Joint Task Force and Work Group
Meeting Notes

Date:	***June 24, 2015***	**Location:**	*9075 West Diablo Drive* *Las Vegas, NV* *Suite 250*
Time:	*3:00 – 5:00 pm (PT)*	**Call-In #:**	*(888) 363-4735*
Facilitator:	*Jerry Dubberly*	**PIN Code:**	*1329143*

Purpose: Present to the workgroups the proposed aims and primary drivers as recommended to date by stakeholders in previous individual task force and work group meetings.

Jan Prentice explained that the purposes of holding a joint meeting of all work groups and taskforces are to validate the information we have heard thus far, to update all participants regarding possible solutions that have been offered, to get further input from stakeholders, and to shape the agenda for the upcoming workgroup and taskforce meetings.

Jerry Dubberly added that the group needs to affirm or redefine the aims and primary drivers to promote transformation, and he asked the group to consider whether the proposed solutions are complete and appropriate.

Going forward the task forces and work groups will need to be focused and work in collaboration to answer the questions posed during the presentation as well as other components of the solution that may arise during those discussions.

Jan Prentice shared comments from the Executive Committee regarding their desire to adopt a phased-in approach for SIM initiatives with the youth population as the first phase. CMS was contacted to confirm whether the population-specific phased-in approach will be acceptable. The Executive Committee believes starting smaller with a narrow focus and rolling out other populations later will be more manageable. Ms. Prentice indicated that even with the phased-in approach, the proposed solutions from stakeholder input are doable.

Jerry Dubberly presented the challenges, barriers, and the proposed aims, drivers, and solutions collected from stakeholder meetings. A consistent theme heard from the communities is that a holistic approach looks at non-traditional services that contribute to health. A general question was asked if Nevada could add areas of focus other than the CMS-required tobacco cessation, obesity, and diabetes. The group was advised that this is permissible, and CMS encourages states to make sure their SIM Plan addresses the unique needs of the state. The sections below summarize the discussion which followed each of the main topics presented.

Access

Brenda Staffan with REMSA stated that access to behavioral health services is a determinant and will vary based on payer source and that there will be both access and payer source issues for behavioral health. Bill Welch, with the NV Hospital Association agreed there is a provider shortage and reminded the group that there is a difference between a shortage situation and a healthcare access shortage due to providers' willingness to participate and engage.

Gene Gantt mentioned that respiratory therapists could further address the shortage issue by allowing practitioners to spread out what they can do (i.e. practice at the top of their license) but there is a reimbursement issue that would need to be addressed.

Patient Centered Medical Homes (PCMH)
Dr. Lee stated the devil is in the details and the success of the PCMH depends on how it is defined. Chris Bosse agreed and stated that until PCMH is defined and the baseline is known, it is hard to respond to whether the 80% target is a good number. Not everyone needs a medical home. She recommended focusing on chronic conditions.

Jan Prentice recommended the work groups drill down and define PCMH for SIM purposes.

Nancy Hook reminded the group that SB 6 defines PCMH and the bill was signed by the Governor, and can be used as a starting point.

Joan Hall recommended speaking to people who have obtained NCQA certification and said it was aggressive to think that 80% will be tied to certified PCMHs by 2019.

Health Homes
Brenda Staffan recalled from a CMS bulletin that there are specific parameters for defining a patient as a frequent user and a super user. She believes that 3 – 11 Emergency Department visits was a frequent user and a super user had more than 12 visits. In defining frequent use and super user, REMSA also looks at the record of 911 calls because not all calls result in a transport to the Emergency Department. However, high use of the 911 system could be part of the definition of a superutilizer. The information regarding 911 calls was obtained from work conducted with UNV/CHIA; Dr. Larson and Dr. Yang.

Telemedicine
Joan Hall stated that Renown has a great system. The cost of equipment is the biggest barrier. Joan mentioned that some of the rural health clinics and FQHCs still struggle with bandwidth issues.

Bill Welch stated the challenge in NV is that they are building broadband capacity to the hospitals only; not to the physician offices and community centers. The technology for them to be involved requires resources. To get federal grants they have to put up 30% - 50% of dollars (not in-kind contributions). He stated that he believes one SIM state planned to allocate funds to develop telemedicine, understanding that it is a real potential solution to access.

Joan Hall stated their members use Project ECHO, but funding is an issue. She believes it is worthy of funding because when she looks at rural NV, she sees that the efforts of Project ECHO are keeping patients at home instead of transporting to specialists because rural doctors can get the specialty help they need. Chris Bosse mentioned that the issue with payers is that there is no direct patient care and therefore payers have not made reimbursement available.

Paramedicine
Chris Bosse asked if the REMSA model is being replicated and whether the model is sustainable now. Brenda Staffan said that sustaining it comes before replicating it. They are measuring outcomes, providing proof of concept, then looking at sustainability and replicating the program.

Fergus Laughridge said their experience at Winnemucca is that paramedicine is reducing the number of readmissions, which is part of ACA. Joan Hall agrees that Humboldt has set up a process that works with the hospital employing the EMS personnel. However, in much of rural NV, EMS personnel are volunteers. There are no paramedics and no method to get them employed. It is not clear who would employ them, except for the Fire Departments.

Fergus Laughridge pointed out that there is a difference between paramedicine and paramedics. The services can be intermediate or basic. Each of the 17 counties has different systems on how they deliver pre-hospital care. There could be a different method based on the community needs. He recommended conducting a needs assessment.

Jan Prentice indicated there would need to be an assessment, and a lot of work still needs to be done by the groups.

Community Health Workers (CHW)
Fergus Laughridge stated that as part of their model at Humboldt, community paramedicine serves as that trusted individual/advocate. A handful of selected individuals were sent to training to learn interaction skills. They may or may not be a direct provider of care but they know resources to get the patients the care they need.

Joan Hall said that training has been developed for CHWs and Monica Morales has great experience, knowledge, and data on CHW program. Ms. Hall agreed that the Native American and Hispanic populations are helped by CHWs. She also suggested looking at the work of the Governor's Workforce Investment Board.

Jan Prentice mentioned that in other workgroup meetings Monica Morales has shared information about the CHW program and DHCFP is working with her. DHCFP has also reached out to Indian Health Services

Regional Health Improvement Office
Jan Prentice indicated that Regional Health Improvement Offices are truly innovative. She is aware that counties are doing similar work and it is something that DHCFP is looking at.

Joan Hall stated that from the rural perspective, the community coalitions would be a great resource.

Deb Sisco and Jan Prentice mentioned that the community coalitions have participated in other workgroup meetings and other conversations.

Existing Initiatives
Chris Bosse appreciates identifying specific populations because phasing-in populations feels manageable to try some things out and make some headway instead of trying to solve for all of the populations.

Dena Schmidt said within the Department they have 2 or 3 National Governor's Association initiatives that are child-focused or behavioral health-focused. Clark County also has a homeless initiative. The Division of Aging and Disabilities has initiatives as well. She said that departmentally they need to gather that information and chart it out.

A representative of Clark County Social Services stated she could help provide information on targeting the medically fragile people who are frequent users of the Emergency Room, as well as the chronically homeless.

Katie Baumruck works closely with Children's Heart Center, as discussed in other workgroup meetings. She is also working on the BIPP team to oversee the 2-1-1 project. They are switching their phone call provider. The 2-1-1 program is trying to connect all of their databases and felt the SIM grant could help with that initiative.

Daniel Mathis recommended adding enhanced LPN training so that LPNs can provide a greater array of services in the post-acute care setting.

Additional Topics
Brenda Staffan asked if a multi-payer collaborative is intended and are other payers being recruited to help participate in the SIM stakeholder forums.

Jerry Dubberly replied that the SIM grant has always been intended ultimately for all payers. Those listed (Medicaid/CHIP, Public Employees, Indian Health Services, Culinary Fund) agreed at the time of the grant to participate. The goal is to have other payers join as well.

Jerry Dubberly also reinforced that all of the changes have to be supported by health information technology.

Chris Bosse asked if registry data such as immunizations could be used.

Jerry Dubberly replied that registry data, including immunization registries and cancer registries will be used. In fact, other states utilize social media as well, but that raises questions about the reliability of data and how it is validated.

Chris Bosse asked if *HealthyNevada* was at the table because they have a master patient index. It was affirmed that they are. Dena Schmidt offered her help in moving the HIT issue to appropriate key personnel.

Jerry Dubberly asked if anyone was aware of other landmark bills that might be important to the SIM project. None were offered by the group. However, Chris Bosse made the point that some of the barriers to moving forward are not a state-level policy lever, but federal. For example, Medicaid recipients cannot be incentivized or steered to access care at an appropriate level based on the way CMS writes the rules. Jan Prentice mentioned that CMS Technical Assistance is available to help address those issues and provide guidance.

Deb Sisco indicated that CMS Technical Assistance partners were on the call and she is glad that they are hearing from the stakeholders in their own words.

Closing Points

Jan Prentice recommended the task force and work group participants think about how to start focusing on the youth groups. She stated that we don't have to have everything fully operational and ready to stand up 2/1/2016, but there needs to be a plan. The phased-in approach allows for one piece in the next year; and another piece that may not be implemented until four or five years out.

Bill Welch recommended identifying common barriers across all payers to prioritize strategies. He offered that many things would be addressed if the private sector was involved. We should identify those barriers and draw the private sector to the table.

Jan Prentice reiterated the need to develop the payer collaboration group.