

**Legislative Committee on Health Care**  
(*Nevada Revised Statutes 439B.200*)

**WORK SESSION  
DOCUMENT**

**(Includes Attachments)**



**July 29, 2008**

Prepared by the Research Division  
Legislative Counsel Bureau

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## **WORK SESSION DOCUMENT**

Legislative Committee on Health Care  
(*Nevada Revised Statutes* 439B.200)

**July 29, 2008**

The following “Work Session Document” has been prepared by the staff of Nevada’s Legislative Committee on Health Care (LCHC) (*Nevada Revised Statutes* [NRS] 439B.200). This document contains recommendations that were submitted in writing to Committee staff, provided through correspondence with Committee members, or presented during one of the Committee’s hearings.

This document is designed to assist the Committee members in determining what action they may wish to take on certain issues, which may include making statements in the Committee’s final report, writing letters of recommendation or support, or forwarding recommendations for legislation to the 2009 Session of the Nevada Legislature. The Committee may vote to make as many statements or send as many letters as they choose; however, pursuant to NRS 218.2429, the Committee is limited to ten bill draft requests (BDRs), including requests for the drafting of resolutions. The BDRs must be submitted to the Legal Division of the Legislative Counsel Bureau (LCB) before September 1, 2008.

The recommendations listed in this document are conceptual recommendations arranged by topic, are in no particular order of importance, and do not necessarily have the support or opposition of the Committee Chairwoman or members. The members may accept, reject, modify, or take no action on any of the proposals. The source of each recommendation is noted in parentheses when available. Please note that specific sources may not be provided if the proposals were raised and discussed by numerous individuals during the course of the interim, or only one main source may be listed when there were also others who contributed. Additional recommendations may be considered based on discussions held and presentations made at the July 29, 2008, hearing. Please see the agenda for details concerning the scheduled presentations. The Chairwoman of the Committee may choose to raise related issues for discussion or Committee action during the work session.

The recommendations may have been modified by being combined with similar proposals or by the addition of necessary legal or fiscal information. It should also be noted that some of the recommendations may contain an unknown fiscal impact. If a recommendation is adopted for a BDR, then the Committee staff will work with interested parties to obtain fiscal estimates for inclusion in the final report. During the drafting process, specific details of approved requests for legislation or other Committee action may be further clarified by staff in consultation with the Chairwoman or others, as appropriate. Also, if a recommendation includes reference to specific chapters or statutes of NRS, as part of the drafting process, amendments to other related chapters or sections of NRS may be made to fully implement the recommendation.

## RECOMMENDATIONS

### RECOMMENDATIONS CONCERNING ACCESS TO CARE

- 1. Draft legislation requiring the Department of Health and Human Services (DHHS) to establish a system that allows applications for Medicaid and the Children’s Health Insurance Program to be submitted electronically. This bill would further require an agency that is designated by the Director of the DHHS to receive applications or determine eligibility for the programs to use the system to forward applications, but applicants for services must not be required to submit applications electronically. (Submitted by Chairwoman Leslie, October 31, 2007.) (See Tab 1.)**

Estimated Biennium Cost: \$590,792.00 for the start-up year (27% or \$159,513.84 from the State General Fund), and \$46,092.00 for subsequent years (27% or \$12,444.84 from the State General Fund).

- 2. Draft a letter to Nevada’s Congressional Delegation requesting that certain federal policy revisions be made to enhance Nevada’s ability to support, recruit, and retain physicians that work through the J-1 Visa Waiver Program, including a provision that gives priority or preference, or both, to physicians that have participated in the J-1 Visa Waiver Program, when they apply for lawful permanent residency. (Discussed October 31, 2007.) (See Tab 2.)**

### RECOMMENDATIONS CONCERNING MENTAL HEALTH AND SUBSTANCE ABUSE

- 3. Draft a letter or include a statement in the Committee’s final report encouraging the Division of Mental Health and Developmental Services (DMHDS), DHHS, to collaborate with the mental health redesign work group to continue to review Nevada’s process for admitting persons to mental health facilities under emergency circumstances, known as the “Legal 2000” process. The letter will request the DMHDS to prepare recommendations to refine the “Legal 2000” process, including, without limitation:**

- a. Suggestions to:
    - 1) Expand the criteria of what must be included in an examination required pursuant to NRS 433A.165 before a person may be transferred to a mental health facility. *(Discussed November 27, 2007.)*
    - 2) Reconcile the definition of “admission” as the term is used in NRS and the practical application as the term is used for billing practices of medical professionals. *(Discussed November 27, 2007.)*
    - 3) Propose amendments to change the statutory language which requires an examination be performed before a person may be transferred to a mental health facility in order to allow for one-stop-shop arrangements. *(Discussed November 27, 2007.)*
  - b. Propose amendments to NRS 433A.165 to clarify the legal status of patients and ensure that patients are tracked by the court psychiatrists and hospital risk management offices until medically stable and either transferred to a mental health facility or psychiatrically cleared for discharge. *(Submitted by Lesley Dickson, M.D., President, Nevada Psychiatric Association, June 17, 2008.)*
  - c. Suggest developing procedures and policies within hospitals to ensure the psychiatric and legal status of patients is known to all members of the treatment team and hospital risk management office. *(Submitted by Lesley Dickson, M.D., President, Nevada Psychiatric Association, June 17, 2008.)*
  - d. Suggest requirements for in-service training for physicians, nurses, social workers, ward clerks, and others regarding the “Legal 2000” process. *(Submitted by Lesley Dickson, M.D., President, Nevada Psychiatric Association, June 17, 2008.)*
  - e. Suggestions that would require general hospitals to have psychiatric coverage available and encourage financial arrangements that facilitate psychiatric consultation to the medically or psychiatrically uninsured. *(Submitted by Lesley Dickson, M.D., President, Nevada Psychiatric Association, June 17, 2008.)*
- 4. Draft a letter to Nevada’s Congressional Delegation requesting the amendment of various federal lands acts to allow for the conveyance of federal land to support the development of behavioral health and substance abuse facilities, with the intent of encouraging investment and management of these types of facilities in Nevada, as part of a strategy for decreasing the number of out-of-state patient placements. *(Submitted by Ernie Nielsen, Senior Law Project Attorney, Washoe County Senior Law Project, January 23, 2008.)***

## **SUBSTANCE ABUSE AND MENTAL HEALTH TREATMENT FOR PERSONS IN THE CRIMINAL JUSTICE SYSTEM**

- 5. Make an appropriation to support the work of the Justice Center, Council of State Governments, to continue work to improve public safety through effective substance abuse and mental health treatment for persons in the criminal justice system in Nevada. The amount of the appropriation will be determined in consultation with the Fiscal Analysis Division, LCB. (Submitted by Fred C. Osher, M.D., Director of Health Systems and Services Policy, Justice Center, Council of State Governments, June 17, 2008.)**
- 6. Draft a letter to the Senate Committee on Finance and the Assembly Committee on Ways and Means requesting an ongoing line item for mental health and substance abuse services and programs within the Department of Corrections' budget. (Submitted by Senator Horsford, January 23, 2008.)**

## **RECRUITING AND RETAINING PSYCHIATRISTS WITHIN THE DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL SERVICES**

- 7. Draft a letter or include a statement in the Committee's final report encouraging the DMHDS to create a plan for addressing compensation and organizational challenges which constrict the DMHDS's ability to recruit and retain psychiatrists, including, without limitation, recommendations to:**
  - a. Make the pay rate more flexible and to allow for certain overtime pay or nighttime differential pay;
  - b. Adjust the on-call rate of \$60 per weeknight and \$100 per weekend day so that those rates are competitive; and
  - c. Provide additional compensation for psychiatrists who take on additional administrative responsibility or residency training.

## **RURAL MENTAL HEALTH**

- 8. Draft legislation to require certain emergency mental health services in rural Nevada. (Submitted by Ray C. Kendall, L.C.S.W., Agency Director, Rural Clinics, DMHDS, DHHS, April 10, 2008.)**

Estimated costs for providing emergency room (ER) services 24 hours per day, 7 days per week, are as follows:

Center Directors' standby pay	\$130,100.00
Line staff standby pay	\$123,930.00
Center Director call-out pay	\$28,080.00
Line staff call-out pay	<u>\$334,380.00</u>
Annual costs for 24/7 ER	\$616,490.00

Estimated Biennium Cost: \$1,232,980. (*Fiscal information provided by Harold Cook, Administrator, DMHDS, DHHS, submitted July 2, 2008.*)

9. **Draft a letter to encourage the DMHDS to work with hospitals and law enforcement in rural Nevada to document the impact of the loss of mental health emergency services in rural Nevada on suicide rates, the wait time for patients to see a psychiatrist, and the relationships between mental health providers, hospitals, and law enforcement.** (See Tab 3.)

<b>RECOMMENDATIONS CONCERNING CHILDREN AND SENIOR HEALTH ISSUES</b>
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10. **Draft legislation creating the Legislative Committee on Child Welfare and Juvenile Justice in accordance with Sections 2 through 8, inclusive, of Senate Bill 170, 2007 Legislative Session.** (*Submitted by Senator Washington, December 18, 2007.*) (See Tab 4.)

Estimated Biennium Cost: \$242,582 (based on a fiscal note for S.B. 170, submitted February 28, 2007). The fiscal note for S.B. 170 included the cost for the creation and support of two committees, due to differences in the meeting schedules and membership of those committees this estimate is based on 40 percent of the total original cost.

11. **Draft a letter to the Director of the DHHS to encourage the Aging Services Division, DHHS, to work with the Bureau of Licensure and Certification (BLC), Health Division, and the Division of Health Care Financing and Policy (DHCFP), DHHS, to develop a plan to:**
  - a. Support and encourage the development of effective and ongoing training for existing care staff to transition and stabilize residents diagnosed with dementia, Alzheimer's disease, and Traumatic Brain Injury (TBI). (*Submitted by The Honorable Frances Doherty, Department 12, Family Division, Second Judicial District Court of Nevada, January 23, 2008.*)
  - b. Create industry incentives and remediation of potential misperceptions of licensing challenges encountered by facilities housing individuals diagnosed with dementia, Alzheimer's disease, and TBI. (*Submitted by The Honorable Frances Doherty, Department 12, Family Division, Second Judicial District Court of Nevada, January 23, 2008.*)



**12. Draft legislation to amend the definition of mental illness pursuant to NRS 433A.115 to include Alzheimer's disease. (Discussed January 23, 2008.)**

According to the DMHDS, changing the statutory definition so that Alzheimer's disease is specifically included as a mental illness could have a significant budgetary impact on the State. Such a statutory change would mean that individuals with Alzheimer's disease could be referred to State mental health hospitals as an emergency admission. According to the DMHDS, no State mental health hospital is equipped or staffed to serve and treat these individuals; thus, provisions for doing so would have to be made if such a statutory change goes into effect.

Estimated Biennium Cost: According to the DMHDS, significant cost is associated with this change; however, no specific estimate is available at this time.

<b>RECOMMENDATIONS CONCERNING PUBLIC HEALTH PROGRAMS</b>
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**13. Draft legislation to maintain the Health Insurance for Work Advancement (HIWA) Program and the TBI waiver and make an appropriation for the necessary amount. (Submitted by Paul Gowins, Strategic Plan for People with Disabilities Statewide Accountability Committee, May 6, 2008.)**

Estimated Biennium Cost: The budget approved by the Legislature for Fiscal Year (FY) 2008-2009 included funding to exclude unearned income when determining eligibility for the HIWA Program and to provide 45 waiver slots for TBI patients. Because these were new programs, they were eliminated to achieve necessary budget reductions. To eliminate the unearned income cap for the HIWA Program in FYs 2010 and 2011 would require a total funding of \$2,180,933 over the biennium with a State General Fund appropriation of \$996,254. The program would increase the HIWA Program's caseload by an average of 216 in FY 2010 and 268 in FY 2011. To reintroduce the TBI waiver slots in FYs 2010 and 2011 would require total funding of \$4,641,988 over the biennium with a State General Fund appropriation of \$2,320,995. This would provide 30 residential habitation slots and 15 adult day care slots. Cost estimates for both programs assume a start date of October 1, 2009. Funding requirements could be reduced by moving the start date on one or both programs.

**14. Draft legislation to expand the Lead Poisoning Prevention Project by requiring State and local health authorities to adopt and enforce regulations for testing children under the age of six for lead exposure in accordance with standards set forth by the National Centers for Disease Control and Prevention. (Submitted by the Southern Nevada Health District [SNHD], May 6, 2008.) (See Tab 5.)**

Estimated Biennium Cost: No estimate available at this time.

15. **Draft legislation that requires laboratories that examine the blood of a child under the age of 18 for the presence of lead to report the results of the examination to the appropriate health authority not later than five calendar days after the examination.** *(Submitted by the SNHD, May 6, 2008.)* (See Tab 5.)

<b>RECOMMENDATIONS CONCERNING THE HEPATITIS C INVESTIGATION</b>
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**PUBLIC HEALTH RESPONSE**

16. **Draft a letter or include a statement in the Committee’s final report to support the BDR of the Health Division, DHHS, to revise provisions relating to the State’s public health system. The purpose of the BDR is to:** (See Tab 6.)
- a. Allow the State Board of Health to adopt regulations to specify the conditions under which a medical facility can be closed during an ongoing investigation;
  - b. Clarify statutory language as it relates to the power of the Health Division to fine medical facilities for violations;
  - c. Give authority to the Health Division to take control over a facility’s medical records in the event the facility is closed during the course of an investigation;
  - d. Clarify statutory language related to sentinel events and establish penalties for facilities that do not report a sentinel event;
  - e. Strengthen the authority of local health authorities or officers of health districts to subpoena records related to an ongoing investigation of a medical facility;
  - f. Clarify statutory language as it relates to the powers of a local health authority or officer of a health district during disease investigations and establish methods to cover the costs of such disease investigations; and
  - g. Clarify the method by which information in an investigation is shared with law enforcement authorities.
17. **Amend Chapter 449 of NRS, “Medical and Other Related Facilities,” to require the recommendations of a health authority which investigated a disease outbreak or potential exposure to be included in any statement of deficiency of a licensed health care facility and require an appropriate response in the resulting action plan.** *(Submitted by the SNHD, April 21, 2008.)*

**18. Draft legislation to define the process for a declaration of a “public health emergency.” This bill will provide clear authority and expectations for the coordinated actions of all public agencies that have statutory responsibilities for some aspects of any required investigation, intervention, or sanctions. (Submitted by Larry Matheis, Executive Director, Nevada State Medical Association, June 17, 2008.) (See Tab 7.)**

**19. Draft legislation to authorize the BLC, when a public health emergency exists, to:**

- a. Temporarily close a facility, or the appropriate portion of a facility, in order to make a determination within 24 hours as to whether the facility can be reopened and provide safe services. During that 24-hour period, the facility employees will be tested and/or educated in order to ensure that the services being provided are safe;
- b. Designate a location for a central record repository in the case of a public health emergency and ensure that the team working with the records is trained regarding Health Insurance Portability and Accountability Act compliance, and allow a facility or medical professional to voluntarily allow the records to remain on the grounds of the facility and to allow the team handling the records to work out of the facility; and
- c. Develop a central information and education hotline. *(Submitted by Assemblyman Hardy, March 24, 2008.)*

Estimated Biennium Cost: No estimate available at this time.

#### **REGULATION OF SURGICAL CENTERS FOR AMBULATORY PATIENTS AND OFFICES WHERE OUTPATIENT PROCEDURES ARE BEING PERFORMED**

**20. Draft legislation to require surgical centers for ambulatory patients (ASCs) and offices where outpatient surgical procedures are being performed to be accredited by a federally recognized accrediting entity. (Discussed April 21, 2008.)**

**21. Recommendations relating to surveys of ASCs include:**

- a. Draft legislation to require the BLC to survey ASCs once every two years and require the BLC to increase the fees for licensing these types of facilities to include the additional cost for conducting these surveys. *(Discussed April 21, 2008.)*

Estimated Biennia Cost: No estimate available at this time.

- b. Draft legislation that shifts the responsibility for surveying ASCs from the BLC to the health district in which the ASC is located, if applicable. The health district would be required to conduct the initial survey for licensure, scheduled surveys, and any surveys that result from a complaint. Fiscal impact information has been requested from each health district. Currently there are two health districts in the State: Southern Nevada Health District and Washoe County Health District. *(Submitted by Senator Washington, April 21, 2008.)* (See Tab 8.)

Estimated Biennium Cost: No estimate available at this time.

22. **Draft a letter encouraging the State Board of Pharmacy, in collaboration with the Board of Medical Examiners, the State Board of Osteopathic Medicine, the State Board of Nursing, and the State Board of Health, to develop a system for monitoring the sale and use of anesthesia in Nevada to determine where surgical procedures are being performed and the type of health care professionals that are conducting those surgeries.** *(Submitted by Senator Washington, April 21, 2008.)*
23. **Draft legislation that requires the BLC to prepare and submit an annual report regarding the frequency of inspections of health care facilities licensed in this State and the findings from those inspections. The report must include a summary of any major issues and problems that have been identified and any follow-up. The report must be submitted to the LCHC and the Legislative Commission.** *(Discussed April 21, 2008.)*
24. **Make an appropriation or send a letter of support to the Assembly Committee on Ways and Means and the Senate Finance Committee to increase the salary for non-nurse Health Facility Surveyors to an amount equal to the salary for nurse Health Facility Surveyors.**

Estimated Biennium Cost: \$400,000. (Fiscal impact estimate provided by Marla McDade Williams, Chief, BLC, Health Division, DHHS.)

<p style="text-align: center;"><b>RECOMMENDATIONS CONCERNING HEALTH CARE PROFESSIONAL LICENSING BOARDS</b></p>
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#### **APPOINTMENT PROCESS**

25. **Draft legislation to require professional associations and educators affiliated with a particular professional group to submit to the Governor recommendations for nominees to serve on respective professional licensing boards.**

- a. The Governor's final appointments must include recommendations from the following entities: (1) the medical societies; (2) the University of Nevada School of Medicine; and (3) a public member chosen by the LCHC.
- b. Require the nominating entities to submit their recommendations for consideration to a committee which will perform a background check to, among other considerations, ensure the absence of any conflicts of interests, ensure ethical patterns of practice, et cetera. *(Submitted by James S. Tate Jr., M.D., F.A.C.S., F.I.C.S., President, Association of Black Physicians, and Chairman, Board of Directors, Association of Black Physicians, May 6, 2008.)*

**OR**

**26. Draft legislation that creates a screening committee to select nominees for gubernatorial appointment to boards. Require the Governor to select appointees from a screening committee slate. The screening committee panel will present a minimum of three names to the Governor for each vacancy and the Governor would be required to select one of the three candidates. *(Discussed April 21, 2008.)***

- a. To accommodate the number of appointees in any given year, several screening panels may be convened in a configuration that allows members from one panel to serve as substitutes on another panel.
- b. Each panel would consist of seven members, with three selected by the Governor, one each by the Senate Majority and Minority Leaders, and one each by the Speaker of the Assembly and the Assembly Minority Leader. A substitute from one panel may only replace a member of another panel if both were appointed by the same official. One of the Governor's selections, designated by the Governor, would serve as panel President and five members of a panel would have to agree on a nominee.
- c. The screening panels would be composed of volunteers who serve without pay as a public service.
- d. Videoconferencing and electronic mail could be used whenever possible to reduce travel time and expense.
- e. The Governor may suggest nominees to the screening committee; however, the process may be open for individuals to make their own application. Incumbents, if not term limited by statute, may be considered for reappointment.
- f. Nominees would be presented to the Governor at least 30 days prior to the occurrence of the vacancy or, if insufficient notice was given, as soon as practicable. The Governor would be required to make an appointment by the time the position is vacant.

**27. Require involvement of the LCHC in the process for appointment to health care professional licensing boards, including:** *(Submitted by James S. Tate Jr., M.D., F.A.C.S., F.I.C.S., President, Association of Black Physicians, and Chairman, Board of Directors, Association of Black Physicians, May 6, 2008.)*

- a. Draft legislation to require the LCHC to provide a list of nominees to the Governor. The Governor must select appointments for health care professional licensing boards from the list provided by the Committee; or
- b. Draft legislation to require the Governor to provide to the LCHC advance notice of potential appointments. The LCHC would be authorized to make inquiries concerning the potential appointments. The LCHC would not be able to veto any selections but may report to the Governor concerning the advisability of making such appointments.

#### **COMPOSITION OF BOARDS**

**28. Draft legislation to revise the membership of all health care professional licensing boards to require that a majority of members be public members.**

- a. Include the limitation that a public member may not be the spouse or the parent or child, by blood, marriage or adoption, of a person licensed in any state to practice any related profession; see for example, NRS 630.060(3)(b) relating to the Board of Medical Examiners.
- b. The incumbent board members would be replaced with public members as their terms expire until the majority of the board is composed of public members.
- c. In some cases where existing boards are composed of several different licensees (e.g., the Board of Dental Examiners of Nevada is composed of six dentists and three dental hygienists), the number of nonpublic positions on the board must be reduced proportionally to maintain existing ratios to the extent possible. *(Discussed April 21, 2008.)*

**OR**

**29. Draft legislation to revise the membership of all health care professional licensing boards to increase the number of public members serving on each board. The incumbent board members would be replaced with public members as their terms expire until the board is composed of the requisite number of public members. (See Tab 9.)**

## BOARD AUTHORITY

30. **Draft legislation that authorizes health care professional licensing boards to temporarily suspend a practitioner's license until final resolution of a complaint when the board determines there is an immediate danger to the public. The bill would further require a hearing to be conducted within a specified time (possibly 45 days). (Discussed April 21, 2008.) (See Tab 9.)**
31. **Provide that the removal of a board member does not require impeachment, including:** *(Submitted by Chairwoman Leslie, June 17, 2008.)*
  - a. Draft legislation amending the term of each member of a health care professional licensing board so that he serves at the pleasure of the Governor; or
  - b. Draft a resolution to propose an amendment to the *Nevada Constitution* to provide for removal of appointed public officers in a manner specified by the Legislature. This is patterned after Article 7, Section 4, of the *Nevada Constitution*, which provides for the removal from office "of other civil officers."
32. **Draft legislation that establishes grounds for a health care professional licensing board to suspend or revoke a professional license held by the owner or another principal of a health care facility that has responsibility in the creation of a public health threat or is currently being investigated, under certain circumstances. This provision is similar to the provisions of NRS 449.160. (Submitted by Senator Heck, June 17, 2008.)**

## STANDARDIZATION OF CERTAIN BOARD FUNCTIONS

33. **Draft legislation to expand the role of the Office for Consumer Health Assistance (NRS 223.500 through 223.580) or create an ombudsman position to assist in the filing of a complaint against a health care facility or health care professional with the appropriate licensing agency or professional licensing board. (Submitted by the SNHD, April 21, 2008.)**

Estimated Biennium Cost: No estimate available at this time.

34. **Draft legislation to create a two-tiered approach for filing complaints against a health care professional. Tier one consists of individuals submitting complaints and tier two consists of complaints filed by another health care agency (such as the BLC or a statutorily recognized health authority). Tier two complaints would authorize the board or agency receiving the complaint to use the findings of the complainant to expedite the investigative process. (Discussed April 21, 2008.)**

- 35. Draft legislation to provide for a standardized and streamlined process for filing a complaint with a health care professional licensing board including, without limitation, a single form that must be used by all boards. (Submitted by the Health Division, DHHS, April 21, 2008.)**
- 36. Draft legislation that requires all members of health care professional licensing boards be provided a copy of the conflict of interest provisions of Chapter 281A of NRS, “Ethics in Government” and require the signature of each board member acknowledging receipt of the conflict of interest provisions. (Discussed May 6, 2008.) (See Tab 10.)**
- 37. Draft legislation to require all health care professional licensing boards to retain every complaint that is filed with the board, including, without limitation, complaints that receive no action.**
- 38. Establish an interim legislative study to:**
  - a. Determine the feasibility and efficiency of creating a central office to provide administrative support for all of the health care professional licensing boards. (Submitted by Larry Matheis, Executive Director, Nevada State Medical Association, April 10, 2008.)
  - b. Determine the benefit of combining the Board of Medical Examiners and the State Board of Osteopathic Medicine or combining other boards that regulate similar licensed health care professionals.
  - c. Review the licensing chapters of the NRS related to health care licensing boards with the intent of expanding Chapters 622 and 622A of NRS, “General Provisions Concerning Regulatory Bodies” and “Administrative Procedure Before Certain Regulatory Bodies,” respectively, to contain all the statutes that are common to the various health care professional licensing boards, standardizing the provisions if appropriate by selecting the best version, and leaving only those provisions that are in fact unique to a specific board in the board’s separate chapter. (Discussed April 21, 2008.)
  - d. Standardize and streamline the health care boards’ complaint process.



## RECOMMENDATIONS CONCERNING WHISTLEBLOWER PROTECTIONS

- 39. Draft legislation to provide statutory protections for a nurse who: (a) reports concerns about patients being exposed to substantial risk of harm due to failure of a facility or practitioner to conform to minimum professional standards, regulations, or accreditation standards; (b) is requested to engage in conduct that would violate the nurse's duty to protect patients from actual or potential harm as defined in Chapter 632 of NRS, "Nursing," and Chapter 632 of *Nevada Administrative Code* (NAC), "Nursing"; (c) refuses to engage in conduct that would violate the provisions of Chapter 632 of NRS or Chapter 632 of NAC or that would make the nurse reportable to the State Board of Nursing; (d) reports the actions of another nurse who engages in conduct subject to mandatory reporting to the State Board of Nursing as defined in Chapter 632 of NRS Chapter 632 of NAC; or (e) reports staffing concerns or situations that reasonably could contribute to patient harm. (*Submitted by the Nevada Nurses Association, May 6, 2008.*) (See Tab 11.)**
- 1) The bill would apply the protections to reporting both internally and externally (i.e. within the facility, to legal, governmental, or legislative bodies).
  - 2) The bill would further provide an enforcement mechanism to provide a clear and direct recourse to those who experience workplace sanctions after having reported an unsafe health care practice, including civil action to include at least double compensation for damages resulting from lost wages, compensation for legal representation, and additional punitive damages.
  - 3) Additionally, the bill would create a presumption that any disciplinary action taken against a nurse within 60 days of that nurse reporting conduct specified in the statute was taken in retaliation against the nurse having made such a report.

**RECOMMENDATIONS FROM THE SUBCOMMITTEE OF THE LEGISLATIVE  
COMMITTEE ON HEALTH CARE TO REVIEW THE LAWS AND  
REGULATIONS GOVERNING THE PROVIDERS OF HEALTH CARE, THE USE  
OF LASERS AND INTENSE PULSED LIGHT THERAPY, AND THE USE OF  
INJECTIONS OF COSMETIC SUBSTANCES (SENATE BILL 4, CHAPTER 4,  
STATUTES OF NEVADA 2007, 23<sup>RD</sup> SESSION)**

40. **Draft legislation to modify the requirement that an applicant for a license to practice medicine must prove to the Board of Medical Examiners he is a citizen or lawfully entitled to remain and work in the United States by creating an exception for applicants who are trying to enter the J-1 Visa Waiver Program. This bill would allow an application for a license to be processed; however, the applicant would not be permitted to begin the practice of medicine until the J-1 Visa Waiver has been issued.** *(Submitted by the Subcommittee to Review the Laws and Regulations Governing Providers of Health Care, the Use of Lasers and Intense Pulsed Light Therapy, and the Use of Injections of Cosmetic Substances [Senate Bill 4, Chapter 4, Statutes of Nevada 2007, 23<sup>rd</sup> Special Session].)* (See Tab 12.)
41. **Draft a letter requesting the Board of Medical Examiners, the State Board of Osteopathic Medicine, and the State Board of Nursing to regularly survey licensees to obtain details about locations and areas of practice in order to provide information to support programs to obtain more practitioners.** *(Submitted by the Subcommittee to Review the Laws and Regulations Governing Providers of Health Care, the Use of Lasers and Intense Pulsed Light Therapy, and the Use of Injections of Cosmetic Substances [Senate Bill , Chapter 4, Statutes of Nevada 2007, 23<sup>rd</sup> Special Session].)* (See Tab 12.)
42. **Draft legislation to allow physicians who have recently completed a residency program to be provisionally licensed upon receipt of satisfactory fingerprint reports, pending completion of the remainder of the board application process, including completion of certain examinations or board certifications.** *(Submitted by the Subcommittee to Review the Laws and Regulations Governing Providers of Health Care, the Use of Lasers and Intense Pulsed Light Therapy, and the Use of Injections of Cosmetic Substances [Senate Bill 4, Chapter 4, Statutes of Nevada 2007, 23<sup>rd</sup> Special Session].)* (See Tab 12.)
43. **Draft legislation to make it easier for professionals licensed in other states to become licensed in Nevada if certain criteria are met.** *(Submitted by the Subcommittee to Review the Laws and Regulations Governing Providers of Health Care, the Use of Lasers and Intense Pulsed Light Therapy, and the Use of Injections of Cosmetic Substances [Senate Bill 4, Chapter 4, Statutes of Nevada 2007, 23<sup>rd</sup> Special Session].)* (See Tab 12.)

- 44. Draft legislation to specify that supervision of physician assistants can be done through telecommunications and remote file review.** *(Submitted by the Subcommittee to Review the Laws and Regulations Governing Providers of Health Care, the Use of Lasers and Intense Pulsed Light Therapy, and the Use of Injections of Cosmetic Substances [Senate Bill 4, Chapter 4, Statutes of Nevada 2007, 23<sup>rd</sup> Special Session].)* (See Tab 12.)
- 45. Draft legislation to allow professional licensing boards to hire counsel outside the Office of the Attorney General when appropriate.** *(Submitted by the Subcommittee to Review the Laws and Regulations Governing Providers of Health Care, the Use of Lasers and Intense Pulsed Light Therapy, and the Use of Injections of Cosmetic Substances [Senate Bill 4, Chapter 4, Statutes of Nevada 2007, 23<sup>rd</sup> Special Session].)* (See Tab 12.)
- 46. Draft legislation to provide professional licensing boards with the authority to investigate and refer unlawful professional practice to authorities for penalties.** *(Submitted by the Subcommittee to Review the Laws and Regulations Governing Providers of Health Care, the Use of Lasers and Intense Pulsed Light Therapy, and the Use of Injections of Cosmetic Substances [Senate Bill 4, Chapter 4, Statutes of Nevada 2007, 23<sup>rd</sup> Special Session].)* (See Tab 12.) (See Tab 12.)

<p style="text-align: center;"><b>RECOMMENDATIONS CONCERNING THE LEGISLATIVE COMMITTEE ON HEALTH CARE</b></p>
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- 47. Draft legislation to repeal or amend NRS 439B.225, which requires the LCHC to review each regulation that a licensing board proposes or adopts which relates to standards for licensing or registration or to the renewal of a license or certificate of registration issued to a person or facility regulated by the board.**

# **TAB 1**

## **DWSS Electronic Application/Self Service Project**

### **PHASE I:**

The Division of Welfare and Supportive Services (DWSS) has recently initiated multi-phase development of a web based application for the TANF, Food Stamps and Medicaid programs. Phase I development will allow applicants to input circumstantial information to determine if they might be eligible for a DWSS administered program, print and proceed with an application and upon application completion obtain a full listing of required documentation. The application will be dynamically built seeking only that information which is relevant to the applicant's circumstances and the program for which they are seeking assistance. Until the electronic submission of the application is completed in Phase II the customer will be required to take their printed application to their local DWSS District Office to initiate the eligibility determination process.

DWSS believes it currently possesses the staff, expertise and other automation resources necessary to complete Phase I without the need for any additional funds. Absent of unforeseen circumstances DWSS plans to complete Phase I and have this tool available for public use on or before June 30, 2009.

### **PHASE II:**

Phase II of the project advances the application functionality to allow applicants or their representatives the ability to create, save partially completed applications, and electronically submit their completed applications for DWSS eligibility consideration. To accomplish this DWSS must purchase security software which is DoIT compliant and establishes and manages identification credentials for every applicant thereby permitting them controlled access to partially completed applications and the ability to view their real-time case information. Through use of the aforementioned software DWSS staff will realize business efficiencies through the initial introduction of work flow which will afford staff the opportunity to verify the identity of the applicant and then import client contributed data directly into DWSS's eligibility and payments system.

The DWSS business analysis suggests Phase II will require the assistance of skilled professionals to effectively introduce required security software. DWSS automation staff will work in conjunction with contracted services from Novell and independent third party vendors to enable the provisioning and management of issuing application authorizations (user ID's) to clients and ensure the required security is in place to protect client's personal information and to comply with State security requirements as defined by DoIT.

Hereafter is a brief description of what DWSS believes to be necessary to effectively and efficiently complete Phase II responsibilities:

- Acquire additional Novell Access Manager licensing – Controls customer access to the Electronic Web Application.
- Engage Novell, or a Novell business partner, to help with design and implementation of the application authorization (user ID) and provisioning process
- Engage an independent third party vendor to asses the application for security vulnerabilities and to conduct an application penetration test to identify and recommend remediation techniques and methodologies for any security deficiencies identified by the test.
- Required funding in the amount of \$630,894 for Fiscal Years 2010 and 2011 is NOT presently being included in the DWSS budget request due to budgetary constraints.

**PHASE III:**

Phase III of this project provides the customer with the ability to use this electronic tool to update case information such as address, income or changes to household composition. In addition, should the recipient encounter a break in program eligibility and wish to apply again for a DWSS program the applicant, once identified, would be presented with the last known information for their case and merely update changed information to complete the application and initiate a new application event.

DWSS believes it currently possesses the staff, expertise and other automation resources necessary to complete Phase III after completion of Phase II without the need for any additional funds.

	<b>Fiscal Year 2010</b>	<b>Fiscal Year 2011 and Subsequent Years</b>
<b>PHASE I</b>	No Funds Requested	No Funds Requested
<b>PHASE II - Hardware for Hosting Access Manager (eight servers)</b>	\$ 56,000.00	Maintenance included in purchase price
<b>PHASE II - Software Licensing</b>		
Novell Access Manager Licensing	\$ 150,000.00	\$ 30,000.00
Novell Identity Manager 3.5 Government-to-Citizen Licensing	\$ 47,000.00	\$ 9,300.00
<b>PHASE II - Professional Services</b>		

Consulting services used to integrate Access Manager with the Electronic Application - this should encompass all three phases

\$ 231,000.00      \$ 0.00

**PHASE II - Software Development - MSA @ \$100 per hour**

MSA Software Development - Security Authentication with Novell estimated at 1000 hours, this line item is to include an application security review and a penetration test.

\$ 100,000.00      \$ 0.00

**PHASE III**

No Funds Requested      No Funds Requested

**ANNUAL OPERATING COSTS**

**DoIT Hosting Charges for eight servers**

\$ 6,792.00      \$ 6,792.00

Hosting Charges

\$ 12,000.00      \$ 12,000.00

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\$ 590,792.00      \$ 46,092.00

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**Funding Sources:**

<b>General Fund - 27%</b>	\$ 159,513.84	\$ 12,444.84
<b>Various other Federal funds - 73%</b>	\$ 431,278.16	\$ 33,647.16

All costs listed are estimates and based upon 2008 fees and schedules

## **TAB 2**



## **J-1 Visa Program Update**

*Information provided by Lynn O'Mara, MBA, Health Planning Program Manager, Bureau of Health Planning and Statistics, Nevada State Health Division*

### ***Program Oversight***

To Ensure oversight of the program the Health Division created the Primary Care Advisory Council within the Bureau of Health Planning and Statistics. The Council is charged with oversight responsibility. As part of its bylaws and mission, the Health Division Primary Care Advisory Council provides transparent oversight of the J-1 Visa Waiver program, including the approval process for the required state Letter of Support, the monitoring of program compliance by both J-1 Visa physicians and their employers, the timely resolution of complaints, and J-1 Visa physician recruitment and retention. The seven-member Council meets at least quarterly and follows Nevada Open Meeting Law.

Formal program policies and procedures are being drafted to thoroughly address compliance with federal program requirements, pre-qualification of employers, employer and J-1 Visa physician education on their respective rights and responsibilities, processing and analysis of Letter of Support applications, program and physician monitoring, tracking and semi-annual reporting requirement, the complaint process from submission to resolution, and the exit survey process.

Compared to states with a similar population size, Nevada is receiving more waivers than Kansas, Mississippi and Utah. Arkansas and Iowa receive more than Nevada, and we have contacted them to discuss their success rate.

To date, 122 waivers have been issued to Nevada for Federal FY2000-2008. Currently, Nevada has 34 J-1 Visa Waiver physicians placed statewide, and 4 more will begin work during the first half of SFY09. There are 6 new applications in process, all received since the first Council meeting. From 2001-2003, Nevada typically filled 90-100% of its Conrad 30 J-1 Visa Waiver slots. Approx. 87% of J-1 Visa physicians completed their 3-yr. commitment in Nevada, and 65% were retained, staying at least one more year to serve in an underserved area. In 2008, we have only been able to fill 33% of our Conrad 30 slots. In addition to the abuse issues reported by the *Las Vegas Sun*, four other events appear to be contributing factors. The cap was raised for the less restrictive H-1B Visa and the first 20,000 applicants with higher than a Master's Degree were not included in the cap, thus making it more attractive to obtain this Visa versus a J-1 Visa. In addition, when it was last renewed, the J-1 Visa Waiver program permitted the J-1 Visa Waiver recipients to now practice in urban medically underserved areas, such as North Las Vegas, in addition to rural areas. This has become a disincentive for J-1 Visa physicians to seek rural employers, a trend noted

nationwide. Lastly, the number of foreign physicians doing medical residencies in the US has been steadily decreasing, resulting in fewer J-1 Visas being issued nationwide.

A gap analysis of the program files was recently completed. A confidential survey has been sent to the 98 J-1 Visa Waiver physicians who we believe are still in Nevada, and the response data is expected to fill in many of the blanks. It also serves as another vehicle to ascertain program deficiencies and identify problems. Since the first Council meeting, J-1 Visa physicians have begun to contact us directly with questions and concerns, although they remain uncomfortable about giving their names. We believe that over this SFY, as they observe the effectiveness of the Council's oversight and the transparency of the open meeting process, the J-1 Visa community will again have confidence in the Nevada program and the Health Division.

Finally, the Health Division has begun working in collaboration with Nevada Medicaid and Nevada Check Up to develop a tracking mechanism to ensure that J-1 Visa Waiver physicians are indeed working in medically underserved areas.

### ***Program Fees***

In response to the recommendations that fees be adjusted for J-1 applicants in order to encourage more applicants; fees are mostly associated with immigration attorneys not costs imposed by the state. The approximate total non-attorney costs and fees that a J-1 Visa physician incurs to obtain a waiver for Nevada is currently \$2,500. When the Health Division receives a request for the mandatory Letter of Support from the Health Division Administrator, there is no fee for the determination process of approving / not approving the request.

### ***Non-compete Clauses***

With regard to concerns regarding non-compete clauses being included in contracts of J-1 Visa physicians, Federal prohibition for such clauses exists as of April 2007. The Health Division is not approving requests for Letters of Support, unless the employment agreement meets all federal and state requirements. We are developing an employment agreement template, which will be reviewed by the Attorney General's Office. This template can be provided to J-1 Visa waiver applicants and potential employers who seek guidance regarding this matter. It is expected to be used as a tool for benchmarking applicant requests. In addition, the Health Division is working with the AG's Office to better understand Nevada law regarding the matter of non-compete clauses, when federal law trumps state law. We are finding that non-Nevada based immigration attorneys do not always understand this point of law. The other issue being studied is when an agreement/contract is null and void, as opposed to simply being breached. Health Division needs to know when it can immediately and legally relocate a J-1 Physician, if mistreatment or abuse is occurring, and also understand what actions need to be taken, such as notifying the US Dept. of State, Immigration, Board of Medical Examiners, BLC, etc. It is possible that a formal AG's Opinion will

be needed to clarify either or both issues, beyond formal program policies and procedures. If deemed prudent, they will be obtained.

***Lawful Permanent Residence ("Green Card")***

To be eligible for a green card, a J-1 Visa physician who completes their J-1 Visa education must first obtain a waiver from the U.S. Department of State and work in the U.S. for five years. Once they have completed this work requirement, during which three years must be in a federally-designated medically underserved area, they can apply for their green card. However, when they submit their green card applications, no priority or preference is currently given to these individuals, who have helped improve access to health care in underserved areas. They must start at the back of the line, with no way to move them ahead of more standard / typical applicants or to move them through the process more quickly. This incentive may make both the J-1 Visa Waiver and follow-on National Interest Waiver program more attractive to J-1 Visa physicians, and assist with improving primary care access nationwide.

## **TAB 3**



July 14, 2008

## Nevada works to close distance

By Jaclyn O'Malley  
jomalley@rgj.com

Officials responding to a critical lack of mental health resources are hoping technology, newly licensed counselors, partnerships with higher education and community education about suicide will reduce deaths and improve the quality of life for rural Nevadans.

Nevadans in the 15 rural counties, excluding Washoe and Clark, commit suicide at a rate more than double the national rate. In 2004, the most recent year for which data are available, 27 out of 100,000 people in the state's rural counties killed themselves. The rate for the state and Washoe County was 19 per 100,000. The national rate was 11 per 100,000.

Officials say a precise reason for the high rate is unknown, but lack of mental health professionals, distance between communities and the stigma of seeking treatment all contribute to the problem.

Nevada is addressing the crisis with an Internet-based program called telemedicine, which connects patients to a psychiatrist through a Web camera. Last year, legislators enacted a law to license new mental health counselors and partnered with state colleges and universities to create academic programs specific to rural mental health.

The state also achieved many goals on the 2007 suicide

prevention plan, including awareness campaigns and training.

Officials say the problems of rural mental health extend throughout the country, and other states have addressed them a variety of ways.

The Sowing the Seeds of Hope program established in 1999 in seven Midwest states works to make citizens comfortable seeking help in privacy. In Iowa, Kansas, Nebraska, Wisconsin, Minnesota and North and South Dakota, statewide hot lines are staffed by mental health professionals trained on agricultural issues faced by the citizens. The professionals then direct callers to resources.

Sowing the Seeds of Hope includes outreach workers who go to homes, assess needs and refer residents to services, coordinator Michael Rosmann said.

"Historically, the problem with behavioral health in rural areas has been attributed to its few providers, but the culture is one of reluctance to reach out," Rosmann said. "They think if they ask for help, it's a sign of weakness or their neighbor will find out.

"What we've done is try to present behavior health treatment in a way that people are comfortable with accessing help."

Alaska, the national leader in suicides, is mostly rural communities. Many parts of Alaska are accessible only by boat or aircraft.

Ron Adler, CEO and executive director of the Alaska Psychiatric Institute, said the state also has a shortage of professionals, especially to treat children.

The cold and heavy snow prevent professionals from traveling to rural areas in Alaska.

Adler said the state has used telemedicine for about 20 years. In the last five years, video conferencing was added for assessments and patient sessions with psychiatrists at eight rural clinic hubs throughout the state.

Telemedicine also is used to train physicians in Alaska. Since April, free monthly video conference trainings have been offered to physicians regarding medications and treatment for mental illness.

"Technology makes a world of difference in providing care in a timely and affective way," Adler said. "We all know that when people ask for help, they are inviting you in. That's the time to give them services. That's what video conferencing does."

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July 13, 2008

## What Nevada is doing about the rural mental health crisis

*Jaclyn O'Malley*  
*Reno Gazette-Journal*

- The rural mental health crisis prompted legislators last year to establish the "licensed clinical professional" to increase the pool of qualified counselors in the state, especially in rural areas. The legislation expands the scope of practice for some drug and alcohol counselors to work with mental illness and emotional issues.

The law won't be implemented until the Nevada Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors establishes procedures for licensing and overseeing these counselors. The board is preparing to submit its procedures to the Legislative Counsel Bureau for review.

Officials said a number of the new counselors want to work in rural areas beset by high turnover rates and difficulty recruiting workers.

- The rural mental health clinics have been using telemedicine, in which people can see and speak to a psychiatrist in Reno, Carson City or Las Vegas over the Internet. Telemedicine is used throughout the country and worldwide, especially in rural areas with geographic barriers to facilities and a lack of professionals. It also reduces travel time for traveling professionals.

According to the American Telemedicine Association, the technology has been around for 40 years. The organization estimates at least 3,500 health care institutions in the nation use telemedicine programs.

Last year, the Federal Communications Commission dedicated more than \$417 million for telemedicine networks throughout the country. Its top priority was getting the networks in rural areas.

The program reduces the need for general practitioners to prescribe medication for illnesses they are not trained to diagnose and manage.

The program runs on the state's Intranet, which provides a secure, confidential and inexpensive mode of providing care. The only costs are for equipment maintenance and upgrades.

"This is the future of delivery of services in rural clinics across the country," said Jeff Langeway, state information technology director.

- A partnership between the Nevada System of Higher Education and the state's mental health and developmental services seeks a "homegrown" workforce of mental health professionals. Their goal is to train students through the state's university and medical school to work in rural areas, with internships and job opportunities for those unable to travel to one of the state universities.

The groups are also considering a public service campaign to promote jobs in state mental health and increasing interest in school-aged children who are contemplating careers.

Officials are also discussing having medical school students seeing rural patients via telemedicine programs.

- In 2007 the state released its suicide prevention plan through 2012 that had goals such as increasing prevention training to community professionals, maintaining a state Web site with current statistics and implementing local media campaigns.

The plan was mandated by the legislature in the 2001 and 2003 sessions. The legislators also created a state suicide prevention coordinator in Carson City supported by a counterpart in Clark County. The state plan is founded on the National Strategy for Suicide Prevention.

State suicide prevention coordinator Misty Allen said she has trained about 1,900 gatekeepers during fiscal year 2007-08. Gatekeepers are professionals such as teachers or counselors who contact people at risk for suicide. Allen said more than 2,500 people have been trained since her office was established in 2006.

The \$1.2 million funding the state suicide prevention office received the last three years through the Substance Abuse and Mental Health Services Administration was targeted to efforts in Clark County. She said she hopes the next round of funding will expand efforts to Washoe County. The state also funds staffing for the office and travel expenses at around \$200,00 per year.

"Half the battle is increasing awareness and getting people comfortable about talking about it," she said.

But will all these things help reduce the rural suicide rate, which is more than twice the national average?

"My sense is that frontier mental health services at the clinics were underfunded and understaffed," said sociologist Matt Wray, who conducted a report in 2006 on suicide in Nevada. "People can say you can't solve these problems by throwing money at them, but you can't solve them without money, either."

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## Rural Nevada's mental health hopes pinned on technology, licensing new counselors

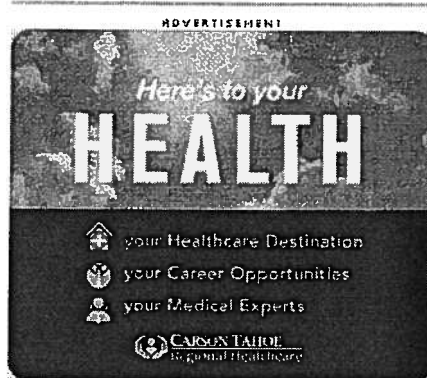
BY JACLYN O'MALLEY • JOMALLEY@RGJ.COM • JULY 13, 2008

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Officials responding to a critical lack of mental health resources are hoping technology, newly licensed counselors, partnerships with higher education and community education about suicide will reduce deaths and improve the quality of life for rural Nevadans.

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The state also achieved many goals on the 2007 suicide prevention plan, including awareness campaigns and training.

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"Historically, the problem with behavioral health in rural areas has been attributed to its few providers, but the culture is one of reluctance to reach out," Rosmann said. "They think if they ask for help, it's a sign of weakness or their neighbor will find out.

"What we've done is try to present behavior health treatment in a way that people are comfortable with accessing help."



Marilyn Newton / Reno Gazette-Journal

Jan Bassier of Elko lost her son, Brian, to suicide. He had some mental issues before taking his own life.

### SPECIAL REPORT

#### Rural Suicide

Stigma of mental health treatment prevails in small towns  
 Officials trying to spare mental health from more budget cuts  
 What Nevada is doing about the rural mental health crisis  
 Advocate: If you notice symptoms, tell somebody  
 Nevada suicide rates

#### WHERE TO GO

The state's office of suicide prevention may be accessed at <http://dhhs.nv.gov/SuicidePrevention.htm>. If you or someone you know is in crisis, call the Nevada Suicide Prevention Hot Line at 877-855-4673, or the state lifeline at 1-800-273-8255.

#### PHOTO GALLERIES



Mental Health in Elko



Mental Health in Battle Mountain

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Alaska, the national leader in suicides, is mostly rural communities. Many parts of Alaska are accessible only by boat or aircraft.

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The cold and heavy snow prevent professionals from traveling to rural areas in Alaska.

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Telemedicine also is used to train physicians in Alaska. Since April, free monthly video conference trainings have been offered to physicians regarding medications and treatment for mental illness.

"We find that children and adolescents are adaptable to the technology while adults are initially apprehensive, but are grateful after the services are rendered," Adler said. "Without a question this is the next step in providing greater access to treatment to people in rural and frontier communities."

"Technology makes a world of difference in providing care in a timely and affective way," he said. "We all know that when people ask for help, they are inviting you in. That's the time to give them services. That's what video conferencing does."

restrictions (1)

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July 12, 2008

## Mental health statistics and issues

Jaclyn O'Malley  
jomalley@rgj.com

### Nevada Suicide Rates

- 27 per 100,000 people in Nevada's 15 rural communities
- 19 per 100,000 in Washoe County
- 16 per 100,000 in Clark County
- 11 per 100,000 in National Rate

### Rural Issues

Here's what officials and others see as the problems in Nevada's rural mental-health care system:

- **NOT ENOUGH COUNSELORS:** In many rural counties, it can take up to a year to see a professional, and by that time, many psychiatric problems have worsened. "They have absolutely nowhere to go in the rurals. That's why they have the highest suicide rates, because there is no help out there," said Bunchie Tyler, president of the Northern Nevada chapter of the National Alliance on Mental Illness. "It's a big crisis, an absolutely horrendous crisis in rural Nevada."
- **GROWING WAITING LISTS:** Last year there was about a 4 percent spike in clients seen at the clinics, and by 2016, the rural population is expected to grow by nearly 52,000, according to the state demographer's office.
- **CHILDREN AREN'T TREATED:** Mentally ill children are not getting treatment that could prevent their illnesses from worsening or going out of control. Only 14 percent of children who need help get treated, according to a state report. The only licensed child psychiatrist in the state is in Douglas County.
- **PHYSICIAN RELIANCE:** Rural residents rely on physicians for psychiatric medications. Mental health experts say these doctors are not trained to diagnose and manage chronic and complex mental disorders. Some physicians, state officials said, refuse to see patients who suffer from an illness beyond mild depression or anxiety because it's beyond their scope of practice. The physician shortage in the state is worst in rural communities.
- **STIGMA:** In rural communities, everyone knows everyone and whose car is parked in front of the mental health clinic. Stigma prevents many from seeking health. "If I went to the hospital in Battle Mountain with a broken leg, are they going to send me to Reno? No. They'll take care of it there," Tyler said. "But with mental illness, it's not that way because it is completely stigmatized."
- **LACK OF ASSESSMENT:** Due to budget cuts last year, there is no rural mental health counselor who assesses patients and helps facilitate emergency psychiatric hospital committals when the clinics are closed.
- **EMERGENCY CARE:** When mental health clinics are closed, mentally ill people often end up in emergency rooms and jails. Between 2005 and September 2007, 1,525 people went to Carson Valley Medical Center's emergency room with a mental health issue, officials there said. The county population is about 47,000. "None of us want to be that little town featured on

'Dateline' where someone didn't get any follow-up care and went and shot up the high school," said Christy Raynes, emergency room nurse supervisor at Carson Valley Hospital in Gardnerville, where 95 people are on the waiting list to see a mental health counselor.

- **STAFF TURNOVER:** The employee turnover rate at rural mental health clinics is 40 percent annually. Officials have been meeting with higher education representatives to find ways to attract professionals to the rural areas. One idea is to train workers already living in rural Nevada and offer them financial incentives and a steady job to stay and work.
  - **GEOGRAPHIC BARRIERS:** The nearest towns are at least 50 miles apart. The average distance between an acute care hospital and the next level of care is 114 miles, according to the Nevada Office of Rural Health.
-

**TAB 4**

SENATE BILL NO. 170—COMMITTEE ON LEGISLATIVE  
OPERATIONS AND ELECTIONS

(ON BEHALF OF THE LEGISLATIVE COMMITTEE ON HEALTH CARE)

FEBRUARY 28, 2007

Referred to Committee on Legislative Operations and Elections

**SUMMARY**—Creates the Legislative Committee on Child Welfare and Juvenile Justice and the Legislative Committee on Senior Citizens and Veterans. (BDR 17-310)

**FISCAL NOTE:** Effect on Local Government: No.  
Effect on the State: Yes.

EXPLANATION – Matter in *bolded italics* is new; matter between brackets [~~omitted material~~] is material to be omitted.

AN ACT relating to legislative affairs; creating the Legislative Committee on Child Welfare and Juvenile Justice and the Legislative Committee on Senior Citizens and Veterans; prescribing the powers and duties of the committees; and providing other matters properly relating thereto.

**Legislative Counsel's Digest:**

- 1 **Section 3** of this bill creates the Legislative Committee on Child Welfare and  
2 Juvenile Justice as a statutory committee and provides for its membership. **Section**  
3 **4** of this bill prescribes the manner in which meetings are to be conducted and  
4 provides for the compensation of members of the Committee. **Section 5** of this bill  
5 provides the duties of the Committee including evaluation, review and comment  
6 upon issues relating to the provision of child welfare services and issues relating to  
7 juvenile justice in this State. **Sections 6 and 7** of this bill authorize the Committee  
8 to conduct investigations and hearings and provide for the administration of oaths,  
9 deposition of witnesses, and subpoenas to compel the attendance of witnesses and  
10 the production of books and papers.  
11 **Section 10** of this bill creates the Legislative Committee on Senior Citizens and  
12 Veterans as a statutory committee and provides for its membership. **Section 11** of  
13 this bill requires the Committee to meet each month during the legislative interim,  
14 prescribes the manner in which meetings are to be conducted and provides for the  
15 compensation of members of the Committee. **Section 12** of this bill requires the  
16 Committee to evaluate, review and comment upon issues relating to senior citizens  
17 and veterans. **Sections 13 and 14** of this bill authorize the Committee to conduct



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18 investigations and hearings and provide for the administration of oaths, deposition  
19 of witnesses, and subpoenas to compel the attendance of witnesses and the  
20 production of books and papers. Section 16 of this bill provides for the prospective  
21 expiration of this Committee on July 1, 2011.

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THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN  
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

1 **Section 1.** Chapter 218 of NRS is hereby amended by adding  
2 thereto the provisions set forth as sections 2 to 15, inclusive, of this  
3 act.

4 **Sec. 2.** *As used in sections 2 to 8, inclusive, of this act, unless*  
5 *the context otherwise requires, "Committee" means the Legislative*  
6 *Committee on Child Welfare and Juvenile Justice.*

7 **Sec. 3. 1.** *The Legislative Committee on Child Welfare and*  
8 *Juvenile Justice is hereby created. The membership of the*  
9 *Committee consists of three members of the Senate and three*  
10 *members of the Assembly, appointed by the Legislative*  
11 *Commission.*

12 **2.** *The Legislative Commission shall select the Chairman and*  
13 *Vice Chairman of the Committee from among the members of the*  
14 *Committee. After the initial selection of those officers, each of*  
15 *those officers holds the position for a term of 2 years commencing*  
16 *on July 1 of each odd-numbered year. The chairmanship of the*  
17 *Committee must alternate each biennium between the houses of*  
18 *the Legislature. If a vacancy occurs in the chairmanship or vice*  
19 *chairmanship, the vacancy must be filled in the same manner as*  
20 *the original selection for the remainder of the unexpired term.*

21 **3.** *A member of the Committee who is not a candidate for*  
22 *reelection or who is defeated for reelection continues to serve until*  
23 *the convening of the next regular session of the Legislature.*

24 **4.** *A vacancy on the Committee must be filled in the same*  
25 *manner as the original appointment.*

26 **Sec. 4. 1.** *The members of the Committee shall meet*  
27 *throughout the year at the times and places specified by a call of*  
28 *the Chairman or a majority of the Committee.*

29 **2.** *The Director of the Legislative Counsel Bureau or his*  
30 *designee shall act as the nonvoting recording Secretary of the*  
31 *Committee.*

32 **3.** *The Committee shall prescribe regulations for its own*  
33 *management and government.*

34 **4.** *Except as provided in subsection 5, four members of the*  
35 *Committee constitute a quorum, and a quorum may exercise all*  
36 *the power and authority conferred on the Committee.*



1 5. Any recommended legislation proposed by the Committee  
2 must be approved by a majority of the members of the Senate and  
3 by a majority of the members of the Assembly appointed to the  
4 Committee.

5 6. Except during a regular or special session of the  
6 Legislature, for each day or portion of a day during which a  
7 member of the Committee attends a meeting of the Committee or is  
8 otherwise engaged in the work of the Committee, the member is  
9 entitled to receive the:

10 (a) Compensation provided for a majority of the members of  
11 the Legislature during the first 60 days of the preceding regular  
12 session;

13 (b) Per diem allowance provided for state officers and  
14 employees generally; and

15 (c) Travel expenses provided pursuant to NRS 218.2207.

16 ↪ The compensation, per diem allowances and travel expenses of  
17 the members of the Committee must be paid from the Legislative  
18 Fund.

19 Sec. 5. The Committee shall evaluate and review issues  
20 relating to:

21 1. The provision of child welfare services in this State,  
22 including, without limitation:

23 (a) Programs for the provision of child welfare services;

24 (b) Licensing and reimbursement of providers of foster care;

25 (c) Mental health services; and

26 (d) Compliance with federal requirements regarding child  
27 welfare; and

28 2. Juvenile justice in this State, including, without limitation:

29 (a) The coordinated continuum of care in which community-  
30 based programs and services are combined to ensure that health  
31 services, substance abuse treatment, education, training and care  
32 are compatible with the needs of each juvenile in the juvenile  
33 justice system;

34 (b) Individualized supervision, care and treatment to  
35 accommodate the individual needs and potential of the juvenile  
36 and his family, and treatment programs which integrate the  
37 juvenile into situations of living and interacting that are  
38 compatible with a healthy, stable and familial environment;

39 (c) Programs for aftercare and reintegration in which  
40 juveniles will continue to receive treatment after their active  
41 rehabilitation in a facility to prevent the relapse or regression of  
42 progress achieved during the recovery process;

43 (d) Overrepresentation and disparate treatment of minorities  
44 in the juvenile justice system, including a review of the various  
45 places where bias may influence decisions concerning minorities;



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1 (e) Gender-specific services, including programs which  
2 consider female development in their design and implementation  
3 and which address the needs of females, including issues relating  
4 to:

- 5 (1) Victimization and abuse;
- 6 (2) Substance abuse;
- 7 (3) Mental health;
- 8 (4) Education; and
- 9 (5) Vocational and skills training;

10 (f) The quality of care provided in state institutions and  
11 facilities, including:

- 12 (1) The qualifications and training of staff;
- 13 (2) The documentation of the performance of state  
14 institutions and facilities;
- 15 (3) The coordination and collaboration of agencies; and
- 16 (4) The availability of services relating to mental health,  
17 substance abuse, education, vocational training and treatment of  
18 sex offenders and violent offenders;

19 (g) The feasibility and necessity for independent monitoring of  
20 state institutions and facilities; and

21 (h) Programs developed in other states which provide a system  
22 of community-based programs that place juvenile offenders in  
23 more specialized programs according to their needs.

24 Sec. 6. 1. The Committee may:

25 (a) Conduct investigations and hold hearings in connection  
26 with its duties pursuant to section 5 of this act;

27 (b) Request that the Legislative Counsel Bureau assist in the  
28 research, investigations, hearings and reviews of the Committee;  
29 and

30 (c) Propose recommended legislation concerning child welfare  
31 and juvenile justice to the Legislature.

32 2. The Committee shall, on or before January 15 of each odd-  
33 numbered year, submit to the Director of the Legislative Counsel  
34 Bureau for transmittal to the Legislature a report concerning the  
35 evaluation and review conducted pursuant to section 5 of this act.

36 Sec. 7. 1. If the Committee conducts investigations or holds  
37 hearings pursuant to section 6 of this act:

38 (a) The Chairman of the Committee or, in his absence, a  
39 member designated by the Committee may administer oaths;

40 (b) The Chairman of the Committee may cause the deposition  
41 of witnesses, residing within or outside of this State, to be taken in  
42 the manner prescribed by rule of court for taking depositions in  
43 civil actions in the district courts; and



1 (c) *The Chairman of the Committee may issue subpoenas to*  
2 *compel the attendance of witnesses and the production of books*  
3 *and papers.*

4 2. *If a witness refuses to attend or testify or produce books or*  
5 *papers as required by the subpoena, the Chairman of the*  
6 *Committee may report to the district court by a petition which sets*  
7 *forth that:*

8 (a) *Notice has been given of the time and place of attendance*  
9 *of the witness or the production of the books or papers;*

10 (b) *The witness has been subpoenaed by the Committee*  
11 *pursuant to this section; and*

12 (c) *The witness has failed or refused to attend a hearing, testify*  
13 *or produce the books or papers required by the subpoena.*

14 ↪ *The petition may request an order of the court compelling the*  
15 *witness to attend a hearing, testify or produce the books or papers*  
16 *required by a subpoena.*

17 3. *Upon such a petition, the court shall enter an order*  
18 *directing the witness to appear before the court at a time and place*  
19 *to be fixed by the court in its order, the time must not exceed 10*  
20 *days after the date of the order, and to show cause why he has not*  
21 *attended the hearing, testified or produced the books or papers*  
22 *required by the subpoena. A certified copy of the order must be*  
23 *served upon the witness.*

24 4. *If it appears to the court that the subpoena was regularly*  
25 *issued by the Committee, the court shall enter an order that the*  
26 *witness appear before the Committee at the time and place fixed in*  
27 *the order and testify or produce the required books or papers.*  
28 *Failure to obey the order constitutes contempt of court.*

29 Sec. 8. *Each witness who appears before the Committee by*  
30 *its order, except a state officer or employee, is entitled to receive*  
31 *for his attendance the fees and mileage provided for witnesses in*  
32 *civil cases in the courts of record in this State. The fees and*  
33 *mileage must be audited and paid upon the presentation of proper*  
34 *claims sworn to by the witness and approved by the Secretary and*  
35 *Chairman of the Committee.*

36 Sec. 9. *As used in sections 9 to 15, inclusive, of this act,*  
37 *unless the context otherwise requires, "Committee" means the*  
38 *Legislative Committee on Senior Citizens and Veterans.*

39 Sec. 10. 1. *The Legislative Committee on Senior Citizens*  
40 *and Veterans is hereby created. The membership of the Committee*  
41 *consists of:*

42 (a) *Five members of the Senate appointed by the Majority*  
43 *Leader of the Senate from the following committees, except that if*  
44 *a committee no longer exists, from another committee designated*  
45 *by the Majority Leader:*



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## **TAB 5**



DATE: July 20, 2008

TO: Legislative Committee on Health Care  
Assemblywoman Sheila Leslie, Chair  
Senator Maurice Washington, Vice Chair  
Senator Joe Heck  
Senator Stephen Horsford  
Assemblywoman Susan Gerhardt  
Assemblyman Joseph P. Hardy, M.D.

FROM: Dr. Lawrence Sands  
Chief Health Officer, SNHD  
Dr. Keith Zupnik  
CLPPP Coordinator  
Denise Tanata Ashby, J.D.  
CLPPP Legislative Affairs Workgroup Chair

RE: SNHD Childhood Lead Poisoning Prevention Project (CLPPP)

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We would like to thank you for allowing the CLPPP to present our recommendations for legislation to help eliminate childhood lead exposure in Nevada at the meeting of the Legislative Committee on Health Care held on May 6, 2008. Pursuant to the request of the Chair and in response to questions posed by several of the committee members, we have revised our recommendations for legislation and have attached this, along with supporting documentation, for your consideration at the July 29<sup>th</sup> meeting of the Committee.

Support for these recommendations is evidenced by the Legislative Proclamation signed by Speaker Barbara Buckley in the 2007 Legislative Session, which states, in part: "RESOLVED, that the implementation of the recommendations of the Centers for Disease Control and Prevention for screening children for lead exposure, especially those at high risk, is hereby encouraged and healthcare providers are hereby urged to ensure that all children under age 6 are screened for lead exposure." Additionally, the CLPPP has received support in the form of a resolution from the Nevada State Medical Association which provides that "the NSMA supports the routine screening of children for elevated lead levels prior to school entry..[and] that the NSMA supports mandatory reporting of all elevated blood lead levels to local public health authorities."

The revised legislative recommendations include two parts - policies for screening children for lead exposure and policies regarding appropriate reporting of lead test results to local health authorities.

## Screening Children for Lead Exposure

The recommendation regarding screening children for lead exposure has been revised to require local and state health authorities to adopt and enforce regulations for testing children under the age of six for lead exposure in accordance with standards set forth by the National Centers for Disease Control and Prevention (CDC). This revision will allow local health authorities to identify the best practices for meeting the needs of the local community to help identify childhood lead exposure. This, in turn, will assist the health authorities in identifying potential sources of lead exposure which will guide prevention efforts in our State.

Efforts to determine the actual or most probable sources of lead exposure in Nevada are currently underway. However, the CLPPP recognizes that traditional sources of lead exposure, such as lead based paint in older homes, is not the only, or even the primary, source of lead exposure in children in Nevada. Until more data can be collected statewide regarding potential sources of lead exposure in children, selective screening of pockets of “at-risk” children is not a viable option. According to the American Academy of Pediatrics (AAP), “Evidence continues to accrue that commonly encountered blood lead concentrations, even those less than 10 µg/dL, may impair cognition, and there is no threshold yet identified for this effect. Most US children are at sufficient risk that they should have their blood lead concentration measured at least once.”

The CDC recommends that children be tested for lead exposure at twelve and twenty-four months of age. This recommendation is currently mandated by the Centers for Medicare and Medicaid Services (CMS) as part of the Early and Periodic Screening and Diagnostic Benefit (EPSDT). According to the CMS:

The EPSDT benefit, in accordance with section 1905(r) of the Act, must include the following services:

Screening Services -- Screening services must include all of the following services:

- Lead Toxicity Screening - All children are considered at risk and must be screened for lead poisoning. CMS requires that all children receive a screening blood lead test at 12 months and 24 months of age. Children between the ages of 36 months and 72 months of age must receive a screening blood lead test if they have not been previously screened for lead poisoning. A blood lead test must be used when screening Medicaid-eligible children. A blood lead test result equal to or greater than 10 ug/dl obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample.

At this time, States may not adopt a statewide plan for screening children for lead poisoning that does not require lead screening for all Medicaid-eligible children.

Although lead screening is required for all children who participate in the Medicaid program, Nevada consistently ranks well below the national average for the number of children enrolled in Medicaid who have had lead screenings – approximately 1%.

The costs for lead screening are minimal and have significant cost-benefits when lead exposure is identified at an early age. In Nevada, lead screening is billed as part of the EPSDT screening exam and is not allowable as a separate billable expense. A physician performing an EPSDT screening is paid a lump sum for the EPSDT, which is to include lead screening. Hence, enforcing the requirement to perform lead screening during the EPSDT, as required by the CMS, would not cause the State Division of Health Care Financing and Policy, which administers Medicaid, to incur any additional expense.

### **Reporting of Elevated Blood Lead Test Results to Local Health Authorities**

The recommendation from the CLPPP regarding reporting requires laboratories which examine the blood of a child for the presence of lead to report to the appropriate health authority the results of the test within 5 days in an electronic format determined by the State health authority, including specific information. This recommendation has not been revised from the version that was previously submitted to the Committee for consideration.

Although laboratories are currently reporting elevated blood lead test results to the local health authority, there is no statewide mandate for the laboratories to do this. Additionally, essential demographic data is often missing from the reports which, inhibits the efforts of the health authorities to track and analyze childhood lead exposure. Electronic reporting, which here means having the laboratories submit reports using a database compatible with both the laboratory and the health authority, is necessary to eliminate duplicate data entry by the laboratory and the health authority. The two major laboratories in Nevada performing blood-lead testing, Quest and LabCorp, submit their reports in a similar electronic format in several other states. The intent of the proposed legislation is to minimize any financial impact on these laboratories by evaluating the infrastructure used by their sister laboratories in other states and establish similar systems in Nevada.

Thank you for your consideration of these legislative recommendations to assist in meeting the Healthy People 2010 goal of eliminating childhood lead exposure in Nevada. We look forward to working with you to pass this important legislation in the 2009 session.

**Childhood Lead Poisoning Prevention Project (CLPPP)  
Proposed Legislative Language**

**Screening**

State and local health authorities shall adopt and enforce regulations for testing children under the age of six for lead exposure in accordance with standards set forth by the National Centers for Disease Control and Prevention.

**Reporting**

A laboratory that examines the blood of a child under the age of 18 for the presence of lead must report to the appropriate health authority the results of the examination not later than 5 calendar days after completing the examination. The report must include at a minimum of the following information:

- (1) With respect to the individual whose blood is examined:
  - (A) the name;
  - (B) the date of birth;
  - (C) the gender;
  - (D) the race;
  - (E) the address, including street and zip code;
  - (F) the name and phone number of the parent or guardian of the child; and
  - (G) any other information that is deemed appropriate by the State Health

Department or local health authorities.

- (2) With respect to the examination:
  - (A) the date;
  - (B) the type of blood test performed;
  - (C) the laboratories' normal detection limits for the test;
  - (D) the results of the test; and
  - (E) the laboratories' interpretation of the results of the test.

- (3) The names, addresses, and telephone numbers of:

- (A) the laboratory; and
- (B) the attending physician, hospital, clinic, or other specimen submitter.

Laboratories must submit reports in an electronic format determined by the health authority.

# Nevada State Medical Association

## Policy Compendium

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### 2007-13 Prevention of Childhood Lead Poisoning

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*That the NSMA supports the routine screening of children for elevated lead levels prior to school entry; and ... That the NSMA supports mandatory reporting of all elevated blood lead levels to local public health authorities; and ... That the NSMA supports efforts to educate health professionals and the public regarding the importance of screening for blood lead levels, the risks of elevated blood lead levels, and the methods for eliminating sources of lead exposure.*

See also: AMA H-60.956 (Lead Poisoning Among Children): The AMA: (1) encourages physicians and public health departments to regularly screen all children under the age of six for lead exposure through history-taking and when appropriate by blood lead testing. The decision to employ blood testing should be made based on prevalence studies of blood lead levels in the local pediatric population. Findings from these studies will determine whether universal or targeted screening should be employed; and (2) encourages the reporting of all children with elevated blood levels to the appropriate health department in their state or community. In some cases this will be done by the physician, and in other communities by the laboratories. See also: **AMA H-60.977 (Lead Poisoning Threat to Children):** *Our AMA supports evaluating the adequacy of existing and proposed guidelines concerning environmental lead exposure (including the CDC's Strategic Plan for the Elimination of Childhood Lead Poisoning), and supports appropriate initiatives designed to more effectively protect young children from exposure to lead.*



## LEGISLATIVE PROCLAMATION

### Supporting the Childhood Lead Poisoning Prevention Program

WHEREAS, The State of Nevada supports a safe environment for all children and is dedicated to the promotion of good health for all children; and

WHEREAS, The Southern Nevada Health District, in collaboration with community partners, has secured funding from the Centers for Disease Control and Prevention to develop a Childhood Lead Poisoning Prevention Program; and

WHEREAS, Lead poisoning, which is an elevated level of lead in the blood, is especially dangerous for children, particularly those under 6 years of age, and can cause serious health problems, such as learning disabilities and behavioral problems, and at very high levels can cause seizures, coma and even death; and

WHEREAS, Lead-contaminated paint, dust and soil may be found in and around buildings constructed before 1978 and is the primary source of lead exposure for children, making it vital that older homes and childcare facilities be tested and made lead safe; and

WHEREAS, All children can be affected by lead exposure, but children of some racial and ethnic groups and those living in older housing are disproportionately affected; and


WHEREAS, Since lead poisoning is preventable if proper precautions are taken, and treatable if identified early, all Nevadans, especially parents and childcare givers, should be aware of the dangers and should seek screening for children; now, therefore, be it

RESOLVED, That the implementation of the recommendations of the Centers for Disease Control and Prevention for screening children for lead exposure, especially those at high risk, is hereby encouraged and health care providers are hereby urged to ensure that all children under age 6 are screened for lead exposure; and be it further

RESOLVED, That the efforts of the Childhood Lead Poisoning Prevention Program to enhance awareness of the dangers of childhood lead exposure, to support data collection and research efforts and to provide strategies to prevent childhood lead exposure should be supported; and be it further

RESOLVED, That all public and private entities are hereby encouraged to support the goal of eliminating childhood lead poisoning in Nevada by 2010, and to support continual monitoring to protect against any resurgence of childhood lead poisoning; and be it further

RESOLVED, That the Health Division of the Department of Health and Human Services is hereby requested to distribute a copy of this proclamation to each town, municipality, city council, board of county commissioners and health district in this State.



Assemblywoman Barbara Buckley  
Speaker of the Assembly

### State Comparison of Childhood Lead Laws

Does not include specific provisions located in state or local regulations

<b>Screening Laws</b>	AL	AK	AZ	AR	CA	CO	CT	DE	FL	GA	HI	ID	IL	IN	IA	KS	KT	LA	ME	MD	MA	MI	MN
No applicable laws or status of lead laws is unknown	X	X								X	X	X											X
Mandatory screening of children for lead poisoning/exposure.					X			X							X						X		
Enabling legislation to allow health department to develop standards, plans or regulations for screening/testing for lead exposure			X	X	X	X	X		X						X	X	X	X	X		X		
Lead screening/testing required before entry into public school.							X	X					X		X								
School body may require children to be tested for lead poisoning.														X									
Lead screening/testing required before entry into child care facility.								X					X								X		
Lead screening/testing required for children at risk.						X			X				X					X	X	X			
Lead screening required for children enrolled in state health insurance program.									X										X				
<b>Reporting Laws</b>																							
Enabling legislation to allow health authorities to develop mandatory reporting regulations.			X													X		X					
Mandatory reporting by labs or providers							X	X					X	X				X		X	X	X	X
Mandatory electronic reporting								X															

Comparisons based on information provided in the NCSL State Lead Law Database:

<http://www.ncsl.org/programs/enviro/health/leadStatutesdb.cfm>



## **TAB 6**

## **Proposed Bill Draft Request Related to Enhancing Authority over Medical Facilities in Nevada**

This document provides for a bill draft request to enhance the authority of the state's public health system. The purpose of the BDR is to:

1. Allow the State Board of Health to adopt regulations to specify the conditions under which a medical facility can be closed during an on-going investigation;
2. Clarify statutory language as it relates to the power of the Health Division to fine medical facilities for violations;
3. Give authority to the Health Division to take control over a facility's medical records in the event the facility is closed during the course of an investigation;
4. Clarify statutory language related to sentinel events and establishes penalties for facilities that do not report a sentinel event;
5. Strengthen the authority of local health authorities or officers of health districts to subpoena records related to an on-going investigation of a medical facility;
6. Clarify statutory language as it relates to the powers of a local health authority or officer of a health district during disease investigations and establishing methods to cover the costs of such disease investigations; and
7. Clarify the method by which information in an investigation is shared with law enforcement authorities.

The following sections describe the statutory barriers that the proposal is intended to address.

### Closing a Medical Facility During an Investigation

Currently, Section 1 of Nevada Revised Statutes (NRS) 449.163, "Administrative sanctions: Imposition by Health Division; disposition of money collected," has been interpreted as limiting the authority of the Health Division to take action against a facility for a violation of a condition, standard, or regulation unless due process is given to the facility in relation to the violation. This interpretation has resulted in weeks or months passing before a decision is made that a facility's practices may jeopardize the health of patients. Further, Section 1(c) of NRS 449.163 also has been interpreted in a manner that has resulted in less than \$10,000 being assessed against a medical facility in Nevada when it is determined the facility committed a violation.

This BDR should strengthen NRS 449.163 to state clearly that the Health Division has the authority to close the doors of a facility while an investigation is being conducted. Further, the monetary penalty for violations should be defined by regulations that may include a per day penalty, a per occurrence penalty, and a per patient penalty with a minimum penalty of \$1,000 per violation and a maximum penalty of \$10,000 per violation.

**NRS 449.163 Administrative sanctions: Imposition by Health Division; disposition of money collected.**

1. If a medical facility or facility for the dependent violates any provision related to its licensure, including any provision of [NRS 439B.410](#), [449.001](#) to [449.240](#), inclusive, or any condition, standard or regulation adopted by the Board, the Health Division in accordance with the regulations adopted pursuant to [NRS 449.165](#) may:

(a) Prohibit the facility from admitting any patient until it determines that the facility has corrected the violation;

(b) Limit the occupancy of the facility to the number of beds occupied when the violation occurred, until it determines that the facility has corrected the violation;

(c) Impose an administrative penalty of not more than \$1,000 per day for each violation, together with interest thereon at a rate not to exceed 10 percent per annum; and

(d) Appoint temporary management to oversee the operation of the facility and to ensure the health and safety of the patients of the facility, until:

(1) It determines that the facility has corrected the violation and has management which is capable of ensuring continued compliance with the applicable statutes, conditions, standards and regulations; or

(2) Improvements are made to correct the violation.

2. If the facility fails to pay any administrative penalty imposed pursuant to paragraph (c) of subsection 1, the Health Division may:

(a) Suspend the license of the facility until the administrative penalty is paid; and

(b) Collect court costs, reasonable attorney's fees and other costs incurred to collect the administrative penalty.

3. The Health Division may require any facility that violates any provision of [NRS 439B.410](#), [449.001](#) to [449.240](#), inclusive, or any condition, standard or regulation adopted by the Board, to make any improvements necessary to correct the violation.

4. Any money collected as administrative penalties pursuant to this section must be accounted for separately and used to protect the health or property of the residents of the facility in accordance with applicable federal standards.

(Added to NRS by 1989, 863; A 1989, 1663; [2003, 858](#))

In addition to the Health Division having the authority to close a medical facility during the course of an investigation, a local health officer or district health officer should have the authority to close a facility if it finds practices that may jeopardize the health of patients during the course of a disease investigation. The disease investigation would have been initiated as a result of a communicable disease reported pursuant to state law. Suggested language is as follows:

**NRS 439.130 State Health Officer and Administrator: Duties.**

1. The State Health Officer shall:

(a) Enforce all laws and regulations pertaining to the public health.

(b) Investigate causes of disease, epidemics, source of mortality, nuisances affecting the public health, and all other matters related to the health and life of the people, and to this end he may enter upon and inspect any public or private property in the State.

(c) Direct the work of subordinates and may authorize them to act in his place and stead.

(d) Perform such other duties as the Director may, from time to time, prescribe.

*2. The State Health Officer, District Health Officer, or County health authority may:*

*(a) Issue a written order to cease and desist any act or other conduct which is either harmful to the public to control or prevent the spread of*

*communicable disease or while an investigation of the health authority is pending, or the condition is corrected.*

*(b) Assess costs and expenses incurred in carrying out the provisions of this section.*

*(c) Take any other action designed to reduce or eliminate the harmful act or conduct.*

3. The Administrator shall direct the work of the Health Division, administer the Division and perform such other duties as the Director may, from time to time, prescribe.

[Part 5:199:1911; A 1939, 297; 1945, 130; 1943 NCL § 5239]—(NRS A 1963, 939; 1983, 833)

NRS 439.565 Injunctions against violations.

1. Any person, corporation, firm, partnership, joint stock company, or any other association or organization which violates or proposes to violate this chapter, provisions of law requiring the immunization of children in public schools, private schools and child care facilities, any regulation of the State Board of Health or any regulation of a county, district or city board of health approved by the State Board of Health pursuant to this chapter may be enjoined by any court of competent jurisdiction.

2. Actions for injunction under this section may be prosecuted by the Attorney General, any district attorney in this State or any retained counsel of any local board of health in the name and upon the complaint of the State Board of Health or any local board of health, or upon the complaint of the State Health Officer or of any local health officer or his deputy.

3. *If the act or conduct which is harmful to the public does not cease as specified in written order, the State Health Officer, District Health Officer, or County health authority may apply to any court of competent jurisdiction for injunctive relief.*

4. *The Court may issue a temporary restraining order without proof of actual damages sustained by a person.*

5. *Any person subject to a written cease and desist order may also seek an injunction or other appropriate process in district court to challenge the written order.*

(Added to NRS by 1973, 315; A 1979, 317)

### Assuming Control of Medical Records

The BDR should also give exclusive authority to the Health Division to control medical records in a medical facility. The purpose of this authority is to ensure that records needed in an investigation have a central source to obtain them from, to protect and allow patients to obtain copies of their records if they need to continue with their medical care, and to ensure that all entities, including law enforcement, health care professional licensing boards, and other regulatory boards, have access to the records for their purposes. The Health Division should have the authority to establish regulations governing the assumption of the records, and the

regulations should identify a payment source if an outside company must be hired to control the records.

### Sentinel Events

To clarify the statutes related to sentinel events, this BDR adds provisions to impose monetary penalties upon a medical facility that does not report a sentinel event pursuant to NRS 439.800, et. seq., “Health and Safety of Patients at Certain Medical Facilities,” if the event is discovered as a result of a disease investigation or other investigation. Further, the BDR will establish a standardized report for sentinel events, will requires an annual report about these events to be reported to the State Board of Health, and will allow the Health Division to examine the events reported by medical facilities. Suggested language follows at Attachment A.

### Subpoena Power

Currently, local health authorities and district health officers do not have the authority to issue a subpoena that can be enforced or disputed in court. Therefore, it is necessary to grant this authority during the course of a disease investigation that may be done independent of investigations done by the Health Division through its Bureau of Licensure and Certification.

### Costs of Disease Investigations

When a disease investigation is done now, a local health authority, a health district, or the Health Division likely pays for it. When investigations are on one or two cases, the cost can be absorbed as part of the regular operating expenses of the authority, district, or Health Division. However, when there are hundreds of thousands of patients involved, the cost cannot be absorbed during the regular course of business. In these cases, a local health authority, health district, or the Health Division should have the statutory authority to require an entity being investigated to pay the costs of laboratory testing, personnel to collect necessary laboratory tests, and if necessary, costs of additional epidemiological personnel.



## ATTACHMENT A

### HEALTH AND SAFETY OF PATIENTS AT CERTAIN MEDICAL FACILITIES

**NRS 439.800 Definitions.** As used in [NRS 439.800](#) to [439.890](#), inclusive, unless the context otherwise requires, the words and terms defined in [NRS 439.802](#) to [439.830](#), inclusive, have the meanings ascribed to them in those sections.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#))

**NRS 439.802 “Facility-acquired infection” defined.** “Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

1. Surgical site infections;
2. Ventilator-associated pneumonia;
3. Central line-related bloodstream infections;
4. Urinary tract infections; and
5. Other categories of infections as may be established by the **[Administrator]** *State Board of Health* by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#))

**NRS 439.805 “Medical facility” defined.** “Medical facility” means:

1. A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
2. An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
3. A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
4. An independent center for emergency medical care, as that term is defined [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

**NRS 439.810 “Patient” defined.** “Patient” means a person who:

1. Is admitted to a medical facility for the purpose of receiving treatment;
2. Resides in a medical facility; or
3. Receives treatment from a provider of health care.

(Added to NRS by [2002 Special Session, 13](#))

**NRS 439.815 “Patient safety officer” defined.** “Patient safety officer” means a person who is designated as such by a medical facility pursuant to [NRS 439.870](#).

(Added to NRS by [2002 Special Session, 13](#))

**NRS 439.820 “Provider of health care” defined.** “Provider of health care” means a person who is licensed, certified or otherwise authorized by the laws of this state to administer health care in the ordinary course of the business or practice of a profession.

(Added to NRS by [2002 Special Session, 13](#))

**NRS 439.825 “Repository” defined.** “Repository” means the Repository for Health Care Quality Assurance created by [NRS 439.850](#).

(Added to NRS by [2002 Special Session, 13](#))

**NRS 439.830 “Sentinel event” defined.** “Sentinel event” means an unexpected occurrence involving facility-acquired infection, death or serious physical or psychological injury or the risk thereof, including, without limitation, any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. The term includes loss of limb or function.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#))

**NRS 439.835 Mandatory reporting of sentinel events.**

1. Except as otherwise provided in subsection 2:

(a) A person who is employed by a medical facility shall, within 24 hours after becoming aware of a sentinel event that occurred at the medical facility, notify the patient safety officer of the facility of the sentinel event; and

(b) The patient safety officer shall, within 13 days after receiving notification pursuant to paragraph (a), report the date, the time and a brief description of the sentinel event to:

(1) The Health Division; and

(2) The representative designated pursuant to [NRS 439.855](#), if that person is different from the patient safety officer.

2. If the patient safety officer of a medical facility personally discovers or becomes aware, in the absence of notification by another employee, of a sentinel event that occurred at the medical facility, the patient safety officer shall, within 14 days after discovering or becoming aware of the sentinel event, report the date, time and brief description of the sentinel event to:

(a) The Health Division; and

(b) The representative designated pursuant to [NRS 439.855](#), if that person is different from the patient safety officer.

3. The Administrator shall prescribe the manner in which reports of sentinel events must be made pursuant to this section.

*4. Each medical facility required to report sentinel events shall file with the Health Division on or before March 1 of each year a reporting such form as required by the State Board of Health documenting the total number and types of sentinel events reported to the Health Division for the preceding calendar year, as well as information pursuant to NRS 439.865 and NRS 439.875 as deemed reasonable and necessary by the State Board of Health.*

*5. On or before June 1 of each year, the Health Division shall submit to the State Board of Health an annual report summarizing the information submitted under this section, for the immediately preceding calendar year and in accordance with NRS 439.840. The report shall include any additional relevant information deemed reasonable and necessary by the Administrator for the protection of the interests of the people of this State.*

*6. The Health Division shall make an examination concerning the provisions of NRS 439.800 to 439.890 inclusive by a medical facility as often as it deems necessary for the protection of the interests of the people of this State, and the results shall be reported to the State Board of Health within 30 days of examination completion. Every medical facility shall submit its books and records relating to NRS 439.800 to 439.890 inclusive for such examination and in every way facilitate the examination. The expenses of examinations pursuant to this section must be assessed against the medical facility being examined and remitted to the Health Division.*

(Added to NRS by [2002 Special Session, 13](#))

**NRS 439.840 Reports of sentinel events: Duties of Health Division; confidentiality.**

1. The Health Division shall, to the extent of legislative appropriation and authorization:

(a) Collect and maintain reports received pursuant to [NRS 439.835](#); and

(b) Ensure that such reports, and any additional documents created from such reports, are protected adequately from fire, theft, loss, destruction and other hazards and from unauthorized access.

2. Reports received pursuant to [NRS 439.835](#) are confidential, not subject to subpoena or discovery and not subject to inspection by the general public.

(Added to NRS by [2002 Special Session, 14](#))

**NRS 439.845 Analysis and reporting of trends regarding sentinel events; treatment of certain information regarding corrective action by medical facility.**

1. The Health Division shall, to the extent of legislative appropriation and authorization, contract with a quality improvement organization, as defined in 42 C.F.R. § 400.200, to analyze and report trends regarding sentinel events.

2. When the Health Division receives notice from a medical facility that the medical facility has taken corrective action to remedy the causes or contributing factors, or both, of a sentinel event, the Health Division shall:

(a) Make a record of the information;

(b) Ensure that the information is aggregated so as not to reveal the identity of a specific person or medical facility; and

(c) Transmit the information to a quality improvement organization.

3. A quality improvement organization to whom information is transmitted pursuant to subsection 2 shall, at least quarterly, report its findings regarding the analysis of aggregated trends of sentinel events to the Repository for Health Care Quality Assurance.

(Added to NRS by [2002 Special Session, 14](#))

**NRS 439.850 Repository for Health Care Quality Assurance: Creation; function.**

1. The Repository for Health Care Quality Assurance is hereby created within the Health Division.

2. The Repository shall, to the extent of legislative appropriation and authorization, function as a clearinghouse of information relating to aggregated trends of sentinel events.

(Added to NRS by [2002 Special Session, 14](#))

**NRS 439.855 Notification of patients involved in sentinel events.**

1. Each medical facility that is located within this state shall designate a representative for the notification of patients who have been involved in sentinel events at that medical facility.

2. A representative designated pursuant to subsection 1 shall, not later than 7 days after discovering or becoming aware of a sentinel event that occurred at the medical facility, provide notice of that fact to each patient who was involved in that sentinel event.

3. The provision of notice to a patient pursuant to subsection 2 must not, in any action or proceeding, be considered an acknowledgment or admission of liability.

4. A representative designated pursuant to subsection 1 may or may not be the same person who serves as the facility's patient safety officer.

(Added to NRS by [2002 Special Session, 14](#))

**NRS 439.860 Inadmissibility of certain information in administrative or legal proceeding.** Any report, document and any other information compiled or disseminated pursuant to the provisions of [NRS 439.800](#) to [439.890](#), inclusive, is not admissible in evidence in any administrative or legal proceeding conducted in this State.

(Added to NRS by [2002 Special Session, 15](#); A [2005, 600](#))

**NRS 439.865 Patient safety plan: Development; approval; notice; compliance.**

1. Each medical facility that is located within this state shall develop, in consultation with the providers of health care who provide treatment to patients at the medical facility, an internal patient safety plan to improve the health and safety of patients who are treated at that medical facility.

2. A medical facility shall submit its patient safety plan to the governing board of the medical facility for approval in accordance with the requirements of this section.

3. After a medical facility's patient safety plan is approved, the medical facility shall notify all providers of health care who provide treatment to patients at the medical facility of the existence of the plan and of the requirements of the plan. A medical facility shall require compliance with its patient safety plan.

(Added to NRS by [2002 Special Session, 15](#))

**NRS 439.870 Patient safety officer: Designation; duties.**

1. A medical facility shall designate an officer or employee of the facility to serve as the patient safety officer of the medical facility.

2. The person who is designated as the patient safety officer of a medical facility shall:

(a) Serve on the patient safety committee.

(b) Supervise the reporting of all sentinel events alleged to have occurred at the medical facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).

(c) Take such action as he determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the medical facility.

(d) Report to the patient safety committee regarding any action taken in accordance with paragraph (c).

(Added to NRS by [2002 Special Session, 15](#))

**NRS 439.875 Patient safety committee: Establishment; composition; meetings; duties; proceedings and records are privileged.**

1. A medical facility shall establish a patient safety committee.

2. Except as otherwise provided in subsection 3:

(a) A patient safety committee established pursuant to subsection 1 must be composed of:

(1) The patient safety officer of the medical facility.

(2) At least three providers of health care who treat patients at the medical facility, including, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility.

(3) One member of the executive or governing body of the medical facility.

(b) A patient safety committee shall meet at least once each month.

3. The Administrator shall adopt regulations prescribing the composition and frequency of meetings of patient safety committees at medical facilities having fewer than 25 employees and contractors.

4. A patient safety committee shall:

(a) Receive reports from the patient safety officer pursuant to [NRS 439.870](#).

(b) Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred at the medical facility.

(c) Review and evaluate the quality of measures carried out by the medical facility to improve the safety of patients who receive treatment at the medical facility.

(d) Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events that occur at the medical facility.

(e) At least once each calendar quarter, report to the executive or governing body of the medical facility regarding:

(1) The number of sentinel events that occurred at the medical facility during the preceding calendar quarter; and

(2) Any recommendations to reduce the number and severity of sentinel events that occur at the medical facility.

5. The proceedings and records of a patient safety committee are subject to the same privilege and protection from discovery as the proceedings and records described in [NRS 49.265](#).

(Added to NRS by [2002 Special Session, 15](#))

**NRS 439.880 Immunity from criminal and civil liability.** No person is subject to any criminal penalty or civil liability for libel, slander or any similar cause of action in tort if he, without malice:

1. Reports a sentinel event to a governmental entity with jurisdiction or another appropriate authority;

2. Notifies a governmental entity with jurisdiction or another appropriate authority of a sentinel event;

3. Transmits information regarding a sentinel event to a governmental entity with jurisdiction or another appropriate authority;

4. Compiles, prepares or disseminates information regarding a sentinel event to a governmental entity with jurisdiction or another appropriate authority; or

5. Performs any other act authorized pursuant to [NRS 439.800](#) to [439.890](#), inclusive.

(Added to NRS by [2002 Special Session, 16](#); A [2005, 600](#))

**NRS 439.885 Violation by medical facility: Administrative sanction prohibited when voluntarily reported.** *Administrative sanctions: Imposition by Health Division; disposition of money collected* If a medical facility:

1. Commits a violation of any provision of [NRS 439.800](#) to [439.890](#), inclusive, or for any violation for which an administrative sanction pursuant to [NRS 449.163](#) would otherwise be applicable; and

2. Of its own volition, reports the violation to the Administrator,

such a violation must not be used as the basis for imposing an administrative sanction pursuant to [NRS 449.163](#)

*3. Commits a violation of any provision of NRS 439.800 to [439.890](#), inclusive, and, of its own volition, does not report it to the Administrator, or the violation is discovered during examination pursuant to NRS 439.835, section 6, the Health Division may impose an administrative penalty not to exceed:*

*(a) One hundred dollars (\$100) for each day that the sentinel event is not reported following the initial 13-day period, pursuant to NRS 439.835 section 1 subsection (b);*

*(b) One thousand dollars (\$1,000) for each month during which the medical facility did not have a patient safety plan implemented, pursuant to NRS 439.865; and*

*(c) Two thousand dollars (\$2,000) for each mandatory medical facility Patient Safety Committee meeting not held, pursuant to NRS 439.875.*

*4. Any money collected as administrative penalties pursuant to this section must be accounted for separately and used for training and education of Health Division and medical facilities employees and of the public regarding safe, quality health care.*

(Added to NRS by [2002 Special Session, 16](#); A [2005, 600](#))

**NRS 439.890 Adoption of regulations.** The ~~[Administrator]~~ *State Board of Health* shall adopt such regulations as ~~[the Administrator]~~ *is* determine[s] *d* to be necessary or advisable to carry out the provisions of [NRS 439.800](#) to [439.890](#), inclusive.

(Added to NRS by [2002 Special Session, 16](#); A [2005, 600](#))

**TAB 7**



# *Nevada State Medical Association*

Richard P. Selzer, M.D., President  
Jack L. Davis, D.O., President-Elect  
Edwin C. Kingsley, M.D., Immed. Past President  
Ronald M. Kline, M.D., Secretary  
T. Brian Callister, M.D., Treasurer  
Marietta Nelson, M.D., AMA Delegate  
Ralph J. Coppola, M.D., AMA Delegate  
Wayne C. Hardwick, M.D., AMA Alternate Delegate  
Ronald M. Kline, M.D., AMA Alternate Delegate  
Lawrence P. Matheis, Executive Director

June 17, 2008

The Honorable Sheila Leslie, Chair  
Legislative Committee on Health Care  
Legislative Building  
401 South Carson Street  
Carson City, Nevada 89701-4747

Dear Chairwoman Leslie:

At the Committee's April 21, 2008 meeting, I addressed a number of issues resulting from the hepatitis C outbreak. On behalf of the Nevada State Medical Association, I recommended that the Committee consider drafting a bill to define by statute the process for a declaration of a "Public Health Emergency". The purpose is to provide clear authority and expectations for the coordinated actions of all public agencies that have statutory responsibilities for some aspect of any required investigation, intervention, or sanctions.

The current crisis resulted from the exposure of patients of one or more Las Vegas licensed ambulatory surgical centers to blood borne diseases as a result of failure to maintain proper infection control procedures regarding the use of injectibles. A number of coordination problems were identified as the various County, State and federal agencies responded to this public health emergency. Many of these derived from current statutory provisions intended to protect confidentiality and "due process" rights, but which impaired the ability of the various agencies to gather and share the information needed to coordinate their interventions in a timely way. It also impaired the ability of these agencies to release necessary information to the public in a clear and consistent manner. Similar problems were identified during the 2002 anthrax scare.

It is possible that there will be future public health emergencies in Nevada. The attached suggestions are intended only to begin this discussion. Multiple statutes would be affected and the operations of numerous State and local agencies need to be addressed.

Sincerely,



Larry Matheis, Executive Director

CC: Members, Legislative Committee on Health Care  
Governor Jim Gibbons  
Nevada State Medical Association Council

## Public Health Emergency Declaration and Response Issues

1. The Legislature might want to consider defining the circumstances and process by which the Governor may declare a “public health emergency”. (This could be modeled on the powers of the Governor to declare emergencies related to water or energy in NRS 416, or regarding emergency management in NRS 414.) This could be a separate statute, or it could be included in NRS 223 regarding the authority of the Governor. It could also be included in NRS 439 (Administration of Public Health)
2. It is likely that a “public health emergency” will imply an immediate threat to public health or safety resulting from a finding and report to the Governor by one or more of the Nevada “health authorities”. The duties regarding identifying the source of a communicable disease outbreak and the “epidemiology” of disease are well defined for the State Health Division (in rural Nevada), the Washoe County District Health Department, the Southern Nevada Health District and the Carson City Health District. It is clear that the Southern Nevada Health District applied its authority properly throughout the current crisis. It made its evidence and actions transparent as soon as it could be concluded that there was a hepatitis C cluster and not random occurrences. Initially, it served as the single source for information (with creative use of both its web site and of a hotline set up for the specific crisis). While it sent letters to all identifiable patients, the form of notification (letters sent by regular mail) was clearly less effective than the same information being provided through the media. This demonstrates the value in providing clear and consistent information to the media throughout a crisis.
3. The public health authorities can (and should continue) to arrange directly with the Centers for Disease Control and Prevention (CDC) for immediate assistance and have the clear responsibility to notify the public about their findings. If a Health District has primary public health authority on a crisis, it should coordinate with the State Health Division, which should assure that all State agencies with authority is notified immediately.
4. In the event (as with the current hepatitis C cluster and infection control crisis) that there is a licensed health care facility involved in a “public health emergency”, the State Health Division (which licenses and certifies health care facilities for Medicare and Medicaid purposes) can (and should continue) to arrange directly with the Centers for Medicare and Medicaid Services (CMS) regarding closure, records management or other immediate interventions. In the event that there may be continuing risk to the public or the extent of previous risk cannot be defined, the statute should allow for immediate State control of the premises and records of any State licensed health care facility.
5. If a “public health emergency” requires immediate health care facility survey or inspections, but conducting such surveys are beyond the immediate resource capacity of the State, the Governor should request from Governors in contiguous States to borrow the services of federally certified surveyors. These States may wish to enter a formal compact for such occasions. The Nevada Congressional delegation could propose legislation to facilitate this, since these surveyors are generally funded to provide certifications for
6. When several State agencies/boards have simultaneous authority, the statute should require the Governor to convene an Emergency Response Team.
  - a. This team should be comprised of the “point person” assigned by each State agency that has authority over some aspect of the response. (In the current hepatitis C cluster and infection control crisis, such a team would include: Office of the Attorney General, State Health Division for facility licensing/certification, State Division of Health Care Financing and Policy, State Board of Medical Examiners, State Board of Osteopathic Medicine, State Board of Nursing, State

- Board of Podiatry, possibly the State Board of Pharmacy.) This team should have statutory emergency authority to suspend any existing statutory or regulatory prohibitions on sharing information, investigation reports or personnel among these agencies. This would require specific waivers of the existing rules to be included in each of the governing statutes.
- b. In addition, the Governor should request that the Attorney General designate the Deputy Attorney General assigned to each of these agencies be assigned to support the team. The team should be directed by the State Health Officer. (In the event, as currently, there is no State Health Officer, or the SHO has a conflict of interest then the Governor should appoint an independent licensed health professional. In the current crisis, former State Health Officer and current Dean of the UNLV School of Public Health Mary E. Guinan, MD was appointed.) To be effective, the Team Leader (or an authorized designee) should be the only one who speaks to the media on the detailed status of any agency action and should be the official liaison with the local health authority (Southern Nevada Health District, the Washoe County District Health Department or the Carson City Health District), the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC). The Team Leader should liaise with the Speaker of the Assembly and the Senate Majority Leader as well as the Attorney General. Also, the Team Leader should liaise with key staff of the Nevada Congressional delegation.
  - c. A single press officer should be assigned to the team and all information regarding any activities by any of the agencies specific to the emergency are communicated from the single source, assuring consistency and completeness. All information should be made public as soon as possible, consistent with the State and Federal laws regarding individual privacy and public safety.
  - d. The Emergency Response Team's charge and authority should include: assure coordination of the response and have the authority to require sharing of needed documents and activity information. The team should be empowered to draw from any State agency upon any resources and workforce needed for any necessary action. Part of the purpose of the group should be to evaluate all agency responses and to develop a formal plan to improve their future responses and collectively to develop a specific plan to assure that the causes of the public health emergency couldn't be repeated. Both of these plans should be public.
  - e. The team should issue a complete written public report as soon as possible following the conclusion of the public health emergency. This report should compile recommendations for revising any regulations or statutes in light of the experience of the agencies responding to the crisis and report them to the Governor and the Legislature.

**TAB 8**

## Local Inspections of ASCs Evaluation of Resource Needs

The Southern Nevada Health District (SNHD) was asked to evaluate the resources needed to assume inspection authority of local ambulatory surgical centers (ASCs) as a result of the hepatitis C outbreak linked to a local endoscopy center.

Currently there are 31 ambulatory surgical centers licensed in Southern Nevada. It is estimated the minimum staff needed to conduct inspections would include two health facility surveyor nurses, one health facility surveyor and one senior administrative assistant. SNHD does not have existing positions with the required skills and would have to recruit to fill these new staff positions.

The nurse surveyors would be responsible for performing required inspections including the on-site surveys, completing a statement of deficiencies if required, reviewing plans of correction and conducting follow-up inspections. The plan review surveyor would be trained in the facility requirements for ASCs and would conduct plan reviews for new facilities, modifications to existing facilities and physical surveys of the facilities. One administrative assistant would be needed to support the operations of this inspection unit.

The estimated combined costs for these positions, including benefits, would amount to approximately \$305,500. This does not include the additional resources that would be needed such as office space, equipment, supplies and training. The facilities currently occupied by the health district are at capacity making it necessary to lease office space to meet the needs of additional staff positions and new programs.

An important consideration related to recruitment of staff is that SNHD would be directly competing with the Nevada State Health Division (NSHD) Bureau of Licensure and Certification (BLC), as well as the other local health authorities, if this responsibility was shifted to the local level. NSHD noted in its Health Facilities Surveyor Workforce Plan that:

“A 2003 survey of shrinking public health workforce revealed a growing trend toward shortage in the public health workforce. Data from a recent 2007 survey of the members of the Association of State and Territorial Health Officials confirm that little has changed in the past several years and that state and governmental public health still faces a workforce crisis.”

Additionally, BLC staff currently inspects more than 33 types of facilities. The transfer of inspections of ASCs to the local health authorities would not decrease the staffing levels BLC requires to meet the inspection requirements of the remaining facilities.

Other considerations include the amount of training, as well as the duplication of training, required to assume authority for these inspections. Of particular concern is the training required by the Centers for Medicaid and Medicare Services (CMS). ASCs eligible for reimbursement under Medicare would require inspections by a surveyor trained under CMS guidelines. To meet these federal requirements BLC staff would need to perform the CMS

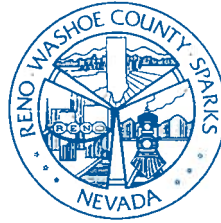
inspections or staff hired by the health district would have to complete the training requirements. The local health district's ability to complete these inspections would also be contingent on CMS recognizing SNHD as a locally certified agency.

If local staff were granted authority to perform CMS inspections of ASCs there would be duplicate costs for training staff and two separate agencies (BLC and the local public health agency) would be performing the same federally required inspections of different facilities in the same jurisdictions. Two different agencies providing CMS certification at the local level would not only lead to a duplication of training and resources, it could lead to issues of consistency across facilities. Additionally, information technology requirements would have to be met in order to ensure health district staff had access to the required forms and the system for submitting the inspection reports. This system is already in place at the state level and would need to be maintained in order to continue service to the facilities they are still required to inspect.

Based on these considerations, including negligible changes to the staffing levels required by BLC, the duplication of training requirements and additional resource requirements, it is the recommendation of SNHD that the authority for regulating ASCs remain under the purview of the Nevada State Health Division. We believe the needs of our community will be best met through a consolidated inspection process for health care facilities. By working to improve the current system we will maximize the limited public health resources available in our community.

Additionally, the local health authorities and state public health officials have already taken proactive steps to close gaps identified during the response to the hepatitis C outbreaks and are making policy recommendations in order to solidify and enhance the current system.

We are confident the infrastructure exists to ensure our community's health care facilities are safe and are committed to working with our partners to ensure the resources and necessary legal authorities are identified to strengthen the current system.



# DISTRICT HEALTH DEPARTMENT

July 18, 2008

Ms. Sarah Lutter  
Senior Research Analyst  
Research Division  
Legislative Counsel Bureau  
State of Nevada  
401 S. Carson Street  
Carson City, Nevada 89701-4747

Dear Ms. Lutter:

The Washoe County Health District has been asked to comment on the feasibility of undertaking the task of performing random surveys of ambulatory surgery centers (ASCs) and “responding to certain complaints that relate to public health.” This request resulted from a review of ASCs undertaken by the Legislative Committee on Health Care as a result of the widely-publicized Hepatitis C outbreak which was directly traced to inadequate infection control practices.

There are 19 ambulatory surgery centers in Northern Nevada of which 12 are located in Washoe County. Inspection of those facilities is under the purview of the Nevada State Health Division, Bureau of Licensure and Certification. In our opinion, the responsibility for performing inspections of the ASCs should remain at the Nevada State Health Division for the following reasons:

1. There is no precedent for the delegation of inspection activities to Local Health Authorities (LHAs) among the states. The Centers for Medicaid and Medicare Services (CMS) certify the state agencies that perform inspections of healthcare facilities.
2. Inspection services would be fragmented and the likelihood that inconsistencies in inspection procedures would occur is increased.
3. The lines of authority would be blurred especially if the requirement for inspections by LHAs was exercised only for random surveys or in response to “certain complaints” of a public health nature.

4. Cost savings would not occur as the low volume of inspections performed in Northern Nevada facilities would necessitate the use of partial FTEs for the various locations.

Per the “Health Facilities Surveyor Facilities Recruitment Plan” prepared by the State of Nevada, Department of Health and Human Services, Health Division, in April of 2008, there is high vacancy rate for Health Facilities Surveyors. The state is unable to recruit and retain adequate numbers of surveyors. LHAs needing part-time surveyors could not effectively compete with a state agency that can pay salaries and benefits for full-time positions. The professional requirements for surveyors dictate the need for a substantial salary to attract and retain qualified personnel. According to the recruitment document, the “...State cost for 1 full-time equivalent staff member is \$83,247.”

The economic downturn in the nation and the State of Nevada has affected every state and county agency. For the foreseeable future, due to the moratorium on hiring in Washoe County, the Washoe County Health District would be unable to hire any additional personnel to perform surveyor functions. Furthermore, an entirely new personnel classification would have to be created—a lengthy process, under any circumstances.

We concur with the recommendation of our colleagues at the Southern Nevada Health District that the inspection of all healthcare facilities—including ambulatory surgery centers—remain under the purview of the Nevada State Health Division, Bureau of Licensing and Certification.

Respectfully,



M. A. Anderson, MD, MPH  
District Health Officer

cc: Mr. Richard Whitley  
Dr. Mary Guinan  
Dr. Larry Sands  
Ms. Marena Works  
Dr. George Furman





July 19, 2008

Ms. Sarah Lutter  
Senior Research Analyst  
Research Division  
Legislative Counsel Bureau  
State of Nevada  
401 S. Carson Street  
Carson City, Nevada 89701-4747

Dear Ms. Lutter:

Carson City Health and Human Services has been asked to comment on the feasibility of undertaking the task of performing random surveys of ambulatory surgery centers (ASCs) and "responding to certain complaints that relate to public health." This request resulted from a review of ASCs undertaken by the Legislative Committee on Health Care as a result of the widely-publicized Hepatitis C outbreak which was directly traced to inadequate infection control practices.

It is my understanding that three of the nineteen northern Nevada ambulatory surgery centers are located in Carson City. Currently the inspection responsibilities fall under the State of Nevada Bureau of Licensure and Certification (BLC).

The Carson City Health Department employs approximately 25 people who perform services from city welfare to family planning. Medical personnel consist of three staff that whose hours are occupied full time in their current positions. The Health Department currently does not employ an engineer nor any personnel trained in health care facilities except for environmental health staff whose expertise is food safety.

It is my opinion that the Carson City Health Department would need staff, training and resources in order to perform ambulatory care center surveys. The financial requirements and additional employees needed would not be practical. It is the position of the Carson City Health Department to leave ASC inspections under the auspices of BLC.

Respectfully,

A handwritten signature in black ink that reads "Marena Works".

Marena Works, MSN, MPH, RN  
Director, Carson City Health and Human Services

**TAB 9**

**TABLE OF HEALTH RELATED STATE BOARDS**

<b>Board Name</b>	<b>NRS Chapter</b>	<b>Professions</b>	<b>Total Number of Board Members</b>	<b>Public Members</b>
<b>Board of Medical Examiners</b>	630		<b>9</b>	<b>3</b>
		Physician		
		Physician assistant		
		Practitioner of respiratory care		
<b>Board of Homeopathic Medical Examiners</b>	630A		<b>7</b>	<b>3</b>
		Advanced practitioner of homeopathy		
		Homeopathic assistant		
		Homeopathic physician		
<b>Board of Dental Examiners of Nevada</b>	631		<b>11</b>	<b>1</b>
		Dental hygienist	3	
		Dentist	6	
<b>State Board of Nursing</b>	632		<b>7</b>	<b>1</b>
		Nurse	3	
		Advanced practitioner of nursing		
		Practical nurse	1	
		Nursing assistant	1	
<b>State Board of Osteopathic Medicine</b>	633		<b>7</b>	<b>2</b>
		Osteopathic physician		
		Physician assistant		
<b>Chiropractic Physicians' Board of Nevada</b>	634		<b>7</b>	<b>2</b>
		Chiropractor		
		Chiropractor's assistant		
<b>State Board of Oriental Medicine</b>	634A		<b>5</b>	<b>1</b>
		Doctor of oriental medicine		

**TABLE OF HEALTH RELATED STATE BOARDS**

<b>State Board of Podiatry</b>	635		<b>5</b>	<b>1</b>
		Podiatric physician		
		Podiatry hygienist		
<b>Nevada State Board of Optometry</b>	636		<b>4</b>	<b>1</b>
		Optometrist		
<b>Board of Dispensing Opticians</b>	637		<b>5</b>	<b>1</b>
		Dispensing optician		
		Apprentice dispensing optician		
<b>Board of Hearing Aid Specialists</b>	637A		<b>5</b>	<b>2</b>
		Hearing aid specialist		
		Apprentice hearing aid specialist		
<b>Board of Examiners for Audiology and Speech Pathology</b>	637B		<b>5</b>	<b>1</b>
		Audiologist	1	
		Speech pathologist	2	
<b>State Board of Pharmacy</b>	639		<b>7</b>	<b>1</b>
		Pharmacist		
		Intern pharmacist		
		Pharmaceutical technician		
<b>State Board of Physical Therapy Examiners</b>	640		<b>5</b>	<b>1</b>
		Physical therapist		
		Physical therapist's assistant		
<b>Board of Occupational Therapy</b>	640A		<b>5</b>	<b>1</b>
		Occupational therapist		
		Occupational therapy assistant		
<b>State Board of Athletic Trainers</b>	640B		<b>4</b>	<b>1</b>
		Athletic trainer		
<b>Board of Massage Therapists</b>	640C			

**TABLE OF HEALTH RELATED STATE BOARDS**

		Massage therapist	<b>6</b>	<b>1</b>
<b>Board of Psychological Examiners</b>	641		<b>5</b>	<b>1</b>
		Psychologist		
<b>Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors</b>	641A		<b>9</b>	<b>2</b>
		Clinical professional counselor	3	
		Clinical professional counselor intern		
		Marriage and family therapist	4	
		Marriage and family therapist intern		
<b>Board of Examiners for Social Workers</b>	641B		<b>5</b>	<b>1</b>
		Associate in social work		
		Social worker		
		Independent social worker		
		Clinical social worker		
		Clinical social worker intern		
		Independent social worker intern		
<b>Board of Examiners for Alcohol, Drug and Gambling Counselors</b>	641C		<b>7</b>	<b>1</b>
		Alcohol and drug abuse counselor		
		Alcohol and drug abuse counselor intern		
		Clinical alcohol and drug abuse counselor		
		Clinical alcohol and drug abuse counselor intern		
		Problem gambling counselor		
		Problem gambling counselor intern		
		Detoxification technician		

**TABLE OF HEALTH RELATED STATE BOARDS—MEMBERSHIP QUALIFICATIONS**

	<b>Board Name</b>	<b>Membership Qualifications</b>
<b>1.</b>	<b>Board of Medical Examiners</b>	<p><b>NRS 630.060 Qualifications of members.</b></p> <p>1. Six members of the Board must be persons who are licensed to practice medicine in this State, are actually engaged in the practice of medicine in this State and have resided and practiced medicine in this State for at least 5 years preceding their respective appointments.</p> <p>2. One member of the Board must be a person who has resided in this State for at least 5 years and who represents the interests of persons or agencies that regularly provide health care to patients who are indigent, uninsured or unable to afford health care. This member must not be licensed under the provisions of this chapter.</p> <p>3. The remaining two members of the Board must be persons who have resided in this State for at least 5 years and who:</p> <p>(a) Are not licensed in any state to practice any healing art;</p> <p>(b) Are not the spouse or the parent or child, by blood, marriage or adoption, of a person licensed in any state to practice any healing art;</p> <p>(c) Are not actively engaged in the administration of any facility for the dependent as defined in <a href="#">chapter 449</a> of NRS, medical facility or medical school; and</p> <p>(d) Do not have a pecuniary interest in any matter pertaining to the healing arts, except as a patient or potential patient.</p> <p>4. The members of the Board must be selected without regard to their individual political beliefs.</p> <p>[Part 2:169:1949; 1943 NCL § 4107.02]—(NRS A 1973, 506; 1977, 307; 1985, 1766, 2226; <a href="#">2003, 1189, 3431</a>; <a href="#">2003, 20th Special Session, 265</a>)</p>
<b>2.</b>	<b>Board of Homeopathic Medical Examiners</b>	<p><b>NRS 630A.110 Qualifications of members.</b></p> <p>1. Three members of the Board must be persons who are licensed to practice allopathic or osteopathic medicine in any state or country, the District of Columbia or a territory or possession of the United States, have been engaged in the practice of homeopathic medicine in this State for a period of more than 2 years preceding their respective appointments, are actually engaged in the practice of homeopathic medicine in this State and are residents of the State.</p> <p>2. One member of the Board must be a person who has resided in this State for at least 5 years and who represents the interests of persons or agencies that regularly provide health care to patients who are indigent, uninsured or unable to afford health care. This member may be licensed under the provisions of this chapter.</p> <p>3. The remaining three members of the Board must be persons who:</p> <p>(a) Are not licensed in any state to practice any healing art;</p> <p>(b) Are not the spouse or the parent or child, by blood, marriage or adoption, of a person licensed in any state to practice any healing art;</p> <p>(c) Are not actively engaged in the administration of any medical facility or facility for the dependent as defined in chapter 449 of NRS;</p> <p>(d) Do not have a pecuniary interest in any matter pertaining to such a facility, except as a patient or potential patient; and</p> <p>(e) Have resided in this State for at least 5 years.</p> <p>4. The members of the Board must be selected without regard to their individual political beliefs.</p> <p>5. As used in this section, “healing art” means any system, treatment, operation, diagnosis, prescription or practice for the ascertainment, cure, relief, palliation, adjustment or correction of any human disease, ailment, deformity, injury, or unhealthy or abnormal physical or mental condition for the practice of which long periods of specialized education and training and a degree of specialized knowledge of an intellectual as well as physical nature are required.</p> <p>(Added to NRS by 1983, 1480; A 1985, 1034, 1766; 1987, 2057; 2003, 1190)</p>

**TABLE OF HEALTH RELATED STATE BOARDS—MEMBERSHIP QUALIFICATIONS**

	<b>Board Name</b>	<b>Membership Qualifications</b>
3.	<b>Board of Dental Examiners of Nevada</b>	<p><b>NRS 631.130 Qualifications of members; restrictions on participation in examinations.</b></p> <p>1. The Governor shall appoint:</p> <p>(a) Six members who are graduates of accredited dental schools or colleges, are residents of Nevada and have ethically engaged in the practice of dentistry in Nevada for a period of at least 5 years.</p> <p>(b) One member who has resided in Nevada for at least 5 years and who represents the interests of persons or agencies that regularly provide health care to patients who are indigent, uninsured or unable to afford health care. This member may be licensed under the provisions of this chapter.</p> <p>(c) Three members who:</p> <p>(1) Are graduates of accredited schools or colleges of dental hygiene;</p> <p>(2) Are residents of Nevada; and</p> <p>(3) Have been actively engaged in the practice of dental hygiene in Nevada for a period of at least 5 years before their appointment to the Board.</p> <p>(d) One member who is a representative of the general public. This member must not be:</p> <p>(1) A dentist or a dental hygienist; or</p> <p>(2) The spouse or the parent or child, by blood, marriage or adoption, of a dentist or a dental hygienist.</p> <p>2. The members who are dental hygienists may vote on all matters but may not participate in grading any clinical examinations required by <a href="#">NRS 631.240</a> for the licensing of dentists.</p> <p>3. If a member is not licensed under the provisions of this chapter, the member shall not participate in grading any examination required by the Board.</p> <p>[Part 4:152:1951; A 1953, 363]—(NRS A 1971, 533; 1977, 1250; 1981, 1972; 1983, 1112; 1989, 52; 1995, 275; <a href="#">2003, 519, 1190; 2005, 271</a>)</p> <p><b>NRS 631.140 Appointment of members from particular areas of State.</b></p>

**TABLE OF HEALTH RELATED STATE BOARDS—MEMBERSHIP QUALIFICATIONS**

	<b>Board Name</b>	<b>Membership Qualifications</b>
4.	<b>State Board of Nursing</b>	<p><b>NRS 632.030 Qualifications of members; duration of term; consecutive terms. [Effective January 1, 2008.]</b></p> <p>1. The Governor shall appoint:</p> <p>(a) Three registered nurses who are graduates of an accredited school of nursing, are licensed as professional nurses in the State of Nevada and have been actively engaged in nursing for at least 5 years preceding the appointment.</p> <p>(b) One practical nurse who is a graduate of an accredited school of practical nursing, is licensed as a practical nurse in this State and has been actively engaged in nursing for at least 5 years preceding the appointment.</p> <p>(c) One nursing assistant who is certified pursuant to the provisions of this chapter.</p> <p>(d) One member who represents the interests of persons or agencies that regularly provide health care to patients who are indigent, uninsured or unable to afford health care. This member may be licensed under the provisions of this chapter.</p> <p>(e) One member who is a representative of the general public. This member must not be:</p> <p>(1) A licensed practical nurse, a registered nurse, a nursing assistant or an advanced practitioner of nursing; or</p> <p>(2) The spouse or the parent or child, by blood, marriage or adoption, of a licensed practical nurse, a registered nurse, a nursing assistant or an advanced practitioner of nursing.</p> <p>2. Each member of the Board must be:</p> <p>(a) A citizen of the United States; and</p> <p>(b) A resident of the State of Nevada who has resided in this State for not less than 2 years.</p> <p>3. A representative of the general public may not:</p> <p>(a) Have a fiduciary obligation to a hospital or other health agency;</p> <p>(b) Have a material financial interest in the rendering of health services; or</p> <p>(c) Be employed in the administration of health activities or the performance of health services.</p> <p>4. The members appointed to the Board pursuant to paragraphs (a) and (b) of subsection 1 must be selected to provide the broadest representation of the various activities, responsibilities and types of service within the practice of nursing and related areas, which may include, without limitation, experience:</p> <p>(a) In administration.</p> <p>(b) In education.</p> <p>(c) As an advanced practitioner of nursing.</p> <p>(d) In an agency or clinic whose primary purpose is to provide medical assistance to persons of low and moderate incomes.</p> <p>(e) In a licensed medical facility.</p> <p>5. Each member of the Board shall serve a term of 4 years. If a vacancy occurs during a member's term, the Governor shall appoint a person qualified under this chapter to replace that member for the remainder of the unexpired term.</p> <p>6. No member of the Board may serve more than two consecutive terms. For the purposes of this subsection, service of 2 or more years in filling an unexpired term constitutes a term.</p> <p>[Part 3:256:1947; 1943 NCL § 4756.03]—(NRS A 1963, 609; 1973, 523; 1977, 1251; 1983, 256; 1995, 1649; <a href="#">2003, 1191</a>; <a href="#">2007, 1828</a>, effective January 1, 2008)</p>



**TABLE OF HEALTH RELATED STATE BOARDS—MEMBERSHIP QUALIFICATIONS**

	<b>Board Name</b>	<b>Membership Qualifications</b>
<b>5.</b>	<b>State Board of Osteopathic Medicine</b>	<p><b>NRS 633.191 Qualifications of members.</b></p> <ol style="list-style-type: none"> <li>1. Five members of the Board must:               <ol style="list-style-type: none"> <li>(a) Be licensed under this chapter;</li> <li>(b) Be actually engaged in the practice of osteopathic medicine in this State; and</li> <li>(c) Have been so engaged in this State for a period of more than 5 years preceding their appointment.</li> </ol> </li> <li>2. One member of the Board must be a resident of the State of Nevada and must represent the interests of persons or agencies that regularly provide health care to patients who are indigent, uninsured or unable to afford health care. This member must not be licensed under the provisions of this chapter.</li> <li>3. The remaining member of the Board must be a resident of the State of Nevada who is:               <ol style="list-style-type: none"> <li>(a) Not licensed in any state to practice any healing art;</li> <li>(b) Not the spouse or the parent or child, by blood, marriage or adoption, of a person licensed in any state to practice any healing art; and</li> <li>(c) Not actively engaged in the administration of any medical facility or facility for the dependent as defined in <a href="#">chapter 449</a> of NRS.</li> </ol> </li> </ol> <p>(Added to NRS by 1977, 942; A 1985, 1767; <a href="#">2003, 1192</a>)</p>
<b>6.</b>	<b>State Board of Oriental Medicine</b>	<p><b>NRS 634A.040 Qualifications of members.</b></p> <ol style="list-style-type: none"> <li>1. The Governor shall appoint three members to the Board who:               <ol style="list-style-type: none"> <li>(a) Have a license issued pursuant to this chapter;</li> <li>(b) Currently engage in the practice of Oriental medicine in this State, and have engaged in the practice of Oriental medicine in this State for at least 3 years preceding appointment to the Board;</li> <li>(c) Are citizens of the United States; and</li> <li>(d) Are residents of the State of Nevada and have been for at least 1 year preceding appointment to the Board.</li> </ol> </li> <li>2. The Governor shall appoint one member to the Board who:               <ol style="list-style-type: none"> <li>(a) Is licensed pursuant to <a href="#">chapter 630</a> of NRS by the Board of Medical Examiners as a physician;</li> <li>(b) Does not engage in the administration of a facility for Oriental medicine or a school for Oriental medicine;</li> <li>(c) Does not have a pecuniary interest in any matter pertaining to Oriental medicine, except as a patient or potential patient;</li> <li>(d) Is a citizen of the United States; and</li> <li>(e) Is a resident of the State of Nevada and has been for at least 1 year preceding appointment to the Board.</li> </ol> </li> <li>3. The Governor shall appoint one member to the Board who:               <ol style="list-style-type: none"> <li>(a) Does not engage in the administration of a facility for Oriental medicine or a school for Oriental medicine;</li> <li>(b) Does not have a pecuniary interest in any matter pertaining to Oriental medicine, except as a patient or potential patient;</li> <li>(c) Is a citizen of the United States; and</li> <li>(d) Is a resident of the State of Nevada and has been for at least 1 year preceding appointment to the Board.</li> </ol> </li> </ol> <p>(Added to NRS by 1973, 636; A <a href="#">2003, 1639</a>)</p>

**TABLE OF HEALTH RELATED STATE BOARDS—MEMBERSHIP QUALIFICATIONS**

	<b>Board Name</b>	<b>Membership Qualifications</b>
7.	<b>State Board of Podiatry</b>	<p><b>NRS 635.020 Creation; number, appointment and qualifications of members; compensation of members and employees.</b></p> <ol style="list-style-type: none"> <li>1. The State Board of Podiatry, consisting of five members appointed by the Governor, is hereby created.</li> <li>2. The Governor shall appoint:               <ol style="list-style-type: none"> <li>(a) Three members who are licensed podiatric physicians in the State of Nevada.</li> <li>(b) One member who represents the interests of persons or agencies that regularly provide health care to patients who are indigent, uninsured or unable to afford health care. This member may be licensed under the provisions of this chapter.</li> <li>(c) One member who is a representative of the general public. This member must not be:                   <ol style="list-style-type: none"> <li>(1) A licensed podiatric physician in the State of Nevada; or</li> <li>(2) The spouse or the parent or child, by blood, marriage or adoption, of a licensed podiatric physician in the State of Nevada.</li> </ol> </li> </ol> </li> <li>3. The members of the Board are entitled to receive:               <ol style="list-style-type: none"> <li>(a) A salary of not more than \$150 per day, as fixed by the Board, while engaged in the business of the Board; and</li> <li>(b) A per diem allowance and travel expenses at a rate fixed by the Board, while engaged in the business of the Board. The rate must not exceed the rate provided for state officers and employees generally.</li> </ol> </li> <li>4. While engaged in the business of the Board, each employee of the Board is entitled to receive a per diem allowance and travel expenses at a rate fixed by the Board. The rate must not exceed the rate provided for state officers and employees generally.</li> </ol> <p>[Part 2:149:1949; 1943 NCL § 1077.2]—(NRS A 1963, 153; 1969, 906; 1975, 304; 1977, 1253; 1979, 1868; 1981, 1993; 1985, 492; 1987, 1853; 1989, 1699; 1993, 2219; <a href="#">2003, 1194</a>; <a href="#">2007, 1042, 2949</a>)</p>
8.	<b>Nevada State Board of Optometry</b>	<p><b>NRS 636.035 Qualifications of members; representative of general public not to participate in examination.</b></p> <ol style="list-style-type: none"> <li>1. The Governor shall appoint:               <ol style="list-style-type: none"> <li>(a) Three members who are licensed to practice optometry in the State of Nevada and are actually engaged in the practice of optometry.</li> <li>(b) One member who is a representative of the general public. This member must not be:                   <ol style="list-style-type: none"> <li>(1) Licensed to practice optometry; or</li> <li>(2) The spouse or the parent or child, by blood, marriage or adoption, of a person licensed to practice optometry.</li> </ol> </li> </ol> </li> <li>2. A person shall not be appointed if he:               <ol style="list-style-type: none"> <li>(a) Is the owner or co-owner of, a stockholder in, or a member of the faculty or board of directors or trustees of, any school of optometry;</li> <li>(b) Is financially interested, directly or indirectly, in the manufacture or wholesaling of optical supplies; or</li> <li>(c) Has been convicted of a felony or a gross misdemeanor involving moral turpitude.</li> </ol> </li> <li>3. The member who is a representative of the general public shall not participate in preparing, conducting or grading any examination required by the Board.</li> </ol> <p>[15:208:1955]—(NRS A 1977, 1254; <a href="#">2003, 1194</a>)</p>

**TABLE OF HEALTH RELATED STATE BOARDS—MEMBERSHIP QUALIFICATIONS**

	<b>Board Name</b>	<b>Membership Qualifications</b>
<b>9.</b>	<b>Board of Dispensing Opticians</b>	<p><b>NRS 637.030 Creation; number, appointment, qualifications and removal of members; representative of general public not to participate in examination.</b></p> <ol style="list-style-type: none"> <li>1. The Board of Dispensing Opticians, consisting of five members appointed by the Governor, is hereby created.</li> <li>2. The Governor shall appoint:               <ol style="list-style-type: none"> <li>(a) Four members who have actively engaged in the practice of ophthalmic dispensing for not less than 3 years in the State of Nevada immediately preceding the appointment.</li> <li>(b) One member who is a representative of the general public. This member must not be:                   <ol style="list-style-type: none"> <li>(1) A dispensing optician; or</li> <li>(2) The spouse or the parent or child, by blood, marriage or adoption, of a dispensing optician.</li> </ol> </li> </ol> </li> <li>3. The Governor, after hearing, may remove any member for cause.</li> <li>4. The member who is the representative of the general public shall not participate in preparing, conducting or grading any examination required by the Board.</li> </ol> <p>[Part 10:216:1951; A 1953, 554]—(NRS A 1977, 1255; 1979, 1195; <a href="#">2003, 1195</a>)</p>
<b>10.</b>	<b>Board of Hearing Aid Specialists</b>	<p><b>NRS 637A.035 Qualifications of members; terms; members serve at pleasure of Governor.</b></p> <ol style="list-style-type: none"> <li>1. The Governor shall appoint:               <ol style="list-style-type: none"> <li>(a) One member who is a physician with a specialty in otorhinolaryngology or otology.</li> <li>(b) One member who is licensed to engage in the practice of audiology pursuant to <a href="#">chapter 637B</a> of NRS.</li> <li>(c) One member who is a hearing aid specialist.</li> <li>(d) Two members who are representatives of the general public and have hearing disorders. These members must not be:                   <ol style="list-style-type: none"> <li>(1) A hearing aid specialist, a physician with a specialty in otorhinolaryngology or otology or a person licensed to engage in the practice of audiology pursuant to <a href="#">chapter 637B</a> of NRS; or</li> <li>(2) The spouse or the parent or child, by blood, marriage or adoption, of a hearing aid specialist, a physician with a specialty in otorhinolaryngology or otology or a person licensed to engage in the practice of audiology pursuant to <a href="#">chapter 637B</a> of NRS.</li> </ol> </li> </ol> </li> <li>2. After their initial terms, the members of the Board shall serve terms of 3 years.</li> <li>3. No member of the Board may be a stockholder of a manufacturer.</li> <li>4. The members of the Board serve at the pleasure of the Governor.</li> </ol> <p>(Added to NRS by 1973, 990; A 1977, 1255; 1993, 1339; <a href="#">2003, 1195</a>)</p>

**TABLE OF HEALTH RELATED STATE BOARDS—MEMBERSHIP QUALIFICATIONS**

	<b>Board Name</b>	<b>Membership Qualifications</b>
11.	<b>Board of Examiners for Audiology and Speech Pathology</b>	<p><b>NRS 637B.100 Creation; number, appointment and qualifications of members; representative of general public not to participate in examination.</b></p> <ol style="list-style-type: none"> <li>1. The Board of Examiners for Audiology and Speech Pathology, consisting of five members appointed by the Governor, is hereby created.</li> <li>2. The Governor shall appoint:               <ol style="list-style-type: none"> <li>(a) Two members who have been engaged in the practice of speech pathology for 2 years or more;</li> <li>(b) One member who has been engaged in the practice of audiology for 2 years or more;</li> <li>(c) One member who is a physician and who is certified by the Board of medical examiners as a specialist in otolaryngology, pediatrics or neurology; and</li> <li>(d) One member who is a representative of the general public. This member must not be:                   <ol style="list-style-type: none"> <li>(1) A speech pathologist or an audiologist; or</li> <li>(2) The spouse or the parent or child, by blood, marriage or adoption, of a speech pathologist or an audiologist.</li> </ol> </li> </ol> </li> <li>3. Members of the Board who are speech pathologists and audiologists must be representative of the university, public school, hospital or private aspects of the practice of audiology and of speech pathology.</li> <li>4. Each member of the Board who is a speech pathologist or audiologist must hold a current license issued pursuant to this chapter or a current certificate of clinical competence from the American Speech-Language-Hearing Association.</li> <li>5. The member who is a representative of the general public may not participate in preparing, conducting or grading any examination required by the Board.</li> </ol> <p>(Added to NRS by 1979, 1254; A <a href="#">2003, 1195</a>)</p>
12.	<b>State Board of Pharmacy</b>	<p><b>NRS 639.030 Qualification and terms of members; oath; vacancies; grounds for removal from office. [Effective January 1, 2008.]</b></p> <ol style="list-style-type: none"> <li>1. The Governor shall appoint:               <ol style="list-style-type: none"> <li>(a) Six members who are registered pharmacists in the State of Nevada, are actively engaged in the practice of pharmacy in the State of Nevada and have had at least 5 years' experience as registered pharmacists preceding the appointment.</li> <li>(b) One member who is a representative of the general public and is not related to a pharmacist registered in the State of Nevada by consanguinity or affinity within the third degree.</li> </ol> </li> <li>2. Appointments of registered pharmacists must be representative of the practice of pharmacy.</li> <li>3. Within 30 days after his appointment, each member of the Board shall take and subscribe an oath to discharge faithfully and impartially the duties prescribed by this chapter.</li> <li>4. After the initial terms, the members of the Board must be appointed to terms of 3 years. A person may not serve as a member of the Board for more than three consecutive terms. If a vacancy occurs during a member's term, the Governor shall appoint a person qualified under this chapter to replace that member for the remainder of the unexpired term.</li> <li>5. The Governor shall remove from the Board any member, after a hearing, for neglect of duty or other just cause.</li> </ol> <p>[Part 5:286:1913; A 1947, 667; 1943 NCL § 5044]—(NRS A 1963, 474; 1975, 1307; 1977, 1256; 1987, 1817; 1989, 2036; <a href="#">2007, 1844</a>, effective January 1, 2008)</p>

**TABLE OF HEALTH RELATED STATE BOARDS—MEMBERSHIP QUALIFICATIONS**

	<b>Board Name</b>	<b>Membership Qualifications</b>
13.	<b>State Board of Physical Therapy Examiners</b>	<p><b>NRS 640.030 Creation; qualifications, terms and removal of members; representative of public not to participate in examination; quorum; personal liability.</b></p> <ol style="list-style-type: none"> <li>1. The State Board of Physical Therapy Examiners, consisting of five members appointed by the Governor, is hereby created.</li> <li>2. The Governor shall appoint:               <ol style="list-style-type: none"> <li>(a) Four members who are licensed physical therapists in the State of Nevada.</li> <li>(b) One member who is a representative of the general public. This member must not be:                   <ol style="list-style-type: none"> <li>(1) A physical therapist, a physical therapist’s assistant or a physical therapist’s technician; or</li> <li>(2) The spouse or the parent or child, by blood, marriage or adoption, of a physical therapist, a physical therapist’s assistant or a physical therapist’s technician.</li> </ol> </li> </ol> </li> <li>3. The member who is a representative of the general public shall not participate in preparing, conducting or grading any examination required by the Board.</li> <li>4. No member of the Board may serve more than two consecutive terms.</li> <li>5. The Governor may remove any member of the Board for incompetency, neglect of duty, gross immorality or malfeasance in office.</li> <li>6. A majority of the members of the Board constitutes a quorum.</li> <li>7. No member of the Board may be held liable in a civil action for any act which he has performed in good faith in the execution of his duties under this chapter.</li> </ol> <p>[Part 3:364:1955]—(NRS A 1957, 77; 1977, 1257; 1981, 933; 1989, 1574; <a href="#">2003, 1196</a>)</p>
14.	<b>Board of Occupational Therapy</b>	<p><b>NRS 640A.080 Creation; qualifications, appointment and terms of members. [Effective January 1, 2008.]</b></p> <ol style="list-style-type: none"> <li>1. The Board of Occupational Therapy, consisting of five members appointed by the Governor, is hereby created.</li> <li>2. The Governor shall appoint to the Board:               <ol style="list-style-type: none"> <li>(a) One member who is a representative of the general public. This member must not be:                   <ol style="list-style-type: none"> <li>(1) An occupational therapist or an occupational therapy assistant; or</li> <li>(2) The spouse or the parent or child, by blood, marriage or adoption, of an occupational therapist or an occupational therapy assistant.</li> </ol> </li> <li>(b) One member who is an occupational therapist or occupational therapy assistant.</li> <li>(c) Three members who are occupational therapists.</li> </ol> </li> <li>3. Each member of the Board must be a resident of Nevada. An occupational therapist or occupational therapy assistant appointed to the Board must:               <ol style="list-style-type: none"> <li>(a) Have practiced, taught or conducted research in occupational therapy for the 5 years immediately preceding his appointment; and</li> <li>(b) Except for the initial members, hold a license issued pursuant to this chapter.</li> </ol> </li> <li>4. No member of the Board may serve more than two consecutive terms.</li> <li>5. If a vacancy occurs during a member’s term, the Governor shall appoint a person qualified under this chapter to replace that member for the remainder of the unexpired term.</li> </ol> <p>(Added to NRS by 1991, 987; A 1995, 93; <a href="#">2003, 1197</a>; <a href="#">2007, 1846</a>, effective January 1, 2008)</p>

**TABLE OF HEALTH RELATED STATE BOARDS—MEMBERSHIP QUALIFICATIONS**

	<b>Board Name</b>	<b>Membership Qualifications</b>
<b>15.</b>	<b>State Board of Athletic Trainers</b>	<p><b>NRS 640B.170 Creation; appointment and qualifications of members; terms, vacancies and removal from office; limitations on civil liability; representative of general public not to participate in examination.</b></p> <ol style="list-style-type: none"> <li>1. The Board of Athletic Trainers is hereby created.</li> <li>2. The Governor shall appoint to the Board:               <ol style="list-style-type: none"> <li>(a) Three members who:                   <ol style="list-style-type: none"> <li>(1) Are licensed as athletic trainers pursuant to the provisions of this chapter; and</li> <li>(2) Have engaged in the practice of athletic training or taught or conducted research concerning the practice of athletic training for the 5 years immediately preceding their appointment;</li> </ol> </li> <li>(b) One member who is licensed as a physical therapist pursuant to <a href="#">chapter 640</a> of NRS and who is also licensed as an athletic trainer pursuant to this chapter; and</li> <li>(c) One member who is a representative of the public.</li> </ol> </li> <li>3. Each member of the Board:               <ol style="list-style-type: none"> <li>(a) Must be a resident of this State; and</li> <li>(b) May not serve more than two consecutive terms.</li> </ol> </li> <li>4. After the initial terms, the members of the Board must be appointed to terms of 3 years.</li> <li>5. A vacancy on the Board must be filled in the same manner as the original appointment.</li> <li>6. The Governor may remove a member of the Board for incompetence, neglect of duty, moral turpitude or malfeasance in office.</li> <li>7. No member of the Board may be held liable in a civil action for any act he performs in good faith in the execution of his duties pursuant to the provisions of this chapter.</li> <li>8. The member of the Board who is a representative of the public shall not participate in preparing or grading any examination required by the Board. (Added to NRS by <a href="#">2003, 896</a>)</li> </ol>

**TABLE OF HEALTH RELATED STATE BOARDS—MEMBERSHIP QUALIFICATIONS**

	<b>Board Name</b>	<b>Membership Qualifications</b>
16.	<b>Board of Massage Therapists</b>	<p><b>NRS 640C.150 Creation; appointment and qualifications of members; terms, vacancies and removal from office. [Effective January 1, 2008.]</b></p> <p>1. The Board of Massage Therapists is hereby created. The Board consists of seven members appointed pursuant to this chapter and one nonvoting advisory member appointed pursuant to <a href="#">NRS 640C.160</a>.</p> <p>2. The Governor shall appoint to the Board seven members as follows:</p> <p>(a) Six members who:</p> <p>(1) Are licensed to practice massage therapy in this State; and</p> <p>(2) Have engaged in the practice of massage therapy for the 2 years immediately preceding their appointment.</p> <p>➔ Of the six members appointed pursuant to this paragraph, three members must be residents of Clark County, two members must be residents of Washoe County and one member must be a resident of a county other than Clark County or Washoe County.</p> <p>(b) One member who is a member of the general public. This member must not be:</p> <p>(1) A massage therapist; or</p> <p>(2) The spouse or the parent or child, by blood, marriage or adoption, of a massage therapist.</p> <p>3. The members who are appointed to the Board pursuant to paragraph (a) of subsection 2 must continue to practice massage therapy in this State while they are members of the Board.</p> <p>4. After the initial terms, the term of each member of the Board is 4 years. A member may continue in office until the appointment of a successor.</p> <p>5. A member of the Board may not serve more than two consecutive terms. A former member of the Board is eligible for reappointment to the Board if that person has not served on the Board during the 4 years immediately preceding the reappointment.</p> <p>6. A vacancy must be filled by appointment for the unexpired term in the same manner as the original appointment.</p> <p>7. The Governor may remove any member of the Board for incompetence, neglect of duty, moral turpitude or misfeasance, malfeasance or nonfeasance in office.</p> <p>(Added to NRS by <a href="#">2005, 1120</a>; A <a href="#">2007, 1847</a>, effective January 1, 2008)</p>
17.	<b>Board of Psychological Examiners</b>	<p><b>NRS 641.040 Qualifications of members; representative of general public; conflict of interest.</b></p> <p>1. The Governor shall appoint to the Board:</p> <p>(a) Four members who are licensed psychologists in the State of Nevada with at least 5 years of experience in the practice of psychology after being licensed.</p> <p>(b) One member who is a representative of the general public.</p> <p>2. A person is not eligible for appointment unless he is:</p> <p>(a) A citizen of the United States; and</p> <p>(b) A resident of the State of Nevada.</p> <p>3. The member who is a representative of the general public:</p> <p>(a) Shall not participate in preparing, conducting or grading any examination required by the Board.</p> <p>(b) Must not be a psychologist, an applicant or former applicant for licensure as a psychologist, a member of a health profession, the spouse or the parent or child, by blood, marriage or adoption, of a psychologist, or a member of a household that includes a psychologist.</p> <p>4. Board members must not have any conflicts of interest or the appearance of such conflicts in the performance of their duties as members of the Board.</p> <p>(Added to NRS by 1963, 188; A 1977, 1258; 1989, 1540; <a href="#">2003, 1197</a>)</p>

**TABLE OF HEALTH RELATED STATE BOARDS—MEMBERSHIP QUALIFICATIONS**

	<b>Board Name</b>	<b>Membership Qualifications</b>
<b>18.</b>	<b>Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors</b>	<p><b>NRS 641A.100 Qualifications of members; representative of general public not to participate in examination; removal for misconduct. [Effective July 1, 2008.]</b></p> <p>1. The Governor shall appoint to the Board:</p> <p>(a) Four members who are licensed marriage and family therapists and are in good standing with or acceptable for membership in their local or state societies and associations when they exist;</p> <p>(b) Three members who are licensed clinical professional counselors and are in good standing with or acceptable for membership in their local or state societies and associations when they exist; and</p> <p>(c) Two members who are representatives of the general public. These members must not be:</p> <p>(1) A marriage and family therapist;</p> <p>(2) A clinical professional counselor; or</p> <p>(3) The spouse or the parent or child, by blood, marriage or adoption, of a marriage and family therapist or clinical professional counselor.</p> <p>2. The members who are representatives of the general public shall not participate in preparing, conducting or grading any examination required by the Board.</p> <p>3. The Governor may, after notice and hearing, remove any member of the Board for misconduct in office, incompetence, neglect of duty or other sufficient cause.</p> <p>(Added to NRS by 1973, 486; A 1977, 1258; 1987, 2124; <a href="#">2003, 1198</a>; <a href="#">2007, 3056, 3057</a>, effective July 1, 2008)</p>
<b>19.</b>	<b>Board of Examiners for Social Workers</b>	<p><b>NRS 641B.100 Appointment by Governor; qualifications.</b></p> <p>1. The Board of Examiners for Social Workers consists of five members appointed by the Governor.</p> <p>2. Four members appointed to the Board must be licensed or eligible for licensure pursuant to this chapter, except the initial members who must be eligible for licensure.</p> <p>3. One member appointed to the Board must be a representative of the general public. This member must not be:</p> <p>(a) Licensed or eligible for licensure pursuant to this chapter; or</p> <p>(b) The spouse or the parent or child, by blood, marriage or adoption, of a person who is licensed or eligible for licensure pursuant to this chapter.</p> <p>(Added to NRS by 1987, 1117; A <a href="#">2003, 1198</a>)</p>



**TABLE OF HEALTH RELATED STATE BOARDS—MEMBERSHIP QUALIFICATIONS**

	<b>Board Name</b>	<b>Membership Qualifications</b>
<b>20.</b>	<b>Board of Examiners for Alcohol, Drug and Gambling Counselors</b>	<p><b>NRS 641C.150 Creation; appointment and qualifications of members; limitations on civil liability.</b></p> <p>1. The Board of Examiners for Alcohol, Drug and Gambling Counselors, consisting of seven members appointed by the Governor, is hereby created.</p> <p>2. The Board must consist of:</p> <p>(a) Three members who are licensed as clinical alcohol and drug abuse counselors or alcohol and drug abuse counselors pursuant to the provisions of this chapter.</p> <p>(b) One member who is certified as an alcohol and drug abuse counselor pursuant to the provisions of this chapter.</p> <p>(c) Two members who are licensed pursuant to <a href="#">chapter 630, 632, 641, 641A</a> or <a href="#">641B</a> of NRS and certified as problem gambling counselors pursuant to the provisions of this chapter.</p> <p>(d) One member who is a representative of the general public. This member must not be:</p> <p>(1) A licensed clinical alcohol and drug abuse counselor or a licensed or certified alcohol and drug abuse counselor or a certified problem gambling counselor; or</p> <p>(2) The spouse or the parent or child, by blood, marriage or adoption, of a licensed clinical alcohol and drug abuse counselor or a licensed or certified alcohol and drug abuse counselor or a certified problem gambling counselor.</p> <p>3. A person may not be appointed to the Board unless he is:</p> <p>(a) A citizen of the United States or is lawfully entitled to remain and work in the United States; and</p> <p>(b) A resident of this State.</p> <p>4. No member of the Board may be held liable in a civil action for any act that he performs in good faith in the execution of his duties pursuant to the provisions of this chapter.</p> <p>(Added to NRS by <a href="#">1999, 3050</a>; A <a href="#">2003, 1198, 1420</a>; <a href="#">2007, 3066</a>)</p>

**TAB 10**

Policy Section: Board Procedures

Policy Title: **Conflict of Interest Policy Acknowledgment**

Date Adopted:

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- I. **PURPOSE:** To provide each Nevada State Board of Nursing board member, the Nevada State Board of Nursing, and the public with the required Code of Ethical Standards required of each Nevada State Board of Nursing board member.
- II. **POLICY STATEMENT:** Each person who appears before the Nevada State Board of Nursing is entitled to an unbiased board member who will hear the facts of the matter unburdened by any conflicts of interest in the matter. Also, the citizens of the State of Nevada are entitled to believe that Nevada State Board of Nursing board members will disclose conflicts of interest in matters that appear before them such that no person will receive unduly beneficial or detrimental treatment by the Board.

Every Board member engages in outside employment, consulting, and/or other business activities because the activities of a Board member are not a full time job and an outside income is necessary for each Board member to sustain a standard of living in Nevada. It is the policy of the Nevada State Board of Nursing to encourage the Board members to engage in outside employment, consulting, and/or other business activities provided that no actual or potential conflict of interest or appearance of such conflict exists, and such activity does not adversely affect their ability to perform the duties of a Board member. Board members must not use their Board positions for financial gain for themselves or for persons with whom they have personal, business, or financial interests. Board members must avoid any outside activity that could be reasonably expected to adversely affect or to give the appearance of adversely affecting the independence and objectivity of their judgment, or interfere with the timely and effective performance of their duties and responsibilities or discredit the Nevada State Board of Nursing.

- III. **LEGAL BACKGROUND.** The provisions of the “Nevada Ethics in Government Law” (NRS Chapter 281A) provide statutory guidance for a Nevada State Board of Nursing Conflict of Interest Policy. This “Ethics in Government Law” states:

1. It is hereby declared to be the public policy of this State that:

- (a) A public office is a public trust and shall be held for the sole benefit of the people.
- (b) A public officer or employee must commit himself to avoid conflicts between his private interests and those of the general public whom he serves.

2. The Legislature finds that:

- (a) The increasing complexity of state and local government, more and more closely related to private life and enterprise, enlarges the potentiality for conflict of interests.

Policy Section: Board Procedures

Policy Title: **Conflict of Interest Policy Acknowledgment**

Date Adopted:

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- (b) To enhance the people's faith in the integrity and impartiality of public officers and employees, adequate guidelines are required to show the appropriate separation between the roles of persons who are both public servants and private citizens.

Board members of the Nevada State Board of Nursing are considered to be "Public Officers" (NRS 281A.160). As such, each Board member is required to abide by and follow the "Code of Ethical Standards" set forth at NRS 281A.400 as set forth below:

**NRS 281A.400 General requirements; exceptions.** A code of ethical standards is hereby established to govern the conduct of public officers and employees:

1. A public officer or employee shall not seek or accept any gift, service, favor, employment, engagement, emolument or economic opportunity which would tend improperly to influence a reasonable person in his position to depart from the faithful and impartial discharge of his public duties.
2. A public officer or employee shall not use his position in government to secure or grant unwarranted privileges, preferences, exemptions or advantages for himself, any business entity in which he has a significant pecuniary interest, or any person to whom he has a commitment in a private capacity to the interests of that person. As used in this subsection:
  - (a) "Commitment in a private capacity to the interests of that person" has the meaning ascribed to "commitment in a private capacity to the interests of others" in subsection 8 of [NRS 281A.420](#).
  - (b) "Unwarranted" means without justification or adequate reason.
3. A public officer or employee shall not participate as an agent of government in the negotiation or execution of a contract between the government and any private business in which he has a significant pecuniary interest.
4. A public officer or employee shall not accept any salary, retainer, augmentation, expense allowance or other compensation from any private source for the performance of his duties as a public officer or employee.
5. If a public officer or employee acquires, through his public duties or relationships, any information which by law or practice is not at the time available to people generally, he shall not use the information to further the pecuniary interests of himself or any other person or business entity.
6. A public officer or employee shall not suppress any governmental report or other document because it might tend to affect unfavorably his pecuniary interests.
7. A public officer or employee, other than a member of the Legislature, shall not use governmental time, property, equipment or other facility to benefit his personal or financial interest. This subsection does not prohibit:

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- (a) A limited use of governmental property, equipment or other facility for personal purposes if:
    - (1) The public officer who is responsible for and has authority to authorize the use of such property, equipment or other facility has established a policy allowing the use or the use is necessary as a result of emergency circumstances;
    - (2) The use does not interfere with the performance of his public duties;
    - (3) The cost or value related to the use is nominal; and
    - (4) The use does not create the appearance of impropriety;
  - (b) The use of mailing lists, computer data or other information lawfully obtained from a governmental agency which is available to members of the general public for nongovernmental purposes; or
  - (c) The use of telephones or other means of communication if there is not a special charge for that use. If a governmental agency incurs a cost as a result of a use that is authorized pursuant to this subsection or would ordinarily charge a member of the general public for the use, the public officer or employee shall promptly reimburse the cost or pay the charge to the governmental agency.
8. A member of the Legislature shall not:
- (a) Use governmental time, property, equipment or other facility for a nongovernmental purpose or for the private benefit of himself or any other person. This paragraph does not prohibit:
    - (1) A limited use of state property and resources for personal purposes if:
      - (I) The use does not interfere with the performance of his public duties;
      - (II) The cost or value related to the use is nominal; and
      - (III) The use does not create the appearance of impropriety;
    - (2) The use of mailing lists, computer data or other information lawfully obtained from a governmental agency which is available to members of the general public for nongovernmental purposes; or
    - (3) The use of telephones or other means of communication if there is not a special charge for that use.
  - (b) Require or authorize a legislative employee, while on duty, to perform personal services or assist in a private activity, except:
    - (1) In unusual and infrequent situations where the employee's service is reasonably necessary to permit the Legislator or legislative employee to perform his official duties; or
    - (2) Where such service has otherwise been established as legislative policy.
9. A public officer or employee shall not attempt to benefit his personal or financial interest through the influence of a subordinate.
10. A public officer or employee shall not seek other employment or contracts through the use of his official position.

Policy Section: Board Procedures

Policy Title: **Conflict of Interest Policy Acknowledgment**

Date Adopted:

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IV. ACKNOWLEDGMENT. By the signature affixed below, the individual Board member of the Nevada State Board of Nursing acknowledges the “Nevada Ethics in Government Law” as described above and the “Code of Ethical Standards” set forth above. The individual Board member further acknowledges and agrees to declare any known conflict of interest between the Board member and any applicant for licensure or certification or respondent in a disciplinary matter.

Dated this \_\_\_\_ day of \_\_\_\_\_, 2008.

\_\_\_\_\_  
Board member

## **The Role of a Member of Nevada State Board of Nursing**

*(WHAT a Board Member does)*

1. A Board Member:
  - a. Is a public official, appointed by the governor, to carry out the Board's mission of protecting the public by enforcing the state's laws and regulations regarding the nursing profession.
  - b. Is an advocate for the public, not a representative of the nursing profession or any professional association, group, or specialty within nursing.
  - c. Brings expertise from the member's own background that is useful to the Board in decision-making.
  - d. Makes informed decisions regarding nursing education, licensure, practice and discipline in order to protect the public's health, safety and welfare.
  - e. Makes decisions bound by the Nurse Practice Act (chapter 632 of the Nevada Revised Statutes and the Nevada Administrative Code).
  - f. Meets and makes decisions in a public forum, in accordance with Nevada's Open Meeting Law. Meeting minutes are public record.

## **The Responsibilities of a Member of the Nevada State Board of Nursing**

*(HOW a Board member does it)*

1. A Board Member
  - a. Abides by the Nevada State Board of Nursing's Code of Ethics.
  - b. Understands and supports the Board's mission statement.
  - c. Engages in strategic planning to establish major goals and priorities.
  - d. Provides effective fiscal oversight.
  - e. Selects executive director and reviews his/her performance.
  - f. Understands relationship between Board and staff—board sets policy and staff carries it out.
  - g. Attends and actively participates in several regular, statewide Board meetings of 2-3 days each during the year, and additional special meetings as required to conduct the business of the Board.
  - h. Carefully reviews all Board materials in advance of the meeting, asking staff for more information about items if needed. This material may take several hours to review.
  - i. Nominates, elects and/or serves as an officer of the Board.
  - j. Orients and mentors new Board members.
  - k. Serves as liaison to Board Advisory Committees.
  - l. Represents the Board in local, state and national meetings.
  - m. Supports and upholds Board decisions.
  - n. Listens to stakeholders to keep abreast of current issues.

## **The Responsibilities of a Member of the Nevada State Board of Nursing (con't.)**

- o. Hears contested cases, exercising both rights and obligations:
  - 1) A Board member has the right to
    - ask questions of witness(es), attorneys, and staff members
    - review the allegations prior to the hearing
    - be a part of the decision-making process
    - deliberate
    - counsel by an attorney
  - 2) A Board member has the obligation to
    - protect the public
    - afford due process
    - interpret and enforce the Nurse Practice Act
    - treat all parties fairly and objectively
    - read the information provided
    - ask relevant questions
    - make sound decisions based on the facts
- p. Maintains strict confidentiality pursuant to NRS 632.405 and refers all requests for information to Board staff.
- q. Declares any conflict of interest, either personal or professional, and refrains from participation in consideration or voting on that matter.
- r. Keeps abreast of local, state, and national health care issues as a basis for making sound decisions.
- s. Contributes significant quantities of time, energy, and personal commitment, which may outweigh the monetary compensation provided by statute.

Revised and Adopted by the Board:

7/18/01

7/17/02

7/23/03

7/13/05

7/19/06

7/12/07



## **ETHICS IN GOVERNMENT**

### General Provisions

(For complete text, click on Chapter 281 at [www.leg.state.nv.us/NRS/Index.cfm](http://www.leg.state.nv.us/NRS/Index.cfm))

<a href="#">NRS 281.411</a>	Short title.
<a href="#">NRS 281.421</a>	Legislative declaration and findings.
<a href="#">NRS 281.431</a>	Definitions.
<a href="#">NRS 281.432</a>	“Business entity” defined.
<a href="#">NRS 281.4323</a>	“Candidate” defined.
<a href="#">NRS 281.4325</a>	“Commission” defined.
<a href="#">NRS 281.4327</a>	“Compensation” defined.
<a href="#">NRS 281.433</a>	“Decision” defined.
<a href="#">NRS 281.4333</a>	“Executive director” defined.
<a href="#">NRS 281.434</a>	“Household” defined.
<a href="#">NRS 281.4345</a>	“Legislative function” defined.
<a href="#">NRS 281.435</a>	“Member of the executive branch” defined.
<a href="#">NRS 281.4355</a>	“Member of the legislative branch” defined.
<a href="#">NRS 281.4357</a>	“Panel” defined.
<a href="#">NRS 281.436</a>	“Public employee” defined.
<a href="#">NRS 281.4365</a>	“Public officer” defined.
<a href="#">NRS 281.437</a>	“Vexatious” defined.
<a href="#">NRS 281.4375</a>	“Willful violation” defined.

#### **Commission on Ethics**

<a href="#">NRS 281.455</a>	Creation; appointment, terms and qualifications of members; prohibited activities by members; vacancies.
<a href="#">NRS 281.461</a>	Chairman; meetings; compensation; facilities.
<a href="#">NRS 281.462</a>	Panels: Appointment; members; review and final determination of just and sufficient cause; disqualification of members from participation in further proceedings in matter.
<a href="#">NRS 281.463</a>	Executive director: Appointment; qualifications; classification; prohibited activities and other employment.
<a href="#">NRS 281.4635</a>	Executive director: Duties; employment of staff.
<a href="#">NRS 281.464</a>	Commission counsel: Appointment; qualifications; classification; prohibited activities and other employment.
<a href="#">NRS 281.4645</a>	Commission counsel: Duties; legal advice; appointment of deputy attorney general to perform tasks under certain circumstances.
<a href="#">NRS 281.465</a>	Jurisdiction.
<a href="#">NRS 281.471</a>	Duties of commission; inclusion of annotations of abstracts and opinions of commission in Nevada Revised Statutes.
<a href="#">NRS 281.475</a>	Oaths; written requests and subpoenas for attendance and production of books and papers.
<a href="#">NRS 281.477</a>	Public hearing on request for opinion as to whether person committed act to impede success of political campaign: Request; notice; response; continuance; actions of commission; judicial review of final opinion.

### **Code of Ethical Standards**

- [NRS 281.481](#) General requirements; exceptions.
- [NRS 281.491](#) Additional standards: Representation and counseling of private person before public agency; disclosure required.
- [NRS 281.501](#) Additional standards: Voting by public officers; effect of abstention from voting on quorum; disclosures required of public officers and employees.
- [NRS 281.505](#) Contracts in which public officer or employee has interest prohibited; exceptions.
- [NRS 281.511](#) Rendering of opinions by commission: Requests; determination of just and sufficient cause; notice and hearings; confidentiality.
- [NRS 281.521](#) Questions which advisory opinions may address; guidance on campaign practices prohibited.
- [NRS 281.525](#) Use of false or misleading statement regarding advisory opinion of commission; penalty.
- [NRS 281.541](#) Specialized or local ethics committee: Establishment; functions; confidentiality.
- [NRS 281.551](#) Commission authorized to impose civil penalties; filing by commission of report or proceeding concerning willful violation committed by public officer; circumstance in which violation not deemed willful; effect of code upon criminal law; judicial review; burden of proof.

### **Miscellaneous Provisions**

- [NRS 281.552](#) Acknowledgment of statutory ethical standards: Filing; retention; penalty for willful refusal to file.
- [NRS 281.553](#) Public officer or employee prohibited from accepting or receiving honorarium; "honorarium" defined; penalty.
- [NRS 281.555](#) Purchase of goods or services by local government from member of governing body not unlawful or unethical; conditions.
- [NRS 281.557](#) Governmental grant, contract or lease and certain actions taken in violation of chapter are voidable; prohibited contract is void; recovery of benefit received as result of violation.
- Financial Disclosure Statement
- [NRS 281.561](#) Filing.
- [NRS 281.571](#) Contents; distribution of forms; costs related to production and distribution of forms.
- [NRS 281.573](#) Retention by commission, secretary of state, county clerk and city clerk.
- [NRS 281.575](#) Candidates for public office to receive form and instructions for completion of form.
- [NRS 281.581](#) Civil penalty for failure to disclose: Amount; waiver or reduction; procedure.

## **DISCLOSURE OF IMPROPER GOVERNMENTAL ACTION**

- [NRS 281.611](#) Definitions.
- [NRS 281.621](#) Declaration of public policy.
- [NRS 281.631](#) State or local governmental officer or employee prohibited from using authority or influence to prevent disclosure of improper governmental action by another state or local governmental officer or employee.
- [NRS 281.635](#) Local government authorized to enact ordinance providing greater protection to local governmental officers and employees against reprisal and retaliation.
- [NRS 281.641](#) Reprisal or retaliatory action against state officer or employee who discloses improper governmental action: Written appeal; hearing; order; negative ruling may not be based on identity of persons to whom disclosure was made; rules of procedure.
- [NRS 281.645](#) Reprisal or retaliatory action against local governmental officer or employee who discloses improper governmental action: Procedures for hearing appeals established by ordinance; contents of ordinance.
- [NRS 281.651](#) Use of provisions for harassment prohibited; disciplinary procedures authorized for disclosure of untruthful information.
- [NRS 281.661](#) Summary of provisions to be prepared and made available to state and local governmental officers and employees each year.
- [NRS 281.671](#) Effect of provisions upon criminal law.

Policy Section: Purpose and Organization

Policy Title: **Functions and Activities of the Board**

Date Originated: 12-12-94, Revised: 11-28-00, 11-7-01, 7/17/03, 7/13/05, 7/19/06, 7/12/07

- i. MAJOR PURPOSE: To protect the public's health, safety and welfare through effective regulation of nursing.
  
- ii. FUNCTIONS AND ACTIVITIES:
  1. Establishes minimum standards of nursing practice.
  2. Approves schools of nursing for registered nurse and practical nurse licensure.
  3. Adopts examinations for nurse licensure and nursing assistant certification.
  4. Licenses Registered Nurses and Licensed Practical Nurses, with and without examination.
  5. Certifies Nursing Assistants, Advanced Practitioners of Nursing, Certified Registered Nurse Anesthetists, and Emergency Medical Service/Registered Nurses.
  6. Writes and adopts regulations enabling the Board to administer the provisions of NRS 632.
  7. Appoints members of the Advanced Practice Advisory Committee, the CNA Advisory Committee, the Disability Advisory Committee, the Nursing Practice Advisory Committee, and the Education Advisory Committee.
  8. Develops criteria for approval of, and approves, nursing education programs, nursing assistant training programs, and continuing education providers.
  9. Develops and adopts nursing regulations.
  10. Investigates complaints against licensed nurses and certified nursing assistants.
  11. Carries out disciplinary proceedings against professional nurses, licensed practical nurses and certified nursing assistants.
  12. Keeps records in accordance with the provisions of NRS 239.080..
  13. Publishes, distributes, and provides education on the Nurse Practice Act.
  14. Develops and adopts board policies and procedures.
  15. Administers nondisciplinary alternative program for nurses recovering from chemical dependency.
  16. Researches issues related to regulation and safe practice of nursing.
  17. Collects fees.
  18. Collaborates with consumers, individuals, other agencies, groups and organizations.
  19. Provides education to increase public awareness and understanding of the Board's role and purpose.

Policy Section: Purpose and Organization

Policy Title: **Functions and Activities of the Board**

Date Originated: 12-12-94, Revised: 11-28-00, 11-7-01, 7/17/03, 7/13/05, 7/19/06, 7/12/07

Policy Section: Board Procedures

Policy Title: **Non-discrimination Policy**

Date Originated: 5-7-96, Revised: 5-30-96, 6-4-98, 5-13-99, 5-17-00, 5-10-01, 6-21-02, 7-13-05, 7-19-06,  
7-12-07

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- I. **PURPOSE:** To define the Board's policy related to non-discrimination in the work place.
  
- II. **POLICY STATEMENT:** Pursuant to Title VI of the Civil Rights Act of 1964, 12 U.S.C. 2000d, and implementing regulation, 45 CFR Part 80; Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794, and implementing regulation, 45 CFR Part 84; and the Age Discrimination Act of 1974, 42 U.S.C. 6101 et seq., and implementing regulation, 45 CFR Part 91, the Nevada State Board of Nursing adheres to an equal opportunity/affirmative action policy for all persons and does not discriminate on the basis of race, color, religion, sex, national origin, disability, or age. This applies to all persons employed by the Nevada State Board of Nursing and in the provision of all services, programs and activities including licensure and certification and the regulation of the practice of nursing.

This policy supersedes all other policies on this subject.

## **NEVADA STATE BOARD OF NURSING MEMBER CODE OF ETHICS**

Board of Nursing members shall:

1. Assume personal responsibility to be knowledgeable of and uphold the Nurse Practice Act.
2. Review and make decisions regarding all issues presented to the Board from the perspective that the consumer has the right to receive safe nursing care.
3. Accept responsibility and accountability for majority decisions of the Board and support those decisions to peers and the public, regardless of personal opinion.
4. Not represent the Board unless specifically authorized to do so.
5. Not hold elected or appointed office in a state, regional or national nursing or nursing related organization.
6. Conduct themselves in accordance with the Nevada Ethics In Government Law as set forth in NRS Chapter 281.
7. Promote the cooperative and collaborative position of the Board with other health care disciplines and professional groups.
8. Disqualify themselves from participating and voting on any questions if they determine the issues to have personal, private or professional conflict of interest.
9. Conduct all proceedings in a fair, respectful, equitable manner and without discrimination as to age, gender, sexual orientation, disability, race and/or creed.
10. Adhere to the Board of Nursing statute (NRS 632.405) and policy on confidentiality.
11. Consider nursing issues based on current information, trends, standards, public need, safety and welfare.

Revised & Adopted by the Board:

12/4/85  
1/10/93  
1/13/97  
9/17/98  
7/15/99  
7/19/00  
7/18/01  
7/17/02  
7/23/03  
7/14/04  
7/13/05  
7/19/06  
7/12/07

**TAB 11**





PO Box 34660  
Reno, NV 89533  
Telephone: (775) 747-  
2333

To: Legislative Committee on Health Care  
From: Lisa Black, PhD, RN; Legislative Committee, Nevada Nurses  
Association  
Date: May 6, 2008

EXHIBIT C Health Care Document consists of 4 pages.  
 Entire document provided.  
Due to size limitations, pages \_\_\_ provided. A copy of the complete document is available through the Research Library (775/684-6827) or e-mail [library@lcb.state.nv.us](mailto:library@lcb.state.nv.us). Meeting Date 5/06/08

Madam Chair, thank you for inviting the Nevada Nurses Association (NNA) to present on this very important issue. For the record, I am Dr. Lisa Black, member of the legislative committee of the Nevada Nurses Association. The chair has asked the Nevada Nurses Association to address changes to existing statutory language that might better assist Nevada health care providers to report practices that potentially cause harm to patients. The recent Hepatitis C outbreak linked to unsafe injection practices involving one or more outpatient surgery centers in Southern Nevada underscores the need for strong and effective legal avenues through which nurses and others can act as patient advocates without fear of employment sanctions or workplace retaliation. In short, patients are best served when those caring for them are provided with the legal support to advocate for patient safety without fear of reprisal.

Patient advocacy laws have become commonly known as "whistleblower protections." Whistleblowing is the disclosure of information by an employee who alleges willful misconduct carried out by an individual or a group of individuals within an organization. Increased attention has been given to the concept of whistleblowing for healthcare professionals since the release of the Institute of Medicine's (IOM) report, "To Err is Human." This seminal report found that between 44,000 and 98,000 people die in U.S. hospitals every year and many of these errors are not reported. The IOM recommended that health care facilities develop a "culture of safety" such that their workforce and processes are focused on improving the reliability and safety of patient care. The report further states that safety should be an explicit organizational goal that is demonstrated by strong leadership on the part of clinicians, executives, and governing bodies. Among other things, a culture of safety speaks to issues of job design, safe working conditions, as well as standardization of procedures, equipment, supplies, and processing. A culture of safety also is one in which those charged with protecting patients from harm are able to do so in an environment that supports patient advocacy without fear of reprisal.

Legislatively, whistleblowing is not a new concept. The key component to effective whistleblower legislation is to balance the best interests of the individual, the profession, the patient, the community, and the healthcare facility. Legislation must provide mechanisms to report unsafe practices without reprisal, allow for adequate response time internally, allow for an external process when internal processes fail, and deter false claims. Nurses have an ethical and moral obligation to their profession and their patients to report practices that may harm patients, with the intention of having the condition or error corrected. To date, 18 states have passed some form of whistleblower protection, though each of these state laws have different enforcement mechanisms and levels of recourse for employees who have experienced reprisal for reporting unsafe practices.

The Nevada legislature was convened into an 18th special session in 2002 to consider a medical malpractice crisis that led many insurers to cease writing medical malpractice

policies in Nevada. During the course of this session, patient advocacy language was ultimately amended into NRS 449.205 stating that:

A medical facility shall not retaliate or discriminate unfairly against an employee who in good faith (1) reports to the Board of Medical Examiners information relating to the conduct of a physician that raises a reasonable question regarding the competence of the physician to practice medicine with reasonable skill and safety to patients, (2) reports a sentinel event to the Nevada State Health Division, or (3) participates in an investigation or proceeding conducted by a governmental entity. NRS 449.205 defines retaliation as frequent or undesirable changes in work location, frequent or undesirable transfers or reassignments, issuance of letters of reprimand or admonition, evaluations of poor performance, demotion, reduction in pay, denial of promotion, suspension, dismissal, transfer, or frequent changes in working hours or workdays if such action is taken solely because the employee made a report as previously defined.

While the language added to NRS 449 was an important first step, existing Nevada law is lacking in several ways that limit the ability of nurses to advocate for the safety of our patients. Specifically, the existing statute addresses only reports to the Board of Medical Examiners, reporting of sentinel events, and cooperation with governmental investigations. Many situations exist in which a nurse or health care worker may need to report unsafe practices that are not addressed in existing law. The Nevada Nurses Association suggests that existing law be strengthened to provide statutory protections for nurses who:

- Report concerns about patient(s) being exposed to substantial risk of harm due to failure of a facility or practitioner to conform to minimum professional standards or regulatory/accreditation standards.
- Are requested to engage in conduct that would violate the nurse's duty to protect patients from actual or potential harm as defined by NRS and NAC Chapters 632.
- Refuse to engage in conduct that would violate Chapters 632 of NRS/NAC or that would make the nurse reportable to Nevada State Board of Nursing.
- Report the actions of another nurse who engages in conduct subject to mandatory reporting to the Nevada State Board of Nursing as defined by NRS/NAC 632.
- Report staffing concerns or situations that reasonably could contribute to patient harm.

In all of these cases, it is important to note that the law must address reporting both internally within a facility, or externally to legal, governmental, and/or legislative bodies.

Legislative language that protects nurses who report unsafe healthcare practices must also include an enforcement mechanism that provides clear and direct recourse to those who experience workplace sanctions after having reported an unsafe healthcare practice. This is an area where existing statutory language must be strengthened. The original 2002 proposal that added reporting protections to Nevada law included an enforcement mechanism that was deleted in a subsequent revision to the bill. Current law states that a nurse or other employee who believes that s/he has been retaliated or discriminated against may file an action in a court of competent jurisdiction for such relief as may be appropriate.

The Nevada Nurses Association recommends strengthening this section to provide clear, direct, and automatic recourse that would authorize civil action to include at least double compensation for damages resulting from lost wages, compensation for legal representation, and additional punitive damages as may be appropriate under law with a minimum monetary recovery specified in statute.

The Nevada Nurses Association also recommends the addition of legislative language that creates a presumption that any disciplinary action taken against a nurse within 60 days of that nurse reporting conduct specified above was taken in retaliation against the nurse's having made such a report. In the event that the nurse has engaged in other activity that would normally make that nurse subject to disciplinary action unrelated to having reported a patient care concern, the facility would then bear the burden of proof that disciplinary action was independent of the nurse having reported a patient safety concern.

We appreciate the opportunity to propose legislative changes that would better provide nurses the legal support to advocate for patient safety without fear of workplace reprisal. The Nevada Nurses Association looks forward to continuing to work with this legislative body and with the many key stakeholders on this issue to ensure that patients in Nevada receive safe and effective nursing care. I would be glad to address questions from the committee.

## Nevada Revised Statutes - Chapter 449

### **NRS 449.205 Medical facility prohibited from retaliating or discriminating against certain persons for reporting or participating in investigation or proceeding relating to sentinel event or certain conduct of physician or reporting or refusing to provide nursing services beyond his competence; restriction of right prohibited.**

1. A medical facility or any agent or employee thereof shall not retaliate or discriminate unfairly against:

(a) An employee of the medical facility or a person acting on behalf of the employee who in good faith:

(1) Reports to the Board of Medical Examiners or the State Board of Osteopathic Medicine, as applicable, information relating to the conduct of a physician which may constitute grounds for initiating disciplinary action against the physician or which otherwise raises a reasonable question regarding the competence of the physician to practice medicine with reasonable skill and safety to patients;

(2) Reports a sentinel event to the Health Division pursuant to NRS 439.835; or

(3) Cooperates or otherwise participates in an investigation or proceeding conducted by the Board of Medical Examiners, the State Board of Osteopathic Medicine or another governmental entity relating to conduct described in subparagraph (1) or (2).

(b) A registered nurse, licensed practical nurse or nursing assistant who is employed by or contracts to provide nursing services for the medical facility and who, in accordance with the policy, if any, established by the medical facility:

(1) Reports to his immediate supervisor, in writing, that he does not possess the knowledge, skill or experience to comply with an assignment to provide nursing services to a patient; and

(2) Refuses to provide to a patient nursing services for which, as verified by documentation in the personnel file of the registered nurse, licensed practical nurse or nursing assistant concerning his competence to provide various nursing services, he does not possess the knowledge, skill or experience to comply with the assignment to provide nursing services to the patient, unless such refusal constitutes unprofessional conduct as set forth in chapter 632 of NRS or any regulations adopted pursuant thereto.

2. A medical facility or any agent or employee thereof shall not retaliate or discriminate unfairly against an employee of the medical facility or a registered nurse, licensed practical nurse or nursing assistant who is employed by or contracts to provide nursing services for the medical facility because the employee, registered nurse, licensed practical nurse or nursing assistant has taken an action described in subsection 1.

3. A medical facility or any agent or employee thereof shall not prohibit, restrict or attempt to prohibit or restrict by contract, policy, procedure or any other manner the right of an employee of the medical facility or a registered nurse, licensed practical nurse or nursing assistant who is employed by or contracts to provide nursing services for the medical facility to take an action described in subsection 1.

4. As used in this section:

(a) "Physician" means a person licensed to practice medicine pursuant to chapter 630 or 633 of NRS.

(b) "Retaliate or discriminate":

(1) Includes, without limitation, the following action if such action is taken solely because the employee or the registered nurse, licensed practical nurse or nursing assistant took an action described in subsection 1:

(I) Frequent or undesirable changes in the location where the employee works;

(II) Frequent or undesirable transfers or reassignments;

(III) The issuance of letters of reprimand, letters of admonition or evaluations of poor performance;

(IV) A demotion;

(V) A reduction in pay;

(VI) The denial of a promotion;

(VII) A suspension;

(VIII) A dismissal;

(IX) A transfer; or

(X) Frequent changes in working hours or workdays.

(2) Does not include action described in sub-subparagraphs (I) to (X), inclusive, of subparagraph (1) if the action is taken in the normal course of employment or as a form of discipline.

**NRS 449.207 Retaliation or discrimination in violation of NRS 449.205: Legal remedy.** An employee of a medical facility or a registered nurse, licensed practical nurse or nursing assistant who is employed by or contracts to provide nursing services for the medical facility who believes that he has been retaliated or discriminated against in violation of NRS 449.205 may file an action in a court of competent jurisdiction for such relief as may be appropriate under the law.

**TAB 12**



**REPORT OF THE SUBCOMMITTEE OF THE LEGISLATIVE  
COMMITTEE ON HEALTH CARE TO REVIEW THE LAWS AND  
REGULATIONS GOVERNING PROVIDERS OF HEALTH CARE, THE  
USE OF LASERS AND INTENSE PULSED LIGHT THERAPY, AND THE  
USE OF INJECTIONS OF COSMETIC SUBSTANCES**

**Senate Bill 4 (Chapter 4, *Statutes of Nevada 2007, 23<sup>rd</sup> Special Session*)**

**Presented to the Legislative Committee on Health Care  
June 17, 2008**

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Senate Bill 4 of the 23<sup>rd</sup> Special Session required the Legislative Committee on Health Care to consider studying two issues during the interim: the regulation of health care providers and the regulation of the use of lasers, intense pulsed light therapy, and injections of cosmetic substances. During the November 27, 2007, meeting of the Legislative Committee on Health Care, Assemblywoman Sheila Leslie, Chair, appointed the Subcommittee.

**MEMBERS**

Senator Maggie Carlton, Chair  
Senator Joseph J. Heck  
Assemblywoman Susan I. Gerhardt  
Assemblyman Joe Hardy (Substitute for Senator Heck in case of absence)

**MEETINGS**

The Subcommittee met three times. The first meeting was held in Las Vegas, Nevada, on January 10, 2008; the second in Las Vegas on May 2, 2008; and the third in Las Vegas on June 3, 2008. All three meetings were broadcast live on the Internet and videoconferenced between the Grant Sawyer State Office Building in Las Vegas and the Legislative Building in Carson City.

**ACTIVITIES**

The Subcommittee spent the first two meetings considering a variety of issues related to health care providers, followed by a work session at the beginning of the final meeting. During the final meeting, the members were provided with testimony regarding the regulation of the use of lasers, intense pulsed light therapy, and injections of cosmetic substances. Following are brief summaries of the Subcommittee's activities at each of the three meetings. For more

complete information, please refer to the minutes and exhibits of the meetings, available at [www.leg.state.nv.us](http://www.leg.state.nv.us).

***Meeting 1: January 10, 2008***

The first meeting of the Subcommittee began with an overview of the Subcommittee's activities and responsibilities. The Subcommittee also heard the following testimony:

- Presentation from Kelly S. Gregory, Senior Research Analyst, Research Division, regarding research on the number of health care providers in Nevada and comparative statistics for other states. The Subcommittee also received an overview of the different types of licenses, certificates, and other kinds of professional recognition the boards are currently authorized to grant.

At the end of the meeting, the Chair directed staff to work with the members to create a survey questionnaire to be sent to each of the boards regulating health care professionals to obtain data on their policies and procedures, with the goal of identifying possible barriers to entry in the various professions.

***Meeting 2: May 2, 2008***

The second meeting of the Subcommittee included a review of the results obtained in the survey questionnaires, as well as an update from several of the boards on additional questions the original surveys had generated. The Subcommittee also heard the following testimony:

- Presentation by Lynn O'Mara, Health Planning Program Manager, Bureau of Health Planning and Statistics, Health Division, Department of Health and Human Services, regarding the Primary Care Advisory Council and the J-1 Physician Visa Waiver Program.

***Meeting 3: June 3, 2008***

The third meeting of the Subcommittee included a work session and testimony on the use of lasers, intense pulsed light therapies, and injections of cosmetic substances.

- Presentations that examined the medical spa industry and training and experience of professionals working in those settings were provided by Susan L. Fisher, Lobbyist, Associated Aestheticians of Southern Nevada; Courtney Hernandez, medical assistant and medical spa employee; Cristy Thomas, advanced practitioner of nursing and medical spa employee; and Louis Silberman, President, National Laser Institute.

- A presentation that examined the role for policy makers in addressing these problems and situations the medical profession is being confronted with was given by Cindy L. Lamerson, M.D., Member, Nevada's Board of Medical Examiners.

## RECOMMENDATIONS

During the Subcommittee's final meeting on June 3, 2008, the members conducted a work session and voted to forward certain recommendations to the Legislative Committee on Health Care for consideration. The Subcommittee recommends that the Legislative Committee on Health Care take the following actions:

- 1. Request the drafting of a bill to modify the requirement that an applicant for a license to practice medicine must prove to the Board of Medical Examiners he is a citizen or lawfully entitled to remain and work in the United States by creating an exemption for applicants in the J-1 Physician Visa Waiver Program. Also direct the Board of Medical Examiners, the State Board of Osteopathic Medicine and the State Board of Nursing to regularly survey licensees to obtain details about locations and areas of practice in order to provide information to support programs to obtain more practitioners.**

Background:

Dr. Carl Heard, Chief Medical Officer, Nevada Health Centers, provided testimony during the May 2 Subcommittee meeting regarding the difficult position J-1 visa applicants were put in because of the requirement in Section 630.160 of the *Nevada Revised Statutes* (NRS) that all applicants be citizens or lawfully entitled to remain and work in the United States. Dr. Heard testified that because the visa application and licensing application run concurrently, the requirement complicates the visa process and adds an additional hurdle to obtain licensure. Dr. Heard also told the Subcommittee that Nevada is only one of two states with this requirement.

During the discussion of the J-1 visa program, Lynn O'Mara of the Health Division and Caroline Ford, Assistant Dean/Director, Center for Education and Health Services Outreach, University of Nevada School of Medicine, came forward with a proposal related to the difficulty their respective programs had in obtaining data on the health care workforce in Nevada. The Subcommittee discussed possible ways to address this problem, and considered suggestions from Ms. O'Mara and Ms. Ford. The Subcommittee decided to recommend that the boards regulating physicians and nurses be directed to obtain this data from licensees.

- 2. Request the drafting of a bill to allow physicians who have recently completed a residency program to be provisionally licensed upon receipt of satisfactory fingerprint reports, pending completion of the remainder of the board application process, and**



**allow physicians who have recently completed a residency program to be provisionally licensed pending completion of certain examinations and/or board certifications.**

Background:

These two recommendations were made by Assemblyman Hardy as a way to create a fast-track program for resident physicians already working in Nevada facilities. The first recommendation allows physicians who have recently completed a residency program to continue practicing during the application process, which will help ensure the applicant can be continuously employed here in Nevada.

The second recommendation pertains to physicians who have completed a residency but may not yet have passed board certification or other types of examinations. The Subcommittee felt that an alternate path should be created allowing these physicians to practice pending completion of the examinations within a certain timeframe. Upon further discussion, the Subcommittee also felt that it may be prudent for the Committee to discuss the elimination of the board certification requirement for physicians. The Subcommittee members felt this requirement may not be adding to the quality of physicians practicing in Nevada and may be impeding the recruitment of new physicians.

- 3. Request the drafting of a bill to create provisions to make it easier for professionals licensed in other states to become licensed in Nevada if certain criteria are met. (See Exhibit A, attached.)**

Background:

This recommendation was made by Senator Carlton, based on language created over the past several sessions that utilizes a credentialing concept for licensing. The recommendation is intended to address the problem of shortages in the various health care professions by encouraging practitioners from other states to move their practices to Nevada.

- 4. Request the drafting of a bill to specify that supervision of physician assistants can be done through telecommunications and remote file review.**

Background:

Dr. Carl Heard approached the Subcommittee during the May 2 meeting and recommended that the regulations pertaining to supervision of physician assistants be modified. He indicated that it was difficult for physicians supervising physician assistants in the rural areas to meet the requirements for reviewing files and visiting the practice location of a physician assistant in person. He suggested that the Legislature specify that supervision of a physician assistant could be done from a remote location via videoconference or teleconference and electronic review of patient files. Supervision of physician assistants is

currently regulated by the Board of Medical Examiners in Chapter 630 of the *Nevada Administrative Code*.

**5. Request the drafting of a bill to allow boards to hire counsel outside the Office of the Attorney General where appropriate.**

Background:

Rosalind Tuana, Executive Director of the Board of Examiners for Social Workers, recommended that the boards be provided with the authority to hire counsel outside the Office of the Attorney General. Ms. Tuana indicated this would allow the boards to save money on attorneys' fees.

**6. Request the drafting of a bill to provide boards with the authority to investigate and refer unlawful professional practice to authorities for penalties.**

Background:

Ms. Tuana also submitted this recommendation to the Subcommittee. Ms. Tuana indicated that the Board of Examiners for Social Workers, along with several other boards, did not have the authority to investigate unlawful professional practice and therefore the board could not take any action against persons acting as a social worker without a license. The Subcommittee recommends that legislation be drafted to provide all the boards with the appropriate authority. Suggested language from the chapter relating to the State Contractors' Board was discussed as possible model language for the boards regulating health care providers.

## ISSUES OF CONCERN

In addition to the recommendations listed above, at the final meeting members heard testimony on a number of issues that they believe warrant reporting to the Legislative Committee on Health Care for further discussion relating to the use of lasers, intense pulsed light therapy, and injections of cosmetic substances. Some of the issues of concern brought forward by those testifying before the Subcommittee follow.

1. There is no current consensus on appropriate level of regulation for the use of these devices and therapies. According to information received by the Subcommittee, many states have taken action to regulate the following areas:
  - a. Delegation of authority and supervision of non-physician personnel, including a determination of which procedures constitute the practice of medicine;
  - b. Definition of various types of treatments, personnel, and facilities;
  - c. Educational requirements for users;

- d. Equipment safety standards; and
  - e. Mandatory injury reporting.
2. It appears that professionals with licenses and certificates in various professions (such as medical assistants, nurses, and aestheticians) may provide similar client services or patient care without being appropriately licensed. Because no regulation exists, these roles are currently undefined and treatment facilities and insurance companies are taking the lead in structuring the training required and scope of work or practice for these professionals.
  3. The use of the terms “medical spa,” “medical aesthetician,” and “medical advisor” as it relates to a physician supervising the activities of the professionals in a facility may be misleading to consumers, as no formal definition currently exists for any of these frequently-used terms.

## CONCEPTUAL LANGUAGE REGARDING CREDENTIALING

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**Explanatory Note:** The following statutory language, with technical modifications as needed, may be added to a chapter governing a health care profession to provide an additional method for obtaining a license to practice the profession.

**Section 1. 1. *Notwithstanding any other provision of this chapter to the contrary, the Board shall issue a license to practice [INSERT field of practice, e.g., “dentistry”] to a person who:***

***(a) Has a license to practice [INSERT field of practice, e.g., “dentistry”] issued pursuant to the laws of another state or territory of the United States or the District of Columbia;***

***(b) Has practiced [INSERT field of practice, e.g., “dentistry”] pursuant to the laws of another state or territory of the United States or the District of Columbia for a minimum of 5 years;***

***(c) Has not had his license to practice [INSERT field of practice, e.g., “dentistry”] revoked or suspended in this State, another state or territory of the United States or the District of Columbia;***

***(d) Has not been refused a license to practice [INSERT field of practice, e.g., “dentistry”] in this State, another state or territory of the United States or the District of Columbia;***

***(e) Is not involved in and does not have pending a disciplinary action concerning his license to practice [INSERT field of practice, e.g., “dentistry”] in this State, another state or territory of the United States or the District of Columbia;***

***(f) Pays the application and renewal fees set forth in [INSERT internal reference to applicable statute(s) containing fees, e.g., NRS 631.345] in the same manner as a person licensed pursuant to [INSERT internal reference to an applicable existing licensing statute, e.g., NRS 631.240];***

***(g) Submits the statement required by [INSERT internal reference to an applicable statute regarding child support statements, e.g., NRS 631.225]; and***

***(h) Submits a complete set of his fingerprints and written permission authorizing the Board to forward the fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for its report.***

***2. The provisions of this section do not limit a person from obtaining a license to practice [INSERT field of practice, e.g., “dentistry”] pursuant to any other provision of law.***