WEDNESDAY, JUNE 3

8:30 a.m. - 2:15 p.m.   District Director’s Meeting
2:30 p.m. - 4:30 p.m.   Trustee Meeting
5:00 p.m. - 7:00 p.m.   Registration / Reception

THURSDAY, JUNE 4

7:30 a.m. - 8:30 a.m.   Breakfast / Registration
8:30 a.m. - 8:45 a.m.   Welcome
8:45 a.m. - 10:45 a.m.   Business Meeting
10:45 a.m. - 11:00 a.m.  Break
11:00 a.m. - 12:00 p.m.  SHIP: The Vision for the Future of Healthcare in Idaho — Dr. Ted Epperly
12:00 p.m. - 1:15 p.m.   Lunch
1:15 p.m. - 2:30 p.m.   Regional Collaboratives, Patient Centered Medical Homes, Community Health Workers, Community EMS and Telehealth — Elke Shaw-Tulloch and Mary Sheridan
2:30 p.m. - 3:15 p.m.   SHIP from the Community Health Center Perspective Including Behavioral Health and Primary Care Integration — Dr. Andrew Baron
3:15 p.m. - 3:30 p.m.   Break
3:30 p.m. - 4:15 p.m.   What SHIP Means to the Rural Primary Care Provider — Dr. Keith Davis
4:15 p.m. - 4:45 p.m.   Next Steps for the Public Health Districts — Tom Faulkner
4:45 p.m. - 5:00 p.m.   Final Business and Farewell
5:30 p.m.   No-Host Bar Opens
6:00 p.m. - 7:00 p.m.   Dinner
7:00 p.m. - 9:00 p.m.   Evening Activity – Sunset Cruise by McCall Lake Cruises
You're invited to become a sponsor of the 2015 Idaho Association of District Boards of Health conference. This year’s conference will be held at the beautiful Shore Lodge in McCall, Idaho.

Your exclusive sponsorship will allow you to attend this event which brings together board members from Idaho’s seven local health districts, district directors and managers for a two-day gathering filled with guest speakers, an annual decision-making health board meeting and social opportunities.

Benefits of your sponsorship include:

- Positioning your company and services/products with attendees which include statewide Board of Health members and their spouses, District Directors from the seven local health departments throughout Idaho, and members of additional state agencies
- Developing networking opportunities with attendees by participating in the conference and breaks
- Advertisement of your company name and logo through multiple mediums

Contact Name ___________________________________________ Title ____________________________________________
Company Name __________________________________________________________________________________________
Address/City/State/Zip ____________________________________________________________________________________
Phone ___________________________ Email ___________________________
Website URL ___________________________ Fax Number __________________________
Company representative attending the conference ________________________________________________________________

Please return this form to the address below and make checks payable to:
Central District Health Department - IADBH
707 N. Armstrong Place
Boise, ID 83704

If you have questions, please contact Norma Russell:
- Phone: (208) 327-8573
- Email: nrussell@cdhd.idaho.gov
$2,000 - PLATINUM SPONSOR

- One complimentary conference registration, including breakfast and lunch
- One booth space with table (2 days)
- Full page advertisement in the conference program - company name, logo and company biography
- Verbal acknowledgment of your sponsorship during the conference
- Company name and logo on continuous AV loop during all breaks
- Logo placement on table tents
- Company name, biography and logo on two websites - cdhd.idaho.gov & idahopublichealthdistricts.org
- Recognition in “thank you” advertisement in Central District Health Department’s Public Health Informer fall 2015 newsletter
- Promotional items advertising your company are also welcome

$1,500 - GOLD SPONSOR

- One complimentary conference registration, including breakfast and lunch
- One booth space with table (2 days)
- Half page advertisement in the conference program - company name, logo and company biography
- Verbal acknowledgment of your sponsorship during the conference
- Company name and logo on continuous AV loop during all breaks
- Logo placement on table tents
- Company name, biography and logo on two websites - cdhd.idaho.gov & idahopublichealthdistricts.org
- Recognition in “thank you” advertisement in Central District Health Department’s Public Health Informer fall 2015 newsletter
- Promotional items advertising your company are also welcome

$1,000 - SILVER SPONSOR

- One complimentary conference registration, including breakfast and lunch
- One booth space with table (2 days)
- Quarter page advertisement in the conference program - company name, logo and company biography
- Verbal acknowledgment of your sponsorship during the conference
- Company name and logo on continuous AV loop during all breaks
- Logo placement on table tents
- Company name and logo on two websites - cdhd.idaho.gov & idahopublichealthdistricts.org
- Recognition in “thank you” advertisement in Central District Health Department’s Public Health Informer fall 2015 newsletter
- Promotional items advertising your company are also welcome

$500 - BRONZE SPONSOR

- Company name and logo in the conference program, including breakfast and lunch
- Logo placement on table tents
- Company name and logo on two websites - cdhd.idaho.gov & idahopublichealthdistricts.org
- Recognition in “thank you” advertisement in Central District Health Department’s Public Health Informer fall 2015 newsletter
- Promotional items advertising your company are also welcome
AGENDA

1. Call to Order – Steve Scanlin
2. Roll Call by District – Steve Scanlin
3. Proxy Votes Collected per By-Laws – Steve Scanlin
4. Call for Additional Agenda Items – Steve Scanlin
5. Approval of Minutes from May 29, 2014 – Steve Scanlin
6. Association Office Budgets (Action) – Bruce Krosch
7. IAC-IPHD Contract Review – Bruce Krosch
8. Annual Review of IADBH Bylaws – Steve Scanlin
9. 2015 IABDH Proposed Resolutions (Action) – Steve Scanlin
10. NALBOH/SALBOH Future Options – Steve Scanlin
11. Adjournment – Steve Scanlin
BYLAWS

ARTICLE I
NAME

This Association, approved by members of the seven (7) public health districts of the State of Idaho, shall be called the Idaho Association of District Boards of Health.

ARTICLE II
PURPOSE

The purpose of this Association shall be:

1. To exchange information among the District Boards of Health.
2. To coordinate policies and programs among the seven (7) public health districts.
3. To pursue new, as well as amend existing public health laws, standards, regulations, and rules to prevent disease, disability, and premature death; to promote healthy lifestyles; and to protect and promote the health and quality of our environment.

ARTICLE III
MEMBERSHIP

Membership in the Association shall be limited to members of the seven (7) District Boards of Health of the State of Idaho who are appointed pursuant to Section 39-411 Idaho Code.

The District Directors are ex-officio members of the Association.
ARTICLE IV
FINANCING

Funding for the Association shall be provided by the seven (7) public health districts on an equal basis.

ARTICLE V
OFFICERS of the ASSOCIATION

Section A. Officers

Leadership of the Association will consist of an elected Trustee from each local Board of Health. The leadership of the association will be referred to as the "Board of Trustees" and shall consist of the following:

1. President of the Association: The President shall be the Trustee from the hosting District where the current year's Annual meeting will take place.

2. Vice-President: The Vice President shall be a Trustee from the District which hosts the following year's Annual meeting.

3. Secretary: The secretary shall be the District Director from the District hosting the current year's Annual meeting. The secretary shall have no vote.

4. Executive Council: The Executive Council will be comprised of a Board of Health member from each health district which has been elected as the health district's Trustee in accordance with Idaho Code 39-411.

Section B. Terms

The new President, Vice-President, and Secretary of the Association shall take office at the conclusion of the Annual meeting and shall serve until the conclusion of the next Annual meeting. Executive Council members shall serve for the term in which they have been elected by their local Boards of Health.
Section C. Duties of Officers

1. The President of the Association shall:
   a. Preside at the annual Association meeting and at any special Association meetings.
   b. Determine the need, dates, times, and location of the annual Association meeting and any special meetings of the Association’s Board of Trustees.

2. The Vice-President shall:
   a. Preside at all meetings of the Association in the absence of or at the request of the President.
   b. Perform such other duties as may be required.

3. The Secretary of the Board shall:
   a. Record minutes of the Association and Board of Trustees' meetings.
   b. Conduct correspondence as directed by the President.
   c. Send all notices in accordance with these bylaws.
   d. Perform such other duties as may be required.

Section D. Duties of the District Trustee and the Board of Trustees

1. The Trustee of each health district shall represent their local Boards of Health throughout the year except at the Annual meeting. This includes providing their Board's position on such laws, standards, regulations, and rules to the Boards of Trustees. As issues arise between the annual Association meetings, decisions of the Board of Trustees shall constitute interim decisions of the Association.

2. The Board of Trustees shall:

   a. Conduct the affairs of the Association in accordance with the purpose and Bylaws of the Association and directives adopted by the Association.
   b. Have authority to allocate appropriations from the legislature to the health districts. (IC 39-411)
   c. Develop and administer a formula for the allocation of legislative appropriations. (IC 39-411)
   d. In the event a Trustee cannot attend, an alternate Board Member from his/her District shall represent that District at meetings and on conference calls.
Section E. The Association Office shall:

1. Serve as custodian of the Association records.
3. Have custody of, and be responsible for, all funds and securities of the Association.

Section F. The SALBOH Representative

The SALBOH (State Association of Local Boards of Health) Representative is a Board of Health Member elected by the Association and:

1. Shall serve as the NALBOH (National Association of Local Boards of Health) contact for Idaho's SALBOH.
2. May attend the annual SALBOH and NALBOH meetings and provide a written summary or an annual report of each meeting to the Association during the Annual business meeting. As a representative of the Association, expenses for travel to the annual SALBOH and NALBOH meetings shall be reimbursed by the Association.
3. Shall serve a three (3) year term and must be reappointed or a new representative appointed at the conclusion of the term.
4. An alternate Representative will be elected by the Association to serve in the absence of the SALBOH Representative.

ARTICLE VI
ANNUAL MEETING AND SPECIAL MEETINGS

Section A. Purpose.

To fulfill the objectives of ARTICLE II of these Bylaws.

Section B. Date and Site of Annual Meeting.

An Annual meeting of the Association shall be held each year. The location shall be on a
rotating basis in each of the seven (7) Health Districts (District 1, 7, 3, 2, 6, 5 and 4). The date and site of the Annual meeting shall be set by the host district. Invitations and information shall be mailed to the District Boards of Health at least two (2) months prior to the meeting.

Section C. Special Meetings.

Special meetings of the Association may be called by:

1. The Association President or

2. A majority of the members of the Board of Trustees, provided all members are notified not less than seven (7) days before the date of the meeting.

Section D. Voting.

Voting at the Annual meeting and at special meetings shall be limited to the membership in attendance and by proxy of the absent members. Absent members must provide a written proxy to their designee.

Section E. Quorum.

Representation from membership from four of the seven (7) District Boards of Health shall constitute a quorum for the transaction of business at the Annual meeting and special meetings.

ARTICLE VII
PARLIAMENTARY AUTHORITY

ROBERT'S RULES OF ORDER NEWLY REVISED shall apply on all questions of procedure and parliamentary law not specified in these Bylaws.
ARTICLE VIII
AMENDMENTS

These Bylaws may be amended by a two-thirds (2/3) vote of the Association members, at the Annual Association meeting, when the proposed action has been sent out in the notice of such meeting to all members. Proposed amendments must be submitted to the Association Chair for distribution to the Association board members at least sixty (60) days prior to the Annual meeting, for the purpose of giving the seven (7) District Boards of Health notice of the proposed amendments. Exception to this ruling is allowed when the amendment has the majority consent at the Annual meeting to allow consideration. It may then be adopted by a two-thirds (2/3) vote of the Association members in attendance or by proxy according to ARTICLE VI, Section D. All amendments adopted at the Annual Association meeting shall become effective thirty (30) days following the Association meeting unless otherwise specified.

1988  Adopted at the Annual meeting of IAB.
5/93  Adopted by the Board of Trustees on 7/8/93.
5/95  Adopted by the Board of Trustees on 5/21/95.
5/95  Adopted at the Annual meeting of the Association on 5/4/95.
6/08  Adopted at the Annual meeting of the Association on 6/30/08.
6/10  Adopted at the Annual meeting of Association on 6/17 /10.
5/14  Adopted at the Annual meeting of the Association on 5/29/2014.

ARTICLE IX
RESOLUTIONS

1. Resolutions must be submitted to the Association Chair for distribution to the Association Board members at least sixty (60) days prior to the Annual meeting, for the purpose of giving the seven (7) District Health Boards of an opportunity to review and comment.

2. Emergency Resolutions, defined as anything that represents a sudden and urgent public health need or anything that is needed to keep the organization moving forward, may be brought up for discussion as long as approved by a two-thirds (2/3) vote of the Association members at any Annual Association meeting.

5/29/2014
WEDNESDAY, JUNE 3
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2:30 p.m. - 4:30 p.m. Trustee Meeting
5:00 p.m. - 7:00 p.m. Registration / Reception

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5:30 p.m. No-Host Bar Opens
6:00 p.m. - 7:00 p.m. Dinner
7:00 p.m. - 9:00 p.m. Evening Activity – Sunset Cruise by McCall Lake Cruises

idahopublichealthdistricts.org/AnnualConference -or- cdhd.idaho.gov/iadbh
Registration Form
IDAHO ASSOCIATION OF DISTRICT BOARDS OF HEALTH • ANNUAL MEETING
JUNE 3 & 4, 2015 • MCCALL, IDAHO

Name: ______________________________________ Title: ______________________________________
Address: __________________________________ City: _______________________________
State: _____ Zip Code: _______ Phone: ___________ Email: ________________________________

ROOM RESERVATION – Per Night
Please contact the Administrative/Management Assistant in your Public Health District to arrange your hotel reservations.

SHORE LODGE
Reservation requests after April 30 are subject to availability. Please inform the registration clerk that you are with the Idaho Association of District Boards of Health. With Shore Lodge offering limited rooms under $170 for block reservation, the following are options: Standard Queen @ $124; Standard King @ $129, and Garden King @ $169. Check-in time is 3 p.m. and check-out time is 12 p.m. Call Shore Lodge at 1-800-657-6464.

ADDITIONAL HOTEL OPTIONS
Most attendees will need to reserve rooms at other hotels near Shore Lodge and drive to the conference. Hotels to consider include: The Hunt Lodge Holiday Inn Express (208) 634-4700; Hotel McCall (208) 634-8105; The Scandia Inn (208) 634-7394; America’s Best Value Inn and Suites of McCall (208) 634-6300. Please make reservations early.

REGISTRATION FEES
All Events - $200
Includes meetings; breakfast, lunch & dinner, and sunset cruise on June 4
Dinner Choice:  □ Beef    □ Chicken    □ Vegetarian    $_______
Spouse / Guest Option 1 - $100
Includes breakfast, lunch & dinner, and sunset cruise on June 4
Dinner Choice:  □ Beef    □ Chicken    □ Vegetarian    $_______
Spouse / Guest Option 2 - $50
Includes dinner and sunset cruise on June 4
Dinner Choice:  □ Beef    □ Chicken    □ Vegetarian    $_______

Make checks payable to Central District Health Department
Total: $_______

PLEASE RETURN FORM AND FEES BY APRIL 24, 2015 TO:
CDHD, Attn: Donna Mahan
707 North Armstrong Place • Boise, ID 83704
Phone: (208)327-8502 • Fax: (208)327-8500
Email: dmahan@cdhd.idaho.gov

For more information visit:
idahopublichealthdistricts.org/AnnualConference -or- cdhd.idaho.gov/iadbh.
Business Meeting
Continental Room, Sun Valley Inn
Thursday May 29, 2014
DRAFT

D1: Present: Jai Nelson; Allan Banks; Glen Bailey.
    Proxies: Marlow Thompson; Walt Kirby; Leslee Stanley; Richard McLandress, MD.

D2: Present: Don Davis (Chair); John Allen (Vice-Chair); Shirley Greene (Trustee); Doug Zenner; Rose Gehring; Dave McGraw; Glenn Jefferson, MD.
    Proxies: N/A

D3: Present: Richard Roberge, MD (Chair); Lan Smith (Vice-Chair).
    Proxies: Denise Groves; Rick Michael; Larry Church; Kelly Aberasturi; Kathryn Alder.

D4: Present: Steve Scanlin (Chair); Betty-Ann Nettleton, RN (Vice-Chair/Trustee); Jane Young, CRN-P, DNP; Al Hofer; Frank Eld.
    Proxies: Ted Epperly, MD; Barbara Balding.

D5: Present: Linda Montgomery (Chair); Charles Ritter (Vice-Chair); Tom Faulkner (Trustee); Angenie McCleary; Donald Clark; Cheryl Juntunen, RN; Terry Kramer; Peter Curran, MD.
    Proxies: N/A

D6: Present: Donavan Harrington (Chair/Trustee); Ken Estep (Vice-Chair); Phil Christensen; Susan Collins; Vaughn Rasmussen; Scott Workman; Jerry Bush.
    Proxies: Howard Manwaring.

D7: Present: Barbara Nelson, MD (Vice-Chair); Lee Staker; Brian Farnsworth; LeRoy Miller; Kimber Ricks.
    Proxies: Robert Cope, DVM; Greg Shenton; Lin Hintze; Kathy Rinaldi.
I. **CALL TO ORDER** – Tom Faulkner, Chair of Trustees called the meeting to order at 9:00 am.

II. **ADMINISTRATION:**
   A. Roll Call – by district
   B. Proxy Votes collected per By-Laws (3/1/2012)
   C. Other agenda items requested

III. **CONSENT AGENDA**
   A. Approval of minutes from 6/05/2013
   B. Ratify the Decision made by Trustees during FY 2014
   C. FY 2013 Actuals Revenue/Expense by Program
   D. IADBH By-Laws (as of 3/1/2012)

**MOTION:** Doug Zenner (D2) moved to approve the Consent Agenda; Ken Estep (D6) seconded. Motion passed.

IV. **OTHER BUSINESS – ACTION ITEMS**
   A. Items pulled from the Consent Agenda – N/A
   B. Association Office Updates – Bruce Krosch (D3)
      i. FY 2015 Budget (Proposed)
      ii. IAC-IPHD Contract

**MOTION:** Shirley Greene (D2) moved to approve the FY 2015 Budget for IADBH as presented; Dr. Roberge seconded. Motion passed. Note: There was no need to amend or ratify the IAC contract since there were no changes presented.

C. **Compendium of Resolutions** – Rene LeBlanc (D5)
   i. Resolution Concerning the Prevention of Prescription Drug Abuse. Discussion – none.  **MOTION:** Ken Estep (D6) moved to approve the Resolution as presented; Betty-Ann Nettleton (D4) seconded. Motion passed.
   ii. Resolution to Support Insurance Coverage for Low Income Idahoans. Discussion – Comments were received suggesting a “waiver” option to purchase insurance in lieu of Medicaid; concerns that Medicaid expansion would negatively affect the CAT Fund during a transition period; that the Governor’s TF would look at Medicaid Redesign during the coming
months. **MOTION:** Linda Montgomery (D5) motioned to approve the Resolution as presented; Angenie McCleary (D5) seconded. The motion passed.

iii. Resolution to Support Medicaid Redesign in Idaho. Discussion – the resolution was amended to replace “expansion” with “redesign”; the amendment was presented at the business meeting. The primaries didn’t “look good” for either approach; support was lost in the primary. Concern over “Medicaid” trips opposition. **MOTION:** Shirley Green (D2) moved to approve the Resolution with amendments; Angenie McCleary (D5) seconded. **Motion passed.**

iv. Resolution to Support Purchasing Healthier Food Options with the Idaho Supplemental Nutrition Assistance Program (Idaho Food Stamp or SNAP). Discussion: The body agreed that child/adult obesity continues to be a challenge in Idaho; Sen. Patty Ann Lodge supports the concept of increasing access to healthier foods for Idahoans using SNAP. **MOTION:** Don Davis (D2) moved to approve the Resolution as presented; Dr. Roberge (D3) seconded. **Motion passed.**

v. Resolution to Support Purchasing Healthier Food Options with Idaho Food Stamp Benefits – **DELETED.**

vi. Resolution to Oppose Legalization of Marijuana in Idaho. Discussion – This resolution netted the most attention and debate. The body did agree to amend the resolution to insert “Recreational” in front of any reference to Marijuana; this was done to not impair efforts on legalizing the medical benefits of marijuana; however, there is concern over some of the by-products and abuse. The body debated the benefit-cost of criminalization (cost of enforcement /incarceration) versus the public health impact and to wait to see what develops in WA and CO. The resolution was amended to replace “legalization” with “use”; to insert “recreational” in front of marijuana. **MOTION:** Shirley Greene (D2) moved to approve the Resolution, as amended by the body; Lee Staker (D7) seconded. **Motion passed with three (3) opposed.**
vii. Resolution to Support a Food Establishment License Fee Increase. There are two (2) motions; one supports “actual” costs and the other supports “one-half actual” costs. Discussion – The resolution that supported actual cost was rejected by the body; the resolution supported one-half the actual cost was accepted. **MOTION:** Shirley Greene (D2) moved to approve the Resolution supporting “one-half of the actual costs”; Doug Zenner (D2) seconded. Motion passed.

V. **DISCUSSION ITEMS – NO ACTION**

A. **NALBOH/SALBOH – Future Options.** The body discussed at length what options each board of health was contemplating with regards to membership to NALBOH and the SALBOH. The majority of the boards felt it was prudent to wait and see how NALBOH handles their funding issues, debt. And relationship with CDC. No board indicated they were proceeding with payment of membership dues.

B. **Accreditation (PHAB) –** This received active discussion regarding the “pro’s” and “con’s” to moving forward with PHAB.
   i. **Pro’s:** Encourages good public health; credibility.
   ii. **Con’s:** Expensive fee structure; total man-hours required to prepare or endeavor to undergo accreditation (1.0 – 1.5 dedicated FTE just to PHAB); failing to achieve accreditation might negatively impact Medicaid reimbursements.
   iii. The body elected to defer to each individual district to make a decision on accreditation.

VI. **ADJOURN:** The Business Meeting adjourned at 10:00 am.
Trustee Meeting

Sage Room, Sun Valley Lodge
Wednesday May 28, 2014
1:00 – 3:00 p.m.

D1: Comm. Glen Bailey
D2: Shirley Greene
D3: Richard Roberge, MD
D4: Betty Ann Nettleton, RN
D5: Comm. Tom Faulkner – Chair
D6: Ken Estep
D7: Comm. Kimber Ricks

Lora Whalen
Carol Moehrle
Bruce Krosch
Russ Duke
Rene LeBlanc – Secretary
Tyler Butler (for Maggie Mann)
Geri Rackow

Guests:
Comm. Don Davis (D2)
Comm. Dave McGraw (D2)
Comm. Doug Zenner (D2)
Dan Chadwick – IAC Ex. Dir.

1. Call to order – 1:06 p.m.

2. Roll call.

3. Approval of minutes from 3/13/2014.

**MOTION:** Betty Ann (D4) moved to approve the minutes from March 13, 2014. Dr. Roberge (D3) seconded. Motion passed.

4. **Discussion Items:** (consent to move forward to the business meeting)
   a. **IAC Contract** – Tom Faulkner (D5) & Dan Chadwick (IAC). Dan indicated that there is nothing to change for FY 2015; the amount is unchanged; and he identified new staff members. Kerry Elliot retired and Katlyn Rusche will now take over those duties. Seth Grigg and Katlyn will be our primary contacts for the next legislative session. The contract was approved by consent to move to the business meeting.
b. Review IADBH Bylaws (annual review) – Rene LeBlanc (D5). There were no comments or recommendations for edits or changes. Approved by consent to move to the business meeting.

c. IADBH Resolutions – Tom Faulkner/Rene LeBlanc (D5). Rene updated the group on resolutions moved to the archive and then introduced new resolutions for discussion.
   • Archived resolutions –
     o 10-01: State Option to Expand Family Planning Coverage.
     o 11-01: Support the Prohibition of the Sale and Distribution of Electronic Cigarettes to Minors and the Use of Electronic Cigarettes by Minors.
   • New resolutions –
     o Resolution Concerning the Prevention of Prescription Drug Abuse. No comments.
     o Resolution to Support Insurance Coverage for Low Income Idahoans. Comments: Concern over this would replace Medicaid Expansion and impact to the CAT board. Other affects include the "woodworking" population and the need for >$50M to cover. There was mention of a "waiver" to the state to purchase insurance on the exchange in lieu of enrolling in Medicaid (OK model).
     o Resolution to Support Medicaid Redesign in Idaho. There was extensive comment regarding the unpalatability of the term "Medicaid Expansion" with elected officials and the potential for change due to outcomes of the state primaries. A few trustees felt the insurance buy option was a better sell vice Medicaid expansion.
     o Resolution to Support Purchasing Healthier Food Options with the Idaho Supplemental Nutrition Assistance Program (Idaho Food Stamp). Comments: Betty Ann (D4) feels that obesity among Idahoans warrants more control by the FNS, USDA for items that are healthier food options. Dr. Roberge (D3) indicated that Sen. Patty Ann Lodge (Dist. 11) was very much in support of healthier food options for SNAP.
     o Resolution to Oppose [Use] Legalization of [Recreational] Marijuana in Idaho. Active discussion on the precise intent of the resolution; recreational vs. medical properties and research. The trustees identified edits to be made to
the resolution prior to the business meeting; inserting "use" and "recreational" to the language.

- (2) Resolutions to Support a Food Establishment License Fee Increase: 1-for actual cost and 1-for half of the actual cost. Both received active discussion and directed edits prior to the business meeting. Dan Chadwick felt the group should wait until the general election in November is over to see the outcome and committee assignments. He suggested we solicit both Sen. Lee Heider (Dist. 24), Senate H&W Chair, and Fred Wood (Dist. 27), House H&W Chair, for support before expending political capital to ensure a bill could make it out of committee. It was recommended that the trustees/boards of health adopt a wait and chat with committee chairs and focus on the 2016 Legislative Session; too late this year.

- All new resolutions were approved by consent to move to the business meeting on May 29, 2014.

- d. IADBH FY 2015 Budget – Bruce Krosch (Association Office) (D3).
  Bruce presented the budget sheets for the IADBH and Association Office accounts. There were no comments; approved by consent to move to the business meeting.

- e. PHAB: Future Plans – Dr. Roberge (D3). There was brief discussion regarding each district’s plans for accreditation. Comments covered the cost and benefits of accreditation. Given budget concerns the question of whether anyone could afford the FTE and costs was solicited. The general consensus was each district would evaluate their situation and budget and make an independent decision whether to move forward with accreditation.

- f. NALBOH/SALBOH & Future Options – Shirley Greene (D2). NALBOH is going through a reorganization the staffing change. Most efforts are being handled through volunteers and there is a concerted effort to revitalize the organization. The main point was for the districts to be patient and not pull support. Most districts felt a wait and see approach was warranted before renewing membership.

5. Adjourn: 3:00 p.m.
RESOLUTION SUPPORTING PREVENTION OF EXCESSIVE ALCOHOL USE

WHEREAS, excessive alcohol use includes binge drinking (five or more drinks during a single occasion for men and four or more drinks in a single occasion for women), underage drinking, drinking while pregnant, and alcohol impaired driving\(^1\); and

WHEREAS, recognizing that children who consume alcohol before age 15 are four times more likely to develop alcohol dependence at some point in their lives versus children who abstain from alcohol until they are 21\(^1\); and

WHEREAS, excessive alcohol use still continues to play an important role in unintentional injuries, homicides, and suicides which are the leading causes of death among youth\(^2\); and

WHEREAS, recognizing that alcohol use is implicated in at least one-third of sexual assault and acquaintance or “date” rape cases among teen and college students\(^2\); and

WHEREAS, alcohol is more likely to be a factor in violence where the attacker and victim know each other (such as domestic violence). Two-thirds of victims who were attacked by an intimate partner (including a current or former spouse, boyfriend, or girlfriend) reported that alcohol had been involved, whereas only 31% of victimizations by strangers are alcohol-related \(^3\); and

WHEREAS, reports by the Center on Alcohol Marketing and Youth revealed that underage youth are heavily exposed to alcohol advertising on radio, in magazines, and on the Internet\(^2\); and

WHEREAS, recognizing the Idaho Youth Risk Behavior Surveillance Survey found that in 2013, 28% of high school students had at least one drink of alcohol during the 30 days prior to the survey\(^4\); and

WHEREAS, recognizing one in five (18%) Idaho students engaged in binge drinking (defined as having five or more drinks in a row) during the 30 days prior to completing the survey\(^5\); and

WHEREAS, excessive drinking results in 437 deaths and 12,311 years of potential life lost each year in Idaho\(^5\).

THEREFORE BE IT RESOLVED, that the Idaho Association of District Boards of Health support the best practice recommendations to decrease excessive alcohol use by raising state excise taxes on alcohol; restricting access to alcohol through increased compliance checks and responsible beverage service programs; and increasing community mobilization efforts to assess problems and resources needed to combat underage drinking.
References


RESOLUTION TO SUPPORT RESEARCH ON THE USE OF MEDICAL MARIJUANA AND MONITORING OF THE PUBLIC HEALTH IMPACT OF MEDICAL MARIJUANA LEGALIZATION

WHEREAS, As of December 2014, 23 states and the District of Columbia have enacted laws to legalize medical use of marijuana.

WHEREAS, using marijuana can produce adverse physical, mental, emotional and behavioral changes, can significantly reduce motor coordination and slow reaction time, and use during pregnancy may be associated with neurological problems in babies and impaired school performance later in childhood. Whether smoking or otherwise consuming marijuana has therapeutic benefits that outweigh its health risks is still an open question that science has not resolved.\(^1\)

WHEREAS, Marijuana has been used to treat certain health conditions such as glaucoma and seizure disorders.\(^2\)

WHEREAS, Tetrahydrocannabinol (THC) and marijuana are promoted to relieve pain, control nausea and vomiting, and stimulate appetite in people with cancer and AIDS.\(^3\)

WHEREAS, cannabidiol, an active chemical in marijuana, may help prevent cancer from spreading.\(^4\)

WHEREAS, Marijuana may be able to slow the progression of Alzheimer's disease.\(^5\)

WHEREAS, THC, the active chemical in marijuana, has been shown to slow the formation of amyloid plaques by blocking the enzyme in the brain that makes them.\(^6\)

WHEREAS, Marijuana may ease painful symptoms of multiple sclerosis.\(^7\)

WHEREAS, A 2006 study in the European Journal of Gastroenterology and Hepatology\(^8\) found that 86% of patients using marijuana successfully completed their Hep C therapy, while only 29% of non-smokers completed their treatment. Marijuana also may improve the treatment's effectiveness.

THEREFORE, BE IT RESOLVED, that the Idaho Association of District Boards of Health (IAB) supports adequate and well-controlled studies under the oversight of the Department of Health and Human Services, National Institutes of Health of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease.

THEREFORE, BE IT FURTHER RESOLVED, that IAB strongly encourages the Department of Health and Human Services to establish a monitoring program to assess the public health impact of legalizing medical use of marijuana.


RESOLUTION TO SUPPORT AN EXCISE TAX ON ELECTRONIC NICOTINE DELIVERY SYSTEMS

WHEREAS, It was in 1912 that smoking tobacco was linked to lung cancer, and it took more than 50 years for the US Surgeon General to declare smoking a health hazard and another 45 years before the Food and Drug Administration (FDA) was given the authority to regulate tobacco products.

WHEREAS, Many electronic nicotine delivery system (ENDS), also marketed as electronic cigarettes, contain juices with nicotine, a highly addictive drug for which there are no safe levels.

WHEREAS, There is currently insufficient evidence to conclude that ENDS, or electronic cigarettes, help users quit smoking.1

WHEREAS, Many electronic cigarette juices are flavored in such a way to be attractive to youth such as peanut butter and jelly, Mountain Dew, Skittles, bubblegum, cotton candy, cherry licorice and grandma's apple pie.

WHEREAS, Electronic cigarette companies currently advertise their products to a broad audience that includes 24 million youth in the United States. Youth exposure to electronic cigarette advertisements increased by 256% from 2011 to 2013 and young adult exposure to electronic cigarette ads jumped 321 percent in the same time period. More than 80% of the advertisements in 2013 were for a single brand, Blu eCigs, which is owned by the tobacco company Lorillard.2

WHEREAS, A recent study from the Centers for Disease Control and Prevention reported that rates of electronic cigarette use among U.S. youth more than doubled from 2011 to 2012, with 10 percent of high school students admitting to having used electronic cigarettes.3

WHEREAS, Almost 76% of youth who had tried an electronic cigarette had also tried a regular cigarette. Altogether, in 2012 more than 1.78 million middle and high school students nationwide had tried electronic cigarettes.3

WHEREAS, while electronic cigarettes are likely to be less toxic than conventional cigarettes, their use poses threats to adolescents and fetuses of pregnant mothers using these devices.4

WHEREAS, the FDA conducted an analysis on samples of electronic cigarettes and components from two leading brands, which showed that the product contained detectable levels of known carcinogens and toxic chemicals to which users could potentially be exposed. The FDA’s findings also suggested that quality control processes used to manufacture these products are inconsistent or non-existent.5

WHEREAS, According to FDA the electronic cigarette cartridges that were labeled as containing no nicotine had low levels of nicotine present in all cartridges tested, except one.5

WHEREAS, The American Association of Poison Control Centers reports that, through December 31, 2014, there have been 3,957 calls so far this year involving exposures to electronic cigarette devices and liquid nicotine. That is up from 1,542 in 2013, 460 in 2012 and 271 in 2011.5
WHEREAS, North Carolina, the number one tobacco producing state, taxes liquid nicotine at 5 cents per milliliter.  

WHEREAS, More than 100 studies from high-income countries clearly demonstrate that increases in taxes on cigarettes and other tobacco products lead to significant reductions in cigarette smoking and other tobacco use.

THEREFORE BE IT RESOLVED, that the Idaho Association of Local Boards of Health support establishing an excise tax on ENDS including the delivery devices and liquid solutions used in the devices.

7General Assembly of North Carolina Session 2013. §14-313 HB 1050 (2014)
RESOLUTION TO IMPROVE HEALTHY FOOD CHOICES BY IMPLEMENTING A TRAFFIC LIGHT FOOD LABELING POLICY

WHEREAS, obesity continues to rise in the United States and is a leading cause of preventable death in Idaho, with 35% of adults being obese and 68.5% either overweight or obese1-2; and

WHEREAS, the USDA’s 2010 Dietary Guidelines recommend limiting intakes of saturated fat, sodium, trans fat, cholesterol, and added sugars to manage and prevent obesity3; and

WHEREAS, energy dense, nutrient deficient foods are vigorously marketed4,5; and

WHEREAS, current food labels are often misunderstood and misused, particularly in the low-income, literacy, and numeracy households with as little as 10.5% of college students being able to use them correctly6,7,8; and

WHEREAS, labels that are readily accessible and easy-to-understand best support healthy dietary decisions9,10; and

WHEREAS, traffic light labels quickly reflect the overall healthfulness of an item and how frequently it should be consumed11; and

WHEREAS, the use of traffic light labels increase the purchasing of healthier items by 10%, while decreasing purchases of less healthy by 16.5% 12,13; and

WHEREAS, food labeling policy changes can be more cost effective than other obesity treatments14; and

WHEREAS, changes to environment and public policy can affect healthy choices in overall populations15,16; and

WHEREAS, the State of Idaho does not have a policy regarding promotion of healthy food choices using easy-to-understand food labels.

THEREFORE BE IT RESOLVED, that the Idaho Association of Local Boards of Health supports and promotes healthy food choices by enacting a traffic light food labeling policy.

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SHIP: The Vision for the Future of Healthcare in Idaho

Idaho Association of District Boards of Health Annual Meeting | Thursday, June 4, 2015

Ted Epperly, MD, FAAFP
President and Chief Executive Officer | Family Medicine Residency of Idaho, Boise, Idaho
Chairman | Idaho Healthcare Coalition
What is the SHIP?

The State Healthcare Innovation Plan (SHIP) is a statewide plan to redesign our healthcare delivery system, evolving from a volume-driven, fee for service system to a outcome-based system that achieves the triple aim of improved health, improved healthcare and lower costs for all Idahoans.
Idaho’s Healthcare Transformation

Idaho Health System Transformation 1.6M People

Medicaid Redesign 274K People

Medicaid Expansion 78K People
Seven Idaho SHIP Goals

Goal One: Transform Primary Care Practices to Patient-Centered Medical Homes (PMCH)

Goal Two: Develop Virtual PCMH’s for Rural and Frontier Areas (CHW’s, CHEMS, Telehealth)

Goal Three: Build out the PCMH Neighborhood (EMR’s / IHDE)

Goal Four: Develop Seven Regional Health Collaboratives to Oversee Delivery and Quality Integration

Goal Five: Build Statewide Data Gathering and Analytics System

Goal Six: Align Payment Mechanisms

Goal Seven: Reduce Healthcare Costs
Idaho Healthcare Coalition (IHC) Model Testing Grant

- $40M Grant (CMMI)
- Four Years
- Achieve Triple Aim: Better Health; Better Healthcare, Lower Costs
- Projected Savings $89M/Three Years
- ROI (197%) over Five Years
IHC Model Testing Deliverables

- 165 Primary Care Practices (PCMH's) over Three Years (825 PCP's); 1.3M People (80%)
- EHR/HIE Integration (PCMH / Neighborhood)
- Build Seven Regional Health Collaboratives
- 75 Virtual PCMH's (>550 CHW's/CHEMS) / Telehealth
- Data Analysis – Collecting, Analyzing, Reporting
- Align Payment Mechanisms
Idaho Medical Home Pilot

- Two Year Pilot
- \(\Downarrow\) Hospitalizations – 33%
- \(\Downarrow\) ER Utilization – 27%
- \(\Downarrow\) Prescription Drugs – 19%
- \(\Downarrow\) Health Care Costs (PMPM) – 26%
- \(\uparrow\) Patient Satisfaction
- \(\uparrow\) Physician Satisfaction
- ROI – 10:1
Idaho Healthcare Coalition (SHIP) Summary

- Vehicle and Model for Healthcare Transformation for Idaho
- Built on Foundation of Primary Care and the Patient Centered Medical Home (PMCH)
- Integrates and Coordinates the PCMH with Secondary Providers, Hospitals, and Other Members of Healthcare Team
- Connects Public Health to Population Health Quality Metrics
- Integrates Clinical and Claims Data
- Aligns Payment Systems with Access and Outcomes
Questions
Integrated Behavioral Health and Primary Care & SHIP Quality Measures

Andrew Baron, MD, MBA, FAAFP, CPE
Medical Director
Terry Reilly Health
Outline

• Terry Reilly and Community Health Centers
• SHIP Integrated Behavioral Health-Primary Care
  – Terry Reilly example
• SHIP Quality Measures
• Please Feel Free to Ask Questions
Idaho’s 13 CHCs Serve 160,000 Idahoans
Over 70,000 people need us
Why should you care?

• Care received at health centers is ranked among the most cost-effective.
  – For each $1 spent results in $3 healthcare cost savings.
  – Without compromising Quality

• We reduce health disparities in our Idaho communities, big and small, that need us the most
The new face of Healthcare SHIP

• Unsustainable Model, Cost and poor outcomes
  – US Ranked 38th Health Outcomes
  – We spend the most of any other country 19% GDP

• Healthcare Services is Shifting Away from fee for service (volume) to Value

• Being held accountable for Outcomes, Quality and Cost of Care

• Moving to an Integration of Coordination and Care
Our Mission

Terry Reilly, in the tradition of our founders, is a community health center (FQHC) dedicated to providing affordable, comprehensive health care to everyone in our community to improve health and quality of life.

• Integrated healthcare for all, regardless of insurance, income or ability to pay.
  – Sliding fee scale (25%, 50%, 75%) based on income
  – Zero pay fund (100%)
  – Homeless Grants

• Language should not be a barrier to care
  – Over 40% of TR employees speak Spanish
  – All patient material is in both English and Spanish
  – Translation Services available for other languages
Terry Reilly Community Health Center

• Serving the communities of Ada, Canyon, and Owyhee Counties
  – 8 medical/behavioral health clinics
  – 5 dental clinics
    • 2 integrated with medical/behavioral health
  – 5 specialty behavioral health clinics
  – Allumbaugh House: Detoxification/Mental Health Stabilization Facility
Who we serve

In 2014, we served Nearly 30,000 patients

Source: 2014 UDS Data
Who we are –

• Over 275 employees
• Counselors, Dentists, Front Desk staff, Hygienists, MAs, Management Staff, Physician Assistants, Pharmacists, Physicians, Nurse Practitioners, Psychiatric Nurse Practitioners, RNs, Volunteers
Serving our Community

• Work with our community members
• Able to receive subsidized care to fully insured
• Provides a sliding scale fee structure for the poor and those in need ($5.4M to date)
• We provide free care to the homeless community in Boise and Nampa
• Zero Pay Fund for those that need it most.
What role do we play?

- Joint Commission Accredited Health Care Organization 2013
- The only CHC in Idaho to have that achievement!
- NCQA level III and Joint Commission accredited Patient Centered Medical Home
PCPs Provide >60% of diagnosis and medication management
50% of psychoactive drugs prescribed by PCPs
PCPs, PNPs Refer patients for counseling
Complicated MH patients need healthcare
Rural Access to Care
Tele-psychiatry
Psychiatrist Shortage
Why Integrated BH-PC?

• We need to do a better job helping them be healthy
• The Leading Cause of Disability for those with Serious Persistent Mental Illness (SPMI) is their mental illness
• The Leading Cause of Death and Disability for those with SPMI is Chronic Diseases
  – Coronary Artery Disease
  – Diabetes
  – COPD
  – Stroke
• 6 Levels of Collaboration/Integration
SAMSHA-HRSA

Level 1: Minimal Collaboration

Level 2: Basic Collaboration at a Distance

Level 3: Basic Collaboration Onsite

Level 4: Close Collaboration Onsite with Some System Integration

Level 5: Close Collaboration Approaching an Integrated Practice

Level 6: Full Collaboration in a Transformed Merged Integrated Practice
• Six Levels of Collaboration & Integration for Behavioral Health (BH) and Primary Care (PC)

- Coordinated: key element is Communication
  - Level I Minimal Collaboration
    - separate facilities, separate systems; driven by provider need not patient need or issue, don't meet in person, limited understanding of roles, BH & PC separate

- level II Basic Collaboration at a Distance
  - separate systems, communicate periodically about shared patients, communication is driven by specific patient issues, appreciate others' roles as resources
Co-located: the Element is Physical Proximity

Level III Basic Collaboration on-site
- same facility but not same offices -- separate systems, communicate regularly about shared patients by phone or e-mail and meet occasionally in person to discuss cases, collaborations; driven by the need for each others services and a more reliable referral, feel part of a larger yet ill-defined team

Level IV Close Collaboration on-site with Some System Integration
- same space within the same facility, share some systems like scheduling, medical records, communicate in person as needed, collaborations; driven by the need for consultation in coordinated plans for difficult patients, regular face-to-face interactions about patients, basic understanding of roles and cultures
Transformed integrated practice

- Integrated: key element is Practice Change
  - Level V Close Collaboration Approaching an Integrated Practice
    - same space within the same facility with some shared space, actively seek system solutions together, communicate frequently in person, collaboration is driven by the desire to be a member of the team, regular team meetings, in-depth understanding of roles and cultures
  - level VI Full Collaboration in a Transformed/merged Integrated Practice
    - same space within the same facility sharing practice space, function as one integrated system, consistent communication at the system team and individual levels, collaboration is driven by the shared concept of team care, have formal and informal meetings to support integrated model of care, have roles and cultures that blur or bend
The Level of Integration Has Implications for:

• Clinical Delivery
  – Seamless & Coordinated
  – Shared guidelines

• Patient Experience
  – Patient Centered vs Clinician Centered

• Practice organization
  – Staffing, physical layout, teams

• Business & Payment Model
Terry Reilly has varying levels of integration within practices depending on clinic site

- Idaho’s Rural Clinics
  - Have limited behavioral health resources available
  - Implications for all of Idaho to deliver BH services
  - How do we ensure access to BH services?
Transitions of Care

• Allumbaugh Hospital
  Managed by Terry Reilly Health Services
  Integrated and coordinated discharge planning and follow-up at Terry Reilly Boise clinic
  Regular communication and meetings between AH and Boise clinic
  EHR access for AH; documentation immediately scanned into electronic record by AH
Transitions of Care

• AH & Psychiatric Hospital Discharges
  – Case manager reviews patients who are inpatient and require discharge follow-up
  – Psychiatric facilities communicate with our case managers to ensure needed follow-up
  – Patients are seen either by BH or PC depending on availability
What does Integrated BH-PC Care look like?

• Pod Concept; physical co-location of BH & PC
• Most integrated behavioral health and primary care practice with the teams interacting on a continuous basis during delivery of care
• Allows for interaction and collegiality as well as curbside consults on a regular basis
• Include process improvement, and specific case reviews of complicated patients
• Same Shared Electronic Health Record
How it works

• By having BH and PC integrated it allows:
  – patient needs can be met effectively by multiple disciplines that comprise the patient team
  – Patient with depression seen by psychiatric nurse practitioner and BP is elevated; primary care provider initiates BP management that same day.
  – Primary care provider has a patient that is suicidal; immediate access to a counselor who can do an assessment of the patient and determine disposition in concert with PC/PNP.
SHIP Quality Measures

• Began in 2013
• Work Group
  – Comprised of providers, payors, DHW, Interested Entities
  – Met Monthly and developed quality measures
  – For this to be effective must have payors and providers working together
Workgroup Wanted to Include

– Hospital measures
– Outpatient measures (Disease and Preventive)
– OB measures
– Pediatric measures
– Behavioral Health measures
– Cost measures
By the end of Year 1

• The IHC will engage stakeholders in this discussion to ensure that a statewide solution is viable and acceptable to the different communities in Idaho

• Exciting to have Idaho establishing state-wide performance measures as we move toward population health

• Due to the lack of uniform reporting that exists today:
  – IHC will develop a baseline from the information currently available across payers and populations
  – An external organization with expertise in performance data collection, analysis, and reporting will assist the IHC in gathering and analyzing the data to establish a baseline
In Year 2, the IHC will select four core performance measures from the initial Performance Measure Catalog to be reported by all PCMHs in Year 2

- The statewide performance measures for Year 2 will include the three SIM measures: tobacco cessation intervention, weight assessment and counseling for children and adolescents, and comprehensive diabetes care
Year 3

• In consultation with the IHC, RCs will identify additional performance measures from the Performance Measure Catalog to be collected from PCMHs in their respective regions in Year 3.

• The additional measures collected in Year 3 may vary from region to region depending on performance and regional health needs and will be informed by community health assessments and regional specific clinical data.
First Year Measures

- Tobacco Use Assessment
- Diabetes Measures
- Weight Assessment
1\textsuperscript{st} Year

Performance Measures for Population Health

- **Tobacco use assessment (SIM):**
  - % of patients queried about tobacco use one or more times during the two-year measurement period
- **Tobacco cessation intervention (SIM):**
  - % of patients identified as tobacco users who received cessation intervention during the two-year measurement period.
1st Year
Performance Measures for Population Health

- **Adult BMI Assessment (SIM):**
  - % of 18 - 74 years of age who had an outpatient visit & who’s BMI was documented during the measurement year or the year prior.

- **Weight assessment and counseling for children and adolescents (SIM):**
  - % of children, 2 - 17 years of age, whose weight is classified based on Body Mass Index (BMI), who receive counseling for nutrition and physical activity.
1st Year
Performance Measures for Population Health

• Comprehensive diabetes care (SIM):
  – with the intent of preventing/reducing future complications of poorly managed diabetes
  – % of patients 18-75 with diabetes, with 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
Performance Measures for Population Health

• **Screening for clinical depression:**
  • % of patients aged 12 years and older screened for depression using a standardized tool and follow up plan documented

• **Adherence to antipsychotics for individuals with schizophrenia (HEDIS):**
  – The % of individuals 18–64 years of age with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period
Performance Measures for Population Health

- **Asthma ED visits:**
  - % of patients with asthma who have greater than or equal to one visit to the ED for asthma during the measurement period

- **Avoidable emergency care without hospitalization (risk-adjusted):**
  - % of patients who had avoidable use of a hospital ED
Performance Measures for Population Health

• **Readmission rate within 30 days:**
  – % of patients who were readmitted to the hospital within 30 days of discharge from the hospital

• **Acute Care Hospitalization (risk-adjusted):**
  – % of patients who had to be admitted to the hospital
Performance Measures for Population Health

• Elective delivery:
  – Rate of babies electively delivered before full-term.

• Low birth weight rate:
  – # of low birth weight infants per 100 births.
Performance Measures for Population Health

• **Access to Care:**
  – % who report adequate and timely access to PCPs, behavioral health, and dentistry (measure adjusted to reflect shortages in Idaho).

• **Childhood immunization status**
  – % of children 2 years of age who had:
    – 4 DtaP/DT, 3 IPV,
    – MMR, Chicken pox vaccine
    – 3 H influenza type B, 3 hepatitis B, 4 pneumococcal conjugate vaccines
Performance Measures for Population Health

• Non-malignant opioid use:
  – % of patients chronically prescribed an opioid medication for noncancer pain (defined as three consecutive months of prescriptions) that have a controlled substance agreement in force (updated annually)
Care Experience Measures:

• Patient Engagement:
  – % of enrolled PCMH patients reporting they are an active participant in their healthcare.

• Stakeholder Engagement:
  – Number of stakeholder forums occurring to inform, refine and improve delivery system model.
Idaho’s Cost Measures to Monitor Cost Savings Targets

– Appropriate Generic Drug Use: % of all generic fill rates.
– Re-hospitalizations: % of all hospitalizations.
– Acute Care Hospitalizations: % all acute hospitalizations.
– Non-Emergent ED use: % of all ED visits.
– Early Deliveries (in weeks 37–39 of gestation): % of total NICU admissions.
QUESTIONS
Model Test Proposal Organizational Structure

Idaho Healthcare Coalition (IHC)
- HIT & Data Analytics Workgroup
- Multi-Payer Workgroup
- Telehealth Council
- Clinical Quality Measures Workgroup
- Community EMS Task Force
- Population Health Workgroup
- Idaho Oral Health Alliance
- Behavioral Health Integration Workgroup
- Regional Collaboratives
- Local Public Health Districts

Idaho Department of Health and Welfare
- DHW Director
  - Richard Armstrong
- DHW Deputy Director
  - Denise Chuchkovich
- Program Administrator
  - Granika York

Population Health
- Division of Public Health
  - Elke Shaw-Tulloch

Public Health
- Bureaus of Rural Health & Primary Care
  - Mary Sheridan

Project/Contract Manager
- Regional Collaboratives
  - Miro Barac
  - Liaison: Public Health Districts
  - Telehealth Development
  - Community Health EMS Training
  - Community Health Worker Training

Project/Contract Manager
- PCMH Transformation
  - Heather Clark
  - Technical Assistance
    - Training, Education and Outreach
    - Performance Reporting Training
    - Incentives to Primary Care Providers

Administrative Support
- Kim Thieszen

Grants & Contract Officer
- Ann Watkins

Operations Project Manager
- Casey Meyer

Project Management & Financial Analysis Contract

Administrative Support
- (1) FTE

Technical Assistance Contractors
Oversees the development of this performance driven population management system

Support practices in transformation to a PCMH

Idaho Healthcare Coalition

Provides primary care services and coordinates care across the larger medical neighborhood of specialists, hospitals, behavioral health and long-term care services and supports

RCs

PCMH and Medical Neighborhood Care Team

Improved health by receiving all primary care services through a patient-centered approach

Patient
HEALTH DISTRICT INVOLVEMENT

- Regional Health Collaboratives
  - Convene, promote, facilitate an RHC
    - PCPs, PCMHs, medical/health neighborhood service providers, decision-makers, social services, public health
  - Provide RHC representative to the IHC
  - Identify data-driven initiatives to help improve population health by providing regional and practice-level dataanalytic support through the IHC and SHIP contractors
  - Help connect patient centered medical homes with resources and integration in the regional medical/health neighborhoods and health and community services
  - Develop sustainability plans
    - It’s about the relationships!
**Health District Involvement**

- Patient Centered Medical Home Transformation Support
  - Hire a PCMH Transformation support staff and
  - Support the primary care provider locations after the PCMH Transformation contractor has done initial training
    - Identify technical assistance and resources to support the primary care providers as they transform
  - Support the primary care provider locations with connections to the other SHIP Model Test Grant contractors
    - Data Analytics, IHDE, etc.
  - Assess opportunity and need for Community Health Worker, Community EMS and telehealth services
  - Support behavioral health integration
What does this really look like?
**SOME EXAMPLES…….**

- **Local City Ordinance:** providing for physical activity, limited screen time and nutritional standards in child care settings
  - Local healthcare providers and hospital CEOs testified at city council to support changes; saw need to address childhood obesity

- **Awareness and Action:** pediatrician realizing that children he delivered were coming back as overweight/obese youth
  - Got involved in local efforts to provide healthy options

- **Potential Scenario:** Non-compliant smoker population in PCMH
  - Physician and EHR flag this stratified population, automatically connected to QuitLine that calls patient directly, supported with enrollment in local tobacco prevention classes
LEGACY/SUSTAINABILITY OF RHCs

• This is a TEST grant – testing the SHIP model

• No one has all of the answers right now

• There will be regional nuances & cross-district issues to address

• Stakeholder engagement to change population health, build camaraderie to develop and implement local policy changes, connect business/public health/healthcare

• Greatest outcome – long-lasting relationships
**Next Steps**

- Finalize contracts with health districts
- Participate in PCMH trainings
- Participate in the RHC kickoff in late October or early November
  - Develop tools, templates, resources for all health districts to use
  - Participate in medical home collaborative learning session
  - Meet existing Medicaid Health Home/PCMH clinics
  - Meet SHIP staff and contractors and federal officers
Questions?
IHC: RURAL PCMH CHALLENGES

IDAHO ASSOCIATION OF DISTRICT BOARDS OF HEALTH

ANNUAL MEETING | THURSDAY, JUNE 4, 2015

Keith E. Davis, MD, DABFM, FAAFP
Owner/CEO/Medical Director
Shoshone Family Medical Center
Independent RHC, Shoshone, Idaho
NCQA Level 3 PCMH
30 years experience

SHIP/IHC Member

Rural/Frontier Practice

WHY IS DR. DAVIS HERE?
Only clinic in an area larger than Rhode Island!

EMR: eClinicalWorks Since 2009 (Patient Portal, Meaningful Use, Patient Registries, PCMH Functionality)

Three Cities: Shoshone, Richfield and Dietrich

County Population About 4,700
Clinic One of 47 RHCs in Idaho

HOW RURAL IS SFMC?
WHO IS AT SHOSHONE FAMILY MEDICAL CENTER?

Dr. Davis and Staff

2 PA-C, 2 NP, CNM
LCSW, CRC, CDE
2 RN, 2 LPN, 3 MA, CPC
Goal 1: Transform Primary Care Practice to PCMH
Goal 2: Develop Virtual PCMHs for Rural/Frontier Areas
Goal 3: Build Out the PCMH Neighborhood (EMRS, IHDE)
Goal 4: Develop Seven Regional Health Collaboratives to Oversee Delivery and Quality Integration
Goal 5: Build Statewide Date Gathering and Analytics System
Goal 6: Align Payment Mechanisms
Goal 7: Reduce Healthcare Costs

WHAT ARE THOSE IHC GOALS?
LET'S FOCUS ON 1 THROUGH 4
RURAL STRENGTHS

- NIMBLE (Quick to Adapt/Change) (NCQA Level 3)
- Great Quality of Life and Healthy Living Possible
- Lower Levels of Noise, Air, Water and Light Pollution
- Great Provider/Patient Relationships (Everyone Knows Everyone)
- Other
Limit Resources: Staff, I.T., Provider Access, Capital
2. Dependence on Leadership and Other Skills of a Few
3. Loosely (Or Poorly) Defined Job Descriptions Common
4. FHQCs Well Organized Via IPCA; RHCs Not
5. Other

Rural Challenges
IHC Hopes to Transition About 55 Practices to PCMH Each Year of the Study With Assistance from the Seven Regional Centers

The Assistance to Be Provided by the Centers is Yet Undefined

“We don’t know what assistance is needed. But we’ll know it when we see it!”

Rural Practices Have Some Fairly Predictable Strengths and Challenges
Thank you for the opportunity to attend your annual meeting and spend some time with you focusing on the Rural/Frontier aspects of the Idaho Healthcare Coalition!
VIRTUAL
PATIENT CENTERED MEDICAL HOME (PCMH)

- Expanding access to primary care services in rural and underserved areas.

- Community Health Workers (CHW) and Community Health Emergency Medical Services (CHEMS) are part of the primary care team.

- Use of Telehealth increases access to behavioral health and specialty care.
COMMUNITY HEALTH EMS (CHEMS)

- Licensed EMS personnel complete additional education
- Community paramedics:
  - Expansion of duties within existing scope of practice
  - Work with primary care clinicians, medical director, and hospitals to identify patient populations and services
- CHEMS: non-paramedic agencies in years 3 and 4
- Health district involvement:
  - Engage CHEMS agencies in Regional Health Collaborative
  - Medical neighborhood asset: learn about existing programs and link EMS-PCMH to explore SHIP CHEMS opportunity
COMMUNITY HEALTH WORKERS (CHW)

- Develop and implement CHW training statewide
- Stakeholder engagement: kick-off March 3, 2015, and second meeting on July 30, 2015
- Health district involvement:
  - Link PCMH to CHW resources and training opportunity
  - Promote CHW as medical neighborhood asset
  - Provide meeting space for in-person regional CHW training
  - Share best practices through the Regional Health Collaborative
• Expand access to behavioral health and specialty care services via Telehealth

• Equipment and on-site program support available

• Health district involvement:
  ▪ Provide information to PCMH and link to SHIP Telehealth resources
  ▪ Identify similar health service needs within and across districts
  ▪ Opportunity to participate in Telehealth expansion planning

**TELEHEALTH**
REGIONAL HEALTH COLLABORATIVE

- Kick-off November 5, 2015, in Boise
- Health district SHIP staff meet with IDHW SHIP staff and contractors
- Develop tools and strategies for statewide use
- Meet with PCMHs on November 6 during Idaho Medical Home Collaborative/Medicaid Health Homes learning session
Questions?