Legislative Committee on Health Care

Legislative Counsel Bureau

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LEGISLATIVE COMMITTEE ON HEALTH CARE

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SUMMARY OF RECOMMENDATIONS

LEGISLATIVE COMMITTEE ON HEALTH CARE

Nevada Revised Statutes 439B.200

This summary presents the recommendations approved by the Legislative Committee on Health Care (LCHC), *Nevada Revised Statutes* (NRS) 439B.200 at its July 29, 2008, meeting. The LCHC submits the following proposals to the 75th Session of the Nevada Legislature:

ACCESS TO CARE

1. Draft legislation requiring the Department of Health and Human Services (DHHS) to establish a system that allows applications for Medicaid and the Children's Health Insurance Program to be submitted electronically. This bill would further require an agency that is designated by the Director of the DHHS to receive applications or determine eligibility for the programs to use the system to forward applications, but applicants for services must not be required to submit applications electronically. Include a provision that designates unclaimed property funding to support the development of this e-application. **(BDR 38–210)**

MENTAL HEALTH AND SUBSTANCE ABUSE

2. Draft legislation to clarify the involuntary commitment process term "transported" from NRS 433A.165 and replace with the term "admitted" (See Assembly Bill 225, 2007 Session). Clarify and expand the list of health care professionals authorized to release patients off of the "Legal 2000" hold status, to include: psychiatrists, psychologists, physicians (M.D., D.O.), and persons trained and licensed in clinical social work or nursing who have a graduate degree and clinical experience in mental health. (**BDR 39–211**)

3. Make an appropriation of $100,000 to support the work of the Justice Center, The Council of State Governments, to continue to improve public safety through effective substance abuse and mental health treatment for persons in the criminal justice system in Nevada. **(BDR S–212)**

CHILDREN AND SENIOR HEALTH ISSUES

4. Draft legislation creating the Legislative Committee on Child Welfare and Juvenile Justice in accordance with Sections 2 through 8, inclusive, of Senate Bill 170 of the 2007 Legislative Session. **(BDR 17–213)**

PUBLIC HEALTH PROGRAMS

5. Draft legislation to maintain the Health Insurance for Work Advancement Program and the Traumatic Brain Injury (TBI) waiver and make an appropriation for the necessary amount. **(BDR S–212)**

HEPATITIS C INVESTIGATION

6. Draft legislation to define the process for a declaration of a "public health emergency." This bill will provide clear authority and expectations for the coordinated actions of all public agencies that have statutory responsibilities for some aspects of any required investigation, intervention, or sanctions. In addition to other items, the following provisions must be included:

    - Authority to temporarily close a facility, or the appropriate portion of a facility, in order to make a determination within 24 hours as to whether the facility can be reopened and provide safe services. During that 24-hour period, the facility employees will be tested and/or educated in order to ensure that the services being rendered are safe.

    - Authority to establish a central record repository in the case of a public health emergency and ensure that the team working with the records is trained regarding Health Insurance Portability and Accountability Act compliance, and allow a facility or medical professional to voluntarily allow the records to remain on the premises if they can be secured.

    - Inclusion of electronic records in the determination as to the most appropriate manner in which to handle the medical records.

    - Development of a central information and education hotline.

    - Assurance that the appropriate law enforcement agency is included in securing medical records to maintain the chain of evidence/custody.

    - Authority for the Director of the DHHS to appoint a replacement for the State Health Officer, Health Division, DHHS, under certain circumstances. The replacement must meet the qualifications of the State Health Officer.

    - Assurance that State agencies and local health authorities' current powers to react to such crises are not diminished as they await the declaration of a "public health emergency." **(BDR 40–214)**

7. Draft legislation requiring surgical centers for ambulatory patients (ASCs) and physicians' offices where outpatient surgical procedures are being performed to be accredited by a federally recognized accrediting entity. Set the threshold for physicians'

offices that must be accredited as those that utilize any of the three deepest levels of sedation. Provide for the appropriate sanctions to be used by the Bureau of Licensure and Certification (BLC), Health Division, DHHS (who will have authority over facilities), and the Board of Medical Examiners (BME) (who will have authority over the practitioners), should there be a failure to maintain accreditation. **(BDR 40–215)**

8. Draft legislation to require the BLC to survey the ASCs once every year and require the BLC to increase the fees for licensing these types of facilities to include the additional cost for conducting these surveys. Include annual inspections of physicians' offices that would be required to be accredited pursuant to Recommendation No. 7. Require the annual inspections to be unannounced. In addition, include transitional funding to support the positions required to conduct the surveys, as the new fee and survey schedule is implemented. A fee increase will be utilized in order to accomplish these more frequent inspections. **(BDR 40–215)**

9. Draft legislation that requires the BLC to prepare and submit an annual report regarding the frequency of inspections of health care facilities licensed in this State and the findings from those inspections. The report must include a summary of any major issues and problems that have been identified and any follow-up. The report must be submitted to the LCHC. **(BDR 40–215)**

HEALTH CARE PROFESSIONAL LICENSING BOARDS

10. Draft legislation to require Governor Jim Gibbons to provide to the LCHC advance notice of potential appointments to the BME, the State Board of Osteopathic Medicine, and the Board of Homeopathic Medical Examiners. Authorize: (a) the medical societies and professional associations; (b) the University of Nevada School of Medicine; and (c) individuals to nominate persons to fill vacancies on the BME, the State Board of Osteopathic Medicine, and the Board of Homeopathic Medical Examiners.

    Require the nominations to be submitted for consideration to the LCHC not later than 30 days after the notice of potential vacancy is made. The LCHC would be authorized to make inquiries concerning the potential appointments. The LCHC may report to the Governor concerning the advisability of making such appointments. The LCHC will have 60 days from the deadline for the receipt of nominations to make any and all inquiries. If the LCHC does not submit at least three names to the Governor within 90 days after the notice of vacancy, the Governor may act without input from the LCHC. **(BDR 54–216)**

11. Draft legislation that places the current statutory provisions which authorize health care professional licensing boards to temporarily suspend a practitioner's license in Chapter 630 of NRS, "Physicians, Physician Assistants and Practitioners of Respiratory Care" (BME); Chapter 630A of NRS, "Homeopathic Medicine" (Board of Homeopathic Medical Examiners); and Chapter 633 of NRS, "Osteopathic Medicine" (State Board of Osteopathic Medicine). **(BDR 54–217)**

12. Draft legislation that establishes grounds for a health care professional licensing board to suspend or revoke a professional license held by the owner or another principal of a health care facility that has responsibility in the creation of a public health threat or is currently being investigated, under certain circumstances. This provision is similar to the provisions of NRS 449.160. **(BDR 54–217)**

13. Draft legislation that requires all members of health care professional licensing boards to be provided a copy of the conflict of interest provisions of Chapter 281A of NRS, "Ethics in Government," and require the signature of each board member acknowledging receipt of the conflict of interest provisions. **(BDR 54–216)**

14. Draft legislation to require all health care professional licensing boards to retain every complaint that is filed with the board, including, without limitation, complaints that receive no action for at least ten years. **(BDR 54–217)**

WHISTLEBLOWER PROTECTIONS

15. Draft legislation to provide statutory protections for a nurse who: (a) reports concerns about patients being exposed to substantial risk of harm due to failure of a facility or practitioner to conform to minimum professional standards, regulations, or accreditation standards; (b) is requested to engage in conduct that would violate the nurse's duty to protect patients from actual or potential harm as defined in Chapter 632 of NRS, "Nursing," and Chapter 632 of *Nevada Administrative Code* (NAC), "Nursing"; (c) refuses to engage in conduct that would violate the provisions of Chapter 632 of NRS or Chapter 632 of NAC or that would make the nurse reportable to the State Board of Nursing; (d) reports the actions of another nurse who engages in conduct subject to mandatory reporting to the State Board of Nursing as defined in Chapter 632 of NRS or Chapter 632 of NAC; or (e) reports staffing concerns or situations that reasonably could contribute to patient harm. **(BDR 40–219)**

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

16. Draft legislation to modify the requirement that an applicant for a license to practice medicine must prove to the BME he is a citizen or lawfully entitled to remain and work in the United States by creating an exception for applicants who are trying to enter the J-1 Visa Waiver Program. This bill would allow an application for a license to be processed; however, the applicant would not be permitted to begin the practice of medicine until the J-1 Visa Waiver has been issued. **(BDR 54–220)**

17. Draft legislation to allow physicians who have recently completed a residency program to be provisionally licensed upon receipt of satisfactory fingerprint reports, pending completion of the remainder of the board application process, including completion of certain examinations or board certifications. **(BDR 54–220)**

18. Draft legislation to make it easier for professionals licensed in other states to become licensed in Nevada if certain criteria are met. Establish a pilot program to apply to professionals licensed by the following boards: the Board of Examiners for Social Workers; the BME; the Board of Psychological Examiners; and the State Board of Osteopathic Medicine. Model this legislation after similar legislation related to the Board of Dental Examiners of Nevada. **(BDR 54–220)**

19. Draft legislation to specify that supervision of physician assistants can be done through telecommunications and remote file review. **(BDR 54–220)**

20. Draft legislation to allow professional licensing boards to hire counsel outside the Office of the Attorney General when appropriate. **(BDR 54–220)**

21. Draft legislation to provide professional licensing boards with the authority to investigate and refer unlawful professional practice to authorities for penalties, applicable only to the health care-related boards. Model the legislation after similar authority given to the State Contractors' Board. Allow the boards to fine those that misrepresent themselves as a professional licensed by the boards. **(BDR 54–220)**

LETTERS

The LCHC authorized the Chair to send the following letters on its behalf:

22. Draft a letter to Nevada's Congressional Delegation requesting that certain federal policy revisions be made to enhance Nevada's ability to support, recruit, and retain physicians who work through the J-1 Visa Waiver Program, including a provision that gives priority or preference, or both, to physicians who have participated in the J-1 Visa Waiver Program, when they apply for lawful permanent residency.

23. Draft a letter and include a statement in the LCHC's final report encouraging the Division of Mental Health and Developmental Services (DMHDS), DHHS, to collaborate with the mental health redesign work group to continue to review Nevada's process for admitting persons to mental health facilities under emergency circumstances, known as the "Legal 2000" process. The letter will request the DMHDS to prepare recommendations to refine the Legal 2000 process.

24. Draft a letter to Nevada's Congressional Delegation requesting the amendment of various federal lands acts to allow for the conveyance of federal land to support the development of behavioral health and substance abuse facilities, with the intent of encouraging

investment and management of these types of facilities in Nevada, as part of a strategy for decreasing the number of out-of-state patient placements.

25. Draft a letter to the Senate Committee on Finance and the Assembly Committee on Ways and Means requesting an ongoing line item for mental health and substance abuse services and programs within the Department of Corrections' budget.

26. Draft a letter and include a statement in the LCHC's final report encouraging the DMHDS to create a plan for addressing compensation and organizational challenges which constrict the DMHDS's ability to recruit and retain psychiatrists.

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

28. Draft a letter to the Director of the DHHS to encourage the Aging Services Division, DHHS, to work with the BLC, Health Division, DHHS, and the Division of Health Care Financing and Policy, DHHS, to develop a plan related to the development of certain services/resources for residents diagnosed with (a) Alzheimer's disease; (b) dementia; and (c) TBI.

29. Draft a letter and include a statement in the LCHC's final report to support the BDR of the Health Division, DHHS, to revise provisions relating to the State's public health system.

30. Draft a letter encouraging the State Board of Pharmacy, in collaboration with the BME, the State Board of Health, the State Board of Nursing, and the State Board of Osteopathic Medicine to develop a system for monitoring the sale and use of anesthesia in Nevada to determine where surgical procedures are being performed and the type of health care professionals that are conducting those surgeries. Include both ASCs and physicians' offices performing outpatient procedures under one or more of the three deepest levels of sedation.

31. Draft a letter requesting the BME, the State Board of Nursing, and the State Board of Osteopathic Medicine to regularly survey licensees to obtain details about locations and areas of practice in order to provide information to support programs to obtain more practitioners.

32. Draft a letter to Nevada's Congressional Delegation to support an increase in the Federal Medical Assistance Program (FMAP) by raising federal match rates and by holding states harmless if the FMAP decreases from one year to the next.

STATEMENT OF SUPPORT

The LCHC directed staff to include the following statement of support in the final report:

33. Establish an interim legislative study to review health care professional licensing boards.

REPORT TO THE 75TH SESSION OF THE NEVADA LEGISLATURE BY THE LEGISLATIVE COMMITTEE ON HEALTH CARE

I. INTRODUCTION

The Legislative Committee on Health Care (LCHC), 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 LCHC was established in 1987 to provide continuous oversight of matters relating to health care.

The LCHC for the 2007-2008 Interim was comprised of six members. The members of the LCHC were as follows:

Assemblywoman Sheila Leslie, Chairwoman
Senator Maurice E. Washington, Vice Chairman
Senator Joseph J. Heck
Senator Steven A. Horsford
Assemblywoman Susan I. Gerhardt
Assemblyman Joe Hardy

The following Legislative Counsel Bureau (LCB) staff members provided support for the LCHC:

Marsheilah D. Lyons, Principal Research Analyst
Sarah J. Lutter, Senior Research Analyst
Kristin C. Roberts, Senior Principal Deputy Legislative Counsel
Sara L. Partida, Senior Deputy Legislative Counsel
Rebecca Dobert, Senior Administrative Assistant

The LCHC met 12 times, and the Subcommittee of the Legislative Committee on Health Care to Review the Laws and Regulations Governing Providers of Health Care, the Use of Lasers and Intense Pulsed Light Therapy, and the Use of Injections of Cosmetic Substances (Senate Bill 4, Chapter 4, *Statutes of Nevada 2007, 23rd Special Session*) met a total of 3 times. All public hearings were conducted through simultaneous videoconferences between Carson City, Nevada, and Las Vegas, Nevada.

At the twelfth meeting, members conducted a work session at which they adopted 21 recommendations to be included in 10 bill draft requests (BDRs). The recommendations concern: access to care; mental health and substance abuse; children and senior health issues; public health programs; the hepatitis C investigation in southern Nevada; health care professional licensing boards; and whistleblower protections for certain health care workers. Additionally, included are 6 recommendations from the Subcommittee of the LCHC to Review the Laws and Regulations Governing Providers of Health Care, the Use of Lasers and Intense

Pulsed Light Therapy, and the Use of Injections of Cosmetic Substances. Lastly, members authorized the Chair to send 11 letters on behalf of the LCHC, and members directed staff to address four specific points in the final report.

In addition to information concerning the LCHC, this summary provides background information addressing the Subcommittee of the Legislative Committee on Health Care to Review the Laws and Regulations Governing Providers of Health Care, the Use of Lasers and Intense Pulsed Light Therapy, and the Use of Injections of Cosmetic Substances.

II. REVIEW OF COMMITTEE FUNCTIONS

The primary responsibilities of the LCHC are established pursuant to NRS 439B.220 through 439B.240. These responsibilities include: (1) reviewing and evaluating the quality and effectiveness of programs for the prevention of illness; (2) reviewing and comparing the costs of medical care among communities in Nevada with similar communities in other states; and (3) 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 LCHC may also review health insurance issues, as well as examine hospital-related issues, medical malpractice issues, and the health education system. See Appendix A for the statutes that govern the LCHC.

Further, certain entities are required by statute to submit reports to the LCHC. Including:

- A report of the activities and operations of the Division of Health Care Financing and Policy (DHCFP), Department of Health and Human Services (DHHS), concerning the review of health care costs. The report must be submitted on or before October 1 of each year as required by NRS 449.520.

- An annual report concerning the review of the health and health needs of the residents of this State and a system to rank the health problems of the residents of this State, including, without limitation, the specific health problems that are endemic to urban and rural communities, and the allocations of money from the Fund for a Healthy Nevada pursuant to NRS 439.630 to determine whether the allocations reflect the needs of this State and the residents of this State.

- A report on the results of the DHHS's study and any progress it has made toward establishing group purchasing plans for immunizations on or before January 30, 2008, and at such other times as requested by the LCHC. (Assembly Bill 410, Chapter 334, *Statutes of Nevada 2007*)

- An annual report concerning the percentage of uncompensated care provided by hospitals in larger counties as required by NRS 422.3807.

- A report concerning the activities of the DHHS pursuant to the development of programs to increase public awareness of information concerning hospitals and surgical centers for ambulatory patients as outlined in NRS 439A.220 and 439A.230. The report must be submitted on or before December 1, 2008.

- A quarterly report, as required by NRS 450B.795, from the Health Division, DHHS, regarding its finding in the study concerning the cause of excessive waiting time for a person to receive emergency services and care from a hospital after being transported to the hospital by a provider of emergency medical services.

- A quarterly report as required by NRS 422.2728, from the DHHS concerning program benefits provided through the Health Insurance Flexibility and Accountability (HIFA) waiver.

III. DISCUSSION OF TESTIMONY AND RECOMMENDATIONS FOR THE STATE OF NEVADA

A variety of issues were addressed at the meetings of the LCHC. This section provides background information and discusses only those issues for which the LCHC made recommendations. These issues relate to:

A. Access to Care;
B. Mental Health and Substance Abuse Services;
C. Children and Senior Health Issues;
D. Public Health Programs;
E. Hepatitis C Investigation;
F. Health Care Professional Licensing Boards; and
G. Whistleblower Protections.

This bulletin also includes the report of the Subcommittee of the Legislative Committee on Health Care to Review the Laws and Regulations Governing Providers of Health Care, the Use of Lasers and Intense Pulsed Light Therapy, and the Use of Injections of Cosmetic Substances (Senate Bill 4, Chapter 4, *Statutes of Nevada 2007, 23rd Special Session*). (Appendix C).

A. ACCESS TO CARE

In 2006, approximately 18 percent of Nevada's population (or 456,999 people) were uninsured. Of those individuals, 25 percent were children and 75 percent were adults. Nevada has the 4th highest adult uninsured rate in the nation and the highest rate in the country (67.4 percent) of uninsured adults without a personal doctor or health care provider. Additionally, Nevada ranks 47th in the percentage of uninsured children (17 percent compared to 12 percent nationally).

In addition, Nevada is experiencing significant shortages of qualified, competent health care workers in virtually every health care profession including health information technologists,

laboratory technologists, medical coders, nurses, pharmacists, physicians, and radiology technologists. The situation in Nevada reflects a national phenomenon and the shortage is of great concern because it compromises access to quality patient care.

1. Electronic Application for Medicaid and the Children's Health Insurance Program

According to a report titled *The Uninsured: A Primer*, by the Kaiser Commission on Medicaid and the Uninsured, the lack of insurance ultimately compromises the health of persons because they are less likely to receive preventative care, are more likely to be hospitalized for avoidable health problems, and are more likely to be diagnosed in the late stages of disease. Having insurance improves health overall and could reduce mortality rates for the uninsured by 10 to 15 percent. Individuals lacking coverage are also more financially vulnerable to the high cost of care, are exposed to higher out-of-pocket costs compared to the insured, and are more often burdened by medical bills.

In addition to Nevada's current status related to the uninsured, the LCHC discussed various alternatives to enhance the number of qualified individuals getting enrolled in the government coverage options (i.e., Medicaid and the Children's Health Insurance Program). The Division of Welfare and Supportive Services, DHHS, submitted an outline to the LCHC which described a multiphase development plan for a web-based application for the Temporary Assistance for Needy Families, Food Stamp, and Medicaid programs. The plan would allow an applicant to input circumstantial information which could determine if the applicant would likely qualify for particular assistance. In addition, the program provides the applicant with a full listing of required documents for any application. Eventually, the program could enable a customer to update case information such as address, income, or changes to household composition.

After deliberations on these topics, members of the LCHC adopted the following recommendation:

> **Draft legislation requiring the DHHS to establish a system that allows applications for Medicaid and the Children's Health Insurance Program to be submitted electronically. This bill would further require an agency that is designated by the Director of the DHHS to receive applications or determine eligibility for the programs to use the system to forward applications, but applicants for services must not be required to submit applications electronically. (BDR 38–210)**

2. The J-1 Visa Waiver Program

Nevada ranks among the lowest states for the number of health care professionals per 100,000 residents, and the State's physician-to-population ratio of 172 physicians per 100,000 residents ranks 47th in the nation. The J-1 Visa program, also known as the Conrad 30 program, is federal legislation designed to allow foreign physicians who completed

a medical residency in the United States to work in underserved areas for three years. What is considered an underserved area is established according to federal definition and includes health professional shortage areas, medically underserved areas, and medically underserved populations.

Nevada's J-1 Visa program has the following two requirements: (a) the physician must be located in a federally designated underserved area; and (b) the J-1 physician's practice must meet a primary care definition unless approved otherwise by the State. To date, 122 waivers have been issued to Nevada. Currently, Nevada has 34 J-1 Visa Waiver physicians placed statewide, and 4 more will begin work during the first half of Fiscal Year (FY) 2009. Of the 122 waivers, 87 percent have completed their three-year commitment and Nevada has retained 65 percent of those physicians. However, in 2008, Nevada was only able to fill 33 percent of the job openings.

During the 2007-2008 Interim, the State launched an investigation of primary care medical clinics in response to reports of employers exploiting foreign doctors and neglecting medically needy patients. One significant complication within the program is that J-1 physicians generally do not complain for fear of riling their employers, who sponsor their visas. In an attempt to remedy the abuses of the J-1 Visa Waiver program, the Health Division, DHHS, took the following actions: (a) created the Primary Care Advisory Council within the Bureau of Health Planning and Statistics and charged it with providing transparent oversight of the program, monitoring compliance of the physicians and employers, aiding with timely resolution of complaints, and assisting with physician recruitment and retention; and (b) drafted formal policies and procedures in order to address compliance with the federal program requirements, pre-qualification of employers, physician education on their rights and responsibilities, compliance with reporting requirements, the complaint process, and the exit survey process.

Through various conversations related to challenges within the J-1 Visa Waiver program, it was discussed that one significant disincentive for international physicians to join the program is the fact that it is no easier for those physicians who have already committed so much of their time practicing in the United States to get lawful permanent residency. In order to be eligible for a green card, a J-1 Visa physician who completes the J-1 Visa education must first obtain a waiver from the U.S. Department of State and work in the United States for five years. Once they have completed this work requirement, during which three years must be in a federally designated medically underserved area, they can apply for their green card. However, when the J-1 physician submits their green card application, no priority or preference is given to those individuals.

Following discussions related to this topic, the LCHC decided that the incentive of being granted preference when applying for lawful permanent residency may make the waiver program more attractive to J-1 Visa physicians and assist with improving primary care access in Nevada and nationwide. Therefore, the LCHC members voted and agreed to do the following:

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

3. Federal Medical Assistance Program

The Federal Medical Assistance Programs (FMAPs) are used in determining the amount of federal matching funds for State expenditures for assistance payments for certain social services, and State medical and medical insurance expenditures. The Social Security Act (SSA) requires the U.S. Secretary of Health and Human Services to calculate and publish the FMAPs each year.

The FMAPs are for Medicaid. Section 1905(b) of the SSA specifies the formula for calculating FMAPs. The "enhanced FMAPs" are for use in the State Children's Health Insurance Program under Title XXI, and in the Medicaid program for certain children for expenditures for medical assistance described in Section 1905(u)(3) of the SSA.

In 2003, Congress provided a 2.95 percent FMAP temporary increase, helping states meet Medicaid and overall state budget shortfalls and warding off potentially larger Medicaid program cuts. States used the extra cash to preserve Medicaid.[1] In an effort to maintain Medicaid during the current economic downturn, the Committee agreed to:

Draft a letter to Nevada's Congressional Delegation to support an increase in the Federal Medical Assistance Program (FMAP) by raising federal match rates and by holding states harmless if the FMAP decreases from one year to the next.

B. MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

1. Mental Health, Developmental, and Substance Abuse Services in Nevada

In Nevada, the Division of Mental Health and Developmental Services (DMHDS) is responsible for oversight and operation of the State-funded community mental health programs, inpatient programs, mental health forensic services, services and programs for persons with developmental disabilities, and services for the prevention and treatment of substance abuse. The DMHDS is a division of the DHHS.

[1] "Medicaid and the States," National Conference of State Legislatures (www.ncsl.org/programs/health/medicaid.htm)

Due to State budget shortfall projections the DHHS reduced budgets by 4.5 percent in January 2008. The value of these reductions was $81.8 million in State General Funds. The cuts also resulted in the loss of $44.9 million in federal funds (due to the State's inability to provide matching dollars). In June 2008, as a result of even worse budget revenue forecasts, the DHHS reduced budgets by an additional $31.8 million in State General Funds.[2]

The legislatively approved budget for mental health agencies during the 2008-2009 biennium was $364,181,681. Including the Substance Abuse Prevention and Treatment Agency (SAPTA), the total budget for mental health services (DMHDS) during FY 2008-2009 was $423,589,883.[3] To meet the budget requirements, the DMHDS reduced mental health treatment facilities, programs, and enhancements. In addition, reductions were made to developmental services, and substance abuse prevention and treatment programs. These included reductions in:

- Funding to the Triage Centers operated by Westcare;
- Funding to Lakes Crossing Center for mentally disordered offenders (budget reduced by approximately $1 million in General Funds);
- Mental Health Court growth funding;
- Medication clinic budgets based on anticipated surpluses and additional free medications (client services should not be impacted);
- Budgeted growth in residential services for mental health patients;
- Substance Abuse Prevention and Treatment Agency funding;
- Budgets for three Regional Centers for Developmental Services;
- Several Capital Improvements Projects (deferred or reduced); and
- One-shot equipment.

Additionally, the budget cuts resulted in:

- The elimination of psychiatric testing materials in Rural Clinics;
- Delayed hiring of additional staff in Rural Clinics;
- $1.1 million in added Medicare revenue being reverted to the State General Fund as a result of "cost report settlements";
- Closure of the North Las Vegas Mental Health Clinic upon lease expiration on February 29, 2008; and
- Closure of Westcare contracted emergency observation beds in December 2007.

Due to the continued economic downturn in Nevada and the nation, additional budget cuts are anticipated. The DMHDS budget request for FY 2010 and FY 2011 includes State General Fund reductions of $43.6 million in FY 2010 and $43.8 million in FY 2011, and notes the elimination of 222 staff positions.

[2] "Department of Health & Human Services Summary of 4.5% Budget Reduction" (Revised 1/10/08)

[3] "Budget Highlights FY 2008-2009, Division of Mental Health and Developmental Services"

Testimony emphasized that continuing budget cuts would further impact client services resulting in the redesign of the service delivery models to increase efficiencies and increases in the DMHDS's collection of other revenue sources. Further testimony encouraged the LCHC to support and encourage amendments to various federal lands acts to allow for the conveyance of federal land to support the development of behavioral health and substance abuse facilities, with the intent of encouraging investment and management of these types of facilities in Nevada. Following deliberations on this issue, the LCHC agreed to:

> **Draft a letter to Nevada's Congressional Delegation requesting the amendment of various federal lands acts to allow for the conveyance of federal land to support the development of behavioral health and substance abuse facilities, with the intent of encouraging investment and management of these types of facilities in Nevada, as part of a strategy for decreasing the number of out-of-state patient placements.**

Among the many challenges faced by the DMHDS is the challenge to recruit and retain psychiatrists. While the shortage of health care professionals and psychiatrists in particular contributes to this problem, testimony indicated that staff turnover, fiscal constraints, and an inflexible compensation system contribute to the DMHDS's inability to recruit and retain psychiatrists. To begin to develop a comprehensive plan to address this issue, the LCHC agreed to:

> **Draft a letter and include a statement in the LCHC's final report encouraging the DMHDS to create a plan for addressing compensation and organizational challenges which constrict the DMHDS's ability to recruit and retain psychiatrists.**

Accessing mental health services in rural Nevada has always been a challenge. Testimony indicated that the impact of staff turnover, the impact of the loss of 24-hour emergency services in rural areas of Nevada, and the lack of emergency transportation in rural Nevada greatly exacerbate an already challenging situation. According to testimony provided to the LCHC, the lack of services has impacted the law enforcement community in rural areas of Nevada due to their increasing role in mental health care.

In an effort to better document and respond to this challenge, the LCHC agreed to:

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

2. Mental Health and Substance Abuse Services in the Criminal Justice System in Nevada

The Justice Center, The Council of State Governments (CSG), provides technical assistance to a limited number of states that demonstrate a bipartisan interest in justice reinvestment, a data-driven strategy for policymakers to reduce spending on corrections, increase public safety, and improve conditions in the neighborhoods to which most people released from prison return. The technical assistance is provided to states, including Nevada, with support from the U.S. Department of Justice's Bureau of Justice Assistance and private grant makers such as The Pew Charitable Trusts, the JEHT Foundation, and the Open Society Institute.

As it relates to health care, the Justice Center detailed Nevada's opportunities to improve public safety through effective substance abuse and mental health treatment for the criminal justice population. The Nevada assessment noted the impact of limited outpatient mental health services, substance abuse treatment programs, and lack of collaboration between programs to address the needs of individuals with co-occurring disorders.

Recognizing the limits in available funding to continue the Justice Center's work in Nevada, the LCHC agreed to request a bill draft to:

> **Make an appropriation of $100,000 to support the work of the Justice Center, CSG, to continue to improve public safety through effective substance abuse and mental health treatment for persons in the criminal justice system in Nevada. (BDR S–212)**

Additionally, the LCHC agreed to:

> **Draft a letter to the Senate Committee on Finance and the Assembly Committee on Ways and Means requesting an ongoing line item for mental health and substance abuse services and programs within the Department of Corrections' budget.**

3. Emergency Admissions–"Legal 2000"

The term "Legal 2000" is a colloquial reference to a form (revised in 2000) that is used to initiate the emergency admission of an allegedly mentally ill person to a public or private mental health facility or hospital for evaluation, observation, and treatment. *Nevada Revised Statutes* 433A.160 establishes the procedure for these emergency admissions—also commonly called "involuntary admissions"—which may be initiated without a warrant.

Nevada requires that allegedly mentally ill persons be screened to determine that there are no physical conditions, as opposed to mental conditions, warranting their behavior or symptoms. In an effort to meet this requirement, emergency transporters and law enforcement officials have routinely transported these individuals to hospital emergency departments for medical clearances. Due to a variety of factors, including the lack of resources for outpatient mental

health care, this has frequently contributed to overcrowding in emergency rooms, particularly in Las Vegas.

Based on a previous legal opinion issued by staff of the Legal Division, LCB, concerning the statutory requirements as they relate to medical screening of an allegedly mentally ill person, members of the LCHC concluded that a medical screening must be performed by a physician, a physician assistant, or an advanced practitioner of nursing; the screening can be done at any location where such a person may perform the examination; and it must be conducted prior to transporting the person to a mental health facility.

To address mental health concerns, a coalition assessing mental health issues in southern Nevada was developed. The coalition included a diverse cross section of health care providers, mental health professionals and advocates, including representatives of the DMHDS. In addition to other recommendations, the coalition proposed various statutory changes, including, amending the statute to require medical screening to occur before an allegedly mentally ill person is admitted to a mental health facility, rather than being initially transported to such a facility. Secondly, clarify which health care professionals have authority to release patients off of the "Legal 2000" hold status.

The LCHC encourages the DMHDS to collaborate with the mental health redesign coalition (work group) to continue to review Nevada's "Legal 2000" process and to prepare recommendations to further refine the process.

As a result of testimony on this issue, the LCHC agreed to:

> **Draft legislation to clarify the involuntary commitment process by removing the term "transported" from NRS 433A.165 and replacing with the term "admitted" (See Assembly Bill 225, 2007 Session). Clarify and expand the list of health care professionals authorized to release patients off of the "Legal 2000" hold status, to include: psychiatrists, psychologists, physicians (M.D., D.O.), and persons trained and licensed in clinical social work or nursing who have a graduate degree and clinical experience in mental health. (BDR 39–211)**
>
> **Draft a letter and include a statement in the LCHC's final report encouraging the DMHDS, DHHS, to collaborate with the mental health redesign work group to continue to review Nevada's process for admitting persons to mental health facilities under emergency circumstances, known as the "Legal 2000" process. The letter will request the DMHDS to prepare recommendations to refine the Legal 2000 process.**

C. CHILDREN AND SENIOR HEALTH ISSUES

Throughout the 2007-2008 Interim, the LCHC heard a myriad of testimony regarding health issues affecting two of our State's most vulnerable populations—Nevada's children and seniors.

1. Legislative Committee on Child Welfare and Juvenile Justice

During the 2007 Legislative Session, the LCHC was charged with reviewing the health-related issues, needs, and priorities of children in Nevada. At the LCHC's December 18, 2007, meeting, the members focused on issues related to children, including: childhood immunizations, childhood lead poisoning, children with disabilities, substance abuse and adolescents in Nevada, children and adolescent behavioral health services, et cetera. Testimony from Nevada's Substance Abuse Prevention and Treatment Agency revealed that in 2007, approximately 14,471 adolescents needed substance abuse treatment and services. From July 1 through December 13, 2007, there were 125 adolescents placed on wait lists (with an average wait of 14 days).

It was observed by members of the LCHC that many of the issue areas affecting children and adolescents are recurring and significant enough to merit a committee to address those issues alone. As a result of this observation and the related testimony, the LCHC recommended the following:

> **Draft legislation creating the Legislative Committee on Child Welfare and Juvenile Justice in accordance with Sections 2 through 8, inclusive, of Senate Bill 170 of the 2007 Legislative Session. (BDR 17–213)**

2. Adults with Behavioral Health Issues

Alternatively, at the LCHC's meeting on January 23, 2008, the focus turned to many issues related to Nevada's aging population. Several concerns were raised that day regarding the treatment of adults with behavioral health challenges associated with Alzheimer's disease or dementia in Nevada. At the basis of the issue is the lack of facilities and beds for this patient population—in northern Nevada, there are no acute adult behavioral units and no viable long-term residential placements for adults with dementia and behavioral health challenges. As a result, the State frequently turns to out-of-state placements which separate patients from their families. In January 2008, there were 79 out-of-state Medicaid placements for adults.

Many of the interested parties verbalized a commitment to addressing these issues and working toward finding a solution. Several proposals were discussed throughout the meeting, including:

- Expanding alternative housing in the least restrictive environment (i.e., group homes or in-home options);

- Developing community response teams in order to assist individuals with the transition to a stable home within Nevada;

- Providing industry incentives and remediation of potential misperceptions of licensing complications;

- Offering effective and ongoing training to existing staff in order to be able to better transition and stabilize residents;

- Expanding bed space capacity locally and stop out-of-state transfers; and

- Partnering with the university system in order to address issues such as the shortage of geriatric psychiatrists.

Importantly, it was recognized that this issue is only going to get worse due to the aging population throughout the State. Following deliberation on this issue, the LCHC members recommended the following:

> **Draft a letter to the Director of the DHHS to encourage the Aging Services Division, DHHS, to work with the Bureau of Licensure and Certification, Health Division, DHHS, and the Division of Health Care Financing and Policy, DHHS, to develop a plan related to the development of certain services/resources for residents diagnosed with (a) Alzheimer's disease, (b) dementia, and (c) traumatic brain injury.**

D. PUBLIC HEALTH PROGRAMS

1. Health Insurance for Work Advancement Program and the Traumatic Brain Injury Waiver

Nevada's Medicaid program ranks last in per capita spending, and near the bottom in Medicaid enrollment as a percentage of our total population. Because of the "bare-bones" nature of Nevada's Medicaid program, the program is particularly vulnerable in the present economic crisis. To date, none of the current services to clients have had to be cut. However, several "enhancements" which were funded by the last Legislature have been cut back or eliminated. Among those programs were: (a) a roll back of the approved elimination of the unearned income cap in the Health Insurance for Work Advancement (HIWA) program; and (b) the $1.9 million expansion of Nevada Medicaid's waiver for people with physical disabilities program (WIN waiver) for traumatic brain injury (TBI) services.

The HIWA program is a Medicaid buy-in program that began in Nevada in July 2004. According to the Division of Health Care Financing and Policy, DHHS, the program has had up to 40 enrollees at any point in time. The unearned income requirement has changed four times since it was first set at $699 in 2004. The most recent change to the cap resulted in 19 individuals losing their opportunity to receive health care coverage through the program. In testimony to the LCHC, it was suggested that a minimum unearned income level that is stable and predictable would be a beneficial addition to the program.

There are 2,700 TBIs in Nevada each year. Currently, there is only one provider in Nevada to provide comprehensive rehabilitation (COR) services, and in 2007 this provider was able to

serve a total of 22 patients. In addition, the Medicaid fees for these services have been frozen since 1999 while the costs for providing those services have steadily increased.

On top of the challenges related to obtaining Medicaid-funded services for TBI, the State funding through the Office of Disability Services, DHHS, that is provided for uninsured/indigent services was cut in a round of budget cuts by over $30,000. In 2007, 36 persons with TBI were served through this program, resulting in a decrease of their long-term care needs. All individuals served through this program have returned to living in the community.

The COR and State program, through the Office of Disability Services, funded 50 percent of the TBI clients in 2007—without the money from these programs, most of the individuals would have had to remain institutionalized. The Nevadans that would have been served by funding the addition of TBI to the WIN waiver currently live in skilled nursing homes, out-of-state placements, and mental health facilities. In an effort to improve the lives of individuals with disabilities in the State of Nevada, the LCHC voted to recommend the following:

Draft legislation to maintain the HIWA program and the TBI waiver and make an appropriation for the necessary amount. (BDR S–212)

2. Lead Poisoning Prevention Project

During the 2007-2008 Interim, the LCHC heard testimony explaining the value and need for the adoption and enforcement of increased lead testing for children under the age of six and pregnant women, as well as the value of mandatory laboratory reporting of increased lead levels found in individuals tested.

In July 2006, the Southern Nevada Health District (SNHD) was awarded a grant from the Centers for Disease Control and Prevention (CDC) to establish a comprehensive statewide screening, surveillance, and primary prevention outreach and education program to eliminate childhood lead poisoning as a pediatric public health problem in Nevada. Using the grant funding, the SNHD created the Childhood Lead Poisoning Prevention Program.

In 2006, less than 5,000 of the 137,000 children in Clark County under the age of five had been tested for increased levels of lead. Based on current screening data, almost 25 percent of the children screened in Clark County were exposed to lead—Hispanic children showed to be at particular risk accounting for over 50 percent of all childhood lead exposures.

Currently, the State of Nevada has little to no data to indicate whether the State has a lead problem. However, many of the demographics of the state (particularly those found in Clark County) justify the need to explore sources of possible lead exposure. These demographics include: population growth, immigration, and poverty. Lead is a metallic element that can be absorbed by the body—usually through ingestion or inhalation. Lead then

enters the blood and travels to the tissues and organs affecting nearly every system in the body. At high levels, lead exposure can cause kidney damage, mental retardation, coma, and death. At lower levels, lead can result in IQ deficiencies, learning disabilities, behavioral problems, stunted or slowed growth, and impaired hearing. There is no safe blood level for children.

Advocates for comprehensive child lead testing provided testimony to the LCHC that argued that all children should be tested at ages 12 and 24 months, and also if a child is less than 6 years old and has never been tested. The required blood test to check for lead levels is covered by most insurance companies, including Medicaid and Medicare.

Although the LCHC did not propose legislation to the 2009 Legislative Session, several members expressed an interest in individually addressing these issues.

E. HEPATITIS C INVESTIGATION

1. Public Health Response

In December 2007, the SNHD became aware of an acute case of hepatitis C that did not have risk factors typically associated with the disease. A second case of acute hepatitis C was identified soon after. A common factor was identified, as both cases had received endoscopy procedures in a single ambulatory surgery center (ASC) (Endoscopy Centers of Southern Nevada). The State Epidemiologist in Nevada's Health Division was notified for consultation and assistance at the end of December 2007. Simultaneously, the Health Division notified the CDC and requested its assistance in conducting the epidemiological investigation. Additionally, the Bureau of Health Care Quality and Compliance (BHCQC) (formerly the Bureau of Licensure and Certification) was notified as the responsible agency for licensing and regulating ASCs. A full-scale investigation began on January 9, 2008, continuing through January 17, 2008, at the Endoscopy Center. The investigative team included staff from the SNHD, BHCQC, and the CDC.

Following the completion of the inspection of the Endoscopy Center on January 17, 2008, the BHCQC issued a "Statement of Deficiencies" on February 4, 2008, which identified concerns related to injection safety, reuse of disposable equipment, and improper disinfectant techniques. A corrective action plan was requested at that time; however, all concerns were considered abated prior to the departure of the investigation team.

The BHCQC began to review additional ASCs in the weeks following the review of the Endoscopy Center. Based on concerns identified through the subsequent facility inspections, a decision was made to inspect all ASCs as rapidly as possible. The DHHS requested assistance from the CDC and the Centers for Medicare and Medicaid Services (CMS) to complete the inspections as rapidly as possible. The CDC responded and sent four Infectious Disease Specialists to assist the BHCQC and CMS responded by providing assistance in overtime costs and help in maintaining other BHCQC workload. [4]

[4] "Hepatitis C and Ambulatory Surgical Centers," April 2008, Michael J. Willden, Director, DHHS

Consequent to the inspections several other actions were taken, including:

- Notifying several licensing boards regarding unsafe practices identified during the investigations;

- Notifying patients (approximately 40,000) about potential hepatitis C exposure at the Endoscopy Center and establishing information/help phone lines and web pages;

- Preparing technical bulletins that were disseminated to all health care providers regarding potential hepatitis C exposure; and

- Seizing medical records following the closure of several ASCs and physicians' practices by local government business licensing entities and the execution of search warrants by Nevada's Office of the Attorney General and the Federal Bureau of Investigation.

Testimony emphasized the need to strengthen the coordinated actions of various public agencies that have statutory responsibilities for some aspects of a public health emergency and communications with other health care providers and the public. In an effort to improve the State's ability to collaborate with county and local health authorities and law enforcement agencies, the LCHC agreed to:

> **Draft legislation to define the process for a declaration of a "public health emergency." This bill will provide clear authority and expectations for the coordinated actions of all public agencies that have statutory responsibilities for some aspects of any required investigation, intervention, or sanctions. In addition to other items, the following provisions must be included:**
>
> - **Authority to temporarily close a facility, or the appropriate portion of a facility, in order to make a determination within 24 hours as to whether the facility can be reopened and provide safe services. During that 24-hour period, the facility employees will be tested and/or educated in order to ensure that the services being rendered are safe.**
>
> - **Authority to establish a central record repository in the case of a public health emergency and ensure that the team working with the records is trained regarding Health Insurance Portability and Accountability Act compliance, and allow a facility or medical professional to voluntarily allow the records to remain on the premises if they can be secured.**
>
> - **Inclusion of electronic records in the determination as to the most appropriate manner in which to handle the medical records.**

- **Development of a central information and education hotline.**

- **Assurance that the appropriate law enforcement agency is included in securing medical records to maintain the chain of evidence/custody.**

- **Authority for the Director of the DHHS to appoint a replacement for the State Health Officer, Health Division, DHHS, under certain circumstances. The replacement must meet the qualifications of the State Health Officer.**

- **Assurance that State agencies and local health authorities' current powers to react to such crises are not diminished as they await the declaration of a "public health emergency." (BDR 40–214)**

Following an evaluation of the response to this emergency, the Health Division indicated its intentions to submit an additional request for legislation to further refine the State's public health system. The LCHC agreed to:

Draft a letter and include a statement in the LCHC's final report to support the BDR of the Health Division, DHHS, to revise provisions relating to the State's public health system.

2. Regulation of Surgical Centers for Ambulatory Patients and Offices Where Outpatient Procedures are Being Performed

Nationally, surgical procedures performed in outpatient settings have more than doubled in the last decade—nearly 10 million procedures have been performed annually in office-based settings since 2000. The CMS recommends that surveys/inspections of Medicare-qualified ASCs occur once every six years. This timeline is considered a "recommendation" because these facilities fall within CMS's fourth tier of priority. Therefore, the inspections are not federally mandated and there is no fine or penalty if they are not inspected at that rate. Without further state requirements, there is no mandate that these facilities be monitored after their initial review.

Testimony at the April 21, 2008, meeting of the LCHC discussed the fact that the CMS recognizes the following accreditation organizations for the accreditation of ASCs: (a) the American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF); (b) the Accreditation Association for Ambulatory Health Care (AAAHC); (c) the Joint Commission of Accreditation of Healthcare Organizations (JCAHO); and (d) the American Osteopathic Association (AOA). Discussions of the LCHC also focused on the cost and effort associated with facilities acquiring accreditation, and the fact that many states require various levels of accreditation based on the highest level of anesthesia used in the facility.

With the rapid increase in the presence, as well as the use, of outpatient surgical facilities, many states have promulgated various rules and regulations to address the myriad of issues that

come along with those types of facilities. In an attempt to improve safety and prevent another event like the hepatitis C crisis, the LCHC voted to recommend the following pieces of legislation:

> **Draft legislation requiring surgical centers for ambulatory patients (ASCs) and physicians' offices where outpatient surgical procedures are being performed to be accredited by a federally recognized accrediting entity. Set the threshold for physicians' offices that must be accredited as those that utilize any of the three deepest levels of sedation. Provide for the appropriate sanctions to be used by the Bureau of Licensure and Certification (BLC), Health Division, DHHS (who will have authority over facilities), and the Board of Medical Examiners (BME) (who will have authority over the practitioners), should there be a failure to maintain accreditation. (BDR 40–215)**

> **Draft legislation to require the BLC to survey the ASCs once every year and require the BLC to increase the fees to licensing these types of facilities to include the additional cost for conducting these surveys. Include annual inspections of physicians' offices that would be required to be accredited pursuant to the previous recommendation. Require the annual inspections to be unannounced. In addition, include transitional funding to support the positions required to conduct the surveys, as the new fee and survey schedule is implemented. A fee increase will be utilized in order to accomplish these more frequent inspections. (BDR 40–215)**

At the April 21, 2008, LCHC meeting, the LCHC also discussed the concept of regulating/monitoring purchases of anesthesia in the office-based surgery industry. The discussion revolved around the idea of tracking individual vials of medicine.

Appreciating the fact that there were several aspects of a tracking program that need further discussion and development, the LCHC chose to:

> **Draft a letter encouraging the State Board of Pharmacy, in collaboration with the Board of Medical Examiners, the State Board of Health, the State Board of Nursing, and the State Board of Osteopathic Medicine to develop a system for monitoring the sale and use of anesthesia in Nevada to determine where surgical procedures are being performed and the type of health care professionals that are conducting those surgeries. Include both ASCs and physicians' officers performing outpatient procedures under one or more of the three deepest levels of sedation.**

Testimony to the LCHC also urged proposing an annual report that would go to various stakeholders regarding the frequency and findings of inspections of ASCs. It was commented that only through an annual report can the following be accomplished: (a) identification of

issues/problems in facilities; and (b) monitoring of whether there is follow-through when problems are identified. As a result, the LCHC recommended the following:

> **Draft legislation that requires the BLC to prepare and submit an annual report regarding the frequency of inspections of health care facilities licensed in this State and the findings from those inspections. The report must include a summary of any major issues and problems that have been identified and any follow-up. The report must be submitted to the LCHC. (BDR 40–215)**

F. HEALTH CARE PROFESSIONAL LICENSING BOARDS

During the 2006-2007 Interim, the LCHC was charged with the responsibility of developing a comprehensive plan concerning the provision of health care in the State. The health care planning process revealed the necessity to review the operation of health care professional licensing boards to determine the need for maintaining separate licensing boards and barriers to licensing. Additionally, the LCHC was encouraged to review statutes regarding the scope of practice for licensed health care professionals. In an effort to further review health care licensing boards, the LCHC created the Subcommittee of the Legislative Committee on Health Care to Review the Laws and Regulations Governing the Providers of Health Care, the Use of Lasers and Intense Pulsed Light Therapy, and the Use of Injections of Cosmetic Substances (Senate Bill 4, Chapter 4, *Statutes of Nevada 2007, 23rd Special Session*). (See Appendix B.)

In addition, during the course of the hepatitis C and related investigations, questions and concerns regarding the authority, responsiveness, and cooperation of certain health care licensing boards were brought to the attention of the LCHC. The BHCQC notified the Board of Medical Examiners, State Board of Nursing, State Board of Osteopathic Medicine, and the State Board of Podiatry regarding unsafe practices identified during the hepatitis C investigations. Testimony provided to the LCHC indicated that licensed professionals implicated in the public health crisis were being investigated; however several concerns were expressed, including:

- The cooperation and compliance of boards with law enforcement agencies investigating licensees;

- The authority of licensing boards to temporarily suspend the license of health care professionals that are being investigated pursuant to their potential involvement in the creation of a public health crisis or emergency;

- Consistency with regard to the manner in which appointed members address a conflict of interest or the appearance of a conflict of interest;

- Consistency with regard to the retention of complaints that are filed with each board;

- The boards' ability to provide the public with information about licensees' locations and areas of practice; and

- Maintaining the licensing boards' focus on protecting public interest; ensuring that boards are not co-opted by the professionals they are responsible for licensing and disciplining.

After deliberations on this topic, members of the LCHC adopted the following recommendations:

> **Draft legislation that places the current statutory provisions which authorize health care professional licensing boards to temporarily suspend a practitioner's license in Chapter 630 of NRS, "Physicians, Physician Assistants and Practitioners of Respiratory Care" (BME); Chapter 630A of NRS, "Homeopathic Medicine" (Board of Homeopathic Medical Examiners); and Chapter 633 of NRS, "Osteopathic Medicine" (State Board of Osteopathic Medicine). (BDR 54–217)**
>
> **Draft legislation that establishes grounds for a health care professional licensing board to suspend or revoke a professional license held by the owner or another principal of a health care facility that has responsibility in the creation of a public health threat or is currently being investigated, under certain circumstances. This provision is similar to the provisions of NRS 449.160. (BDR 54–217)**
>
> **Draft legislation that requires all members of health care professional licensing boards to be provided a copy of the conflict of interest provisions of Chapter 281A of NRS, "Ethics in Government," and require the signature of each board member acknowledging receipt of the conflict of interest provisions. (BDR 54–216)**
>
> **Draft legislation to require all health care professional licensing boards to retain every complaint that is filed with the board, including, without limitation, complaints that receive no action for at least ten years. (BDR 54–217)**

The LCHC heard testimony concerning the appointment process and the membership of various licensing boards in response to public perceptions concerning the capacity of certain boards to maintain a focus on protecting the public, rather than protecting the interest of the regulated health care professionals. Testimony asserted that the appointing process lacks transparency, which results in the potential for political influence to play an increased role in the appointing process. Testimony further asserted that the current process does not provide for the public to participate in nominating or vetting potential board members and does not contribute to creating a diverse (cultural, ethnic, gender, practice setting-public/private, et cetera) board.

To address these concerns, the LCHC agreed to:

> **Draft legislation to require Governor Jim Gibbons to provide to the LCHC advance notice of potential appointments to the BME, the State Board of Osteopathic Medicine, and the Board of Homeopathic Medical Examiners. Authorize: (a) the medical societies and professional associations; (b) the University of Nevada School of Medicine; and (c) individuals to nominate persons to fill vacancies on the BME, the State Board of Osteopathic Medicine, and the Board of Homeopathic Medical Examiners.**
>
> **Require the nominations to be submitted for consideration to the LCHC not later than 30 days after the notice of potential vacancy is made. The LCHC would be authorized to make inquiries concerning the potential appointments. The LCHC may report to the Governor concerning the advisability of making such appointments. The LCHC will have 60 days from the deadline for the receipt of nominations to make any and all inquiries. If the LCHC does not submit at least three names to the Governor within 90 days after the notice of vacancy, the Governor may act without input from the LCHC. (BDR 54–216)**

In an effort to respond to inquiries regarding the locations and practice areas of licensees, and to encourage boards to support health care planning efforts, the LCHC further agreed to:

> **Draft a letter requesting the BME, the State Board of Nursing, and the State Board of Osteopathic Medicine to regularly survey licensees to obtain details about locations and areas of practice in order to provide information to support programs to obtain more practitioners.**

Recognizing the need to continue the review of health care professional licensing boards, the LCHC supports the establishment of an interim legislative study to review health care professional licensing boards.

G. WHISTLEBLOWER PROTECTIONS

As stressed in testimony to the LCHC, the hepatitis C outbreak that came to light in 2008 and was linked to unsafe injection practices involving one or more outpatient surgery centers in southern Nevada underscored the need for strong and effective legal avenues through which nurses and others can act as patient advocates without fear of employment sanctions or workplace retaliation. One of the realizations that resulted from the crisis was that many health care professionals, especially nurses, do not feel that they will be protected should they notify a licensing board of a bad practice of another practitioner in the office.

Testimony was provided to the LCHC that stressed the following: "Patients are best served when those caring for them are provided with the legal support to advocate for patient safety

without fear of reprisal." During the May 6, 2008, meeting of the LCHC, representatives from the Nevada Nurses Association stated that anecdotally it was reported to them that the nonreporting of abuses by nurses in Nevada was often due to fear of losing their employment. The representatives then introduced several proposals for changes to existing statutory language that might better assist Nevada health care providers with reporting abusive practices. The suggestions would all strengthen and/or clarify existing Nevada whistleblower law.

In order to better assist Nevada health care providers to report practices that could potentially cause harm to patients, the LCHC voted to:

> **Draft legislation to provide statutory protections for a nurse who: (a) reports concerns about patients being exposed to substantial risk of harm due to failure of a facility or practitioner to conform to minimum professional standards, regulations, or accreditation standards; (b) is requested to engage in conduct that would violate the nurse's duty to protect patients from actual or potential harm as defined in Chapter 632 of NRS, "Nursing," and Chapter 632 of the *Nevada Administrative Code* (NAC), "Nursing"; (c) refused to engage in conduct that would violate the provisions of Chapter 632 of NRS or Chapter 632 of NAC or that would make the nurse reportable to the State Board of Nursing; (d) reports the actions of another nurse who engages in conduct subject to mandatory reporting to the State Board of Nursing as defined in Chapter 632 of NRS or Chapter 632 of NAC; or (e) reports staffing concerns or situations that reasonably could contribute to patient harm. (BDR 40-219)**

IV. CONCLUSION

This report presents a summary of the bill drafts requested by the LCHC members for discussion before the 2009 Nevada State Legislature. In addition, this report provides information identifying certain other issues that were addressed during the 2008-2009 Interim. Persons wishing to have more specific information concerning these issues may find it useful to review the "Summary Minutes and Action Reports" and related exhibits for each of the meetings of the LCHC.

V. APPENDICES

APPENDIX A

Nevada Revised Statutes 439B.200

APPENDIX A

Nevada Revised Statutes 439B.200, 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 LCHC 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 LCHC 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 LCHC 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 LCHC 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 LCHC from among the members of the LCHC. 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 LCHC must alternate each biennium between the houses of the Legislature.

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

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

7. The LCHC 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)

APPENDIX B

Suggested Legislation

The following bill draft requests will be available during the 2009 Legislative Session and can be accessed at the following website: http://www.leg.state.nv.us/75th2009/BDRList.

BDR 38–210 (S.B. 4) Revises provisions relating to Medicaid and the Children's Health Insurance Program.

BDR 39–211 (A.B. 6) Revises provisions relating to mental health.

BDR S–212 (A.B. 7) Makes appropriations relating to health care.

BDR 17–213 (S.B. 3) Creates the Legislative Committee on Child Welfare and Juvenile Justice.

BDR 40–214 Revises provisions relating to public health.

BDR 40-215 Revises provisions relating to medical facilities.

BDR 54–216 (S.B. 8) Revises provisions relating to health care professional licensing boards.

BDR 54–217 Revises provisions relating to the discipline of certain health care professionals.

BDR 40–219 (A.B. 10) Establishes certain protections for nurses.

BDR 54–220 Revises provisions relating to professional licensing boards and professional licenses.

APPENDIX C

Report of the Subcommittee of the Legislative Committee on Health Care to Review the Laws and Regulations Governing the Providers of Health Care, the Use of Lasers and Intense Pulsed Light Therapy, and the Use of Injections of Cosmetic Substances (Senate Bill 4, Chapter 4, *Statutes of Nevada 2007, 23rd Special Session*)

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

JANUARY 2009

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SUMMARY OF RECOMMENDATIONS

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

During the Subcommittee's final meeting on June 3, 2008, the members conducted a work session and voted to forward six recommendations to the Legislative Committee on Health Care *(Nevada Revised Statutes* [NRS] 439B.200) for consideration. More information can be found in the meeting minutes of both the Subcommittee and Committee at http://www.leg.state.nv.us/74th/Interim/Scheduler/committeeIndex.cfm?ID=10192 and http://www.leg.state.nv.us/74th/Interim/Scheduler/committeeIndex.cfm?ID=10146.

1. Request the drafting of a bill to modify the statutory requirement that an applicant for a license to practice medicine must prove to the Board of Medical Examiners he is a citizen or lawfully entitled to remain and work in the United States by creating an exemption for applicants in the J-1 Physician Visa Waiver Program. Also direct the Board of Medical Examiners, the State Board of Osteopathic Medicine, and the State Board of Nursing to regularly survey licensees to obtain details about locations and areas of practice in order to provide information to support programs to obtain more practitioners. The Subcommittee heard testimony that J-1 Visa applicants were put in a difficult position regarding their licensing applications because of the requirement in NRS 630.160 that all applicants be citizens or lawfully entitled to remain and work in the United States. Additionally, the Subcommittee was advised that health care researchers had difficulty obtaining data on the health care in Nevada. **(BDR 54–220)**

2. Request the drafting of a bill to allow physicians who have recently completed a residency program to be provisionally licensed upon receipt of satisfactory fingerprint reports, pending completion of the remainder of the board application process, and allow physicians who have recently completed a residency program to be provisionally licensed pending completion of certain examinations and/or board certifications. The Subcommittee determined resident physicians already working in Nevada facilities should be able to continue practicing during the licensing process in order to allow continuous employment as a practitioner in the State. **(BDR 54–220)**

3. Request the drafting of a bill to create provisions to make it easier for professionals licensed in other states to become licensed in Nevada if certain criteria are met. The recommendation was based on language created over the past several sessions that utilizes a credentialing concept for licensing. It is intended to address the problem of shortages in the various health care professions by encouraging practitioners from other states to move their practices to Nevada. **(BDR 54–220)**

4. Request the drafting of a bill to specify that supervision of physician assistants can be done through telecommunications and remote file review. The members heard testimony that it was difficult for physicians supervising physician assistants in the rural areas to meet the requirements for reviewing files and visiting the practice location of a physician assistant in person on a regular basis. The Subcommittee felt a provision in the *Nevada Revised Statutes* could be added to specify that supervision of a physician assistant could be done from a remote location via videoconference or teleconference and electronic review of patient files. **(BDR 54–220)**

5. Request the drafting of a bill to allow boards to hire counsel outside the Office of the Attorney General where appropriate. The boards may be able to save money by utilizing counsel outside the Office of the Attorney General. **(BDR 54–220)**

6. Request the drafting of a bill to provide boards with the authority to investigate and refer unlawful professional practice to authorities for penalties. While some boards have the authority to regulate persons who practice without a license or certification, several boards do not have the authority to investigate unlawful professional practice and therefore cannot take any action against persons improperly engaging in a profession. The Subcommittee recommends that legislation be drafted to provide all the boards with the appropriate authority. Suggested language from the chapter relating to the State Contractors' Board was discussed as possible model language for the boards regulating health care providers. **(BDR 54–220)**

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

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

I. INTRODUCTION

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

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

Legislative Counsel Bureau (LCB) staff services were provided by Kelly S. Gregory, Senior Research Analyst, Research Division; William L. Keane, Senior Principal Deputy Legislative Counsel, Legal Division; and Anne Vorderbruggen, Senior Research Secretary, Research Division.

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

The Subcommittee spent the first two meetings considering a variety of issues related to health care providers, followed by a work session at the beginning of the final meeting. During the final meeting, the members were provided with testimony regarding the regulation of the use of lasers, intense pulsed light therapy, and injections of cosmetic substances. For more complete information, please refer to the minutes and exhibits of the meetings, available at http://www.leg.state.nv.us/74th/Interim/Scheduler/committeeIndex.cfm?ID=10192.

II. DISCUSSION OF RECOMMENDATIONS

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

Recruiting Hurdles Faced by Applicants

Dr. Carl Heard, Chief Medical Officer, Nevada Health Centers, provided testimony during the May 2, 2008, Subcommittee meeting regarding the difficult position J-1 Visa Waiver Program applicants were put in because of the requirement in *Nevada Revised Statutes* (NRS) 630.160 that all applicants be citizens or lawfully entitled to remain and work in the United States. Dr. Heard testified that because the visa application and licensing application run concurrently, the requirement complicates the visa process and adds an additional hurdle to obtain licensure. Dr. Heard also told the Subcommittee that Nevada is only one of two states with this requirement.

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

> **RECOMMENDATION NO. 1—Request the drafting of a bill to modify the statutory requirement that an applicant for a license to practice medicine must prove to the Board of Medical Examiners he is a citizen or lawfully entitled to remain and work in the United States by creating an exemption for applicants in the J-1 Physician Visa Waiver Program. Also direct the Board of Medical Examiners, the State Board of Osteopathic Medicine, and the State Board of Nursing to regularly survey licensees to obtain details about locations and areas of practice in order to provide information to support programs to obtain more practitioners. (BDR 54-220)**

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

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

RECOMMENDATION NO. 2—Request the drafting of a bill to allow physicians who have recently completed a residency program to be provisionally licensed upon receipt of satisfactory fingerprint reports, pending completion of the remainder of the board application process, and allow physicians who have recently completed a residency program to be provisionally licensed pending completion of certain examinations and/or board certifications. (BDR 54-220)

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

RECOMMENDATION NO. 3—Request the drafting of a bill to create provisions to make it easier for professionals licensed in other states to become licensed in Nevada if certain criteria are met. (See Appendix B, attached.) (BDR 54-220)

Access to Services

Dr. Carl Heard approached the Subcommittee during the May 2 meeting and recommended that the regulations pertaining to supervision of physician assistants be modified. He indicated that it was difficult for physicians supervising physician assistants in the rural areas to meet the requirements for reviewing files and visiting the practice location of a physician assistant in person. He suggested that the Legislature specify that supervision of a physician assistant could be done from a remote location via videoconference or teleconference and electronic review of patient files. Supervision of physician assistants is currently regulated by the Board of Medical Examiners in Chapter 630 of the *Nevada Administrative Code*.

RECOMMENDATION NO. 4—Request the drafting of a bill to specify that supervision of physician assistants can be done through telecommunications and remote file review. (BDR 54-220)

Board Operation

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

RECOMMENDATION NO. 5—Request the drafting of a bill to allow boards to hire counsel outside the Office of the Attorney General where appropriate. (BDR 54-220)

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

RECOMMENDATION NO. 6—Request the drafting of a bill to provide boards with the authority to investigate and refer unlawful professional practice to authorities for penalties. (BDR 54-220)

III. ISSUES OF CONCERN

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

1. There is no current consensus on appropriate level of regulation for the use of these devices and therapies. According to information received by the Subcommittee, many states have taken action to regulate the following areas:

    a. Delegation of authority and supervision of nonphysician personnel, including a determination of which procedures constitute the practice of medicine;

    b. Definition of various types of facilities, personnel, and treatments;

    c. Educational requirements for users;

    d. Equipment safety standards; and

    e. Mandatory injury reporting.

2. It appears that professionals with licenses and certificates in various professions (such as aestheticians, medical assistants, and nurses) may provide similar client services or patient care without being appropriately licensed. Because no regulation exists, these roles are currently undefined and treatment facilities and insurance companies are taking the lead in structuring the training required and scope of work or practice for these professionals.

3. The use of the terms "medical advisor," "medical aesthetician," and "medical spa," as they relate to a physician supervising the activities of the professionals in a facility may be misleading to consumers, as no formal definition currently exists for any of these frequently used terms.

IV. CONCLUDING REMARKS

The Subcommittee wishes to thank the many individuals who contributed to this study through their correspondence or testimony at the public hearings. The Subcommittee members also recognize the cooperation and assistance provided by the staffs of the each of the boards regulating health care professions, who responded to the survey questionnaires and many inquiries submitted in follow-up to those responses.

V. APPENDICES

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APPENDIX A

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

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

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

Sec. 2. 1. The Legislative Committee on Health Care shall, during the 2007-2009 interim, consider studying:

(a) The regulation of providers of health care in Nevada, including, without limitation:

(1) A review of the laws of this State relating to the scope of practice authorized for providers of health care; and

(2) A study concerning the operation of the professional licensing boards for providers of health care with respect to barriers to licensing.

(b) The regulation of the use of lasers and intense pulsed light therapy in the performance of medical procedures on patients and the use of injections of cosmetic substances in the performance of procedures on patients. The Committee shall consider conducting a review of the laws and regulations of this State relating to the issues described in this paragraph and a study concerning those issues. In carrying out the provisions of this paragraph, the Committee may consult with a representative of:

(1) The practice of ophthalmology in this State;

(2) The practice of dermatology in this State;

(3) The practice of cosmetic or plastic surgery in this State; and

(4) The medical spa industry in this State.

2. At the discretion of the Chairman of the Legislative Committee on Health Care, and within limits of legislative appropriations:

(a) A subcommittee of members of the Legislature may be appointed to conduct any of the studies authorized by this section.

(b) The Committee or subcommittee may contract with such experts, researchers and consultants as may be necessary for the Committee or subcommittee to carry out any such study.

3. The Legislative Committee on Health Care shall submit a report of the results of any study conducted pursuant to subsection 1 and any recommendations for legislation to the Director of the Legislative Counsel Bureau for transmission to the 75th Session of the Legislature.

APPENDIX B

"Conceptual Language Regarding Credentialing"

CONCEPTUAL LANGUAGE REGARDING CREDENTIALING

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

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

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

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

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

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

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

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

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

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

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

APPENDIX C

Suggested Legislation

The following bill draft request will be available during the 2009 Legislative Session and can be accessed at the following website: http://www.leg.state.nv.us./75th2009/BDRList.

BDR 54–220 Revises provisions relating to professional licensing boards and professional licenses.