Provider Workgroup
Meeting #1 Notes

Date:	***May 8, 2015***	**Location:**	*Carson City, NV*
Time:	*4:00 – 6:00 pm (PDT)*	**Call-In #:**	*(888) 363-4735*
Facilitator:	*Jay Outland*	**PIN Code:**	*1329143*

Purpose: Meeting to identify areas of focus for Provider Workgroup.

In attendance –

NV – Deb Sisco, Jan Prentice, Chani Overli, Missy Sanford
MSLC – Jerry Dubberly, Jay Outland, Charlyn Shepherd, Catherine Snider, Ruthanne Freeman

Nancy Hook (NV Primary Care Association), Larry Trilops (Renown), Todd Sklamberg (Sunrise Hospital), Gail Yant (University medical center), Mike Johnson (St. Mary's)
.

The background was given by Jay via PowerPoint.

Mr. Johnson Care Management should be added to the agenda.

Jan gave an overview of the uncertainty regarding a Phase 3 funding opportunity. 80% payments VBP by 2019

Access to Care Discussion

- Mr. Johnson – Access to care and effective ways to integrate Behavioral Health (BH) and Physical health (PH). Ex. cannot bill BH and PH on same day.
- Larry – Care Teams. Licensing board and Medical board needs to consider how care teams work together and how care is delivered. (Ex. APRN cannot delegate some activites to MAs since they work under the MD and not the APRN.) Refer this issue to the Policy and Regulatory Taskforce.
- Nancy – Scope of practice debate extends to pharmacists and the work they can do in managing the patient.
- Nancy – Community Health Centers have started using CHWs but very clinical and not so much community resource. Focus on certification, curriculum, etc. because this started as a job stimulation program.
- Gail – NY has robust CHW program.
- Jan – role of CHWs as navigators to help individuals get connected with care and learn how to access health care services.
- Jay – Paramedicine
- Larry – would like to see paramedicine work throughout the state but not sure there is capacity with the paramedic workforce.

- Nancy – Have to look at how much NV depends on the DPBH to provide services in the rural area because they do not have the private sector to contract with.
- Jan asked how we could fix that issue? Nancy says we need more community health centers to provide comprehensive care.
- Nancy - RHC to convert to FQHC but too tied to CAH to make a move.
- Jan – we have heard about relationships in the rural model with hub and spoke model to get greater access to care for its residents.
- Nancy – a strong FQHC is going to do more than hub and spoke approach or traveling doc.
- Jan – Recruiting docs is still challenging
- Nancy – If FQHC, then federal dollars to attract providers to rural areas.
- Jay- Barriers to growth of FQHCs – Nancy-Primary Care Association was fairly inactive until the last couple of years ago. Need 18 months of start-up funding to get FQHC status. There has not been state support. Population is small in most areas. FQHC needs to be associated with a health care system to leverage the enterprise functions.
- Mr. Johnson – in rural areas, people may not have the "health IQ" that is needed to navigate health care system or better access
- Larry – Non-brick and mortar – telemedicine but more than that need to have greater access like through nurse call centers to help triage and coordinate
- Deb – the call center is part of the REMSA model – Larry- works well but how do you fund it?
- Mr. Johnson – with call center you still need to know where to refer people to and that is still an issue in rural areas.
- Nancy – No payment for patient touches. Have to rethink the payment system.
- Johnson – look at all payer types and use of chronic care management even through telephonic programs but have to recognize limits and make sure there is value. Different people need different approaches to care management.
- Larry – Not short term investments. Need sustainable funding recognizing it's a long term investment.
- Jerry – Attracting additional providers. Mr. Johnson – additional incentives like offset to loans or subsidies to set up practice in a rural area.
- Nancy- still have to have community ability to support a provider and some just don't have that. There is no state match to draw down federal dollars to support loan forgiveness programs offered by the feds so give back millions of dollars per year.
- Nancy – need to focus on primary care to take care of basic needs and avoid progression of diseases. Pay for performance – have to able to realize return is in future period.
- Nancy- obesity is not solved in the exam room. Need community resources.
- Mr. Johnson- Social determinants of health and the 80902 (?) project (check notes from clinical outcomes meeting)
- Deb- CMS is interested in challenging and innovative plans.
- Mr. Johnson – new grant being pursued to focus on food security, under/unemployment, housing, access to health care (Through the Arnold Foundation)
- Charlyn –ACO and PCMHs in the state- what percent is paid for through those models and what makes it attractive to you?

    - Larry- Renown has an ACO but has not seen a lot from reimbursement. An ACO teaches you how to take risk for a population. That is their mission with the ACO experience.
    - Larry - Medicare shared saving is really a withhold program.
    - Nancy- no one pays a differential for PCMH services.
    - Larry- No incentive to become a PCMH and make that investment
    - Larry – in home monitoring. Mr. Johnson even with in home monitoring, there is an issue with connectivity.
- Johnson ER Data – need more uniform reporting of data from emergency encounters because ER is more about presenting diagnosis than about diagnosis.
- Gail – ER physicians at her facility are using the HIE data to view information especially regarding frequent fliers and finding this very helpful
- Nancy- need to work with those frequent fliers and get those patients connected with primary care resources.
- Johnson – Need to get frequent fliers connected with case manager which makes a huge impact but there is no reimbursement.
- Gail – Use HIE to help with ER diversion and to avoid duplicative services/procedures
- Mr. Johnson – Don't forget emergency transport to get the folks to the ER which only adds to the cost.

Next meeting we will discuss Provider Shortages and Pay for Performance Models.