

2020-2025 Community Health Improvement Plan

Northern Nye County Hospital District, Nevada

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## EXECUTIVE SUMMARY

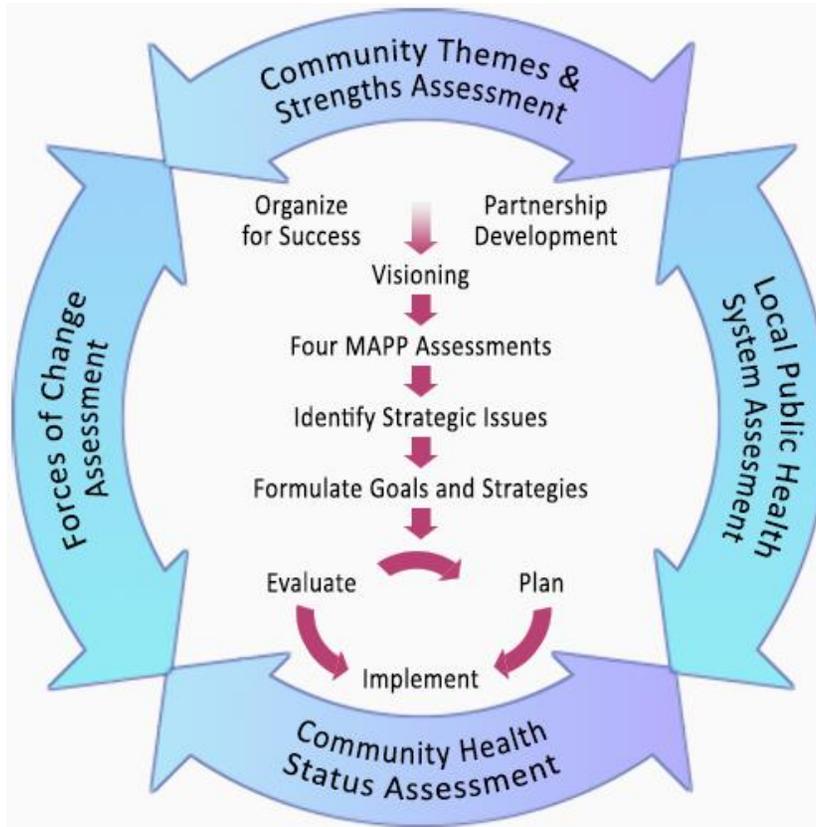
A community health improvement plan (or CHIP) is a long-term, systematic effort to address healthcare problems based on the results of community health assessment activities and the community health improvement process. A plan is typically updated every three to five years  
*(Source: CDC)*

This document is intended to describe the objectives and action steps the Northern Nye County Hospital District (hereinafter “Hospital District”) and various community members (hereinafter “Community Partners”) have developed to address healthcare needs.

It is important to note that these objectives and action steps were created in a problem-solving atmosphere. While Community Partners attempted to consider limitations to their suggestions, the goal was to develop and explore creative solutions given the relative lack of local resources.

The objectives and action steps in this CHIP include those that involve Community Partners. The Hospital District is operating under their own, separate set of guidelines and priorities.

The Hospital District and Community Partners followed the MAPP process for both the Comprehensive Health Needs Assessment (completed in May 2019) and this Community Health Improvement Plan, see below:



*(Source: University of Kansas, Community Tool Box)*

Each of the components of the MAPP process is discussed in a corresponding section below.

## ORGANIZING FOR SUCCESS/PARTNERSHIP DEVELOPMENT

The driving force behind this effort is the Hospital District. The Hospital District was created in May 2015 under the provisions of state law NRS 450.550 and including NRS 450.760 through Nye County Resolution No. 2015-17.

The purpose of the District is to facilitate the provision of accessible health care services to the residents of and visitors to Northern Nye County. The Board of Trustees recognizes that the delivery of health care services is a dynamic process, and the District must utilize its limited available financial resources in the best and most efficient manner possible. *(Source: nyecounty.net)*

Current Board Members include: Karmin Greber, Chair; Emily Hendrickson, Vice Chair; Justin Zimmerman, Secretary/Treasurer; Don Kaminski, Trustee; and, Timothy Gamble, Trustee. Lorinda Whichman acts as the liaison between the Nye County Commission and the NNCHD.

Since forming in 2015 the Board spent time forming relationships and agreements with Nye County, REMSA, and Renown. Recent board activities include:

- September 2018      NyE Communities Coalition was awarded a USDA grant. They contracted with Russell Pillers, PhD, owner of Biowerx Consulting, LLC, for the following two purposes:
1. Duckwater. Facilitate the creation of a USDA-compatible preliminary engineering report (PER) focused on the revitalization of the Duckwater area's agricultural irrigation system. The end product of this effort will be a pre-feasibility study
  2. Tonopah. Similarly, the final product will create a pre-feasibility study that includes, among other envisioned initiatives, a Preliminary Architectural Report (PAR) on the Nye Regional Medical Center
- October 2018      The Hospital District entered into a contract with Russell Pillers, PhD, owner of Biowerx Consulting, LLC, to conduct professional services in the development of an integrated healthcare delivery

system in Tonopah and the surrounding areas. Biowerx Consulting, LLC, assists NNCHD in their efforts to achieve goals of establishing a self-sustaining healthcare system that will effectively and efficiently address the health concerns of the population

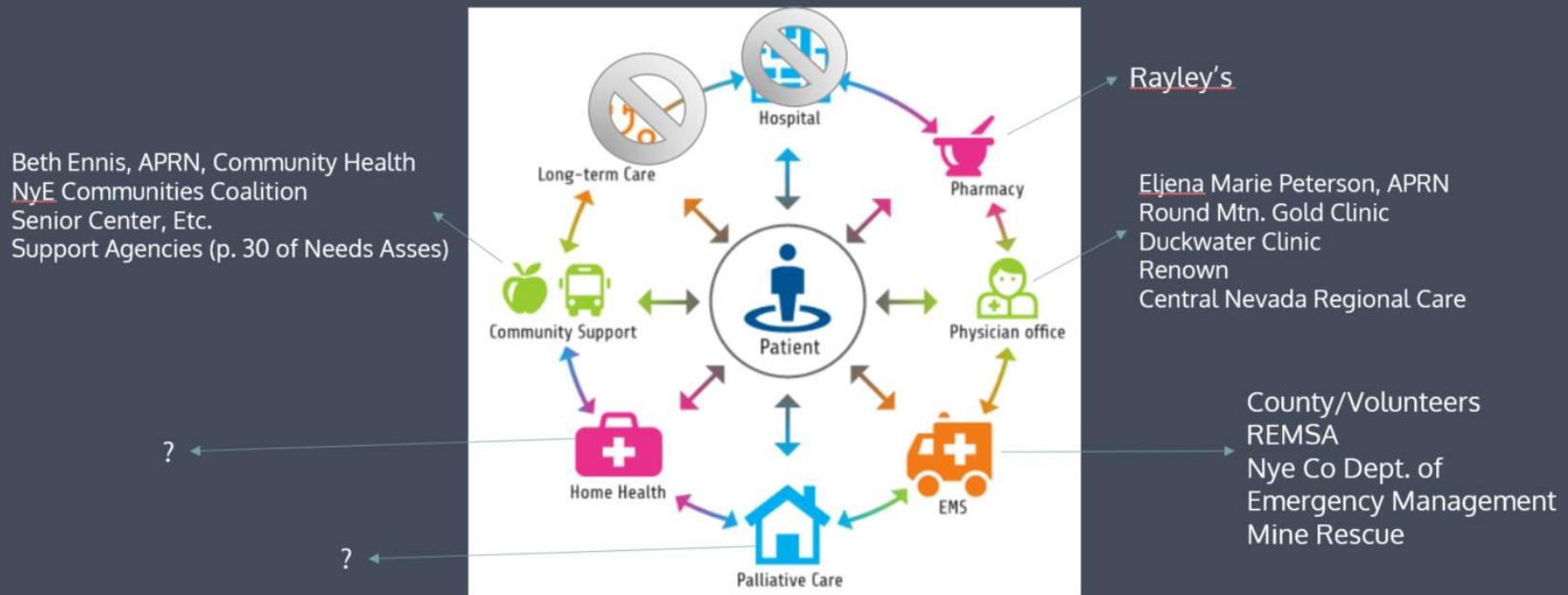
December 2018 The Hospital District entered into a contract with Margo Teague, MA, owner of Impact Evaluation & Assessment Services, to complete a Comprehensive Health Needs Assessment. The Needs Assessment was completed in May 2019. The board and Impact Evaluation then entered into a contract for the completion of this Community Health Improvement Plan.

December 2019 The Hospital District entered into an agreement with Central Nevada Regional Care for certain healthcare services. Their clinic will open in March 2020.

#### HEALTHCARE ECOSYSTEM IN NORTHERN NYE COUNTY

The following graphic depicts the healthcare system in Northern Nevada as of January 2020. This is constantly in flux as healthcare providers and community supports come and go.

# Local Healthcare System - Communication



Source: <https://markmdmph.wordpress.com/2015/09/30/transitions-of-care-or-improving-your-health-at-home/>

Representatives from several segments of the healthcare ecosystem (see graphic above) attended the Community Workshops, including emergency services personnel, Hospital District Board Members, healthcare providers, etc.

One of the “community support” agencies listed in the graphic above, NyE Communities Coalition (“NyECC”), is a particularly willing and capable partner in meeting healthcare needs. NyECC is a non-profit agency serving Nye County. Their missions is:

The mission of NyE Communities Coalition is to grow healthy organizations, people and environments (HOPE) across Nye, Esmeralda and Lincoln Counties by joining together individuals, organizations, and agencies in a cooperative and collaborative effort to increase services and opportunities. (*Source: nyecc.org*)

NyECC’s priorities for Tonopah and the surrounding areas for the 2019/2020 fiscal year include:

1. Support food pantries in general via Three Square or other funders
2. Establish consistent in-person/telehealth MH services across lifespan via Serenity Mental Health Services
3. Recruit two adults for before school school programs
4. Recruit two volunteers for food distribution to/from NYECC and pantries/school
5. Work with existing resources for non-emergency medical transport
6. Work on transportation for travelers stuck in Tonopah or people released from jail who want to go elsewhere
7. Develop childcare resources/access
8. Increase health care access

Several of these priorities closely parallel the strategic issues identified by Community Partners during CHIP workshops and are identified with their symbol throughout this document.



## COMMUNITY WORKSHOPS

Again, the purpose of the Community Workshops was to brainstorm solutions to address the 10 health-related needs identified in the Community Health Needs Assessment completed in May 2019. The following procedures were followed:

1. Margo Teague of Impact Evaluation & Assessment Services worked with all available local calendars and multiple key informants in the service area to schedule the dates and times for Community Workshops.
2. Ms. Teague recruited participants by emailing, telephoning and/or texting key informants she had met with during the completion of the Comprehensive Health Needs Assessment. A flyer was created (see Attachment 1). The flyer was emailed and posted to the Hospital District's Facebook page. It was subsequently shared on several other individuals' Facebook pages. NyECC forwarded the flyer through their listserve and the first workshop was held immediately following NyECC's regularly scheduled monthly meeting. All of these individuals were asked to share the invitation with anyone who might be interested and were invited to print the flyer. Printed flyers were seen posted at several locations throughout Tonopah.
3. Online meeting space was scheduled through Zoom and advertised for individuals who could not attend in person.
4. Unfortunately some key individuals were not aware of the first round of Community Workshops until the day they were held and participation was not as high as expected. The "Substance Abuse Prevention and Treatment" session was rescheduled to maximize participation.
5. Each workshop was facilitated by Margo Teague of Impact Evaluation & Assessment Services. Tiffany Grigory, Administrative Secretary for Northern Nye County Hospital District, attended each meeting.
6. Participants in each workshop reviewed data from the Comprehensive Health Needs Assessment and then discussed possible approaches given available resources. These discussions were captured by Ms. Teague and the results are included in strategic plans outlined below in the "Formulating Goals and Strategies" section.

## FOUR MAPP ASSESSMENTS

The four MAPP assessments (Community Strengths and Needs; Local Public Health System; Community Health Status; and, Forces of Change) are included in the Comprehensive Health Needs Assessment completed in May 2019.

A Comprehensive Health Needs Assessment is defined as follows:

A community health assessment (sometimes called a CHA), also known as community health needs assessment (sometimes called a CHNA), refers to a state, tribal, local, or territorial health assessment that identifies key health needs and issues through systematic, comprehensive data collection and analysis.

*(Source: CDC)*

The Needs Assessment is available for review through the Hospital District. The Needs Assessment identified the following priorities:

1. Emergency Care
2. Communication Protocols/Systems/Public Education
3. Behavioral Health
4. Substance Abuse
5. Geriatric Care
6. Cardiovascular Health
7. Maternal and Infant Care
8. Obesity
9. Dental
10. Vision

## IDENTIFYING STRATEGIC ISSUES

Community Partners met to identify strategic issues during the first Community Workshop on November 6, 2019, at 1:00pm. Criteria for selection of strategic issues, or issues that could potentially be impacted, included: size; seriousness; and, available resources. Community Partners concluded that all ten of the needs identified in the Comprehensive Health Needs Assessment were in fact strategic issues and chose to formulate strategic goals to identify each one.

## FORMULATING GOALS AND STRATEGIES

The Community Partners then met (see schedules in Appendix A) to formulate objectives and action steps to address each of the 10 needs listed above. They are addressed below in the order the Community Workshops were held, not in any order of importance.

As mentioned above, anyone who expressed an interest in healthcare was invited to these meetings. Community Partners also worked to invite agencies or individuals they knew to be already working on specific issues. For example, members expressly invited Public Health Nurse Beth Ennis when Maternal and Infant Care was addressed.

The objectives and action steps created by Community Partners for each of the identified health needs are set forth below. A Lead Partner volunteered for most objectives. Some of the objectives are without a Lead Partner as of this writing and are identified with pink shading. Potential Partners are also identified for each objective. These Potential Partners were identified by Community Partners during brainstorming sessions. Any omissions are strictly accidental. All interested parties are invited to participate on working groups. Working groups are encouraged to review Appendix A to the Comprehensive Health Needs Assessment when identifying a full list of potential partners.

### SHORTAGE OF DENTAL PROVIDERS

Objective 1: Increase Access to Dental Care		
Action Steps	Lead Partner	Potential Partners
Explore options for pop up (in a building) or mobile dental clinics (in a van or bus). Tasks include: 1) Exploring locations; 2) Recruiting provider(s); 3) Learning about licensing requirements; 4) Setting predictable schedule; 5) Determining levels/types of services provided;	Tiffany Grigory, Administrative Secretary for Northern Nye County Hospital District	Antonina Capurro, Nevada State Dental Health Officer  UNLV School of Dentistry  Southern NV Health District  NyE CC

<p>6) Determining which forms of payment will be accepted (e.g. which private insurances, cash, sliding fee, Medicare, Medicaid);</p> <p>7) Advertising availability, levels of service, pay sources, schedule, etc., throughout service area</p>		<p>Miles for Smiles</p> <p>Private Providers</p> <p>Local Businesses (Round Mountain Gold, etc.)</p> <p>Governmental Entities (e.g. County welfare, NV Test Site, etc.)</p>
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Notes

Community Partners would like to explore the idea of a single building that could be used by various specialty care providers (dental, vision, cardiology, etc.) on a rotating basis. Community Partners did not believe this was feasible in the existing hospital campus. The old Silver Rim Elementary School was suggested as a potential building that could be renovated for this purpose.

Community Partners explained that citizens lose trust and patience when providers start and stop services to an area. They want sustainability and predictability to be emphasized with this potential approach.

NyECC has an existing relationship with Dr. Capurro and offered to connect Tiffany Grigory.

Southern Nevada Health District may have an existing pilot grant for dental care. Again, sustainability was mentioned as a concern with grant-funded options.

There was some question about whether or not Miles for Smiles is still coming to Tonopah and whether there was a similar option for adults.

Community Partners would prefer that these services be available for people with or without private insurance, Medicaid, and Medicare.

Community Partners recommended that if this were to be a free service (grant-funded or otherwise) that marketing include a notice that people could make a donation. The idea is that people who can afford to travel out of town for dental care would be more willing to use a free service if they were able to make a donation.

## SHORTAGE OF VISION CARE PROVIDERS

Objective 1: Increase Access to Vision Care		
Action Steps	Lead Partner	Potential Partners
<p>Explore options for pop up (in a building) or mobile vision clinics (in a van or bus). Tasks include:</p> <ol style="list-style-type: none"> <li>1) Exploring locations;</li> <li>2) Recruiting provider(s);</li> <li>3) Learning about licensing requirements;</li> <li>4) Setting predictable schedule;</li> <li>5) Determining levels/types of services provided;</li> <li>6) Determining which forms of payment will be accepted (e.g. which private insurances, cash, sliding fee, Medicare, Medicaid);</li> <li>7) Advertising availability, levels of service, pay sources, schedule, etc., throughout service area</li> </ol>	<p>Stacy Smith, NyECC</p>	<p>Southern NV Health District</p> <p>Private Providers</p> <p>Local Businesses (Round Mountain Gold, etc.)</p> <p>Governmental Entities (e.g. County welfare, NV Test Site, etc.)</p>
Notes		
<p>Community Partners would like to explore the idea of a single building that could be used by various specialty care providers (dental, vision, cardiology, etc.) on a rotating basis. Community Partners did not believe this was feasible in the existing hospital campus. The old Silver Rim Elementary School was suggested as a potential building that could be renovated for this purpose.</p>		

Community Partners explained that citizens lose trust and patience when providers start and stop services to an area. They want sustainability and predictability to be emphasized with this potential approach.

Stacy Smith from NyE CC is aware of a mobile semi, Remote Area Mobile, which provides vision care for rural areas. The semi comes fully equipped but does require some local volunteers for set up and operation, including an Ophthalmologist or Optometrist. This service does not accept any type of insurance, all services are free of charge. Community Partners would prefer that these services be available for people with or without private insurance, Medicaid, and Medicare.

Community Partners recommended that if this were to be a free service (grant-funded or otherwise) that marketing include a notice that people could make a donation. The idea is that people who can afford to travel out of town for vision care would be more willing to use a free service if they were able to make a donation

## CARDIOVASCULAR DISEASE

Community Partners who attended the Strategic Issues Community Workshop believe that cardiovascular disease and obesity are very closely related. They did not, however, wish to collapse the two into the same category. Strategic plans related to diagnosis and treatment of cardiovascular disease are included under the "Cardiovascular Disease" section. Strategic plans related to diet and exercise are included under the "Obesity" section.

Objective 1: Increase Access to Cardiovascular Care Provider		
Action Steps	Lead Partner	Potential Partners
Explore options for pop up (in a building) cardiovascular clinic Tasks include: 1) Exploring locations; 2) Recruiting provider(s); 3) Setting predictable schedule;	Tiffany Grigory, Administrative Secretary for Northern Nye County Hospital District	REMSA  Sierra Cardiology  Private Providers

<p>4) Determining levels/types of services provided;  5) Determining which forms of payment will be accepted (e.g. which private insurances, cash, sliding fee, Medicare, Medicaid);  6) Advertising availability, levels of service, pay sources, schedule, etc., throughout service area</p>		<p>Local Businesses (Round Mountain Gold, etc.)   Governmental Entities (e.g. County welfare, NV Test Site, etc.)</p>
<b>Notes</b>		
<p>Community Partners would like to explore the idea of a single building that could be used by various specialty care providers (dental, vision, cardiology, etc.) on a rotating basis. Community Partners did not believe this was feasible in the existing hospital campus. The old Silver Rim Elementary School was suggested as a potential building that could be renovated for this purpose.</p> <p>Community Partners are uncertain whether patients would be willing to sever relationships with existing cardiologists out of town in order to see someone locally. A suggestion was made to survey residents to determine: 1) how many residents are in need of cardiology services; 2) where they are currently seeing a cardiologist; and, 3) whether they would be willing to see someone different locally. Recruitment efforts could then be centered on those cardiologists most often seen by patients living in the service area.</p> <p>Community Partners explained that citizens lose trust and patience when providers start and stop services to an area. They want sustainability and predictability to be emphasized with this potential approach.</p> <p>Community Partners mentioned that diagnostics (specifically EKG, sonogram, and blood work) are extremely important to cardiologists. See Objective 2 below.</p>		
<b>Objective 2: Increase Access to Local Diagnostic and Management Services</b>		
<b>Action Steps</b>	<b>Lead Partner</b>	<b>Potential Partners</b>
<p>Explore options. Specific tasks include:  1) Research mobile diagnostic options, such as a van, equipped with EKG and sonogram that could travel throughout service area</p>	<p>Tiffany Grigory,  Administrative Secretary for  Northern Nye County  Hospital District</p>	<p>Lab Corp   REMSA</p>

<p>2) Research whether existing providers may wish to add these diagnostics to their existing services</p> <p>3) Work with local providers and labs to decrease time lapses between blood draws and results and work around lapses when labs are required on or near a weekend</p>		<p>Sierra Cardiology</p> <p>Private Providers</p> <p>Local Businesses (Round Mountain Gold, etc.)</p> <p>Governmental Entities (e.g. County welfare, NV Test Site, etc.)</p>
<b>Notes</b>		
<p>Community Partners discussed complications when labs are needed on a Friday or over a weekend. The courier does not operate so labs are not analyzed in a timely fashion.</p> <p>Community Partners would prefer that any of these options for diagnostics and maintenance would be covered by all types of insurance, private pay, Medicare, and Medicaid.</p> <p>Community Partners believe that prevention is the biggest tool to fight cardiovascular disease. See "Obesity" section below.</p>		

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## OBESITY

Objective 1: Increase Opportunities for Exercise		
Action Steps	Lead Partner	Potential Partners
<p>1) Explore options for re-furbishing and re-opening Nye County Fitness Center (e.g. grant funding)</p>	<p>Emily Hendrickson, Round Mountain Gold</p>	<p>Hadley Rec Center</p> <p>Tonopah Fitness Club</p>

<p>2) In the alternative, explore options for re-furbishing and re-opening Silver Rim Elementary School as a recreation center</p> <p>3) Consider multi-purpose use of either facility to offset costs. One example was housing a physical therapist in the space</p> <p>4) Support and encourage local residents to offer exercise classes such as Zumba, yoga, or aerobics. Encourage and support these individuals to receive appropriate certifications</p> <p>5) Work with Town of Tonopah to advertise existing walking/exercise trail</p> <p>6) Create new or collaborate and re-invigorate existing community exercise events. Suggestions for collaboration included: Big Bill's Run; Walk the Rock; and, Bike-a-Thon. Suggestions for creation of new events included: dog walk; "Tough Mudder" (Mucker) endurance events; a 5K Poker/Health Run/Walk; host Ultimate Frisbee Tournament; and, the American Heart Association's Jump Rope for the Heart program</p> <p>7) Coordinate efforts of local employer's for Wellness Programs. Suggestions included creating a "step challenge" for employees incentivized with "get fit" gift baskets that include water bottles and pedometers</p>		<p>Senior Center</p> <p>Nye County School District PE/Health</p> <p>Tonopah City Pool</p> <p>Duckwater Rec Center</p> <p>NyECC</p> <p>Wellness Programs for local employers</p> <p>REMSA</p> <p>Private Providers</p> <p>Local Businesses (Round Mountain Gold, etc.)</p> <p>Governmental Entities (e.g. County welfare, NV Test Site, etc.)</p> <p>Civic Organizations (e.g. VFW, Rotary, Scouts, etc.)</p>
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## Notes

Community Partners are uncertain how many residents in the service area would regularly use a gym or rec center, however, they stated that Water Aerobics and Hasana Tribal Fusion Dance classes are well attended in Tonopah.

Community Partners mentioned that the service area's extreme heat, extreme cold, and high winds can hinder outdoor exercise, which is why the focus turned to indoor options.

Community Partners cited the lack of childcare as a barrier to this objective. They suggested the formation of a childcare co-op for parents or creating a volunteer system for young people interested in early childhood. They would like to see space dedicated to childcare in any facility that might be refurbished or used as a recreation center.



Community Partners believe that smaller employers struggle to implement wellness programs. The support listed in Action Step 7 above should be marketed and supported in such a way as to make a Wellness Program feasible for small employers. Community Partners also discussed the tight-knit culture of mining crews. Because these crews often view one another as family, Wellness Programs should emphasize accountability and mutual support.

### Objective 2: Increase Opportunities for Nutrition Education

Action Steps	Lead Partner	Potential Partners
1) Create a support group for local cardiology patients. This would include formal nutrition education and exercise opportunities and informal support. This may be an opportunity to collaborate with cardiologists from Objective 1 above	Karmin Greber	REMSA Sierra Cardiology  Private Providers  NyECC (already working on produce distribution)
2) Explore opportunities for collaboration with existing Nevada Main Street Economic Development Program for		

<p>a community garden and/or farmer's markets to increase access to fresh fruits and vegetables</p> <p>3) Invite local residents to provide healthy cooking classes for the community. Explore opportunities for partnering with existing nationwide programs (e.g. SNAP-Ed, Cook It Up!, etc.). Consider use of local school buildings, Convention Center, or (refurbished) Silver Rim Elementary to host</p> <p>4) Collaborate with local grocery store to post healthy recipes next to produce</p> <p>5) Explore options for supporting existing or creating new greenhouses at schools. One example given was the Round Mountain School Farm.</p>		<p>Tonopah High School (Megan Wilson)</p> <p>Raley's</p> <p>Subway Restaurant</p> <p>Nevada Main Street Economic Development Program</p> <p>Senior Center</p> <p>UNR Cooperative Extension Service</p> <p>Future Farmers of America</p>
Notes		
<p>Community Partners cited the lack of childcare as a barrier to this objective. They suggested the formation of a childcare co-op for parents or creating a volunteer system for young people interested in early childhood. They would like to see space dedicated to childcare in any facility that might be refurbished or used as a recreation center.</p>		

## EMERGENCY MEDICINE

Community Partners identified cardiovascular events as their main concern for emergency medicine. In the absence of a true emergency room, the following objectives were identified as steps that could be taken immediately to help protect the health of service area residents.

Objective 1: Educate Community About Existing Emergency Services		
Action Steps	Lead Partner	Potential Partners
<p>1) Create magnets and/or flyers for residents in service area that include directions about the following:</p> <ul style="list-style-type: none"> <li>a) Nurseline</li> <li>b) Providing 911 with accurate address and cross streets</li> <li>c) Accurately describing nature of emergency</li> <li>d) Accurately describing age of victim/patient</li> <li>e) Where to learn about emergency protocols for hazmat or mass casualty events</li> <li>f) Who to contact if the household has a member reliant on electricity (e.g. home dialysis or breathing machines)</li> </ul> <p>2) Capitalize on existing community events (e.g. spaghetti feed, Christmas programs at schools, etc.) by setting up a booth to share information with public</p> <p>3) Collaborate with Hospital District to issue routine, topic-specific "health bulletins." Suggestions included "what is the difference between REMSA and emergency flight companies?" and "what is the difference between urgent and emergency care?"</p>	<p>Steffanie Otteson and Naomi Wilde, REMSA</p>	<p>Local Ambulance Crews</p> <p>Local Law Enforcement</p> <p>Local Fire Personnel</p> <p>Hospital District</p> <p>Town Offices (include flyer in billings)</p> <p>Multi-Unit Housing</p> <p>Nye County School District</p>

Notes

As of this writing a proposal for Objective 1 is being considered by the Hospital District.

Community Partners suggested that this education approach may partially mitigate problems related to mapping issues in the service area.

**Objective 2: Collaborate with Local Emergency Planning Committee (LEPC)**

Action Steps	Lead Partner	Potential Partners
1) Determine steps necessary to become more involved with LEPC, including being included in communication protocols for emergency events	Don Kaminski	Scott Lewis, Director of Emergency Management, Nye County, NV
2) Explore possibility of hosting disaster drill in service area with LEPC support		REMSA
3) Determine if a reverse 911 system is available in the service area for emergency notifications		Local Ambulance Crews Local Law Enforcement  Local Fire Personnel

Notes

Community Partners mentioned that they are not all familiar with local equipment or personnel available or protocols for large-scale emergencies. For example, some of them only learned about availability of emergency trailers because of the recent "Storm Area 51" prank.

**Objective 3: Continue to Work on Communication Problems with 911 Dispatch Center in Pahrump**

Action Steps	Lead Partner	Potential Partners
1) Consider hosting a field trip to service area for dispatch officers housed in Pahrump to better orient them. 2) Continue to work to resolve barriers to installing "Spillman" in all ambulances and at fire station 3) Explore options for re-instating a local dispatcher	Don Kaminski	Scott Lewis, Director of Emergency Management, Nye County, NV  REMSA  Local Ambulance Crews  Local Law Enforcement  Local Fire Personnel

**Notes**

Community Partners mentioned that they often rely on the mapping apps on their personal cell phones because the on-board mapping system is not up-to-date.

Community Partners explained that dispatchers in Pahrump do not fully understand that they are being dispatched from their homes, or from their regular places of businesses, rather than from a central location. This can hinder communication.

Community Partners at this particular workshop expressed appreciation for the opportunity to meet and would like routine meetings (perhaps quarterly) so they can keep informed of each other's strengths and struggles.

Objective 4: Implement Active Shooter Plan and Trainings		
Action Steps	Lead Partner	Potential Partners
1) Create, support and publicize Active Shooter Plan and trainings	Chris Perham, REMSA	Scott Lewis, Director of Emergency Management, Nye County, NV  REMSA  Local Ambulance Crews  Local Law Enforcement  Local Fire Personnel
Notes		
None.		

## GERIATRIC CARE

Community Partners believe that all of the objectives and action steps outlines in this CHIP will impact the older population, but there are a few strategies that specifically target increasing the health of this population.

Objective 1: Increase Access to Hearing Services		
Action Steps	Lead Partner	Potential Partners
1) Determine if there is an audiologist who would be willing to travel to the service area routinely for screenings and hearing aid fittings and checks. See	VACANT	Senior Center Medicare

discussion of "pop up clinics" above in the Vision, Dental, and Cardiology strategic plans		
Notes		
Community Partners discussed how isolating hearing loss can feel to senior citizens and how much it reduces their quality of life. There are no local options for audiology.		
Objective 2: Increase Access to Hospice Care		
Action Steps	Lead Partner	Potential Partners
1) Determine if there is a way to support and expand the services of the Comfort Hospice Care located in Round Mountain	VACANT	Senior Center Private Providers Hospital District Medicare Comfort Hospice Care
Notes		
None.		

Objective 3: Increase Access to Home Health Care		
Action Steps	Lead Partner	Potential Partners
<p>1) Support legislation that would allow REMSA Community Paramedics to provide home health services</p> <p>2) Research opportunities to support Comfort Hospice Care (Round Mountain) in their efforts to add home health care to their services</p>	VACANT	<p>Senior Center</p> <p>REMSA</p> <p>Private Providers</p> <p>Hospital District</p> <p>Medicare</p> <p>Medicaid</p> <p>Comfort Hospice Care</p>
Notes		
<p>Community Partners explained the difficulties associated with moving an elderly friend, relative, or neighbor away from their hometown to a large city so they can receive home health services. The consensus of Community Partners is that people would be much more content and it would be better for families if elderly or sick individuals could receive home health services at home.</p>		
Objective 4: Increase Access to Prescription Medications		
Action Steps	Lead Partner	Potential Partners
<p>1) Explore options of an on-call pharmacist or technician at Raley's for weekends and after hours. This would be for emergency medications only such as insulin</p> <p>2) Explore options for a medication courier service. Community Providers suggested this is already happening between Raley's and the Round Mountain Clinic</p>	VACANT	<p>Senior Center</p> <p>Raley's</p> <p>REMSA</p> <p>Private Providers</p>

<p>3) Provide training and informational brochures for Raley's, case workers, the senior center, and private providers regarding patient assistance programs through pharmaceutical companies</p> <p>4) Explore option for Raley's Pharmacist to fill prescriptions during working hours that could then be picked up by customers and sold by a tech during off hourse</p>		<p>Hospital District</p> <p>Medicare</p> <p>Medicaid</p>
Notes		
<p>Community Partners discussed the lack of support if an elderly person runs out of necessary medication after hours or during a weekend.</p>		
Objective 5: Provide Opportunities for Elderly Population to Seek Their Own Solutions/Provide Input		
Action Steps	Lead Partner	Potential Partners
<p>1) Specifically invite elderly population to attend regularly scheduled Hospital District Meetings</p> <p>2) Consider hosting viewing sessions of Hospital District Meetings at Senior Center, perhaps with question and answer period to follow</p>	<p>Tiffany Grigory</p>	<p>Senior Center</p> <p>REMSA</p> <p>Private Providers</p> <p>Hospital District</p> <p>Medicare</p> <p>Medicaid</p>
Notes		
<p>None.</p>		

Objective 6: Increase Access to Vaccinations		
Action Steps	Lead Partner	Potential Partners
1) Support vaccination clinic for vaccines specific to elderly population (high dose flu, pneumonia, shingles, and TDAP)	Beth Ennis, Public Health Nurse	Senior Center Raley's REMSA Private Providers State of NV Dept. of Public Health
Notes		
Community Partners explained that vaccination clinics often require medical support. In other words, the public health nurse cannot host a vaccination clinic by herself.		
Objective 7: Increase Access to Case Workers/Patient Navigators		
Action Steps	Lead Partner	Potential Partners
1) Research and publish options for patient navigators through Medicare or State offices 2) Request that any provider seeking support or assistance from Hospital district provides some form of patient advocacy or case management, especially for elderly population	VACANT	Senior Center REMSA Private Providers State of NV Division of Aging and Disability Services
Notes		
Community Partners explained that vaccination clinics often require medical support. In other words, the public health nurse cannot host a vaccination clinic by herself.		

## MENTAL HEALTH CARE

Community Partners who attended the Mental Health and Substance Abuse Community Workshops believed that the two topics are very closely related. Community Partners did not, however, wish to collapse the two into the same category.

In addition, Community Partners did not appreciate the terms “Mental Health” or “Mental Illness”. They would prefer this need to be referred to as “Mental Health Wellness” from now on.

Objective 1: Increase Access to Mental Health Wellness Education Opportunities		
Action Steps	Lead Partner	Potential Partners
1) Research and market availability of mental health wellness classes or workshops (e.g. Mental Health 1 <sup>st</sup> Aid and Safe Talk)  2) Specifically encourage employers to allow employees to take these courses during working hours to maximize participation	VACANT	NyECC  Stacy Burns, Regional Behavioral Health Coordinator  Private Providers
Notes		
Not all Community Partners were aware of existing resources. These courses prepare parents, friends, co-workers, and others to recognize and react appropriately to mental or behavioral health crises in others.		

Objective 2: Implement "Sequential Intercept Model"		
Action Steps	Lead Partner	Potential Partners
1) Research and implement Sequential Intercept Model for judicial system, first responders, and law enforcement. This would include Crisis Intervention Training (CIT) for law enforcement officers	Tiffany Grigory	NyECC  Stacy Burns, Regional Behavioral Health Coordinator  Local law enforcement
Notes		
"Sequential Intercept Model" is a conceptual tool that identifies five points at which standard criminal processing can be interrupted to offer community alternatives" (Munetz & Griffin, et al).		
Objective 3: Work with Nye County School District to Reduce Stigma and Increase Education		
Action Steps	Lead Partner	Potential Partners
1) Explore options for collaborating with school(s) to create a video that de-stigmatizes seeking help for a mental or behavioral health issue and provides information about who to turn to if a young person or their friend is struggling  	Sarah Allen	NyECC  Stacy Burns, Regional Behavioral Health Coordinator  Nye County School District
2) Determine if there is a way to support social workers, guidance counselors, or community health workers already working in schools		

Notes		
Community Partners mentioned that NyECC hopes to add a Community Health Worker to their staff soon. If this comes to fruition this person will be available to facilitate these types of activities.		
Objective 4: Encourage Employers to Include Mental Health Wellness in Employee Wellness Programs		
Action Steps	Lead Partner	Potential Partners
1) Refer to Action Step #7 under "Obesity" strategic plan above. Include information about mental health wellness resources available through insurance coverage (e.g. Employee Assistance Programs, call lines or free visits) and local providers	VACANT	NyECC  Stacy Burns, Regional Behavioral Health Coordinator  Wellness Programs for local employers  Private Providers  Local Businesses (Round Mountain Gold, etc.) Governmental Entities (e.g. County welfare, NV Test Site, etc.)  Civic Organizations (e.g. VFW, Rotary, Scouts, etc.)
Notes		
None.		

Objective 5: Encourage High-Quality Tele-Health Services		
Action Steps	Lead Partner	Potential Partners
<p>1) Research and market continuing education opportunities for those who provide tele-health to maximize their effectiveness</p> <p>2) Consider requiring any mental health wellness providing seeking support from the Hospital District to provide proof of attendance at tele-health continuing education</p>	VACANT	<p>NyECC</p> <p>Stacy Burns, Regional Behavioral Health Coordinator</p> <p>UNR School of Medicine</p> <p>Private Providers</p>
Notes		
<p>The success of tele-health, especially for mental health wellness, is highly dependent on the skills of the provider. There are specific classes available to support high quality tele-health service provision.</p>		

**SUBSTANCE ABUSE PREVENTION AND TREATMENT**

Objective 1: Increase Adult Substance Abuse Education Efforts		
Action Steps	Lead Partner	Potential Partners
<p>1) Refer to Action Step #7 under "Obesity" strategic plan above. Include information about substance abuse treatment resources available through insurance coverage (e.g. Employee Assistance Programs, call lines or free visits) and local providers</p> <p>2) Partner with NyECC to create and market prevention campaign geared toward adults</p> 	VACANT	<p>NyECC</p> <p>Stacy Burns, Regional Behavioral Health Coordinator</p> <p>Private Providers</p> <p>Wellness Programs for local employers</p> <p>Local Businesses (Round Mountain Gold, etc.)</p> <p>Governmental Entities (e.g. County welfare, NV Test Site, etc.)</p> <p>Civic Organizations (e.g. VFW, Rotary, Scouts, etc.)</p>
Notes		
<p>Community Partners believe that much adult substance abuse stems from undiagnosed or untreated mental illness. They believe that increasing access to mental health treatment (see previous strategic plan) will result in lower substance abuse rates.</p>		

Community Partners recommended that any prevention efforts geared toward adults focus on the following:

- a) Dispelling the myth that the “work hard/play hard” ethic has to include substance abuse
- b) Dispelling the “Nevada image” of alcohol and tobacco indulgence
- c) Use humor adults will appreciate. One example offered was, “Remember the Marlboro man? He’s dead.”

**Objective 2: Decrease Harms Resulting from Adult Substance Abuse**

Action Steps	Lead Partner	Potential Partners
1) Work with local law enforcement and health care providers to re-institute more efficient legal blood draw protocol to detect DUI  2) Work with NyECC to provide Responsible Alcohol Server Training for local bars and restaurants  	VACANT	NyECC  Private Providers  Local Law Enforcement

**Notes**

None.

**Objective 3: Support Efforts to Prevent Substance Abuse Among Youth**

Action Steps	Lead Partner	Potential Partners
1) Support parent education efforts, specifically related to dangers of marijuana use and the idea there is no risk to young people who drink alcohol at home or under the supervision of their parents	VACANT	NyECC  Private Providers  Local Law Enforcement



2) Seek opportunities to support existing substance abuse prevention efforts (e.g. MAGIC is a University of Nevada Cooperative Extension funded in part by NyECC and "Positive Actions" is through Nevada Outreach program NO to Abuse).



3) Seek opportunities to support Juvenile Probation

Notes

None.

Objective 4: Support Alcohol-Free Entertainment Options

Action Steps

Lead Partner

Potential Partners

1) See Action Steps for increasing physical exercise options under "Obesity" strategic plan above

VACANT

NyECC  
Private Providers  
Local Law Enforcement  
Town Boards  
Parks and Rec Departments

2) Explore opportunities to support healthy alternatives. Examples provided included a bowling alley and free movie nights)

Notes
None.

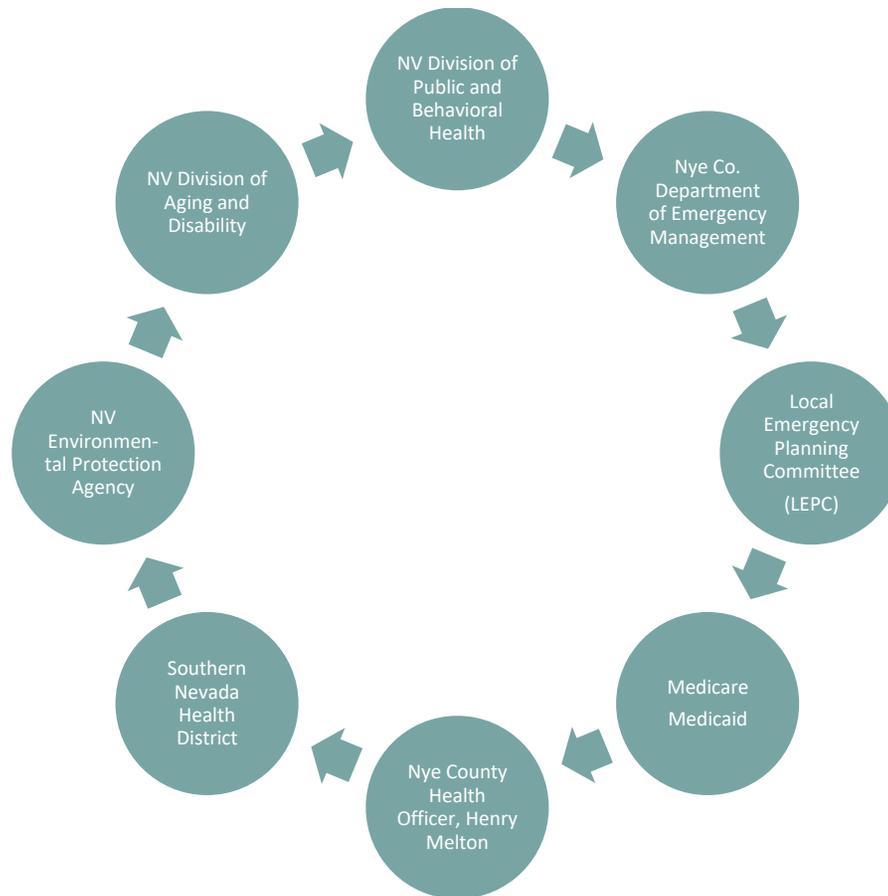
## MATERNAL AND INFANT CARE

Objective 1: Educate Population About Need For Early Prenatal Care and Available Local Resources		
Action Steps	Lead Partner	Potential Partners
<p>1) Support Beth Ennis, Public Health Nurse, in her efforts to educate population about the need for early prenatal care*</p> <p>2) Support Beth Ennis in creation and distribution of educational posters/flyers. Suggested locations for posting included: hair salon; apartment complexes; near pregnancy tests in stores; WIC; County Human Services Office; thrift store; laundry mat; Post Office; and schools</p>	Beth Ennis, Public Health Nurse	<p>Family Resource Center (Ashley)</p> <p>Private Providers</p> <p>REMSA</p> <p>NyECC (especially for Tobacco Quitline)</p>
Notes		
<p>*Beth Ennis defined "early" as being in the first 8-9 weeks of a pregnancy. Recommended screening and education include: blood work; nutrition education; taking a complete health history and making any necessary referrals; referrals for substance abuse treatment; and, beginning case management protocols. Community Partners believe it is important to emphasize that early prenatal care can be provided by any medical provider. Expectant mothers do not have to travel out of town to see an obstetrician for this early care.</p>		
Objective 2: Increase Support for Newborn Health		

Action Steps	Lead Partner	Potential Partners
<p>1) Support existing parent education efforts (e.g. Cribs for Kids, carseat programs, WIC, County Welfare, etc.)</p> <p>2) Explore options to increase access to newborn health support including: breastfeeding education; postpartum depression screening; and well-baby checks. Suggestions included implementing a home health model or adding this to REMSA community paramedic services</p> <p>3) Provide information packets to hospitals where mothers from the service area typically deliver their babies (e.g. Fallon, Bishop, Las Vegas, Reno, etc.) containing contact information for local resources</p> <p>4) Support creation of “mommy and daddy groups” that will provide a conduit for sharing health information and camaraderie among new parents</p>	VACANCY	<p>NyECC</p> <p>Family Resource Center WIC</p> <p>Local Law Enforcement (esp. for carseats)</p> <p>Governmental Entities (e.g. County welfare, NV Test Site, etc.)</p>
Notes		
None.		

### COMMUNICATION/SYSTEMS/PUBLIC EDUCATION

This section has implications for improving all of the other identified health needs. The following graphic depicts some of the entities involved with public health in the service area:



The Community Partners were tasked with developing plans for improving communication and systems collaboration between all of these entities and the Northern Nye County Hospital District with the goal of improving health outcomes for people living in the service area.

Objective 1: Encourage Centralized Office/Position for Health-Related Communications		
Action Steps	Lead Partner	Potential Partners
<p>The current administrative support staff for the Hospital District (Tiffany Grigory) is willing to act as a liaison between the Hospital District, NyECC, state, county, and town entities, and the general public. This can be facilitated through:</p> <ol style="list-style-type: none"> <li>1) Publicizing contact information (email, telephone number, address)</li> <li>2) Formally communicating with state, county, and town entities to inform them of Hospital District existence, goals, and contact information</li> <li>3) Establish and maintain communication with other regional hospital districts and health boards</li> <li>4) Attend and network at events where health providers gather (e.g. UNR's Nevada Rural Healthcare Day)</li> <li>5) Attending NyECC monthly meetings.</li> </ol>	Hospital District	Entities in Graphic Above
Notes		
<p>Community Partners described the following scenario as an example of increased communication and partnership: Representatives from the Medicare office in Pahrump visit the service area routinely. They do their best to advertise these visits, but are frustrated by low turnout. They know they are not reaching all of the people who need their services while they are here. Community Partners suggested that if the Medicare representatives contacted the Hospital District Administrative Support office ahead of time, that person could then reach out to local providers, senior centers, NyECC, and others to ensure that the maximum number of people heard about this opportunity. The administrative support staff is in a position to form relationships and know who is in need of these services.</p>		

**Objective 2: Create and Support Efforts for Public Education**

Action Steps	Lead Partner	Potential Partners
<p>1) Explore options for setting up secured “health boards” throughout service area that are specific to health-related information. Information on these boards would be pre-approved and posted only by the Hospital District. It would include information such as upcoming vaccination clinics, information about existing or new health services in the area, nutrition or education information, etc. Community Partners suggested the health board in Tonopah could be located near the car charging center</p> <p>2) Support and publicize routine, rotating open houses for service providers to familiarize citizens with availability, types of services, etc. For example, EMS could host one quarter, Marie Peterson another quarter, and so on. This is similar to the “Business After Hours” hosted by Chambers of Commerce</p> <p>3) Other venues for communication suggested by Community Partners included: Facebook; senior centers; an electronic reader board in front of the existing hospital campus; sending brochures out with Meals on Wheels; and, pharmacy</p> <p>4) Organize and host routine (perhaps annual) “resource fairs” where community members can learn about health services and social supports available in the service area</p> <p>5) Create and distribute a printed footsteps-type map of resources. An example provided was from Bishop, CA</p>	<p>Hospital District</p>	

6) Create an email list of providers, case managers, and other interested parties to share Hospital District agendas, links to recorded meetings, flyers, etc.		
Notes		
None.		
<b>Objective 3: Systems Collaboration</b>		
<b>Action Steps</b>	<b>Lead Partner</b>	<b>Potential Partners</b>
<p>1) Host and otherwise support informal, routine gatherings of local providers to improve collaboration, communication and service delivery coordination</p> <p>2) Attend (in person and via web or phone connections) as many statewide meetings as possible (see page 106 of Comprehensive Health Needs Assessment for a list) and ask to be included on any of their email lists</p>	Hospital District	
Notes		
None.		

The following two issues (housing and transportation) were not identified as specific health needs, but were identified by the Community Partners as imperative for each strategic issue:

## HOUSING

Objective 1: Increase Access to Affordable Housing		
Action Steps	Lead Partner	Potential Partners
1) Work with local low income and/or subsidized housing managers to keep informed of availability, accessibility, potential partnerships	Vacant	
Notes		
Community Partners noted that there is a lack of affordable housing in the service area. This can impact the health and well-being of citizens, especially those on fixed incomes or low income.		

## TRANSPORTATION

Objective 1: Non-Emergency Medical Transport		
Action Steps	Lead Partner	Potential Partners
1) Explore and publish reimbursement rates and procedures for non-emergency medical transportation through Medicaid, Medicare, and Lyft  2) Work with Albert Bass, Mobility Manager, to explore options for non-emergency medical transport  	Tiffany Grigory	Albert Bass, Mobility Manger, NyECC

## Notes

Community Partners defined “non-emergency medical transport” as: 1) transport from service area to routine medical appointments and back; and, 2) transport from hospital or care facility back to service area (e.g. after a hospitalization).

## IMPLEMENTATION

Keeping in mind that this CHIP spans the timeframe of 2020-2025, Community Partners and the Hospital District will follow the following implementation plan:

1. Community Partners and the Hospital District will form working groups based on each of the topics listed above.
2. The first working group meeting will be called and led by the “Lead Partner” listed above. Each working group will then determine their own leadership and delegation of tasks.
3. Each working group will determine the frequency and location of their meetings.
4. Each working group will advertise their meetings to gain maximum interest/participation from community members and healthcare providers.
5. Working groups will strive to have representation from at least one Northern Nye County Hospital District Trustee and one person employed in the healthcare industry.
6. Working groups will determine if they will meet for a full topic (e.g. “Geriatric Care”) or if they will meet for one specific action step (e.g. “Research Home Health Options”).
7. Each working group will complete a “Stoplight Report” (see Attachment 2) each time they meet and will forward the Stoplight Reports to the Administrative Secretary for the Hospital District.

8. The contents of the Stoplight Reports will be summarized and reported during routine Hospital District and NyECC meetings in an effort to keep all parties informed of progress and obstacles and to maximize participation. These Stoplight Reports will also be used for any future evaluation (see below).
9. The strategic plans outlined in the “Formulating Goals and Strategies” section above can be updated or altered at the discretion of each working group as goals are accomplished and/or changed. Any changes to strategic plans, however, should be detailed in Stoplight Reports and provided to the Administrative Secretary for the Hospital District.
10. Community Partners requested that this CHIP be presented to the various town boards and Nye County Commissioners when it is completed for their input and to gain support and participation.

## EVALUATE

The Hospital District is not currently under contract with an external evaluator, however planning and implementation efforts have been designed with evaluation in mind.

An evaluation plan should be developed that clearly defines which aspects of the CHIP will be evaluated, how data will be collected, and responsible parties. In the meantime, the Hospital District will continue to maintain minutes of Hospital District meetings and will gather Stoplight reports from working groups.

# Health Care Community Workshops

## It's Time to Act!



The Northern Nye County Hospital District is working to improve healthcare



We are seeking input from ALL COMMUNITY MEMBERS for our Action Plan



- Wednesday, November 6**
  - 1:00pm Strategic Issues/Kick Off
  - 2:00pm Dental and Vision
  - 4:15pm Cardiovascular Disease
  - 6:15pm Emergency Care
- Tuesday, November 19**
  - 3:00pm Strategic Issues/Refresher
  - 4:00pm Geriatric Care
  - 6:15pm Mental Health
- Thursday, November 7**
  - 9:00am Obesity
  - 11am Substance Abuse
- Wednesday, November 20**
  - 9:00am Maternal/Infant Care
  - 11am Communication/Systems Public Education

## How to Participate



Tonopah Convention Center  
301 Brougner Ave,  
Tonopah, NV



Want to contribute but can't be in Tonopah?  
Join Zoom Meeting  
<https://zoom.us/j/805188192>

## What is this all about?

At the direction of the Northern Nye County Hospital District, a Comprehensive Health Needs Assessment was completed in May 2019. Ten issues were identified as priorities.

THIS IS WHERE YOU COME IN!

We are seeking input from all community members to develop an action plan to address these issues. Come to any session that interests you, or all of the sessions!



Margo Teague  
margo.impactevaluation@gmail.com



Justin Zimmerman  
Justin.B.Zimmerman@gmail.com

-or-



# Health Care Community Workshops

## It's Time to Act!



The Northern Nye County Hospital District needs  
**YOUR** help to improve health in our area



Tuesday, November 19  
3:00pm Substance Abuse  
4:00pm Geriatric Care  
6:15pm Mental Health

Share your ideas  
about improving  
health in Northern  
Nye County



Wednesday, November 20  
9:00am Maternal/Infant Care  
11am Communication/Systems  
Public Education

Join us for any or all  
sessions

## How to Participate



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Margo Teague  
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-or-

Justin Zimmerman  
[Justin.B.Zimmerman@gmail.com](mailto:Justin.B.Zimmerman@gmail.com)

**ATTACHMENT 2 –STOPLIGHT REPORT**

<b>Working group:</b>	<b>Date:</b>
-----------------------	--------------

<b>GREEN/COMPLETE</b>	<b>YELLOW/WORK IN PROGRESS</b>	<b>RED/CAN'T COMPLETE AT THIS TIME AND HERE'S WHY</b>