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ABSTRACT

Presenting summaries of the speeches and panel and audience discussions at the Conference on Rural Health Services in Nevada (Reno, 1974), these proceedings include the following: (1) Introduction ("The objective of this Conference was to get the providers together with the consumers to discuss problems of health services in rural Nevada and to set some priorities in what can be done to get better health services to these areas."); (2) Speech by Governor O'Callaghan, Keynote Speaker (emphasis on local accountability and the conflicts which exist between providers and consumers as perceived in transactional analysis terms); (3) "Getting Physicians to Rural Areas" (presents characteristics describing the rural physician and the rationale cited by physicians who leave rural areas); (4) "Consumer Health Education" (describes Oregon's plan for extension health education involving the community development agent, the agricultural agent, and the county home economist working with all related health personnel in their areas); (5) "Increasing Health Manpower Through Alternatives" (seven arguments are presented for expanding and developing the new health practitioner professions--physician assistants, nurse practitioners, health associates, medex, etc.); (6) "Emergency Medical Programs" (describes development of Nevada's Emergency Medical Service). (JC)

PROCEEDINGS OF THE CONFERENCE ON RURAL HEALTH SERVICES IN NEVADA

GOVERNOR MIKE O'CALLAGHAN, KEYNOTE SPEAKER

JANUARY 17 - 18, 1974

UNIVERSITY OF NEVADA - RENO

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NEVADA RURAL HEALTH SERVICES CONFERENCE

THURSDAY, JANUARY 17, 1974

&

FRIDAY, JANUARY 18, 1974

UNIVERSITY OF NEVADA, RENO

INTRODUCTION

While the urban centers in Nevada compare quite favorably with the rest of the nation in the availability of health services, the rural areas lack many of the basic health services. Some of the rural communities are located hours away from physician's services, hospitals or other medical care. These rural communities are trying to do something about the general nation-wide movement of centralization of consumer, especially health, services. Many have not been very successful. There exists in rural Nevada several small communities that have financed and built health facilities only to find that they are unable to attract the needed trained professionals to work in these facilities.

Because of the vast distances, communication between rural communities about common problems and objectives many times does not exist. A group was needed that could speak for most of the rural people. This group could channel problems to those agencies that could be able to solve some of the common problems. This group could also act to keep the Nevada Legislature informed of the consensus of the health services needs of rural Nevada.

A Nevada Rural Health Services Conference was held at the University of Nevada, Reno, January 17 - 18, 1974. The objective of this Conference was to get the providers together with the consumers to discuss problems of health services in rural Nevada and to set some priorities in what can be done to get better health services to these areas.

Sessions were held on the special problems of "Getting Physicians to Rural Areas;" "Consumer Health Education;" "Increasing Health Manpower Through Alternatives;" and, "Emergency Medical Services." Very frank discussion took place in these special sessions and in the two general sessions. Problems were discussed and priorities established. An "Action Committee" of 15 rural Nevadans was selected by Conference participants to work with the providers of health services and the State Legislature to bring about needed administrative changes and to help prepare needed legislation.

The Nevada office of the Mountain States Regional Medical Program provided funding for the Conference and future meetings of the "Action Committee." Their help, and the help of many other people and agencies involved in the organization of the Conference, is greatly appreciated.

- Hans D. Radtke -
Conference Coordinator

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GENERAL SESSION

THURSDAY MORNING
JANUARY 17, 1974

TOM WILSON, CHAIRPERSON

GOVERNOR MIKE O'CALLAGHAN, KEYNOTE SPEAKER

SPEECH BY GOVERNOR O'CALLAGHAN

"I am impressed by this gathering. As I look about this room, I see the faces of people from across Nevada, people whom I count on as friends and partners in a quest for good government.

This is the first time I have seen this group together, yet you face a common challenge of great proportions. You are the people who must provide health care to rural residents scattered over some 110 thousand square miles. I see citizens here who are leaders in their communities...who love their communities and prefer to build at home rather than rush off to metropolitan areas where health care is admittedly more accessible. As rural consumers of health care, some of you must drive hundreds of miles for dental care, or for the services of a specialist. I see other people here who are, or should be, partners in building a rural health care system that is responsive to the consumer and magnifies the strength of the providers.

For the first time, the Cooperative Extension Service of the University of Nevada has joined with the leadership of the Medical School, the Nursing School, the Health Sciences Program, State Comprehensive Health Planning and the Federal Regional Medical Programs to build this Conference.

Like many other consumers, I have some strong feelings about health care in Nevada. I believe the Legislature and your State Government has made its commitment clear. We are spending $80 million to $120 million this biennium on health care, depending on how you want to define health and health related problems. I believe our State Legislature is being responsive to the health needs of the

public. We are spending more than $50 thousand a day in health care for Nevada's poor under the Medicaid Program, and thousands of dollars more each day under other programs, such as crippled children, rheumatic heart, family planning and public health nursing. We are pouring more money into training health professionals than ever before in Nevada history. We have programs aimed at stemming the rising cost of hospital care and at developing coherent, responsive statewide health planning. But, this is not enough.

It is not enough because for all the State's effort, it only represents a small part of the estimated $2 billion Nevadans spend on health each year.

The private sector is where most of the action is. The public employees involved in health are only a miniscule part of the 8,000-plus persons who work in the health care industry in Nevada. This industry, for comparison, is as large as the mining industry in Nevada.

During the past session, we brought about a revolution in Emergency Medical Services, and, for the first time, put State dollars up front to pay for training, equipment, ambulances and communications. We expanded our Dental Health Program. We broadened our coverage and benefits under our Industrial Insurance Program, which already purchases more than $7 million worth of health care each year for Nevada's working men and women. We are in the process of building a facility in Sparks for mental offenders charged with crimes.

We are building a facility for the emotionally disturbed children in Southern Nevada. We have expanded our Air and Water Pollution Control Programs and inaugurated a major statewide solid waste pollution control program. Our Rural Clinics Program, which brings mental health care to the rural areas, has been greatly expanded in both volume and variety of services. Health related programs, such as Drug Abuse, Alcoholism and Aging, have become the focus for major statewide efforts.

Somehow this structure must be brought together to be responsive to those who are paying the bill, and for those who are willing to put behind them the profits of a big city practice in order to provide health care to rural Nevadans.

I do not propose to tell the health professionals here today how to deliver better care. I think we are lucky here in Nevada in many ways. While we may complain that we have only about 600 active medical doctors, we can communicate well. In Nevada, a person can speak in a calm voice, he can say something complicated and he can be heard and understood. I think we have a fine leadership in our professional health care organizations.

But, two things are working against us: First, the challenge is enormous. Despite the size of that challenge, Nevada does not have the advantages of a major medical school and dozens of Congressmen to lobby in Washington for grant funds. We must get the job done ourselves with less resources and less outside help than other states.

Secondly, we have the same conflicts that exist between providers and consumers in other states.

The psychologist, Eric Berne, wrote a book about transactional analysis, in which he described how people block adult communications. I think many of the same games are played too often in government, and too often in the health care field.

A game to Berne is a recurring set of transactions, often repetitious, superficially plausible, but in which is a concealed motive, and a snare or a gimmick, and a predictable outcome. According to Berne, the most persuasive game of childhood is one calle "Mine is better than yours." We sometimes see it in the health care field, when one institution will claim that its physician assistants are better than somebody else's nurse practitioners. But, it is the consumer, not the hospital, that is the victim of such transactions.

Another game is called, "Why don't you? Yes, but." This game involves somebody putting forth solutions while somebody else--usually the one who would most benefit by the solution--finds reasons why the solution will not work. These discussions go a full circle with every proposal being knocked down. We see this in health care when consumer groups ask for a change and providers find a multitude of obscure reasons why the change will not be forthcoming.

Another version of this game is "If it weren't for you, I could." This can be played by a provider who does not provide responsive services because the consumers do not live up to his expectations. And, it is often played by consumers who find reasons for not getting health care because they disapprove of something a provider does.

Another game is called "Let's you and him fight." We see this when people attempt to pit either leaders of health organizations against each other, or perhaps a legislative committee against an institution.

Finally, there is the game called, "Uproar." It begins when the participants move with suspicion and ill-will toward an inevitable confrontation. Sometimes it starts with leaders of a citizen group more bent on criticizing an institution than solving a problem.

The only way to end game playing is for all participants to move to a new position in which one recognizes that the provider and the consumer have postures which are justifiable and defensible. This is what I hope this Conference here today will achieve.

Nevada has made too many mistakes in health care to allow petty disputes to block progress and better resource allocation. We look across the State and see about half of our hospital beds empty. This represents an investment of perhaps $50 million which could have been spent elsewhere. At the same time, we look around the State and see a great shortage of cheap long-term care beds in our metropolitan areas. Who set these priorities?...Why?

The fact is that the State and the Federal Government subsidized the construction of many unneeded beds through the Hill-Burton Program.

We find our health manpower situation growing more critical. From 1972 to 1973, we saw five counties in Nevada lose seven physicians. This may not seem a large number, but it represented more than a third of the medical doctor manpower available in those counties. Only four out of Nevada's 15 counties enjoyed an increase in the number of medical doctors. But, two of those four added new people so fast that the public found fewer doctors serving them per capita than at the start.

The problem is not just a shortage of physicians. There is every indication that the overall migration of physicians is slightly greater than its population increase. But, the physician manpower is poorly distributed. In one county... Washoe...there is a doctor for about every 550 persons. Carson City is richer per capita than Clark County in doctors. In the rest of rural Nevada, each doctor must serve about 1,700 residents. And, they must render this service without the back-up of the specialist and specialized equipment found in medical centers. We are going to have to try out some new ideas.

I do not mean simply adding public money to the medical pot. I believe the public is paying enough for services. We are not going to try to convert to some system where government becomes the deliverer of medical services because the present pluralistic system has too many strengths. I believe we have the brains and the know-how and the will to improve our health services to rural areas.

To many, a rural area means a better life and often a better place to raise a family. But, we must assure adequate financial reward for our rural doctors. New rural doctors should develop a health care team to share the burden and to reach out with better services. This means using physician assistants and nurse practitioners, social workers, health educators and counselors.

Health care means more than expensive operations in medical centers. Health care means prevention of disease and maintenance of health. We must try to use the educational experience of the doctor and the nurse, the Extension Service, the Farm Bureau, the Four-H Clubs and schools to improve the level of health education across the State. We must teach people how to take better care of themselves and how to use the health care services available more efficiently. We must devise communications for easy contact with the health team.

We should look at radio, closed circuit TV and monitoring devices to allow physicians to treat and advise patients in remote locations. We can use the same technology in rural centers for obtaining consultations. We must continue to improve our emergency transportation system to cut down the time lapses before a patient receives proper care in an adequately staffed center. We must find better ways to finance health care and to build incentives which go beyond the doctor's face-to-face relationship with a patient at a time of crisis. We need new modes for using allied health manpower. Incentives should encourage the use of all preventive and theraputic measures.

Rural Nevada suffers seriously from a lack of health services and health manpower. We cannot wait for startling new medical discoveries. Science fiction marvels will not solve problems of maldistribution of manpower. We need a statewide commitment backed up with action and adequate financing. Every Nevadan has a right to good health care at a cost he can afford.

Our problem in government and in the health field is to build on what is an excellent system to make it accessible to all Nevadans; to make it more efficient, to make it more cost effective, and to make it more responsive to both the provider and the consumer. I wish you Godspeed in your deliberations. And, I pledge to you the support of this State to help push for the sound and workable solutions which I hope you develop today and tomorrow. Thank you."

DISCUSSION BY THE PANEL OF PROVIDERS, RURAL RESIDENTS, AND AUDIENCE

The usefulness of a two year medical school was questioned. The Medical School's two year program at the University of Nevada - Reno is the only one of its kind left in the United States. To get students to locate and to stay in rural areas in Nevada, a program should be established that gives students greater experience in rural communities.

Some of the suggestions made in this session to get a better distribution of physicians in rural areas were as follows:

1. A program of "Circuit Riders," much like the doctors and judges in the pioneer days. With the transportation facilities available today, a system could be established whereby rural areas could be covered by all the major specialties.
2. The National Health Services Corps has established a scholarship fund for students who are willing to practice in rural areas. The Lovelock Hospital has qualified for two National Health Service Corps physicians; if these can be recruited.
3. Several Associations, Hospitals and rural towns are trying to recruit physicians for rural Nevada. What is needed is a combined effort by all these groups to sell Nevada to prospective physicians.
4. Foreign qualified physicians could provide many of the needed personnel in these areas. A better system needs to be set up to attract and to license these qualified physicians.

There was a general consensus that an assessment of the care available in rural Nevada be made. From such an inventory, the available alternatives based on these resources and population base to pay for additional services could be integrated.

For example, many of the rural towns have available facilities - empty clinics and hospitals - but there is no longer the population in the area to pay for the services of a doctor. These areas could possibly use the services of a physician assistant or a nurse practitioner who would be in close telephone or radio contact with a physician.

Emergency medical services are needed in many of the rural communities. It costs about $75,000 each year to adequately staff each ambulance. What should be considered is a state wide system of well trained volunteer emergency workers much like the Volunteer Fire Department that exists in each rural community.

Many times, educational requirements are separated from license requirements in the medical professions. A closer look needs to be taken into the whole question of preparation of personnel for the profession and the means of allowing qualified personnel to practice their profession. A question was asked of the purpose of license requirements - Is it to protect the members of the profession, or is it to insure a minimum level of services for the consumer?

The dialogue that took place between the providers and the consumers was frank, and, for the most part, very constructive. This session provided the general tone for the session on four specific areas of concern: Recruitment of Physicians; Alternatives to Physician services when these are not available; Emergency Medical Services; and, Consumer Health Education. The task for each one of these sessions was to discuss the problems concerning these specific areas and to establish some goals that needed to be reached in order for the rural residents to receive adequate health care services.

SUMMARY OF SESSION ON
"GETTING PHYSICIANS TO RURAL AREAS"
THURSDAY AFTERNOON, JANUARY 17, 1974

BUD BALDWIN, CHAIRPERSON

ROY SCHWARZ, LEAD OFF SPEAKER

SUMMARY OF SPEECH BY ROY SCHWARZ

The number of rural physicians in the United States has been declining for many years. Part of this decline can be attributed to the general decline of population in rural areas. Services of all types have also experienced a trend of specialization. For example, as the general store separates into a grocery store and a hardware store, a larger population base is needed to keep these units in business. The same trend of specialization has moved many of the physicians into urban areas of the United States. Although 25% of the United State's population (55-60 million) lives in communities of less than 2,500, this segment has less than 12% of the physicians, 3% of the dentists, 18% of the nurses, and 14% of the pharmacists.

Not every town can have a physician of its own, or may even need a physician. When searching for a physician, the community should investigate whether it has the economic base to be able to keep a physician in business. The community should be in a position to provide a physician with medical facilities and personal services that a physician may need.

Past studies of physicians have concluded that the following characteristics describe the rural physician fairly well:

1. they were originally from small towns;
2. spouses of rural M.D.'s also have rural backgrounds;
3. they tend to be independent, outgoing, and like the outdoor recreation the rural areas provide;

4. they like to deal with people;

5. they have had professional experience in rural areas; and,

6. they like the status they have in the community.

The physicians that leave the rural areas usually cite these reasons for leaving:

1. they were overworked;

2. they didn't like the professional isolationism;

3. there was no proper channel for referral or consultive back-up system;

4. there is inadequate training for rural practice;

5. there are inadequate professional facilities; and,

6. there are inadequate educational, cultural, and recreational facilities for the family.

The W.A.M.I. (Washington, Alaska, Montana and Idaho) Program tries to recognize the characteristics that make up the typical rural physician and recruit and train students specifically for rural family medical practice. The students are given opportunities early in their medical student program to associate with rural people and rural physicians. The aim of the W.A.M.I. Program is to educate the medical student who wants to practice in rural communities for rural medicine.

DISCUSSION BY THE PANEL AND AUDIENCE

There was a general consensus that the medical schools have for too long emphasized specialized medicine. However, most medical schools are now again emphasizing Family Practice, or the General Practitioner.

A physician from a small rural community thought that the many residents expected too much from a physician in a rural town. The physician is expected to be on call 24 hours professionally, and to have many social and community obligations as well. The physician, like any other person, needs some time for himself and his family.

It was felt by the many participants that some of the licensing procedures were awkward. For example, some applicants did not understand the basic science examination or reciprocity agreement.

GOALS ESTABLISHED DURING THE SESSION:

A. University Directed:

1. recruit medical students from rural areas;
2. create student learning experiences in rural health care;
3. train students in rural areas (preceptorships);
4. create family practice department in medical school (role models);
5. have consumer input into medical school;
6. train appropriate support personnel (team); and,
7. have degree-granting medical school in Nevada.

B. Rural Areas:

1. educate community to reasonable expectations of M.D. and Health Care Delivery System;
2. subsidize student in medical school in exchange for future service;
3. subsidize medical practice opportunities in rural areas (tax incentives, facilitate development);
4. create (group) practice opportunities in rural areas (system); and,
5. recruit appropriate support personnel (RN, MT, PT, PA, and RNP).

C. General

1. early recruitment into health careers (educate High School counselors);
2. coordinated and cooperative recruiting efforts in State (non-competitive);
3. establish group to examine needs of communities (CHP); and,
4. facilitate licensing procedure (reword letter from Medical Examiners about Basic Science requirement).

SUMMARY OF SESSION ON

"CONSUMER HEALTH EDUCATION"

THURSDAY AFTERNOON, JANUARY 17, 1974

BARBARA GUNN, CHAIRPERSON

ANN LITCHFIELD, LEAD OFF SPEAKER

SUMMARY OF SPEECH BY ANN LITCHFIELD

The delivery system of Cooperative Extension can extend health education into even the remotest of rural areas. Oregon's plan for Extension Health Education involves the Community Development Agent, the Agricultural Agent, and the County Home Economist working with all related health personnel in their area. Some of the programs include: public information programs in nutrition, health insurance, dental health, mental health, 4-H health programs--the horse project is an excellent one in which to teach horse--and human--nutrition; advocacy for health care systems and rural clinics; helping parents to identify simple conditions by showing slides developed by the Medical School; preparing study group lessons and correspondence courses; two programs developed in response to the Oregon Board of Health's concern with low sodium diets and diabetic diets, "Without a Tablespoon of Salt' and "Without a Teaspoon of Sugar" combined with recipe books and cooking hints.

Oregon's Extension has a liaison with CISCO (a Chicano and Indian organization), where they work together with the Indian Medicine Man and the Chicano Cuerandero who still occupy in the people's minds the ideal of the general old family doctor. CISCO provides relevant and practical courses in First Aide, Health, Nutrition, and Mental Health.

Oregon's program has four goals: (1) Education to develop and inform the consumer; (2) Creation of an informed public to take positive steps to prevent illness; (3) Improvement of the health care delivery system, including informing the public of what is available, how to gain access, and how to work for

additional services; and, (4) Coordination on a statewide basis of the existing agencies and their health care services.

Extension's function is twofold: (1) informational, including deepening motivation, and (2) problem solving.

If we are to make health education a high priority thrust, these are questions to consider: What kinds of people should be informed and what kinds of people should be doing this? What should be the qualifications of a health educator? If we ask people who are already overworked to take on health education, what are we prepared to relinquish in our present programs? Just how high a priority are we going to give health education?

DISCUSSION BY THE PANEL AND AUDIENCE

The discussion centered around two areas of consumer education: Education in the High Schools in rural areas, and continued education provided by such organizations as the Cooperative Extension Service.

The State of Nevada is one of the few states that has a health education requirement for graduation from High School. Although this law is in effect, there was some question whether the rural High Schools can use the school nurses to fulfill this role of teacher as well as nurse.

The Cooperative Extension Service has the delivery system in rural areas. The County Agent can be used to contact people in rural areas, to identify local problems, and to channel questions to those agencies that may be able to do something about the problems. He can also be used to get information on consumer health education to the people in rural areas.

A consumer can take care of some of his health needs if the information about the effects of his decisions are made clear to him. What is needed is a program to teach people to solve many of their problems on their own. In many instances, early detection of a problem, such as diabetes, is the most important step in the medical treatment process. In many instances, too, the physician in treating problems

becomes the last link in the health services chain. The first links of preventive care by the consumer are just as essential in good health care.

The point was also made that sometimes consumers demand too much from the physician. A program is needed to educate the public about the abilities of nurses and other paramedical personnel. In many instances these very capable people can provide services that are asked of the physician.

GOALS ESTABLISHED DURING THE SESSION:

1. Identify resources for Health Education.
2. Identify resources needed to teach the lay people.
3. Decide what we mean by Health Education.
4. Determine the goals of Health Education.
5. Identify the needs in the community that need to be served; get community involvement; get the power structure involved.

SUMMARY OF SESSION ON

"INCREASING HEALTH MANPOWER THROUGH ALTERNATIVES"

FRIDAY MORNING, JANUARY 18, 1974

ETHELDA S. THELEN, CHAIRPERSON

PAUL MOSON, LEAD OFF SPEAKER

SUMMARY OF SPEECH BY PAUL MOSON

New health practitioners (Physician Assistants or Associates, Nurse Practitioners, Health Associates, Medex, etc.) is a generic name for non-physician health personnel who are trained to carry out many of the primary medical functions and tasks which heretofore have been the sole province of physicians.

Specialization of the physician has led to neglect of the primary and general practice functions; New health practitioners help fill this void, as well as to make up for the lack of physicians.

Experience has taught that pouring millions of dollars into the medical system does not in itself provide the necessary services. Until we have enough physicians and other health professionals trained to practice health care delivery in new and more efficient ways, we can hope for little improvement. The training of new health practitioners is a new and efficient way that health care delivery can be provided.

Three model programs are illustrative of the new health practitioner concept. The Duke Physicians Associate Program (founded in 1965); the University of Colorado Pediatric Nurse Practitioner Program (developed in 1965); and the Medex Program (founded in 1969). Graduates of all programs work under the supervision of and are responsible to a licensed physician who maintains final authority for patient and management decisions. Since they sometimes work in remote areas, away from the physician, considerable independent decision making is required.

Physician assistants are categorized according to the degree of specialization and level of judgement. Type A Assistants have extensive training in general medical theory and practice: Type B have extensive training in the theory and practice of one specialty area; and, Type C have narrowly circumscribed backgrounds in general medical practice.

There are seven cogent arguments for expanding and developing the new health practitioner profession:

1. Health practitioners can provide the solution for the manpower shortage in primary care, an area which has attracted few physicians until recently.
2. The new health practitioner can improve the quality of patient care by freeing the physician from management and many commonplace illnesses.
3. The new health practitioner can increase the quality of patient care by spending more time with the patients than can the overworked physician.
4. The new health practitioner's role provides career opportunities for many practicing health personnel who wish to become more heavily involved in direct patient medical care.
5. The new health practitioner field provides an alternative to medical school for many young people looking for a prominent position with patient responsibilities in the health care field, and which carries communsurate financial reward.
6. The training of new health practitioners can help to check the rising costs of medical education.
7. New health practitioners should help to check the spiraling costs of medical care while maintaining the high quality of medical care.

Over 36 programs have been approved by the A.M.A. and more than 32 states have amended their Medical Practice Acts to encourage and codify the practice of new health practitioners.

Licensure of health professionals has been justified on the grounds that it upholds a certain quality of health services. However, the A.M.A. concedes that strict licensure regulations have not kept incompetent physicians out of service. Before any state adopts new licensure regulations, it should investigate very carefully whether those new regulations serve to shorten the supply of health manpower or whether they will serve to increase the quality and availability of health care services.

DISCUSSION BY THE PANEL AND AUDIENCE

Panel and audience participation responding to the lead off speaker's presentation was lively and covered many points. Questions and answers related to the three main groups of health practitioners; physician assistants, nurse practitioners and medics. Points covered were utilization, insurance coverage, legal status, impact on primary care, reimbursement for services, dependent and independent functions, conflict of existing health laws, employment by agencies, and expanding roles. A nurse practitioner explained the changes in her professional practice as a result of her advanced education as a nurse practitioner. She described dependent and independent roles in working with her physician employer in a current preceptorship, and anticipated increased independent action in the future. The functions and practice of graduates of the Physicians Assistant and Medex Programs in the immediate mountain area were explained by the director of this program in Nevada. A planned education program to prepare rural nurse practitioners in Nevada, through the University of Nevada - Reno, was discussed.

GOALS ESTABLISHED DURING THE SESSION:

1. The University of Nevada - Reno, Medical School's staff should investigate sponsoring nurse practitioners or physician assistants in rural areas when local physicians are not available.

2. Administrative rulings should be made to utilize the nurse practitioner or physician assistant in continuity of care to patients in extended care facilities.

3. A program to provide education for physicians and consumers to utilize nurse practitioners and physician assistants is needed.

4. The University of Nevada - Reno should develop a coordinated educational program for nurse practitioners and physician assistants utilizing common core courses and coordination of facility services.

5. Continuing education for nurse practitioners and physician assistants should be provided.

6. An investigation of the congruousness between health professional laws, such as pharmacy, nursing and medicine take place to avoid duplication of laws.

7. Legal aspects of using a variety of health practitioners functioning in expanded roles by agencies should be investigated.

SUMMARY OF SESSION ON
"EMERGENCY MEDICAL PROGRAMS"
FRIDAY MORNING, JANUARY 18, 1974
SENATOR SPIKE WILSON, CHAIRPERSON
DR. ROBERT SIMON, LEAD OFF SPEAKER

SUMMARY OF SPEECH BY DR. SIMON

Physically, Nevada presents problems for Emergency Medical Services. It has large sections of empty roads, and yet has one of the highest general death rates in the nation.

The training of people who were concerned with the initial contact of those needing medical treatment was minimal until the middle 1960's. Confronted with this situation, many people became interested in upgrading the standards of training for those involved in emergency medical treatment. The professional rescue instructors of Nevada provided the training for the Emergency Medical Service in many of the communities. In the 1970's, the Federal Government got involved in the program. To provide some coordination, three regional E.M.S. councils were formed.

Four primary problems were identified: Legislation, transportation, communications and training. Over the last year and a half, a Good Samaritan Law has been extended to protect the volunteers in E.M.S. Training requirements were also made statutory, and the Office of E.M.S. was established. In addition, communications were improved by planning for a state-wide communication net.

The principal training program is centered around an 81 hour course made up of four sections over a span of four months.

The problem in E.M.S. today is the duplicate standard of training requirements. Volunteers must have 16 hours of training beyond the advanced first aid care by 1978, and yet the paid professional with them must have 80 hours of training. There is a need for additional training in all rural areas of the State.

DISCUSSION BY THE PANEL AND AUDIENCE

A standardized training program is needed so that all areas of the state receive the same quality of training. Standards which have to be met by volunteer emergency health personnel, especially ambulance drivers, need to be developed.

A person's chances of dying from accidental causes are four times greater in rural than in urban areas. It is very important that prompt and immediate care be administered at the scene of the accident. The overall planning thrust of any E.M.S. program should be to get training to the persons who will be at the scene of an accident.

The formal educational system could be used to provide emergency care training programs at many different levels. There are many people in rural areas, from elementary students to retirees, who could benefit from some training in emergency medical care.

GOALS ESTABLISHED DURING THE SESSION

1. Standardized training programs and minimum standards for volunteers and professionals need to be established.
2. Adequate funding from all sources needs to be made available to provide an adequate network of emergency medical care.
3. Emergency medical care training programs should be part of the formal educational program of every community.
4. The State office of E.M.S. must be recognized and utilized as the clearinghouse and source of emergency medical information.
5. There must be coordinated health care efforts between nurses, M.D.s, L.P.N.s, P.H.N.s and all related health professionals.
6. Training programs must first be utilized by those in an immediate response position.
7. Communication systems must be initiated through the cooperative, coordinated efforts of consumers, providers and politicians.

SUMMARY OF
GENERAL SESSION

FRIDAY AFTERNOON
JANUARY 18, 1974

SENATOR CARL DODGE, CHAIRPERSON

There was general agreement that the momentum generated by this Conference should not be allowed to die; that we should appoint articulate spokesmen for action in the rural health area. They should work for community involvement and get the power structure enlisted. Perhaps the Governor should be given feedback from this Conference and asked to appoint a committee--an action group to get something started. This charge could be given to the University or an ad hoc committee. But, have some group from this Conference report to the Governor!

An "Action Committee" consisting mostly of rural residents was chosen to carry out the priorities established by the Conference, and to generally act as a funnel between problems of rural residents and the agencies or institutions that have the capacity to solve the problems. Appendix D is a list of the members of the "Action Committee."

All agencies and associations that are concerned with providing rural health care were asked to be on this "Action Committee" in an advisory or resource capacity.

The full session agreed to separate the recommendations of the four basic groups. These are Legislation, Education, Communication and Public Relations, and Medical Service Procurment. Appendix E is a list of these recommendations by group.

Appendix A

PANEL MEMBERS

General Session, Thursday Morning, January 17, 1974

GOVERNOR MIKE O'CALLAGHAN - Keynote Speaker

TOM WILSON - Chairperson - Comprehensive Health Planning

GEORGE T. SMITH - University of Nevada, Reno, Medical School

ROGER S. TROUNDAY - Nevada State Department of Human Resources

RICHARD PUGH - Nevada State Medical Association

MARJORIE E. NEFF - Nevada Nurses Association

JAMES K. JONES - District Representative for Congressman David Towell

LOYD KEPFERLE - Mountain States Regional Medical Program

THOMAS A. SNOKE - Indian Health Program

MARY V. WHITE - Nevada Home Health Service

SHARON GREENE - Nevada Hospital Association

MARGARET KNOUS - Area Health Advisory Council - Ely

ROBERT BAKER - Hospital Board - Lovelock

LORIN A. CORBIN - Hospital Administration - Caliente

PATRICIA SIMS - Hawthorne

DOROTHY ELTON - Wells

EDWIN C. BISHOP - Eureka

MEL TOHM - Schurz

Getting Physicians to Rural Areas, Thursday Afternoon

ROY SCHWARZ - Lead Off Speaker

BUD BALDWIN - Chairperson - University of Nevada, Reno, Health Sciences

NORM CHRISTENSEN - Ely

ROBERT BAKER - Hospital Board - Lovelock

Getting Physicians to Rural Areas (Con't.)

CONNIE BLACKET - Area Health Advisory Council

KENNETH MACLEAN - Nevada State Board of Medical Examiners

OTTO RAVENHOLT - Clark County Health Department

NELSON NEFF - University of Nevada, Reno, Medical School

FORREST JOHNSON - National Health Services Corps

Consumer Health Education, Thursday Afternoon

ANN LITCHFIELD - Lead Off Speaker

BARBARA GUNN - Chairperson - University of Nevada, Reno, Extension Service

DALLAS RYCHENER - Mountain States Regional Medical Program

DARLENE HERRERA - County Extension Home Economist

GERALD MATHESON - University of Nevada, Reno, Health Sciences Program

LINDA GOLDEN - Clark County Health Department

GRACE LOUISE HALL - Health Chairperson of Home Makers

MARY ANN KEDZUF - University of Nevada, Las Vegas, School of Nursing

ROGER GLOVER - Division of Mental Hygiene and Mental Retardation

Increasing Health Manpower Through Alternatives, Friday Morning January 18, 1974

PAUL MOSON - Lead Off Speaker

ETHELDA S. THELEN - Chairperson - University of Nevada, Reno, School of Nursing

ANNETTE EZELL - Mountain States Regional Medical Program

BEE BIGGS - Nurse Practitioner - Winnemucca

HENRY HAYES - Tonopah

LESLIE A. MOREN - Nevada State Board of Medical Examiners

JEAN PEAVY - Nevada State Board of Nursing

WILLIAM WILSON - Utah Medex Program

Emergency Medical Programs, Friday Morning

DR. ROBERT SIMON - Lead Off Speaker

SENATOR SPIKE WILSON - Chairperson - Nevada State Legislature

JIM HOLDRIDGE - Washoe Medical Center

ROBERT EDMONDSON - Carson City

ROBERT SUMMERS - Nevada State Health Division

TOM HOOD - Elko

ED HANSSEN - Humboldt General Hospital

LAWRENCE JACOBSEN - Nevada State Assembly

RICHARD NUTLEY - Comprehensive Health Planning

Appendix B

NEVADA RURAL HEALTH SERVICES CONFERENCE

REPRESENTATION BY AREA OF RESIDENCE

Nevada

County, Town, Representation

Carson City County
- Carson City (15)

Churchill County
- Fallon (9)

Clark County
- Las Vegas (10)

Douglas County
- Minden (2)
- Zephyr Cove (1)

Elko County
- Elko (3)
- Wells (1)

Esmeralda County
- Coaldale (2)
- Goldfield (2)

Eureka County
- Eureka (3)

Humboldt County
- Winnemucca (7)

Lander County
- Austin (2)
- Battle Mountain (3)

Lincoln County
- Caliente (1)

Lyon County
- Yerington (2)

Mineral County
- Hawthorne (10)
- Schurz (2)

Nye County
- Gabbs (2)
- Tonopah (1)

Pershing County
- Lovelock (5)

Storey County
- None

Washoe County
- Reno area (51)
- Sparks (6)

White Pine County
- East Ely (1)
- Ely (3)

No Address Given (3)

Out-of-State

Town, Representation

California
- Alturas (2)
- Cedarville (1)
- Northridge (1)
- San Francisco (1)
- Susanville (1)

Connecticut
- New Haven (1)

Idaho
- Boise (1)

Indiana
- Indianpolis (1)

Ohio
- Glendale (1)

Oregon
- Corvallis

Utah
- Salt Lake City (5)

Appendix C

ORGANIZATIONS, AGENCIES, & GROUPS REPRESENTED
AT THE
NEVADA RURAL HEALTH SERVICES CONFERENCE
January 17-18, 1974

Organization (No. Attending)

Area Health Advisory Council (1)
Austin Ambulance (1)
Austin Volunteer Fire (1)
Battle Mountain Gen. Hospital (1)
CHP Council (1)
Carson City Sherrif's Rescue (1)
Carson-Tahoe Hospital (1)
Churchill County Welfare (1)
Churchill Public Hospital (2)
Clark Co. Health Dept. (2)
  Coroner (1)
Coaldale Ambulance Service (2)
College of Idaho (1)
Comprehensive Health Planning (2)
Dept. of Human Resources (1)
Economic Opportunity Board
  Washoe County (2)
Esmeralda County Ambulance (1)
Emergency Medical Service Committee
  Carson (1)
  Clark County (2)
  Esmeralda County (1)
  Humboldt County (1)
Eureka Co. Planning Commission (1)
Fallon Convalescent Center (1)
Gabbs Ambulance & Fire Dept. (2)
Great Basin Health Council (1)
Dept. H.E.W. (Region IX)
  San Francisco (1)
Homemaker's Council (2)
Humboldt Hospital (3)
Humboldt Search & Rescue (1)

Organization (No. Attending)

Indian Health Program (1)
Indian Health Service Hospital (1)
Indiana University (1)
Lander Co. Board of Commissioners (1)
Lincoln Co. Hospital (1)
Litton Bionetics (1)
Lyon Co. Health Center (1)
Medicare (2)
Mineral Co. Shelter Workshop (1)
Modoc Medical Centers
  Administration, Alturas, Cal. (1)
  Cedarville, Cal. (1)
Mount Grant General Hospital (5)
Mountain States Regional Medical
  Program & Intermountain Regional
  Medical Program (6) (3 each)
Nevada Highway Department (1)
Nevada Home Health Services (2)
Nevada Hospital Association (2)
Nevada League for Nursing (1)
Nevada Mental Health Institute (1)
Nevada Nurses Assocation (1)
Nevada State Board Medical Examiners
  (3)
Nevada State Division of Health (5) +
  Dental Health (1)
  Mental Hygiene & Retardation (1)
  Public Health Nursing (3)
  Rehabilitation (1)
Nevada State Legislature & Government
  Governor (1)
  Legislature (3)
Nevada State Medical Association (1)

Organizations, Agencies, & Groups Represented
At The Nevada Rural Health Services Conference
(Continued)

Organization (No. Attending)

Nevada State Welfare (1)

Pershing Co. Hospital Board (1)

Pershing General Hospital (1)

Private Citizens (6)

Private Practice
- Doctors (8)
- Nurses (3)

Reno Special Children's Clinic (1)

San Fernando Valley Health
Consortium (1)

School Districts
- Churchill (2)
- Clark (1)
- Washoe (2) +
  - Follow Through Program (1)

School Nurses
- Douglas Co. (2)

Southern Nevada Memorial Hosp. (1)

U.S. Legislature
- Congressman Towell's Office (1)

U.S. Public Health Service (1)

University of California
- Community Resource Development
  Alturas (1)

University of Nevada, Reno
(Faculty & Students)
- Biochemistry (1)
- Clinical Science (1)
- Cooperative Extension (13)
- General University Extension (2)
- Health Sciences (3)
- Home Economics (2)
- Medical School (6)
- Nursing (3)

University of Oregon
- Extension Service (1)

University of Utah
- Family & Community Medicine (1)
- Family Nurse Practitioner Prog. (1)
- Medex Program (1)

Organization (No. Attending)

Veteran's Hospital (1)

Washoe Co. District Health Office (2)

Washoe Medical Center (2)

White Pine Co. Welfare (1)

William Bee Ririe Hospital (1)

Winnemucca Ambulance Corps (1)

Yale University
- Physician Associate Program (1)

More than one affiliation (7)

No affiliation listed (6)

Appendix D

NEVADA RURAL HEALTH SERVICES

"ACTION COMMITTEE"

MEL HOLDERMAN
3335 Barbara Circle
Reno, Nevada 89503
(Chairperson)

ROBERT BAKER Hospital Board
Box 851
Lovelock, Nevada 89419

LENORE S. HOLBERT
1871 Manzanita Drive
Elko, Nevada 89801

ROSE BEEMER
Overton, Nevada 89040
(Not present at Conference)

MARGARET E. KNOUS Welfare Officer
996 Pine Street
Ely, Nevada 89301

DOROTHY ELTON, R.N.
Box 367
Wells, Nevada 89835

PAUL McCORMICK
494 Ida
Winnemucca, Nevada 89445

JAMES C. FULPER, M.D.
604 W. Washington
Carson City, Nevada 89701

KAZUKO NOJIMA Welfare Officer
128 E. Williams
Fallon, Nevada 89406

GENIVEVE HANSON
Fish Lake Valley
Tonopah, Nevada 89049

VIRGINIA OUELLETTE
4-H Specialist
Univ. of Nevada, Reno 89507

E.J. HANSSEN Hospital Admin.
1450 S. Bridge
Winnemucca, Nevada 89445

JO POWELL NU
875 Lahontan
Reno, Nevada 89502

JOAN HAWBOLT, R.N.
Box 1796
Carson City, Nevada 89701

BRUCE WILKIN Medical Student
367 Granada Way
Sparks, Nevada 89431

Appendix E

PRIORITIES

LEGISLATION

1. Review the basic science requirement.
2. Review the Medical Practice Act, Nursing Act and Drug Acts to bring them into coordination.
3. Funding for Emergency Medical Programs. 101,000
4. Funding of Nurse Practitioner and Physician Assistant programs. $50, 4 staff
5. Explore and evaluate consumer representation on examiner boards for health professionals.
6. Investigate legal aspects of Physician Assistants and Nurse Practitioners working for an agency.
7. Funding for a degree-granting medical school.

EDUCATION (University of Nevada, Reno, Medical School)

1. Recruitment of medical students from rural areas.
2. Provide student experience and training in rural health care.
3. Establish family practice department in UNR Medical School.
4. Provide for consumer input in Medical School.
5. Train appropriate support personnel.
6. Subsidize medical students from rural areas.

EDUCATION (Continued Health Education)

1. Educate High School Counselors on health careers.
2. Establish a consumer health education program in such areas as:
   a) nutrition b) physical fitness c) accident prevention
   d) V.D. e) birth defects f) etc.
3. Coordinate Health Education in the state.

PRIORITIES

Education (con't.)

4. Educate consumers on how they can make use of the Nurse Practitioner and Physician Assistant's skills. Searchlight
5. Provide for the continued education of the P.A.s and the N.P.s.
6. Standardize training programs for Emergency Medical Services.
7. Educate rural consumers of what they can expect of a physician.
8. Education of the importance of emergency services.

COMMUNICATIONS AND PUBLIC RELATIONS

1. Create a state-wide group to assess the needs of communities (a state-wide health resource inventory).
2. Educate communities on the use of Health Care Delivery System.

MEDICAL SERVICES PROCUREMENT

1. Subsidize medical practice in rural areas:
   a) loans b) grants in form of facilities or guaranteed income.
2. Create group practices.
3. Coordinate physician and other medical personnel recruitment in the State.
4. Facilitate licensing of new physicians. The letter explaining the Basic Science requirement should be rewritten.
5. Provide continuity of care through the use of P.A.s and N.P.s in extended care facilities.