Legislative Committee on Health Care

Legislative Counsel Bureau
Bulletin No. 03-19

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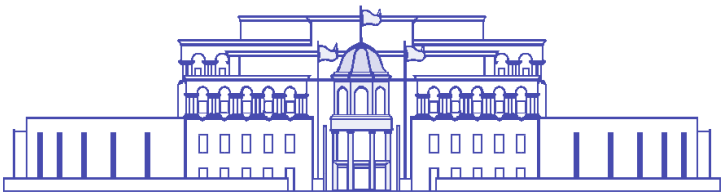

LEGISLATIVE COMMITTEE ON HEALTH CARE

BULLETIN NO. 03-19

JANUARY 2003

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SUMMARY OF RECOMMENDATIONS

This summary presents the recommendations approved by the Legislative Committee on Health Care (*Nevada Revised Statutes* 439B.200) at its April 23, August 22, and October 28, 2002, meetings. The committee submits the following proposals to the 72nd Session of the Nevada Legislature:

Emergency Room Diversion

1. **Require certain hospitals to charge a reduced rate for emergency hospital admissions that occur when a patient is transported to a hospital with which their insurance company is not contracted because of diversion from a contracted hospital. (BDR 40–679)**

2. **Amend Chapter 458 of *Nevada Revised Statutes* (NRS) to include provisions that require peace officers to place an individual under the influence of drugs in civil protective custody when the individual is unable to exercise care of his health or safety, or the health or safety of other persons. Additionally, amend Chapter 433 of NRS to allow certain persons who are mentally ill to be transported directly to a mental health facility without examination by a licensed physician, physician assistant, or an advanced practitioner of nursing. The Division of Mental Health and Developmental Services, Nevada's Department of Human Resources (DHR), and Health Division, DHR, shall develop an algorithm to guide in determining individuals who safely may be transported directly to a mental health facility without certain medical screening. (BDR 39–745)**

3. **Provide an appropriation of $681,810 for each year of the biennium to WestCare to establish a mental health screening and stabilization component to a substance abuse community triage center. (BDR S–678)**

4. **Transmit a letter to Assemblywoman Sheila Leslie expressing support for her bill draft to fund specialty courts, particularly mental health courts.** (The Assembly Committee on Judiciary requested the drafting of this measure; therefore, the letter of support was addressed to the chairman of the Assembly Committee on Judiciary.)

5. **Transmit a letter to urgent care facility administrators informing them of the emergency room diversion problem and encouraging the facilities to work together with emergency medical services in their respective communities to resolve the issue, including consideration of coordinating their hours of operation with peak 911 times.**

Licensure of Certain Mobile Medical Facilities

6. Require the exemption of certain mobile medical facilities that are operated by medical facilities accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association from licensure by the State Board of Health, DHR. (BDR 40–744)

Access to Health and Human Services Providers and Information

7. Adopt a resolution expressing the Legislative Committee on Health Care's support for the development of the abbreviated telephone code 2-1-1 within the State of Nevada. The abbreviated code will provide free access to health and human services information and referrals on a local and national level. (BDR R–680)

8. Provide an appropriation of $6,775,000 for the first year of the biennium and $4,450,000 for the second year of the biennium to the University of Nevada School of Medicine to expand its Rural Obstetrical Access Program. The expansion effort shall include provisions to encourage minorities to pursue careers in the health care field; and further, the list of data to be collected shall include information on public health programs such as Healthy Kids and Nevada Check Up. (BDR 40–743)

Indigent Care Costs and Disproportionate Share Hospital Payments

9. Amend NRS 422.380 through 422.390, which currently authorizes payment of certain hospitals for treatment of Medicaid, indigent, and other low-income patients, to revise the methodology and distribution of disproportionate share hospital payments and intergovernmental transfers as outlined in the *Report on Indigent Care Costs and Disproportionate Share* developed pursuant to Senate Bill 377 (Chapter 598, *Statutes of Nevada 2001*). (BDR 38-746)

Antibiotic Resistance Awareness Program

10. Adopt a resolution expressing the Legislative Committee on Health Care's support for Nevadans for Antibiotic Awareness in its effort to reduce the rate of antibiotic resistance through public education, provider education, promotion of increased adherence to infection control practices, and the development of a surveillance plan for tracking resistance rates and prescribing practices. (BDR R–681)

Long-Term Strategic Health Care Plans

11. Adopt a resolution expressing the Legislative Committee on Health Care's support for the long-term strategic health care plans developed by the Department of Human Resources regarding senior services, rural health, persons with disabilities, and provider rates pursuant to Assembly Bill 1 (Chapter 3, *Statutes of Nevada*

***2002 Special Session*). The resolution should include language urging the continuous allotment of 10 percent of the tobacco settlement funds that are designated to address the needs of disabled persons for the purpose of: (a) home and environmental modifications and assistive technology to allow community access, independent living, or return from institutional care; (b) permanent funding of the state's positive behavioral support program; and (c) respite for families providing primary care to a severely disabled family member. The resolution should also include language conveying the committee's support for establishing permanent long-term funding, which may be a percentage of liquor tax revenue, for chronic public inebriate and mental health services. (BDR –742)**

Detection and Control of Certain Diseases

12. Amend Chapters 439 and 441A of NRS, which currently authorize certain agencies and officers of the state and local governments to quarantine and isolate persons in certain circumstances, to specifically authorize these agencies and officers to quarantine and isolate a group of persons if necessary. Additionally, amend NRS to include due process protections for persons who are quarantined or isolated. Further, require the State Board of Health, DHR, to develop a syndromic reporting and active surveillance system to monitor public health in this state. The syndromic reporting and active surveillance system shall be implemented during certain major events or when determined appropriate and necessary by the district health officer in a district, or his designee, or if none, the State Health Officer, or his designee. The State Board of Health is further required to adopt regulations to carry out the system. (BDR 40-677)

REPORT TO THE 72ND SESSION OF THE NEVADA LEGISLATURE BY THE LEGISLATIVE COMMITTEE ON HEALTH CARE

I. INTRODUCTION

The Legislative Committee on Health Care, in compliance with *Nevada Revised Statutes* (NRS) 439B.200 through 439B.240, oversees a broad spectrum of issues related to the quality, access, and cost of health care for all Nevadans. The committee was established in 1987 to provide continuous oversight of matters relating to health care. Since that time, the committee has addressed a variety of issues including health care cost containment, access to health care for the uninsured, Medicaid, managed care, the rural health service delivery system, and other health-related issues.

During the 2002-2003 legislative interim period, the committee met nine times at meeting sites alternating between Carson City and Las Vegas, Nevada. All public hearings were conducted through simultaneous videoconferences.

The members conducted four work sessions in which they adopted 12 recommendations. The recommendations address the following topics: (a) emergency room diversion; (b) licensure of certain mobile medical facilities; (c) access to health and human services providers and information; (d) indigent care costs and disproportionate share payments to hospitals; (e) an antibiotic resistance awareness program; (f) long-term strategic health care plans; and (g) detection and control of certain diseases.

In addition, a number of recommendations for bills and resolutions were presented to the committee. Although members did not recommend that these proposals be drafted as legislative measures, they are referenced in the report of the committee. These proposals address issues such as the development of a system for reporting medical errors and the availability of inpatient medical care and long-term care to individuals with mental illnesses or disorders such as Alzheimer's disease and dementia.

Senator Raymond D. Rawson served as the chairman of the committee, and Assemblywoman Ellen M. Koivisto served as the vice chairman. Other legislative members of the committee during the 2001-2002 interim included:

Senator Bernice Mathews
Senator Maurice E. Washington
Assemblywoman Merle A. Berman
Assemblywoman Bonnie Parnell

Legislative Counsel Bureau staff services were provided by:

Marsheilah D. Lyons, Senior Research Analyst
Marjorie Paslov Thomas, Senior Research Analyst
Leslie K. Hamner, Principal Deputy Legislative Counsel
Susan Furlong Reil, Principal Research Secretary
Gayle Nadeau, Senior Research Secretary

II. REVIEW OF COMMITTEE FUNCTIONS

The primary responsibilities of the committee are established pursuant to NRS 439B.220 through 439B.240. These responsibilities include reviewing and evaluating the quality and effectiveness of programs for the prevention of illness, reviewing and comparing the costs of medical care among communities in Nevada with similar communities in other states, and analyzing the overall system of medical care in the state. In addition, members strive to avoid duplication of services and achieve the most efficient use of all available resources. The committee also may review health insurance issues and may examine hospital-related issues, medical malpractice issues, and the health education system. See Appendix A for the statutes that govern the committee.

Further, by statute, certain entities are required to submit reports to the committee. They are:

- An annual report of the activities and recommendations of the Advisory Committee on Traumatic Brain Injuries as required by NRS 426A.060. This report provides information on the programs for traumatic brain injury patients and statistics from the head trauma registry.

- A biennial report from Nevada's Department of Human Resources (DHR) regarding any laws or regulations that add to the cost of health care in the state as required by NRS 439A.083.

III. DISCUSSION OF TESTIMONY AND RECOMMENDATIONS

A variety of issues were addressed at the meetings of the committee. This section provides background information and discusses only those issues for which the committee made recommendations. These issues relate to emergency room diversions, licensure of certain mobile medical facilities, access to health and human services providers and information, indigent care and disproportionate share payments to hospitals, antibiotic resistance awareness, long-term strategic health care plans, and detection and control of certain diseases.

A. EMERGENCY ROOM DIVERSION

Pursuant to Senate Bill 484 (Chapter 292, *Statutes of Nevada 2001*), the committee studied emergency room diversions. Emergency room diversion occurs when an emergency room is full and can no longer safely accept additional patients. When this occurs, a hospital is placed on "divert" status. When a hospital is on divert, ambulances are redirected from that hospital emergency room to another hospital. The study included a review of: (1) the causes of diversions; and (2) the effect of diversions on the delivery of health care services to patients in this state and the costs of health care incurred by patients and employers in this state.

Areas related to emergency room diversions for which recommendations are presented specifically relate to insurance payments for certain emergency admissions, patients who have a mental illness or are publicly inebriated and are frequently transported to emergency rooms, and urgent care facilities.

Additionally, testimony was presented which indicates the serious business implications overcrowded emergency rooms and divert have on emergency medical service (EMS) providers who transport patients to emergency rooms. Advocates for emergency medical response personnel testified that the largest cost for any EMS provider is staffing. Citing subsection 1(c) of *Nevada Administrative Code* (NAC) 450B.450, it was indicated that the transfer of care from ambulance provider to the regular staff of the hospital may take several hours. During this time, the emergency service providers are responsible for providing the needed care. This impacts the number of calls emergency transport personnel are able to respond to. However, delays such as those mentioned impact an ambulance company's response time. The response time standards for 911 calls are approximately nine minutes. When unable to meet the response time standard, a penalty is assessed against the ambulance company. One company testified to having spent $180,000 on response time penalties during 2001. Of these, 40 percent were directly related to having crews delayed in hospital emergency rooms rather than being able to respond to additional calls.

According to testimony, emergency room diversion initially only occurred in the Clark County area on a seasonal basis; however, within the last several years, it has become a daily occurrence within the Clark County EMS system. Although, not to the extent of Clark County, presenters indicated that emergency room diversions were also occurring at greater levels in the northern Nevada area, particularly Washoe County. Several items were presented as being attributable to the increase in diversions. Among them are:

- Population growth in metropolitan areas (such as Clark and Washoe Counties);
- Lack of qualified medical staff;
- Decreasing number of hospitals and emergency departments;

- Implementation of certain federal requirements such as the Consolidated Omnibus Budget Reconciliation Act (COBRA) and the Emergency Medical Treatment and Active Labor Act (EMTALA);

- Seasonal disease fluctuations such as the annual influenza epidemic;

- Increasing number of seriously ill patients; and

- Lack of specialty care resources and services to address individuals who are publicly inebriated, mentally ill, or have disorders such as Alzheimer's disease and dementia.

1. Insurance Coverage for Certain Emergency Admissions

Testimony indicated that health plans and insurers establish contracts with physicians, hospitals, and other providers at agreed upon rates to allow access to care at projected costs. Due to emergency room diversions, patients are sometimes diverted from a hospital with which the insurer is contracted to a noncontracted hospital. When an emergency inpatient admission to a noncontracted hospital occurs, substantially higher charges are billed (referred to as "billed charges"). Statistics were provided which indicated that billed charges for admissions to a noncontracted hospital due to emergency room diverts were more than three times the charges generally paid to contracted facilities.

Persons who testified emphasized the adverse effect these unpredictable costs have on the insured population. Specifically, it was indicated that divert has led to an increase in premiums to cover the unexpected expenses. To account for such increases in costs, large employers may require employees to pay higher premiums, deductibles, coinsurance, and copayments; and smaller employers are reducing benefits, shifting costs to employees, or eliminating health care coverage altogether.

Information was provided regarding Medicare and Medicaid programs and federal legislation, which requires noncontracted hospitals and physicians to accept established rates for emergency room admissions and services. It was emphasized that prescribing a reasonable rate to be paid to a noncontracted hospital for admissions (due to a diversion from the patient's contracted hospital) would greatly increase an insurer's ability to project and contain costs.

Representatives of the hospital industry testified to the complexity of the divert issue and reiterated that a multitude of factors contribute to the problem. Emphasizing rapid growth in metropolitan areas (particularly Clark County), uninsured and underinsured individuals utilizing hospital emergency departments for primary care, a shortage of health care professionals, and a lack of long-term care and psychiatric facilities, it was argued that hospitals are not the cause of divert. As such, it was indicated that hospitals should not be required to carry a greater share of the fiscal impact of the problem than other involved industries.

Continuing, hospital representatives stressed that the hospital industry has contributed significantly to address the divert problem including the following:

- Clark County has opened three new hospitals in the last seven to ten years to address space availability.

- Every major hospital in Clark County, including two of the three new hospitals, has undergone renovation and/or expansion to better accommodate patient demands.

- A number of urgent care centers have been opened.

- Nevada hospitals are funding expansion of four University and Community College System of Nevada nursing programs in an effort to relieve the health care professional staffing shortages.

- Clark County hospitals are raising funds to help implement the new Nevada State College nursing program so it can begin in 2002 rather than 2003.

- Nevada hospitals are spending $2 million annually on recruitment and $1.5 million on retention for licensed health care professionals.

- Nevada hospitals also work with more than 22 temporary employment agencies to fill staffing needs, spending $4 million annually, a cost much greater than if licensed health care professionals could be hired.

The chairman concluded that an intermediate solution was necessary to contain certain costs of health care premiums as the committee and local authorities continue in their efforts to address the larger issue of emergency room diversion. Consequently, additional legislation is deemed necessary to delineate: (a) rates to be paid to noncontracted hospitals for admissions (due to a diversion from the patient's contracted hospital); (b) insurers that are eligible to provide reimbursement at the prescribed rate; and (c) hospitals to which this set rate will be applicable.

Based on testimony presented, the members agreed to have a bill drafted to:

> **Require certain hospitals to charge a reduced rate for emergency hospital admissions that occur when a patient is transported to a hospital with which their insurance company is not contracted because of diversion from a contracted hospital. (BDR 40–679)**

2. Mental Health, Substance Abuse, and Public Inebriate Issues

According to testimony, lack of specialty care resources and services for individuals with mental illness exacerbate the divert situation. Subsection 1(a) of NRS 433A.165 requires that before an allegedly mentally ill person may be transported to a public or private mental health facility, he must first be examined by a licensed physician, physician assistant, or an advanced practitioner of nursing to determine whether the person has a medical problem, other than a psychiatric problem, which requires immediate treatment. Testimony asserted that at the time of the adoption of this provision, hospitals possessed the resources necessary to carry out the task; however, as the population (and the percentage of mentally ill) drastically increased, hospitals have found it progressively more difficult to medically clear and transfer the patient to an appropriate mental health facility. It was indicated that the increase of mentally ill patients seeking treatment in emergency rooms is due to inadequate community support services available for this population. Additionally, the ability to transfer a patient from an emergency room to a mental health facility is hampered by extremely limited psychiatric emergency services and acute care psychiatric placement options.

Testimony provided by the Administrator of the Division of Mental Health and Developmental Services, DHR, indicated that Psychiatric Emergency Service Units are comprised of two separate and distinct programs. The first is the psychiatric ambulatory services (PAS) and the second is the psychiatric observation unit (POU). These two programs are staffed with mental health technicians, psychiatric nurses, psychiatrists, psychologists, and social workers. The PAS programs at Southern Nevada Adult Mental Health Services (SNAMHS) and Northern Nevada Adult Mental Health Services (NNAMHS) are the ports of entry for individuals seeking voluntary psychiatric assistance. In emergencies, staff is drawn from the psychiatric hospitals. Noting items such as lack of bed space and staffing shortages, it was further stated that the ability of SNAMHS to manage the volume of emergency referrals had been exceeded, causing delays in timeliness of service for some of the hospital's patients.

Emergency transporters and law enforcement officials emphasized the impact of limited placement options and follow-up care or treatment for persons who are chronic public inebriates (CPIs) or mentally ill. According to testimony, emergency responders are required by law to transport mentally ill persons to hospital emergency rooms for full medical clearance. In addition, agencies also transport CPIs to hospital emergency rooms for medical clearance. Such individuals sometimes remain in hospital emergency room beds for extended periods until they become sober or can be transferred to a mental health treatment center, if appropriate. In the meantime, rescue personnel and police must wait hours in hospital emergency rooms for these patients.

It was indicated that a vast number of CPIs and mentally ill persons are indigent and are frequently released from hospital emergency rooms without receiving certain follow-up care or treatment. These individuals continue to cycle through the criminal justice and health care systems. To address certain facets of this issue, mental health advocates and certain members of law enforcement noted the success of mental health courts. It was indicated that statute

currently authorizes the creation of mental health courts and that a successful pilot project is presently being operated in Washoe County without funding. Proponents point out that mental health courts would offer a means of identifying persons entering the criminal justice system because of mental health issues. It was further emphasized that such a court would operate around the same principles currently being utilized by the drug court to decrease recidivism. Testimony indicated that proposed legislation was forthcoming that would require funding for mental health courts in both Clark and Washoe Counties and the committee was urged to write a letter in support of such a measure.

Testimony further indicated that the cost for providing care to CPIs and mentally ill patients in hospital emergency room beds is the most expensive care provided. It was noted that the cost of detoxification services varied from $1,500 per visit for treatment in a hospital emergency department to $130 per day for care received at WestCare. It was further indicated that the estimated cost of care provided to psychiatric patients presented at hospital emergency departments has increased significantly in the past three years, from $3,330,356 in 1999 to $9,292,976 in 2001.

Continuing testimony emphasized the need to establish a crisis triage center to evaluate persons in crisis regardless of the initial assessment, which may be among other things, alcohol abuse, dementia, or drug misuse. Additionally, it was indicated that providing emergency personnel with the option of transporting patients who meet specific criteria directly to the state mental health hospital or other qualified facility for treatment would greatly reduce the number of individuals with such disorders in emergency room beds for extended periods of time. A representative of the Division Health Care Financing and Policy, DHR, indicated that federal laws related to Medicaid and Medicare prohibit payment for such transports at the same level as transports to hospital emergency rooms.

After considering several proposals on this topic, members of the committee adopted the following recommendations:

> **Amend Chapter 458 of *Nevada Revised Statutes* (NRS) to include provisions that require peace officers to place an individual under the influence of drugs in civil protective custody when the individual is unable to exercise care of his health or safety, or the health or safety of other persons. Additionally, amend Chapter 433 of NRS to allow certain persons who are mentally ill to be transported directly to a mental health facility without examination by a licensed physician, physician assistant, or an advanced practitioner of nursing. The Division of Mental Health and Developmental Services, Nevada's Department of Human Resources (DHR), and Health Division, DHR, shall develop an algorithm to guide in determining individuals who safely may be transported directly to a mental health facility without certain medical screening. (BDR 39–745)**

Provide an appropriation of $681,810 for each year of the biennium to WestCare to establish a mental health screening and stabilization component to a substance abuse community triage center. (BDR S-678)

Transmit a letter to Assemblywoman Sheila Leslie expressing support for her bill draft to fund specialty courts, particularly mental health courts. (The Assembly Committee on Judiciary requested the drafting of this measure; therefore, the letter of support was addressed to the chairman of the Assembly Committee on Judiciary.)

3. Urgent Care Facilities

Information presented by EMS providers indicated that many minor injuries and illnesses could be treated at urgent care centers. The committee was urged to expand the facilities that are authorized to accept emergencies to include urgent care centers. As with transporting patients directly to a mental health facility, representatives of the Division of Health Care Financing and Policy indicated that federal laws related to Medicaid and Medicare prohibit payment for such transports at the same level as transports to hospital emergency rooms.

Testimony indicated that many urgent care facilities are closed during peak 911 hours, which range from afternoon until late evening. It was further emphasized that patients who might otherwise seek care at urgent care facilities are referred to hospital emergency rooms. The committee was urged by representatives of the EMS system to draft a letter informing urgent care facility administrators of the emergency room diversion problem and encouraging the facilities to work together with EMS providers in their respective communities to resolve this issue, including consideration of coordinating their hours of operation with peak 911 times.

Upon consideration of the recommendations related to urgent care facilities, the committee agreed to:

Transmit a letter to urgent care facility administrators informing them of the emergency room diversion problem and encouraging the facilities to work together with emergency medical services in their respective communities to resolve the issue, including consideration of coordinating their hours of operation with peak 911 times.

B. LICENSURE OF CERTAIN MOBILE MEDICAL FACILITIES

Testimony indicated that Senate Bill 483 (Chapter 291, *Statutes of Nevada 2001*) required the State Board of Health, DHR, to license mobile medical facilities and facilities for refractive laser surgery. It was indicated that the intent of this measure was to exempt certain mobile medical facilities that were operated by the Joint Committee on Accreditation of Health Care Organizations (JCAHO). Testimony emphasized that these mobile medical units provide basic primary care and preventative services to underserved populations and outlying rural areas.

Further testimony indicated that a certain mobile medical facility worked with the Bureau of Licensure and Certification, Health Division, DHR, to request variances. However, due to the mandates in statute, such variances were unavailable. Additionally, several areas were cited as being potential impediments to continuing certain mobile medical programs at their current levels of service with the present licensure requirements. They are as follows:

- Flexibility—Because dental offices are not included in the definition of medical facilities, they are not subject to the regulations required under S.B. 483. However, if such mobile units are used for medical purposes, such as providing immunizations or counseling services, they will be subject to the regulations required under S.B. 483.

- Record-Keeping—Record-keeping must comply with standards of practice. In addition, it must meet JCAHO standards and serum provider requirements. However, regulations developed pursuant to S.B. 483, which would require physically maintaining patient records would be difficult to accomplish in certain partnership situations. When certain mobile medical providers work in partnership with public health agencies, the responsibility for maintaining records is shared. In these instances, mobile health records are kept by those providing the service in the mobile unit, which in most instances are local public health authority officials (as opposed to being the proprietors of the mobile medical facility).

The chairman and members determined that compliance with the regulations developed pursuant to S.B. 483 would decrease the current level of service provided by mobile medical facilities that make available preventative and primary care service. The committee further recognized that S.B. 483 was developed to regulate certain surgical procedures, and was not developed because of concerns regarding the preventative and primary care services being provided.

Therefore, committee members recommended that a bill be drafted to:

> **Require the exemption of certain mobile medical facilities that are operated by medical facilities accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association from licensure by the State Board of Health, DHR. (BDR 40–744)**

C. ACCESS TO HEALTH AND HUMAN SERVICES PROVIDERS AND INFORMATION

1. Abbreviated Calling Code 2-1-1

Testimony indicated that the Federal Communications Commission designated 2-1-1 for national three-digit access to health and human services information and referrals. It was also indicated that with a myriad of social service organizations and programs, individuals (particularly those in stressful situations) are not always aware of the resources available to

assist them. Designating 2-1-1 would provide one number for individuals to call to receive appropriate assistance and referrals. Additionally, 2-1-1 builds on the existing infrastructure allowing social service organizations an opportunity to participate in more centralized human services access programs. It was further indicated that the endorsement of the Public Utilities Commission of Nevada is essential to the development of the 2-1-1 concept.

Finally, it was indicated that the 2-1-1 concept has been considered as an opportunity to provide a single point of entry into the State of Nevada's Department of Human Resources (and other human services). It was emphasized that a single point of entry system for DHR would be beneficial. Proponents reiterated that the 2-1-1 national system has not been developed as a state programs administrative system, but rather for information, referral, and crisis situations only.

Subsequently, committee members agreed to:

> **Adopt a resolution expressing the Legislative Committee on Health Care's support for the development of the abbreviated telephone code 2-1-1 within the State of Nevada. The abbreviated code will provide free access to health and human services information and referrals on a local and national level. (BDR R–680)**

2. Obstetrical and Gynecological Access Program

Testimony indicated that there was a lack of affordable medical malpractice insurance for obstetricians and gynecologists (OB/GYNs) in Nevada, which is negatively affecting the number of physicians practicing in these fields. In an effort to address this problem, the Clark County Obstetric and Gynecological Task Force was developed by the Board of Trustees of University Medical Center of Southern Nevada (UMC). The Task Force was responsible for developing and evaluating potential solutions to the lack of affordable medical malpractice insurance for OB/GYNs. It was indicated that the task force discussed a variety of potential solutions, which include: (a) creating a liability compensation fund; (b) providing in-state training for OB/GYNs; (c) establishing a subsidy with a sunset provision; and (d) requiring physicians who utilize the subsidy to increase their participation in state-funded health care programs such as Baby Your Baby and Medicaid.

A representative of the University of Nevada School of Medicine (UNSOM) Center for Education and Health Services Outreach provided the committee with a draft proposal to expand the UNSOM's Rural Obstetrical Access Program. In summarizing the background of the existing program and the proposed expansion, the following points were emphasized:

- The UNSOM's Rural Obstetrical Access Program was first authorized in 1991. The program was originally intended to subsidize the differential cost of malpractice insurance for family practitioners delivering prenatal care and for OB/GYN physicians.

Before operations could commence, however, budget reductions forced closure of the program.

- In 1995, the Legislature appropriated $75,000 per year for the Rural Obstetrical Access Program. All applications for program grants were required to include plans to provide: (a) community-based prenatal care; (b) prenatal services to low-income and uninsured women; and (c) improved health care for pregnant women in counties or communities served by clinics or rural practitioners. The Rural Obstetrical Access Program began operating in Fiscal Year (FY) 1996 with eight practitioners.

- During the 1999 Session, the Rural Obstetrical Access Program was expanded to provide additional education and skill enhancement for practitioners and routine and subspecialty obstetrical consultation through telemedicine. In addition, the program expanded prenatal services to rural communities that previously had no access to such care. Further, some resources were used to ease the burden of uncompensated care on rural practices.

- As of the most recent fiscal year, the program assisted in providing coverage for 17 practitioners, or 65 percent of all those who practice in frontier and rural Nevada. In five communities, the Rural Obstetrical Access Program provided coverage for all medical practitioners.

- Based on a survey conducted by UNSOM, factors contributing to the decline in Nevada's obstetrical work force include practitioner age, declining reimbursements, medical malpractice insurance costs, physician turnover, and increasing levels of uncompensated care. A decrease in the number of practitioners providing obstetrical care will hamper the state's efforts to ensure access to OB/GYN services.

- In addition, recruitment of OB/GYN physicians and family practitioners that provide obstetrical services is difficult. For instance, a replacement has not yet been secured for a physician in Churchill County, Nevada, who plans to discontinue the practice of medicine within the next few months. If a replacement is not found, only two physicians will be available to serve a community that is currently experiencing a leukemia cluster.

- The UNSOM has forecasted about 4 percent of the work force delivering obstetrical care will discontinue such services before April 2003 because of the medical malpractice insurance crisis.

- For the year ending June 30, 2002, the UNSOM Rural Obstetrical Access Program received requests totaling approximately $900,000 for an appropriation of $150,000. The largest proportionate request was for uncompensated care.

- Because OB/GYNs expect to provide care within their specialty, they usually assume the cost of medical malpractice insurance and seek to maintain the viability of their practices

in other ways. Such practitioners typically approach the UNSOM for assistance with uncompensated care costs of patients without Medicaid or other insurance coverage. In contrast, family practitioners that provide obstetrical services often seek assistance with the differential cost of medical malpractice insurance rather than with the uncompensated care burden.

To address many of the challenges mentioned, a proposal was presented to expand the current Rural Obstetrical Access Program by opening it to urban communities and providing the following improvements:

- Expansion of training programs within the School of Medicine (family practice and OB/GYN), which serves to educate and diffuse additional practitioners into the state;

- Expansion of the clinical services program offered by the School of Medicine to populations that have unmet or compromised need for obstetrical services;

- Provide education and training opportunities to community practitioners to enhance their clinical skills or initiate additional services directed to prenatal and obstetrical care;

- Provision of funding to Nevada Health Centers, Inc., for expansion of its clinical practice base to allow for increased access of uninsured, underinsured, and Medicaid patients while participating in federal tort protection;

- Provision of funding to community practitioners to offset the financial burden of necessary care provided to those patients with no financial access, which would increase the supply of practitioners; and

- Collection and analysis of data base information to monitor the impact of declining services, and the impact of access to care issues for pregnant women including birth outcomes. Data base analysis specifically addresses key points brought up by Health Care Committee members.

It was pointed out that medical malpractice subsidies offer a short-term solution to the health care crises and that in the long-term steps should be taken to ensure the continued availability of OB/GYNs.

Therefore, members of the committee recommended that a bill be drafted to:

> **Provide an appropriation of $6,775,000 for the first year of the biennium and $4,450,000 for the second year of the biennium to the University of Nevada School of Medicine to expand its Rural Obstetrical Access Program. The expansion effort shall include provisions to encourage minorities to pursue careers in the health care field; and further, the list of data to be**

collected shall include information on public health programs such as Healthy Kids and Nevada Check Up. (BDR 40–743)

D. INDIGENT CARE COSTS AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

Pursuant to Senate Bill 377 (Chapter 598, *Statutes of Nevada 2001)*, which "revises provisions governing payment of hospitals for treating disproportionate share of Medicaid patients, indigent patients or other low-income patients," the committee was directed to conduct a study of programs and funding for the treatment of Medicaid, indigent, and other low-income persons. The committee contracted with EP&P Consulting, Inc. (EP&P), a national organization with expertise in a variety of health care and public policy programs, to conduct the study.

Payment to hospitals for treating a disproportionate share of indigent patients (DSH) is a component of the Medicaid program. States receive a DSH allotment from the federal government and utilize the revenue, along with matching state funds, to make payments to hospitals that provide a large amount of care to low-income groups. According to information provided by EP&P, hospitals automatically qualify to receive DSH payments if they meet one of two federal criteria: (1) greater than 25 percent of their utilization is low-income; or (2) their Medicaid days are greater than one standard deviation of the mean Medicaid days statewide. However, hospitals are precluded from receiving such payments if they provide 1 percent or less of Medicaid utilization or if they supplied obstetric services in 1987 but no longer offer such care. Federal law also provides that DSH payments cannot be made to institutions for mental disease (IMD) if the state was not making payment to the IMD in 1995. Otherwise, the federal government gives states wide latitude in distributing DSH funds.

To guide the study, the committee adopted three basic principles that are as follows:

- Access—Nevada should assure that there is access to care for Medicaid and indigent care by:
    - Using available funds to assure such access;
    - Promoting policies to maintain the viability of rural hospitals; and
    - Encouraging hospitals to provide care to Medicaid patients, both in fee for service and managed care populations.
- Distribution of Funds—Nevada should distribute indigent care funds in a manner that ensures:
    - Indigent care costs are spread proportionally over all hospitals in a geographic area;

- Indigent care payments are proportional to the indigent care provided;
- Competitive imbalances are not created; and
- Hospitals are not allowed to profit from indigent/uncompensated care.

- Maximize Federal Funds—Nevada should maximize the federal funds that it receives under the Medicaid program, within the limits of state expenditures available for matching funds.

Testimony indicated that Nevada hospitals currently receive DSH payments in one of three ways:

- Public hospitals receive funds for the first $500,000 of uncompensated care they provide plus a pro rata share of any program funds remaining after distribution to other facilities;
- Private hospitals in counties with no public hospitals receive funds based on a proportion of the population they serve as set by the Legislature; and
- Those private hospitals with Medicaid utilization greater than 20 percent (i.e., 20 percent of their bed days are dedicated to Medicaid patients) receive $200 per uncompensated day. Facilities whose Medicaid utilization is below 20 percent receive $100 per day.

In conducting the study, EP&P measured indigent care costs, including Medicaid, low-income services supplied by the counties, and treatment provided through the general subsidy, in dollars and as a percentage of operating revenue as follows: (1) gross costs; (2) gross costs less Medicaid payments; (3) gross costs less Medicaid reimbursements, payments by the counties, direct tax subsidies to various hospitals, and all other payments except DSH; and (4) gross costs less DSH and all other payments. According to testimony, EP&P used the percentage of indigent care costs to operating revenues as a standardized measurement tool to compare hospitals. Testimony further indicated that operating revenues were obtained from the hospitals' Medicare cost reports.

The study found that the state's gross indigent care costs totaled approximately $279 million, or 16 percent of Nevada hospitals' combined operating revenue. In terms of dollars spent, the three hospitals providing the most indigent care were UMC ($122 million), Washoe Medical Center ($42 million), and Sunrise Hospital ($26 million). Furthermore, a comparison of the individual hospitals' percentage of indigent care costs to operating revenues revealed that UMC experienced the highest expenditures to operating revenue (38.94 percent), followed by Lake Mead Hospital Medical Center (25.87 percent) and Washoe Medical Center (20.40 percent). With the addition of revenue from Medicaid, the gross indigent care costs of all hospitals declined to approximately $168 million. Given the amount of the decrease in gross indigent care costs, it is evident Medicaid provided about $111 million in compensation to Nevada's hospitals.

The study shows that after deducting all revenue except DSH, including payments by the counties and direct tax subsidies provided to various hospitals, Nevada's indigent care costs decreased to approximately $100.5 million. The three hospitals providing the most indigent care as a percentage of their overall operating revenue, net of all payments except DSH, were UMC with 9.9 percent ($31 million), Washoe Medical Center with 8 percent ($16.9 million), and Lake Mead Hospital with 12 percent ($6 million). The statewide average percentage of indigent care costs to operating revenue is 5.78 percent. Additionally, Washoe County's average (6.48 percent) exceeded that of Clark County (5.09 percent). The study presents a comparison of indigent care costs as a relative share of operating revenues net of DSH and all other payments, indicating the largest net providers as UMC at 5.33 percent, Washoe Medical Center at 6.54 percent, and Lake Mead Hospital at 12 percent.

The study also notes the current distribution of DSH dollars correlates well to the population of the state. It was indicated that Clark County has approximately 69 percent of the state's population, and it receives 69 percent of the net DSH benefit. Likewise, about 15.6 percent of the population resides in Washoe County, and it receives 14.6 percent of the net DSH benefit. Overall, the rural counties represent about 15 percent of the population, and they receive slightly more than 15 percent of net DSH dollars. It was also noted that Nevada's DSH allotment is not sufficient to offset the cost of indigent care.

With regard to rural hospitals, testimony indicated that the higher percentages of indigent care costs to operating revenue reported by some private rural hospitals is attributable in part to a data reporting error. The miscalculation relates to some rural hospitals incorrectly including, as part of their indigent care costs, the uncompensated portion of charges for which the hospitals received compensation at a rate of 25 percent or more. Nevada law provides that if a hospital is not compensated for at least 25 percent of the services it renders, such treatment is considered indigent care. Additionally, several rural hospitals that list percentages of indigent care costs to operating revenue as negative, received direct tax subsidies from the counties in which they are located. These subsidies may be for indigent care costs or simply to maintain the hospitals' viability. However, for purposes of the study, the direct tax subsidies were used to offset total net indigent care costs.

A representative of EP&P explained the manner in which DSH is funded in the State of Nevada, covering the following points:

- Through its DSH program, the federal government makes available to Nevada $38 million to be distributed to qualifying hospitals. In order to access these funds, however, the State of Nevada must provide matching funds. Once matched, $76 million must be distributed to hospitals.

- Like many other states, Nevada recoups its matching funds and retains a portion of the federal DSH revenue. To accomplish this, the state distributes $76 million to the hospitals. Through a series of intergovernmental transfers, the state then recoups its

$38 million initial outlay and collects an additional $16 million "handling fee," leaving a net distribution to the hospitals of $22 million.

- The federal government has imposed complex and intricate rules designed to prevent hospitals from providing and recovering matching funds.

- Through Nevada's intergovernmental transfer system, counties with public hospitals return funds to the state. For example, the state made an initial payment of $57 million to UMC in FY 2000; $42 million was returned to the state via intergovernmental transfer, leaving a net payment of $14 million to UMC. Every county with a hospital that receives DSH funds participates in the intergovernmental transfer mechanism.

- The Legislature has empowered those counties with only one private hospital and no public hospital to impose a tax on such facilities. This mechanism enables certain private hospitals to provide counties with the funds that must be returned to the state.

- In an effort to spread and equalize the burden of providing indigent care, a .6 percent service requirement is imposed on counties with two or more licensed hospitals of 100 or more beds. This requirement provides that counties are not obligated to reimburse hospitals for indigent care until they furnish services equivalent to .6 percent of their net revenues from the prior year. Clark County has waived this requirement for UMC.

- In studying the needs of rural hospitals, EP&P found private facilities had the highest percentage of uncompensated indigent care costs. Rural public hospitals that received direct tax subsidies had a low percentage of such expenditures. In contrast, the uncompensated indigent care costs of rural public hospitals that did not receive direct tax subsidies were higher.

- Clark County's uncompensated indigent care costs were higher than those of Washoe County in funds expended. However, Washoe County's indigent care costs represented a higher percentage of its operating revenue.

- After deducting DSH payments, Washoe Medical Center experienced the highest indigent care costs, both in dollars and as a percent of its operating revenue, of all the hospitals in northern Nevada. In Clark County, UMC and Lake Mead Hospital were higher than the state as a whole in uncompensated indigent care costs as a percent of their operating revenues.

- The Legislature made certain changes in the DSH distribution for FY 2002. It increased the net DSH distribution from $20.9 million in FY 2000 to $22.5 million for FY 2002. The additional funds were used to: (1) raise Lake Mead Hospital's payment from $60,000 to almost $700,000; (2) provide Sunrise Hospital with an amount in excess of $660,000; (3) increase funding to the rural public hospitals from $618,000 to almost $790,000; (4) make state payments—not DSH disbursements—of $50,000 each to

Grover C. Dils Medical Center, Battle Mountain Hospital, and Pershing General Hospital; and (5) increase the state's share of federal DSH funds from $16 million to $16.69 million.

Based on their findings, EP&P made the following recommendations:

- Nevada's current DSH distribution and associated intergovernmental transfer processes are complex and should be simplified.

- All the geographic regions and the hospitals within the regions should receive at least the same DSH benefit as in past years, depending upon availability of funds, with the following exceptions:

  - Terminate the DSH distribution to Sunrise Hospital. While Sunrise Hospital provides a substantial amount of indigent care, these expenditures represent a significantly smaller percentage of its net operating revenue than that of the State of Nevada or Clark County.

  - Recognize the change of ownership of Carson-Tahoe Hospital and Churchill Community Hospital from public to private facilities in the DSH distribution formula.

  EP&P also recommended that as changes are made, they should not be radical or should be implemented over a period of time, as many hospitals depend upon DSH funding.

- Distribution of DSH revenues should be made in a manner that equalizes the percentage of operating revenues comprising uncompensated indigent care costs. Direct tax subsidies are not necessarily designed to cover indigent care costs. In some instances, the purpose of such subsidies is to maintain a hospital's viability, particularly in rural areas. For this reason, EP&P recommends the Legislature use gross indigent care costs net of all payments except direct transfers from the counties to measure the impact of such services.

- To facilitate distribution of DSH revenue, five pools should be created as follows:

  - Clark County's public hospital (UMC);

  - Private hospitals in Clark County;

  - Washoe County hospitals;

  - Rural public hospitals; and

  - Private rural hospitals.

In addition, a separate pool should be established for Nevada hospitals that do not qualify for DSH benefits but in the past have received a state payment of $50,000. The DSH funds distributed to the proposed five largest pools should approximate those distributed in state FY 2002.

Under EP&P's proposal, distribution to the hospitals within the Clark and Washoe County pools would be based on the providers' uncompensated care costs net of all payments except direct transfers from the counties. The following example was provided to illustrate the methodology for disbursing DSH funds within these pools:

> Hospital A's uncompensated care costs comprise 30 percent of its net operating expenses. The same costs comprise only 15 percent of the net operating expenses of Hospital B, the next closest hospital within the pool. All DSH dollars allocated to the pool would be disbursed to Hospital A until such time as its uncompensated care costs decreased to the same level as that experienced by Hospital B (15 percent). Thereafter, Hospitals A and B would receive DSH revenue until such time as their uncompensated care costs reached the same level as that of the third highest provider of such services within the pool.

- Distribution of DSH revenue to rural private hospitals would be based upon the hospitals' gross revenues. By applying this methodology to Carson-Tahoe Hospital and Churchill Community Hospital, both of which are now private facilities, DSH payments would decline by $345,000 and $118,000, respectively, thus equalizing the burden among the rural private hospitals.

  Pending data clarification, the $345,000 and $118,000 previously allocated to Carson-Tahoe Hospital and Churchill Community Hospital would be distributed to: (1) Nye Regional Hospital to lower the level of its uncompensated care costs from 30 percent to 20 percent of its net operating revenue; and (2) the rural public hospital pool for disbursement to South Lyon Medical Center to decrease the percent of its uncompensated care costs to the same level as that of Mount Grant General Hospital.

- With respect to intergovernmental transfers necessary to return to the state its matching funds and DSH benefit, EP&P made the following recommendations:

  - Washoe County has historically provided a $1.5 million intergovernmental transfer to the state. Because changing this mechanism would be difficult, Washoe County should continue its current practice.

  - All other funds should be returned to the state through an intergovernmental transfer from Clark County. In order to provide Clark County with the funds necessary for such a transfer, UMC's DSH allotment would be increased $52 million to approximately $66.48 million. Through intergovernmental transfer, UMC would

return $52 million to the State of Nevada, leaving a net benefit to Clark County of almost $14.5 million.

This methodology would simplify the process by: (1) eliminating the need for the hospital tax enacted by the Legislature during the 2001 Session; and (2) limiting intergovernmental transfers to Clark and Washoe Counties. Increasing Clark County's DSH allotment, however, would place UMC near its Omnibus Budget Reconciliation Act (OBRA) limit. A hospital's OBRA limitation is the amount of net uncompensated care it provides before it receives any payments. Because Congress enacted a law raising the OBRA limit of public hospitals to 175 percent of their previous cap for the years 2004 and 2005, increasing UMC's DSH allotment to accommodate the proposed intergovernmental transfer method would not pose a problem. However, the state would need to monitor federal action in this area to ensure UMC does not exceed its OBRA limit in 2006 and beyond.

- To effectively administer the proposed distribution pools, a standardized reporting format should be established. A standardized format would enable the Division of Health Care Financing and Policy (DHCFP), DHR, to verify information submitted by the hospitals through use of historical data. To ensure accurate, consistent reporting, hospitals would require training.

- The DHCFP would require adequate resources to assure equity and to monitor the process.

Representatives of EP&P reiterated the committee's charge to study the potential for maximizing federal funds. With respect to state and county health care expenditures that are unmatched by federal funds, EP&P's findings and recommendations emphasized the following points:

- County expenditures of approximately $46 million for health care costs are currently unmatched by federal funds. The counties spend about $32 million per year for accident and indigent health care costs, and Clark County directly transfers $14 million annually to UMC for emergency room expenses.

- Assuming programs could be developed that exactly matched the services currently being provided with unmatched state funds and met the requirements for receiving 50 percent federal matching funds, it would be possible to either reduce expenditures for such care by half or to double the amount of health care provided.

- The State Children's Health Insurance Program (SCHIP) allotment is available to Nevada with a 65 percent federal funding match. If these funds are not utilized over the next five years, they will be reallocated to other states. Waiver programs could be designed to capitalize on these federal funds.

To continue work on the development of a strategy to maximize federal funds available for indigent care, the committee entered into an agreement with EP&P to perform a more in-depth study of this topic. The study will be directed by the committee and jointly funded with contributions from several hospitals that are members of the Nevada Hospital Association and from the Nevada Association of Counties. The findings of this study will be made available to the 2003 Legislature prior to sine die.

As a result of testimony on this issue, the committee recommended that a bill be drafted to:

> **Amend NRS 422.380 through 422.390, which currently authorizes payment of certain hospitals for treatment of Medicaid, indigent, and other low-income patients, to revise the methodology and distribution of disproportionate share hospital payments and intergovernmental transfers as outlined in the *Report on Indigent Care Costs and Disproportionate Share* developed pursuant to Senate Bill 377 (Chapter 598, *Statutes of Nevada 2001*). (BDR 38-746)**

E. ANTIBIOTIC RESISTANCE AWARENESS PROGRAM

Nevadans for Antibiotic Awareness (NAA) is a statewide task force consisting of private and public sector entities collaborating to educate the health care community and the public regarding appropriate antibiotic use.

Representatives of NAA testified that many people view antibiotics as a cure for a wide range of ailments, from life threatening infections to the common cold. Although viral illnesses do not respond to antibiotic treatment, patients frequently demand prescriptions. The proliferation of antibiotics has resulted in an increased number of bacteria that are highly resistant to common antibiotics. Once exposed to antibiotics, bacteria mutate and become resistant. It is estimated about 70 percent of the bacteria that currently cause infections in hospitals are already resistant to common antimicrobial agents. Furthermore, it was indicated that Nevada is one of six states that experienced a rare form of resistant bacteria, primarily because of inappropriate hospital use of antibiotics. Nevada's patient was the sole survivor.

Testimony also indicated that according to the Centers for Disease Control and Prevention (CDC), about one-third of the 150 million prescriptions written annually are inappropriate. The CDC studies also indicate that over the past five years, the resistance of streptococcus pneumonia has increased over 300 percent. It is anticipated antibiotic resistant bacteria will cause over a million infections this year, some resulting in death. The NAA has joined with the CDC and 31 other states to address antibiotic resistance.

According to information provided, a yearlong NAA outreach program has had a positive impact, as Nevada is one of the few states showing a decrease in the use of common outpatient antibiotics. This achievement has been demonstrated through pharmacy data. The four major health plans in the state have shown a decrease in the number of outpatient common antibiotic

scripts per member per year. Although Nevada's susceptibility rate is not yet improving, it was indicated that the decrease should lead to improvement.

Because of the potential impact of antibiotic resistance on Nevadans and the significant work of NAA, the committee members moved to:

> **Adopt a resolution expressing the Legislative Committee on Health Care's support for Nevadans for Antibiotic Awareness in its effort to reduce the rate of antibiotic resistance through public education, provider education, promotion of increased adherence to infection control practices, and the development of a surveillance plan for tracking resistance rates and prescribing practices. (BDR R–681)**

F. LONG-TERM STRATEGIC HEALTH CARE PLANS

Assembly Bill 513 (Chapter 541, *Statutes of Nevada 2001*) made an appropriation of $800,000 to the Department of Human Resources for the development of four long-term strategic plans concerning the health care needs of the citizens of Nevada. The strategic plans address senior services, rural health care, persons with disabilities, and provider rates. Testimony indicated that a task force was established to facilitate the development of each of the four strategic plans. In addition, a steering committee provided guidance and coordinated the overall efforts of each task force.

1. Senior Services

Testimony indicated that the Senior Services Task Force included persons from both rural and urban areas of the state. To gather public input, the Senior Services Task Force conducted focus group meetings throughout the state. It also established a Web site that allowed interested parties to provide comment. Further, the Task Force published a survey in *Senior Spectrum*, a newspaper that is distributed statewide. Over 2,000 Nevadans provided input to the Task Force.

The Senior Services Task Force identified six primary objectives:

- Ensure more Nevada seniors live in the setting of their choice and receive needed support to maintain their independence and health. Suggested strategies to implement this objective include:
    - Adopting a statewide policy that calls for a shift to home- and community-based services as opposed to the current institutional-based settings;
    - Establishing an integrated data system;

- Providing more assisted living options for persons afflicted with Alzheimer's disease and related cognitive impairments; and

- Supplying fully accessible housing units with integrated and wraparound services, thereby diverting entry of certain seniors into nursing homes.

- Ensure more Nevada seniors engage in the occupation of life. Suggested strategies to implement this objective include:

  - Promoting out-of-home respite options;

  - Increasing the availability of assistive and adaptive devices; and

  - Providing for flexible respite care options.

- Ensure improved health outcomes for Nevada seniors. Suggested strategies to implement this objective include:

  - Educating seniors and their caregivers;

  - Expanding the current Senior Rx Program and existing medication management programs; and

  - Providing a comprehensive oral health strategy.

- Ensure more Nevada seniors live in homes that are safe, fully accessible, and affordable. Suggested strategies to implement this objective include:

  - Ensuring newly constructed homes for seniors are fully accessible;

  - Encouraging low-interest bond financing;

  - Identifying funding for heating and air conditioning repairs;

  - Retrofitting existing senior housing units to be fully accessible; and

  - Including in Medicaid waiver conditions an allowance for repairs and modifications to maintain seniors in their homes rather than placing them in institutional settings.

- Ensure more disabled and frail Nevada seniors receive adequate transportation services. The majority of questionnaire respondents cited transportation as a significant issue. Suggested strategies to implement this objective include:

  - Conducting an independent study of Nevada transit programs; and

- Requiring that all existing providers of transit services become eligible for Medicaid reimbursement.

- Ensure more Nevada seniors receive needed benefits, services, and support. Suggested strategies to implement this objective include:

  - Establishing a single point-of-entry system;

  - Examining the roles and responsibilities of state and county agencies and identifying opportunities to work cooperatively to provide improved services to seniors; and

  - Adopting the recommendations of the Personal Assistance Services Advisory Council.

2. Rural Health Care

Testimony indicated that public hearings were held throughout the state in accordance with the provisions of A.B. 513 to ensure interested persons had an opportunity to provide input. Approximately 200 individuals were involved in the stakeholder meetings and key interviews were held with 32 people with particular interest in rural health care. In addition, written opinion surveys were received from 253 rural residents and a variety of experts provided direct comment.

The Rural Health Care Strategic Plan provides statewide goals and strategies related to four general categories:

- Planning and Coordination:

  - Create an ongoing mechanism for planning and coordination of rural health care.

- Services Delivery:

  - Enhance rural physical health primary care model;

  - Create long-term viability in behavioral health, substance abuse, and support services;

  - Improve service access and response capabilities; and

  - Invest in public preventative health for long-term benefits.

- Sustainable Financing:

  - Improve insurance coverage for uninsured and underinsured Nevadans;

- Develop adequate capital funding; and
- Develop adequate operations funding.

- Infrastructure Development:
  - Ensure long-term viability of rural health care facilities;
  - Expand capacity to provide health care services within rural communities; and
  - Support maximum use of technology in rural communities.

During testimony, it was emphasized that the Rural Health Task Force and its consulting team had difficulty obtaining reliable health care data. Therefore, the plan maintains that another key factor to the success of any rural health initiative is the development of an integrative data collection and outcome measurement system.

3. Persons with Disabilities

In compliance with A.B. 513, DHR established a task force of advocates, consumers, parents, payers, and providers to guide the development of a strategic plan to address the needs of persons with disabilities. This Task Force on Disability, in turn, appointed four subcommittees consisting of 49 additional advocates and consumers. In addition, a technical advisory group was developed to address issues related to the *Olmstead* decision, in which the United States Supreme Court held that individuals with disabilities have the right to receive public benefits and services in the most integrated setting appropriate to their needs.

According to the report, the Task Force on Disability and other participants initially identified 185 perceived barriers to service, independence, and inclusion for persons with disabilities. The Task Force identified nine goals and 227 strategies to resolve the barrier presented to improve community capacity and to provide quality assurance and monitoring of plan implementation.

The nine goals established by the Task Force to guide all disability planning and funding are as follows:

- Social policy, program structure, regulation, and planning affecting the lives of children and adults with disabilities will fully reflect their view, culture, and involvement.
- Service provision to people with disabilities in the most integrated, appropriate settings will be assured through the application and resulting service plan of individualized, setting-neutral assessments, and expedited service entry.

- Children and adults with disabilities of all ages will receive services expeditiously and in the most integrated environment appropriate to their needs.

- Children and adults with unique needs will obtain services in a timely and appropriate manner.

- The risk of disability institutionalization will be decreased in the general disability population by improving and protecting critical health care services.

- Children and adults with disabilities will not be placed at risk of institutionalization while living independently and/or inclusively in their communities for lack of adequate information and support, and will easily and appropriately access the services they require.

- People with disabilities and families of children with disabilities will knowledgably and appropriately choose and direct the services they receive and receive them at each critical juncture of life.

- The state system of service delivery and long-term care will be managed and monitored so services in most integrated settings become the norm throughout Nevada.

- Independent in-state compliance monitoring and mediation of *Olmstead* and Americans with Disabilities Act issues will be funded and implemented.

During testimony, it was indicated that the 10 percent disability designation of tobacco settlement funds should be continuously allotted for specific purposes. According to testimony, the Task Force determined that expenditure of these funds should focus on:

- Ensuring families providing primary care to a severely disabled family member receive respite within 90 days of application;

- Providing permanent funding for the state's Positive Behavioral Supports Program at a level that, at a minimum, will support adequate training and service delivery to 1,500 families of children with autism, brain injury, and others in need of such intervention; and

- Providing home and environmental modifications and assistive technology that allows community access and/or return from institutional care.

4. Provider Rates

The Provider Rates Task Force was charged with developing the strategic plans for the rates paid for services, specifically focusing on:

- The need for standardized rate methodology across programs when services are the same;

- Inclusion of providers in the rate setting process; and

- Methodologies, which include mechanisms for regular adjustments to those rates.

According to testimony, the following areas were identified for the study: (a) community support services for persons with a disability; (b) mental illness; and (c) the elderly. Additionally, certain services were identified as a priority by the Legislature, including community triage centers, supported living arrangements (SLAs), services to individuals with autism, targeted case management, and personal assistance services. The remaining services the study addresses fall into four broad categories: (a) fiscal intermediary services; (b) home- and community-based services to seniors and persons with a disability; (c) children and adult mental health rehabilitative services; and (d) therapies.

Testimony indicated that stakeholders participating in the process included representatives of county agencies, providers, individuals who access the services and their family members, as well as state personnel. Additionally, interstate surveys reviewed home and community services offered by other states. Finally, the Task Force considered cost collection data, including quantitative historical cost information and qualitative input directly from service providers.

Through the cooperative efforts of the DHCFP and service providers, an independent model was developed to reflect the benefits, wages, administrative, and programmatic costs associated with service delivery. Testimony provided emphasized the value of the independent model on the Legislature's ability to set and analyze rates, currently and in the future.

According to testimony, an independent model was used to develop a rate for community training centers of $7.16 per person per hour for a six-hour day, with a ratio of 1 staff person to 5 clients. Clients are provided services in community training centers under four different staff-to-client ratios: 1-to-1, 1-to-2, 1-to-5, and 1-to-8. The proposed rates for the 1-to-1, 1-to-2, and 1-to-8 staff-to-client ratios were calculated by multiplying the hourly rate for the 1-to-5 ratio by 5 and dividing the product by 8, 2, or 1.

For supported living arrangement services, the Provider Rates Task Force also used an independent model to establish a proposed rate of $20.75 per person per hour for up to 16 hours of service, with a proposed rate of $6.56 for any hours of service in excess of 16 hours per day, which would essentially cover sleep time. In addition, a rate of $42.74 per hour was proposed for nursing services.

The Provider Rates Task Force's recommendations included the following:

- Improved standardization of Medicaid program policies;

- Standardization of the rate-setting process for public agencies such as state and county entities that provide targeted case management to certain groups in Medicaid;

- Development of standards for claiming and reporting services;

- With respect to targeted case management services, development of outcome and performance measures (e.g., require that a child in a target group receiving case management be facilitated in accessing appropriate medical and social services whenever such services are rendered and payment is made);

- Development of a per person, per month rate;

- Allow the private sector to provide case management services for lower levels of care; and

- Utilization of a level of care system for individuals who are chronically mentally ill, such as seriously emotionally disturbed children and acutely mentally ill adults. A similar system exists for adolescents and children to ensure a child who meets certain clinical criteria receives the appropriate level of service.

Through an independent model, it was recommended that agency providers of personal care aid services be reimbursed at a rate of $18.50 per hour and individual providers at an hourly rate of $15.50. During testimony, it was noted that these rates are likely more appropriate to Medicaid although Nevada's Department of Employment, Training and Rehabilitation offers a personal care aid services program. Further, the recommended rates would likely require modification to allow for the manner in which the agencies budget for services.

The Provider Rates Task Force also recommended that a statewide fiscal intermediary waiver program be established to allow Medicaid programs to provide funds to a client through a fiscal agent of the recipient. With the assistance of the fiscal agent, the recipient could then choose and pay for needed services. Testimony indicated that fiscal intermediary services would primarily benefit disabled persons.

Home- and community-based service rates were also evaluated, including adult day health care, assisted living, and supported employment. According to testimony, because group residential care is being phased out, a rate was not provided for this service.

Also analyzed were adult and child mental health services involving rehabilitative assistance provided through the Medicaid State Plan. Children's community-based service rates analyzed included attendant care, day treatment, intensive community-based care, mobile crisis and therapeutic foster care services, parent and family support, rehabilitation partial care programs, rehabilitation skills training, and residential care. Adult community-based service rates considered included independent living, psychosocial rehabilitation, and other services. A rural add-on for mental health services is recommended to compensate for distances traveled.

Testimony indicted the Provider Rates Task Force's recommendations relative to adult and child mental health services are consistent with the provisions of A.B. 1 (Chapter 3, *Statutes of Nevada 2002 Special Session*). They are also consistent with the proposal for a new model of care delivery for adult and child mental health currently being developed by the Division of Child and Family Services, DHR; the Nevada Medicaid Office; and the Division of Mental Health and Developmental Services for consideration by the Director of DHR.

According to testimony, establishing a methodology for evaluating the community training centers and other services was a significant undertaking. Furthermore, the Provider Rates Task Force experienced obstacles related to the inability of the state's data system to provide needed information. It was noted that DHR is working to improve the state's data system. In addition, it was emphasized that due to variations in the method in which service providers maintain cost data, analysis was sometimes difficult. The following recommendations were presented to address these issues:

- Require service providers to maintain cost data in a more uniform manner to facilitate future analysis and comparison of information.

- Provide that rates be reevaluated at least every five years. Further, establish an independent third-party inflationary index to rebase rates during the interim years. Service rates were last rebased 14 years ago.

Based on testimony presented, the members agreed to:

> **Adopt a resolution expressing the Legislative Committee on Health Care's support for the long-term strategic health care plans developed by the Department of Human Resources regarding senior services, rural health, persons with disabilities, and provider rates pursuant to Assembly Bill 1 (Chapter 3, *Statutes of Nevada 2002 Special Session*). The resolution should include language urging the continuous allotment of 10 percent of the tobacco settlement funds that are designated to address the needs of disabled persons for the purpose of: (a) home and environmental modifications and assistive technology to allow community access, independent living, or return from institutional care; (b) permanent funding of the state's positive behavioral support program; and (c) respite for families providing primary care to a severely disabled family member. The resolution should also include language conveying the committee's support for establishing permanent long-term funding, which may be a percentage of liquor tax revenue, for chronic public inebriate and mental health services. (BDR –742)**

G. DETECTION AND CONTROL OF CERTAIN DISEASES

The State Epidemiologist, Health Division, DHR, testified that following the September 11, 2001, attack on the World Trade Center, and recent incidents involving Anthrax, the nation's attention has shifted from conventional kinds of terrorist attacks to biological acts of terrorism. It was presented that the public bases many notions of disaster preparedness on conventional problems that responders have experience handling and are generally immediately recognizable. Additionally, in a conventional attack traditional first responders, such as police, fire, and emergency medical personnel, would be able to identify casualties occurring at the time of the event or shortly thereafter.

Testimony emphasized that unlike conventional or chemical weapons, biological agents can be disseminated in a covert fashion. The casualties would not be immediately apparent, as the incubation period for the agent may take days or weeks before casualties become known. It was also noted that police, fire, or even traditional emergency medical responders would not identify the casualties. Instead, health care providers in doctors' offices, clinics, and emergency rooms would detect them. Further testimony indicated that even health care providers might not immediately recognize causalities, as the persons affected might appear to a large number of health care professionals with nonspecific health complaints.

The State Epidemiologist further indicated that the public health community has three key roles in dealing with bioterrorism: (1) determine that an attack has occurred; (2) identify the organism; and (3) mount some prevention strategies immediately.

According to information provided by public health representatives, public health agencies must be able to differentiate between natural disease occurrence and intentional transmission of disease. This distinction is critical when working with law enforcement partners to address a health crisis. Additionally, it was indicated that identifying the organism is critical to react appropriately, and having enhanced public health laboratory capacity is key to identifying agents or organisms. It was further noted that to avoid more causalities, prevention strategies were necessary and access to antibiotics, vaccines, and other medical supplies would be critical.

It was emphasized that public health agencies in the state need to be capable of detecting unusual patterns of disease, including those that are caused by unusual or even unknown threat agents to determine that an attach has occurred. In order to accomplish this, education and training needs to occur, as health care workers are not accustomed to reporting clusters of symptoms referred to as syndromic reporting. Additionally, it was emphasized that state and local health departments must also be trained to respond appropriately based on the information provided because of such reports.

In support of the concept of syndromic reporting, the State Epidemiologist encouraged the committee to require the State Board of Health to develop a syndromic reporting and active surveillance system. The system would monitor public health in Nevada during certain major

events or when the district health officer or State Health Officer (or his designee) determines it is appropriate and necessary to do so. Such a system could assist state health officials in the prompt detection of the presence of an infectious or contagious disease. The details of such a system would be included in regulations adopted by the State Board of Health.

Nevada Revised Statutes authorizes public health officials to isolate or quarantine an infected or exposed person. However, according to testimony, the relevant statutes do not expressly provide for the isolation or quarantine of groups of persons. Certain public health representatives proposed amending the existing provisions of NRS, which authorize public health officials to isolate and quarantine to specifically authorize the isolation or quarantine of groups of persons as may be necessary to limit the spread of disease under certain circumstances.

Certain representatives of the medical and legal communities emphasized their view that the state's current legal authority with regard to isolation and quarantine is primarily based on police powers and does not take into consideration the current environment regarding civil liberties. A representative of Nevada's Office of the Attorney General emphasized the court challenges that have ensued in jurisdictions that have relied heavily on police powers with regard to isolation and quarantine provisions, and have not provided for a consistent due process mechanism. Subsequently, individuals advocating for consistent due process procedures appealed to members of the committee to amend the existing sections of NRS that authorize the isolation or quarantine of persons to include due process protections similar to those provided to mentally ill persons who are involuntarily admitted to mental health facilities. These due process protections would require:

- The filing of a written petition with the district court within a certain period of time after the person is isolated or quarantined;
- A hearing on the petition within a certain period of time;
- An evaluation of isolated or quarantined persons by experts; and
- The appointment of counsel to represent such persons.

Continuing, certain public health officials expressed concerns regarding the proposed inclusion of stringent due process provisions that must be followed when persons are isolated or quarantined. It was stressed that in the event a horrific incident occurred, which required the isolation or quarantine of a group of persons in a geographic area, it may not be possible to meet all of the time requirements for filing a written petition, conducting an evaluation of each quarantined person, or hearing the petition. The committee was asked to consider the ability of a health authority to perform these tasks following a significant health emergency.

As a result of this discussion, members of the committee agreed to request that a bill be drafted to:

> **Amend Chapters 439 and 441A of NRS, which currently authorize certain agencies and officers of the state and local governments to quarantine and isolate persons in certain circumstances, to specifically authorize these agencies and officers to quarantine and isolate a group of persons if necessary. Additionally, amend NRS to include due process protections for persons who are quarantined or isolated. Further, require the State Board of Health, DHR, to develop a syndromic reporting and active surveillance system to monitor public health in this state. The syndromic reporting and active surveillance system shall be implemented during certain major events or when determined appropriate and necessary by the district health officer in a district, or his designee, or if none, the State Health Officer, or his designee. The State Board of Health is further required to adopt regulations to carry out the system. (BDR 40-677)**

IV. ADDITIONAL ISSUES

In addition to the bills that were requested for introduction and discussion to the 2003 Nevada Legislature, committee members specified their support for other issues that members discussed during the 2001-2002 interim period. These issues include development of a system for reporting medical errors and the availability of inpatient medical care and long-term care to individuals with mental illnesses or disorders such as Alzheimer's disease and dementia. This section summarizes certain discussions before the committee concerning these issues.

A. SYSTEM FOR REPORTING MEDICAL ERRORS

Assembly Concurrent Resolution No. 7 (File No. 77, *Statutes of Nevada 2001*) directed the Legislative Committee on Health Care, through a subcommittee, to conduct an interim study concerning the development of a system for reporting medical errors. Among other things, the study was to determine what constitutes: (1) a medical error; (2) an outcome that is detrimental to a patient; and (3) a medical error that causes an outcome that is detrimental to a patient. Additionally, the study was required to evaluate: (1) systems for reporting medical errors; (2) whether such a system should be established in Nevada; (3) effective ways the system may impose mandatory reporting of medical errors; and (4) methods for ensuring that information reported to the system remains confidential and that the system does not encourage blaming an individual medical professional for a medical error. Furthermore, the study was required to use the report *To Err is Human: Building a Safer Health System*, which was released by the Institute of Medicine (IOM) in November 1999. This section briefly lists the issues discussed in the "Report and Summary of Recommendations" submitted by the Legislative Committee on Health Care's Subcommittee to Study the Development of a System for Reporting Medical Errors.

The subcommittee met three times and consisted of five members, including two members of the Legislative Committee on Health Care. The subcommittee heard formal presentations, staff reports, and public testimony regarding medical errors and other related matters.

The subcommittee considered topics such as:

- Mandatory and voluntary medical error reporting systems;
- A mechanism for reporting medical errors by Nevada's professional licensing boards;
- Patient safety initiatives in Nevada and other states;
- The shortage of nurses in Nevada and the United States;
- Efforts of Nevada's hospitals and medical facilities to respond to reported adverse events;
- Medical errors and outcomes that are detrimental to patient;
- Benefits of root cause analysis, which is performed by hospitals, to identify potential opportunities for failure before they occur; and
- Responsibilities and surveying activities of the Bureau of Licensure and Certification, Health Division, DHR.

The final report of the subcommittee was presented to the committee at its June 4, 2002, meeting. In a special session called by Governor Kenny C. Guinn, the Legislature convened in Carson City on July 29, 2002, to consider issues associated with the cost and availability of medical malpractice insurance. The report and recommendations of this subcommittee were presented to the Legislature. Following three days of testimony presented from several perspectives, the Legislature passed Assembly Bill 1.

Assembly Bill 1 contained provisions that limit civil damages in certain circumstances. Additionally, the measure established a general limit on the amount of noneconomic damages that may be awarded to a plaintiff, with certain exceptions. Mandatory medical error reporting was also a significant component of A.B. 1. The measure established a method for reporting medical errors to assist medical facilities and the state in tracking problems and improving patient safety.

B. INPATIENT AND LONG-TERM CARE FOR PATIENTS WITH MENTAL ILLNESS OR DISORDERS SUCH AS ALZHEIMER'S DISEASE AND DEMENTIA

Members of the committee heard discussion about the lack of placement options for patients with mental illness or disorders such as Alzheimer's disease and dementia. The issue was highlighted during the committee's hearings regarding emergency room diversions. These patients frequently wait for long-term placements while occupying acute and emergency room beds. Additionally, many indicated concern regarding assistance available from the state mental health system and the time it takes to complete federally mandated mental health/mental retardation screenings for nursing home placements. A recommendation was made to conduct a study during the 2003-2004 interim regarding available placement options for care of individuals suffering from the previously mentioned illnesses. The chair felt that a review of the issue should not be delayed until the next interim. This section provides a discussion of the areas of concern and proposed recommendations to address this matter.

In response to a request for information from the committee regarding this issue, the Department of Human Resources provided a written response, which is included in this report as Appendix I. The response outlines three issues that greatly impact the time required to find an appropriate placement for a patient with the previously mentioned disorders. They are: (1) Pre-Admission Screening and Resident Review (PASRR); (2) limited placement options for patients who require greater patient-staff ratios or extensive staff training to manage behaviors; and (3) the Medicaid Eligibility process.

The response also emphasized the difference between the treatment of persons with Alzheimer's disease and dementias and persons with mental illness. The response indicates that treatment of persons with dementia-related disorders requires long-term institutional care as cognitive function decreases because of disease progression. Thus, the focus of treatment of such individuals is safety and security. Alternatively, persons who are mentally ill require short-term acute institutional care and long-term community care. Furthermore, the goal of the recovery model for mental illness focuses on stabilizing the client so that they might be progressively more independent.

Testimony presented before the committee indicated that federal regulations require all potential nursing facility residents to be screened for indicators of mental illness and/or mental retardation. This is known as a PASRR process. All individuals, regardless of their pay source, must be screened. Medicaid cannot pay nursing facilities until the PASRR screening is complete and an individual has been cleared for placement. If an individual is identified with indicators of mental illness or mental retardation, a second stage of screening by a psychologist or psychiatrist is required to determine severity and course of treatment. This second screening is a PASRR II. Testimony indicated that the Division of Health Care Financing and Policy contracts with HealthInsight to complete and coordinate PASRR screenings. The first screening (PASRR) is completed within 24 hours of request for an individual in an acute setting such as a hospital or within 72 hours of request for an individual

in a community setting, which include an emergency room or nursing facility. It was indicated that 86 percent of those screened only require the first level of screening for placement to occur. However, it typically takes from three to seven days for completion of the screening process if both levels of screening need to be performed.

Further testimony indicated that once an individual is cleared for placement, the process of locating an appropriate nursing facility is initiated. For a patient in an acute care hospital, the hospital discharge planner, patient, and the patient's family work together to find a nursing facility placement.

Based on 2001 statistics, it was indicated that there are approximately 5,091 Medicare/ Medicaid certified nursing facility beds in Nevada, of which Medicaid residents occupy approximately 2,781. Eight nursing facilities throughout the state have a designated "Alzheimer's Unit" (also referred to as a secure unit) meaning that a wing of the facility may be "locked." Facilities with such units are often full and have ongoing waiting lists.

According to the response, there are currently no nursing facilities in Nevada that accept residents with severe behavior problems, whether the behaviors are related to a dementia, dementia-related disorder, mental illness, or another medical condition. Nursing facilities that accept individuals who demonstrate severe behavior problems require staffing ratios above the minimum standard and extensive staff training. There are currently 72 Nevada residents who are Medicaid recipients residing in out-of-state nursing facilities. All of these residents have severe behavior problems. According to testimony, there are approximately one to two new out-of-state placements per month and the requests for placement have increased in frequency since late 1999.

In addition, testimony indicted that during recent meetings of the DHCFP's Long-Term Care Task Force, Nevada facilities were offered the opportunity to negotiate higher reimbursement for residents with behavior issues. They refused the offer, noting the major drawback as the increased potential for cited deficiencies and possible sanctions, including monetary, from the Bureau of Licensure and Certification, Health Division, and federal government. Furthermore, long-term care facilities indicated that the nursing shortage limits their ability to extend staffing ratios and the competition with the gaming industry in Nevada causes a unique challenge in obtaining adequate numbers of nursing assistants.

It was noted that Nevada Medicaid pays an average price per day of $97 for 60 of the 72 residents in out-of-state placement facilities in comparison to the current nursing facility daily rate in Nevada of $121. Twelve of the 72 out-of-state placements require very high nurse to resident ratios and specially trained staff. The reimbursement rate for these 12 residents averages $250 per day.

To further emphasize the challenge of placing and retaining in-state placement for residents with behavioral problems, it was noted that when patients (who are already in a nursing facility) exhibit significant behavior problems, they are discharged to an acute hospital to be

stabilized. When the resident is ready to return to the nursing facility, that facility frequently will refuse to readmit the patient citing its inability to provide for the patient's needs.

Finally, it was noted that Medicaid eligibility is another limitation to obtaining adequate care in a timely manner. Testimony indicated that when a patient is admitted to an acute care hospital from the community setting, arranging for a discharge to a nursing facility may be difficult if the patient is not a current Medicaid recipient. If the patient applies to the Welfare Division, DHR, for eligibility, it can take up to 45 days to process the application. The process may take much longer (several months to a year or more) if the Welfare Division requires additional information from the United States Social Security Administration. Most nursing facilities require a guarantee of eligibility or, at minimum, the patient should be pending eligibility to be admitted. Additionally, if the patient has behavior problems in addition to pending eligibility, nursing facilities are not likely to accept these patients prior to a final determination of eligibility. Oftentimes, the patient can spend several months in an acute care facility while waiting for an eligibility determination. This becomes frustrating for the hospitals that need to free up beds and are not structured to maintain patients with difficult behaviors for a lengthy period.

Several options were presented regarding methods to address this issue. One option presented would be to market a facility from another state that may be interested in establishing a business in Nevada. An out-of-state facility with a well-established behavior management program might respond to the offer of an enhanced Medicaid rate.

Another option presented in the response is to develop a team that would be responsible for identifying the behavioral interventions necessary to address the needs of an individual and enhance patient safety for other residents. This team would consist of representatives of various state agencies that are responsible and influential in this issue. The team would be readily available to assist nursing facility providers when a patient exhibits behavioral problems. It was emphasized that a greater level of retention of patients with behavioral problems (that are placed in Nevada facilities) may be achieved by providing such concentrated assistance.

Lastly, the option was presented of using state owned and operated mental health facilities for serving individuals with severe behavior problems. This facility could serve both Medicaid and pending eligible individuals.

Pursuant to NRS 433A.115, the Division of Mental Health and Developmental Services specifically excludes the treatment of both dementia and Alzheimer's disease. It was noted that the *Diagnostic and Statistical Manual of Mental Disorders* distinguishes the difference between Serious Mental Illness and the dementias (including Alzheimer's disease). Consequently, services administered by the Division of Mental Health and Developmental Services are only available to persons with mental illness.

For the placement of individuals with mental illness, testimony indicated that (with current expansions) there are more than 170 licensed psychiatric beds in the State of Nevada; however, only 128 of these beds are funded for staffing. Several proposals are being considered by DHR administration, to meet the growing demands for service, particularly in Henderson and Las Vegas. Additionally, DHR is in the process of evaluating the need for additional capacity.

According to information provided by DHR, the state's current options for addressing the growing demand for mental health acute care services are to continue funding and expand current Community Psychiatric Services. These services include:

- Program for Assertive Community Treatment (PACT). This is a "hospital without walls" program consisting of a multidiscipline treatment team that currently staffs at a ratio of 1-to-12 with licensed professionals. This program successfully maintains 70 clients in the community with intensive treatment that otherwise would require hospital care.

- Intensive Personal Service Coordination. This program, staffed by specially trained service coordinators at a ratio of 1-to-15, has treatment directed to persons coming out of the prison and jail systems with serious mental illness. It has proven successful in markedly reducing recidivism with regard to the justice and mental health hospital systems.

- Full Spectrum of Residential Housing. The residential options presented provide for clients to move progressively through increasingly independent residential options with effective training. This is the recovery model for the treatment of the seriously mentally ill.

    - Intensive Supportive Living Arrangements, which provide 24-hour support to clients living in the community.

    - Special Needs Supportive Living Arrangements is a form of residential support that provides additional nursing management care to persons with mental illness.

    - Group Homes provide a living situation for those clients who are thus far unable to manage independent living skills. Skill training is provided to prepare these individuals for independent living.

    - Supportive Living Arrangements provide persons with mental illness the opportunity to lease their own apartments, utilizing contracted education skill training and support to increase and maintain independent living.

V. CONCLUSION

This report presents a summary of bill drafts that were requested by committee members for discussion before the 2003 Nevada Legislature. In addition, the report provides information identifying certain other issues that were addressed during the interim. Persons wishing to have more specific information concerning these documents may find it useful to review the meeting minutes and exhibits for each of the meetings of the committee.

VI. APPENDICES

APPENDIX A

Nevada Revised Statutes 439B.200 through 439B.240,
"Legislative Committee on Health Care"

LEGISLATIVE COMMITTEE ON HEALTH CARE

NRS 439B.200 Creation; appointment of and restrictions on members; officers; terms of members; vacancies; annual reports.

1. There is hereby established a legislative committee on health care consisting of three members of the senate and three members of the assembly, appointed by the legislative commission. The members must be appointed with appropriate regard for their experience with and knowledge of matters relating to health care.

2. No member of the committee may:

(a) Have a financial interest in a health facility in this state;

(b) Be a member of a board of directors or trustees of a health facility in this state;

(c) Hold a position with a health facility in this state in which the legislator exercises control over any policies established for the health facility; or

(d) Receive a salary or other compensation from a health facility in this state.

3. The provisions of subsection 2 do not:

(a) Prohibit a member of the committee from selling goods which are not unique to the provision of health care to a health facility if the member primarily sells such goods to persons who are not involved in the provision of health care.

(b) Prohibit a member of the legislature from serving as a member of the committee if:

(1) The financial interest, membership on the board of directors or trustees, position held with the health facility or salary or other compensation received would not materially affect the independence of judgment of a reasonable person; and

(2) Serving on the committee would not materially affect any financial interest he has in a health facility in a manner greater than that accruing to any other person who has a similar interest.

4. The legislative commission shall select the chairman and vice chairman of the committee from among the members of the committee. Each such officer shall hold office for a term of 2 years commencing on July 1 of each odd-numbered year. The chairmanship of the committee must alternate each biennium between the houses of the legislature.

5. Any member of the committee who does not return to the legislature continues to serve until the next session of the legislature convenes.

6. Vacancies on the committee must be filled in the same manner as original appointments.

7. The committee shall report annually to the legislative commission concerning its activities and any recommendations.

(Added to NRS by 1987, 863; A 1989, 1841; 1991, 2333; 1993, 2590)

REVISER'S NOTE.

Ch. 620, Stats. 1993, the source of paragraph (b) of subsection 3 of this section, contains the following preamble and provisions not included in NRS:

"WHEREAS, The legislative committee on health care provides continuous oversight of matters relating to health care; and

WHEREAS, It is important to encourage participation on the legislative committee on health care of persons with the appropriate experience and knowledge of matters relating to health care; and

WHEREAS, The cost for medical care coverage for Medicaid-eligible patients is increasing at a rapid and unpredictable rate; and

WHEREAS, The number of Medicaid-eligible patients is also increasing at a rapid and unpredictable rate; and

WHEREAS, The need for health care reform is a national concern and the State of Nevada desires to be on the forefront of such reform; and

WHEREAS, The University of Nevada School of Medicine has 10 years of important and successful experience in a coordinated care program that currently serves 25 percent of the state's recipients of Aid to Families with Dependent Children; now, therefore,"

"1. The legislative committee on health care shall conduct a study to evaluate and develop a mandatory coordinated care medical system for all persons covered by the State of Nevada's Medicaid program. The study must include:

(a) An evaluation of the systems available to provide medical care to recipients of Medicaid;

(b) A review of the sources of available funding for a coordinated care system and the various methods of compensating providers of health care;

(c) An evaluation of the methods of containing the costs of providing medical care to recipients of Medicaid;

(d) The impact that a coordinated care medical system may have on the revenue received from the tax on hospitals imposed pursuant to NRS 422.383 and an analysis of the methods that may be used to replace lost revenues, if any; and

(e) The committee's recommendations for establishing a mandatory coordinated care program by July 1, 1995, to serve persons participating in the state's Medicaid program.

2. The legislative committee on health care shall:

(a) Report its recommendations to the governor and the department of human resources on or before July 1, 1994; and

(b) Submit quarterly reports to the interim finance committee concerning the progress of its study, its recommendations for establishing a coordinated care program and the implementation of the demonstration project and coordinated care program established pursuant to subsection 3.

3. The department of human resources shall, with the consent of the interim finance committee:

(a) Seek all necessary approvals and waivers and establish and conduct a demonstration project pursuant to section 1115 of the Social Security Act, 42 U.S.C. § 1315, in compliance with those recommendations of the legislative committee on health care that are approved by the governor. The purposes of the demonstration project must be to:

(1) Reduce the rate of growth in the overall costs of medical care over the long term;

(2) Improve access to primary and preventative health care for the Medicaid population;

(3) Institute health education programs for the Medicaid population; and

(4) Mainstream the Medicaid population into a coordinated care program with a balance of public and private members;

(b) Establish a mandatory coordinated care program not later than July 1, 1995; and

(c) Enroll all recipients of Aid to Families with Dependent Children upon the commencement of the program, with phased-in enrollment of the Aged, Blind and Disabled populations by the end of the second year of the program.

4. The coordinated care program established pursuant to subsection 3 must include participation by the University of Nevada School of Medicine in the development and implementation of the program, as well as in the delivery of services. The department of human resources shall cooperate with the University of Nevada School of Medicine to assist in the provision of an adequate and diverse patient population on which the school can base educational programs, including programs that support the education of generalist physicians. The University of Nevada School of Medicine may establish a nonprofit organization to assist in the research necessary for the program, receive and accept gifts, grants and donations to support the program and assist in establishing educational services for patients.

5. The director of the department of human resources shall report to the interim finance committee and the legislative committee on health care quarterly concerning the demonstration project and the coordinated care program established pursuant to this section.

6. As used in this section, "Medicaid"means the program established pursuant to Title XIX of the Social Security Act (42 U.S.C. §§ 1396 et seq.) to provide assistance for part or all of the cost of medical care rendered on behalf of indigent persons."

WEST PUBLISHING CO.

Health and Environment ⇐ 3.
Officers and Public Employees ⇐ 30.3.
WESTLAW Topic Nos. 199, 283.
C.J.S. Health and Environment §§ 9, 10.
C.J.S. Officers and Public Employees § 29.

NRS 439B.210 Meetings; quorum; compensation.

1. The members of the committee shall meet throughout each year at the times and places specified by a call of the chairman or a majority of the committee. The director of the legislative counsel bureau or a person he has designated shall act as the nonvoting recording secretary. The committee shall prescribe regulations for its own management and government. Four members of the committee constitute a quorum, and a quorum may exercise all the powers conferred on the committee.

2. Except during a regular or special session of the legislature, members of the committee are entitled to receive the compensation provided for a majority of the members of the legislature during the first 60 days of the preceding regular session for each day or portion of a day during which he attends a meeting of the committee or is otherwise engaged in the business of the committee plus the per diem allowance

provided for state officers and employees generally and the travel expenses provided pursuant to NRS 218.2207.

3. The salaries and expenses of the committee must be paid from the legislative fund.

(Added to NRS by 1987, 864; A 1987, 1629; 1989, 1221)

NRS CROSS REFERENCES.

Fee imposed on health insurers for support of committee, NRS 449.465

NRS 439B.220 Powers. The committee may:

1. Review and evaluate the quality and effectiveness of programs for the prevention of illness.

2. Review and compare the costs of medical care among communities in Nevada with similar communities in other states.

3. Analyze the overall system of medical care in the state to determine ways to coordinate the providing of services to all members of society, avoid the duplication of services and achieve the most efficient use of all available resources.

4. Examine the business of providing insurance, including the development of cooperation with health maintenance organizations and organizations which restrict the performance of medical services to certain physicians and hospitals, and procedures to contain the costs of these services.

5. Examine hospitals to:

(a) Increase cooperation among hospitals;

(b) Increase the use of regional medical centers; and

(c) Encourage hospitals to use medical procedures which do not require the patient to be admitted to the hospital and to use the resulting extra space in alternative ways.

6. Examine medical malpractice.

7. Examine the system of education to coordinate:

(a) Programs in health education, including those for the prevention of illness and those which teach the best use of available medical services; and

(b) The education of those who provide medical care.

8. Review competitive mechanisms to aid in the reduction of the costs of medical care.

9. Examine the problem of providing and paying for medical care for indigent and medically indigent persons, including medical care provided by physicians.

10. Examine the effectiveness of any legislation enacted to accomplish the purpose of restraining the costs of health care while ensuring the quality of services, and its effect on the subjects listed in subsections 1 to 9, inclusive.

11. Determine whether regulation by the state will be necessary in the future by examining hospitals for evidence of:

(a) Degradation or discontinuation of services previously offered, including without limitation, neonatal care, pulmonary services and pathology services; or

(b) A change in the policy of the hospital concerning contracts,

as a result of any legislation enacted to accomplish the purpose of restraining the costs of health care while ensuring the quality of services.

12. Study the effect of the acuity of the care provided by a hospital upon the revenues of the hospital and upon limitations upon that revenue.

13. Review the actions of the director in administering the provisions of this chapter and adopting regulations pursuant to those provisions. The director shall report to the committee concerning any regulations proposed or adopted pursuant to this chapter.

14. Identify and evaluate, with the assistance of an advisory group, the alternatives to institutionalization for providing long-term care, including, without limitation:

(a) An analysis of the costs of the alternatives to institutionalization and the costs of institutionalization for persons receiving long-term care in this state;

(b) A determination of the effects of the various methods of providing long-term care services on the quality of life of persons receiving those services in this state;

(c) A determination of the personnel required for each method of providing long-term care services in this state; and

(d) A determination of the methods for funding the long-term care services provided to all persons who are receiving or who are eligible to receive those services in this state.

15. Evaluate, with the assistance of an advisory group, the feasibility of obtaining a waiver from the Federal Government to integrate and coordinate acute care services provided through Medicare and long-term care services provided through Medicaid in this state.

16. Evaluate, with the assistance of an advisory group, the feasibility of obtaining a waiver from the Federal Government to eliminate the requirement that elderly persons in this state impoverish themselves as a condition of receiving assistance for long-term care.

17. Conduct investigations and hold hearings in connection with its review and analysis.

18. Apply for any available grants and accept any gifts, grants or donations to aid the committee in carrying out its duties pursuant to this chapter.

19. Direct the legislative counsel bureau to assist in its research, investigations, review and analysis.

20. Recommend to the legislature as a result of its review any appropriate legislation.

(Added to NRS by 1987, 864; A 2001, 2376)

WEST PUBLISHING CO.
Health and Environment ⇐ 6.

WESTLAW Topic No. 199.
C.J.S. Health and Environment § 13.

NRS 439B.225 Committee to review certain regulations proposed or adopted by licensing boards; recommendations to legislature.

1. As used in this section, "licensing board" means any board empowered to adopt standards for licensing or for the renewal of licenses pursuant to chapter 449, 630, 631, 632, 633, 637B, 639, 640, 641, 641B, 652 or 654 of NRS.

2. The committee shall review each regulation that a licensing board proposes or adopts that relates to standards for licensing or to the renewal of a license issued to a person or facility regulated by the board, giving consideration to:

(a) Any oral or written comment made or submitted to it by members of the public or by persons or facilities affected by the regulation;

(b) The effect of the regulation on the cost of health care in this state;

(c) The effect of the regulation on the number of licensed persons and facilities available to provide services in this state; and

(d) Any other related factor the committee deems appropriate.

3. After reviewing a proposed regulation, the committee shall notify the agency of the opinion of the committee regarding the advisability of adopting or revising the proposed regulation.

4. The committee shall recommend to the legislature as a result of its review of regulations pursuant to this section any appropriate legislation.

(Added to NRS by 1991, 940)

NRS CROSS REFERENCES.

Administrators of facilities for long-term care, NRS ch. 654
Audiologists and speech pathologists, NRS ch. 637B
Dentistry and dental hygiene, NRS ch. 631
Medical and other related facilities, NRS ch. 449
Medical laboratories, NRS ch. 652
Nursing, NRS ch. 632
Osteopathic medicine, NRS ch. 633
Pharmacists and pharmacy, NRS ch. 639
Physical therapists, NRS ch. 640
Physicians and assistants, NRS ch. 630
Psychologists, NRS ch. 641
Social workers, NRS ch. 641B

NRS 439B.230 Investigations and hearings: Depositions; subpoenas.

1. In conducting the investigations and hearings of the committee:

(a) The secretary of the committee, or in his absence any member of the committee, may administer oaths.

(b) The secretary or chairman of the committee may cause the deposition of witnesses, residing either within or outside of the state, to be taken in the manner prescribed by rule of court for taking depositions in civil actions in the district courts.

(c) The chairman of the committee may issue subpoenas to compel the attendance of witnesses and the production of books and papers.

2. If any witness refuses to attend or testify or produce any books and papers as required by the subpoena, the chairman of the committee may report to the district court by petition, setting forth that:

(a) Due notice has been given of the time and place of attendance of the witness or the production of the books and papers;

(b) The witness has been subpoenaed by the committee pursuant to this section; and

(c) The witness has failed or refused to attend or produce the books and papers required by the subpoena before the committee which is named in the subpoena, or has refused to answer questions propounded to him,

and asking for an order of the court compelling the witness to attend and testify or produce the books and papers before the committee.

3. Upon such petition, the court shall enter an order directing the witness to appear before the court at a time and place to be fixed by the court in its order, the time to be not more than 10 days from the date of the order, and to show cause why he has not attended or testified or produced the books or papers before the committee. A certified copy of the order must be served upon the witness.

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

(Added to NRS by 1987, 866; A 1987, 1630)

NRS 439B.240 Investigations and hearings: Fees and mileage for witnesses. Each witness who appears before the committee by its order, except a state officer or employee, is entitled to receive for his attendance the fees and mileage provided for witnesses in civil cases in the courts of record of this state. The fees and mileage must be audited and paid upon the presentation of proper claims sworn to by the witness and approved by the secretary and chairman of the committee.

(Added to NRS by 1987, 866)

APPENDIX B

Overcrowded Hospital Emergency Rooms Data

TESTIMONY BEFORE

THE LEGISLATIVE COMMITTEE ON HEALTH CARE

TUESDAY, JANUARY 8, 2002

PRESENTED BY

MARIE H. SOLDO, EXECUTIVE VICE PRESIDENT, GOVERNMENT AFFAIRS
SIERRA HEALTH SERVICES, INC.

Thank you for the opportunity to testify today. My name is Marie Soldo and I am representing Health Plan of Nevada (HPN). I have been asked to provide an industry prospective on how divert is impacting hospital emergency room admissions of the insured population.

As the largest health insurer in Nevada, we understand how the marketplace is always changing. We have had the good fortune to be part of one of the fastest growing communities in the United States. While the growth has been good for our community, it has had unintended consequences. Health insurance plans have experienced a significant change in the supply and demand of hospital beds. For years Las Vegas had an excess number of hospital beds for the existing population. Given our growth, and, in spite of the addition of two new hospitals during recent years, there continues to remain an inadequate number of hospital beds as well as medical support staff. This results in emergency patients being taken to hospitals that are not contracted with their health plan.

Health plans/insurers are responsible for providing their members with access to appropriate quality care at reasonable costs. To do this health plans/insurers contract with physicians, hospitals and other providers. Contracted partnerships with hospitals are critical to controlling costs enabling health plans and insurers to reimburse hospitals at agreed upon rates. These agreements keep insurance rates affordable for both employer sponsored plans and individual policyholders. As a result of the growth in the marketplace, insurers and health plans may not be able to contract with every hospital as they have in the past. When health plan members require *non-emergency*, inpatient care they are admitted to contracted or preferred hospital and payments for these hospital stays are at the agreed upon contract rates. Unfortunately, those same health plans/insurers experience emergency inpatient admissions to non-contracted hospitals when hospitals are on divert status and the contracted or preferred hospital is unavailable. When this occurs and health plan/insured members are admitted to non-contracted hospitals, the hospitals

charge "billed charges." Billed charges are the upper limit rates established by hospitals and are dramatically higher than the predetermined or agreed upon contracted rates. Basically there are no limits on what a hospital may charge in the absence of agreed upon rates. This results in unpredictable costs to all payors.

To provide you with an example of the economic affects, we will refer to Health Plan of Nevada's experience. Excluding Medicare admissions, in the year 2000, HPN incurred 341 admissions to non-contracted hospitals in the Las Vegas area due to emergency room diverts. Those 341 admissions, or patients, utilized 960 days at an average daily charge of $5,000 per day. Compare this cost with the $1,637 of operating revenue per day reported to the State by the Big 6 Hospitals[1] (see attached chart). More than three times the charges you would expect to pay. In the case of HPN, the 341 admissions represent less than 4% of total admissions; however, the costs of these admissions represented 14% of total inpatient expenses incurred or $4.8 million.

As a result of the uncontrollable costs attributable to the divert emergency admissions, HPN's 2001 premiums included a factor to cover these unexpected expenses and we anticipate that this will only get worse as the trend continues.

One interesting point – and reason we excluded Medicare and Medicaid statistics from our example – is because of the way the Federal Government has resolved the problem. Congress, in their effort to control Medicare and Medicaid costs, requires non-contracted and non-participating providers including physicians and hospitals to accept established rates for emergency room services and emergency hospital admissions under both programs.

[1] State of Nevada, Department of Human Resources, Division of Health Care Financing and Policy, year End December 31, 2000 Summary Financial Report-1 Statement of Revenues & Expenses.

Divert is a complicated subject – one only has to look at today's agenda to see that. We believe that while this committee reviews and discusses the causes and how to reduce the number of diverts it also needs to address the economic impact of diverts on the insured population.

The recent William M. Mercer, Inc. nationwide survey found that employers can expect their health care premiums to increase on an average of 13% in 2002 and some companies expect increases of 20% or more. These double-digit healthcare cost increases come at a time when businesses are struggling and the economy is weak. In response, large employers are shifting the burden requiring employees to pay higher premiums, deductibles, co-insurance and co-pays. Small employers are reducing benefits, shifting costs to employees or eliminating offering insurance entirely to employees adding to the underinsured and uninsured population.

While health plans are free to negotiate market driven rates with hospitals, good faith efforts to contract for reasonable rates are severely impaired when the supply of beds is limited and the divert status is high. As a result we are losing the ability to accurately predict inpatient costs. This affects consumers, employers and all types of health insurers including self-insured health plans. Therefore, in the absence of agreed upon rates and until the divert situation is relieved, we believe a legislative remedy should be considered for emergency hospital admissions. The Federal model is one method of controlling the cost of diverts but other solutions are available. Regardless of which legislative proposals you choose please consider the economic impact these policies will have on the health care industry. Keeping health insurance affordable while protecting and nurturing the health care provider community will be difficult but absolutely necessary.

Thank you for the opportunity to address you today. I will be happy to answer any questions the committee may have.

Billed Charges Comparison 1999-2000[2]
Per Adjusted Day

Big Six Hospital	Desert Springs	Saint Mary's	Sunrise	UMC	Valley	Washoe	Total Big Six	Statewide
Billed Charges 1999	$4,452	$4,061	$4,787	$3,691	$4,757	$4,037	$4,305	$4,086
2000	5,031	4,759	5,170	3,925	5,078	4,324	4,671	4,419
Increase	13%	17%	8%	6%	6%	7%	8%	8%
Operating Revenue 1999	1,471	1,774	1,484	1,603	1,393	1,610	1,546	1,497
2000	1,602	1,843	1,597	1,656	1,471	1,702	1,637	1,569
Increase	9%	4%	8%	3%	6%	6%	6%	5%

[2] Taken from State of Nevada, Department of Human Resources, Division of Health Care Financing and Policy, Year End December 31, 2000 Summary Financial Report-1, Statement of Revenues & Expenses (Source: Nevada Hospital Quarterly Reports Submitted By the Facilities)

Legislative Committee on Health Care
NRS 439B.200

"Efforts of the Division of Mental Health and Developmental Services to address concerns related to emergency room diversions"

January 8, 2002

Good Morning, Chairman Rawson and Members of the Committee on Health Care.

For the record my name is Dr. David Rosin. I am the Statewide Medical Coordinator for the Division of Mental Health and Developmental Services (MHDS) and the Medical Director and Acting Agency Director of the Southern Nevada Adult Mental Health Services (SNAMHS).

My testimony this morning offers general background material on the availability of emergency services for mentally ill patients in Clark County and the efforts of Southern Nevada Adult Mental Health Services (SNAMHS) to address the issues of mentally ill patients as they relate to emergency room diversion.

The salient features of this testimony are as follows:

- **The current crisis is complex and is caused by multidimensional interrelated factors. Effective solutions are not simple nor single dimensional.**
- **The demand for emergency psychiatric services in Clark County has grown faster than predicted because of:**
  - **Rapid population growth**
  - **An increase in service accessibility**
  - **A decrease in barriers to emergency treatment.**
- **The ability of Southern Nevada Adult Mental Health (SNAMHS) to manage the volume of emergency referrals has been exceeded.**

- **SNAMHS is working closely with the emergency room consortium in an effort to provide prompt service and reduce the current crisis in emergency care.**

I. BACKGROUND

SNAMHS is the public, State Mental Health Care System for adults in Clark County and Southern Nevada.

It is a comprehensive service system consisting of the following:

- A 78 bed acute care psychiatric hospital
- 4 outpatient medication clinic sites
- An emergency service department (PES), which includes a 10-bed emergency observation unit (POU) and an ambulatory walk in emergency clinic (PAS).
- As of November 30, 2001 SNAMHS had an active caseload of 8,666 clients.

I. Emergency Psychiatric Care

Psychiatric Emergency Service (PES)

- Over the past three years the number of clients treated per year in the Emergency Department rose from 10,900 in 1999 to 11,868 in 2001. Based on 6 months data, the number of clients served in 2002 is projected to be 13,344. **This represents an increase of 2,444 emergency clients per year over those seen in 1999. ***

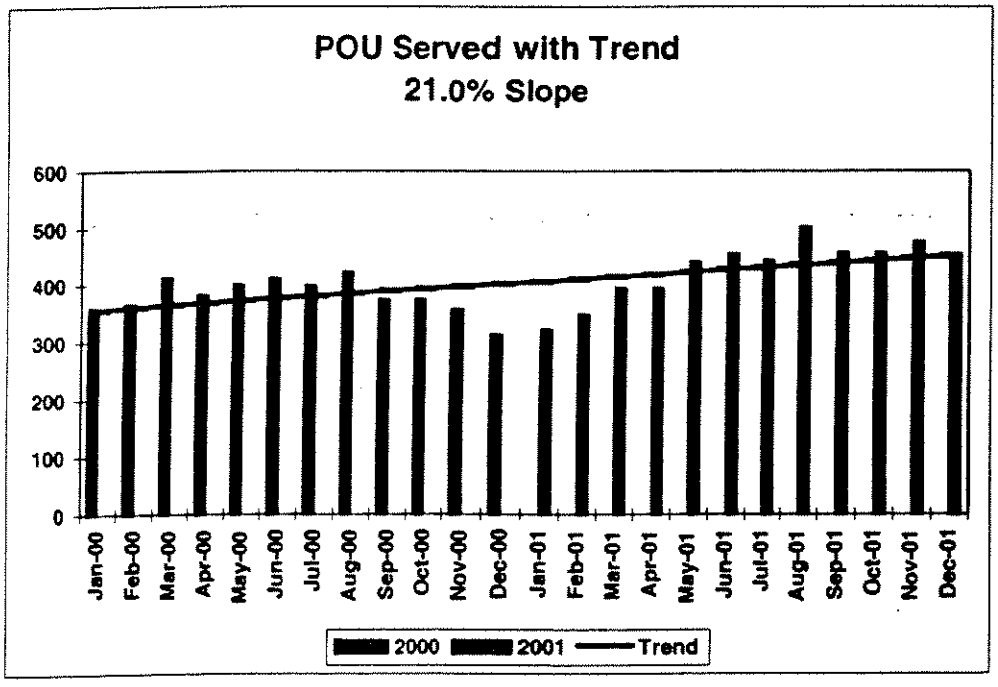
*The major increase in clients served noted above is due to increased availability and accessibility of services as well as population growth.

- Services are available 24 hours a day 7 days a week.
- Staffs in both the observation unit and ambulatory unit are cross-trained and provide service to both areas dependent upon need. This provides for the most efficient use of personnel.

Psychiatric Observation Unit (POU)

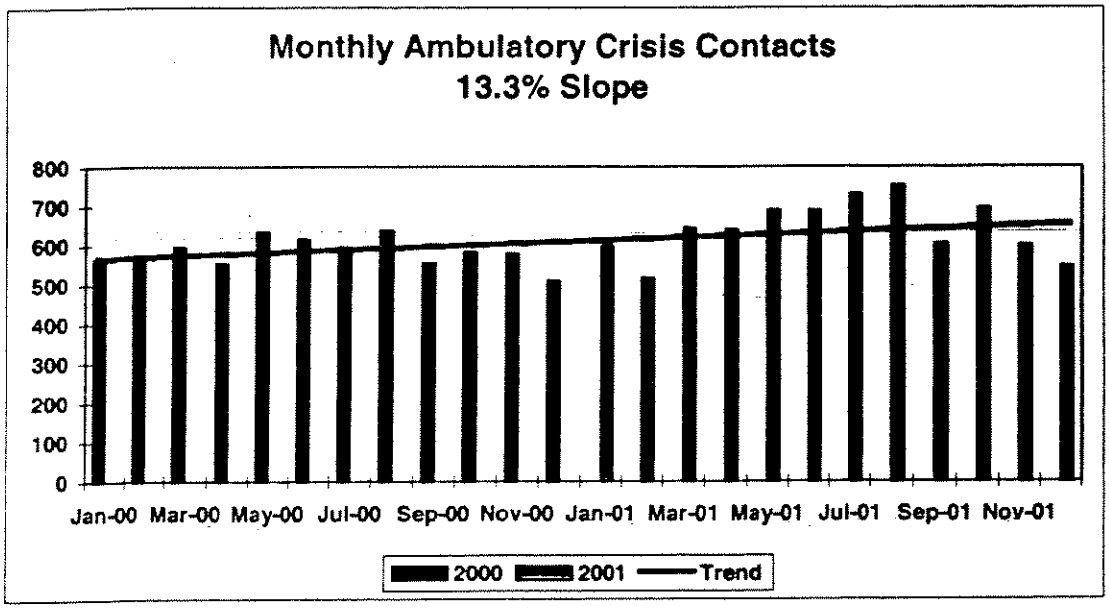
- The ten-bed observation unit (POU) is capable of evaluating and treating clients for up to 48 hours in an effort to avoid inpatient psychiatric hospitalization and make referral to appropriate community care. Most of the clients served in this setting have been detained on a 2000-R legal hold to allow the psychiatric evaluation process.
- In 2001, approximately 51% of the clients treated in the Emergency Observation Unit (POU) on legal holding orders were able to avoid inpatient care and be referred directly to appropriate community follow up treatment.
- In 1999 the Emergency Observation unit evaluated and treated 4,356 clients. This increased to 4,632 clients served in 2001. Based on 6 month's data, the number of clients served in 2002 is projected to be 5,496. **This represents an increase of 1,140 emergency clients per year treated in the Emergency Observation Unit over those seen in 1999.**
- (Graph #1 shows a 21.0% slope increase in clients treated in the observation unit over the past 24 months.)

Graph #1



Emergency Psychiatric Ambulatory Service (PAS)

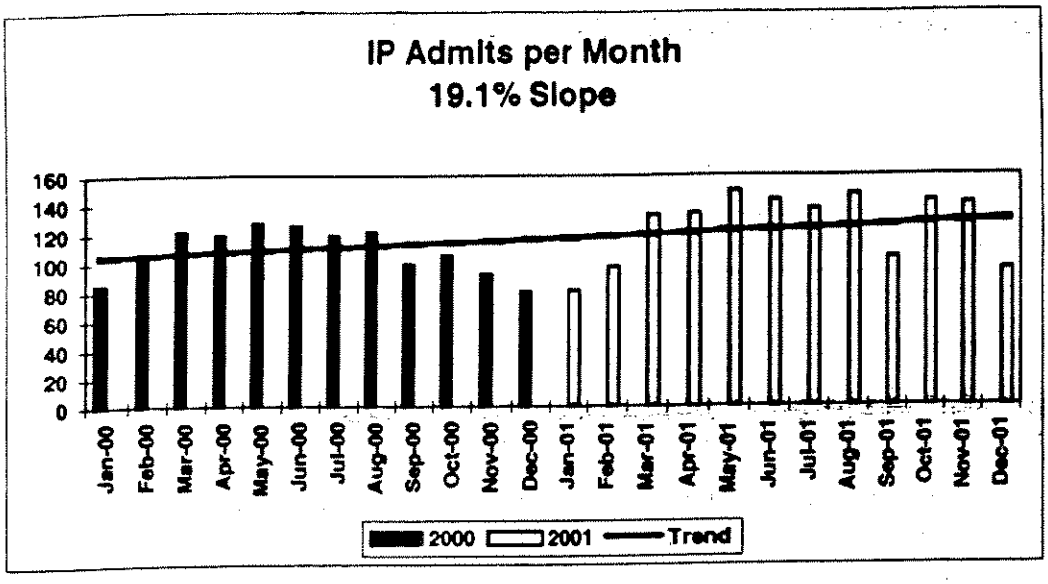
- The ambulatory walk in emergency clinic (PAS) is projected to evaluate 7,848 clients by the end of 2002. Approximately 85% of the clients treated in the Emergency Ambulatory Department are referred directly to the community for appropriate follow-up treatment, thus avoiding high cost hospital care.
- In 1999 the Walk in Clinic (PAS) evaluated and treated 6,552 clients. This increased to 7,236 clients served in 2001. Based on 6 month's data, the number of clients served in 2002 is projected to be 7,848. **This represents an increase of 1,296 emergency clients per year evaluated and treated in the Emergency Walk-In Clinic over those seen in 1999.**
- (Graph #2 shows a 13.3% slope increase in clients treated over the past 24 months)



Graph #2

- During the same 3 year period, the number of admissions to the acute inpatient hospital facility rose from 1044 to 1332. Based on 6 month's data, the number of clients admitted into the acute care hospital in 2002 is projected to be 1,512. **This represents an increase of 468 emergency clients per year treated in the inpatient hospital over those seen in 1999.**

- (Graph #3 shows a 19.1% slope increase in clients admitted to the hospital over the past 24 months.)



Graph #3

- The need for an Emergency Psychiatric Service building including a 20 bed Observation Unit was recognized in 1999. Consequently, $288,500 in funding for planning such a unit was made available. However, following the planning process, the project was not funded.
- Since 1999 the demand for both emergency services as well as inpatient care has increased at rates higher than that predicted by population growth. During this period of rapid growth, additional successful efforts have been made to place difficult long-term psychiatric inpatients into the community thereby allowing the psychiatric hospital to focus more efforts into providing acute care.
- In achieving this goal SNAMHS has successfully created 4 additional "Intensive Need" SLA apartments and will add 4 more in FY 2003.
- In addition, SNAMHS was funded for 12 "Special Needs" group home placements for psychiatric clients with serious medical conditions. Two clients have been successfully placed and we are in the process of contracting the additional homes with an existing list of 25 eligible clients.

II. Factors Associated with the Growing Crisis in Providing Emergency Psychiatric Services

- There are multiple factors associated with the growing crisis. Many are intertwined. The issues are not single dimensional nor are there simple solutions.
- Clark county population increased from **1,343,540** in July 1999 to 1,425,723 in 2001. Current population is estimated to be over **1,500,000**
    - In February 2000 Charter Hospital closed with a loss of 80 acute psychiatric beds. In August 2001 Valley Hospital Psychiatric Unit closed with a loss of 10 psychiatric beds. **This accounts for a loss of 90 acute care psychiatric beds in the local community.**
    - **The total number of psychiatric beds in the community has dropped from 270 to 178.**
    - Currently acute psychiatric beds are located at SNAMHS (78 beds); Monte Vista (80 beds); and Lake Meade (22 beds). This excludes the children's beds at Willows Springs

- In February 2001.after performing an analysis of admissions to SNAMHS Emergency Services, I found that there were a number of accessibility issues due both to internal admission policies as well as with transportation from the acute care hospitals to SNAMHS.
- To become more community responsive and accessible, I redesigned SNAMHS admission procedures for Psychiatric Emergency Services. This resulted in rapid transfer of psychiatric clients from the hospital emergency rooms to SNAMHS 10 bed Psychiatric Observation Unit.
- Prior to July 2001, SNAMHS was staffed for 86 acute psychiatric beds plus the 10-bed emergency observation unit.
- In July 2001 the number of staffed beds at SNAMHS was reduced by 8 beds, from 86 to 78. Funds resulting from the bed

reduction were shifted to create community Special Needs Supportive Living (SLA) residential placements.

- Between July 2001 and August 2001, 8 long-term clients were successfully placed into the community dropping the hospital to its current staffing current level of 78. No acute care psychiatric beds have been lost in the process.
- Between February 2001 and August 2001, referrals to SNAMHS from the hospital emergency rooms increased markedly
- During this time there was marked increase in hospital census. This increase in census was directly related to SNAMHS community response to the emergency room crowding crisis.
- In order to move patients out of the community emergency rooms and into SNAMHS emergency observation unit (PES), clients were shifted from the Psychiatric Emergency Unit (PES) to the inpatient hospital to make room for clients in the community hospitals.

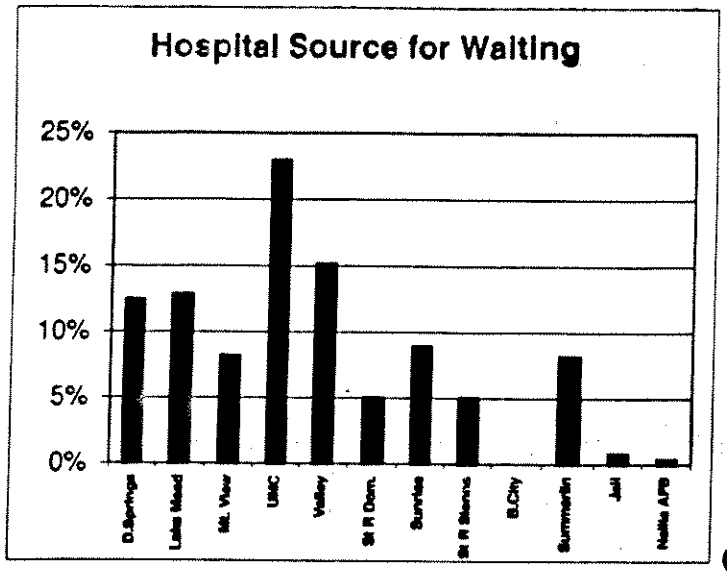
By September 2001 the community need for psychiatric observation beds clearly exceeded SNAMHS bed availability.

- Referrals to SNAMHS Emergency Services come from different sources. The primary referral sources are as follows:

Hospitals	34.7%
Self	52.3%
All other sources	13.0%

Of the hospital referrals, which are primarily to the Emergency Observation Unit, almost half (45.6%) come from University Medical Center and Valley Hospital

The distribution is given in Graph #4 below.



Graph #4

In September 2001, responding to the needs of patients at UMC and Valley Hospital Emergency Rooms, SNAMHS obtained treatment privileges for a psychiatrist and a social worker at both hospitals.

- They began seeing psychiatric patients at UMC awaiting transfer to SNAMHS to begin evaluation and treatment prior to transfer.
- Admission of many of these clients to SNAMHS was avoided, as the clients were stabilized and returned to community care directly from UMC.
- This project was extended to Valley Hospital.
- The project, however, has been temporarily put on hold because of staffing shortages at SNAMHS.

In July 2001 because of a change in the NRS, the State Board of Medical Examiners ruled that physicians seeking temporary licensure in Nevada were required to have all of the qualifications needed for full licensure.

- Consequently, our ability to hire Locum psychiatrists to assist in the staffing shortage has been severely curtailed.
- The law as now interpreted requires all physicians to pass the SPEC examination if they have not been specialty boarded in the past 10 years.

- SPEC is a general medical examination designed to test the knowledge that one would expect a Family Practice physician to have 2 years after completing his residency training.
- Locum psychiatrists required to take this examination, who have not practiced general medicine in many years, do not chose to take this examination and consequently work in states other than Nevada.

In spite of an active ongoing recruitment program, SNAMHS remains severely understaffed. The continuing psychiatric staffing shortage has had a negative effect on care both in the community clinics and in the ability to provide additional emergency services.

III. SNAMHS Attempts To Address the Crisis in Collaboration with the Emergency Room Coalition

- SNAMHS began participating in monthly Emergency Room Managers meeting with all of the Clark County Emergency Room directors in 1999.
- From November 1999 to September 2000 SNAMHS participated in the "Chronic Public Inebriate Task Force" which addressed the impact that drugs and alcohol had on growing emergency room crowding. The action plan to address these issues remains in force.
- In May 2000 SNAMHS participated in an evaluation of transportation, which identified the issue of ambulance delay in transporting clients from the emergency rooms to SNAMHS. Issues of ambulance transfer delays have been reduced as a result of the addition of a second provider of transportation service.

- In November 2000 SNAMHS eliminated its policy of limiting Emergency Service admissions to one per hour.
- In November 2000 SNAMHS began participating with University Medical Center in a pilot program to modify laboratory examinations to clients in the medical emergency rooms in an effort to curtail both cost and time spent in the medical setting. This has proved successful and is slowly being adopted by other local emergency rooms including Sunrise and ST. Rose Hospitals.
- In February 2001 SNAMHS revised its admission procedure to process emergency admissions every 30 minutes.
- There was a resultant increase in admissions from the Psychiatric Emergency Services into the acute care psychiatric hospital. This allowed for more rapid transfer of patients from the community emergency rooms.
- Many of these clients admitted into the psychiatric inpatient hospital might have been directly returned to community care had they remained in the emergency service area for a longer time of treatment.
- This revision of admission practice provided temporary relief from February 2001 to August 2001.
- SNAMHS presented training at Sunrise and Valley hospitals targeted at reducing errors in processing clients transferred from the emergency rooms. This greatly reduced significant administrative delays.
- Beginning in March 2001, SNAMHS has participated in the Blue Ribbon Task Force of the Clark County Health Department, which is attempting to find solutions to the problem of emergency room crowding.
- SNAMHS is an active participant in Sheriff Keller's Task force that is addressing various issues involving the mentally ill including those of emergency room crowding
- I am a member of the subcommittee that is working to prepare an emergency services proposal to the task Force.
- Recognizing the large number of referrals from UMC and Valley Hospital (45.6%), in September 2001,SNAMHS began sending a psychiatrist and a social worker to UMC emergency room to evaluate and treat psychiatric patients awaiting transfer to SNAMHS. These were persons held for

an excessive length of time in the emergency room because of lack of bed availability. This service has been temporarily halted because of staffing shortages.

- In December Valley Hospital granted privileges to the psychiatrist and social worker. They will begin evaluating and treating psychiatric clients in the Valley Hospital Emergency room when staffing shortages at SNAMHS are lessened.

IV. PLANS FOR THE IMMEDIATE FUTURE

- Currently SNAMHS Acute Care Hospital is undergoing a Life-Safety retrofit, which is scheduled to be completed in February 2001.
- Once the retrofit is completed, SNAMHS may be able to identify temporary additional space to house additional emergency observation beds on a short term crisis basis.
- The addition of these temporary beds will not address any of growing needs of the Ambulatory Walk–In Emergency Clinic. (Expanded emergency observation beds and emergency walk in clinic expansion were addressed fully in the original plan that was developed by Public Works as a result of the 1999 funding.)
- It was initially believed that after the retrofit, when the additional crisis beds became available, there would be a consequent reduction in the need for inpatient beds and a resulting move of adequate inpatient staff into the Emergency Service Unit.
- The effect of the creation of the special needs group home beds and the intensive SLA placements will have to be fully analyzed along with the increased demand for services to determine if existing staffing funds are adequate.

THE

CHRONIC

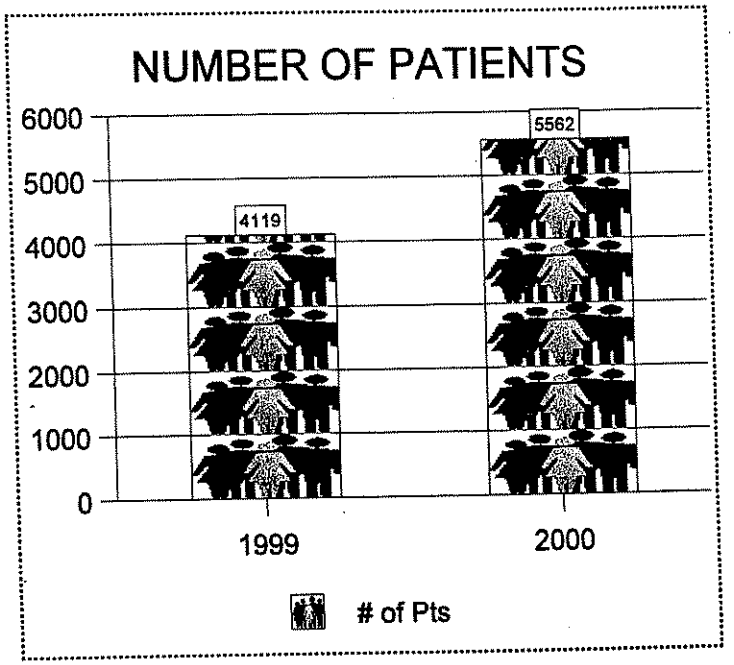
PUBLIC

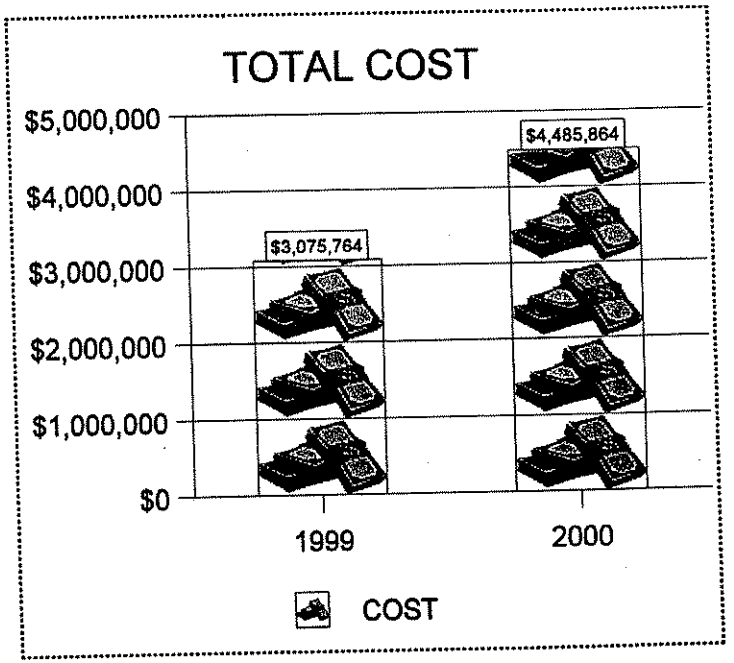
INEBRIATE

Provided by: Janelle Kraft
Senior Fiscal Analyst
Intergovernmental Relations
City of Las Vegas, Nevada
January 8, 2002

COMPARISON

	NUMBER OF PATIENTS	TOTAL COST AMOUNT
1999	4119	$3,075,764.00
2000	5562	$4,485,864.00
INCREASE OF :	**1443**	**$1,410,100.00**

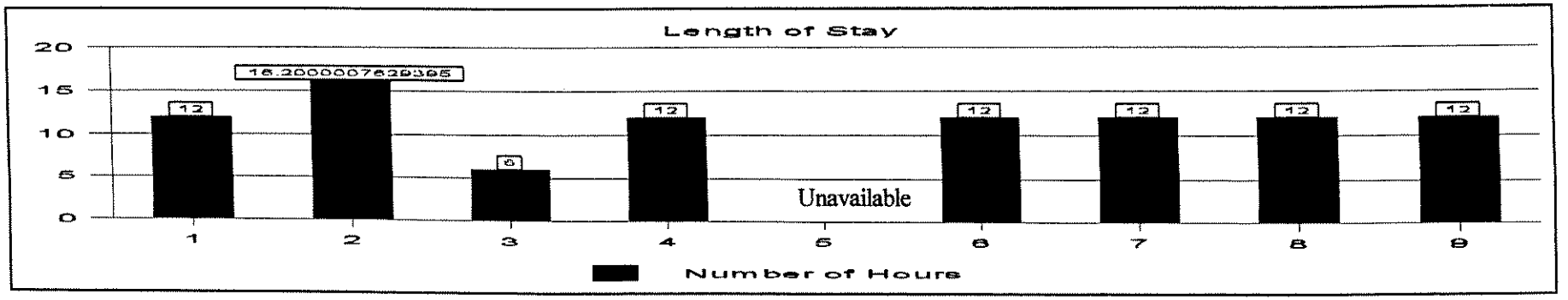


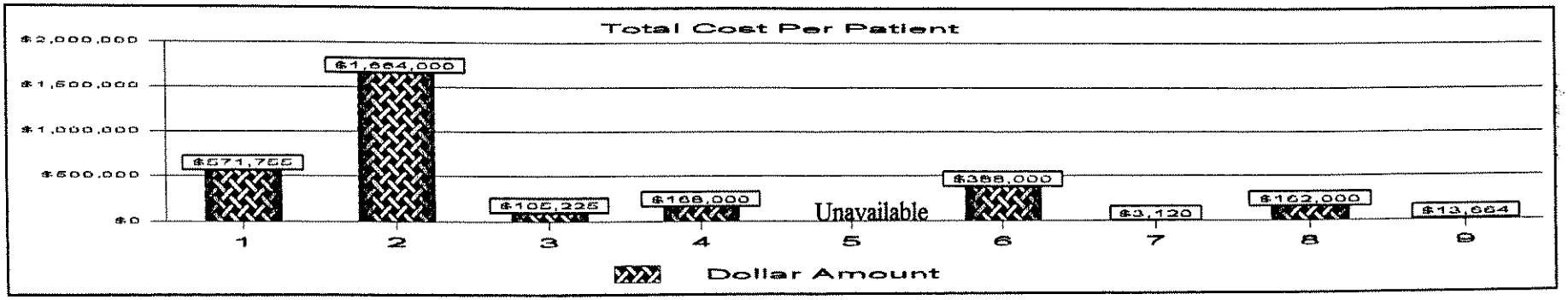


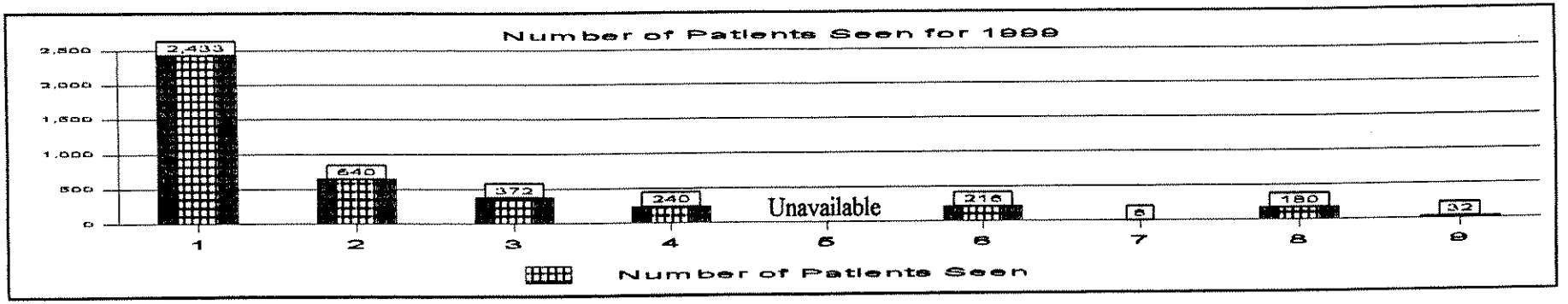
Reflects 25% increase

Reflects 30% increase

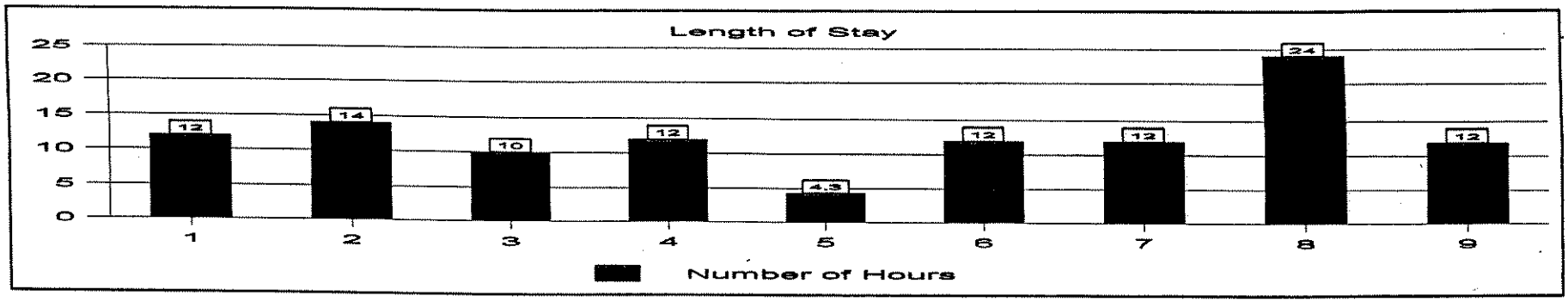
CHRONIC PUBLIC INEBRIATE
for 1999

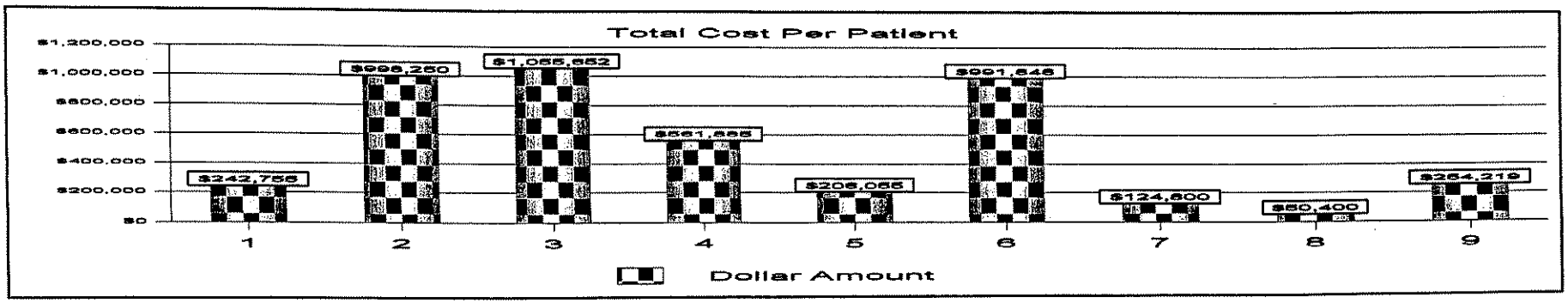


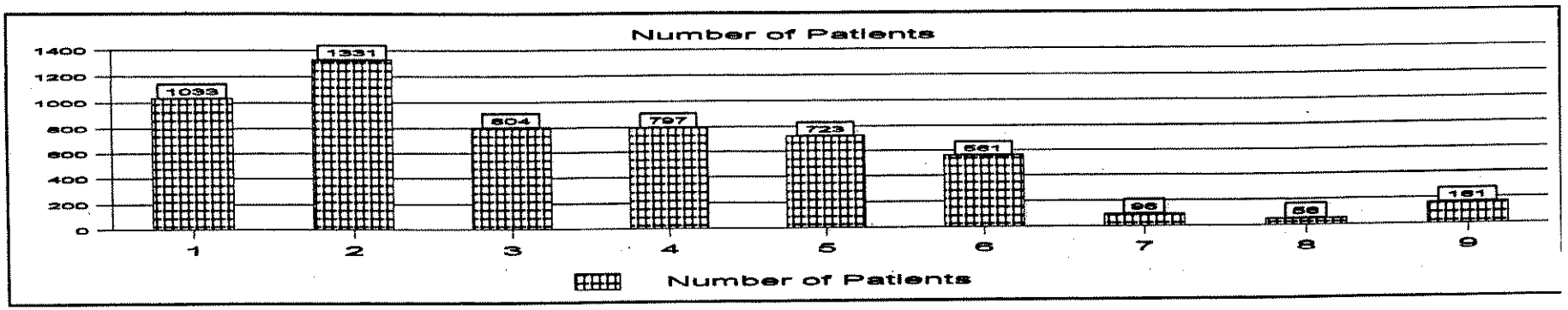




CHRONIC PUBLIC INEBRIATE
for 2000





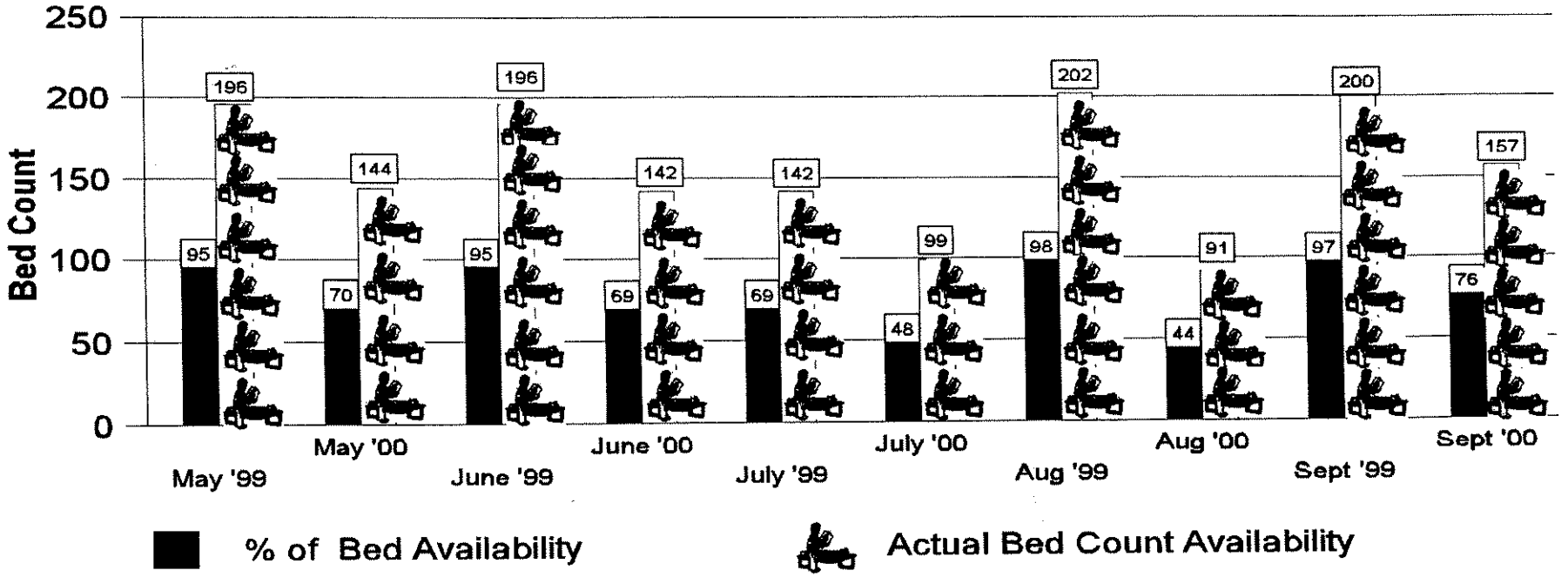


Emergency Department Bed Count

1	2	3	4	5	6	7	8
20	31	28	32	21	13	22	39

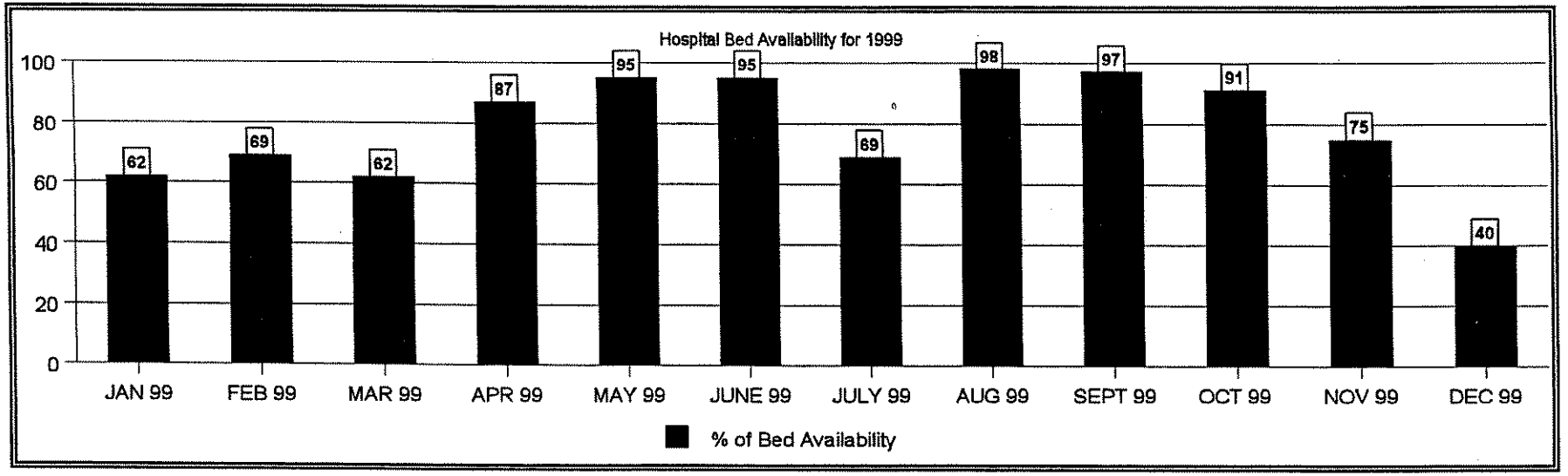
Total number of beds = 206

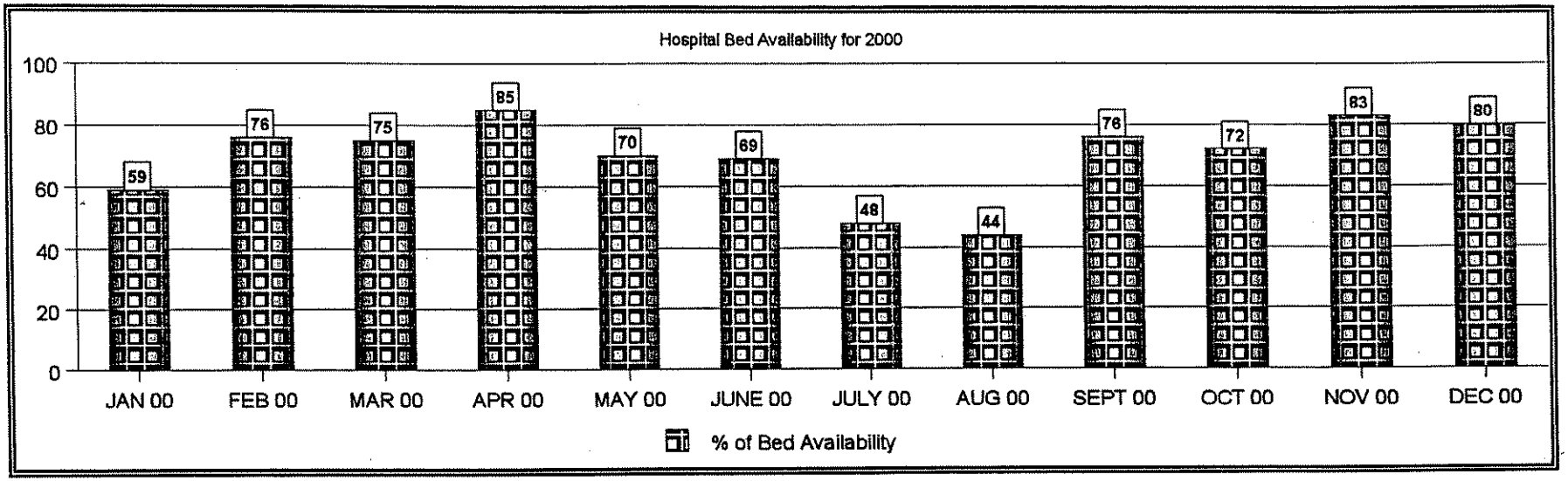
Hospital Bed Availability Vs Divert



Disclosures- Siena Emergency Department not represented due to recent opening.
Boulder City Emergency Department not represented as they are not included in the Health District Divert Statistics.

DIVERT COMPARISON ON BED AVAILABILITY 1999-2000

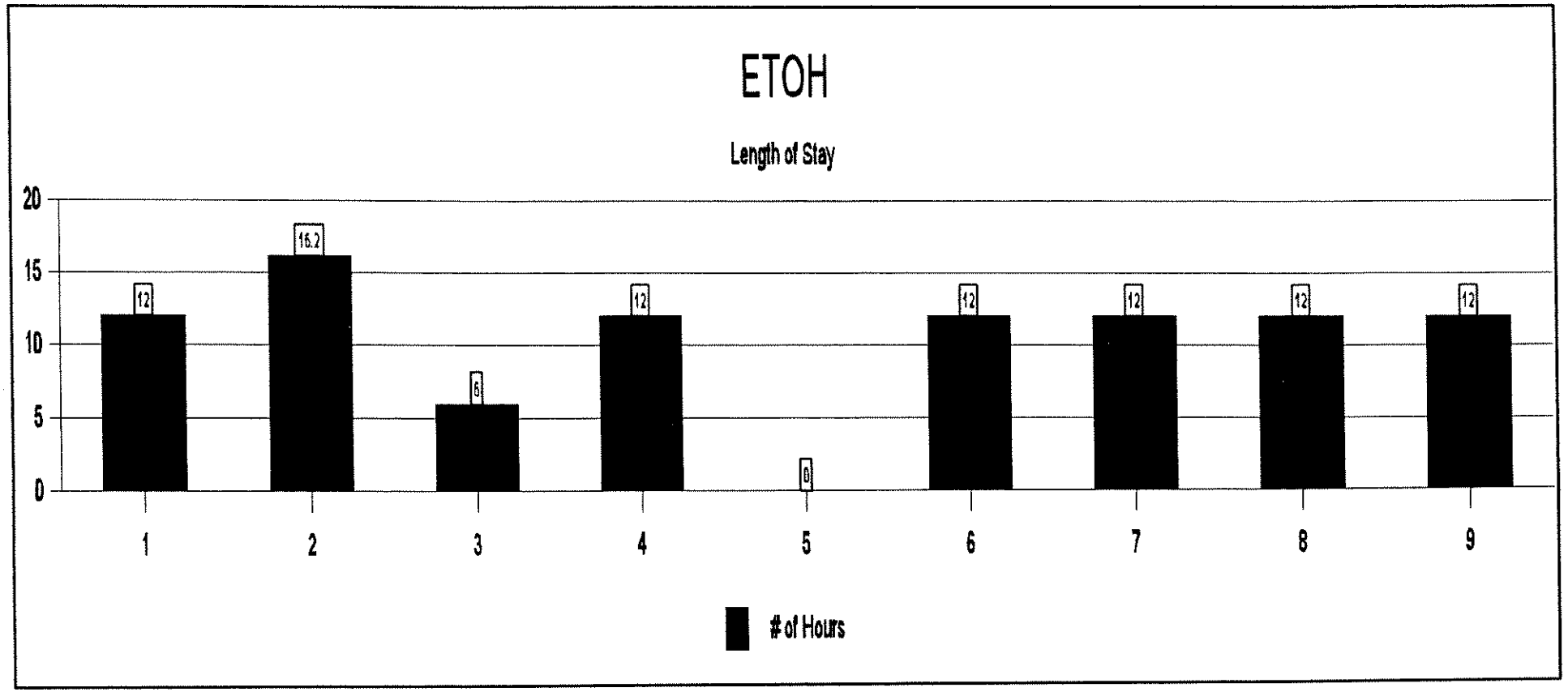




Statistics provided by Clark County Health Department

LENGTH OF TIME INEBRIATE PATIENTS SPEND IN EMERGENCY DEPARTMENTS

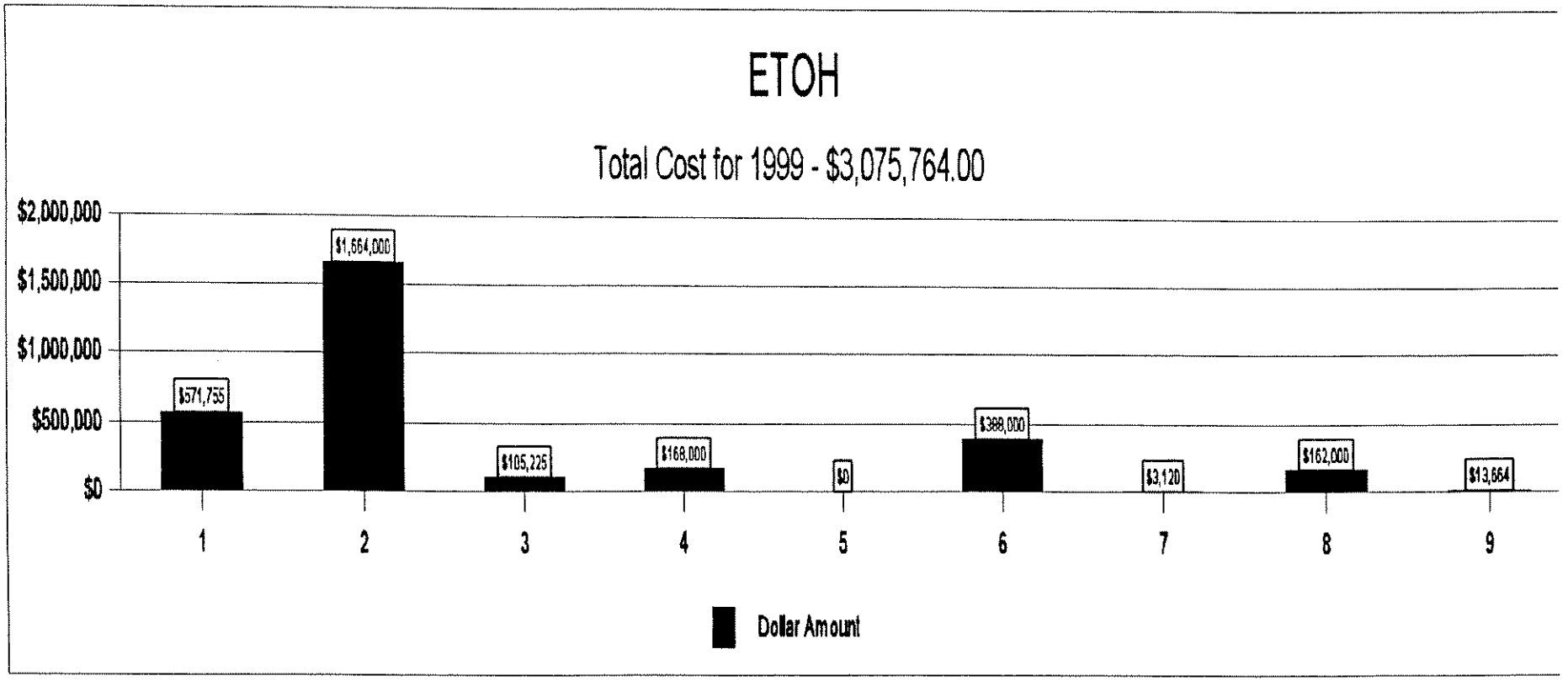
TOTAL NUMBER OF PATIENTS FOR 1999 EQUALS 4119



Hospital	1	2	3	4	5	6	7	8	9
# of Pts seen for 1999	2433	640	372	240	Not Available	216	6	180	32

Information was provided by hospitals with the understanding that it would remain confidential

DOLLAR AMOUNT TO CARE FOR INEBRIATE PATIENTS IN EMERGENCY DEPARTMENTS

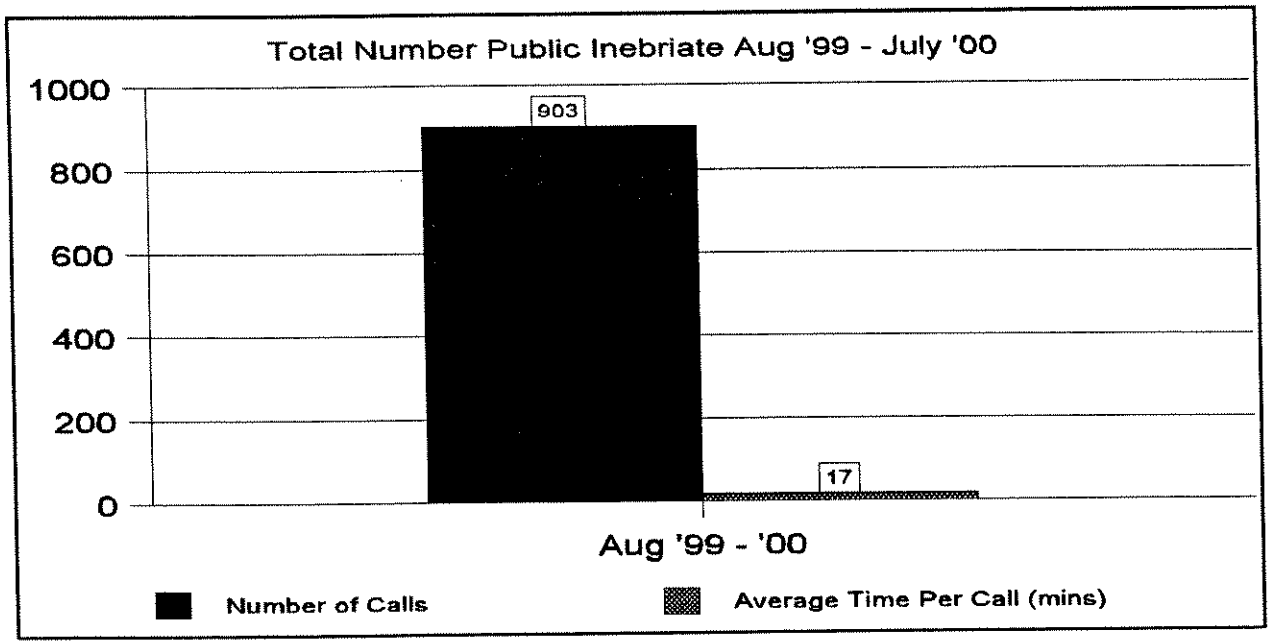


Hospital	1	2	3	4	5	6	7	8	9
# of Pts seen for 1999	2433	640	372	240	Not Available	216	6	180	32

Information was provided by hospitals with the understanding that it would remain confidential

Las Vegas Metropolitan Police

Number of Inebriate Patients transported to Westcare by LVMPD



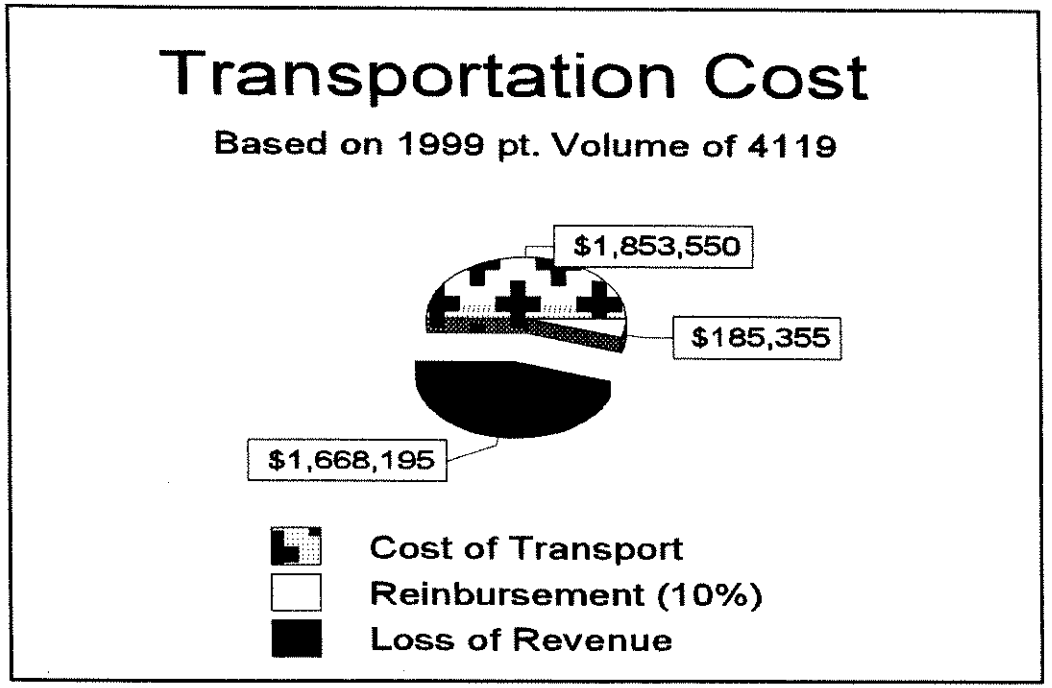
These numbers do not reflect all Alcohol involved calls, additional calls may be recorded as:

1. Disturbance's 2. Trespassing 3. "Man Down"

Total cost for this time period $5,628.70. (This amount is based on an hourly wage of $22.00)
Total time spent interacting with these calls - 255 hrs 0 mins. The Metro Officers can be detained for prolonged time frames and this can decrease their availability for more urgent calls in the community. The number of clients transported to Westcare by all Metropolitan Jurisdiction for this time period is **903** (this number supplied by Westcare)

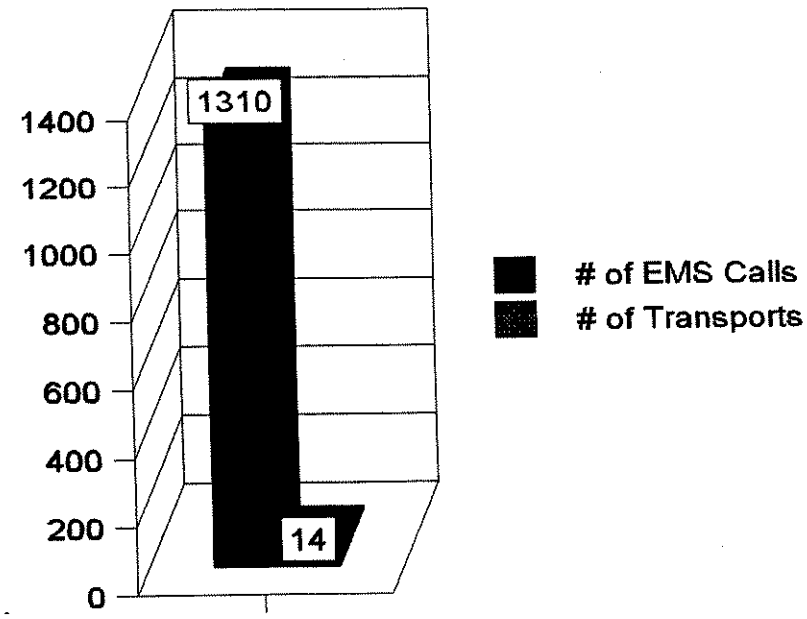
Westcare provide a viable resource for the Las Vegas Metropolitan Police Department for disposition of the CPI Client - Metro also transfers directly to jail or uses EMS for CPI needing medical treatment.

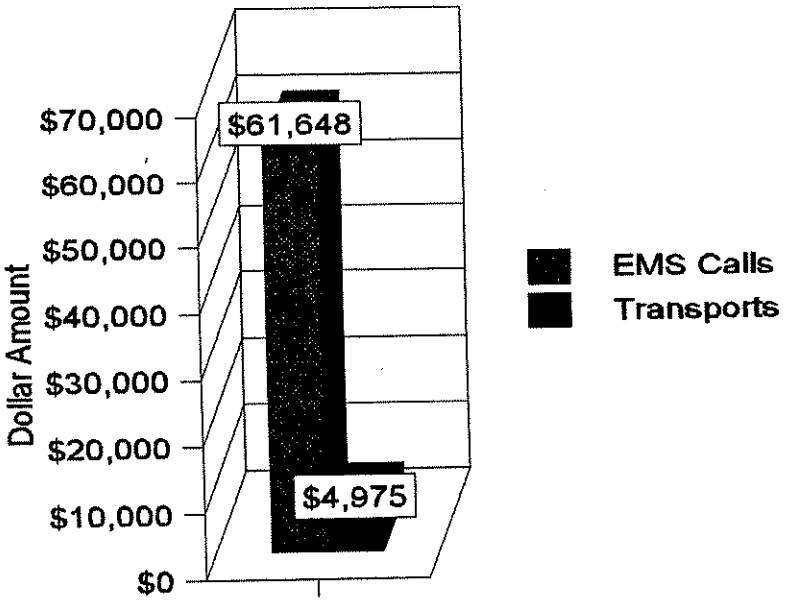
AMERICAN MEDICAL RESPONSE



These figures are calculated from the total number of CPI patients throughout the Emergency Departments. American Medical Response charge $450.00 per non-emergent transports. Reimbursement falls at 10%.
90% of these patient types are uninsured.

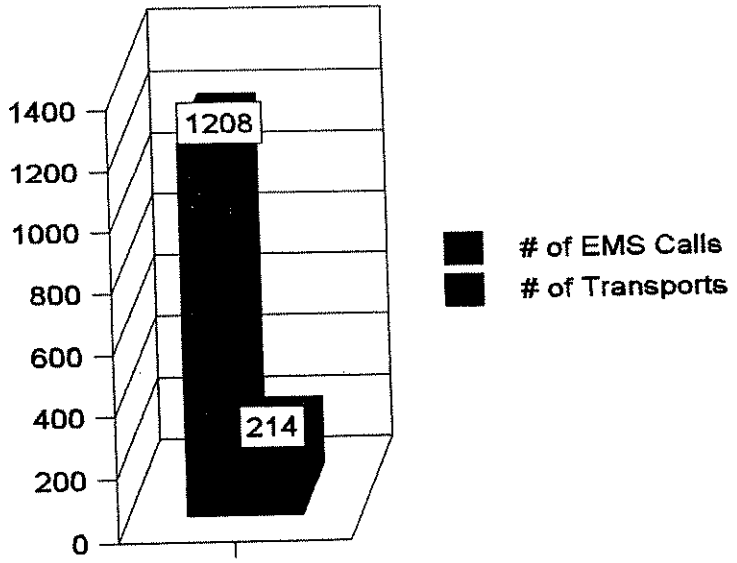
Clark County Fire Department
CPI Report
First Quarter 2000

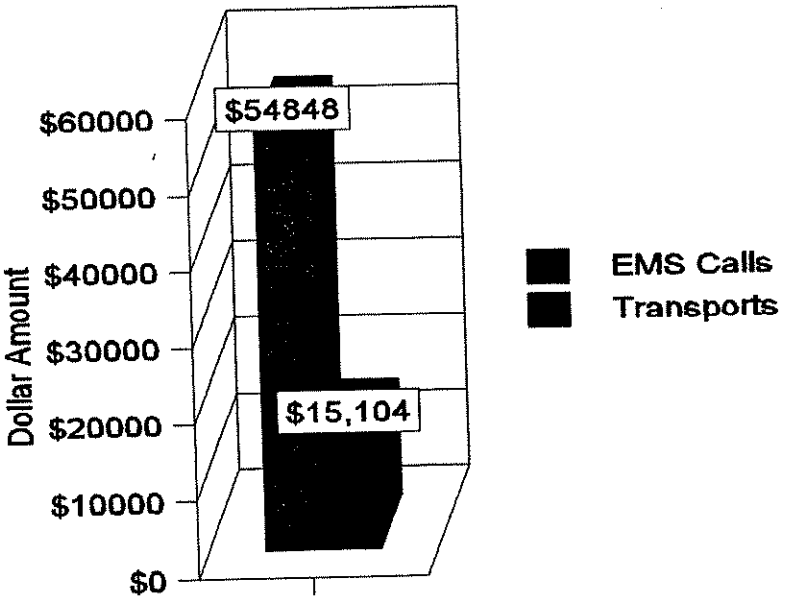




Average Medic Hourly Rate: $23.53 x 2 person crew
Average Time on Call: 60 Minutes
Average Time on Transports: 90 Minutes

Las Vegas Fire & Rescue
CPI Report
First Quarter 2000





Average Medic Hourly Rate: $23.53 x 2 person crew
Average Time on Call: 60 Minutes
Average Time on Transports: 90 Minutes

CHRONIC PUBLIC INEBRIATE ALGORITHM

[redacted]

EMS NOTIFIED

CPI PROTOCOL INITIATED

ASSESSMENT

1. Patient is able to Stand
2. Normal Vitals/Accucheck
3. No Acute Medical Complication
4. No Signs/History of Trauma
5. No Suspected Closed Head Injury

No Medical Treatment Required

PATIENT TO WEST CARE

Staffing:
1. Nurse Practitioner
2. 24hr coverage
3. 24hr Observation
4. Treatment Offered

Decline in Patient's Condition

1. Patient is unable to Stand
2. Abnormal Vitals/Accucheck
3. Acute Medical Complication
4. Signs/History of Trauma
5. Suspected Closed Head Injury

Medical Treatment Required

EMERGENCY DEPARTMENT

Evaluation and Treatment

Transferred to West Care

Decline in Patient's Condition

RETURNED TO EMERGENCY DEPARTMENT

"Serving the Community - A Plan of Action"
for
The Chronic Public Inebriate (CPI) Variance

PROPOSAL: **CPI Educational Seminar - Systems Perspective Training Plan**
Designed and presented by Jackie Harrigan, Ph.D., MSW, DAC

Consultant will provide a three (3) hour training for trainers based on review of current paramedic textbooks specifically in reference to addiction and alcoholism plus documents pertaining to the CPI, i.e., the CPI algorithm protocol and Field CPI Checklist approved by the CCHD Medical Advisory Board, NRS, EMS Regulations, and the Variance for the Regulation allowing the CPI to be transported to a place of care other than the local emergency departments.

COMPLIANCE with Variance to EMS Regulations to transport the CPI LEGAL MANDATES–State and City Regulatory Statutes

QUALITY ASSURANCE: Field CPI Checklist will provide the system with a QA TOOL to monitor the appropriate referral system.

ORGANIZATIONAL/NEEDS ASSESSMENT: Will be based on input from Assistant EMS Medical Director, WESTCARE, provider Training Departments both private and public, paramedic representatives and CCHD staff.

WRITTEN MANUAL for trainers based on principles from American Society of Addiction Medicine (ASAM), and the National Institute on Alcohol Abuse & Alcoholism, U.S. Department of Health and Human Services.

ADDICTIONS: **Alcoholism Disease Concept**
Understanding that the CPI has an Illness
Alcohol - A Psychoactive Drug
Other Drugs

PATIENT PLACEMENT CRITERIA: **Physical and Mental Signs**
Role Playing

TRAINERS will be able to identify addictions, an appropriate referral system and have an awareness of legal mandates and legal liabilities. CEU's or CME's will be applied for through BADA & CCHD.

WESTCARE PROCEDURES: Admission and After Admission

FOLLOW-UP: Consultant will be available to conduct follow-up with physicians, CCHD staff, ambulance providers, WESTCARE and program participants. Evaluation of training and award certificates.

- **Founded in 1973**
- **Created to provide community-based substance abuse treatment for people who are indigent or from low-income households.**
- **Currently provides a comprehensive continuum of care in Clark County, including Henderson, Laughlin and Las Vegas.**
- **Began providing detoxification services in Clark County in 1987.**
- **Approximately 4,000 admissions for detoxification services annually.**
- **Sole provider for Civil Protective Custody (CPC)/Detoxification services for Clark County.**
- **Currently only 25 intake beds for CPI/1.6 Million Population**
- **1999 Over 8000 CPI patients were treated, but only 4000 at Westcare because the other 4000+ were needlessly transported to the Emergency Department due to EMS Regulations and lack of available beds at Westcare.**

SERVICES PROVIDED BY WESTCARE

Nevada Community Involvement Center:

*Intake, Assessment and Referrals
*Alcohol/Drug Education, Prevention and Intervention Programs
*Community Services
*Family Support
*Speakers Bureau
*Welfare to Work
*Adult Outpatient Services

Adult Services Center:

*Intake, Assessment and Referral
*Clinically Managed Detoxification
*Emergency Shelter for Runaway, Homeless and Exploited Youth and Youth in Crisis
*Crisis Hotline
*Outpatient Counseling/Intensive Outpatient Counseling
*Residential Treatment
*Transitional Living
*Parent Support Groups

SERVICES PROVIDED BY WESTCARE - Cont

Harris Spring Ranch:

*Adult Male and Female Residential Treatment

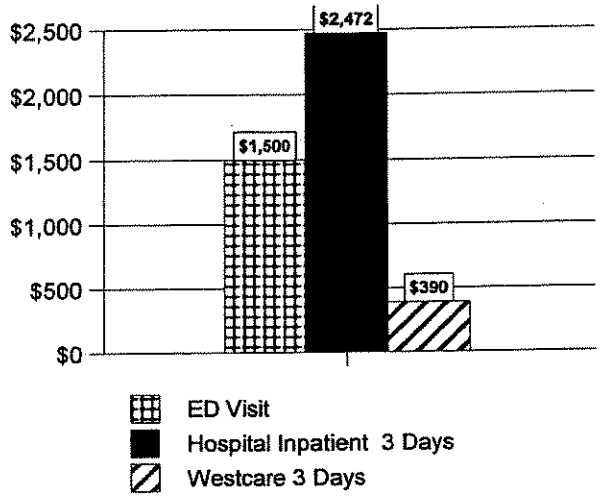
Youth and Family Services Center:

*Intake Assessment and Referral
*Clinically Managed Detoxification
*Emergency Shelter for Runaway, Homeless and Exploited Youth and Youth in Crisis
*Accredited School Program for High Risk Youth on Property
*Crisis Intervention, Evaluation, Referral and Placement
*Crisis Hotline
*Outpatient Counseling/Intensive Outpatient Counseling
*Residential Treatment
*Transitional Living
*Parent Support Groups

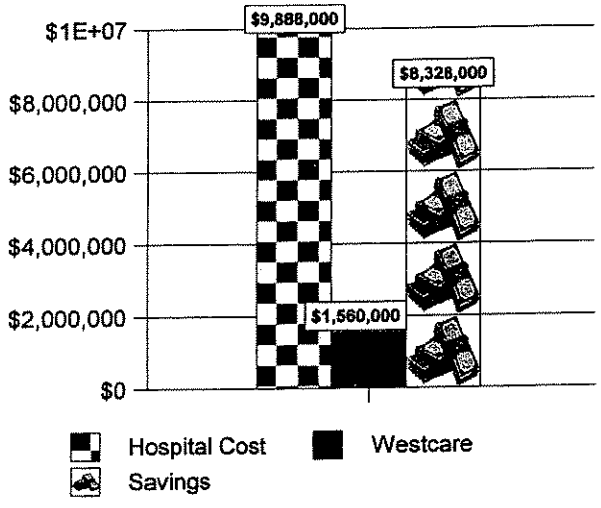
COST OF DETOXIFICATION SERVICES

EMERGENCY DEPARTMENT (PER VISIT)	**$1,500.00**
HOSPITAL STAY (PER DAY)	**$834.00**
WESTCARE STAY (PER DAY)	**$130.00**

The Average Stay for Patient Type - 3 Days



Total cost for 1999 - Based on Patient Volume at Westcare (4000) For a 3 Day Stay



LAS VEGAS REVIEW-JOURNAL

Saturday, September 16, 2000

Conference examines hospital overcrowding

Expert says Las Vegas ER crisis nation's worst

By JOELLE BABULA
REVIEW-JOURNAL

Las Vegas medical professionals must learn to route patients quickly through hospitals and keep noncritical patients out to combat what one expert said is possibly the worst emergency room crisis in the nation.

Although the lack of empty hospital beds and clogged emergency rooms is a nationwide dilemma, "It's more severe here than any other place I've seen," said Mike Williams, the key speaker at a Friday conference aimed at solving hospital overcrowding in Las Vegas. "We're holding onto patients in the ER that could be tracked faster or are waiting for services, tests and consultations that could be done differently."

Williams is the president of the Abaris Group, an independent consulting firm from northern California specializing in emergency medical systems. Williams and his team work with hospitals across the country to improve emergency medical services. They spent several days earlier this month combing through Las Vegas hospitals and interviewing health officials prior to holding the conference.

"One out of three people go to an emergency department every year, and we need to look for ways to move patients through the ER faster, which means we free up a bed faster," Williams said prior to the day-long divert conference.

When a hospital goes on divert, it means there are no longer empty beds available at that facility to care for more patients. Hospitals on divert status still receive ambulance patients, but they enter into a rotation with other hospitals also on divert rather than receive a constant stream of patients.

More than 70 representatives from local hospitals, the Clark County Health District, fire departments and ambulance services attended the conference -- sponsored by American Medical Response -- to gain insight into

the hospital problems and brainstorm about solutions.

Williams said the goal of the hospitals in the valley should be to wipe out the divert system completely, a position that was greeted with some skepticism from hospital administrators. He said if hospital officials took an in-depth look at their internal operations, they could find ways to free up enough beds so diverting patients would not be necessary.

"The biggest issue in Las Vegas and from a global standpoint is how well we manage internal resources on a day-to-day basis," Williams said.

William Hale, the chief executive officer for University Medical Center, said he did not think it would be possible to stop diverting patients.

"It will create compromises in patient care," Hale said. "There will be hospitals that won't be able to handle it. To say to a hospital you cannot go on divert at anytime, I think it will create a calamity."

Williams, however, suggests developing a discharge unit so patients who are ready to go home but are merely waiting for lab results or transportation can wait in a waiting room rather than tying up a bed.

He also said hospitals need to look at developing or revamping a fast track system adjacent to the emergency room department. A fast track would ideally move non-critical patients in and out of the hospital in a couple of hours, freeing up resources for true emergencies.

"There are hospitals that have a fast track designed to move a patient through in an hour, and they work really well," he said. "I know it sounds like a bottle factory, but the public really responds well when they can come in and out in two hours."

Several hospital administrators attending the conference said they already have fast track programs.

"We have a fast track area, but it's only open when we have enough people to staff it," said Dr. Rick Henderson, the director of the emergency department at St. Rose Dominican Hospital.

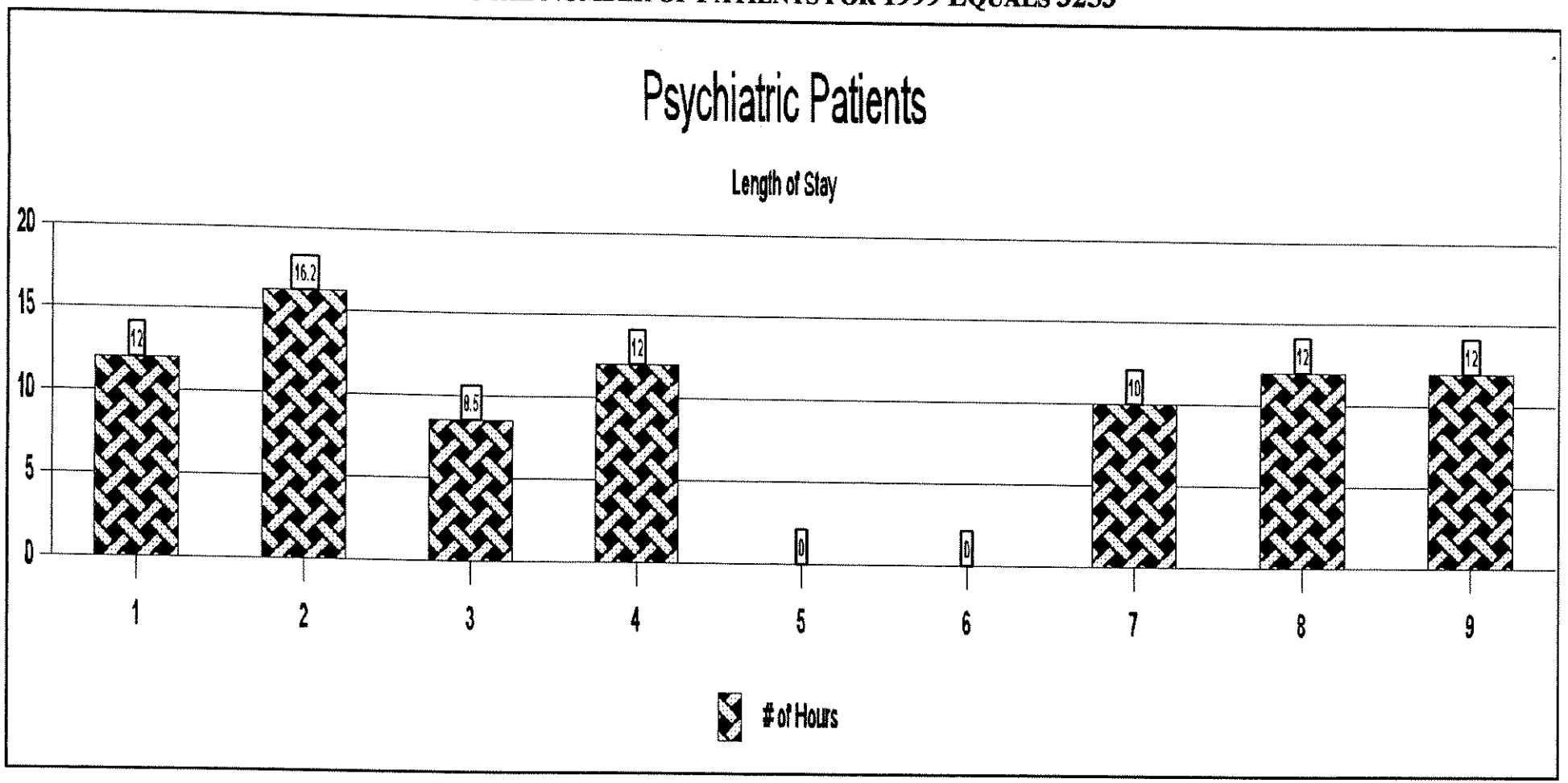
Besides routing patients quickly through emergency rooms by diverting non-critical patients, utilizing beds on other hospital floors and making the admitting process more efficient, Williams said it's important to allow paramedics to transport patients without a dire emergency to urgent care facilities. At a minimum, those paramedics should at least have the option of contacting an advice nurse for recommendations.

"An ambulance has no alternative now but to transport to an ER and it can work better other ways," he said.

Following the conference, participants gathered to discuss the issues and develop solutions.

This story is located at:
http://www.lvrj.com/lvrj_home/2000/Sep-16-Sat-2000/news/14402278.html

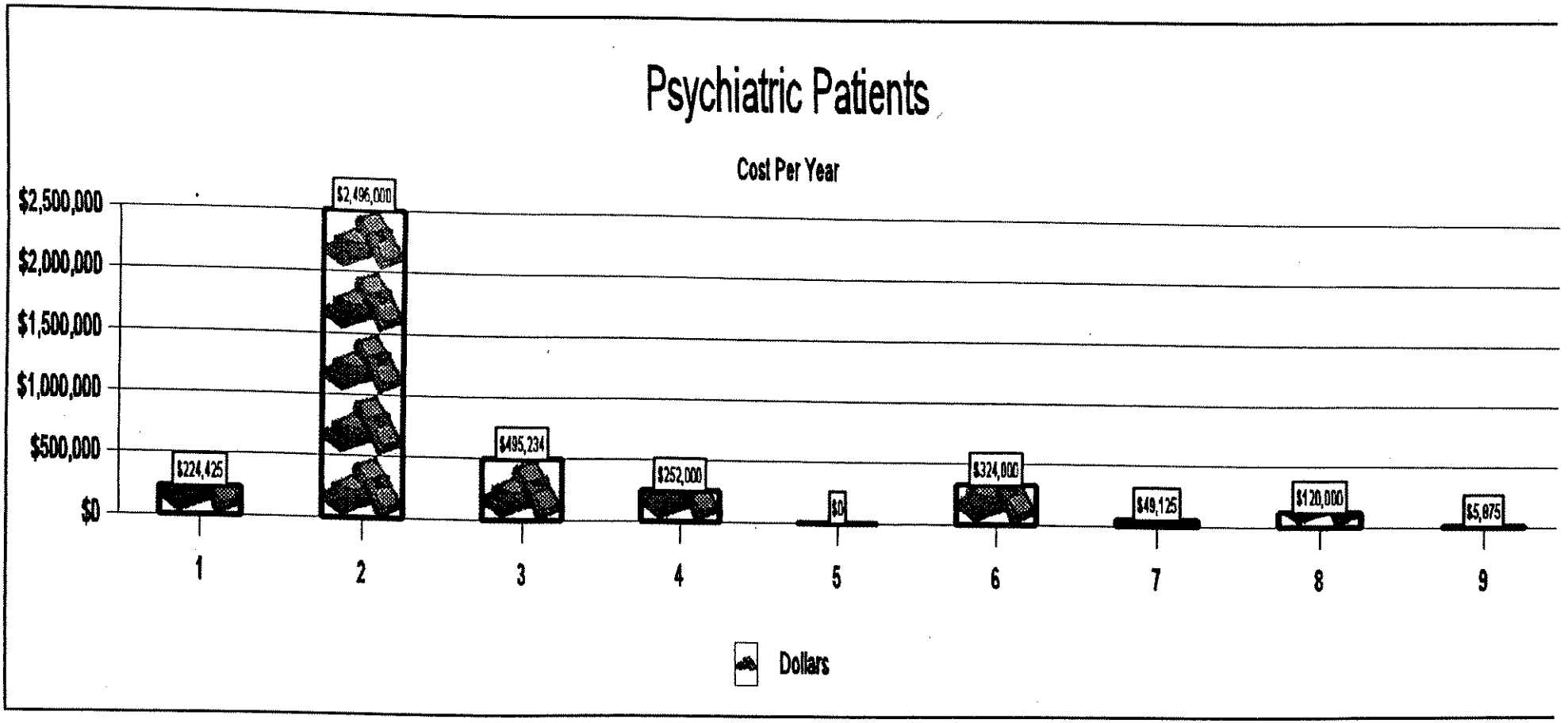
LENGTH OF TIME PSYCHIATRIC PATIENTS SPEND IN EMERGENCY DEPARTMENTS
TOTAL NUMBER OF PATIENTS FOR 1999 EQUALS 3253



Hospital	1	2	3	4	5	6	7	8	9
# of Pts for 1999	955	960	486	360	Not Available	216	131	120	25

Information was provided by hospitals with the understanding that it would remain confidential

TOTAL COST OF TREATMENT OF PSYCHIATRIC PATIENTS IN EMERGENCY DEPARTMENTS
TOTAL NUMBER OF PATIENTS FOR 1999 EQUALS 3253

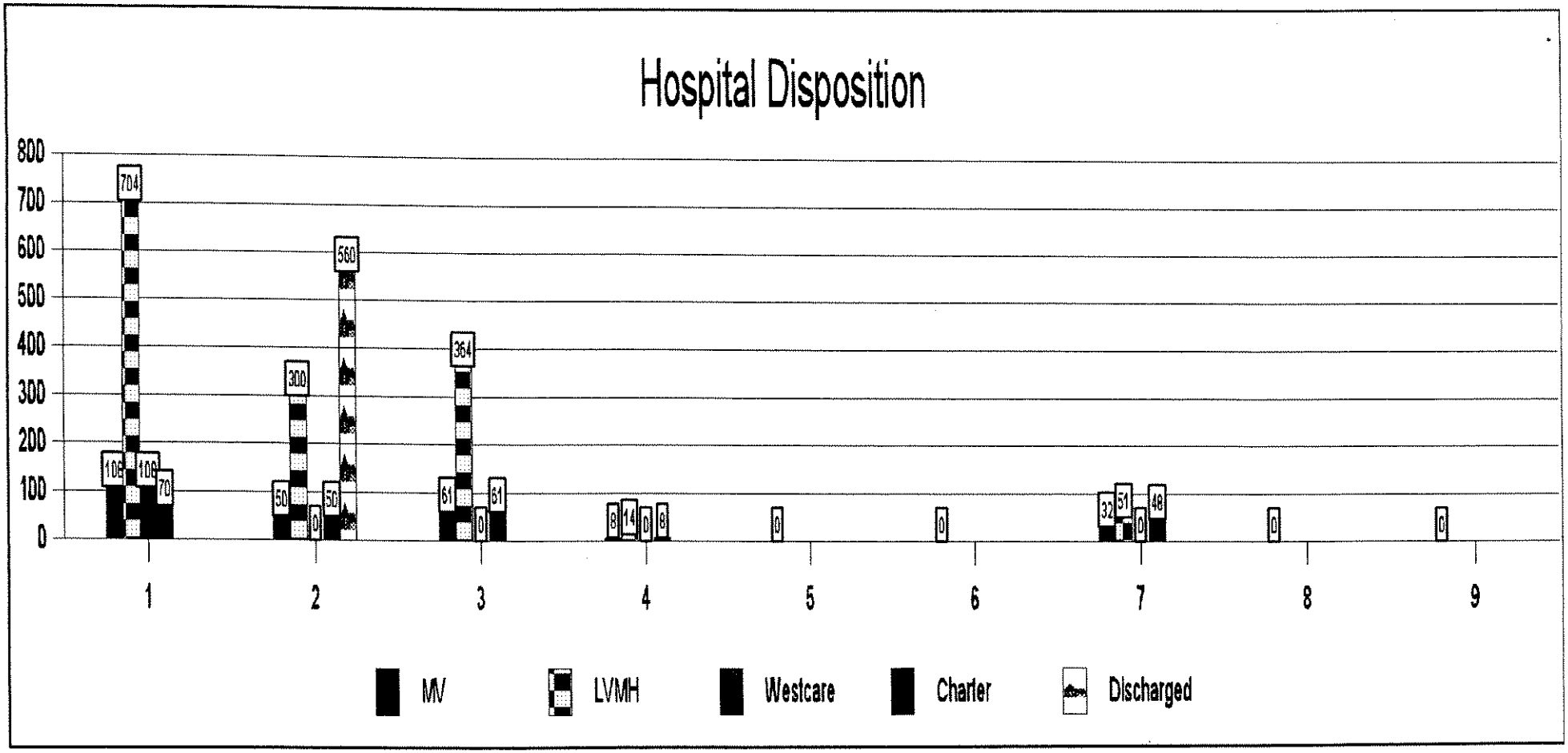


Total Cost for Treatment in the Emergency Department = $3,966,659.00

Hospital	1	2	3	4	5	6	7	8	9
# of Pts for 1999	955	960	486	360	Not Available	216	131	120	25

Information was provided by hospitals with the understanding that it would remain confidential

DISPOSITION OF PSYCHIATRIC PATIENTS IN EMERGENCY DEPARTMENTS



TOTAL NUMBER OF PATIENTS FOR 1999 EQUALS 3253

Charter Hospital Service No Longer Available

Hospital	1	2	3	4	5	6	7	8	9
# of Pts for 1999	955	960	486	360	Not Available	216	131	120	25

Information was provided by hospitals with the understanding that it would remain confidential

APPENDIX C

2-1-1 Initiative Data

211.org

MENU

This site is maintained by United Way of Connecticut

211.org

A National Initiative to Link People with Community Services

What Is 2-1-1?

2-1-1 is the national abbreviated dialing code for free access to health and human services information and referral (I&R). 2-1-1 is an easy-to-remember and universally recognizable number that makes a critical connection between individuals and families in need and the appropriate community-based organizations and government agencies. 2-1-1 makes it possible for people in need to navigate the complex and ever-growing maze of human services' agencies and programs. By making services easier to access, 2-1-1 encourages prevention and fosters self-sufficiency.

Why 2-1-1?

Access to emergency police and fire services through the "911" telephone number is nearly universal and an indispensable service. Telephone directory assistance available by dialing "411", is another service we have come to depend upon. However, thousands of individuals and families search every day for emergency financial assistance, food or shelter. Looking for help means finding dozens of phone numbers and then searching through a confusing maze of agencies and services. For those who want to give back to the community through volunteerism, donations or civic involvement, the situation is only marginally better. Information and referral services have known for years that a similar universal number, that all I&R services could use would mitigate this problem.

Benefits of Having a 2-1-1 System in Your State

- Streamlined access to existing services by eliminating confusing and frustrating searches.
- An efficient and accurate database and referral system for existing services.
- Helping vulnerable people (those who are elderly, disabled, non-English speaking, incapacitated by crisis, illiterate, new to their communities, etc.) to help themselves.
- Expanded civic involvement by matching volunteers and donors with programs and services.
- Improved information for community planning.

APPENDIX D

Obstetrical Access Program Information

Draft Legislation Provided by Caroline Ford, Assistant Dean/Director. University of Nevada School of Medicine (UNSOM), Center for Education and Health Services Outreach, Reno, Nevada

AN ACT relating to the supply and distribution of health care professionals, in particular, those that provide clinical services to obstetrical patients that are the most vulnerable; collection and analysis of health workforce data; establishing a program to enhance health professions training revenue, and direction of those resources; enhance the Area Health Education Center programs that recruit students and foster clinical training in professions of need; establish the Nevada Office of Rural Health with data collection functions; and providing other matters properly relating thereto.

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

The recent malpractice crisis has caused significant parts of the health care system, including education and training and the production of a health care workforce, to examine, revise and amend its ability to meet the most critical needs of some of our most vulnerable populations. In particular, obstetrical malpractice premiums have forced practitioners out of business and for Nevada to further extend cost controls, liability limits and consider tort reform to preserve the remaining practitioners and services in the state. Calculating the health and economic impacts of the crisis, and providing reliable data upon which to forecast necessary changes has become an imperative. Broad systematic changes are needed to address the spectrum of health issues to mitigate and intervene in this crisis, and to prepare for the supply and distribution of health professionals.

Five specific program areas are addressed in this legislation to direct resources which assess and quantify health profession workforce needs, health data collection (pertaining to rural counties), training and education of the health care workforce, collection and distribution of training revenue, and provide interventions to the ongoing crisis in the provision of obstetrical care in Nevada.

Section 1. Chapter 396 of NRS is hereby amended and added thereto a new section to read as follows:

1. The University of Nevada School of Medicine shall provide expansion of programs directed at the training of obstetrical practitioners, and in addition, collect and analyze obstetrical data and direct resources to support community based obstetrical practitioners, including Nevada Health Centers, Inc.
2. The School of Medicine shall enhance their current obstetrical access program, NRS 442.119 – 442.1198 by hereby amending it to read as follows:

NRS 442.119 Definitions. As used in NRS 442.119 to 442.1198, inclusive, unless the context otherwise requires:

1. "Health officer" includes a local health officer, a city health officer, a county health officer and a district health officer.

2. "Medicaid" has the meaning ascribed to it in NRS 439B.120.

3. "Medicare" has the meaning ascribed to it in NRS 439B.130.

4. "Provider of prenatal care" is limited to:

(a) A physician who is licensed in this state and certified in obstetrics and gynecology, family practice, general practice or general surgery.

(b) A certified nurse midwife who is licensed by the state board of nursing.

(c) An advanced practitioner of nursing who has specialized skills and training in obstetrics or family nursing.

(d) A physician assistant who has specialized skills and training in obstetrics or family practice.

(e) A determination of need for underserved women is established.

(Added to NRS by 1991, 2159; A 1995, 2685; 2001, 782)

NRS 442.1192 Subsidy authorized for provider of prenatal care in county or community that lacks services for such care.

1. A ~~[health officer~~] a practitioner in a county or community that lacks or is deficient in services for prenatal care may submit an application to the University of Nevada School of Medicine for a grant to subsidize a portion of the malpractice insurance of a provider of prenatal care who provides a certain volume of services to pregnant women that are covered under Nevada Medicaid and that are under and/or uninsured in the county or community.

2. A county or community lacks services for prenatal care if at least one of the following conditions is present:

(a) A provider of prenatal care does not offer services to pregnant women within the county or the community.

(b) Fifty percent or more of the live births to women who are residents of the county occur outside the county.

(c) The percentage of live births to women in the county or community who received no prenatal care exceeds the percentage of live births to women in the state who received no prenatal care.

(d) The percentage of live births of babies with low birthweight to women in the county or community is higher than the percentage of live births of babies with low birthweight to women in the state.

3. If the applicant is a county or district health officer, he must provide proof of the financial contribution by the county or district for the provision of prenatal services for women who do not qualify for reimbursement pursuant to the state plan for Medicaid.

(Added to NRS by 1991, 2159; A 1997, 1255)

NRS 442.1194 University of Nevada School of Medicine authorized to grant subsidy; amount of subsidy; consultation with director of program for maternal and child health required.

1. The University of Nevada School of Medicine may grant money to an applicant to furnish a subsidy for the malpractice insurance of a provider of prenatal care who provides services in a county or community that lacks or is deficient in services for prenatal care for women.

2. An applicant who receives a grant from the University of Nevada School of Medicine may furnish a provider of prenatal care a subsidy in an amount up to the

difference between the cost of his malpractice insurance with coverage for the provision of prenatal care and without such coverage.

3. [~~Before disbursing a grant pursuant to the provisions of NRS 442.119 to 442.1198, inclusive, the University of Nevada School of Medicine shall consult with the director of the program for maternal and child health of the health division.~~]

(Added to NRS by 1991, 2160)

NRS 442.1196 Form and contents of application; eligibility.

1. The application for a grant must be on the form required by the University of Nevada School of Medicine.

2. The application must contain:

(a) Information concerning the collaboration between the applicant and a provider of prenatal care and medical facilities within the county or community.

(b) A plan for providing prenatal care for women in the county or community who have low incomes or who do not qualify for any state program for medical care.

(c) A plan for improving the health care of pregnant women in the county or community.

3. To be eligible for a subsidy for his malpractice insurance, a provider of prenatal care must submit evidence that:

(a) He has completed training in prenatal care that is approved by the University of Nevada School of Medicine;

(b) He is currently covered by malpractice insurance;

(c) He accepts reimbursement for services rendered from Medicaid and Medicare; and

(d) He will continue to provide prenatal care in the specified county or community for not less than 1 year.

(Added to NRS by 1991, 2160; A 1995, 2685)

NRS 442.1198 Duties of provider of prenatal care who receives subsidy. A provider of prenatal care who receives a subsidy for his malpractice insurance pursuant to NRS 442.119 to 442.1198, inclusive, shall:

1. Attend 15 hours per year of continuing education concerning risk management or the care of a patient relating to prenatal services and submit documentation of attendance at the continuing education to the University of Nevada School of Medicine.

2. Collect data as required by the University of Nevada School of Medicine or the health division.

3. Provide prenatal care for a woman without regard to her economic status or ability to pay.

4. Refer a pregnant woman to another provider of prenatal care if, in the judgment of the provider, he cannot provide the care required by the woman.

5. Carry out the plan for improving the health care of pregnant women in the county or community pursuant to paragraph (c) of subsection 2 of NRS 442.1196.

(Added to NRS by 1991, 2160)

To be added: Additional funds shall be appropriated to the University of Nevada School of Medicine to:

Provide for additional faculty and resident financial support in the Department of Family and Community Medicine and Obstetrics and Gynecology within the University of Nevada School of Medicine, to expand their direct clinical services to areas and populations that are determined to have an unmet or compromised need for obstetrical services;

Provide for the ability of practitioners funded under these sections, to pool their community risk which could lower the collective ability of practitioners to affect their malpractice premiums;

Provide additional educational outreach for those community practitioners who seek to continue and/or expand their ability to provide prenatal and obstetrical services;

Provide funds to Nevada Health Centers, Inc. to expand the clinical prenatal/obstetrical practice base of Community Health Center clinics that participate in federal tort protection, to allow for increased access of uninsured, underinsured and Medicaid patients in addition to their efforts to expand service delivery methods with community practitioners;

Provide for a monetary fund that allows practicing community practitioners, participating in the Obstetrical Access Program, to draw upon funds to partially compensate for those patients who have no financial access to clinical care; and

Develop and analyze the database of clinical practitioners providing prenatal/obstetrical services throughout the state to monitor the impact of declining services on the supply and distribution of the appropriate health care workforce, and the impact of access to care issues on pregnant women including birth outcomes. This analysis would include the financial impact of poor birth outcomes, inadequate prenatal care and the impact of adverse legal decisions affecting the delivery of obstetrical services.

Section 2. Chapter 396 of NRS is hereby amended by adding thereto a new section to read as follows:

1. The Nevada office of rural health is hereby established within the University of Nevada School of Medicine.
2. The Nevada office of rural health shall address the need for and recommend programs concerning the delivery of health care services to rural and frontier populations. The office shall administer or coordinate, or both, programs and services which affect the delivery of health care services in rural and frontier areas including, without limitation, programs and services in the following categories:
   (a) Education and training;
   (b) Needs of special populations;
   (c) Delivery of health services;
   (d) Financing of health care; and
   (e) Data collection.

e.1 The Nevada office of rural health would:

a) Determine the data sets necessary for collection in partnership with rural and frontier stakeholders and state officials;
b) Determine the health policy considerations of lawmakers concerning issues such as obstetrical care and health workforce needs in order to establish baseline data needs;
c) Collect and analyze data and information in order to forecast economic and health interventions and outcomes;
d) Assist policy makers and programs with data and information by which to make health care improvements in Nevada's rural and frontier populations and health care system.

Section 3. NRS 396.900 is amended as follows:

NRS 396.900 Establishment. The [~~board of regents~~] University of Nevada School of Medicine may establish a Nevada health service corps to encourage physicians to practice in areas of Nevada in which a shortage of physicians exists.

(Added to NRS by 1989, 2155; A 1993, 360)

NRS 396.901 Purposes. The primary purposes of the Nevada health service corps must be to:

1. Recruit [~~physicians~~] practitioners for participation in the program;
2. Designate areas of Nevada in which a critical shortage of [~~physicians~~] health practitioners exists;
3. Match [~~physicians~~] practitioners with the designated areas; and
4. Help [~~physicians~~] practitioners to negotiate contracts to serve in the designated areas.

(Added to NRS by 1989, 2156)

NRS 396.902 Powers of [~~board of regents~~] University of Nevada School of Medicine. The [~~board of regents~~] University of Nevada School of Medicine may:

1. Apply for any matching money available for the program from the Federal Government.
2. Adopt regulations necessary to carry out the provisions of NRS 396.900 to 396.903, inclusive.
3. Receive, invest, disburse and account for all money received from the Federal Government or any other source for this program.

(Added to NRS by 1989, 2156)

NRS 396.903 Program for repayment of loans on behalf of certain [~~physicians~~] practitioners.

1. The board of regents may authorize the Nevada health service corps to administer a program under which [~~$15,000~~] funds for [~~of~~] loans are repaid on behalf of a [~~physician~~] practitioner for each year he practices [~~medicine~~] in an area of Nevada in which a shortage [~~of physicians~~] exists as determined by the University of Nevada School of Medicine, Office of Rural Health.
2. To qualify for the program the physician must have completed his primary care residency and hold an active license issued pursuant to

chapter 630, 630A, 633 or 634 of NRS. All other practitioners must have completed training in a certified program and hold an active license issued within the State of Nevada.

(Added to NRS by 1989, 2155)

Section 4. To be added. (check School of Medicine references pertaining to area health education or multidisciplinary health education) 1987 check bdr. S-479

Direct the University of Nevada School of Medicine, Area Health Education Center Program to address support of training programs that are essential for Nevada's health care workforce, but importantly, train and expose students and residents to the particular needs of medically underserved areas both urban and rural. Activities include:

1) Direct the three AHEC Centers within Nevada to provide health careers opportunities, information resources for community practitioners, CME and CE for health professionals-especially those serving the most vulnerable populations, and student/resident stipends which allow for education and training to occur in medically underserved sites;
2) Assess and develop training programs and opportunities which target appropriate curriculum for primary care and other priority need health professions;
3) Enhance the primary care training programs with additional entry-level slots and faculty to increase the health workforce supply;
4) Maintain and enhance the percentage of medical students committing to primary care residencies and careers;
5) Diffuse a greater percentage of primary care residents into medically underserved areas and serve increased numbers of vulnerable populations;
6) Develop and enhance appropriate training programs which are identified as needed to address priority health needs of Nevada's population;
7) Configure interdisciplinary opportunities amongst Nevada health profession education programs to engage health care team training.

Section 5: Establish a Medical Education Council in Nevada. The Council's mission would be to assure that Nevada has an adequate, well trained, health workforce to meet the needs of the citizens of the state and the region. The Council would be established with authority and have composition by statute to:

1. Create the authority for determination of health workforce needs within the state, including current supply, demand and projections;
2. Determine the number and type of positions for health professionals in training for which program monies may be used;
3. Study, recommend and advise the Board of Regents and the Legislature on the status and needs of health care professionals in training;
4. Determine the method for reimbursing institutions that sponsor health care professionals in training;

5. Prepare a formal application to CMS (Centers for Medicare and Medicaid Services) for the purpose of receiving and disbursing federal funds for direct and indirect graduate medical education expenses;
6. Distribute program monies for graduate medical education in a manner that: a) prepares postgraduate medical and dental residents, as defined by the accreditation council on graduate medical education, for inpatient, outpatient, hospital, community, and geographically diverse settings; b) encourages the coordination of interdisciplinary clinical training among health care professionals in training; c) promotes stable funding for the clinical training of health care professionals in training and d) only funds accredited clinical training programs;
7. Seeks private and public contributions for the program;
8. Collaborates and initiates a Cooperative Agreement with Nevada Medicaid to promote Intergovernmental Transfer of funds for the purposes of receiving and disbursing monies directed to the above mentioned objectives;
9. Distributes additional financial resources to training programs determined to meet a health professions need within the state.

Sec. 6. There is hereby appropriated from the state general fund to provide assistance to certain health programs the sum of

FY 04.....$ 6,775,000
FY 05.....$ 4,450,000

APPENDIX E

Nevada Legislative Study Committee on Health Care—Report on Indigent Care Costs and Disproportionate Share—July 15, 2002, prepared by EP&P Consulting, Inc.

Nevada Legislative Study
Committee on Health Care

Report on Indigent Care Costs and Disproportionate Share

July 15, 2002

EXECUTIVE SUMMARY

This study is a result of a legislative mandate given to the Legislative Committee on Health Care by Senate Bill 377. The study examines indigent health care costs from a number of perspectives and then examines the distribution of Disproportionate Share Hospital (DSH) payments in Nevada. The study then presents recommendations for the revision of the DSH program. In the recommendations in Section 5 of the report, there is also a recommendation to study a potential opportunity to maximize federal funding by the State of Nevada by using currently unmatched county expenditures and drawing down the state's unused SCHIP funds.

Introduction

In conducting the study of the costs of indigent care experienced by Nevada's hospitals, three important state and federal policies provided guidance:

- Senate Bill (S.B.) 377 and the mandated study of indigent care
- Federal disproportionate share requirements
- Nevada's current disproportionate share distribution

Section 7 of Senate Bill 377 mandated a study of programs for the provision of indigent care in general, and the distribution of DSH funds specifically.

The study was instigated because of the Legislative concern over the DSH distribution formula, particularly whether the DSH payments tended to equalize or disequalize the impact of providing indigent care among the hospitals in the state. There was also concern about the inclusion of a tax provision for counties with exactly one private hospital.

The primary aim of the study was to determine the net impact of Medicaid and other indigent or uncompensated care on the hospitals throughout the state. The study focused on general acute care hospitals.

Disproportionate share is a component of the Medicaid program, a federal/state partnership to provide health care to indigent and other low-income individuals. It provides for payments to hospitals that provide a large amount of Medicaid and/or indigent care. Unlike other payments to providers, DSH payments are not necessarily tied directly to services provided to Medicaid eligible individuals.

States are required to have a DSH program, but states are given broad latitude to determine its size and scope. Federal laws and regulations set broad parameters for each state's DSH program. Specifically, hospitals that meet either of two criteria (Medicaid utilization that is one standard deviation above the mean for hospitals in the state, or hospitals with a low-income utilization percentage over 25%) are automatically defined as DSH hospitals. Hospitals that meet either of

these criteria must be provided a DSH payment of some amount if a state intends to make any DSH payments at all.

Under current law, the Nevada DSH program qualifies hospitals in several different ways and has different payment methodologies based on the qualifying criteria.

Until the enactment of S.B. 377, hospitals qualified for DSH payments under one of three categories:

- all public county hospitals (except those precluded under federal law),
- private hospitals that provide the greatest amount of Medicaid and indigent care and are within counties that do not have a public hospital, and
- any other hospitals that qualify under the federal criteria.

As a result of Senate Bill 377 a fourth group was qualified for DSH in fiscal year 2002: private hospitals in a county with a public hospital that have a Medicaid utilization rate at least equal to the statewide average.

The hospitals that received DSH for SFY 2002 were: Lake Mead Hospital Medical Center, Sunrise Hospital & Medical Center, University Medical Center, Washoe Medical Center, Humblodt General Hospital, Mt. Grant General Hospital, South Lyon Medical Center, William Bee Ririe Hospital, Carson Tahoe Hospital, Churchill Community Hospital, Northeastern Nevada Medical Center, Nye Regional Medical Center, Grover C. Dils Medical Center, Battle Mountain Hospital, Pershing General Hospital.

Results

Hospitals submitted schedules showing the billed charges and revenues received for various categories of indigent and uncompensated care. This data was converted to cost (using the cost-to-charge methodology) and summarized in a variety of ways.

Because indigent care costs can be measured in a variety of ways – gross cost; costs net of Medicaid payment; costs net of all payments; as a percentage of operating revenues; etc. – the series of schedules at the end of the report were prepared. The indigent care costs and payments were calculated using SFY 2000 data. In total there is $279 million in gross indigent care cost, $191 million in Clark County, $59 million in Washoe County and $29 million in the rural counties. UMC, Washoe Medical Center and Sunrise Hospital and Medical Center had the greatest gross costs of indigent care.

After payments by local governments, hospitals have uncompensated indigent care costs of 5.78% of operating revenues. When the direct tax payments are not included in the analysis indigent care costs represent 6.7% of operating revenue. In SFY 2000, the hospitals received

approximately $20.9 million in DSH payments. After the DSH and all other payments, the uncompensated indigent care costs represent 4.58% of operating revenue. When direct tax subsidy payments are not included in the analysis, uncompensated indigent care costs represent 5.49% of operating revenue.

In addition to compiling the results required by S.B. 377, the federal tests for disproportionate share eligibility of hospitals were applied. These tests did not result in any additional hospitals qualifying for DSH.

The DSH program (together with the associated intergovernmental transfer requirements) has operated in a manner that has provided net benefit to Clark County, Washoe County and the rural counties in aggregate in rough correlation to their population.

Clark County has approximately 69.5% of the population and receives 69.77% of the net DSH benefits. Washoe County has 15.6% of the population and received 14.6% of the net DSH benefit. While this is less than the other two regions, Washoe County does not have a public hospital.

Rural counties in total receive a higher percentage of DSH benefit than their populations would indicate. This higher benefit is due to the amount received by the private rural hospitals. However, two hospitals have recently reclassified from public to private hospitals, so the net benefit based on current law would decrease to approximately $2.0 million. This realignment would bring the DSH benefits more in line with the population of those counties with private hospitals. It should be noted that under current formulas, the benefit that would be lost by the private rural hospitals will go almost entirely to Clark County.

Data Issues

S.B. 377 provided for the collection of data from hospitals in conducting this study. Two sources of data were used: a hospital survey and the hospitals' Medicare cost report.

The hospital survey collected inpatient and outpatient indigent care billed charges, inpatient days, county indigent, accident and general fund revenues received, and other payments received.

The second source, the Medicare cost report, was used to determine hospital cost of care. Costs of care were determined based on the cost-to-charge ratios for inpatient and outpatient services. A second measure of inpatient hospital costs was determined based on hospital cost per day.

The most current complete set of Medicare cost reports available were used. This included the cost reports for the hospitals' fiscal year ending during state fiscal year 2000. Indigent care data collected from hospitals is from the same time period.

In preparing the tables and schedules in this report, the cost-to-charge ratio methodology for costing inpatient care was utilized rather than the cost per day methodology. The decision to use the cost-to-charge ratio methodology for this study was based on the methodology's wide acceptance nationally, and 12 of the 19 hospitals had higher costs for indigent care using the cost-to-charge ratio methodology.

Quick Care Centers (QCC) of UMC have a different charge structure from most outpatient services, which results in a much higher cost-to-charge ratio. In compiling the study, UMC costs were examined both with and without the inclusion of the QCC. In the final compilation of the schedules and the report, QCCs were excluded.

In total, the impact of using a cost-to-charge ratio including the Quick Care Centers would increase total uncompensated outpatient care costs of UMC by $11,240,640, from $31,093,973 to $42,334,613.

Removing the QCC brings UMC outpatient costs more in line with the other hospitals. For example, including the Quick Care Centers, UMC receives only 42% of its costs in Medicaid outpatient reimbursement, as compared with 78.5% for all other hospitals. Removing the Quick Care Centers, the percentage reimbursement climbs to 56.1%.

The Nevada statutes define indigent care costs to include any service for which the hospital received less than 25% of the cost of care. It appears that some data submitted by hospitals may include "excess costs." That is, the amount the hospital reported included un-reimbursed costs for patients where at least 25% of costs were reimbursed. Such costs are inappropriate and appear to be included in the information reported by four hospitals.

Considerations for an Equitable Disproportionate Share (DSH) Distribution

Total costs in SFY 2000 to provide care to Medicaid, indigent and other low-income patients in Nevada is $279 million before any payments are deducted. After deducting the payments except direct transfers by county governments, the amount of uncompensated Medicaid, indigent and low income care falls to $115 million. After deducting direct county transfers, the amount of uncompensated care is approximately $101 million. In determining an equitable distribution of DSH, one primary consideration is what is the proper starting point, or on what basis, are disproportionate share funds to be distributed.

While it is clear that at least some payments should be subtracted from gross indigent care costs for determining the basis to evaluate the equity of the DSH distribution, the analysis presents several factors to consider in determining the equity of the payments. The factors explored include Medicaid payment levels, the county indigent programs, the intergovernmental transfer program, the .6% service requirement, rural community needs, northern and southern Nevada considerations, and the changes to the DSH program made in S. B. 377.

One fact reflected in the information is that no matter what distribution formula is adopted, Nevada's disproportionate share allotment of approximately $76 million (gross before intergovernmental transfers) will not be sufficient to cover the entire uncompensated indigent care burden in the state.

Recommended Distribution of Disproportionate Share

Based on the charge of the study by the Legislature, the principles adopted by the Committee, and the analysis presented, a redesign of the DSH program is recommended.

Among the elements of the recommended system are:

- Simplification of both the distribution process and the intergovernmental transfer process.
- Generally, hospitals should receive – depending upon the availability of funds – at least the same net benefit as past years.
- Exceptions to the general hold harmless rule should be made for Sunrise Hospital and Medical Center, Carson Tahoe Medical Center and Churchill Community Hospital. These facilities should have their SFY 2002 DSH distributions reduced or eliminated.
- Distributions should be made in a manner that equalizes the percentage of operating revenue that are composed of uncompensated indigent costs.
- Lagged historic data should be used for the calculation of the distribution. This would allow DSH allocations to be calculated before legislative appropriations, at least for the first year of the biennium. This lagged historic data will add greater certainty to the process.

As a starting point, the data was examined to see if the information would directly lead to a simplified distribution formula that satisfied the elements above. It did not.

Using the formulaic basis as the sole factor to determine the DSH benefit allocation significantly changes the DSH distribution to Washoe (more DSH) and Clark County (less DSH) when compared with the SFY 2002 DSH distribution. The formula would treat rural private hospitals marginally better but significantly reduce the benefits to rural public hospitals. Although this approach would simplify the DSH calculation, it would fall short of a total solution.

The recommended methodology begins with a DSH benefit allocation to each hospital group approximating the SFY 2002 DSH benefit. The amount of funds distributed to each pool would be set into law as percentages, with appropriate language to modify the amounts if there is a change in the amount of DSH funds become available to the state.

Once the pools are established the distribution to the hospitals within the pool will be made. For the Clark County and the Washoe pools, the distribution will be made to hospitals within each pool based on the percentage of uncompensated costs.

For the Rural Public Hospitals, each hospital would first be distributed the amount of funds it received as a "net benefit" in the previous year. For the Rural – Private Hospital Pool, allocations would be made based on the overall size of the hospital.

After the initial pool allocation, any additional DSH funds received by the hospital pool would be allocated among the pool's hospitals according to the percentage of uncompensated costs, in the same manner as the Clark County and Washoe County pools.

The above distribution only provided for the net benefit to the hospitals. It is also necessary to distribute the DSH funds that will be recovered through the intergovernmental transfers.

Because of the current and long standing arrangements between Washoe County and the Washoe Medical Center, it is necessary to continue the $1.5 million transfer in that situation. Other than this case, all other intergovernmental transfers would come from Clark County.

This recommended intergovernmental transfer system would comport with the OBRA limits for SFY 2004 and 2005 when the public hospital limit is temporarily set at 175% of the regular OBRA limit. The state will have to monitor congressional action to ensure that the intergovernmental transfer process remains viable after these dates.

Other recommendations made by the report include standardizing the format for hospital reporting, validating the hospital reports submitted and providing sufficient resources to DHCFP to properly administer the program.

The final recommendation is to study the possibility that Nevada could increase its expenditures of federal funds at either no additional cost to the state, or, in fact, at a savings of state and local funds. This possibility would use the funds the counties now spend that are not matched with federal funds, and the SCHIP allotments that appear will be unspent by the end of FFY 2007.

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Nevada Legislative Study
Committee on Health Care
Report on Indigent Care Costs and Disproportionate Share

SECTION 1 INTRODUCTION

This study is a result of a legislative mandate given to the Legislative Committee on Health Care by Senate Bill 377. The study examines indigent health care costs from a number of perspectives and then examines the distribution of Disproportionate Share Hospital (DSH) payments in Nevada. The study then presents recommendations for the revision of the DSH program. In the recommendations in Section 5 of the report, there is also a recommendation to study a potential opportunity to maximize federal funding by the State of Nevada by drawing down the state's unused SCHIP funds.

In conducting the study of the costs of indigent care experienced by Nevada's hospitals, three important state and federal policies provided guidance:

- Senate Bill (S.B.) 377 and the mandated study of indigent care
- Federal disproportionate share requirements
- Nevada's current disproportionate share distribution

Senate Bill 377

Section 7 of Senate Bill 377 mandated a study of programs for the provision of indigent care in general, and the distribution of DSH funds specifically. (Attachment 1.0 contains relevant excerpts from Senate Bill 377.) Specifically, S.B. 377 specified:

> **Sec. 7.** 1. The legislative committee on health care shall conduct a study of:
> (a) The programs conducted in this state for the provision of medical care to Medicaid patients, indigent patients and other low-income patients; and
> (b) The methodology used in determining the amount and distribution of payments made to public and private hospitals pursuant to NRS 422.387.

The questions to be addressed in the study as articulated in the legislation included:

- The needs of rural hospitals
- The sources of funding to provide medical care to Medicaid patients, indigent patients and other low-income patients
- Alternative methods of funding medical care for such patients

The study was instigated because of the Legislative concern over the DSH distribution formula, particularly whether the DSH payments tended to equalize or disequalize the impact of providing indigent care among the hospitals in the state. There was also concern about the inclusion of a tax provision for counties with exactly one private hospital. (See Section 6 of Senate Bill 377)

The primary aim of the study was to determine the net impact of Medicaid and other indigent or uncompensated care on the hospitals throughout the state. The study focused on general acute care hospitals. In Nevada, psychiatric hospitals are not eligible for disproportionate share because of the limitation on disproportionate share spending for IMDs described below.

Psychiatric, rehabilitation and other specialty hospitals were however included in the federal test of Medicaid days because they are licensed as hospitals. The final disproportionate share distribution must include these hospitals. Based on the data that is available, it appears that only one hospital will qualify for a disproportionate share payment. However, additional data collection is needed to make a final determination.

The study also excluded the four public hospitals (Battle Mountain General Hospital, Boulder City Hospital, Grover C. Dils Hospital in Caliente and Pershing General Hospital) that are federally precluded from receiving DSH payments because they had obstetric services in December 1987 but have subsequently dropped those services.

Three basic principles were adopted by the Legislative Committee on Health Care to guide this study:

1. **Access**

   Nevada should assure that there is access to care for Medicaid and indigent care by:

   A) Using available funds to assure such access
   B) Promoting policies to maintain the viability of rural hospitals
   C) Encouraging hospitals to provide care to Medicaid patients, both in fee-for-service and managed care populations.

2. **Distribution of funds**

   Nevada should distribute indigent care funds in a manner that:

   A) Indigent care costs are spread proportionally over all hospitals in a geographic area
   B) Indigent care payments are proportional to the indigent care provided
   C) Does not create competitive imbalances
   D) Does not allow hospitals to profit from indigent/uncompensated care.

3. **Maximize federal funds**

Nevada should maximize the federal funds that it receives under the Medicaid program, within the limits of state expenditures available for matching funds.

Federal Disproportionate Share Requirements

Disproportionate share (DSH) is a component of the Medicaid program, a federal/state partnership to provide health care to indigent and other low-income individuals. It provides for payments to hospitals that provide a large amount of Medicaid and/or indigent care. Unlike other payments to providers, DSH payments are not necessarily tied directly to services provided to Medicaid eligible individuals.

States are required to have a DSH program, but states are given broad latitude to determine its size and scope. Federal laws and regulations set broad parameters for each state's DSH program. Specifically, hospitals that meet either of two criteria (Medicaid utilization that is one standard deviation above the mean for hospitals in the state, or hospitals with a low-income utilization percentage over 25%) are automatically defined as DSH hospitals. Hospitals that meet either of these criteria must be provided a DSH payment of some amount if a state intends to make any DSH payments at all.

Certain hospitals are also excluded by federal law from being DSH hospitals. This exclusion includes hospitals that provided obstetric services as of December 22, 1987 but no longer do so, and hospitals with a Medicaid utilization rate of less than 1 percent. The Medicaid utilization rate is the percentage of Medicaid inpatient days to total inpatient days of care provided by a hospital. As noted below, these limitations do exclude some Nevada hospitals from the disproportionate share program.

Federal law also limits the amount a state can pay each hospital. The limit is generally the net uncompensated care costs of the hospital, excluding payments from state and local government programs. This limitation is referred to as the OBRA limit. However, for a two-year period beginning in 2004, federal law will permit disproportionate share payments to be made to a public hospital of up to 175% of the public hospitals' OBRA limit.

One further limitation in federal law is particularly relevant to Nevada. That is, states may not make payments to hospitals which are Institutions for Mental Disease or other mental health facilities (e.g. psychiatric hospitals) that exceed the payments they made to such institutions in FFY 1995. Because Nevada did not make any payments to these hospitals in 1995, they can make none today.

"States have an annual total DSH allotment that they can pay to hospitals. Under current federal law, Nevada's allotment for FFY2003 will revert back to its Balanced Budget Act DSH allotment plus an annual increase measured by the CPI Urban inflation index. Accordingly its

DSH allotment will be approximately $76,000,000 ($38,000,000 federal), or nearly $2,600,000 less than its FFY2002 allotment."

Attachment 2.0 to this report provides key subsections of Section 1923 of the Social Security Act governing disproportionate share.

Nevada's Current Disproportionate Share Distribution

Under current law, the Nevada DSH program qualifies hospitals in several different ways and has different payment methodologies based on the qualifying criteria.

Until the enactment of S.B. 377, hospitals qualified for DSH payments under one of three categories:

- all public county hospitals (except those precluded under federal law),
- private hospitals in counties that do not have a public hospital that provide the greatest amount of Medicaid and indigent care.
- any other hospitals that qualify under the federal criteria.

As a result of Senate Bill 377 a fourth group was qualified for DSH in fiscal year 2002: private hospitals in a county with a public hospital that have a Medicaid utilization rate at least equal to the statewide average.

Below is a listing of the hospitals that qualify for DSH payments today under each of the criteria as well as a description of how their DSH payment is calculated. Hospitals are listed in the group for which they currently qualify.

Public Hospitals

Five public hospitals in Nevada qualify for disproportionate share under Nevada's current disproportionate share program:

Humboldt General Hospital (Winnemucca)
Mt. Grant General Hospital (Hawthorne)
South Lyon Medical Center (Yerington)
University Medical Center (Las Vegas)
William Bee Ririe Hospital (Ely)

The DSH payment for these hospitals is based on their uncompensated costs, excluding payments from state and local government programs. Hospitals receive DSH for the first $500,000 in uncompensated costs and then receive a pro rata share of all additional costs based on the total DSH allotment available. This latter portion of the payment – the pro rata share –

can only be determined after all other distributions to all other hospitals have been made in a particular year.

Private Hospitals in Counties Without a Public Hospital

Five private hospitals in counties without a public hospital receive disproportionate share payments:

Carson Tahoe Hospital (became private in 2002)
Churchill Community Hospital (Fallon)
Northeastern Nevada Regional Medical Center (Elko)
Nye Regional Medical Center (Tonopah)
Washoe Medical Center (Reno)

A private hospital that is located in a county with no public hospitals and provides the largest volume of care to indigent patients receives a payment based on the population of their county. The DSH payment for these hospitals is set by the Nevada Legislature. (Note: Churchill Community Hospital has been treated as a public hospital but based on its ownership should be classified as a private hospital.)

Private Hospitals in Counties with a Public Hospital

Two private hospitals in counties that do have a public hospital receive disproportionate share payments today.

Lake Mead Medical Center (prior to 2002 this hospital qualified under the federal criteria)
Sunrise Hospital & Medical Center (did not qualify prior to 2002)

These hospitals qualify under a category that was added by S.B. 377 for fiscal year 2002. That category is defined as any private hospital with a Medicaid utilization rate higher than the state average. The payment amount is set at $200 for each uncompensated inpatient day if the hospital's Medicaid utilization percentage is greater than 20%, and $100 for each uncompensated inpatient day for hospitals with Medicaid utilization below 20%.

Federal Criteria Only

There are currently no hospitals that receive disproportionate share payments under the federal criteria group. All hospitals that qualify under this criterion meet the criteria for one of the previously described groups.

Hospitals qualifying in only this category receive a DSH payment of $10 per Medicaid inpatient day. Prior to 2002, Lake Mead Hospital was the only hospital qualifying in this category.

Limitation on DSH Payments

Hospitals may receive DSH payments only to the extent of total uncompensated costs (excluding public hospitals that may receive 175% for a two-year period beginning in SFY 2004). In Nevada, any funds remaining in the DSH allotment as a result of this limitation (or for any other reason) are allocated pro rata to public hospitals based on the amount of indigent care costs to total costs.

Intergovernmental Transfers

In order for Nevada to draw down federal disproportionate share funds, the required state matching share is provided through a series of intergovernmental transfers. These transfers are made from public hospitals receiving DSH and counties with private hospitals receiving DSH.

The objective of these transfers is to repay the state for the state share that it has provided to draw down the federal DSH funds, as well as to provide the state general fund with a financial gain.

In general, public hospitals pay an intergovernmental transfer equal to 75% of their DSH payment, less $75,000. The effect of this formula is that public hospitals retain 100% of the first $150,000 in federal monies collected from DSH, and half of all additional federal monies received in the program.

Intergovernmental transfers do not apply to private hospitals for the obvious reason that they are not public entities, and because under federal law, private hospitals may not pay the state matching share. Private provider payments are considered provider donations and are prohibited.

Disproportionate Share Payments

Although Nevada receives its disproportionate share allotment on a federal fiscal year basis, DSH payments are made on a state fiscal year. Nevada's disproportionate share payments for SFY 2000 to SFY2002 are summarized by category below:

Table 1.0
Nevada Disproportionate Share Payments 2000, 2001, and 2002

Category of DSH Qualification	Final DSH Payments 2000	Final DSH Payments 2001	Interim DSH Payments 2002
Public Hospitals	$58,929,009	$59,796,684	$62,613,106
Private Hospitals with No Public Hospitals in County	$15,011,251	$14,202,576	$14,501,235
Hospitals with Medicaid Days > Statewide Average			$665,910
Other Hospitals with Medicaid Utilization > 20%	$59,740	$59,740	$677,000
All Hospitals Eligible For DSH	**$74,000,000**	**$74,000,000**	**$78,457,251**
Federal Allotments	**$74,000,000**	**$76,042,494**	**$78,581,340**

[1] Payments are gross payments before Intergovernmental Transfers. Hospitals are categorized according to SFY 2002 classification, even though certain hospitals may have been in different classes when the payments were made.

Schedule 13 at the conclusion of this report provides the same information by hospital, as well as the net benefit received by each hospital and category of hospitals after the intergovernmental transfers.

SECTION 2 RESULTS

Data Presentation

Hospitals submitted schedules showing the billed charges and revenues received for various categories of indigent and uncompensated care. This data was converted to cost (using the cost-to-charge methodology) and summarized in a variety of ways.

Because indigent care costs can be measured in a variety of ways – gross cost; costs net of Medicaid payment; costs net of all payments; as a percentage of operating revenues; etc. – the series of schedules at the end of the report were prepared. The following discussion introduces and summarizes each schedule:

Schedule 1 – Total Gross Indigent Care Costs This schedule shows total indigent care costs before consideration of any payments. Included are the costs of Medicaid, indigent care and other government programs. All costs are calculated as described by Attachment 4.0 and are broken down by inpatient and outpatient hospital services, where data was available. In total there is $279 million in gross indigent care cost, $191 million in Clark County, $59 million in Washoe County and $29 million in the rural counties. UMC, Washoe Medical Center and Sunrise Hospital and Medical Center had the greatest gross costs of indigent care.

Schedule 2A – Cost of Indigent Care Net of Medicaid Payments Schedules 2A and 2B show the breakdown of indigent care costs broken down by Medicaid, uncompensated care, and other government programs, broken down between inpatient and outpatient within each category. Schedule 2A shows the indigent costs net of Medicaid payments.

In Schedule 2A Graduate Medical Education ("GME") and certain provider-based physician costs ("PBP") are shown separately. These costs have been directly allocated to indigent care, as explained in the Cost Methodology in Attachment 4.0, rather than being apportioned to all patients. This is because the costs of these services relate primarily to the provision of indigent care, and not to the general hospital population. For example, some hospitals have to pay physicians to provide emergency room coverage to compensate them for patients who will not pay their bill. These costs would not have to be incurred if the hospital did not have a significant percentage of patients for whom the physicians would not otherwise be able to receive payment.

While this schedule shows indigent care costs net of Medicaid, no other payments from state or local governments have been subtracted. Please note that not all hospitals provided full breakdowns, particularly between inpatient and outpatient. When breakdowns were not made, costs were classified as inpatient.

Schedule 2A shows there is $168 million in indigent care cost once Medicaid payments are taken into account. In other words, Medicaid contributes $111 million toward the cost of care. Once Medicaid payments are taken into account, University Medical Center, Washoe

Medical Center and Saint Mary's Regional Medical Center have the largest indigent care expenses.

Schedule 2B – OBRA Limitation By Component of Indigent Care The difference between Schedule 2A and 2B is that graduate medical education and PBP costs are not totally allocated to indigent care in the Schedule 2B OBRA limitation schedule. Since these are not recognized by Medicare and Medicaid as costs that can be totally allocated using Medicare principles of reimbursement, they are allocated on the basis of Medicaid to total inpatient days for use in calculating the Schedule 2B OBRA limitation. This modification of the GME and PBP costs reduces total indigent care to $154 million. The change has impact on those facilities with these costs, most notably UMC, Washoe Medical Center and most of the rural hospitals.

Schedule 3 – Comparison of Indigent Care Costs from Schedule 2A to Operating Revenues This schedule shows that the $168 million in indigent and uncompensated care costs (net of Medicaid payments) represents 9.7% of operating revenues for Nevada hospitals. However, the percentage has a great deal of variation. For public rural hospitals, indigent care represents 14.92% of operating revenue; for private rural hospitals the figure is 14.80%, for hospitals in Clark County the figure is 9.11%, and 9.3% in Washoe County. Hospitals with particularly high percentages of indigent cost (net of Medicaid payments) to operating revenue include UMC (at 23.72%), Humboldt General Hospital (at 26.52%), Northeastern Nevada Medical Center (at 22.08%), and Nye Regional Medical Center (at 38.84%).

Schedule 4 – Components of Indigent Care Costs, Net of Payments This schedule is similar to Schedule 2A, but subtracts out payments from state and local government for indigent care (the county accident and county indigent care funds), any patient payments and any other transfers made by county governments to the hospitals. The "Other Revenue" column depicts direct payments from counties, including direct tax assessments. The amount of direct tax payments for University Medical Center includes a $13,653,951 payment from county general funds for emergency room services that are not related to individual patients. The Mt. Grant, South Lyon, and William Bee Ririe hospitals also received direct tax subsidy from the counties in which they are located.

Comparing Schedule 2A to Schedule 4, hospitals receive approximately $31 million in indigent care payments for inpatient hospital services, $13 million in payments for outpatient services, and $16 million in direct tax subsidies. The net indigent care expense once these payments are removed is $100.5 million.

The seven hospitals with the highest net indigent care costs (in descending order) are UMC (at $31 million), Washoe Medical Center (at $17 million), St. Mary's Regional Medical Center (at $8.3 million), Carson Tahoe Hospital (at $6.8 million), Valley Hospital Medical Center (at $6.1 million), Lake Mead Hospital Medical Center (at $6 million), and Sunrise Hospital and Medical Center (at $6 million).

Schedule 5A – Comparison of Indigent Care Costs from Schedule 4 to Operating Revenues
Schedule 5B – Comparison of Indigent Care Costs, Excluding Direct Tax Subsidies, to Operating Revenue

Schedule 5A compares each hospital's net indigent care costs (excluding DSH) to operating revenue to illustrate the percentage of uncompensated indigent care costs for that hospital. Schedule 5B provides a similar calculation, except the net indigent care costs do not include any direct tax subsidy payment the hospital may have received.

Schedule 5A shows that after payments by local governments, hospitals have uncompensated indigent care costs of 5.78% of operating revenues. If the direct tax payments are not included in the analysis (as depicted in Schedule 5B) indigent care costs would represent 6.7% of operating revenue.

In Clark County, indigent care costs net of payments represented 5.09% of operating revenues. If direct tax payments are not included, indigent care would represent 6.25% of Clark County hospital operating revenues.

In Washoe County, indigent care costs net of payments are 6.48% of operating revenues in both schedules. Private rural hospitals have the greatest percentage of uncompensated indigent care costs at 10.9%, and since no county payments are made to these hospitals, this amount is unchanged in both schedules.

For public rural hospitals, the percentage on Schedule 5A is quite small, at 1.65%. However, this low figure reflects the impact of the direct tax subsidies received by these hospitals. If the direct subsidies are excluded from the analysis, the percent of operating revenue devoted to uncompensated indigent care costs is 8.6% and, rather than being negative, Mt. Grant's percentage is 11.4%, South Lyon's is 11.3% and William Bee Ririe is 5.5%.

All hospitals in Clark County, with the notable exceptions of UMC and Lake Mead Hospital Medical Center, have an uncompensated indigent care cost percentage of less than 5%. UMC's uncompensated indigent care costs are 9.91% (14.26% if direct tax subsidies are excluded) and Lake Mead Hospital Medical Center's cost represent 12.17% of operating revenues. In Washoe County, Washoe Medical Center has the highest percentage at 8.09%.

Northeastern Nevada Medical Center (Elko) and Nye Regional Medical Center have two of the highest percentages of uncompensated care costs at 14.28% and 34.13% respectively. It should be noted however, that there may be data problems associated with the results for these two hospitals.

Schedule 6A – Comparison of Indigent Care Costs, Net of DSH, to Operating Revenues
Schedule 6B – Comparison of Indigent Care Costs, Net of DSH, but Excluding Direct Tax Subsidies, to Operating Revenues

Schedule 6A shows the percentage of operating revenues that indigent care costs net of payments – including the net SFY 2000 DSH payment – represent. Schedule 6B provides the same point of reference while excluding any direct tax subsidies that the hospital received.

In these depictions, Lake Mead Hospital Medical Center has the largest percentage to operating revenue (at 12.04%) of all Clark County hospitals. Lake Mead is followed in Clark County by University Medical Center which has 5.33% when tax subsidies are included. If direct tax subsidies were not considered, UMC's indigent care costs net of payments (including disproportionate share payments) would exceed 9%.

The DSH benefit shown for Washoe Medical Center is overstated. The total benefit shown is actually split between Washoe County and WMC. Nonetheless, its percentage (at 6.54%) is still higher than any other hospital in the county.

For rural private hospitals, indigent care as a percent of operating revenue is high at 8.88%. The highest percentage is for Nye Regional Medical Center where indigent care costs represent 31.61% of operating revenue, even after disproportionate share is considered. Northeastern Nevada Medical Center (at 12.43%) also remains high. As noted above however, there may be data reporting problems associated with these results.

For public rural hospitals the percentage of uncompensated care net of disproportionate share as reported on Schedule 6A is low at -.31%. Here again, however, the effect of direct tax subsidies is an issue. If direct tax subsidies are not included in the calculation as is the case on Schedule 6B, public rural hospitals would have a net uncompensated care ratio of 6.6% with Mt. Grant's at 9.0%, South Lyon at 9.0% and William Bee Ririe at 3.8%.

Schedule 7 – Calculation of Net Uncompensated Cost for Medicaid Inpatients This schedule shows that overall Nevada Medicaid is paying more than 90% of the total cost (as compiled for this study) for Medicaid inpatients. This is a relatively high amount when viewed from a national perspective.

Schedule 8 – Calculation of Net Uncompensated Cost for Medicaid Outpatients This schedule shows that the payment percentage for Medicaid outpatient is significantly less than it is for inpatient, but still remains high from a national perspective.

Schedules 9 to 13 provide the background for the calculations presented in the Schedules reviewed thus far. Therefore, they are presented but will not be discussed. Schedule 14A and Schedule 14B are discussed below under "Federal Tests" and Schedule 15 is discussed under "Population."

Schedule 9 – Calculation of Net Uncompensated Cost for Indigent Inpatients, Including County Indigent Care Programs and Others Without Third Party Coverage

Schedule 10 – Calculation of Net Uncompensated Cost for Indigent Outpatients, Including County Indigent Care Programs and Others Without Third Party Coverage

Schedule 11 – Calculation of Net Uncompensated Cost for Other State and Local Programs Providing Medical Care to Low-Income Inpatients

Schedule 12 – Calculation of Net Uncompensated Cost for Other State and Local Programs Providing Medical Care to Low-Income Patients

Schedule 13 – Schedule of Disproportionate Share and Intergovernmental Transfer Payments for State Fiscal Years Ending 2000-2002

Federal Tests

In addition to compiling the results required by S.B. 377, the federal tests for disproportionate share eligibility of hospitals were applied. Schedule 14A provides the results for the low income test (25% low income utilization) and Schedule 14B provides the results of application of the test for Medicaid days more than one standard deviation greater than the mean Nevada experience for hospitals.

Three hospitals met the low income utilization criteria of 25%:

- UMC
- Humboldt
- Northeastern Nevada Medical Center

All three of these hospitals currently receive DSH payments.

Two additional hospitals exceeded 20% low income but did not meet the 25% threshold. These hospitals are Washoe Medical Center and Lake Mead.

Six hospitals met the Medicaid days test:

- Battle Mountain General Hospital
- Charter Hospital
- Lake Mead Hospital Medical Center
- UMC
- Humboldt General Hospital
- West Hills Hospital

Battle Mountain does not qualify for a disproportionate share payment because the hospital does not meet the federal criteria regarding the availability of obstetrics as described earlier in this report. Similarly, Charter Hospital and West Hills Hospital are classified as Institutes for Mental Disease and as such Nevada may not make DSH payments to them. This is because the state did not make any DSH payments to them in 1995, and states are precluded from paying more DSH to IMDs than they did in that year.

All of the remaining hospitals are receiving DSH payments. If the distribution system were to change, they must continue to receive payments. However, the state has great flexibility to pay any amount that is proportional to their indigent care and under any qualifying criteria.

Population

The DSH program (together with the associated intergovernmental transfer requirements) has operated in a manner that has provided net benefit to Clark County, Washoe County and the rural counties in aggregate in rough correlation to their population. This is illustrated on Schedule 15.

Clark County has approximately 69.5% of the population and receives 69.77% of the net DSH benefits. Washoe County has 15.6% of the population and received 14.6% of the net DSH benefit. While this is less than the other two regions, Washoe County does not have a public hospital.

Rural counties in total receive a higher percentage of DSH benefit than their populations would indicate. This higher benefit is due to the amount received by the private rural hospitals. However, with the change from public to private status for Carson Tahoe Hospital and the reclassification of Churchill Regional Medical Center as a private hospital, the net benefit based on current law would decrease to approximately $2.0 million. This realignment would bring the DSH benefits more in line with the population of those counties with private hospitals. It should be noted that under current formulas, the benefit that would be lost by the private rural hospitals will go almost entirely to Clark County.

SECTION 3 DATA ISSUES

This section of the report briefly reviews the data collection and methodology used in the study then discusses a number of data issues that emerged in compiling this report.

Data collection and methodology

S.B. 377 provided for the collection of data from hospitals in conducting this study:

> "3. The legislative committee on health care shall request such relevant information from public and private hospitals, counties and other entities as is necessary to conduct the study. A hospital, county or other entity that receives such a request from the committee shall provide the appropriate information. Any such information obtained by the committee may be used only for the purpose of conducting the study."

Two sources of data were used: a hospital survey and the hospitals' Medicare cost report.

The hospital survey collected inpatient and outpatient indigent care billed charges, inpatient days, county indigent, accident and general fund revenues received, and other payments received.

The second source, the Medicare cost report, was used to determine hospital cost of care. Costs of care were determined based on the cost-to-charge ratios for inpatient and outpatient services. A second measure of inpatient hospital costs was determined based on hospital cost per day.

The most current complete set of Medicare cost reports available were used. This included the cost reports for the hospitals' fiscal year ending during state fiscal year 2000. Indigent care data collected from hospitals is from the same time period. For a description of data collection and the calculation of cost-to-charge ratios, see Attachments 3.0 "Data Collection" and 4.0 "Methodology for Calculating the Cost of Indigent Care."

Nevada hospitals participated in the development of the methodology for the study. In particular, hospitals voted on methods for inclusion of graduate medical education costs, the methodology for costing indigent care, the cost reporting form and year, as well as the definition of hospital costs to be included in "indigent care."

Cost to Charge

In preparing the tables and schedules in this report, the cost-to-charge ratio methodology for costing inpatient care was utilized rather than the cost per day methodology as described in Attachment 4.0. As Table 2.0 below shows, the total costs of indigent care for hospitals was larger using the cost per day methodology. The effect, however, was not consistent. Clark

County and Public Rural hospitals had a higher cost of care using the cost per day methodology and Private Rural hospitals and Washoe County had lower costs of care.

The decision to use the cost-to-charge ratio methodology for this study was based on the methodology's wide acceptance nationally, and 12 of the 19 hospitals had higher costs for indigent care using the cost-to-charge ratio methodology. The results of a comparison of the two approaches are reported in Table 2.0.

Table 2.0
Comparison of Cost Methodologies

Hospital Name	Inpatient Cost of Care Based On Cost-To-Charge Ratio Methodology	Inpatient Cost of Care Based On Cost Per Day Methodology	Variance
Desert Springs Hospital	$3,299,786	$3,005,249	$294,537
Lake Mead Hospital Medical Center	$2,810,402	$3,197,554	-$387,152
Mountain View Hospital	$1,171,684	$1,451,117	-$279,433
Saint Rose Dominican Hospital-Rose De Lima	$3,215,775	$3,967,691	-$751,916
Summerlin Hospital Medical Center	$2,055,887	$915,847	$1,140,040
Sunrise Hospital & Medical Center	$5,182,445	$6,840,661	-$1,658,216
University Medical Center of Southern Nevada	$34,089,492	$39,534,192	-$5,444,700
Valley Hospital Medical Center	$5,225,565	$4,950,052	$275,513
Total Clark County	**$57,051,036**	**$63,862,363**	**-$ 6,811,327**
Northern Nevada Medical Center	$490,246	$406,279	$83,967
Saint Mary's Regional Medical Center	$6,607,930	$5,878,245	$729,685
Washoe Medical Center	$15,285,386	$15,254,925	$30,461
Total Washoe County	**$22,383,562**	**$21,539,449**	**$844,113**
Humboldt General Hospital	$1,273,869	$2,053,880	-$780,011
Mt. Grant General Hospital	$103,757	$55,686	$48,071
South Lyon Medical Center	$72,844	$63,281	$9,563
William Bee Ririe Hospital	$175,657	$175,902	-$245
Carson-Tahoe Hospital	$3,868,510	$3,344,397	$524,113
Churchill Community Hospital	$784,667	$766,707	$17,960
Northeastern Nevada Medical Center	$5,357,591	$5,102,950	$254,641
Nye Regional Medical Center	$108,525	$81,369	$27,156
Total Rural Hospitals	**$11,745,420**	**$11,644,172**	**$101,248**
Total All Hospitals	***$91,180,018***	***$97,045,984***	***-$5,865,966***

Quick Care of UMC

Quick Care Centers (QCC) of UMC have a different charge structure from most outpatient services, which results in a much higher cost-to-charge ratio. In compiling the study, UMC costs were examined both with and without the inclusion of the QCC. In the final compilation of the schedules and the report, QCCs were excluded.

The cost-to-charge ratio for UMC outpatient services excluding Quick Care is 34.30%. Including Quick Care, the ratio increases to 48.44%. If the cost-to-charge ratio including Quick Care were to be used, Medicaid outpatient uncompensated costs would increase by

over 50%, from $4,477,161 (as depicted on Schedule 8) to $7,968,004. Similarly the outpatient indigent care net cost would increase from $12,868,459 (as depicted on Schedule 10) to $20,462,466.

In total, the impact of using a cost-to-charge ratio including the Quick Care Centers would increase total uncompensated outpatient care costs by $11,240,640, from $31,093,973 (as depicted on Schedule 4) to $42,334,613.

Removing the QCC brings UMC outpatient costs more in line with the other hospitals. For example, including the Quick Care Centers, UMC receives only 42% of its costs in Medicaid outpatient reimbursement, as compared with 78.5% for all other hospitals. Removing the Quick Care Centers, the percentage reimbursement climbs to 56.1%.

Even though QCC were excluded from the calculations, UMC has more than $17 million in outpatient uncompensated costs, including $4.5 million for Medicaid.

Potential overstatement of indigent care costs

The Nevada statutes define indigent care costs to include any service for which the hospital received less than 25% of the cost of care. It appears that some data submitted by hospitals may include "excess costs." That is, the amount the hospital reported included un-reimbursed costs for patients where at least 25% of costs were reimbursed. Such costs are inappropriate and appear to be included in the information reported by four hospitals.

SECTION 4 CONSIDERATIONS FOR AN EQUITABLE DISPORPORTIONATE SHARE (DSH) DISTRIBUTION

This section of the report describes the considerations for an equitable disproportionate share (DSH) distribution. First, the section provides an overview of total uncompensated indigent care costs and payments available to offset those costs. The section then examines Medicaid payments versus the cost, as calculated for this analysis, of providing both inpatient and outpatient care to patients eligible to participate in the Medicaid program. Other sources of funds to offset indigent care costs including the county indigent, accident, as well as county general funds are discussed next. A discussion of intergovernmental transfers then follows. The section concludes with a discussion of the needs of rural communities and northern and southern Nevada.

Overview of Uncompensated Costs Net of Total Payments

Total costs in SFY 2000 to provide care to Medicaid, indigent and other low-income patients in Nevada is $279 million before any payments are deducted. In determining an equitable distribution of DSH, one primary consideration is what is the proper starting point, or on what basis, are disproportionate share funds to be distributed. There are a number of options to consider for a starting point:

- Gross indigent care costs without consideration of any payments received by hospitals
- Gross indigent care costs net of Medicaid payments
- Gross indigent care costs net of Medicaid, county accident and indigent fund and patient payments
- Gross indigent care costs net of all payments including direct tax subsidies received by hospitals from counties
- Gross indigent care costs less Medicaid costs, with or without deductions for the various other sources of payment

While it is probably clear that at least some payments should be subtracted from gross indigent care costs, analysis will help to determine which types of payments to exclude.

Table 3.0 provides each of the pieces that enter into this decision. One critical fact reflected in Table 3.0 is that no matter what distribution formula is adopted, Nevada's disproportionate share allotment of approximately $76 million (gross before intergovernmental transfers) will not be sufficient to cover the entire indigent care burden in the state.

Table 3.0
Summary Depiction
Costs and Revenues for Indigent Care

Government Program	Medicaid IP	Medicaid OP	County, Indigent and Other Low-Income IP	County, Indigent and Other Low-Income OP	Other IP and OP	Directly Allocated Costs (GME & PBP)	Total
Gross Costs	$108,456,961	$17,784,507	$91,180,019	$35,645,930	$9,090,754	$16,823,202	$278,981,373
Less: Payments	$99,715,411	$11,679,070	$31,432,045	$13,305,144	$7,755,128		$163,886,798
Uncompensated Costs	$8,741,549	$6,105,437	$59,747,974	$22,340,787	$1,335,626	16,823,202	$115,094,575
Less: Other Revenue (Direct Tax & ER)			$15,837,363				$15,837,363
Adjustment: Payments in Excess of Costs	$331,131	$445,423		$493,303			$1,269,856
Net Uncompensated Costs	$9,072,680	$6,550,860	$43,910,611	$22,834,089	$1,335,626	$16,823,202	$100,527,068
% of Net Uncompensated Costs	9%	7%	44%	23%	1%	17%	100%

Medicaid Payments

Based on a comparison of the Medicaid costs as defined in this study to total Medicaid payments, a total of $14,846,986, or 12% of calculated Medicaid costs is uncompensated, prior to adjustments. Inpatient uncompensated Medicaid costs account for $8,741,549, or 8% of total Medicaid inpatient cost of care. Outpatient uncompensated Medicaid costs are $6,105,437, or 34% of total Medicaid outpatient cost of care. The percentage of Medicaid costs covered is quite high relative to other states, and is partially a function of the data manipulation used in this study.

Total uncompensated Medicaid costs (excluding DSH) represent 15.1% of the $98.3 million in total statewide uncompensated costs of indigent care, prior to adjustments.

The gap in Medicaid payments to cost is a factor that can either be considered or not considered in a DSH distribution formula.

Other Sources of Funds

In Nevada, counties are primarily responsible for the provision of indigent care, other than Medicaid. Counties impose property taxes for the provision of indigent care, generally 6 to 10 cents per hundred dollars assessed valuation. Additionally, counties assess 1.5 cents for the "fund for hospital care of indigent persons" for accidents involving motor vehicles,

generally referred to as the indigent accident fund ("IAF"), and 1 cent for the "supplemental account," also referred to as the supplemental fund. These two funds are administered through the Nevada Association of Counties.

The funds raised by the counties are primarily used for two purposes, paying the non-federal share for certain Medicaid patients in institutional care and paying for inpatient hospital services for persons who qualify under county indigent standards.

While county payments to hospitals are generally made at Medicaid rates, there are some counties that have different payment rates under certain circumstances. Also, the counties vary in their definition of indigent.

Certain rural counties have hospital districts that operate hospitals and assess taxes specifically for the hospital. These funds are in addition to the indigent care funds and generally necessary for the overall operation of the hospital, not specifically for indigent care.

Finally Clark County makes a $1 million appropriation from a gaming tax in support of UMC.

In Table 3, the amount of total uncompensated care from the Inpatient and Outpatient categories of "County, Indigent and Other Low Income" costs is $43.9 million and $22.8 million respectively, or about 67% of total uncompensated costs. While the data submitted by the hospitals was not conducive to separating indigent from other low income payments, as a category, uncompensated costs represented 48% and 64% of total costs – far higher than Medicaid. These levels of uncompensated care assume inclusion of the direct tax and emergency room transfers made by the counties.

There are a number of issues raised with respect to the payments received from the counties. For example, given the lack of uniformity of administration in the indigent care program, and the direct payment program for public hospitals, should these costs and payments be used in the determination of the DSH distribution?

Match and Intergovernmental Transfers

Under current Nevada Law the DSH program is funded through the use of intergovernmental transfers ("IGT") from counties, or their hospitals. The transfers are imposed in the following manner:

- Counties that have a public hospital that receives DSH payments are required to transfer to the state IGT account an amount equal to 75% of the funds distributed to all hospitals in the county (public and private), less $75,000 per hospital.

- Counties that have only private hospitals that are receiving DSH are required to transfer to the IGT an amount as established by the Legislature. In exchange for this transfer, these counties are relieved of the obligation to pay for inpatient indigent care to the hospital receiving DSH.

When the IGT program was established in 1995 all transfers were made by public hospitals with the exception of Washoe County. Washoe County was able to fund its IGT through the savings in inpatient indigent care. Because of the increasing trend privatization of county hospitals, more counties without public hospitals have had to make IGT payments, and these payments have been greater than the savings realized by being relieved of the obligation to pay for inpatient indigent care to the hospital receiving DSH. This has led to the imposition of hospital taxes in counties that have no public hospitals and only one private hospital, in order for the counties to raise the necessary funds to make the transfer.

This taxing mechanism (which was enacted in 2001) appears to be in compliance with federal rules concerning taxes and donations, but raises the potential liability to the state if the counties do not fully comply with the federal rules. The new tax, together with the IGT system, has added both administrative cost and complexity to administering the DSH program. Because the taxing authority was only enacted for two years, and therefore the Legislature must take action, it presents an opportunity for simplification and removing any potential liability that the current system may have.

The State has a number of alternatives available to ensure that it can maintain the flow of federal revenues for the DSH program:

1) Make the current tax program permanent. This alternative would be the easiest to enact, but would maintain the administrative cost and complexity and potential federal liability.

2) Reduce the state general fund benefit so that IGTs are not required from rural counties without public hospitals or from rural counties at all. Whether this option is viable will depend upon state revenue availability.

3) Change the IGT system so that the only counties to pay IGT would be Clark County (through UMC) and Washoe County and reduce DSH payments to rural hospitals and counties by the amount of the intergovernmental transfer.

   This would require an adjustment of the DSH program to reduce the DSH payments to rural hospitals by the amount of IGT currently being made by the rural counties and hospitals. There would also be a corresponding increase in the amount of DSH paid to UMC to allow it to make the additional IGT payment. Because the state makes the DSH payments before the hospital makes the corresponding IGT payments, UMC would not have to fund these transfers from any source but their DSH revenue.

Under this alternative (and without regard to any other changes in DSH contemplated by this study), the DSH calculation would be changed to first establish several distribution pools. Clark County and the rural areas would each have two separate pools, one for private hospitals and one for public hospitals. Washoe County would have one pool because it does not have a public hospital. The amount of disproportionate share received by the rural public hospitals would need to be determined.

Sufficient money would be allocated to the Clark County public hospital pool to ensure that UMC can make its IGT payment and retain its appropriate DSH benefit.

The .6% service requirement

The .6% service requirement is imposed only on counties with two or more licensed hospitals of 100 beds or more. Currently, Clark and Washoe are the only counties in the state to meet these qualifications.

Hospitals in the counties subject to the requirement must provide, without charge, care for indigent inpatients in an amount that equals .6% of net revenues from the prior year. The service requirement is intended to equalize the burden of providing care to indigent patients and to increase the counties' funds to compensate hospitals for providing such care. Unless waived by the county, a hospital will only be reimbursed by the county for indigent care after the requirement is met. Clark County has waived the requirement for UMC.

As reflected in Schedule 5.0, many of the hospitals in Clark County provide a relatively low amount of uncompensated indigent care compared to UMC. The imposition of the .6 percent service requirement tends to equalize the burden of the care among all hospitals in the county.

Rural community needs

As a group, rural private hospitals have the highest percentage of uncompensated indigent care costs. As depicted on Schedules 5A and 6A, either with or without DSH payments, these hospitals are well above the statewide average percent of indigent care costs to operating cost. Nye Regional Hospital at 34.13% (Schedule 5) or 31.61% (Schedule 6) has the highest percentage in the state.

While rural public hospitals have a very low percentage on uncompensated indigent costs when direct tax subsidies are considered (1.65% to negative .31% on Schedules 5A and 6A), they also have a high percentage of uncompensated care when direct county transfers are excluded (8.56% without considering DSH). In order for both groups of rural hospitals to remain viable, additional disproportionate share should be considered.

Northern and Southern Nevada considerations

While Clark County has greater uncompensated indigent costs in dollar terms than does Washoe, Washoe County has higher costs in percentage terms than do the Clark County hospitals as a group.

The disproportionate share payment made to Washoe Medical Center brings this northern Nevada hospital within approximately 2% of the average statewide uncompensated indigent care burden as reflected on Schedule 6A. Washoe has the highest indigent care costs (in both dollars and percentage of operating revenues) of the hospitals in the North, even after the DSH payment.

UMC and Lake Mead Hospital Medical Center in Clark County are considerably higher in uncompensated indigent care costs than the state as a whole (Schedule 5A). The addition of DSH payments moves UMC to within 1% of the statewide average. In the case of Lake Mead, FY2000 DSH payments leave the hospital at more than 2.5 times the statewide average (Schedule 6A). However, when county direct tax subsidies are deducted, UMC is more than five percentage points higher than the statewide average of 5.49%. Lake Mead remains approximately seven percentage points higher than the statewide average burden.

DSH Distribution Changes

The Schedules discussed in Section 2 used fiscal year 2000 cost and DSH information. The SFY 2002 DSH allocation included some notable changes from prior years. Those changes are reflected in Schedule 13.

The overall DSH net benefit to hospitals increased by approximately $1.6 million, from $20.9 million to $22.5 million. Clark County's Lake Mead Hospital received a ten fold increase or close to $620,000 over the previous two years. Added to the DSH distribution in SFY 2002 was Sunrise Medical Center, a hospital that did not receive a DSH allocation in the prior two SFYs. Sunrise received a DSH payment in SFY 2002 almost equal to Lake Mead. This distribution was likely based on the dollar volume of indigent care given ($6.0 million), not its percentage of operating revenue devoted to this service (less than 2%).

Also in SFY 2002, the Rural-Public group received a $171,000 increase over SFY 2000. Table 4.0 illustrates the DSH distribution for the Rural-Public hospital group. Each of the hospitals within the group received a portion of the increase with the result being a decrease in the uncompensated costs for these hospitals from a low of 0.1% up to 1.74%

Table 4.0
Comparison of DSH Distributions in SFY 2000 to SFY 2002

Rural - Public	SFY 2000		SFY 2002		Change in %
	Net DSH benefit	% Uncomp Costs [1]	Net DSH benefit	% Uncomp Costs [1]	
Humboldt General Hospital	175,267	6.48%	215,109	6.08%	-0.40%
Mt. Grant General Hospital	114,016	8.96%	195,838	7.22%	-1.74%
South Lyon Medical Center	166,907	8.97%	174,417	8.86%	-0.10%
Wm. Bee Ririe Hospital	162,174	3.77%	204,001	3.34%	-0.44%
Total	**618,364**		**789,365**		

[1] Percentages are calculated against SFY 2000 operating revenue and indigent care costs for illustration purposes.

Within the Rural-Private hospital group, the overall DSH distribution decreased when compared with SFY 2000, but increased over the SFY 2001 DSH distribution. Two of the hospitals within this group (Northeastern and Nye) have some of the highest uncompensated cost percentages, but as mentioned previously, are also suspected of having data abnormalities.

Three public hospitals that are not federally qualified to receive DSH each received $50,000 of "DSH like" funding. These three hospitals are Grover C. Dils, Battle Mountain and Pershing General.

When examining the SFY 2000 through SFY 2002 DSH distributions to each hospital group, the percentage of DSH allocated to each subset of hospitals has varied by less than 1%. If SFY 2000 is compared directly to SFY 2002, the group allocation percentages vary by 1.24% at most.

SECTION 5 RECOMMENDED DISTRIBUTION OF DISPROPORTIONATE SHARE

This section contains the study's recommendations. The section begins with a discussion of the basis for future DSH distributions, presents an analysis that illustrates that a simple formulaic approach would not be appropriate, presents a recommended distribution formula for net benefits and intergovernmental transfers, and concludes with a series of other recommendations, one of which is to maximize federal funds utilization by the State of Nevada by drawing down unused SCHIP funding.

Basis for Future DSH Distributions

Based on the charge of the study by the Legislature, the principles adopted by the Committee, and the analysis presented, a redesign of the DSH program is recommended.

Among the elements of the recommended system are:

- Simplification of both the distribution process and the intergovernmental transfer process.

- A general provision that the geographic regions and the hospitals within the regions should receive – depending upon the availability of funds – at least the same net benefit as past years.

- Distributions should be made in a manner that equalizes the percentage of operating revenue that are composed of uncompensated indigent costs. For the purpose of measurement, uncompensated indigent care costs should be measured as costs less all payments except for direct county transfers.

- Exceptions should be made to the "hold harmless" or "grandfather" recommendation in three circumstances:

    1) Sunrise Hospital and Medical Center should not receive a DSH distribution. While Sunrise Hospital does have a significant dollar amount of uncompensated indigent costs (at $6.0 million), the percentage of operating revenues (at 1.7% - see Schedule 5B) is the lowest in the state.

    2) The distribution for hospitals that change ownership from public to private, should have a DSH payment more akin to the historic patterns that have been made for private facilities. This implies that the distribution for Carson Tahoe Hospital (which went private in FY 2002) should be reduced.

    3) The distribution for Churchill Community Hospital should be reduced. This facility has inappropriately been treated as a public facility rather than as a

private for some years. Its treatment should change, and its payment brought more in line with other private facilities.

- Lagged historic data should be used for the calculation of the distribution. By using lagged historical data (such as 2000 Medicare Cost Reports to distribute SFY 2003 DSH amounts), DSH allocations can be calculated before legislative appropriations, at least for the first year of the biennium. This lagged historic data will add greater certainty to the process.

In designing a replacement DSH allocation program, a formulaic approach was first tested. It failed to satisfy the necessary elements of the recommended solution, but is briefly presented for background purposes.

Formulaic Approach

As a starting point, the data was examined to see if the information would directly lead to a simplified distribution formula that satisfied the elements above. The distribution basis of indigent care costs net of all payments except direct tax subsidies (and DSH) was selected for testing.

In order to test this and other examples, it was assumed that the total disproportionate share amount available was $76 million and that $53.5 million is required for the state to yield a gain of $15.5 million in state general fund. Therefore, $22.5 million would be available in DSH benefit for the hospitals. It should be noted that this level of gain to the state general fund compares to a gain of $16.0 million in SFY 2000 and 2001 and a gain of $16.7 million in SFY2002.

The formula tested used the 2000 Medicare Cost Report information to distribute the hypothetical DSH dollars. Presumably, if this were being done for SFY 2004 DSH, the 2001 Medicare Cost Report would be used.

The results of the analysis of using this new formulaic basis for distributing the net DSH benefit to the previously existing geographic areas are presented in Tables 5 and 6. Table 5 presents the resulting DSH benefit distribution as a percentage of the overall DSH benefit monies available. Table 6 presents the monetary distributions that the table 5 percentages would yield, assuming $22.5 million in DSH benefits.

Table 5.0
Comparison of Formulaic Distributions of DSH Benefits to Geographic Areas
Percentage of DSH to be Distributed to Each Hospital Group

Hospital Group	Formulaic Distribution	Dist of SFY 2002 DSH (Net)	Dist of SFY 2000 DSH (Net)
Clark County	63.10%	70.23%	68.86%
Washoe County	22.28%	14.74%	15.52%
Rural, Public	2.32%	3.53%	2.95%
Rural, Private	12.30%	11.50%	12.67%
Total	**100%**	**100%**	**100%**

Table 6.0
Comparison of Formulaic Distributions of DSH Benefits to Geographic Areas
Dollar Amount of DSH to be Distributed to Each Hospital Group

Hospital Group	Formulaic Distribution	Dist of SFY 2002 DSH (Net)	Dist of SFY 2000 DSH (Net)
Clark County	$14,196,812	$15,724,639	$14,423,628
Washoe County	$ 5,012,299	$3,300,000	$ 3,250,000
Rural, Public	$522,921	$939,365	$618,364
Rural, Private	$2,767,967	$2,575,309	$ 2,652,812
Total	**$22,500,000**	**$22,539,313**	**$20,944,804**

As the above Tables illustrate, using the formulaic basis as the sole factor to determine the DSH benefit allocation significantly changes the DSH distribution to Washoe (more DSH) and Clark County (less DSH) when compared with the SFY 2002 DSH distribution. The formula would treat rural private hospitals marginally better but significantly reduce the benefits to rural public hospitals. Although this approach would simplify the DSH calculation, it would fall short of a total solution.

Recommended DSH Allocation Process

The recommended methodology begins with a DSH benefit allocation to each of five hospital groups (or "pools") that will be created:

1) Clark County Public Hospitals

2) Clark County Private Hospitals

3) Washoe County Hospitals

4) Rural-Public Hospitals

5) Rural-Private Hospitals

There would also be a pool for hospitals that do not qualify for federal DSH payments.

DSH Benefit Distribution

The initial funding for each pool would approximate the SFY 2002 DSH benefit allocation. The exceptions to the SFY 2002 benefits would occur for two reasons:

- The amount that is recommended to be reduced from Churchill Hospital is transferred from the SFY 02 Rural Private Pool to the Rural Public Pool

- The small amount ($39,000) of reduction in SFY 2002 funds necessary to meet the assumed $22.5 million benefit is removed from the two Clark County Pools.

The amount of funds distributed to each pool would be set into law as percentages, with appropriate language to modify the amounts if there is a change in the amount of DSH funds become available to the state. In drafting this language, the state should consider if increases in DSH will first be distributed to the state (to make up for the reduction the state is suffering to ensure $22.5 million benefit to hospitals in the current example), and whether reductions should be made across the board or with some priority system.

The proposed distribution to the pools is presented below in Table 7.0:

Table 7.0
Comparison of SFY 2002 Net DSH benefit to Proposed DSH Distribution
Distribution by Hospital Group

Hospital Group	SFY 2002 Net DSH Benefit	Proposed Net DSH Benefit	Difference
Clark County Public	$ 14,381,729	$ 14,481,729	$ 100,000
Clark County Private	$ 1,342,910	$ 1,203,597	$ (139,313)
Washoe County	$ 3,300,000	$ 3,300,000	$ 0
Rural-Public	$ 789,365	$ 908,098	$ 118,733
Rural- Private	$ 2,575,309	$ 2,456,576	$ (118,733)
Subtotal	**$ 22,389,313**	**$ 22,350,000**	**$ (39,313)**
Non DSH Hospitals	$ 150,000	$ 150,000	$ 0
Total	**$ 22,539,313**	**$ 22,500,000**	**$ (39,313)**[1]

[1] this decrease is due to the assumption that 22.5 million in DSH is available, rather than the 22.539 million that was distributed in SFY 2002.

Once the pools are established the distribution to the hospitals within the pool will be made. For the Clark County and the Washoe pools, the distribution will be made to hospitals within each pool based on the percentage of uncompensated costs.

The methodology would iteratively buy down each hospital's uncompensated cost percentage within the pool to the statewide average. The hospital with the highest percentage of uncompensated costs would receive the first allocation. Once enough DSH monies were allocated to reduce that hospital's uncompensated costs percentage to the same percentage as the next closest hospital, DSH monies would be distributed equally to both hospitals until the uncompensated cost percentage reached the third highest uncompensated cost percentage. This process would continue until the DSH money ran out, or until the statewide average was reached – which ever came first.

The two Clark County pools, UMC and Lake Mead have uncompensated costs that are significantly higher than the remainder of the hospitals in the respective pools (in fact, for the Clark County Public Pool, UMC is the only member of the pool). The result of the allocation would be to reduce the percentages for these two hospitals before DSH is allocated to any other hospitals in the county. Therefore, the proposed distribution does not contain any allocation to Sunrise Hospital and Medical Center.

For the Washoe County pool, the effect will be that only Washoe Medical Center will receive the entire distribution.

For the Rural Public Hospitals, each hospital would first be distributed the amount of funds it received as a "net benefit" in the previous year. If additional funds become available in the pool, these funds would be distributed according to the same methodology as is specified for the Clark County and Washoe pools.

Under the proposed distribution formula, all Rural Public Hospitals would receive the amount of funds they received in SFY 2002 with the exception of South Lyon Medical Center. Because this hospital has a higher uncompensated percentage than the other participants in the pool, all the new funds going to this pool would go to this facility.

For the Rural – Private Hospital Pool, allocations would be made based on the overall size of the hospital. The allocations would be based on their operating revenues. Hospitals with operating revenues of less than $20 million would receive an initial DSH allocation of $115,000. Hospitals reaching the next operating revenue tier of greater than $20 million but less than $50 million would receive $500,000 in DSH distribution. Those hospitals with more than $50 million in operating revenue would receive an initial DSH allocation of $1 million.

After the initial pool allocation, any additional DSH funds received by the hospital pool would be allocated among the pool's hospitals according to the percentage of uncompensated costs, in the same manner as the Clark County and Washoe County pools.

Under this distribution plan, the benefit for Carson - Tahoe Hospital would be $1,000,000; the amount set by the 2001 Legislature in contemplation of their becoming a private facility. The benefit for Churchill Community would be $500,000, the same as the amount for Northeastern Nevada Medical Center, a similar sized facility. While this will result in a smaller payment to Churchill than it has been receiving, Churchill will still receive more than it would have if the current rules regarding private hospitals were applied.

Table 8 provides the summarized results of the proposed DSH allocation methodology. As illustrated in Table 8, the proposed distribution produces a 1% reduction in the Lake Mead Hospital uncompensated cost percentage, a slight increase in Sunrise Hospitals percentage and a slight reduction in UMC's percentage. The distribution formula also produces no change in Washoe County and over a 1.5% reduction in South Lyon's percentage.

In the Rural Private Pool, there would be an increase in the uncompensated care percentage for Carson Tahoe and Churchill (commensurate with their new treatment) and a 10% reduction in the Nye Regional Medical Center uncompensated costs percentage.

Table 8
Comparison of SFY 2002 DSH Net Benefit to Proposed DSH Net Benefits
Individual Hospital DSH Net Benefits

HOSPITAL	SFY 2002		Proposed	
	DSH Net Benefit	Post DSH Percent[1]	DSH Net Benefit	Post DSH Percent [1]
Clark County				
Desert Springs Hospital		3.44%		3.44%
Lake Mead Hospital Medical Center	$677,000	10.80%	$1,203,597	9.73%
Mountain View Hospital		2.21%		2.21%
Saint Rose Dominican Hospital - Rose De Lima		3.78%		3.78%
Summerlin Hospital Medical Center		4.41%		4.41%
Sunrise Hospital & Medical Center	$665,910	1.52%		1.71%
Valley Hospital Medical Center		4.00%		4.00%
Subtotal	**$1,342,910**	**3.17%**	**$ 1,203,597**	**3.19%**
University Medical Center of Southern Nevada	$14,381,729	9.68%	$14,481,729	9.64%
Subtotal	**$14,381,729**	9.68%	**$14,481,729**	9.64%
Subtotal	**$15,724,639**	**4.91%**	**$15,685,326**	4.91%
Washoe County				
Northern Nevada Medical Center		2.01%	-	2.01%
Saint Mary's Regional Medical Center		5.27%	-	5.27%

HOSPITAL	SFY 2002 DSH Net Benefit	SFY 2002 Post DSH Percent[1]	Proposed DSH Net Benefit	Proposed Post DSH Percent [1]
Washoe Medical Center	$3,300,000	6.52%	$ 3,300,000	6.52%
Subtotal	**$3,300,000**	**5.65%**	**$ 3,300,000**	5.65%
Rural - Public				
Humboldt General Hospital	$215,109	6.08%	$ 215,109	6.08%
Mt. Grant General Hospital	$195,838	7.22%	$ 195,838	7.22%
South Lyon Medical Center	$174,417	8.86%	$ 293,150	7.23%
William Bee Ririe Hospital	$204,001	3.34%	$ 204,001	3.34%
Subtotal	**$789,365**	**6.06%**	**$ 908,098**	5.69%
Rural - Private				
Carson Tahoe Hospital	$1,345,287	7.50%	$1,000,000	7.98%
Churchill Community Hospital	$618,733	6.79%	$ 500,000	7.19%
Northeastern Nevada Medical Center	$500,000	12.43%	$ 500,000	12.43%
Nye Regional Medical Center	$111,289	30.76%	$ 456,576	20.28%
Subtotal	**$2,575,309**	**8.94%**	**$2,456,576**	**9.03%**
Total Net Benefit	**$22,389,313**		**$ 22,350,000**	**5.41%**
Other Hospitals				
Grover C. Dils Medical Center	50,000		50,000	
Battle Mountain Hospital	50,000		50,000	
Pershing General Hospital	50,000		50,000	
Subtotal	**150,000**		**150,000**	
Total DSH Dish Net Benefit	**$22,539,313**		**$ 22,500,000**	

[1] Percentages are calculated against SFY 2000 operating revenue and indigent care costs for illustration purposes.

Intergovernmental Transfers

The above distribution only provided for the net benefit to the hospitals. It is also necessary to distribute the DSH funds that will be recovered through the intergovernmental transfers.

In sum, $53.5 million will have to be recovered given the assumptions used in the proposed distribution. This amount represents the $15.5 million required for the state general fund, and $38 million required for the state match.

Because of the current and long standing arrangements between Washoe County and the Washoe Medical Center, it is necessary to continue the $1.5 million transfer in that situation. Other than this case, all other intergovernmental transfers would come from Clark County. Therefore, $52 million would be added to the Clark County Public Pool and $1.5 million would be added to the Washoe County Pool for distribution purposes. Both counties would be required by state law to transfer an identical amount to the state.

This recommended intergovernmental transfer system would comport with the OBRA limits for SFY 2004 and 2005 when the public hospital limit is temporarily set at 175% of the regular OBRA limit. The state will have to monitor Congressional action to ensure that the intergovernmental transfer process remains viable after these dates.

The step by step results of the complete allocation methodology is contained in Schedule 16.

Other Recommendations

During the course of the study, issues emerged that are worthy of attention. This discussion presents those issues together with a recommended course of action.

Standardized format

If the recommended formula is to be used in the future, a recommended format for data collection with a more detailed set of instructions should be developed. Because the request for information for this indigent care study was ad hoc, some hospitals did not have, or were not able to retrieve the information necessary. Going forward, the reporting format should be formalized with attendant instructions. To the extent that hospitals know what is required of them, they will have the capability of complying.

Verification of data submitted

For the purposes of this study, there was neither the time nor the mechanism to verify the data submitted. Again, if the recommended distribution formula is to be adopted, the state should develop steps to ensure that the data submitted is accurate. This would remove the suspicion that emerged during the course of the study that some reported data was inaccurate. These audit criteria should include a set of desk procedures for testing the reasonableness of information as well as formal audit in certain circumstances.

Use of lagged historical data

As discussed in the body of the study, it is recommended that lagged historical data be used in the DSH process. It should be noted that the choice of past reporting year for a current distribution year does not mean that the reporting data is not reflective of indigent care costs for the distribution period, or that using such historical data for the distribution of DSH base on this data would be inaccurate.

This is the situation in most states. If historical data is used, the nuances that develop in the system will catch up over time. Most states are in situations where 2000 data serves as the basis for the distribution of DSH in 2003, then 2001 data is used for distribution in 2004, and 2002 data is used in 2005 and so forth. The major advantage of using this lagged information is that final distribution of a given year's DSH allotment is not dependent upon all actual data for a year to be collected and processed.

DHCFP resources

It is recommended that the Division of Health Care Financing and Policy ("DHCFP") be given sufficient resources to collect and validate all necessary information to administer the DSH program. This particularly relates to data validation. It was observed that some of the data submitted by hospitals for use in the DSH calculation appeared to have errors. In discussions with hospitals, particularly those that had recent turnover in their accounting staffs, there was a lack of awareness of exactly what information was needed and how the data was to be reported. Additional DHCFP resources would help to ensure that DSH funds are distributed accurately and equitably.

Federal funds maximization

There is a possibility that Nevada could increase its expenditures of federal funds at either no additional cost to the state, or, in fact, at a savings of state and local funds. This possibility should be explored in depth.

In examining the indigent costs of the counties for this study, it was noticed that these expenses were unmatched by federal funds. A rough approximation of these expenditures is some $32 million annually. In addition, approximately $14 million in direct county transfers are made to hospitals each year. If these funds could be matched at the regular Nevada Federal Medical Assistance Percentage (FMAP) rate of 50%, either the counties could save half of their current expenditures ($23 million annually), or health care expenditures in the state could increase by $46 million annually, at no additional state or local expense.

It was also discovered during the study that the state has been returning to the federal government unused SCHIP funds. These funds carry with them an enhanced FMAP of 65%. An estimate performed during this study indicated that as much as $45 million in these SCHIP funds may be unspent by the end of FFY 2007. To fully expend these funds, the state would have to commit approximately $24 million of state or local funds.

In order to maximize the federal funds and produce savings, a federal waiver program would have to be designed. To fully maximize the funding, the newly designed program would have to match the eligibility and reimbursement provisions of counties' programs perfectly and would not allow any additional expenditures beyond those being made today.

While such a perfect outcome is doubtful, it is worth investigating the subject in some detail. It may be possible to design a program that would save the counties money, provide for the pregnant women eligibility expansion and asset test elimination presented by DHCFP during the last legislative session, and further expand health care in the state.

The next steps required to develop this concept would be to:

- Document the counties' programs with respect to eligibility levels, reimbursement methodologies and expenditures

- Identify state priorities for a federal waiver

- Prepare a draft concept paper that would present a framework describing:
  - Benefit package
  - Eligibility
  - Service delivery e.g. managed care /other
  - Cost-sharing requirements

- Expose the framework to policy makers and stakeholders

- Develop cost and caseload estimates

- Assess feasibility of initiative

ATTACHMENT 1.0

SECTION 6 AND 7 OF SENATE BILL 377

Sec. 6. 1. The board of county commissioners of a county within which is located only one private hospital or one group of affiliated hospitals and which makes a transfer of money pursuant to paragraph (b) of subsection 1 of NRS 422.382 may impose a tax on the revenue of those hospitals during the fiscal years 2001-2002 and 2002-2003 at a rate that does not exceed 6 percent of that revenue, to pay for indigent care.
2. The proceeds of the tax imposed pursuant to this section are exempt from the limitations imposed by NRS 354.59811 and must be excluded in determining the allowed revenue from taxes ad valorem for the county.

Sec. 7. 1. The legislative committee on health care shall conduct a study of:
(a) The programs conducted in this state for the provision of medical care to Medicaid patients, indigent patients and other low-income patients; and
(b) The methodology used in determining the amount and distribution of payments made to public and private hospitals pursuant to NRS 422.387.
2. The study must review:
(a) The sources of funding used for the provision of medical care to Medicaid patients, indigent patients and other low-income patients, including any applicable federal, state and local governmental programs;
(b) The costs to provide medical care to Medicaid patients, indigent patients and other low-income patients, and the extent to which the sources of funding identified pursuant to paragraph (a) are sufficient to pay those costs;
(c) Whether the payments received by hospitals based on the volume of medical care provided to Medicaid patients, indigent patients and other low-income patients are equitable;
(d) The statewide effect of the provisions of NRS 439B.300 to 439B.340, inclusive, on the provision of medical care to Medicaid patients, indigent patients and other low-income patients;
(e) The policies employed by counties to administer the provisions of NRS 439B.300 to 439B.340, inclusive;
(f) Whether the amendment of the provisions of NRS 439B.300 to 439B.340, inclusive, to provide for a direct tax would enable the state to increase any revenue from other sources for the provision of medical care to Medicaid patients, indigent patients and other low-income patients;
(g) Whether it is feasible for the state to provide for the reimbursement of public hospitals for the provision of medical care to Medicaid patients on a cost basis as a means to increase any revenue from other sources for

the provision of that care;
(h) Whether it is feasible to redistribute payments to increase payments to hospitals located in rural counties, including hospitals that are not currently eligible for payments pursuant to NRS 422.387; and
(i) Alternative methodologies for providing funding for the provision of medical care to Medicaid patients, indigent patients and other low-income patients in Washoe County.
3. The legislative committee on health care shall request such relevant information from public and private hospitals, counties and other entities as is necessary to conduct the study. A hospital, county or other entity that receives such a request from the committee shall provide the appropriate information. Any such information obtained by the committee may be used only for the purpose of conducting the study.

ATTACHMENT 2.0
EXERPTS FROM SECTION 1923 OF THE SOCIAL SECURITY ACT

Low income definition 1923 (b)

"(A) the fraction (expressed as a percentage) –

(i) the numerator of which is the sum (for a period) of (I) the total revenues paid the hospital for patient services under a State plan under this title (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) and (II) the amount of the cash subsidies for patient services received directly from State and local governments, and

(ii) the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of the cash subsidies in the period); and

(B) a fraction (expressed as a percentage)

(i) the numerator of which is the total amount of the hospital's charge for inpatient hospital services which are attributable to charity care in a period less the portion of any cash subsidies described in clause (i)(II) of subparagraph (A) in the period reasonably attributable to inpatient hospital services, and

(ii) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital period.

The numerator under subparagraph (B)(i) shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under a State plan approved under this title).

OBRA Limitation

Section 1923 (c) (1) (A)

(1) AMOUNT OF ADJUSTMENT SUBJECT UNCOMPENSATED COSTS -

(A) IN GENERAL – A payment adjustment during a fiscal year shall not be considered to be consistent with subsection (c) with respect to a hospital if the payment adjustment exceeds the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of

payments under this title, other than under this section, and by uninsured patients) by the hospital to individuals who are either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year. For purposes of the preceding sentence, payments made to a hospital for services provided to indigent patients made by a State or unit of local government within a State shall not be considered to be a source of third party payment.

ATTACHMENT 3.0

DATA COLLECTION

The indigent care hospital work group reached a decision to utilize the Medicare Cost Report for FY 2000 in order to calculate the cost-to-charge ratios and inpatient cost per day used to determine the cost of indigent care. The following worksheets from the Medicare Cost Report are used in the calculations.

- Worksheet C (Computation of Ratio of Cost-To-Charges)
- Worksheet S-3, Part I (Hospital Statistical Data)
- Worksheet A-8 (Adjustments to Expense)
- Worksheet A-8-2 (Provider-Based Physicians Adjustments)
- Worksheet B, Part I (Allocation of General Service Costs)
- Worksheet A (Reclassification and Adjustment of Trial Balance of Expenses)

In addition, it was determined that the hospitals would be required to complete a supplemental form based on Nevada Hospital Quarterly Reports for SFY 2000 that included the following information:

Revenue

- Government Program
  - Medicare Inpatient and Outpatient
  - Medicaid Inpatient and Outpatient
  - Medicaid DSH (net of indigent)
  - County Inpatient
    1. County Indigent Fund
    2. County Accident Fund
    3. County Supplemental Fund
  - County Outpatient
  - Direct Tax Subsidy
  - Other Government subsidized
- Source of Funds (Federal, State, Local)
- Basis For Payment (Direct/Indirect)
- Revenue
- Inpatient Admissions and Days
- Billed Charges

Uncompensated Care

- Inpatient and Outpatient (Direct Payments, Billed Charges)
- Inpatient Admission and Days

A few hospitals that were not eligible for DSH, not opened during SFY 2000, or simply did not report are excluded from the analyses and report.

ATTACHMENT 4.0

METHODOLOGY FOR CALCULATING THE COST OF INDIGENT CARE

The hospital work group determined that directly using the cost-to-charge ratios and the inpatient cost per day from the Medicare Cost Report would not fairly represent the total costs of providing indigent care. Specifically, some costs that are offset or assigned to non-reimbursable cost centers were determined by the work group to be attributable to the provision of indigent care. These costs include provider-based physician (PBP), marketing, telephone & television, therapy & non-physician anesthetist, physician assistant and other costs. These costs are added back to total costs prior to calculating the cost-to-charge ratios and inpatient cost per day.

In addition, the hospital work group determined that Graduate Medical Education (GME), and PBP costs for anesthesiology, trauma and emergency are directly correlated to indigent care. Thus, PBP cost for the applicable cost centers are directly allocated to indigent care. The work group also discussed options for the direct allocation of GME costs, and the hospitals were allowed to vote on this issue. GME costs are allocated to Medicare, Medicaid, and indigent based on days. The resulting portion of Medicaid and indigent GME costs are directly allocated to indigent care. These costs are directly added to indigent care, after applying cost-to-charge ratios and inpatient costs per day to determine indigent care costs.

The work group identified two methodologies for determining indigent care inpatient costs and one methodology for outpatient. The hospitals were allowed to vote which inpatient calculation they preferred. The results were a fairly even split so it was decided to calculate inpatient indigent costs using both methodologies. The two inpatient methods are:

- ❑ Inpatient cost-to-charge ratios
- ❑ Inpatient costs per day

This section of the report describes the methodology for the two inpatient calculation options and the outpatient cost calculation method. The section also addresses directly allocated costs and adjustments to costs that are added back to Medicare to derive total costs. While subproviders who are not traditionally defined as inpatient hospital are excluded e.g. nursing facility, home health, rehabilitation hospital subproviders and psychiatric hospital subproviders were included. The total inpatient hospital cost-to-charge ratios include these subproviders.

The calculations begin with Worksheet C, Computation of Ratio of Cost to Charges. The methodology described here assumes that all providers are subject to PPS reimbursement. The next section provides an overview of the methodology for calculating and applying cost-to-charge ratios to determine the inpatient and outpatient indigent cost of providing services.

Total Costs on Worksheet (W/S) C, Part I, Computation of Ratio of Cost to Charges and Additional Adjustments

Column 3 Total Costs (From W/S B, Part I, Col. 27)

Used as the basis for total cost pool for each revenue center in the calculation of individual cost-to-charge ratios and includes/excludes the following:

1. Includes total expenses for each cost center from provider's trial balance of expenses (includes salaries and other).

2. Includes net allocation of General Service Costs attributable to each cost center.

3. For purposes of determining the total cost of indigent care, Lines 34 SNF, 35 Other Nursing Facility and 36 Other Long Term Care will be excluded from the total cost pool.

Adjustments to total cost pool from W/S C, Column 3:

4. Add back provider-based physician (PBP) adjustment to total cost pool for each applicable revenue center from W/S A-8-2, Column 18. For A-8-2 adjustments that are related to non-revenue cost centers, accumulate these costs into a separate cost pool, i.e. "additional costs." *(Note: Column 5 of W/S C only includes RCE Disallowance, not total PBP cost adjustments.)*

5. Add-back costs eliminated from the Medicare Cost Report on W/S A-8 that are directly or indirectly related to patient care to total cost pool for each applicable revenue center, which may include the following:

   - Line 9 Telephone Services
   - Line 10 Television and Radio Services
   - Line 11 Parking Lot
   - Line 15 Laundry and Linen Service
   - Line 16 Cafeteria-Employees and Guests
   - Line 25 Adjustment for Respiratory Therapy Costs
   - Line 26 Adjustment for Physical Therapy Costs
   - Line 33 Non-Physician Anesthetist
   - Line 34 Physician's Assistant
   - Line 35 Adjustment for Occupational Therapy Costs
   - Line 36 Adjustment for Speech Pathology Costs
   - Line 37 Other Adjustment (Directly or Indirectly Related to Patient Care)

   For A-8 adjustments that are related to non-revenue cost centers, accumulate these costs and add to separate cost pool of additional costs.

6. Add costs reported on W/S A, Non-Reimbursable Cost Centers (Marketing), Column 7, Line 98 to separate cost pool of additional costs. Marketing may be included as an offset to cost on W/S A-8.

7. To insure no duplication of costs, any costs directly allocated to indigent care should be excluded from the W/S C cost pool (Column 3 adjusted) prior to determining all cost-to-charge ratios and the inpatient cost per day.

Total Charges on Worksheet C, Part I

Column 6 Total Inpatient Charges

1. Includes total inpatient gross patient charges for each revenue center.

2. For purposes of determining the total cost of indigent care, Lines 34 SNF, 35 Other Nursing Facility and 36 Other Long Term Care will be excluded from total charges.

Column 7 Total Outpatient Charges

1. Includes total outpatient gross patient charges for each revenue center.
2. For purposes of determining the total cost of indigent care, Lines 34 SNF, 35 Other Nursing Facility and 36 Other Long Term Care will be excluded from total charges.

Cost-to-Charge Ratios

A. Individual Cost-to-Charge Ratios

The individual cost-to-charge ratio for each revenue center is used to determine adjusted inpatient and outpatient costs for inclusion in the calculation of total inpatient and outpatient cost-to-charge ratios.

1. Individual cost-to-charge ratios are calculated by dividing total adjusted costs from each revenue center (net of directly allocated costs and other cost adjustments noted above) by total charges from W/S C, Column 8, for the following revenue centers:

   - 25 Adults and Pediatrics
   - 26 Intensive Care Unit
   - 27 Coronary Care Unit
   - 28 Burn Intensive Care Unit
   - 29 Surgical Intensive Care Unit
   - 30 Other Special Care
   - 31 Subprovider

- ❑ 33 Nursery
- ❑ 37 Operating Room
- ❑ 38 Recovery Room
- ❑ 39 Delivery Room and Labor Room
- ❑ 40 Anesthesiology
- ❑ 41 Radiology-Diagnostic
- ❑ 42 Radiology-Therapeutic
- ❑ 43 Radioisotope
- ❑ 44 Laboratory
- ❑ 46 Whole Blood & Packed Red Blood Cells
- ❑ 47 Blood Storing, Processing and Trans.
- ❑ 48 Intravenous Therapy
- ❑ 49 Respiratory Therapy
- ❑ 50 Physical Therapy
- ❑ 51 Occupational Therapy
- ❑ 52 Speech Pathology
- ❑ 53 Electrocardiology
- ❑ 54 Eletroencephalography
- ❑ 55 Medical Supplies Charged to Patients
- ❑ 56 Drugs Charged to Patients
- ❑ 57 Renal Dialysis
- ❑ 58 ASC (Non-Distinct Part)
- ❑ 59 Other Ancillary
- ❑ 60 Clinic
- ❑ 61 Emergency
- ❑ 62 Observation Beds
- ❑ 63 Other Outpatient Service
- ❑ 64 Home Program Dialysis
- ❑ 65 Ambulance Services
- ❑ 66 Durable Medical Equipment-Rented
- ❑ 67 Durable Medical Equipment-Sold
- ❑ 68 Other Reimbursable Cost Centers

2. Multiply the individual cost-to-charge ratios by W/S C, Column 6, Inpatient Charges, and Column 7, Outpatient Charges to determine inpatient and outpatient costs for each applicable revenue center.

B. ***Cost-to-Charge Ratio for Additional Costs***

The cost-to-charge ratio for additional costs is used to determine the addition to the total inpatient and outpatient cost-to-charge ratios for A-8 and A-8-2 adjustments that are related to non-revenue cost centers included in the separate cost pool of additional costs.

1. The cost-to-charge ratio for additional costs is calculated by dividing total additional costs from each non-revenue center by total charges from W/S C, Column 8.

2. Add the cost-to-charge ratio for additional costs to both the total inpatient and outpatient cost-to-charge ratio bases to determine the overall inpatient and outpatient cost-to-charge ratios.

C. ***Total Inpatient Cost-to-Charge Ratio (Includes Inpatient Routine and Ancillary Services Revenue Centers for the hospital and hospital rehabilitation and psychiatric subproviders – this requires addition of the Worksheet C data for the hospital subproviders)***

1. Divide the sum of inpatient costs by the sum of inpatient charges to determine the basis for the inpatient cost-to-charge ratio.

2. Add the cost-to-charge ratio for additional costs to the basis to determine the overall inpatient cost-to-charge-ratio.

D. ***Total Outpatient Cost-to-Charge Ratio (Includes Outpatient and Ancillary Services Revenue Centers)***

1. Divide the sum of outpatient costs by the sum of outpatient charges to determine the basis for the outpatient cost-to-charge ratio.

2. Add the cost-to-charge ratio for additional costs to the basis to determine the overall outpatient cost-to-charge-ratio.

The resulting overall inpatient cost-to-charge ratio is multiplied times indigent care charges for SFY 2000, as reported by the hospitals, to determine inpatient indigent care costs. The resulting overall outpatient cost-to-charge ratio is multiplied times indigent care outpatient charges for the same time period, as reported by the hospital, to determine indigent care outpatient costs.

The next section provides an overview of an alternative methodology for calculating and applying inpatient cost per day to determine the indigent inpatient cost of providing services.

Inpatient Cost per Day to Determine Total Inpatient Costs in Lieu of I/P Cost-to-Charge Ratio

A. ***Inpatient Cost per Day***

1. An overall inpatient cost per day is calculated by taking the sum of adjusted inpatient routine and ancillary costs plus additional inpatient costs, noted in

#2, divided by inpatient routine days from W/S S-3, Part I, Column 6 for the following.

- Adults and Pediatrics
- Intensive Care Unit
- Coronary Care Unit
- Burn Intensive Care Unit
- Surgical Intensive Care Unit
- Other Special Care
- Subprovider

(Note: Nursery days are excluded from calculation of inpatient cost per day.)

2. Additional inpatient costs are calculated by multiplying the separate cost pool for additional costs by the ratio of inpatient charges to total charges from W/S C. Additional inpatient costs are added to the adjusted inpatient routine and ancillary costs to determine the overall inpatient cost per day.

3. Inpatient indigent costs are calculated by multiplying indigent days by the overall inpatient cost per day.

The next section provides an overview of the adjustments to gross indigent costs necessary to determine the overall total cost of indigent care.

Direct Allocations to the Total Cost of Indigent Care

The following costs should be directly allocated to the gross cost of indigent care. *As noted above, directly allocated costs should be excluded from the W/S C total cost pool used to calculate cost-to-charge ratios.*

A. *Graduate Medical Education (GME) Costs*

1. Determine total costs for GME.

   - Total costs from W/S B Part I, Allocation of General Service Costs, Column 22 (Interns and Residents Salary & Fringes) and Column 23 (Interns and Residents Program Costs), for each applicable line.

2. Find the ratio of program days for Medicare, Medicaid, and indigent days from the supplemental schedules, to the sum of Medicare, Medicaid and indigent days.

3. Apply the ratio of program days from Step 2 to GME total costs from Step 1 to allocate GME Costs to Medicare, Medicaid and indigent.

4. Add allocated GME costs of indigent and Medicaid from Step 3 to the gross cost of indigent care.

B. *Provider-Based Physician Costs*

The direct allocation of provider-based physician costs reported on W/S A-8-2, for specific cost centers, is necessary for the purpose of determining the total cost of providing indigent care.

1. Add the total physician compensation for professional services for Column 1, W/S A Line Number, Lines 40 Anesthesiology, 61 Emergency and 63 Trauma, from Column 4, Professional Component, of W/S A-8-2 Provider-Based Physician Adjustments, to the gross cost of indigent care.

Inflation

Inflation or deflation of data from the Medicare Cost Report to adjust hospitals' data, based on varying fiscal year ends, to SFY 2000 is not necessary. The data from the cost report is used only to calculate the cost-to-charge ratios and inpatient costs per day. The cost-to-charge ratios and inpatient costs per day are then applied to the Medicaid, county indigent, and uncompensated care charges and days data from the supplemental forms supplied by the hospital, based on Nevada Hospital Quarterly Reports from SFY 2000, to determine indigent care costs.

State Of Nevada
Indigent Care Provided By Hospitals
Total Gross Indigent Care Costs
State Fiscal Year Ending June 30, 2000

Schedule 1

	HOSPITAL	Medicaid Inpatient	Medicaid Outpatient	Uncomp. Care - I/P	Uncomp. Care - O/P	Other Inpatient	Other Outpatient	GME	PBP	Gross Cost Of Indigent Care
	Clark County									
Private	Desert Springs Hospital	1,902,709	286,210	3,299,786	546,427	0	0	0	0	6,035,132
Private	Lake Mead Hospital Medical Center	7,914,866	563,216	2,810,402	1,502,734	0	0	0	0	12,791,217
Private	MountainView Hospital	1,285,269	185,459	1,171,684	394,401	0	0	0	0	3,036,812
Pri-NFP	Saint Rose Dominican Hospital - Rose De Lima	1,665,553	509,905	3,215,775	0	0	0	0	0	5,391,234
Private	Summerlin Hospital Medical Center	963,236	179,823	2,055,887	473,989	0	0	0	0	3,672,935
Private	Sunrise Hospital & Medical Center	16,517,885	1,939,984	5,182,445	2,382,930	0	0	0	0	26,023,244
Public	University Medical Center of Southern Nevada	42,747,954	10,201,942	34,089,492	22,193,382	2,008,609	0	6,696,597	4,260,518	122,198,493
Private	Valley Hospital Medical Center	5,027,729	566,787	5,225,565	776,175	0	0	0	0	11,596,257
	Subtotal	78,025,201	14,433,327	57,051,036	28,270,036	2,008,609	0	6,696,597	4,260,518	190,745,324
	Washoe County									
Private	Northern Nevada Medical Center	432,680	108,760	490,246	567,146	0	0	0	0	1,598,833
Pri-NFP	Saint Mary's Regional Medical Center	5,585,847	1,673,135	6,607,930	440,106	375,248	0	0	120,000	14,802,266
Pri-NFP	Washoe Medical Center	19,471,774	0	15,285,386	0	6,694,316	0	1,325,393	0	42,776,869
	Subtotal	25,490,302	1,781,895	22,383,562	1,007,252	7,069,564	0	1,325,393	120,000	59,177,968
	Rural - Public									
Public	Humboldt General Hospital	626,361	0	1,273,869	1,206,301	0	0	0	114,368	3,220,898
Public	Mt. Grant General Hospital	67,657	224,466	103,757	114,440	0	0	0	214,782	725,103
Public	South Lyon Medical Center	12,551	260,856	72,844	430,611	0	0	0	388,444	1,165,306
Public	William Bee Ririe Hospital	353,925	349,448	175,657	155,831	0	0	0	0	1,034,862
	Subtotal	1,060,494	834,771	1,626,128	1,907,183	0	0	0	717,594	6,146,169
	Rural - Private									
Pri-NFP	Carson Tahoe Hospital	1,588,196	0	3,868,510	2,385,895	0	0	0	2,987,392	10,829,993
Private	Churchill Community Hospital	1,086,281	0	784,667	1,727,832	0	0	0	0	3,598,780
Private	Northeastern Nevada Medical Center	1,162,555	598,079	5,357,591	0	0	0	0	19,600	7,137,824
Private	Nye Regional Medical Center	43,932	136,435	108,525	347,733	0	12,581	0	696,109	1,345,314
	Subtotal	3,880,964	734,514	10,119,294	4,461,459	0	12,581	0	3,703,101	22,911,912
	Total	108,456,961	17,784,507	91,180,019	35,645,930	9,078,173	12,581	8,021,989	8,801,213	278,981,373

State Of Nevada
Indigent Care Provided By Hospitals
Cost of Indigent Care Net of Medicaid Payments
State Fiscal Year Ending June 30, 2000

Schedule 2A

	HOSPITAL	Medicaid Inpatient	Medicaid Outpatient	Uncomp. Care - I/P	Uncomp. Care - O/P	Other Inpatient	Other Outpatient	GME	PBP	Net Cost Of Indigent Care
	Clark County									
Private	Desert Springs Hospital	52,314	0	3,299,786	546,427	0	0	0	0	3,898,526
Private	Lake Mead Hospital Medical Center	1,394,271	563,216	2,810,402	1,502,734	0	0	0	0	6,270,622
Private	MountainView Hospital	4,795	3,147	1,171,684	394,401	0	0	0	0	1,574,026
Pri-NFP	Saint Rose Dominican Hospital - Rose De Lima	0	0	3,215,775	0	0	0	0	0	3,215,775
Private	Summerlin Hospital Medical Center	267,259	0	2,055,887	473,989	0	0	0	0	2,797,135
Private	Sunrise Hospital & Medical Center	871,888	254,018	5,182,445	2,382,930	0	0	0	0	8,691,281
Public	University Medical Center of Southern Nevada	721,034	4,477,161	34,089,492	22,193,382	2,008,609	0	6,696,597	4,260,518	74,446,792
Private	Valley Hospital Medical Center	105,901	0	5,225,565	776,175	0	0	0	0	6,107,641
	Subtotal	3,417,462	5,297,542	57,051,036	28,270,036	2,008,609	0	6,696,597	4,260,518	107,001,799
	Washoe County									
Private	Northern Nevada Medical Center	85,020	58,938	490,246	567,146	0	0	0	0	1,201,351
Pri-NFP	Saint Mary's Regional Medical Center	2,062,065	568,632	6,607,930	440,106	375,248	0	0	120,000	10,173,981
Pri-NFP	Washoe Medical Center	2,524,676	0	15,285,386	0	6,694,316	0	1,325,393	0	25,829,771
	Subtotal	4,671,762	627,570	22,383,562	1,007,252	7,069,564	0	1,325,393	120,000	37,205,103
	Rural - Public									
Public	Humboldt General Hospital	78,389	0	1,273,869	1,206,301	0	0	0	114,368	2,672,926
Public	Mt. Grant General Hospital	14,112	107,183	103,757	114,440	0	0	0	214,782	554,275
Public	South Lyon Medical Center	0	67,207	72,844	430,611	0	0	0	388,444	959,106
Public	William Bee Ririe Hospital	14,516	179,927	175,657	155,831	0	0	0	0	525,932
	Subtotal	107,017	354,318	1,626,128	1,907,183	0	0	0	717,594	4,712,239
	Rural - Private									
Pri-NFP	Carson Tahoe Hospital	286,725	0	3,868,510	2,385,895	0	0	0	2,987,392	9,528,522
Private	Churchill Community Hospital	180,436	0	784,667	1,727,832	0	0	0	0	2,692,935
Private	Northeastern Nevada Medical Center	379,466	185,657	5,357,591	0	0	0	0	19,600	5,942,313
Private	Nye Regional Medical Center	29,812	85,774	108,525	347,733	0	12,581	0	696,109	1,280,533
	Subtotal	876,439	271,430	10,119,294	4,461,459	0	12,581	0	3,703,101	19,444,304
	Total	9,072,680	6,550,860	91,180,019	35,645,930	9,078,173	12,581	8,021,989	8,801,213	168,363,446

State Of Nevada
Indigent Care Provided By Hospitals
OBRA Limitation By Component of Indigent Care
State Fiscal Year Ending June 30, 2000

Schedule 2B

	HOSPITAL	Net Medicaid Inpatient	Net Medicaid Outpatient	Uncompensated Care - I/P	Uncompensated Care - O/P	Other Inpatient	Other Outpatient	GME	PBP	OBRA Limitation
	Clark County									
Public	University Medical Center of Southern Nevada	721,034	4,477,161	34,089,492	22,193,382	2,008,609	0	1,308,076	832,226	65,629,979
Private	Sunrise Hospital & Medical Center	871,888	254,018	5,182,445	2,382,930	0	0			8,691,281
Private	Lake Mead Hospital Medical Center	1,394,271	563,216	2,810,402	1,502,734	0	0			6,270,622
Private	Valley Hospital Medical Center	105,901	0	5,225,565	776,175	0	0			6,107,641
Private	Desert Springs Hospital	52,314	0	3,299,786	546,427	0	0			3,898,526
Pri-NFP	Saint Rose Dominican Hospital - Rose De Lima	0	0	3,215,775	0	0	0			3,215,775
Private	Summerlin Hospital Medical Center	267,259	0	2,055,887	473,989	0	0			2,797,135
Private	MountainView Hospital	4,795	3,147	1,171,684	394,401	0	0			1,574,026
	Subtotal	3,417,462	5,297,542	57,051,036	28,270,036	2,008,609	0	1,308,076	832,226	98,184,986
	Washoe County									
Pri-NFP	Washoe Medical Center	2,524,676	0	15,285,386	0	6,694,316	0	172,329		24,676,707
Pri-NFP	Saint Mary's Regional Medical Center	2,062,065	568,632	6,607,930	440,106	375,248	0		6,875	10,060,856
Private	Northern Nevada Medical Center	85,020	58,938	490,246	567,146	0	0			1,201,351
	Subtotal	4,671,762	627,570	22,383,562	1,007,252	7,069,564	0	172,329	6,875	35,938,915
	Rural - Public									
Public	Humboldt General Hospital	78,389	0	1,273,869	1,206,301	0	0		17,112	2,575,671
Public	South Lyon Medical Center	0	67,207	72,844	430,611	0	0		13,722	584,384
Public	Mt. Grant General Hospital	14,112	107,183	103,757	114,440	0	0		15,787	355,281
Public	William Bee Ririe Hospital	14,516	179,927	175,657	155,831	0	0		0	525,932
	Subtotal	107,017	354,318	1,626,128	1,907,183	0	0	0	46,622	4,041,267
	Rural - Private									
Pri-NFP	Carson Tahoe Hospital	286,725	0	3,868,510	2,385,895	0	0		192,109	6,733,239
Private	Elko General Hospital	379,466	185,657	5,357,591	0	0	0		2,224	5,924,937
Private	Churchill Community Hospital	180,436	0	784,667	1,727,832	0	0			2,692,935
Private	Nye Regional Medical Center	29,812	85,774	108,525	347,733	0	12,581		96,465	680,889
	Subtotal	876,439	271,430	10,119,294	4,461,459	0	12,581	0	290,797	16,032,001
	Total	9,072,680	6,550,860	91,180,019	35,645,930	9,078,173	12,581	1,480,405	1,176,520	154,197,168

State Of Nevada
Indigent Care Provided By Hospitals
Comparison Of Indigent Care Costs From Schedule 2A To Operating Revenues
State Fiscal Year Ending June 30, 2000

Schedule 3

HOSPITAL	Operating Revenue	Indigent Care Costs	Percentage
Clark County			
Desert Springs Hospital	110,360,002	3,898,526	3.53%
Lake Mead Hospital Medical Center	49,441,864	6,270,622	12.68%
MountainView Hospital	70,906,677	1,574,026	2.22%
Saint Rose Domincan Hospital - Rose De Lima	63,181,622	3,215,775	5.09%
Summerlin Hospital Medical Center	63,355,770	2,797,135	4.41%
Sunrise Hospital & Medical Center	351,151,349	8,691,281	2.48%
University Medical Center of Southern Nevada	313,825,863	74,446,792	23.72%
Valley Hospital Medical Center	152,586,589	6,107,641	4.00%
subtotal	1,174,809,736	107,001,799	9.11%
Washoe County			
Northern Nevada Medical Center	33,597,029	1,201,351	3.58%
Saint Mary's Regional Medical Center	156,941,480	10,173,981	6.48%
Washoe Medical Center	209,717,488	25,829,771	12.32%
subtotal	400,255,997	37,205,103	9.30%
Rural - Public			
Humboldt General Hospital	10,078,239	2,672,926	26.52%
Mt. Grant General Hospital	4,691,934	554,275	11.81%
South Lyon Medical Center	7,281,090	959,106	13.17%
William Bee Ririe Hospital	9,528,715	525,932	5.52%
subtotal	31,579,978	4,712,239	14.92%
Rural - Private			
Carson Tahoe Hospital	72,034,881	9,528,522	13.23%
Churchill Community Hospital	29,113,528	2,692,935	9.25%
Northeastern Nevada Medical Center	26,918,175	5,942,313	22.08%
Nye Regional Medical Center	3,297,084	1,280,533	38.84%
subtotal	131,363,668	19,444,304	14.80%
Total	1,738,009,379	168,363,446	9.69%

Note: Costs shown are before any payments from Counties or state, other than Medicaid payments. Medicaid amounts are calculated net of payments. Disproportionate Share payments are not considered.

State Of Nevada
Indigent Care Provided By Hospitals
Components of Indigent Care Costs, Net of Payments
State Fiscal Year Ending June 30, 2000

Schedule 4

	HOSPITAL	Medicaid Inpatient	Medicaid Outpatient	Uncomp. Care - I/P	Uncomp. Care - O/P	Other Inpatient	Other Outpatient	GME	PBP	Less: Other Revenue	Net Cost Of Indigent Care
	Clark County										
Private	Desert Springs Hospital	52,314	0	3,192,414	546,427	0	0	0	0	0	3,791,154
Private	Lake Mead Hospital Medical Center	1,394,271	563,216	2,564,701	1,492,650	0	0	0	0	0	6,014,837
Private	MountainView Hospital	4,795	3,147	1,168,859	393,441	0	0	0	0	0	1,570,241
Pri-NFP	Saint Rose Dominican Hospital - Rose De Lima	0	0	2,388,533	0	0	0	0	0	0	2,388,533
Private	Summerlin Hospital Medical Center	267,259	0	2,055,887	473,989	0	0	0	0	0	2,797,135
Private	Sunrise Hospital & Medical Center	871,888	254,018	2,509,766	2,369,260	0	0	0	0	0	6,004,932
Public	University Medical Center of Southern Nevada	721,034	4,477,161	15,344,254	12,868,459	379,902	0	6,696,597	4,260,518	13,653,951	31,093,973
Private	Valley Hospital Medical Center	105,901	0	5,225,565	776,175	0	0	0	0	0	6,107,641
	subtotal	3,417,462	5,297,542	34,449,979	18,920,399	379,902	0	6,696,597	4,260,518	13,653,951	59,768,447
	Washoe County										
Private	Northern Nevada Medical Center	85,020	58,938	355,702	175,800	0	0	0	0	0	675,461
Pri-NFP	Saint Mary's Regional Medical Center	2,062,065	568,632	5,486,645	0	34,107	0	0	120,000	0	8,271,449
Pri-NFP	Washoe Medical Center	2,524,676	0	12,211,601	0	913,792	0	1,325,393	0	0	16,975,462
	Subtotal	4,671,762	627,570	18,053,948	175,800	947,899	0	1,325,393	120,000	0	25,922,372
	Rural - Public										
Public	Humboldt General Hospital	78,389	0	387,962	247,584	0	0	0	114,368	0	828,302
Public	Mt. Grant General Hospital	14,112	107,183	100,841	97,658	0	0	0	214,782	551,029	-16,452
Public	South Lyon Medical Center	0	67,207	70,050	293,979	0	0	0	388,444	398,854	420,826
Public	William Bee Ririe Hospital	14,516	179,927	175,046	152,371	0	0	0	0	1,233,529	-711,668
	Subtotal	107,017	354,318	733,900	791,592	0	0	0	717,594	2,183,412	521,008
	Rural - Private										
Pri-NFP	Carson Tahoe Hospital	286,725	0	2,450,876	1,025,265	0	0	0	2,987,392	0	6,750,258
Private	Churchill Community Hospital	180,436	0	722,313	1,691,708	0	0	0	0	0	2,594,457
Private	Northeastern Nevada Medical Center	379,466	185,657	3,260,419	0	0	0	0	19,600	0	3,845,141
Private	Nye Regional Medical Center	29,812	85,774	76,539	229,326	0	7,825	0	696,109	0	1,125,384
	Subtotal	876,439	271,430	6,510,148	2,946,298	0	7,825	0	3,703,101	0	14,315,241
	Total	9,072,680	6,550,860	59,747,974	22,834,089	1,327,801	7,825	8,021,989	8,801,213	15,837,363	100,527,068

State Of Nevada
Indigent Care Provided By Hospitals
Comparison of Indigent Care Costs from Schedule 4 to Operating Revenues
State Fiscal Year Ending June 30, 2000

Schedule 5A

HOSPITAL	Operating Revenue	Net Indigent Care Costs	Percentage
Clark County			
Desert Springs Hospital	110,360,002	3,791,154	3.44%
Lake Mead Hospital Medical Center	49,441,864	6,014,837	12.17%
MountainView Hospital	70,906,677	1,570,241	2.21%
Saint Rose Domincan Hospital - Rose De Lima	63,181,622	2,388,533	3.78%
Summerlin Hospital Medical Center	63,355,770	2,797,135	4.41%
Sunrise Hospital & Medical Center	351,151,349	6,004,932	1.71%
University Medical Center of Southern Nevada	313,825,863	31,093,973	9.91%
Valley Hospital Medical Center	152,586,589	6,107,641	4.00%
Subtotal	1,174,809,736	59,768,447	5.09%
Washoe County			
Northern Nevada Medical Center	33,597,029	675,461	2.01%
Saint Mary's Regional Medical Center	156,941,480	8,271,449	5.27%
Washoe Medical Center	209,717,488	16,975,462	8.09%
Subtotal	400,255,997	25,922,372	6.48%
Rural - Public			
Humboldt General Hospital	10,078,239	828,302	8.22%
Mt. Grant General Hospital	4,691,934	-16,452	-0.35%
South Lyon Medical Center	7,281,090	420,826	5.78%
William Bee Ririe Hospital	9,528,715	-711,668	-7.47%
Subtotal	31,579,978	521,008	1.65%
Rural - Private			
Carson Tahoe Hospital	72,034,881	6,750,258	9.37%
Churchill Community Hospital	29,113,528	2,594,457	8.91%
Northeastern Nevada Medical Center	26,918,175	3,845,141	14.28%
Nye Regional Medical Center	3,297,084	1,125,384	34.13%
Subtotal	131,363,668	14,315,241	10.90%
Total	1,738,009,379	100,527,068	5.78%

State Of Nevada
Indigent Care Provided By Hospitals
Comparison of Indigent Care Costs, excluding Direct Tax Subsidies, to Operating Revenues
State Fiscal Year Ending June 30, 2000

Schedule 5B

HOSPITAL	Operating Revenue	Net Indigent Care Costs	Percentage
Clark County			
Desert Springs Hospital	110,360,002	3,791,154	3.44%
Lake Mead Hospital Medical Center	49,441,864	6,014,837	12.17%
MountainView Hospital	70,906,677	1,570,241	2.21%
Saint Rose Domincan Hospital - Rose De Lima	63,181,622	2,388,533	3.78%
Summerlin Hospital Medical Center	63,355,770	2,797,135	4.41%
Sunrise Hospital & Medical Center	351,151,349	6,004,932	1.71%
University Medical Center of Southern Nevada	313,825,863	44,747,924	14.26%
Valley Hospital Medical Center	152,586,589	6,107,641	4.00%
Subtotal	1,174,809,736	73,422,398	6.25%
Washoe County			
Northern Nevada Medical Center	33,597,029	675,461	2.01%
Saint Mary's Regional Medical Center	156,941,480	8,271,449	5.27%
Washoe Medical Center	209,717,488	16,975,462	8.09%
Subtotal	400,255,997	25,922,372	6.48%
Rural - Public			
Humboldt General Hospital	10,078,239	828,302	8.22%
Mt. Grant General Hospital	4,691,934	534,577	11.39%
South Lyon Medical Center	7,281,090	819,680	11.26%
William Bee Ririe Hospital	9,528,715	521,861	5.48%
Subtotal	31,579,978	2,704,420	8.56%
Rural - Private			
Carson Tahoe Hospital	72,034,881	6,750,258	9.37%
Churchill Community Hospital	29,113,528	2,594,457	8.91%
Northeastern Nevada Medical Center	26,918,175	3,845,141	14.28%
Nye Regional Medical Center	3,297,084	1,125,384	34.13%
Subtotal	131,363,668	14,315,241	10.90%
Total	1,738,009,379	116,364,431	6.70%

State Of Nevada
Indigent Care Provided By Hospitals
Comparison of Indigent Care Costs, Net of DSH, to Operating Revenues
State Fiscal Year Ending June 30, 2000

Schedule 6A

HOSPITAL	Operating Revenue	Net Indigent Care Costs	SFY 2000 DSH Benefit	Costs Net of DSH Benefit	Percentage
Clark County					
Desert Springs Hospital	110,360,002	3,791,154		3,791,154	3.44%
Lake Mead Hospital Medical Center	49,441,864	6,014,837	59,740	5,955,097	12.04%
MountainView Hospital	70,906,677	1,570,241		1,570,241	2.21%
Saint Rose Dominican Hospital - Rose De Lima	63,181,622	2,388,533		2,388,533	3.78%
Summerlin Hospital Medical Center	63,355,770	2,797,135		2,797,135	4.41%
Sunrise Hospital & Medical Center	351,151,349	6,004,932		6,004,932	1.71%
University Medical Center of Southern Nevada	313,825,863	31,093,973	14,363,888	16,730,085	5.33%
Valley Hospital Medical Center	152,586,589	6,107,641		6,107,641	4.00%
Subtotal	1,174,809,736	59,768,447	14,423,628	45,344,819	3.86%
Washoe County					
Northern Nevada Medical Center	33,597,029	675,461		675,461	2.01%
Saint Mary's Regional Medical Center	156,941,480	8,271,449		8,271,449	5.27%
Washoe Medical Center	209,717,488	16,975,462	3,250,000	13,725,462	6.54%
Subtotal	400,255,997	25,922,372	3,250,000	22,672,372	5.66%
Rural - Public					
Humboldt General Hospital	10,078,239	828,302	175,267	653,035	6.48%
Mt. Grant General Hospital	4,691,934	-16,452	114,016	-130,468	-2.78%
South Lyon Medical Center	7,281,090	420,826	166,907	253,919	3.49%
William Bee Ririe Hospital	9,528,715	-711,668	162,174	-873,842	-9.17%
Subtotal	31,579,978	521,008	618,364	-97,356	-0.31%
Rural - Private					
Carson Tahoe Hospital	72,034,881	6,750,258	1,388,714	5,361,544	7.44%
Churchill Community Hospital	29,113,528	2,594,457	681,036	1,913,421	6.57%
Northeastern Nevada Medical Center	26,918,175	3,845,141	500,000	3,345,141	12.43%
Nye Regional Medical Center	3,297,084	1,125,384	83,062	1,042,322	31.61%
Subtotal	131,363,668	14,315,241	2,652,812	11,662,429	8.88%
Total	1,738,009,379	100,527,068	20,944,804	79,582,264	4.58%

State Of Nevada
Indigent Care Provided By Hospitals
Comparison of Indigent Care Costs, Net of DSH, but Excluding Direct Tax Subsidies, to Operating Revenues
State Fiscal Year Ending June 30, 2000

Schedule 6B

HOSPITAL	Operating Revenue	Net Indigent Care Costs	SFY 2000 DSH Benefit	Costs Net of DSH Benefit	Percentage
Clark County					
Desert Springs Hospital	110,360,002	3,791,154		3,791,154	3.44%
Lake Mead Hospital Medical Center	49,441,864	6,014,837	59,740	5,955,097	12.04%
MountainView Hospital	70,906,677	1,570,241		1,570,241	2.21%
Saint Rose Domincan Hospital - Rose De Lima	63,181,622	2,388,533		2,388,533	3.78%
Summerlin Hospital Medical Center	63,355,770	2,797,135		2,797,135	4.41%
Sunrise Hospital & Medical Center	351,151,349	6,004,932		6,004,932	1.71%
University Medical Center of Southern Nevada	313,825,863	44,747,924	14,363,888	30,384,036	9.68%
Valley Hospital Medical Center	152,586,589	6,107,641		6,107,641	4.00%
Subtotal	1,174,809,736	73,422,398	14,423,628	58,998,770	5.02%
Washoe County					
Northern Nevada Medical Center	33,597,029	675,461		675,461	2.01%
Saint Mary's Regional Medical Center	156,941,480	8,271,449		8,271,449	5.27%
Washoe Medical Center	209,717,488	16,975,462	3,250,000	13,725,462	6.54%
Subtotal	400,255,997	25,922,372	3,250,000	22,672,372	5.66%
Rural - Public					
Humboldt General Hospital	10,078,239	828,302	175,267	653,035	6.48%
Mt. Grant General Hospital	4,691,934	534,577	114,016	420,561	8.96%
South Lyon Medical Center	7,281,090	819,680	166,907	652,773	8.97%
William Bee Ririe Hospital	9,528,715	521,861	162,174	359,687	3.77%
Subtotal	31,579,978	2,704,420	618,364	2,086,056	6.61%
Rural - Private					
Carson Tahoe Hospital	72,034,881	6,750,258	1,388,714	5,361,544	7.44%
Churchill Community Hospital	29,113,528	2,594,457	681,036	1,913,421	6.57%
Northeastern Nevada Medical Center	26,918,175	3,845,141	500,000	3,345,141	12.43%
Nye Regional Medical Center	3,297,084	1,125,384	83,062	1,042,322	31.61%
Subtotal	131,363,668	14,315,241	2,652,812	11,662,429	8.88%
Total	1,738,009,379	116,364,431	20,944,804	95,419,627	5.49%

State Of Nevada
Indigent Care Provided By Hospitals
Calculation of Net Uncompensated Cost for Medicaid Inpatients
State Fiscal Year Ending June 30, 2000

Schedule 7

HOSPITAL	BILLED CHARGES	MEDICAID INPATIENT COST OF CARE	PAYMENTS	NET
Clark County				
Desert Springs Hospital	6,256,292	1,902,709	1,850,395	52,314
Lake Mead Hospital Medical Center	33,852,742	7,914,866	6,520,595	1,394,271
MountainView Hospital	4,422,951	1,285,269	1,280,474	4,795
Saint Rose Domincan Hospital - Rose De Lima	5,129,366	1,665,553	1,987,995	0
Summerlin Hospital Medical Center	2,879,011	963,236	695,977	267,259
Sunrise Hospital & Medical Center	65,283,723	16,517,885	15,645,997	871,888
University Medical Center of Southern Nevada	126,623,540	42,747,954	42,026,920	721,034
Valley Hospital Medical Center	19,827,577	5,027,729	4,921,828	105,901
subtotal	264,275,202	78,025,201	74,930,181	3,417,462
Washoe County				
Northern Nevada Medical Center	1,167,179	432,680	347,660	85,020
Saint Mary's Regional Medical Center	14,551,700	5,585,847	3,523,782	2,062,065
Washoe Medical Center	57,867,100	19,471,774	16,947,098	2,524,676
subtotal	73,585,979	25,490,302	20,818,540	4,671,762
Rural - Public				
Humboldt General Hospital	563,641	626,361	547,972	78,389
Mt. Grant General Hospital	69,672	67,657	53,545	14,112
South Lyon Medical Center	15,304	12,551	21,240	0
William Bee Ririe Hospital	566,811	353,925	339,409	14,516
subtotal	1,215,428	1,060,494	962,166	107,017
Rural - Private				
Carson Tahoe Hospital	3,227,435	1,588,196	1,301,471	286,725
Churchill Community Hospital	2,238,986	1,086,281	905,845	180,436
Northeastern Nevada Medical Center	1,450,725	1,162,555	783,089	379,466
Nye Regional Medical Center	34,426	43,932	14,120	29,812
subtotal	6,951,572	3,880,964	3,004,525	876,439
Total	346,028,181	108,456,961	99,715,411	9,072,680

State Of Nevada
Indigent Care Provided By Hospitals
Calculation of Net Uncompensated Cost for Medicaid Outpatients
State Fiscal Year Ending June 30, 2000

Schedule 8

HOSPITAL	BILLED CHARGES	MEDICAID OUTPATIENT COST OF CARE	PAYMENTS	NET
Clark County				
Desert Springs Hospital	907,554	286,210	309,674	0
Lake Mead Hospital Medical Center	2,626,904	563,216	0	563,216
MountainView Hospital	778,649	185,459	182,312	3,147
Saint Rose Domincan Hospital - Rose De Lima	1,827,652	509,905	708,345	0
Summerlin Hospital Medical Center	622,868	179,823	229,362	0
Sunrise Hospital & Medical Center	8,382,288	1,939,984	1,685,966	254,018
University Medical Center of Southern Nevada	28,063,847	10,201,942	5,724,781	4,477,161
Valley Hospital Medical Center	2,510,092	566,787	740,768	0
Subtotal	45,719,854	14,433,327	9,581,208	5,297,542
Washoe County				
Northern Nevada Medical Center	295,473	108,760	49,822	58,938
Saint Mary's Regional Medical Center	4,642,207	1,673,135	1,104,503	568,632
Washoe Medical Center	0	0	0	0
Subtotal	4,937,680	1,781,895	1,154,325	627,570
Rural - Public				
Humboldt General Hospital	0	0	0	0
Mt. Grant General Hospital	449,052	224,466	117,283	107,183
South Lyon Medical Center	286,967	260,856	193,649	67,207
William Bee Ririe Hospital	559,641	349,448	169,521	179,927
Subtotal	1,295,660	834,771	480,453	354,318
Rural - Private				
Carson Tahoe Hospital	0	0	0	0
Churchill Community Hospital	0	0	0	0
Northeastern Nevada Medical Center	1,024,837	598,079	412,422	185,657
Nye Regional Medical Center	123,519	136,435	50,661	85,774
Subtotal	1,148,356	734,514	463,083	271,430
Total	53,101,550	17,784,507	11,679,070	6,550,860

State Of Nevada
Indigent Care Provided By Hospitals
Calculation of Net Uncompensated Cost for Indigent Inpatients, Including County Indigent Care Programs and Others Without Third Party Coverage
State Fiscal Year Ending June 30, 2000

Schedule 9

HOSPITAL	BILLED CHARGES	Indigent Care Inpatient COST OF CARE	PAYMENTS	NET
Clark County				
Desert Springs Hospital	10,850,014	3,299,786	107,372	3,192,414
Lake Mead Hospital Medical Center	12,020,396	2,810,402	245,701	2,564,701
MountainView Hospital	4,032,075	1,171,684	2,825	1,168,859
Saint Rose Domincan Hospital - Rose De Lima	9,903,547	3,215,775	827,242	2,388,533
Summerlin Hospital Medical Center	6,144,834	2,055,887	0	2,055,887
Sunrise Hospital & Medical Center	20,482,605	5,182,445	2,672,679	2,509,766
University Medical Center of Southern Nevada	100,976,344	34,089,492	18,745,238	15,344,254
Valley Hospital Medical Center	20,607,772	5,225,565	0	5,225,565
Subtotal	185,017,587	57,051,036	22,601,057	34,449,979
Washoe County				
Northern Nevada Medical Center	1,322,466	490,246	134,544	355,702
Saint Mary's Regional Medical Center	17,214,330	6,607,930	1,121,285	5,486,645
Washoe Medical Center	45,425,801	15,285,386	3,073,785	12,211,601
Subtotal	63,962,597	22,383,562	4,329,614	18,053,948
Rural - Public				
Humboldt General Hospital	1,146,312	1,273,869	885,907	387,962
Mt. Grant General Hospital	106,847	103,757	2,916	100,841
South Lyon Medical Center	88,825	72,844	2,794	70,050
William Bee Ririe Hospital	281,315	175,657	611	175,046
Subtotal	1,623,299	1,626,128	892,228	733,900
Rural - Private				
Carson Tahoe Hospital	7,861,348	3,868,510	1,417,634	2,450,876
Churchill Community Hospital	1,617,315	784,667	62,354	722,313
Northeastern Nevada Medical Center	6,685,614	5,357,591	2,097,172	3,260,419
Nye Regional Medical Center	85,043	108,525	31,986	76,539
Subtotal	16,249,320	10,119,294	3,609,146	6,510,148
Total	266,852,803	91,180,019	31,432,045	59,747,974

State Of Nevada
Indigent Care Provided By Hospitals
Calculation of Net Uncompensated Cost for Indigent Outpatients, Including County Indigent Care Programs and Others Without Third Party Coverage
State Fiscal Year Ending June 30, 2000

Schedule 10

HOSPITAL	BILLED CHARGES	Indigent Care Outpatient COST OF CARE	PAYMENTS	NET
Clark County				
Desert Springs Hospital	1,732,682	546,427	0	546,427
Lake Mead Hospital Medical Center	7,008,924	1,502,734	10,084	1,492,650
MountainView Hospital	1,655,891	394,401	960	393,441
Saint Rose Domincan Hospital - Rose De Lima	0	0	0	0
Summerlin Hospital Medical Center	1,641,791	473,989	0	473,989
Sunrise Hospital & Medical Center	10,296,167	2,382,930	13,670	2,369,260
University Medical Center of Southern Nevada	61,050,308	22,193,382	9,324,923	12,868,459
Valley Hospital Medical Center	3,437,391	776,175	0	776,175
subtotal	86,823,154	28,270,036	9,349,637	18,920,399
Washoe County				
Northern Nevada Medical Center	1,540,785	567,146	391,346	175,800
Saint Mary's Regional Medical Center	1,221,100	440,106	933,409	0
Washoe Medical Center	0	0	0	0
subtotal	2,761,885	1,007,252	1,324,755	175,800
Rural - Public				
Humboldt General Hospital	1,759,033	1,206,301	958,717	247,584
Mt. Grant General Hospital	228,941	114,440	16,782	97,658
South Lyon Medical Center	473,714	430,611	136,632	293,979
William Bee Ririe Hospital	249,563	155,831	3,460	152,371
subtotal	2,711,251	1,907,183	1,115,591	791,592
Rural - Private				
Carson Tahoe Hospital	5,363,079	2,385,895	1,360,630	1,025,265
Churchill Community Hospital	3,153,762	1,727,832	36,124	1,691,708
Northeastern Nevada Medical Center	0	0	0	0
Nye Regional Medical Center	314,814	347,733	118,407	229,326
subtotal	8,831,655	4,461,459	1,515,161	2,946,298
Total	101,127,945	35,645,930	13,305,144	22,834,089

State Of Nevada
Indigent Care Provided By Hospitals
Calculation of Net Uncompensated Cost for Other State Local Programs Providing Inpatient Medical Care to Low-Income Patients
State Fiscal Year Ending June 30, 2000

Schedule 11

HOSPITAL	BILLED CHARGES	Other Inpatient COST OF CARE	PAYMENTS	NET
Clark County				
Desert Springs Hospital	0	0	0	0
Lake Mead Hospital Medical Center	0	0	0	0
MountainView Hospital	0	0	0	0
Saint Rose Domincan Hospital - Rose De Lima	0	0	0	0
Summerlin Hospital Medical Center	0	0	0	0
Sunrise Hospital & Medical Center	0	0	0	0
University Medical Center of Southern Nevada	5,949,692	2,008,609	1,628,707	379,902
Valley Hospital Medical Center	0	0		0
Subtotal	5,949,692	2,008,609	1,628,707	379,902
Washoe County				
Northern Nevada Medical Center	0	0	0	0
Saint Mary's Regional Medical Center	977,558	375,248	341,141	34,107
Washoe Medical Center	19,894,472	6,694,316	5,780,524	913,792
Subtotal	20,872,030	7,069,564	6,121,665	947,899
Rural - Public				
Humboldt General Hospital	0	0	0	0
Mt. Grant General Hospital	0	0	0	0
South Lyon Medical Center	0	0	0	0
William Bee Ririe Hospital	0	0	0	0
Subtotal	0	0	0	0
Rural - Private				
Carson Tahoe Hospital	0	0	0	0
Churchill Community Hospital	0	0	0	0
Northeastern Nevada Medical Center	0	0	0	0
Nye Regional Medical Center	0	0	0	0
Subtotal	0	0	0	0
Total	26,821,722	9,078,173	7,750,372	1,327,801

State Of Nevada
Indigent Care Provided By Hospitals
Calculation of Net Uncompensated Cost for Other State Local Programs Providing Inpatient Medical Care to Low-Income Patients
State Fiscal Year Ending June 30, 2000

Schedule 12

HOSPITAL	BILLED CHARGES	Other Outpatient COST OF CARE	PAYMENTS	NET
Clark County				
Desert Springs Hospital	0	0	0	0
Lake Mead Hospital Medical Center	0	0	0	0
MountainView Hospital	0	0	0	0
Saint Rose Domincan Hospital - Rose De Lima	0	0	0	0
Summerlin Hospital Medical Center	0	0	0	0
Sunrise Hospital & Medical Center	0	0	0	0
University Medical Center of Southern Nevada	0	0	0	0
Valley Hospital Medical Center	0	0	0	0
subtotal	0	0	0	0
Washoe County				
Northern Nevada Medical Center	0	0	0	0
Saint Mary's Regional Medical Center	0	0	0	0
Washoe Medical Center	0	0	0	0
subtotal	0	0	0	0
Rural - Public				
Humboldt General Hospital	0	0	0	0
Mt. Grant General Hospital	0	0	0	0
South Lyon Medical Center	0	0	0	0
William Bee Ririe Hospital	0	0	0	0
subtotal	0	0	0	0
Rural - Private				
Carson Tahoe Hospital	0	0	0	0
Churchill Community Hospital	0	0	0	0
Northeastern Nevada Medical Center	0	0	0	0
Nye Regional Medical Center	11,390	12,581	4,756	7,825
subtotal	11,390	12,581	4,756	7,825
Total	11,390	12,581	4,756	7,825

State Of Nevada
Indigent Care Provided By Hospitals
Schedule of Disproportionate Share and Intergovernmental Transfer Payments For State Fiscal Years Ending 2000-2002

Schedule 13

HOSPITAL	Fiscal Year 2000 DSH	IGT	Net Benefit	% of Net Benefit	Fiscal Year 2001 DSH	IGT	Net Benefit	% of Net Benefit	Fiscal Year 2002 DSH	IGT	Net Benefit	% of Net Benefit
Clark County												
Desert Springs Hospital												
Lake Mead Hospital	59,740	0	59,740		59,740	0	59,740		677,000	0	677,000	
MountainView Hospital												
Saint Rose Domincan Hospital - Rose De Lima												
Summerlin Hospital Medical Center												
Sunrise Hospital	0	0	0		0	0	0		665,910	0	665,910	
University Medical Center	$57,255,554	$42,891,666	$14,363,888		$57,783,874	$43,287,905	$14,495,969		$60,655,647	$45,416,735	$15,238,912	
Clark County										$857,183	-$857,183	
Valley Hospital Medical Center												
Subtotal	**57,315,294**	**42,891,666**	**14,423,628**	**68.86%**	**57,843,614**	**43,287,905**	**14,555,709**	**69.50%**	**61,998,557**	**46,273,918**	**15,724,639**	**69.77%**
Washoe County												
Northern Nevada Medical Center												
Saint Mary's Regional Medical Center												
Washoe Medical Center*	4,800,000	1,550,000	3,250,000		4,800,000	1,550,000	3,250,000		4,800,000	1,500,000	3,300,000	
Subtotal	**4,800,000**	**1,550,000**	**3,250,000**	**15.52%**	**4,800,000**	**1,550,000**	**3,250,000**	**15.52%**	**4,800,000**	**1,500,000**	**3,300,000**	**14.64%**
Rural - Public												
Humboldt General Hospital	501,066	325,799	175,267		557,550	368,163	189,387		560,435	345,326	215,109	
Mt. Grant General Hospital	256,063	142,047	114,016		483,353	312,515	170,838		483,353	287,515	195,838	
South Lyon Medical Center	467,628	300,721	166,907		397,667	248,250	149,417		397,667	223,250	174,417	
Wm. Bee Ririe Hospital	448,698	286,524	162,174		515,240	336,430	178,810		516,004	312,003	204,001	
Subtotal	**1,673,455**	**1,055,091**	**618,364**	**2.95%**	**1,953,810**	**1,265,358**	**688,452**	**3.29%**	**1,957,459**	**1,168,094**	**789,365**	**3.50%**
Rural - Private												
Carson Tahoe Hospital	5,354,856	3,966,142	1,388,714		4,862,450	3,596,837	1,265,613		5,081,149	3,735,862	1,345,287	
Churchill Community	2,524,145	1,843,109	681,036		2,094,971	1,521,229	573,742		2,174,931	1,556,198	618,733	
Northeastern Nevada Medical Center*	2,000,000	1,500,000	500,000		2,000,000	1,500,000	500,000		2,000,000	1,500,000	500,000	
Nye Regional Medical Center*	332,250	249,188	83,062		445,155	333,866	111,289		445,155	333,866	111,289	
Subtotal	**10,211,251**	**7,558,439**	**2,652,812**	**12.67%**	**9,402,576**	**6,951,932**	**2,450,644**	**11.70%**	**9,701,235**	**7,125,926**	**2,575,309**	**11.43%**
Other Hospitals												
Grover C. Dils Hospital**	0	0	0		0	0	0		0	-50,000	50,000	
Battle Mountain Hospital**	0	0	0		0	0	0		0	-50,000	50,000	
Pershing General Hospital**	0	0	0		0	0	0		0	-50,000	50,000	
Subtotal	**0**	**0**	**0**	**0.00%**	**0**	**0**	**0**	**0.00%**	**0**	**-150,000**	**150,000**	**0.67%**
Total	**74,000,000**	**53,055,196**	**20,944,804**	**100.00%**	**74,000,000**	**53,055,195**	**20,944,805**	**100.00%**	**78,457,251**	**55,917,938**	**22,539,313**	**100.00%**
State Benefit			$16,055,196				$16,055,195				$16,689,313	
Federal revenue	$37,000,000				$37,000,000				$39,228,626			

* Private hospitals do not make intergovernmental transfers. Amounts shown for IGT represent county provider taxes.

** These public hospitals do not currently receive DSH.

State Of Nevada
Indigent Care Provided By Hospitals
Federal Test of Medicaid Eligibility - Low Income Utilization
State Fiscal Year Ending June 30, 2000

Schedule 14A

	HOSPITAL	Medicaid IP Payments	Medicaid OP Payments	Other State & Local IP Payments	Other State & Local OP Payments	Direct Tax Subsidy & ER Payment	Indigent Care IP Charges	Total IP Charges (Based on Medicare Cost Report)	Operating Revenue	Ratio of Total Medicaid Payments + Cash Subsidies to Total Patient Services Revenues	Ratio of IP Charity Care Charges - Cash Subsidies to Total IP Charges	Total Ratio for Federal Medicaid Test	Eligible?
	Clark County												
1	Desert Springs Hospital	1,850,395	309,674	-	-		10,850,014	290,198,014	110,360,002	1.96%	3.74%	5.70%	N
1	Lake Mead Hospital Medical Center	6,520,595	-	-	-		12,020,396	148,813,936	49,441,864	13.19%	8.08%	21.27%	N
1	MountainView Hospital	1,280,474	182,312	-	-		4,032,075	190,537,837	70,906,677	2.06%	2.12%	4.18%	N
1	Saint Rose Domincan Hospital - Rose De Lima	1,987,995	708,345	-	-		9,903,547	147,251,047	63,181,622	4.27%	6.73%	10.99%	N
1	Summerlin Hospital Medical Center	695,977	229,362	-	-		6,144,834	132,220,053	63,355,770	1.46%	4.65%	6.11%	N
1	Sunrise Hospital & Medical Center	15,645,997	1,685,966	-	-		20,482,605	885,863,400	351,151,349	4.94%	2.31%	7.25%	N
1	University Medical Center of Southern Nevada	42,026,920	5,724,781	1,628,707	-	13,653,951	100,976,344	572,747,615	313,825,863	20.09%	14.96%	35.05%	Y
1	Valley Hospital Medical Center	4,921,828	740,768		-		20,607,772	461,657,068	152,586,589	3.71%	4.46%	8.17%	N
	subtotal	74,930,181	9,581,208	1,628,707	-	13,653,951	185,017,587	2,829,288,970	1,174,809,736				
	Washoe County												
2	Northern Nevada Medical Center	347,660	49,822	-	-		1,322,466	50,930,035	33,597,029	1.18%	2.60%	3.78%	N
2	Saint Mary's Regional Medical Center	3,523,782	1,104,503	341,141	-		17,214,330	243,983,583	156,941,480	3.17%	6.92%	10.08%	N
2	Washoe Medical Center	16,947,098	-	5,780,524	-		45,425,801	394,155,188	209,717,488	10.84%	10.06%	20.90%	N
	subtotal	20,818,540	1,154,325	6,121,665	-	-	63,962,597	689,068,806	400,255,997				
	Rural - Public												
3	Humboldt General Hospital	547,972	-	-	-		1,147,726	3,539,992	10,078,239	5.44%	32.42%	37.86%	Y
3	Mt. Grant General Hospital	53,545	117,283	-	-	551,029	106,847	1,434,466	4,691,934	15.39%	0.00%	15.39%	N
3	South Lyon Medical Center	21,240	193,649	-	-	398,854	88,825	1,263,150	7,281,090	8.43%	0.00%	8.43%	N
3	William Bee Ririe Hospital	339,409	169,521	-	-	1,233,529	281,315	6,281,484	9,528,715	18.29%	0.00%	18.29%	N
	subtotal	414,194	480,453	-	-	2,183,412	1,624,713	12,519,092	31,579,978				
	Rural - Private												
4	Carson Tahoe Hospital	1,435,563	-	-	-		7,861,348	74,345,983	72,034,881	1.99%	10.57%	12.57%	N
4	Churchill Community Hospital	905,845	-	-	-		1,617,315	21,891,439	29,113,528	3.11%	7.39%	10.50%	N
4	Northeastern Nevada Medical Center	783,089	412,422	-	-		6,685,614	15,465,910	26,918,175	4.44%	43.23%	47.67%	Y
4	Nye Regional Medical Center	14,120	50,661	-	4,756		85,043	1,404,774	3,297,084	2.11%	6.05%	8.16%	N
	subtotal	3,138,617	463,083	-	4,756	-	16,249,320	113,108,106	131,363,668				
	Total	99,301,531	11,679,070	7,750,372	4,756	15,837,363	266,854,217	3,643,984,974	1,738,009,379				

Note: Costs shown are before any payments from Counties or state, other than Medicaid payments.
Medicaid amounts are calculated net of payments. Disproportionate Share payments are not considered.

State Of Nevada
Indigent Care Provided By Hospitals
Federal Test of Medicaid Eligibility -- Medicaid Days
State Fiscal Year Ending June 30, 2000

Schedule 14B

HOSPITAL NAME	Regular Days	Nursery Days	Total Days	Fee For Service Medicaid Days	Managed Care Medicaid Days	Total All Medicaid Days	Medicaid Utilization %	Eligible Based on Medicaid Utilization?
Battle Mountain General Hospital (1108837)	335		335	49	-	49	14.63%	Y
Boulder City Hospital (1102839)	4,094		4,094	27	1	28	0.68%	N
Carson Rehab Center (5613500)	6,315		6,315	69	-	69	1.09%	N
Carson Tahoe Hospital (1113843)	24,241	1,153	25,394	1,633	-	1,633	6.43%	N
Charter Hospital (1302800)	8,747		8,747	2,224	5	2,229	25.48%	Y
Churchill Community Hospital (1101845)	6,588	589	7,177	691	-	691	9.63%	N
Desert Springs Hospital (1102847)	62,210	1,904	64,114	1,478	332	1,810	2.82%	N
Elko General Hospital (1104851)	6,650	1,000	7,650	868	-	868	11.35%	N
Grover C. Dils Medical Center (1109850)	404		404	26	-	26	6.44%	N
Healthsouth Hospital NV-Reno (5616005)	9,901		9,901	596	-	596	6.02%	N
Horizon Specialty Hospital (5602006)	8,496		8,496	504	-	504	5.93%	N
Humboldt General Hospital (1107855)	1,728	404	2,132	319	-	319	14.96%	Y
Lake Mead Hospital (1102867)	39,468	1,615	41,083	5,974	911	6,885	16.76%	Y
Montevista Hospital (1302890)	-		-	3,702	162	3,864	0.00%	N
Mount Grant Hospital (1111865)	584	1	585	43	-	43	7.35%	N
Mountain View Hospital (1102006)	41,501	3,461	44,962	1,080	1,308	2,388	5.31%	N
NV Mental Health Institute (1316864)	17,311		17,311	272	-	272	1.57%	N
Nye Regional Medical Center (1112869)	266	1	267	37	-	37	13.86%	N
Northern Nevada Medical Center (1116400)	16,156		16,156	655	7	662	4.10%	N
Pershing General Hospital (1114871)	468		468	24	-	24	5.13%	N
Rehab of Nevada-Las Vegas (5602005)	22,008		22,008	288	36	324	1.47%	N
South Lyon Medical Center (1110863)	736		736	26	-	26	3.53%	N
St.Marys Regional Medical Center (1116875)	61,748	3,897	65,645	3,717	44	3,761	5.73%	N
St. Rose Dominican Hospital (1102873)	34,899	3,467	38,366	871	622	1,493	3.89%	N
Summerlin Hospital/Medical Center(1102008)	42,399	2,112	44,511	715	233	948	2.13%	N
Sunrise Hospital (1102878)	187,177	9,546	196,723	11,794	5,337	17,131	8.71%	N
Tahoe-Pacific Hospital (5616015)	7,022		7,022	8	-	8	0.11%	N
University Medical Center (1102877)	147,165	7,242	154,407	26,157	4,004	30,161	19.53%	Y
Valley Hospital (1102881)	95,498	3,861	99,359	4,645	1,395	6,040	6.08%	N
Vencor Hospital Las Vegas (5602007)	16,428		16,428	1,236	-	1,236	7.52%	N
Washoe Medical Center (1116885)	94,719	4,780	99,499	12,025	912	12,937	13.00%	N
West Hills Hospital (1316900)	14,612		14,612	3,323	-	3,323	22.74%	Y
William Bee Ririe Hospital (1117887)	2,542	101	2,643	220	-	220	8.32%	N
Hospital Totals	**982,416**	**45,134**	**1,027,550**	**85,296**	**15,309**	**100,605**		
						Mean	7.95%	
						St Dev	6.52%	
						Cutoff	14.47%	

State Of Nevada
Comparison of Disproportionate Share Benefits to Population
State Fiscal Year Ending June 30, 2002

Schedule 15

County	Population Estimate 2002 (Note 1)	% of Total	Estimated DSH Benefit SFY2002 (Note 2)	% of Total
Clark County	1,538,542	69.47%	$15,724,640	69.77%
Washoe County	346,005	15.62%	3,300,000	14.64%
Rural Counties w/ public hospitals (Note 3)	94,313	4.26%	939,364	4.17%
Rural Counties w/ private hospitals (Note 4)	180,264	8.14%	2,575,309	11.43%
Rural Counties w/ no hospital (Note 5)	55,688	2.51%		
Total Rurals	330,265	14.91%	3,514,673	15.59%
Total State	2,214,812	100.00%	$22,539,313	100.00%

Note 1 - Population estimates are from the state publication, Nevada County Population Projection, 2000 - 2010, published in June 2000

Note 2 - Data is from Division of Health Care Financing and Policy, and includes $150,000 paid to three rural public hospitals that cannot receive DSH under federal law.

Note 3 - Includes Humboldt, Lander, Lincoln, Lyon, Mineral, Pershing and White Pine Counties.

Note 4 - Includes Carson City, Churchill, Elko and Nye Counties. Carson - Tahoe Hospitalbecame a private hospital in 2002. Churchill Regional Medical Center has been considered as a public hospital for purposes of the DSH program but is clearly private at this time and must be reclassified to reflect their actual ownership position. Had these two hospitals beenclassified as private hospitals for 2002, their net benefit would have been $1,936,288, or 8.56% of the total DSH benefit for the state.

Note 5 - Includes Douglas, Esmerelda, Eureka and Storey Counties.

State Of Nevada
Indigent Care Provided By Hospitals
Proposed DSH Alocation
Based on SFY 2002 DSH Distribution
State Fiscal Year Ending June 30, 2000

Schedule 16

HOSPITAL	SFY 2002 DSH Benefit	SFY 2002 Costs Net of DSH Benefit	SFY 2002 % Post DSH 1	Proposed Distribution Methodology SFY02 Alloc	% Post DSH 1	Addtl DSH Allocation	Total DSH Alloc	% Post Ttl DSH 1	Addtl DSH Distrbtn	Total DSH Distrbtn	OBRA
Clark County											
Desert Springs Hospital		3,791,154	3.44%		3.44%			3.44%			6,822,421
Lake Mead Hospital Medical Center	677,000	5,337,837	10.80%	677,000	10.80%	526,597	1,203,597	9.73%		1,203,597	10,973,589
MountainView Hospital		1,570,241	2.21%		2.21%			2.21%			2,754,546
Saint Rose Domincan Hospital - Rose De Lima		2,388,533	3.78%		3.78%	-		3.78%			5,627,606
Summerlin Hospital Medical Center		2,797,135	4.41%		4.41%			4.41%			4,894,986
Sunrise Hospital & Medical Center	665,910	5,339,022	1.52%	665,910	1.52%	(665,910)	-	1.71%			15,209,742
Valley Hospital Medical Center		6,107,641	4.00%		4.00%			4.00%			10,688,372
subtotal	**1,342,910**	**27,331,564**	**3.17%**	**1,342,910**	**3.17%**	**(139,313)**	**1,203,597**	3.19%	**-**	**1,203,597**	**56,971,262**
University Medical Center of Southern Nevada	14,381,729	30,366,195	9.68%	14,381,729	9.68%	100,000	14,481,729	9.64%	52,000,000	66,481,729	114,852,463
subtotal	**14,381,729**	**30,366,195**	9.68%	**14,381,729**	9.68%	**100,000**	**14,481,729**	9.64%	**52,000,000**	**66,481,729**	**114,852,463**
Subtotal	**15,724,639**	**57,697,759**	**4.91%**	**15,724,639**	4.91%	**$ (39,313)**	**15,685,326**	4.91%	**52,000,000**	**67,685,326**	**171,823,725**
Washoe County											
Northern Nevada Medical Center		675,461	2.01%		2.01%		-	2.01%			2,102,364
Saint Mary's Regional Medical Center		8,271,449	5.27%		5.27%		-	5.27%			17,606,499
Washoe Medical Center	3,300,000	13,675,462	6.52%	3,300,000	6.52%		3,300,000	6.52%		3,300,000	43,184,238
Subtotal	**3,300,000**	**22,622,372**	**5.65%**	**3,300,000**	**5.65%**		**3,300,000**	5.65%		**3,300,000**	**62,893,101**
Rural - Public											
Humboldt General Hospital	215,109	613,193	6.08%	215,109	6.08%		215,109	6.08%		215,109	4,507,424
Mt. Grant General Hospital	195,838	338,739	7.22%	195,838	7.22%		195,838	7.22%		195,838	621,741
South Lyon Medical Center	174,417	645,263	8.86%	174,417	8.86%	118,733	293,150	7.23%		293,150	1,022,673
William Bee Ririe Hospital	204,001	317,860	3.34%	204,001	3.34%		204,001	3.34%		204,001	920,380
Subtotal	**789,365**	**1,915,055**	**6.06%**	**789,365**	**6.06%**	**118,733**	**908,098**	5.69%		**908,098**	**7,072,218**
Rural - Private											
Carson Tahoe Hospital	1,345,287	5,404,971	7.50%	1,345,287	7.50%	(345,287)	1,000,000	7.98%		1,000,000	11,783,169
Churchill Community Hospital	618,733	1,975,724	6.79%	618,733	6.79%	(118,733)	500,000	7.19%		500,000	4,712,637
Northeastern Nevada Medical Center	500,000	3,345,141	12.43%	500,000	12.43%		500,000	12.43%		500,000	10,368,640
Nye Regional Medical Center	111,289	1,014,096	30.76%	111,288.75	30.76%	345,287	456,576	20.28%		456,576	1,191,556
Subtotal	**2,575,309**	**11,739,933**	**8.94%**	**2,575,309**	**8.94%**	**(118,733)**	**2,456,576**	9.03%		**2,456,576**	**28,056,001**
Total RegHospital Group Distr	**22,389,313**			**22,389,313**		**$ (39,313)**	**22,350,000**	5.41%	**52,000,000**	**74,350,000**	
Other Hospitals											
Grover C. Dils Medical Center	50,000			50,000			50,000				
Battle Mountain Hospital	50,000			50,000			50,000				
Pershing General Hospital	50,000			50,000			50,000				
Subtotal	**150,000**			**150,000**			**150,000**				
Total	**22,539,313**	**93,975,118**		**22,539,313**		**$ (39,313)**	**22,500,000**		**52,000,000**	**74,350,000**	

1 Percentages are calculated against SFY 2000 operating revenue and indigent care costs for illustration purposes

APPENDIX F

Antibiotic Resistance Awareness Data

Presentation before the Legislative Committee on Health Care
August 20, 2002

Nevadans for Antibiotic Awareness (NAA)

Chairman Rawson and members of the committee, I am Dr. Christine Petersen, Chief Medical Officer for Sierra Health Services, and executive committee member and chairman of the public awareness committee, for Nevadans for Antibiotic Awareness - or NAA. With me I have Dr. William Berliner, Medical Director for Health Insight and executive director of Nevadans for Antibiotic Awareness. On behalf of NAA, we both thank you for the opportunity to speak to you today.

NAA is a statewide task force of over 40 state and local public and private agencies and companies committed to addressing the major public health problem of increasing antibiotic resistance. Our goal is to educate healthcare professionals and the public about the consequences of inappropriate use of antibiotics, to decrease inappropriate antibiotic use, and to improve infection control and surveillance.

Sierra Health Services, the Clark County Health District and Health Insight started the task force a little over a year ago. The task force has grown and now includes the Nevada State Health Department, Washoe County Health District, Nevada Board of Pharmacy, University of Nevada School of Medicine, Nevada Broadcasters Association, all the major hospital systems plus laboratories, pharmaceutical companies and other public and private sector entities.

The NAA in partnership with the Centers for Disease Control (CDC) joined 31 other states in developing programs to increase awareness of the public health dangers of this antibiotic resistance issue which is growing both in size and scope nationally and internationally.

Antibiotics have become the "magic wand" that people call upon and expect to cure everything from life-threatening infections to the common cold. Patients frequently demand prescriptions for antibiotics from their health care providers, even when their illnesses are viral in nature and will not respond to antibiotics - and sometimes they are successful in getting those prescriptions.

According to the CDC, more than 50 million of the 150 million prescriptions written each year for patients outside of a hospital setting are unnecessary. Even patients who are appropriately prescribed antibiotics for a bacterial infection frequently fail to complete the fully prescribed dose, and hoard the antibiotics - just in case – so they can self-diagnose and self-treat should they come down with a sore throat or cough. Additionally, the rush of citizens across our borders to obtain low-cost antibiotics that can be purchased over the counter further contributes to the problem.

Facts indicate that more than 70 percent of bacteria that cause infections in hospitals are already resistant to at least one of the antibiotic drugs most commonly used to treat infections. In fact, Nevada had the dubious honor of being one of six states that had developed a very rare form of resistant bacteria because of inappropriate antibiotic use.

CDC studies also indicate that over the past five years, the rate of resistance to penicillin for the common bacterial strain *Streptococcus pneumonia* has increased nationwide by more than 300%. This year, antibiotic resistant bacteria will cause over a million infections – tragically some of them will be fatal. Bacteria are experts at survival and their survival tactic is to mutate to resist the onslaught of antibiotic agents. The overuse and inappropriate use of antibiotics has enabled them to do just that. All indicators clearly tell us that we must act quickly to stem the tide of the increasing numbers of drug-resistant or "superbug" bacteria.

The NAA through countless volunteer hours, donated dollars and substantial "in kind" donations including the development of our logo and TV and radio spots by Virgen

Advertising has been able to move forward very rapidly and effectively. We are pleased to report that NAA is used by the CDC as an example as one of the most successful programs in the country.

We had our formal campaign kick-off on October 29, 2001, with Governor Guinn offering his full support by participating in this special event and press conference and by proclaiming the week of October 29, 2001, as *"Antibiotic Awareness Week in Nevada"*.

Some of the major items that we have accomplished since our kick-off include:

- The development and distribution of statewide guidelines for outpatient antibiotic use.
- Development and delivery of a comprehensive provider education program, which included distributing provider packets on two or more occasions to every primary care, emergency room and urgent care provider in the state.
- The coordination of speaking programs to over 600 providers (with CME credits offered).
- A media campaign, with the support of the Nevada Broadcasters Association, airs on TV and radio in both English and Spanish over 1200 times a month.
- The distribution of brochures, posters, bookmarks and tote bags throughout the state's emergency rooms, pharmacies, urgent care centers, doctor's offices, school nurse offices and childcare centers.

We have made a difference. Recent evaluation of the pharmacy data of four of Nevada's Health Plans has shown a decrease in the use of the common outpatient antibiotics, which over time should lead to improvement in Nevada's antibiotic susceptibility rate.

I have provided copies of our provider packets and I would ask that Dr. Berliner give you a brief outline as to what is included.

On behalf of all of the members of NAA, Dr. Berliner and I respectfully request your formal recognition of the importance of this public health issue and public support for our

efforts to address this problem. We believe that the committee's public validation of the work of NAA will lend additional credibility to our educational campaign.

This concludes our presentation. Thank you for allowing us to appear before you today. We would be happy to answer any questions that you may have.

APPENDIX G

Detection and Control of Certain Diseases Information

Biodefense Briefing
Interim Committee on Health
Nevada State Legislature

Randall Todd, DrPH
State Epidemiologist

I. Introduction

II. Biological Attack vs. Disaster or Conventional Attack

A. Characteristics of Disaster – Flood, Earthquake, Hurricane, etc.
   1. Immediate knowledge of event
   2. Rapid assessment of the scope of damage
   3. Casualties occur at the time of the event or shortly afterward
   4. Casualties identified by first responders – police / fire

B. Characteristics of Conventional Terrorist Attack – Explosion
   1. Immediate knowledge of event
   2. Rapid assessment of the scope of damage
   3. Casualties occur at the time of the event or shortly afterward
   4. Casualties identified by first responders – police / fire

C. Characteristics of Chemical Terrorist Attack
   1. Inhalation
   2. Absorption through the skin
   3. Effects usually immediate and obvious
   4. Casualties identified by first responders – police / fire

D. Characteristics of Biological Terrorist Attack
   1. Covert dissemination of agent = no immediate knowledge of event
   2. No apparent damage
   3. Casualties begin to occur after the incubation period for the agent
   4. Casualties identified by healthcare providers
   5. Healthcare providers may not initially recognize casualties as such

III. Example of a Biological Attack Scenario – Smallpox (variola virus) covert release

A. After 1-2 weeks patients present at doctors' offices and clinics
   1. fever
   2. back pain
   3. headache
   4. nausea
   5. other symptoms of what initially might appear to be an ordinary viral infection

B. As the disease progresses
   1. papular rash characteristic of early-stage smallpox
   2. remember that most physicians have never seen a case of smallpox and may not recognize it immediately

C. By the time the rash becomes pustular and patients begin to die
   1. terrorists would be far away
   2. disease disseminated though the population by person-to-person contact
   3. only a short window of opportunity will exist between the time the first cases are identified and a second wave of the population becomes ill
   4. As person-to-person contact continues, successive waves of transmission could carry infection to other localities throughout the state, the nation, and the world
   5. Plague and certain viral hemorrhagic fevers could have similar scenario

IV. Role of Public Health

A. determine that an attack has occurred
   1. must be capable of detecting unusual patterns of disease including those caused by unusual or unknown threat agents
      (a) education and training of healthcare providers re: syndromic reporting
      (b) staffing and training to receive and respond to syndromic reports
      (c) high profile events – Comdex, Hot August Nights
   2. differentiate between natural disease and intentional transmission
      (a) control measures similar
      (b) involvement of law enforcement if intentional

B. identify the organism – public health laboratory capacity

C. prevent more casualties through prevention strategies such as mass vaccination, prophylactic treatment, isolation, and quarantine
   1. access to vaccines, antibiotics, and other supplies
   2. distribution infrastructure
   3. legal authority to act

V. Biological Agents of Concern

A. CDC considers bioagents a high priority if they possess some or all of the following characteristics
   1. can be easily disseminated
   2. can be transmitted person-to-person
   3. cause high mortality or morbidity
   4. might cause public panic and social disruption
   5. require special action for public health preparedness such as stockpiling of antibiotics and vaccines

B. High priority bioagents
   1. Variola major (smallpox)
   2. Bacillus anthracis (anthrax)
   3. Yersinia pestis (plague)
   4. Clostridium botulinum toxin (botulism)
   5. Francisella tularensis (tularemia)
   6. Filoviruses
      (a) Ebola hemorrhagic fever
      (b) Marburg hemorrhagic fever
   7. Arenaviruses
      (a) Lassa (Lassa fever)
      (b) Junin (Argentine hemorrhagic fever) and related viruses

C. Lower priority bioagents
   1. More difficult to disseminate
   2. Less severe illness
   3. Need for enhanced public health surveillance
   4. Include food- and waterborne diseases

VI. Preparedness

A. WMD vs. Bioagents
B. National Pharmaceutical Stockpile
C. Surge Capacity
D. Public Health Infrastructure
E. Role Clarification
F. Public Information
G. Live drills and tabletop exercises
H. Responsible Citizens

VII. Nevada Preparedness

A. HAN
B. Epidemiology and Surveillance
C. Laboratory Capacity
D. WMD Steering Committee – Homeland Security

VIII. Lessons Learned from Recent Anthrax Scare

A. Threat does not have to be confirmed to cause panic
B. Limited surge capacity
C. Need for live drills to improve coordination among public health, law enforcement, healthcare providers, and other first responders
   1. HazMat containers that could not be opened at lab
   2. Different standards for assessing threat of letters and packages
   3. Protocols for lab result dissemination

IX. Conclusion

A. Cause for concern not panic
B. Much has already been accomplished
C. Much still needs to be accomplished

X. Questions

KENNY C. GUINN
Governor

MICHAEL J WILLDEN
Director

STATE OF NEVADA

YVONNE SYLVA
Administrator

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October 22, 2001

Testimony by Mary Guinan, M.D., PhD State Health Officer

To: Legislative Committee on Health Care

Since 1999, the Health Division has been preparing a bioterrorism defense plan and building infrastructure to implement the plan. Funding comes from a grant from the Centers for Disease Control and Prevention in Atlanta and is provided for the Health Alert Network program which is situated in the Bureau of Community Health under the direction of Jeff Whitesides. The purpose of the grant was to ensure the rapid development of a coordinated federal, state and local capacity to address potential bioterrorism events. Nevada is one of 23 states which receives this funding.

The Health Alert Network integrates planning and training to facilitate the development of core competencies and capacities in public health preparedness, including disease surveillance, epidemiology, rapid laboratory diagnosis, emergency response and information systems.

As of this date the Health Alert Network (HAN) program has implemented a rapid notification system capable of communicating with the public health workforce, nurses, physicians, emergency medical personnel, hospitals and medical laboratories in the state. This notification

system uses both fax and e-mail broadcast to provide an early warning and response system to address bioterrorism and other health threats. During the last two weeks, this system allowed the immediate distribution of CDC Health Alerts and communication of critical information to responsible parties throughout the State. The Health Alert Network is working to implement high speed, secure connection to the Internet and when complete, will enable local, state and federal health authorities to communicate and coordinate rapidly and securely with each other and with law enforcement agencies. HAN will allow local health officials nationwide to instantaneously access and share surveillance data, electronic laboratory test reports and CDC diagnostic and treatment guidelines. The HAN supports local planning for health emergencies including exercises and simulations involving first responder agencies and other community organizations.

The Health Division is currently working in cooperation with the Clark County Health District, Washoe District Health Department and Southern Nevada Area Health Education Center to conduct training for physicians and emergency healthcare professionals, to provide education on recognition, reporting and response to bioterrorism. Training began in Las Vegas in September 2001 and is expected to continue throughout 2001/2002 with statewide bioterrorism training of over 5000 healthcare professionals.

The Health Alert Network, Distance Learning Program provides satellite broadcast distance learning programs statewide for continuous upgrading of skills in preparedness for bioterrorism and other health threats. The Distance Learning Program plays a key role in the training and education of public health professionals in state-of-the-art skills to address bioterrorism and other high priority health issues. This ensures that public health agencies that serve all Nevada communities can meet accepted high levels of performance related to bioterrorism and other health threats.

In August 2001, additional CDC Bioterrorism funding was obtained for laboratory capacity building. This funding, in the amount of $163,000 is being transferred to the Nevada State Public Health Laboratory, located at the University of Nevada-Reno, and will allow the Laboratory to enhance its ability to respond to an act of bioterrorism by the rapid detection and analysis of chemical and biological agents. First year funding will be used to purchase the PCR test equipment and staff two microbiologist who will be able to provide 24 hour 7 day lab coverage.

CDC Bioterrorism Preparedness funding for Nevada for Federal Fiscal Year 2002 is $716,000. No state funding is currently provided for this effort. CDC funding for this program will continue until 2004.

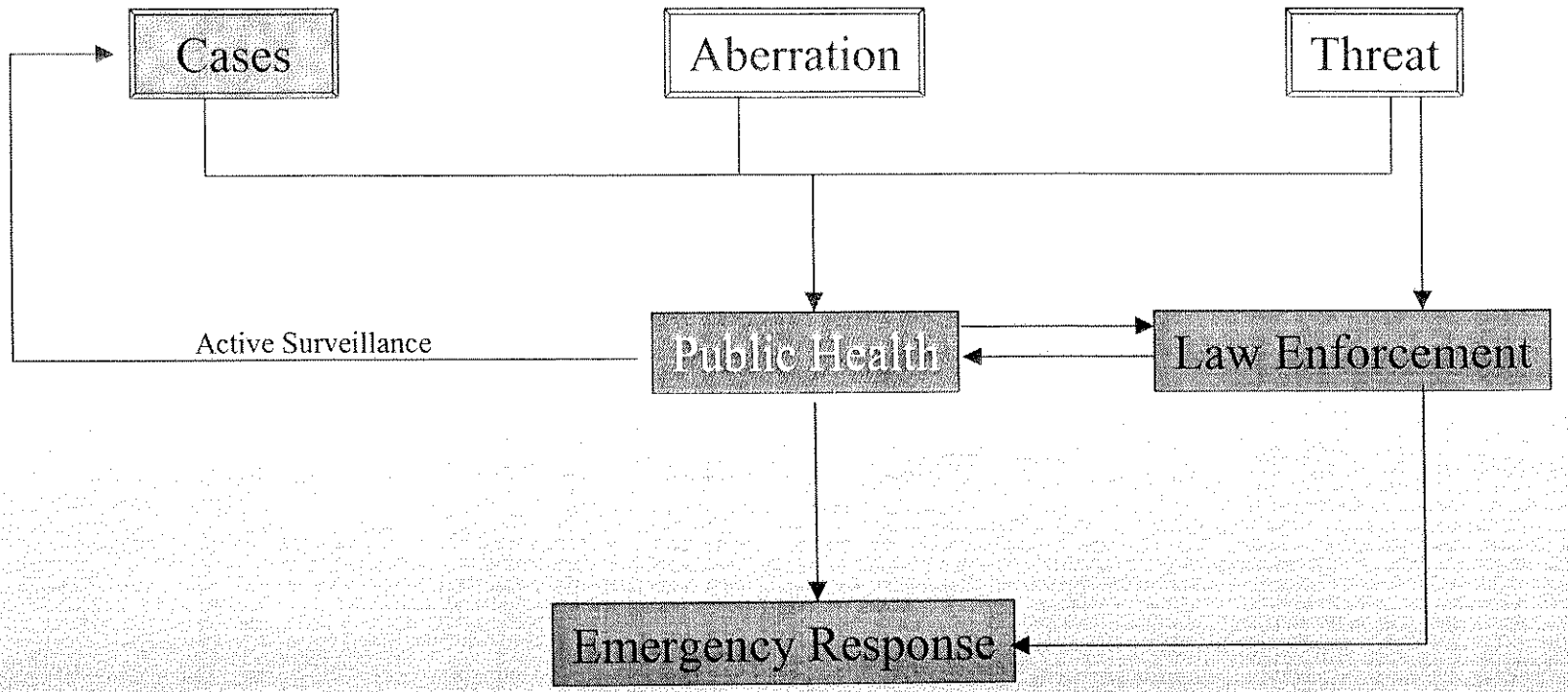
The Health Alert Network was put on high alert on September 11, 2001 at 8:30 AM. A test message was sent out to the database emergency contacts in the state requesting a response to determine that we were able to communicate statewide via Fax. The response rate was over 90%.

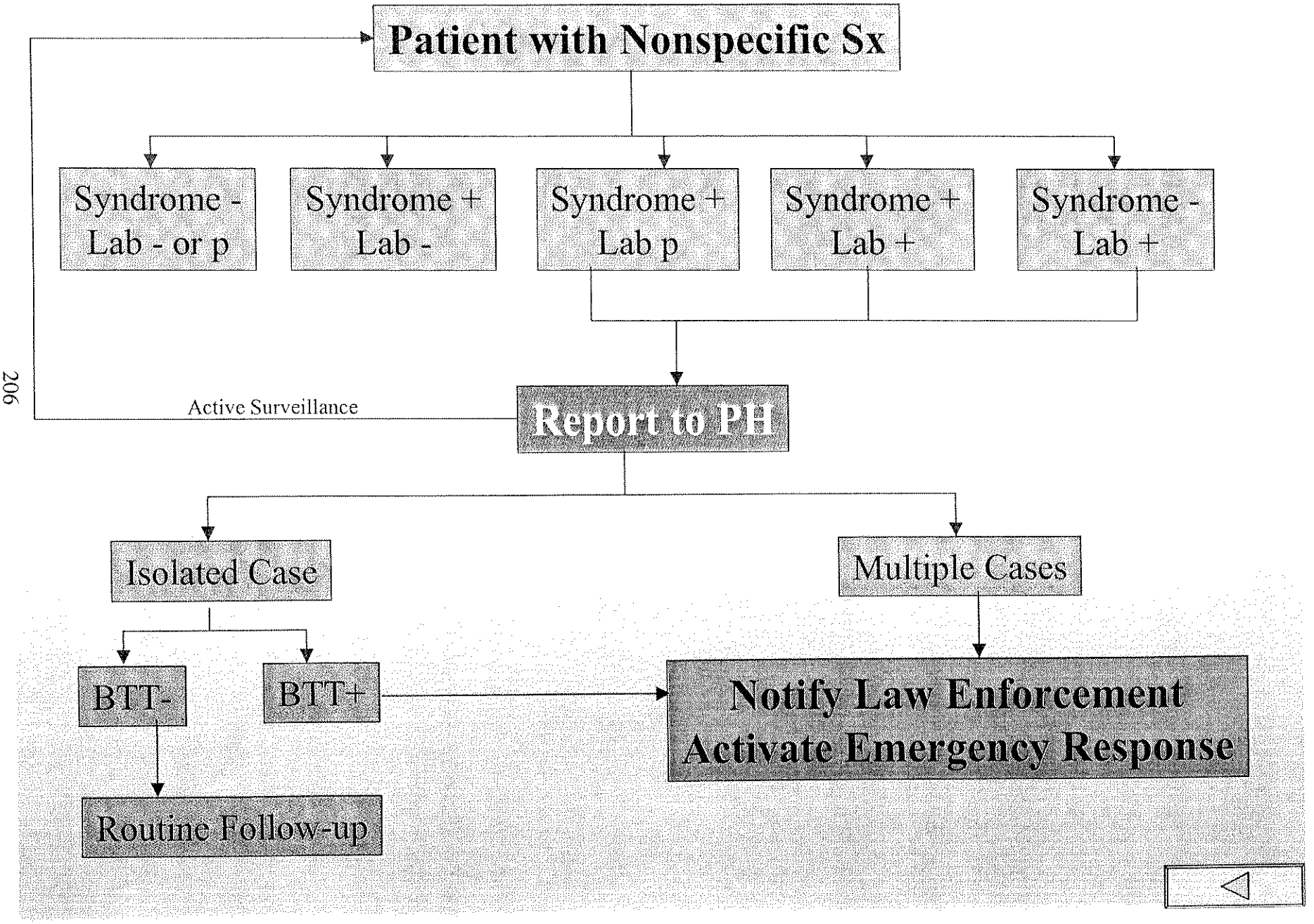
At approximately 10:00 a.m. on September 11, 2001 the Health Alert Network received a CDC Health Alert urging heightened awareness for higher than normal incidences of communicable/infectious disease. A broadcast fax containing the CDC Health Alert was then sent throughout the state of Nevada to local health districts, hospitals, urgent cares, community health nurses (rural areas), state emergency officials, and law enforcement.

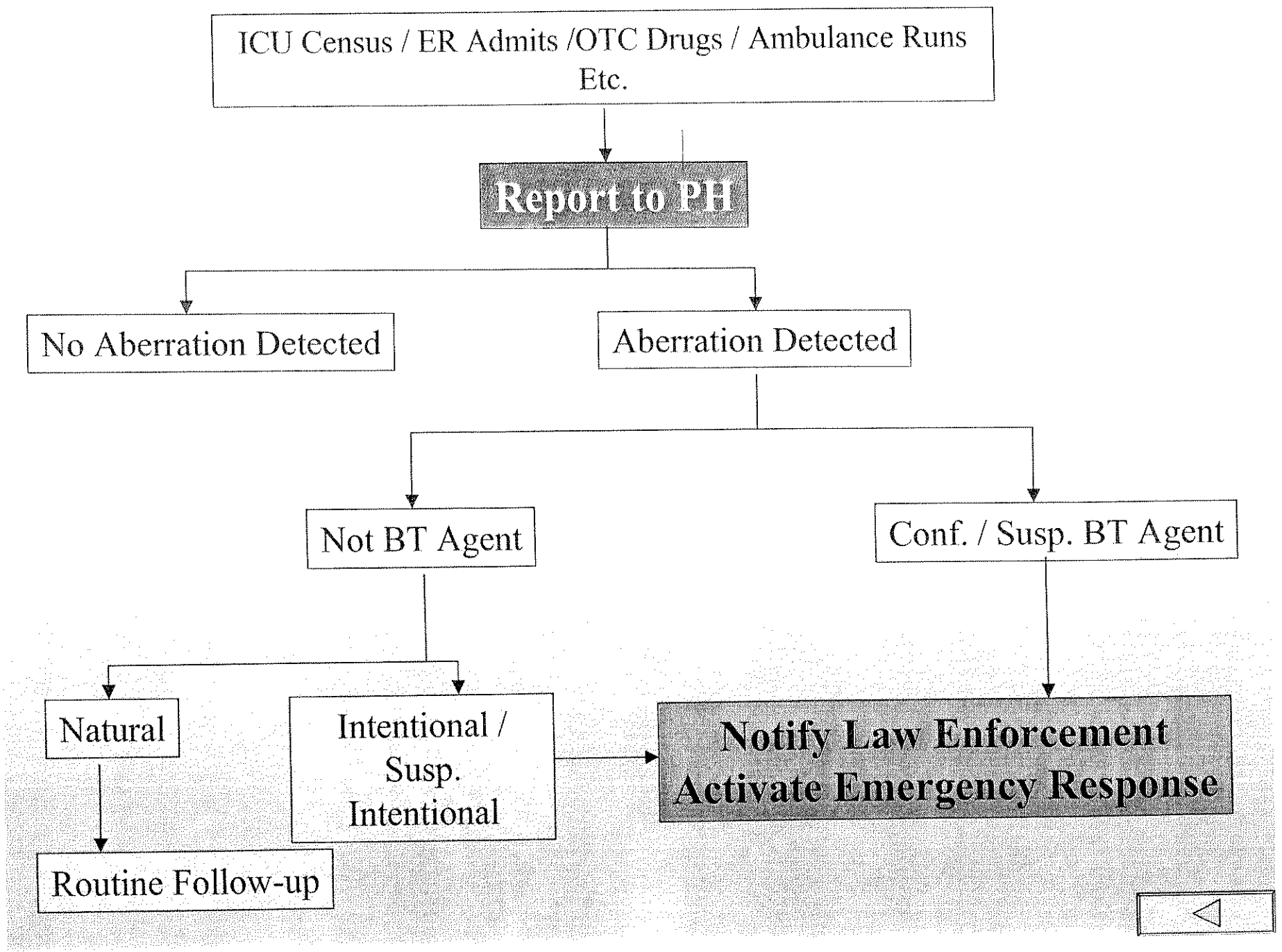
Attached please find the October 21, 2001 report by the Health Alert Network entitled *Health Authorities (Nevada State Health Division, Clark County Health District, Washoe District Health Department) Response to the Events of September 11, 2001.*

On October 19th Secretary of Health and Human Services, Tommy Thompson, conducted a conference call for all State Health Officials through the Association of State and Territorial Health Officers. Attached is a draft of a letter sent to the President of the United States requesting further emergency assistance for state health departments.

Recognition of Bioterrorist Events
Cases / Aberration / Threat (CAT)




Patient with Nonspecific Sx
Syndrome - Lab - or p
Syndrome + Lab -
Syndrome + Lab p
Syndrome + Lab +
Syndrome - Lab +
Active Surveillance
Report to PH
Isolated Case
Multiple Cases
BTT-
BTT+
Notify Law Enforcement
Activate Emergency Response
Routine Follow-up


ICU Census / ER Admits /OTC Drugs / Ambulance Runs Etc.
Report to PH
No Aberration Detected
Aberration Detected
Not BT Agent
Conf. / Susp. BT Agent
Natural
Intentional / Susp. Intentional
Notify Law Enforcement Activate Emergency Response
Routine Follow-up

Threat Announced
Notify Law Enforcement
Lab Analysis
Active Surveillance
Activate Emergency Response

STATE OF NEVADA

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FRANKIE SUE DEL PAPA
Attorney General

THOMAS M. PATTON
First Assistant Attorney General

February 12, 2002

Chairman Raymond D. Rawson
and Committee Members
Legislative Committee on Health Care
401 S. Carson Street
Carson City, Nevada

Re: February 12, 2002, Work Session on State Emergency Health Powers Act- Testimony

Dear Chairman Rawson and Committee Members:

My name is Randal Munn and I am a Senior Deputy Attorney General, representing the Department of Human Resources, Health Division. Attorney General Frankie Sue Del Papa is very interested that the substance of the Model State Emergency Health Powers Act proposed by the Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities makes its way into Nevada Law. Upon the leadership of Chairman Rawson, this Interim Legislative Committee on Health Care has courageously proposed the introduction of the Model Act as a Bill Draft for the 2003 Legislative Session. The Legislative Counsel Bureau released its first draft of the proposed Bill on December 18, 2001, essentially including the entire Model Act in its original form as a proposed new Public Health chapter to the Nevada Revised Statutes. The Committee's Principal Deputy Legislative Counsel, Leslie Hamner, has graciously agreed to consider comments on the first draft and the recently disclosed second draft, which was made available upon the Committee's website on February11, 2002. We apologize that our one-day review of the second draft is not a complete as we would like.

This Office has gone on record as fully supporting the intent to modernize our law, anticipating the potential need for broader authority in the event of bioterrorism. The Model Act is a valuable starting point to ensure that the existing holes in the statutory scheme are filled and strengthened.

However, it must be carefully crafted and integrated into the existing statutory scheme to avoid conflicting with, or causing redundancy in, the authority that does already exist, in part, in the Governor's NRS chapter 414 authority regarding declared "emergencies and disasters" and State and county health officers' authority regarding communicable diseases under NRS chapter 441A. Ms. Hamner has made significant strides in the second draft to bring the Model Act within the existing statutory scheme, specifically NRS chapter 414 (Emergency Mangement), avoiding the creation of a new public health chapter of the NRS.

As you know the Model Act merely set forth the elements of modern due process, not the procedure. The first draft proposed to include these elements without any procedural definition. The second draft attempts to provide more procedural definition, but the Office of the Attorney General is reluctant to support the creation of a unique and separate due process procedure for bioterrorism. This office has proposed changes to the current Bill Draft for Nevada's Emergency Health Powers Act that are consistent with the spirit and intent of the Model Act, and has proposed a completely fleshed-out single due process procedure that mimics Nevada's civil commitment of the mentally ill to be used in the event of a bioterrorism emergency and likewise in the run-of-the-mill isolated TB or other communicable disease case.

For the Model Act to be successfully advocated for passage by the Legislature, the fiscal impact of the added due process requirements must be fully identified and justified. Under Nevada's statutory scheme the modern due process requirements of "civil commitment" applied to "isolation and quarantine" would be new. The existing statutory scheme in NRS chapter 441A, for isolation and quarantine, has been based upon traditional "police powers" authority under the Nevada Constitution. Modernizing this due process consistent with court precedent will enhance the Bill's ability to obtain support from advocacy groups. Protecting due process will be the loudest opposition the Committee will hear regarding the Model Act. However, it will have a fiscal impact, and that expense will likely fall upon the counties, which currently primarily bears the due process responsibilities for civil commitment for the mentally ill.

The Office of the Attorney General strongly believes a same or similar due process procedure, with identical steps for: 1) civil commitment of the mentally ill; 2) civil commitment of those with communicable diseases; and, 3) civil commitment of the victims of a bioterrorism emergency will ensure that those responsible for providing procedural due process of law will not fail for lack of "experience" in the event that the need for a real emergency response is forced upon us. The same procedural due process, utilized every week in the courts of this state for the mentally, will ensure that judges, court staff, the prosecutors and the public defenders are always "trained" to timely respond to a public health emergency. The immediate legitimate fears of bioterrorism notwithstanding, public health emergencies will be rare events, We are advocating this Committee propose the same due process for all of these similar events, just simply applied to different facts.

Case law that supports modern concepts of procedural due process for those subject to isolation and quarantine rejects reliance of the State upon traditional police powers and requires essentially 5 elements of minimum due process: 1) an adequate written notice detailing the grounds and underlying facts on which commitment is sought; 2) the right to legal counsel; 3) the right to be present, cross-examine, confront and present witnesses; (4) the standard of proof to warrant commitment to be by clear, cogent and convincing evidence; and 5) the right to a verbatim transcript of the proceeding for purposes of appeal. Only in very extreme cases, such as historically supported case law regarding small pox or plague outbreaks, should the State feel justified in relying upon traditional police powers as its defense to the deprivation of liberty without procedural due process of law.

This office greatly appreciates the work done by this Committee and Legislative Counsel Bureau on this important issue. Attached is my mark-up edit to the second draft of the Bill. Due to the limited time available to review the second draft, I must caveat that the review of the second draft cannot be considered to be complete. The summary of the recommend changes and concerns are as follows:

- **Sec. 25(2)(a)**: Add new language: "...subsection *1* ~~2~~ of section 22 of the act;"
- **Sec. 25(3):** Add new sub-subsection: *"(d) Must be maintained as confidential except as otherwise provided in sections 27 and 28 of this act."*
- **Sec. 26(2):** Add new sub-subsection: *"(c) Must be maintained as confidential except as otherwise provided in sections 27 and 28 of this act."*
- **Sec. 27(1):** Add new language: "*Within each jurisdiction, a* ~~Each~~ health authority shall:"
- **Sec. 28(2):** Add new language: "Except as otherwise provided in subsection 3, the state health officer shall immediately notify the *governor, the legislative counsel, the* division of emergency management, ~~of~~ the department of human resources,..."

- **Sec 29:** The Office of the Attorney General does not know the Governor's position regarding the Interim Finance Committee being granted a form of veto power over an executive branch function. This office cautions that granting such power to a interim committee of the Legislature could prove problematic during a disputed public health emergency.
- **Sec 31(2):** Add new language: *"The state health division, after consultation with* the state health officer is responsible for:"
- **Sec 31(3):** Add new language: "In carrying out the provisions of subsection 2, the state health *division* ~~officer~~ shall work closely with:"
- **Sec. 35(2)(a):** Add new language: "2. Except as otherwise provided in this section, during a state of public health emergency, each health authority may: (a) If the state of public health emergency results in a statewide or regional shortage or threatened shortage of antitoxins, serums, vaccines, immunizing agents, antibiotics and other pharmaceutical agents or medical supplies, *maintain* control, restrict or...."
- **Sec. 41 though 48**: Omit and Replace with due process procedure, as edited: NRS 433A.145 to 433A.330, inclusive, regarding adapting civil commitment of the mentally ill to the facts of communicable diseases and bioterrorism through NRS chapter 441A (communicable diseases).
- **Sec. 54(1):** Add new language: "The state health *division* ~~officer~~ shall, in the manner set forth in subsections 2 and 3, inform the persons of this state:"
- **Sec 55:** The Office of the Attorney General does not know the position of the Governor regarding the need for and the participants in a new commission. If a commission is created, there needs to be expressed authority to provide payment for travel and per diem for commission members.
- **Sec 67(3):** Add new language: "...The chief and the state health *division* ~~officer~~, subject to the direction and control of the governor, shall carry out a response to a public emergency."
- **Sec 81 through 88:** Omit and Replace with Sections 41 through 48, as proposed to be amended by the Office of the Attorney General, will provide a constitutional procedural due process for both NRS chapter 414 (Emergency Management) and NRS chapter 441A (Communicable Diseases).

Thank you for your consideration.

Cordially,

FRANKIE SUE DEL PAPA
Attorney General

By: Randal R. Munn

Randal R. Munn
Senior Deputy Attorney General
Human Resources Division
(775) 684-1135

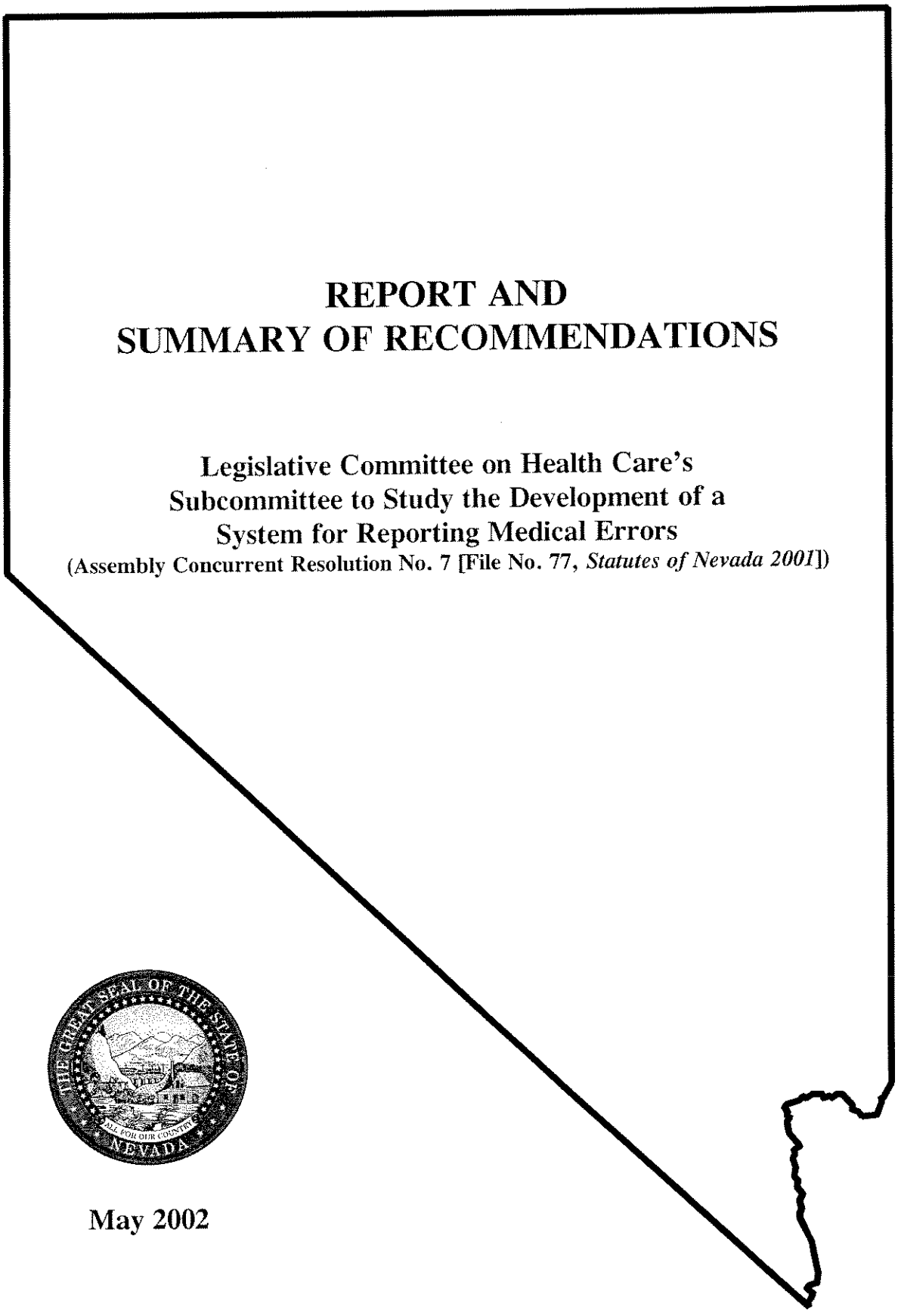
APPENDIX H

Report and Summary of Recommendations—Legislative Committee on Health Care's Subcommittee to Study the Development of a System for Reporting Medical Errors (Assembly Concurrent Resolution No. 7 [File No. 77, Statutes of Nevada 2001])—May 2002

REPORT AND SUMMARY OF RECOMMENDATIONS

Legislative Committee on Health Care's Subcommittee to Study the Development of a System for Reporting Medical Errors

(Assembly Concurrent Resolution No. 7 [File No. 77, *Statutes of Nevada 2001*])



May 2002

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SUMMARY OF RECOMMENDATIONS

LEGISLATIVE COMMITTEE ON HEALTH CARE'S SUBCOMMITTEE TO STUDY THE DEVELOPMENT OF A SYSTEM FOR REPORTING MEDICAL ERRORS (2001-2002)

(Assembly Concurrent Resolution No. 7 [File No. 77, *Statutes of Nevada 2001*])

This summary presents the recommendations approved by the Legislative Committee on Health Care's Subcommittee to Study the Development of a System for Reporting Medical Errors during the 2001-2002 legislative interim at its final meeting on April 16, 2002, in Las Vegas, Nevada. The recommendations have been forwarded to the Legislative Committee on Health Care for its consideration.

General Recommendations for Statements

1. **Send a letter from the Legislative Committee on Health Care to the medical professional associations and organizations in this state urging them to create a Nevada Alliance for Patient Safety (NAPS). The goals of the alliance are: (1) to establish a mechanism to identify and implement best practices to minimize medical errors; (2) to increase awareness of error prevention strategies through public and professional education; and (3) to identify areas of mutual interest and minimize duplication of regulatory and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requirements so that efforts are focused on initiatives that can best improve patient care. Membership in the NAPS would include all professional associations and organizations and advocacy groups that are willing to participate, with relevant state agencies invited to serve as advisory members. The NAPS would provide an annual report to the Legislative Committee on Health Care.**

2. **Send a letter from the Legislative Committee on Health Care to each licensed medical facility in this state urging the facility to provide to each patient upon admission: (1) a statement referencing its mission to ensure a safe patient environment and that the rights of patients are recognized and respected; and (2) a copy of the Patient's Rights provisions set forth in the *Nevada Revised Statutes* (NRS). The facility would also include in its admission package the telephone number and address for: (1) the facility's safety director; (2) the Bureau of Licensure and Certification, Health Division, Nevada's Department of Human Resources (DHR); (3) JCAHO; and (4) the Office of Consumer Health Assistance in the Office of the Governor. This information would be provided to assist a patient who may have a question and to assist if an issue arises that the patient believes should be reported.**

Recommendations for Statements Related to State Agency Programs

3. Send a letter from the Legislative Committee on Health Care to DHR urging the Department to require, to the extent authorized by law, medical facilities that are not accredited by JCAHO to maintain a confidential file of "sentinel events" as defined by JCAHO. This file would only be available to the licensure survey personnel of the Bureau of Licensure and Certification at the time of on-site surveys.

4. Send a letter from the Legislative Committee on Health Care to DHR and the chairmen and members of the Legislature's Senate Committee on Finance and the Assembly Committee on Ways and Means urging support for sufficient funding for the Bureau of Licensure and Certification to conduct on-site annual reviews of all medical facilities to ensure that the requirements contained in the *Nevada Administrative Code* (NAC) relating to quality of care and patient safety are being satisfied.

5. Send a letter to the Board of Regents of the University and Community College System of Nevada encouraging the Board to make programs for licensed health care professionals such as nursing a top priority for the upcoming biennium. See Appendix C.

General Recommendation for Legislative Measure

6. Request the drafting of a bill requiring DHR to develop a statewide medical adverse event surveillance system. This system must protect the privacy of patients and should be administered by an entity with experience in health care data analysis using existing vital statistics and electronic hospital discharge data.

Recommendation for Legislative Measure Concerning Reporting Systems for Reporting Medical Errors

7. Request the drafting of a bill authorizing DHR to establish an Internet-based registry for an anonymous, voluntary, password-protected, standardized incident reporting system and registry. Medical facilities would be authorized to input confidential information into the registry. The system would track adverse events and near misses attributable to errors in medical facilities and in the practice of dentistry, medicine, nursing, and pharmacy. Participation in the registry would be voluntary. The system would be operated by an entity under contract with the DHR, and the entity would present its findings to the Legislative Committee on Health Care and the Nevada Alliance for Patient Safety, if established as set forth in Recommendation 1, to provide public access to aggregate data and reports. The establishment of the reporting system would be dependent on state funding or grants, gifts, endowments, bequests, or direct appropriation for its creation.

REPORT TO THE LEGISLATIVE COMMITTEE ON HEALTH CARE BY THE LEGISLATIVE COMMITTEE ON HEALTH CARE'S SUBCOMMITTEE TO STUDY THE DEVELOPMENT FOR A SYSTEM FOR REPORTING MEDICAL ERRORS

I. INTRODUCTION

This report is submitted in compliance with Assembly Concurrent Resolution No. 7 (File No. 77, *Statutes of Nevada 2001*) of the 71st Session of the Nevada Legislature, which directs the Legislative Committee on Health Care to appoint a subcommittee to conduct a study concerning the development of a system for reporting medical errors. A copy of A.C.R. 7 is included as Appendix A.

The Legislative Committee on Health Care appointed the following members:

John Yacenda, Ph.D., M.P.H., P.A.H.M., Chairman
Senator Bernice Mathews
Assemblywoman Bonnie Parnell
Bernard Feldman, M.D., M.P.H.
Nancy Whitman

Staff services from the Legislative Counsel Bureau (LCB) were provided by Marjorie Paslov Thomas, Senior Research Analyst; Leslie K. Hamner, Principal Deputy Legislative Counsel; and Deborah Rengler, Senior Research Secretary.

This report summarizes and provides a comprehensive review of the topics considered and acted upon by the Subcommittee relating to developing a system for reporting medical errors. Only information that bears directly on the scope of the study and the Subcommittee's recommendations is included. All other supporting documents and minutes of meetings are on file with the LCB's Research Library.

The Subcommittee considered topics such as:

- Mandatory and voluntary medical error reporting systems;
- Mechanisms for reporting medical errors by Nevada's professional licensing boards;
- Patient safety initiatives in Nevada and other states;
- Shortage of nurses in Nevada and the United States;
- Efforts of Nevada's hospitals and medical facilities to respond to reported adverse events;
- Medical errors and outcomes that are detrimental to a patient;

- Benefits of root cause analysis, which is performed by hospitals, to identify potential opportunities for failure before they occur; and

- Responsibilities and surveying activities of the Bureau of Licensure and Certification (BLC), Health Division, Nevada's Department of Human Resources (DHR).

The consideration and deliberation of these matters were integral to the understanding of whether a system should be established for reporting medical errors in Nevada. Formal presentations, staff reports, and public testimony informed the members and meeting attendees of these issues.

Many people attended the Subcommittee's hearings and listened to the meetings via the Internet. To ensure the greatest level of participation, the Subcommittee notified interested parties by written correspondence to submit recommendations. (A copy of the letter is included in this report as Appendix B.)

At its work session, the Subcommittee approved seven recommendations. The recommendations address the following issues:

- Creating an alliance among state agencies and existing medical professional associations and organizations for the purpose of sharing information and knowledge regarding the causes of and potential strategies for preventing medical errors;

- Increasing patient safety by providing certain information at the time a patient is admitted to a medical facility;

- Allowing licensure survey personnel of the BLC, Health Division, DHR, access to confidential files of adverse events at medical facilities that are not accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO);

- Increasing funding to the BLC to conduct on-site annual reviews of all medical facilities;

- Encouraging the Board of Regents of the University and Community College System of Nevada (UCCSN) to make nursing programs a top priority during the next biennium;

- Developing a statewide medical adverse event surveillance system; and

- Authorizing the establishment of an Internet-based incident reporting system and registry.

The Subcommittee has forwarded these recommendations to the Legislative Committee on Health Care for its consideration.

II. REVIEW OF ASSEMBLY CONCURRENT RESOLUTION NO. 7 (FILE NO. 77, *STATUTES OF NEVADA 2001*)

Assembly Concurrent Resolution No. 7 (File No. 77, *Statutes of Nevada 2001*) directs the Legislative Committee on Health Care, through a subcommittee, to conduct an interim study concerning the development of a system for reporting medical errors. The resolution sets forth the criteria that must be included in the study.

The study must make a determination of what constitutes:

- A medical error;
- An outcome that is detrimental to a patient; and
- A medical error that causes an outcome that is detrimental to a patient.

The study must evaluate:

- Systems for reporting medical errors;
- Whether such a system should be established in Nevada;
- Effective ways the system may impose mandatory reporting of medical errors; and
- Methods for ensuring that information reported to the system remains confidential and that the system does not encourage blaming an individual medical professional for a medical error.

The study must also consider:

- The proper use of the information that is reported to the system, including whether standards should be established to use the information to prevent or reduce preventable medical errors;
- Which health care entities should be required to report information concerning medical errors to the system;
- Whether sanctions should be imposed on a medical professional who fails to comply with the reporting requirements of the system; and
- The relationship between medical errors and the licensing of medical professionals.

In addition, the study must use the report "To Err is Human: Building a Safer Health System," which was released by the Institute of Medicine (IOM) in November 1999.

III. BACKGROUND

In 1999, the IOM released a report titled "To Err is Human: Building a Safer Health System." The authors of this report stated that between 44,000 and 98,000 people die each year in hospitals from preventable medical errors, which are a leading cause of death in this country. The IOM based its estimate of the number of deaths due to medical errors on the results of two large studies, one conducted in Colorado and Utah and the other in New York. The Colorado and Utah study indicated that at least 44,000 Americans die each year as a result of medical errors. The New York study suggested that the number may be as high as 98,000. Comparing these figures with data on the number of deaths attributable to other causes, which are contained in the National Center for Health Statistics reports, the authors concluded that the number of deaths attributable to preventable medical errors annually exceeds the number of deaths attributable to motor vehicle accidents (43,458), breast cancer (42,297), or acquired immunodeficiency syndrome (AIDS) (16,516).

Medical errors have direct consequences for patients and their families. Moreover, the IOM reports the country incurs direct and indirect costs as a result of preventable medical errors, including higher expenditures for health care and lost productivity. Total national costs related to lost income, lost household production, disability, and health care costs of preventable adverse events are estimated to be between $17 billion and $29 billion, of which health care costs represent over one-half.

The IOM report proposed several error prevention and reduction strategies including a proposal to implement a state-based mandatory reporting system, beginning with hospitals, to collect information about adverse events that cause death or serious harm; and public disclosure of reported information in order to hold providers publicly accountable for egregious errors. Also, the IOM report recommended that states establish voluntary reporting systems to collect information about "near misses" and errors that result in less serious injury or no harm. Further, the IOM report proposes "a comprehensive strategy to improve patient safety is to create an environment that encourages organizations to identify errors, evaluate causes, and take appropriate actions to improve performance in the future."

Following the release of the IOM's 1999 report, Nevada's Legislative Committee on Health Care heard discussion about medical errors during the 1999-2000 interim period. The Committee listened to testimony regarding nurse staffing levels and medical errors relating to patient safety. People who testified on this matter indicated that Nevada does not have an external medical error reporting system. Therefore, the Committee recommended that the Legislature establish an interim subcommittee to consider whether a health care errors reporting system should be established in Nevada.

In addition, according to the National Academy for State Health Policy (NASHP), mandatory and voluntary reporting programs throughout the country are evolving. Although no one model exists, many states have laid the foundation from which other states can learn as they build programs explicitly designed to report on adverse events for the identification of

medical errors. For instance, Maryland has established a confidential mandatory reporting system for reporting of egregious and nonegregious medical errors. Also, legislation enacted in Minnesota provides for voluntary reporting of near misses and adverse events through a publicly accessible Web-based site. Patient and provider identities are confidential, and only aggregated trend data is made available.

IV. SUBCOMMITTEE ACTIVITIES

The Legislative Committee on Health Care's Subcommittee to Study the Development of a System for Reporting Medical Errors held three meetings, including a work session. Two meetings were held in Las Vegas, and one meeting was held in Carson City. All three meetings were public hearings and were videoconferenced between the Legislative Building in Carson City and the Grant Sawyer State Office Building in Las Vegas.

During the course of the interim study, the Subcommittee reviewed a variety of issues related to medical errors and the current systems for reporting medical errors in Nevada. The Subcommittee received testimony regarding medical errors and reporting systems, including statements from representatives of state agencies, the National Conference of State Legislatures (NCSL), advocacy groups, citizens, health care organizations, and professional health care unions. Following are summaries of the Subcommittee's deliberations and activities at each of the three meetings:

- **December 5, 2001, Meeting in Las Vegas**

  The Subcommittee's first meeting was held in Las Vegas on December 5, 2001. The Subcommittee was charged, among other things, with determining what constitutes a medical error and an outcome that is detrimental to a patient. Therefore, the Subcommittee heard from: (1) a variety of state agencies, including the BLC and the Division of Mental Health and Developmental Services, DHR; (2) professional health care licensing boards; and (3) professional associations, including the Nevada Nurses Association; the Nevada Pharmacy Alliance; and the Service Employees International Union, Local 1107, concerning their perspectives of a definition for a medical error. Also, the Subcommittee received a description of their respective systems currently in place for reporting medical errors. This information served as a basis for: (1) determining the types of medical error reporting systems that are currently being utilized in Nevada; (2) the function of these reporting systems to protect consumers from health care professionals who violate their practice act; and (3) ensuring problems do not reoccur.

- **February 11, 2002, Meeting in Carson City**

  During the second meeting of the Subcommittee, members received testimony concerning mandatory and voluntary reporting systems. The Subcommittee focused its attention on

hospital facilities and listened to presentations concerning the current system for reporting medical errors from the perspective of the nursing staff and hospital administrators.

First, representatives from an association of nurses recommended the State of Nevada create a mandatory medical error reporting system that would encourage health care providers to invest in and improve patient safety. The system would require information about adverse events, information regarding nurse-to-patient ratios, hours worked, and ratio of licensed-to-unlicensed personnel be reported.

Subcommittee members also received a comprehensive report by members of the Nevada Hospital Association (NHA) regarding hospital reporting systems, BLC and Medicare patient safety standards, and how the hospital industry meets those standards. Moreover, the NHA's report highlighted risk management programs, quality assurance activities, health care quality management practices, and community-wide patient safety initiatives.

Additionally, the Subcommittee received testimony from the Health Policy Tracking Service of the NCSL on state statutes relating to medical errors and patient safety. This information was provided as background to the members. According to NCSL, at least 21 states have adopted regulations or enacted laws since the early 1990s addressing some aspect of reducing medical errors, including medication error reporting and quality improvement programs. These states include: Colorado, Florida, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Montana, New Jersey, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Virginia, and Washington.

Staff of the LCB presented comparative information obtained from six of Nevada's professional licensing boards with respect to their policies and statutory responsibilities for reporting medical errors. Through licensure, licensing boards ensure that providers have the appropriate education and training and comply with standards of professional conduct. Information to the contrary is furnished to the boards through complaints from consumers, malpractice data, information from hospitals and other medical facilities, and reports from government agencies. When a board receives information that might indicate a violation of professional standards, the board has the authority to investigate, hold hearings, and impose discipline. Staff also provided a worksheet designed to provide technical information to assist in designing and implementing a mandatory reporting system.

Based on testimony from the December 2001 meeting, the Subcommittee used the IOM's definition as its model, and it adopted the following definition regarding what constitutes a medical error and an outcome that is detrimental to a patient:

> An adverse event is "an injury or complication caused by medical management rather than the underlying condition of the patient."

➢ **April 16, 2002, Meeting and Work Session in Las Vegas**

The third meeting of the Subcommittee began with a presentation concerning the current systems for reporting medical errors in medical facilities other than hospitals. A representative of the BLC made a presentation concerning the definition of a medical error and a description of the current system for reporting medical errors relating to medical facilities as defined in Chapter 449 of the *Nevada Revised Statutes*. Following, a presentation was given by the Executive Director of the Nevada Health Care Association on the same subject. The Subcommittee heard an overview regarding consumer rights and patient safety in hospitals.

At each of the meetings, the Subcommittee heard from health care experts who dismissed the IOM report "To Err is Human: Building a Safer Health System" as flawed. For instance, the report was based on data from one study that was performed in 1984 yielding 98,000 deaths due to medical errors and a 1992 study yielding 44,000 deaths due to medical errors. Also, a number of health care professionals and professional groups dispute the reliability of the report.

The work session portion of the meeting included discussion of and action on recommendations presented during this interim. Specific information on the approved recommendations is located under the section of this report titled "Discussion of Recommendations."

V. DISCUSSION OF RECOMMENDATIONS

At its work session in Las Vegas, the Subcommittee considered several recommendations relating to medical errors and patient safety. The Subcommittee members voted on eight of the recommendations. The Subcommittee recommended the Legislative Committee on Health Care consider two bill draft requests and sending four policy statements to various agencies and medical facilities. The members of the Subcommittee, with the approval of the Chairman of the Legislative Committee on Health Care, also sent a policy statement to the Board of Regents of the UCCSN. In addition, four recommendations were considered but not acted on by the Subcommittee.

It is important to note that A.C.R. 7 specifies that no action may be taken by the Subcommittee on recommended legislation unless it is approved by a majority of the members of the Senate and a majority of the members of the Assembly appointed to the Subcommittee. All recommendations presented to the Subcommittee, including those not acted upon, are found in the Work Session Document included as Appendix C.

A. General Statements

This section provides background information for each recommendation that was approved by the Subcommittee.

Creating a Nevada Alliance for Patient Safety

The Chairman of the Subcommittee based his recommendation to establish the Nevada Alliance for Patient Safety (NAPS) on his personal research as a member of the NASHP's patient safety network and as Chief Executive Officer of Health Care Strategies, Inc. The Subcommittee reviewed this proposal during the work session. According to the Chairman, much like Nevada, Massachusetts and several other states have been studying the issue of medical errors. Studies on medical errors have found these events often result from system problems rather than human error. The Chairman asserted that the most effective means for achieving a consensus on significant system changes is to involve professionals in productive dialogue.

The Chairman also noted that other states have formed similar coalitions, and he provided the Massachusetts Coalition for the Prevention of Medical Errors as a model for the NAPS (Appendix D). The Coalition is a forum for sharing information about the causes of medical errors and possible prevention strategies. The participants in the Coalition include federal and state agencies with responsibility for licensure and oversight; accrediting bodies; clinical researchers; consumer organizations; individual health care providers; malpractice insurance carriers; and professional associations representing hospitals, long-term care institutions, nurses, and physicians. (Appendix A of a NASHP report scheduled for release in June 2002 detailing patient safety coalitions in 17 states is included in this report as Appendix E.)

The members of Subcommittee recognized NAPS would build a consensus among established organizations on prevention strategies and provide a public policy forum for different groups to discuss patient safety and encourage consumer education. Members agreed an organization such as NAPS may increase the public's awareness of patient safety.

Therefore, the Subcommittee recommends:

Sending a letter from the Legislative Committee on Health Care to the medical professional associations and organizations in this state urging them to create a Nevada Alliance for Patient Safety (NAPS). The goals of the alliance are: (1) to establish a mechanism to identify and implement best practices to minimize medical errors; (2) to increase awareness of error prevention strategies through public and professional education; and (3) to identify areas of mutual interest and minimize duplication of regulatory and Joint Commission on Accreditation of Healthcare Organizations requirements so that efforts are focused on initiatives that can best

improve patient care. Membership in the NAPS would include all professional associations and organizations and advocacy groups that are willing to participate, with relevant state agencies invited to serve as advisory members. The NAPS would provide an annual report to the Legislative Committee on Health Care.

B. STATEMENTS RELATED TO STATE AGENCY PROGRAMS

1. *Increasing Patient Safety in Medical Facilities*

Testimony indicated some medical facilities in Nevada currently provide information to patients regarding their rights while in a facility, yet others do not. A medical facility may provide telephone numbers for its safety director, the BLC, and the Office of Consumer Health Assistance in the Office of the Governor in the event that a problem arises. Also, the Service Employees International Union, Local 1107, indicated in written correspondence that health care consumers are not aware how to contact state agencies to report problems. As a result, many problems are not reported or investigated.

The Subcommittee noted that there were two similar recommendations and merged them to create one statement. Members were of the opinion it is valuable for patients to receive a copy of their rights and the contact information to report problems. However, members stated it might not be effective to provide the information at the time of admission since the patient receives so much paperwork. The Subcommittee was unable to reach agreement on the exact time this information should be provided to patients but felt the recommendation to provide an admission package with key information to patients of all medical facilities should be forwarded to the Legislative Committee on Health Care for its consideration.

Therefore, the Subcommittee recommends:

Sending a letter from the Legislative Committee on Health Care to each licensed medical facility urging the facility to provide to each patient upon admission: (1) a statement referencing its mission to ensure a safe patient environment and that the rights of patients are recognized and respected; and (2) a copy of the Patient's Rights provisions set forth in the *Nevada Revised Statutes*. The facility would also include in its admission package the telephone number and address for: (1) the facility's safety director; (2) the Bureau of Licensure and Certification, Health Division, Nevada's Department of Human Resources; (3) the Joint Commission on Accreditation of Healthcare Organizations; and (4) the Office of Consumer Health Assistance in the Office of the Governor. This information would be provided to assist a patient who may have a question and to assist if an issue arises that the patient believes should be reported.

2. *Confidential File of Sentinel Events*

The JCAHO is the largest accrediting organization of hospitals, accrediting about 80 percent of the nation's 6,200 hospitals. Accreditation by JCAHO is a voluntary form of self-regulation for which hospitals pay a fee. Industry experts define operational standards to which organizations must conform in order to be accredited, and survey teams that visit the hospital systematically assess the organization's performance against a set of standards.

The JCAHO has established a Sentinel Event Policy that defines occurrences that are subject to review by the Joint Commission. The JCAHO accreditation process, including all full accreditation surveys and random unannounced surveys, reviews an organization's activities in response to a sentinel event.[1] If the Joint Commission becomes aware of a sentinel event in an accredited organization and the occurrence meets the criteria for review under the Sentinel Event Policy, the organization is required to submit or otherwise make available an acceptable root cause analysis and action plan or otherwise provide for Joint Commission evaluation of its response to the sentinel event under an approved protocol within 45 calendar days of the event or of its becoming aware of the event.

The BLC provided written information during the interim indicating it licenses 289 medical facilities, of which 44 are JCAHO accredited. A representative of the BLC testified that of the 46 licensed hospitals in Nevada, JCAHO accredits 28. Testimony indicated that non-JCAHO accredited hospitals and other licensed medical facilities monitor the quality of care received in a facility; however, there is no common system used for reporting errors throughout the state by non-JCAHO accredited facilities.

The members of the Subcommittee discussed using the JCAHO's definition of "sentinel events" as it would negate the need to develop a separate or additional list for non-JCAHO accredited hospitals and other licensed medical facilities. Members also noted that the recommendation would broaden the collection, analysis, and review of medical errors to include health care facilities other than hospitals.

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[1] A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. (Sentinel Event Policy and Procedure, JCAHO, January 2002).

Therefore, the Subcommittee recommends:

Sending a letter from the Legislative Committee on Health Care to the Department of Human Resources (DHR) urging the Department to require, to the extent authorized by law, medical facilities that are not accredited by JCAHO to maintain a confidential file of "sentinel events" as defined by JCAHO. This file would only be available to the licensure survey personnel of the Bureau of Licensure and Certification, Health Division, DHR, at the time of on-site surveys.

3. ***On-Site Annual Reviews by the Bureau of Licensure and Certification of All Medical Facilities***

Testimony indicated the BLC became a fee-funded agency through licensure fees charged to each facility seeking to be licensed as of July 1, 1993. The BLC's primary function is to license medical facilities and facilities for dependent persons in accordance with NRS and the *Nevada Administrative Code*. Surveys (inspections) are conducted in accordance with applicable regulations based on the type of facility and following specific time frames and survey procedures. The BLC also conducts complaint investigations for all licensed facilities.

The NHA presented a recommendation urging support for funding to the BLC of $3 million in the upcoming biennium to conduct on-site annual reviews. A representative of NHA explained this appropriation would provide for increased reviews of facilities without substantially increasing the fees charged to facilities for the BLC to conduct the surveys. The NHA indicated annual reviews of medical facilities, rather than variable schedules, assist facilities in complying with regulations.

The representative from the Health Division noted that for Fiscal Year 2003, the Division is projecting a workload increase that requires additional staff to conduct surveys as currently required. The BLC will be proposing fee increases in June 2002 to the State Board of Health. The NHA indicated its proposal for funding to the BLC is the result of the rate increase proposed by the BLC to cover an anticipated shortfall in resources.

Members of the Subcommittee recognized the importance of the BLC performing on-site annual reviews of all medical facilities. Annual reviews would ensure all medical facilities are in compliance with licensure regulations. Such reviews would also establish a baseline for data that could then be utilized by the state. However, members were of the opinion that the recommendation should simply urge support for funding, rather than specifying a dollar amount. This would allow the Legislative Committee on Health Care to determine an appropriate dollar amount.

Therefore, the Subcommittee recommends:

The Legislative Committee on Health Care send a letter to the Department of Human Resources and the chairmen and members of the Legislature's Senate Committee on Finance and the Assembly Committee on Ways and Means urging support for providing funding for the Bureau of Licensure and Certification, Health Division, Department of Human Resources, to conduct on-site annual reviews of all medical facilities to ensure that the requirements contained in the *Nevada Administrative Code* relating to quality of care and patient safety are being satisfied.

C. SUBCOMMITTEE LETTER

This section provides background information concerning a letter sent from the Subcommittee to the Chairman of the Board of Regents of the UCCSN for the April 18, 2002, meeting. A copy of the letter is included as Appendix F of this report.

Education Programs for Nursing

According to the NCSL's Health Policy Tracking Service, many states across the nation are creating ways to retain registered nurses and stop the rising nursing shortages. The NHA indicated there is a 13 percent shortage of nurses in Nevada's hospitals, compared to the national figure of 9.8 percent. Further, they noted that anything in excess of 8 percent could be considered a crisis. Therefore, the country is experiencing a nursing shortage, which is particularly acute in Nevada. Testimony also disclosed that Nevada ranks first in the severity of the nursing shortage experienced in this country followed by California.

According to testimony presented to the Subcommittee, of the six nursing programs in Nevada, all but one had a sufficient number of qualified applicants to increase their nursing enrollments by 50 percent. Further, some nursing programs had enough nursing applicants to double their enrollment during the last school year. The Subcommittee also heard there are several licensed practical nurses and certified nursing assistants in Clark County wishing to become registered nurses; however, the Community College of Southern Nevada does not offer courses in the evening, thereby excluding those who work during the day from attending classes.

Testimony indicated the State of Nevada finances the educational costs of approximately 300 registered nurses per year, and the hospital industry provides funding for facilities, nursing instructors, and other student nurses. These programs are producing almost 400 registered nurses each year. However, there is a need for 697 new nurses each year. This figure takes into consideration a 25 percent allowance for attrition.

Members of the Subcommittee discussed the fact that the Nevada Legislature passed Assembly Bill 378 (Chapter 580, *Statutes of Nevada 2001*) during the 2001 Session in part

to address the nursing shortage. Among the provisions of A.B. 378, the UCCSN is required to develop a plan for doubling the enrollment of nursing. The NHA recommended the Subcommittee request the drafting of a bill by the Legislative Committee on Health Care to appropriate $11 million for the first year of the next biennium and $5 million for the following year to fund the UCCSN programs for licensed health care professionals with an emphasis on nursing.

The Subcommittee recognized and supported doubling the enrollment of students in Nevada's nursing programs. However, the UCCSN is still developing its plan to increase the capacity of nursing programs within the system. Therefore, the UCCSN and the 2003 Legislature would have to determine an appropriation funding level for the program once the plan is presented.

Therefore, the Subcommittee voted unanimously to:

Send a letter to the Board of Regents of the University and Community College System of Nevada encouraging the Board to make programs for licensed health care professionals such as nursing a top priority for the upcoming biennium.

D. LEGISLATIVE MEASURE CONCERNING REPORTING SYSTEMS FOR REPORTING MEDICAL ERRORS

1. *Statewide Medical Adverse Event Surveillance System*

Based on testimony presented during the Subcommittee's meetings, the members concluded there is no state agency, program, or system in Nevada that identifies and tracks medical errors or adverse events. Thus, there are no numbers or accurate reports reflecting the occurrence of medical errors, adverse events, or deaths due to medical errors.

Testimony indicated a statewide medical adverse event surveillance system provides surveillance data that is not available on adverse events across the state. This type of system would review the number of adverse events that occur, culling information from all existing sources of reporting. Information should not be collected on people who suffered unfortunate events. Instead, the information should be used to profile care, determine whether there are issues that need to be addressed, and to evaluate whether circumstances are improving.

The surveillance system would be used to actively track adverse event occurrences, their distribution, and trends. The ongoing collection, analysis, and dissemination of the data would provide for appropriate policy and program responses to the occurrence of adverse events based on Nevada-specific data and trended analyses.

Members of the Subcommittee noted that this system would actively review adverse events associated with health care in various medical settings. Members expressed concern about allowing a public entity to review confidential medical records. Members of the Subcommittee also recognized the budget constraints facing the State of Nevada and expressed concern regarding the appropriation to establish a system. The Subcommittee determined the recommendation should be forwarded without an appropriation to allow the Legislative Committee on Health Care to consider the recommendation. In this way, the Legislative Committee on Health Care can determine the appropriate amount of money necessary to establish such a system.

Therefore, the Subcommittee recommends:

The Legislative Committee on Health Care request the drafting of a bill requiring the Department of Human Resources to develop a statewide medical adverse event surveillance system. This system must protect the privacy of patients and should be administered by an entity with experience in health care data analysis using existing vital statistics and electronic hospital discharge data.

2. ***Internet-Based Reporting System and Registry***

According to the NASHP, mandatory and voluntary reporting systems should be complimentary, not mutually exclusive. Mandatory reporting requirements impose a legal obligation to report error-related events to a governmental entity, a nongovernmental entity like a hospital risk manager, or both. Voluntary reporting requirements do not impose any obligations on the part of the reporter. The focus of voluntary reporting is on research, detection of systemic problems, and the identification of prevention strategies. Because these collect information about different kinds of errors and because their primary goals are not the same, mandatory and voluntary reporting systems provide a balanced approach to achieving two important goals of reporting: (a) public accountability; and (b) increased understanding about how and why errors occur.

Proponents of a mandatory system indicated this type of system is crucial to ensure serious adverse events are investigated and corrected. Further, a mandatory system is an important part of the BLC's oversight responsibilities and may give health care facilities an incentive to improve patient safety or be subject to penalties or public exposure.

Opponents of a mandatory system explained a mandatory system discourages reporting and the ability to learn about medical errors. While Nevada should consider establishing a medical error reporting system, it was the consensus of the Subcommittee that such a system should not be established at this time given the lack of a documented statewide medical error problem, significant financing issues, and the availability of other alternatives that would collectively reduce adverse events and increase patient

safety. The Subcommittee noted that a goal of a reporting system is to reduce medical errors, and the evidence does not support this assumption. Other reporting systems should be analyzed to determine whether they are decreasing medical errors.

Based on his research of other state's medical error reporting systems, federal and health care organization report cards on medical facilities, and testimony provided throughout the interim period, the Chairman of the Subcommittee proposed a confidential, voluntary, password-protected, standardized incident Internet-based reporting system and registry. This system would track information obtained from medical facilities and offer the public a better perspective of medical errors. By design, this system would aggregate the data and generate a report by area such as a community or region. Interested parties would be able to obtain this information without reviewing complex statistical reports.

As a model for this proposed reporting system and registry, the Chairman used Minnesota's Senate File 560. A copy of S.F. 560 is included as Appendix G to this report. This legislation allows medical peer review organizations to participate in an Internet-based information-sharing system to identify and analyze trends in medical errors. The goal of S.F. 560 is to permit the exchange of information regarding medical errors and mistakes between health care providers in a protected manner so that Minnesota health care providers learn from each other's experiences and prevent future mistakes.

The Subcommittee members agreed establishing a system that shares information about patient safety is important. Members noted the aggregate data should be provided to the Legislative Committee on Health Care and the NAPS, if created. This data may result in measurable quality and safety improvements in Nevada's health care system.

Therefore, the Subcommittee recommends:

The Legislative Committee on Health Care request the drafting of a bill authorizing the Department of Human Resources (DHR) to establish an Internet-based registry for an anonymous, voluntary, password-protected, standardized incident reporting system and registry. Medical facilities would be authorized to input confidential information into the registry. The system would track adverse events and near misses attributable to errors in medical facilities and in the practice of dentistry, medicine, nursing, and pharmacy. Participation in the registry would be voluntary. The system would be operated by an entity under contract with the DHR, and the entity would present its findings to the Legislative Committee on Health Care and the Nevada Alliance for Patient Safety, if established as set forth in Recommendation 1, to provide public access to aggregate data and reports. The establishment of the reporting system would be dependent on state funding or grants, gifts, endowments, bequests, or direct appropriation for its creation.

VI. CONCLUDING REMARKS

The Legislative Committee on Health Care's Subcommittee to Study the Development of a System for Reporting Medical Errors spent the interim considering numerous topics as they relate to medical errors and the current systems for reporting medical errors in Nevada. Based on testimony, medical error reporting systems are continuing to evolve. The IOM's report laid the groundwork for identifying possible actions at the state level for ensuring patient safety. The appropriate and beneficial uses for the information collected from any reporting system will be critical to the success of a reporting system.

Based on Nevada's licensure requirements, the JCAHO accreditation standards, and hospital patient safety practices, medical facilities spend a great deal of time trying to prevent adverse outcomes and promote patient safety. The professional licensing boards act to protect the public from incompetent and negligent professionals once these individuals are identified. Medical facilities adhere to federal or state quality assurance regulations that are designed to ensure that medical errors are identified, causes are evaluated, changes are implemented to prevent reoccurrences, and there is timely evaluation of the outcome of these changes, yet medical errors still occur.

The Subcommittee has made recommendations that take steps toward creating a reporting system based on testimony provided at hearings and written correspondence in proposing its recommendations to the Legislative Committee on Health Care. A statewide medical surveillance system was recommended to actively survey adverse events associated with health care in various settings. In addition, a voluntary and confidential system for reporting adverse events and near misses was also recommended. This system would provide aggregate reports based on information received from medical facilities, allow feedback to reporters, and share information among providers in different settings.

The Chairman notes the words of Judy Smetzer, R.N., Vice President of the Institute for Safe Medication Practices, as a fitting conclusion to this study:

> Leaders should position patient safety as a priority in the organization's mission and engage the community and staff in proactive quality control improvement efforts, including an annual self-assessment of patient safety. This model of shared accountability spreads far beyond the walls of individual health care settings to encompass licensing, regulatory, and accrediting bodies; the federal government and public policy makers; the pharmaceutical industry; medical device and technology vendors; schools for medical training; professional associations; and even the public at large. These often-overlooked participants share equal accountability for doing their part to error-proof health care. (A copy of the article is included in this report as Appendix H.)

Finally, the participation of many people, agencies, professional licensing boards, and organizations has been crucial to the success of this study and the thoroughness of the deliberations that took place. Appreciation is expressed to the representatives from the state agencies, professional licensing boards, and health care organizations who provided insight into the statutes, regulations, and programs they administer.

Copies of the minutes from all Subcommittee meetings are available through the Legislative Counsel Bureau's Web site (www.leg.state.nv.us) and through its Research Library (775/684-6827).

VII. APPENDICES

APPENDIX A

Assembly Concurrent Resolution No. 7 (File No. 77, *Statutes of Nevada 2001*)

Assembly Concurrent Resolution No. 7–Committee on Health and Human Services

FILE NUMBER.....

ASSEMBLY CONCURRENT RESOLUTION—Directing the Legislative Committee on Health Care to conduct an interim study concerning the development of a system for reporting medical errors.

WHEREAS, At least 44,000 persons die each year in hospitals in the United States from preventable medical errors, making preventable medical errors a leading cause of death in this country, exceeding the number of deaths attributable to motor vehicle accidents, breast cancer or AIDS; and

WHEREAS, In addition to the unfortunate consequences suffered by many patients and families as a result of preventable medical errors, the direct and indirect costs borne by the nation as a result of preventable medical errors, including, without limitation, higher expenditures for health care, lost productivity, costs related to disabilities and costs for personal care, are approximately $17 billion annually; and

WHEREAS, Establishing a reporting system for medical errors is an effective way to improve the safety of patients in this state and reduce the number of preventable medical errors that occur in this state by gathering sufficient information about medical errors from multiple sources to attempt to understand the factors that contribute to the errors and then using this information to prevent the recurrence of such errors throughout the health care system; now, therefore, be it

RESOLVED BY THE ASSEMBLY OF THE STATE OF NEVADA, THE SENATE CONCURRING, That the Legislative Committee on Health Care is hereby directed to appoint a subcommittee to conduct an interim study concerning the development of a system for reporting medical errors in this state; and be it further

RESOLVED, That the study must include, without limitation:

1. A determination of what constitutes:

(a) A medical error;

(b) An outcome that is detrimental to a patient; and

(c) A medical error that causes an outcome which is detrimental to a patient.

2. A comprehensive evaluation of:

(a) Systems for reporting medical errors that are designed to:

(1) Inform patients of the occurrence of medical errors that cause outcomes which are detrimental to patients;

(2) Ensure that preventable medical errors are not systematically repeated; and

(3) Encourage medical institutions to improve the safety of their patients;

(b) Whether such a system should be established in this state;

(c) Effective manners in which the system may impose mandatory reporting of medical errors;

(d) Methods for ensuring that information reported to the system concerning the identity of a specific patient or medical professional remains confidential to encourage the reporting of medical errors and to

ensure that the system does not encourage blaming an individual medical professional for a medical error;

(e) The proper use of the information that is reported to the system, including, without limitation, whether standards should be established for using the information to prevent or reduce preventable medical errors;

(f) Which medical and other related facilities, medical professionals and pharmacies should be required to report information concerning medical errors to the system;

(g) Whether sanctions should be imposed on a medical professional who fails to comply with the reporting requirements of the system; and

(h) The relationship between medical errors and the licensing of medical professionals, and the manner in which the system may be coordinated with the licensing of medical professionals to reduce medical errors.

3. The use of the report *To Err is Human: Building a Safer Health System* that was released by the Institute of Medicine in November, 1999; and be it further

RESOLVED, That no action may be taken by the subcommittee on recommended legislation unless it receives a majority vote of the Senators on the subcommittee and a majority vote of the Assemblymen on the subcommittee; and be in further

RESOLVED, That the Legislative Committee on Health Care shall submit a report of the results of the study and any recommendations for legislation to the 72nd session of the Nevada Legislature.

20_____01

APPENDIX B

Letter of February 15, 2002, to all interested parties from John Yacenda, Ph.D., M.P.H., P.A.H.M., Chairman, Subcommittee to Study the Development of a System for Reporting Medical Errors, soliciting specific recommendations concerning the development of a system for reporting medical errors

STATE OF NEVADA
LEGISLATIVE COUNSEL BUREAU
LEGISLATIVE BUILDING
401 S. CARSON STREET
CARSON CITY, NEVADA 89701-4747
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(775) 684-6800

LEGISLATIVE COMMISSION (775) 684-6800
RICHARD D. PERKINS, *Assemblyman, Chairman*
Lorne J. Malkiewich, *Director, Secretary*

INTERIM FINANCE COMMITTEE (775) 684-6821
WILLIAM J. RAGGIO, *Senator, Chairman*
Gary L. Ghiggeri, *Fiscal Analyst*
Mark W. Stevens, *Fiscal Analyst*

Wm. GARY CREWS, *Legislative Auditor* (775) 684-6815
ROBERT E. ERICKSON, *Research Director* (775) 684-6825
BRENDA J. ERDOES, *Legislative Counsel* (775) 684-6830

February 15, 2002

All Interested Parties:

The final meeting of the Legislative Committee on Health Care's Subcommittee to Study the Development of a System for Reporting Medical Errors (Assembly Concurrent Resolution No. 7 [File No. 77, *Statutes of Nevada 2001*]) will be held on April 16, 2002, in Las Vegas, Nevada. **At that time, the Subcommittee will adopt its recommendations as they relate to reporting medical errors in Nevada.**

You are being sent this letter because you are an integral part of Nevada's healthcare industry or the licensing of professionals in this industry. Therefore, as chairman, I am requesting your specific recommendations concerning the development of a system for reporting medical errors. Your suggestions may range from retaining the current procedures to modifying any or all of the current policies and programs in place throughout the state that address patient safety and medical errors. With regard to your proposed recommendations, please be as detailed as possible and focus on matters upon which the Subcommittee is able to take action. If you recommend retaining current procedures and practices, please be detailed in your explanation of how these currently work to promote patient safety and the reduction of medical errors. Please send your recommendations no later than **March 29, 2002**, to:

Subcommittee to Study the Development of a System for Reporting Medical Errors
c/o Marjorie Paslov Thomas, Senior Research Analyst
Research Division, Legislative Counsel Bureau
401 South Carson Street, Carson City, Nevada 89701-4747

A work session document containing the recommendations will be prepared, and the Subcommittee will consider each proposal at its April 16 meeting. An agenda will be transmitted at a later date.

Thank you for participating in the Subcommittee's meetings. It is my hope that a number of important proposals will be formulated, which may be presented to the Legislative Committee on Health Care on April 23, 2002.

Sincerely,

John Yacenda, Ph.D., M.P.H., P.A.H.M.
Chairman
Subcommittee to Study the Development of a
System for Reporting Medical Errors

JY/dlr:L07
cc: Senator Raymond D. Rawson, Chairman, Legislative Committee on Health Care
Marsheilah D. Lyons, Senior Research Analyst, Legislative Counsel Bureau

(O) 1578E

APPENDIX C

Revised Work Session Document of the Legislative Committee on Health Care's Subcommittee to Study the Development of a System for Reporting Medical Errors dated April 16, 2002

(Exhibits to the Revised Work Session Document may be obtained from the Legislative Counsel Bureau's Research Library)

REVISED
WORK SESSION DOCUMENT

Legislative Committee on Health Care's
Subcommittee to Study the Development of a System for Reporting Medical Errors
(Assembly Concurrent Resolution No. 7 [File No. 77, *Statutes of Nevada 2001*])

April 16, 2002

The following work session document has been prepared by staff of the Legislative Counsel Bureau. It is designed to assist the subcommittee members in determining which recommendations may be forwarded to the Legislative Committee on Health Care.

The possible actions listed in the document do not necessarily have the support or opposition of the subcommittee. These possible actions simply are compiled and organized so the members may review them to decide if they should be adopted, changed, rejected, or further considered. Sponsors of recommendations may be noted in parentheses.

In addition, Assembly Concurrent Resolution No. 7 [File No. 77, *Statutes of Nevada 2001*] specifies that no action may be taken by the subcommittee on recommended legislation unless it is approved by a majority of the members of the Senate and a majority of the members of the Assembly appointed to the subcommittee.

GENERAL RECOMMENDATIONS FOR STATEMENTS

1. **Send a letter from the Legislative Committee on Health Care** to the medical professional associations and organizations in this state urging them to create a Nevada Alliance for Patient Safety (NAPS). The NAPS would strive to achieve consensus on recommendations to promote systemic change within medical facilities to improve patient safety by discussing patient safety issues, encouraging sharing of best practices, creating documents and issuing press releases to the public on good patient behavior and for professionals on best practices. Membership of the NAPS would include all professional associations and organizations and advocacy groups that are willing to participate, with relevant state agencies invited to serve as advisory members. The NAPS would provide an annual report to the Legislative Committee on Health Care. See Exhibit A. (Recommended by Chairman John Yacenda.)

2. **Send a letter from the Legislative Committee on Health Care** to the Nevada Hospital Association urging the association to publicize to consumers and health care advocacy organizations information about the coordinated efforts of its members to promote patient safety and to create centers of excellence for best practices in order to share knowledge and experience as it relates to the prevention of medical errors and adverse events and the promotion of patient safety. (Recommended by Chairman John Yacenda.)

3. **Send a letter from the Legislative Committee on Health Care** to each licensed medical facility urging the facility to provide to each patient a statement referencing its mission to ensure a safe patient environment and to ensure that the rights of patients are recognized and respected. The telephone numbers for the facility's safety director; the Bureau of Licensure and Certification, Health Division, Nevada's Department of Human Resources; and the Joint Commission on Accreditation of Healthcare Organizations should also be provided to assist a patient who may have a question and to assist if an issue arises that the patient believes should be reported. (Recommended by Assemblywoman Bonnie L. Parnell; Bill Welch, Nevada Hospital Association, 4/5/02 correspondence.)

4. **Send a letter from the Legislative Committee on Health Care** to each licensed medical facility urging the facility to include in its admission package: (1) the telephone number and address for the Office for Consumer Health Assistance in the Office of the Governor and the Bureau of Hospital Patient Safety within the Office for Consumer Health Assistance; (2) information to assist a patient who may have a question and to assist if an issue arises that the patient believes should be reported; and (3) a copy of the Patient's Rights provisions set forth in *Nevada Revised Statutes*. (Recommended by Assemblywoman Bonnie L. Parnell.)

5. **Send a letter from the Legislative Committee on Health Care** to all health profession licensing and oversight boards urging them to meet and coordinate their efforts to ensure and encourage patient safety by agreeing, to the extent authorized by law, to standardize their practices and policies for: (1) informing the public of professional licensees and how this information is provided to consumers; (2) accepting and investigating complaints from the public or other health care providers or institutions; (3) disclosing their findings to the public; and (4) disclosing the names of patients and professionals involved in the complaints and investigations. In the letter to the licensing boards, urge them to coordinate their policies relating to consumer and professional education through public service announcements, mailers, or partnering with appropriate agencies. Also, express in this letter that the licensing boards should propose and support changes to the *Nevada Revised Statutes* that would accommodate the standardization of their practices and policies. (Recommended by Chairman John Yacenda.)

6. **Send a letter to the Legislative Committee on Health Care** requesting the committee to not propose any changes to the state's current methods of reporting potential violations of the state regulations and statutes that govern the practice of individual health care providers. See Exhibit B. (Recommended by the State Board of Nursing, 3/29/02 correspondence.)

7. **Send a letter to the Legislative Committee on Health Care** listing the legal implications and protections that should be considered in any action taken by the committee concerning the reporting of adverse events attributable to errors in the practice of medicine, dentistry, nursing, pharmacy, and care received at medical facilities, and urging the committee to consider these implications and protections. These implications and protections include, without limitation, qualified immunity, whistleblower protections, and confidentiality. (Recommended by Chairman John Yacenda.)

RECOMMENDATIONS FOR STATEMENTS RELATED TO STATE AGENCY PROGRAMS

8. **Send a letter from the Legislative Committee on Health Care** to Nevada's Department of Human Resources (DHR) urging the department to require, to the extent authorized by law, medical facilities that are not accredited by the Joint Commission on Accreditation of Healthcare Organizations to maintain a confidential file of certain sentinel events. This file would only be available to the licensure survey personnel of the Bureau of Licensure and Certification, Health Division, DHR, at the time of on-site surveys. (Recommended by Assemblywoman Bonnie L. Parnell; Robin Keith, Nevada Rural Hospital Project, 3/24/02 correspondence.)

9. **Send a letter from the Legislative Committee on Health Care** to Nevada's Department of Administration, Nevada's Department of Human Resources (DHR), and the chairmen and members of the Legislature's Senate Committee on Finance and the Assembly Committee on Ways and Means, urging support for funding vacant positions in the Bureau of Licensure and Certification, Health Division, DHR. Also, send a letter urging the DHR and the Department of Personnel to review the position of a Health Facilities Surveyor and upgrade the requirements for all positions in this series to ensure expertise in the areas being surveyed. (Recommended by Assemblywoman Bonnie L. Parnell; Robin Keith, Nevada Rural Hospital Project, 3/24/02 correspondence; Bill Welch, Nevada Hospital Association, 4/5/02 correspondence; Mark VanderLinden, 3/27/02 correspondence.)

10. **Send a letter from the Legislative Committee on Health Care** to the Health Division of Nevada's Department of Human Resources urging the division to require, to the extent authorized by law, hospitals to report medical errors, adverse events, preventable adverse events, adverse outcomes that are related to nurse staffing levels, and nurse-to-patient ratios. Also, urge the division to include, to the extent authorized by law, through progressive monetary penalties not to exceed $10,000, suspension or revocation of licensure and/or public disclosure of penalties for acute care facilities that fail to report medical errors, adverse events, preventable adverse events, adverse outcomes that are related to nurse staffing levels, and staffing levels. (Recommended by Maryanne Dawicki, Service Employees International Union, 3/29/02 correspondence.)

11. **Send a letter from the Legislative Committee on Health Care** to Nevada's Department of Human Resources (DHR) urging the department to include in its proposed budget to the Office of the Governor funding to enhance the current database of the Bureau of Licensure and Certification, Health Division, DHR. The bureau would implement an Internet-based information system to permit health care providers access to information obtained by the bureau. (Recommended by Mark VanderLinden, 3/27/02 correspondence.)

12. **Send a letter from the Legislative Committee on Health Care** to Nevada's Department of Human Resources (DHR) urging the department to require the Bureau of Licensure and Certification, Health Division, DHR, to annually review all regulations related to quality improvement and patient safety in health care facilities. Also, request the department to sanction facilities that do not comply with such regulations and do not address the issue within the required time frame. (Recommended by Assemblywoman Bonnie L. Parnell; Robin Keith, Nevada Rural Hospital Project, 3/24/02 correspondence.)

13. **Send a letter from the Legislative Committee on Health Care** to the Health Division of Nevada's Department of Human Resources urging the division to consolidate the efforts of its Bureau of Licensure and Certification and Bureau of Health Planning and Statistics to generate a consolidated report detailing all deaths and adverse outcomes attributable to errors in the practice of medicine, dentistry, nursing, pharmacy, and care received at medical facilities. The report would be submitted to the Nevada Alliance for Patient Safety, if such an alliance were created as urged in the first recommendation, for review, analysis, abstraction, and dissemination of findings. (Recommended by Chairman John Yacenda.)

14. **Send a letter from the Legislative Committee on Health Care** to the Division of Health Care Financing and Policy of Nevada's Department of Human Resources, requesting the division to submit quarterly reports to the Nevada Alliance for Patient Safety (of which Nevada Medicaid would be an advisory member), if such an alliance is created as urged in the first recommendation, of the division's response and follow-up to the Drug Utilization Review Board's actions identifying beneficiaries of assistance provided by or administered by the division who are potentially at risk for drug therapy problems, and the manner in which the division is ensuring that actions are being taken to prevent drug therapy problems among these beneficiaries. (Recommended by Chairman John Yacenda.)

15. **Send a letter from the Legislative Committee on Health Care** to Nevada's Department of Human Resources (DHR) and the chairmen and members of the Legislature's Senate Committee on Finance and the Assembly Committee on Ways and Means urging support for funding $3 million over the 2003-2005 biennium to the Bureau of Licensure and Certification, Health Division, DHR, to conduct on-site annual reviews of all medical facilities to ensure that the requirements contained in the *Nevada Administrative Code* relating to quality of care and patient safety are being satisfied. (Recommended by Bill Welch, Nevada Hospital Association, 4/5/02 correspondence.)

16. **Send a letter from the Legislative Committee on Health Care** to the Insurance Commissioner of the Division of Insurance, Nevada's Department of Business and Industry, urging the commissioner, to the extent authorized by law, to consider mandated discounts for professional liability insurance premiums when hospitals, physicians, and others participate in a state-sponsored health collaborative. (Recommended by Mark VanderLinden, 3/27/02 correspondence.)

17. **Send a letter from the Legislative Committee on Health Care** urging Nevada's Department of Human Resources (DHR) to adopt the reporting and investigating mechanism for adverse events of the Division of Mental Health and Developmental Services, DHR, as a model for all publicly funded programs of medical, dental, and psychological care administered by the department. (Recommended by Chairman John Yacenda.)

GENERAL RECOMMENDATIONS FOR LEGISLATIVE MEASURES

18. **Request the drafting of a bill** appropriating $100,000 to fund the development and maintenance of a statewide medical adverse event surveillance system. This system should be developed by a private agency with expertise in patient safety and health care data analysis using existing vital statistics and electronic hospital discharge data supplemented with targeted review of medical records. (Recommended by Michael P. Silver, HealthInsight, 3/27/02 correspondence.)

19. **Request the drafting of a bill** requiring professional licensing boards to keep reports of medical errors confidential. This measure would allow the boards to release information to the public only after a potential violation is confirmed and disciplinary action is taken against a licensee. (Recommended by Bill Welch, Nevada Hospital Association, 4/5/02 correspondence.)

20. **Request the drafting of a bill** appropriating $11 million for the first year and $5 million for the next year to fund the University and Community College System of Nevada programs for licensed health care professionals with an emphasis on nursing. (Recommended by Assemblywoman Bonnie L. Parnell; Bill Welch, Nevada Hospital Association, 4/5/02 correspondence; Robin Keith, Nevada Rural Hospital Project, 3/24/02 correspondence.)

RECOMMENDATIONS FOR LEGISLATIVE MEASURE CONCERNING REPORTING SYSTEMS FOR REPORTING MEDICAL ERRORS

Mandatory Medical Error Reporting Systems

21. **Request the drafting of a bill** establishing a mandatory medical error reporting system requiring preventable medical errors, adverse events, adverse outcomes that are related to nurse staffing levels, and nurse-to-patient ratios to be reported by hospitals to the Bureau of Licensure and Certification, Health Division, Nevada's Department of Human Resources. Provide that the reporting system includes nurse staffing information and public access to all mandatory reports. Under this system, the directors of risk management and/or quality improvement of hospitals would be required to submit the information to the Bureau of Licensure and Certification. See Exhibit C. (Recommended by Maryanne Dawicki, Service Employees International Union, 3/29/02 correspondence.)

22. **Request the drafting of a bill** establishing a mandatory medical error reporting system that includes the following elements:

    (a) An anonymous and confidential reporting system, which would protect the identity of the patient and health care practitioner;

    (b) Coordination by the Division of Health of Nevada's Department of Human Resources (DHR) to act as a data repository and facilitate information flow, communication, and task allocation among regulatory bodies;

    (c) Aggregation of facility performance data with disclosure of aggregated data through annual and accessible public reports;

    (d) Performance of a thorough follow-up and analysis of internal facility processes utilized to identify and improve medical error and quality-of-care issues by the Bureau of Licensure and Certification, Health Division, DHR;

    (e) Protection of information in the report from subpoena or discovery process in legal actions; and

    (f) Limitation of $50,000 in recoverable damages in medical malpractice actions in which errors have been reported in good faith.

    (Recommended by Nina Carter, Health Research/Product Manager, HealthMarketInsights, 4/1/02 correspondence.)

23. **Request the drafting of a bill** specifically authorizing each county whose population is 400,000 or more to establish and maintain a medical error reporting system. See Exhibit D. (Recommended by Donald S. Kwalick, M.D., Clark County Health District, 3/29/02 correspondence.)

Voluntary Medical Error Reporting Systems

24. **Request the drafting of a bill** establishing a voluntary medical error reporting system that would include information concerning adverse events to analyze current trends and enhance or improve best practices. This system would require data from medical facilities to be reported to a central repository. A state agency or a private agency under contract with the state would manage the repository. Information submitted to the repository would remain confidential. Require protection from legal discovery of the data in the system. (Discussed at the February 2002 meeting during the interim; recommended by subcommittee members.)

25. **Request the drafting of a bill** establishing a voluntary medical error reporting system that would include information concerning adverse events and near misses to identify hazardous conditions, practices, and linkages in health care. This system would include secure Web-based capability with its design adapted from the Aviation Safety Reporting System maintained and run by the National Aeronautics and Space Administration. Require this system to be integrated with existing and national reporting systems and also have the ability to support analysis of conditions of concern locally. Any information reported to this system must remain confidential and protected from legal discovery. See Exhibit E. (Recommended by Michael P. Silver, HealthInsight, 3/27/02 correspondence.)

26. **Request the drafting of a bill** appropriating $300,000 to ensure credible and thorough analysis of data of voluntary reports received by a private agency with expertise in patient safety and health care data analysis, effective feedback to the reporting community, and timely dissemination of information to health care providers. Funding considerations should include the development and maintenance of analysis, feedback, and dissemination of information received through the voluntary reporting system. (Recommended by Michael P. Silver, HealthInsight, 3/27/02 correspondence).

27. **Request the drafting of a bill** establishing a voluntary, anonymous, and confidential medical error reporting system. Require protection of reported information from subpoena or discovery process in legal actions. A centralized data system established and run by a private, independent organization would collect the reported information. The organization would issue reports quarterly to the public. See Exhibit F. (Recommended by Beatrice Razor, 3/7/02 correspondence.)

28. **Request the drafting of a bill** establishing within the Bureau of Licensure and Certification, Health Division, Nevada's Department of Human Resources, a complementary, voluntary reporting program providing confidentiality and protection to participating caregivers and hospitals if a mandatory medical error reporting system is established as set forth in Recommendation 21. Information collected through this system would not be publicly available. Hospitals would be required to share this information to prevent medical errors and adverse outcomes. (Recommended by Maryanne Dawicki, Service Employees International Union, 3/29/02, correspondence.)

29. **Request the drafting of a bill** requiring Nevada's Department of Human Resources (DHR) to establish an Internet-based registry for an anonymous, voluntary, password-protected, standardized incident reporting system and registry. Hospitals, long-term care facilities, ambulatory surgery centers, and other related facilities would be authorized to input confidential information into the registry. The system would track adverse events attributable to errors in the practice of medicine, dentistry, nursing, pharmacy, and medical facilities. Participation in the registry would be voluntary. The system would be operated by a private agency under contract with the DHR. The establishment of the reporting system would be dependent on state funding or grants, gifts, endowments, bequests, or direct appropriation for its creation. See Exhibit G. (Recommended by Chairman John Yacenda.)

Other

30. **Send a letter to the Legislative Committee on Health Care** recommending to the committee that the State of Nevada not develop a mandatory reporting system for medical errors, adverse events, or sentinel events. (Recommended by Michael P. Silver, HealthInsight, 3/27/02 correspondence.)

31. **Send a letter to the Legislative Committee on Health Care** recommending to the committee that the State of Nevada not develop an external medical error reporting system until internal reporting systems in health care facilities are identified and remediated. (Recommended by Lisa Black, Nevada Nurses Association, 4/4/02 correspondence.)

32. **Request the drafting of a resolution** providing for an interim study to continue identifying and reviewing internal reporting systems in health care facilities. The study might consider system failures to determine whether they contribute to medical errors. The study may also examine the changes that are necessary in an internal reporting system to effectively implement an external reporting system. (Recommended by Lisa Black, Nevada Nurses Association, 4/4/02 correspondence.)

APPENDIX D

Massachusetts Coalition for the Prevention of Medical Errors' Mission Statement, Background Information, Coalition Participants, and Error Prevention Initiative

Massachusetts Coalition for the Prevention of Medical Errors

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Check out our Publication page, which includes the "Safe Medication Use" Patient Guide.

[Mission Statement] [Background] [Coalition Participants] [Error Prevention Initiative]
[Medication Error Prevention Project]

Mission Statement

The Massachusetts Coalition for the Prevention of Medical Errors was established to develop and implement a statewide initiative to improve patient safety and minimize medical errors. The goals of the coalition are:

- to establish a mechanism to identify and implement best practices to minimize medical errors;
- to increase awareness of error prevention strategies through public and professional education;
- to identify areas of mutual interest and minimize duplication of regulatory and Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) requirements so that efforts are focused on initiatives that can best improve patient care.

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Background

The issue of medical errors has received increasing attention from the public, regulatory bodies and health professionals and providers. Recent studies on medical errors have found that these events often result from system problems rather than human error. Currently, there is no single forum for sharing knowledge and information about the causes and potential strategies for preventing medical errors. To fill this void, the Massachusetts Coalition for the Prevention of Medical Errors was formed.

Member Organizations

- AARP
- American College of Physicians
- Boston University School of Medicine Center for Primary Care
- Centers for Medicare and Medicaid Services
- Group Insurance Commission
- Harvard School of Public Health
- Institute for Healthcare Improvement
- Joint Commission on Accreditation of Healthcare Organizations
- Massachusetts Association of Behavioral Health Systems
- Massachusetts Association of HMOs
- Massachusetts Board of Registration in Nursing
- Massachusetts Board of Registration in Pharmacy
- Massachusetts Board of Registration in Medicine
- Massachusetts Department of Medical Assistance
- Massachusetts Department of Mental Health
- Massachusetts Department of Public Health
- Massachusetts Extended Care Federation
- Massachusetts Health Council
- Massachusetts Health Quality Partnership

- Massachusetts Healthcare Purchaser Group
- Massachusetts Hospital Association
- Massachusetts Independent Pharmacists
- Massachusetts Medical Society
- Massachusetts Nurses Association
- Massachusetts Organization of Nurse Executives
- Massachusetts Peer Review Organization
- Massachusetts Pharmacists Association
- Professional Liability Foundation
- ProMutual Group
- Risk Management Foundation

Paula Griswold
Executive Director
5 New England Executive Park
Burlington, MA 01803-5096
Phone: (781) 272 - 8000 ext. 152
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Coalition Participants

The Coalition participants include senior leadership and expert staff from the following organizations with a long-standing commitment to quality and public accountability:

- state and federal agencies with responsibility for licensure and oversight
- professional associations representing hospitals, physicians, nurses, nurse executives, and long-term care institutions
- individual health care providers
- malpractice insurance carriers
- accrediting bodies
- clinical researchers
- consumer organizations

Building on the wealth of existing knowledge and expertise both in Massachusetts and across the country, the Coalition will develop models of prevention for health care organizations with different resources, needs, and capabilities. Oversight will be provided by a working group of the Coalition. This working group will consist of key leadership organizations and individuals that are willing to commit time and resources to this initiative. The working group will solicit input and participation from the broader cross-section of interested parties that make up the Coalition to ensure that the objectives of this initiative are met.

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Error Prevention Initiative

The Coalition will target major categories of sentinel events or serious incidents for the development of prevention strategies. A Best Practices Subcommittee of the Coalition, made up of experts in the area of error prevention, will conduct research into the causes of targeted errors under study and gather information about potential remedies. Recommendations from the Best Practices Subcommittee will be submitted to consensus groups convened by the appropriate professional associations representing health care providers, administrators, and Coalition members, who will help to build a consensus on prevention strategies and interventions. Composition of these groups will vary depending on the sentinel event or error under study in each phase of the program as it is carried out over the next few years.

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Medication Error Prevention Project

The first prevention strategy focused on medication errors, building on the Massachusetts Hospital Association (MHA) medication error prevention project. Using a survey tool developed by MHA and the Institute for Safe Medication Practices, baseline data was analyzed on the different approaches to safe medication administration practices. The results of the survey, along with available research on the causes and remedies to medication errors, has been used to build consensus on the specific actions health care institutions and providers can take to reduce the potential for such errors. The MHA medication error prevention project serves as a model for engaging the health care community in the development of prevention strategies targeted to other categories of preventable errors.

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APPENDIX E

Appendix A of a National Academy for State Health Policy report scheduled for release in June 2002 detailing patient safety coalitions in 17 states

APPENDIX A PATIENT SAFETY ORGANIZATIONS

Arkansas	Arkansas Patient Safety Initiative William Golden, MD Arkansas Foundation for Medical Care 401 W. Capital, Suite 410 Little Rock, AR 72201 501 375-5700 goldenwilliame@uams.edu
California	California Institute for Health Systems Performance Marsha Nelson, MBA, RN Vice President 1215 K Street, Suite 800 Sacramento, CA 95814 916 552-7642 Mnelson@chisp.org www.cishp.org
Colorado	Colorado Patient Safety Coalition Chair, Mark Levine, MD 303 360-1743 (w) Marklevinedenver@hotmail.com
Florida	Patient Safety Steering Committee Susan V. White, Ph.D VP/Quality Management Florida Hospital Association 307 Park Lake P.O. Box 531107 Orlando, Fl 32853-1107 407-841-6230 susiew@fha.org www.fha.org/quality
Georgia	Sandra A. Walczak, FACHE VP, Partnership for Health & Accountability Georgia Hospital Association 1675 Terrell Mill Road Marietta, GA 30067 770 955-0324 swalczak@gha.org www.gha.org
Iowa	Patient Safety Advisory Committee John Durbin Iowa Dept. of Health Directors Office 515-281-8938 jdurbin@health.state.ia.us www.idph.state.ia.us/dir_off/csha/patientsafety.htm

Maryland	Maryland Patient Safety Coalition Enrique Martinez-Vidal Deputy Director, Performance and Benefits Maryland Health Care Commission 410 764-3482 evidal@mhcc.state.md.us or Marie MacBee Delmarva Foundation for Medical Care 410 763-6232 www.marylandpatientsafety.org Interim Report On The Study Of Patient Safety In Maryland www.mhcc.state.md.us/legislative/patientsirpt.pdf Advisory group to Maryland Health Care Commission, Final report due 1/1/03
Massachusetts	Paula Griswold Executive Director 5 New England Executive Park Burlington, MA 01803-5096 Phone: 781 272 - 8000 ext. 152 pgriswold@mhalink.org www.mhalink.org/mcpme
Michigan	Michigan Health and Safety Coalition 27000 W. Eleven Mile Road Mail Code: B713 Southfield, MI 48034 Diane Valade 248 448-6266 dvalade@bcbsm.com This group has not formalized its structure, but stakeholders are involved in several patient safety initiatives described on the web site.
Minnesota	Minnesota Alliance for Patient Safety Minnesota Hospital and Healthcare Partnership Tania Krueger 2550 W. University Ave. Suite 350-S St. Paul, MN 55114-1900 Tel: 651 641-1121; tkrueger@mhhp.com. www.mnpatientsafety.org
Ohio	Ohio Patient Safety Institute Ohio Health Council www.ohiopatientsafety.org

Pennsylvania	John Combes, MD Senior Medical Advisor The Healthcare Alliance of Pennsylvania 4750 Lindle Road Harrisburg, PA 17105-8600 717 561-5235 jcombes@hap2000.org www.hap2000.org/quality/safety/
Tennessee	Tennessee Improving Patient Safety (TIPS) Judy Eads Asstistant Commissioner Tennessee Department of Health 615-741-5542 o jeads@mail.state.tn.us
Texas	Texas Patient Safety Alliance (New) John Holcomb, M.D., Chair Includes Texas Hospital Association, Texas Medical Association, Texas Nurses Association, and the Texas Pharmacy Congress. No further information is available
Utah	Scott Williams Deputy Health Commissioner Utah Department of Health 801 538-6111 swilliams@doh.state.ut.us Utah has an AHRQ grant to evaluate coding and operational issues surrounding sentinel event reporting systems and has a formal public/private partnership associated with this grant.
Virginia	Carl Armstrong, MD 804 965-1208 Senior Medical Advisor c/o Virginia Hospital & Healthcare Association PO Box 31394, Richmond, VA 23294-1394 804 965-1208 carmstrong@vhha.com http://vipcs.org/aboutus_final.htm
Wisconsin	Catherine Frey MPH, MPA, Interim CEO Wisconsin Patient Safety Institute 330 East Lakeside Street Madison, Wisconsin 53715 608 283-5497 1-800-762-8976 CatherF@wismed.org http://www.wismet.org

APPENDIX F

Letter of April 17, 2002, to Thalia M. Dondero, Chairman, Board of Regents, University and Community College System of Nevada, from John Yacenda, Ph.D., M.P.H., P.A.H.M., Chairman, Legislative Committee on Health Care's Subcommittee to Study the Development of a System for Reporting Medical Errors, encouraging the Board of Regents and the University and Community College System of Nevada to make programs for licensed health care professionals a priority

STATE OF NEVADA
LEGISLATIVE COUNSEL BUREAU
LEGISLATIVE BUILDING
401 S. CARSON STREET
CARSON CITY, NEVADA 89701-4747
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LORNE J. MALKIEWICH, *Director*
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LEGISLATIVE COMMISSION (775) 684-6800
RICHARD D. PERKINS, *Assemblyman, Chairman*
Lorne J. Malkiewich, *Director, Secretary*

INTERIM FINANCE COMMITTEE (775) 684-6821
WILLIAM J. RAGGIO, *Senator, Chairman*
Gary L. Ghiggeri, *Fiscal Analyst*
Mark W. Stevens, *Fiscal Analyst*

Wm. GARY CREWS, *Legislative Auditor* (775) 684-6815
ROBERT E. ERICKSON, *Research Director* (775) 684-6825
BRENDA J. ERDOES, *Legislative Counsel* (775) 684-6830

April 17, 2002

Thalia M. Dondero, Chairman
Board of Regents
University and Community College System of Nevada
2601 Enterprise Road
Reno, Nevada 89512-1666

Dear Ms. Dondero:

For the past five months, the Legislative Committee on Health Care's Subcommittee to Study the Development of a System for Reporting Medical Errors (Assembly Concurrent Resolution No. 7 [File No. 77, *Statutes of Nevada 2001*]) has considered a broad range of issues relating to the occurrence and prevention of medical errors. The subcommittee listened to testimony from a variety of sources regarding the shortage of professionals actively engaged and remaining in the nursing profession, with some mention of allied nurse professionals as well.

Based on a preponderance of testimony, the subcommittee encourages the Board of Regents of the University and Community College System of Nevada (UCCSN) to make programs for licensed health care professionals a top priority. To this end, we are hopeful the Board will provide adequate funding in its plan as required under Assembly Bill 378 (Chapter 580, *Statutes of Nevada 2001*) to double the capacity of the nursing programs in the UCCSN.

I know the subcommittee members would appreciate your attention to this very important matter. I would be pleased to discuss this matter in greater detail if you so desire.

Sincerely,

John Yacenda, Ph.D., M.P.H., P.A.H.M.
Chairman
Legislative Committee on Health Care's Subcommittee to Study the Development of a System for Reporting Medical Errors

JY/sfr:W21435
cc: Senator Raymond D. Rawson, Chairman
Legislative Committee on Health Care

APPENDIX G

Minnesota Senate File No. 560, first engrossment, posted on February 19, 2001

MN

KEY: ~~stricken~~ = old language to be removed
underscored = new language to be added

NOTE: If you cannot see any difference in the key above, you need to change the display of stricken and/or underscored language.

Authors and Status ▪ List versions

S.F No. 560, 1st Engrossment: 82nd Legislative Session (2001-2002) Posted on Feb 19, 2001

A bill for an act

relating to health; modifying review organization provisions; allowing review organizations to participate in Internet-based information sharing systems; amending Minnesota Statutes 2000, sections 145.61, subdivision 5; and 145.64, subdivision 1, and by adding subdivisions.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2000, section 145.61, subdivision 5, is amended to read:

Subd. 5. [REVIEW ORGANIZATION.] "Review organization" means a nonprofit organization acting according to clause ~~(h)~~ (i), a committee as defined under section 144E.32, subdivision 2, or a committee whose membership is limited to professionals, administrative staff, and consumer directors, except where otherwise provided for by state or federal law, and which is established by one or more of the following: a hospital, a clinic, a nursing home, an ambulance service or first responder service regulated under chapter 144E, one or more state or local associations of professionals, an organization of professionals from a particular area or medical institution, a health maintenance organization as defined in chapter 62D, a community integrated service network as defined in chapter 62N, a nonprofit health service plan corporation as defined in chapter 62C, a preferred provider organization, a professional standards review organization established pursuant to United States Code, title 42, section 1320c-1 et seq., a medical review agent established to meet the requirements of section 256B.04, subdivision 15, or 256D.03, subdivision 7, paragraph (b), the department of human services, a health provider cooperative operating under sections 62R.17 to 62R.26, or a nonprofit corporation ~~organized under chapter 317A~~ that owns, operates, or is established by one or more of the above referenced entities, to gather and review information relating to the care and treatment of patients for the purposes of:

(a) evaluating and improving the quality of health care ~~rendered in the area or medical institution or by the entity or organization that established the review organization~~;

(b) reducing morbidity or mortality;

(c) obtaining and disseminating statistics and information relative to the treatment and prevention of diseases, illness and injuries;

(d) developing and publishing guidelines showing the norms of health care in the area or medical institution or in the entity or organization that established the review organization;

(e) developing and publishing guidelines designed to keep within reasonable bounds the cost of health care;

(f) developing and publishing guidelines designed to improve the safety of care provided to individuals;

(g) reviewing the safety, quality, or cost of health care services provided to enrollees of health maintenance organizations, community integrated service networks, health service plans, preferred provider organizations, and insurance companies;

~~(g)~~ (h) acting as a professional standards review organization pursuant to United States Code, title 42, section 1320c-1 et seq.;

~~(h)~~ (i) determining whether a professional shall be granted staff privileges in a medical institution, membership in a state or local association of professionals, or participating status in a nonprofit health service plan corporation, health maintenance organization, community integrated service network, preferred provider organization, or insurance company, or whether a professional's staff privileges, membership, or participation status should be limited, suspended or revoked;

~~(i)~~ (j) reviewing, ruling on, or advising on controversies,

disputes or questions between:

(1) health insurance carriers, nonprofit health service plan corporations, health maintenance organizations, community integrated service networks, self-insurers and their insureds, subscribers, enrollees, or other covered persons;

(2) professional licensing boards and health providers licensed by them;

(3) professionals and their patients concerning diagnosis, treatment or care, or the charges or fees therefor;

(4) professionals and health insurance carriers, nonprofit health service plan corporations, health maintenance organizations, community integrated service networks, or self-insurers concerning a charge or fee for health care services provided to an insured, subscriber, enrollee, or other covered person;

(5) professionals or their patients and the federal, state, or local government, or agencies thereof;

~~(j)~~ (k) providing underwriting assistance in connection with professional liability insurance coverage applied for or obtained by dentists, or providing assistance to underwriters in evaluating claims against dentists;

~~(k)~~ (l) acting as a medical review agent under section 256B.04, subdivision 15, or 256D.03, subdivision 7, paragraph (b);

~~(l)~~ (m) providing recommendations on the medical necessity of a health service, or the relevant prevailing community standard for a health service;

~~(m)~~ (n) providing quality assurance as required by United States Code, title 42, sections 1396r(b)(1)(b) and 1395i-3(b)(1)(b) of the Social Security Act;

~~(n)~~ (o) providing information to group purchasers of health care services when that information was originally generated within the review organization for a purpose specified by this subdivision; ~~or~~

~~(o)~~ (p) providing information to other, affiliated or nonaffiliated review organizations, when that information was originally generated within the review organization for a purpose specified by this subdivision, and as long as that information will further the purposes of a review organization as specified by this subdivision; or

(q) participating in a standardized incident reporting system, including Internet-based applications, to share information for the purpose of identifying and analyzing trends in medical error and iatrogenic injury.

Sec. 2. Minnesota Statutes 2000, section 145.64, subdivision 1, is amended to read:

Subdivision 1. [DATA AND INFORMATION.] ~~All~~ (a) Except as provided in subdivision 4, data and information acquired by a review organization, in the exercise of its duties and functions, or by an individual or other entity acting at the direction of a review organization, shall be held in confidence, shall not be disclosed to anyone except to the extent necessary to carry out one or more of the purposes of the review organization, and shall not be subject to subpoena or discovery. No person described in section 145.63 shall disclose what transpired at a meeting of a review organization except to the extent necessary to carry out one or more of the purposes of a review organization. The proceedings and records of a review organization shall not be subject to discovery or introduction into evidence in any civil action against a professional arising out of the matter or matters which are the subject of consideration by the review organization. Information, documents or records otherwise available from original sources shall not be immune from discovery or use in any civil action merely because they were presented during proceedings of a review organization, nor shall any person who testified before a review organization or who is a member of it be prevented from testifying as to matters within the person's knowledge, but a witness cannot be asked about the witness' testimony before a review organization or opinions formed by the witness as a result of its hearings. For purposes of this subdivision, records of a review organization include Internet-based data derived from data shared for the purposes of the standardized incident reporting system described in section 145.61, subdivision 5, clause (q).

(b) Notwithstanding paragraph (a), a review organization may release nonpatient-identified aggregate trend data on medical error and iatrogenic injury without violating this section or being subjected to a penalty under section 145.66 and without compromising the protections provided under sections 145.61 to 145.67 to the reporter of such information; to the review organization, its sponsoring organizations, and members; and to the underlying data and reports.

(c) The confidentiality protection and protection from

discovery or introduction into evidence provided in this subdivision shall also apply to the governing body of the review organization and shall not be waived as a result of referral of a matter from the review organization to the governing body or consideration by the governing body of decisions, recommendations, or documentation of the review organization.

(d) The governing body of a hospital, health maintenance organization, or community integrated service network, that is owned or operated by a governmental entity, may close a meeting to discuss decisions, recommendations, deliberations, or documentation of the review organization. A meeting may not be closed except by a majority vote of the governing body in a public meeting. The closed meeting must be tape recorded and the tape must be retained by the governing body for five years.

Sec. 3. Minnesota Statutes 2000, section 145.64, is amended by adding a subdivision to read:

Subd. 4. [STANDARDIZED INCIDENT REPORTING SYSTEM DATA.] A review organization that is participating in a standardized incident reporting system described in section 145.61, subdivision 5, clause (q), may release data for purposes of the reporting system, provided that the data do not identify an individual and are not released in a manner in which an individual can be identified.

Sec. 4. Minnesota Statutes 2000, section 145.64, is amended by adding a subdivision to read:

Subd. 5. [COMMISSIONER OF HEALTH.] Nothing in this section shall be construed to prohibit or restrict the right of the commissioner of health to access the original information, documents, or records acquired by a review organization as permitted by law.

APPENDIX H

Article titled "Prescriptions for Safety" written by Judy Smetzer, R.N., Institute for Safe Medication Practices, published in the January 28, 2002, edition of the *AHA News*

by Judy Smetzer, R.N.
Institute for Safe Medication Practices

It's time for a new model of accountability

Health care is struggling to come to terms with the role of accountability in a non-punitive, system-based approach to error reduction. Even when we seem to understand the system-based causes of errors, it's still hard to let individuals off the hook. We ask, "How can we hold individuals accountable for their actions without punishment?" Some have even suggested that a non-punitive approach to error reduction could lead to increased carelessness as people learn that they will not be punished for their mistakes. In our recent survey on perceptions about a non-punitive culture, 21% of respondents agreed with this premise and another 16% felt that a non-punitive approach to errors absolves staff of personal responsibility for patient safety. However, a non-punitive, system-based approach to error reduction does not diminish accountability; it redefines it and directs it in a much more productive manner.

Typically, when an error happens, all accountability falls on individuals involved where the caregiver/patient interaction occurs in an error. But accountability — not for zero errors, but for making patient safety job one — should be equally shared among all health care stakeholders. In part, Webster's defines "accountability" as an obligation to provide a satisfactory explanation, or to be the cause, driving force, or source. Individuals in the workforce should be held accountable for speaking out about patient safety issues, voluntarily reporting errors and hazardous situations, and sharing personal knowledge of what went wrong when an error occurs. On the other hand, health care leaders should be held equally accountable for making it safe and rewarding for the workforce to openly discuss errors and patient safety issues. They must hold regular safety briefings with staff to learn about improvement needs, discuss strategic plans, and identify new potential sources of error. When the workforce recommends error prevention strategies, leaders must support

them and provide the means necessary within a reasonable time frame to implement technology and other system enhancements to improve efficiency and safety. Leaders should be held accountable for understanding and addressing barriers to safe practice, such as distractions and unsafe workloads. Likewise, the workforce must be empowered to ask for help when needed and be willing to change practices to enhance safety and quality. Leaders should position patient safety as a priority in the organization's mission and engage the community and staff in proactive quality control improvement efforts, including an annual self-assessment of patient safety. The workforce should be held accountable for working together as a team, not as autonomous individuals. Finally, leaders and staff should follow the safety literature continuously and offer visible support to their colleagues who have been involved in errors.

This model of shared accountability spreads far beyond the walls of individual health care settings to encompass licensing, regulatory and accrediting bodies; the federal government and public policy makers; the pharmaceutical industry; medical device and technology vendors; schools for medical training; professional associations; and even the public at large. These often-overlooked participants share equal accountability for doing their part to error-proof health care. Who can argue with the multidimensional nature of medical care? Isn't it time to accept a multidimensional, shared accountability model for patient safety? Organizational leaders and other stakeholders who simply hold the workforce accountable when an error happens are inappropriately delegating their own responsibility for patient safety. We must stop blaming and punishing those closest to an error, and instead accept a model of shared accountability to collectively translate our sincere concern for patient safety into effective system-based error solutions.

JUDY SMETZER, R.N., is vice president for the Institute for Safe Medication Practices (ISMP) in Huntingdon Valley, PA. The AHA and ISMP are partners in a campaign to reduce drug errors. ISMP's Web site is *http://www.ismp.org*.

APPENDIX I

Inpatient and Long-Term Care Data

KENNY C. GUINN
Governor

MICHAEL J. WILLDEN
Director

DEPARTMENT OF HUMAN RESOURCES
DIRECTOR'S OFFICE
505 E. King Street, Room 600
Carson City, Nevada 89701-3708
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May 28, 2002

M E M O R A N D U M

TO: Marsheila Lyons, Senior Research Analyst, Legislative Council Bureau

FROM: Mike Willden, Director

SUBJECT: Your May 8, 2002, Request / Mental Health and Disorders Such as Alzheimer's Disease and Dementia

Enclosed with this memo is a copy of the Department of Human Resources' response to your May 8, 2002, letter. Also, although not specifically a part of your request, I have included a list of resources for Alzheimer's and related dementias provided by the Division of Aging Services.

Regarding the presentation on June 4, both Carlos Brandenburg and I must attend an Employee/Management Committee hearing on a grievance. The EMC hearing is scheduled at the same time as the Legislative Subcommittee on Health Care. We will have Dr. Rosin from MHDS and Charles Duarte from DHCFP attend the Legislative hearing and do the presentation; however, we may want to talk before the hearing to discuss the presentation and ideas.

Enclosures
cc: Carlos Brandenburg
Charles Duarte
Mary Liveratti

MW:sl

5/28/2002
June 4 Health Care - Lyons.doc

LONG-TERM PLACEMENT OPTIONS FOR MEDICAID RECIPIENTS WITH BEHAVIORAL ISSUES RELATED TO MENTAL ILLNESS, DEMENTIA DISORDERS AND OTHER MEDICAL CONDITIONS

Hospitals have expressed concerns regarding difficulty in placing individuals with mental illness, including dementia-related disorders. These individuals are waiting for long-term placements while occupying acute and emergency room beds. Hospitals have also expressed concerns regarding available assistance from the state mental health system and the time it takes to complete federally mandated mental health/mental retardation screenings for nursing home placements. The following information is intended to explain the screening system for nursing home admissions as well as long-term care options for these individuals.

HISTORY OF THE PROBLEM:

There are currently 72 Nevada residents who are Medicaid recipients residing in out-of-state nursing facilities. The Division of Health Care Financing and Policy's (DHCFP) out-of-state placement coordinator receives two to three calls monthly requesting consideration and information for placements. One or two of these inquiries end with placements out-of-state. The primary reason for these is the refusal of Nevada nursing facilities to accept individuals with difficult behavior management problems. Generally, these difficult behaviors are a direct result of a medical condition, mental illness, traumatic brain injury, mental retardation, or a dementia-related condition.

The geriatric population presents unique and challenging medical problems. When difficult behaviors are added to their already complex health problems, placement difficulties arise. This is not a new situation for Nevada Medicaid and has been the topic of discussion amongst both the nursing facility providers and various state agencies over a number of years. Because hospitals are now at bed capacity, they can no longer keep patients for extended periods of time while these placement issues are resolved.

DISTINGUISHING PLACEMENT OPTIONS:

Federal Regulation requires all potential nursing facility residents to be screened for indicators of mental illness and/or mental retardation. This is known as the Pre-Admission Screening and Resident Review (PASRR) process. The purpose of the PASRR process is to identify individuals with either mental illness or mental retardation and to ensure they are placed in the most appropriate setting with services to meet their individual needs. All individuals, regardless of their pay source, must be screened. If identified with indicators of mental illness or mental retardation, an individual receives a second stage of screening by a psychologist or a psychiatrist to determine severity and course of treatment. Some individuals with mental illness or mental retardation can be admitted to nursing homes, as long as specialized services are provided to assure the diagnosed condition is properly addressed. The Division of Mental Health and Developmental Services has final authority over PASRR determinations and is

mandated by federal regulation to direct treatment for individuals who are identified to need specialized services.

Currently, DHCFP contracts with HealthInsight to complete and coordinate PASRR screenings. The first level of screening, commonly known as PASRR, is completed within 24 hours of request for an individual in an acute setting such as the hospital, or within 72 hours of request for an individual in a community setting, which includes an emergency room or nursing facility. HealthInsight had difficulty meeting the required screening time frames after initially assuming responsibility for the process in July 2001. However, current information indicates the screenings for acute settings occur within 24 hours. Compliance with the completion of community-based screenings has taken longer, but a majority of the screenings are now being finished according to Medicaid's stated time frames. HealthInsight has also been asked to address screening requests from emergency rooms within one day if at all possible. If an individual requires a second level of screening (commonly known as PASRR II), HealthInsight arranges for a consultation with a psychiatrist or psychologist, which typically takes a day or two to arrange. The individual is not cleared for placement until MHDS staff verifies the results of this consultation. It typically takes from three to seven days for completion of the screening process if both levels of screening need to be performed.

Medicaid cannot pay nursing facilities until the PASRR screening is complete and clears an individual for placement. Therefore, most facilities will not accept Medicaid or Medicaid-pending residents until screening completion is validated, and the individual's needs are deemed appropriately addressed in a nursing home. The screening process may delay placement for several days if both levels of screening are required. Six out of seven individuals screened (86%) require only the first level of screening for placement to occur.

Once an individual is cleared for placement, the process of locating an appropriate nursing facility is initiated. For a patient in an acute care hospital, the hospital discharge planner, patient, and/or the patient's family work together to find an acceptable nursing facility placement. Nursing facilities in Nevada most often refuse to admit anyone with severe behavior problems stating that they are unable to meet the individual's needs. Regardless of an individual's diagnosis, nursing facilities are federally mandated to meet the needs of every nursing facility resident. Nursing facilities must develop individualized comprehensive care plans which address the steps the facility intends to take to meet each resident's needs.

The Health Division's Bureau of Licensure and Certification (BLC) regulates nursing facilities and the quality of care provided. Sanctions are levied against those facilities found to provide substandard care. If a placement cannot be arranged within the state, Nevada Medicaid is contacted to assist with out-of-state placement.

PLACEMENT OPTIONS AND CURRENT OUT-OF-STATE PLACEMENT STATISTICS:

Based on 2001 statistics, there are approximately 5,091 Medicare/Medicaid certified nursing facility beds in Nevada of which Medicaid residents occupy approximately 2,781. Eight nursing facilities throughout the state have a designated "Alzheimer's Unit" meaning that a wing of the facility has the feature of being "locked." The Alzheimer's Units (sometimes called Secured Units) have a certain number of beds designated for residents with dementia who exhibit wandering behavior and must be confined for safety reasons. Nevada nursing facilities with Alzheimer's Units are often full and have waiting lists. In addition, they do not accept individuals with extremely difficult and challenging behaviors. Typical residents need continual redirection and coaxing, but are usually not aggressive toward other residents and staff. As of May 20, 2002, there were 255 of these beds in the state of which there were only five vacancies. Residents with dementia may occupy any nursing facility bed and are not limited solely to an Alzheimer's Unit if the resident's behavior and medical needs can be addressed outside of a secured area.

Currently there are no nursing facilities in Nevada that accept residents with severe behavior problems whether the behaviors are related to a dementia, dementia-related disorder, mental illness, or another medical condition. Therefore, the majority of out-of-state placements are made because the nursing facilities in Nevada refuse to admit residents with behavior issues that require specialized staff training and a higher than average nursing staff ratio. During recent meetings of the DHCFP's Long-Term Care Task Force, Nevada facilities were offered the opportunity to negotiate higher reimbursement for residents with behavior issues. They refused, stating the major drawback was the increased potential for cited deficiencies and possible sanctions, including monetary, from the BLC and federal government. Apparently this has been their experience in the past. Facility representatives specifically fear deficiencies for improper use of chemical restraints (medications) and for resident-to-resident abuse situations. They also state that the nursing shortage limits their ability to extend staffing ratios and that competition with the gaming industry in Nevada causes a unique problem with obtaining adequate numbers of nursing assistants.

Currently, Nevada Medicaid has 72 recipients with severe behavior problems who are placed in out-of-state nursing facilities. Of these, 9 have a diagnosis of Alzheimer's Type Dementia, 4 have Huntington's Disease and 14 have traumatic brain injury (TBI). One resident is diagnosed with depression with psychosis, and 42 residents have other types of severe dementia or related illness. As mentioned previously, there are usually one to two new out-of-state placements per month and approximately the same number of residents who either expire or are discharged leaving the total number of out-of-state nursing facility residents between 70 and 75 individuals. Requests for placements have increased in frequency since late 1999.

Nevada Medicaid pays an average price per day of $97 for 60 of the 72 residents in out-of-state facilities in comparison to the current nursing facility daily rate in Nevada of

$121 per day. Twelve of these 72 out-of-state placements require very high nurse-to-resident ratios and specially trained staff. The reimbursement rate for these 12 residents averages $250 per day.

DIFFERENCE IN LEVEL OF CARE REQUIRED:

Nursing facilities that accept individuals who demonstrate severe behavior problems require staffing ratios above the minimum standard. One of the most formidable staff challenges is safely preventing and managing behaviors including verbal abuse, agitation, combativeness, and self injury. Nursing facility staff also require comprehensive training in numerous behavioral protocols.

Examples of various behaviors that have resulted in out-of-state placements are as follows:

- A resident with an eating disorder known as Pica who "eats everything" requires continuous 24-hour monitoring to ensure his safety.
- A resident with sexual aggression may try to rape other residents and needs close supervision.
- Residents who suffer from alcohol dementia may exhibit exit-seeking behavior and continually seek to escape the nursing facility to obtain alcohol. These residents can become angry and aggressive toward staff or other residents when denied access to alcohol.
- Brain injuries or disease processes that result in behavior problems present many unique healthcare concerns:
    - Residents with brain injuries are often young or middle aged men, and are very strong. They can they become unexpectedly verbally and physically aggressive if another confused resident intrudes into their area. Behavior problems result in injuries to residents and staff.
    - The ex-boxer with a brain injury may suddenly punch another resident or staff. Many of the brain-injured individuals are extremely strong and become agitated and aggressive during small incidents.

Few, if any health care providers in Nevada, including nursing facility staff, receive the amount of extensive training necessary to deal effectively with these challenges. Some facilities offer training specific to managing behavior. Others are offered training by outside entities, such as Senior Bridges, which is an inpatient psychiatric unit designed to address the needs of the geriatric population. Appropriately trained and adequate staff is essential to defuse the above-described problem situation, and such staff is difficult to find.

LIMITATIONS IN OBTAINING ADEQUATE CARE:

Limitations in obtaining adequate care, including the number of beds available in Alzheimer's Units, has been identified, but most important is the limitation of nursing facilities that are willing and able to accommodate individuals with behavior management problems. Currently, a nursing facility's solution to a resident who

develops a significant behavior problem is to discharge the resident to an acute hospital to stabilize the behavior and possibly adjust medications. Then, when the resident is ready to return to the nursing facility, the facility refuses to readmit the patient citing that they are unable to provide for the patient's needs.

Medicaid eligibility is another limitation. When a patient is admitted to an acute care hospital from the community setting, arranging for a discharge to a nursing facility may be difficult if the patient is not a current Medicaid recipient. If the patient applies to the Nevada Welfare Division for eligibility, it can take up to 45 days to process the application. The process can take much longer (several months to a year or more) if Welfare requires additional information from Social Security. Most nursing facilities want a guarantee of eligibility, or at a minimum the patient needs to be pending eligibility. Some of the Nevada nursing facilities may decline a resident with behavior problems based on the fact eligibility is pending, but will accept residents who are easier to care for and who are also pending eligibility. Oftentimes, the patient can spend several months in an acute care facility while waiting for an eligibility determination. This becomes frustrating for the hospitals that need to free up beds and are not structured to maintain patients with difficult behaviors for a lengthy period of time.

OPTIONS THE STATE MIGHT CONSIDER IN OBTAINING CARE:

One option would be to market a facility from another state that may be interested in establishing a business in Nevada. An out-of-state facility with a well-established behavior management program may respond to the offer of an enhanced Medicaid rate whereas the Nevada providers have consistently shown a lack of interest and willingness to develop a program to provide services to residents with severe behavior problems. Division staff recently held a meeting with one such provider from Utah.

Another option would be for the various state agencies responsible and influential in this issue to join together with the nursing facility providers to form a "behavioral SWAT team." The team would be responsible for identifying the behavioral interventions necessary to address the needs of an individual and enhance patient safety for other residents. This team would need to work together on a continuing basis and be readily available to respond when issues arise in nursing facilities.

The state could consider using the state owned and operated mental health facilities for serving individuals with severe behavior problems. This facility could serve both Medicaid and pending eligible individuals.

THE ROLE OF THE DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL SERVICES:

Pursuant to NRS 433A.115, the Division of Mental Health and Developmental Services (MHDS) specifically excludes the treatment of both Dementia and Alzheimer's disease.

The Diagnostic and Statistical Manual of Mental Disorders (DSM IV) clearly distinguishes the differences between Serious Mental Illness and the dementias, including Alzheimer's disease. For example, the DSM IV specifically excludes medical conditions from the diagnosis of Schizophrenia and Major Depressive Disorder. Alzheimer's disease, as defined by the DSM IV, on the other hand, excludes the diagnosis of Major Depressive Disorder and Schizophrenia. Dementias are caused by the following medical conditions:

- Vascular Dementia (formerly Multi-Infarct Dementia
- HIV Aids
- Head Trauma
- Parkinson's disease
- Huntington's disease
- Pick's disease
- Creutzfeldt-Jakob disease
- General medical conditions such as: normal pressure hydrocephalus, hypothyroidism, brain tumor, Vitamin B12 deficiency, and intracranial radiation.

Consequently, the following responses address only the services provided to persons with mental illness.

1. Bed space available for the long – term care of patients with previously mentioned disorders:

Currently, the State of Nevada has 86 licensed psychiatric beds at Southern Nevada Adult Mental Health Services (SNAMHS). However, 2 of the beds are used by SNAMHS' Psychiatric Emergency Services and six of the beds are unavailable for use while SNAMHS awaits approval from the State Fire Marshal. The state also has 70 licensed beds at Northern Nevada Adult Mental Health Services (NNAMHS). Ten of these beds are used for NNAMHS' Psychiatric Emergency Services. There is a current proposal with the State Fire Marshal to increase the licensed beds available at SNAMHS by 17 beds. Once that proposal is approved, there will be a total of 103 licensed beds at SNAMHS. However, even though SNAMHS currently has 86 licensed beds and will have 103 licensed beds, the hospital is currently funded for the staff of only 78 beds. Similarly, NNAMHS, though it has 70 licensed beds, it is funded for staffing of only 50 beds. Consequently, the total number of staff psychiatric beds for the State of Nevada is 128.

2. An estimate of the actual number of beds needed to adequately address the growing demand for service within the state.

The new Dini-Townsend hospital at NNAMHS was constructed to allow for expansion into an additional 40 beds based on future population growth. This additional capacity could possibly be used to serve individuals with severe behavior problems as noted above.

SNAMHS has submitted a CIP proposal for the construction of a new 32-bed Psychiatric Emergency Services building to meet the growing demands for service in Las Vegas and Henderson. Additionally, the psychiatric hospital at SNAMHS currently operates at capacity nearly every day. We are currently evaluating the need for additional capacity.

3. Options that the state might consider in its effort to address the growing demand for services, including an estimate of the potential cost to the state.

The state's current options in addressing the growing demands for services are to continue funding for and the expansion of the Community Psychiatric Services. These services include, but are not limited to, the following:

- Program for Assertive Community Treatment (PACT). This is a "hospital without walls" program consisting of a multidiscipline treatment team that currently staffs at a ratio of 1:12 with licensed professionals and successfully maintains 70 clients in the community with intensive treatment that otherwise would require more costly hospital care for the recipients. Note: SNAMHS is proposing an additional PACT team to serve the growing homeless mentally ill population in Clark County.
- Intensive Personal Service Coordination. This is a program staffed by specially trained service coordinators at a ratio of 1:15 with treatment directed to persons coming out of the prison and jail systems with serious mental illness. It has proven successful in markedly reducing recidivism both in return to the forensic systems as well as to the state hospital system. MHDS is currently proposing an expansion of this service.
- Newer and Safer Medications. Continued funding for the newer medications with increases that have kept up with population growth has occurred. This enabled clients treated by MHDS to transition to the community and increase their level of functioning consistent with a recovery model of mental health treatment. This has allowed increasing numbers of state mental health clients to become independent and gainfully employed.
- Psychosocial Rehabilitation. This program helps to prepare clients to return to the productive work force. It includes prevocational training for clients who have never been gainfully employed. It teaches how to prepare a work resume, how to seek employment and how to participate in a job interview. This program will need to expand as more of our clients respond to the recovery model and move to independence.
- A Full Spectrum of Residential Housing. The following residential options provide for clients to move progressively through increasingly independent residential options with effective training. This is the recovery model for the treatment of the seriously mentally ill.
    - Intensive Supportive Living Arrangements (ISLA) The ISLA provides 24 hour supports for clients living in the community that otherwise would heave required long–term, more expensive hospital care. It has proved successful in allowing persons with mental illness to live in the community.
    - Special Needs Supportive Living Arrangements. This form of residential supports provides additional nursing management care to persons with

mental illness who otherwise would have to be served long-term within the hospital because of the complicating features of medical disease management such as diabetes. The community placement with medical/nursing support is provided at a lesser cost than hospital care.

- Group homes. Group home care provides a living situation for those clients who are yet unable to manage independent living skills. MHDS provides for skills training in the community, which allows for a progression to more independent living situations.
- Supportive Living Arrangements (SLA). Persons with mental illness in this living option lease their own apartments, successfully using contracted educational skill training and support to increase and maintain independent living.

4. An explanation distinguishing the placement options for persons with mental illness and individuals with alzheimer's disease, dementia and other disorders:

The goal of treatment for clients with Alzheimer's disease and Dementia is safety and security. Placement options over time become more restrictive, more institutional, and less independent as cognitive skills decrease. In this treatment model, there is most always a progressive shift from Community to Institution.

The goal of the recovery model for mental illness is just the opposite. With the newer and safer medications, there is no decrease in cognitive function. This enables an emphasis on increased independence and a progressive decrease in restrictions. In this model there is always a progressive shift from Institution to Community.

5. A description in the level of care required for such patients:

The treatment of persons with mental illness requires short-term acute institutional (hospital) care and long-term community care.

The treatment of Alzheimer's disease and the Dementias requires long-term institutional (nursing home) care as cognitive function decreases as a result of disease progression.

COMMENT: Historically, there have been many requests for MHDS to treat and find placement for clients with Alzheimer's disease and Dementia. These requests go counter to MHDS training and experience. MHDS placement functions are designed to secure progressive, least -restrictive living situation as a result of positive clinical response to treatment. MHDS has little, if any, competence or experience in long-term nursing home placement required for Alzheimer and Dementia patients. When there is a cognitive impairment coexisting along with a mental illness, MHDS has the capacity to provide consultation to nursing homes for a review of the treatment and medication management.

RESOURCES FOR ALZHEIMERS AND RELATED DEMENTIAS

CLARK COUNTY ADULT DAY CARE

EOB Hollyhock Adult Day Care

Person to Contact: Jana Coffman
Address: 380 North Maryland Pkwy
Las Vegas, NV 89101-
Phone: 702-382-0093 Fax: 702-382-3683
The overall mission of the Hollyhock Adult Day Care Center is to provide quality and loving care to individuals 18 years and older who are functionally impaired, in an effort to maintain their dignity in a community-based setting and prevent placement in institutional programs.

* Nursing services

* Nutritional meals & snacks

* Assistance with ADL's (Activities for Daily Living)

* Recreational & therapeutic activities

* Bathing

* Specializing in care for the memory impaired

* Extended hours

Ages: 18 years and older
Criteria: In need of supervision

EOB Lied Senior Care Center

Person to Contact: Kate Mead, LSW
Address: 901 North Jones Blvd

Las Vegas, NV 89108-
Phone: 702-648-3425 Fax: 702-648-8153

The overall mission of the Lied Senior Care Center is to provide quality and loving care to individuals 18 yrs of age or older who are functionally impaired, in an effort to maintain their dignity in a community-based setting
and prevent placement in institutional programs.

* Nursing services

* Nutritional meals & snacks

* Assistance with ADL's (Activities for Daily Living)

* Recreational & therapeutic activities

* Bathing

* Specializing in care for the memory impaired.

* Extended hours

Ages: 18 years and older
Criteria: In need of supervision

The Salvation Army/Henderson Adult Health Day Care Center (Friendship Circle)

Person to Contact: Bill Sampson, Director
Address: 830 E. Lake Mead Drive
Henderson, NV 89015-
Phone: 702-565-8836 Fax: 702-558-8277

The Salvation Army Henderson Adult Health Day Care Center provides protective care, therapeutic and creative activities, counseling and health resources to allow the disabled elderly the opportunity for participation in an enriching program and the ability to remain in their own homes and communities. The objectives of the program are to maintain and improve health, provide fellowship with others and offer training in adaptive living. The Center provides day respite care, nursing care, meals, personal care, socialization and activities.

Ages: 60+
Criteria: Frail elderly and disabled adults who are at risk and need assistance in maintaining independence and personal dignity

RESOURCES FOR ADULT DAY SERVICES IN WASHOE COUNTY

Day Break Adult Health Services

Person to Contact: Dottie Piekarz, CHN III, RN
Address: 1155 E. Ninth Street
Reno, NV 89512-
Phone: 775-328-2591 Fax: 775-328-6635

Therapeutic daytime activity program for disabled adults and elderly in a supportive, supervised and safe environment. Programs include recreational, social and educational activities under supervision of a registered nurse to keep families together by delaying , preventing institutionalization.

Ages: 18 years and older
Criteria: an evaluation is done on an individual basis

The Continuum/Regenerations

Person to Contact: Denise Hund
Address: 3700 Grant Drive, Suite A
Reno, NV 89509-
Phone: 775-829-4700 Fax: 775-829-4710

Provides a daytime alternative for adults in need of supportive activities and environment, encourages independence and allows an individual to remain a part of the home, family and community. We also provide an intergenerational program as well as occupational, speech, and physical therapy.

Ages: 18 years and older
Criteria: based on individual assessment

Resources for Adult Day Services in Elko County

Bright Path Adult Day Care Center

Person to Contact: Lisa Dinwiddie
Address: P. O. Box 2006
Elko, NV 89803
Phone: 775-778-0547

This is a new program, which will be opening in June/July 2002. This Center will be working closely with the Alzheimer's Diagnostic and Treatment Clinic in Elko.

RESOURCES FOR ALZHEIMERS AND RELATED DEMENTIAS

RESPITE CARE VOUCHER PROGRAM

Alzheimer's Association of Northern Nevada

Person to Contact: Craig Farnum, Outreach Coordinator
Address: 705 S. Wells Ave., #225
Reno, NV 89502-
Phone: 775-786-8061 Fax: 775-786-1920
800 Line: 800- 779-5711

Alzheimer's Association of Southern Nevada

Person to Contact: Myra Davis
Address: 5190 S. Valley View Blvd.
Las Vegas, NV 89118-
Phone: 702-248-2770 Fax: 702-248-2771

Respite refers to a short time of rest or relief. It allows the caregiver a break from day to day duties while the person with dementia receives care from qualified individuals.

Approximately $1000.00 is available to families each calendar year. The program is available to families who are caring for a loved-one with dementia. The respite funds may be used for short-term residential placement, adult day centers, home health services, and/or companionship services.

MEDICAL/COUNSELING

University of Nevada School of Medicine

Alzheimer's Disease Diagnostic and Treatment Center-Department of Internal Medicine

Person to Contact: Charles Bernick MD/ Debra Fredericks, PhD.
Address: 1707 W. Charleston Blvd. Suite 230
Las Vegas, NV 89102-
Phone: 702-671-5070 Fax: 702-385-3932

Address: 401 W. 2nd St.
Reno, NV
Phone: 775-327-5003

Address: The Terraces – Elko Senior Center
1795 Ruby View Drive
Elko, NV 89801
Phone: 775-934-3468

Diagnosis and treatment of Alzheimer's Disease and related disorders. Screening for anyone concerned about memory problems. Counseling, education, and resource referral provided to families throughout the course of the disease. Behavior management by a trained behavior analyst. Training and education for community professionals and university students. Opportunities to participate in clinical drug trials and other research projects.
Ages: All
Criteria: Memory or cognitive impairment

Nevada Caregiver Support Center (NCSC)

Person to Contact: Jane E. Fisher, PhD.
Address: 705 S. Wells Ave, Suite 250
Reno, NV 89502-
Phone: 775-784-4335 Fax: 775-327-5043

The NCSC provides support for seniors with memory disorders. Also, training, education, and support are provided to families and professionals caring for elderly adults with dementia. Services provided include: individual counseling, family counseling, professional caregiver training, coordinated medical and psychosocial services, and family caregiver training concerning issues such as managing challenging behaviors and successfully communicating with persons with dementia. The NCSC works in collaboration with the Alzheimer's Disease Diagnostic and Treatment Center.
Ages: All ages
Criteria: family or professional caregiver of a person with Alzheimer's disease or a related dementia

This program began as a demonstration project in Northern Nevada. It will be expanded to Las Vegas in August 2002.

HOUSING SAFETY ASSESSMENT/ACCOMMODATION

The Continuum

Person to Contact: Diane Ross
Address: 3700 Grant Drive, Suite A
Reno, NV 89509-
Phone: 775-829-4700 Fax: 775-829-4710

This organization specializes in geriatric rehabilitation offering physical, occupational and speech/communication/ swallowing therapies both individual and in groups. The agency also offers home safety/accommodation evaluations to promote a safe environment for persons with physical or cognitive disabilities.
Ages: birth to 110
Criteria: call for information

SENIOR BRIDGES

Returning Older Adults To Emotional Health

June 3, 2002

To: Marshelia D. Lyons, Senior Research Analyst
Legislative Committee on Health Care

From: Paula Proulx, RN
Program Director, Senior Bridges

Subject: Long Term Placement For Nevada Residents with Mental Illness and Dementia Related Disorders

Senior Bridges is a 14-bed Gero-Psychiatric inpatient unit located at Northern Nevada Medical Center in Sparks, Nevada. Senior Bridges has provided comprehensive geriatric behavioral health care to seniors 55 years of age and older in northern Nevada for nearly eight years. Our sophisticated treatment team consists of a gero-psychiatrist, LCSW's, MFT's, Nurses, Physical Therapists, Speech Language Pathologists, Occupational Therapists, and an Activity Therapist. We strive to provide acute behavioral stabilization along with positive patient outcomes and the most favorable discharge planning possible to accommodate the patient's needs.

Again, Senior Bridges is an acute, inpatient gero-psychiatric unit. Referrals are made to our program from physicians, hospital emergency rooms, hospital units, NNAMHS, skilled nursing facilities, assisted living facilities, group homes, families, Elder Protective Services, local police departments, local area senior service providers, etc. All clinical information is then conveyed to our medical director who makes the decision to admit or not admit based upon the information that has been provided to us by the referring caller.

We do admit patients who have a known dementia related illness who are experiencing sudden changes in their mood, behaviors or cognition. We also see patients who have lived a lifetime with mental illness and as they have gotten older, now have dementia on top of their mental illness. These patients do benefit from behavior/medication stabilization. Once treatment goals have been achieved and no new treatment problems have arisen, patients need to be discharged to the most appropriate level of care.

Our projected length of stay is 7 to 10 days. Lengths of stay are prolonged when placement cannot be secured. Presently, our average length of stay is about 12 days.

Discharge planning begins when the patient is admitted to the unit. Examples of some possible discharge placements might include: home with maximum services allowed, group home care, assisted living care, skilled nursing home facilities, dementia care units, etc.

A number of barriers exist which preclude appropriate long-term care placement for Nevada residents who clinically manifest mood, behavioral or cognitive problems.

The following list identifies just a few:

- Nevada has seen the loss of several hundred skilled nursing home beds over the last couple of years.

At Northern Nevada Medical Center
2375 E. Prater Way, Sparks NV 89434 · 702/356-4071 · FAX 702/356-4082

- There are approximately 8 skilled nursing facilities in Nevada that have secured units (and these beds are reserved for residents with dementia related disorders only) 3 facilities are located in the Reno-Carson City area and the remaining 5 are in the Las Vegas area. All of them inevitably are full and have a waiting list.

- A screening process must be conducted. HealthInsight completes these screenings within 24 hours of request. They have done a great job of streamlining this process and getting PASRR's back in a timely manner since the contract with HealthInsight was first made. If a diagnosis of Mental Illness has been made, a PASRR II must be completed.

- Skilled nursing facilities more often than not will refuse a patient's admission to their facility based upon the patient's history of aggressive, assaultive behaviors, or, the use of multiple psychoactive medications. Facilities have stated to me that they do not feel they can provide the level of care the patient needs with behavioral issues while providing for the safety of their residents currently residing in their facility.

- Skilled nursing facilities have voiced concerns about the threat of impending citations or fear of "getting dinged on survey" due to resident-to-resident incidents or multiple psychoactive medication use.

- No funding source is available. Patients and their families have not applied for Medicaid and this is a lengthy process for sure. Patients are not presumed eligible.

- There is a lack of knowledge on the part of patients and their families with respect to gaining access to a skilled nursing home. Patients are admitted to skilled nursing homes who have skilled clinical needs, private pay or Medicaid (at least Medicaid pending with county back-up)

- Due to the lack of bed availability, out of state options must be explored. In 2001, Senior Bridges placed 12 patients out of state. To date in 2002, 6 patients have been placed out of state. The majority of these patients have been Medicaid.

- Skilled nursing facilities have referred patients to our program, stating they will accept the patient back. When all is said and done, readmission to their facility is denied, stating "You will have to find another place for this patient because we will not take him back", or "I'd rather take the hit from the front end from the state for not taking the patient back, than get cited for a resident-to-resident incident when they return".

- Another facility stated to me upon referral, "You have to admit this patient, it is in our plan of correction to the state".

- Group home care or assisted living care is unfortunately not an option for many patients due to lack of finances. These facilities are generally private pay.

- Guardianship often needs to be acquired to admit a patient to a secured unit (in or out-of-state). This can take up to several weeks in Washoe County and sometimes just a few days in other counties.

- Families require maximum education and support regarding discharge planning which may unfortunately include out-of-state placement due to no bed availability. They do not understand why their loved one can't "just live here in the hospital until a bed opens up" Despite maximum teaching, families frequently blame the hospitals when no facility in the state will accept their loved one for admission.

- Direct care providers in nursing homes are not mental health workers and have not been provided with the education, training which is required to care for individuals with acute or chronic behavior problems in the mentally ill population.

Some options to consider in providing the appropriate level of care in an appropriate setting for this population who require specialized care and treatment might include:

- Conduct research to ascertain what other states have done to provide care for individuals with behavioral problems due to mental illness vs. individuals with dementia related disorders.
- Expedite the Medicaid eligibility process.
- Conduct a statewide needs assessment to gain insight into the demand for the number of beds that would be needed to accommodate residents with mental illness and dementia related disorders.
- Decide if the state is going to use any of its existing facilities to provide care for people who exhibit behavior problems. Establish eligibility requirements for admission/access to these facilities.
- Conduct a search for businesses who currently provide behavioral healthcare/management services for patients with mental illness and dementia related disorders and inquire if they might be willing to partner with the state in developing units and or managing these units in Nevada.
- Continue educating existing facilities regarding regulations or standards that address psychoactive medication use, behavioral issues, etc.
- Collaboration among private facilities and state agencies to conduct automatic staffing for residents with behavioral problems from the electronic MDS information submitted.

Cordially,

Paula Proulx, RN
Program Director, Senior Bridges

APPENDIX J

Suggested Legislation

The Following Bill Draft Requests Will Be Available During the 2003 Legislative Session

BDR 38–746 Revise the provisions governing the payment of hospitals for treating a disproportionate share of Medicaid patients, indigent patients or other low-income patients.

BDR 39–745 Makes various changes concerning certain persons who are mentally ill and certain persons who are under the influence of a controlled substance.

BDR 40–679 Revises provisions governing payments to major hospitals that admit patients upon diversion from another hospital.

BDR 40–743 Make various changes concerning health care professionals to improve access to health care for all persons in this state.

BDR R–680 Resolution expressing support for the development of the telephone code 2-1-1 in Nevada.

BDR S–678 Makes appropriation to establish mental health component to substance abuse community triage center.

BDR –742 Express the Legislative Committee on Health Care's support for the long-term strategic health care plans developed by the Department of Human Resources regarding senior services, rural health, persons with disabilities and provider rates.

SUMMARY—Makes various changes concerning public health laws. (BDR 40-677)

FISCAL NOTE: Effect on Local Government: Yes.

Effect on the State: Yes.

AN ACT relating to public health; establishing procedures for the isolation or quarantine of a person with a communicable disease; authorizing public health officials to isolate and quarantine a group of persons; requiring the State Board of Health to develop a syndromic reporting and active surveillance system for monitoring public health; expanding the exclusive jurisdiction of the family court to include proceedings for an involuntary court-ordered isolation or quarantine; 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 439.360 is hereby amended to read as follows:

439.360 The county board of health may:

1. Abate nuisances in accordance with law.

2. Establish and maintain an isolation hospital or quarantine station when necessary ~~.~~

for the isolation or quarantine of a person or a group of persons.

3. Restrain, quarantine and disinfect any person ***or group of persons*** sick with or exposed to any contagious or infectious disease that is dangerous to the public health.

4. Appoint quarantine officers when necessary to enforce a quarantine, shall provide whatever medicines, disinfectants and provisions which may be required, and shall arrange for the payment of all debts or charges so incurred from any funds available, but each patient shall, if he is able, pay for his food, medicine, clothes and medical attendance.

5. Subject to the prior review and approval of the board of county commissioners and except as otherwise provided in NRS 576.128, adopt a schedule of reasonable fees to be collected for issuing or renewing any health permit or license required to be obtained from the board pursuant to a law of this state or an ordinance adopted by any political subdivision of this state. Such fees must be for the sole purpose of defraying the costs and expenses of the procedures for issuing licenses and permits, and investigations related thereto, and not for the purposes of general revenue.

Sec. 2. NRS 439.470 is hereby amended to read as follows:

439.470 The city board of health may:

1. Abate nuisances in accordance with law.

2. Establish a temporary isolation hospital or quarantine station when ***an*** emergency demands ~~[.]~~ ***the isolation or quarantine of a person or a group of persons.***

3. Restrain, quarantine and disinfect any person ***or group of persons*** sick with or exposed to any contagious or infectious disease which is dangerous to the public health.

4. Appoint quarantine officers when necessary to enforce a quarantine, and shall provide whatever medicines, disinfectants and provisions which may be required. The city council shall pay all debts or charges so incurred , ~~[;]~~ but each patient shall, if able, pay for his food, medicine, clothes and medical attendance.

5. Subject to the prior review and approval of the governing body of the city and except as otherwise provided in NRS 576.128, adopt a schedule of reasonable fees to be collected for issuing or renewing any health permit or license required to be obtained from such board pursuant to state law or an ordinance adopted by any political subdivision. Such fees must be for the sole purpose of defraying the costs and expenses of the procedures for issuing licenses and permits, and investigations related thereto, and not for the purposes of general revenue.

Sec. 3. Chapter 441A of NRS is hereby amended by adding thereto the provisions set forth as sections 4 to 27, inclusive, of this act.

Sec. 4. ***"Isolation" means the physical separation and confinement of a person or a group of persons infected or reasonably believed by a health authority to be infected with a communicable disease from persons who are not infected with and have not been exposed to the communicable disease, to limit the transmission of the communicable disease to persons who are not infected with and have not been exposed to the communicable disease.***

Sec. 5. *"Quarantine" means the physical separation and confinement of a person or a group of persons exposed to or reasonably believed by a health authority to have been exposed to a communicable disease who do not yet show any signs or symptoms of being infected with the communicable disease from persons who are not infected with and have not been exposed to the communicable disease, to limit the transmission of the communicable disease to persons who are not infected with and have not been exposed to the communicable disease.*

Sec. 6. *As used in sections 6 to 26, inclusive, of this act, unless the context otherwise requires, "health authority" means:*

1. The officers and agents of the Health Division;

2. The officers and agents of a health district; or

3. The district health officer in a district, or his designee, or, if none, the State Health Officer, or his designee.

Sec. 7. *If a health authority isolates or quarantines a person or group of persons infected with, exposed to, or reasonably believed by a health authority to have been infected with or exposed to a communicable disease, the authority must isolate or quarantine the person or group of persons in the manner set forth in sections 6 to 26, inclusive, of this act.*

Sec. 8. *1. If a person infected with or exposed to a communicable disease is voluntarily isolated or quarantined in a public or private medical facility, the facility shall not change the status of the person to an emergency isolation or quarantine unless, before the change in status is made:*

(a) The facility provides:

(1) An application to a health authority for an emergency isolation or quarantine pursuant to section 10 of this act; and

(2) The certificate of a health authority, physician, licensed physician assistant or registered nurse to a health authority pursuant to section 11 of this act; or

(b) The facility receives an order for isolation or quarantine issued by a health authority.

2. A person whose status is changed to an emergency isolation or quarantine pursuant to subsection 1 must not be detained in excess of 48 hours after the change in status is made, unless within that period a written petition is filed by a health authority with the clerk of the district court pursuant to section 14 of this act.

3. If the period specified in subsection 2 expires on a day on which the office of the clerk of the district court is not open, the written petition must be filed on or before the close of the business day next following the expiration of that period.

Sec. 9. *1. Any person or group of persons alleged to have been infected with or exposed to a communicable disease may be detained in a public or private medical facility, a residence or other safe location under emergency isolation or quarantine for testing, examination, observation and the provision of or arrangement for the provision of consensual medical treatment in the manner set forth in sections 6 to 26, inclusive, of this act, and subject to the provisions of subsection 2:*

(a) Upon application to a health authority pursuant to section 10 of this act;

(b) Upon order of a health authority; or

(c) Upon voluntary consent of the person, parent of a minor person or legal guardian of the person.

2. Except as otherwise provided in subsection 3 or 4, a person voluntarily or involuntarily isolated or quarantined under subsection 1 must be released within 72 hours, including weekends and holidays, from the time of his admission to a medical facility or isolation or quarantine in a residence or other safe location, unless within that period:

(a) The additional voluntary consent of the person, the parent of a minor person or a legal guardian of the person is obtained;

(b) A written petition for an involuntary court-ordered isolation or quarantine is filed with the clerk of the district court pursuant to section 14 of this act, including, without limitation, the documents required pursuant to section 15 of this act; or

(c) The status of the person is changed to a voluntary isolation or quarantine.

3. If the period specified in subsection 2 expires on a day on which the office of the clerk of the district court is not open, the written petition must be filed on or before the close of the business day next following the expiration of that period.

4. During a state of emergency or declaration of disaster regarding public health proclaimed by the Governor or the Legislature pursuant to NRS 414.070, a health authority may, before the expiration of the period of 72 hours set forth in subsection 2, petition, with affidavits supporting its request, a district court for an order finding that a reasonably

foreseeable immediate threat to the health of the public requires the 72-hour period of time to be extended for no longer than the court deems necessary for available governmental resources to investigate, file and prosecute the relevant written petitions for involuntary court-ordered isolation or quarantine pursuant to sections 6 to 26, inclusive, of this act.

Sec. 10. *1. An application to a health authority for an order of emergency isolation or quarantine of a person or a group of persons alleged to have been infected with or exposed to a communicable disease may only be made by another health authority, a physician, a licensed physician assistant, a registered nurse or a medical facility by submitting the certificate required by section 11 of this act. Within its jurisdiction, upon application or on its own, subject to the provisions of sections 6 to 26, inclusive, a health authority may:*

(a) Pursuant to its own order and without a warrant:

(1) Take a person or group of persons alleged to and reasonably believed by the health authority to have been infected with or exposed to a communicable disease into custody in any safe location under emergency isolation or quarantine for testing, examination, observation and the provision of or arrangement for the provision of consensual medical treatment; and

(2) Transport the person or group of persons alleged to and reasonably believed by the health authority to have been infected with or exposed to a communicable disease to a public or private medical facility, a residence or other safe location for that purpose, or arrange for the person or group of persons to be transported for that purpose by:

(I) A local law enforcement agency;

(II) A system for the nonemergency medical transportation of persons whose operation is authorized by the Transportation Services Authority; or

(III) If medically necessary, an ambulance service that holds a permit issued pursuant to the provisions of chapter 450B of NRS,

only if the health authority acting in good faith has, based upon personal observation, its own epidemiological investigation or an epidemiological investigation by another health authority, a physician, a licensed physician assistant or a registered nurse as stated in a certificate submitted pursuant to section 11 of this act, if such a certificate was submitted, of the person or group of persons alleged to have been infected with or exposed to a communicable disease, a reasonable factual and medical basis to believe that the person or group of persons has been infected with or exposed to a communicable disease, and that because of the risks of that disease the person or group of persons is likely to be an immediate threat to the health of members of the public who have not been infected with or exposed to the communicable disease.

(b) Petition a district court for an emergency order requiring:

(1) Any health authority or peace officer to take a person or group of persons alleged to have been infected with or exposed to a communicable disease into custody to allow the health authority to investigate, file and prosecute a petition for the involuntary court-ordered isolation or quarantine of the person or group of persons alleged to have been infected with or

exposed to a communicable disease in the manner set forth in sections 6 to 26, inclusive, of this act; and

(2) Any agency, system or service described in subparagraph (2) of paragraph (a) to transport, in accordance with such court order, the person or group of persons alleged to have been infected with or exposed to a communicable disease to a public or private medical facility, a residence or other safe location for that purpose.

2. The district court may issue an emergency order for isolation or quarantine pursuant to paragraph (b) of subsection 1:

(a) Only for the time deemed necessary by the court to allow a health authority to investigate, file and prosecute each petition for involuntary court-ordered isolation or quarantine pursuant to sections 6 to 26, inclusive, of this act; and

(b) Only if it is satisfied that there is probable cause to believe that the person or group of persons alleged to have been infected with or exposed to a communicable disease has been infected with or exposed to a communicable disease, and that because of the risks of that disease the person or group of persons is likely to be an immediate threat to the health of the public.

Sec. 11. *A health authority shall not accept an application for an emergency isolation or quarantine under section 10 of this act unless that application is accompanied by a certificate of another health authority or a physician, licensed physician assistant or registered nurse stating that he has examined the person or group of persons alleged to have been infected with*

or exposed to a communicable disease or has investigated the circumstances of potential infection or exposure regarding the person or group of persons alleged to have been infected with or exposed to a communicable disease and that he has concluded that the person or group of persons has been infected with or exposed to a communicable disease, and that because of the risks of that disease the person or group of persons is likely to be an immediate threat to the health of the public. The certificate required by this section may be obtained from a physician, licensed physician assistant or registered nurse who is employed by the public or private medical facility in which the person or group of persons is admitted or detained and from the facility from which the application is made.

Sec. 12. *1. No application or certificate authorized under section 10 or 11 of this act may be considered if made by a person on behalf of a medical facility or by a health authority, physician, licensed physician assistant or registered nurse who is related by blood or marriage to the person alleged to have been infected with or exposed to a communicable disease, or who is financially interested, in a manner that would be prohibited pursuant to NRS 439B.425 if the application or certificate were deemed a referral, in a medical facility in which the person alleged to have been infected with or exposed to a communicable disease is to be detained.*

2. No application or certificate of any health authority or person authorized under section 10 or 11 of this act may be considered unless it is based on personal observation, examination or epidemiological investigation of the person or group of persons alleged to have been infected with or exposed to a communicable disease made by such health authority or person

not more than 72 hours before the making of the application or certificate. The certificate must set forth in detail the facts and reasons on which the health authority or person who submitted the certificate pursuant to section 11 of this act based his opinions and conclusions.

Sec. 13. *Within 24 hours after a person's involuntary admission into a public or private medical facility under emergency isolation or quarantine, the administrative officer of the public or private medical facility shall reasonably attempt to ascertain the identification and location of the spouse or legal guardian of that person and, if reasonably possible, mail notice of the admission by certified mail to the spouse or legal guardian of that person.*

Sec. 14. *A proceeding for an involuntary court-ordered isolation or quarantine of any person in this state may be commenced by a health authority filing a petition with the clerk of the district court of the county where the person who is to be isolated or quarantined resides. The petition may be pled in the alternative for both isolation and quarantine, if required by developing or changing facts, and must be accompanied:*

1. By a certificate of a health authority or a physician, a licensed physician assistant or a registered nurse stating that he has examined the person alleged to have been infected with or exposed to a communicable disease or has investigated the circumstances of potential infection or exposure regarding the person alleged to have been infected with or exposed to a communicable disease and has concluded that the person has been infected with or exposed to a communicable disease, and that because of the risks of that disease the person is likely to be an immediate threat to the health of the public; or

2. By a sworn written statement by the health authority that:

(a) The health authority has, based upon its personal observation of the person alleged to have been infected with or exposed to a communicable disease, or its epidemiological investigation of the circumstances of potential infection or exposure regarding the person alleged to have been infected with or exposed to a communicable disease, a reasonable factual and medical basis to believe that the person has been infected with or exposed to a communicable disease and, that because of the risks of that disease the person is likely to be an immediate threat to the health of the public; and

(b) The person alleged to have been infected with or exposed to a communicable disease has refused to submit to voluntary isolation or quarantine, examination, testing, or treatment known to control or resolve the transmission of the communicable disease.

Sec. 15. *In addition to the requirements of section 14 of this act, a petition filed pursuant to that section with the clerk of the district court to commence proceedings for involuntary court-ordered isolation or quarantine of a person pursuant to section 8 or 9 of this act must include a certified copy of:*

1. If an application for an order of emergency isolation or quarantine of the person was made pursuant to section 10 of this act, the application for the emergency isolation or quarantine of the person made to the petitioning health authority pursuant to section 10 of this act; and

2. A petition executed by a health authority, including, without limitation, a sworn statement that:

(a) The health authority or a physician, licensed physician assistant or registered nurse who submitted a certificate pursuant to section 11 of this act, if such a certificate was submitted, has examined the person alleged to have been infected with or exposed to a communicable disease;

(b) In the opinion of the health authority, there is a reasonable degree of certainty that the person alleged to have been infected with or exposed to a communicable disease is currently capable of transmitting the disease, or is likely to become capable of transmitting the disease in the near future;

(c) Based on either the health authority's personal observation of the person alleged to have been infected with or exposed to the communicable disease or the health authority's epidemiological investigation of the circumstances of potential infection or exposure regarding the person alleged to have been infected with or exposed to the communicable disease, and on other facts set forth in the petition, the person likely poses an immediate threat to the health of the public; and

(d) In the opinion of the health authority, involuntary isolation or quarantine of the person alleged to have been infected with or exposed to a communicable disease to a public or private medical facility, residence or other safe location is necessary to prevent the person from immediately threatening the health of the public.

Sec. 16. *1. Immediately after he receives any petition filed pursuant to section 14 or 15 of this act, the clerk of the district court shall transmit the petition to the appropriate district judge, who shall set a time, date and place for its hearing. The date must be within 5 judicial days after the date on which the petition is received by the clerk.*

2. The court shall give notice of the petition and of the time, date and place of any proceedings thereon to the subject of the petition, his attorney, if known, the petitioner and the administrative office of any public or private medical facility in which the subject of the petition is detained.

3. The provisions of this section do not preclude a health authority from ordering the release from isolation or quarantine of a person before the time set pursuant to this section for the hearing concerning the person, if appropriate.

4. After the filing of a petition pursuant to section 14 or 15 of this act and before any court-ordered involuntary isolation or quarantine, a health authority shall file notice with the court of any order of the health authority issued after the petition was filed to release the person from emergency isolation or quarantine, upon which the court may dismiss the petition without prejudice.

Sec. 17. *1. After the filing of a petition to commence proceedings for the involuntary court-ordered isolation or quarantine of a person pursuant to section 14 or 15 of this act, the court shall promptly cause two or more physicians or licensed physician assistants, at least one of whom must always be a physician, to either examine the person alleged to have been*

infected with or exposed to a communicable disease or assess the likelihood that the person alleged to have been infected with or exposed to a communicable disease has been so infected or exposed.

2. To conduct the examination or assessment of a person who is not being detained at a public or private medical facility, residence or other safe location under emergency isolation or quarantine pursuant to the emergency order of a health authority or court made pursuant to section 9 or 10 of this act, the court may order a peace officer to take the person into protective custody and transport him to a public or private medical facility, residence or other safe location where he may be detained until a hearing is held upon the petition.

3. If the person is being detained at his home or other place of residence under an emergency order of a health authority or court pursuant to section 9 or 10 of this act, he may be allowed to remain in his home or other place of residence pending an ordered assessment, examination or examinations and to return to his home or other place of residence upon completion of the assessment, examination or examinations if such remaining or returning would not constitute an immediate threat to others residing in his home or place of residence.

4. Each physician and licensed physician assistant who examines or assesses a person pursuant to subsection 1 shall, not later than 24 hours before the hearing set pursuant to section 16 of this act, submit to the court in writing a summary of his findings and evaluation regarding the person alleged to have been infected with or exposed to a communicable disease.

Sec. 18. *1. The Health Division shall establish such evaluation teams as are necessary to aid the courts under sections 17 and 24 of this act.*

2. Each team must be composed of at least two physicians, or at least one physician and one physician assistant.

3. Fees for the evaluations must be established and collected as set forth in section 19 of this act.

Sec. 19. *1. In counties where the examining personnel required pursuant to section 17 of this act are not available, proceedings for involuntary court-ordered isolation or quarantine shall be conducted in the nearest county having such examining personnel available in order that there be minimum delay.*

2. The entire expense of proceedings for involuntary court-ordered isolation or quarantine shall be paid by the county in which the application is filed, except that when the person to be admitted last resided in another county of this state the expense must be charged to and payable by such county of residence.

Sec. 20. *1. The person alleged to have been infected with or exposed to a communicable disease, or any relative or friend on his behalf, is entitled to retain counsel to represent him in any proceeding before the district court relating to involuntary court-ordered isolation or quarantine, and if he fails or refuses to obtain counsel, the court shall advise him and his guardian or next of kin, if known, of the right to counsel and shall appoint counsel, who may be the public defender or his deputy.*

2. Any counsel appointed pursuant to subsection 1 must be awarded compensation by the court for his services in an amount determined by the court to be fair and reasonable. The compensation must be charged against the estate of the person for whom the counsel was appointed or, if the person is indigent, against the county where the person alleged to have been infected with or exposed to a communicable disease last resided.

3. The court shall, at the request of counsel representing the person alleged to have been infected with or exposed to a communicable disease in proceedings before the court relating to involuntary court-ordered isolation or quarantine, grant a recess in the proceedings for the shortest time possible, but for not more than 5 days, to give the counsel an opportunity to prepare his case.

4. Each district attorney or his deputy shall appear and represent the State in all involuntary court-ordered isolation or quarantine proceedings in his county. The district attorney is responsible for the presentation of evidence, if any, in support of the involuntary court-ordered isolation or quarantine of a person to a medical facility, residence or other safe location in proceedings held pursuant to section 14 or 15 of this act.

Sec. 21. *In proceedings for involuntary court-ordered isolation or quarantine, the court shall hear and consider all relevant testimony, including, but not limited to, the testimony of examining personnel who participated in the evaluation of the person alleged to have been infected with or exposed to a communicable disease and the certificates, if any, of a health authority or a physician, licensed physician assistant or registered nurse accompanying the*

petition. The court may consider testimony relating to any past actions of the person alleged to have been infected with or exposed to a communicable disease if such testimony is probative of the question of whether the person presently has been infected with or exposed to a communicable disease and is likely to present an immediate threat to the health of the public.

Sec. 22. *In proceedings for an involuntary court-ordered isolation or quarantine, the person with respect to whom the proceedings are held has the right to be present by live telephonic conferencing or videoconferencing and may, at the discretion of the court, testify. A person who is alleged to have been infected with or exposed to a communicable disease does not have the right to be physically present during the proceedings if such person, if present in the courtroom, would likely pose an immediate threat to the health of the judge or the staff or officers of the court.*

Sec. 23. *Witnesses subpoenaed under the provisions of sections 6 to 26, inclusive, of this act shall be paid the same fees and mileage as are paid to witnesses in the courts of the State of Nevada.*

Sec. 24. *1. If the district court finds, after proceedings for the involuntary court-ordered isolation or quarantine of a person to a public or private medical facility, residence or other safe location:*

(a) That there is not clear and convincing evidence that the person with respect to whom the hearing was held has been infected with or exposed to a communicable disease or is likely to be an immediate threat to the health of the public, the court shall enter its finding to that

effect and the person must not be involuntarily detained in such a facility, residence or other safe location.

(b) That there is clear and convincing evidence that the person with respect to whom the hearing was held has been infected with or exposed to a communicable disease and, because of that disease, is likely to be an immediate threat to the health of the public, the court may order the involuntary isolation or quarantine of the person and may order the most appropriate course of treatment after considering the rights of the person and the desires of the person concerning treatment. The order of the court must be interlocutory and must not become final if, within 14 days after the court orders the involuntary isolation or quarantine, the person is unconditionally released by a health authority from the medical facility, residence or other safe location.

2. An involuntary isolation or quarantine pursuant to paragraph (b) of subsection 1 automatically expires at the end of 30 days if not terminated previously by a health authority. At the end of the court-ordered period of isolation or quarantine, the health authority may petition to renew the detention of the person for additional periods not to exceed 120 days each. For each renewal, the petition must set forth to the court specific reasons why further isolation or quarantine is appropriate and that the person likely poses an ongoing immediate threat to the health of the public. If the court finds in considering a petition for renewal that the person is noncompliant with a court-ordered measure to control or resolve the risk of transmitting the communicable disease, it may order the continued isolation and treatment of

the person for any period of time the court deems necessary to resolve the immediate and ongoing risk of the person transmitting the disease.

3. Before issuing an order for involuntary isolation or quarantine or a renewal thereof, the court shall explore other alternative courses of isolation, quarantine and treatment within the least restrictive appropriate environment as suggested by the evaluation team who evaluated the person, or other persons professionally qualified in the field of communicable diseases, which the court believes may be in the best interests of the person.

Sec. 25. *The order for involuntary court isolation or quarantine of any person to a medical facility, public or private, must be accompanied by a clinical abstract, including a history of illness, diagnosis and treatment, and the names of relatives or correspondents.*

Sec. 26. *When any involuntary court isolation or quarantine is ordered under the provisions of sections 6 to 26, inclusive, of this act, the involuntarily isolated or quarantined person, together with the court orders, any certificates of the health authorities, physicians, licensed physician assistants or registered nurses, the written summary of the evaluation team and a full and complete transcript of the notes of the official reporter made at the examination of such person before the court, must be delivered to the sheriff of the appropriate county who must be ordered to:*

1. Transport the person; or

2. Arrange for the person to be transported by:

(a) A system for the nonemergency medical transportation of persons whose operation is authorized by the Transportation Services Authority; or

(b) If medically necessary, an ambulance service that holds a permit issued pursuant to the provisions of chapter 450B of NRS,

to the appropriate public or private medical facility, residence or other safe location.

Sec. 27. *1. The Board shall develop a system which provides for syndromic reporting and active surveillance to monitor public health in this state during major events or when determined appropriate and necessary by a health authority.*

2. The Board shall adopt regulations concerning the system it develops pursuant to this section, including, without limitation:

(a) The manner in which and situations during which the system actively gathers information;

(b) The persons who are required to report information to the system; and

(c) The procedures for reporting required information to the system.

Sec. 28. NRS 441A.010 is hereby amended to read as follows:

441A.010 As used in this chapter, unless the context otherwise requires, the words and terms defined in NRS 441A.020 to 441A.110, inclusive, *and sections 4 and 5 of this act* have the meanings ascribed to them in those sections.

Sec. 29. NRS 441A.120 is hereby amended to read as follows:

441A.120 The Board shall adopt regulations governing the control of communicable diseases in this state, including regulations specifically relating to the control of such diseases in educational, medical and correctional institutions. The regulations must specify:

1. The diseases which are known to be communicable.

2. The communicable diseases which are known to be sexually transmitted.

3. The procedures for investigating and reporting cases or suspected cases of communicable diseases, including the time within which these actions must be taken.

4. For each communicable disease, the procedures for testing, treating, isolating and quarantining a person ***or group of persons*** who ~~[has or is]~~ ***have been exposed to or have or are*** suspected of having the disease.

Sec. 30. NRS 441A.160 is hereby amended to read as follows:

441A.160 1. A health authority who knows, suspects or is informed of the existence within his jurisdiction of any communicable disease shall immediately investigate the matter and all circumstances connected with it, and shall take such measures for the prevention, suppression and control of the disease as are required by the regulations of the Board or a local board of health.

2. A health authority may:

(a) Enter private property at reasonable hours to investigate any case or suspected case of a communicable disease.

(b) Order any person whom he reasonably suspects has a communicable disease in an infectious state to submit to any medical examination or test which he believes is necessary to verify the presence of the disease. The order must be in writing and specify the name of the person to be examined and the time and place of the examination and testing, and may include such terms and conditions as the health authority believes are necessary to protect the public health.

(c) Except as otherwise provided in NRS 441A.210, issue an order requiring the isolation, quarantine or treatment of any person ***or group of persons*** if he believes that such action is necessary to protect the public health. The order must be in writing and specify the person ***or group of persons*** to be isolated ~~[,]~~ ***or quarantined,*** the time during which the order is effective, the place of isolation or quarantine and other terms and conditions which the health authority believes are necessary to protect the public health, except that no isolation or quarantine may take place if the health authority determines that such action may endanger the life of ~~[the person .]~~ ***a person who is isolated or quarantined.***

(d) Each order issued pursuant to this section must be served upon each person named in the order by delivering a copy to him.

3. If a health authority issues an order to isolate or quarantine a person with a communicable or infectious disease in a medical facility, the health authority must isolate or quarantine the person in the manner set forth in sections 6 to 26, inclusive, of this act.

Sec. 31. NRS 3.223 is hereby amended to read as follows:

3.223 1. Except if the child involved is subject to the jurisdiction of an Indian tribe pursuant to the Indian Child Welfare Act of 1978 , ~~[(]~~ 25 U.S.C. §§ 1901 et seq. , ~~(),]~~ in each judicial district in which it is established, the family court has original, exclusive jurisdiction in any proceeding:

(a) Brought pursuant to chapter 31A, 62, 123, 125, 125A, 125B, 125C, 126, 127, 128, 129, 130, 159, 425 or 432B of NRS, except to the extent that a specific statute authorizes the use of any other judicial or administrative procedure to facilitate the collection of an obligation for support.

(b) Brought pursuant to NRS 442.255 and 442.2555 to request the court to issue an order authorizing an abortion.

(c) For judicial approval of the marriage of a minor.

(d) Otherwise within the jurisdiction of the juvenile court.

(e) To establish the date of birth, place of birth or parentage of a minor.

(f) To change the name of a minor.

(g) For a judicial declaration of the sanity of a minor.

(h) To approve the withholding or withdrawal of life-sustaining procedures from a person as authorized by law.

(i) Brought pursuant to NRS 433A.200 to 433A.330, inclusive, for an involuntary court-ordered admission to a mental health facility.

(j) Brought pursuant to sections 6 to 26, inclusive, of this act for an involuntary court-ordered isolation or quarantine.

2. The family court, where established, and the justices' court have concurrent jurisdiction over actions for the issuance of a temporary or extended order for protection against domestic violence.

3. The family court, where established, and the district court, have concurrent jurisdiction over any action for damages brought pursuant to NRS 41.134 by a person who suffered injury as the proximate result of an act that constitutes domestic violence.

Sec. 32. This act becomes effective on July 1, 2003.

SUMMARY—Removes certain mobile units from requirement of being regulated as medical facility. (BDR 40-744)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State: No.

AN ACT relating to medical facilities; removing certain mobile units from the requirement of being regulated as a medical facility; 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 449.01515 is hereby amended to read as follows:

449.01515 ~~[~~"Mobile~~]~~

*1. **Except as otherwise provided in subsection 2, "mobile** unit" means a motor vehicle ~~[,~~ ~~other than a vehicle operated under the authority of a permit issued pursuant to chapter 450B of NRS,]~~ that is specially designed, constructed and equipped to provide any of the medical services provided by a medical facility described in subsections 1 to 13, inclusive, of NRS 449.0151.

*2. **"Mobile unit" does not include:***

(a) A motor vehicle that is operated by a medical facility described in subsections 1 to 13, inclusive, of NRS 449.0151 which is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association;

(b) A motor vehicle that is operated by a health center that is funded under section 330 of the Public Health Service Act, 42 U.S.C. § 254b, as amended; or

(c) A vehicle operated under the authority of a permit issued pursuant to chapter 450B of NRS.

Sec. 2. NRS 449.230 is hereby amended to read as follows:

449.230 1. Any authorized member or employee of the Health Division may enter and inspect any building or premises at any time to secure compliance with or prevent a violation of any provision of NRS 449.001 to 449.245, inclusive. ~~[For the purposes of this subsection, "building or premises" does not include a mobile unit that is operated by a medical facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association.]~~

2. The State Fire Marshal or his designee shall, upon receiving a request from the Health Division or a written complaint concerning compliance with the plans and requirements to respond to an emergency adopted pursuant to subsection 7 of NRS 449.037:

(a) Enter and inspect a residential facility for groups; and

(b) Make recommendations regarding the adoption of plans and requirements pursuant to subsection 7 of NRS 449.037,

to ensure the safety of the residents of the facility in an emergency.

3. The State Health Officer or his designee shall enter and inspect at least annually each building or the premises of a residential facility for groups to ensure compliance with standards for health and sanitation.

4. An authorized member or employee of the Health Division shall enter and inspect any building or premises operated by a residential facility for groups within 72 hours after the Health Division is notified that a residential facility for groups is operating without a license.

Sec. 3. NRS 449.235 is hereby amended to read as follows:

449.235 ~~[1. Except as otherwise provided in subsection 2, every]~~ ***Every*** medical facility or facility for the dependent may be inspected at any time, with or without notice, as often as is necessary by:

~~[(a)]~~ ***1.*** The Health Division to ensure compliance with all applicable regulations and standards; and

~~[(b)]~~ ***2.*** Any person designated by the Aging Services Division of the Department of Human Resources to investigate complaints made against the facility.

~~[2. The provisions of subsection 1 do not authorize the Health Division to inspect a mobile unit that is operated by a medical facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association, unless the Health Division has reasonable cause to believe that the mobile unit has violated any provision of NRS 449.001 to 449.240, inclusive, or any regulation or standard adopted pursuant thereto.]~~

Sec. 4. This act becomes effective on July 1, 2003.

SUMMARY—Commends Nevadans for Antibiotic Awareness for its work on preventing abuse of antibiotics and urges public health agencies to work to prevent abuse of antibiotics in this state. (BDR R-681)

_____ CONCURRENT RESOLUTION—Commending Nevadans for Antibiotic Awareness for its work on preventing the abuse of antibiotics, and urging public health agencies to work to prevent the abuse of antibiotics in this state.

WHEREAS, Antibiotics are strong medicines used to treat infections caused by bacteria, and they have been responsible since their discovery in the 1940s for dramatically reducing illness and death caused by infectious diseases and for revolutionizing medical care in the 20th century; and

WHEREAS, The bacteria that are controlled by antibiotics have developed a resistance to the antibiotics to the point where today virtually all important bacterial infections in the United States and throughout the world are becoming resistant to antibiotics, thereby reducing the ability of antibiotics to effectively control bacterial growth and treat infectious diseases; and

WHEREAS, Antibiotics are only effective against bacterial infections and thus should only be used to treat bacterial infections and not to treat viral infections such as the common cold, cough, most sore throats and the flu; and

WHEREAS, According to the Centers for Disease Control, up to 50 percent of antibiotic use may be inappropriate; and

WHEREAS, The widespread overuse and abuse of antibiotics promotes the spread of antibiotic resistance thus jeopardizing the usefulness of essential medicines; and

WHEREAS, Antibiotic resistance can cause significant danger and suffering for children and adults who have common infections which were at one time easily treatable with antibiotics, making antibiotic resistance one of the world's most pressing public health problems as well as one of the top concerns of the Centers for Disease Control; and

WHEREAS, The consequences of larger numbers of bacteria becoming resistant to antibiotics include extra visits to health care providers, hospitalization and extended hospital stays, the need for more expensive antibiotics to replace the ineffective antibiotics, lost time at school or work, and sometimes death; and

WHEREAS, Persons who are ill and the parents of ill children can prevent the development of antibiotic-resistant infections by ensuring that antibiotics are only taken for bacterial infections and not for viral infections, that antibiotics are taken exactly as directed, that the entire regimen is completed as directed by a health care provider and that antibiotics are taken only by the person for whom they were prescribed; and

WHEREAS, Health care providers can prevent the development of antibiotic-resistant infections by prescribing antibiotic therapy only when it is likely to be beneficial to the patient and by prescribing antibiotic therapy in the proper dose and for the correct amount of time using an agent that targets the bacteria that are likely causing the illness; and

WHEREAS, By practicing good hygiene, including washing hands often and thoroughly, cooking meat properly, washing fruits and vegetables thoroughly, and handling food hygienically, people can prevent many infections and thus lessen the need for antibiotics; and

WHEREAS, Nevadans for Antibiotic Awareness is a statewide task force of over 40 state and local public and private agencies and companies committed to addressing the problem of antibiotic resistance by educating the public about the consequences of the inappropriate use of antibiotics, training health care providers concerning the appropriate use of antibiotics, decreasing the inappropriate use of antibiotics and improving the control and surveillance of infections; and

WHEREAS, Nevadans for Antibiotic Awareness has partnered with the Centers for Disease Control and 31 other states to develop programs to increase awareness of the public health dangers of antibiotic resistance; and

WHEREAS, Nevadans for Antibiotic Awareness has addressed the serious public health issue of antibiotic resistance in the State of Nevada by developing and distributing statewide guidelines for the use of antibiotics, developing and delivering a comprehensive educational program for health care providers, establishing a bilingual media campaign with the support of its partners, conducting surveillance of antibiotic resistance rates for certain bacteria, and distributing educational materials throughout emergency rooms, pharmacies, health care facilities, doctor's offices, school nurse offices and childcare facilities in this state; and

WHEREAS, The effectiveness of the work done by Nevadans for Antibiotic Awareness is evidenced by a decrease in the use of common antibiotics by outpatients in Nevada and its

recognition by the Centers for Disease Control as having one of the best programs in the United States addressing the abuse of antibiotics and the development of antibiotic-resistant bacteria; now, therefore, be it

RESOLVED BY THE _____ OF THE STATE OF NEVADA, THE _____ CONCURRING, That the Nevada Legislature is committed to creating a greater public understanding of the abuse of antibiotics and to supporting the need for educating the public and health care providers on the consequences of abusing antibiotics; and be it further

RESOLVED, That the Nevada Legislature commends Nevadans for Antibiotic Awareness for its efforts in educating the public and health care providers in this state about the harm that results from the abuse of antibiotics and the actions that residents of this state can take to address this serious public health issue; and be it further

RESOLVED, That the Health Division of the Department of Human Resources and the local health authorities in this state are urged to take actions to prevent the abuse of antibiotics in Nevada, including, without limitation, working with the medical community and health care providers to educate the public concerning antibiotic resistance, its causes and the steps that can be taken to reduce and inhibit its spread; and be it further

RESOLVED, That the _____ of the _____ prepare and transmit a copy of this resolution to Nevadans for Antibiotic Awareness, and to the Health Division of the Department of Human Resources for transmittal to all local health authorities in Nevada.