The meeting was called to order at 1:30 p.m. in Room 213. Senator Thomas R.C. Wilson was in the Chair.

PRESENT: Senator Thomas R.C. Wilson, Chairman
Senator Richard E. Blakemore, Vice Chairman
Senator Don Ashworth
Senator Clifford E. McCorkle
Senator Melvin D. Close
Senator William H. Hernstadt

ABSENT: Senator C. Clifton Young
Senator Richard E. Blakemore (part of meeting)
Senator William H. Hernstadt (part of meeting)

OTHERS PRESENT: See attached guest list (Exhibit A).

SB 275 Requires Nevada industrial commission and the rehabilitation division of the department of human resources to conclude certain annual agreements.

Del Frost, Administrator, Nevada Rehabilitation Division, testified that he supports Senate Bill 275, presented documents for the Committee's consideration (see Exhibits B and C).

(Following is testimony on Senate Bill 275.)

Del Frost: It took eight pages to describe to you the period of time since 1973; the action that's taken place before these agencies and our attempt to work out some way of getting an agreement whereby we could use, on the purchase of service basis, the facilities and services of the Nevada Industrial Commission; specifically, as it culminated in the development and opening of the Jean Hanna Clark Rehabilitation Center in Southern Nevada.

The second document is a one page item that is a response to questions asked of us by various legislators regarding this particular type of legislation. Very briefly, in 1973, the Legislature adopted NRS 616.233 which allows NIC to utilize the resources of the Rehabilitation Division (of the Department of Human Resources). It outlined that there be a payment of benefits for services received by NIC clients that are served by the Rehabilitation Division.

The statute has not been changed. It was a very one-sided statute in that it allows NIC to refer clients to us (Rehab) for us to serve. It allowed them to use employee benefits to pay back to us into our fund for services; but none of those payments have ever been made. We have served clients from NIC, but have not charged for those services.

We, in turn, over a period of time attempted to get NIC to agree that when the Jean Hanna Clark Center was opened, that we would be allowed to purchase services through that center which would

(Del Frost testimony continued)

be available for non-industrially injured rehabilitation clients. It is our intent to pay for those services. It was never intended to ask NIC to make available to non-industrial or persons in the community, services that they (NIC) would pay for. We intend to pay for the services on a purchase of service basis.

In looking through the document, you'll find that it alludes to certain types of evidence that indicate that verbal agreements have been made over the years. Intent between the two agencies has been spelled out at various public meetings and other ways, that the Rehabilitation Division would be allowed to purchase services through the NIC Jean Hanna Clark Rehabilitation Center up to the types of services and the number of service slots not being used by industrially-injured clients.

It has always been the intent that the Rehabilitation Division would be able to refer into that Center non-industrially injured persons, pay for the services received; but not to fill one slot needed by an industrially-injured person. Only slots that were not being filled because the Center had the capacity to serve more than the industrially-injured people required; it is only good business.

In Southern Nevada alone in 1978 the Rehabilitation Division spent $86,996 on 1,247 persons for diagnostics and evaluations. These services could have been purchased at the NIC Center. During the same period of time, the Rehabilitation Division spent $200,000 statewide for 2,590 clients needing the same kind of services provided at the NIC Center. The NIC Center is a statewide center; and restoration services are available there.

Senator Don Ashworth: Does that mean that you could have spent those monies with NIC; that the facility was available, not being used in other areas; or those are just dollars that were spent and we don't know whether or not they could have been covered by NIC?

Mr. Frost: Those dollars could have been spent with NIC.

Senator Don Ashworth: I understand that; but my question relates to capacity. Did they have the capacity then to fill that need without going outside like they were doing?

Mr. Frost: Well, the center opened about a year ago, I guess, and would probably not have been capable of serving that many people in that time. We are saying that it is (capable) now.

Senator Don Ashworth: So your testimony is that you spent the dollars that could have been spent with NIC.

Mr. Frost: We spent it with other resources, out-of-state and in-state. We could now spend those same dollars with NIC, and they in turn could recoup their operating costs through selling those services to us.

Senator Don Ashworth: The question I have though, is do they have the facility to be able to do that without overloading?

Mr. Frost: Their facility will serve 250 people and they're presently serving, according to their estimates to us, 110 per day. So we're saying that the capacity is there. We're also saying that we, at no time, intend to demand that they allow us to purchase service or fill slots that could be filled by an industrially-injured person; only to take up their surplus. We want to buy their surplus and pay them back for it. The Center opened in May or June 1978.

Senator McCorkle: Why doesn't it say in here that the NIC has priority?

Mr. Frost: It's NIC's law and it relates to their program; it only related to them referring to us, it does not allow us to refer back to them. We want to change that law so that we can refer back to them and purchase their services.

Senator McCorkle: If you're going to change the law, why can't you put in a first priority for them?

Mr. Frost: We would have no objection to that. That's the intent.

Senator Don Ashworth: That's the testimony. If the facilities are there, and Rehabilitation Division can't buy them, they have to somewhere else. As long as it's there and not being used, they have a right to purchase the services.

Mr. Frost: It could be handled administratively. The problem we have had administratively is that we've tried for years to get an adequate cooperative agreement between the two agencies that would allow us to refer non-industrially-injured persons. We're still locked in to where they will only let us refer industrially-injured and we don't handle industrially-injured, except on referral from them (NIC), so it's a "Catch 22".

Senator Close: Is there any savings in using the NIC facility, for example, your first paragraph where you spent $86,996.84 on 1,247 people for diagnostics and evaluations to an outside agency. If you went to the NIC to save money, would you have saved money or spent more money or would it have been the same?

Mr. Frost: It could be the same amount of money unless you look at the second page of the bill, on line 18, that the services would be based on medicaid rates.

Senator Close: Was that the rate which reimbursed NIC for their cost of providing services?

Mr. Frost: Yes.

Senator Close: What if that is not sufficient to reimburse NIC for their expenditures?

Mr. Frost: We would have no problem with trying to work out a more agreeable fee schedule. The problem we have at this time though, administratively, we've been unable to do that between the two agencies.

Senator Close: Since the bill has been introduced, have you talked with them, to see what type of a fee schedule would be acceptable?

Mr. Frost: Yes sir. That eight-page document will tell you that we've exhausted many hours and many efforts to try to reach some kind of administrative agreement, and we've failed.

Senator Close: If it's going to cost the same amount of money to go through the NIC as it does to go through a private supplier, where is the benefit for you to go through NIC?

Mr. Frost: The benefit to us is that it is one of the most comprehensive rehabilitation centers in the state. There is no other center like it that compares to what they've done. They deserve a lot of credit for developing a fantastic resource in the state. The range of services available--we could refer a person in there and get the full range of rehabilitation services that are needed, depending on what the doctor says they need. We send people out of state, and it's going to cost us more, their board, transportation, attendants, etc. By doing it in Nevada, we have family support and other support systems that save money.

Senator Hernstadt: Why do you provide the service to NIC and not charge them?

Mr. Frost: The kind of agreement we have with them is that we will provide those services that do not relate to the industrial injury. For example, if a person falls off a scaffolding and breaks their back and NIC is treating them, NIC's objective is to get them back to work as quickly as possible, regardless of the type of work that they put them back to. They may put a person back to a radio dispatcher job in a wheelchair, let's say, making $500 a month when the person was making $20,000 a year.

We may be able to provide some supportive services in there to teach the person a new trade that would get him back into an occupation where he could earn a salary more comparable to what he was earning before, to meet the kind of demands that their family has, adding to the longevity of the rehabilitation program; so they don't come back into the program later. If NIC gets them into that radio dispatcher job, we're off their rolls, but they may say 'come back to us later and we'll spend more public funds on them later on down the road.' We might as well do it now and add to it to make a better rehabilitation program.

Senator Hernstadt: Did NIC give you any reason why they were so uncooperative about working out a possible relationship for the use of that facility?

Mr. Frost: At the risk of providing testimony for John Reiser, I can tell you what John Reiser has said to me. That is that his advisory committee is adamantly opposed to our using that center and that's their policy; and he's going to follow the advice of that committee.

Senator Hernstadt: Isn't it their pet and they really want to have sole control over it?

Mr. Frost: That's my personal opinion. I wouldn't want to say it any stronger than that.

Chairman Wilson: Ancillary to the first question; have you any handle on how much rehabilitation service you provide to ones who have been industrially injured, who have been returned to a type of work that would have earned less than he had before, and how much was expended in rehabilitation services trying to increase his earning capacity after he was off the NIC rolls.

Mr. Frost: Yes sir. We have so very few of their people on a referral basis because they set up their own rehabilitation division and provide most of the services themselves; and there tends to be some rivalry between the two agencies. The figure we have for last year is that we spent, roughly, $60,000 of funds on their clients; there were twenty-seven of their clients that we served; and these same services would have been available at their Center.

Chairman Wilson: Do you get their clients, even though it's not pursuant to referral by them; that is, they rehabilitate an industrially-injured workman; he goes through their rehabilitation program, he is returned to work and off their rolls. Did you get him on a non-referral basis?

Jane Douglas, Program Evaluator, Nevada Rehabilitation Division

Ms. Douglas: No, we actually are receiving considerably more than our computer identified. It identified 206 NIC clients. However, they come in on their own; they are still on NIC.

Chairman Wilson: That's what I am asking. You might not have a direct referral by them for rehabilitation work. My question is, do you have a lot of people come in after they have completed NIC rehabilitation for further rehabilitation by your division? It's not a referral basis, they just show up on your doorstep.

Mr. Frost: We do get them from other sources, and many times coming from those other sources and also NIC. The sample I gave you on the $59,000, was only a sample. The exact number I can't say right now, except that we did identify 206 clients in the last sixteen months that were shared by the two agencies. There are

(Del Frost testimony continued)

many more that we haven't been able to identify, who came to us from other sources; but are also either past NIC clients, or others.

Senator McCorkle: It appears that you're just trying to buy two or three years' worth of time until they run out. What are you going to do then?

Mr. Frost: Hopefully, the state will develop to the point where other facilities' resources can be developed in the community. It's my opinion, that with the mood of the whole legislative process right now, we're not in a position to recommend to you that we spend the kind of money that NIC spent to develop a similar kind of facility, like Washoe or Clark County. The state, at the same time, hasn't the population to warrant such an expenditure.

So what we're doing is just buying time, and trying to buy available resources that we can use; and down the road we'll deal with that as we can. John Reiser has expressed an interest in going with us to try to work with Washoe or Clark in developing such a facility. But that's folly in that we don't have any more federal money to pump in there. And unless we've got federal money to pump into those hospitals, they're not going to come up with the kind of resources that we need. They shouldn't be expected to.

Senator McCorkle: The old language being taken out says that "within the limits of the money so made available to the rehabilitation division", obviously there's a monetary limitation given to you there. The new language says "each agency shall provide services to clients of a referring agency at cost which does not exceed current rates for payment of state aid to the medically indigent. Where such aid is not payable, services must be provided without cost to the referring agency." If I'm interpreting that right, you're going from a limited availability of monies to a carte blanche policy. Am I misreading that?

(Jane Douglas, Program Evaluator, Rehabilitation Division)

Ms. Douglas: First of all, in the old law as Mr. Frost mentioned, it was a one-sided thing; and there is somewhere provided in here to the extent that the disabled employee agrees to turn over his benefits to our rehabilitation division, then we could provide the services. What we're looking for is a two-way street; so that we can also serve their clients where possible (which we have been doing) and be reimbursed.

Senator McCorkle: Whatever the cost? That's the way it works now?

Mr. Frost: We're not being reimbursed. We're serving their clients, but they are not serving ours.

Senator McCorkle: How do you account for that?

Mr. Frost: That's the way the law was written - allowing them to refer to us; and under our federal laws and regulations, we have to serve handicapped, physically and mentally, people. So we're allowed under the law to serve their clients. What we do is require them to pay for everything that they (NIC) should be required to pay for under their program, and we'll pick up the attendant costs that support that kind of rehabilitation program if it's going to lead to the longevity of service that we ought to have. We're saying now that we're doing that; we just want the law to allow us to turn around and buy services from them for our clients. That's all this bill intends to do.

Senator Don Ashworth: Mr. Chairman, for all intents and purposes, they aren't buying services from you either; they are to a certain degree - people over and above that to help in rehabilitation, to maybe a greater degree as far as the proficiency of this individual being able to do other work and other means past what you just talked about; and they pay you nothing for that because that's outside the scope of the NIC. Once they're made so that they're productive as far as being able to produce, whether it's $200 or $400, then they basically can fulfill their obligation. What you are saying is that you want to increase them up to the scope closest to the job, amenable with the job they had prior to the time of injury.

Mr. Frost: That is true.

Senator Hernstadt: Del, this exhibit you gave us has some numbers saying how much you spent, I presume the total. Presumably a substantial portion of it, this dollar amount that was spent at the NIC rehabilitation Center. Isn't that correct? Would those funds indirectly result in lower charges to employers, because then the underused facility would have been less underused?

Mr. Frost: I really don't have an answer to that. NIC would have to answer that question. I can tell this though; it just makes business sense that if you've got a facility that is constructed and equipped to handle 250 people a day, and you're only handling 110 a day, it's sure going to save you money if you operate at peak capacity. It proves out, and if we, in turn then, send 50 people a day to that facility; have it reach capacity, and pay them for that service, then the're recouping that cost that they're paying for the ongoing operation anyway.

Senator Hernstadt: In other words, they're fully staffed now for 250 people and the employees are just sitting there reading magazines or doing something else.

Mr. Frost: No, NIC indicates that they're still trying to acquire two other physiatrists, and having trouble recruiting them.

Senator Hernstadt: What's a physiatrist?

Mr. Frost: A doctor of physical medicine, working with physical therapy.

Senator Hernstadt: So they're short two doctors; but do they have anything else?

Mr. Frost: Well, the whole facility is open and operating and most of the staff are there; they're short two doctors but it's been difficult for us to get accurate information on that. They control the information, of course. They claim that they are staffed to handle 110; we are maintaining that isn't possible - if your facility is constructed, equipped, and designed to handle 250 a day, you've got to be able to handle somewhere between 110 and 250 if you're staffed up at all.

Senator Don Ashworth: Going along that line, an answer to Senator Hernstadt's question; whether or not they're staffed up to 250 or not really makes a question on part of it; because you've got to have fixed costs there which is the hard plant, that's got to amortized over how many people use it. I can see where if they brought in another 160, they're going to have to hire more people to take care of, that only sounds reasonable to me, I can't imagine, they've got ten or twenty people who sit there and do nothing all day. But they do have a fixed cost that has to be amortized, and that's the problem I think we're missing out, that large fixed capital cost that's there that's not being amortized over a 250 patient base as opposed to 110 or whatever else you've got.

Mr. Frost: That's right. If I have a rehabilitation counselor whose work load has been established at 200 cases per year, it's going to cost me the same for that rehabilitation counselor if they're handling 100, as it is if they're handling 200.

Senator Don Ashworth: And on the other side, when you add a fixed cost of that, of the equipment and eveything, then your costs go way up; but if you've already got those fixed costs, those could be covered. Then, you minimize the expense to everyone.

Mr. Frost: That's right, that's the heart of our testimony.

Chairman Wilson out for testimony in another hearing.
Senator Blakemore out, ill.
Senator Close in the Chair.

Senator McCorkle:

Would you be able to draw us an amendment giving this priority of use to NIC? I can see some problems mechanically, if you're using twenty-five percent of the capacity; and at that point you exceed capacity for the whole facility, what do they do then - kick all your people out? Do they wait until the rehabilitation period is over, or do they throw them out on the street halfway through, or how does that work?

Mr. Frost: We don't really need an amendment of that type, in my opinion; in that they have full control all the time, it's their

(Del Frost testimony continued)

facility. We can't get in there now. If you pass this law, all that it does is to allow us to purchase services, they have the hammer. All they have to say is "we're not taking any more referrals, we're full".

Senator McCorkle: Couldn't someone be a cripple, and their recovery unfinished?

Mr. Frost: The average stay, as I recall, is just a matter of weeks in that facility - two to six weeks or something, so it's not likely you're going to throw somebody out. The intake of people, the turnover is such that you would be able to work that out. I just can't imagine a time when you'd be up to 249 beds full, and a 250th person as a Rehabilitation Division client who gets in there; and they don't have room for the next industrially-injured person because somebody's coming out, and making room on an ongoing basis. It really is not a necessary part of the law. They've got all the control that they could possibly have. It's their facility.

All the law does is allow us, and require them, to enter into that agreement with us. Right now we can't get them to do it. Even though Governor O'Callaghan, in his dedication ceremony address, went out on point, and said that that facility would be available for other handicapped people. In spite of the fact that Governor O'Callaghan insisted on signing the cooperative agreement, the intent that was there has not been followed. The rationale that's been given to us by NIC, is that the law as it's presently worded, doesn't allow it. We're simply trying to correct that. We would have no problem with amending the fee schedule so long as we protect ourselves, because they could very easily hit us with a fee schedule that would make it prohibitive, and we couldn't use it anyway. That's what we've got to protect ourselves against.

Senator Close: Further questions? Thank you very much.

(Richard A. Petty, M.D., Medical Advisor, Nevada Industrial Commission)

Dr. Petty: I've been in the State of Nevada since 1941 in the general practice of medicine in the Carson City area. As a result of being in proximity to various state agencies, I was asked to consult with the Rehabilitation Division in 1947, and have been on their consulting panel until 1972. In 1962, I was asked to consult as a part-time medical advisor to NIC and am still functioning in that capacity. This past year I spent the bulk of each week at the rehab center as acting medical director. I had a prepared presentation here; but after hearing Mr. Frost, I feel that there should be a certain amount of rebuttal. To my recollection, I haven't seen Mr. Frost at the rehab center at any time, and he's advising you how the center should be run.

Senator Hernstadt: Excuse me, are you with NIC?

Dr. Petty: I'm with NIC, yes.

Senator Hernstadt: You are. Mr. Chairman, I would request that any testimony by NIC persons be sworn in.

Senator Close: That's not necessary. I think that Dr. Petty, whom I've known for some time, will not give any false information. I see no reason to swear him in, any more than anybody else should be sworn in.

Senator Hernstadt: Well, from experience, I think I would like to hear sworn testimony, or I don't care to participate in listening to it.

Senator Close: If you leave, you take away our quorum, so I suggest that you don't leave.

(Senator Hernstadt left the room as this point.)

Senator Close called a five-minute recess.

The meeting reconvened at 2:30 p.m. with Senator Hernstadt present.

Dr. Petty: I endorse Del Frost's program 100 percent. What I object to in SB 275 is an attempt to marry the rehabilitation center services of two agencies. One is supported by management and free enterprise dollars; and the other by federal and state tax dollars.

I feel that it's unfair to the employer who is asked to essentially be double taxed. Strictly from a medical point of view, Mr. Frost said we have 110 or 120 patients, with capabilities of handling 250 to 300. That's true. That's our physical plant. The treatment and function of any facility depends upon its staff and that is the limiting factor as fara as taking any more patients as far as the rehabilitation center is concerned. We do not have a full complement of staff; and we're operating at maximum load at this time.

If we wanted to do anything to solve this question, I would prefer to have a cooperative common-law marriage rather than a legal marriage, as Mr. Frost wants.

Senator Don Ashworth: Nevada doesn't recognize common-law marriages. May I interrupt for just a moment? Along the same line of the question that I asked Mr. Frost, basically if we've got them, and I understand your concern, I have it also in regard to the facilities being built with private dollars for all intents and purposes. We've got a fixed investment there, a beautiful facility, and the only thing we're talking about fluctuating is the variable factor; which is the salary of the individuals that come in to take care of 250 as opposed to 110; that's the variable factor. The other is fixed. Don't we for all intents and purposes, if they're willing to pay hard dollars for those services, that are being increased, don't we really cut the bill back to the employer that paid, for the simple reason, now the dollar and the fixed cost that is going to the 110 patients that are already there is lessened. From an accounting vantage point, it

would seem to me like this is going to be a benefit, basically to the employer. Is that correct?

(At this point, Chairman Wilson returned.)

Dr. Petty: I'm not a fiscal analyst or an expert in that sort of thing. We have some others here, who can probably answer your question better than I. But from a strictly medical point of view, when a patient is admitted to the center, he has to have a complete diagnostic work up and a program is planned for him in the form of treatment. As I said before, taking a patient through this process takes time and staff. We're operating now at our maximum.

Senator Don Ashworth: I realize that, but that's a variable cost, not a fixed cost. That cost varies as your patient load goes up. I'm talking about the fixed cost which is a straight line cost with a hard plant, plus all of the equipment. It only stands to reason, all I'm saying is that basically what you do, is spread the cost of the fixed plant over a larger base than over a smaller base; and consequently the unit cost for each unit is smaller.

(At this point Senator Hernstadt left the hearing.)

Dr. Petty: That would seem proper, yes,

Senator Close: Why would NIC be reluctant to permit the Division of Rehabilitation to refer patients to you, if they are willing to pay the cost of those patients? Your limit now of capacity is based upon your staff, not your facility. If they pay the cost that was necessary to employ additional rehabilitation people or doctors, or physiatrists or whatever, why would you not, then, want to utilize your physical capacity to the fullest?

(Karvel Rose, Assistant Coordinator, Las Vegas office, NIC.)

Mr. Rose: Basically, we're talking about two distinct things. We're talking about the usage and the allocation of cost on a fixed cost basis, and also the philosophy behind the marriage, as it's been called.

Senator Ashworth is correct. I think that later testimony that you will received will indicate that I doubt that there would be any capacity anyway, for the rehabilitation individuals. The second is, I was originally present at the labor management advisory board's meeting when they decided that they were going to build the rehab center. At that time, it was emphatically indicated that no federal monies would be permitted or used in the building of the facility.

Now I can only presume the reasons behind this. We have had some experience with the Occupational Safety and Health Administration (OSHA) and the additional costs for record keeping, accounting, staffing required to disburse and receive federal monies is significant.

Chairman Wilson: If you're paid by the Rehabilitation Division for contract patients which were referred to you, where would you be disbursing federal monies?

Mr. Rose: As Mr. Frost has indicated, and I'm not certain, because this is his area of expertise.

Chairman Wilson: Well, is this your point?

Mr. Rose: Considerable federal monies are received by the Bureau of Vocational Rehabilitation. I'm quite certain that they have requirements on the individuals to whom those are paid for. Accounting requirements, that would be different from us.

Chairman Wilson: What are they?

Mr. Rose: I do not know.

Chairman Wilson: You're dealing with public monies. I don't care if these are premiums charged business men. They're premiums charged, presumably because legislation gave you that authority to hold those monies in trust. You have invested in a facility and you have a public obligation to run that facility on a cost effective basis to the benefit of your insured.

The question we have of you is, on what basis can you justify not getting maximum use of that plant? If you're going to take the positions that you are not going to accept federal monies because of accounting and OSHA and other requirements, and that your advisory board has said to you that you're not going to do that because it's going to be burdensome, I expect you to be responsive to my question - to tell me how and in what way it's burdensome. You don't know the answer to that question.

Mr. Rose: Yes, I do. Because there would be a different cost basis for the provision of a Bureau of Vocational Rehabilitation candidate than there would be for a cost basis on the allocation of depreciation, which we do now, is an administrative expense.

Senator Close: Why is the cost different on a patient-to-patient basis?

Mr. Rose: Because the cost of the overall industrial insurance program which includes the physical plant is based upon the fees that we now charge. We don't build a depreciation cost for the facility as it is now in our fee schedules - because they're assumed by the employer as a whole, so we would have to reevaluate that and allocate the depreciation charge in those fees and recalculate the fees for those.

Chairman Wilson: What's wrong with that?

Senator Don Ashworth: Why couldn't you do that? There's nothing wrong with that.

Mr. Rose: We can either do that - but we can do it by...

Chairman Wilson: What's wrong with doing that?

Mr. Rose: There's nothing wrong with it.

Chairman Wilson: All right, that answers that question. What's the next one?

Senator Close: I can assure you of one thing, that OSHA will come into your facility whether or not you get federal funds. OSHA's jurisdiction is not limited to areas - facilities that receive federal funds.

Mr. Rose: I'm talking about our involvement with the OSHA program as the state agency, that would administer the program. Nevada, as has been indicated, our program is an employers' funded workman's compensation program specifically with the responsibility for the industrial injured in the State of Nevada. I think it's a credit to the labor management board that it is a very good facility. There are additional resources in this state, I doubt that they are as good, but there is approximately 13,000 square footage in Washoe Medical Center, that is available for that. They have the same problem that we do, staffing.

Chairman Wilson: Let me ask a question, you're suggesting, and you're quite right, the facility is a fine one, NIC should be complimented for it. It's a model, maybe the best in the state. Nobody is raising that issue. The implication, I guess, is to send patients elsewhere for rehabilitation and maybe that's the alternative.

Our question of you is: indeed, doesn't it make economic sense to save all the money that you can to charge the lowest premiums to businessmen that you can, to afford the highest level of service that you can to the injured workmen, the beneficiaries, by giving the maximum use of that plant?

Mr. Rose: I agree. There is no excess capacity, and that will be pointed out.

Senator McCorkle: That seems to be incredible how they can do that now.

Mr. Rose: If I might call on Mr. Kevin Maher who's the administrator of the facility.

Chairman Wilson: It certainly is as to the plant. If you're talking about staff, we'll talk about staff. We don't have an issue on the plant, do we?

Mr. Rose: No, not to my knowledge.

Chairman Wilson: The plant has the capacity of about 250 and you're running through, roughly, 180. Now let's go to the question about -

Mr. Rose: May I make one other point, then I'll call Mr. Maher up to give -

Chairman Wilson: You may have all the time you want.

Mr. Rose: Thank you. Another reason that our expansion from the non-industrial treatment mold into the competitive non-industrial treating facilities that are available in the community - we don't know whether we should be in that particular "ball park".

Senator Don Ashworth: You mean competing -

Mr. Rose: For non-industrial treatments.

Senator Close: Is there a difference in the rehabilitation process of a person who has a broken back because he fell off a scaffold, and a person who has a broken back because he got in a car wreck?

Mr. Rose: No, there is not.

Senator Close: It's the same for both patients, right?

Senator Don Ashworth: The only question I have for Senator Close along that line would be whether or not they should be in a competitive line with other people in private enterprise doing the same thing.

Mr. Rose: Or the non-industrial.

Senator Close: They're competing with them right now, as far as the NIC is concerned, before the facility was built, they were sending them all someplace else.

Mr. Rose: The treatment at the facility is post-acute care, and they are referred by the treating physicians in the community. In many cases the facility provides a source (of treatment) that was not available anywhere - at the time it was conceived.

Senator Close: At the time it was conceived, that may have been true; but that may not be true today, for all -

Mr. Rose: It's limited in the availability. Here's an opinion from our counsel regarding the bill and he'll probably address it later. (See Attachment E.)

Chairman Wilson: Is he here?

Mr. Rose: Yes, he is.

(Kevin Maher, Administrator, NIC Rehabilitation Center, Las Vegas.)

Mr. Maher: Mr. Chairman, Senators, my name is Kevin Maher. I'm the administrator for the (NIC) rehabilitation center in Las Vegas. On my right is Robert Voyett. He is programs superintendent at the center, and I've asked him to sit with me, with your permission, as a resource person.

I've been in worker's compensation 26 years and I'll take a minute or two for background as to what this is about. Mainly, in the field of rehabilitation, seventeen years in the province of Saskatchewan, looking after their program as director; seven years in British Columbia as director of their claims and rehabilitation program.

Over the years I've testified before a number of senate groups in the U.S. just in the interest of getting rehabilitation active in the fields of workers' compensation. I was aware of the programs, the efforts being made to generate rehabilitation activity for industrially-injured in Nevada long before I came here on July 5, 1976.

The system in the State of Nevada today is the best system that there is in the country; and I say that because I know. I've been to many of these centers, most all of them. Here in Nevada, we have a system of disability prevention that is housed, not only in the rehabilitation center, but is housed in various departments of the NIC throughout the state.

There are nineteen disability prevention teams, each one of them has a rehabilitation counselor, a nurse, and a claims examiner. Right from the time an individual is hurt, that team looks after the needs of the injured worker. They are the ones that are responsible to refer the injured worker at an appropriate time to the rehabilitation center.

We're concerned, in the main, with returning the injured worker to employment as soon as possible at the best cost to the employer. And I want to thank Mr. Frost for his complimentary remarks. The rehabilitation center in Las Vegas is not the best in Nevada, it's the best in the country.

We took possession of the building March 11, 1978. There were many constructural things that still had to be done, but we did physically occupy the building on that date. March 12, we had our dedication ceremonies and we were receiving patients at that time, but in very limited numbers. It was mainly to test our accounting procedures, our patient scheduling systems, provide in-service training to staff, and all of those kinds of things. We have the finest physical plant in the states and we also have the finest staff. It's not simply a case, sir, of going out and hiring an occupational therapist or a nurse or any of the other therapies in the center and bringing those people in and planting them down and say, "Hey, go to work," because we are developing experts in workers' compensation.

Chairman Wilson: Well, I can assume the therapy is no different.

Senator McCorkle: What is unique about an industrial action as opposed to a physical action in the Vocational Rehabilatation Bureau?

Mr. Maher: I think that we're looking at different kinds of things. There is a reward system to those attached to the industrially-injured that isn't for others. Not in all others.

Senator McCorkle: What do you mean, "reward system"?

Mr. Maher: I think that people with our appeals systems and so on they're looking for pensions and different kinds of things. We have an obligation to the patients to prevent that kind of thing from happening.

Chairman Wilson: You're not taling about rehabilitation. Senator McCorkle's question was - I don't know what a reward system is, and how it affects rehabilitation - his question is a good one.

Mr. Maher: If people can show disability, they probably have an opportunity to be rewarded for it. By pensions -

Chairman Wilson: I assume your mission, once a patient is referred to you by your various rehabilitation teams, is to rehabilitate.

Mr. Maher: Yes sir.

Chairman Wilson: And, I assume that once the team refers the patient to you, the judgement has been made that he needs rehabilitation. I assume your mission then, is to rehabilitate.

Mr. Maher: Yes, but rehabilitation takes many forms. It isn't just a case of "laying on of hands", its other kinds of things.

Chairman Wilson: I'm sure that's true, but I'm sure it's true that if you have a car accident and break your back as opposed to falling off a scaffold, you still have to rehabilitate. Is that right?

Mr. Maher: Yes, that's right.

Chairman Wilson: I assume the judgment is a valid one, that when a rehabilitation team refers a patient to you, the patient does have the need to rehabilitate. I assume your mission at that point is not to impeach that judgment, but, indeed, to rehabilitate.

Mr. Maher: Yes sir, it is. In all aspects.

Senator McCorkle: You describe the need for specially trained people, and you didn't want to hire anyone off the street.

Mr. Rose: I didn't quite say that sir. I said we took the people with the raw expertise, and we wanted to build on that.

Senator McCorkle: All right, now if your have an increase in demands by NIC claimants, you would, indeed, hire people. You would find them - today. Wouldn't you?

Mr. Maher: I would like to qualify that - my response to that, Senator. The current case load at the center is 110. That is because we only have two physiatrists, specialists in physical medicine and rehabilitation. We also have a problem in recruiting physical therapists.

So it's not just a case of being short in one area. The rating list, if you care to all it that, is based on our 100 day list of people who have been on workers' compensation 100 days or longer. That list, which I think can be equated to a waiting list, totals 1,775. So, if we fully staffed tomorrow morning we could fill the rehabilitation center with injured workers, and keep it filled.

Senator McCorkle: You have a waiting list of over a thousand?

Senator Close: And you're operating at one-half capacity?

Mr. Maher: The center is structurally and architecturally designed to treat 250 patients at optimum, and it could go to 300.

Senator Close: Why is there a waiting list of over 1,000 people who are sitting out there collecting NIC payments, unproductive in Nevada? Why are you sitting there with a facility that is less than 1/3 of its capacity?

Mr. Maher: Because we can't recruit the staff that we need under the present personnel system in the state.

Senator McCorkle: How long have you been under this limitation, six months, two months, a year? How long have you been unable to satisfy the demands?

Mr. Maher: Since last summer, the summer of 1978.

Senator McCorkle: What's the limiting factor in the personnel system that keeps you from being able to do this in six months?

Mr. Maher: They set the rates. They will not let us recruit and pay relocation expenses or whatever, to bring these people in from other states. There aren't that many physical therapists in Nevada. This publication by the American Physical Therapy Association (APTA), indicates that fifty-four percent of the physical therapists across the United States are paid more, and thirteen percent are paid the same.

(Robert Voyett, Programs Superintendent, NIC Center, Las Vegas)

Mr. Voyett: May I correct that. At our present allowed pay schedules by state personnel, fifty-four percent of the physical

therapists in the U.S. make more money than we can offer. Thirty-three percent make equal to what we can offer. But we cannot pay relocation allowance, therefore, why should they move, for the same amount of money?

Senator Close: What is that level of pay right now?

Mr. Voyett: With a B.A. and one year of experience, we can start a therapist at $14,600 annually. With 5 years of experience, which would be the maximum that would be allowed in the state personnel system, we can pay $18,300 annually.

Senator McCorkle: I'd like to hear Mr. Frost's response to this revelation here. From everything that's just been brought out here, it seems to beat the hell out of your point.

Mr. Frost: I really don't believe it will. The first point that I would make is that I'm sure that if you asked these gentlemen, they'll tell that they hire physicians on a contract basis. They contract with many of the same physicians that we contract with, and that is outside the personnel system. In addition, the point was made that they are not allowed to hire physicians because of the resident requirement, physicians are exempt from the residence requirement.

Chairman Wilson: They're talking about physical therapists on a level that state personnel permits them.

Mr. Frost: I think that the 2 physicians they're dealing with - Young and Knowles - they're dealing with them on a contract basis.

Mr. Maher: They're doctors. We're talking about a different thing. Physical therapists.

Mr. Frost: I don't know what their problems are in terms of hiring -

Chairman Wilson: Can you have contracts with physical therapists?

Mr. Maher: That's a thought, sir, and we're certainly looking at it. It seems to be the only device that we can use to do this.

Mr. Frost: I can tell you that we do.

Chairman Wilson: How long have you been looking for additional personnel.

Mr. Voyett: Beginning in the summer of 1977, we began staffing up at the center. We did not even hire a chief of physical therapy. Could not obtain him because of the pay rate, until March of last year (1978).

Chairman Wilson: When it opened?

Mr. Voyett: Correct. We had already hired our other chiefs of our other therapies; but we couldn't obtain a chief of physical therapy because of the pay rate. And since that time, we've exhausted our local resources. We've hired every Nevadan that wanted to come to us.

Chairman Wilson: Have you advertised?

Mr. Voyett: Yes sir, we've advertised statewide numerous times.

Senator Close: Have you advertised outside of Nevada?

Mr. Voyett: Yes sir.

Mr. Maher: Twelve newspapers, at the peak of winter; it didn't help, in major cities.

Chairman Wilson: How many patients are you sending out-of-state for treatment that you can't treat?

Mr. Maher: We aren't sending any from the rehabilitation center. Some patients are being referred.

Chairman Wilson: NIC is referring patients elsewhere because you can't do it. I assume some of them are going out-of-state, and I assume some are getting treatment inside of the state. My question is, if you can acquire the talent on a contract basis for a physical therapist or some other classification of rehabilitation service - why don't you do that?

Mr. Maher: We have considered the contract arrangement only in recent months. The feeling there, sir, is if we go contract with physical therapists, and we're able to pay them more, the move then will be - it would cause dissension in other kinds of therapies at the center. They're all on one pay group.

Chairman Wilson: You must be spending more money sending people, for NIC to send people, out-of-state or to other sources than it would cost if you were to service them at the center.

Mr. Maher: Yes sir, but we're dealing with the state personnel system, and damn it all, our hands are tied. We can't make our own rules.

Chairman Wilson: I don't mean to be disrespectful, but I'm having a difficult time understanding how you can make your 1,775 people wait or go out of state for treatment, while you're operating at a little over a third of capacity; where there may be alternatives available to provide that treatment. I don't understand that. It seems to me it's unfair to people.

Mr. Maher: I agree with you; and it's unfair that it took as long to get the center going as it did; because that same condition

(Mr. Maher testimony continued)

was prevalent before then.

Chairman Wilson: You've been open now 3 or 4 years.

Senator McCorkle: What does personnel have to say about this? Aren't they the ones that set the base entry level pay for a physical therapist?

Mr. Voyett: In our workings with them, only up until 3 weeks ago did we get an adjustment as far as the basic entry level salary. Up until 3 weeks ago, we could only pay $11,000, beginning per month; and now it's up to $14,000 annually.

Senator McCorkle: Why did it take 6 months to get that adjustment?

Mr. Voyett: Because we had to convince them that this was a critical recruiting -

Mr. Maher: We made every effort to recruit etc., etc.

Senator McCorkle: If you still can't recruit, why did they only raise it to $14,000?

Mr. Voyett: That's as far as they thought they could go. Within the state personnel system, when they classify a particular job as a critical recruitment, they take it to the step 5 level; that would be the $14,600 as far as physical therapists are concerned. What it's done is, this has brought us competitive with the Las Vegas area; with the Las Vegas hospitals. We were under that previously, but now we're competitive with what Sunrise pays, what Southern Nevada Memorial Hospital pays physical therapists. We were not previously.

Senator Close: What is the present prospect for obtaining therapists to staff your hospital completely?

Mr. Voyett: My opinion is that it's poor.

Senator Close: Due to salary increase?

Mr. Voyett: Yes, because we're not allowed to - we've exhausted the Nevada resources as far as physical therapists go, so we have to attract out-of-staters. And as our statistics show here, by the American Physical Therapy Association, that we would be looking at attracting 13 percent of the working population of physical therapists with our present salary, as we cannot pay relocation allowance. This is not allowed on that level, the rank-and-file level, semi-professional level.

Chairman Wilson: How fast could you staff to capacity on a contract basis?

Mr. Voyett: On a contract basis, we could fill it in no time at all, because we could pay the going rate, what would be necessary.

Senator Close: What's the going rate? How many people are we talking about?

Mr. Voyett: In order for us to really stay competitive - we're only talking about, in the area of physical therapy -

Mr. Maher: We're only talking about three people.

Mr. Voyett: Five total.

Mr. Maher: Three people plus two more doctors.

Mr. Voyett: That's the other factor we haven't gotten into yet.

Mr. Maher: And their treatment has to be under aegis of a physiatrist.

Chairman Wilson: What's the difficulty getting doctors?

Mr. Maher: We've had 14 or 15 doctors to our center and they're completely turned on to the program, the physical plant, the concepts and all that sort of thing; but for one reason or another, they cared not to come to the desert climate or Las Vegas.

Chairman Wilson: You couldn't find two doctors? You're operating at one-third capacity because you lack three physical therapists? Is that what you're telling me?

Mr. Maher: Assuming we could have 2 doctors, yes. But sir, I already explained that we also wanted to have this intervening time up to the end of the year to test our accounting procedures and our scheduling systems and do a lot of in-service training for staff. All of those things took place from August to December, so it wasn't just a case of opening with the official dedication ceremonies on August (?) 12, and we were full bore, even if we had all the staff.

Senator Close: From what I see, and what Mr. Frost has given to us is the classic "red tape", put back upon the bureaucrats. Both of you are involved in so much "red tape", it's incredible. You both have, apparently, given each other conflicting promises and statements, and I cannot understand why that would occur between two state agencies. There have been promises to go ahead and bring the other people; there were contracts entered into and not fulfilled; and now I find out, we're only talking about getting three physical therapists and two doctors, that you can get. There's no problem, you could find those people; the real problem's with physical therapists.

Mr. Maher: I don't mean to intrude, but it is today; it took us time to get all those other 96 people too.

Senator Close: Because you have a thousand people sitting out there on NIC who should be taking advantage of your services. I find that to be incredible.

Senator McCorkle: Did you just say you have 96 people? And five more will triple your capacity?

Mr. Maher: Yes sir.

Senator McCorkle: That doesn't make any sense.

Mr. Maher: Yes, it does sir - all of those people, they're not all therapists involved in the treatment process; there are janitors, kitchen workers, all these different things. We created two "new breeds of cat" in that center - one is an industrial therapist, the body never existed before, but it was needed and it had to be trained. We've developed a remedial therapist, which is an unheard of thing.

Chairman Wilson: Taking out the administrative posts, which are a part of the 96 or however many you have; you're saying that by bringing on board 5 professionals, 2 doctors and 3 physical therapists, you can utilize the remaining 2/3 capacity of that plant?

Mr. Maher: Two-thirds is the maximum, Senator.

Chairman Wilson: You're not close to that now.

Mr. Maher: No, 110.

Chairman Wilson: Senator McCorkle's question is a good one. Your answer appears to be an anomaly. We're just simply country legislators -

Mr. Maher: Well, I'm a simple adminstrator -

Chairman Wilson: I assume there's a simple answer to this dilemma, but I haven't perceived it yet.

Mr. Voyett: One physician, in order to carry out the appropriate medical care, should not saddle himself with more than between 55 and 60 patients at one time. Then you're starting to stretch your self awfully thin; and that's why, with only 2 physicians, we can fluctuate around the 100 to 120 mark, as far as our patient load goes.

Chairman Wilson: How many physicians do you have now?

Mr. Voyett: Two.

Chairman Wilson: How many physical therapists?

Mr. Voyett: Three.

Chairman Wilson: And you're saying that when you're at capacity you're going to have four M.D.'s, six physical therapists - you have 96 personnel now, all of whom are adminstrative - what is your staff?

Mr. Voyett: No - we have five registered occupational therapists, with six technicians at different levels. Some are trainees, some are more experienced; and there are some that are certified; so there are 11 in occupational therapy.

Mr. Maher: How many of those are technicians?

Mr. Voyett: Six.

Mr.Maher: Six, and none of them had any training before; so all of that in-service training has to be done. In our remedial therapy program, we have 5 therapists and 5 technicians, that's a staff of 10. In our industrial therapy program, at the present time we have 4 therapists with 4 technicians. (I'm adding one and losing one occasionally, so I may be 1 or 2 off on my numbers). We have three physical therapists along with 5 technicians, so that's 8, as far as an actual treating staff of direct patient care.

Senator McCorkle: It sounds as though you're overstaffed in each of these areas and way understaffed in a couple of selected ones. You have 3 times the staff you need, because of your patient load, in some areas.

Mr. Voyett: Correct. You're absolutely right, because when we went out to find people for this program, when we found the qualified individual, we had to hire him or we would lose him. They have to be trained in workers' compensation and the type rehabilitation program we're running. Our problem is in the type of medical care - physical therapy is our beginning level. In other words, in physical therapy, we'll take a person and work with them until they've reached a certain range of motion, and their ability to do more exercise. When they've reached that point, they can go into the other programs within the center. But our remedial therapist is not trained to work on the more acute type patient that the physical therapist is.

Senator McCorkle: That's what you call a "bottleneck".

Mr. Voyett: Correct sir. That's exactly what I'm under.

Senator Don Ashworth: What have you done to obviate the problem? It seems that you would have recognized - the testimony that you're saying right now - that you need 5 more individuals to pick up the slack that's been generated, in order to make this a full-fledged functioning operation as far as full capacity. It seems to me like you should have gone to the Interim Finance Committee or some other committee and got your funds and taken off.

Mr. Voyett: Correct sir. It may work for a Senator, but it's not that easy.

Chairman Wilson: I'm not so sure about that.

Mr. Voyett: Being locked into the state classified system; one thing you've asked - why don't we go contract on physical therapists. If we do go contract on physical therapists, that means that occupational therapists, remedial therapists, who have the same professional qualifications in their own areas, are going to be demanding the same amount of money that I'm paying a physical therapist to do the same job - but in a different way professionally, of course. And they would be on good grounds. So we're not talking only 5 contracts in the measure, we're talking as many as 20 or 30.

Senator Close: How much more money do you need? You've never answered that one question. How much money would you have to have to acquire the 3 physical therapists that you need?

Mr. Voyett: I believe the salary range of beginning therapists with a B.A. plus 1 year of experience, in the are of $15,000 beginning salary.

Senator Close: Four hundred dollars (per month) is what we're talking about?

Mr. Voyett: And the ability to pay relocation allowance. That is a key - key factor because it's so expensive.

Senator Close: With that problem, it's beyond my comprehension that you would go to somebody that understands what the problem is in this area and they would say no, they can't give you any additional money to relocate someone. I can't comprehend that.

Mr. Voyett: Senator, it's not the amount of the additional money, it's the fact that once you're in the classified system, under state personnel, you're locked into certain rules and regulations. When you start breaking one category out, I'll show you the effect state personnel say it has. There are other state agencies with physical therapists. So if we were to stay in the state classified system, and try to upgrade them, then every other physical therapist or occupational therapist in the state would have the right, in order to be paid -

Senator Ashworth: But, you see how many dollars we've got sitting out there that are being wasted? What you're telling me is what the IRS tells me all the time when I deal with them, when I'm not in session. I say it's a bunch of baloney.

Mr. Voyett: The system has not allowed us, to date, to do it, sir.

Senator Close: You're talking about $100 a month, $30 per person, for 3 therapists.

Mr. Voyett: As a beginning, sir. When I said salary range, that physical therapist we're after may have 5 years of experience, and we may have to pay him $20,000 in order to get him. Right now, I can only pay him $18,000.

Senator Wilson: How much additional money is NIC spending sending these folks elsewhere, because you're saving $100 or more a month butnot going on a contract basis?

Mr. Voyett: It's absolutely ridiculous.

Senator Wilson: It is ridiculous. I don't understand sitting here in a public hearing, why this has been permitted. You've got a waiting list of 1,775 people who troop to San Francisco or someplace for physical therapy. That's a hardship, gentlemen, how do you treat people like that?

Mr. Voyett: Sir, I'm not sure of the number from Las Vegas are from northern Nevada.

Senator Wilson: Don't you treat Las Vegas folks in Las Vegas, isn't that what you should do? Should you send them out of town if you don't have to, incur the expense, charge the business man the premium he pays to fund that kind of a program; is that fair?

Mr. Voyett: No sir, it is not.

Mr. Maher: But, Senator, if I might - I am very much opposed to sending anybody out of the state to be treated for rehabilitation. But until this program got up and was going, it was the only thing to do. So, it's not a case of being sinners all the way today. Maybe yesterday, or the day before.

Senator Wilson: We support the Center, we endorse it, we compliment you for it. We want to see it fly. We want to see it used to capacity. What you're telling me is, is that this subject is moot because; because if you had the additional 5 people, you could increase your present case load by twice, and you'd be at capacity, and have no room for rehabilitation patients. If that's true, fine, it means that you're providing better service to the industrially injured. I guess we're saying, my goodness it makes no sense, you're not doing this no matter what you're spending per month., when you compare it to the cost of sending patients elsewhere; including out of state, the cost, it seems to me to the human beings involved, having to go out of state.

Senator McCorkle: Mr. Chairman, this whole fiasco seems to be a reflection on the competence of either your office and your inability to convince the proper people to make the change, or it reflects on the competence of the personnel department, or the competence of the budget department.

I think I would recommend that we send a copy of these minutes to both the personnel and the budget office and get them to respond as to action that was taken and how sincere an effort was made to correct the problem. We're really talking about a big thing here.

(Frank King, General Counsel, NIC, Las Vegas)

Mr. King: I'd like to respond to what you've been talking about the last 20 minutes and point out that it's not only a reflection on the NIC and on state personnel, but it's a reflection on the legislature as well. And it's not a reflection on the fact that we are a political entity, like it or not.

Senator Wilson: My phone number's in the book. You never called me.

Mr. King: Maybe I should have.

Senator Wilson: Have you talked to the Governor? Did you ever talk to Mike O'Callaghan?

Mr. King: I've tried to make my views known to other committees. But what I know basically, what I know, to a large extent, is what I read in the newspapers, and what I read last week, from the Assembly Ways and Means Committee on this very issue; referring to what the NIC can pay physiatrists, and how easy it should be to find physiatrists, it was stated, under oath at that hearing, how much we pay physiatrists, the response, quoting from the newspaper, from the Las Vegas Review Journal by Assemblyman Mann said "that seemed an excessive amount for a doctor under a state agency to get paid." Several other committee members agreed. Later on, from the same article, Barengo asked to see all NIC contracts, and also wanted some information on the $20,000,000 surplus. The same day, there's an article in the Las Vegas Sun on the same legislative hearing in the Assembly Ways and Means Committee.

Senator Wilson: Is that related to this?

Mr. King: It's related to how easy it is to find physiatrists and physical therapists. You are stating that the NIC has committed negligence or the state personnel system has committed negligence by not cutting through the red tape and going by contract to get these people. What I'm saying is, that if we did that, we'd be torn to pieces in the legislature.

Senator Wilson: Now, you can't have it both ways. If you're saying Ways and Means is going to criticize you for spending some more money by going on contract, I assume you have justification for that, but you come in here and tell us you've got 1,775 people waiting for treatment.

Mr. King: Mr. Chairman, I'm just telling you what I read in the newspapers.

Senator Wilson: I don't think we're really concerned with what's in the newspapers.

Mr. King: I'm just telling you it's not easy to go out and get independent contracts with physiatrists and physical therapists when you can't pay them what the market requires.

Senator Close: We have 2 members of the Senate Finance Committee sitting here, so when you come to them, I think you'll get more favorable treatment.

Mr. King: God bless. I don't mean to seem contentious, I'm sure I sound that way. I don't mean to show disrespect for the Assembly Ways and Means Committee, and certainly not for the legislature, I don't mean that at all. I'm just telling you what I see as a political reality, and I'm explaining to you that that is a limiting factor in hiring these people.

Senator Don Ashworth: Evidently the testimony they've given - I've seen where this is basically good to question committees by this legislation in regard to rehab. because if they had to be filled up - they've got over 1,000 people out there waiting. My question is, if there is a problem, let's get to the bottom of it, and not let it go. Let's have a sub-committee to find out what's going on here, get this thing taken care of. There's a facility down there that's not being used and only needs 5 more people- let's get them hired.

Senator Wilson: We're going to get this problem resolved or know the reason why. There are some others here to testify on some other bills. Did you want to say anything in reply, Del, before - we're going to recess the hearing and continue it because we're not through with this problem.

Mr. Frost: I just want to suggest that the Committee contact state personnel.

Senator Wilson: We're going to contact state personnel and we'll have a continued hearing on this matter, the status quo is intolerable.

Mr. Frost: We recruit for equally difficult classes; perpetologists who work with the blind, we require an M.A. for our rehabilitation counselor, they don't. They've found ways around the academic training problem.

We have no problem filling our positions. If you look at our budget, we've got four and a half positions on our budget. We fill our positions. Granted, there's a problem with a low unemployment rate in getting people to fill jobs; but not in Nevada and there are ways around it.

The state personnel division, while you are locked into this kind of a system, has always been willing, on these kinds of difficult classes, to assist us by going nationwide recruitment; dropping the residence requirements. If you look at the salaries for our positions, we are comparable with the western states.

Senator Wilson: We're going to have personnel - we'll have you gentlemen in for another hearing. You'll all be at the same table, so that you can discuss this problem and resolve it.

(Norman Anthonisen, Personnel Services Manager, Summa Corporation)

Mr. Anthonisen: I came in here today with the thought in mind of supporting the bill as written, with two modifications. One being, people be sent there on an as-available basis; the other, the language in lines 17, 18, 19 and 20, on page 2, be cleaned up as to how this is going to be paid for.

As I sat there - I could empathize with you people in the abject frustration you were faced with, in trying to resolve this problem. In dealing with the NIC for the last 4 years, I've been continually confronted with that sort of information. You ask them for the time of day, they tell you how to build a watch. You ask them what 2 plus 2 is, they say 17 and 3/4. Now, you know they're intelligent people, and you know they answered a question; the only thing is, they didn't answer the question you asked.

We do have going through the Assembly right now a bill covering self-insurance for employers. One of the major reasons is the lack of communication we have with the NIC. I don't know if you've had an opportunity to read a report put out by SRI. The report is bigoted, biased report I've ever seen. It's replete with half truths, quarter truths, and no truths at all.

In summary, very shortly, I did intend to support that particular bill. Now, I'm literally appaled at what happened to the $2,300,000 of SUMMA Corporation's money that the NIC appropriated from us. They didn't use it any other place, it must have gone to that rehabilitation center. And, under those circumstances, to find out only a third of that area is being utilized is beyond my comprehension. In going through that area (the center), there must be room for 250 people in the foyer, between the time you get in the front door, before you go up the stairs. You can get 250 people in there, I swear; and you've got about 25 acres of space in there. And to hear that you can only put 250 in there is beyond my belief. The aisleway, I think you could march 20 people abreast down the aisle. The major reason that I decided to come up and testify, since this bill became moot; was to let you people know we would be back again when these other bills come through this side of the house.

Senator Wilson: We're not through with this subject. The bill is a vehicle, and we're going to solve the problem, or find out why we can't. Thanks.

(John Reiser, Chairman, Nevada Industrial Commission)

Mr. Reiser: The problem that we are discussing today really surrounds the physiatrist which is the specialist in rehabilitation medicine. These people are in short supply throughout the country. There are many rehabilitation centers around the country that have these people working for them.

Mr. Maher and his associates have recruited very vigorously and have identified 2 additional physiatrists that we hope to have with us within the next several months which will take care of that problem we've been wrestling with.

Senator Wilson: You have recruited them?

Mr. Reiser: Yes, we have them; saying they want to come out and we're preparing a contract with them now. The contract isn't signed yet. Hopefully, the adverse publicity that Mr. King referred to about hiring doctors on contract; these are fees for service people, rather than contract people. I hope that this doesn't have any effect upon them in terms of agreeing to come with our center.

Senator Wilson: I don't see the difference between contracting patients out-of-state or other places, and contracting services for them at home.

Mr. Reiser: No question about it. I think it's entirely justified. We are pressing forward on this despite the fact that some of the legislators want to see the contracts, are questioning whether we should be hiring people on contract. I think we'll be able to answer their questions because the merits are definitely there.

As Mr. Maher has pointed out, we've been concerned with quality control, we want to be sure that the patients who have the benefit of the center are getting the full service and we do have some good centers over in San Francisco. It costs very little to send the people across the line to San Francisco.

What we're concerned with is the employer, as you pointed out, Senator, that small - less than 4 percent of our total accounts for about 50 percent of our total cost. So we're looking at the $50,000,000 being spent for less than 3,000 people. So it makes sense to get early comprehensive care for these people, wherever we get it. The rehabilitation center is the primary in-state facility that we have in mind to handle these people.

The Washoe Medical Center also has the same problem. They have one physiatrist, Dr. Wally Trainer, whom we have been working with as closely as possible to try to get their center also up and functioning. I believe Mr. Frost said that they poured large amounts of funds into that physical plant, which isn't operating anywhere near capacity, and it hasn't been staffed. That's the problem. For years, Washoe Medical Center hasn't been able to hire the physiatrists they need to run that center. We're going to do everything we can, to work with them and with Del Frost to make sure we have both northern and southern centers available to our patients.

As I say, we'll show you what our problems have been, we think we have solutions on most of them. We do have a couple of areas of unanswered problems that we'll be talking with you about. California and Oregon, I intended to get you a copy of the bills that they're looking at along the same lines of putting workers' compensation program into a public enterprise type of posture so that they can be run as a business and not have the type of problems that we've run into in the past. I think it makes a lot of sense, there's no reason for us to duplicate the problems that these other states have had, because we now have the center up and running,

(Mr. Reiser's testimony continued)

it's functioning very well, all we need now is to be sure that we solve these few remaining problems, we will be back with you to present what we think is legislative solutions to those problems.

Senator Close: If Del will give you 50 therapists, will you give them 50 beds?

Mr. Reiser: We don't have beds. That was another thing that I was going to mention. It's an outpatient center. Our problem, Senator, is that we've built this as Mr. Maher pointed out, for the industrially rehabilitative people. The concept is a good one. It's already proven itself as far as we're concerned. The $20,000,000 dividend that they've returned to employers this year is a reflection of the improvements that have been made over the years that have been made possible by the legislature. You authorized that rehab program in 1973.

Senator Wilson: That's not why premiums are returned, John.

Mr. Reiser: That is part of the reason. Our disability period is being reduced, Spike.

Senator Wilson: Because of the center?

Mr. Reiser: Not because of the center alone, because of the whole disability prevention -

Senator Wilson: We're talking about the center now. Mel's question was if Del Frost gives you 3 people, how many could you take care of?

Mr. Reiser: Let's take Del Frost's recource and develop both Washoe Medical Center and Southern Nevada Memorial and Valley and the other hospitals that want to provide this rehab approach. We can't possibly meet the many thousands of needs that there are in the non-industrially -

Senator Wilson: But those that are of the same or similar to industrial type accidents, you can?

Mr. Reiser: But we don't have room. We didn't build that center to have room for the non-industrial injured. We can apply that concept to the other facilities, so that they can benefit -

Senator Wilson: You're expressing a proprietary point. Our response is that if you're full of industrially-injured, great, we're glad you're at capacity.

Mr. Reiser: We will be, and we've got a few additional staff to add.

Senator Wilson: Not at the rate you're going. You're one-third utilized, you have a waiting list; if you utilize that capacity, great, but if you don't, you have an obligation to fill it with someone else.

Mr. Reiser: But the point is, no matter who we put in there, we're going to have to have a staff, a very rare and hard to come by staff. Those two doctors are the key to getting that plant up to full capacity; and then the physical therapists, we need to solve those problems and then we'll be there.

Senator Wilson: We're going to have a continued hearing on this matter. We'll want rehab. here, personnel and you. I'd like to know what you've been paying to send patients to other places from this center during the period of time you've been using -

Mr. Reiser: Would you also like to have figures, when I talked about that dividend, it was made possible by the disability prevention program. That's a good portion of that savings, our disability has decreased. I'll bring you the figures, we have reduced disability team complex. The rehab center is just the final chapter in that.

Senator Wilson: I'm not criticizing your program. I'm only talking about one part of it. You've got a lot of capital invested in that plant, and you've got an obligation to use it.

Mr. Reiser: Yes, we do, and we intend to do everything necessary to do that.

(Don Hill, SCE, Incorporated)

Mr. Hill: I've had experience in the past with Harrah's and Harvey's, but I'm speaking directly to individuals. NIC's system is the best in the states. Compared to SUMMA, he has indicated certain figures, $100,000, we have come down to at least 50 percent of whatever Mr. Anthonisen indicated.

Mr. Anthonisen: Speak for yourself.

Chairman Wilson continued the public hearing on Senate Bill 275 to a later date.

AB 50 Increases maximum compensation payable to members of the Nevada board of nursing and licenses fees for nurses.

Pat Gothberg, Executive Director, Nevada Nurse's Association, presented background information regarding Assembly Bill 50 (see Exhibit G).

Jean Peavy, Executive Secretary, Nevada State Board of Nursing, explained that in 1975 the Board was advised by an auditing firm

(Jean Peavy, testimony continued)

to carefully look at its financial situation in 1977. In 1976, the fund balance, at audit, was $64,000, in 1977, it was down to $39,000; at that time the board raised its fees to maximum. She continued that in 1978, the audit report fund balance, because of the addition of the renewal period, was $122,000; and on hand, as of March 1, 1979, there was, in savings, $901000; commercial checking, $18,000. Ms. Peavy explained that if continuing education becomes mandatory, there will be a need for more office space, more staff, there would be more board meetings, etc.

In reply to Chairman Wilson's question, she explained that if the mandatory continuing education bill doesn't pass, there would not be the need to raise the rates.

Ms. Gothberg, in answer to Senator Hernstadt's question, stated that the Nurse's Association had sent all of the legislative issues out to all members so that they are aware of the proposed rates, and do not object to a rate raise. She clarified that the Nurses' Association does not presume to represent all of the nurses in Nevada.

Ms. Peavy replied to Senator Ashworth that about $4,800 per month is spent in the functioning of the office, and that if the foreign nurse bill passes, about $15,000 would be lost. She continued that it is not the intent of the Nurses' Association to build up a surplus. She explained to Senator Hernstadt that another reason for raising rates would be for expenses incurred from a pending law suit, particularly in the case of losing it.

Ms. Peavy explained that nurse practitioners would be able to do an expanded practice of nursing if regulations promulgated by the Nevada State Board of Medical Examiners and the Nevada Board of Nursing. She concluded that, at present, the Nursing Board's fees are at maximum.

Chairman Wilson closed the public hearing on Assembly Bill 50.

AB 51 Sets certain requirements for continuing education of nurses.

Pat Gothberg, Executive Director, Nevada Nurses' Association, presented background information regarding Assembly Bill 51 (see Exhibit H).

Shirley Howard, representing the Nevada Nurses' Association Legislative Committee, presented prepared testimony (see Exhibit I). Ms. Howard explained to Senator Hernstadt that there are workshops available that include hospitals, other agencies, private providers. The Nevada Nurses' Association approved 146 programs during 1977 which met the criteria for continuing education, whose range of availability includes White Pine, Ely, Elko, Winnemucca, Tonopah,

Clark County, Washoe County and Carson City. She added that there are many correspondence courses available.

Pat Peer, representing the Nevada State Board of Nursing, answered Senator Close's question about the reasons for creating an advisory council, self-appointed and not responsible to anyone but itself, by explaining the board meets 4 times a year for the purpose of reviewing state board test pool examinations, general business, disciplinary actions and studying such things as the nurse practitioner.

The advisory council would be made up of people in education who could identify continuing education as a benefit to nurses when looking at applications. She continued that the $40 fee would be a consulting fee, and this would be too great a load for the board to handle. Ms. Peer explained to Chairman Wilson that the state board does not have the expertise to determine the required programs, hence the need for the council.

Jean Peavy explained that the intent would be for the advisory council to advise on developing criteria.

Senator McCorkle stated that he doesn't feel there is the need to authorize an advisory board.

Senator Hernstadt clarified that the council exists now, but should be compensated for the long hours of studying course material.

Joyce Washabaugh, Director of Nurses, Carson Tahoe Hospital, representing concerned nurses from Carson City area, stated that she opposes AB 51, and asked that another hearing be scheduled in order to prepare background information. She stated that professional nurses are interested in continuing education; but are opposed to mandatory continuing education for relicensure, and that the Nevada Nurses' Association does not represent the majority of nurses in Nevada, but represents 500 to 600 nurses out of the 3,439 registered nurses. Ms. Washabaugh continued that the implementation of AB 51 would be too costly to all concerned, and that mandatory education would not insure knowledge. Ms. Washabaugh presented prepared testimony and a petition in opposition to AB 51 (see Exhibit J).

Chairman Wilson asked for alternatives should the legislation not pass.

Ms. Washabaugh stated that most nurses feel that the bill is not necessary and that competent nurses continue education. Carson Tahoe Hospital has a training and education department, and most other hospitals have them.

Jeannine Madson, representing the Training and Education Department, Carson Tahoe Hospital, stated that there are many types of education programs available at Carson Tahoe Hospital such as the orientation programs, safety, fire and others designated as continuing education for nurses such as coronary care and pediatric courses and others that upgrade the skills of nurses.

Ms. Madson stated that these courses are offered on a voluntary basis and the nurses are reimbursed for attendance.

Senator Ashworth stated that if continuing education is not mandatory, there are those cases where people are not self-motivated and do not keep up with their professions, and that mandatory education protects the consumer.

Ms. Washabaugh explained that she had attended many classes from which she had learned nothing.

Senator Hernstadt suggested that the board give examinations every two years to learn if these courses are effective.

Shirley Wolfe, Director of Nurses, Air Ambulance of Nevada, stated that since January, she has obtained 61.5 continuing education units and it is not difficult to continue education. Ms. Wolfe explained that she requires continuing eduction for the Air Ambulance nurses, and the military, paramedics and many others require continuing education. She continued that she had been against continuing education initially, but had discovered that nurses in Nevada are apathetic towards continuing education, and had reversed her position.

Ms. Wolfe stated that a flier had been sent out to nurses in Nevada inquiring about opinions regarding changing the election time for the nurses's convention, and that from district 6, which includes Carson City, Minden, Gardnerville and Incline, there was not one reply. She continued that less than 10 percent of the nurses in Nevada have gone through voluntary recognition, and in district 6 who have been voluntarily recognized.

Sadie Thelen, Nevada Nurses' Association, stated that a questionnaire, in conjunction with the state health planning agency was sent out, and of over 5,200 nurses who had been licensed, 70 percent returned their questionnaire. She continued that licensed practical nurses have a higher percentage of taking continuing education than registered nurses, and of those who did report continuing education, fifty five percent reported less than 10 hours a year.

Senator Close stated that the total questionnaires returned were 3,500 but that the total number of nurses with any continuing education was 4,100 which would mean that there were more nurses with continuing education than there are nurses.

Reverend Douglas Thunder, Methodist minister, stated that he does not think that mandating continuing education is the right approach He suggested that employers should provide incentives instead.

Phillis Ott, registered nurse, stated that section 4, regarding the $40 per day not be allowed, and suggested that the expenses be paid out of the increased license fees.

Sadie Thelen, Nevada Nurses' Association, clarified for Senator McCorkle, that 10 percent of the nurses bothered to be voluntarily recognized for continuing education.

Ms. Washabaugh stated that it is not necessary to be recognized for continuing education.

Pat Gothberg stated that there are many nurses receiving continuing education that are not using the Nurses' Association program and that there are many who receive none.

Ms. Gothberg explained that the Nevada Nurses' Association does not presume to represent all of the nurses in Nevada, but that it does hold hearings, holds forums, sends out newsletters and takes the time to inquire and inform. She continued that at least 75 percent of the members are staff nurses, and the Association's concern is only with the nurses who do not take continuing education. She concluded that the University of Nevada is starting to work toward providing continuing education in all areas of the northern part of the state.

Chairman Wilson closed the public hearing on Assembly Bill 51.

SB 145 Permits registered nurses to perform additional functions under certain circumstances.

For previous discussion and testimony on Senate Bill 145, see minutes of meeting dated February 12, 1979.

Chairman Wilson read from a letter from Dr. Richard Grundy, President, Nevada Board of Medical Examiners, as follows: "Our position remains that we are unanimously opposed to Senate Bill 145. To review with you the progress made over the last several weeks, I would like to inform you of the intended position reached by the board. This is not an official position because each of the other representatives must go back to the respective associations and boards to receive final approval. The Board of Nursing will meet on March 30, 1979 to study and hopefully approve the revisions that govern nurse practitioners as recommended by the Board of Medical Examiners. The key provision in these regulations is the inclusion of the requirement that a member of the Board of Medical Examiners must be present to assist in the evaluation of the clinical competence of the nurse practitioner when he/she appears before the Board of Nursing for consideration of certification.

Furthermore, the Board of Medical Examiners must approve the position of nurse practitioner as it pertains to the possession, administration and dispensing of drugs. We respectfully request that your Committee withhold any action on Senate Bill 145 until we are able to present recommendations which are in substantial agreement with the above organizations (Nevada State Board of Pharmacy, Nevada Nurses) to protect the health and welfare of the people of Nevada."

Sadie Thelen, Nevada Nurses' Association, stated that the two provisions in Dr. Grundy's letter have been agreed upon by the Nurses and the Pharmacy Board, but they are waiting for word from the Medical Board.
Chairman Wilson closed the public hearing on Senate Bill 145.

AB 49 Increases standards for licensing of nurses and limits reciprocity of admission of foreign nurses.

Pat Gothberg presented background information on Assembly Bill 49 (see Exhibit J).*

Senator Close stated that if the test is the one currently given in Nevada, people from out of state would not be able to pass it.

It was agreed that the language is not clear in the bill. Ms. Gothberg explained that there is a test that is given in all the states, the State Board Test Pool Examination, and that the intent of the legislation would be that out of state applicants would be tested for equal level of competency with Nevada. She clarified that Nevada has been deluged with applications from Phillipine nurses, and there is fear that their standards may not be as high as Nevada's; the goal is to have a uniform quality of educational experience.

Ms. Thelen, stated that Nevada is getting so many license applications because other states won't issue them; and that Nevada's law allows out of state nurses to practice without being tested. In other states, they must pass the State Board Test Pool Examination.

Ms. Gothberg explained that the statute now requires a 10th grade high school completion for licensed practical nurses and that AB 49 would upgrade the requirement to a high school diploma.

Pat Peer, Nevada State Board of Nursing, clarified that applicants have taken the State Board Test Pool Exam in other states and failed but that Nevada is forced to license them.

Chairman Wilson closed the public hearing on Assembly Bill 49.

SB 312 Authorizes registered nurses to perform certain obstetric acts under certain circumstances.

Pat Flanagan, M.D., Las Vegas, Nevada, stated that he instigated Senate Bill 312 because there is a place for midwifery in modern obstetrics. Dr. Flanagan presented background material (see Exhibit L).

Dr. Flanagan clarified that the term "midwife" refers to a registered nurse who has had further specialized training in an approved midwifery school. He continued that there are many advantages to having a midwife such as the fact that she has more time for the individual patient, particularly during labor; that she would recognize complications more readily than someone not so trained; that there is a great feeling in the practice of medicine for the need of midwives; that mothers are becoming more involved with their pregnancies and births and they identify with a woman better.

*Also see Exhibit K

Dr. Flanagan read from a statement from the American College of Obstetrics and Gynecology as follows: "The American College reaffirms its policy that the health team necessary to provide optimal maternity care must be directed by qualified obstetricians and gynecologists. Fully recognized in this policy is the role of the certified nurse midwife who, as a member of this team, may assume responsibility for the complete management of the uncomplicated pregnant woman."

Dr. Flanagan continued that the Clark County OBGYN Society endorses Senate Bill 312, and more than 40 states have midwives, including California.

Senator Ashworth referred to lines 8 and 9, page 1, "considered diagnosis and prescription". He stated that there is such jealousy within the medical profession, and asked the reaction of the obstetricians to the phrase. Dr. Flanagan stated that as far as he knows, there is no objection. He stressed that in emergency conditions anybody can function anyway, and that this just provides for that with midwives; the other special conditions would be when a physician delegates the midwife, as a member of the team, to make an uncomplicated delivery.

In explanation to Senator Hernstadt's question, Dr. Flanagan stated that surgery would mean care beyond a normal situation. He continued that on line 10, the work "midwifery" replaces "obstetrics; line 13 should include "complicated" before the word "obstetrics"; line should read "practice of emergency obstetrics".

Senator Ashworth suggested that line 10 should include "midwifery" and keep "obstetrics".

Dr. Flanagan suggested that his definition of midwifery be included in the bill as follows: "A midwife is a licensed registered nurse with additional training in an approved school of midwifery, who assists in the prenatal care and delivery of a normal pregnant female." He stressed that these deliveries should be in a hospital; not birth clinics or others.

Sadie Thelen of Nevada Nurses' Association stated that the nurses consider a nurse midwife to be a nurse practitioner.

Dr. Flanagan stressed that nurse midwife remain (that).

No further business, the meeting adjourned at 5:00 p.m.

Respectfully submitted,

APPROVED:

Betty Kalicki, Secretary

Thomas R.C. Wilson, Chairman

SENATE Commerce and Labor COMMITTEE

GUEST LIST

DATE: Wednesday, March 21, 1979

NAME	AGENCY OR ORGANIZATION
Karvel Rose	NIC
Jeannine Madison	Training & Ed Dept Carson Tahoe Hosp
Alice M. Brown	RN - Staff Nurse - CTH
Emily Jones	RN - Supervisor 11-7 CTH
[illegible]	SCE Inc
[illegible]	NIC
Joyce Washabaugh	RN - Acting DNS Carson Tahoe Hosp
Alice Estee RN	CTH staff nurse
Bonnie [illegible]	RN - CTH. Staff nurse
[illegible]	[illegible]
H. CURTIS	N.I.C.
[illegible]	RN SBN
N.C. ANTHONISEN	SUMMA CORP
[illegible]	L/M NIC
J M [illegible] MD	obstetrician
V. Maddocks	midwife
[illegible] Douglas	Rehab
Ann M [illegible]	Nev Nurses Assoc.
[illegible]	Nev Nurses Assoc.
Scott Baker	NIC
Frank King	NIC
[illegible]	NIC
[illegible]	Rehabilitation Div
[illegible]	Nevada Nurses Assn
Shirley J Howard	Nevada Nurses Association
Jean D. Peavy	Nev. State Board of Nursing
Nellie [illegible]	Nev Nurses assoc.

GUEST LIST Exhibit A

Del Frost, Administrator, Nevada Rehabilitation Division

Jane Douglas, Coordinator of Evaluation Services, Nevada Rehabilitatio Division

Richard A. Petty, M.D., Advisor, Nevada Industrial Commission

Karvel Rose, Nevada Industrial Commission

Kevin Maher, Administrator, Jean Hanna Clark Rehabilitation Center

Robert Voyett, Programs Superintendant, Jean Hanna Clark Rehabilitation Center

Frank King, Attorney, Nevada Industrial Commission

Norman Anthonisen, SUMMA Corporation

John Reiser, Chairman, Nevada Industrial Commission

Don Hill, SCE Incorporated

Pat Peer, Nevada State Board of Nursing

Shirley Howard, Nevada Nurses Association

Jean Peavy Executive Secretary, Nevada Nurses' Association

Joyce Washabaugh, Director of Nurses, Carson Tahoe Hospital

Jeannine Madson, Training and Education Department, Carson Tahoe Hospital

Shirley Wolfe, Director of Nurses, Air Ambulance of Nevada

Sadie Thelen, Registered Nurse

Douglas Thunder, Methodist Minister

Phillis Ott , Registered Nurse

Pat Gothberg, Executive Director, Nevada Nurses' Association

Pat Flanagan, M.D.

Alice Brown, Registered Nurse

Emily Jones, Registered Nurse

Alice Ertel, Registered Nurse

H. Curtis, Nevada Industrial Commission

V. Muddocks, Midwife

Ann M. Hibbs, Nevada Nurses Association

Scott Baker, Nevada Industrial Commission

RESPONSES TO LEGISLATORS' QUESTIONS RELATING TO REHABILITATION DIVISION USE OF THE JEAN HANNA CLARK NIC REHABILITATION CENTER:

On September 11, 1978, a cooperative agreement was signed by most NIC parties. On September 22, 1978, John Reiser, following several communications, signed the document. Subsequently, an NIC attorney determined that the current statutes, NRS 616.222 and NRS 616.223 disallow use of the Rehabilitation Center by non-industrially injured persons. The Division was therefore refused information on fee schedules and referral procedures.

Without a fee schedule, it is difficult to report exact savings to the Rehabilitation Division, however:

1. In Southern Nevada alone, in 1978, the Division spent $86,996.84 on 1,247 persons, for Diagnostics/Evaluations.

   These services are available at the NIC Center; it makes sense to pay such monies to another state agency rather than to other vendors.

2. In the same period, the Division spent $200,444.43, Statewide, for 2,590 clients needing this service. The NIC Center is a Statewide Center.

3. Restoration Services, available at the NIC Center, in 1978 cost the Division $260,846.82 for 670 clients in Southern Nevada, and $363,825.61 Statewide for 1084 clients.

The Division therefore has a potential referral base of over 1000 clients in Southern Nevada, and over 2000 on a Statewide basis.

Division computer-identified NIC cases in the VR caseloads in the last 16 months amounted to only 206 shared clients, however:

a. NIC clients are generally referred by other sources; there are, therefore, many more NIC clients served by the Division than the 206

b. 87% of the cases sampled of verified NIC clients received services directly related to the NIC injury. The reasons for our provision of services varied from length of time for NIC hearing to limits by NIC as to the length of time allowed their clients to be retrained (rehabilitated).

c. The average cost per VR case for the sampled cases through January of this year was $1,086.70

4. The reported capacity of the NIC Center is 250 clients daily

5. A recent report quoted 108 clients being served daily

6. Division use of the Center would not preclude services to NIC clients since NIC would have the right to determine extent of available service to the non-industrially injured persons.

7. Division clients would spend the same length of time at the Center since they would be served by the same physicians for the same diagnoses.

8. It would seem logical that employers would prefer substantial sums of reimbursement to their NIC fund, rather than to carry the burden of costs for the Center alone.

HISTORY OF ADMINISTRATIVE ATTEMPTS TO ACHIEVE NIC COOPERATION IN SHARING RESOURCES

1. The history of the Human Resources' Rehabilitation Division expressed interest in participation in NIC resources, specifically NIC Rehabilitation facilities, is first documented in the minutes of the Governor's Committee on Employment of the Handicapped, January 29, 1976, in a speech by John Reiser of NIC to that Committee. Mr. Reiser is quoted as saying, among other things that:

> NIC will begin construction in the very near future on a 4.5 million dollar rehabilitation facility, with an anticipated completion date of September, 1977.

In response to questions by the Division Administrator and the Committee, Mr. Reiser said:

> that the program is designed to return people to work in the shortest possible time, so they will be working with the industrially injured first, then others. It is sponsored by employers of the state, and job injuries must come first, although it makes sense to serve the total community after getting into operation;

2. Additional documentation as far back as 1976, is found in a memorandum I have here, dated March 22, 1976. The memorandum is from Dave Nichola of State Comprehensive Health Planning to Del Frost, Rehabilitation Division Administrator. It states:

> "I heard from John Reiser concerning the new facility in Las Vegas. He passed on the following to me:
>
> "As you know, the statutory responsibility of the Nevada Industrial Commission is to prevent or reduce disability due to industrial injuries and diseases. Therefore, priority of all NIC facilities must be given to meeting these statutory responsibilities. However, to the extent that NIC resources are greater than those necessary to meet the needs of industrially injured Nevadans, the commission intends to makes these services available on a fee-for-service basis under an extension of the attached cooperative agreement."

3. During the planning stages for the Center, NIC Director of Rehabilitation, Bob McMillan, informed Rehabilitation Division employee, Al Frenzel that "you'll never see a BVR client in that facility."

4. On August 26, 1977, Del Frost wrote a letter to John Reiser, complimenting the facility and NIC stating:

"Since your optimum capacity is planned for 250, and since it appears initially you will not utilize the facility to capacity, I am hopeful that we can develop a cooperative agreement which

would allow the Rehabilitation Division to refer clients for rehabilitation treatment services."

The letter requested a meeting in the near future "to begin discussions on the above. . ."

5. During the ensuing year, a Division staff member had a series of informal discussions with NIC Commissioners Evans and Lorigan. The discussions centered on Division use of the Center and the fact that the Division was paying for NIC clients' services. Both Commissioners agreed that a substantive cooperative agreement should be drawn up.

6. In the winter of 1977, a Division Bureau Chief was informed by the Center Administrator, Kevin Maher, that it would be illegal for the Division to have referral privileges to the Center. That statement was reiterated by Mr. Maher in a speech given to the NRA convention on December 9, 1977

7. On July 28, 1978, Donald Klasic, then Deputy Attorney General, and now Chief Deputy Attorney General of the Civil Division, wrote a legal opinion responding to Del Frost's request for same. The four-page document concludes as follows:

> "Therefore, under NRS 277.180 the Rehabilitation Division would have to enter into an interlocal contract with the NIC for use of the NIC's rehabilitation center and the Division would be responsible, as provided in the contract, for reimbursing the NIC for the resulting expenditures."

8. On July 26, two days prior to the issuance of Don Klasic's opinion, Del Frost wrote a letter to Mr. Evans, thanking him for meeting with the Division's staff member, and stating:

> "It would be to our advantage in serving Nevada's handicapped to utilize the excellent facilities of the new NIC Las Vegas Center. Since the Center will be opening soon, it's timely to develop an affirmation of cooperation between our agencies, with specific reference to the services of the Center.
>
> "I suggest a document that will embody the terms of our February 1976 Agreement with certain additions. For purposes of maximum participation by the Division, I would like the Agreement to include all bureaus of Rehabilitation.
>
> "It is my understanding that you will discuss the possibility of a new Agreement with Commissioners Reiser and Lorigan. I am therefore having a draft agreement prepared for purposes of discussion; it will be sent to you as soon as it is completed.

"I appreciate your assistance and cooperation. Please let me know when we can get together and discuss this matter."

9. Commissioner Evans responded by reviewing the above-mentioned February 1976 agreement: He met with the Division staff member to suggest specific changes.

10. A first draft, August 8, 1978, was prepared by the Division and submitted. On August 25, 1978, NIC Legal Advisor, William Crowell, wrote an Opinion stating that their statutes do not preclude a cooperative agreement including use of the Center, but that certain specific stipulations need to be added to the draft.

11. The Division prepared a second draft, adding the provisions required by Mr. Crowell and submitted it to NIC on September 5, 1978. Note: The first draft had already been approved by Chief Deputy Attorney General, Jim Thompson.

12. NIC Commissioners reviewed the second draft, and John Reiser struck one of the paragraphs that William Crowell had required for the second draft.

13. On September 11, 1978, the third and final draft, with the aforementioned paragraph deleted, was submitted to NIC.

14. The Division staff member then met with John Reiser, Claude Evans, Bob McMillan, and Hal Curtis, newly appointed NIC Commissioner for Labor (Commissioner Lorigan was not available). The meeting was purportedly to finalize signatures and establish procedures for implementation. Mr. Reiser decided instead to refer the matter back to his attorneys.

15. September 22, 1978, John Reiser finally signed the September 11, 1978 Agreement. He did so, following a series of contacts by the Division through Human Resources Director Mike Melner to the Governor.

16. Well over a month prior to the Reiser signature, at the August 12, 1978, Center dedication, given the understanding that NIC was cooperating, the Governor in his speech stated:

> "I am convinced that this building will save the State many thousands of dollars that would otherwise be paid on a long-term basis to disabled workers.
>
> "Priority here will be given to workers under NIC. As time and space are available, we will also work with those Nevadans who need rehabilitation from non-employment connected causes. This portion of the program will be administered through our older Rehabilitation Division of the Department of Human Resources.

"These two programs working hand-in-hand help Nevadans retain or regain the dignity each human being deserves to feel. It is that purpose of this building which makes it most appropriate that it be named in honor of Jean Hanna Clark."

17. On September 27, 1978, the Governor signed the Agreement and issued a press release as follows:

"CARSON CITY -- Disabled Nevadans will be assured of the best possible rehabilitation services as the result of a new cooperative agreement between the Nevada Industrial Commission (NIC) and the Rehabilitation Division of the Department of Human Resources, announced Governor Mike O'Callaghan.

"The agreement signed by O'Callaghan today mandates total use of all available resources of both agencies for mutual clients.

"One aspect of the agreement allows clients of the rehabilitation division to use the facilities of the NIC Jean Hanna Clark Rehabilitation Center in Las Vegas when time and space are available, he said. The Jean Clark Center is one of the foremost rehabilitation centers in the nation, he noted.

"These two programs working hand-in-hand will help Nevadans retain or regain the dignity each human being deserves to feel, the Governor said."

18. Following the Reiser signature, Mr. Evans quoted preliminary rates to the Division staff member and suggested that a copy of the rates could best be submitted by Bob Haley. In a memo to Del Frost, November 1, 1978, the Haley contact was described:

"Bob Haley, who worked up the rates, would not agree to a meeting with me and Lucille to discuss fee schedules. He first indicated that he understood that fees would be set on a case-by-case basis. I said that we wanted an agreed-upon schedule for all services, as indicated by the Agreement. He said:

a. The facility is at full capacity now and backed up by two weeks.

b. Rates developed were for employers only; haven't been tested to determine coverage of actual costs; are being utilized first billing today.

c. The capacity problem is not one of space, but man-power. They plan for four physiatrists and "only" have two. Note: This is ridiculous in my opinion, having worked at

SNMH when they had a very part-time consulting physiatrist and handled the majority of P.T. cases for the entire county.

'Any (of our) needs would be considered on 'an extreme emergency and one-on-one basis,' establishing a fee for that particular case.

"There is no possibility of establishing a fee schedule for us (and meeting with us) until after the first of the year."

Note: The negative comment in "c" above was her first and only reflection of frustration over the NIC attitude. All correspondence with NIC was very positive and is available for review.

19. January 18, 1979, following Mr. Haley's instructions for contact after the first of the year, Haley was contacted again. The resulting memo to Del Frost stated:

"Bob Haley, NIC, in response to my request for a meeting, said that the latest Advisory Board meeting dropped discussion of our Agreement following discussions of all the legal complications and primarily due to their general counsel's legal opinion that NIC had no right under the law to enter into the agreement. When I mentioned all the lawyers involved, he said, 'Well, Bill Crowell isn't with us anymore.' He said he was surprised that no one from NIC had informed us of same."

20. On January 22, 1979, Del Frost wrote both John Reiser and the attorney involved in the "ruling" that the agreement was invalid, Frank King. He did so following verbal verification by Mr. King of his opinion and his statement that other attorneys aside, he had "just recently been involved," and had "no intention of changing his opinion." The Del Frost letters requested written explanations. The letter to Reiser closed with:

"It is still my hope and intent to resolve whatever issues that exist within your agency and which continue to block the development of an effective cooperative agreement which would make it possible for said services to be made available to disabled citizens."

The letter to Mr. King closed with:

"The Rehabilitation Division spent many hours trying to achieve a good faith agreement with the Commission. I therefore request the courtesy of a written opinion from you regarding the Subject Agreement for review by our attorneys."

21. On January 24, 1979, Mr. Reiser responded by attaching copies of the Disability Prevention Policy Statement approved by the Commission and some members of the Labor Management Advisory Board on January 24, 1979.

The Reiser memorandum stated:

> "This policy statement is consistent with the purpose of our September 11, 1978 cooperative agreement which is to develop the maximum utilization of resources of each agency toward the provision of rehabilitation services to the industrially disabled citizens of the state and enable them to return to gainful employment."

22. On January 31, 1979, Del Frost's response referred to the above Reiser statement:

> "The above statement is incorrect. I refer you to Page 2, Section IV, subsections B and C of our 1978 Cooperative Agreement. You will note that our agreement states in part, "To accept client referrals one to another and act in a timely manner to the benefit of the clients. To share respective specialized services and facilities to the extent that time and space will allow."
>
> "You indicated in your January 24 memorandum that you 'will be pleased to meet with me to resolve the misunderstandings reflected in my January 22, 1979 letter.' I suggest that the meeting take place between you and I in Dr. Ralph R. DiSibio's office at a time convenient to you and him."

23. That meeting did take place, and Mr. Reiser cleverly called attention to a mistake made in the continually redrafted agreement, which allowed the one phrase "to the industrially disabled citizens of the state. . .". The fact that the introduction and all other parts of the agreement did not make any such reference, was totally disregarded by Mr. Reiser. The meeting concluded with the knowledge that a bill draft was already being prepared to mandate cooperation and shared resources.

24. Based on legislators' requests, the Division staff member sampled VR-NIC computer identified clients. The "shared" clients were verified by NIC. Rehabilitation Division computer-identified NIC cases in the last 16 months amounted to only 206 shared clients.

However, the Division, by doing a sample of 35 verified NIC clients stratified by VR office, found that:

A. NIC clients are generally referred by other sources; there are, therefore, many more NIC clients served by the Division than the computer has identified.

B. 87% of the cases sampled received services directly related to the NIC injury.

The average cost per case through January was $1,086.70.

C. In the other 13% of NIC-BVR clients the Division evaluator disallowed the cases as directly related to the injury when, for

example, client also had an unrelated injury, or when monies were spent for medication, dental repair, etc. In each of these cases, however, the predominant costs related to the NIC injury.

D. The RD counselors are faced with a dilemma of conflicting federal regulations regarding NIC clients: They cannot refuse disabled applications, but they are required to utilize "similar benefits" --in this case--NIC.

E. Reasons for rendering RD services could be categorized as follows:

1. NIC agreed to cooperate in VR plan and then withdrew; NIC then reverts to paying compensation only.

2. NIC expected clients to accept minimum wage jobs when their prior profession paid much more and they had families to support.

3. NIC closed cases when they were not medically and/or vocationally rehabilitated. These cases are in the appeals and/or lawsuit process.

4. NIC returns clients to previous occupation and client is injured again. These cases are in NIC reopening process.

5. NIC limits certain clients in length of training.

6. NIC provides clients with contracts that require clients to go to the Division and complete rehabilitation plan in 60 days.

7. NIC continues client on compensation for years without rehabilitation services.

8. NIC disregards the psychological effects of the injury; clients need professional counseling and guidance.

9. According to Rehabilitation Division counselors, actual NIC case expenditures do not reflect the extensive costs of counselor time in counseling NIC clients and working with NIC. One of the sampled cases, e.g., cost $117, but the counselor estimated 80 full hours of direct contact with the client.

Note: Within the sample were cases where clients reported being verbally threatened for going to the Division.

Also within the sample are two NIC letters stating:

Letter Number 1, April 7, 1978:

"we will provide the services necessary to allow you to take the course. This offer is based on your decision to be a client

of the Nevada Industrial Rehabilitation Department. If you hold with your present decision to accept the services of Vocational Rehabilitation, then you should look to them for any services you desire."

The letter infers that the client must make a choice and that cooperation between the agencies is non-existent.

Letter Number 2, February 5, 1979:

"It is the decision of the Commission that you are to cooperate with the Bureau of Vocational Rehabilitation in Winnemucca during this sixty (60) day period, in the development of a program which will return to you to gainful employment. Should you fail to cooperate in this matter, the Rehabilitation Maintenance Program will be stopped.

"In addition, we have forwarded to you a check covering the period beginning November 14, 1978, through January 18, 1979. This check represents compensation for that period of time.

"Finally, the decision has set aside the Hearing Examiner's decision dated January 5, 1979. You will be reevaluated at a later date, soon after your rehabilitation program comes to an end."

Letter Number 2 contained a cover memo to the Division evaluator from the VR counselor as follows:

"I received this cc (carbon copy) on February 9. I would like to note that this action was taken only after the client's wife called the Governor's Office. However, the way the letter is stated, BVR is once again left with the real responsibility of 'Rehabilitation'."

POSSIBLE QUESTIONS TO BE ASKED OF NIC :

1. What are the current number of employees at the Center?

2. How many employees are planned?
   (Staffing patterns are contained in a red cover book. The Committee may wish to request the book, as the numbers appear excessive)

3. In what service area are there employees missing?

4. What is the problem in recruitment?
   (They are expecting too many top professional persons, like 15 Physical Therapists, with not enough pay. Answer: Use more attendants)

5. How many employees have quit or been terminated since the Center opened?
   (At least 2 Physical Therapists have tried to quit; 1 did for sure)

6. Has there been a problem, caused by any particular physician, in that the clients are kept at the Center beyond normal time frames?
   (If answer is "no", response can be that a highly regarded Physical Therapist, a constituant of Assemblyman Jeffrey, has reported lengthly stays, by chronic patients. Physical Therapists complain of boredom; chronic patients are not discharged.
   Also, the Maher Report for 3-13-78 to 12-31-78, under Goals and Objectives, states:
   #4. Develop a "chronic pain" program, and
   #12 Reduce average patient length of treatment to 35 working days)

7. During the absence of the Center Administrator, was anyone responsible for providing timely management reports to the Commission?
   (If answer is "yes", suggest that Committee request those reports.)

8. What is the average length of time that the physiatrists are spending in direct contact with the clients?
   (NIC Advisory Committee member reports 4 hours average in evaluation alone. Even if client is given an EMG, evaluation should take no more than 1½ hours.)

9. Have you had problems getting management information regarding the Center operations?
   (If "no", the Maher Report for 3-13-78 to 12-31-78, Goals and Objectives,
   #28 Train more staff in the operation of the system 6 and the accounting functions for the Center.
   #29 Provide more computer information in the form of management type reports to assist in the analysis of the effectiveness in the treating departments.
   #30 Complete an inventory system to provide control of all commission assets. This will cover both fixed assets and supplies and materials.
   #31 Implement a minimum/maximum control on all supplies and materials to ensure that goods are on hand as needed so as to eliminate patient care interruptions.)

EXHIBIT D

10. With all the preparation time for this Center, why were the controls and management systems mentioned above as needed, not planned and tested prior to this late date?

11. Does the Commission employ a fiscal and program evaluator? If so, for an operation the size of the Center, has there been a full evaluation of Center operations, including verification of management reports?
(If not, why not?) (If there has been an independent evaluation, what changes have been made?)

12. What is the daily utilization rate of each of the service areas?
(If answer is unavailable, ask how they know that the equipment and the service area is necessary?)

13. Are staff using some of the more amenable aspects of the facility(eg, the pool)?
(One legislator reported having seen this.)

14. ~~Is the NIC Center in Las Vegas accredited?~~
~~(If not, why not?)~~

15. Is there any logical reason as to why you would not want the proposed bill to pass?
(Whatever the answer, respondent should be asked how he would feel as an employer if he knew that considerable sums of money could be reimbursed to the NIC employers' fund, rather than carrying the burden of such a huge Center alone?)

NOTE: Rehabilitation funds are 80% Federal Dollars; 20% State.

M E M O R A N D U M

TO: COMMISSION

FROM: SKIP KING

REGARDING: SB 275

DATED: MARCH 20, 1979

You have requested a written legal opinion concerning this issue:

Does SB 275, as presently worded, raise an issue of possible unconstitutionality?

In my opinion, the language contained on page 2, lines 14-31, creates a potential violation of the Nevada Constitution, Article 9, section 2. That section reads in part as follows:

> Any moneys paid for the purpose of providing compensation for industrial accidents and occupational diseases, and for administrative expenses incidential thereto, and for the purpose of funding and administering a public employees' retirement system, shall "be segregated in proper accounts" in the state treasury, and such money "shall never be used for any other purposes," and they are hereby declared to "be trust funds" for the uses and purposes herein specified.

The Rehabilitation Center was funded entirely by employer premiums taken from the state insurance fund. To the extent that NRS 616.223, as amended by SB 275, would require the Commission to make services available at less than actual cost, it would be in violation of the Constitution.

Also, to the extent that this amendment would require the Commission to accept referrals from the Rehabilitation Division of the Department of Human Resources to the exclusion of injured workers, it would be in conflict with NRS 616.222 and may be in violation of the Constitution.

Frank A. King

FRANK A. KING, General Counsel

Nevada Industrial Commission

Exhibit F

STATE OF NEVADA
COMPREHENSIVE HEALTH PLANNING
SUITE 217, CAPITOL PLAZA
1150 EAST WILLIAMS STREET
CARSON CITY, NEVADA 89701
TELEPHONE (702) 885-4720

MIKE O'CALLAGHAN
GOVERNOR

DAVE NICHOLAS
STATE HEALTH PLANNER

March 22, 1976

MEMORANDUM

TO: DEL FROST, ADMINISTRATOR
REHABILITATION DIVISION, DEPT. OF HUMAN RESOURCES

FROM: DAVE NICHOLAS

SUBJECT: NIC

I heard from John Reiser concerning the new facility in Las Vegas. He passed on the following to me:

"As you know, the statutory responsibility of the Nevada Industrial Commission is to prevent or reduce disability due to industrial injuries and diseases. Therefore, priority of all NIC facilities must be given to meeting these statutory responsibilities. However, to the extent that NIC resources are greater than those necessary to meet the needs of industrially injured Nevadans, the commission intends to make these services available on a fee-for-service basis under an extension of the attached cooperative agreement."

John attached a copy of the 2/5/76 cooperative agreement between Rehabilitation and NIC. He also referred to the Advisory Committee to the Department of Education and Rehab for the Vocational Education and Handicapped Services Plan by saying that he planned to join in the efforts of the committee.

DN:bg

Exhibit G

Nevada Nurses' Association

3660 Baker Lane Reno, Nevada 89509 (702) 825-3555

AB 50 - FACT SHEET

HISTORY: This bill is the result of study by a joint task force of the Nevada Nurses' Association and the Nevada State Board of Nursing. The bill increases license fees for nurses.

REASON FOR BILL: The present fee structure of the Nevada State Board of Nursing has not been changed since 1963. It took until 1977 for the Board to "grow into" the maximum amounts in the fee schedule. The Board anticipates:

1. A loss of income due to Fillipino nurses' loss of interest in pursuing Nevada licenses at $45.00 each if they must first pass our licensing examination as provided in AB 49.

2. A cost involved in carrying out a mandatory continuing education requirement if a bill passes this session which would direct their requiring continuing education for relicensure.

3. Cost will most certainly continue to increase for the operation of the Board's business even if the first two situations do not materialize.

WHAT THE BILL DOES: The bill allows for the Nevada State Board of Nursing to increase licensing and other fees as its costs of operating increase.

Nevada Nurses' Association

3660 Baker Lane Reno, Nevada 89509 (702) 825-3555

AB 51 - FACT SHEET

HISTORY: The subject of mandatory continuing education as a requirement for relicensure has been discussed within the nursing profession in Nevada for years. This bill is the result of study by a joint task force of the Nevada Nurses' Association and the Nevada State Board of Nursing. Nurses all over Nevada have participated in hearings on this subject, and a vote was taken at the Nevada Nurses' Association convention in Las Vegas last October. Controversy still remains on the subject of mandatory continuing education, or C.E., as it is often called. However, no other organization or group within Nevada represents as many nurses as NNA does, and no other organization or group can claim state-wide discussion of this issue.

REASON FOR BILL: To date, at least 25 states either have a mandatory continuing education requirement or else have legislation pending on the subject. In Nevada, many professional groups already have a state law which requires continuing education for relicensure. We believe that this is truly a consumer bill. As this legislature has demonstrated in the past in passing mandatory continuing education bills for other professions and occupations, it can demonstrate again its support of the members of a profession maintaining quality control over their own profession.

WHAT THE BILL DOES: This bill would add a new section to the Nurse Practice Act which would require that all nurses show proof of having received 30 contact hours of continuing education within the two-year period prior to renewal of licenses. The Nevada State Board of Nursing would have the option of appointing an advisory committee of no more than 5 persons to assist them in establishing the program. The requirement would become effective in time for the 30 hours of continuing education to be gathered during 1980 and 1981 for renewal of licenses in March of 1982.

I am Shirley Howard, representing the Nevada Nurses Association Legislative Committee.

The Nevada Nurses Association supports AB51 which requires that each RN and LPN participate in continuing education to maintain a license to practice in Nevada. It is a commitment of 1 hour and 15 minutes each month to maintain current knowledge.

Nurses are not being singled out, but rather, are feeling the need to raise professional standards. Teachers, real estate agents, pharmacists, nutritionists are also others who already must participate in continuing education in order to maintain their right to carry out their professional responsibilities. As a matter of fact, school nurses in Nevada are already required to show proof of continuing education to maintain their certification.

Concern has been expressed about the effect of this requirement on nurses living in rural areas. There has been much support for this bill from rural nurses. In a survey completed just one year ago, 48.8% of the nurses living in counties other than Washoe and Clark reported continuing education. It would appear that the opportunity is available for rural nurses to meet this requirement.

Another issue which has been raised is one of prematurity. Yet, this issue has been under study in Nevada since 1970. Since 1974, a voluntary program of recognition of nurses for continuing education efforts has been supported by both the Nevada Nurses Association and Nevada Licensed Practical Nurse Association. The results have been disappointment, thus, the movement to a mandatory program to help insure up-to-date care to people needing nursing care.

Thank you for your attention. I will try to answer any questions you may have.

I. Professional Nurses ARE in favor of Continuing Education, but we are OPPOSED to MANDATORY Continuing Education for RE-LICENSURE.

The following represents our justification in requesting a delay in the hearing of AB-51, as there is a very real concern regarding a lack of significant input from Nurses in Nevada regarding this Bill. A delay in the hearing would allow time for input from a broader representation of Nurses in Nevada.

II. Although NNA has sponsored this bill, they do not represent the majority of Nurses in Nevada. As of March 21, 1978 there are 3,439 Nurses registered in Nevada. The NNA represents only 500-600 Registered Nurses. How many Registered Nurse opinions are represented through this Bill?

III. We have a concern regarding the added costs of implementing this Bill.

1. Will costs to the State Board of Nursing for increased Staff and Budget result in increased license fees to Nurses? Will these fee increases cover the costs of implementing these programs? Will additional fees be passed on to the individual Nurse should the flood of applications for program presentation be submitted from Private Enterprise and Educational Facilities?

   Will increased costs of such a program create additional fiscal burdens on the State, the Health Care facilities and the Consumer?

IV. There are many programs currently offered by Health Care facilities, which are vital to keeping Nurse's skills updated, but do not meet the minimum requirements of Approved Programs, such as number of hours in presentation. Will Nurses need additional time and money to comply with requirements?

V. Does Mandatory Education insure knowledge, and improvement of skills or does attendance at Programs only to obtain necessary requirements give a false definition of competency?

VI. Why, when there are currently no programs to assist Nurses who have not been in practice for several years, are we mandating that education is needed for those already practicing?

VII. Will passage of this Bill cause a more serious recruitment problem than we now have?

EXHIBIT J

THIS PETITION IS A SMALL REPRESENTATIVE SAMPLE OF CARSON CITY NURSES, GATHERED IN TWO DAYS, WHO ARE OPPOSED TO AB-51.

EXHIBIT J

PETITION

THE NEVADA NURSES ASSOCIATION IS ENCOURAGING MANDITORY CONTINUING EDUCATION FOR RELICENSURE,

THE NEVADA NURSES ASSOCIATION DOES NOT REPRESENT THE MAJORITY OF NURSES IN THE STATE OF NEVADA.

WE THE UNDERSIGNED DO NOT AGREE WITH THE NEVADA NURSES ASSOCIATION'S STAND AND THEREFORE ARE AGAINST MANDITORY CONTINUING EDUCATION FOR RE-LICENSURE.

NAME	ADDRESS
Nancy Rachel RN	1319 n. Mnt. CC
Jennie Long	P.O. 5344 So. Lake Tahoe, Ca 95729
Ruth E. Kolbeck.	
Patricia A. Thunder RN	505 Bat Lane CC
L. Ingler R.N.	1462 So D. Virginia City Nev. 89440
E. Watson	5 Zephyr Cr. Carson City, Nev.
Lorraine Dishman	1050 Ruby Ln. Carson City, Nev.
[illegible]	12 Miller Way Carson City Nev 89701
Marilyn Adams	804 Sharron Way - Carson City Nev.
Janet V. Jones	470 Bavarian Dr. Carson City, Nev 89701
Victoria J. Hamilton R.N.	1520 Valley View Dr. Carson City, NV 89701
Ethel E. Thurman RN	204 Winters Dr. Carson City Nev 89701
Katharine Mallory RN	804 W. Sunset Way Carson City Nev 89701
Sandra Sullivan R.N.	21010 Ames Ln. Reno, Nev 89511
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Carolyn M VanPelt RN	P.O. Box 2 Silver Springs NV
[illegible]	
Kim Hourquin R.N.	P.O. Box 837 Dayton, Nv.
Susan Maloney RN	PO Box 6699 So Lake Tahoe, Ca 95729
Jan Lindsey	PO Box 214 Carson City, Nv. 89701
Betty Hood RN	P.O. Box 1014 Carson City, Nev
Karen Boone RD	700 N. Andrews, Carson City, NV. 89701

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EXHIBIT J

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NAME	ADDRESS
O.J Allred LPN	#6 Menlo Ct Carson City
S.T. Haynes LPN	176 Marion Ave Carson City
Y.A. Benton RN.	P.O.Box 344, Dayton, Nevada, 89403
L. Canaday LPN	P.O. Box 111, Minden, Nev. 89423
S. Bryant LPN	P.O. Box 164, Carson City, Nev. 89701
L Landee LPN	3580 E. Nye Lane-Carson City Nev. 89701
B Spurgeon LPN	Box 824 Dayton, Nev
JS Byrne, RN	PO Box 505 - Virginia City, Nev. 89440
Emily Jones RN -	211 Carville Circle CC
Alice Brown RN	2269 Bunch Way, C.C. Nevada 89701
Virginia Butler LPN	702 So Fall St, P.O. Box 2785 Carson City Nev.
Grace Meeks RN	2305 Michael Dr Carson City Nev
Rose M Downs R.N	Box 343 Gardnerville Nevada
Carole Bridgeman	15320 Callaha Rd Reno, Nv 89511
Janet Gail RN	1328 Saratoga, Rte 3, Minden, Nev
Alice Estil RN	709 Terrace Dr. C.C.
[illegible] RN	308 Boulder Dr CC
Mary Stuchell RN	717 Pioche CC
Jean Valentine RN	P.O Box 1359, CC Nv.
[illegible] LPN	509 W. Arlington St. CC Nev 89701
Doreena Vogue	P.O. Box 983 C.C. Nev. 89701

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EXHIBIT J

PETITION

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B Sperong LPN	Box 824 Dayton, Nev
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[illegible] RN	308 Boulder Dr CC
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Doreena Vogue	P.O. Box 983 C.C. Nev. 89701

007

EXHIBIT J

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Terrie Haynes LPN	Rt. 3 1502 Dover St. Minden, Nev.
Peggy Dumas LPN	1976 Marian Ave. CC
Marymore RN	P.O. Box 201 CC
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Lois Brunean LPN	700 Pioche St. Carson City, Nev. 89701
Harriet Jones LPN	4384 Ponderosa Dr. Carson City
Betty Sibbitt, RN	602 Poplar St. Carson City, Nev.
Ann Heffington	1217 Calaveras Drive. CC Nev. 89701
Martha Carpenter RN	Box 96. Minden, Nev.
[illegible] Lawson, RN	Box 209, Carson City, Nev.
Bonnie [illegible]	605 Pat Ln Carson City NV 89701
Joan K. Keister	34 Crownpoint Dr. Carson City - 883-5770
Kathy Bonger	2420 Bunch Way C.C.
Debbie Grabski	1301 Colorado St C.C 882-0103
Dorothy O'Hearn	Rt 3 Box 391 Minden 882-4721
Anita d'Paolo	PO Box 2124 CC. 89701 882-[illegible]
Esther Hakkila	1327 Lahona Drive CC NV 89701
Ellene Rake RN	3205 Northgate Lane C.C. NV. 89701
Joann McCormick RN	5030 [illegible] Ln C.C, Nev 89701
Ann Mason, RN.	R.R. - Jacks Valley Rd. - CC, NV.

EXHIBIT J

J. Williams, L.V.N. 2716 MOAC CT-WEST

Patricia Small R.N. 705 Terrace Dr. C.C.

Mina Moser R.N. 104 Elm St. C.C.

Blacked out names appear on first pages of petition

PETITION

EXHIBIT J

The Nevada Nurses Association is encouraging manditory continuing education for relicensure.

The Nevada Nurses Association does not represent the majority of nurses in the State of Nevada.

We the undersigned do not agree with the Nevada Nurses Association's stand and therefore are against manditory continuing education for re-licensure.

1001 WAGNER DR. C.C.
Jeannine Madson, R.N.
[redacted]
Kallda 4880 [illegible] 883-3381
[redacted]
M. Kerby RN 1773 Camille Dr C.C.
M. Packmore RN 3650 E NYE LN C.C.
1060 APPIONI[illegible] C.C. Sue Rockwood LPN
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Joan Dewell RN Box 3663 STATELINE, NV. 89449
G. Danchell RN Box 2[illegible] STATELINE, NV 89449
M. Mechum LVN 7[illegible] Circle, C.C.
C Freeman LVN 1511 N. [illegible] St C.C.
Wood RN 1780 WINNIE LN, C.C.
[redacted]

[illegible] Box 581 ZEPHYR COVE, NV 89448.
Joan Johnson RN 2518 Lilly DR. C.C.
[redacted]
A. [illegible] RN 3784 PEBBLE DR. WELLINGTON, NV 89444
Russell Classon LPN 3707 CITRUS DR SILVER SPRINGS, NV 89429
[redacted]
A. [illegible] RN 12 SUNSET WAY C.C.
[redacted]
Carolyn M. VanPalt RN Box 2 SILVER SPRINGS NV.
Marlene Lanes LPN 5 Homewood Ave C.C.
Marilyn Smith LPN 2720 Love Lace Way C.C.

EXHIBIT J

PETITION

THE NEVADA NURSES ASSOCIATION IS ENCOURAGING MANDITORY CONTINUING EDUCATION FOR RELICENSURE,

THE NEVADA NURSES ASSOCIATION DOES NOT REPRESENT THE MAJORITY OF NURSES IN THE STATE OF NEVADA.

WE THE UNDERSIGNED DO NOT AGREE WITH THE NEVADA NURSES ASSOCIATION'S STAND AND THEREFORE ARE AGAINST MANDITORY CONTINUING EDUCATION FOR RE-LICENSURE.

NAME	ADDRESS
Margaret M. [illegible] RN	210 Albany CC Nev
[illegible] RN	[illegible] Enterprise Way Carson City
[illegible] O'Shaughnessy RN	[illegible] CARSON CITY
[illegible]	3576 [illegible] View CT " "
Carole E. Raab	3510 Woodside Dr. CC.
Eloise Ozaine	3606 Woodside Dr. C.C. Nv.
Ann Collier	812 Wagner Dr. Carson City, NV.
Teri Parker	1420 N. Edmonds Dr #3 C.C. NV
Evelyn Charles	2641 Brentwood Dr. C.C. Nv.
Barbara J Lyle	P.O. Box 918, Carson City, Nev.
Ann Evans	Star Rt 1 Box 753A Carson City

Exhibit K

Nevada Nurses' Association

3660 Baker Lane Reno, Nevada 89509 (702) 825-3555

AB 49 - FACT SHEET

HISTORY: This bill is the result of study by a joint task force of the Nevada Nurses' Association and the Nevada State Board of Nursing. The bill deals with minimum requirements for licensure as a registered nurse and as a practical nurse in Nevada.

REASON FOR BILL: Nurses from the Philippines are seeking information from the Nevada State Board of Nursing on obtaining licenses in Nevada since our law does not permit our testing foreign nurses prior to issuing licenses. There are now two file drawers of these inquiries at the Nevada State Board of Nursing. We are concerned about the quality of patient care if we must issue licenses without being able to test applicants.

WHAT THE BILL DOES:

1. It eliminates the current practice of licensing foreign nurses without examination by simply requiring that all nurses who have passed the test currently being required in this state may receive licenses without being tested, and all nurses who have never passed the test currently required in Nevada must pass the test before receiving a Nevada license. (The State Test Pool Examination is given in all 50 states, as well as some territories, and has been given in some Canadian provinces.)

2. It requires that Licensed Practical Nurses must have a high school diploma or its equivalent as determined by the Nevada State Board of Education. This is already required by the Board of Nursing but needs to be included in the law.

acog **statement of policy**
AS ISSUED BY THE EXECUTIVE BOARD OF ACOG

THE RESPONSIBILITIES OF THE HEALTH TEAM IN MATERNITY CARE

The American College of Obstetricians and Gynecologists reaffirms its policy that the health team necessary to provide optimal maternity care must be directed by a qualified obstetrician-gynecologist. Fully recognized in this policy is the role of the certified nurse-midwife who, as a member of this team, may assume responsibility for the complete management of the uncomplicated pregnant woman.

The ACOG supports the worldwide standards endorsed by the World Health Organization concerning the education of midwives. Midwives should have a minimum of three years of formal training, including at least one year of nursing. For those midwives who have already completed nursing education, two years of midwifery education is the minimum requirement. The American College of Nurse-Midwives has set comparable additional standards in the United States which are also supported by The American College of Obstetricians and Gynecologists. The certified nurse-midwife meets these standards. Lower standards are unacceptable for the care of women in the United States.

The ACOG supports actions and programs which encourage family-centered maternity care while continuing to provide the mother and her infant with the accepted standards of safety available only in a hospital setting.

The ACOG supports regional planning which provides for easy access to quality care at the primary level and the availability of more specialized care at regional centers when necessary. This planning should provide continuity of care for the individual woman throughout pregnancy and the interconceptional period.

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
ONE EAST WACKER DRIVE • SUITE 2700 • CHICAGO, ILLINOIS 60601 • (312) 222-1600

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The ACOG supports the right of the pregnant woman to informed consent while recognizing that at the same time the woman assumes responsibility for decisions which she makes in the interest of her own health and the health and welfare of her infant. Government and its agencies have a responsibility to insure that inadequately trained personnel and unsafe facilities are not approved.

Approved by the Executive Board
December, 1977
Amended April, 1978

(CALIFORNIA) SB 1332

EXHIBIT L

Senate Bill No. 1332

CHAPTER 1407

An act to amend Section 2815 of, and to add Article 2.5 (commencing with Section 2746) to Chapter 6 of Division 2 of, and to add Section 2815.5 to, the Business and Professions Code, relating to midwives.

[Approved by Governor September 25, 1974. Filed with Secretary of State September 25, 1974]

LEGISLATIVE COUNSEL'S DIGEST

SB 1332, Beilenson. Nurse-midwives.
Provides for the certification of qualified nurses, as specified, to be nurse-midwives and authorizes the practice thereof, as defined.

Appropriation: yes.

The people of the State of California do enact as follows:

SECTION 1. Article 2.5 (commencing with Section 2746) is added to Chapter 6 of Division 2 of the Business and Professions Code, to read:

Article 2.5. Nurse-Midwives

2746. The board shall issue a certificate to practice nurse-midwifery to any person who qualified under this article and is licensed pursuant to the provisions of this chapter.

2746.1. Every applicant for a certificate to practice nurse-midwifery shall comply with all the provisions of this article in addition to the provisions of this chapter.

2746.2. Each applicant shall show by evidence satisfactory to the board that he has met the educational standards established by the board or has at least the equivalent thereof. The board is authorized to appoint a committee of qualified physicians and nurses, including but not limited to, obstetricians and nurse-midwives, to develop the necessary standards relating to educational requirements, ratios of nurse-midwives to supervising physicians, and associated matters.

2746.3. Midwife's certificates issued by the Board of Medical Examiners of the State of California prior to the effective date of this article shall be renewable only by such board.

2746.4. Nothing in this article shall be construed to prevent the practice of midwifery by a person possessing a midwife's certificate issued by the Board of Medical Examiners of the State of California on the effective date of this article.

2746.5. The certificate to practice nurse-midwifery authorizes the holder, under the supervision of a licensed physician and surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother, and immediate care for the newborn.

As used in this chapter, the practice of nurse-midwifery constitutes the furthering or undertaking by any certified person, under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics, to assist a woman in childbirth so long as progress meets criteria accepted as normal. All complications shall be referred to a physician immediately. The

practice of nurse-midwifery does not include the assisting of childbirth by any artificial, forcible, or mechanical means, nor the performance of any version.

As used in this article, "supervision" shall not be construed to require the physical presence of the supervising physician.

A nurse-midwife is not authorized to practice medicine and surgery by the provisions of this chapter.

2746.6. The board may take disciplinary action against a person possessing a certificate as a nurse-midwife for:

(a) Unprofessional conduct, which includes but is not limited to the following:

(1) Incompetence, or gross negligence in carrying out the usual functions of a nurse-midwife.

(2) A conviction of practicing medicine without a license in violation of Chapter 5 (commencing with Section 2000) of Division 2, in which event the record of conviction shall be conclusive evidence thereof.

(3) The use of advertising relating to nursing which violates Section 17500.

(b) Procuring his certificate by fraud, misrepresentation, or mistake.

(c) Procuring, or aiding, or abetting, or attempting, or agreeing, or offering to procure or assist at a criminal abortion.

(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter.

(e) Making or giving any false statement or information in connection with the application for issuance of a license.

(f) Conviction of a felony or of any offense involving moral turpitude, in which event the record of the conviction shall be conclusive evidence thereof.

(g) Impersonating any applicant or acting as proxy for an applicant in any examination required under this chapter for the issuance of a license or a certificate.

(h) Impersonating another licensed practitioner, or permitting or allowing another person to use his license or certificate for the purpose of nursing the sick or afflicted.

(i) Aiding or assisting, or agreeing to aid or assist any person or persons, whether a licensed physician or not, in the performance of or arranging for a violation of any of the provisions of Article 13 (commencing with Section 2360) of Chapter 5 of Division 2.

(j) Commission of any act coming within the scope of Section 2762.

2746.7. An applicant for certification pursuant to this article shall submit a written application in the form prescribed by the board, accompanied by the fee prescribed by Section 2815.5.

2746.8. Each certificate issued pursuant to this article shall be renewable biennially, and each person holding a certificate under this article shall apply for a renewal of his certificate and pay the biennial renewal fee required by Section 2815.5 every two years on or before the last day of the month following the month in which his birthday occurs, beginning with the second birthday following the date on which the certificate was issued, whereupon the board shall renew the certificate.

Each such certificate now renewed in accordance with this section shall expire but may within a period of eight years thereafter be reinstated upon payment of the biennial renewal fee and penalty fee required by Section 2815.5 and upon submission of such proof of the applicant's qualifications as may be required by the board, except that during such eight-year period no examination shall be required as a condition for the reinstatement of any such expired certificate which has lapsed solely by reason of nonpayment of the renewal fee. After the expiration of such eight-year period the board may require as a condition of reinstatement that the applicant pass such examination as it deems necessary to determine his present fitness to resume the practice of nurse-midwifery.

Sol T. DeLee, M.D.
1005 SOUTH THIRD STREET
LAS VEGAS, NEVADA 89101
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TELEPHONE 382-6100

EXHIBIT L

January 9, 1979

Patrick M. Flanagan, M.D.,
Chief of Staff
Womens Hospital
2025 E. Sahara Avenue
Las Vegas, Nevada 89105

Dear Dr. Flanagan:

The purpose of this letter is to summarize our discussions regarding the subject of nurse-midwives and their role at Womens Hospital and other hospitals in this community.

The "Criteria for Evaluation of Educational Programs in Nurse-Midwifery", published by the American Collage of Nurse-Midwives, is herein enclosed, as well as policies and procedures of approval for these programs. It is obvious that when a trainee has finished this formal schooling, which includes a B.S. or B.A. degree and a residency program, he or she is well qualified to perform in the field of obstetrics within the limitations as carefully outlined and designated.

There are numerous schools of midwifery throughout the country and those that adhere to the criteria of the American College of Nurse-Midwives graduate very fine practitioners. The University of Utah, the Armed Forces and the University of San Francisco are just three of many prestigious schools available.

The American College of Obstetrics and Gynecology works cooperatively with the American College of Nurse-Midwives, and a Fellow of the former serves on the Nurse-Midwife certifying board. The book entitled "Maternal Care in the World", published by the United States government, describes the current status of obstetric care in over 200 nations. Midwives are permitted privileges in all of these nations.

Under current law, nurse-midwives may practice their profession by law in 46 states. Kansas, Michigan and Wisconsin prohibit midwives from practicing. In Nevada, no specific legislation exists, although one can interpret Nevada legislation pertinent to the use of surgical assistants as the right for qualified nurse-midwives to practice within the scope of their training under the guidance and responsibility of a licensed M.D.

For several years now, a nurse-midwife has delivered a large percentage of the babies at Nellis Air Force Base, and the results have proven to be most satisfactory. This has been substantiated and documented, facts made available to the specialists of Southern Nevada.

EXHIBIT L

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TELEPHONE 382-6100

January 9, 1979

Patrick M. Flanagan, M.D. - 2

You have asked me to present an opinion from the members of the Clark County Obstetrical & Gynecological Society, of which there are some 30 members, comprising all the specialists in Southern Nevada. In written statements from most and verbally from the others, all but three have approved the privileges of nurse-midwives in the hospitals in Southern Nevada, sanctioning their working for specialists in obstetrics, with the reservation that the employer must be responsible for their performance and adhering to the guidelines and restrictions as set forth, not only by the American College of Nurse-Midwives, but according to the hospital bylaws passed for this very purpose, specifically in this instance at Womens Hospital.

California, New York, Illinois and other populous States make extensive use of nurse-midwives and many other communities where physicians are not so numerous and available, such as in the South (Kentucky, Arkansas, Tennessee, Louisiana are a few), also find nurse-midwives (and even lay midwives) very useful. Our neighbor State, California, is considering the outlawing of lay midwives, but have made nurse-midwives feel most welcome.

I trust this information may prove helpful in your efforts to have the position of nurse-midwives made clear in Nevada, allowing them to work as designated. Certainly such legislation is long overdue.

Yours very truly,

Sol T. DeLee, M.D.

Sol T. DeLee, M.D., President
Clark County Obstetrical & Gynecological Society

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JOINT STATEMENT ON MATERNITY CARE, 1971 AND SUPPLEMENTARY STATEMENT, 1975

The American College of Nurse-Midwives
The American College of Obstetricians and Gynecologists
The Nurses Association of The American College
of Obstetricians and Gynecologists

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JOINT STATEMENT ON MATERNITY CARE (1971)

The American College of Obstetricians and Gynecologists, The Nurses Association of The American College of Obstetricians and Gynecologists and the American College of Nurse-Midwives recognize the increasing needs for general health care and, more specifically, the deficits in availability and quality of maternity care. The latter, which are not confined to any social class, can best be corrected by the cooperative efforts of teams of physicians, nurse-midwives, obstetric registered nurses and other health personnel. The composition of such teams will vary and be determined by local needs and circumstances. The functions and responsibilities of team members should be clearly defined according to the education and training of the individuals concerned.

To achieve the aims of providing optimal maternity care for all women the following recommendations are made:

1. The health team organized to provide maternity care will be directed by a qualified obstetrician-gynecologist.

2. In such medically-directed teams, qualified nurse-midwives may assume responsibility for the complete care and management of uncomplicated maternity patients.

3. In such medically-directed teams, obstetric registered nurses may assume responsibility for patient care and management according to their education, training and experience.

4. In such medically-directed teams, other health personnel who have been trained in specific areas of maternity care may participate in the team functions according to their abilities and within the definitions of responsibility established by the team.

5. Written policies describing the specific functions of each of the team members should be prepared. They should be reviewed and revised periodically according to changing needs.

In endorsing the above statement, The American College of Obstetricians and Gynecologists, The Nurses Association of The American College of Obstetricians and Gynecologists and the American College of Nurse-Midwives recognize as their common goal the need for improvement and expansion of health services now being provided for women.

In order to maintain a continuing evaluation of the health services being provided for women and to plan for needed improvements and expansion, a mechanism for continued communication between all the organizations responsible for their provision is being developed.

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SUPPLEMENTARY STATEMENT (1975)

Many questions have arisen concerning the meaning of the recommendation in the Joint Statement on Maternity Care (1971) that the health care team be "directed by a qualified obstetrician-gynecologist." These questions are justified and are accentuated by other developments in the specialty of obstetrics-gynecology which include the changing birth rate, formalization of new roles for personnel, emphasis on preventive care, HMO's, plans for national health insurance, PSRO, and regionalization of health services.

It is recognized that the obstetrician-gynecologist cannot under all circumstances be physically present to direct the health team; therefore it is essential that mechanisms of communication be clearly established for him or her to provide direction. Thus, the nature of the direction of the health team indeed becomes crucial.

"The obstetrician-gynecologist working within a team giving health care to women has many responsibilities. These range from the direct provision of services to community health efforts and include:

a. The supervision of the medical care provided by all team members.

b. The direct provision of care for complications of pregnancy and for complex medical and surgical gynecological conditions.

c. The setting of medical care standards.

d. The provision of consultation to other team members.

e. The surveillance of task distribution within the team.

f. Participation in the ongoing educational activities of the team.

g. The introduction of new medical techniques as they become available.

h. The development of medical research."[1]

In view of the diversity of health care systems in which the obstetric-gynecologic health team currently functions, no universal systems model can be applied. Generally, however, the team is found in the following broad contexts:

1. Urban (intramural, on site, immediate referrals);
2. Rural (with institutional affiliation);
3. Rural (without institutional affiliation but with obstetric consultation available);
4. Private office (urban or rural).

The logistics of consultation and referral may vary with geographic and climatic conditions, but the following basic principles of team interaction are valid regardless of these conditions:

1. There must be a written agreement among members of the team clearly specifying consultation and referral policies and standing orders. The representatives of each practice discipline should participate in the development of and be signatory to the agreement.
2. The obstetrician-gynecologist, upon signing protocols, must accept full responsibility for direction of medical care rendered by the team in accordance with his or her orders.
3. In circumstances wherein the functions of the team leader are necessarily performed by physicians without specialty training in obstetrics-gynecology, medical direction should be provided through a formal consultative arrangement with a qualified obstetrician-gynecologist who is available to team members for continuing consultation and assurance of quality care.

[1]From "Medical Practice in the Obstetric-Gynecologic Health Care Team," Interorganizational Committee on Ob/Gyn Health Personnel, September, 1973.

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Nurse-Midwives
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EXHIBIT L

standards for ambulatory obstetric care

SUPPLEMENT TO
STANDARDS FOR
OBSTETRIC-GYNECOLOGIC
SERVICES, 1974

[1977]

THE AMERICAN COLLEGE
OF OBSTETRICIANS
AND GYNECOLOGISTS

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PERSONNEL

PERSONNEL WITHIN THE AMBULATORY OBSTETRICAL CARE FACILITY OR CENTER

The personnel requirements for the ambulatory care center will vary considerably depending upon the patient load and upon the organization of the physician supervising the care. The number of individuals and the type of responsibilities assigned to each will vary considerably depending upon the ambulatory setting.

Within each center the obstetric care should be provided under the supervision of a qualified obstetrician or family physician. Depending upon the size and patient load of the facility, the following personnel may be involved:

- Certified nurse midwife
- Nurses
- Allied health assistants
- Aides
- Administrative staff
- Support personnel such as nutritionists, social workers and health educators

In the smaller facilities such as those of the individual physician with a relatively small obstetric practice, all of the functions of the individuals named above may be carried out by a single assistant. Whether the health care team is composed of one assistant or of many individuals, the members of the team should participate in the specific areas of maternity care according to their individual abilities and within the definitions of responsibilities established by the team. Written policies describing specific functions of each member of the team should be prepared. The written policies should be reviewed and revised periodically according to the changing needs. Regular staff meetings are advised.

PERSONNEL RESOURCES WITHIN THE COMMUNITY

Patient Education and Welfare

Cooperative efforts should be undertaken by the physicians within a community for patient education and ancillary services utilizing community or hospital-based programs. The physicians should identify and utilize the resources already existing within the community. Such resources will usually include:

- Social services
- Community services
- Welfare services
- Volunteer service agencies
- Schools: elementary, high schools, colleges, technical schools and alternative schools

Depending upon the organization of the medical community, the community resources may be coordinated through a hospital staff or through the local county or specialty medical society. At times the resources may be organized by

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standards for obstetric-gynecologic services

[redacted] PROTECTED BY
[redacted] 37 U.S. CODE)

THE AMERICAN COLLEGE
OF OBSTETRICIANS
AND GYNECOLOGISTS

1974

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consider the following issues before implementing any change:

- The availability of the various personnel composing the team.
- The needs of the facility, community, and individual patients.
- The educational preparation and clinical skill levels of available personnel.
- The willingness of the team members to accept new roles and their competence to accept their responsibilities.
- The availability of either formal or continuing educational facilities to train these team members adequately, and to evaluate the academic and clinical skills of each team member.

Perhaps the most important factor in considering any change is that of mutual consent and collaboration between the professional disciplines involved. Each local agency must identify its long-term goals and needs. Medicine, nursing, and hospital administration must then identify their roles in a cooperative manner.

House staff and students should participate in the development and functions of the health care team. They can then carry new and efficient methods into their future practice of medicine.

NURSING SERVICES

Nursing Service Philosophy

The philosophy of the nursing service should be clearly defined and documented to ensure the highest quality of nursing care, emphasizing individualized patient care, recognition of immediate and long-term patient needs, patient and family education, environmental and safety controls, and the awareness of the need for a strong continuous educational program for staff development to ensure competence and skill.

Team nursing

The team approach to care recognizes the abilities and skills of both professional and allied health personnel. It encourages the development of nursing care plans, assessments, and team conferences that ensure the high quality of individualized care. It also is an efficient and less costly utilization of nursing time and effort.

Nursing Personnel

Supervision

The nursing service of the obstetric-gynecologic-neonatal divisions should be directed by an individual who is a registered nurse, and who has had specific education or experience in this specialty and has demonstrated clinical and supervisory skill in her field.

Staff

The nursing staff may include:

- Registered nurses who should be in charge of each of the nursing units. Each should have special education or experience in the areas for which she is responsible.
- Nurse-midwives who may be of assistance in providing care for obstetric patients under medical direction and in patient and staff education.
- Other obstetric-gynecologic personnel. Many obstetric-gynecologic tasks

can be performed by persons who have less training than that usually required for obstetric registered nurses or nurse-midwives and who give care under the direct supervision of the registered nurse. The appropriate use of these categories — licensed practical nurse, obstetric assistant, obstetric technician, and obstetric aide — can greatly strengthen the care of the obstetric patient.

Staffing

The complement of nursing personnel assigned to obstetric-gynecologic service should be adequate to provide necessary established nursing hour standards within each unit. Approximate ratios of nurse-patient care hours should be established for each eight-hour period, according to the needs of the patients in the area concerned.

Non-nursing activities should be identified and reassigned to other hospital personnel to enable the nursing staff to concentrate on nursing care, patient education, and staff development.

Orientation and rotation of the nursing staff at regular intervals through the obstetric, gynecologic, and nursery areas are desirable. They should not have assignments in other hospital services, except in extreme emergencies.

The obstetric supervisor should be aware of the nursing personnel and patient census within the various departments of the obstetric services. She should be responsible for the prompt reassignment of the staff from less busy areas to those of critical need.

Labor-Delivery Suite. Staffing depends on the size of the suite, the architectural arrangements of the facility, and the variations in responsibilities delegated to the various categories of the nursing staff. The extent of medical coverage, the types of procedures performed within the unit, and the extent of the patient teaching program also affect the nursing staff ratios. The greater the responsibilities for departmental and patient management, the greater the need for increasing the nursing staff to maintain a high quality of nursing care. When the labor and delivery suite is inactive, staff may be assigned elsewhere in the obstetric service. However, the labor and delivery room is their primary responsibility, and they must be instantly available when the activity resumes. One experienced registered nurse must be available constantly. The labor and delivery suite must have adequate staffing on each of the three shifts.

Obstetric-Gynecologic Surgery in the Obstetric Department. If it is the policy of the hospital to perform "clean" gynecologic procedures within the suite, the nursing personnel must be adequately trained. The additional activities require more nursing personnel. The addition of trained obstetric scrub nurses or technicians should be considered. The surgical schedule must be flexible enough to assure priority for obstetric patient care, deliveries, and emergencies. It is desirable to have a resident or surgically qualified physician assisting the operator whenever a major obstetric-gynecologic operation is to be performed. However, a trained operating-room assistant is acceptable if the obstetric-gynecologic staff of the hospital has approved the concept of non-physician assistants and if the individual has been accepted as an assistant by the operating surgeon.

Obstetric Recovery Room. A registered nurse must direct the care within the recovery room regardless of its geographic location.

Obstetric-Gynecologic Area. The exact number of personnel in each category is determined by local needs and policies. Nursing care standards should be established, evaluated, and reviewed periodically. If the area provides care for "clean" gynecologic as well as for obstetric patients, the need for a qualified nursing staff is increased. (See also *Intrapartum Care*, p. 38.) Adequate skilled

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nursing staff must be provided to ensure high-quality care and to provide staff for maternal and infant care teaching programs.

Nursery. See *Standards and Recommendations for Hospital Care of Newborn Infants*, American Academy of Pediatrics, P.O. Box 1034, Evanston, Ill. 60204, 1971.

Nursing Practice and Policies

Obstetric nursing policies, nursing duties, and staff responsibilities must be clearly defined, and should be written, signed, and readily available to all members of the team. They should be developed by the nursing department in collaboration with the medical staff, and be regularly reviewed and evaluated. Medicolegal responsibility must be considered in developing policy. If there is a nurse-midwifery service, policies should be determined by this service in collaboration with both the nursing and medical departments.

EDUCATIONAL PROGRAMS

An active, continuous educational program is an important part of any obstetric service. The director of nursing inservice education or the obstetric supervisor should assume this responsibility, with active participation from nurse educators and physicians. The inservice education program should be sufficiently developed to include instructions in both academic and clinical skills for all members of the nursing team. Documentation of attendance of persons participating in all such classes is recommended.

Parent Education

Parent education, both antepartum and inpatient, is an integral responsibility of the obstetric-gynecologic health team. Whenever possible, a sound educational program should be available for expectant parents in the areas of antepartum care, infant care, and postpartum care, to include family planning when indicated. Follow-up care and continuation of family education in the home should be considered during the hospital stay. Participation of patients in acceptable education programs by agencies other than the hospital also should be encouraged.

SENATE BILL NO. 275—SENATOR WILSON

FEBRUARY 28, 1979

Referred to Committee on Commerce and Labor

SUMMARY—Requires Nevada industrial commission and rehabilitation division of department of human resources to conclude certain annual agreements. (BDR 53-1007)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State or on Industrial Insurance: No.

EXPLANATION—Matter in *italics* is new; matter in brackets [ ] is material to be omitted.

AN ACT relating to industrial insurance; requiring the Nevada industrial commission and the rehabilitation division of the department of human resources to conclude annual agreements for rehabilitation services to disabled persons; and providing other matters properly relating thereto.

The People of the State of Nevada, represented in Senate and Assembly, do enact as follows:

SECTION 1. NRS 616.223 is hereby amended to read as follows:

616.223 1. Subject to the provisions of this section, the commission [is authorized to] *shall each year* enter into [cooperative agreements] *a cooperative agreement* with the rehabilitation division of the department of human resources [for the benefit of] *, and may annually enter into agreements with other agencies to benefit* disabled employees entitled to compensation and benefits pursuant to the provisions of this chapter [.] *by best using the resources of each agency to provide rehabilitation services and to enable those employees and other disabled persons to enter or return to gainful employment.*

2. Among other things [such] *the* cooperative agreements [may] *must* provide [that:

(a) With the consent of the disabled employee, the compensation and money benefits due him under the provisions of this chapter shall be paid to the rehabilitation division of the department of human resources for deposit by such division in the vocational rehabilitation fund hereby created in the state treasury to be expended by such division for the benefit of such disabled employee.

(b) Within the limits of the money so made available to the rehabilitation division of the department of human resources such division shall:

(1) Provide allowances for living expenses while the disabled

(REPRINTED WITH ADOPTED AMENDMENTS)
FIRST REPRINT

A. B. 50

ASSEMBLY BILL NO. 50—ASSEMBLYMEN GETTO, DINI, HORN, PRICE AND HICKEY

JANUARY 16, 1979

Referred to Committee on Health and Welfare

SUMMARY—Increases maximum compensation payable to members of state board of nursing and license fees for nurses. (BDR 54-702)
FISCAL NOTE: Effect on Local Government: No.
Effect on the State or on Industrial Insurance: No.

EXPLANATION—Matter in *italics* is new; matter in brackets [ ] is material to be omitted.

AN ACT relating to nursing; increasing the maximum and minimum license fees for nurses; and providing other matters properly relating thereto.

The People of the State of Nevada, represented in Senate and Assembly, do enact as follows:

SECTION 1. NRS 632.345 is hereby amended to read as follows:

632.345 1. The board shall establish and may amend a schedule of fees and charges for the following items and within the following ranges:

	Not less than	Not more than
Application for license to practice professional nursing (registered nurse)	[$30.00] *$45*	[$45.00] *$65*
Application for license as a practical nurse	[20.00] *30*	[30.00] *50*
Application for temporary license to practice professional nursing (registered nurse) which fee [shall] *must* be credited toward the fee required for a regular license, if the applicant applies for a license [as provided in such section]	[8.00] *15*	[15.00] *30*

(REPRINTED WITH ADOPTED AMENDMENTS)
SECOND REPRINT

A. B. 51

ASSEMBLY BILL NO. 51—ASSEMBLYMEN GETTO, DINI, HORN, PRICE AND HICKEY

JANUARY 16, 1979

Referred to Committee on Health and Welfare

SUMMARY—Sets certain requirements for continuing education of nurses. (BDR 54-700)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State or on Industrial Insurance: No.

EXPLANATION—Matter in *italics* is new; matter in brackets [ ] is material to be omitted.

AN ACT relating to nursing; setting certain requirements for the continuing education of nurses; and providing other matters properly relating thereto.

The People of the State of Nevada, represented in Senate and Assembly, do enact as follows:

SECTION 1. Chapter 632 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this act.

SEC. 2. 1. *The board shall not renew any license issued under this chapter until the licensee has submitted proof satisfactory to the board of completion, during the 2 year period before renewal of the license, of 15 hours in a program of continuing education approved by the board.*

2. The board shall review all courses offered to nurses for the completion of the requirement set in subsection 1. The board may approve nursing and other courses which are directly related to the practice of nursing as well as others which bear a reasonable relationship to current developments in the field of nursing or any special area of practice in which a licensee engages. These may include academic studies, workshops, extension studies, home study and other courses.

SEC. 3. *1. The board may appoint an advisory council on continuing education for nurses to consist of no more than five members who serve at the pleasure of the board.*

2. The advisory council shall advise the board and assist it in establishing criteria for the approval of programs for the continuing education of nurses.

SEC. 4. NRS 632.080 is hereby amended to read as follows:

632.080 The compensation of the members of the board [shall] *and of the advisory council on continuing education for nurses must* be fixed by the board, but [shall] *may* not exceed the sum of $40 for

(REPRINTED WITH ADOPTED AMENDMENTS)
THIRD REPRINT

A. B. 49

ASSEMBLY BILL NO. 49—ASSEMBLYMEN GETTO, DINI AND HORN

JANUARY 16, 1979

Referred to Committee on Health and Welfare

SUMMARY—Increases standards for licensing of nurses and limits reciprocity of admission of foreign nurses. (BDR 54-701)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State or on Industrial Insurance: No.

EXPLANATION—Matter in *italics* is new; matter in brackets [ ] is material to be omitted.

AN ACT relating to nurses; limiting permanent licenses by reciprocity to nurses who have passed the same examinations required in Nevada; and providing other matters properly relating thereto.

The People of the State of Nevada, represented in Senate and Assembly, do enact as follows:

SECTION 1. NRS 632.160 is hereby amended to read as follows:

632.160 The board [may,] *shall,* without examination, issue a license to practice nursing as a professional nurse to any applicant who meets the qualifications required of professional nurses in this state and who has been duly licensed or registered as a registered nurse *in another jurisdiction after* [examination, under the laws of any other state, territory or foreign country.] *having passed the same licensing examination as that currently required in Nevada for registered nurses.*

SEC. 2. NRS 632.200 is hereby amended to read as follows:

632.200 Upon application and payment of the required fee the board may without examination grant a temporary license to practice professional nursing to [an individual] *a person* whose license from another [state, territory or country] *jurisdiction* is in good standing. Only one temporary license may be issued to any one person during any 12-month period.

SEC. 3. NRS 632.270 is hereby amended to read as follows:

632.270 Each applicant for a license to practice as a practical nurse shall submit to the board written evidence, under oath, that he:

1. Is of good moral character.
2. Has [completed 2 years of] *a* high school *diploma* or its equivalent [and has such other preliminary qualification requirements as the board may prescribe.] *as determined by the state board of education.*

SENATE BILL NO. 312—COMMITTEE ON COMMERCE AND LABOR

MARCH 8, 1979

Referred to Committee on Commerce and Labor

SUMMARY—Authorizes registered nurses to perform certain obstetrical acts under certain circumstances. (BDR 54-1318)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State or on Industrial Insurance: No.

EXPLANATION—Matter in *italics* is new; matter in brackets [ ] is material to be omitted.

AN ACT relating to nursing; authorizing registered nurses to perform certain obstetrical acts under certain circumstances; and providing other matters properly relating thereto.

The People of the State of Nevada, represented in Senate and Assembly, do enact as follows:

SECTION 1. Chapter 632 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this act.

SEC. 2. *1. Except as provided in this section and section 3 of this act, a registered nurse may perform, under emergency or other special conditions prescribed by the board by regulation, acts which are recognized by the medical and nursing professions as proper to be performed by a registered nurse under those conditions, even though the acts constitute the practice of obstetrics or might otherwise be considered diagnosis and prescription. The special conditions must include special training, and in the case of acts constituting the practice of obstetrics, supervision by a licensed physician.*

2. A registered nurse may not perform acts constituting the practice of obstetrics which involve surgery or other procedures specified by regulation of the board as improper to be performed by a nurse under this section.

SEC. 3. *Nothing in this chapter authorizes registered nurses to perform those functions and duties specifically delegated by law to those persons licensed as dentists, podiatrists, optometrists or chiropractors.*

SEC. 4. NRS 632.010 is hereby amended to read as follows:

632.010 As used in this chapter:

1. "Accredited school of nursing" means a school of nursing which is accredited by the board or other body or agency authorized by law to