorney general said that the medical board probably could not do that.

You cannot limit this to two boards, one certifying M.D.s and the other certifying D.O.s, if there are other viable boards, the kind that are not offering weekend courses in Las Vegas to learn your practice. We do not do that. We require that you have a residency, take an examination, and do an oral examination in some of the specialties. We are very rigorous and check our physicians every year to make sure they are allowed to continue to practice in the state they are residing in. We are vigilant in making sure we have the best of the best.

We do not think the State of Nevada should limit access with the upcoming health care changes. You are going to need more physicians, not less. My physicians would like to let the public know they are board-certified in one of 17 specialties we certify. We do not certify plastic surgeons or cosmetic surgeons. We do not tread into those territories. We agree with the bill sponsor that the public should be made aware. I agree that most people have no idea what the board certification means or what it is. We, too, want to be able to tell you what our training and specialty is.

We are here today to respectfully request the Committee consider writing us into section 1, subsection 1, paragraph (d), subparagraph (1), which states, "Is a member board of the American Board of Medical Specialties or the American Osteopathic Association." We would like to be included as the American Board of Physician Specialties so our physicians in Nevada can also advertise their specialty. We would also like to draw your attention to section 1, subsection 1, paragraph (d), subparagraph (2), subsubparagraph (II), which states, "Prerequisite certification by the American Board of Medical Specialties or the American Osteopathic Association in the specialty or subspecialty." In essence, that means my doctors would be board-certified with ABPS and go back after many years to attempt to retake the test with one of those boards. We do require our doctors recertify every eight years and take

an examination. We owe the public that they know our doctors are within their scope of practice and are trained to do what they are doing.

If we cannot amend this bill, is there a possibility you would hold off and do an interim study where we might have more time to address this issue? I think it is an important issue to the public. My board or any other board could come forward and present their information, so you can delve a little deeper into the subject.

Chairman Bobzien:
You mentioned you are new to lobbying, so this is not an issue that was brought up on the Senate side. I am going to assume you have not contacted the bill sponsor on this issue. [Ms. Gray Murphy shook her head no.] I guess the concern is there are a whole bunch of bills we are dealing with right now that deal with these different organizations. Is this the only one you are concerned about, or is this the first one you caught so you are coming in late to make us aware of your organization and advocating for inclusion?

Linda Gray Murphy:
Yes, sir.

Chairman Bobzien:
Interim studies are tough. We will probably see you back here in two years with a bill so you can make the case for your organization. That may be the best way to go forward. With that, I believe we have some questions.

Assemblyman Ellison:
I have been working with the bill sponsor and some of the doctors to come to a conclusion on this. Can you tell us how many doctors in the state of Nevada are with your organization?

Linda Gray Murphy:
I believe we have about ten physicians in Nevada. I will have to check that for sure. I did not call before I came here, but I do not think there are many more than ten here in Nevada. I represent ABPS in many states as a lobbyist. I am currently working in Oklahoma, Texas, and Louisiana. The majority of states in the United States do not have advertising rules through their medical board or legislation. We are currently working on something in the state of Oklahoma where we are going to do a task force or interim study to address the issue. Texas grandfathered us in. We are recognized in Florida. In Oklahoma, the osteopathic board wrote us into the rule, and we are currently working on being written into the rule with the M.D.s as well.

Assemblyman Ellison:
How many states are you licensed in?

Linda Gray Murphy:
We have physicians in all 50 states.

Chairman Bobzien:
Mr. Ellison, were you asking how many states would we find this organization written into the statute?

Assemblyman Ellison:
That is correct. We are trying to find out about these different boards. There are three different boards out there, and they are all certifying boards. I am trying to find out where they are. Could you tell me how long you have been in operation? Maybe that will help me.

Linda Gray Murphy:
We organized in 1950. We have physicians practicing in all 50 states. They are all licensed to practice medicine in the state in which they are currently residing. All of the medical boards recognize my physicians, but when it comes to advertising, most states do not have a rule that addresses this issue.

Assemblyman Hansen:
How many of these boards exist? When I read the bill, there are two. Now there is yours as well. Are there others out there that are legitimate boards with legitimate physicians that would be excluded from being able to practice without going through another board?

Linda Gray Murphy:
There are only three boards that do multiple specialties. For instance, we certify 17 different specialties, and ABMS certifies more than that. There are many legitimate boards out there that certify just one specialty. There are also many that are not legitimate that offer a weekend in Las Vegas and a certificate.

Chairman Bobzien:
Do we have additional questions? [There were none.]

Denise Selleck Davis, Executive Director, Nevada Osteopathic Medical Association:
Our national organization sent a letter to you under their letterhead as well as ours (Exhibit G). They had a concern on section 1, subsection 2, paragraph (a),

where the requirement that health care advertisements provide honest and accurate information applies only if you are not in a licensed medical facility or hospital. They ask that be excluded so those individuals also have to play by the same rules in advertising. Transparency is one of our national agendas, and one that we think is very beneficial to patients. It is long overdue. Having said that, if this would in any way inhibit passage of this bill as it is, we would withdraw that position. This bill is that important to us.

Chairman Bobzien:
Are there any questions? [There were none.] Do we have additional opposition testimony? [There was none.] Is there anyone wishing to speak as completely neutral on this bill? [There was no one.] Senator Cegavske, would you like to say some closing words?

Senator Cegavske:
If I might have Dr. Edwards or somebody else come and talk in reference to the statements that were made by the previous speaker, I would appreciate it. I am not the specialist, but I would like to have that explained.

Chairman Bobzien:
We can make a little bit of time for a brief rebuttal. We do have a number of other bills we have to cover today.

Michael Edwards:
The American Board of Medical Specialties was developed in 1933 and currently certifies 24 specialties. I had not heard of the ABPS until they came to my attention for this bill. The concern is that of the 17 specialties they certify, there is not a clear consistency across the board in terms of how things are accomplished. For instance, for an emergency room doctor to be board-certified as an emergency room doctor through the ABPS, you do not have to have completed an emergency medicine residency. I think that is pretty much the standard practice across the country now. You can test into or certify with some work experience and have a certification in another specialty such as anesthesiology. That is not considered to be equivalent to having residency education in emergency medicine.

We do not want to muddy the issue with the public in terms of all these other boards. It is interesting the members of this Committee have not heard of the other boards as well. They are out there. It has a lot to do with cosmetic medicine and other specialties. The purpose of this bill is to provide clarity and patient safety to the citizens of Nevada.

Gregory Juhl:
I would echo what Dr. Edwards said. Within my specialty, the standard is to complete a residency in emergency medicine. With this other certifying board, that is not necessary.

Chairman Bobzien:
Are there any final questions?

Assemblyman Horne:
For clarity, do you not find their board to be a legitimate board? Do their doctors not rise to the level of what you would certify as a physician? Are you afraid too many boards are going to ask to be included?

Keith Lee, representing Board of Medical Examiners:
We had no interest in this bill until a week ago when Senator Cegavske called this to our attention. I inquired of our board if they had ever heard of ABPS, and they said no. The executive director had never heard of it. We sent an email out to the network of boards of examiners, and we have only received 12 responses, including California, and none of them have recognized them for purposes of licensure. Let me indicate very quickly, a number of years ago, this Legislature made a recognition of ABMS as an alternative to one of the provisions to licensure in NRS 630.160. This body has made a recognition of ABMS as the only board representing medical specialties, which creates a route to alternate licensure. Clearly, if ABPS wants to pursue recognition in this state, there is certainly a mechanism to that. At this point, from the Board of Medical Examiners, we have never heard of them. We have gone by what this Legislature told us years ago as an alternative to licensing by accepting ABMS as a certifying board for physicians.

Chairman Bobzien:
With that, we will close the hearing on S.B. 211 (R1).

[An additional letter in support was submitted by Dirk M. Elston, President of the American Academy of Dermatology Association (Exhibit H).]

We will open the hearing on Senate Bill 198 (1st Reprint).

Senate Bill 198 (1st Reprint): Revises provisions relating to the practice of chiropractic. (BDR 54-834)

Senator Joseph Hardy, Clark County Senatorial District No. 12:
I would like to introduce Dr. James Overland to my right and Marlene Lockard to my left. I will let them present Senate Bill 198 (1st Reprint).

James Overland, Sr., President, Nevada Chiropractic Association:
I will try to paraphrase much of my testimony, which is fairly long (Exhibit I). On behalf of the doctors in Nevada, this bill revises provisions relating to the practice of chiropractic. I would also like to state that this bill only applies to the chiropractic profession and in no way conflicts with any other health profession and their respective scope of practice. [Continued to read prepared testimony (Exhibit I).]

Briefly, within the state of Nevada, the chiropractic assistant program has been around for approximately 20 years. There are currently only about a dozen states that have such a certification program. [Continued to read from prepared testimony (Exhibit I).]

Some of the more important aspects of the bill referring to indirect procedures would apply to established patients only. That is to say these patients have been previously examined by the practicing chiropractor, a diagnosis has been rendered, and a treatment plan has been created for their treatment. That would include standing orders in their files for the patient's supportive care, which is what the chiropractic assistants perform. This is identified under section 7, subsection 1, paragraph (a) of the bill. [Continued to read from prepared testimony (Exhibit I).] According to the National Chiropractic Mutual Insurance Company (NCMIC), which provides chiropractic malpractice insurance, chiropractic assistants are covered whether they perform these duties indirectly or directly, as long as they are practicing within their scope of practice. We are also covered under section 7, subsection 2 of S.B. 198 (R1), where it is required that all chiropractors in the state have $1 million/$3 million malpractice coverage. In addition, all the supervising chiropractors must be reasonably accessible when not in the office, which is listed in section 7, subsection 1, paragraph (b).

This format of indirect supervision follows closely to Florida, which is one of only two states to have this law. The other state is Tennessee. Florida has had this law from the early 1980s, and Tennessee has had this law since 2000. [Continued to read from prepared testimony (Exhibit I).]

In summary, the Nevada Chiropractic Association (NCA) believes this is a good bill on behalf of the doctors in Nevada. We respectfully request that you see the value of this bill as well. Hopefully it will move through this process and become law.

Chairman Bobzien:
Since we have another Committee that needs to meet tonight, and we still have some bills to hear, we are now in the "me too" phase of the afternoon.

Tiffany Stevens, Executive Director, Tennessee Chiropractic Association:
The bill you have before you today is what our legislative body considered back in 2000. I wanted to concur that it has been working effectively. We work very well with our board of chiropractic examiners and regulators of our state. There has not been one incident in the 13 years that has come before us as being an issue with the language regarding direct and indirect supervision. Education was the primary goal within our state, and that has been afforded here. It has not been an issue but is meant to be a support to the doctors if they have to leave for deposition within a regular business day.

Chairman Bobzien:
It is helpful to hear perspectives from another state.

Marlene Lockard, representing Nevada Chiropractic Association:
In a short period of time in two doctors' offices in Las Vegas, the doctors had more than 500 signatures of their patients who would like to see the enactment of this legislation to make their visits to their chiropractic physician much easier.

Chairman Bobzien:
Are there questions for the panel?

Assemblyman Ellison:
This practice goes on as we speak. The assistants do the X-rays and get everybody prepared and ready for the chiropractor, correct?

James Overland:
That is correct. The procedures they would be performing would be no different than if the doctor had been on premises. They will not be doing anything outside their particular area of expertise, whether we are down the block, in another county, in a court of law, or stuck in traffic on the freeway. They would be performing exactly what they do day in and day out.

Assemblyman Ellison:
Is there a time period where you have to be back in the office, whether it be an hour or five hours?

James Overland:
With the licensing board we will help define the parameters of some of these issues, including time allowed away from the office, once this bill has been passed and enacted. Those requirements will become part of the bill before it is allowed to be used by chiropractors in the state.

Chairman Bobzien:
Do we have additional questions for the panel?

Assemblyman Ohrenschall:
My question has to do with how it works in Tennessee. What is allowed for the assistant to perform, and what is prohibited?

Tiffany Stevens:
As Dr. Overland stated, medical decision making relies solely on the chiropractic physician. With regard to what they are allowed to do, it is only what is within their scope of practice and nothing beyond that. So that is what they are trained and knowledgeable to do. It would only be if, as stated, the physician could not get back to the office or had to leave for lunch, but they still needed to follow through with their continuity of care.

Assemblyman Ohrenschall:
Is that the kind of regulation you envisioned the Nevada board promulgating?

James Overland:
What we envision is for the doctor to be able to be out of the clinic for unforeseen circumstances. All of the different regulations, parameters, and covenants will be worked on at the end of the bill. We could not foresee everything that could come up with respect to the doctor being out of the office that has to be addressed, but we will address all of the key safety features that might come up with the licensing board.

Marlene Lockard:
When this bill was heard on the Senate side, we had worked with the Chiropractic Physicians' Board of Nevada, and they asked us to adopt an amendment to this bill, which would require regulations to be completed before this bill goes into effect to clarify the exact process that would be in place. You can read those provisions in the bill. They identify the services the chiropractic assistants could perform through regulation of the licensing board.

Chairman Bobzien:
Are there additional questions? [There were none.] Is there anyone else wishing to speak in support? We will start with those in Las Vegas.

Roper Dollarhide, Vice President, Nevada Chiropractic Association:
I have been a licensed chiropractic physician practicing in Las Vegas for the last 14 years. Over that period of time, I have seen over 100,000 patient visits. With most of those visits, the patients require some type of physical therapy, which is administered primarily through my chiropractic assistants, who are

licensed through the board. With all of those patient visits, I have never had one instance where a patient's safety has been compromised or even an instance where a patient has been harmed. Some of the opposition of this bill is that there is a patient-safety issue. In my personal experience, and the experience of my colleagues, there would be no patient-safety issue because we have not had one in the past, and we do not foresee anything in the future. Having said that, I would like to express my support for this bill and ask for your consideration and passage.

Joseph Nicola, Chiropractic Physician, Las Vegas, Nevada:
I have been a licensed chiropractor here in Nevada for around 12 years. I want to thank you for your time regarding S.B. 198 (R1). I want to clarify the intent of the bill. I mirror everybody else's sentiments so far who are in favor of this bill. The intent is continuity of care for the patients. Unforeseen circumstances happen, and when those things happen currently, we have to cancel our patients and send our employees home. Nobody gets treatment and nobody gets paid. It is not good for our patients and our employees. If our chiropractic assistants are able to continue an established treatment plan with an established patient, at least that patient is able to undergo the therapeutic exercises and physiotherapy under the chiropractic assistant's guidance that he or she already performs. They already do this day in and day out for us.

There are many objections to the idea of doing this. One of them is that chiropractors will open up multiple clinics. We do feel as if we have addressed this. Another objection, as Dr. Dollarhide stated, is there might be an increased malpractice risk. We have contacted NCMIC, and they do not see any increased malpractice risk with this, nor do they feel there would be an increase in our malpractice rates or premiums as a result of enacting this legislation.

Another objection is the screening process as to how the chiropractic assistant would screen the patient when he or she comes in. Is this a new patient? Does he or she have a new condition that needs to be evaluated by the chiropractic physician? What mechanism would be in place to allow that to happen? I can justify in my personal practice for the last 12 years that this already occurs. We assume this occurs in everybody's practice. We establish a treatment plan for our patient, and our chiropractic assistants undertake that treatment plan. And every day when the patient comes in, he or she is asked, "Do you have a new condition?" and "How are you feeling today?" If there is a new condition upon questioning, he or she does not get treatment until seen by me. There is already a mechanism in place for that. For new patients, this is routine in every doctor's office. New patients are screened at the front desk. They are not going to be brought back and seen without having an established treatment plan from the doctor.

We feel we are trying to give the chiropractic assistants the ability to continue patient continuity of care in the absence of the doctor because of an emergency. We feel this is a good piece of legislation, not just for the patients being able to establish a treatment plan and not being sent home, but we also feel it is good for our employees who would ultimately miss out on income or revenue as a result of an unforeseen circumstance happening to the doctor.

Lastly, I would like to mention that what we are proposing is not a novel idea. It is already happening in Tennessee and Florida for an accumulative aspect of nearly 30 years. According to those two states, and the representatives from them, there is really no issue with it. We feel we are proposing good legislation for the state of Nevada for the patients, doctors, and employees in our offices.

Chairman Bobzien:
Could you please stay at the table? We may have some questions once we receive all of your testimony.

Derek Day, Chiropractic Physician, Anthem Chiropractic, Henderson, Nevada:
I am a native Nevadan, and I have been in practice in Henderson for 17 years. I thank you for allowing me the opportunity to testify in support of S.B. 198 (R1). Chiropractic physicians and their assistants do not prescribe drugs or perform surgeries. The safety of the profession is well documented over our history of more than 100 years. Typically, we treat nonemergency, non-life-threatening musculoskeletal conditions such as neck and back pain. Historically, the profession has paid very low malpractice insurance premiums because of this record. Chiropractic assistants in Nevada also have a record of safety and contribute to this credibility and integrity of our profession.

We have submitted patient signatures, as Ms. Lockard mentioned earlier, and I think the patients understand the spirit of this bill is to allow them better access to medically necessary chiropractic care in the event the doctor is unavailable. We have also submitted numerous letters from doctors in numerous specialties and from other professions as well, including many attorneys. Senate Bill 198 (R1) is supported by the American Chiropractic Association, which is the largest such group in the United States. This bill is also supported by numerous other states. Florida and Tennessee have already been mentioned, and there has been very little risk or injury.

This bill allows patients, especially chiropractic patients, the access other health care professions in Nevada already have. We talked about the doctor being out of the office, and I have had some personal experience with that over the last 17 years. Even though I am happy to be here today in support of this bill,

my patients are not being treated and some of my staff went home. It has certainly caused some economic issues. I think this bill allows a reasonable solution to some of these problems. Chiropractors are small business owners in Nevada, and this will help these small businesses in many ways during this economic downturn. Nevada has always been a progressive state, and this bill helps our profession keep in step with the constantly changing health care industry.

Recently hearing your discussions about telemedicine, I think this makes our bill look more reasonable. In closing, I believe there is a net benefit to Nevadans, and I strongly urge you to support it.

Chairman Bobzien:
Are there questions for the panel in Las Vegas?

Assemblywoman Carlton:
I apologize for being out of the room for a few moments. It is that time of the session. I believe I have come to the answer for part of my question. One chiropractor can have four assistants, if I understand that correctly. Can someone nod their head yes? [The witnesses nodded their heads yes.] It also says "at a time." I am trying to figure out how this would work if the chiropractor had two offices. If he or she had a couple of offices with four in each office, the total number of assistants equals eight. I am trying to understand the mechanics of how this would work. The last thing I want to see is one chiropractor with four or five offices and four or five assistants in each office. I do not believe that is any supervision at all. I think we need to make sure we understand that portion. If we went over this when I was out of the room, I apologize.

Marlene Lockard:
If the doctor had another office, the bill would require a chiropractic physician in that office at well.

Assemblywoman Carlton:
If you could point that out to me either now or later, I want to make sure I know where it is when I am asked about it.

James Overland:
We did address this briefly when you were out of the room. In reference to the four assistants, a chiropractor can supervise four assistants in their office at any one time and no more than those four. With respect to this particular bill, under section 7, subsection 1, paragraph (c) it states, "The services are performed: (1) In the primary place of practice of the supervising chiropractic physician

to whom the chiropractor's assistant has been assigned." This does not allow a chiropractor to have multiple locations with just assistants running those offices. A supervising chiropractor has to be in each office with a designated assistant. If I had multiple offices, I need to have chiropractors in each office, and they must have separate assistants working for them. If one of those chiropractors is absent, their assistant can step up and provide the therapy that is normally done by the assistant when the chiropractor is there as well.

Assemblywoman Carlton:
I appreciate your pointing out that language. I read these a number of times, and it does not read that way to me. I do not think it is very clear, and I think it would open this up for debate or discussion. We want to make sure it is very clear that this would not apply to multiple locations. We need to really draw that line because an argument could be made in the regulatory process. I am not sure how "primary place" is defined, so we could get into all types of discussions on "primary place." I think we need a couple more definitions to make sure this is clear. With that consideration, I would understand it a little better.

Chairman Bobzien:
That is fair. Do we have any additional questions for our panel in Las Vegas? [There were none.] Do we have anyone else in support? [There was no one.] Do we have anyone in opposition?

Annette Zaro, Chiropractic Physician, Las Vegas, Nevada:
Thank you in advance for your time and consideration regarding S.B. 198 (R1). As you are aware, many professions have an association whose charge it is to protect and advance the profession, as well as a legislative regulatory board whose charge is to protect the public. Many times, these two can achieve their goals working together for the same purpose. Senate Bill 198 (R1) does not fall into that category. This is a bill that will allow indirect supervision of certified chiropractic assistants. Indirect supervision means the doctor does not have to be on the premises but must be available by phone or other electronic means.

In my opinion, and the opinion of many others, this poses a danger to the public. The current requirement to be a certified chiropractic assistant in Nevada is that you must be 18 years old. The educational requirement is six months of full-time, on-the-job training, as well as passing the chiropractic assistant test and jurisprudence test. The current first-time pass rate for this test is less than 15 percent. Many chiropractic assistants in training must take the test several times in order to pass. As you can clearly see, the education is not there to allow for chiropractic assistants to treat a patient unsupervised. I have enclosed two letters, one from the International Chiropractors

Association (ICA), which Dr. Youngblood will address (Exhibit J). This is an organization whose charge it is to protect and promote the profession of chiropractic as stated above. The other is a letter from the Federation of Chiropractic Licensing Boards (FCLB) (Exhibit J).

I will tell you a brief history of the FCLB. It is the association of governmental agencies that regulate the practice of chiropractic. Their member boards include boards from the United States, Canada, Australia, New Zealand, and the United Kingdom. Chiropractic regulatory boards have been working together under the banner of FCLB since 1926. The Federation of Chiropractic Licensing Boards has established the Certified Clinical Chiropractic Assistants (CCCA) Program. This program's requirements are similar to Nevada's; however, the education component is not. In order to become a CCCA, you must first take a 24-hour course and then sit for a national examination given by the National Board of Chiropractic Examiners and not just a state agency. After passing this examination, you will receive the certification to work in a clinic under the direct supervision and training of a licensed doctor of chiropractic for a minimum of 300 hours. Even with this, you will have to be under the direct supervision of a chiropractor. The program has uniformity. However, after the person has earned that CCCA certification, it only allows them to work under the direct supervision of a chiropractor.

Tennessee has been brought up. In Tennessee, there are requirements to take a board-approved course of 50 hours. This board-approved course has stringent educational background behind it. After the 50 hours, you are required to take 1,200 hours of an internship, which is under the direct supervision of a chiropractor. I am not quite sure where Dr. Overland received his information, but there was a power poll performed. A power poll is done through the FCLB where they poll all licensing and regulatory boards. I was asked, "Do you allow for indirect supervision?" Tennessee's response was that the supervising chiropractor must be present in the office while the chiropractic assistant is performing therapy on their orders. To me, Tennessee is saying that you required direct supervision, although it was said here that they allow indirect supervision. According to the power poll, which came directly from the board, they do not allow it.

Chairman Bobzien:
Could you hit the highlights rather than reading directly from your testimony?

Annette Zaro:
If you want to compare another profession, that would be the physical therapy assistants. They require two years, and they must have direct supervision. I also heard Oregon brought up. Although the association may be working

on something like this, Dr. Daniel Cote, who is the president of the Oregon board, and I had an opportunity to speak. The Oregon board is not looking at this at all to go into effect. Sometimes the associations have one viewpoint and the regulatory board has another. In Oregon, that is the case.

I have also heard testimony that it is really safe because we are only working with established patients. I would like to tell you a story that just happened to me on Monday. I have an established patient. We have been seeing him since April 8 for a motor vehicle accident. He came into my office and went through the regular process of signing a form before he enters the room. He was asked if he had any other new complaints. He did not write anything down. He went back into the room and therapy was performed as usual. If this bill passes, the patient would have left at that time, and everything would have been fine. Because I would not allow indirect supervision, and it is against the law, I was in the office. I saw the patient afterwards and he said something weird was going on, that when he brushed his teeth and opened his mouth, this happens. When he opened his mouth, his lower jaw deviated to the left. I said, "Yes, that is a little weird." I went ahead and got my penlight and did pupillary reflex. His right pupil was fixed and dilated, while his left pupil was reactive. At this point I did sensory tests on his face and a couple other neurological examinations, and I determined at that time that he was having a medical emergency. He went to University Medical Center and was admitted. These things happen. This was not a coincidence that he walked into my office on Monday. If I can save one person from a long-term disability because I was in the office, I think that is a positive thing.

Chairman Bobzien:
We are going to have to move this along. I have asked for the highlights of the opposition, and I think you have covered it well. Do you have any other salient points you need to get across?

Annette Zaro:
Dr. Louis Sportelli, the president of NCMIC, which is our malpractice carrier, told me that a chiropractic assistant would not be covered through malpractice if he or she triaged the patient.

One last point would be the economic factor I heard during testimony today. It may be beneficial to the doctor and the chiropractic assistant who can stay an extra 30 minutes, but it is not beneficial to an associate or covering doctor. Right now, if a doctor leaves the office, they require a covering doctor to go in there. That doctor would no longer need the employment. In addition, an associate doctor would not be needed.

Chairman Bobzien:
We will keep you at the table in case we have any questions for you. We will move to the next presenter.

Stephanie Youngblood, Board Member, International Chiropractic Association:
I have been practicing in Las Vegas for 24 years. I was a member of the Chiropractic Physicians' Board of Nevada for eight years and chaired it for four years. I am currently on the board of the International Chiropractors Association (ICA). You should have a letter in your file that was sent to you (Exhibit J). The ICA met two weeks ago in Iowa. The legislative committee and the board of directors of the ICA have studied the legislation in question, S.B. 198 (R1), and out of deep concern for issues of public safety, credibility, and integrity of the chiropractic profession, we urge that this bill be defeated.

This morning, I had a conversation with Dr. Stuart Hoffman, who is the president of ChiroSecure, another malpractice carrier for the chiropractic profession. He wants you to know that he is very concerned that this can open the door to unsupervised therapy, leading to additional liability exposure. I urge you to table this bill.

Chairman Bobzien:
Do we have anyone else in opposition in Las Vegas? [There was no one.] Committee, do we have any questions?

Assemblywoman Carlton:
Is there someone from the Board who can answer these questions?

Stephanie Youngblood:
We have Dr. Benjamin Lurie here representing the Board as a neutral party.

Assemblywoman Carlton:
I think that is what we need.

Chairman Bobzien:
We will go to Las Vegas.

Assemblywoman Carlton:
Was this discussed with the Board before it was proposed to the Legislature?

Benjamin Lurie, Vice President, Chiropractic Physicians' Board of Nevada:
We were not made aware of this bill until around April. The bill was presented to us on a piece of paper back in our January meeting. However, the Board never had the opportunity in January to discuss the nature of the bill along with

the regulations and public safety that would go with it. In the meantime, this happened to be passed through the Senate before the Board had the opportunity to meet as a regulatory board and take a position on whether this bill was supported, opposed, or neutral. It was not until April that we came in neutral with the bill, as the Board had a vote of 4 to 2 with some opposition from two of the board members present today. There was a lot of discussion, and there were two different motions made on this bill. Our Board attorney advised us to come in neutral because it had already passed through the Senate.

However, from the Board's standpoint, there are obviously some concerns we can talk about now or during my actual testimony. These concerns are regarding writing these regulations. I have heard other testimony today about the many factors that go into this. I had the opportunity to sit down with Dr. Overland from the NCA, and between the two of us, we had about three or four pages of "what if" scenarios. As you know, this is a program that is hardly in any state with indirect supervision. We would be in the forefront, leaders in the industry, to write such regulation for public protection. I am sure you are aware of the daunting task that would be for us as regulators.

Assemblywoman Carlton:
Thank you for the answer. My next question is do you have "primary place of practice" defined anywhere within your *Nevada Revised Statutes* (NRS) or *Nevada Administrative Code* (NAC)? That seems to be the crux of my concerns. Is there an actual definition of that?

Benjamin Lurie:
There is a definition of it, and it is that your place of license is where you spend approximately 80 percent of your time.

Assemblywoman Carlton:
You can spend 20 percent someplace else?

Benjamin Lurie:
That is correct. That is an issue we will have to deal with in this bill.

Assemblywoman Carlton:
I will not ask any more questions now, but I have a long list. I will reach out to the other people. It seems to me that if we are changing the practice this drastically, it should be in partnership with a regulatory agency.

Chairman Bobzien:
Fair point. Sir, let us take neutral testimony now. If you have additional comments to make, please proceed.

Benjamin Lurie:
I am a native of Las Vegas and have been in practice for 12 years here. The Board met on April 6, 2013, at which time S.B. 198 (R1) was brought up on the agenda for a vote. In briefing, as you have already heard, the vote was 4 to 2 to come in neutral at this time on this bill. That is our position at this time.

Chairman Bobzien:
Do we have any further questions for the Board? [There were none.] This seems like a fairly complete record on this bill. Before anyone has a compelling need to come back to the table to provide further comments, we will turn it back over to Senator Hardy to bring us home with a brief closing.

Senator Hardy:
I am a doctor, and these are chiropractors. These are things that they are trying to help people with. The American Chiropractic Association, with their 14,000 members, has given you a letter (Exhibit K) that says they endorse this legislation. I think I would compliment the Committee in their being thorough. We will provide documentation from Tennessee as to what the reality is, and we will get the Committee the definition of "primary practice," which is at the bottom of page 3 and the top of page 4 where they can do this. This is subject to the regulatory process where the Board will have to be involved and have their say. It will eventually have to go through all of the regulatory things including the Legislative Commission, so the Legislature still has fingerprints all over it.

Marlene Lockard:
Can I put one correction on the record? Both Dr. Overland and I attended the Chiropractic Physicians' Board meeting in December 2012, and we presented this bill to them at that time.

[An additional letter of support was submitted (Exhibit L).]

Chairman Bobzien:
We will close the hearing on Senate Bill 198 (R1). We will open the hearing on Senate Bill 220 (1st Reprint).

Senate Bill 220 (1st Reprint): Makes various changes relating to certain professional licensing boards. (BDR 54-502)

Senator Joseph Hardy, Clark County Senatorial District No. 12:
I would like to thank the people who are interested in trying to solve the problem of unlicensed medical care in Nevada. The Attorney General received

the report, "Responding to Unlicensed Health Care in Nevada: A Plan for Action." This is a committee bill, and Senator Jones and I were assigned to work on the bill and figure out what we could do. We have had a lot of input from staff, Legal Division attorneys, and lobbyists. Senate Bill 220 (1st Reprint) is an interim health care focus on what to do with the unlicensed care. The boards have all been looked at. We have identified 16 boards in *Nevada Revised Statutes* (NRS) that are subject to this bill. Those are enumerated by reference to the statutes. There were many differences among the boards as to penalties, authority to enter premises, investigating anonymous complaints to cease and desist, authority to seek injunction, and the authority to find people who are practicing medicine without the permission to do it.

I am in a quandary right now because your mock-up I would work from is technically an amendment (Exhibit M). I do not want to be in opposition to the bill. I will proceed if you would like.

Chairman Bobzien:
For the bill sponsor, you do not have to oppose the bill with your amendment.

Senator Hardy:
The bill protects the patient confidentiality. If patients are getting unlicensed care but think they are getting licensed care, they still have to be protected for their confidentiality. We need to treat them as if they were getting licensed care. This also addresses the unlicensed care and puts the Board of Medical Examiners as the umbrella default call to make if people feel there is something going on. The language on page 3, lines 5 through 14 makes the Board of Medical Examiners the one that can delegate out to the boards that may have individual responsibility for the practice involved.

Likewise, you will see common language throughout. With the inspections of licensed care, there are only three boards in NRS allowed to go in and look at licensed care in a specific way, verbiagewise. It allows the boards to go into their licensee and inspect them. Likewise, it allows inspections for unlicensed care to be under probable cause with law enforcement to go in to find out what is happening.

This bill also allows the Board to have flexibility to extend a license, so you do not have somebody who is three days late on their license renewal and is now guilty of unlicensed care. As an example, my friend was in a coma for three months and woke up and found all sorts of things that were taken away from him. It allows the Board to understand those kinds of things where they need flexibility.

At the end of the bill, it talks about the cosmetology schools and the students who have to go to a postsecondary school in order to allow the $35 million that goes into the students' pockets to continue their cosmetology evaluations and teaching methods. I have the new State Board of Cosmetology Executive Director to my right and the Board of Medical Examiners to my left. You will see the common language repeated under every single board. The exception is the Board of Dispensing Opticians because they did not need as much authority as we were going to give them. Their portion, which is in the mock-up (Exhibit M), is a little shorter. The opticians were integral in their part, and they are one of the reasons we have so much commonality in the statute. They contributed vitally to this program.

Chairman Bobzien:
Do you want your panel to provide remarks and then open it up to questions?

Senator Hardy:
Only if they are brief.

Keith Lee, representing Board of Medical Examiners:
We worked diligently with Dr. Hardy and others in crafting this legislation. We think the mock-up before you (Exhibit M) achieves the public purpose that it was intended to do. We started on this, and we wholeheartedly support it and urge its adoption.

Gary Landry, Executive Director, State Board of Cosmetology:
I have submitted a letter dated March 7, 2013, in support of the amendments to S.B. 220 (R1) that specifically affect the cosmetology industry (Exhibit N). On this past Monday, May 6, 2013, the Board voted to support the amendments on the bill for section 98.5, 100.5, and section 111, subsections 1 and 2 of S.B. 220 (R1) and endorsed me to write a letter of support, come and speak in support of the amendments, and instruct our lobbyists to do the same. The State Board of Cosmetology is in full support of the amendments.

Chairman Bobzien:
Do we have any questions for those at the table? [There were none.] Is there anyone in support? "Me too" is highly encouraged.

Lawrence Matheis, representing Nevada State Medical Association:
Me too.

Frederick Olmstead, General Counsel, State Board of Nursing:
Me too.

Paula Berkley, representing Board of Occupational Therapy; State Board of Physical Therapy Examiners:
Me too.

Neena Laxalt, representing Board of Dispensing Opticians:
Me too.

Rodney Moore, Operational Manager, Carson City Beauty Academy, Carson City, Nevada:
We have been in business for 24 years, and from 1990 to 2000, we had more than 300 people graduate from our institution, and from 2000 to present, we have graduated 751 students. We would love to support the amendment to this bill.

Richard Moreira, Private Citizen, Carson City, Nevada:
I am a cosmetology student at Carson City Beauty Academy. I am in support of the amendment because if you took away the funding, students like myself who have no outside income other than student loans and grants would not be able to continue schooling. I would not be able to continue my education in any other way. Me too.

Dennis Wood, General Counsel, Marinello Schools of Beauty, Beverly Hills, California:
We have three schools in Nevada: Las Vegas, Henderson, and Reno. Currently we have 148 students enrolled in Las Vegas, 126 students in Henderson, and 142 students in Reno. We support the amendment to S.B. 220 (R1) for cosmetology because this will ensure our students are able to continue to be eligible for federal financial aid.

Joyce Mikesell, representing International Academy of Style, Reno, Nevada:
We are a cosmetology school in Reno. This bill is important to us because 90 percent of our students are Title IV financial aid recipients. If financial aid became unavailable to us, we would have to close our doors. We currently have 93 students attending our school. Since 2007, we have graduated approximately 124 students per year. We are currently employing 16 people at our school. If we no longer had financial aid, we would not be able to offer positions for these women.

This would have a chain effect on our industry as a whole. There is already a shortage of qualified professionals in our industry. In a time when our country is struggling economically, our industry is continuing to grow and be prosperous. If we are not able to have professionals continue to graduate and be available to the salons in our communities, it would impact the income of the

salons. They would eventually be forced to close down if no one was available to rent space in their businesses.

Furthermore, this would impact the building owners where the space is leased. The supply houses these professionals shop at would also be dramatically affected, which in turn would affect their ability to maintain their employees and continue to lease their building spaces as well.

Last but not least, this would be a devastating blow to our many students and families who have made the commitment to attend school to pursue a better future for them as well as their families. They would no longer be able to avail themselves of this opportunity if financial aid were not available.

In closing, I ask when you are making this decision you take the time to consider the far-reaching ramifications of taking away cosmetology schools' ability to offer Title IV financial aid.

Chairman Bobzien:
Are there any questions for our panelists? [There were none.] We will move to Las Vegas.

Sandy Dunham, Owner, Academy of Hair Design, Las Vegas, Nevada:
We have been in operation since 1972. Currently, we have approximately 20 employees. Over the years, we have graduated over 6,000 students, with the majority of them successfully employed in Nevada. We urge your support of S.B. 220 (R1). We need State authorization in order to be recognized by the U.S. Department of Education.

RoseAnn Perea, representing Supercuts, Las Vegas, Nevada:
Supercuts is a chain hair salon with over 2,000 salons nationwide. We operate 48 salons in Nevada. We currently employ over 500 licensed cosmetologists in Nevada. We depend on cosmetology educational institutions in our state to be able to supply a qualified licensed workforce for our salons. We strongly urge that you support S.B. 220 (R1) for state authorization of cosmetology schools to be recognized by the U.S. Department of Education.

Kristie Chiles, Regional Executive Director, Euphoria Institute, Las Vegas, Nevada:
I would like to say a short "me too." Euphoria Institute has three locations in the Las Vegas Valley. We are in each corner of that valley. I would like to say that we have 400-plus current students. We will see many more this year. We have over 70 employees. Not supporting this bill will adversely impact our company, our employees, and most importantly our students and community.

Without this bill being passed, we will have to close our doors. I hope that you understand the importance of S.B. 220 (R1).

Chairman Bobzien:
Are there any questions for our panel in Las Vegas? [There were none.] Is there anyone else in support of S.B. 220 (R1)? [There was no one.] Is there anyone in opposition? [There was no one.] Is there anyone neutral? [There was no one.] Dr. Hardy, would you like to come back up for some final words?

Senator Hardy:
Me too.

Assemblyman Daly:
I was looking through this and have a question about section 5, subsection 6, where it says, "The Board shall, to the extent feasible, communicate or cooperate with or provide any documents or other information to any other licensing board . . . ." I know there is similar language there, but the previous sections talk about documents and investigations, closed meetings not subject to the Open Meeting Law, and the information disclosed is confidential. This is in about ten different places in the bill. Is there anything else indicating when you cooperate and provide this information, that the second board needs to keep that information confidential as well? If it was confidential to begin with, it should follow. I do not know if there is already a regulation or rule that requires that, but it should be made clear or at least put on the record.

Senator Hardy:
If I may go back to the issue of personal identification, with the victim of unlicensed care, the victim must be kept confidential. I will defer to Mr. Lee.

Keith Lee:
Assemblyman Daly, I can speak only for the Board of Medical Examiners, but all information we obtain during an investigation remains confidential until such time as we file a disciplinary complaint. At that point in time, it becomes a matter of public record. I believe the other boards of which I am familiar treat that information the same way.

[Three additional exhibits were submitted by Senator Hardy (Exhibit O), (Exhibit P), (Exhibit Q), and another was submitted by Neena Laxalt for the Board of Dispensing Opticians (Exhibit R).]

Chairman Bobzien:
We will close the hearing on S.B. 220 (R1). We will open the hearing on Senate Bill 319 (1st Reprint).

Senate Bill 319 (1st Reprint): Revises provisions governing certain professions. (BDR 54-713)

Senator Joseph Hardy, Clark County Senatorial District No. 12:
I am the sponsor so I will refer to the mock-up of Senate Bill 319 (1st Reprint) (Exhibit S). This particular bill is trying to get at addiction and the many facets of addiction and pain management care. The first part of the mock-up talks about the education that we will allow an allopathic physician and an osteopathic physician to have. Right now, an allopathic physician, or M.D., must have four hours of ethics training. This would allow two of those hours to be used to address addiction and pain management care so we can get more education into that process.

The bill also talks about trying to get more caregivers into the state. Inasmuch as we have challenges with care, we are trying to get clinical professional counselors, marriage and family therapists, and drug and alcohol therapists. Page 4 deals with that permissive language to get a license by endorsement if people are qualified. It then talks about a fee on page 4, line 15, in lieu of an examination. If we are endorsing these people because they are indeed qualified somewhere else, we want them to come here and allow them to be here by endorsement.

Helen Foley wisely recommended putting in the 45 days on line 37, for the marriage and family therapists, so it matches all of the other bills to give a definite period of time where someone can expect to get their license. Finally, at the bottom of page 4, we are talking about a further encouragement. Going along with what the Governor is trying to do, this allows active members and veterans of the military, spouses of veterans, and surviving spouses of veterans to come into Nevada with an incentive of paying half the cost of the fee. This will affect those who are active duty and bring their spouses with them.

Keith Lee, representing Board of Medical Examiners:
We wholeheartedly endorse and support Senate Bill 319 (R1). We worked with Dr. Hardy on it, and we think it addresses the concerns we had. We urge your support.

Helen Foley, representing Marriage and Family Therapy Association of Nevada:
We worked very closely with Senator Hardy on this, and we congratulate him on combining many different types of issues and making them consistent with other bills we have this session. He addressed his concern about making sure we could have more people working on drug and alcohol issues and mental health issues in Nevada. This streamlines the process so people do not have

delays if they had similar credentials from other states. We wholeheartedly support his effort.

Chairman Bobzien:
Do we have any questions? [There were none.] Do we have anybody in support of S.B. 319 (R1)?

Lawrence Matheis, representing Nevada State Medical Association:
We support this bill for the reasons already presented.

Denise Selleck Davis, Executive Director, Nevada Osteopathic Medical Association:
We are in support of this bill.

Chairman Bobzien:
Are there any questions? [There were none.] Is there anyone wishing to testify in support? [There was no one.] Is there anyone in opposition? [There was no one.] Is there anyone neutral? [There was no one.] We will close the hearing on S.B. 319 (R1). We will open the hearing on Senate Bill 324 (1st Reprint).

Senate Bill 324 (1st Reprint): Revises provisions governing professions. (BDR 54-701)

Senator Joseph Hardy, Clark County Senatorial District No. 12:
Senate Bill 324 (1st Reprint) also deals with endorsement, and I will turn the time over to the Governor's representative, Vance Farrow. This bill has its genesis in the Governor's Office, so it is only fair to let them have their say.

Vance K. Farrow, Industry Specialist, Health Care, Governor's Office of Economic Development:
I would like to begin by thanking all of the representatives from the boards and the special interest groups that came together to help draft this piece of legislation, as well as Senator Hardy and Assemblyman Eisen for their leadership and support in this process.

On page 2 of the PowerPoint we provided you (Exhibit T) it notes that S.B. 324 (R1) authorizes boards in *Nevada Revised Statutes* (NRS) Chapters 630 to 641C and Chapter 644 to expedite health professional licensure for veterans, spouses of veterans and widows/widowers of veterans. [Continued to read from PowerPoint presentation (Exhibit T).]

I will not belabor you with many of the problem statements I am sure you are aware of, in terms of our shortage of health professionals or our medical

pipeline and educational programs that are not able to meet our needs. At current pace, it will take approximately ten years to produce enough physicians to treat our population—provided there is no additional growth in our population, which we know to be unlikely.

Page 7 has a brief summary of the impact of the Affordable Care Act and a number of additional individuals who have the option to be insured under the Affordable Care Act. It also shows estimated population growth over the next 20 years, given the baby boomers are turning 65 and becoming eligible for Medicare. On page 8, you will see a diagram that shows the current Nevada population. On page 9, you will see the drop-off for surgeons, psychiatrists, and podiatrists while the state's population has maintained its growth. On page 10, in blue you have Nevada's providers per 100,000 population as compared to the United States equivalent. You will see the disparity in medicine and primary care, surgeons, psychiatry, and podiatrists. Page 11 shows a similar disparity in employment.

Solutions are summarized on page 12. It notes that S.B. 324 (R1) creates new provisions for granting Nevada medical licensure with expedited timelines within 60 days. [Continued to read from PowerPoint presentation (Exhibit T).] Lastly, you will see some of the supporters listed.

Chairman Bobzien:
Mr. Lee, do you have any comments to add?

Keith Lee, representing Board of Medical Examiners:
We wholeheartedly endorse this bill. We appreciate the energy and effort that Dr. Hardy, Mr. Farrow, and others have put into this bill. We urge your support.

Chairman Bobzien:
Are there questions for the sponsor or presenters?

Assemblyman Livermore:
The bill requires a two-thirds vote. Could you tell me why that is? The last bill did also.

Senator Hardy:
Anytime you see a fee, such as on page 11 and later in the bill, and language that deals with that, it will affect how the board does things. In the bill, we have not increased fees as much as we have alluded to them. I am not sure that the two-thirds will still stand. I expect well more than two-thirds to come out of this body.

Chairman Bobzien:
Mr. Mundy, do you have perspective on that?

Matt Mundy, Committee Counsel:
The actual fees charged are not increased, but since we have created a few sections with new qualifications for licensure, there is a new category of licensure. So new fees would be received as revenue. That triggers the two-thirds requirement.

Chairman Bobzien:
For that category.

Matt Mundy:
Yes, for that category.

Assemblyman Daly:
On the reciprocal agreement, who is going to be negotiating those? Obviously, we need to have similar licensing, qualifications, and scope in relation to the other states. How much variance is there going to be? We are recognizing their doctors, and they will recognize ours. Do you plan on doing this across the country or just bordering states? What is the plan?

Vance Farrow:
This is a trend that the national boards are following. They are looking to create reciprocal agreements in the United States. They will be the ones leading that charge. We are encouraging the boards within Nevada to begin having those conversations with neighboring and other states to foster that conversation as it progresses on a national level.

Keith Lee:
Through a national association of professional licensing boards, we have already begun discussions in this respect. There are a lot of things that can be done at the national level that can speed up the licensing of physicians in various states, such as a central repository of where the person went to school, certifications, and those types of things. We are already working on that at the national level. Once we have that in place, we think it will cut even shorter the time for licensure. It is the boards that will do this.

Assemblyman Daly:
I understand with reciprocal agreements you get a lot of different questions that must be asked; for instance, a dispute, a lawsuit, what state has jurisdiction, and all of those things. Have those been fleshed out yet?

Keith Lee:
No, they have not. Mr. Farrow, Dr. Hardy, and I have had many discussions over the fact we are very solicitous of our requirements and our responsibilities. We are not going to willy-nilly sacrifice that and what we think are good standards for licensure. That is why you will see we put a lot of hard work into these endorsement provisions that, at the end of day, allow the Board of Medical Examiners the discretion in determining the person's qualifications. We are working at the national level and with sister states as to how we can speed up the licensing process so we can get qualified physicians licensed as quickly as possible.

Assemblyman Daly:
I want to make sure simple things—like choice of laws, fingerprint requirements, and various things that people double-check to make sure people are who they say they are—are covered for our people who are treated by a doctor coming from another state.

Keith Lee:
From our perspective at the Board of Medical Examiners, as we read this and do this, we maintain all of those requirements we think are necessary. At the end of the day, we still retain the ultimate discretion to determine the person's qualifications. We are just looking at ways to speed up the process.

Assemblyman Ellison:
In your previous testimony, you said the recipients are the spouses of veterans and others. I did not catch it.

Vance Farrow:
That specifically pertains to veterans, spouses of veterans, and widows/widowers of veterans.

Assemblywoman Bustamante Adams:
Your presentation had the list of supporters. I noticed everybody was from the health care industry. Is there anybody from the Department of Defense, the Nevada National Guard, or Veterans' Services who gave input into the drafting of the bill?

Senator Hardy:
The Governor has reached out and done this with an Executive Order. This puts it in statutorily. What Vance Farrow alluded to is that what the Governor did by Executive Order, we are trying to do by Nevada law.

Chairman Bobzien:
Are there any final questions for our panel? [There were none.] Is there anyone else wishing to speak in support?

Senator Hardy:
Nevada is one of two states that require everybody to do everything in the same place at the same time. On page 5 and page 12 of the mock-up (Exhibit U), those two greened amendments look at allowing the doctor to have the same training but have it interrupted and still complete the training requirements to become certified.

Keith Lee:
That was a point of some discussion. We all agreed that this was a good way to go. When we are talking about programs and whatnot, the Board retains its discretion. The way we have it worded here, it satisfies everyone's concern, including those concerns expressed by Assemblyman Daly. At the end of the day, the Board of Medical Examiners still retains the discretion to determine the qualifications of the physicians. This is one more avenue for us to allow a physician to apply so we can review. From our perspective, this was the most negotiated point we had. We are pleased with where we are in it.

Lawrence Matheis, representing Nevada State Medical Association:
We do support S.B. 324 (R1). The issue here is not just about physicians. It is about trying to get all of the health care workforce boards to begin looking at ways to expedite increasing our workforce. It is not just the number of our physicians that is dramatically below need. It is across the board. This does begin to develop policy that can then be fine-tuned to each of the variations. The idea is to be able to move forward in meeting the workforce demands that are only going to increase during the coming years.

Joan Hall, President, Nevada Rural Hospital Partners:
We are in support of this bill.

Bill Welch, President and Chief Executive Officer, Nevada Hospital Association:
We are in support of this legislation.

Chairman Bobzien:
Is there anyone in opposition? [There was no one.] Is there anyone neutral? [There was no one.] Dr. Hardy, is there anything else? [Senator Hardy indicated no.] With that, we will close the hearing on S.B. 324 (R1). Does anyone wish to offer public comment? [There was no response.]

The meeting is adjourned [at 5:16 p.m.].

RESPECTFULLY SUBMITTED:

_____
Julie Kellen
Committee Secretary

APPROVED BY:

_____
Assemblyman David P. Bobzien, Chairman

DATE: _____

EXHIBITS

Committee Name: Committee on Commerce and Labor

Date: May 8, 2013 **Time of Meeting: 1:38 p.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
S.B. 327 (R2)	C	John D'Angelo	Written Testimony
S.B. 327 (R2)	D	Robert Groves	PowerPoint Presentation
S.B. 327 (R2)	E	Liz MacMenamin	Proposed Amendment
S.B. 211 (R1)	F	Linda Gray Murphy	Packet
S.B. 211 (R1)	G	Denise Selleck Davis	Letter
S.B. 211 (R1)	H	American Academy of Dermatology Association	Letter in Support
S.B. 198 (R1)	I	James Overland	Written Testimony
S.B. 198 (R1)	J	Annette Zaro	Letters in Opposition
S.B. 198 (R1)	K	Senator Joseph Hardy	Letters in Support
S.B. 198 (R1)	L	James Overland	Letter in Support
S.B. 220 (R1)	M	Senator Joseph Hardy	Amendment Mock-up

S.B. 220 (R1)	N	Gary Landry	Letter in Support
S.B. 220 (R1)	O	Senator Joseph Hardy	"Comparison of the Authority of certain Health Care Licensing Boards"
S.B. 220 (R1)	P	Senator Joseph Hardy	"Responding to Unlicensed Health Care in Nevada"
S.B. 220 (R1)	Q	Senator Joseph Hardy	"Comparison of Penalties of Practicing without a Professional License"
S.B. 220 (R1)	R	Neena Laxalt	Board of Dispensing Opticians Handout
S.B. 319 (R1)	S	Senator Joseph Hardy	Amendment Mock-up
S.B. 324 (R1)	T	Vance Farrow	PowerPoint
S.B. 324 (R1)	U	Senator Joseph Hardy	Amendment Mock-up