MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES

Eighty-First Session
March 22, 2021

The Committee on Health and Human Services was called to order by Chair Rochelle T. Nguyen at 1:31 p.m. on Monday, March 22, 2021, Online. 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 www.leg.state.nv.us/App/NELIS/REL/81st2021.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Rochelle T. Nguyen, Chair
Assemblywoman Sarah Peters, Vice Chair
Assemblywoman Teresa Benitez-Thompson
Assemblywoman Annie Black
Assemblywoman Michelle Gorelow
Assemblyman Gregory T. Hafen II
Assemblywoman Lisa Krasner
Assemblyman Andy Matthews
Assemblyman David Orentlicher
Assemblywoman Shondra Summers-Armstrong
Assemblywoman Clara Thomas
Assemblywoman Robin L. Titus

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Patrick Ashton, Committee Policy Analyst
Abigail Lee, Committee Manager
Terry Horgan, Committee Secretary
Trinity Thom, Committee Assistant

OTHERS PRESENT:

Mason Van Houweling, Chief Executive Officer, University Medical Center
Susan Pitz, General Counsel, University Medical Center
Joan Hall, President, Nevada Rural Hospital Partners
Hugh Qualls, Administrator, Mt. Grant General Hospital
Richard Karpel, Executive Director, Nevada Press Association; and Member, Nevada Open Government Coalition
Justin Watkins, representing Nevada Justice Association

Chair Nguyen:
[Roll was taken. The Chair reminded Committee members, witnesses, and members of the audience of Committee rules, protocol, and procedures for virtual meeting.]

I will now open the hearing on Assembly Bill 44. Today we have with us Mason Van Houweling, CEO of University Medical Center, and I will turn it over to you.

Assembly Bill 44: Revises provisions relating to county hospitals. (BDR 40-401)

Mason Van Houweling, Chief Executive Officer, University Medical Center:
As many of you are aware, University Medical Center (UMC) is one of the busiest hospitals in southern Nevada. Situated in the urban core, located in the heart of the Las Vegas medical district, the hospital serves as southern Nevada's safety net for residents and visitors alike. University Medical Center provides a number of services that are home and "one-of-a-kind" here at UMC, including the Level I Trauma Center, the Lions Burn Care Center, the Center for Transplantation, Children's Hospital of Nevada at UMC, and a Level II Pediatric Trauma Center.

University Medical Center retains more than 4,000 employees and cares for hundreds of thousands of visitors and patients each year. In addition, UMC is affiliated with the University of Nevada, Las Vegas School of Medicine in the creation and pursuit of a career academic health center. Over the last year, UMC has played an integral role in the state of Nevada's COVID-19 response. Being the state's leader in COVID-19 testing, we have performed well over a million PCR [polymerase chain reaction] tests with result turnaround times of less than 12 hours. Now we have moved on to the next chapter in the COVID-19 vaccination efforts. As of right now, we have done 41,400 vaccinations to date.

We are here to discuss Assembly Bill 44, a bill that is sponsored by Clark County and supports the mission of UMC to provide the highest level of care to our patients while ensuring exceptional quality and meeting our goal of being good taxpayer stewards of the taxpayer dollars. This bill serves two purposes. It codifies in *Nevada Revised Statutes* (NRS) our UMC governing board. The governing board was created by Clark County ordinance in 2013. The governing board members are appointed by the Clark County Commission, which remains as UMC's hospital board of trustees and UMC's ultimate authority. In 2013, the commissioners had the foresight to recognize the importance of

having dedicated members of the community with specialized knowledge and skill sets to provide oversight and guidance with respect to daily management of hospital operations. As I know and members of this Committee understand, health care law and regulations are very complex and always evolving.

The second purpose of A.B. 44 is meant to address the complex, unique issues the hospital faces in health care—issues around the regulatory environment. University Medical Center would like the ability to have frank and open conversations and dialogue with our board leaders, whether with the governing board or the actual board of hospital trustees. In fact, our licensing and regulatory and accreditation standards require us to ensure both of our boards are fully informed when making very difficult decisions. Whether it is the ability to have these private deliberations under other Nevada law, those procedures and those statutes can sometimes conflict. Furthermore, it can lead to delays informing our board earlier than we would like where there are proactive measures that can serve to improve the quality and care as we have discussed.

To be clear, this bill does not allow for the governing board of any public hospital to take action or make decisions in a closed session. We have heard from various stakeholders since our bill was introduced. Throughout these discussions with our stakeholders, we understand that the original language in the bill early on was perhaps a little too broad. It did not clearly address those narrow instances where closed sessions and deliberations are needed. The amendment before you today is narrowly tailored to meet our needs [Exhibit C]. Furthermore, we understand that the Nevada Rural Hospital Partners is seeking to introduce an amendment that will extend these opportunities to rural county hospitals as well so they can better address patient safety and quality concerns. We support our rural partners and their amendment as we believe that this bill would ensure that public hospitals across Nevada will have the same ability as private hospitals to address federal and state regulations aimed at providing safe and quality patient care.

This bill will also serve as a safeguard to the Nevada taxpayers, an investment in their own public hospital by allowing a public hospital's governing board to proactively address any potential legal or regulatory issue. Adverse outcomes, costly fines, or protracted litigation can be avoided. This bill is not against transparency. University Medical Center's governing board will always be transparent in the decision-making process. This merely addresses the ability to deliberate and have discussions with our board members. All votes on matters will occur in open session in accordance with all existing requirements.

We want to stress that we have been working with various stakeholders to address the concerns with this bill and we will continue to do so. We are more than willing to listen and work with everyone to find a suitable compromise for a final bill.

Chair Nguyen:
There are two amendments on the Nevada Electronic Legislative Information System (NELIS). Both amendments on NELIS are friendly, is that correct?

Mason Van Houweling:
Yes, that is correct.

Chair Nguyen:
Committee members, I did have staff email those amendments to you this morning, and they are both on NELIS. We have a lot of questions, and we will start with Assemblywoman Thomas.

Assemblywoman Thomas:
Does this mean that UMC becomes a private/public entity?

Mason Van Houweling:
No, that is not correct. We celebrated 90 years of serving our community this year and will continue for the next 90 years as a public institution operating for the Clark County community.

Assemblywoman Thomas:
In reading this bill, the board of hospital trustees, which would be the county commissioners, would still be the hospital board of governors' bosses. Am I correct?

Mason Van Houweling:
Correct. That is not changing, it is codifying. Back in 2013, Clark County established UMC's governing board. The hospital board of trustees are the Clark County commissioners when it comes to hospital business; they are serving as hospital trustees. They have oversight of the UMC governing board, which are those community members. We meet monthly but there are four subcommittees under that board: finance, quality, strategy, and human resources. They meet often throughout the month and serve as the overall operating oversight at the hospital. Those governing board members report to the hospital trustees who are our Clark County commissioners. This would be codifying it in the NRS, which are already in the Clark County Code of Ordinances.

Assemblywoman Thomas:
How does this affect the union?

Mason Van Houweling:
There is no direct or indirect impact to the union. As I mentioned, any deliberations, votes, or decision-making always would occur in the public session. We have great attendance at our meetings with the union. I meet with them frequently, and our team meets with them frequently. I cannot see any direct or indirect impact to our union partners here at UMC. They are always welcome to our meetings and they frequently attend governing board meetings, the subcommittees, but also, if there is a need, hospital trustees' business matters that go in front of Clark County commissioners. They are often there supporting or making their voices heard. Usually, I am there with them side by side.

Assemblywoman Thomas:
My concern was the fact that the governing board would be tasked to make bylaws, changes, and things of that nature, and I was wondering how that would affect the union at UMC.

Mason Van Houweling:
Those would always be handled at the county commission level, again wearing their hospital trustee hats. They are very good at switching from Clark County Commission business to hospital business. There would be no changes to bylaws that would come out of a closed session within UMC. All those decisions, any votes, are always done in the public eye, properly noticed, vetted out, and discussions made—nothing that I would see that would directly impact the union with this particular bill.

Assemblywoman Thomas:
In your presentation you mentioned that A.B. 44 would prevent litigation. How is that possible?

Mason Van Houweling:
It would not prevent litigation, but it would perhaps minimize protracted litigation. It would allow us to inform our board of any potential regulatory litigation issues sooner than later to be able to address those matters. Again, everything would be properly done, done throughout the process in an open decision, but it would allow us to be more proactive on litigation matters and also in protecting our patients and our employees.

Assemblywoman Peters:
It is my understanding that there are already some protections for closed meetings, discussions in certain cases and scenarios. Can you talk about those and the difference this bill will make to those scenarios and why this is particularly needed if we already have some protections for other specific scenarios.

Mason Van Houweling:
I may lean on our general counsel for this one. There are instances when we have been going into closed session, particularly concerning litigation matters, but I would prefer that our general counsel, Ms. Pitz, answer that question.

Susan Pitz, General Counsel, University Medical Center:
Yes, there are other areas and other statutes where you can go into closed session; for example, to talk about the competency and conduct of practitioners. There, you would follow the procedure under that statute. Here, we are trying to put that ability under NRS Chapter 450, which is specific to running a hospital, so that we can follow our specific procedures related to that. The medical board has done similar in NRS Chapter 630 where they make references to this and following their procedure, as has state's mental health and the Commission on Behavioral Health's statute under NRS Chapter 433.

Assemblywoman Peters:
By running the hospital, can you give us a couple of examples of where this is important?

Susan Pitz:
Part of why we made the amendment to specifically reference review committees under NRS Chapter 49 is practitioners reviewing practitioners—peer review. When you are doing peer review in a hospital setting with physicians, it is important that the peers review each other. The hearing, the witnesses, the testimony, all get done with a panel of their peers. It is that setting when I see us using this the most—being able to do that hearing, call witnesses, and take testimony at the peer level. Then when it gets up to the governing board level, they are just reviewing the record and not providing a full new hearing.

Assemblywoman Peters:
That peer review practice does not have confidential components that are already protected under statute?

Susan Pitz:
Yes, it absolutely does have confidential and privileged information. That is in the review committee statute in NRS Chapter 49, but that is not going to evolve at that level. It is not involving any public official employment.

Assemblywoman Peters:
I am having a hard time tracking where this particular piece comes into play in the importance for the hospital. Could you narrow that down for me? What is missing right now? What do you not have? Maybe I am not understanding, but I need a little more discussion about that.

Susan Pitz:
Using that example of peer review and practitioner review, it has long been recognized in Nevada law that to get physicians to participate in peer review, to look at the role of other physicians in instances where maybe they did not do the best or there was an adverse outcome, they review each other at that level. It is at the hospital that was actually involving our medical staff, which is an independent entity though it is under UMC. It is a group of physicians who are elected who meet and discuss these issues. What happens with all hospitals is you have this peer review at the medical-staff level and the fair hearing panel of the peers. But the ultimate decision, according to health care laws and regulations, needs to be approved, so the medical staff or the fair hearing panel may make a recommendation, for example, that privileges are revoked. In every instance in hospitals, it has to go up to the board to approve that recommendation. Here, our board happens to be a public board, so if the public board had questions about the record that might include that sensitive information that was at the peer review, they would be doing that in open meeting or they would be going under NRS Chapter 241. While we have done that in the past and continue to do that, it does not follow the same procedure we would like to do under NRS Chapter 450. That is the missing piece we are looking to solve here.

Assemblywoman Peters:
Thank you, that makes sense. So there is a very narrow place where this would affect how you are able to run the review of issues within the hospital. Looking at your amendment, it

says to discuss "Matters . . . including, without limitation, deliberations of the character, alleged misconduct, professional competence, or physical or mental health of a provider of health care." So that is the scenario you are talking about, the peer review piece.

Susan Pitz:
Correct.

Assemblywoman Peters:
And then the second is, "Reports related to the compliance of the hospital with all laws, regulations, rulemaking guidance of the Centers for Medicare and Medicaid Services, or with any conditions of participation in the Medicare or Medicaid program." Can you describe a scenario in which that is applicable?

Susan Pitz:
As a hospital, we are licensed and accredited by a number of different bodies both on the state and federal level. The Centers for Medicare and Medicaid Services (CMS) has oversight over the Medicare and Medicaid programs. Obviously at UMC, we take Medicare and Medicaid. To be able to take Medicare and Medicaid, you have to follow certain rules of CMS in their conditions of participation. They expect, and part of those conditions of participation is, that you have a fully informed board, that you are bringing any issues to them that you are policing yourself, much like in the peer-review setting in which physicians are tasked with policing themselves. In a hospital that is a CMS provider, you are expected to police yourself and report those issues to a fully informed board. That is what we are looking to address. In this amendment, we tried to narrow that and we will continue to try to narrow that. That is what we are trying to accomplish.

Assemblywoman Peters:
I appreciate your entertaining these questions and talking about the specific scenarios, but I may have more questions as we go along.

Assemblywoman Benitez-Thompson:
My question concerns the amendment. As I read section 1, subsection 5, any conversations and supporting records and transcripts for those closed meetings will be outside that five-year rule in which it has to become public so they will indefinitely remain not public records. Is that right?

Mason Van Houweling:
Correct. Those would become public after five years unless they are privileged and confidential. You have read that correctly.

Assemblywoman Benitez-Thompson:
I worry about the need for this. In other statutes, even information that is held outside of public record, even some of the most sensitive records indeed do become public after about 30 years or so. Could you talk about why you would need perpetual protection around this information?

Susan Pitz:
Because five years was already in NRS Chapter 450 related to the other closed sessions that we have; we kept that. So actually, it is saying that we will turn it over, that it would be open to public record after five years unless it is privileged, which is how existing law is now—if it is privileged once, it is privileged for all time. In instances where it is not privileged, like some of those issues I was speaking about with Assemblywoman Peters, CMS-type issues, those would not necessarily hold a privilege and would be subject to disclosure after five years.

Assemblywoman Benitez-Thompson:
I see you are keeping the five years in there whenever you use NRS 49.117 or 49.265 in the way you use it now. However, if your board deems that you need to have that perpetual protection, then it will fall outside that five years. Am I misunderstanding that, or is it really just five years for everything?

Susan Pitz:
Yes, I believe it is meant to be and we can certainly look at the language if it is not clear on its face. It is meant to be that everything is subject to being open in five years unless it holds a privilege. Those review committees under NRS Chapter 49 would hold that privilege, but anything else would not necessarily hold that privilege, so it would be open. We are not looking to keep that perpetually protected.

Assemblywoman Benitez-Thompson:
I know you are referencing some of the CMS conditions of participation. For the legislative record I would feel more comfortable if you could get to us what specific pieces of CMS data collection you are concerned about. So much of that is aggregate data. I cannot think of a time when you are really getting into protected health information at the aggregate level once you start collecting data. You might have more of those conversations at a different level, but I think I need help with what you specifically mean—whether it is sentinel events—and then some examples where you have run into problems with the data collection piece, satisfying CMS, and the inability to provide information because of a sensitivity to public health records. That would help it be more concrete for me as I am trying to understand this. I have additional questions about section 2, but I will hold onto them and let the conversation continue.

Assemblywoman Titus:
Having been on the Nevada State Board of Medical Examiners, on the peer review committee when it was in existence for the entire state, and having served as chief of staff for a hospital, I have been involved in lots of peer review cases. They are not bad, they are not good, they are something that has to happen in standard of care. For clarification, charts get peer-reviewed that fall into certain categories; for instance, if you transfer a patient out of the emergency room within 24 hours, if someone dies in a certain stay, if someone leaves AMA [against medical advice], all those are subject to peer review by standard. It does not mean that there is anything good or bad, it is just that they fall into a category where they would

be reviewed. Frequently I would look at those, determine they had met standard of care, end of story.

This law, NRS 450.140, already exists. It already reads that the board of trustees has this ability, but what you are adding here is the language "or any hospital governing board" because it is different between county hospitals, rural hospitals, and private hospitals. Is this adding a clarification on covering for all hospitals and not just those with a board of hospital trustees?

Susan Pitz:
Yes, the language you are reading is a clarification that a board of hospital trustees can go into closed session and so can its appointed and delegated governing board. We are trying to make a clarification there with that language.

Assemblywoman Titus:
That is in section 1, subsection 3. Looking at section 2, subsection 1, what we are adding here are counties because many counties do not have hospital trustees. "In counties in which the board of hospital trustees appoints a hospital governing board . . . ," which is a different structure. It is clarifying that they may also be "exercising powers and duties delegated to the governing board . . . ." There are different ways of organizing hospital structure. The way I am looking at this bill, it clarifies that all those levels of structure would be included in being able to have that peer review in certain situations already afforded in general language. Is that how I am reading this?

Susan Pitz:
Absolutely. If you look at the language in section 2 that talks about NRS 450.175, it states that "In counties in which the board of hospital trustees appoints a hospital governing board, the governing board is the governing body of the county hospital when exercising powers and duties delegated to the governing board pursuant to this chapter." What that is saying is that whoever is the delegated authority and whichever structure you are under, when they are taking action, they have the authority to take the action. Throughout the NRS it uses the term "governing body," so at times that can be confusing—whether or not you are talking about the board of hospital trustees, the governing board, either one. Whoever has the authority to take that action is the governing body for that matter.

Assemblywoman Titus:
I see this as clarifying language to statutes that already exist under the many different conditions of hospitals. We have to allow those who do conduct peer review to do their jobs, which, as the opening statement said, will help for patients' overall outcomes and patient protection. Thank you for bringing the bill forward.

Chair Nguyen:
What do "privileged" and "confidential" mean within the context of this statute? Is that similar language you are trying to capture that applies to other hospital facilities right now?

Susan Pitz:
In the amended language at section 1, subsection 3, paragraph (c), we specifically called up NRS Chapter 49 because various stakeholders asked us to narrow the bill and get to what we were really trying to address. In NRS Chapter 49, those references, that is "confidential and privileged" conversations and materials that are used in those peer review settings.

Chair Nguyen:
It appears to me that the board gets to determine what is "privileged." Am I reading that incorrectly or is that how the process takes place?

Susan Pitz:
I do not believe the board determines what is privileged. If it is part of a review committee proceeding that fits under NRS Chapter 49, it is privileged. Unless, of course, like any privilege, it is somehow waived.

Chair Nguyen:
Under current law, it does not allow for privileged information to avoid this disclosure after five years. Is that correct?

Susan Pitz:
Yes, that is correct. We wanted to because existing law in NRS has that five-year requirement if we went into closed session. It would be available for me to request that information and supporting materials. We wanted to make clear that it would apply here, but if something is privileged, it is still going to maintain that privilege. We did not want it to be read as a waiver of any privilege after a certain period of time.

Chair Nguyen:
So the board determines that it is privileged, then they can waive that five years?

Susan Pitz:
It was intended to be the opposite, but as we talked about earlier, if that needs to be clarified, we certainly could. The privilege is there and after five years, anything that does not hold the privilege is subject to request for disclosure.

Chair Nguyen:
I would also appreciate clarifying language on that area.

Assemblywoman Summers-Armstrong:
The original language talked about health care facilities and spoke specifically of peer review and then it was crossed out. I am a little concerned about that. Now, it just references "provider of health care." In my opinion, that seems broader, more expansive, and still not clear. Who would be considered to be providers of health care?

Susan Pitz:
The statute specifically points to a defined term of "health care provider" which is licensed providers. Our intent with that was to narrow it to those instances of peer review of those practitioners. There was concern we heard from various stakeholders that talking about the facility and some of the more general information might catch up other areas of law, such as OSHA requirements, for the facility. The intent in that language was to narrow it to licensed professionals, licensed providers, peer review.

Assemblywoman Summers-Armstrong:
In looking at NRS 49.117, it is talking about committees of the hospital, the ambulatory surgical center, and all that. "Peer" would be the people working for those organizations that are providing the service, is that correct? That could include anyone working inside those facilities, is that right?

Susan Pitz:
What would be in the review committee could involve other people, I suppose. The review committee the hospital is using in this instance is for its licensed professionals. If your concern is that it not include something specifically, perhaps we could look at making it clear that it excludes certain things related to the facility. We use the review committee privilege for our peer review of licensed professionals, and that is why the reference is there.

Assemblywoman Summers-Armstrong:
The committee deciding what things are privileged is a concern of mine. I am also concerned about a statement you made earlier about policing yourselves and the need for this to be confidential in some manner. Often, that has not worked for the general public, when information is not available to the general public to at least know that there could be issues in a particular area of government. This is all being paid for by taxpayer dollars. Even though UMC is providing services, it is still a part of the community. We own it because we pay taxes and we contribute in our communities for that hospital to run, not fully, but we have a stake in what happens at UMC. Self-policing is very concerning to me, especially when we talk about the people who are on these committees, who are already public servants. They are elected officials and I think there is an expectation that some of what goes on would already be open to the community. I am concerned about adding another layer of what could be perceived as secrecy to a review panel, especially when you already have a tool to protect people's identities. I cannot get clarity on the necessity for this additional ability to meet in secret. If you have other information you could share, I would appreciate that very much to help clarify for me. This is my first time hearing anything about UMC and how you want to do this.

Susan Pitz:
When I use the term "self-policing," that is the term CMS uses. They require all hospitals, public or private, to engage in these types of activities, and that is what I was referring to.

Chair Nguyen:
Are there other questions from Committee members? [There were none.] At this time, I will start testimony in support, opposition, and neutral on A.B. 44. We will begin with testimony in support of A.B. 44.

Joan Hall, President, Nevada Rural Hospital Partners:
Thank you for allowing me this friendly amendment [Exhibit D]. Do you want to go over that now, or just my testimony in support of this bill?

Chair Nguyen:
We are doing support testimony now. I know Committee members have had the opportunity to review your amendment.

Joan Hall:
Nevada Rural Hospital Partners (NRHP) is a consortium of 13 critical access hospitals, 7 of which are county district hospitals. They are all in support of this process. The National Quality Improvement Act of 1987 laid out the foundation for peer review, recognizing that physicians were the best reviewers of physicians. That is why they put this process in place. They also recognized that doing this confidentially and in a safe manner was very important. So nationally, that standard has already been set.

We appreciate this verbiage going into NRS Chapter 450. It is already in law in NRS Chapter 49, but putting it in NRS Chapter 450 makes it clearer for both the district hospitals and the county hospitals, and the public we serve. We are very much in support of this.

Chair Nguyen:
Is there anyone else in support?

Hugh Qualls, Administrator, Mt. Grant General Hospital:
I would like to express my support for A.B. 44 and echo what Joan Hall from NRHP expressed, and add a rural, but in Mt. Grant's case, a frontier concern. There are two major issues I wish the Assembly to be aware of. In any hospital, especially a small one like ours, that level of candor from peer to peer that exists in peer review is critical to getting specific information about any provider care that did not meet the standard of care. If that were to be disclosed to the public, in my experience, you do not have much candor or specificity that is required for continuous improvement. We are all concerned about patient outcomes and if we cannot have candid conversations, it will be difficult to have the improvements necessary to provide the best care possible for our patients.

The second issue involves being in a very small town like Hawthorne. It does not take very much for people to put two and two together. If this became public knowledge or was disclosed, no matter what level of discretion we exercise, people will soon know the exact patient being talked about and who the provider was, as well. It does not take much to connect the dots, so that is a concern. And my recommendation for keeping this as private as

possible in order to improve the quality of care and to provide some PHI [protected health information] protection for our patients.

Chair Nguyen:
Are there any more callers in support? [There were none.] Can we go next to our callers in opposition to A.B. 44.

Richard Karpel, Executive Director, Nevada Press Association, and Member, Nevada Open Government Coalition:
We oppose the sections of A.B. 44 that close meetings and make public records confidential and we do not think the amendment that was submitted helps. My understanding is that there are other members of our coalition who are in communication with the bill proponents and that we will be meeting with them to work through our issues. Based on what we already know, it is not clear why A.B. 44 or even the stuff that is already closed in the underlying statute, it is not clear why any of it needs to be secret.

For instance, why should residents of the state not be allowed to participate in meetings where the compliance of their local public hospital with federal laws is going to be discussed? What could possibly be more important to the public than whether their local hospital is complying with federal law?

If I am understanding the peer reviews correctly, they should already be covered by the Open Meeting Law which allows public bodies to discuss personnel matters in closed session. The proponents appear to be conflating privileged and confidential information, but they are actually two different things. We are opposed to A.B. 44.

Justin Watkins, representing Nevada Justice Association:
On behalf of the Nevada Justice Association, we are opposed to A.B. 44. The intent stated in this hearing does not mesh with the language of the bill nor do the policies align with the language of the bill.

The reason why peer review committees and their deliberations are not disclosed for five years is so there can be honesty among peers and not retribution among peers and have an honest review. That policy does not comport with the bosses of the company or the hospital reviewing the conduct of its employees. So there can be no fear of reprisal from the employees against the governing body and therefore, there is no need to have secrecy or lack of transparency in this regard. Further, the stated timelines of the secrecy, the five years, now get extended indefinitely under the language of this bill if the committee determines that the information is privileged. In existing law, it must be disclosed after five years; now, there would be no disclosure.

What this means is that people who have been wronged by the hospital will be unlikely to find out any relevant information as to why they were wronged, who was responsible for the wrong, as the five years far exceeds the statute of limitations for bringing a claim, and the people of the state of Nevada will not be able to hold their elected officials accountable for

being good or bad stewards of their tax dollars and administering the governance of the hospital. For those reasons, there is a lack of accountability in this bill, there is a lack of need for this language in its entirety, and it certainly is against public policy to increase the level of secrecy among government-funded hospitals.

Chair Nguyen:
May we go to our next caller in opposition to A.B. 44. [There was no one.] Do we have any callers in neutral on A.B. 44? [There were none.] I will turn this back over to Mr. Van Houweling to make any closing remarks.

Mason Van Houweling:
We want to continue to work to refine the bill as needed. We will be reaching out to those who had additional questions. There are two things: codifying the board in NRS is important to Clark County and also narrowing down the bill to make sure we have discussions and dialogue, but always we will do things in open session. Any actions and any votes will always be done in open session.

Chair Nguyen:
There were a couple of follow-up questions. Previously, Assemblywoman Benitez-Thompson had some questions about section 2 and I do not believe they were answered.

Assemblywoman Benitez-Thompson:
I think section 2 is much more the meat and potatoes of what you are trying to get at. The counties do not get very many bills, so this must be important. I do not know what the distinction would be between the practice right now where UMC has a governing board and the powers and duties it is using without it being specifically stated in statute, or that someone has given the opinion that it is not specifically stated in statute and then putting the provisions of section 2 into place. How would things change from how they are operating today versus how they would operate after the effective date of this bill?

Mason Van Houweling:
It is clarifying. Since 2013, this has been a Clark County ordinance. As you heard reference to NRS Chapter 450, codifying that and clarifying whether it is a governing board, governing body, the authority would be clarified in section 2. Again, the hospital trustees here in Clark County are elected officials. They appoint governing board members to oversee the governing board and also the subcommittees. As Joan Hall mentioned, this would help other district hospitals, other public hospitals, clarifying the language on the authority and putting it in the right section of NRS Chapter 450.

Assemblywoman Benitez-Thompson:
I appreciate that. So there is nothing else I need to hold in my head to give consideration to this. As you see section 2, it is a cleanup. There are no other conversations going on. I am from northern Nevada and not from Clark County, so I do not know if there are other considerations I should be holding in my head.

Mason Van Houweling:
It is an important piece, but it is just codifying and bringing clarity with no other intent around that—just make it in NRS Chapter 450, which defines all the hospitals here in the state as previously mentioned.

Assemblywoman Benitez-Thompson:
Tying back to section 1, subsection 3 in the amended version, you use the word "any." It says, "the board of hospital trustees or any hospital governing board," but the intent is "the" hospital governing board. You cannot imagine a scenario in which there would be multiple governing boards, you mean it as the one and only appointed governing board that would hold that authority. There is not a plan for additional governing boards to hold additional authority.

Mason Van Houweling:
You are correct. There is no other intent, certainly not here in southern Nevada. I am not speaking for Joan Hall, because the structure could be different in a district hospital versus a public hospital—county hospital—but there is no other intent. You have the trustees and the governing board here and that is how we see it for the future ahead.

Chair Nguyen:
Does anyone have any follow-up questions? [There were none.] At this time, I will close the hearing on A.B. 44. Thank you for your presentation. We will move to public comment. Do we have any callers on the line for public comment? [There were none.] I will close public comment. Are there any comments from Committee members? [There were none.] The meeting is adjourned [at 2:32 p.m.].

RESPECTFULLY SUBMITTED:

_____
Terry Horgan
Committee Secretary

APPROVED BY:

_____
Assemblywoman Rochelle T. Nguyen, Chair

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a proposed amendment to Assembly Bill 44, dated March 22, 2021, presented by Mason Van Houweling, Chief Executive Officer, University Medical Center, submitted by Susan Pitz, General Counsel, University Medical Center.

Exhibit D is a proposed amendment to Assembly Bill 44, dated March 22, 2021, presented and submitted by Joan Hall, President, Nevada Rural Hospital Partners.