Meeting Minutes
February 2, 2016

Mission: *To organize healthcare stakeholders by providing a structured forum for sharing valuable knowledge, finding common solutions, and identifying resources to improve health outcomes, improve quality and patient experience of care, and to lower costs of care in the region.*

Members: Dr. Kevin Rich, Co-Chair; Dr. David Peterman, Co-Chair; Russ Duke, CDHD, Public Health District Director; Gina Pannell, SHIP Manager; Jennifer Burlage; Dr. David Gough; Matt Johnson; Luis Lagos; Deena LaJoie; Lyle Nelson; Todd York; Dr. Troy Clovis; Dr. Karl Watts; Dr. George Beauregard; Melissa Mezo
Members Absent: Megan Stright; Kelli Fairless
Guests: Carolyn Brammer; Kim Thurston; Melissa Dilley; Mindy Anderson; Miro Barac; Rob Howarth

Agenda Item	Outcome	Process	Person
Welcome and Introductions 1:00-1:15	Identify CHC Members	Round Robin	Russ Duke
Discussion: Russ Duke, PHD Director, welcomed the attendees, and introduced CHC Co-Chairs, Dr. Rich and Dr. Peterman. Introductions of CHC Members were made. *Action Items:* None			
PCMH Recognition Process 1:05-1:45	Increase knowledge on PCMHs commitment to change when seeking recognition	Presentation PHMG Pediatrics: Medical Home Coordinator Perspective FMRI: Physician Perspective	Gina Pannell Gina Pannell Kevin Rich
Discussion: Gina Pannell explained the NCQA PCMH Recognition Process and presented PowerPoint which included PCMH key components, recognizing bodies, content and scoring, clinician and clinic eligibility, and provided a personal perspective on PCMH Transformation from her experience as a Medical Home Coordinator at Primary Health Pediatrics by depicting Pre-PCMH/Post-PCMH progression. Dr. Peterman stated that the concept of the SHIP grant stems from the Federal government reinforcing the need to improve healthcare and the PCMH model is Idaho's chosen method to meet the triple aim. The Regional Collaborative is tasked with supporting and augmenting these SHIP clinics through their transformation. The CHC will need to identify critical health needs that could be met by PCMH's working together. Dr. Rich provided his perspective on PCMH - PCMH is a journey, not a destination and everyone has their own definition. FMRI was recognized under the 2008 NCQA standards and are now re-recognized under 2011 standards. Each time they apply for recognition the focal point is on how to make patients the center of care. A few things they've done are: • Healthcare used to be delivered in physician centered care, now moving to patient centered care. • Switched to advanced open access scheduling, and found that no show rate dropped from 30% to 12%.			

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- Developed a new phone system adding the ability for patients to get access to a human to address their needs, and are led to triage nurse system from RN's.
- Developed a secure messaging patient portal, which allows email messaging between providers and patients, and are now starting to look at texting as another mode of communication.
- Developed a Behavioral Health Integration System.
- Developed Care Managers that work w/ populations of health and patients at risk, using referral tracker.
- Developed a patient advisory committee where patients examine and express their experience within their practice and use these experiences to drive change.
- Population health registries and standardization across their clinics is an important thing. It has not easy, but is necessary to make this work.

Dr. Rich stated that one role of the CHC is to assist and be peer mediators and supports for practices that are going through this for the first time, as well as help build the Medical Health Neighborhood.

Dr. Watts agreed with Dr. Rich and Dr. Peterman, stating that this process is hard, challenging, and transformative, but after talking to providers at recognized clinics they unanimously agreed they did not want to revert to the way healthcare used to be practiced. Providers realize the value and patient comment about how PCMH model of care works better. He stated NCQA recognition does not guarantee that your quality is going to improve and that PCMH transformation is a continuous effort.

Action Items: None

CHC Member Roles 1:45-2:10	Improve understanding of why you were selected for the CHC	Discussion	Russ Duke Gina Pannell Kevin Rich David Peterman

Discussion: Gina Pannell asked the group what they see their role on the Collaboration as. Answers were as follows:

- Dr. Gough stated that his goals are the triple aim and improving the health of the community. He views his work would be to create a functional system in terms of care. They have more independent physicians and would like to figure out how to integrate the die-hard independents, align independent providers w/ employed providers, and align common objectives while maintaining autonomy and keeping the patient at the center. He hopes to synchronize providers from different walks of life and employment and compensation models to get to a standard that is functional and works in real time. Dr. Gough has added a 4$^{th\ goal}$ to his mantra – Joy in practice for providers. He believes that if physicians are happy and that will translate into a better patient experience.
- Dr. Beauregard stated that 90% of his practice and leadership experience has been in the Boston market, which is about 3 to 5 years ahead of Idaho. He has seen providers organize into big networks taking on PCMH. He feels that the Collaboration needs to think about the "what's next?". He is hopeful that his 15 years of experience is helpful to the group.
- Lyle Nelson liked the question of "what's next?". What interests him most is the integration of the community. He hopes to bring ideas or contributions about social structure and aligning community of what we are doing and creating a culture of health.
- Todd York is interested in getting provider/payer perspective aligned regarding compensation. As payers, they can see when the patient goes to another provider or another facility, and feel that all aspects of care need to be examined.
- Melissa Mezo would like to see the integration of medical/dental/behavioral health. She can contribute by bringing other ideas to the table, and seeing/sharing what they can do to help the community.
- Jennifer Burlage would like for the Collaboration to look at how we can integrate Behavioral Health

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services more, not with medications, but services that could help in a more holistic way.

Action Items:

WHO	WHAT	WHEN
Gina	*1. Coordinate with Nick Nolte from the Federal Reserve Bank to present on Health Collaboratives from other states by May* *2. Gather and synthesize clinic transformation plans to present to the CHC*	*4/5/2016*

Group Discussion 2:10-2:30	Identify contributions, solutions, next steps.	Discussion	All

Discussion: Dr. Watts asked if there have been any similarities in each of the Regional Collaboratives goals and focuses. Miro Barac addressed this by stating that each Collaborative is going in their own direction, but the main goal is PCMH transformation support and Medical Health Neighborhoods to go beyond these clinical points of care.

Gina brought up that most Regional Collaboratives are in their infancy, and are trying to figure out how to move forward.

WHO	WHAT	WHEN
Gina	*1. Provide update on the other Regional Collaboratives throughout the state*	*4/5/20126*
All CHC Members	*2. Prepare 1-2 ideas to discuss with the CHC on what your organization may be doing that already supports the CHC goals.*	*4/5/2016*

Next Meeting: Tuesday, April 5th, 2016 1:00 p.m. – 2:30 p.m.

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