



# Idaho Healthcare Coalition

## Meeting Agenda

Wednesday, April 13, 2016, 1:30PM – 4:30PM

JRW Building (Hall of Mirrors)

1<sup>st</sup> Floor East Conference Room

700 W State Street, Boise, Idaho

Call-In Number: 877-820-7831; Participation Code: 302163

**Attendee URL:** <https://access.dhw.idaho.gov/meeting/21991374/827ccb0eea8a706c4c34a16891f84e7b>

**Attendee Smartphone URL:**

[junospulse://?method=meeting&action=join&host=access.dhw.idaho.gov&meetingid=21991374&signin=access.dhw.idaho.gov%2Fmeeting%2F&stoken=827ccb0eea8a706c4c34a16891f84e7b](https://junospulse://?method=meeting&action=join&host=access.dhw.idaho.gov&meetingid=21991374&signin=access.dhw.idaho.gov%2Fmeeting%2F&stoken=827ccb0eea8a706c4c34a16891f84e7b)

**Password:** 12345

1:30 p.m.	Opening remarks, roll call, introduce any new members, guests, any new DHW staff, agenda review, and approval of 3/9/2016 meeting notes – <i>Denise Chuckovich, Co-Chair</i> - <b>ACTION ITEM (2)</b>
1:35 p.m.	Workforce Development Presentation – <i>Dr. David Schmitz, Chairman, Idaho Health Professions Education Council</i>
2:05 p.m.	Communications Materials and Dashboard – <i>Katie Falls, Mercer &amp; Jenny Feliciano, Mercer</i> – <b>ACTION ITEM</b>
2:35 p.m.	Results of Learning Collaborative Evaluations and Coaching Call Updates – <i>Pat Dennehy, HMA</i>
3:00 p.m.	Break
3:15 p.m.	CHEMS Update and Transition to Workgroup – <i>Mary Sheridan, Bureau Chief, Bureau of Rural Health and Primary Care</i> - <b>ACTION ITEM</b>
3:30 p.m.	Regional Collaboratives Update – <i>Lora Whalen, Panhandle District RC (Region 1) &amp; Dr. Andrew Baron, Southwest District RC (Region 3)</i>
3:45 p.m.	Clinical Quality Measures Update – <i>Dr. Andrew Baron, CQM Chair</i> - <b>ACTION ITEM</b>
3:55 p.m.	Co-Chair for Multi-Payer and HIT Workgroups – <i>Casey Moyer, DHW</i> - <b>ACTION ITEM (2)</b>
4:05 p.m.	SHIP Operations and Advisory Group Reports/ Updates – Please see written report (SHIP Operations and IHC Workgroup Reports –March, 2016): <ul style="list-style-type: none"><li>• Presentations, Staffing, Contracts, and RFPs status – <i>Cynthia York, DHW</i></li><li>• Regional Collaboratives Update – <i>Miro Barac, DHW</i></li><li>• Telehealth, Community EMS, Community Health Workers – <i>Miro Barac, DHW</i></li><li>• HIT Workgroup – <i>Burke Jensen, DHW</i></li><li>• Multi-Payer Workgroup – <i>Dr. David Peterman, Primary Health and Jeff Crouch, Blue Cross of Idaho, Workgroup Chairs</i></li><li>• Clinical Quality Measures Workgroup – <i>Dr. Andrew Baron, Terry Reilly Clinics, Workgroup Chair</i></li><li>• Behavioral Health/Primary Care Integration Workgroup – <i>Ross Edmunds, Behavioral Health Division, Workgroup Co-Chair</i></li><li>• Population Health Workgroup – <i>Elke Shaw-Tulloch, Health Division, Workgroup Chair</i></li><li>• IMHC Workgroup – <i>Dr. Scott Dunn, IMHC Workgroup Chair</i></li></ul>
4:20 p.m.	Additional business & next steps – <i>Denise Chuckovich, Co-Chair</i>
4:30 p.m.	<b>Adjourn</b>

## Mission and Vision

The goal of the SHIP is to redesign Idaho's healthcare system, evolving from a fee-for-service, volume based system to a value based system of care that rewards improved health outcomes.

**Goal 1:** Transform primary care practices across the state into patient-centered medical homes (PCMHs).

**Goal 2:** Improve care coordination through the use of electronic health records (EHRs) and health data connections among PCMHs and across the medical neighborhood.

**Goal 3:** Establish seven Regional Collaboratives to support the integration of each PCMH with the broader medical neighborhood.

**Goal 4:** Improve rural patient access to PCMHs by developing virtual PCMHs.

**Goal 5:** Build a statewide data analytics system that tracks progress on selected quality measures at the individual patient level, regional level and statewide.

**Goal 6:** Align payment mechanisms across payers to transform payment methodology from volume to value.

**Goal 7:** Reduce overall healthcare costs



# Idaho Healthcare Coalition

## Action Items

April 13, 2016

- Action Item 1 – Minutes

IHC members will be asked to adopt the minutes from the last IHC meeting:

Motion: I, \_\_\_\_\_ move to accept the minutes of the March 9, 2016, Idaho Healthcare Coalition (IHC) meeting as prepared.

Second: \_\_\_\_\_

Motion Carried.

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- Action Item 2 – Recommendation for Appointment to IHC

IHC members will be asked to provide a recommendation to the Governor for appointment to the IHC.

Motion: I, \_\_\_\_\_ move that the Idaho Healthcare Coalition recommend the governor appoint Katherine Hansen to the IHC.

Second: \_\_\_\_\_

Motion Carried.

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- Action Item 3 – Communication Plan Materials

IHC members will be asked to adopt the SHIP Communications Plan materials as presented by Mercer.

Motion: I, \_\_\_\_\_ move that the Idaho Healthcare Coalition adopt the SHIP Communications Plan materials as presented by Mercer.

Second: \_\_\_\_\_

Motion Carried.

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- Action Item 4 – Community Health Emergency Medical Services

IHC members will be asked to accept the CHEMS advisory group's transition to a workgroup as presented by Mary Sheridan.

Motion: I, \_\_\_\_\_ move that the Idaho Healthcare Coalition accept the CHEMS advisory group's transition to a workgroup as presented by Mary Sheridan.

Second: \_\_\_\_\_

Motion Carried.

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■ Action Item 5 – Clinical Quality Measures

IHC members will be asked to adopt the updated Clinical Quality Measures for the SHIP as presented by Dr. Baron.

Motion: I, \_\_\_\_\_ move that the Idaho Healthcare Coalition adopt the updated Clinical Quality Measures for the SHIP as presented.

Second: \_\_\_\_\_

Motion Carried.

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■ Action Item 6 – Multi-Payer Workgroup Chair

IHC members will be asked to accept Josh Bishop as the new co-chair of the Multi-Payer Workgroup as presented.

Motion: I, \_\_\_\_\_ move that the Idaho Healthcare Coalition accept Josh Bishop as co-chair to the Multi-Payer Workgroup.

Second: \_\_\_\_\_

Motion Carried.

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■ Action Item 7 – Health Information Technology Workgroup Chair

IHC members will be asked to accept Janica Hardin as the new co-chair of the Health Information Technology Workgroup as presented and provide a recommendation to the governor for appointment to the IHC.

Motion: I, \_\_\_\_\_ move that the Idaho Healthcare Coalition accept Janica Hardin as co-chair to the Health Information Technology Workgroup and recommend the governor appoint her to the IHC.

Second: \_\_\_\_\_

Motion Carried.



# Idaho Healthcare Coalition

## Meeting Minutes:

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**SUBJECT:** Idaho Healthcare Coalition      **DATE:** March 09, 2016

**ATTENDEES:** Dr. Ted Epperly, Denise Chuckovich, Cynthia York, Josh Bishop, Scott Carrell, Jeff Crouch, Dr. Keith Davis, Russell Duke, Ross Edmunds, Lisa Hettinger, Yvonne Ketchum, Deena LaJoie, Dr. David Peterman, Dr. Robert Polk, Susie Pouliot, Dr. Kevin Rich, Neva Santos, Elke Shaw-Tulloch, Larry Tisdale, Cynthia York, Nikole Zogg

**LOCATION:** 700 W State Street, 1<sup>st</sup> Floor East Conference Room

**Teleconference:** Dr. Mike Dixon, Rene LeBlanc, Dr. Casey Meza, Carol Moehrle, Dr. David Peterman, Lora Whalen, Dr. Bill Woodhouse, Grace Chandler, James Corbett, Pat Dennehy, Dr. Mark Horrocks, Rhonda DeAmico

**Members Absent:** Director Richard Armstrong, Dr. Andrew Baron, Melissa Christian, Dr. Scott Dunn, Senator Lee Heider, Dr. Glenn Jefferson, Maggie Mann, Daniel Ordyna, Dr. David Pate, Tammy Perkins, Mary Sheridan, Dr. Boyd Southwick, Karen Vauk, Anne Wilde, Representative Fred Wood

**DHW Staff** Ann Watkins, Miro Barac, Casey Moyer, Kym Schreiber, Taylor Kaserman, Alexa Wilson, Burke Jensen

**Guests:** Rachel Harris, Gina Pannell, Norm Varin, Sandeep Kapoor, Ashish Virmani, Amy Osborne, Kevin Martin, Cory Serber

**Mercer:** Katie Falls

**STATUS:** Draft 03/14/16

## Summary of Motions/Decisions:

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**Motion:** Jennifer Wheeler moved to accept the minutes of the February 10, 2016, Idaho Healthcare Coalition (IHC) meeting as prepared.

Russell Duke seconded the motion.

Motion carried.

**Motion:** Dr. Keith Davis moved that the Idaho Healthcare Coalition adopt the SHIP Communications Plan materials as presented by Mercer.

Josh Bishop seconded the motion.

Motion carried.

**Motion:** Dr. Keith Davis moved to accept the Population Health Workgroup Spectrum of Population Health Concept Document as presented.

Jeff Crouch seconded the motion.

Motion carried.

**Motion:** Dr. Keith Davis moved to accept the Statewide Healthcare Innovation Plan Operations update as presented.

Susie Pouliot seconded the motion.

Motion carried.

## Agenda Topics:

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**Opening remarks: “Eat food. Not too much. Mostly plants. Get healthcare. Not too much. Mostly primary care.” Michael Pollan, Dr. Epperly**

- ◆ Dr. Epperly called the roll, and welcomed everyone.
- ◆ Dr. Epperly called for a motion to approve the minutes from February 2016.

### Agenda Topics

**Introduction to Data Analytics Contractor – Sandeep Kapoor, CEO HealthTech Solutions:**

- ◆ Mr. Kapoor introduced himself and his team from HealthTech Solutions. HealthTech Solutions is based in Kentucky and has been in business for five years. The company has grown to more than 75 employees since its inception.
- ◆ The majority of the work done by HealthTech Solutions is around Health Information Technology and working with electronic health records. Currently operating in sixteen states and with the federal government.
- ◆ Mr. Kapoor gave examples of work HealthTech Solutions has been doing in Wyoming. Mr. Kapoor provided screenshots of dashboards depicting the use and tracking of health information data. This work is in alignment with what Idaho is trying to do and what work they will be doing in Idaho throughout their contract. In Wyoming they worked to include data from providers, clinics, claims and members information

to work as a whole. The goal was to provide actionable information to states utilizing a large amount of data from diverse sources.

- ◆ Dr. Epperly then asked the IHC members if they had any questions for Mr. Kapoor on his presentation and the work he and his team will be doing in Idaho. Yvonne Ketchum had questions on how the Idaho data analytics work compares and contrasts to Wyoming and the work done there; Mr. Kapoor answered that in Wyoming they have worked with Medicaid data and claims data.
- ◆ Jeff Crouch mentioned the recent Supreme Court ruling on data and how states submit data. Mr. Kapoor answered that this will be handled based on what the state of Idaho decides in terms of data submission. Scott Carrell mentioned how HealthTech's expertise will greatly assist with the complex nature of this project, including the means of data collection. Yvonne Ketchum asked if HealthTech Solutions would just be working with data from SHIP clinics or if it is accessible for other clinics as well. Mr. Kapoor answered that the contract is currently just for clinics participating in SHIP.
- ◆ Dr. Epperly thanked Mr. Kapoor for his presentation and is looking forward to seeing how HealthTech's work plays out.

**Project Management Update – Katie Falls, Mercer:**

- ◆ Ms. Falls presented an overview of the Master Project Management Plan that Mercer has been working on with the Idaho Department of Health and Welfare staff. The Mercer staff hopes to have it completed by the end of March.
- ◆ The Mercer team is also working on a draft dashboard that will help measure progress toward goals of the Model Test for review by the IHC, It is currently being reviewed and edited by the IDHW staff and will go to Dr. Epperly for review and feedback before the April IHC meeting.
- ◆ Ms. Falls presented the brochure Mercer designed for SHIP PCMH clinics as part of the communication toolbox. The IHC members gave feedback on the brochure content and its use to promote the benefits of PCMH transformation to Cohort 1 Clinic patients.
- ◆ Ms. Falls went over brochure content and how it can be a useful tool. If there are changes that a user would like to make, please refer all edits to the IDHW staff to ensure the best wording for these documents is being used and to keep these materials consistent.
- ◆ Members of the IHC asked Ms. Falls questions regarding the brochure and how to use it properly. It was requested that the brochures also be available in Spanish.
- ◆ Casey Moyer demonstrated the IHC member page of the SHIP website to show how members can access the communication toolkit documents approved by the IHC. Ms. Falls asked for a motion to have the brochure approved and asked IHC members what they would like developed next. There was a question about how clinics will access these brochures and it was announced that they will also be made available through the Brilljent/HMA clinic portal. Powerpoint content will be loaded to the Brilljent portal for clinics to use.

**Brilljent update on Learning Collaborative w/PCPs – Grace Chandler, Brilljent:**

- ◆ Ms. Chandler provided an update on Cohort 1 Clinics' PCMH training and implementation that has taken place since the beginning of February. Catherine Snider from Myers and Stauffer updated the IHC members on incentive payment measure one; all 55 clinics have met this incentive payment. The second incentive payment is next on the list for HMA and they will be working with clinics to reach accreditation levels in order to qualify for this incentive payment. Brilljent and HMA are both working on tracking performance participation and the measurement of clinic participation in webinars/learning collaboratives.
- ◆ Pat Dennehy gave an overview of the learning collaboratives that took place last week in Boise, ID. The public health district staff participated in the first learning collaborative on Monday and Tuesday. HMA is

working with public health district staff members to further their training to become effective practice facilitators.

- ◆ Ms. Dennehy described the learning collaborative that took place with cohort one clinics at the University of Phoenix. She discussed the two day learning collaborative and training opportunity for clinics. HMA is still collecting information from clinic participants and determining how they are going to accommodate those who were unable to join in person on March 2-3. A webinar of the learning collaborative was discussed Ms. Dennehy talked about the diversity among the clinics; a lot of clinics wanted to know differences in NCQA recognition between 2011 and 2014, to answer these questions HMA is putting together a webinar in the near future. At that time, they will address these questions. Ms. Dennehy provided an overview of the learning collaborative content and the take aways from clinic staff. Evaluations of the learning collaborative are still being aggregated and a report will be provided in the near future.
- ◆ Dr. Epperly asked if members had any comments or questions on Ms. Dennehy's or Briljent's presentation.
- ◆ Dr. Davis commented on the learning collaborative and the excellence of the speakers. Feedback from his staff - their favorite feature was visiting with other clinics and interacting with them.
- ◆ Cynthia York mentioned a comment she received from Dr. Rich. His takeaway was that he learned he needed to connect with hospitals' transition of care committees. Dr. Rich stated he has already started to connect with them. His observation was that even though there are some clinics that are more advanced in PCMH transformation; there is still a lot to learn from HMA and other clinics.

**Regional Collaborative Report – Miro Barac, SHIP Operations & RC representatives:**

- ◆ Dr. Epperly introduced the speakers that represented each regional collaborative.
- ◆ Mr. Barac provided an update on work that he is doing with Mercer to develop project management plans for Goals three and four from the Statewide Healthcare Innovation Plan. This will be done by the end of the month and will be used to create operational plans for the Regional Collaboratives.
- ◆ Lora Whalen presented on what is currently taking place in region one. They have met three times and are planning a kick off on March 30<sup>th</sup>. The collaborative has discussed challenges and what they need from the IHC; their ask is they are looking for help with Nextgen EMR and access to more data to determine their selection of clinical quality measures.
- ◆ Dr. Kelly McGrath presented from region two; they have met once and are meeting next Tuesday in a face to face meeting. All clinics in their region are already NCQA level three. They are developing their medical neighborhood and working on how to support subsequent cohorts. Regarding the medical neighborhood; they are asking for help on how to develop the medical neighborhood and its components. They would like to know if they need several small medical neighborhoods or is the whole region working as one large medical neighborhood. The collaborative is hoping to get this online in the next six months or by the September meeting. The regional collaborative would also like help with measuring medical neighborhood performance and behavioral health integration.
- ◆ Rachel Harris presented on region three efforts. The region has fifteen established members and is making sure to keep a diverse group in relation to the care community. As a collaborative the region has had three meetings and are meeting once a month. They have sent out invitations for workgroups across the region to talk with their peers on PCMH transformation. For medical health neighborhoods they are creating workgroups to identify health groups within the community and how to support health care across these communities. The collaborative is involved in several healthcare coalitions within their region.
- ◆ Gina Pannell presented on region four where the collaborative has nineteen members in their collaborative and fourteen clinics are represented. The collaborative has tried to create a diverse regional collaborative with various members throughout the health care community. Next steps are waiting for PCMH transformation plans to help clinics on areas they would like to work on individually. The collaborative is working on referral networks and referral management systems and to identify different challenges of

clinics and providers. They will be meeting again in April. Region four's collaborative would like to maximize any help that the IHC members are giving to other collaboratives.

- ◆ Dr. Davis presented on region five; key points that he gave were that the collaborative has met seven times. The collaborative needs representatives from the Sun Valley and Wood River Valley area. With only four clinics in Cohort 1, region five has the smallest collaborative and is using only two electronic medical records; and are challenged with the types of support available to clinics and members. The collaborative is hoping to develop a subcommittee to address their need for more communication about the Idaho Health Data Exchange and payment plans.
- ◆ Dr. Horrocks presented on region six's collaborative; currently they have six clinics and have formed an executive committee comprised of the public health district staff, the regional collaborative chair and co-chair and clinic representatives. The collaborative is allocating time to clinics based on needs for the clinics individually. The neighborhood committee is a rotating committee; everyone on this committee has to bring something to the table that will help clinics undergoing PCMH transformation. Committee membership will change based on what help is needed from the clinics or the committee. Going forward the collaborative would like help with sustainability of PCMH transformation and would like guidance on how to keep this going after the grant funding is gone. The collaborative would also like more information on the sharing of behavioral health notes to primary care doctors; they would like more formal documents on this issue and need clarification on what is and is not allowed for sharing behavioral health information.
- ◆ James Corbett presented on the region seven collaborative which is made up of Dr. Southwick, Dr. Groberg and Geri Rackow. The regional collaborative has eight clinics that are going through cohort one and are represented on the collaborative. They need to build the medical health neighborhood in a way that can help their patients best; they are in the process of identifying gaps and areas of need from clinics to help the clinics in the best way possible. The collaborative feels that networking, avoiding duplication, and building off of other regional collaborative best practices are the best ways to help clinics, clients and patients. They would also want payment reform, data analytics, and sustainable funds to help with behavioral health integration.
- ◆ Dr. Epperly discussed the take aways from the SHIP regional collaborative presentations and what is happening across the state. Behavioral health integration and payment sustainability are two of the biggest areas of concern from the regional collaboratives. He went on to thank all seven districts for their work and for providing an update.
- ◆ Denise Chuckovich commented on this exciting next step on working with the regional collaboratives moving forward. Cynthia York pointed out the need for baseline data and how we can define it and move it out to the regional collaboratives.

**Population Health Presentation – Elke Shaw-Tulloch, Division of Public Health:**

- ◆ Elke Shaw-Tulloch presented the concept document developed by the Population Health Workgroup. This document is meant to define all aspects of population health. The workgroup put a lot of effort and work into what the definition of Population Health is and how to put it into a document that can be utilized by various individuals within the healthcare spectrum. This is a white paper to be used as a conversation starter. The workgroup is looking for the IHC members' endorsement of this document so that it can be utilized by clinics and regional collaboratives.
- ◆ Jeff Crouch had a question regarding clarifying roles on the document. Elke commented that this is meant to apply to several audiences and it depends on who is using it for where they fall within each bucket. Dr. Epperly concurred with the feedback that clarification of roles is important. Nikole Zogg also suggested that additional roles of healthcare professionals needed to be included. Dr. Davis asked if CHEMS is referenced in the graphic in the document. He also asked for clarification on the intended audience of this document.

Denise Chuckovich commented that we may want to look at another similar document but more catered to patients. Dr. Davis asked if there were other graphics available that incorporate the bucket approach.

**SHIP Operations and Advisory Group Reports/Updates – Cynthia York, Administrator, OHPI:**

- ◆ Dr. Epperly asked the IHC members if they had any questions about the SHIP operations report that they would like to discuss specifically.
- ◆ Jeff Crouch gave an update of the Multi-Payer workgroup meeting that took place earlier that morning. The payers were updated on the demographics of cohort one clinics and requested that they be provided a list of selected clinics. The group talked about logistics of linking payer contact information to the SHIP website e.g. a landing page that will link to each of the payers. This type of link will serve as a resource for clinics who want to engage with payers involved in payment reform initiatives. There was a self-funded update from Mannatt on how to engage the self-funded community. There will be a follow up on self-funded engagement. The workgroup discussed the frequency of future meetings and agreed on a quarterly meeting schedule. Jeff Crouch proposed rotating chairs in an effort to engage and involve other members as chair and co-chair. Dr. Davis commented that if engagement is an issue, meeting quarterly may not help this problem. Dr. Peterman addressed Dr. Davis' concerns of the meeting times being moved to quarterly and ensured that it will not interrupt the engagement of the workgroup. Dr. Epperly asked whether two new chairs have been identified. Cynthia York and Jeff Crouch have discussed this and will enlist the help of MP workgroup members to engage potential co-chairs.

**Closing remarks and Next Steps – Dr. Ted Epperly:**

- ◆ Dr. Epperly asked if there were any suggested future meeting topics. Dr. Davis mentioned the future medical school that is coming to Idaho.
- ◆ Ross Edmunds mentioned the legislature's approval of money for an office of suicide prevention. This will be housed under the division of Public Health.
- ◆ Dr. Epperly thanked everyone and concluded the meeting. "Eat food. Not too much. Mostly plants. Get healthcare. Not too much. Mostly primary care." Michael Pollan, Dr. Epperly

There being no further business Dr. Epperly adjourned the meeting at 4:26 p.m.



# SHIP Project Management Dashboard

Prepared for the Idaho Healthcare Coalition

Quarter 1 Grant Year 2

Introduction: The SHIP Project Management (PM) Dashboard is an interim tool prepared for the Idaho Healthcare Coalition on a quarterly basis to monitor the SHIP success measures.

## Project Implementation Updates

- IHDE’s readiness review of PCMHs is behind schedule for several reasons, including practices requesting postponement of the review due to undergoing transition to new EMR vendor, practices not being ready to participate in the readiness review due to not fully understanding the commitment/engagement level required, etc.
- All 55 PCMHs have signed agreements with Brilljent. 80% of practices have completed MOUs with IDHW.

## SHIP Success Measures

<b>Goal 1</b>	1 Q	2 Q	3 Q	4 Q	5 Q	6 Q	7 Q	8 Q	9 Q	10 Q	11 Q	
<b>Goal 2</b>	1 Q	2 A		3 Q	4 Q		5 Q					
<b>Goal 3</b>	1 Q		2 Q		3 Q		4 Q					
<b>Goal 4</b>	1 Q	2 Q	3 Q	4 Q	5 Q	6 Q						
<b>Goal 5</b>	1 Q			2 Q			3 Q					
<b>Goal 6</b>	1 A		2 A		3 A			4 A				
<b>Goal 7</b>	1 A				2 A							

- SHIP success measure is not reported.
- SHIP success measure is on target (≥90% of target).
- SHIP success measure is slightly off target (between 75% and 89% of target).
- SHIP success measure is not on target (<75% of target).

Q = Reported Quarterly (Jan 31, Apr 30, July 31, Oct 31)

A = Reported Annually (Jan 31)

## SHIP Success Measures by Goal

### Goal 1 Measurements

1	Q	Cumulative # (%) of primary care practices that submit an interest application to become a PCMH. Model Test Target: 270.
2	Q	Cumulative # (%) designated PCMHs that have completed a PCMH readiness assessment and goals for transformation. Model Test Target: 165.
3	Q	Cumulative # (%) of practices designated PCMH. Model Test Target: 165.
4	Q	Cumulative # (%) of practices designated PCMH of total primary care practices in Idaho that could become a PCMH. Model Test Target: 165.
5	Q	Cumulative # (%) of providers participating in PCMHs, of total number of providers targeted for participation. Model Test Target: 1,650.
6	Q	Cumulative # (%) of providers participating in PCMHs, of total providers in Idaho. Model Test Target: 1,650.
7	Q	Cumulative # (%) of designated PCMHs receiving PCMH Technical Support and transformation incentives. Model Test Target: 165.
8	Q	Cumulative # (%) of designated PCMHs that have achieved Idaho-specific or national PCMH recognition/accreditation. Model Test Target: 165.
9	Q	Cumulative # (%) of Idahoans who enroll in a designated PCMH. Model Test Target: 825,000.
10	Q	Cumulative # (%) of targeted population who enroll in a designated PCMH. Model Test Target: 825,000.
11	Q	Cumulative # (%) of enrolled PCMH patients reporting they are an active participant in their healthcare. Model Test Target: TBD.

### Goal 2 Measurements

1	Q	Cumulative # (%) of PCMH sites with EHR systems that support Health Information Exchange (HIE) connectivity capabilities. Model Test Target: 165 PCMHs.
2	Q	Cumulative # (%) of patients in designated PCMHs (sites) that have an EHR. Model Test Target: 825,000 (50.4% of Idahoans).
3	Q	Cumulative # (%) of designated PCMHs with an active connection to the IHDE and utilizing the clinical portal to obtain patient summaries, etc. Model Test Target: 165 PCMHs.
4	Q	Cumulative # (%) of hospitals connected to the IHDE. Model Test Target: 21.
5	Q	Cumulative # (%) of hospitals connected to IHDE that provide information on PCMH enrolled patients. Model Test Target: 21.

### Goal 3 Measurements

1	Q	Cumulative # of RCs established and providing regional quality improvement and Medical-Health Neighborhood integration services. Model Test Target: 7.
2	Q	Cumulative # of designated PCMHs and primary care practices that can receive assistance through an RC. Model Test Target: 165.
3	Q	Cumulative # of designated PCMHs who have established protocols for referrals and follow-up communications with service providers in their Medical-Health Neighborhood. Model Test Target: 165.
4	Q	Cumulative # of patients enrolled in a designated PCMH whose health needs are coordinated across their local Medical-Health Neighborhood, as needed. Model Test Target: 825,000 (50.5% of Idahoans).

### Goal 4 Measurements

1	Q	Cumulative # (%) of Virtual PCMHs established in rural communities following assessment of need. Model Test Target: 50.
2	Q	Cumulative # (%) of regional CHEMS programs established. Model Test Target: 16.
3	Q	Cumulative # (%) of CHEMS program personnel trained for Virtual PCMH coordination. Model Test Target: 52.
4	Q	Cumulative # (%) of new community health workers trained for Virtual PCMH coordination. Model Test Target: 200.
5	Q	Cumulative # (%) of continuing education conferences held for CHW and CHEMS Virtual PCMH staff. Model Test Target: 2.
6	Q	Cumulative # of designated Virtual PCMH practices that routinely use telehealth tools to provide specialty and behavioral services to rural patients. Model Test Target: 36.

### Goal 5 Measurements

1	Q	Cumulative # (%) of designated PCMH (sites) with access from the Data Analytics Vendor to the analytics system that provides dashboards and reporting. Model Test Target: 165 PCMHs by 2020.
2	Q	Cumulative # (%) of quality measures that are reported by all PCMH practices. Model Test Target: 16.
3	Q	Cumulative # (%) of designated PCMH practices that receive community health needs assessment results from an RC. Model Test Target: 165.

### Goal 6 Measurements

1	A	Count of providers who are under contract with at least one payer to receive alternative (non-volume based) reimbursements. Model Test Target: TBD.
2	A	Count of payers representing at least 80% of the beneficiary population that adopt new reimbursement models. Model Test Target: 4.    <b>This success measure has been reached.</b>
3	A	Count of beneficiaries attributed for purposes of alternative reimbursement payments. Model Test Target: 1.3M.
4	A	Percentage of payments made in non-FFS arrangements compared to total payments made. Model Test Target 80%.

### Goal 7 Measurements

1	A	Total population-based PMPM index, defined as the total cost of care divided by the population risk score. Model Test Target: TBD.
2	A	Annual financial analysis indicates cost savings and positive ROI. Model Test Target: 225%.    <b>Data is not currently available.</b>

# WE ARE PART OF YOUR MEDICAL-HEALTH NEIGHBORHOOD



## WHAT IS THE MEDICAL-HEALTH NEIGHBORHOOD?

The Medical-Health Neighborhood is a partnership between a primary healthcare provider and other professionals in the community and surrounding area to work together as a team to provide the best care for their patients and clients. These professionals are committed to understanding and responding to a person's TOTAL health needs.

The Medical-Health Neighborhood serving this community includes all types of medical and social support organizations, such as: behavioral health specialists, hospital care, community supports, pharmacy services, nutrition services, oral healthcare, medical specialists, and those providing activities that help keep people healthy and prevent disease.

## WHY IS THE MEDICAL-HEALTH NEIGHBORHOOD IMPORTANT?

Your primary healthcare provider and the healthcare professionals and community organizations in this Medical-Health Neighborhood understand that we must work together to help you, and others that we care for, achieve the best possible health. Our focus is on the whole person: physical, emotional, social, and cultural. We want to understand all the issues impacting your health so we can work with your primary care healthcare professional and others in the Medical-Health Neighborhood to help you get the services you need to be your healthiest.

- Benefits to you as the patient include:
- Better support and communication
  - Stronger relationships with your providers
  - Saves you time

We are proud to be a member of the Medical-Health Neighborhood serving you and our community.





# Advisory and Workgroups:

## Definition prepared for the IHC April 2016

**Context:** Advisory and Workgroups play a critical role in supporting the decision making, realization and monitoring success of the Statewide Healthcare Innovation Plan. Throughout the lifetime of the project, these groups play an instrumental role and represent the robust stakeholder participation and engagement in Idaho. Nearly 200 individuals participate in the ten (10) established groups which report directly to the Idaho Healthcare Coalition (IHC). Advisory and workgroups have an identified role and scope in the Statewide Healthcare Innovation Plan submitted and approved by the Centers for Medicare and Medicaid Innovation.

**Advisory Group Definition:** An established council, entity or body that has a scope overlapping with some portion of SHIP and its goals. These advisory groups recognize and support the mission, vision and goals of SHIP in addition to taking on some portion of SHIP-related advising and implementation. IDHW SHIP staff may participate on these groups and may also provide administrative support in varied capacities.

### Current Advisory Groups:



**TeleC** - Telehealth Council



**CHEMS** - Community Health EMS



**CHW** - Community Health Workers

**Workgroup Definition:** An established or reconvened committee and group with a prescribed scope that includes activities requested by the IHC. Workgroup members include representatives from IDHW, payers, vendors, and other stakeholders. Workgroups serve under the guidance and direction of the IHC with the workgroup Chair being appointed to the IHC. SHIP staff participate on each of the workgroups and also provide administrative support.

### Current Workgroups:



**MPW** - Multi-Payer Workgroup



**BHI** - Behavioral Health Integration Workgroup



**HIT** - Health Information Technology Workgroup



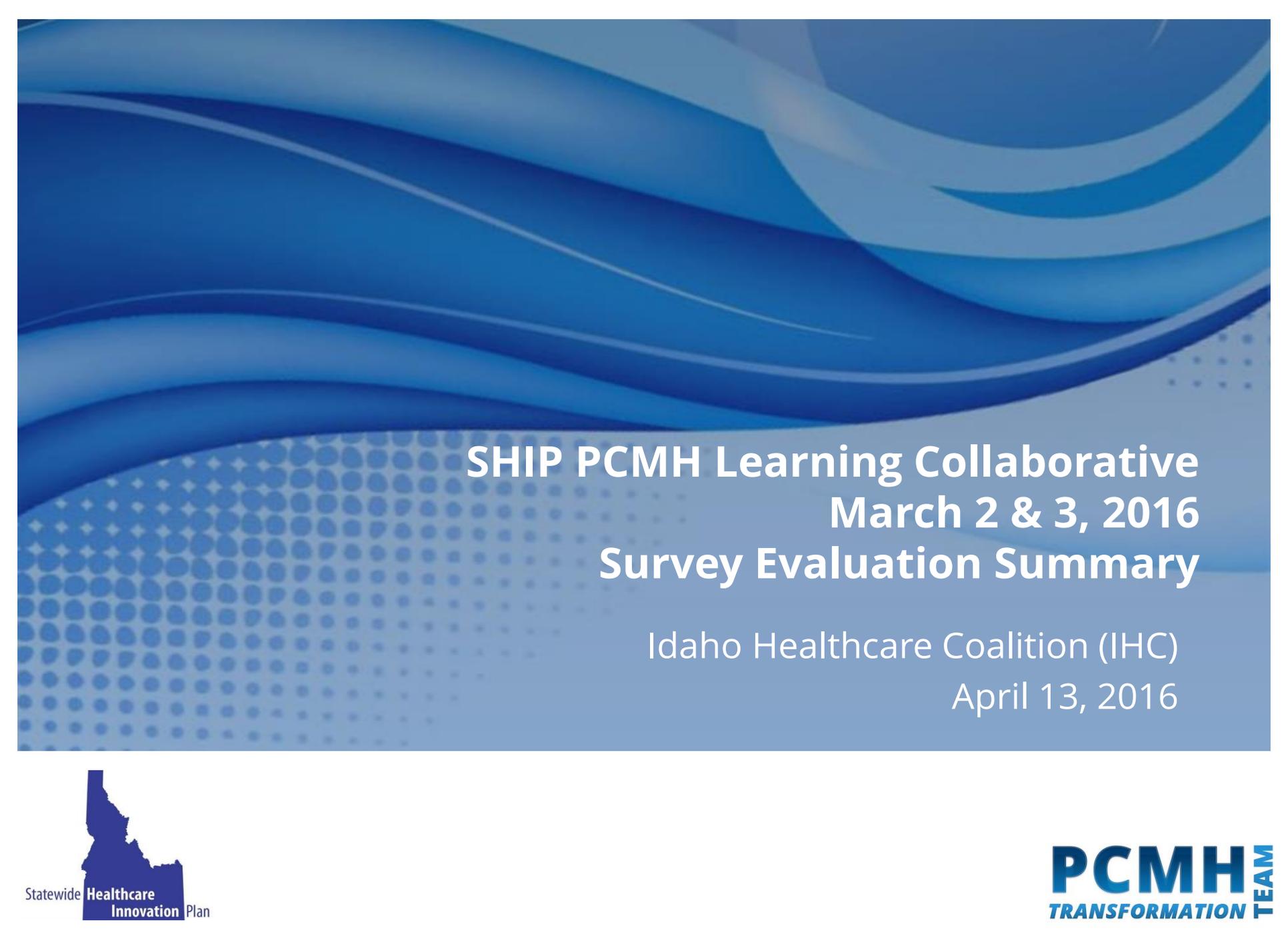
**IMHC** - Idaho Medical Home Collaborative Workgroup



**PHW** - Population Health Workgroup



**CQM** - Clinical Quality Measures Workgroup

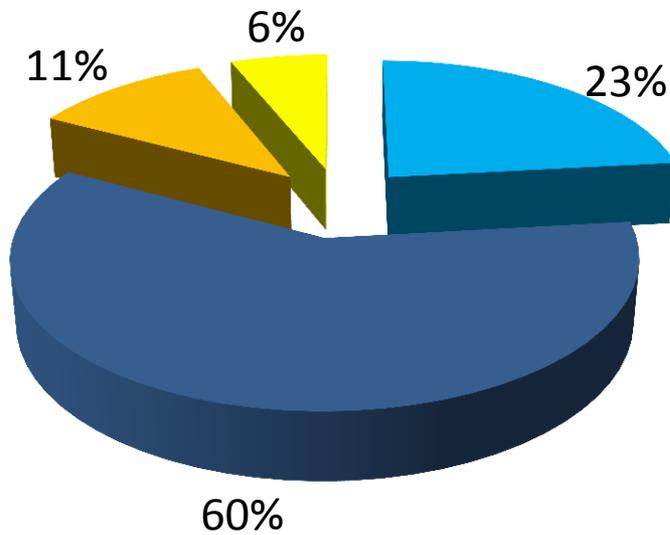


**SHIP PCMH Learning Collaborative**  
**March 2 & 3, 2016**  
**Survey Evaluation Summary**

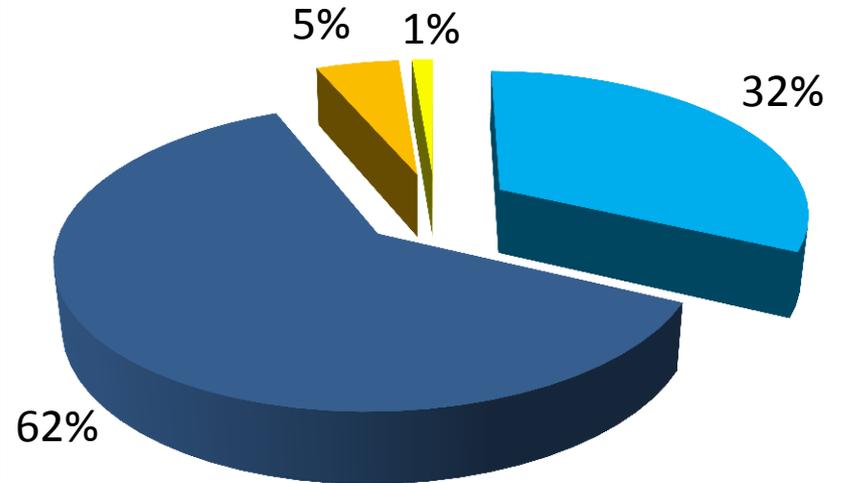
Idaho Healthcare Coalition (IHC)  
April 13, 2016

# Overall Satisfaction Each Day

## Day 1



## Day 2



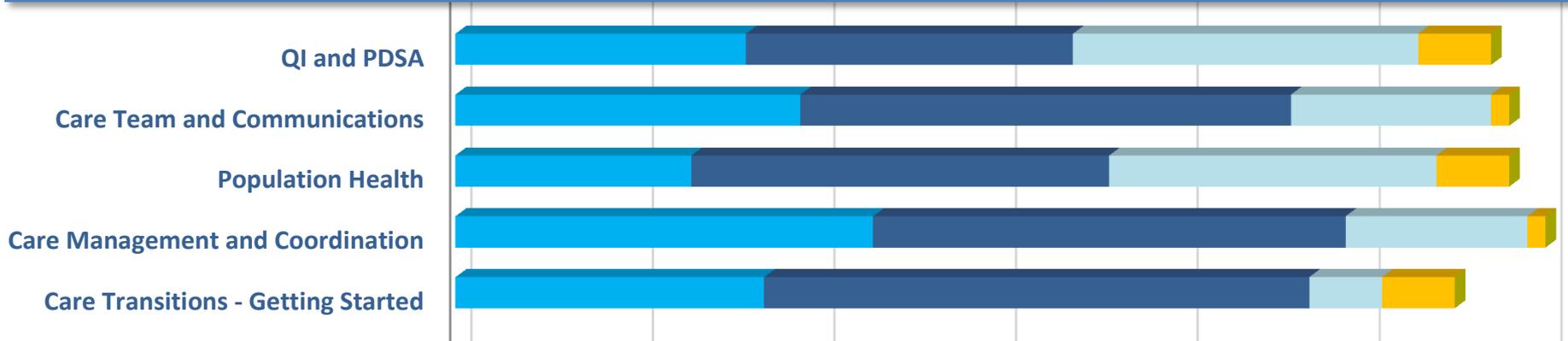
Very Satisfied

Satisfied

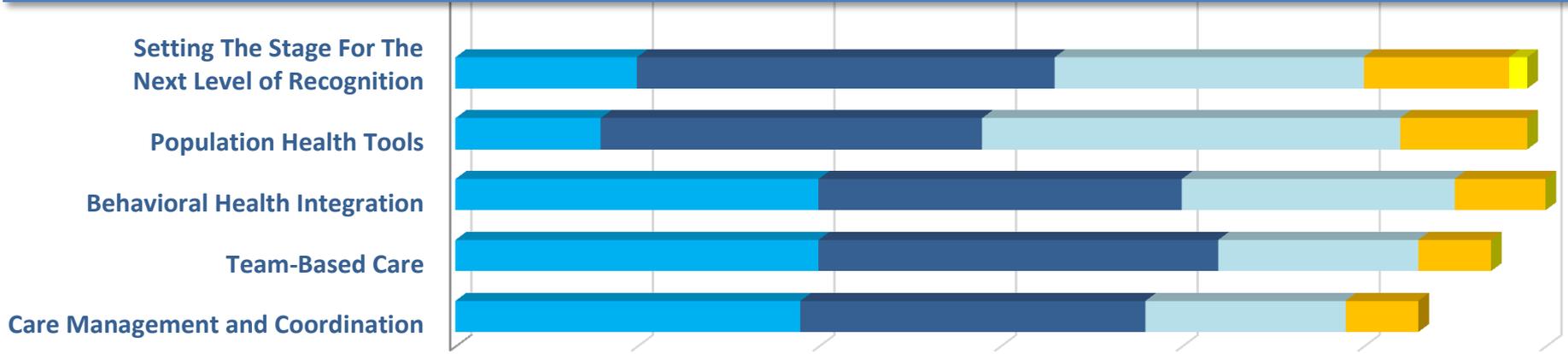
Neutral

Dissatisfied

## Track 1



## Track 2



Very Helpful

Fairly Helpful

About Average

Not Too Helpful

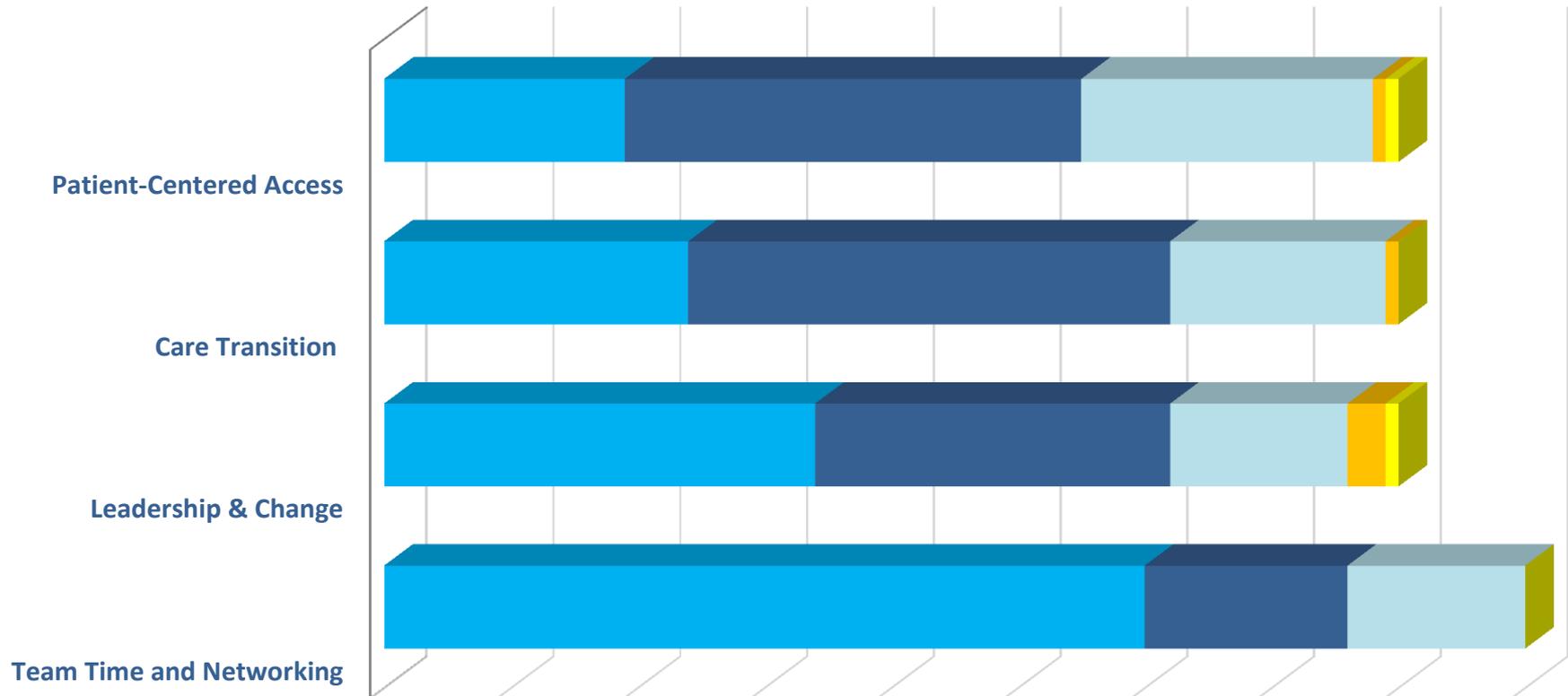
Not At All Helpful

## POSITIVE

- **Panel Discussion and group discussions were highly received.**
  - *“The panel discussion was not only enlightening, it was upbeat. Great after lunch start.”*
- **Examples and scenarios were helpful, speakers were great.**
  - *“Mixing in scenarios and small group activity helped maintain audience engagement; particularly during afternoon hours.”*
  - *“The plan, do, study, act (PDSA) portion was good because it is something we are working on at this time; the examples were great.”*
- **Many liked being able to hear other clinics’ experience.**
  - *“Interesting to see/hear how other clinics are doing; what they're implementing.”*
- **Agenda Topics**
  - *“Review was great; great explanations of care management.”*
  - *“I really liked PDSA/Quality Improvement (QI) and teamwork. It helped create more ideas for how we need to be better/increase productivity.”*

## NEGATIVE

- **81% reported lack of detail or the information was too basic**
  - *“Today had quite a bit of review and not enough specific and actionable information. We want to advance and make progress. We need consulting and examples to support progress.”*
  - *“The panel was interesting but not very practical in how to change our system.”*
  - *A lot of time spent reviewing and providing overview of things that will be talked about “later”; Should be more of a working collaborative.”*
  - *“Information was redundant. Clinic instructions were not helpful; tedious, technology, difficulties not going to remember anyway. Would have preferred more “world café” style or meet with coaches and have coaches make suggestions for connections or partnerships.”*
- **Working with Clinics**
  - *“The whole point of this is to work with the other clinics. We had no time to work with other clinics and the presenters talked between each clinic, so there was no group lead discussion.”*



Very Helpful

Fairly Helpful

About Average

Not Too Helpful

Not At All Helpful

## POSITIVE

- **Leadership and Change**

- *“The leadership part, I anticipate, will help our team quite a bit, as our presence was heavy with leadership and administration.”*
- *“Discussion on accessing Emergency Room (ER) notes leadership and agents of change in clinics.”*
- *“It was refreshing to hear about leadership and change. I also really enjoyed team time to get ideas out with new fresh info, so I didn't forget any of it.”*
- *“The focus of the discussion on leadership and change, we forget sometimes who to not address or try to push our efforts. Team time was important and beneficial but more organized way would have been helpful.”*

- **Time with Coaches**

- *“Time with our coach was productive and motivating.”*

- **Examples and scenarios were helpful**

- *“Being completely new to PCMH, I found everything to be very helpful. The presenters were wonderful; they were engaging, knowledgeable, and overall did an incredible job.”*
- *“The plan, do, study, act portion was good because it is something we are working on at this time and the examples were great.”*

## NEGATIVE

- ***Only 6 negative comment responses were received for Day 2.***
  - *“Space”*
  - *“Hopeful that the team knew a lot more but they were unsure of what to explain to the team and answer our questions. Reg. 4”*
  - *“Too little time with mentors.”*
  - *“I have heard it before.”*
  - *“Info presented was not new for me.”*
  - *“At the beginning of the day I felt everyone was needing to process and ask questions of what they had learned the day before. Jumping right in felt a little overwhelming.”*

## Follow up planning and activities

- Group Coaching call held on March 29, 2016, on the specific differences in the 2011 and 2014 requirements for NCQA recognition
- Webinar – April 19, 2016 – Dr. Greg Vachon, HMA

### **Population Health: A Functional Overview**

- Group Coaching call scheduling for May – Specific requirements for using the Care Management Billing code.

**More to come!**

# Questions



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# Clinical Quality Measures Workgroup

## Proposed Change to Project Measures 4 of 16

Compiled for the IHC 4/8/2016 V1.0

Measure	Original Measure Language	Proposed Measure Language	CQM Comments
1*	Percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period.	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Aligns with CMS 138, PQRS 226, NQF 0028.
2*	Percentage of children, two through 17 years of age, whose weight is classified based on Body Mass Index (BMI), who receive counseling for nutrition and physical activity.	Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP)** or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported. <ul style="list-style-type: none"> <li>- Percentage of patients with height, weight, and body mass index (BMI) percentile documentation</li> <li>- Percentage of patients with counseling for nutrition</li> <li>- Percentage of patients with counseling for physical activity</li> </ul>	Aligns with CMS 155, PQRS 239, NQF 0024.  ** This measure is includes all providers such as Physicians, Physician Assistants, and Nurse Practitioners in Family Medicine, Primary Care Medicine, Internal Medicine, General Practice Medicine, Pediatric Medicine, or Obstetrician/Gynecologist (OB/GYN) Medicine. The data is collected based on procedures conducted rather than the type of provider.
3*	The percentage of patients 18-75 with a diagnosis of diabetes, who have optimally managed modifiable risk factors (A1c<8.0%, LDL<100 mg/dL, blood pressure<140/90 mm Hg, tobacco non-use, and daily aspirin usage for patients with diagnosis of IVD with the intent of preventing or reducing future complications associated with poorly managed diabetes.	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period	Aligns with CMS 122, PQRS 001, NQF 0059.  There are other national measures for diabetes but most present collection challenges. Others have not been updated to reflect the latest clinical best practices.
4	The percentage of members 18 to 74 years of age who had an outpatient visit and who's BMI was documented during the measurement year or the year prior to the measurement year.	Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter.	Aligns with CMS 69, PQRS 128, NQF 421.

\* These are CMMI Year 1 required measures; states may select a national measure or similar state specific metric.

\*\* This measure is inclusive of all providers including Physicians, Physician Assistants, and Nurse Practitioners in Family Medicine, Primary Care Medicine, Internal Medicine, General Practice Medicine, Pediatric Medicine, or Obstetrician/Gynecologist (OB/GYN) Medicine. The data is collected based on procedures conducted rather than the type of provider.



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# SHIP Operations and IHC Workgroup Report to the Idaho Healthcare Coalition April 13, 2016

## **SHIP OPERATIONS:**

### **SHIP Contracting/Request for Proposal (RFP) Status:**

- **Report Items:**

- We are awaiting release of funds from CMMI for commencement of the State Evaluator contract with The University of Idaho.
- A contract was executed with KMP Companies to hire Matthew Clark of Verinovum as a Subject Matter Expert to assist with the HIT Data Element Mapping protocols and processes.

### **SHIP Administrative Reporting:**

- **Report Items:**

- A SHIP Annual Report has been prepared and will be submitted to CMMI this month highlighting SHIP Pre-Implementation Year Activities from 2/1/2015-1/31/2016.
- A Carryover Request was submitted to OAGM and CMMI for pre-implementation year funds.
- Mercer and SHIP project management staff are working on refinements to the Master Project Management Plan (MPMP).
- Mercer and SHIP staff are finalizing data collection protocols related to Goals 1 – 6 metric measurements to comply with CMMI reporting requirements
- Christina Crider was named as our new CMMI Project Officer replacing Bridget Harrison who has assumed other duties on the CMMI SIM Project.
- Casey Moyer, Operations Project Manager and Burke Jensen, Health IT Project Manager attended the 2016 State Healthcare IT Connect Summit on March 21-23, 2016 in Baltimore, MD.
- Research Triangle Institute (RTI), CMMI federal evaluator will be in Idaho the week of May 23, 2016 to conduct their initial site visit to evaluate Idaho's SHIP model test.

### **Regional Collaboratives (RC):**

- **Report Items:**

- Public Health District staff continues to engage designated clinics, closely partnering with the SHIP PCMH transformation contractor.
- Several Regional Health Collaboratives met in March. All RHC are actively identifying priority projects. The Executive Leadership Teams will be reporting to the IHC in a round robin fashion, two districts at the time.

- **Next Steps:**

- Continue supporting establishment of functioning Regional Collaboratives.
- Continue coordinating PHDs effort with other programs and entities.
- PHD Sub grants are due to be renewed by July 1<sup>st</sup> 2016.

## **ADVISORY GROUP REPORTS:**



### **Telehealth SHIP Subcommittee:**

- **Report Items:**
  - Met several times to draft a Request for Quotation for a vendor to provide training and technical assistance curriculum or training package, both on-site 1:1 and via webinar, related to Telehealth equipment and program development.
  - Created a timeline for Telehealth implementation.
  - Began planning a sub-committee meeting and coordinated with the OHSU to provide a presentation to the subcommittee on Oregon’s SIM Telehealth initiative.
  - Contacted Bob Wolverton with the Northwest Regional Telehealth Resource Center to arrange Telehealth technical assistance for IDHW staff.
  - Conducted research on needs assessments, equipment vendors, and technical assistance vendors.
- **Next Steps:**
  - Finalize the one-page Telehealth expansion plan overview.
  - Finalize the Telehealth Council Goal 2 Subcommittee web page.
  - Create assessment tool for CHEMS providers.

**CHW**

**Community Health Workers:**

- **Report Items:**
  - CHW Workgroup met with the IDHW Diabetes, Heart Disease and Stroke Programs to coordinate outreach in identifying and recruiting potential CHW students for the first training cohort.
  - The CHW Training Committee has received a proposal from Idaho State University to adapt and adopt the Massachusetts curriculum for Idaho CHWs. The CHW Training Committee will review and respond to the proposal from ISU.
  - The CHW Outreach Committee will begin reaching out to Idaho CHWs and clinicians who employ CHWs to assess interest in being a part of the Outreach Committee’s media outreach regarding Idaho CHW and promoting the values of CHWs in clinics and community based organizations.
  - The CHW Workgroup began meeting with data specialists within DHW to help support and design specific measurements for CHWs that align with the larger SHIP goals. The CHW Workgroup will continue to engage with stakeholders regarding the design of these measures.
- **Next Steps:**
  - The CHW Workgroup continues to engage stakeholders in soliciting best practices.
  - The CHW Workgroup is actively engaging stakeholders for a workshop on outcome measures, tentatively projected to take place in June.

**CHEMS**

**Community Health EMS:**

- **Report Items:**
  - The CHEMS Outcome Measures Design Workgroup met on March 24th at the Best Western Inn at the Airport for the third and last meeting in the series. The goal of this meeting was to:
    - Finalize initial CHEMS measures
    - Examine and discuss data collection options
    - Discuss CHEMS Measures implementation
  - The CHEMS Advisory Group continues to meet weekly to finalize outcome measures

- **Next Steps:**
  - CHEMS Advisory Group to transition into CHEMS Workgroup.
  - Engage SHIP Data Analytics vendor to operationalize collection and reporting mechanisms for the identified measures with an ultimate goal of demonstrating the value and impact of CHEMS programs.

## **WORKGROUP REPORTS:**



### **IMHC:**

- **Report Item:**
  - No meetings have been scheduled. Nothing to report at this time.
- **Next Steps:**
  - Future meetings will occur ad hoc.



### **Health Information Technology:**

- **Report Item:**
  - Janica Hardin accepted a nomination to be a co-chair for the HIT Workgroup.
  - IHDE has been conducting readiness assessments in preparation for establishing connections with the SHIP Cohort 1 clinics.
  - The HIT Workgroup met on March 17, 2016 to hear a summary the activities of the Data Element Mapping Subcommittee.
  - The Data Element Mapping Subcommittee carried out the following activities:
    - Continued to refine the best transport method for clinical quality measure data from the clinics to IHDE and ultimately to HealthTech Solutions.
    - The Subcommittee provided recommendations for adjusting the language and definitions of the first four clinical quality measures for this grant year, and to align them with national CQM standards.
    - The subcommittee leadership presented those recommendations to the CQM Workgroup on April 7th.
- **Next Steps:**
  - The Data Element Mapping Subcommittee will respond to several questions specific to the measures and will present their findings to the CQM Workgroup.
  - The CQM Workgroup and HIT Workgroup will coordinate on providing additional recommendations for the IHC to consider on the remaining 12 measures.



### **Multi-Payer:**

- **Report Item:**
  - At the Multi-Payer Workgroup help on March 9, 2015 the following items were discussed:

- A presentation on the SHIP Cohort 1 PCMH Clinics was provided and included a demographic profile of the clinics represented. A list of selected clinics in an excel format was requested by each of the payers.
- A discussion took place regarding linking payer contact information to the SHIP website. To facilitate communication between the payers and other SHIP stakeholders, it was proposed that a landing page for each of the payers' contact information link to [www.SHIP.idaho.gov](http://www.SHIP.idaho.gov).
- Manatt provided an overview of their report pertaining to Idaho's self-funded employers. There will be a follow-up meeting to discuss additional strategies relating to the engagement of self-funded employers.
- MPW Co-Chair Jeff Crouch proposed rotating chairs in an effort to engage and involve other members of the MPW. Josh Bishop, Vice President of PacificSource has been nominated to serve as a Co-Chair along with Co-Chair Dr. Peterman.
- **Next Steps:**
  - No future meetings have been scheduled at this time; however the workgroup agreed to meet on a quarterly basis.



### **Clinical/Quality Measures Quality Measures Workgroup:**

- **Report Item:**
  - The CQM Workgroup met on April 7, 2016.
  - During this workgroup meeting, the Data Element Mapping Subcommittee of the HIT Workgroup presented its recommendations to adjust the language and definitions of the first four clinical quality measures for this grant year, and to align them with national CQM standards.
  - The Workgroup supported the following motions:
    - Align the *Tobacco Cessation Intervention* measure with the current CMS measure.
      - *Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention.*
    - Align the *Weight Assessment and Counseling for Children and Adolescents* measure with the current CMS measure.
      - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents.*
    - Instead of using the composite *Comprehensive Diabetes Care* measure, use the CMS *Diabetes: Hemoglobin A1c Poor Control* measure.
    - Selected the *Adult BMI Assessment* measure as the fourth measure and aligned it with the current CMS measure.
      - *Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan*
- **Next Steps:**
  - The Data Element Mapping Subcommittee will respond to several questions specific to the measures and will present their findings to the CQM Workgroup.
  - The CQM Workgroup and HIT Workgroup will coordinate on providing additional recommendations for the IHC to consider on the remaining 12 measures.



### **Behavioral Health:**

- **Report Item:**

- Gina Westcott provided feedback on the final presentation to the IHC on February 10, 2016 and discussed the status of the next steps to move forward with the recommendations.
- Kym Schreiber presented information on how the PCMH contractor will support the first cohort clinics with Behavioral Health Integration through monthly coaching calls, affinity learning groups and bi-monthly webinars. Additionally, there was a Learning Collaborative Session held in March and another is scheduled for the fall.
- BHI established a workgroup that will work towards supporting a Behaviorist Peer to Peer Consultation model, now called the Idaho Integrated Behavioral Health Network. This workgroup lead by Jennifer Yturriondobeitia and Dr. Gerrish, has met once and will meet again mid-April. Clinical Peer to Peer meetings between TRHS and FMRI are scheduled for May.
- Additional SHIP updates were provided by the HIT/Data Analytics Contract Monitor, Burke Jensen and Kym Schreiber.
- Ray Millar was added as a Provider representative to the BHI Sub-Committee.
- **Next steps:**
  - The next BHI Sub-Committee meeting will be held on Tuesday, June 7, 2016 from 9:00-11:00 am at the DHW Office 1720 Westgate Drive, Suite A, room 131.
  - NASHP has offered to provide additional TA training targeted to PHD staff. Four training topics have been identified to include enhancing communications between PCMH and specialty providers, general behavioral health integration concepts, clinical applications and funding mechanisms. Training is being planned for May/June.
  - Gina is currently in early discussions with the District 3 and 4 PHD and the Regional Behavioral Health Executive Committee members to explore how the Regional Behavioral Health Boards can support the work of the PCMH clinics with Behavioral Health Integration efforts. This may include networking, enhancing communication and providing additional training opportunities to PCMH as well as Behavioral Health providers.
  - Gina provided a SHIP update to the NAMI Family to Family group on March 23<sup>rd</sup>, 2016. She will also provide an update to the State Behavioral Health Planning Council the week of April 25<sup>th</sup>.



### **Population Health:**

- **Report Item:**
  - PHW met on April 6, 2016
  - Dr. Sarah Toevs, Director of the BSU Center for the Study of Aging, and a representative for the Idaho Caregiver Alliance, provided information on their mission, which is to advance the well-being of caregivers by promoting collaboration that improves access to quality, responsive support services across the state.
  - Joe Pollard provided an update on the Networks of Care and reaching out to the Regional Collaboratives.
  - Workgroup members gave updates on current projects.
  - Next meeting scheduled for May 4, 2016
- **Next Steps:**

- Next PHW Meeting May 4, 2016, 3:00pm – 4:30pm
- Draft agenda includes:
  - Communication tool for the Regional Health Collaboratives to assist in the clinics-medical health neighborhood linkages
  - Inventory of initiatives, programs and entities engaged with the primary care clinics
  - Review of 6-18 CDC initiative
  - Review of “Live Well” website