Community Meeting Notes

Rural Areas of Nevada

April 8 -10, 2015 – Hawthorne, Ely, Winnemucca, Nevada

Date: April 8-10, 2015 **Locations:** Hawthorne, Ely, Winnemucca

Facilitators: Jerry Dubberly, Charlyn Shepherd & Jan Prentice

Purpose: To introduce the rural areas of Nevada to the SIM grant.
Discuss health care delivery system experience.
Share current and potential challenges, barriers, and benefits.
Where does Nevada need to go with healthcare?

Jerry, Charlyn, and Jan presented an overview of the SIM through the PowerPoint slides. They used the presentation to approach talking points that included: community meetings in the rural areas, putting together workgroups and task forces, Electronic survey – please fill out the survey, are there others who should attend these meetings and how to contact us through the website. Jan stressed the importance of the rurals' involvement and that they are very important to the process.

April 8, 2015 Hawthorne

Participants: Jean (Health Economics Professor at UNR); Richard (Administrator at Mt. Grant General Hospital)

Richard –

- Mental health biggest problem
    - Psychologist brought in 4 days a month….applying for telemedicine grant
    - Local rural health clinic booked up, 4-6 week wait
    - Difficulty accessing provider and transferring patients
    - How to fix?...telemedicine
        - NV Rural Hospital Project/Partners applied for grant for funding for equipment
        - Finding staff to present case and how to do that, reimbursement
        - Affordability of all components, would need to be ground up
        - Not currently using tele health
- Connectivity is not an issues (currently uses AT&T fiber)
- Uses REMSA but not involved in pilot
- Care flight is primary form of transport (hospital to hospital)
- Fixed wing and ground when appropriate

- Is in process of connecting to HIE
- Wants better preventive health services
- Not currently using community health workers

Jean –

- There is a Health Community initiative by Federal Reserves
- Can't make healthcare better unless you fix social network problems, address social determinants
- Thoughts on value based payments and changes in payment methodologies?
    - Evidence is very mixed on success, be careful in design, don't want to sound too cavalier that it will work
    - Physician practices and providers treating patients covered by many different payers, if each payer has different system none will have large impact on the practice due to responding to so many incentive systems…collaboration of payers for less fragmented system
- How to get patient, payer, and providers interests to align?

April 9, 2015 – Ely

Participants: Austin S. (Ely Counseling); Steve T. (EMS); Name (Fire Chief)

Austin –

- Access is number one issue (transportation to/from and getting in to see dr/scheduling)
    - Medical emergency they get flown out and have to find own way back, large bill
- Trying to work with University of Nevada to ease restrictions
- Credentialing issue, may be fully licensed in current state but can't work in Nevada because the state wants them to take more courses when been practicing for years
- Public vs private
- Recruit and retain, big turn over with providers
- Rural areas do tele health (tele psychiatry…just psych meds)
- Tele therapy is effective but a lot of resistance from practitioner (still better than nothing)
- If crisis occurs, 2-3 weeks until patient will see psychiatrist
- Webinars have not been successful, technology is lagging behind
- Access to EHRs would be helpful, especially going through HIE
- Patient engagement can be an issue, comes down to training, empowering patients
- Be more data driven, less focused on being grant driven, to develop data and create gap analysis
- Medicaid reimbursement rate issues; lots of work to get prior authorizations, many claims rejected
- Medicaid patients not showing up for appointments, cannot charge copay; maybe consider block and group scheduling
- Dental coverage is an issue as many do not accept Medicaid; no incentive for more to join

Steve –

- Familiar with para medicine, had some legislation issue move away from pilot study and make more applicable all places
- AB305 no funding attached
- Agency retention, getting volunteers; Need gap analysis completed to identify need; How do you pay a volunteer
- Cost to make ambulance a mobile Wi-Fi high spot, difficult to get service and communicate with providers ($2k for ambulance before telemedicine equipment)
- The need is greater in rural areas and they are the ones with the least amount of access; suburbs less likely to use, close enough to medical facility to where tools and resources may not need to be use
- Community needs assessments; Needs to be data driven and something to show for it (needs to be measurable); Lot of data comes from urban partners with hospitals to prevent 30-day readmission; Need to capture baseline to see if it is helping
- Community health worker could be liaison
- Data is skewed

Fire chief –

- Transportation is an issue
    - Ambulance call vs alternative option, maybe have a community van
    - Just moving bodies around, no real emergency
    - Patients don't have transportation, can't go to dr and therefore wait till health has deteriorated to where they have to call ambulance
- REMSA pilot model par medicine grant, did triage and treatment
- Bill in assembly to expand, no funding attached
- Allow basics to check insulin levels, some patients can be treated at home
- Enhanced 911 to triage calls and answering questions (not medical treatment)
- Currently has no access to EHRs

April 10, 2015 – Winnemucca

Participants: Char P (Humboldt Director of Quality and Risk); Fergus (EMS Rescue); Charlene M (Coalition Coordinator)

Char –

- Mental health issues/needs
    - Extended holds in the ER compromise safety
    - After long period cannot hold patients, patients free to walk, didn't receive care as intended
    - Reservation of space available
    - More and stronger support to hospitals, outpatient mental health, help deal with situations escalating to crisis stage
    - Compromise health and health of individuals who are held for long period of time
    - Compromising other issues: HIPAA compliance, equipment is out (requires nurses to be more surveillant), adds an extra burden, diminishes attention to the medically urgent patient coming in door
    - Across the board follow home par medicine model
        - Sets pace for critical access in what paramedicine can do
        - See techniques used here that have been effective
        - Support for the dollars, not be in compete all the times (competing entities, i.e. home health), legitimate the expense for paramedicine
            - This would help with reducing readmissions, crisis management at home, strengthening education
- Telemedicine problems, especially insuring and paying
    - Providers are not willing to set up patients without insurance needing addiction, recovery support services
    - Hospitals need to recover cost of resources/time and nothing is in place
    - Does not offer same benefits as in-person
- Ideas – buses for transportation of patients (in between school hours); portable clinic inside schools (before and after schools); population health literacy (patients know which type of facility they need to go to based on illnesses/conditions)
- People don't understand how to use the healthcare systems
    - People think they have the right to use the ED and therefore tend to abuse it
- Nurse hotlines has been very helpful
    - Look more into pharmacy assistance (kiosk, hotlines, medicine reminders, follow ups)
- Patients are consuming expired medicine and end up in ED
- PT providers in the area
- Brining orthopedics to the community has helped, there is a need

Charlene –

- Mental health issues
    - School district Project Awareness Grant

- PDMP – patients are doctor shopping, finding doctors to get more prescriptions, patients are getting multiple prescriptions and are confused on what or how much take

Fergus –

- Limited physicians seeing patients
- Actively engaged family nurse practitioners
- Contracted with surgical groups, now have orthopedic surgeons 7 days a week
- 5-bed emergency department, mental health patients can take several days to be sent out, makes it challenging to do day to day care
- Allocate/hold and reserve rooms for rural areas
- Paramedicine
    - In trial period now, CMS does not reimburse, hospital CEO currently approved plan
    - Maybe need to work with discharge planners and social work in rural facilities
    - Define role of paramedicine in the community
    - Needs financial sustainability and ongoing commitment to making it right
    - Community paramedicine
        - Medication reconciliation
        - Continual follow up
        - Community liaison comes to your house to check for home safety
- If you call emergency line and it's not emergent, then they will transfer you (current REMSA model)
- Need one central warehouse for data