
Community Meeting Notes

Rural Areas of Nevada

April 1-3, 2015 – Las Vegas, Tonopah and Caliente, Nevada

Date: April 1 – 3, 2015 **Locations:** Las Vegas, Tonopah & Caliente

Facilitators: Jay Outland and 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?

Jan and Jay 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 1, 2015 Las Vegas

Participants: Joseph G, UNLV – CHIA, Jerry R, Health Insight, Anna C, Care Coalition, Troy T, CCFD, Steve E, Children's Heart Center, Maria L, Amerigroup, Brandi L, Shadetree, Todd J, NV Eye Surgery, Fern P, Health Insight, Jon K, CCFD

Conversations began with this question: What are the three greatest challenges in the area of health care related systems? What are your greatest challenges as you deal with your patients or your providers? Where do you see potential solutions to those issues and what are your barriers to those solutions?

John-

- In the prehospital setting the biggest challenge that we see are the repeat customers that typically never reach resolution
- Current rules only allow transportation of a patient to the ER – this is very expensive. Depending upon the circumstances, it would be better to take them somewhere else.
- Goal would be getting the right patient to the right level of care in the right location

Joseph-

- Switching from a population based payment to an outcome based payment I think is the way it has to go and it's probably the best way but here are a couple challenges
- What is the best treatment for the best outcome?

Jerry-

- Lack of sustained patient engagement.
- Finding systems that can align incentives such that there is better team based care and that team includes the patient and her family. On the provider side and because there are such high expectations and low availability of the highest level resources, we are going to need to be able to use a multi-tier system to provide adequate access because we simply do not have enough of the highest level of providers to provide all the access whether the needs are high or low.
- We have misalignment or misallocation of the resources to be aligned with the needs. We need to have systems that align the allocation of resources with the priority of needs.
- People are going to the wrong place for treatment. Again have to align the location with the need.
- Redesign the system based on Nevada's culture
- Educate consumers about alternative places for care. Urgent care facilities exist. Why don't people use them? In some cases they don't know they exist.
- Reallocation of resources and alignment of systems to provide early intervention at earlier levels of severity such that medications and other ambulatory interventions are superior solutions to inpatient facility care.

Todd-

- Problems are access to care in a timely manner.
- Reimbursement - forced to see more and more patients with less and less reimbursement
- Legal barriers
- VBP – example - savings Cataract surgery most of it is done under topical anesthetic and 30% of those are done in a hospital based setting with an anesthesiologist standing by in an acute care setting. We can remove a cataract in less than 21 minutes so why not put it in a location that is less expensive and frankly it's a better experience for the patients. That's just one example from the ophthalmology side and that one is going to solve 25 billion.

Maria-

- Problems with our new membership due to Medicaid expansion population who have insurance for the first time. Trying to teach them how to use health insurance. Also dealing with the homeless population. No discharge plan but she actually means there isn't anywhere for them to go. Socioeconomic issues are very large and have to be dealt with before the patient can take responsibility for themselves.
- Housing and social support is really the foundation for the members to be incentivized and really take care of their health.

Anna-

- The community health worker pilot program has been very successful. Our grant targets the Hispanic community to bridge that cultural gap. We learned a lot about cultural beliefs and norms against what we are trying to do. You need people in the community to bridge that information. Use of lay case managers without a degree therefore they are more affordable, they meet with clients one on one and make sure they're following doctors' orders and looking at that compliance issue.

Bill-

- Challenges vary from payer type to payer type
- Socio economic challenges and it does have a significant impact on how a person is able to access service
- What we might want to be doing is looking how a system works based on a payer type so we can replicate that across all payers including Medicaid programs
- The adequacy of having those alternate places for care outpatient care adequacy of network will be the difference between how you move through the system
- Educate the consumer
- Incentivize the delivery system in a non-hospital ER setting
- Earlier intervention being seen by someone other than a licensed physician
- Incentivize the delivery system in a non-hospital ER setting
- Other type of providers are not being reimbursed
- Aligning reimbursement with how health care is changing
- We are pushing the patient down to earlier intervention being seen by someone other than a licensed physician. In order to do that other type of providers are not reimbursable – aligning reimbursement with how healthcare is changing – goes back to economics

Todd-

- three years ago all electronic based worked in paper based – largely they have been a headache but once implemented good – we all have different EHRs that don't all talk to one another
- Connectedness would be great! Exchange would be helpful

Troy-

- It's been 5 years on EHR – all hospital given access to the portal into their system, but bringing in our record on top of another proved more than they can handle.
- If the FD has picked up a super user 20 times I can guarantee that there's been another facility that has seen those patient 20 or 30 times.
- We need easy connections.

Jerry-

- Keith Parker from HI was nominated 700 doctors' offices large volume in the VA system and military base going back and forth – they need the information exchanged. Nice to have Dept. of Defense and the VA be part of this group

Gail -

- Involved in a small project designed web based portal system to exchange case notes on super users. Simple design. All providers would have a learning system identified Super Users with EMS you would get notified and all share the notes so a decision could go the service they needed to go to, not the hospital

Todd-

- We do tele health – fundus photography for diabetics. Send shots of the retina and give them a timeline if the person will need follow up. 96% of the results are all clear – saves them a trip to another facility. One of the barriers is reimbursement.

John-

- send CHF patient home with an IPAD – showing the doctor what was going on without leaving the house
- use technology to consult with physicians at the time of the EMS visit - save money instead of taking to the ER

Jerry-

- Variety of work in a variety of states bundled payments, ACOs we've gone through this before – success factor is trusted date that share the risk – validated and transparent.
- Organizations and model bundled payments for certain surgeries – good models for that
- Some ACOs work as long as the doctor and patient know that they are in it.

Todd-

- VBP of healthcare works as long as you tie the value to the provider. Pair the payment to the outcome very specific to the provider. Otherwise people will just be hiding inside the data. For example if you provide cataract surgery for a patient with macular degeneration and the outcome needs to be a vision greater than 20/40, sunk before you begin.

April 2, 2015 Tonopah

Participants: Wayne A, Nye Regional Medical Center, Kim J, Nye Regional Medical Center, Patty W, Nye Regional Medical Center, Jess R, NYECCO, Beth E, State Health Nurse, Joni E, Nye County, James E, Nye Regional Medical Center

Joni representing Nye County National Association of counties shared a unique opportunity - select three teams from a county that they want to put together innovation HC delivery and establishing models. Nye County was selected as one of the counties. Joni to send Jan the link.

How is health care handled in Tonopah? The hospital and outpatient clinic handles 80% of the health needs – trauma gets airlifted. Ground transportation is through the senior buses through the senior nutrition program. Although the subsidy for the senior nutrition program is being eliminated, it is expected that medical transport will stay in place if MDOT continues to provide vehicle maintenance.

Beth-

- Family Practice Clinic
- For specialist care (or any higher level of service), have to go to Reno or Vegas. Cannot pay to bring the specialist in for chronic disease such as CHF or Diabetes.
- Working with St Mary's – tele stroke and tele cardiac for the ER.
- Prenatal care – no prenatal care done here or deliveries of babies on purpose.
- Beth's husband lived in hotel room in Pahrump when he had prostate cancer and needed radiation

Wayne-

- Sees health care transformation as a kind of hub and spoke model for rural Nevada.
- Present hub is St Mary's and the spoke is out in Tonopah and surrounding communities
- Should be capable of a robust comprehended outpatient program. We can recruit for these types of human resources and develop those competencies.
- We don't perform well in the inpatient model – it's not affordable. Not enough volume to make it affordable.
- A stigmatism exists about going to your local hospital for inpatient care in rural communities. Larger hospital - better place to go.
- Transport system - fixed wing sitting at airport. Helicopter in Fallon that can come out here.
- Pharmacy opens 4 days a week – hospital getting a pharmacy.
- Sees the outpatient model for smaller hospitals with large hospitals taking the inpatient lead. Consolidation of systems is key as well as establishing a financial incentive for the largest hospitals to take on the rurals.
- Limited financial risk – payment system needs to have allowances for that by building into their payment system rates in their contracts (Medicare, Medicaid, commercial, MCO) contracts should have a sum built into the contract for taking on these smaller entities
- If you're not seeing 150 inpatient patients per year you're out of that business. The government already does this. If you're not doing 150 open heart surgeries per year you fall off the open heart surgery list of hospitals.
- Manage chronic disease locally

Patti-

- We will always need the ER but will not need the inpatient setting
- I see us moving towards a Health Care Campus – more like a skilled nursing facility or long term care

Beth-

- some of the ER visits are because no appointments at the clinic
- We use a Robot from St. Mary's for diagnostics that can evaluate the patient. Works well. Right now use is cardiology and neurology. Technicians to aid in that process are mandatory. Mental health tele health is used in the jail.
- IT biggest challenge sharing of the records T1 line connectivity.

James-

- Always had the fiber line we should have 2 lines. Connectivity and bandwidth always were there. Who's going to subsidize it?
- Las Vegas to Reno has been done PUC with the govt. PUC requirement.
- Must define what access to care means. Access to care is not the same definition in Reno as it is in Reno. One size does not fit all. 20-30K people are very different from rural communities. Plan should include best fit for your community.

Patient engagement – is there a difference in rural vs urban?

- No it's the same in both – they all put it off no matter where you live.

Beth-

- case managing=disease managing - people are given treatment and written a RX leave the office and come to her to ask what is this and why am I taking it
- Put some money towards the point of care at the point of entry into the system then follow through for those that can't make it back to the clinic.
- Education of the patient at the point of service – this should be a reimbursable service
- Capitate the population of this area.

Dr Pillar-

- He knows of a military contract – when they were overseas they developed 82 % success rate they were able to treat a lot of the trauma right on the battlefield. This would be a tool to track patient care all the way through the system.
- One area lacking is access to mental health services at the school level. No social workers. Counselors are meant for academic guidance. Behavioral or emotional issue hard pressed to get services at the school or even in the community.
- BH worker only comes up once or twice a month.
- Telemedicine? Yes but for example suicidal thoughts at one of the schools what happens? Immediate intervention and ongoing services not readily available. This time period could be life or death situation.
- A suicide screening done recently in Pahrump schools for 2 days resulted in 21 out of 52 screenings came up positive for intervention and should have further follow up. If we had a mental health professional in the school, they could meet with those kids on a regular basis and have follow up.
- Has to be a billable service when the grant money goes away. Psychiatric NP could do these services.

- Barely got enough people to teach the diabetes self-management after advertising 3 times. I'm going to lose my certification for teaching chronic disease classes...you have to teach one a year to be certified. Now I would have to get recertified. Part of the problem with these classes are that they are 6 weeks long - 2-1/2 hours each class and the class has to have 10 or 12 participants. Too many for a rural setting. Too many restrictions. Be good

to use tele health to hold the class at the same time in (Pahrump) two locations so three of us would split up so we could have the class. Class is free. Governors aim – chronic disease management.

- Recognizing some of the alternative services reimbursement for it.

Beth-

- Process to get credentialed as any kind of provider is a nightmare and a viscous circle – I turned in my stuff at Aetna to be able to do more than just immunizations which they readily agreed to because the Goldmine clinic said you will. Still waiting 6 months later. It can take up to a year to get a physician credentialed with the insurance companies. No standard form from insurance company to insurance company. Had to pay a contractor to get the doctors credentials to get through the payers.
- We need a consolidated streamlines process for credentialing.

April 3, 2015 – Caliente

Participants: Laura O,Nye Community Coalition, Darby P, Lincoln County Workforce, Janie R,Caliente Behavioral HealthApril N, Grover C Dils Medical Center, Melissa R, Grover C Dils Medical Center

- Credentialing for providers. Providers are not recognized because the credentialing process is so tedious and takes so long. Our providers see patients but then we can't get paid. Process is very hard!!!
- We do not use telemedicine right now. Have the infrastructure technology – working with Dixie Regional in St George. They have been the best resource than anyone in the state. 95% of Lincoln County would prefer to go there. Dixie Regional is in Utah.
- Mental Health is a huge problem. Access to clinicians is the problem.
- Tele therapy through Mesquite or Ely and is limited. Nice thought but hard to build a relationship over the web....no in person clinicians
- Wait list over 6 month for BH services
- EHR – doing well - the providers don't like it but we're doing well in stage two at the hospital – they are compatible with Dixie
- Mental health records are an issue – no records for months if patient was seen in Vegas.
- Rural - lack of specialists
- Lack of transportation to see the specialists