MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-Eighth Session
March 25, 2015

The Senate Committee on Health and Human Services was called to order by Chair Joe P. Hardy at 3:29 p.m. on Wednesday, March 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 Mark Lipparelli
Senator Joyce Woodhouse
Senator Pat Spearman

GUEST LEGISLATORS PRESENT:

Senator Patricia Farley, Senatorial District No. 8

STAFF MEMBERS PRESENT:

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

OTHERS PRESENT:

Wendy Simons
Bill Welch, President and Corporate Executive Officer, Nevada Hospital Association
Joan Hall, President, Nevada Rural Hospital Partners, Inc.
Connie McMullen, Personal Care Association of Nevada
Laura Coger, Program Manager, Consumer Direct Personal Care
Mary Walker, Carson Tahoe Regional Medical Center
Darryl Fisher, President, Mission Senior Living, LLC

Barry Gold, Director, AARP Nevada
Laura Freed, Deputy Administrator of Regulatory and Planning Services, Division of Public and Behavioral Health, Department of Health and Human Services
Kyle Devine, Chief, Bureau of Health Care Quality and Compliance, Division of Public and Behavioral Health, Department of Health and Human Services
Laura Hale, Manager, Public Health Preparedness Program, Division of Public and Behavioral Health, Department of Health and Human Services
Donna G. Miller, RN, EMSRN, CMTE, President, Flying ICU
Susan Fisher, Air Methods
Tom Clark, Regional Emergency Medical Service Authority
Temple Fletcher, Program Director, Care Flight, Regional Emergency Medical Service Authority
Jessica Ferrato, Nevada Nurses Association
Kelly Martinez, City of Las Vegas
Bryan Pond, RN, CFRN, CCRN, Chief Flight Nurse, California Shock Trauma Air Rescue
Lynn D. Malmstrom, President and CEO, California Shock Trauma Air Rescue

Chair Hardy:
I open the hearing on Senate Bill (S.B.) 210.

SENATE BILL 210: Revises provisions relating to inspections of certain medical facilities and offices. (BDR 40-1132)

Senator Ben Kieckhefer (Senatorial District No. 16):
Oftentimes, the government functions in a way that punishes bad behavior rather than rewarding good behavior. When I worked for the Department of Health and Human Services, that was how health care facilities were treated during the licensing process. Senate Bill 210 provides incentive for good behavior within the health care facilities. The current regulatory system is a step up to encourage compliance by punishing bad behavior rather than providing incentives for positive behavior. Senate Bill 210 allows facilities that have positive inspections records from the Bureau of Health Care Quality and Compliance (HCQC) to have their next periodic inspection extended to 1 1/2 times the usual period required by State law or federal law, whichever is shorter. Additionally, there would be a 25 percent reduction in the facilities' licensing fees for the next consecutive license period. With tight health care dollars, S.B. 210 will reduce costs for health care providers with exceptionally

positive inspection records and encourage facilities to strive to meet the criteria to qualify for this incentive program. Section 2 sets forth the incentivizing provisions for medical facilities or facilities for the dependent that pass the periodic inspection. Medical facilities are defined in *Nevada Revised Statute* (NRS) 449.0151. Sixteen different facilities are listed under the definition, including a surgical center for ambulatory patients, obstetric centers, hospitals, psychiatric hospitals and nursing pools. A facility for the dependent is defined in NRS 449.0045 and includes facilities for the treatment of abuse of alcohol or drugs, adult day care, halfway house, residential facilities for groups and transitional living for released offenders. Section 2, subsection 1, paragraph (a) pertains to extension of the inspection period, and section 2, subsection 1, paragraph (b) provides for the fee reduction. *Nevada Administrative Code* (NAC) dictates the fees from the State Board of Health. Exceptions for the exemptions are covered in section 2, subsection 2, paragraphs (a)-(e) of S.B. 210. Section 3 provides the same mechanisms for incentivizing good behaviors that apply to an additional facility type, which are physicians' offices that provide general anesthesia, conscious sedation or deep sedation as defined in NRS 449.442.

A fiscal note is attached to the bill due to the reduction in fees. As facilities perform well, they will have a 25 percent break in the fees that are imposed upon them.

Wendy Simons:
I served as a compliance consultant for the former Health Division, where I helped 187 facilities statewide improve their performance. I also served as chief for the HCQC for 2 1/2 years. During my time as chief, Senator Kieckhefer brought forth this bill for the first time. That was the first time a governmental body had been encouraged to go to a recognition model of compliance. As a provider for many years and surveyed for 35 years, I never found the survey process to be punitive. I found it to be reasonably motivational to maintain what the statutes and regulations considered the minimal standard of operation. The survey process is a snapshot in time. Some surveys are required to be annual, and some have longer time period requirements. The public does not know where to look for survey results on facilities. In 2009, when the grading system rolled out, 70 percent of the providers were given Cs and Ds. The following year, 11 percent of the providers were Cs and Ds. The grading system alone became a true motivator. It also became a secondary motivator because if the facility received a C or D, it had to pay for a resurvey. One benefit of the

grading system for the residential care facility was marketing and public disclosure as well as public transparency. I recommend an amendment requiring the HCQC to issue grades based on a methodology they come up with that is provider-specific. I also recommend a 2-year inspection history to qualify the facility. This would provide a track record of good performance, and at that point require an evaluation of fee adjustment for good performance, which is the 25 percent fee reduction Senator Kieckhefer proposed. One provider who has six facilities in the State pays $48,000 a year in licensure fees. A reduction in licensure fees would be significant.

Bill Welch (President and Corporate Executive Officer, Nevada Hospital Association):

The Nevada Hospital Association (NHA) supports S.B. 210. It is refreshing to see legislation that rewards positive behavior versus always looking at the punitive side. The NHA has testified repeatedly in support of funding the HCQC and ensuring it had appropriate and adequate staff to perform the surveys. There was a time when surveys happened infrequently. The NHA believes regularly scheduled surveys are appropriate, and we agree there should be recognition for those who excel in meeting all the standards. There will be some who will suggest this will put the quality of care at risk. There are a multitude of factors and tools that are utilized to ensure that safe quality of care is being provided in licensed health care facilities. There are the licensor, the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission. Follow-up opportunities are available if there is a deficiency noted or suspected deficiency, or a filed complaint. Whether substantiated or not, the HCQC will survey the facility to investigate the complaint. There are a multitude of surveys and processes done on a regular basis. In addition to the surveys, there are many reports available to the public to help evaluate facilities. Some of those reports include statistics and information about medical errors, sentinel events, staffing and readmissions. The State has a Website that provides transparency. The NHA has also established a Website that provides additional information.

Joan Hall (President, Nevada Rural Hospital Partners):

The Nevada Rural Hospital Partners supports S.B. 210. We recognize and respect the importance of surveys. For the facilities that are compliant, especially the rural facilities, it is a huge impact to the daily routine when surveyors come into the facilities. It takes time and effort away from patient care and daily duties. With the advent of electronic health records (EHR), it is even more difficult because the surveyors do not know how to access

information from the EHR and facility personnel must assist them. The surveyors must travel over a large area to reach all the facilities in the State. If a certain facility has had a good survey in the last 2-3 years, it seems reasonable to extend the period between the inspections.

Connie McMullen (Personal Care Association of Nevada):
The Personal Care Association of Nevada supports S.B. 210 because it acknowledges good companies that strive to provide quality care for the State's most vulnerable by following required State regulations. Senate Bill 210 also allows the HCQC to inspect more underperforming facilities that are not complying with regulations. The industry has 179 companies statewide. Providers of personal nonmedical care in the home are not the only companies that are licensed in the State and require inspection. Senate Bill 210 would free up time for the HCQC personnel to do their jobs more efficiently because they will reach more companies, provide the necessary education and teach good practice.

Laura Coger (Program Manager, Consumer Direct Personal Care):
Consumer Direct supports incentivizing providers who actually understand the regulations and design their business practices around supporting compliance. Allowing more time between inspections for agencies that consistently follow the rules leaves more time for State staff to focus on the agencies that are not performing. Consumer Direct Personal Care supports S.B. 210.

Mary Walker (Carson Tahoe Regional Medical Center):
Carson Tahoe Regional Medical Center supports S.B. 210.

Darryl Fisher (President, Mission Senior Living, LLC):
Mission Senior Living supports S.B. 210. Mission Senior Living owns and operates three assisted living and memory care communities in northern Nevada that provide care for 165 seniors. Quality care and service for Mission Senior Living is critical. Our mission statement is "Caring People, Serving People, Improving Lives." We use the mission statement to guide our actions and decisions every day. Mission Senior Living does not rely on the survey process to dictate the quality of care and service. Having an independent quality review process is critical to making us better providers. We contract every 6 months with outside individuals to look at our care, service and business practices because we want to get better. All three of our communities have A grades, but we are not satisfied and are pressing forward to get better.

Senate Bill 210 represents another incentive and reward for providers to pursue quality care and service continuously. Mission Senior Living pays $28,000 a year for licensing. Because we plan to continue getting A grades, our savings will be $7,000-$10,000 a year. The savings will be invested into training, salaries and keeping our fees for residents as low as possible. With the passing of S.B. 210, the HCQC can focus on communities that are not doing well.

Chair Hardy:
Is a passing grade A-D?

Mr. Fisher:
The grading system is A-D. I am not sure a D grade is passing.

Senator Kieckhefer:
Senate Bill 210 leaves what constitutes a passing grade up to the regulatory process by HCQC. The conceptual amendment, brought forward by Ms. Simons, which requires the implementation of a grading system for other facility types would be a positive step toward identifying the passing grade for this incentive mechanism. I suggest it should be an A grade.

Chair Hardy:
Should we allow the regulatory system to determine the grading system?

Senator Kieckhefer:
When I first introduced a bill like this in 2011, I tried to put what constituted a passing grade in statute and it was problematic. The people who do the work full time know what constitutes a passing grade.

Barry Gold (Director, AARP Nevada):
The AARP is opposed to S.B. 210. The AARP believes in incentivizing facilities and finding reasons for them to provide good care. However, AARP opposes proposals to lengthen the periods between inspections. There is a reason why inspection intervals were established, and they should be followed; in fact, the intervals should be more frequent if there is cause. I have submitted my written testimony (Exhibit C).

Chair Hardy:
You made reference to an organization that said regular and consistent oversight should be conducted. Was that the organization that said, "at least annually," or was that an interpretation?

Mr. Gold:
That came from the AARP public policy manual, but I will check and get the information to you.

Laura Freed (Deputy Administrator of Regulatory and Planning Services, Division of Public and Behavioral Health, Department of Health and Human Services):
This bill is intended to reward facilities that do well on their inspections. That is a good thing. Chapter 449 of NRS and the NAC do not mandate an inspection frequency for any State facilities except for the three facility types that the sponsor of the bill mentioned, which are outpatient providers that perform some level of sedation, group homes and ambulatory surgery centers. Those three types of facilities are on an annual inspection. Under S.B. 210, if the facilities were graded as passing, they would go to an 18-month inspection period. This bill would only affect our State-licensed facilities. The surveys performed by HCQC, on behalf of the CMS, are tiered and inspection frequencies are determined by them. Except for the three types of facilities just mentioned, everybody else is inspected on 18-month intervals as a matter of budgetary policy. The money authorized in the HCQC budget supports the staff for 18-month inspections, but there is nothing in the law or regulations that states that.

Chair Hardy:
Is it 18 months for the State-licensed facilities or for all facilities?

Ms. Freed:
Although the bill is not written this way, the intent is those facilities that are on 12-month inspection periods go to 18-month inspection periods and the facilities that are on 18-month inspection periods go to 27-month inspection periods. Changing section 2, subsection 1, paragraph (a) to read, "that is otherwise required by state law or regulation or policy" would get all the State-licensed facilities in the net.

Chair Hardy:
Is the Department of Health and Human Services responsible for the inspections of the non-State-licensed or the federally licensed facilities?

Kyle Devine (Chief, Bureau of Health Care Quality and Compliance, Division of Public and Behavioral Health, Department of Health and Human Services):
For the facilities surveyed under contract with CMS, there is a tiered system. Tier 1 inspection intervals are at least 9 months, but not more than 15 months, so we try to average 12 months. Tier 4 could be every 4 years depending on the facility type. We do stick to those timelines for those facilities that are CMS certified.

Chair Hardy:
What is in a tier 4?

Mr. Devine:
A facility for physical therapy is an example of a tier 4.

Chair Hardy:
Are we putting people at risk by going to the 18-month inspection period?

Mr. Devine:
Under contract to CMS, we could not extend the survey time. We would have to stay with the federally prescribed time.

Ms. Freed:
One item discussed, to remove the fiscal impact from S.B. 210, was not giving a fee break and extending the periodicity. As a public policy issue, is it better for the providers to get a price break, or is it better not to see the surveyors as often? We are supportive of an A–F grading system because it has worked very well with the group care homes. Everybody wants to put an A or B at the front of the facility. If S.B. 210 were passed as introduced or with the amendment for a grading system, it would take HCQC some time to promulgate that regulation. The industry would want some input on what kinds of deficiencies are considered minor enough to allow a passing grade. What is budgeted in a fiscal note is one workshop in the north and one in the south. This is an issue where multiple workshops would be required and could affect the effective date of the bill.

Senator Lipparelli:
How many facilities would be covered by the proposed bill? Would it be more than 100?

Ms. Freed:
More than a 100 facilities, but less than 700 would be affected by S.B. 210.

Chair Hardy:
Would you work with the chair of the Senate Committee on Finance concerning the fee issues?

Ms. Freed:
Yes, I will work with the chair of the Senate Committee on Finance.

Chair Hardy:
I close the hearing on S.B. 210.

Senator Kieckhefer:
I open the hearing on S.B. 247.

SENATE BILL 247: Revises provisions governing new construction by or on behalf of health facilities. (BDR 40-981)

Senator Joe P. Hardy (Senatorial District No. 12):
When taking a tour of the Mesa View Hospital in Mesquite, the hospital administrator approached me and said, "We have a problem." If a surgery center were to open next door to the hospital, it would siphon off the revenue source for the hospital. Senate Bill 247 was written to apply to certain towns or cities within a county with the population of 100,000 or more.

Ms. Hall:
The Certificate of Need (CON) processes were originally aimed at restraining health care facility costs and allowing coordinated planning of new services and construction. The intent was to regulate the number of hospitals and nursing homes and to prevent overbuying of expensive equipment. I have submitted more detail in written testimony (Exhibit D). In 1974, the national Health Planning Resources Development Act required all 50 states to have structures for submitting proposals and obtaining approvals from the state health planning agencies before beginning any major health care capital projects. Along with this

federal mandate came state incentives of federal funding for the project. In 1987, the federal mandate was repealed along with the federal funding. Thirty-six states continued with the CON programs. Nevada has had a CON process since 1971. Major revisions occurred in 1991, when Washoe and Clark Counties were exempted from the CON process. In 1995, the law was changed to cover only the construction of new health facilities involving capital expenditures over $2 million. The CON process is administered by the Division of Public Health's Primary Care Office. Nevada Rural Hospital Partners proposes an amendment to include unincorporated cities or towns in the counties with populations over 100,000, currently Clark and Washoe Counties. Mesa View Hospital in Mesquite and Boulder City Hospital in Boulder City would be impacted if they were to have construction projects over $2 million, or if another health care entity wanted to build a new facility in these communities.

The CON process provides safeguards for Nevada's small rural and frontier hospitals. The CMS has put into place new regulations to assist the rural hospitals. There are different reimbursement methodologies for critical access hospitals and rural health clinics. The rural hospitals in the smaller areas operate at a net operating loss. Seven of the fourteen member hospitals are supported by tax dollars. Many are supported by net proceeds of mining and do well from an income standpoint, but not from an operations standpoint. Rural hospitals serve the rural communities as an economic development engine. The rural hospitals are between the first and the third largest employer in their communities and have the biggest payroll impact. Ambulatory surgery centers and outpatient diagnostic centers provide care at less cost to the patient. While it seems counterintuitive that ambulatory surgery centers or diagnostic centers are not wanted, they do take enough revenue from a rural hospital that it could cause its closure. We support the proposed amendments from the Primary Care Office.

Mr. Welsh:
The Nevada Hospital Association supports S.B. 247. It is essential that community critical access care hospitals be protected.

Laura Hale (Manager, Public Health Preparedness Program, Division of Public and Behavioral Health, Department of Health and Human Services):
The Division of Public and Behavioral Health proposes several amendments to S.B. 247. Section 1, subsection 1, is the first amendment (Exhibit E).

Senator Kieckhefer:
Does the proposed amendment expand the counties affected?

Ms. Hale:
The language affects the same people but is more direct and simplified.

Senator Kieckhefer:
If the population limit is 70,000, would Carson City qualify for the CON?

Ms. Hale:
Currently, Carson City qualifies because it is a rural county. The language addresses the county level population of 100,000 or less. It is the rural cities or towns in the large urban counties that are exempted that we did not want exempted.

Senator Kieckhefer:
Is any city with a population less than 70,000 in all counties other than Washoe and Clark Counties exempt?

Ms. Hale:
Counties are no longer referenced; we go directly to the city level. Every city in Clark and Washoe Counties is exempted. It was a circuitous way at getting at the small rural towns and cities.

Senator Kieckhefer:
Are Clark and Washoe Counties no longer directly exempt, but based on the city population threshold?

Ms. Hale:
Yes, that is correct.

Senator Kieckhefer:
Does Incline Village qualify in Washoe County, Boulder City in Clark County and Mesquite in Clark County?

Ms. Hale:
Yes, that is correct.

Senator Kieckhefer:
Are there other cities that meet the population threshold in Washoe or Clark Counties?

Ms. Hale:
No, there are no other cities that meet the population threshold in those counties.

The Division proposes striking section 1, subsection 2, paragraph (c) of S.B. 247. The language is complicated and is not needed since the city population is redefined. Specific components should be included in section 1, subsection 3, paragraph (b), subparagraph (4) to incorporate integration of public health priorities, Exhibit E. It is our intent to coordinate with the applicants for the CON, to integrate public health services and perform outreach for public health care.

Currently, there is a $9,500 fee submitted with the application, and if it is not spent within the fiscal year of receipt, those funds go into the General Fund. The CON applications run at least a year because of the construction of the facility, public hearings and planning. The Division had a CON application go 10 years with several extensions, because of disputes over water rights and legal hearings. It creates a difficulty for our office. The Division proposes additional language to be added to section 2, Exhibit E. That language would give us time to get through a typical CON process.

Senator Kieckhefer:
Is the effective date acceptable?

Ms. Hale:
Yes, it is.

Senator Kieckhefer:
How many applications for CON do you receive in a year?

Ms. Hale:
During the first 3 years I was in my position and for the 2 years prior, we did not receive any applications because the urban counties were exempt. I am currently on the third application and expect two more within the next few

months. We receive inquiries frequently. The economy, Medicaid expansion and the aging population can impact the number of applications received.

Senator Kieckhefer:
I close the hearing on S.B. 247.

Chair Hardy:
I open the hearing on S.B. 327.

SENATE BILL 327: Revises certain provisions governing air ambulances. (BDR 40-1017)

Senator Patricia Farley (Senatorial District No. 8):
Senate Bill 327 specifies the qualifications for attendants aboard an air ambulance and the minimum number of attendants required. Specifically, the measure requires that an air ambulance used to provide emergency services must be staffed with a minimum of one primary attendant and one secondary attendant. The primary attendant is an emergency medical services registered nurse that has a least 5 years of experience, that includes 2 years of critical care nursing experience if working on a fixed-wing air ambulance or 3 years of critical care nursing experience if working on a rotary-wing air ambulance. The primary attendant must have successfully completed an air ambulance attendant course which includes didactic and clinical components and is approved or in compliance with requirements set by the State Board of Nursing. The primary attendant must also demonstrate proficiency in basic prehospital skills and advanced procedures as specified by the Board. The secondary attendant must be certified as an advanced emergency medical technician or paramedic with at least 3 years of field experience. The secondary attendant must have successfully completed an air ambulance attendant course which includes didactic and clinical components and is approved or in compliance with requirements set by the State Board of Nursing. The secondary attendant must have demonstrated proficiency in basic prehospital skills and advanced procedures as specified by the Board.

Senate Bill 327 revises the training requirements necessary for a licensed physician, registered nurse or licensed physician assistant. Each one must be certified as an attendant in the following three areas: advanced life-support procedures for patients who require cardiac care, life-support procedures for

pediatric patients who require cardiac care and life-support procedures for patients with trauma who are administered to before the arrival at the hospital.

The definition of emergency medical services registered nurse is included in S.B. 327. The bill requires an air ambulance receiving a patient in a county whose population is 70,000 or more must obtain a permit from the district board of health in that county. An air ambulance receiving a patient in any other county must obtain a permit from the Division of Public and Behavioral Health.

Donna G. Miller, RN, EMSRN, CMTE (President, Flying ICU):
I am in support of S.B. 327, which provides patient protection to Nevada's vulnerable critically ill and injured citizens on board of an air ambulance aircraft, by requiring certain minimum qualifications for the flight crew members, and by increasing the minimum number of attendants required to accompany a patient. I have submitted my written testimony (Exhibit F).

Senator Kieckhefer:
Are there different requirements for responding to an emergency versus transporting a stable patient?

Ms. Miller:
Yes, there are different requirements.

Senator Kieckhefer:
Is the bill exclusive to emergency response?

Ms. Miller:
"Emergency" is a gray and subjective term. Most people think of helicopters as emergency transport. However, when transporting a patient from a rural Nevada facility to a higher level of care, some think it is not an emergency since the patient is already in a hospital. But, when the level of resources available to the patient are weighed, it may be considered an emergency to move the patient to another facility.

Senator Lipparelli:
What is causing the increase in standards?

Ms. Miller:
Senate Bill No. 285 of the 77th Session required all air ambulances to be licensed in Nevada if transporting patients in the State. Because of the two-tier licenses, all air ambulance companies that chose to be licensed in the State chose to be licensed by the less restrictive system. That is a problem because the level of care those companies provide is uncertain. The Southern Nevada Health District has significantly different regulations in comparison to the rest of the State. My initial proposal was to allow the Southern Nevada Health District, or any county with a larger population that chooses to have its own health authority, to develop and design its own regulations. However, there is a mechanism that allows providers to escape the regulations. When I spoke to multiple Legislators it became clear and made sense to standardize the care in the entire State. All Nevada citizens deserve the right care. Having a nurse with experience on board an aircraft is a must.

Senator Lipparelli:
Could a transport occur if the minimum requirements are not available?

Ms. Miller:
Most companies in Nevada function at that level.

Senator Lipparelli:
Is the standard increasing?

Ms. Miller:
We are standardizing the care.

I have two changes in the Proposed Amendment 9837 to S.B. 327 (Exhibit G). The original bill stated the secondary attendant needed to be a paramedic. The intent is to have a minimum of a paramedic. The proposed revision states the secondary attendant has to be, at a minimum, a paramedic.

Chair Hardy:
Does it mean the secondary attendant could meet the same qualifications as the primary attendant? Or be a certified advanced emergency technician or paramedic?

Ms. Miller:
Yes, that is correct.

The second change, Exhibit G, adds language to S.B. 327 which states the health authority may issue a letter of endorsement and identification card to a nurse, paramedic or advanced emergency medical technician who satisfies the requirements listed. The health authority is not licensing the nurses but endorsing them.

Susan Fisher (Air Methods):
Air Methods operates under the name of Mercy Air in the State. Air Methods is a nationwide company, has over 400 medical aircraft and been in operation for over 35 years. Air Methods supports S.B. 327 with Ms. Miller's amendment. We also support the amendment from the Regional Emergency Medical Services Authority (REMSA).

Tom Clark (Regional Emergency Medical Service Authority):
The REMSA is a primary medical ground and air transport provider in Washoe County.

Temple Fletcher (Program Director, Care Flight, Regional Emergency Medical Service Authority):
Care Flight is proposing a friendly amendment (Exhibit H) to Flying ICU's amendment. Care Flight exceeds all requirements of S.B. 327 and what is in statute. If our proposed amendment is not added, it will hinder Care Flight's operations, patient care, and potentially, patient outcomes. Care Flight has been in operation since 1981. We are the oldest and largest air ambulance in Nevada. Care Flight holds a certificate with the State to act as a first responder. In a case where there are no emergency medical services available in the geographical areas we serve, we are allowed to land and transport patients without other responders on the scene. Occasionally, it is necessary to leave a crew member due to weight, weather or terrain, and the State has allowed Care Flight to do so. Without the proposed language, we may not be able to do that and would have to turn down flights. It could make backcountry rescues almost impossible and delay transport times.

Chair Hardy:
Are you talking about rotor-wing or fixed-wing aircraft?

Ms. Fletcher:
I am talking about rotor-wing aircraft, or helicopter.

Chair Hardy:
We have been hearing about fixed-wing aircraft, but are we now hearing about rotor-winged aircraft?

Ms. Fletcher:
Senate Bill 327 includes both fixed-wing and rotor-wing aircraft.

Chair Hardy:
Are you addressing the rotor-wing aircraft only?

Ms. Fletcher:
Yes, that is correct.

Chair Hardy:
Would you leave a medical team person in the middle of nowhere so a patient could be transported?

Ms. Fletcher:
Yes, that is correct.

For instance, Care Flight works with the search and rescue avalanche teams and dog handlers for transport. We have an avalanche receiver that is used to assist with locating victims, and, on occasions, we transport prisoners or people under custody that require the presence of a guard. Both cases may require leaving a secondary medical person on the ground because of weight restrictions. If the patient is critical, we will do everything in our power to make sure there are two crew members onboard. Often, we will send in a ground crew to assist so we maintain a two-member crew.

Chair Hardy:
Is that in writing, and have you discussed this with the sponsor of the bill?

Ms. Fletcher:
Yes, it is in writing, and I have shared it with the sponsor.

Jessica Ferrato (Nevada Nurses Association):
The Nevada Nurses Association supports S.B. 327 and the proposed amendments. It is imperative to have the most qualified and experienced nurses

on the flights. I have had family members who have taken these flights and I appreciate the care that is provided in the critical times.

Kelly Martinez (City of Las Vegas):
The City of Las Vegas supports S.B. 327 because it provides clarity with regard to qualifications, training and required certification.

Bryan Pond, RN, CFRN, CCRN (Chief Flight Nurse, California Shock Trauma Air Rescue):
I have 28 years of nursing experience and have been a flight nurse for the last 15 years with the California Shock Trauma Air Rescue (CALSTAR). The CALSTAR is based in California, and I am based in South Lake Tahoe. Sitting on the border, CALSTAR transports many patients from California to Nevada. The CALSTAR has concerns with S.B. 327. The bill states a primary attendant must have 5 years of experience as a registered nurse prior to becoming a flight nurse. We have nurses who have worked as paramedics in very busy systems for a number of years. The 5 years of experience as a registered nurse requirement does not take into account other experience. The Commission on Accreditation of Medical Transport Services (CAMTS) requires only 3 years of critical care experience. The CAMTS is a national organization that credentials air ambulance operations. Section 3, subsection 1, paragraph (a), subparagraph (2), sub-subparagraph (I) of S.B. 327 states a requirement of 2 years of critical care nursing experience in order to work on a fixed-wing air ambulance. This would fall out of the CAMTS requirement. The CALSTAR also has concerns with not being able to leave a second crew member on the ground from a rotor-wing aircraft. If the rotor-wing aircraft lands at 10,000 feet to pick up a patient, there may be a situation when a crew member must be left at a lower altitude.

Lynn D. Malmstrom (President and CEO, California Shock Trauma Air Rescue):
The CALSTAR has significant involvement in providing emergency air medical services in Nevada. We fly both helicopters and fixed-wing aircraft. We operate King Air aircraft that have extended distance and have two-patient capability in our fixed-wing program. We also have twin-engine aircraft that are operated across our fleet to ensure we provide the safest care. The CALSTAR has been in business for 31 years and have transported over 60,000 patients without injury or an accident. We are very proud of that record and mindful of what we have to do to keep operations safe.

Any time additional legislation or regulations are put into place, a problem or issue could be created that necessitates additional regulation. I am aware of conversations that operators have had with other lawmakers and other organizations. I have heard of no instances where patient outcomes have been unfavorable because the patients were transported by an air operator that has not met the requirements and permitting processes contained in this bill. If there is not a problem that is being solved, creating additional requirements and regulations is not necessarily a good thing, particularly as it relates to air medical providers. In 1978, Congress passed the Airline Deregulation Act (ADA), which is overseen and administered by the U.S. Department of Transportation. That Act applies to all common air carriers of which CALSTAR is one. Most of the air medical transport companies qualify and can provide a common carrier certificate granted by the Federal Aviation Administration (FAA). The 1978 legislation was designed to ensure there is a free and open market and states and counties cannot enacts laws that would present barriers to the commerce of common air carriers providing routes, rates and services to the communities they serve. I have concerns that this bill introduces higher levels of requirements that effectively would be barriers. If those higher levels of requirements are not based on medical necessity, they could be subject to an action by federal courts to questions of whether the regulations would be preempted by federal law. The CALSTAR meets all the old requirements, and the new ones would be handled. I do not see the need for additional requirements. Because of the needs of the common air carriers and the protection the federal law offers, it could subject Nevada to possible litigation for establishing barriers that are not based in medical necessity but based on an economic agenda. The late amendment proposals are strong indicators the bill was not well or widely vetted, so there could be comment or discussion. I urge the Committee to consider this bill no further.

Senator Lipparelli:
Setting aside the quantity requirement in the bill, do you quarrel with any of the experience requirements?

Mr. Malmstrom:
Yes, I do quarrel with the experience requirements. The proposed requirement of 2 years would automatically be a violation of the CAMTS requirements, which governs the accreditation process for air medical transporters across the United States. The additional fees and permitting processes become an additional barrier unless there were a need for something to change because

negative outcomes were being generated. It is an additional risk the State would take upon itself.

Senator Lipparelli:
Could a person with 2 years and 1 day of critical care experience work on an air ambulance?

Mr. Malmstrom:
I am not in a position to make that interpretation.

Senator Lipparelli:
Are you satisfied with the 2-year requirement?

Mr. Malmstrom:
No, I am not satisfied with that requirement. The 2-year requirement is less than the requirement established by CAMTS.

Senator Lipparelli:
I thought the requirement in the bill is 3 years, and you had referenced you only needed 2 years.

Mr. Pond:
The bill states if the attendant is working on a fixed-wing aircraft, the attendant needs 2 years of critical care experience. If the attendant is working on a rotor-wing aircraft, the attendant needs 3 years of critical care experience. The CAMTS does not differentiate between the two aircrafts and sets the standard at 3 years of experience.

Senator Lipparelli:
Do you quarrel with the 3 years of experience?

Mr. Pond:
No, we have no issue with requiring the 3 years of experience. Our concern is dropping below the 3 years of experience. We want qualified people taking care of patients.

Chair Hardy:
What is the CAMTS criteria for fixed- and rotary-wing aircraft?

Mr. Pond:
The CAMTS requires 3 years of critical care experience. It does not set any limits on the number of years required for a nurse.

Chair Hardy:
Does CAMTS have any differentiation for years of experience between fixed- and rotor-wing aircraft?

Mr. Pond:
No, there is no differentiation.

Ms. Miller:
The CAMTS is the standard in the United States for air ambulances. The Commission has the same requirements for rotor- or fixed-wing aircraft, which is 5 years of nursing experience and 3 years of critical care experience. The reason for the 2 years for fixed-wing and 3 years for rotor-wing were inspired from Southern Nevada Health District regulations. The Southern Nevada Health District's regulations have been successful for a number of years. Instead of making the requirements more stringent, we chose to make it at least at that level. Because we are CAMTS-accredited, all of our medical crews meet their requirements. I would have no problem with changing the 3-years-experience requirement for rotor-wing aircraft to 2 years. There is no database or registry that tracks when a patient leaves the hospital. If a patient was transported by air ambulance to another hospital and the patient had a less than favorable outcome, the air ambulance would land in the closest metropolitan area hospital. We would not know the final outcome of the patient. If the patient passed away in our care, we would call the hospital with the outcome of the transport. I do not know if that is commonly done with all air ambulances.

The 1978 Airline Deregulation Act says an airliner cannot be regulated at the state level. It has to be a federal agency that regulates an airliner, and that is the FAA. In 1978, there was no air ambulance industry as it is today. The thoughts behind that law had to do with the aviation aspect not with the medical aspect.

When we worked on the S.B. No. 285 of the 77th Session, a great deal of research was done as to what the ADA was allowing states to do. Based on research, the states cannot regulate any aviation-related aspect of an air ambulance, but anything to do with regulating an air ambulance that affects

patient care can be done by the states. We have a collection of letters demonstrating that and the Legislative Counsel Bureau has done research on this as well. For example, it is acceptable for a state to expect the airplane to be pressurized. The critical care patient is going to be affected by the differences in pressure. Even though it relates to an aviation aspect, it is still acceptable because it is directly related to the patients' outcomes. There are regions in certain states that choose not to regulate air ambulances. Some companies choose to use the ADA as an excuse for being unsupportive to the states regulating the medical aspects of an air ambulance. Some regions of some states have gone through lawsuits that put them in a position of running out of funds. Companies in those regions can run air ambulance services, but they have no one to oversee their services, quality of care or to dictate the minimum equipment they have onboard and the minimum expertise onboard. We understand the ADA very well and it would not interfere with what we are doing here today.

Chair Hardy:
The State is not able to regulate the aircraft, but is able to regulate what goes on in the aircraft. Is that a correct statement?

Ms. Miller:
Yes, that is correct.

Chair Hardy:
I received a letter from Thomas L. Schwenk, M.D. (Exhibit I) and a letter from Las Vegas Heals (Exhibit J) supporting S.B. 327. There being no further business before the Committee, I adjourn the meeting at 5:29 p.m.

RESPECTFULLY SUBMITTED:

_____
Debra Carmichael,
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. 210	C	1	Barry Gold, AARP Nevada	Written testimony
S.B. 247	D	4	Joan Hall, Nevada Rural Hospital Partners, Inc.	Written testimony
S.B. 247	E	4	Laura Hale, Division of Public and Behavioral Health	Proposed amendment
S.B. 327	F	3	Donna Miller, Flying ICU	Written testimony
S.B. 327	G	2	Donna Miller, Flying ICU	Proposed amendment
S.B. 327	H	1	Temple Fletcher, Regional Emergency Medical Service Authority	Proposed amendment
S.B. 327	I	1	Thomas L. Schwenk, M.D.	Letter of support
S.B. 327	J	1	Las Vegas Heals	Letter of support