# MINUTES OF THE MEETING
# OF THE
# COMMITTEE ON HEALTH AND HUMAN SERVICES

## Seventy-Eighth Session
## March 11, 2015

The Committee on Health and Human Services was called to order by Chair James Oscarson at 1:38 p.m. on Wednesday, March 11, 2015, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4404B 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 John Moore
Assemblywoman Ellen B. Spiegel
Assemblyman Michael C. Sprinkle
Assemblyman Tyrone Thompson
Assemblyman Glenn E. Trowbridge

**COMMITTEE MEMBERS ABSENT:**

Assemblyman Brent A. Jones (excused)

**GUEST LEGISLATORS PRESENT:**

None

**STAFF MEMBERS PRESENT:**

Kirsten Coulombe, Committee Policy Analyst
Karen Buck, Committee Secretary
Jamie Tierney, Committee Assistant

**OTHERS PRESENT:**

Caleb Cage, Director of Military and Veterans Policy, Office of the Governor
William Caron, Associate Director, VA Southern Nevada Health Care System, U.S. Department of Veterans Affairs
Lisa M. Howard, Acting Director, VA Sierra Nevada Health Care System, U.S. Department of Veterans Affairs
Robert B. Yang, Health Care Systems Specialist/Rural Health Coordinator, VA Sierra Nevada Health Care System, U.S. Department of Veterans Affairs

**Chair Oscarson:**
[Roll was taken. Committee rules and protocol were explained.] We have another Committee bill draft request (BDR) introduction today. Bill draft request 38-193 was requested by the Interim Committee on Child Welfare and Juvenile Justice. This measure revises provisions relating to foster care. I will entertain a motion to introduce BDR 38-193.

**BDR 38-193**—Revises provisions relating to foster care. (Later introduced as Assembly Bill 268.)

ASSEMBLYMAN THOMPSON MOVED TO INTRODUCE BDR 38-193.

ASSEMBLYWOMAN BENITEZ-THOMPSON SECONDED THE MOTION.

THE MOTION PASSED. (ASSEMBLYMAN JONES WAS ABSENT FOR THE VOTE.)

**Chair Oscarson:**
As many of you all know, health care is an important topic to me, especially on this Committee and in particular, for veterans who have served our country. We have in our midst several experts on those subjects today. I felt that it was very important to have a discussion on what health care services are available to our veterans, and I appreciate several of these folks readjusting their

schedules and making time to talk to us on this Committee. I do not know if the U.S. Department of Veterans Affairs (VA) has testified before the Committee on veterans' health issues and policies. We appreciate their taking the time to do that. First, we will hear about the Veterans Rural Health Advisory Committee from Caleb Cage, who is the director of Military and Veterans Policy for the Office of the Governor. We look forward to hearing from him. After that, we will hear about the medical services offered by the U.S. Department of Veterans Affairs. William Caron is down in Las Vegas. He is the associate director of the VA Southern Nevada Health Care System, and Lisa Howard, acting director of the VA Sierra Nevada Health Care System. We have the whole state covered.

**Caleb Cage, Director of Military and Veterans Policy, Office of the Governor:**
Thank you for opportunity to present on VA rural health in Nevada from the perspective of the Rural Health Advisory Committee for the U.S. Department of Veterans Affairs. Also, thank you Chair Oscarson. It is always a pleasure to work with your very competent and excellent staff. Although I do have a position here in the state of Nevada, due to my work with the Nevada Department of Veterans Services, previously with the Nevada Office of Veterans Services and the Office of the Governor currently, I have been selected to serve as a member of the VA's Rural Health Advisory Committee. This is a group that is appointed by the Secretary of Veterans Affairs for two-year terms. We meet at least twice a year in person and oftentimes via telephone as well. I will get into the make-up of the committee in a minute and what we do. More important than what this small committee does is what the VA's Office of Rural Health does. Created in 2007, it is a fairly new entity office directorate within the VA in Washington, D.C. They have a national reach and are doing some cutting-edge work for delivering health services to rural veterans.

[Mr. Cage read from slide 2, (Exhibit C).] The VA's Office of Rural Health within the VA was established and funded by the U.S. Congress in 2007, and as I just noted, the Veterans Rural Health Advisory Committee was established in 2008. I have been on it since 2012. It is a very interesting, diverse group that comes together to try to make recommendations to the Secretary of the VA. There are 16 members in the group. Every year we make recommendations to influence priorities, policies, and structures of health care delivery systems in rural communities throughout the country. One of the reasons I worked to get on this committee was because there was a call by various committees from the VA to bring state directors into the Secretary's advisory committees, based on a memorandum of understanding (MOU) with the National Association of State Directors of VA. I chose to compete for participation in the Rural Health Advisory Committee obviously because

of Nevada's rurality and what I thought we could bring as a voice to their discussions. In the past, those recommendations have included conducting research for a nationwide rural health needs assessment. That happened before I was on there, but the document is still accurate and necessary going forward. There is a lot of focus on it throughout our committee and commission meetings.

Telemedicine is one of the major focuses for VA rural health. In fact, through discussions that I have had with the private sector, the U.S. Department of Defense, telehealth providers, and people in that field, they have said that the VA is cutting edge in this phase, and it has to do with the VA's vision of trying to serve veterans as close to their homes as they possibly can. We get into some of those assets in the state here as well. Most recently, our last set of recommendations was really about what the states and local communities could do to enhance service deliveries and service provider coordination at the local level. That recommendation actually was based on some model work we have developed here in Nevada. The City of North Las Vegas Veterans Services Commission was the first in the state to establish one. We are influencing the national dialogue in that sense as well.

[Mr. Cage read from slide 3.] These are specific needs, based on that rural health needs assessment conducted earlier in 2009, that were identified for veterans in particular living in rural places. That aligns with what we are trying to do for veterans here in the state of Nevada.

[Mr. Cage read from slides 4 and 5.] Enrolled rural Nevada veterans use sites across the state to access medical care outside of the 3 main hospitals: 19 in eastern Nevada, 21 in western and northern Nevada, and 22 in central and southern Nevada. One of the care sites that did not make this list is the George E. Whalen VA Medical Center in Salt Lake City as well, which is accessed by many veterans in northwest Nevada.

A note on the Elko community-based outreach clinic is that, to my knowledge, it was one of the first in the nation to have established the telehealth system. They had a nurse who traveled to that outreach clinic in Elko on a regular basis and would assist the veterans with the telehealth equipment and help them through that. They would be communicating with a doctor or service provider at the George E. Whalen VA Medical Center in Salt Lake City. It has been a very much-appreciated service provided there. Since then, the Las Vegas Valley Health System, open since August 2012, has developed a robust telehealth outreach network as well, including signing a MOU with the Nevada Department of Corrections so that they can do telemedicine with incarcerated

veterans as well. This is an absolutely fantastic model that is being seen as a national best practice.

Slide 6 is about the VA's Office of Rural Health. This is the advisory committee that I sit on. They have a director, three centers across the country in Salt Lake City, Iowa, and the East Coast, as well as their office in Washington, D.C. They do a lot of work on developing systems and approaches that have to do with telemedicine and telehealth. They operate or work with the VA service providers in ensuring they can implement those systems. They have medical doctors and research professionals on staff to develop promising practices that have been implemented across the country. They have been primarily responsible for the implementation of the Veterans Choice Program, which was established through the Veterans Access, Choice, and Accountability Act last year. They also are a grant management agency in various degrees. They run the Rural Veterans Coordination Pilot Grant Program. They operate five $2 million coordination pilot programs that have been established nationwide. They also work on other grants, several of which Nevada has competed for and received, including rural transportation. [Mr. Cage continued reading from slide 6.]

We did not list it on this slide presentation, but they have also provided money for Nevada to develop what we are calling the "Veterans Information Database" where the Department of Motor Vehicles can share the geographic information on veterans so that we can know what our veteran distribution is statewide. Veterans can log on and update their own information as well. It has been an effective model in Utah, and we are trying to develop it here in Nevada as a way of determining exactly what our veteran population is. The U.S. Census says it is 224,000, but we think it is a little higher than that. What is the distribution by ZIP code? What are the sorts of things that we can do to drive future resources here in Nevada?

The last slide [slide 7, (Exhibit C)] has goals on it, and I think it speaks for itself in promoting health care, generating and diffusing knowledge regarding rural health, and so on. It is about the Office of Rural Health's mission. I am happy to answer any questions.

**Chair Oscarson:**
You said Clark County, Lincoln County, and Nye County are the top three for the 19 percent in rural Nevada. Do you have that broken down any further than that, by county or another way?

**Caleb Cage:**
I actually have some census data that breaks it down by county. I will be happy to share that with staff.

**Chair Oscarson:**
That would be great. For the Committee's knowledge, my experience with Mr. Cage, while he was doing the job that Katherine Miller is doing now and what he continues to do for the Office of the Governor, has been a tremendous resource to me for veterans' needs and concerns, as has Katherine Miller and her staff. We are grateful for having that representation by both of you for the state of Nevada. It truly benefits those who deserve these services and care. You, as a veteran yourself, and Ms. Miller, who is also a veteran, are passionate about those services being offered in a timely, consistent manner to our veterans. For that, I am very grateful. I encourage the Committee members, if you have concerns about any veterans' issues that come up in your areas, please make sure you contact Ms. Miller, and she will get you in the right direction. Usually within an hour, your veterans have a call back about their issues and their concerns.

**Assemblyman Trowbridge:**
How many veterans are there in Nevada?

**Caleb Cage:**
Currently the census data is right around 224,000 to 225,000. It is declining right now.

**Chair Oscarson:**
In our area in Nye County, we have a significant number of homeless veterans. Do you have any data that shows how many of the veterans are actually homeless and are living in the desert and in other areas? They really need to work with some of our folks to help them with that.

**Caleb Cage:**
We happen to be sitting with one of the foremost and knowledgeable members of the service provider community for people who are homeless in the state of Nevada—Assemblyman Thompson. We worked very closely with him on some issues in the past. I know that Director Miller has conducted a veterans' homelessness study in the state of Nevada, which is in the back of the Nevada Veterans Comprehensive Legislative Reform Report. I do not have that information, but the Department of Veterans Services might.

**Chair Oscarson:**
We will see if we can get it.

**Assemblyman Thompson:**
Every year, we have a homeless census in southern Nevada. We orchestrate it at the same time as northern Nevada. We conducted it the last week of January of this year. Those results have not come out yet. Usually, it is very extensive. We actually go out to try to find our homeless veterans, and we get a lot of demographic information. That is not available for the 2015 count yet, but we do have the count for 2014, so if you need to get that information, we can get it.

**Chair Oscarson:**
That would be great. Mr. Cage, thank you again for your service to the state of Nevada and to our country.

**William Caron, Associate Director, VA Southern Nevada Health Care System, U.S. Department of Veterans Affairs:**
Unfortunately, Isabel Duff, the director of Southern Nevada VA Medical Center, sends her regrets. As of Friday, she had to go on some unexpected leave, so she will be gone for about a month. In anticipation of that, she let me know about the Assembly agenda and the Committee on Health and Human Services. My preparation has a focus on our Veterans Integrated Service Networks (VISN) in rural and highly rural counties (Exhibit D). I have been here about eight months, so if there are any questions I cannot answer, I will certainly get the answers to you and to the Committee in a timely manner. One of the things that drew me to Las Vegas was the fact that it is an extremely veteran-friendly state, and I was excited about working with the team in the new medical center. We went from a very fragmented system with multiple outpatient clinics to having this "diamond in the desert" of a health care system with four primary care clinics that were begun in 2010 through now, including the Southern Nevada VA Medical Center, which activated in late 2012.

In terms of presentation, our catchment area is predominately Clark County, Lincoln County, and Nye County officially (referred to slide 2). We are part of that VISN network that was spoken about by Mr. Cage. Enrolled veterans have been growing at a significant clip, greater than 10 percent per year and a pace greater than 10 percent this year as well. Our highly rural and rural veterans comprise about 10 to 15 percent of the actual services that we provide. The penetration is always interesting with those veterans because, typically, about 60 percent of veterans utilize our services in a more urban area, but it shoots up to around 75 or 76 percent in the rural and highly rural areas. It goes to show that if you bring those services to those veterans, they certainly do utilize them. The highly rural areas have stayed flat in the 2,600 range of veterans that we are seeing, whereas the rural areas have continued to grow over the last two fiscal years (FY) from 4,400 to 4,700 up to 5,200 this last

FY 2014. Our predominant highly rural areas, as was mentioned earlier, are in Pahrump as well as in Laughlin.

Slides 6, 7, and 8 focus on Pahrump (Exhibit D). Pahrump is about 72 miles from the medical center in Las Vegas proper. The drive time is a little over an hour to an hour and a quarter. In that Nye County area, there are about 7,500 veterans. Pahrump itself has about 6,400. In FY 2014, we treated 2,400. Unfortunately, that clinic is rather small, and we have been appealing for a full-scale Community-Based Outpatient Clinic (CBOC) and an expansion out there for quite some time. However, that continues to be an internal review process between the Veterans Health Administration and contracting. We are hoping to have an update on that soon. However, within the current CBOC, there are three providers out there, providing a wide variety of services that you would see in a traditional primary care clinic, including primary care, women's health, social work, pharmacy, lab, phlebotomy, radiology, and imaging. We do utilize a contract with Desert View Hospital, and as Mr. Cage mentioned, the telehealth services are nothing less than cutting-edge. Audiology, dermatology, mental health, nutrition, pain, psychiatry, and even retinal care are provided via telemedicine. That is a tremendous asset in that rural area. The intention is to get a "build to suit" lease, expanding us from the current 4,700 square feet to 10,000 square feet. We anticipate an 8- to 10-month construction after the lease is awarded. That contract, as I mentioned, has not been awarded yet. It is still under internal review.

Slides 9, 10, and 11 have more exciting news in Laughlin (Exhibit D). Laughlin sits right on the border and, of course, Bullhead City, Arizona, is right next to there. In that area, we have about 7,000 veterans, and we have treated about 1,500. The only reason we have been able to treat them is because they have been going up to our southeast primary care clinic. Many of the Arizona veterans use the Kingman primary care clinic, but we had a mobile clinic set up in partnership with the American Legion up there. That has worked out tremendously well, but we were finally able to open our outreach in February of 2015, just last month. We did the groundbreaking, and now we have a provider out there. We are providing primary care and social work. It is not the full scope of services you would see at a CBOC, but hopefully that is the next step for us.

One important note that was not mentioned earlier is the volume of transportation that occurs with those rural areas. There were 1,300 Pahrump veterans transported back and forth between the medical center and Pahrump and approximately 850 Laughlin veterans in FY 2014. There is a tremendous amount of effort between the veterans' transportation service and our Disabled American Veterans partners to provide that service. That is a quick snapshot

of our facility and what is going on in the highly rural areas. I can expand upon that and am open to any questions from the Committee.

**Chair Oscarson:**
I have had multiple conversations with Ms. Duff, and I want to put this on the legislative record that I have been personally working for four years to have a veterans' clinic in Pahrump, and I am sure you may know some of that historical background. My veterans in that area, the numbers that you mentioned, consistently have to go other places for service because of the limited things that the clinic can currently do. As you know, it is a double-wide modular that has been evacuated more than once for significant issues of mold and all kinds of other things. I feel our veterans deserve better. At a higher level than our state, this project has been put on the bottom of the pile for long enough. I look forward to working with you and Ms. Duff to see this project come to fruition in the near future. At least put up a sign telling us where it is going to be. At least give our folks some hope because they have pretty much lost hope by now. Every time they are told a date, it is "In a couple of months, we are going to put a sign up. In a couple of months, we are going to turn shovels of dirt. In a couple of months, we are going to do this." I recognize the U.S. General Services Administration issues. I have been in constant contact with our Congressional and Senate delegations, who are as frustrated as I am that this continues to go on and on and on the way it has. For the record, I appreciate your update, which is more than we have received for quite a while, so quite honestly, I am grateful for that. However, I want you to know that there are many veterans in that community who are frustrated, angry, downtrodden, and feel like they have been left in a situation where nobody cares about them. For what that is worth, I am grateful that you have been able to give us an update.

The other component that I am very interested in is what you do in southern Nevada for mental health. What are your legal rights regarding your physicians being able to detain folks that come to your clinic? I will ask the same of Ms. Howard when she presents, what those procedures are and how they work. There is a bill working through this Legislature to address that. I am interested to know from your perspective how that works, if you know. If you do not know, I understand because I do not know what your clinical role is, but I would love to hear what that is and what your mental health services are at this time. I know there are some telehealth things going on in the clinics currently. I know that you are aware that there are additional broadband services coming through some of those rural communities that these clinics are in. I look forward to expanding those roles and those services to the communities. If you could comment on the mental health component and anything else that you think we need to know, I would be grateful. I know you

have a beautiful hospital there. If you could tell us about it, including the beds and the services that are currently being offered, that would be great as well.

**William Caron:**
I do have some information about mental health. It will be more broad-brush versus specifics. In my background, I am actually a veteran of the United States Air Force. Dad was a veteran. Grandpa was a veteran. I spent some time in the private sector, and then I was the associate director in the Upper Peninsula of Michigan where it is wintery about six months of the year. I spent about four years there and recently relocated here to Las Vegas. Our biggest struggle of the mental health issue, the Legal 2000, or L2K issue as we call it, is the capacity versus demand. At any given point in time, we have 15 to 20 inpatient veterans that are in the actual mental health unit, and we have anywhere from 15, sometimes more, out in the community. Many of those are under the L2K-mandated holds. In terms of the progression and operations, we have not had any recent trouble. When I first came on board about eight months ago, there were some problems, but those were worked out between the state and the VA. I have not heard anything new in the past several months on any issues with our L2K population. As I said before, the biggest problem for us is, frankly, capacity and demand. We have already worked into our capital investment program in the out years on how we are going to accommodate those inpatient needs.

I would like to add a few more comments about Pahrump. I got to meet quite a few of those people at a town hall recently, and I partnered out there and had some great dialogue with Veterans Service Officers (VSO) as well as some of the veterans. Your comments are well noted. I find it to be infuriating, frankly, and we have been pushing at the network level, as well as nationally, to get some consistent updates. I understand that there needs to be any removal of bias, and I know the process has many steps that need to occur. However, it is downright infuriating that we cannot provide the services that we need out there. That is a commitment of mine, as well as Ms. Duff, to keep that perseverance of time and pressure going in the right direction, so that we can give them the services that they need.

Your comments certainly do not fall on deaf ears here in Las Vegas. I am very proud of the group that is here with all the growing pains, the capacity and demand that we talked about, and the lack of the medical school and people graduating here. Doctors tend to practice where they have trained, so that is an issue where we have a very low population of physicians per capita here in southern Nevada. That is of concern. Recruitment retention efforts in making sure that people are practicing to the highest scope of their license are important for us. I am prepared to take any other questions at this time.

**Assemblyman Trowbridge:**
You categorized unique veterans. How are they defined? What is a unique veteran?

**William Caron:**
A unique veteran simply references a unique social security number that is brought into our system. That is tracked at the network level as well as the national level. It gives us a quick snapshot of how many people are utilizing our services.

**Assemblyman Moore:**
Where are the L2K inpatient veterans housed?

**William Caron:**
Some are housed right in our inpatient mental health unit at the Southern Nevada VA Medical Center. Also, there are always a handful or more that are being held within the community as well because we do not have the capacity.

**Assemblyman Moore:**
Are they being held at Rawson-Neil Psychiatric Hospital?

**William Caron:**
They vary across the community, depending who has capacity at any given point in time.

**Assemblyman Moore:**
Where can I get that information as to where in the community they are housed?

**William Caron:**
I will provide that information for you. I just need to pull it when I get back to the medical center.

**Chair Oscarson:**
Are you contracted with entities throughout the southern Nevada area to hold those patients, should you have an overflow situation or no capacity?

**William Caron:**
Yes, we have approximately a $450 million budget, and we expend upwards of about $100 million on what we term "non-VA care," which has now become a blend of the traditional non-VA care, the Patient-Centered Community Care (PC3) contract that is administered by TriWest Healthcare Alliance, as well as

the Choice Act that was created that TriWest also administers. Therefore, in large quantities, approximately $100 million a year, we have to use the PC3 contract for inpatient purposes, when appropriate, if they cannot provide the services from a quantity or quality standpoint. Then we go outside of the PC3 network, utilizing Choice in the other community hospitals. On the outpatient side, it depends on things such as what type of capacity we have internally for specialty care. Then we utilize the community for that as well.

**Assemblyman Trowbridge:**
I still need clarification on your definition of unique veterans. If there are people who are being tracked by social security numbers, how would certain veterans be identified to be tracked in that manner? Is it the ones who have injuries or combat experience or what makes them unique to be tracked?

**William Caron:**
I will do my best to answer that question, but we may need to dive into that deeper. Unique in my experience or definition simply refers to a unique social security number. In terms of enrollment and eligibility, the veterans are broken into eight different groups based on priority. The priority groups are how they work through service connections. Where a veteran falls determines the amount of care that we are able to provide for him. A service-connected veteran with "X" percentage of disability would be in a higher priority group than someone like me who came out of the military with no service-connected issues. Does that help explain it?

**Assemblyman Trowbridge:**
It helps a little. I am not a conspiracy nut, but I guess I might be somewhat. There were certain groups trying to track military personnel and put them on the alert list if they had combat experience in the Middle East. I was wondering if those were unique veterans that were being tracked for reasons other than veterans' benefits types of issues.

**William Caron:**
I see what you are saying. That helps clarify your question. My tenure in the VA—approximately five years—has always meant to me a unique social security number. We have registries for different types of therapies and treatments, such as cancer registries, those things that you tend to see in the private sector as well the VA. However, I cannot answer specifically what you are referencing.

**Chair Oscarson:**
Do you mean that, potentially, the unique social security numbers could be related to a specific medical condition, as you referred to before? If you would

get us whatever information you can on what the definition of unique is, that would be great.

**Assemblyman Moore:**
As a veteran myself, I see the VA every four months. Now that you have mentioned a so-called unique social security number, I would also like that information, as I will be looking at that extremely closely.

**Chair Oscarson:**
Do you have any idea how much money you reinvest back into the southern Nevada area from your facility and the services you provide?

**William Caron:**
The best response to that would be, as I commented earlier, about 20 percent of our overall operating budget goes toward non-VA care, which is directly infused into the community. Of that $420 million, I believe we are running right around $100 million at last count.

**Chair Oscarson:**
Perfect. Could you comment on your residency programs? I know we briefly touched on that earlier. We heard testimony from the Department of Health and Human Services that there are some residency opportunities. I do not know if you are working with the universities or the Department of Health and Human Services, but certainly, we in Nevada are very interested in residency programs and being able to maintain physicians in these local areas, so they can serve their commitment to the military and then move out into the communities in southern, northern, and rural Nevada. I think that those are key cohesive efforts that you could work on together with some of our folks from the state.

**William Caron:**
Yes, Chair Oscarson, I do not have specific data in front of me. Dr. Ramu Komandari has been our chief of staff for several years. He works very closely with the University of Nevada, Las Vegas (UNLV), as well as the Southern Nevada VA Medical Center. Every residency slot that we can pull, we have filled. We are adding wherever we possibly can and hoping for more, so much so that Ms. Duff and Dr. Komandari are working with UNLV to help the university as it embarks on getting its medical school opened. I do agree. I think the key to our success is to "grow our own providers," so to speak, here in the Las Vegas Valley.

**Chair Oscarson:**
We would love to work together with you to make sure those things are done. If you could get the number of residencies that you have to the Committee and

the specialties that you are doing right now, that will be beneficial. I know you do dental and other things out there. I have interacted with Dr. Komandari for about five years now. Please give him my regards. I know he is a huge advocate for the veterans in southern Nevada as well. I look forward to working with all of you down there.

**Assemblywoman Dickman:**
Where did you work in the Upper Peninsula of Michigan?

**William Caron:**
It was Iron Mountain, Michigan, which has a small level 3 facility at the VA.

**Assemblywoman Dickman:**
My dad received a lot of treatment there. That is where I am from, so thank you.

**Lisa M. Howard, Acting Director, VA Sierra Nevada Health Care System, U.S. Department of Veterans Affairs:**
The VA Sierra Nevada Health Care System just celebrated the seventy-fifth anniversary of our first site, which was the hospital in Reno, built in 1939. Of course, health care was always very hospital-centered. I will talk about our hospital-based services, then spread out into the community, and lastly go into individual homes (Exhibit E). We have 64 hospital beds, which include 14 inpatient mental health psychiatry beds, as well as the 60 bed community-living center. We have a broad array of inpatient services, diagnostic services, and extensive mental health programming that has really grown over the last couple of years. We do have partnerships with our tertiary support centers in San Francisco and Palo Alto for complicated brain, heart, or spinal surgery. Other than that, we can handle all hospital-based services here in Reno. There are three levels of hospital rankings: level 1, level 2, and level 3. Reno has been classified as a level 2 facility in the VA for many years. On the Undersecretary of the VA's desk right now is a signature page to elevate us to a level 1C. That speaks to the level of services that have grown and expanded in the Reno area over time.

To answer your question about the unique veterans and what that means, it is really a back-office term that the VA has used to distinguish enrolled veterans and veterans who have actually been seen and sought care in VA. We do have veterans who will seek enrollment that just want to know their eligibility and do not try to access VA services, or who are otherwise not eligible for service. In Reno, we have about 44,000 enrolled veterans. We have 32,000 to 33,000 unique veterans, which really means individual veterans who have

sought care in our health care system. That is really all that a unique veteran means: perhaps a poor term, it does not translate well.

On page 2 (Exhibit E) is a map that shows our primary service area. We handle the northern half of Nevada, as well as some of a catchment area over in the northeast part of California. I listed in order of when we operationalized our hospital in the clinics. We started with Ioannis A. Lougaris VA Medical Center that I have referenced. Our first clinic was actually in Auburn. That was our largest base of population in 1998. We are undergoing a contracting process now to solicit a new building. We have grown, and we need to expand the footprint. Of course, we will maintain our operations in the current site until such time that we move.

The next clinic that we operationalized was in Minden, and that has moved several times, most recently just this last year into the Gardnerville area, just a couple of miles away from its previous location. Our third clinic that opened was Fallon back in 2007. I have provided some numbers, and again we have used the term unique—an individual veteran who is actually seeking care, so those are active patients at each of those clinics (referred to page 3).

Susanville, California, was then our next clinic. We have one additional clinic that is termed an outreach clinic because the center of population is a little lower there, but we recognized we needed to have a presence and some outreach there. Therefore, it is termed an outreach clinic, and it is part-time. Other than that, there is no distinction from a community-based clinic. It is the same offering of primary care and support services for veterans in that area.

We have several sites of care in the greater-Reno area, trying to expand and accommodate more services within our hospital and recognizing that we need to take more care out into the community. Therefore, we do have a community based clinic for our eye clinic and a dental clinic that is in a leasing process now and will open late this year. We also have a large homeless program and staff over at the Capital Hill facility [Health Care for Homeless Veterans], an out-based call center, and two additional sites that are in our strategic capital planning process at this time. Hopefully in the next couple of years, we will receive approval to have two more clinics in the greater-Reno area to pull some of the traffic out of our hospital and get those community services closer to where veterans are living. In line with Mr. Cage's presentation on national numbers in terms of the percentage of veterans that are in the community versus larger centers of population, we, too, have about a third of our overall population receiving care in a community-based clinic.

We are now really looking forward to taking care into the home. We can provide a lot of wonderful opportunity in community-based clinics, but it is much more convenient and cost-effective for both the patients and for us to provide care in the homes. I wanted to introduce Robert Yang. He is our dedicated full-time employee as rural health coordinator and telehealth coordinator. That is what he does all day, every day. We have really benefitted from his expertise and the time that he spends to not only train staff and make sure that not only the technology we are deploying is working, but to be proactive and strategic in how we go about planning for those services. If we have time, he did bring a little show-and-tell that perhaps we can look at after the session, if you are interested, just to get a better idea of how compact these packages are, how wonderful the technology is, and what we really can take into the home.

Historically, you have probably heard about home-based primary care where typically a nurse, maybe support staff, will go into the home and provide care to a veteran. We have had the telebuddy program where we have certain complicated patients that we want to track, sometimes on a daily basis, regarding their weight, their blood pressure, or other kinds of diagnostics. We deployed that program many years ago, and now we are evolving into bringing telemedicine into the home in a much more substantial way. Down at the very bottom of the document that I have provided, we have a listing of future telehealth projects [page 4, (Exhibit E)]. Some of those are bringing more specialty care into our Community Based Outpatient Clinics (CBOC) environment, so that patients do not have to travel from Winnemucca to Reno. There is so much that we can do visually for a clinician, for example in Reno, or a specialty-care provider, orthopedic perhaps, instead of driving or sometimes paying a veteran to drive into Reno. We can visualize those needs and provide that care with a telehealth technician supporting the patient in the clinic. We can do those things in the home as well.

I want to briefly touch on the legal hold process. We also observe the State of Nevada legal hold process. It is not ordinary that we have somebody on hold, but it does happen on occasion. Of course, it is in keeping with state law if a patient expresses or a clinician determines that there is potential for either self-harm or harm to others. We go through the usual process downtown to observe patient rights. We do keep those patients safe in our hospital. We do utilize community resources, Renown Health typically, Northern Nevada Adult Mental Health Services, and some of the other local Reno resources. However, we do try to utilize those 14 psychiatric beds in our hospital to the degree that we can. With that, I will close my presentation. I am happy to answer any questions.

**Assemblyman Trowbridge:**
What is a CBOC?

**Lisa Howard:**
It is a Community Based Outpatient Clinic. We might better call it a primary clinic with other support services, typically mental health and some of the other services that I have listed there.

**Assemblyman Trowbridge:**
My other question is what is PACT [page 3, (Exhibit E)]?

**Lisa Howard:**
That refers to our Patient Aligned Care Team (PACT), which is a model of care found in primary care. It is concerned with the supports surrounding the physician and the patient. The typical model is a physician, nurse—often a licensed practical nurse, social worker, pharmacist, and a clerk. The team is that interdisciplinary approach to supporting the patient goals and what it is they can do to support their lifestyles.

**Assemblyman Trowbridge:**
That was a great answer. Thank you.

**Chair Oscarson:**
I am a little overwhelmed with the number of encounters and the things that you do in some of the these clinics and the number of patients that you are actually seeing. What are your staffing ratios in some of these places?

**Lisa Howard:**
The PACT team can handle 1,200 patients. That is a typical panel size, as they call it. At Sierra Foothills CBOC, the top clinic on page 3 (Exhibit E), there are 23,000 encounters that are essentially visits. That is all that means; 3,700 are unique. We are just slightly overstaffed, but not really, because you look for that growth. Overall, we have about a 4 percent sustained growth rate in our health care system. As we see those panels are becoming full, we start recruiting before we get full, and we have been very successful at some of our clinics. We do have a gap in Winnemucca that indicates the scarcity of some of the medical provider resources. We are currently utilizing telehealth and some visits from our physician to cover Winnemucca because we do have a vacancy for that position. However, we have been able to keep that clinic operational. The patients are very satisfied and growing very accustomed to using telemedicine. It has been a wonderful test for us to deliver primary care almost predominantly through telehealth care the last couple of months at that site.

**Chair Oscarson:**
I understand you utilize in some of the rural areas of southern Nevada, services from the rural hospitals, for example, imaging and labs if they are indicated. Are you participating in those same programs with the local CBOC clinics? I know you have Carson Valley Medical Center in Gardnerville, Carson Tahoe in Carson City, the Lahontan Valley CBOC in Fallon, and some of the other areas. I assume you are contracted or using many of their services to help defray the travel expenses of some of these folks.

**Lisa Howard:**
We do, indeed. Our so-called fee program, where we pay for care in the community is about $30 million. It is a small percentage of our overall budget. Our appropriation is about $200 million. That does not include capital projects and other grants that we apply for and receive. We do utilize all the community hospitals, certainly for cases of emergency. A good example would be the CBOC clinic nearest to us and the partnership with the Chief Executive Officer, Susan Davila, at Carson Valley Medical Center. If we have a patient that walks into the clinic and has symptoms greater than we know we can handle, we call 911 and send them to the nearest medical center. Of course, we pay for that care.

We do have another unique partnership that we just signed with the Fallon Naval Air Station to try to have better leverage of federal resources and to partner where we will be providing service to them. They have a very small need for inpatient mental health services, but we feel we are able to meet that need. We did sign a formal MOU for those services. We are now working on orthopedic services. We have been very fortunate to recruit several new orthopedic surgeons in the last couple of years who are doing a great job. Therefore, we are looking forward to being able to help our active duty service members in Fallon as well.

**Assemblywoman Titus:**
I have seen an improvement of attitude and access to our veterans over the 31 years that I have been practicing. There has been tremendous improvement recently. I owe a lot to the veterans who have allowed me to use them, I will not say as guinea pigs because we were more advanced than that. However, I appreciate the veterans that have welcomed me as a student, intern, and resident doctor to be part of their care team. Therefore, I owe lots to the veterans of our country. Having said that and as one of their advocates, I am curious about the wait times for patient appointments. That has been a huge issue nationwide. It was a huge issue in northern Nevada when they made a phone call for getting an appointment and then maybe for a specialty appointment. Do you have any statistics on where we were and where we are

now? I know there has been improvement. Before you answer that question, I just have one other observation. In recent months, for the first time in years, when I have a patient in Yerington and I need to move them to the Reno VA, I deal with somebody who is happy to help me and who gets it done. There is such a wonderful change in the attitude, so thank you for what you have brought to us.

**Lisa Howard:**
We have spent a lot of time working with staff to understand process improvement and everyone's responsibility in improving everything we do. It is kind of like safety is everyone's job, and improvement is everyone's job. The staff has really stepped up to the plate. Right before the national news broke with some of the centers that were under scrutiny for lack of transparency or whatever we want to term that, we had undergone some process improvement regarding new patient enrollment. Those are the unique veterans that are enrolling in our health care system and seeking care. We had at that time up to a 90-day wait time for new veterans. It was extraordinarily frustrating for outreach staff to say, "Hey. We are here for you. We want to you to access our care. Please come and enroll, and oh, by the way, you can wait 90 days for your first appointment." This was simply not acceptable. We underwent a rapid process improvement workshop, if you are familiar with some of the Lean terms. We locked ourselves in a room for a week, and the aim was 95 percent of our patients enrolling and wishing to be seen that day would be seen that day. Within 60 days, we had achieved that, and we have sustained that ever since. That was really through the hard work of the employees.

The other piece to that equation is recurring appointments, specialty referrals, those kinds of appointments. We have diagnostic testing. I have been in and out of the Reno facility for 15 years now, and we have always had a philosophy that if we are not able to provide the care in a reasonable time, then we feed that care into the community. We have always done that, so we did not have extraordinary waits. There was a lot of discussion nationally about what the right metric is. Is 30 days the right wait if you do not otherwise have a clinically indicated time to be seen? Is 60 days the right time? What is that time period? The VA has really pursued 30 days. If we cannot get you seen within 30 days, we need to give you the option to go into the community. We did have a few clinics that were around the 45-day mark, but we have pulled all of those in. However, if we cannot get to you within the 30 days, you can certainly use the Choice Act, or we will otherwise fee you out. We have seen an extraordinary response in terms of the veterans supporting our health care system and saying that they like their providers. Unless there is otherwise a clinically indicated reason to go sooner, they do wait for us.

We are seeing that. I think that indicates the confidence that they have in the staff and our health care system. It has been a philosophy we have had here for many years, and it has served us well.

**Assemblyman Trowbridge:**
The CBOC in Fallon has three PACT teams that are able to handle 1,200 patients, but yet they had 15,477 encounters in 2014. That is pretty amazing data indicating some drastic staffing shortages, I assume.

**Lisa Howard:**
In this case, if you subscribe to the model of about 1,200 patients per panel, 2,400 patients could be seen by two PACT teams. Those numbers fluctuate. You have provider leave and other issues, so we do staff ahead of that. We do not wait until we have understaffing, or we have such enrollment that we are behind the curve in terms of recruitment. It is difficult sometimes with physician recruitment, less so with nursing and other staff members of those PACT teams. However, in this case, they are very sufficiently staffed to handle that workload and to provide coverage for leave and other situations that might arise. I did put a footnote on that Lahontan clinic in Fallon because the outreach clinic is not a full-fledged, full-time, community-based clinic. It is really an outreach clinic; 300 of those veterans are seen in Winnemucca. The beauty of having a little extra room, if you will, in terms of provider coverage, is when we do have a gap in another clinic, those providers help out. In the case of the Winnemucca telemedicine, those providers are helping us care for those patients outside of Winnemucca. Overall, in some areas, it might look low and in some areas, it might look high, but if you work as a health care system, you are able to cover those needs, and it balances.

**Chair Oscarson:**
Are your telehealth services within the state? Are you utilizing providers within the state, or are you using them all over the United States?

**Lisa Howard:**
Generally, they are here within the state, although we do have some support from the Palo Alto VA for a spinal cord injury program. We have had discussions off and on with some California private sector partners. However, there has always been technological differences that have gotten in the way of things, but that is something that we could explore a little further in some of those northern California rural areas within our jurisdiction.

**Chair Oscarson:**
There is some telemedicine legislation coming forward that might help you with that, and again, some of those broadband Internet connectivity issues with

maybe some of the specialists within the state. Certainly, we would like to work with you to help try and use those that are here, if that is a possibility.

**Assemblyman Moore:**
This is more directed towards southern Nevada because I am from Las Vegas. I would like to say that the care that I have received at the VA clinic there has been far superior to any care that I have received anywhere else. It is as good as or better than my private physician that I see regularly as well. The wait times for me do not seem to be a problem. My question then is you had mentioned earlier that for a 30-day wait sometimes if it takes longer, you will refer them to an outside physician. I have experienced that as well on certain issues. What is the additional wait time that some veterans have experienced? The 30 days and then the private physician may make it another couple of weeks, so we are out to 40 or 50 days?

**Lisa Howard:**
We are still a little new with the partnership for the Veterans Access, Choice, and Accountability Act funding and TriWest, and we have found their provider network is struggling like any other health care system in terms of provider development. We have seen where veterans have said I would like to utilize the Choice Act funding, but there is no provider availability. There have been times where we then can get that appointment quicker than private sector in some specialty areas. We are experiencing that. The bottom line for us is if the patient clinically needs to be seen sooner, we will overbook, do overtime, or whatever we need to do if we otherwise cannot get them seen or the community providers are unable to. We really have not had any extraordinary issues in terms of lengthy wait times.

**Assemblyman Moore:**
Great, thank you.

**Assemblyman Hambrick:**
This is more of a background question. Now that some of our veterans are coming back from areas of conflict around the world, what type of injuries are you seeing? Obviously, we all know there are some mental health issues that have been observed when they come back, but can you give some in-depth information on what you are seeing?

**Lisa Howard:**
We are seeing all manners of issues. As you all know, there are multiple deployments. It is not unheard of to hear of four or five or six deployments. That takes a toll on the family unit and the support system, so certainly we see significant mental health issues where our staff tries to support everything such

as marriage counseling and drug and alcohol treatment. There are significant levels of traumatic brain injury in those that are coming back as well as concussive injuries. We have peer support to try to work with veterans to encourage them to come into our programs. We do a lot of vocational rehabilitation support for employment. Sometimes the way that resumes are built or the skills that have been developed over time in the military are difficult for private sector employers to translate and understand. So really, across the board, it is all age groups coming back. It is not just the twenty-something men and women but also people in their thirties and forties. There are sometimes other health issues, your general medical surgical kinds of issues that will come up. It really is across the board, but is certainly a significant impact on our mental health programs.

**Assemblyman Hambrick:**
You said you look at the family unit for medical counseling. What about the kids, particularly for those veterans that are coming back that may be single parents, and they have been deployed once or twice and their children are being taken care of by aunts, uncles, or grandparents? When they come back, they may face some unique challenges readjusting to the youngsters. Could you address that please?

**Lisa Howard:**
The support we provide for the veteran is for whatever situation they are in. We have expertise in many different kinds of programs and different therapies and techniques that can be deployed. We do not have specific expertise with kids, and so we do not treat the kids, but we do certainly support the husband and wife, sometimes both veterans, in how to manage their relationships on the whole and how to navigate issues with their kids. We look at the whole reintegration back into home, society, and work and everything that is involved with multiple deployments.

**Robert B. Yang, Health Care Systems Specialist/Rural Health Coordinator, VA Sierra Nevada Health Care System, U.S. Department of Veterans Affairs:**
I am the acting rural health/telehealth program manager for the VA Sierra Nevada Health Care System. With me today, I have a BL Healthcare tablet (Exhibit F). This is what we are hoping to deploy with our home-based primary care programs to allow them to utilize telehealth in the patient's home in conjunction with our providers. This is a brand new box that I will open up and talk about each part. The tablet itself looks like a basic iPad or a tablet you may have for personal use, so this is kind of next-generation technology, smaller, faster, more convenient, and more user-friendly. With this unit come a number of peripheral units. Unfortunately, I was not able to bring all of them since they were in many other bulkier boxes. The one that comes with the tablet is a small

exam camera that plugs in, and when it is plugged in and used in concurrence with the patient appointment, the provider on the other side can see exactly what is being examined. For wound care, dermatology, or looking in someone's ears or someone's mouth, it is used for that type of thing.

Other peripherals include a Bluetooth weight scale, glucometer, pulse oximeter, blood pressure meter, and blood pressure cuffs. Those are the main ones we are focusing on right now.

**Assemblywoman Titus:**
For clarification, they do have a pulse oximeter as part of the program?

**Robert Yang:**
Yes, we do have that peripheral available.

**Assemblywoman Titus:**
Is there a blood pressure cuff and heart rate monitor? Will you be doing anything with pacemaker checks with those or anything like that? I am impressed with your Bluetooth weight scale.

**Robert Yang:**
I can double-check to see if we have the peripherals available for use in conjunction with the tablet.

**Assemblywoman Titus:**
There are new programs on the iPad and iPhone where you can monitor an electrocardiogram. Are you going to be able to access this technology, also, because that is out there and current?

**Robert Yang:**
Yes, we will have to talk to the vendor or manufacturer of this to see if they are developing any of those types of units. The beauty of this unit is that it was specifically designed and streamlined to be used by any patient. It can only be used in conjunction with a VA provider and telehealth. It cannot be used to browse the internet, such as going on Amazon or eBay. The user interface has really been streamlined for that.

**Assemblywoman Titus:**
What type of bandwidth does that require? Can you plug that in? Is it fast enough? My 92-year-old father who just passed away was a veteran, and it would have been great for him to have something like this because neither he nor my mom should have been driving for quite a while. However, they were 30 miles away from Gardnerville, so they could not access the kinds of

physicians that they needed without driving. It does have to be so user-friendly. When you turn it on, I like the fact that it will not do anything else but what it was made to do. Then the patients do not have any other options. Does it open up with an easy interface? Does the provider have to tell them to turn it on? Is there a phone call to begin with?

**Robert Yang:**
For our use, we would assign it to our home-based primary care nurses who would be trained and be proficient with the equipment, so when they go out to the patients' homes, they would set everything up with the patient and be there to help facilitate.

**Chair Oscarson:**
Perhaps you can come back and do a demonstration for those of us who are interested so we can see how that works. What is the cost of one of those units?

**Robert Yang:**
For just the tablet, it is around $8,000. The peripherals cost extra.

**Chair Oscarson:**
Are those going into the homes of your patients?

**Robert Yang:**
They will be assigned to the home-based primary care staff who will take it with them into the patients' homes.

**Chair Oscarson:**
It is not something that actually goes in the home. It is something that goes with the staff to do everything they need to do.

**Assemblywoman Titus:**
I really want one because instead of my little black bag, I would now have a little white box. I really like that idea.

**Assemblyman Trowbridge:**
That seems like an absolutely outstanding way to extend the medical coverage and use the paraprofessional people to go out and collect the data and ship it back to a physician and get some diagnoses. What a great approach.

**Robert Yang:**
As Ms. Howard and Mr. Cage alluded to, we are really trying to take that next step and bring the care to the patients' homes. Even though we may have

clinics in well populated areas, there will be patients out there who are housebound and have issues even getting from their homes to the clinics. This will help bridge that gap for them.

**Chair Oscarson:**
I am very appreciative that you presented this. That is fascinating and amazing technology. The members of the Committee would like to see it, so we will have staff get together with you if you can come back and do a demonstration for us. We look forward to working together with the state.

**Lisa Howard:**
Thank you, we would be honored.

**Chair Oscarson:**
To our VA partners, we very much appreciate your being here and sharing what you are doing. Please keep us updated as to the information that you need. Mr. Caron, if you could give us the same information that Ms. Howard has provided us on some of the clinics and encounters that they have had, we can put that in the record. I think that is important and good information for us to be able to follow up with.

**William Caron:**
I appreciate the opportunity and everyone's patience as I enhance my depth of knowledge of the medical center down here. I would echo Ms. Howard's comments on the Choice Act and access. TriWest is trying to develop their network as well. We do have a lack of providers, especially here in the Valley, for things such as ophthalmology, orthopedics, neurology, and sleep medicine. It is a challenge, but we are hearing in our town halls and from our veterans that when given the choice, more often than not, they are choosing to wait maybe a little longer for the medical center, as long as it is not clinically urgent, as opposed to going out into the communities. That is a testament to the fine work that is being done overall. I thank everyone for the opportunity.

**Chair Oscarson:**
With that, we will close the hearing and open to public comment. [There was none.] Meeting is adjourned [at 2:59 p.m.].

RESPECTFULLY SUBMITTED:

_____
Karen Buck
Committee Secretary

APPROVED BY:

_____
Assemblyman James Oscarson, Chair

DATE: _____

**EXHIBITS**

**Committee Name: Committee on Health and Human Services**

**Date: March 11, 2015** **Time of Meeting: 1:38 p.m.**

| Bill | Exhibit | Witness / Agency | Description |
|---|---|---|---|
| | A | | Agenda |
| | B | | Attendance Roster |
| | C | Caleb Cage, Office of the Governor | Veterans Rural Health Advisory Committee Presentation |
| | D | William Caron, VA Southern Nevada Health Care System | State of Rural Health Care in Southern Nevada Presentation |
| | E | Lisa M. Howard, VA Sierra Nevada Health Care System | VA Sierra Nevada Health Care System Presentation |
| | F | Robert Yang, VA Sierra Nevada Health Care System | BL Healthcare Tablet Presentation |