MEETING MINUTES
NEVADA PATIENT PROTECTION COMMISSION (PPC)
September 20, 2024

The Nevada Patient Protection Commission (PPC) held a public meeting pursuant to NRS 241.020(3)(a) online and by phone on Friday, September 20, 2024, beginning at 9:00 AM. The agenda and meeting materials are available online at https://ppc.nv.gov/Meetings/2024/PPC2024/.

1. Call to order: Roll call
By: Dr. Ikram Khan, Chairman

The meeting was called to order at 9:00 am by Dr. Ikram Khan, Chair. Executive Director Joseph Filippi proceeded with roll call, and it was determined that a quorum of the PPC was present.

Commission Members Present
Dr. Ikram Khan, Chair
Marilyn Kirkpatrick, Vice Chair
Bethany Sexton
Flo Kahn
Jalyn Behunin
Walter Davis
Wendy Simons

Commission Members Absent
Dr. Andria Peterson – Excused
Dr. Bayo Curry-Winchell – Excused

Advisory Commission Members Present
Richard Whitley, Director, Nevada Department of Health and Human Services (DHHS); Celestena Glover, Executive Officer, Public Employees Benefits Program (PEBP)

Advisory Commission Members Absent Excused
Scott Kipper, Insurance Commissioner, Division of Insurance (DOI)
Russell Cook, Executive Director, Silver State Health Insurance Exchange

Staff Present
Joseph Filippi, Executive Director, PPC; Madison Lopey, Policy Analyst, PPC; Meybelin Rodriguez, Executive Assistant, PPC

Guests Present

Gabriel D. Lither, Senior Deputy Attorney General, Attorney General; Lindsey Miller, Constituent Services, Governor's Office; Ann Jensen, Agency Manager, DHCFP; Maria Tello Magana, Executive Assistant, DHHS; Kayla Hammond, Family Services Specialist 1; DHHS; Danacamile Roscom, Health Program Manager, DPBH; Todd Rich, Deputy Commissioner; DOI; Thomas Sargent; Insurance Actuarial Analyst II, DOI; Jack Childress, Insurance Actuarial Analyst, DOI; Kareen Filippi, Management Analyst III, WIC; Vance Farrow, Health Industry Specialist, GOED; Bobbie Sullivan, Emergency Medical Services Rep III; Mitch DeValliere, Agency Manager; Andrea Gregg, CEO, High Sierra Area Health Education Center (AHEC); Areli Alarcon; Belz & Case Government Affairs; Dan Musgrove; Elissa Secrist; Gerald Ackerman; Lea Case; Lisa Tripp; Michael Willden; Nadine Kienhoefer; Natalie Gillis; Reagan Hart; Ronald Hall; Stacie Sasso; Sabrina Schnur; Shannon Miller; Shira Hollander; Steve Messinger; Tray Abney.

2. Public Comment *(No action may be taken upon a matter raised under public comment period unless the matter itself has been specifically included on an agenda as an action item).*

No public comment was made.

3. For Possible Action: Review and Approve Meeting Minutes from August 16, 2024
By: Dr. Ikram Khan, Chairman

Chairman Khan motioned for the approval of the August 16, 2024, meeting minutes. Commissioner Wendy Simons motioned to approve the minutes as presented, and Commissioner Walter Davis seconded the motion. The motion carried, and the August 16, 2024, meeting minutes were approved unanimously.

4. Overview of Nevada Area Health Education Centers (AHEC) and Related Policy Considerations
By: Andrea Gregg, Chief Executive Officer, High Sierra AHEC and Gerald Ackerman, Director, Nevada AHEC Program, School of Medicine, University of Nevada Reno (UNR)

Andrea Greg, Chief Executive Officer, High Sierra AHEC and Gerald Ackerman, Director of Nevada AHEC Program, provided a presentation related to Nevada Area Health Education Centers (AHEC) and related policy considerations. The presentation is available on the PPC webpage or by clicking here. The national AHEC organization represents more than 300 AHEC program offices and centers that serve over 85% of United States counties and is funded through the federal Health Resources and Services Administration (HRSA). The AHEC program was established by Congress in 1971 to recruit, train, and retain a health professions workforce dedicated to serving underserved populations. Since then, it has advanced its mission through three designated centers in Nevada, providing services statewide. Mr. Ackerman explained that the FY23-24 state funds allocated were evenly distributed, with $17,000 for each of the three AHEC centers. He noted the importance of equal shares to support healthcare, workforce development, and community health initiatives. Ms. Gregg then provided a more in-depth overview of the current projects of AHEC by connecting communities, advancing workforce development, cultivating inclusivity, and transforming care. She stated that their vision is to empower the next generation of Nevada healthcare leaders, starting as early as 5th grade. AHEC is dedicated to growing future leaders, emphasizing mentorship and skill development, promoting health equity, and forging strong statewide partnerships. Ms. Gregg explained the workforce pipeline, stating that K-12 initiatives offer a variety of hands-on education, virtual reality, and active learning in health and STEM fields, targeting Title I schools and rural communities. At the undergraduate level, they begin to engage community leaders who support the AHEC mission and contribute to healthcare education. Moving along the workforce pipeline to the graduate and doctorate levels, healthcare professionals are equipped with a variety of skills to serve their communities and

improve healthcare access in underserved and rural areas, resulting in 91% of K-12 AHEC participants expressing interest in pursuing higher education after completing the program. Mr. Ackerman then discussed other state initiatives, including those in North Carolina, Virginia, Georgia, and Kentucky. Focusing on Virginia, he stated that they are committed to advancing their healthcare workforce through a broad and integrated approach to establish a statewide infrastructure for assessing and planning workforce needs, engaging health professionals, training programs, and decision-making. Their authority supports policy development, provides evidence-based strategies for workforce development, and addresses healthcare needs in underserved areas. Virginia's Area Health Education Centers aids community recruitment and retention efforts, evaluates graduate medical education programs, and advocates for debt reduction for new professionals. Mr. Ackerman briefly touched on North Carolina, Kentucky, and Georgia's Area Health Education Centers, noting that while each operates differently to establish and meet its workforce needs, all share a common goal of linking academic medical health programs with community partnerships, collaborations, the needs of individual students, and training programs.

Vice Chair Marilyn Kirkpatrick thanked Ms. Gregg and Mr. Ackerman for their presentation. She shared her recent experiences with high school students across the state and noted that they are very interested in a healthcare workforce app. Vice Chair Kirkpatrick expressed her willingness to sponsor this with economic development dollars, emphasizing that the next generation is the future of healthcare leaders, and we must meet them where they are.

Commissioner Flo Kahn inquired about the private funding received in addition to federal and state funding, asking how they engage corporations to provide private grant funding. Ms. Gregg explained that High Sierra AHEC is a 501(c)(3), which requires a focus on long-term sustainability that includes both public and private foundational support.

5. Overview of the Health Care Workforce Website Developed by the Division of Public and Behavioral Health (DPBH)
By: Danacamile Roscom, Health Program Manager II, Public Health Infrastructure and Improvement, DPBH

Danacamile Roscom, Health Program Manager II, shared a presentation regarding an overview of the Health Care Workforce Website developed by the Division of Public and Behavioral Health (DPBH). The presentation is available on the webpage or by clicking here. Ms. Roscom provided an overview of the Public Health Infrastructure & Improvement (PHII) Section and outlined their current priorities, which include workforce development, infrastructure initiatives, quality improvement, and data modernization initiatives. She explained their current projects and programs, include the ARPA Nevada Health Workforce Pipeline Grant, which was disseminated to communities and partners for educational and financial assistance opportunities. She went on to further explain other programs and projects, including the CDC Public Health Infrastructure Grant (PHIG), which focuses on workforce development, foundational capacity, and data modernization; the DPBH Public Service Internship Program, which aims to strengthen partnerships with universities and colleges; the Nursing Apprenticeship Program, currently supporting 220 nurse apprentices statewide; and SB 118, which funds efforts across the state to help address public health priorities. Ms. Roscom then discussed and gave a virtual tour of the NV Health Force website, stating that its purpose is to provide a detailed overview from a workforce development perspective to entice those who are not familiar with healthcare. Upcoming developments include phase two: website reorganization and content expansion, breaking down health into three career categories: public health, behavioral and mental health, and primary care careers; and phase three: user self-assessment. Ms. Roscom stated that the next phase of the website will launch in January 2025 and will include a variety of website exposure, marketing, and collaboration. She concluded the presentation by sharing some final thoughts for the commission to consider regarding the sustainability of workforce development efforts, building a

cohesive and comprehensive pipeline beginning at the early exposure stages, and reconvening the health care workforce development pipeline working groups.

Commissioner Davis thanked Ms. Roscom for her presentation. He inquired about additional information regarding the training for Medical Assistants (MAs), wondering if there are existing dual-track training programs that focus on ancillary services and support teams for individuals interested in the training. Ms. Roscom stated that the MA training program takes place within Federally Qualified Health Centers (FQHCs) to best prepare individuals for working in an FQHC setting.

Commissioner Flo Kahn commented on the NV Health Force website, stating how impressed she is and looks forward to the continued development of the website.

Mr. Filippi thanked Ms. Roscom for her presentation and commented that he wanted to highlight the last two presentations for the Commission to emphasize the various healthcare workforce initiatives ongoing from different stakeholders throughout the state. He suggested that the Commission continue to investigate these different types of initiatives to finalize their formal recommendations on how to best address the shortage of the healthcare workforce in Nevada.

6. Overview of the Emergency Department in Home (EDiH) and Hospital at Home (HaH) Care Delivery Models and Opportunities to Increase Access to Care in Nevada
By: Lisa Tripp, Partner and Shira Hollander, Partner of Tripp Hollander Advisors

Lisa Tripp and Shira Hollander, partners at Tripp Hollander Advisors, presented on the Emergency Department in Home (EDiH) and Hospital at Home (HaH) care delivery models and opportunities to increase access to care in Nevada. The presentation is available on the PPC webpage or by clicking here. Ms. Tripp explained that their ultimate goal is to provide care at home that is typically delivered in a hospital setting. Viewing it from a paradigmatic perspective, she noted that the nation has built many brick and mortar hospital facilities over the past hundred years; however, now in 2024, this facility-building paradigm is failing to deliver the access and quality needed, resulting in workforce burnout. Ms. Tripp presented their proposal to combine in-person clinicians (paramedics) with remote physicians and nurses to provide care from emergency levels to inpatient and primary care for patients who can safely be treated at home. She pointed out that Nevada is at risk of rural hospital closures, which leads to overcrowding in urban and suburban hospitals, causing some to operate at more than 110% capacity and resulting in care being provided in hallways. She explained that while Nevada has shown forward thinking in innovating and using resources differently, we still face hospital closures, such as the Carson Tahoe Continuing Care Hospital closure in July 2023, due to the changing landscape of healthcare. This creates a lack of access to hospital care in Nevada. Ms. Tripp argued that when focusing on rural areas in Nevada, the economy does not support the creation of new hospital buildings, proposing a shift in the paradigm to bring care to rural communities. This approach will benefit patients and the state's EMS system by sharing key insights about safety, quality, and cost to inform regulatory and payment policy. Ms. Tripp stated that the process would begin with a call to 911. Cases deemed non-life-threatening will result in the simultaneous dispatch of a 911 ambulance and the pilot team's community paramedics to the caller's home. When both arrive, they will assess the situation based on pre-established protocols (e.g., obvious emergencies, chest pain, abdominal pain, stroke symptoms, etc.) to determine whether the patient needs to be transported to a hospital or can be treated at home. If a patient is eligible for home treatment, they will receive inpatient-level care at home, placed on the equivalent of observation status or treated and released. Ms. Tripp stated that by taking these ideas and integrating into the healthcare system, it could strengthen the communities for different healthcare providers to work together.

Vice Chair Kirkpatrick inquired about a more detailed process, noting that there are franchise agreements in place and expressed concern about this care model potentially not reaching underserved communities. She also asked if any states are currently utilizing this model. Ms. Tripp acknowledged that she initially felt nervous about implementing this model. However, after learning about the long history of hospital care at home in countries like Australia, the United Kingdom, France, Israel, Spain, and others, she became more confident. Ms. Tripp explained that they conducted a bibliography of approximately 350 studies showing substantial benefits of hospital-at-home care, including lower readmission rates, decreased mortality, and reduced infection rates. Vice Chair Kirkpatrick stated that she would reach out offline for more information.

Commissioner Davis inquired about the payment system and reimbursements, stating that this model could potentially help reduce hospitalization costs and issues with insurance companies. He asked if there is any information regarding the billing process. Ms. Tripp explained that currently, most hospitals bill for hospital-at-home care in the same way they bill for traditional brick-and-mortar hospitalizations. She reiterated that piloting this model is critical, as it will help clarify the actual costs of providing this care. Commissioner Davis thanked Ms. Tripp and expressed his interest in learning more from a Federally Qualified Health Center (FQHC) standpoint, as the presentation mentioned that this model could result in patients being transported to FQHCs. He would like to discuss this further offline.

Commissioner Sexton inquired whether this model includes collaboration with nearby hospitals in rural areas or with hospitals in metropolitan areas. Ms. Tripp stated that this collaboration depends on who is interested and willing to participate.

Commissioner Flo Kahn stated that she is intrigued by the hospital-at-home care model but shares the same concerns expressed by previous commissioners regarding potential trade-offs. She asked how this model measures quality of care and patient outcomes, noting that in a hospital setting, there are specific requirements that need to be reported to ensure quality. She also questioned what will be covered by insurance, the out-of-pocket costs for patients, and what changes in law are necessary to facilitate this model. Ms. Tripp explained that this will be part of the CMS hospital-to-home program, and the requirements will remain the same. She also shared that a 2023 CMS study concluded that unanticipated mortality rates in hospital-at-home settings were lower than those in traditional hospitals. Ms. Tripp then reiterated that when it comes to insurance billing and out-of-pocket costs, there is no difference in billing; it will be billed in the same way as hospital care.

Commissioner Behunin thanked Ms. Tripp for the presentation. She expressed concerns regarding the healthcare workforce and its current shortage, inquiring about the plan to backfill all necessary positions, as the workforce pipeline is not yet strong enough. Ms. Tripp argued that this model aids in workforce retention, noting that they have seen nurses who were considering leaving the profession or who are nearing retirement transition to the hospital-at-home model. Ms. Tripp then outlined the plan to have nursing, physician, and paramedic schools incorporate this model into their curriculum, ultimately improving the healthcare workforce.

Commissioner Simons thanked Ms. Tripp for the presentation. She shared that she has personally experienced the benefits of a house call model from Geriatric Specialty Groups. She inquired about regulatory oversight, noting that hospitals are heavily regulated and monitored. Additionally, she asked about the plan if something goes wrong within the first 12 hours after home discharge. Ms. Tripp explained that the plan has been carefully developed by clinicians over the years. She added that there have been no complaints regarding hospital-at-home programs from either agencies or patients. She reiterated that piloting this program is critical and that establishing new and appropriate regulations will contribute to positive workforce outcomes.

Chair Khan thanked Ms. Tripp for the presentation and the diverse perspectives she shared. He expressed several concerns regarding this care model. First, he raised issues related to liability, noting that in some cases

the nearest hospital may be out of state, which could complicate licensing, as Nevada regulations state that practitioners must be licensed within the state. Second, he pointed out the CMS observation guidelines, explaining that CMS allows for one day or less than two days in a hospital setting. If patients are cleared and discharged but later require hospitalization due to test results, the inpatient system would then need to transition to a DRG payment system, which could create complications if this occurs at home. Chair Khan acknowledged that while these services may be offered in rural areas, he is concerned about the effectiveness of this care, suggesting that some patients might receive second-class treatment compared to what is provided in traditional hospitals. He noted that although other countries may already be implementing hospital-at-home care, many of their hospitals have a history of not delivering the appropriate care needed. Ms. Tripp responded that the characterization of second-class care would be contested by many physicians, nurses, and paramedics currently practicing this model at institutions such as Mount Sinai, Vanderbilt, the University of Chicago, the Mayo Clinic, Cleveland Clinic, and community systems throughout the nation.

Ms. Tripp stated that CMS will be submitting an exhaustive report to Congress at the end of this month and invited any interested members of the Commission to review it. She also expressed her willingness to share the bibliography that includes recent studies conducted across different geographic areas in the nation. Mr. Filippi agreed, noting that this report would be very helpful for the Commission and asked Ms. Tripp for the reports when available.

Commissioner Sexton suggested that while there are many questions and concerns, it would still be beneficial for the Commission to continue reviewing and evaluating the data, as technology has drastically improved and can now support many services being provided remotely, virtually, and digitally. She thanked Ms. Tripp for the presentation and for bringing this important topic forward, and she expressed her eagerness to review the CMS report.

7. **Public Comment** *(No action may be taken upon a matter raised under public comment period unless the matter itself has been specifically included on an agenda as an action item).*

No public comment was made. Mr. Filippi announced that the PPC Policy Analyst, Madison Lopey, was recently offered a promotional opportunity within the department and acknowledged all her hard work over the last few months.

8. **Adjournment**
By: Dr. Ikram Khan, Chairman

Chairman Khan thanked the PPC and those who attended the meeting and adjourned the meeting.

Meeting adjourned at 11:15 AM.