

December 31, 2008

On December 30, 2008, a broad range of medical professionals from the medical school met for a Health Care Community Discussion. We had representatives from multiple areas including medicine, nursing, public health, social work and speech pathology with expertise in geriatrics, pediatrics, mental health, primary care, rural health, health care policy, medical school curricula and residency training.

Melissa Piasecki, M.D. Professor of Psychiatry and Associate Dean of Faculty Affairs and Development was the moderator and wrote this report.

We believe that our discussion and proposals reflect not only the needs of Nevada but the needs of our nation. Our submission includes seven core values that guided our twelve specific proposals. An addendum offers some pilot proposals.

Core Values Identified by University of Nevada School of Medicine Discussion Group

- 1. Americans have a right to basic health care, as well as basic housing and nutrition.**
- 2. Health care should not be provided in a market based system.**
- 3. Any single proposal must be a part of a systemic overhaul of the health care system.**
- 4. The Obama-Biden administration should take bold steps now to overhaul the system.**
- 5. Health care should be based on a preventative and person-based model with active participation by patients.**
- 6. Our nation's health care should be integrated at many levels.**
- 7. Access to health care should not include coercive participation.**

SPECIFIC PROPOSALS

- 1. Cost effective preventative care must be included in health care for all Americans. Examples are: dental care (sealants, timely repair), vaccinations for children and adults and weight management.**

Discussion group members noted that lack of reimbursement for vaccines have prevented providers from giving vaccinations and preventing both acute and chronic illnesses.

Lack of care for minor dental problems can spiral into severe and costly problems such as infection, malnutrition and non-adherence to medications that must be taken with

certain foods. Patients with dental problems may be at risk of other medical illnesses (such as diabetes) due to poor diet. There are many obstacles to access to general dental care including lack of general dentists and reimbursement for preventative and repair services.

Preventative care must include patient health literacy so people can make informed decisions and incentives for patients and providers to begin and maintain healthy lifestyle behaviors. These incentives could be financial and based on clear outcome measures. Funding could come from increased taxation on goods that directly contribute to health problems (e.g. alcohol, tobacco).

Preventative care is especially important for children who require early interventions to avoid problems that limit their lifelong potential.

2. Case management should be adopted from chronic disease management.

Experts in our discussion group offered examples of how case management was an effective and efficient way of meeting the needs of HIV patients and chronically mentally ill patients. Reimbursement rates for case management need to cover 100% of costs. Children require more intensive case management services and there should be enhancements to cover the costs for case management services of children.

3. We need to make changes in our medical professional education to meet the needs of Americans.

Medicine, nursing and dental professionals are gravitating away from primary care and direct patient care because of the incentives offered in specialization. For example, medical school graduates are choosing specialties that reimburse more and offer better lifestyles. Training programs that produce physicians who practice primary care in rural settings do not receive any additional support compared to programs that produce specialists. We support reinstating Title VII funding for health professionals training.

As health care becomes more accessible and as our population ages, there will be an infusion of patients requiring primary care services such as when Massachusetts uncovered a primary care shortage with increased access to care. Schools and training programs must develop primary care tracks that attract more students. Trainees should receive incentives to train in underserved areas, which will make it more likely that they will eventually serve in such an area. The changing face of medicine represents increased diversity in our health care workforce. Medical education, resident training and practice settings must allow for flexibility to recruit and retain these professionals. Medical schools must increase the amount of preventative medicine and patient education in their curricula and must measure these competencies in graduating students.

4. We need to change the way in which physicians are reimbursed and pay with salaries.

Fee for service practice creates inefficiency and obstacles to good care and provider satisfaction. The amount of oversight from insurance companies and regulatory agencies contribute to these problems. Physician salaries would increase efficiency and could be adjusted to incentivize rural and primary care providers.

5. Medical schools should play an important role in health care reform.

Medical schools can provide expertise in developing outcome based measures and as pilots for new models of care or reimbursement. Please see the appendix for examples of potential pilots at the University of Nevada School of Medicine.

6. The UK serves as an important model for US health reform.

No system is perfect, but the overhaul of the health care system in the UK in the 1940's provides many lessons in the costs and benefits of a national model. This is the right time to make a complete overhaul of the U.S. health care system.

7. A priority of the Obama reform must be defining "basic needs" at different life stages.

We propose that dental, vision, preventative care, EMS, ER and basic mental health care must be included among the basic needs.

8. Mental health care is in crisis and must be fixed.

Urban and rural mental health care are in crisis. As our mental health system loses structure, the needs of the mentally ill are shifted to inappropriate and expensive settings: emergency medical services, hospital emergency rooms and law enforcement. Untreated mental health problems have consequences for individuals, families and society in terms of suicide, quality of life and productivity. National health care reform must prioritize mental health care and include resources to build and maintain a functional system of care.

9. Health literacy goals must be included in long term health care reform.

In Nevada, Health Literacy programs for seniors allow patients to become more active partners in their health care. Patients need to become better consumers of health care. All health care professionals can play a role in providing health education.

10. We must avoid the inefficiencies of duplicating services and combine a national health plan with existing entities such as Indian Health Service and the VA health care system.

11. Continuity of care and a "medical home" are essential. Health care reform should put into place restrictions on changes in providers due to payer changes.

12. Liability reform must be a part of health care reform.

Liability concerns drive up physician, hospital and pharmaceutical costs. Mandatory arbitration or other alternatives to our current malpractice problem must be introduced to cut costs related to insurance and to defensive medicine.

Pilot Proposal to Increase Services in Rural Areas through Educating Healthcare Professionals at Rural Locations using the Personal Medical Home Concepts

Health care issues and assessments:

- Geographic distance of Graduate Medical Education training programs to areas of need, impacts the successful recruitment of professionals;
- Exposure of students and residents to extended rural health training experiences and continuity of care in rural sites impacts their practice location decisions;
- Lack of health professional education programs based in rural areas diminishes awareness of practice choices and knowledge of rural health issues;
- Limited ability of urban-based training programs to instruct future rural health professionals in rural community based medicine and engage in community health outcomes;
- Infusing a sustainable supply of health care practitioners into rural communities is an acknowledged method of successful recruitment resulting in multiple economic benefits to the community;
- Need for continuity and person based care
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Needs and issues translating into action strategies:

- Development of a frontier family medicine community network that partners local clinical sites with a School of Medicine, other health professions training programs and network partners;
- Integrating education and training into community patient care;
- Diffusing a rural-trained health professions workforce into recruitment-challenged rural areas;
- Transitioning other health profession programs with medical training resulting in an interdisciplinary rural training track;
- Expanding community based wellness and chronic disease management programs
- Build on the personal medical home model with the supervising interdisciplinary care team.

Proposal:

This project proposes to pilot a rural community medical education and practice residency program, combining the University of Nevada School of Medicine (UNSOM), Department of Family and Community Medicine, with a rural Hospital to prioritize health workforce development and partner, financially and programmatically, to support and expand multiple health professions programs for the benefit of rural Nevada residents. The purpose of the project is to strategically alter the location, curricular and patient base exposure of Family

Medicine resident physicians with the addition of a rural community-based training track program coupling core concepts in community based training with the delivery of health care services in rural communities. By using the physician program as the core, training for other healthcare professionals including nurses, mental health workers, social workers, case managers, dentists, health administration students, etc, may be rotated through the site. The overarching goal of the project is to increase the regional recruitment and retention of health care practitioners as a long term strategy to sustain local health care services in rural and frontier communities throughout Nevada.

To address this problem, the *Nevada Family Medicine Rural Training Project* will bring together UNSOM Family and Community Medicine in cooperation with a rural community hospital to pilot a rural residency training track whereby medical residents in Family and Community Medicine will have the opportunity to spend their initial year of residency in metropolitan Clark County (Las Vegas, Nevada), followed by two years in rural Churchill County.

A Family and Community Medicine rotation will include exposure to at least seven community health care practice sites including, but not necessarily limited to: (1) community health nursing which is often the only medical care available to rural areas; (2) Community Mental Health Center; (3) Case Management; (4) Hospice services in Fallon; (5) School Nursing; (6) Veteran's Services. Allied healthcare professionals would also be educated through these areas.

The project will collaborate with the Northeast Area Health Education Center (AHEC) to identify rural high school and college students to mentor those interested in a medical career and funnel them into an educational and support pipeline to foster their interest and pursuit of medical education in a rural setting.

References:

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