

**MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES**

**Seventy-Eighth Session
February 16, 2015**

The Committee on Health and Human Services was called to order by Chair James Oscarson at 1:34 p.m. on Monday, February 16, 2015, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda ([Exhibit A](#)), the Attendance Roster ([Exhibit B](#)), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website: www.leg.state.nv.us/App/NELIS/REL/78th2015. In addition, copies of the audio or video of the meeting may be purchased, for personal use only, through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

COMMITTEE MEMBERS PRESENT:

Assemblyman James Oscarson, Chair
Assemblywoman Robin L. Titus, Vice Chair
Assemblyman Nelson Araujo
Assemblywoman Teresa Benitez-Thompson
Assemblywoman Jill Dickman
Assemblyman David M. Gardner
Assemblyman John Hambrick
Assemblywoman Amber Joiner
Assemblyman Brent A. Jones
Assemblyman John Moore
Assemblywoman Ellen B. Spiegel
Assemblyman Michael C. Sprinkle
Assemblyman Tyrone Thompson
Assemblyman Glenn E. Trowbridge

COMMITTEE MEMBERS ABSENT:

None



GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Kirsten Coulombe, Committee Policy Analyst
Nancy Weyhe, Committee Secretary
Jamie Tierney, Committee Assistant

OTHERS PRESENT:

Louis Mendiola, Health Systems Development Manager, Humboldt General Hospital and EMS Rescue
Jared Oscarson, Deputy Chief of Medical Operations, Humboldt General Hospital and EMS Rescue
Jim Gubbels, President/Chief Executive Officer, Regional Emergency Medical Services Authority, Washoe County
Bradford H. Lee, Medical Director, Regional Emergency Medical Services Authority, Washoe County
Dan Musgrove, representing Southern Nevada Health District
Rusty McAllister, representing Professional Fire Fighters of Nevada
Joan Hall, President, Nevada Rural Hospital Partners
Patrick T. Sanderson, Private Citizen, Carson City, Nevada

Chair Oscarson:

[Roll was taken. Committee rules and protocol were explained.] We have a committee bill draft request (BDR) introduction. Bill draft request 40-804 was requested by this Committee.

BDR 40-804 — Provides for the collection and application of graywater for a single-family residence. (Later introduced as [Assembly Bill 169](#).)

Voting in favor of introducing a BDR does not imply a commitment to support the measure later; it just allows the BDR to become a bill. I will entertain a motion to introduce BDR 40-804.

ASSEMBLYWOMAN TITUS MOVED FOR COMMITTEE
INTRODUCTION OF BDR 40-804.

ASSEMBLYMAN THOMPSON SECONDED THE MOTION.

THE MOTION PASSED. (ASSEMBLYMEN BENITEZ-THOMPSON,
GARDNER, AND HAMBRICK WERE ABSENT FOR THE VOTE.)

Chair Oscarson:

We have a presentation on community paramedicine programs and mobile integrated health from several experts in that field.

Louis Mendiola, Health Systems Development Manager, Humboldt General Hospital and EMS Rescue:

We have provided a short summary ([Exhibit C](#)) of an innovative program that we have developed by following a number of different models across the country. Those models look at ensuring the well-being of our communities with an innovative approach.

We started our presentation with a quote from Charles Darwin [page 2, ([Exhibit C](#))]. We are at a crossroads regarding health care in the United States and particularly in the state of Nevada. We looked at our systems and approaches to health care, wellness, and emergency response, and we have come up with a great program that we really think meets the needs of our community. The triple aim [page 3, ([Exhibit C](#))] is a widely received concept that was first presented by the Institute for Healthcare Improvement. It proposes that we focus on population health, patient experience, and per capita expenditure, per person or per life, in our health system. We believe community paramedicine does just that.

We want to clear up what community paramedicine is not. It is not a replacement for nurses or any other type of health care professional. It is not another project or program that we are asking that this body divert taxpayers' money to, and it is not a change in the scope of practice for any providers. Instead, we define community paramedicine as using established medical professionals or paramedics in a nontraditional manner within the community in an effort to connect underutilized resources, in our case in a rural setting, with underserved populations.

It is an expanded role, but it is not expanded in scope. Some of the services provided by community paramedicine are health and wellness programs, health screenings, and immunizations. For example, in Humboldt County, we are without a public health nurse to give immunizations and flu shots.

The community recently used our paramedicine program to provide immunizations and flu shots. Community paramedics have the ability to monitor, educate, and provide a wealth of knowledge on chronic diseases such as diabetic problems, heart attacks, and other things of that nature.

Nevada is a unique state that is very diverse in both urban and rural areas. One thing that they have in common is that the health care needs of people living in both areas are often underserved. Not having enough services creates real health problems and disparities. Community paramedicine has the ability to access health care when it is difficult for the patient to access it. In our model in the rural areas, our patients are unable to travel one hour, six hours, or eight hours to seek routine checkups or screenings. The results are costly health problems in the long run.

Jared Oscarson, Deputy Chief of Medical Operations, Humboldt General Hospital and EMS Rescue:

Why do we use community paramedics, and why use the paramedic model? Paramedics are already in your communities providing these services listed on the slide [page 8, ([Exhibit C](#))]. They provide health care to the community, response to 911 and nonemergency calls, and do interfacility transports. They are familiar with doctors, the health care system, and patients. So why not use them? It seemed like the perfect fit. Based on the needs assessment that we did for our system, they are able to fill the gaps within that community.

We looked at providing additional education for the paramedics. That was a process in itself, because what we really needed and looked at was more education on primary care health assessment and being able to educate patients on their disease processes.

Community paramedicine is physician-led. It is meant to be episodic in nature and capable of providing services to diverse patient populations. We looked at the case of people who live in our community who are out 100 miles and then 50 miles off a dirt road on a ranch. They do not qualify for home health because home health providers do not have the vehicles, resources, or providers to do that in our community. We have been able to fill that gap with our community paramedics. The home health model does not make sense financially. A lot of these people have either Medicaid or Medicare and do not qualify for home health care services based on the Centers for Medicare and Medicaid Services (CMS) regulations.

Louis Mendiola:

Another issue facing our state and our communities is the shortage of physicians. Research done by the Nevada Legislative Counsel Bureau listed us

as forty-seventh among all states in the number of physicians per population [referred to page 10, ([Exhibit C](#))]. Another area of significant need is our difficulties in attracting and retaining social workers, nurses, and mental health professionals.

Other characteristics that affect the health and well-being of our communities are the large number of uninsured residents, even after the implementation of the Affordable Care Act. We have rapid population growth in rural areas and in some of the more urban areas, and see some shifting payer mixes, which has complicated things a bit. This is due to the shift or expansion of Medicaid. In a number of the frontier and rural communities, low health statuses and behavioral health issues remain a huge concern of providers of health services in our state.

Jared Oscarson:

We looked at the opportunities for community paramedics to provide a cost-effective model to navigate the health care system through the emergency medical services (EMS) providers already in the system [referred to page 12, ([Exhibit C](#))]. These providers can help low acuity patients by checking vital signs, blood pressure, heart rate, blood glucose, and things of that nature that could lead a primary care provider in the right direction when following up on those patients. When checking vital signs we can also educate and get people to the right resource when they need it. If someone's blood pressure is high when we check on them, we can ask them to see their primary care physician and really get them to that resource, rather than it becoming an emergency later on, or seeing them accessing the ER as a point of care for a chronic illness that can be managed. Other services are wound checks, oxygen saturation, and ear checks in pediatric well-child checks.

Emergency medical services has gradually become a 911 response, and our point of access for your health care is now the 911 system and taking you to the ER, which is also the most expensive health care that can be provided. We assist the patients that do not qualify for home health and hospice services by picking up where the system does not have available resources for them and providing that care in an episodic nature.

Assemblywoman Titus:

You mentioned the EMS providers and you also talked about paramedic providers. Those are two distinct categories and different levels of training, so I want to make sure we are talking about level-training paramedics, not Emergency Medical Technicians (EMT) like EMT Basics or Intermediates.

Also, I have a question about during your training of a paramedic. As you talk about it, you are not really expanding your scope because it is already something you know. Do you have some well-baby checks and training in your paramedic schools programs?

Jared Oscarson:

In our roll out of community paramedicine and paramedics, there is extensive training where they shadow our primary care physicians, who are also obstetric fellows. They do the well-child and primary care training, and an expanded training with those individuals within our health care system in Humboldt County. There is that adjunct in that training for them.

Obviously, from a rural standpoint, there are some systems across this state that are underserved in not only health care in general, but in EMS. In our opinion, there is a place for the EMT and the EMT Advanced to do this program. What that looks like is going to be based on the community's needs and the medical director that drives that community and that EMS system. There is opportunity for those people, those providers, and those systems to provide for rural and frontier Nevada. I encourage them to look at the health care system and that physician medical director that they work with to do this program. For us, it is paramedics.

Assemblywoman Titus:

I have been an EMS medical director for 30 years in my area, and we do not have anything higher than EMT-Intermediate training. In the rurals it is not uncommon that the first person there as a first responder will be the ambulance EMT to see if they need to go somewhere, but they do not do diagnostics or intervention there. They can only advise whether or not the caller needs to be transported based on the information they have. They do not recommend a treatment plan or intervention that way. Are you proposing advice and intervention?

Jared Oscarson:

What we are proposing is that these people are trained to take clinical pathways based on the signs and symptoms presented to them, and provide contact with medical control and medical directors as needed.

Assemblywoman Titus:

Would the paramedic decide then if they needed to make contact with a medical director? Do you have a flow chart where if they follow this, they must call per protocol? Do you make that on an individual case-by-case basis?

Jared Oscarson:

We have some algorithms and things of that nature, and we do have really good collaboration with our medical directors and physicians that are available to us during these calls. There are preconferences before treatment plans are laid out for these patients and, if there is anything deviating from the norm, that physician would be contacted to discuss that, and they are followed up with the findings immediately after our patient visits as well.

Assemblywoman Titus:

Under your plan, were you always within contact of your provider, physician provider, medical director, or some type of physician program protocol?

Jared Oscarson:

That is correct. We are in contact with our medical director. He is available to us 24 hours a day, 7 days a week, and these patients that are referred out by primary care physicians within our health care system are also available. These are done during business hours, so they are available in their offices and, if not, they are available by telephone call, cell phone, or some other form if we need to get in contact with them. They are available to us.

We have talked about assisting the patients that do not qualify for home health and how visits by the paramedics can help them gain a better understanding of the importance of correct, evidence-based disease management. Congestive heart failure, asthma, pneumonia, and cardiac events have high admission rates to ERs, whereas a lot of these disease processes are manageable with the right medications and the right education. It could be something as simple as changing a diet, or knowing why they need to keep taking medication regularly even after they start to feel better. The big goal would be to assist with improving the overall health and wellness of a community.

Louis Mendiola:

What we really want to do is to reduce the strains on the current 911 call system. We know that patients benefit from that change in the long run [referred to page 16, ([Exhibit C](#))]. It is to make sure those patients do have a relationship with a primary care provider and reduce the number of costly admissions into emergency departments. That is what rural EMS providers have been doing for 30 or more years by being that first line of call in the non-real emergency setting. That is what we want to standardize in our system, where a person can call the EMT, medic, or first responder, and they can come out and determine, "Yeah, this one needs to go by ambulance, or maybe we could take him into the local clinic."

Another portion that is important to mention is the decrease in hospital admissions, hospitalizations, and readmissions. An important result of the Affordable Care Act is that a number of health care systems have been looking at innovative ways to decrease those readmission rates.

One thing that is important to us is that our hospital operates its own skilled nursing facility or nursing home. We have a huge demand on long-term care beds. If we can keep our aging and elderly populations in their home, we know they will do better, not only from a clinical standpoint, but because they are able to live a happier, more active life. Coming in and doing fall-check precautions in the home and being the eyes and ears of both the physician and out-of-state family members can keep somebody in their own home and out of the long-term care facilities. We hope EMS becomes a component of that medical home model or that accountable care organization that is required under health care reform [referred to page 17, ([Exhibit C](#))]. This will be a concept that is more important to the larger, urban health care settings.

We want to make sure that we improve the economic efficiencies of delivery of care both for the chronic care patient and for patients that may be accessing their entire medical services through the EMS or the emergency departments. We believe this is more cost-effective, and our friends from Regional Emergency Medical Services Authority (REMSA) will elaborate on their findings.

An unintended benefit to this is that it does give additional career opportunities to EMS professionals. They can have more daytime hours, and that helps them address overwork and reduce the instances of burnout. We know we have EMS providers leaving that career path because of burnout.

To summarize the benefits of a community paramedicine program is that care is provided more economically and efficiently in the patient's home when it can be done. We do have protocols for treat and release, or treat and referral processes. A new type of EMS professionalism could be created and community paramedicine is always driven by community-specific needs after a gap analysis is completed.

Jared Oscarson:

We talked about this being a flexible program and being specific to the communities' needs, and structuring these programs around the communities—be it ours in Humboldt County, yours in Yerington, Tonopah, Hawthorne, or other places like that that are underserved. It has got to really be based on their needs assessment and their ability to provide the needed services and to fill in the gaps.

What is available in the communities? Our EMS providers are great for that because they know the area. They go around the community, are in the community, speak to people in the community, and they know all the health professionals, so they have an idea of what is going on in their community.

What is missing? For instance, in our community, we do not have a community health nurse right now. This is a struggle for us. How do we fill that gap? We found a way to fill a portion of that gap with the community paramedics for immunizations.

Access to resources is a huge thing. We know that we have mental health appointments Monday through Friday and that we have a lot of traveling physicians. We can help refer our ER physicians if they need a consultation point. They will know what the alternate resources are if the social worker is not available at 2 o'clock in the morning. The EMS department has been essential in filling some of those gaps and knowing some of the resources that are available in our community.

This is where we get down to how it works [referred to page 22, ([Exhibit C](#))]. We identify a patient that could benefit from the program based on referral from the providers, the case manager, social workers, or anyone in the hospital health care system. If the community paramedic organization gets a referral from a primary care physician, we contact the patient to schedule a home visit with one of our community paramedics, and then the paramedic provides a service at the patient's home that is within the scope of their practice with the expanded role that we talked about. We are within the scope of their practice, but expanding their role.

The community paramedic will communicate with the primary care physician to ensure the quality of the care and appropriate oversight. The primary care physician may send him out to do an assessment on the home of someone who has fallen and now has a hip injury. Do they have appropriate railings on their stairs, do they have rugs, is their oxygen tubing 50 feet long when it only needs to be 30 feet long? Things as simple as that can keep a patient out of the hospital from another fall.

Community paramedics can also do medication reconciliations. The paramedic can evaluate the patient's medications from the cardiologist, endocrinologist, primary care physician, podiatrist, and all those people that are prescribing medications and then get a list back so that we are not double-dosing medications or having medications interact. Things as simple as that. Other examples are obtaining a 12-lead electrocardiogram on a patient who came into the ER or presented with chest pain four days before and had no findings but

now needs follow-up care, educating recently diagnosed asthma patients, or instructing diabetes patients on their diet and on how to maintain and balance their life. The program that we are doing does not have to be complicated. It is simple social and clinical things with a component of care. We really tie it all together to provide for these patients.

Louis Mendiola:

It is important to explain that this is not a new concept and not one that we dreamed up. These are international programs now, and they go from one side of the country all the way across to the East Coast. One of the first of its kind was in Alaska [referred to page 23, ([Exhibit C](#))]. They did not call it a community paramedicine program, but it had a lot of the same factors as we know them today. Because of their geographical isolation, the program in Alaska has to be innovative in their approach to delivering care as they did with their community health aides. Over 180 villages and more than 300,000 citizens in the state of Alaska are served by these specially trained community health aides. It is similar to an EMS-driven community paramedicine program because it has 24-hour emergency care when needed, but also has the ability to do some urgent care, prenatal care, preventative care, and chronic care management all under the direction of a physician.

This slide [page 24, ([Exhibit C](#))] talks about REMSA. Our neighbors in Washoe County have done an excellent job with their grant-funded program.

At Humboldt General Hospital, the community paramedicine program is based in a mainly rural and frontier area [referred to page 25, ([Exhibit C](#))]. Currently, we operate this program with the philosophy that a lot of these services we do free of charge. In fact, we currently do all of them free of charge to our patients because we believe it is the right thing to do. We believe that if a patient is discharged, we should give them a call within a short timeframe after discharge, maybe one or two days, and make sure they do not have any questions.

We had a patient that is a high user of our EMS system and our ER, and he is constantly falling. He was one of our first community paramedicine patients. We sent our ER crew out there to help him build a ramp into his house, and it decreased the calls to his residence exponentially. Again, our goal is to increase health and decrease readmission rates and make sure we are doing it in the most economically efficient manner. We see ourselves as physician extenders—the eyes and ears of the physicians, taking directions from the primary care provider or from our physician medical director.

What are our challenges [referred to page 26, ([Exhibit C](#))]? That is where this body comes in, obviously integration and collaboration with other existing

providers of health services and health care professionals is important. Where funding and reimbursement are concerned, the challenge is that we are doing this at no cost to our patients. There are grants out there, but in the next few years it is something we are going to want to keep our eye on. How can the regulations and the laws passed by this state improve the overall success of these programs? As we talk about development and expanding roles, what are the needs for the education? What does medical direction and program oversight look like? There is data collection. Collecting data drives change. We believe in transparency at Humboldt General Hospital, and we believe that we need to be able to show the evidence that this actually makes a difference and that it actually saves money.

What are our legislative priorities moving forward? From Humboldt General Hospital's standpoint, ours is to simply continue that dialogue with key stakeholders that was started in the 2013 Legislative Session. We want to make sure we develop statutory language that assures flexibility in each of the communities that community paramedicine can service. We know our communities are very diverse. That is why that flexibility, in regard to regulation and legislation, is important. We want to allow these programs to remain under the control of the individual medical directors that have that intimate knowledge of the needs of the health systems that they service. That concludes our presentation from the rural standpoint.

Jared Oscarson:

One thing I want to add is that we started this as a small circle, then we jumped on this pact with REMSA and we started doing this. REMSA got the grant, and it has grown. We have got a lot of great things from them, and we have communicated with our partners in the south. Our small circle has now become a fairly large circle for the state of Nevada—working with everybody from across the state and really involve everyone from Las Vegas to Tonopah, from White Pine County to Humboldt County, Battle Mountain, Lander County, and back to REMSA. We have done that and collaborated as EMS services in the state. It has been a great process and it has been great to work with some of those people because they have great ideas that we do not and vice versa.

Assemblywoman Titus:

I think community paramedicine is a great idea. We have already been doing that, just not recognizing that we have already been doing that for a long, long time. Obviously the EMS services in the rural areas are the ones that go up there and give feedback to us, such as, "They have 50 cats," or "We cannot get through there," or "I could not get the gurney in," and all those things that we do not necessarily see. Thank you for that, and I appreciate your coming up with some new solutions to these problems of not having adequate services,

not just in rural areas but in urban areas; REMSA can be part of that solution too.

I have a couple of concerns. Number one is liability. When you do this intervention, home assessment, or patient assessment, do you change your liability coverage? Have you changed anything there? My second concern is, in this age where we are pushing telemedicine further and almost everybody can Skype, are you using any of that to contact and show a picture or come online with whoever is supervising you to say, "Hey, look at this?" Have you done any of those interventions?

Jared Oscarson:

On the clinical side, we have worked with several of our physicians to provide iPads for them and for the providers out in the field. We have not run across a whole lot of instances where that would be necessary. Traditionally, these are low acuity patients where the face-to-face conversation with the physician after that meeting is enough. If we do need that, we have the iPads available so that both physicians and providers would be able to access them. The physicians are aware of these visits. They are scheduled so the physician is available if we need them. If they are in a room or if they are with a patient, they are available for an urgent or a non-urgent matter.

Louis Mendiola:

Liability is a kind of untrodden territory and that is a really great question in regards to liability and risk. We have had conversations with the provider of our liability coverage and, as we grow these programs and we start doing a lot more clinically expanded stuff, we will have to talk through that with our liability provider. A lot of what we are doing now is things like going out and taking blood pressure, but it is not going out and taking blood pressure because a patient called 911. It is going out and taking blood pressure because I want to make sure that the new blood pressure medication is working. The dialogue has happened, and it will need to continue to happen, in regard to liability.

Chair Oscarson:

It is my understanding that we have a representative from Nevada Rural Health Partners, Joan Hall, in the room. The Liability Cooperative of Nevada (LiCON) insures a number of providers that are already out in those communities, and they are engaged in that conversation too. I know that is part of the working group that had engaged in that process.

Assemblywoman Spiegel:

I know Humboldt County goes all the way up to Oregon. How does this work logistically if somebody is out on one of these calls, and then a 911 emergency

happens? Does the person who is out on this call have the only truck? Are the paramedics in a private car? How does that work? How is that capacity dealt with?

Jared Oscarson:

These are dedicated providers to the community paramedicine department. They may have other roles and responsibilities within our service and our agency and when they are on these events, they are scheduled for these appointments. They utilize one of our vehicles; generally not an ambulance, but a truck or some other alternative mode of transportation that is equipped to handle low acuity patients. They are also equipped with emergency first response equipment. Should they clear their call and they happen to be up near the Oregon border when a call goes out, they can also cover that as well and be the first person on scene for that. We use them in a dual capacity. If they are driving 100 miles outside of town, we want to be prepared for that patient that inevitably is going to call from 100 miles outside of town.

Louis Mendiola:

It is important to state that community paramedicine patients cannot call 911 or call our dispatch and say, "I would like you to send a community paramedic out, I have a question." Currently, the only way that they can access our program is through the medical director or through their primary care providers.

Assemblyman Trowbridge:

You had an excellent presentation. What level of training do these people have? I have heard EMT Basic, Intermediate, Advanced, and EMS 1 and 2. I am assuming those are different levels of certification. You mentioned a community paramedic would be a level of EMT training plus expanded training. What are we dealing with? Are these paid or volunteer positions, or a combination of both?

Jared Oscarson:

Within the EMS system, our area currently has first responders and EMT Basics. First responders have somewhere around 80 hours of training, EMT Basics are around 100 hours, EMT Advanced are around 120 to 140 hours, and then paramedics have 480 hours of didactic training and then another 500 hours of clinical time on top of that. There is extensive training up to the paramedic level. We are now looking at the education standards that we need to add on to that for these programs, and to provide the right person for the right patient.

They can all be involved in this, and this is where the medical director comes in. The medical director would have to look at their program and what they want these people to do at these levels. They would determine if they want to send

a first responder out to do a safety check on a patient, be it looking around their home at rugs or oxygen tubing, and that level of things. They would consider medication reconciliation. Is there a pharmacist at the hospital? A rural hospital has a pharmacist there. The medical director can call and coordinate with that pharmacist on these patients' medications, and then the pharmacist can get involved in patient care with the primary care physician.

The EMT Advanced level has an expanded scope over that of the Basic and the first responder. There are different levels of training and different skillsets for each one of them that fit into these programs. The medical director will have to drive that. We primarily use paramedics in our system. We do have some EMTs that often accompany our paramedics.

We have both volunteers and paid people in our system. We have our volunteer core, and people that are involved with us and help out a lot. A lot of those individuals live in the more rural part of the county and provide some of these services for us, as well as our paramedics.

Assemblyman Sprinkle:

I am having a little difficulty wrapping my head around the training aspect of this. What I have heard several times now is that these are paramedics of certain levels within the profession. They get some type of extra training and it sounds like that is based off the medical director for each organization. If it is the medical director that decides what he or she wants as training for the community paramedics but then it is not a certification process or program, that brings me back to liability. If the community paramedics are not fully certified based off a curriculum, I would be very surprised if any medical director would put their license on the line for that. If you could address that, I would appreciate it.

Louis Mendiola:

We have had a lot of discussion today about different levels, and it is great that you brought up the education component because that is something we are looking further into and we know it needs to be more developed or formalized. Currently, the majority of our community paramedicine visits are done by community paramedics that have completed a program through a university system in the state of Colorado. Mr. Gubbels with REMSA (Regional Emergency Medical Services Authority) will explain what their education plan is and what they have done with the University of Nevada, Reno (UNR).

We have created some of these added educational components, but as you may or may not be aware, the statute that deals with EMS certification currently does not have an area that differentiates between paramedic and community

paramedic. One thing is that we have been doing a lot of these services for years and years and we do not really know if a paramedic going in to check a blood pressure two weeks after a patient has been given a new medication would require that certification. Community paramedicine, which would be the highest level, currently has some educational curriculums that our program and paramedics working those programs have done, as well as REMSA.

Assemblyman Sprinkle:

I think as soon as you put a title on anything, it is no longer something that you just have done over the years, you are now establishing it. In my opinion, we need to be looking at statute so that this is formalized, and I am saying this as a paramedic. Protecting my fellow colleagues is what we really need to be looking at.

Chair Oscarson:

Any further questions from the Committee? [There were none]. We look forward to Mr. Gubbels' and Dr. Lee's presentation.

Jim Gubbels, President/Chief Executive Officer, Regional Emergency Medical Services Authority, Washoe County:

Regional Emergency Medical Services Authority (REMSA) services Washoe County. We are an exclusive provider for emergent and non-emergent transport ambulance services. We are a not-for-profit and a private company. Our community health programs are actually being funded through the Centers for Medicare and Medicaid Services under a grant [page 1, slide 2, [Exhibit D](#)].

The Health Care Innovation Award is funded under the Affordable Care Act [Read from page 1, slide 3, [Exhibit D](#)]. We have eight community health paramedics and nine nurse navigators. We will talk more about the roles they have. The triple aim has been discussed with you, but everything we are doing through these programs is to provide better care for the community, better health, and to lower those costs in providing these services.

It is critical to form clinical partners in a community. It cannot be done alone. It takes an entire community to improve the health of the community. We listed health care partners under the health care section of this slide [page 2, slide 5, [Exhibit D](#)]. We were able to successfully have all of our hospitals in Reno and Sparks involved, including Northern Nevada Medical Center, Renown Health and Saint Mary's Regional Medical Center. We have 16 urgent care clinics that are assisting us with alternate care for patients. WestCare Community Triage Center is a big provider for care and treatment, and both Northern Nevada Adult Mental Health Services and West Hills Hospital are helping us with some of our non-acute psychiatric patients that we see out in the field. Both of our federally

qualified health care clinics, Health Access Washoe County and Northern Nevada HOPES, are assisting with us as well as Sierra Nevada Pharmacy under the community column on slide 5. The state EMS office has been involved with us from the beginning along with the state health officer, and our Washoe County Health District. [Continued to read from page 2, slide 5, ([Exhibit D](#)).]

Data and evaluation is very key to what we have been able to do with our grants. Not only does the federal Centers for Medicare and Medicaid Services (CMS) review us on a quarterly basis, we also have the University of Nevada, Reno School of Community Health Sciences involved with our programs. The Nevada Center for Health Statistics and Informatics is running all of our data and results, so we have that outside party doing that. An independent evaluation team called RTI International is contracted with CMS, so they are working with us, and we are also working with HealthInsight for readmission data.

The implementation of REMSA showed us the need for technical changes within our services. First Watch is a program that we use that helps do our automatic data triggers for us. We have used KPS3 Marketing for community outreach. Priority Solutions, Inc. is the protocol-driven emergency nurse care system that we use. ZOLL Data Management is developing a community paramedic emergency medical record for us. It has never been done any place in the nation, so we have linked with ZOLL as a company. True Simple is another company that we utilize to help us with performance improvement.

In emergency medical services, our community health programs are an important component of the overall health care safety net. The Regional Emergency Medical Services Authority's new community health care programs expand that safety net and keep patients safe, independent, and out of hospitals. They help patients before they need a 911 call and give patients a non-emergent phone number they can call to talk to a nurse. Ultimately, we can help our patients get better care and easier access to community and health care resources.

There are three interventions that we have [referred to page 3, ([Exhibit D](#))]. The first one is the nurse health line. The nurse health line is a separate 7-digit number that you can call 24 hours a day, 7 days a week and be able to speak to a nurse and talk about your specific medical problem at that time. It has a medically driven protocol. The nurse will go through and ask key questions, and depending on how that caller or patient answers those questions, the nurse can recommend a level of care. That level of care could be self-care at home, going to an urgent care clinic to be seen today and provide the location of the closest urgent care clinic, calling your doctor tomorrow and setting up an appointment,

needing to get to the emergency department, or sending an ambulance immediately because of the symptoms that you are describing. Our nurse health line is located in our emergency medical dispatch center, so there is a warm hand-off for that ambulance to be able to turn around and respond. Another thing we can do with this is follow up with those callers a day later and find out if they actually followed the care that we recommended for them to get. If they have not, we can reinforce that care again.

The second intervention that we have used is ambulance transport alternatives. This is to give patients with low acuities and minor illnesses an alternative for care. Right now if we respond with an ambulance, we only have one option: to ask that patient which emergency department he would like to go to and then transport that patient to the emergency department. With this grant we are able to offer alternatives with patient consent. The alternative could be, for example, say you just sprained your ankle. We cannot tell you whether your ankle is fractured or not, but we can take you to the ER of your choice, or there is a clinic around the corner that can give you the same level of care. Which treatment would you like? Because of this grant we are able to take a minor ankle sprain to a clinic so you can receive the same level of care that you would in an emergency department.

Another example of this is transporting patients to a community triage center. If we transport an intoxicated patient in Reno, we currently have to take that patient to an emergency department, which is the highest level of care. With this alternative method, we can take those patients who are physiologically stable to the community triage center which deals with intoxicated patients in our community. It has been a great resource to take care of the patient but not move them to the emergency department when they do not need to go there. Instead of always taking mental health patients that are physiologically and mentally stable to the emergency department, we can take them directly to our mental health centers.

The third intervention is the community paramedic intervention. A lot of this has already been explained, but I am going to highlight some of the key pieces within our program. One practice that we are doing with this is following post-discharge patients. The patients that we are seeing right now are the patients with chronic conditions—chronic obstructive pulmonary disease (COPD), congestive heart failure, or post-heart attack patients. These are the majority of types of chronic conditions that we are following. With that follow-up visit we can make sure that they have adhered to their discharge plan. Medication reconciliation is a big piece of what we do too. Once an elderly patient, for example, is discharged from the hospital, they go home and they may not fill their new prescription or they may use preexisting medication that is

already at home because they have not finished that bottle yet. They want to be able to finish all those medications. It is important that we get them on their new medications to deal with their health.

We can do point-of-care laboratory tests in-home as well. The biggest part of this service is educating that person on health literacy. Many people, especially elderly patients, are discharged from the hospital but do not fully understand their medical condition. That community paramedic can go in and really explain what their medical condition is and what they need to do to keep themselves in a healthy status.

We are doing three interventions with community paramedics. The first one I just talked about is post-hospital discharge patient follow-up. Within our grant, these patients are being referred to us by all three of our hospitals and all three of the specialists within those hospitals. If the patient consents, we will follow that patient for up to 30 days attempting to keep readmission very low for that particular patient.

The other piece of post-discharge follow-up is episodic evaluation visits. If a primary care physician gets a call from a patient in the middle of the night, instead of referring that patient to the emergency room or telling them to call 911, the physician can call our community paramedics. Our community paramedics will go out and evaluate that patient for them, call the physician back, and then the determination will be made by the physician, the paramedic, and that patient, on what care needs to be rendered at that time.

Assemblywoman Titus:

We asked earlier what type of vehicles the community paramedics use. At the time the community paramedic makes that decision, are they going out in their ambulance? If they decide to transport at that time, can they just take the patient? Or will they now have to access the 911 system? How does that work?

Jim Gubbels:

The community paramedics and the ambulance service are two distinct functions. The ambulance service is there for the 911 caller. The community paramedics are there for follow up and as need be. It is two separate divisions or departments. The community paramedics go out in a Ford Expedition. It is a non-transport vehicle. We do carry both non-emergency and emergency equipment in it if we need to cross-utilize those people, but they are two distinct functions.

Assemblywoman Joiner:

I want to go back to some of your previous slides. You are drawing a line where community paramedics are a different segment of your service than the emergency responders. I believe you said there were eight of them. On one of your slides you mentioned that there were other entities; for example, some of the first responders are our firefighters and you listed the two-city fire fighting departments. How do they fit into that picture? I am trying to fully understand how this operates.

Jim Gubbels:

We have a two-tiered system in Washoe County. The fire department first response will respond to our 911 system along with our ambulance service. The role for the community paramedics is a scheduled type role, so it is a non-emergency response. Only the community paramedics will respond to that.

Assemblywoman Spiegel:

Are community paramedics still employed by their individual employers or are they working under REMSA? For example, if city firefighters or EMS persons are working as a community paramedic, are they doing it in their capacity as a city firefighter on loan, or are they working for you?

Jim Gubbels:

Currently, our community paramedic program is being sponsored by the Health Care Innovation Award grant that is solely for REMSA and REMSA's employees. The fire services are not part of that grant. It is still agency-driven. Those community paramedics work for the agency, the agency is REMSA, and they are a REMSA employee as they go out and do their role as a community paramedic.

The third category of patients that our community paramedic program is looking at is the hotspotter intervention. These are our frequent high users of the 911 system and ambulance response. Because it is REMSA, we are able to see what patient is frequently utilizing us. We send the community paramedics out to have a discussion with that patient to really evaluate what their overall needs are so that they are not calling 911 every time that an event happens for them. We have been successful with this program. If I have a chance at the end of my presentation, I will talk to you about one of our patients and how we have really succeeded in connecting that patient to health care versus always activating the 911 system for his medical condition. The three interventions are actually interdependent, and it is really to balance triage for our patients, really meet what their medical need is, and service that need at the appropriate level. That is a change from our current system which is always taking the patient to the highest cost at the emergency department.

We do have some preliminary results that have been released into our community. I would like to discuss them a little more. Our third-party contracted evaluator for this is UNR, so they are very independent in their review of our data and our results.

The first result is that we have improved access to quality care. For the nurse health line which started in September 2013 through December 2014 we have actually received 28,011 calls to the nurse. That is much higher than we ever anticipated. We are getting over 2,000 calls a month. These are patients that have a medical condition or a medical need and need advice on what to do. Obviously this is much more utilized than we actually thought it would be and those are the number of calls we have received. Through our community paramedicine program, we have gone on 3,045 home visits. This runs from June 2013 through December 2014. Those patients that normally would have gone to an emergency department now go to a clinic or the community triage center because of the alternate transports. We have avoided 786 transports that would have had to go to an emergency department.

We believe that we have improved patient quality of life and we have a high success on our satisfaction rating by the patients we receive.

The total estimated savings for the program is where REMSA has been able to demonstrate its cost-saving capacity. Community paramedicine is all across the nation, but people have not been able to measure cost savings to really show the value of the programs the way that we have been able to do for ours, especially through the grant. We showed a savings in our programs of \$5 million to date. We have avoided 3,203 emergency department visits, and there have been 609 ambulance transports avoided. If that nurse was not answering that call, those calls would have gone into 911. We have reduced readmissions to hospitals by 52 avoided readmissions. This \$5 million figure is actually an estimation for program savings calculated on the average payment. This is not on billings but on the average payment that would be received, which is about 35 cents on the dollar for our reimbursement resources.

Along with coming and introducing this to you today, our next steps include looking at how we can sustain these three programs that we have been able to initiate because of the grant. We are continuing to work with our community and we want to reinvest these savings and the workings that we have done back within our partnerships. Where are those partners? Those partners are certainly our hospitals, insurance companies, and our patients themselves. We will have ongoing discussions with them on how we can continue to fund this program along with discussions with Medicaid and Medicare, to look at the cost savings they are receiving and reinvesting those to keep these

interventions going. Our grant does end on June 30, 2015. It is important that we continue to have aggressive discussions right now for sustainability. There is national focus, as well as in Washoe County, on renewing and sustaining this program so these types of models can be moved nationally and we can be reimbursed for these programs and maintain the cost savings.

There is an independent evaluation team called RTI International, hired by CMS, that is doing their own independent study. Their report will probably come out three to six months after the end of our grant on June 30. That will be shared. We will have our final report on program outcomes about 30 days after the completion of the grant. We survey all of our patients, including all those patients we visit in their homes. We even survey callers to the nurse health line, and here are some of the comments that they have given back [page 5, slide 3, ([Exhibit D](#))]. This has been warmly received by the patients that we treat. This is an acknowledgement from CMS [page 6, slide 1, ([Exhibit D](#))] that they did fund the grant programs that we have.

I would like to quickly tell you a story. This is a story about Adam, who is a resident in Washoe County. In the first three months of 2013, Adam was transported by REMSA to the hospital 23 times, an average of 8 times a month. Adam suffers from anxiety and he was treating his anxiety by calling 911, going to the ER by ambulance, and receiving medication from the ER. As part of REMSA's community health programs, Adam consented to being transported to a local clinic instead of the emergency room. Adam has previously been an established patient of this clinic; however, he has not been in contact with the clinic staff for over six months. During his clinic visit, Adam reestablished his relationship with the primary care provider and also enrolled in our community paramedic program, so we could go out and visit him at least once a week, and he was given the REMSA nurse health line phone card to call. Adam is a success story. Since Adam has been enrolled in the program he was only transported twice in the next three months, and over the last year he has had no transports by ambulance. Most importantly, the program helped reconnect him with the clinic where he needed to receive his primary care. He continues to live independently in Washoe County. These types of programs that connect the right patient to the right resource can reduce our overall health care costs for both the community and our payer sources.

Chair Oscarson:

Would you comment on the collaborative effort that has gone on the last 18 months or so with other organizations? All the organizations communicated about how this process could work better. What has transpired in those conversations? Your people have been the leader with this grant, and I know

people look to you and there have been some very fluent conversations. I would appreciate if you could comment on that.

Jim Gubbels:

Over the last year and a half, we have worked very closely with Humboldt General Hospital and their services to look at their role in community paramedicine in the rural setting and then look at ourselves in the urban setting. The role of the community paramedics really needs to be coordinated to be successful. All the procedures that we use in the field are protocol-driven so that community paramedic cannot go to a house and just make up what type of care he is going to do. There are medical protocols for each of the conditions that we treat. Those medical protocols are signed off on by the medical director, and we stay within the scope of those medical protocols.

As we move this forward in our state, we believe it needs to be coordinated. It should be coordinated through the state EMS office no differently than the regular licensing for a paramedic in the state of Nevada. The skills they are using are the same skills they would use in 911 services, but we are just doing it in a prescheduled, follow-up type visit to patients. We do believe that education is an important piece; we need to define that education. Initially, we are looking at keeping this on a paramedic level because nationally there are some standards that we can follow. One of those standards has been developed by the University of Minnesota and the University of Nebraska, and that is the program that Humboldt General used through Colorado. We modeled our program off of theirs, and we have streamlined it a bit more so there is an additional 150 hours of training above and beyond paramedic training in order to be a community paramedic in Washoe County. That training has to be affiliated with a university or community college so we use UNR as our affiliate to oversee that education.

We have also had discussions with the State Health Officer, and through the state EMS advisory board to make sure we coordinate community paramedics for our state to meet certain criteria. An individual paramedic cannot go out with a certificate and say they can do community paramedicine. It has to be overseen and regulated through an agency in order to perform those duties.

Assemblywoman Titus:

I am hearing different ideas for what you are doing in REMSA in rural versus urban settings. You are now mentioning that some of these practices would be scheduled visits, rechecks, and those types of things. Are you anticipating doing wound care, intravenous (IV) antibiotics, and some of those treatments? Where does this fit in if you are doing scheduled home visits? Where does it fit in with the home health agencies, many of which are private agencies? I am

worried about that fine line there. I understand it in the rural areas where there perhaps is no home health program, but they have it for scheduled visits. What I am hearing from the Humboldt community paramedics is they might go do a well-check or they might go check to see if a person really needs to go on an EMS ambulance ride. There is a little different description of what is actually happening in the two areas.

Jim Gubbels:

There is a distinct role difference between a home health nurse and a community paramedic. That is why we have had conversations all along with the State Board of Nursing, to make sure they understand the scope of a paramedic versus the scope of a nurse. For instance, wound care is a role for a registered nurse because most of those wound care situations will be decubitus or care where they have to irrigate into a wound. That is above and beyond the scope of a community paramedic and, at this point, IV antibiotics is not something a community paramedic would do.

Community paramedics follow patients who are discharged from the hospital. Say their primary physician is a cardiologist and this patient has congestive heart failure. There are certain protocols that we would follow to provide follow-up care for that patient. One of those protocols is to look at the weight of that patient. If that patient is gaining weight, then that means they might have to be readmitted to the hospital. Then we can give diuretics to that patient to get rid of that weight gain. We will ask the patient what they have been eating the last two days. We may find they were on a high-sodium diet, so we need to go through and reeducate that patient as to the types of foods they cannot have with their medical condition because we cannot allow that extra sodium that will result in weight gain. There are written protocols that we would follow in that person's care.

Assemblywoman Titus:

I support the concept. We need to keep thinking of ways to use all of our health care providers when we are so short of them. I like good imagination and new thoughts on how to use the people that have these skills. I want to make sure we are not pushing this way then pushing out another group that has worked hard to stay alive and stay afloat, like home health nurses and other areas that have struggled. We lost our home health services in Yerington because they could not get reimbursed, so I worry about some of those issues. I appreciate your wanting to make sure that we have "all hands on deck" to best use all these trained people that we have to the maximum of their ability. I am on board, I just want to make sure that we have good dialogue and that we are making sure what the roles are and where this is heading.

Bradford H. Lee, Medical Director, Regional Emergency Medical Services Authority, Washoe County:

As part of the partnerships, before we launched any clinical part of this grant, we met with home health, the American Nurses Association, providers, emergency medical doctors, and almost anyone we thought would have a stake in the game. We explained what we were doing and how it would affect them and we got buy-in from everybody.

In terms of home health, we do not tread on any home health turf. In fact, the home health people refer to us to do things that are outside of their purview, so we have had no problem to date with them at all. They asked if they could refer more patients to us. We took their patients with the five highest-cost diagnoses that have a great 30-day recidivism rate, which costs the hospitals the most money in fines, and those are now scheduled patients we enroll and take care of.

Assemblyman Jones:

I like that you are following up and evaluating your success because so many programs do not think about that. You estimate that you saved \$5 million. Is that a cost of \$10 million and you saved \$5 million, so you actually lost \$5 million? Or did you save money on top of the grant?

Bradford H. Lee:

Since we were given no guidance, we used hospital charges and costs on our initial calculations. We got the information from UNR which used actual specific data from Washoe County and specific hospitals. We calculated those cost savings at approximately \$14 million, then we took the 35 percent rate and that translates to payments, so that is how we got the \$5 million. That does not even include Medicare Part B, so that is \$5 million in payments and that is gross payments.

Assemblyman Jones:

So you spent about \$10 million to save \$5 million?

Bradford H. Lee:

Actually, no. To date, we have spent less money than our cost saving in terms of payment.

Assemblyman Jones:

You are positive on the savings then?

Bradford H. Lee:

Yes.

Assemblywoman Benitez-Thompson:

I wanted to ask about the management of your resources while you were doing this grant because I know you only have a fixed number of ambulances. What was the process by which you would delegate resources for 911 calls, home visits, and the program requirements of this grant?

Jim Gubbels:

Those are two distinct services. The ambulance and the 911 side has its own paramedics and its EMT intermediates that we use. The community paramedicine side is a separate division and that is why we have hired eight additional paramedics with additional training that we offered them. They are the only ones that operate the community paramedic program.

Chair Oscarson:

It appears in some instances that your program was grant funded, where some of these others who have tried this work have had to utilize the existing services that they have. You have been very fortunate to have that opportunity, and I think that the synthesis of those different ways that it has been done certainly lends itself to looking at how that model could be best utilized.

Jim Gubbels:

Yes, I believe that is where REMSA comes in. What we have found is all three of these interventions flow into each other. Say you call the nurse and the nurse recommends a different care that avoids an ER visit or ER transport by an ambulance. The community paramedic is able to follow you post-discharge to really help you understand your illness and keep you from being readmitted. By doing all these things at once, we are able to demonstrate cost savings for the community versus just one intervention.

Chair Oscarson:

Obviously smaller communities and rural communities are not going to have the kinds of resources that you have enjoyed. Tonopah may not have the kind of resources that you have, but the collaborative effort of everybody giving their input to how this is going to work is what the successful model will be written after.

Jim Gubbels:

Right now this grant is just servicing Washoe County, but there is no reason the nurse health line could not service all of northern Nevada. We believe that is where it needs to grow so that even a smaller rural community could still have the nurse health line services through that central location at REMSA.

Assemblyman Sprinkle:

What I have heard so far is the only way that community paramedics can be sent somewhere is through an appointment and it has to either go through a medical director or their primary care physician. Is that correct?

Bradford H. Lee:

Are you asking if our community health paramedics go out only with the direction of a physician, a primary care provider, or the medical director?

Assemblyman Sprinkle:

Yes, that it must come from the primary care physician or a medical director.

Bradford H. Lee:

Let me be specific. During the briefing we talked about the three interventions that our community paramedics participate in. When they have scheduled visits, that is with the knowledge and the agreement of the patient's primary care provider, so no one initiates that visit because that is on a scheduled basis. If they call episodically, that is with the knowledge and request of the primary care provider. Did that answer your question?

Assemblyman Sprinkle:

No, actually I do not understand. If somebody is having an issue and they called the nurse health line as opposed to 911, that is not through their primary care physician, that is simply because all of a sudden they are having some type of symptom.

Bradford H. Lee:

Currently our community paramedics are not dispatched through our nurse health line.

Assemblyman Sprinkle:

I must have misunderstood you during your presentation because I thought you said that that was part of the process that allowed us to divert patients from going to the hospitals.

Bradford H. Lee:

Correct. You are talking about the nurse health line?

Assemblyman Sprinkle:

Yes.

Bradford H. Lee:

What that means is the nurses, based on their protocols, can either refer to the ER, order up an ambulance, send the patient to the primary care provider, give them at-home instructions, or they can give them some other point-of-care instruction. They can do all that if they do not need an ambulance.

Assemblyman Sprinkle:

I misunderstood, I thought community paramedics could also be dispatched.

Bradford H. Lee:

We are not doing that currently.

Assemblyman Sprinkle:

Are there other grant recipients or other programs in the state of Nevada? I am curious as to why there are only northern Nevada representatives here right now.

Jim Gubbels:

For this first round of health care intervention awards, REMSA was the only one that received an award. There were some second round awards. One of them went to a physicians group that was to help educate nursing home nurses on when to activate the 911 system. But Nevada was the only one on that first round to receive it and that was REMSA. Remember there were only 107 across the nation out of 3,000 applicants.

Assemblyman Sprinkle:

Just to clarify, the only organizations that are providing community paramedicine right now in Nevada are REMSA and Humboldt General Hospital?

Jim Gubbels:

That is correct.

Assemblyman Sprinkle:

What I have heard right now is that depending on the medical director's level of training, say at Advanced Life Support paramedic level, that medical director can determine whether or not they wish to participate. I have heard from multiple agencies that provide paramedic level service that if they get the level of training through Colorado that has been described, maybe someday it will be mandated through statute. Is this something that you foresee as having multi-agency participation to increase the amount of medical coverage that is provided to these recipients?

Jim Gubbels:

I believe we need to move this forward for the entire state. That is why we had a lot of conversations with Las Vegas. I believe we will see a proposed bill that will help enable this to work through the *Nevada Revised Statutes* (NRS) Chapter 450B so that agencies can apply and provide these types of services provided they meet the criteria. The criteria covers education, protocol, medical direction, and that you report your findings and data back to a state EMS office. That is what we are moving toward. Initially, it should be on the paramedic level because that is where the national training is now. As that training changes to EMT Advanced and, with regulation, we move those paramedic pieces in too. Other places like Yerington that do not have paramedics would be able to provide education at that level and serve to that level, as a community.

Assemblyman Sprinkle:

I appreciate that. With my background and training, I will be very interested in seeing that bill and probably participate very closely with it. I represent the City of Sparks and parts of Reno. Since you have been the driving force in this, I am wondering what your vision is for northern Nevada and the constituents that I represent, specifically.

Jim Gubbels:

I see community paramedics as being able to grow no differently than trauma center designation does. You apply and follow the rules and regulations, and then provide the service. I do not see this limited to one agency or two agencies, I see this as a continuum of care ongoing for a community.

Assemblyman Thompson:

My question goes back to the frequent users of the system. In southern Nevada, we have a huge homeless population, and I am sure they will be part of these frequent users. We have studied the issue for years. What I would like to know is if you have additional data on the frequent users that you have served. How much of it becomes a diversion? You mentioned Northern Nevada Adult Mental Health Services and the community triage center.

Jim Gubbels:

I believe it is broken down on our hotspotters. A lot of the time these patients call 911 because that is all they know. A lot of their needs are social needs and even shelter needs. If we can get the right patient connected to the right primary care, whether it is a clinic or social services, then we can eliminate their reason for calling 911. It is difficult and you are not going to win every time and with every patient, but even 1 out of 10 patients that we can get to utilize

a different social service or different community service versus always calling for the ambulance service, is still a win overall for health care costs.

Assemblyman Thompson:

On the other end, do you do preventative work? For example, if you see a homeless person on the streets, do you go to their aid and try to use that whole process? Or is it basically triggered around phone calls?

Jim Gubbels:

With our Hot Spotter system, we look at those patients that are using our ambulance service now. We have access to their medical records and that way we can determine what patient may benefit from a home visit and an overall review by the community paramedic. Thus, it is not every patient every time because a lot of those patients do not have an address. Some of those patients will not qualify because we do need to be able to have access to them.

Chair Oscarson:

Assemblyman Sprinkle, I would like to answer your question. I know for a fact that there have been people from Las Vegas Fire and Rescue, Sarah McCrea and Rusty McAllister, and I see state EMS and Medicaid representatives in the audience. I think we are paying close attention and there are a lot of people paying close attention to what is going on here. I am in total agreement that it would be nice to see a statewide system. I think that is the only way it will work. We have some great people who have done some great research for us.

Assemblywoman Titus:

You said you have access to medical records. When you have these people that call 911 so many times and they go through the REMSA system, do you keep track of the number of calls they have? When they dial in do you have a phone number attached to a record that now says, "this call has been made from this number five times"? How are you keeping the records on these people?

Jim Gubbels:

All of the records we do out in the field are electronic records. We can go in and query a name, see how many times they called, and see what they called us for.

Assemblywoman Titus:

Are those records viewed by dispatch? Are they viewed by you? Who is seeing those records?

Jim Gubbels:

We can do it a couple different ways, but the main way is doing it through our clinical services, which monitors how well we perform. Then they can also monitor the volume of calls that we have to a patient, then come back to us to say, "Let us put this person in for a home visit."

Assemblywoman Titus:

I understand the connection when someone is being discharged that you can then establish the program; that is an easy segue. When you pick up patients that are in the community, is there a follow up if that patient has made so many calls? Does somebody say, "This person has called ten times in the last month, maybe we need to do a home assessment?" Do you self-refer, and is that how that works?

Jim Gubbels:

In this case, this person is already an existing patient for REMSA, so we can do that because they have already signed a consent for treatment.

Assemblywoman Titus:

That is what I wanted to hear, that they had already consented to you following that information.

Jim Gubbels:

You are correct.

Assemblyman Araujo:

Do these programs offer services in various languages? Can the nurses speak various languages? Are they able to take on those calls should they consider that?

Jim Gubbels:

Currently we always try to recruit bilingual nursing staff whenever we can. It is difficult to do so. We use the language line right now, so we would do a three-way connection in order to be able to still help those calling parties that do not speak English.

Chair Oscarson:

Thank you for your presentations; we appreciate it. I will now close the presentation on community paramedicine, and I will open the floor to public comment.

Dan Musgrove, representing Southern Nevada Health District:

I want to assure you and those southern Nevada legislators that the Southern Nevada Health District, which is the state's designee in Clark County to handle EMS and trauma within the borders of Clark County, is the designee that sets up all the protocols for all of those first responders that we have been talking about today. We have had a series of meetings already in southern Nevada at which all of the agencies that participate in EMS have been present. The government fire departments and the private ambulance companies have been a part of those meetings. It is led and chaired by the Southern Nevada Health District because that is our role. They have asked us to be the point person in interactions here at the state as we work towards coming up with legislation.

We want to make sure that we have the opportunity to work collaboratively to put together the protocols that we need in southern Nevada that might be different than what Washoe County or Humboldt County needs, and that is what we are working on today. Everything that was said today and the questions that were asked are exactly what we want to work through collaboratively to make sure that we have one more tool in our toolbox and to make sure that we get health care to our citizens, because that is really what it is all about. There is a lot of unmet need in our community, whether it is Mr. Thompson's homeless community or frequent service users. This is not looking to replace or supplant anybody, it is to add another resource of some very qualified people in our community that could help. Southern Nevada is very much a part of this discussion and those that went before me today have been such leaders in this, and I want to thank them personally, as well as the Chair.

Rusty McAllister, representing Professional Fire Fighters of Nevada:

On behalf of the 17 fire department locals that I represent, we certainly would welcome the opportunity to participate in any discussions and legislation that will move forward. This is a fantastic opportunity for all the fire departments to at least have the opportunity to participate. Some may not qualify based on the level of service that they provide, but others definitely will. In southern Nevada where we run the most EMS calls in the state of Nevada without a doubt, this will certainly be an opportunity for us to decrease the workload and number of people that are showing up in our emergency rooms.

The fire station that I currently work at is in Assemblyman Trowbridge's district. We do some of this in southern Nevada to some degree, at least in the area I work. You mentioned Sarah McCrea. She set up a program where she went to the University of Nevada, Las Vegas and got students that were interns in the social services programs. As fire department representatives or paramedics, we go out on calls for people in our neighborhood because we are all centrally

located, and when we identified patients that need help beyond just the emergency or the reason they called us to begin with, we let them know that we are going to refer them to our community outreach person and they will set up an appointment for one of the interns from social services to come out and meet with those people. They help get them set up with the services they need, whether it is home health care, a home health care nurse, or other assistance in some form for those people to get help in their homes so they do not have to access the emergency medical services all the time and do not end up in emergency rooms. This is a great opportunity for all the fire departments in the state, being centrally located as we are, for them to participate and be a part of this program.

Joan Hall, President, Nevada Rural Hospital Partners:

The Liability Cooperative of Nevada (LiCON) is a self-funded risk retention pool for public and nonprofit hospitals formed under NRS Chapter 277.055. We have been in force for 25 years, so it is not a fly-by-night type of little insurance company. A little more than two years ago, when I heard about Humboldt's program, as a nurse and a former hospital administrator my back went stiff and I thought, "Oh, those guys are encroaching upon my territory." We insure Humboldt County. When they wanted us to look at this program, we vetted them and did a very critical underwriting process. We looked at their scope, medical direction, risk management program, quality assurance, incident reporting system volumes, and everything that they were proposing. We made sure they had policies and procedures. We met with these two fine gentlemen who testified today, their Assistant Chief Lacey Parrott, their administrator, and their medical director. We really vetted this program and I thought, "This is really pretty cool."

As a nurse and as a hospital administrator, I think health care is at a crossroads. We need to have some paradigm shifts. We are looking at the fact that we do not have enough professionals to do what we need, and Humboldt is fortunate that they were able to financially provide this service without any reimbursement. They also have an Adam story. When we talked with them, they told us about those people who had multiple calls or multiple emergency visits that just needed that gentle touch—somebody to go out to check on them and make sure that their welfare was okay. These guys do a great job at what they do. I think it is also important for everybody to realize there is a national movement towards this. I think REMSA getting their grant was in the forefront. Humboldt General Hospital has been also looking at education and criteria that is required, and have done a great job with that. We think that it is a wonderful program. We are encouraged that it is there in rural Nevada.

Assemblywoman Titus asked about home health. There have been some issues with that. In Humboldt County and some of our more distant rural areas, people live hundreds of miles away from hospitals or from a home health agency. Medicare also has very stringent criteria for someone to qualify for home health services. You have to be homebound, and meet certain intensity of service and severity of illness. Many of these patients do not meet that, so home health would not be able to provide them care anyway. But Humboldt General Hospital goes out there and checks on them, making sure that they are not taking both furosemide and Lasix, and that they understand they are the same medication. They do those medication reconciliations. They can do blood sugar checks on the repeat diabetic patients that they were seeing in their ER time and time again. It has been truly a wonderful program in Winnemucca and the surrounding areas. Battle Mountain has used their product and is developing their service in the same manner. In Nye County, they are looking at such a product for Tonopah. We think it is something that certainly deserves more attention and we appreciate you hearing us.

Chair Oscarson:

Thank you.

Patrick T. Sanderson, Private Citizen, Carson City, Nevada:

I want to thank everyone for getting together because by getting together you come up with more ideas. More ideas make things better if you implement them.

I have lots of family up in Humboldt County and they are all miners. The mines have their own clinics that you can go to if you do not have a hospital that you can get to. In other words, you do not have to go to the emergency room, you can go directly to the clinic to get a lot of the health care. These people have an access to health care especially if they worked in the mines. I was born and raised in rural Nevada, and there are a lot of counties that are not this lucky. Whatever we can do to bring this forward and to make it statewide is a better thing. Without these ideas, we would be 50 years back. Thank you for bringing these ideas forward.

Chair Oscarson:

Thank you for your comments. We have heard some great ideas and great thoughts, and we appreciate the time you have spent to be here. Any comments from the Committee? [There were none]. The meeting is adjourned [at 3:19 p.m.].

RESPECTFULLY SUBMITTED:

Nancy Weyhe
Committee Secretary

APPROVED BY:

Assemblyman James Oscarson, Chair

DATE: _____

EXHIBITS

Committee Name: Committee on Health and Human Services

Date: February 16, 2015

Time of Meeting: 1:34 p.m.

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
	C	Louis Mendiola / Humboldt General Hospital	Community Paramedicine Program Presentation
	D	Jim Gubbels / REMSA Community Health Programs	REMSA Community Health Programs Presentation