MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-Eighth Session
February 25, 2015

The Senate Committee on Health and Human Services was called to order by Chair Joe P. Hardy at 3:30 p.m. on Wednesday, February 25, 2015, in Room 2149 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Joe P. Hardy, Chair
Senator Ben Kieckhefer, Vice Chair
Senator Joyce Woodhouse
Senator Pat Spearman

COMMITTEE MEMBERS ABSENT:

Senator Mark Lipparelli (Excused)

GUEST LEGISLATORS PRESENT:

Senator Patricia Farley, Senatorial District No. 8

STAFF MEMBERS PRESENT:

Marsheilah Lyons, Policy Analyst
Eric Robbins, Counsel
Debra Burns, Committee Secretary

OTHERS PRESENT:

Barry Gold, Director, AARP Nevada
Jane Gruner, Administrator, Aging and Disability Services Division, Department of Health and Human Services
Rachel Blinn

Connie McMullen, Publisher, Senior Spectrum Newspapers, Inc.; Personal Care Association of Nevada
Barbara Paulsen, Nevadans for the Common Good
Marta Poling-Goldenne, D. Min., President, Board of Directors, Nevadans for the Common Good
Sam Lieberman, Easter Seals of Nevada
Stacy Woodbury, M.P.A., Executive Director, Nevada State Medical Association
Stacey Shinn, Progressive Leadership Alliance of Nevada; National Association of Social Workers, Nevada Chapter; Human Services Network
Chris McMullen, Publisher, Senior Spectrum Newspapers, Inc.; President, Senior Coalition of Washoe County
Ed Guthrie, Executive Director, Opportunity Village
Jon Sasser, Legal Aid Center of Southern Nevada; Southern Nevada Senior Law Project; Commission on Services for Persons With Disabilities
Lawrence J. Weiss, Ph. D., CEO, Center for Healthy Aging
Bill Welch, President and CEO, Nevada Hospital Association
Doug Plourde, R.N., Director, Private Duty Nursing, Comfort Keepers
Andy Eisen, M.D., Associate Professor of Pediatrics and Associate Dean of Clinical Education, Tuoro University Nevada; President-elect, Clark County Medical Society
Ellen Cosgrove, M.D., Vice Dean for Academic Affairs and Education, University of Nevada, School of Medicine, University of Nevada, Las Vegas
Mark Penn, M.D., Founding Dean, College of Medicine, Roseman University of Health Sciences
Chris Bosse, Vice President, Renown Health
Brigid J. Duffy, Chief Deputy District Attorney, Juvenile Division, District Attorney, Clark County

Chair Hardy:
We will begin with a request for Committee introduction of Bill Draft Request (BDR) 40-84; it relates to establishing and maintaining the Stroke Registry.

BILL DRAFT REQUEST 40-84: Revises provisions relating to licensing of medical professionals (Later introduced as Senate Bill 196.)

SENATOR KIECKHEFER MOVED TO INTRODUCE BDR 40-84.

SENATOR WOODHOUSE SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

* * * * *

Chair Hardy:
We will open the hearing on Senate Bill (S.B.) 177.

SENATE BILL 177: Allows a person to designate a caregiver when admitted to a hospital or in an advance directive. (BDR 40-512)

Barry Gold (Director, AARP Nevada):
The AARP has focused attention, resources and commitment in support of family caregivers, who are the unsung heroes providing the majority of care for Nevada families. I will refer to my written testimony **(**Exhibit C**).** In Nevada, AARP estimates caregivers provide $4 billion a year in service. A variety of needs is addressed by these providers. A recent survey found 70 percent of caregivers performed medical and nursing tasks, with little or no training.

Senate Bill 177, also known as the CARE Act, recognizes the critical role caregivers play in keeping loved ones out of costly institutions. It also puts in place some small but meaningful supports for patients and caregivers by ensuring three common sense steps: a caregiver can be designated in the medical record, caregiver notification can be made and hospitals will be asked to provide after-care instruction to the designated caregiver.

More than 40 groups, as evidenced by the press release attached (Exhibit D), endorse this bill. Many other states, such as Oklahoma, New Jersey, Virginia and Mississippi have recently passed this CARE Act unanimously. We have counted Senator Hardy and Senator Smith as supportive through recent discussions with them. On behalf of the 314,000 AARP members across the State, we urge you to pass S.B. 177. Four letters submitted on behalf of this bill are also attached (Exhibit E, Exhibit F, Exhibit G, and Exhibit H).

Chair Hardy:
For the record, I have sign-in sheets before me and all are in support of S.B. 177, those speaking please be concise.

Jane Gruner (Administrator, Aging and Disability Services Division, Department of Health and Human Services)
I see this as a life span issue affecting all ages and socioeconomic groups. My testimony is written (Exhibit I). We support this bill because health care will be improved when caregivers, an integral part of the patient's health care team, are involved and trained. Readmissions will be reduced when notification and training are provided to the caregiver. Potential exists for the reduction of first responder calls for assistance and subsequent emergency room visits.

Rachel Blinn:
I was 21 when I was involved in a car accident that resulted in a disability. I went to the hospital, bleeding and in a wheelchair. My family was out of state and there was no one to provide care for me, so my best friend, Ann, volunteered to provide care for me. No training was given my friend in how to perform the bathing, feeding or transfer assistance to help me into my wheelchair. The CARE Act would have prevented several fall incidents I experienced, as well as bumps and bruises. My caregiver would have avoided the back injury she suffered due to improper transferring. I support S.B. 177.

Connie McMullen (Publisher, Senior Spectrum Newspapers, Inc.; Personal Care Association of Nevada):
I am a member of the Nevada Commission on Aging, the Commission on Aging, Senior Services Strategic Plan Accountability Committee and the Personal Care Association of Nevada, which employ 28,461 caregivers to provide personal care to over 37,286 people in need statewide. We would like to go on record as supporting the CARE Act. If a loved one is released from a hospital setting and does not have family or caregivers at home, the professionals go to work to keep hospital readmissions from rising by providing personal care in the home for thousands with disabilities and chronic illnesses. The CARE Act, S.B. 177, is a positive step in caring for people.

Barbara Paulsen (Nevadans for the Common Good):
Nevadans for the Common Good is a broad-based, community organization whose members are faith-based, and nonprofit, social service institutions. Our purpose is to build relational power among diverse people to work on issues of common concern across the Las Vegas Valley. Over the last year, one of our main focuses has been on issues related to seniors and caregiving across the life span.

Statistics indicate that for individuals over 65, two-thirds of them will need assistance during their senior years and for many of these, that will mean a family caregiver. As mentioned earlier, caregivers provide loving care for family or friends, without recognition, often at emotional, physical or financial costs to themselves. Over the last 2 months, many of our member congregations have been holding workshops to provide information and resources on senior issues and, in particular, caregiving. We have reached over 400 with these workshops. We have heard stories related to caregiving repeatedly. One woman was being discharged from the hospital on considerable pain medication. When the nurse came to give her instructions, she had a hard time understanding but signed the discharge papers when asked. When her daughter picked her up, she stated she did not understand. The daughter, a strong advocate, insisted upon receiving instruction. Had the CARE Act been in place, that insistence would not have been needed.

Other stories we have heard relate to how unprepared caregivers feel upon taking care of chronic disease, medication management, or other sophisticated care after the recipient returns home from the hospital.

The CARE Act, S.B. 177, takes an important step in recognizing the invaluable role family caregivers play. It also addresses the need for caregivers to receive information and training to provide quality care for their family and friends. Nevadans for the Common Good strongly supports passage of S.B. 177.

Marta Poling-Goldenne, D. Min., (President, Board of Directors, Nevadans for the Common Good):

I am speaking in favor of S.B. 177. Over the past year I had the opportunity, several times, unfortunately, to be the caregiver for my husband. He was diagnosed with mesothelioma in May and passed in December. I felt very frustrated at the level of instruction I received several times on nursing care and the kinds of medical issues I had to address caring for him upon discharge.

I have a story to share regarding a colleague in Nevadans for the Common Good, Betty Jeanne Cousins, which I will be sharing in the first person, speaking as she:

> Last year, my husband, age 87 at the time, was in the hospital recovering from chest cancer surgery. He has had short-term

> memory loss, starting about 80 years old and it was getting worse as he aged.
>
> He was given instructions by an orderly or nurse, and when I came to pick him up to take him home, he could not remember what the individual had told him as to the care of his incision and when his follow-up appointment was scheduled. I had to track down a nurse and say my husband could not remember the instructions and I was not leaving the hospital until someone told me what those instructions were for his care.
>
> Many individuals are not as forceful as I am and would have gone home not knowing what instructions were for their loved one. I think it is very important that the caregiver is in on the discussions for the patient when that individual is elderly and is easily confused.

Again, Nevadans for the Common Good speaks in favor of S.B. 177.

Sam Lieberman (Easter Seals of Nevada):
On behalf of the 8,000 people we serve with disabilities in multiple generations, we support this bill. You have documentation via email from our CEO and President, Brian Patchett (Exhibit J). We are proud to collaborate with AARP, Nevadans for the Common Good and other entities in this effort.

Stacy Woodbury, M.P.A. (Executive Director, Nevada State Medical Association):
We think this is a fantastic bill. We had a concern about the inclusion of the Physician Order for Life Sustaining Treatment form (POLST), but if I heard Mr. Gold's testimony correctly, that may be eliminated from the bill. We have submitted a document (Exhibit K) as a friendly amendment if the POLST form needs to remain in the bill.

Stacey Shinn (Progressive Leadership Alliance of Nevada; National Association of Social Workers, Nevada Chapter; Human Services Network):
I have the pleasure of representing the Progressive Leadership Alliance of Nevada, the National Association of Social Workers, Nevada Chapter and the Human Services Network in support of S.B. 177.

Chris McMullen (Publisher, Senior Spectrum Newspapers, Inc.; President, Senior Coalition of Washoe County):
I am here on behalf of over 70 businesses and organizations that represent seniors and caregivers in Washoe County. One of these businesses is Senior Spectrum Newspapers, of which I am co-publisher. We support S.B. 177, the CARE Act, to give caregivers support once their loved ones are discharged from a hospital. Senate Bill 177 will assist in reducing hospital readmissions.

Ed Guthrie (Executive Director, Opportunity Village):
Opportunity Village serves people with intellectual disabilities. Approximately 65 percent of the people we serve still live with a parent or family member. We strongly support S.B. 177

Jon Sasser (Legal Aid Center of Southern Nevada; Southern Nevada Senior Law Project; Nevada Commission on Services for Persons With Disabilities):
I represent the Legal Aid Center of Southern Nevada and the Southern Nevada Senior Law Project. I also serve on the Nevada Commission on Services for Persons with Disabilities. All three organizations I represent support S.B. 177.

Lawrence J. Weiss, Ph.D. (CEO, Center for Healthy Aging):
I am in support of S.B. 177 on two accounts: one is personal, with my mother, as it could have helped her discharge plan from the hospital, which did not occur. The second account, I did research on transitional care. Hospitals will greatly benefit from this type of act because it does help facilitate those transitions and decrease readmissions within the 30 days during which Medicare will penalize them.

Bill Welch (President and CEO, Nevada Hospital Association):
My original intent was to sign in as opposing S.B. 177 but, as Mr. Gold indicated, we are working on an amendment. With the language we have conceptually agreed upon put into written form, we would support the bill. The hospitals certainly understand the need to be concerned with not only their discharges but their care throughout the hospitalizations. We see this as a great opportunity to formalize this agreement.

There are areas other than the ones Mr. Gold identified, where we want to be assured the legislation that is passed is meaningful, can be implemented and is functional. We want clarification of how the caregiver process works, how many caregivers and how many times the caregivers might be changed during a

hospitalization. These questions may cause confusion if not addressed. There are strict Health Information Portability and Accountability Act (HIPAA) laws with which we must comply; the language in the bill does not conflict with HIPAA. Those are the main areas we are working with Mr. Gold. I am confident we will be able to agree with the language so we can be supportive of this bill.

Doug Plourde, R.N. (Director, Private Duty Nursing, Comfort Keepers):
I am here to support S.B. 177. Specifically, the component identifying the need for follow-up visits addressed in discharge planning is significant. I believe the bill, as intended, will significantly reduce hospital readmissions.

Senator Kieckhefer:
This is necessary legislation. It is an emotional time for family members when a loved one is discharged from the hospital. It can be overwhelming and without having one's full senses about them, one may not fully absorb what is being told to them, so I want to make sure this works.

I have a few basic questions about the language of the bill. In section 7 and other sections of the bill, the designation of a caregiver is given as one age 18 or older. Is there a reason why age 18 was chosen? Is age 18 the legal age of consent for medical services?

Mr. Gold:
Although I believe 18 is the age of legal consent for medical services; it is not the same as legal age for Medical Power of Attorney. This bill will designate who is taking care of the patient at home. We wished to say that 7-year-olds cannot say who takes care of them but those who are 18 or older or a representative would have the legal standing to do that.

Senator Kieckhefer:
Can they decline to identify a caregiver?

Mr. Gold:
Absolutely, yes. The person could say he or she does not have a caregiver; it would be noted in the record, and the rest of the bill would not apply.

Senator Kieckhefer:
I was not sure if there was a legal reason why age 18 was chosen. I wonder why so many things are designated at age 18 when people younger than 18 are able to make medical decisions for themselves.

At the bottom of page 4 of the bill where the contact information is included on the care plan: are care plans put together by doctors or hospital staff?

Mr. Gold:
That is not my area of expertise, although I think each hospital has its own way of doing that; some are done through the nursing department, some have special discharge planning units and some have social work units. Mr. Welch may be able to tell you more as it may change from hospital to hospital.

Senator Kieckhefer:
The purpose of my question is that there needs to be a contact person from the hospital if the care plan is being put together by a physician who is not an employee of the hospital, would it then be an issue? I will leave that to the professionals to decide.

At the top of page 5, it speaks of a demonstration being provided by a designee of the hospital. The bill states that it would be done in a culturally and linguistically appropriate manner. The way I read that is the demonstrator must be able to speak the language of the person for whom the demonstration is conducted. Is that correct?

Mr. Gold:
Each hospital will do the best it can to have a translator or have someone else do that; being sensitive to the cultural needs and to make sure the person can understand the instructions is most important. You want to have someone on the staff certified to do that. You would not have a social worker demonstrate how to clean a wound, for example. You would want a person demonstrating within the scope of their licensure.

Senator Kieckhefer:
I would hope to avoid having suggested practices become law, then something goes wrong, the statute was not followed to the letter of the law or some such, which creates a potential liability, and so on. Can you address that scenario?

Mr. Welch:
The discharge planning combines all the caregivers who are involved with the services and care being provided to the patient. The doctors will be charting in the medical records of the patients, as will the other clinicians and nurses; all will be involved. Each hospital will have a formalized discharge planning process required by both State and federal law resulting in a team approach involved in how that discharge plan is being developed. There is a designated staff person at each hospital responsible for providing that discharge plan to the patients as they are leaving the hospital.

Senator Kieckhefer:
So is a "contact person" the appropriate language?

Mr. Welch:
This is some of the language Mr. Gold and I are working on; so yes, that would be correct. After the patients leave the hospital, we will provide, through the educational process, contact information for the other types of support services they might need. There might be needs, for instance, for durable medical equipment, home health services, etc. We will make sure the patients have the appropriate contact information for whatever support they may need. They may need to call back to the hospital for clarification on the instructions that were provided but hopefully, we would be providing them with the information to get them the support they need.

Senator Kieckhefer:
Would you address the question of demonstration in linguistically appropriate manner?

Mr. Welch:
We are working with Mr. Gold on the wording. We want to make sure it is an appropriate and educational activity, so we are working on language that will meet the intent. We have some concern on this one.

Mr. Gold:
The AARP of Nevada, along with the large number of community organizations and caregivers all across Nevada appreciate the consideration of the Nevada Legislature to provide these three simple steps that will provide better health outcomes and will prevent people from going back into the hospital.

Senator Hardy:
We will close the hearing on S.B. 177 and open the hearing on S.B. 172.

SENATE BILL 172: Makes various changes relating to the authorized activities of medical students. (BDR 40-797)

Senator Patricia Farley (Senatorial District No. 8):
I present S.B. 172 for your consideration and read from my introductory statement (Exhibit L).

Andy Eisen, M.D. (Associate Professor of Pediatrics and Associate Dean of Clinical Education, Tuoro University Nevada; President-Elect, Clark County Medical Society):
Seated with me today are Dr. Mark Penn and Dr. Ellen Cosgrove. We represent all three of the southern Nevada medical schools and we all support the same piece of legislation, S.B. 172. That is a strong statement in and of itself.

Two entities within the United States accredit medical schools. The Liaison Committee on Medical Education (LCME) accredits all 140 schools that grant doctor of medicine (M.D.) degrees. This involves public institutions like the University of Nevada School of Medicine and private institutions, like Roseman University's College of Medicine and my own alma mater, Northwestern University. It also accredits 17 schools which offer M.D. degrees in Canada. The second entity is the American Osteopathic Association's (AOA) Commission on Osteopathic College Accreditation, which accredits all 30 of the osteopathic medical schools including private, not-for-profit institutions like Tuoro University Nevada and public institutions like Michigan State University. Both of those entities have extremely high standards for curriculum, preparation of students and the education of those students. Though it varies from school to school, essentially the second half of the student's training takes place in the field, with real patients. They have access to real patients and to patient information. We feel it important for these students who have access to Nevada patients and their information, be in good standing at an institution that is accredited by an entity within the United States. Fine physicians are trained elsewhere than the United States. A process is in place through the Educational Commission for Foreign Medical Graduates for those individuals to be certified as adequately prepared to take on postgraduate training and graduate fellowships here in the United States. With S.B. 172, we are talking about students who have not yet achieved their degrees. We think it is incredibly important from a patient safety

standpoint because this ensures that medical students who have access to patients have been trained in terms of universal precautions, infection control, privacy issues including HIPAA and who have received necessary immunizations, such as influenza and measles vaccines, to prevent the spread of infectious diseases. We think this is all about patient safety.

Senator Kieckhefer:
My understanding is that a school's accreditation does not happen until it graduates its first class of students. As it is presented, could this present a problem, particularly for the University of Nevada, Las Vegas (UNLV), as it goes through its initial class of students?

Dr. Eisen:
There are several steps in the process of accreditation. These varying steps include first being a candidate school, having provisional accreditation, and achieving full accreditation. Dr. Cosgrove from UNLV can address that more directly as can Dr. Penn from Roseman University. The school cannot begin until they have provisional accreditation; full accreditation comes later. Those students would qualify under provisional accreditation, as that comes earlier.

Ellen Cosgrove, M.D. (Vice Dean for Academic Affairs and Education, University of Nevada, School of Medicine, University of Nevada, Las Vegas):
I am testifying in the place of Dr. Barbara Atkinson, the Dean, who regrets that she cannot be here today. We strongly support S.B. 172 for the reasons Dr. Eisen outlined.

The bill will not present a problem for our school. When we attain provisional accreditation and are permitted to admit students, it means the accrediting body has reviewed our curriculum, our faculty, our resources and determined that we meet all the standards for accreditation. The clinical resources, our preceptors, both physicians and nurse-practitioners in Nevada, are short and precious resources. That is why this is a time of great expansion of medical education opportunities, particularly in southern Nevada. That resource, as Dr. Eisen mentioned, is the foundation and basis for the student's clinical training, and happens in a hands-on way. Where the resource, the number of preceptors, is limited, and the numbers of medical students undertaking their studies in Nevada are expanding, we at UNLV believe it is important to shepherd this critical resource and give the top priority to students who have chosen to take their medical education in Nevada and to students who have taken their medical

education at top medical schools in the United States who choose to study further with us in Nevada.

Mark Penn, M.D. (Founding Dean, College of Medicine, Roseman University of Health Sciences):
I strongly support S.B. 172. The emphasis is on relationships and partnerships between the hospitals and medical schools of this State, to resolve the need for physicians, and the need for training opportunities for medical students throughout the State.

We know there is a great need for physicians in this State. If hospitals align with nonaccredited schools, they limit the opportunities for medical students, public and private, from our State to become part of their clinical experiences. That increases competition for clinical spots for training, as well as increased costs. That, in turn, reduces the number of students having exposure to our hospitals and would tend to hurt the eventual recruitment of physicians to our State. If the situation is not addressed, where will the purchase of students and allegiances stop and at what price and at what intended or unintended consequences? What I would like to mention, for the record, regarding accreditation in the medical school accreditation process, the school, is an applicant first, then it becomes a candidate, then it is a preliminarily accredited institution about 18 months after application. You can start to recruit students after you receive the preliminary accreditation. Following that, 2 years into the first class's second clinical year, the school can apply for provisional accreditation. Once that first class enters its fourth year, toward graduation, full accreditation can be granted to the medical school.

Senator Kieckhefer:
My understanding is once a student enrolls in a medical school, that student is primarily in the classroom for the first 1–2 years with minimal clinical work. Then the next 2 years involve clinical experience, working with physicians seeing patients in clinical settings?

Dr. Eisen:
That is generally correct. There is sometimes some clinical exposure in the first 2 years; there are certainly didactic experiences in the third and fourth year. Students are out, full time, in clinical settings, hospitals, physician offices and service centers in contact with actual patients.

Senator Kieckhefer:
Does this bill interact with the residency programs at all?

Dr. Eisen:
This has nothing to do with residencies. We have a number of residents currently in the State within programs that are sponsored by the University of Nevada School of Medicine who graduated from schools outside of the United States. There is an additional process there. They are required to have attended a school listed on the World Health Organization's International Medical Education Database. Once they achieve that degree, they must pass some tests administered by American authorities, the United States Medical Licensing Examination, Step 1 and both parts of Step 2, then they can apply to get certification from the Educational Commission for Foreign Medical Graduates, which merely certifies an individual, saying nothing about a school. At that point, they can apply for residency training in the United States. This is what all of our foreign medical school graduates currently in residency in Nevada have done. In order to get a license to practice medicine in Nevada, physicians must have completed their residency and fellowship training within programs accredited by an American authority. We have many physicians practicing medicine within the State who have completed their undergraduate medical education who have gotten their medical degree outside of the Country. They received their M.D. degree, got their postgraduate training, and did their residency or fellowship here in the United States in order to be eligible for their license. This bill does not restrict any of that; this is only about those students who have not yet achieved their medical degree.

Senator Kieckhefer:
Are there currently residency programs partnering with specific medical schools outside the Country, or is eligibility to enter a program determined on a case-by-case basis? Is the student still enrolled outside of the Country? I would like to clarify what we are trying to facilitate.

Dr. Eisen:
All of those things are going on right now in this Country. There are places in this Country where that is happening on a large scale. Within a single hospital, there are large numbers of international medical students coming in for clinical experience. In southern Nevada, it has happened in bits and pieces. In many circumstances, students who are enrolled in international medical schools not accredited by the LCME or AOA, are making their own arrangements. They have

picked up the telephone and called a practicing physician and asked, "Hey, I would like to spend a month or 6 weeks with you and get academic credit." Their schools will grant them academic credit for that experience, but there is not a structured process. Neither UNLV nor Roseman University have fully developed their clinical programs, yet both Tuoro University and the University of Nevada School of Medicine have policies in place where we do not host students who are not enrolled in a U.S.-accredited medical school. If students from my alma mater, Northwestern University, wanted to do clinical courses in Nevada, they could do so by applying through an existing medical school and having us as sponsors. An international student could not do that because neither of the existing Nevada medical schools permit it.

Senator Kieckhefer:
Is there a shortage of available clinical work for our current medical students in Nevada, or are we anticipating a potential shortage based upon the expansion of medical education, particularly in southern Nevada?

Dr. Eisen:
I think it is a little of both. I would not say we have insufficient resources. We are certainly expanding the numbers of medical students we have in the State so we have more demand. More importantly, it is not just that we have a place to put a student, but that we have the best places in the State for students to gain experience. We want to fill those spaces with students attending these accredited schools. My primary driver for this is patient safety; it is not about having a place to put our students, as we do. It is about having folks come in with equivalent preparation. We can say that for schools accredited by the LCME or AOA; we cannot say that for schools outside of the United States, because many of those are merely accredited by their countries' governments. I have seen individuals who have graduated from Shanghai Second Medical University and from Ain Shams University in Cairo who are outstanding, but I cannot attest that, at the institutional level, those schools provide every student with the kind of preparation they need.

Chair Hardy:
You made a comment about purchasing students. Would you explain that?

Dr. Penn:
If you are paying for students to come from another medical school, it is very attractive. If a hospital system would want to have students come from outside

the State, money is being exchanged for that. The students from the United States, as they go through their clinical years, pay the hospitals and key physician preceptors a certain amount of money to take care of their clinical years and their clinical training. I pose the question that if there is going to be thought about purchasing students for activities, and paying for students to come, and there is money at the end of this, what does that mean? When it is a reasonable arrangement, sometimes it will work; if it is helping with the statewide needs. If, however, you are using a foreign entity or those outside of the State, it could mean we will have more spots being taken up for high dollars, and eliminating spots for students from this State. We should make sure that in the bill's concept this is for the best; part of this is quality and part is building relationships with the State entities to make sure we are aligned to increase our physician workforce.

Chair Hardy:
As I understand it, there are schools outside the State or outside the United States paying our people in Nevada to instruct their students here?

Dr. Penn:
The foreign entities want their students to come to the United States because we do excellent clinical care here. They look inside the United States for places to place their students, typically in the third or fourth year of their clinical education. These entities will pay money to the hospital setting to take care of those students. It creates a competition for those limited spots. With the increasing class sizes that we are expecting, the limited number of hospitals and clinical settings, we will be helping them to do more in time. At this time, we do not have as many slots available, but that will grow with time.

Chris Bosse (Vice President, Renown Health):
We appreciate the intent of the bill, but have some language concerns.

When medical students in their third or fourth year pursue their medical training, they try to identify, in part, what area of medicine they want to study as a resident and where they want to study. Years 3 and 4 are not only important for physicians' hands-on medical education, but it is important they decide to get additional training. Those of you involved in graduate medical education know that 70 percent or more of those physicians tend to stay in the locations where they trained. Those facts are important in that, if we limit those who get training in Nevada, to only schools accredited by the Accreditation Council for

Graduate Medical Education (ACGME) and the Association of American Medical Colleges (AAMC), would we not want to see students from Oxford, Cambridge or other fine foreign medical schools? I think we would be interested in these students especially if they were originally residents of California or Nevada who did not get into a U.S. medical school and instead went to school outside the United States. My organization is in talks with a foreign medical school which has 200 medical students who are all from California. Does it not make sense for us to have a relationship with that medical school to encourage those students to do their third or fourth year there and perhaps decide to get their residency in our community and potentially stay in our community? With the physician shortage, and limited State resources, it seems relationships we might enter into, as long as we had adequate standards in place to avoid the training issues previously described ensuring patient safety, immunizations and HIPAA law understanding, would warrant coming up with additional standards. I propose the sponsors of the bill be willing to talk about an additional amendment to consider additional standards to allow well-trained medical students, who did not attend ACGME- or AAMC-accredited schools, the opportunity to come home, get training in our area and potentially stay in our area.

Renown Health is very committed to partnering with the School of Medicine and expanding our training to enable us to retain the best residents and consequently, retain the best physicians in our community.

Ms. Woodbury:
We are absolutely in favor of the bill. We support our medical schools and their obtaining places to train our students.

Chair Hardy:
We will now close the hearing on S.B. 172 and open the hearing on S.B. 148.

SENATE BILL 148: Revises requirements governing certain child welfare proceedings. (BDR 38-195)

Brigid J. Duffy (Chief Deputy District Attorney, Juvenile Division, District Attorney, Clark County):
I oversee a team of 16 attorneys who represent the Department of Family Services (DFS) in Clark County. I have nine attorneys who handle delinquency in Clark County. I am here on behalf of S.B. 148. This bill comes out of the interim

Legislative Committee on Child Welfare and Juvenile Justice. It was brought forward on the part of the Clark County Department of Family Services and the Clark County District Attorney to address notifications to parents after petitions of abuse or neglect are filed. There are no amendments.

It states in section 1, subsection 1, that after the petition is filed, the court clerk shall issue a summons to the person who has custody of the child and if that person is not the child's parent or guardian, then the parent or guardian must be notified of the court hearing. The summons, under section 1, subsection 4, must be served by personal service of a written notice; by registered or certified mail to the last known address of the person; or the posting of written notice on the door of the residence of the person. The only exception is provided in section 1 subsection 5, if the child was delivered pursuant to law to an emergency provider and the location of the parent is unknown.

This bill will bring *Nevada Revised Statute* (NRS) 432B.520, which is notice after a petition has been filed, in line with NRS 432B.470, which is the notice requirement after a child has been removed from the home prior to a protective custody hearing, which also is by personal service of written notice. They include oral notice as being acceptable and posting a notice on the door of the last known residence.

Chair Hardy:
When you say an oral notice being accepted, does that mean a telephone call when you do not know who is actually answering the phone or is it a face-to-face oral notice?

Ms. Duffy:
That is not in the proposed amendment; that is in NRS 432B.470, which is a different proceeding. We are trying to align them. In all processes, oral notification would mean speaking to the parent or other person responsible for the welfare of the child; it would not be to just anyone living in the home. What would happen in those proceedings? The DFS would be called to the home because police are removing the child, and they are telling the parents, as they are being arrested, there will be court on Wednesday 9 a.m. for instance. They know the parents are not necessarily going to be at home so they can serve them notice.

Chair Hardy:
We will close the hearing on S.B. 148. Seeing no further comment or business before the Committee, we will adjourn the meeting at 4:41 p.m.

RESPECTFULLY SUBMITTED:

_____
Debra Burns,
Committee Secretary

APPROVED BY:

_____
Senator Joe P. Hardy, Chair

DATE: _____

EXHIBIT SUMMARY				
Bill	**Exhibit**		**Witness or Agency**	**Description**
	A	1		Agenda
	B	10		Attendance Roster
S.B.177	C	3	Barry Gold	Written Testimony
S.B.177	D	3	Barry Gold	AARP Press Release
S.B.177	E	1	Barry Gold	Erik Schoen Letter of Support
S.B.177	F	1	Barry Gold	Laura Coger Letter of Support
S.B.177	G	1	Barry Gold	Lisa Rosenberg Letter of Support
S.B.177	H	1	Barry Gold	Barbara Paulsen Letter of Support
S.B.177	I	2	Jane Gruner	Written Testimony
S.B.177	J	1	Sam Lieberman	Commission on Services for Persons with Disabilities letter
S.B.177	K	1	Stacy Woodbury	Written Testimony
S.B.172	L	2	Senator Patricia Farley	Written Testimony