



Idaho Healthcare Coalition

Meeting Agenda

Wednesday, February 10, 2016, 1:30PM – 4:30PM

JRW Building (Hall of Mirrors)

1st Floor East Conference Room

700 W State Street, Boise, Idaho

Call-In Number: 720-279-0026; Participation Code: 270901

1:30 p.m.	Opening remarks, roll call, introduce any new members, guests, any new DHW staff, agenda review, and approval of 1/13/16 meeting notes – <i>Ted Epperly, Chair</i>
1:40 p.m.	SHIP Operations Update – <i>Cynthia York, Administrator, Office of Health Care Policy Initiatives</i>
1:50 p.m.	Update on Contracts w/PCPs, learning session training schedule – <i>Grace Chandler, Briljent</i>
2:10p.m.	Regional Collaboratives Update – <i>Miro Barac, SHIP RC Project Manager</i>
2:30 p.m.	SHIP Telehealth Expansion Plan Update – <i>Mary Sheridan, Bureau Chief - Public Health</i> ACTION ITEM
3:00 p.m.	Results of Behavioral Health Survey – <i>Gina Westcott, Hub Administrator – DHW Behavioral Health</i> ACTION ITEM
3:30 p.m.	Break
3:45 p.m.	Communications Update: Slide Decks – <i>Katie Falls, Mercer - ACTION ITEM</i>
4:05 p.m.	SHIP Operations and Advisory Group Reports/ Updates – Please see written report (SHIP Operations and IHC Workgroup Reports – December 2015): Presentations, Staffing, Contracts, and RFPs status – <i>Cynthia York, DHW</i> <ul style="list-style-type: none">• Regional Collaboratives Update – <i>Miro Barac, DHW</i>• Telehealth, Community EMS, Community Health Workers – <i>Miro Barac, DHW</i>• HIT Workgroup – <i>Casey Moyer, DHW</i>• Multi-Payer Workgroup – <i>Dr. David Peterman, Primary Health and Jeff Crouch, Blue Cross of Idaho, Workgroup Chairs</i>• Quality Measures Workgroup – <i>Dr. Andrew Baron, Terry Reilly Clinics, Workgroup Chair</i>• Behavioral Health/Primary Care Integration Workgroup – <i>Ross Edmunds, Behavioral Health Division, Workgroup Co-Chair</i>• Population Health Workgroup – <i>Elke Shaw-Tulloch, Health Division, Workgroup Chair</i>• IMHC Workgroup – <i>Dr. Scott Dunn, IMHC Workgroup Chair</i>
4:15 p.m.	Blue sky, additional business & next steps – <i>Dr. Ted Epperly, Chair</i>
4:30 p.m.	Adjourn

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*

Statewide Healthcare
Innovation Plan



Idaho Healthcare Coalition (IHC)
February 10, 2016
Action Items

■ 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 January 13, 2016, Idaho Healthcare Coalition (IHC) meeting as prepared.

Second: _____

Motion Carried.

■ Action Item 2 – Telehealth Expansion Plan

IHC members will be asked to accept the Telehealth Expansion concept and next steps as presented by Mary Sheridan.

Motion: I, _____ move that the Idaho Healthcare Coalition accept the telehealth expansion concept and next steps as presented.

Second: _____

Motion Carried.

■ Action Item 3 – Behavioral Health Integration

IHC members will be asked to accept the Behavioral Health Integration Workgroup concept and next steps as presented by Gina Westcott.

Motion: I, _____ move that the Idaho Healthcare Coalition accept the Behavioral Health Integration Workgroup's concept and next steps as presented.

Second: _____

Motion Carried.

- Action Item 4 – 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.



Idaho Healthcare Coalition

Meeting Minutes:

SUBJECT: Idaho Healthcare Coalition **DATE:** January 13, 2016

ATTENDEES: Director Richard Armstrong, Dr. Ted Epperly, Denise Chuckovich, Cynthia York, Josh Bishop, Scott Carrell, Melissa Christian, Dr. Keith Davis, Russell Duke, Ross Edmunds, Lisa Hettinger, Deena LaJoie, Dr. David Peterman, Dr. Robert Polk, Susie Pouliot, Dr. Kevin Rich, Neva Santos, Dr. Dave Schmitz, Elke Shaw-Tulloch, Larry Tisdale, Karen Vauk, Jennifer Wheeler, Nikole Zogg

LOCATION: 700 W State Street, 1st Floor East Conference Room

Teleconference: Dr. Andrew Baron, Dr. Mike Dixon, Dr. Scott Dunn, Rene LeBlanc, Maggie Mann, Dr. Casey Meza, Carol Moehrle, Daniel Ordyna, Geri Rackow, Karen Vauk, Lora Whalen, Janet Willis, Dr. Bill Woodhouse, Mark Rouse, Sarah Renner

Members Absent: Jeff Crouch, Senator Lee Heider, Yvonne Ketchum, Dr. Glenn Jefferson, Dr. David Pate, Tammy Perkins, Dr. Boyd Southwick, Representative Fred Wood, Ann Wilde

DHW Staff Ann Watkins, Miro Barac, Casey Moyer, Kym Schreiber, Taylor Kaserman, Kim Thurston, Burke Jensen

Guests: Rachel Harris, Tim Heinze, Hilary Klarc, Norm Varin

Mercer: Katie Falls

Briljent & HMA: Grace Chandler, Pat Dennehy, Nancy Jaekles-Kamp

STATUS: Draft 01/13/16

Summary of Motions/Decisions:

Motion: Neva Santos moved to accept the minutes of the December 09, 2015, Idaho Healthcare Coalition (IHC) meeting as prepared.

Susie Pouliot seconded the motion.

Motion carried.

Motion: Lisa Hettinger moved that the Idaho Healthcare Coalition adopt the Statewide Healthcare Innovation Plan (SHIP) Communications Plan materials as presented by Mercer.

Larry Tisdale seconded the motion.

Motion carried.

Agenda Topics:

Opening remarks: “And now we welcome the New Year. Full of things that have never been.” Rainer Maria Rilke



◆ Dr. Epperly called the roll, and welcomed everyone.

◆ Dr. Epperly introduced Burke Jensen the new SHIP HIT project manager. Mr. Jensen gave a brief background of his previous work history and why he has joined the SHIP team.

Agenda Topics

Operational Plan Feedback– *Cynthia York, Administrator, OHPI, Dr. Ted Epperly, Chair & Denise Chuckovich, Co-Chair:*

- ◆ Ms. York reviewed the positive feedback that CMMI provided on the SHIP Operational Plan. Components of the plan were deemed “best practices” by reviewers. Ms. York also shared the comments provided by CMMI for each SHIP goal. There was very little corrective action or revision suggested by CMMI. Goal Six regarding payment was identified as the component requiring further revision and clarification. CMMI had questions on implementation timelines for each of the payer’s specific payment transformation plans.
- ◆ Dr. Epperly made additional comments on our achievement in the operational plan and asked the Chairs of the Multi-Payer Workgroup (MPW) about the payment models and what timelines are proposed.
- ◆ Dr. David Peterman responded that the MPW is working towards a goal of strengthening the payment plan however the timeline is challenging. He made the suggestion that receiving further information from SHIP staff about the expectations relating to Operational Plan Goal Six would be helpful. Once that information is provided, the Chairs will reconvene the MPW for further discussion on this matter. Josh Bishop stated that it is important to recognize the many innovative payment models currently in place with private payers. Although these methodologies may not follow the Medicaid payment model exactly, they are important advancements in the payment of healthcare for Idahoans and should be reflected positively in our response to CMMI.

- ◆ Dr. Epperly solicited other comments on the operational plan feedback: Dr. Dunn commented that we need to be mindful that our success is contingent upon our timeline commitment.

Reimbursement Presentation – *Lisa Hettinger, IDHW Medicaid Administrator:*

- ◆ Ms. Hettinger presented on Medicaid's PCMH program and the four tier payment system. The Medicaid payment program will be introduced February 1st with the launch of Phase one. There will also be a Phase 1a designed to include mental health as a component of Phase one. This will work without disrupting the current Healthy Connections program. Healthy Connections staff will be closely monitoring the introduction of the Medicaid four tier payment program. Enhanced tier distinction was used in the pilot PCMH program.
- ◆ Ms. Hettinger provided information about the new changes in the payer strategy. Rates were developed to help support care management and to make sure clinics have the ability to share data with IHDE. The IHDE connectivity is a critical component to gather data for the SHIP Model Test.
- ◆ Dr. Davis posed the question about the timelines for sharing information from Electronic Medical Records (EMRs) systems with the IHDE. In the past, clinics were requested to delay connectivity with IHDE due to the conversion to a new vendor. Discussion continued around the concerns that the lack of connectivity with IHDE would delay clinics from qualifying for Tier 4 payments. Scott Carrell from the Idaho Health Data Exchange noted the IHDE team is working on creating an all-inclusive Electronic Health Record (EHR)/IHDE connectivity solution but much work remains.

Primary Care Access Program – *Director Richard Armstrong, Director DHW:*

- ◆ Director Armstrong provided an update on the Primary Care Access Program (PCAP). He thanked those members of the IHC who had been a part of healthcare transformation since 2007. After assessing the upcoming session it became clear that expanding Medicaid would not get into print with the legislature. The PCAP bill was drafted to bring something to the legislature that is not Medicaid. This will move the PCMH agenda forward and will hopefully attract sufficient affirmative votes for passage of the bill this session. It is a major step in policy if it is passed in saying every Idahoan should have a medical home. It is proposed that PCAP be funded by repurposing the current tobacco taxes. The political will to pass this bill is present but passage will come down to budget issues. Director Armstrong is optimistic that this bill will work.
- ◆ IHC members asked questions regarding proposed coverage limits and how it would help clinics and providers in several areas of concern. The Director responded that this is just the beginning of PCAP and that at any point it can be added to in the future. This bill has the potential to build going forward. Any future issues can be addressed as they occur.
- ◆ Dr. Epperly thanked Director Armstrong for his presentation and noted that the usual source of care and care coverage are the two requirements for better healthcare.

Idaho Agency and Coalition Disclosure Laws & Practice – *Casey Moyer, SHIP Operations Project Managers, DHW:*

- ◆ Mr. Moyer gave a high level overview on the Idaho statute regarding the public records act and its application to the IHC. Essentially, everything that the IHC does at this point is public knowledge; Idaho statute requires transparency in government. Only materials that are proprietary, confidential (client records) or privileged are shielded – and thus far, none of those previous designations applies to IHC materials. There are no legal barriers if the IHC chooses a password protected area of the SHIP website. All the content of this area is not publicly posted, yet can be requested at any time by Idaho citizens.

Communications Plan Materials Update – *Katie Falls, Principal Mercer:*

- ◆ Ms. Falls presented content for four more key messages requested by members at the previous IHC meeting. The messages are directed toward Engaged Primary Care Providers, Patients, Medical and Health Neighborhoods, and Potential Primary Care Providers. These key messages are evolving and will change as needed.
- ◆ Members pointed out that the patient key messages document may not be written to an accessible grade level and recommended this be addressed prior to finalization.

Goal Charters Review – *Katie Falls, Principal Mercer:*

- ◆ Ms. Falls reviewed the seven goal charters. She began by highlighting the development process of the operational plan. She then went over the difference between the workgroup charters and the goal charters. A draft of the Master Project Plan will be delivered January 15, 2016 to the Idaho Department of Health and Welfare. Ms. Falls also discussed how they are tracking progress for goals, measurables, deliverables and risk mitigation.
- ◆ Workgroup charters will be revised as needed with updates presented to the IHC. Goal charters are updated quarterly. The operational plan will be updated yearly.
- ◆ Dr. Epperly asked if there was a way to format progress on these items visually to help focus the IHC discussion on areas that need attention.

PCMH Transition Update – *Grace Chandler, Briljent:*

- ◆ Ms. Chandler introduced members of the HMA team. They provided updates regarding PCMH transformation plan development and progress since the last meeting. Ms. Dennehy from HMA reviewed demographics from the selected clinics. They have completed the readiness assessment and have gathered necessary information from the fifty five selected clinics.
- ◆ Ms. Jaekles-Kamp from HMA discussed the SHIP PCMH training models and next steps. A PCMH transformation plan will be developed with each clinic at the learning collaboratives meeting scheduled in early March. This will be the first of two face to face learning collaborations. These collaboratives may be split into different tracks to be able to assist all clinics no matter what their PCMH readiness level. Ms. Dennehy explained the webinars, coaching sessions and other technical assistance that would take place with each clinic as additional tools to assist in the PCMH transformation efforts.
- ◆ Ms. Jaekles-Kamp and Ms. Dennehy took questions regarding the assistance that will be available to clinics as cohort one progresses. Coalition members discussed different concerns and proposals for identifying where different clinics are throughout the cohort 1 process and year. Briljent is to bring back an overall plan on PCMH clinic identification/transformation at the next IHC meeting.
- ◆ Mr. Rouse from Myers & Stauffer went over the PCMH transformation portal, the access it will provide, and what it will feature. There will be different levels of access availability defined in the portal. Special access will be created for different clinics the portal will use a silo method of access to the portal so that different user categories will have access to different information. Mr. Rouse also discussed the IMHC meeting their feedback, questions, concerns and conclusions and what will be implemented.
- ◆ Ms. Renner presented the incentive payment measures. The first incentive of \$10,000 will be paid in one installment. The second incentive of \$5,000 is for PCMH recognition based on evidence of recognition. Virtual PCMHs that are SHIP approved will be given a \$2,500 one-time incentive. Progress measures have not changed since the last meeting. Ms. Renner also went over recoupment of incentive moneys that will be implemented if needed. She concluded by going over the I-PAS system, the incentive payment accounting system. This system will interface with the Briljent SHIP PCMH portal.

SHIP Operations and Advisory Group Reports/Updates:

- ◆ Ms. York announced that Health Tech Solutions is the successful Data Analytics vendor. It is anticipated the contract will be signed in late February. Health Tech Solutions has extensive data analytics experience particularly in the governmental realm and the SHIP team is excited to bring them on board.
- ◆ Dr. Epperly thanked the workgroups for their efforts and contributions. He requested that a dashboard be developed to track Workgroup goals, objectives and measurable in order to better inform the Workgroups and the IHC. This tool would also help to alert the Workgroup and the IHC to any matters requiring further attention.

Closing remarks and Next Steps – Dr. Ted Epperly:

- ◆ We are just nineteen days away from the kickoff of year one model test and we are doing well.
- ◆ Dr. Epperly thanked Kim Thurston for her work on the SHIP team and wished her well as today is her last day with SHIP. She has accepted a position with Public Health District Four as a Health Educator.
- ◆ The next IHC meeting is February 10, 2016, and will be located in the JRW Building East side conference room on the first floor.

There being no further business Dr. Epperly adjourned the meeting at 4:31 p.m.



Way to
go
Idaho!

Congratulations
SHIP team!
Successful
Implementation
Year



Next Steps for Beginning PCMH Transformation February 1 – March 3, 2016



Additional Information:

- Briljent sent all 55 clinics a PCMH Transformation Provider Agreement 2/2 & 2/3. These should be returned to Briljent no later than 2/12/16.
- IHDE will begin contacting SHIP clinics upon receiving confirmation of signed clinic agreement with Briljent. IHDE will send business agreements and conduct HIE readiness assessments.
- IDHW will email a Memorandum of Understanding to SHIP clinics on 2/16/16. These should be returned to IDHW no later than 2/29/16.
- The 1st of 12 Training webinars for Cohort 1 clinics is scheduled for 11:30 AM (PT)/ 12:30 PM (MT) on Tuesday, 2/16/16.
- Learning Collaborative for SHIP Cohort 1 clinics scheduled for 3/2/16 & 3/3/16 in Meridian, ID.

PCMH Transformation Team - UPDATE

Idaho Healthcare Coalition Meeting

February 10, 2016

PCMH TEAM
TRANSFORMATION

UPDATE - AGENDA

- Clinic Agreements
- Reports on Clinic Progress
- Training and Technical Assistance

CLINIC AGREEMENTS

- February 2 & 3 - Clinic Agreements sent to all 55 clinics
- Clinics already signing and returning Agreements
- February 12 – Clinic Agreements due date

REPORT ON CLINIC PROGRESS

- Incentive Payment and Progress Measure results will be generated by the Incentive Payment Accounting System (I-PAS).
- These results will be posted in reports on the PCMH Team portal and displayed in the Dashboard.
- Reports and graphs will be updated on a monthly basis.
- Intended Users:
 - SHIP Team
 - PHD SHIP Staff
 - Individual practice locations/clinics
 - Organization or Practice (upon request)

PCMH TRANSFORMATION

CLINIC S - TRAINING & TECHNICAL ASSISTANCE

Goals:

1. Build knowledge and action plans for the 6 standards of the NCQA PCMH program as a means to reach PCMH transformation through approved NCQA recognition or other certification programs
2. Focus on the “must pass elements” and “critical factors”
3. Enhancing those clinics/practices that have already reached PCMH recognition

Plan:

- Kick-Off Session - 2/16 – Getting Clinics started
- PCMH Self-assessment and introduction to PCMH coaches and SHIP QA/QI Specialists
- Learning Collaborative – 3/2 & 3/3
- Transformation Plans - goals and actions
- Monthly coaching sessions
- Content-specific webinars every other month
- Progress/dashboard towards PCMH transformation

CLINIC TEAM LEARNING COLLABORATIVE – CURRICULUM

Day 1 – March 2, 2016

Clinics with no PCMH recognition

- Overview of QI and PDSA rapid cycle improvement model
- Team-based Care and Communications
- Population Health
- Care management and coordination – components and tools for establishing a good program

Clinics with PCMH recognition

- PCMH tools and population Health – where do you want to go next?
- Team-based care enhanced
- Behavioral Health Integration models
- Care management and coordination – going to the next level

CLINIC TEAM LEARNING COLLABORATIVE – CURRICULUM

Day 2 – March 3, 2016

- Patient-centered access
- Care transitions
- Leadership and change
- Review and discussion
- World Café - networking and team time

IDAHO PCMH – PHD SHIP STAFF TRAINING - YEAR 1

Goal – PHD SHIP QA/QI Specialists will receive training and support to learn how to become PCMH Coaches

- December & January - materials for self-study
- Webinar - 2/5 - review PCMH Self-Assessment Tool
- Learning Session – 2/29 & 3/1
- Learning Collaborative for Clinic Teams, including SHIP QA/QI Specialists – 3/2 & 3/3
- Transformation Plans – working with clinics on goals and action plans
- Monthly coaching sessions – along with PCMH Coaching Team
- Content-specific webinars every other month

Thank you
Questions/Comments?



District	Executive Leadership (chair, co-chair, PHD Director)	Membership Composition	Board Status	Anticipated Direction	Concerns and Questions
D1 Panhandle HC	Dr. Scott Dunn Dr. Mike Dixon Lora Whalen	Family Health Center of Sandpoint, Family Medicine, Panhandle Health District, IDHW, Heritage Health, Kootenai Health, Pediatric Dental Care of North Idaho, Shoshone County EMS	<ul style="list-style-type: none"> 12 members Two full membership meetings RC meetings bi-monthly, future meetings scheduled 	<ul style="list-style-type: none"> Opioid prescribing Fluoride varnish RC kickoff meeting with first year cohort is planned for the end of March 	
D2 North Central HC	Dr. Glenn Jefferson Dr. Kelly McGrath Carol Moehrle	Valley Medical Center, Orofino Health, North Central District Health, Valley Medical Center, St. Mary's Clinic, Community Health Association of Spokane	<ul style="list-style-type: none"> 20 members Kick off meeting was a great success with 100% attendance of invitees Executive Leadership is meeting monthly and the RC is alternating conference calls and face-to-face meetings 	<ul style="list-style-type: none"> No specific projects identified yet Developing topics for outside speakers to present to the RC in March (CHEMS, CHW, IHDE) 	<ul style="list-style-type: none"> Questions regarding the future of payments to the pilot clinics Questions on data collection and analytics
D3 Southwest HC	Dr. Andrew Baron Dr. Sam Summers Nikole Zogg	Terry Reilly Health Services, St. Alphonsus Medical Center, Adams County Health Center, Treasure Valley Hospice, Idaho Quality of Life Coalition, National Alliance on Mental Illness (NAMI), Human Supports of Idaho (HSI), Emmett Family Medicine, Nampa Smiles Dentistry, St. Alphonsus Medical Group, St. Luke's Health System, West Valley Medical Center, Two Rivers Medical Clinic	<ul style="list-style-type: none"> 17 members 2 meetings in-person with conference line available Future meetings scheduled, every first Tuesday 	<ul style="list-style-type: none"> Form topic workgroups (pilot elderly and latino/latina focus workgroups and introduce in 3-6 months) Advocate to IHC re: need for support for telehealth payment and BH data exchange Form PCMH workgroups 	<ul style="list-style-type: none"> Payment for telehealth Support for enhancing BH information exchange Possibility of future referral management capacity in the IHDE
D4 Central HC	Dr. Kevin Rich Dr. David Peterman Russ Duke	Family Medicine Health Center, Primary Health Medical Group, Central District Health Department, St. Luke's McCall, Wellness Impact Nutrition, LLC., Region IV Behavioral Health, Blue Cross of Idaho, Valley Regional Transit, Glens Ferry Health Center, Terry	<ul style="list-style-type: none"> 18 members One representative from each county 2 meetings in-person with conference line available Future meetings scheduled 	<ul style="list-style-type: none"> Education on SHIP and RC's roles and responsibilities Refining medical health neighborhood concept for Region 4 Understanding individual member roles in the 	<ul style="list-style-type: none"> Concern re: conflict of interest for members whose clinics are part of the cohort – this concern has been addressed and resolved

District	Executive Leadership (chair, co-chair, PHD Director)	Membership Composition	Board Status	Anticipated Direction	Concerns and Questions
		Reilly Health Services, FMRI, Benchmark Family Dentistry, St. Luke's - West Region Primary Care, Garden Valley Family Medicine, St. Alphonsus Medical Group, St Luke's Health Partners		community and how we can harness social and intellectual capital	
D5 South Central HC	Dr. Keith Davis Dr. Steven Kohtz Rene LeBlanc	Shoshone Family Medical Center, St. Luke's Magic Valley, South Central Public Health, Family Health Services, The Walker Center, Shoshone Family Medical Center, Minidoka Medical Center	<ul style="list-style-type: none"> • 8 members • RC is meeting monthly • Future meetings scheduled through June, 2016. 	<ul style="list-style-type: none"> • No specific projects have been identified yet. • Executive Leadership is pursuing additional members • Planning to meet with District 5 CHEMS representatives to discuss programs 	<ul style="list-style-type: none"> • Questions regarding data collection and analytics
D6 Southeastern HC	Dr. Bill Woodhouse Dr. Mark Horrocks Maggie Mann	Idaho State University Family Medicine, Health West, Southeastern Idaho Public Health, Not-tsoo Gahnee Indian Health Center, Pocatello Children's Clinic, Portneuf Primary Care and Behavioral Health, Blackfoot Fire Department , Excel Weight Loss Solutions Healthy Connections Following Institutions were identified as potential members: Area Agency on Aging, Head Start, School District 25, Shoshone Bannock Tribes, Pocatello Suicide Prevention Action Network, Fort Hall, Portneuf's Diabetes Education Clinic	<ul style="list-style-type: none"> • 15 members (aprox.) • Three-tiered approach: Executive Leadership, Clinic Committee, Medical Health Neighborhood Committee • 4 meetings of the Executive Leadership • Future meetings scheduled 	<ul style="list-style-type: none"> • The Clinic Committee will be comprised of the Executive Leadership members and staff members from cohort 1 clinics • Co-Chair Dr. Mark Horrocks will lead this tier 	
D7 Eastern HC	Dr. Boyd Southwick Dr. George Groberg Geri Rackow	Complete Family Care, Driggs & Victor Health Clinics, Family First Medical, Madison Memorial Rexburg Medical Clinic, Rocky Mountain Diabetes, Tueller Counseling, Upper Valley Community Health	<ul style="list-style-type: none"> • 25 members (multiple representatives from individual institutions) • First meeting successful • Clinics from Cohort 1 were chosen to be part of initial RC • Recurring monthly meetings scheduled 	<ul style="list-style-type: none"> • No specific projects have been identified yet • Developing referral resources and pathways 	<ul style="list-style-type: none"> • Idaho Health Data Exchange – no clinics or hospital connected to IHDE from this side of the State yet. It is something that the RC knows and wants to change in this area



IDAHO TELEHEALTH COUNCIL GOAL TWO SUBCOMMITTEE

Telehealth Expansion Plan

Background and Introduction

The Idaho Telehealth Council Goal Two Subcommittee was charged with developing a telehealth expansion plan to operationalize and expand telehealth services in rural communities as part of the Statewide Healthcare Innovation Plan (SHIP). This effort includes integrating telehealth in Patient Centered Medical Homes (PCMH) to improve access to behavioral health and specialty care and establishing telehealth in Community Health Emergency Medical Service (CHEMS) programs. The Subcommittee consists of over 30 Idaho stakeholders, including representation from various Idaho Department of Health and Welfare divisions, hospitals, associations, health districts, fire departments, and other key partners from across the state.

SHIP telehealth goals include the following:

1. Establish rural telehealth capacity in 18 PCMHs across a range of specialty services.
2. Establish rural telehealth capacity in 18 PCMHs to provide behavioral health services.
3. Establish telehealth services in 6 CHEMS programs.

SHIP resources to support the goals include the following:

- On-site and virtual training, technical assistance, and coaching
- Equipment

On November 10, 2015, the Subcommittee met for a facilitated day-long planning meeting to identify key action steps necessary to expand telehealth services in PCMHs and CHEMS programs. The Subcommittee meeting notes and information was presented to the Idaho Telehealth Council on December 11, 2015. A high-level summary of the expansion plan is presented below and details are found in the Subcommittee notes at: <http://ship.idaho.gov/workgroups/telehealthcouncil>.

Overarching themes and observations from the day-long planning meeting include the following:

1. Developing and implementing a telehealth readiness assessment for PCMHs will help identify opportunities and barriers for establishing or expanding telehealth programs.
2. Providing training, coaching, mentoring, best practice resources, and billing education are needed to support program development in the PCMH.
3. Establishing telehealth in Community Health Emergency Medical Services (CHEMS) programs will require additional research, training, and resource development.

Telehealth Expansion Plan for Idaho

The Idaho Telehealth Council Goal Two Subcommittee recommends an expansion plan that includes the following elements and action steps:

Phase One - Assessment

1. Conduct a PCMH medical-health neighborhood needs assessment to identify the community's healthcare needs, services gaps, and barriers that may potentially be addressed through telehealth.

2. Conduct a readiness assessment to measure the PCMH or CEMS readiness to develop and implement a new telehealth program or expand a current program; the assessment will also identify unmet needs to establishing or expanding a telehealth program and may include:
 - a. Availability of telehealth policies and procedures, capacity to identify a PCMH or CEMS champion/telehealth coordinator, evaluation of technical infrastructure (equipment and sufficient bandwidth), determination of patient need for additional healthcare services, availability and capacity of providers to deliver needed healthcare services via telehealth, availability of funding and reimbursement opportunities, and determining resource needs.

Phase Two - Develop Telehealth Program & Evaluation Plan:

1. Create a detailed telehealth program plan, which may include a telehealth integration plan, communications strategy, revenue model, training and education, marketing, and technical support.
2. Develop an evaluation plan, specific to the telehealth program's development phase, to monitor the program, and provide quality assurance and risk management.

Phase Three - Implement & Support:

1. Implement or enhance an existing telehealth program, including the purchase of equipment, technical assistance, training and education, and peer learning or mentoring opportunities.
2. Provide assistance with billing and reimbursement, credentialing and licensing, and offer practice standards guidance.

Phase Four - Evaluate & Monitor:

1. Evaluate the telehealth program with metrics such as utilization rates, user satisfaction, cost effectiveness, patient outcomes, potential patient cost savings due to reduced travel for distant services, and new patient populations.
2. Use evaluation data to enhance existing services and improve program performance.
3. Continue to monitor the telehealth program and provide ongoing professional development.

The Subcommittee acknowledged significant challenges and barriers to telehealth adoption and expansion in Idaho and the need for intentional and conscientious oversight of expansion plan implementation.



Behavioral Health Integration

Executive Summary BH Integration Survey

In December 2014, the Department of Health and Welfare received a four-year state Center for Medicare and Medicaid Innovation model grant. The grant totals \$39,683,813 and funds transformation of Idaho's healthcare delivery system. The system will change from a fee-for-service, volume-based system to a value-based system of care focused on improving health outcomes and reducing costs.

The grant design implements the Idaho State Healthcare Innovation Plan (SHIP). Strategic planning encompassed the 2015 grant-year focus. During 2016, the first cohort of patient centered medical home (PCMH) clinics will pursue transformation. Additional clinics will join the project in 2017 and 2018. During the grant period, Idaho will test models for transformation of the state's entire healthcare system.

Idaho recognizes the critical importance of integrating behavioral health into the PCMH model to increase quality of life and life expectancy for individuals with behavioral health conditions. Integrated Primary Care combines medical and behavioral health services to address the full spectrum of health concerns patients present.

It is important to note that integration is not a replacement for specialty mental health care. Close collaboration between specialty mental health and primary care is critical to ensure that individuals with severe and persistent mental illness receive clinically appropriate services. Integration and collaboration are means to increased community-based services.

Most often behavioral health services are integrated into primary care clinics. Reverse integration refers to integration of physical health services into a specialty behavioral health center. With either approach, behavioral health integration will increase through effective care coordination between:

- Primary care providers practicing patient-centered care
- Broader medical neighborhoods of
 - Specialists
 - Hospitals
 - Behavioral health professionals
 - Long-term care providers
 - Other ancillary care services

Defining Levels of Integration

The Integrated Practice Assessment Tool© (IPAT©) is based on the Substance Abuse and Mental Health Service Administration (SAMHSA) Framework for Levels of Integrated Healthcare. Developed by Jeanette

Waxmonsky, PhD, Andrea Auxier, PhD, Pam Wise Romero, PhD, and Bern Heath, PhD, it is a descriptive, qualitative instrument intended to categorize practices along the integration continuum.

The IPAT© focuses on qualitative change. The elements that comprise a high degree of integration are difficult to tease apart and do not occur separately in the real world setting. Rather, they are intertwined. Designed to be user friendly, quick to administer, and equally applicable for both medical and behavioral health settings, the IPAT© serves a “conversation starter” for integration.

Each clinic’s IPAT© score places it somewhere along an integration continuum. The six levels of care are grouped according to pre-coordinated, co-located and integrated criteria.

Pre-coordinated care

- Level 1: Minimal collaboration - Patients are referred to a provider at another practice site, and providers have minimal communication.
- Level 2: Basic collaboration - Providers at separate sites periodically communicate about shared patients.

Co-located care (on-site)

- Level 3: Basic collaboration on-site - Providers share the same facility but maintain separate cultures and develop separate treatment plans for patients.
- Level 4: Close collaboration on-site - Providers share records and some system integration.

Integrated care

- Level 5: Close collaboration approaching an integrated practice - Providers develop and implement collaborative treatment planning for shared patients but not for other patients.
- Level 6: Full collaboration in a merged integrated practice for all patients - Providers develop and implement collaborative treatment planning for all patients.

Additional Idaho Insights

Clinics also answered a series of questions on processes. The specific areas included:

- Clinic Specific Integration Practices, Procedures and Policies
- Referral Practices and Tracking
- Communication Practices
- Internal/External Agreements with Providers of Specialty Services
- Screening Tools and Frequency
- Information Sharing Internal/External
- Treatment Planning Processes
- Follow-up Practices
- Behavioral Health Training

Survey Protocol

Idaho Department of Health and Welfare (DHW) Division of Behavioral Health (DBH) staff conducted onsite surveys between October 14 and December 14, 2015 with existing patient centered medical homes (PCMH) enrolled in the Idaho Medicaid Health Home Program.

The Idaho Medicaid Health Home Program was implemented in January of 2013. Currently 47 primary care clinics participate in the network, serving 9,000 patients with chronic conditions.

Onsite interviews with key center staff (care coordinators, behavioral health specialists, primary care providers and clinic/center administrators) drove data collection. The process yielded a collection of rich qualitative survey data.

Profile of Survey Clinics

Forty-seven clinics enrolled in the Idaho Medicaid Health Homes Pilot participated, representing all seven DHW regions. Ninety-four percent of the clinics were National Committee for Quality Assurance (NCQA) recognized; about two-thirds were recognized at level 3, the highest level. Nearly 60% were Federally Qualified Health Centers (FQHC), with one Rural Health Center (RHC); most were family practice clinics or multiple specialty clinics.

A variety of behavioral health professionals, from psychologist to social workers and counselors are employed by Idaho's PMHC's. Most psychiatrists were not employees but consultants to the clinics.

Findings: Strengths, Observations and Opportunities

The survey reveals strengths among many Idaho clinics, especially those with PMHC recognition. These strengths provide opportunity to expand to new clinics and maintain or enhance in current clinics. A summary of these strengths include:

- Primary care physicians (PCP) provide treatment for mental health issues on a routine basis but not as often for chemical dependency issues.
- PCMH recognition rates were high among survey participants (94%), which lead to good referral processes, access to BH care, and missed appointment follow-up for BH clients.
- Community Health Centers (CHC) and Rural Health Centers (RHC) report higher integration due to funding diversity.
- Screening tools are used but not consistently or routinely for all patients. The Patient Health Questionnaire (PHQ) versions 2 and 9 were the most common screening tool. Screening rates appeared higher among CHC/RHC.
- High use of Electronic Health Records (EHRs) increases ability to access information across disciplines.

The NCQA recognition process provided structure to help clinics increase integration. Given those strengths, these observations were common across most respondents:

- Sharing records and referral information is often one-way communication. (Note: Behavioral health providers share this feeling that their communications are one-way.)
- All respondents cited uncertainty if all patients understand they are part of a health home or belong to a team.
- Integration did not always correlate to collaboration with community providers.
- Despite frequent rate of recording whether or not clients are connected to BH providers, most noted low rates in receiving client treatment information/progress reports.

The survey uncovered areas of opportunity. Currently, respondents indicated a desire for assistance to address:

- Low frequency of agreements or MOA's between BH referral partners
- Low frequency of specific BH registries or using information in a strategic way
- Low utilization of Tele-Health for BH
- Low frequency of training on BH issues for medical staff

Recommendations:

The survey results provide guides for helping current and future cohorts integrate behavioral health into primary care. No single model is proposed as the survey demonstrated that a variety of locally-driven approaches work best for all areas of Idaho. Rather, the following recommendations for actions and next steps provide substantive assistance to Idaho clinics better serve Idahoans' health care needs, including those citizens with behavioral health conditions.

The following opportunities for enhancement are logical next steps:

- Provide Technical Assistance for
 - Mission Statements
 - Business Planning
 - MOU's and Agreements
 - Organization Readiness
 - Policies and Procedures
 - Culture Shift (Individual, Clinic, Community, Public)
 - Workforce Recruitment, Training, and Retention
 - Clinical Tools
 - Collaboration with Relevant Community Partners
 - Collaboration with BH Peers
- Promote Universal Screening
- Provide Training on BH Topics: SBIRT, Motivational Interviewing, Mental Health First Aid
- Promote BH Registries/Reviewing of Outcomes
- Expand of use of Tele-Health

A variety of tools and resources will help clinics achieve these goals. The following is a potential, but not an all-inclusive list of potential partners for securing needed resources:

- PCMH Contractor
- Public Health Districts via SHIP contract
- Regional Health Collaboratives
- BH Integration Sub-Committee
- Division of Behavioral Health
- Peer to Peer Clinics
- Regional Behavioral Health Boards
- Idaho Federation of Families for Children’s Mental Health
- NAMI (National Alliance on Mental Illness)
- Recover Support Centers
- Other Funders-SAMHSA, HRSA, CMMI

Limitations of the Report:

The findings of this survey are qualitative in nature. Limitations include possible variations in interpretation of respondent comments or their understanding of questions. While efforts were made to survey each clinic’s key staff, some information may be missing due to lack of availability of all pertinent staff. The survey’s goal was to acquire general observations with as much specific detail as possible within the limitations. The results may guide next steps for successful behavioral health integration at the local level throughout Idaho – in the variety of forms integration will take.



Behavioral Health Integration A Conversation with Primary Care

Gina R. Westcott
SW Hub Administrator, Division of Behavioral Health
Idaho Department of Health and Welfare

BH Integration

- ▶ Combines medical and behavioral health services
- ▶ Addresses the full spectrum of health concerns patients bring to primary medical care
- ▶ It is NOT a replacement for specialty mental health



Idaho BH Integration Survey

Assessed each provider's

- ▶ Level of BH Integration into Primary Care
- ▶ Referral Practices and Tracking
- ▶ Communication Practices
 - Internal/External
- ▶ Agreements with Specialty Services Providers
- ▶ Screening Tools/Frequency of Use
- ▶ Current Training for All Staff

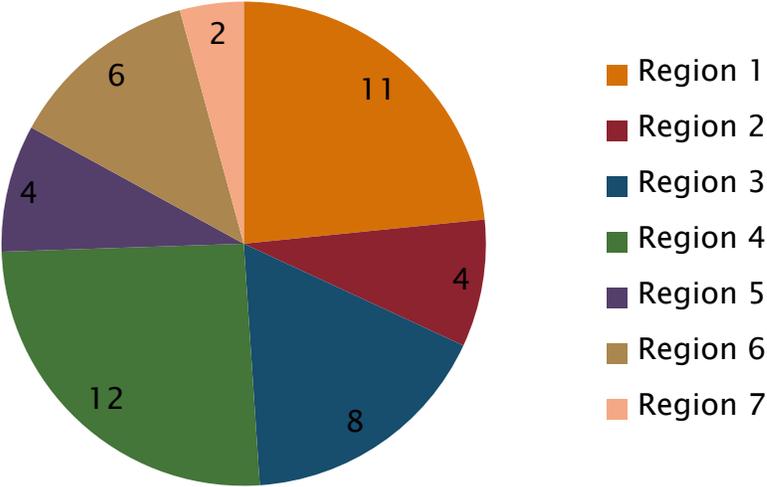


Survey Methods

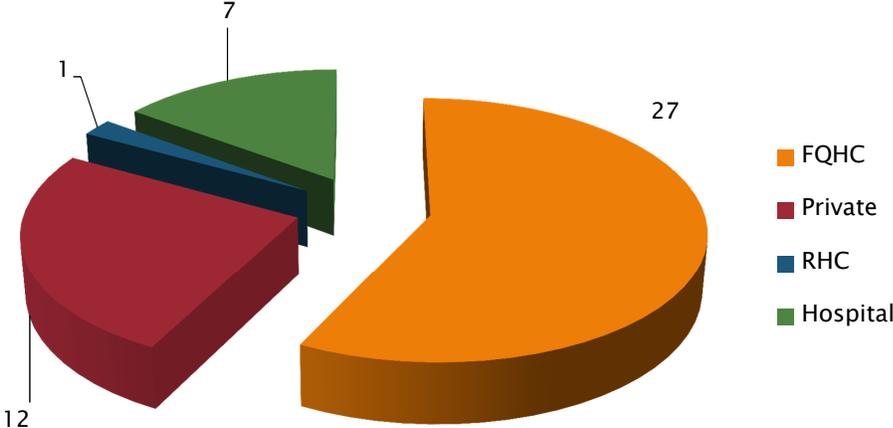
- ▶ Onsite meetings encompassing 47 Medicaid Health Home sites
- ▶ Integrated Practice Assessment Tool©
- ▶ Interview/Conversation on survey focus points



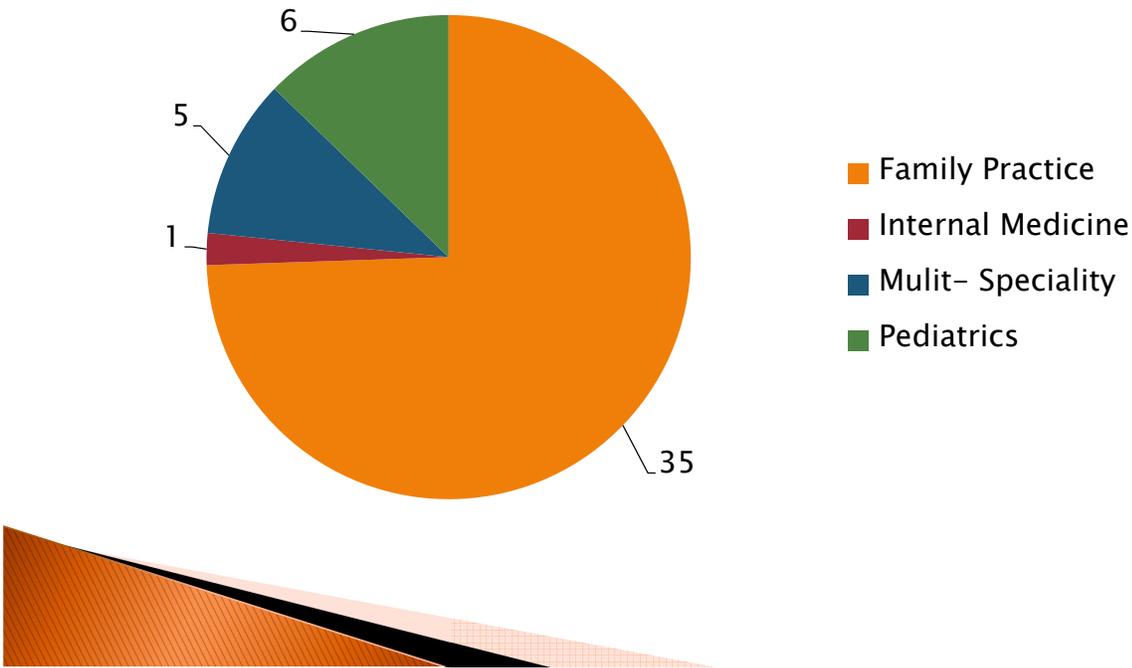
Idaho Medicaid Health Homes-47



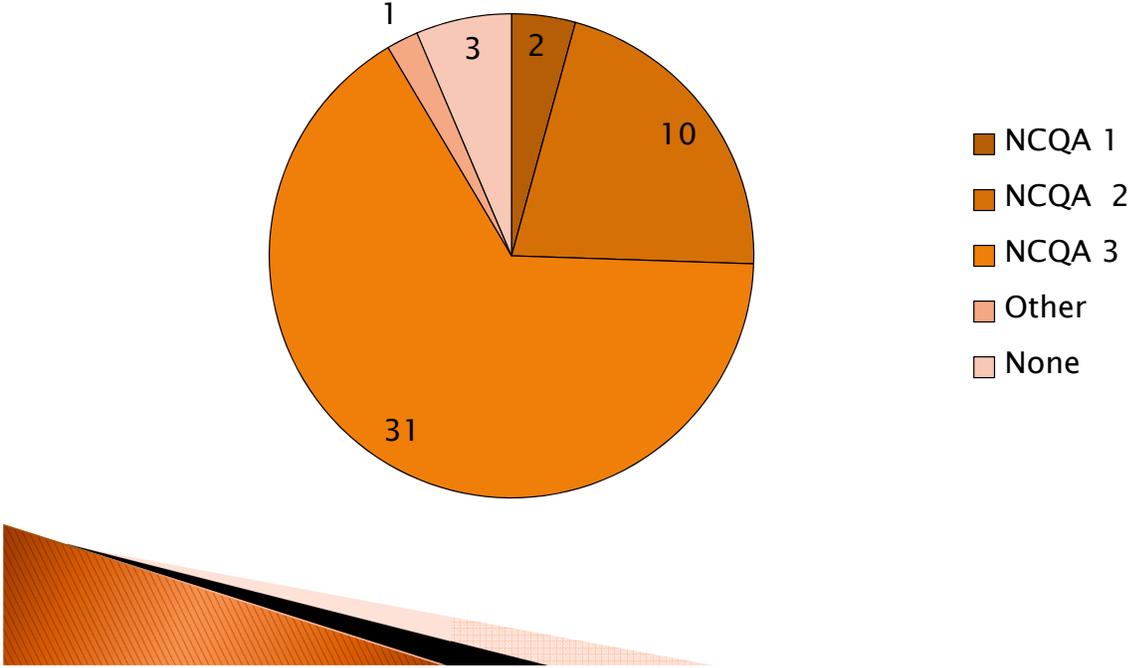
Clinic Type



Clinic Specialty



PCMH Recognition

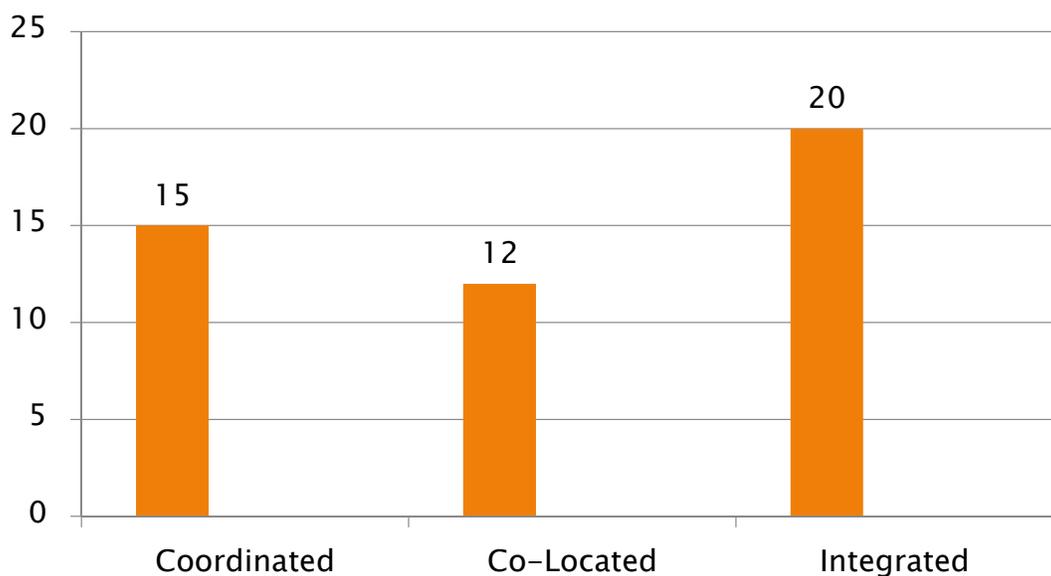


Integrated Practice Assessment Tool – IPAT©

- ▶ Based on SAMHSA Framework
- ▶ Assesses Six Levels of Integrated Healthcare
- ▶ Categorizes Provider Practices along Integration Continuum
- ▶ “Conversation Starter” for Integration



Findings – Idaho IPAT© Levels



Findings – Where is Idaho Now?

- ▶ Validation of Needs in Idaho
- ▶ Primary Care Physicians
 - Routinely treat mental health (mild–severe)
 - Routinely refer out chemical dependency (SUDS)
- ▶ High PCMH recognition (94%)
- ▶ CHC/RHC=higher integration due to funding diversity
- ▶ Integration did not always correlate to collaboration
- ▶ Tight referral and follow up tracking for all patients



Where is Idaho Now?

- ▶ Sharing records and referral information is often one way communication–speciality BH providers will say the same thing about PC
- ▶ MOA's – low frequency
- ▶ Screening tools are used
 - Not consistently or routinely for all patients
- ▶ BH registries – low frequency or strategic use of information (depression, anxiety, addiction, psychosis)
- ▶ Training on BH topics rare in most clinics
- ▶ Very low utilization of Telehealth



Where is Idaho Now?

Among PCMH Recognized Clinics



- ▶ High
 - Rates of referral
 - Established/staffed tracking processes
 - Access to care coordination
 - Follow up for BH clients' missed appointments
 - Same day access for appointments for urgent care needs, including behavioral health services
 - Not all patients understand they are part of a PCMH



Opportunities for Enhancement

- Technical Assistance
 - Mission Statements–Business Planning–Organizational Readiness–Policies and Procedures–
 - Culture Shift–Nuts and Bolts of Integration
- Universal Screening and Use of Registries
- Improve Communications
 - MOA's with partners–Collaboration with Community Partners and Peer Clinics
- Training
 - SBIRT–Motivational Interviewing–MH First Aid
- Telehealth



Many Partnerships to Achieve Goals

- ▶ PCMH Contractor
- ▶ Public Health Districts–SHIP
- ▶ Regional Health Collaborative
- ▶ BH Integration Sub–Committee
- ▶ Division of Behavioral Health
- ▶ Peer to Peer Clinics
- ▶ Regional Behavioral Health Boards
- ▶ Idaho Federation of Families
- ▶ NAMI
- ▶ Recover Support Centers
- ▶ Other Funders–SAMHSA, HRSA, CMMI



Illustration: 9800152



Next Steps

- ▶ Work with the PCMH contractor to develop specific BH curriculum topics for the Learning Collaborative
- ▶ Outline specific BH goals and task that the RC can achieve in PCMH coaching and mentoring
- ▶ Identify well integrated PCMH clinics who are willing to provide TA, consultation and training to other PCMH clinics

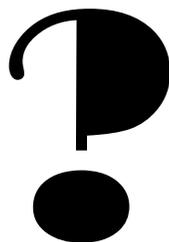


Next Steps

- ▶ Pursue a Behaviorist Peer to Peer model that will support training, networking and advocacy
- ▶ Explore how RBHB can support the work of the PCMH clinics
- ▶ DBH look for additional grant funding that can enhance co-location and integration to include reverse



Questions



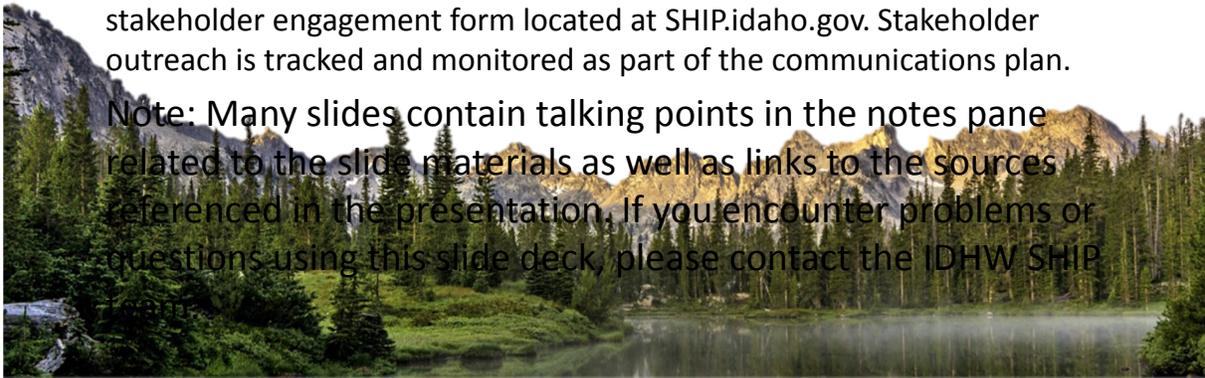


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Upon completion of your presentation, please complete the stakeholder engagement form located at SHIP.idaho.gov. Stakeholder outreach is tracked and monitored as part of the communications plan.

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Presentation Topics

1. Statewide Healthcare Innovation Plan (SHIP)
Model background and timeline
2. Plan for successful healthcare system transformation
3. PCMH transformation success
4. State of PCMH



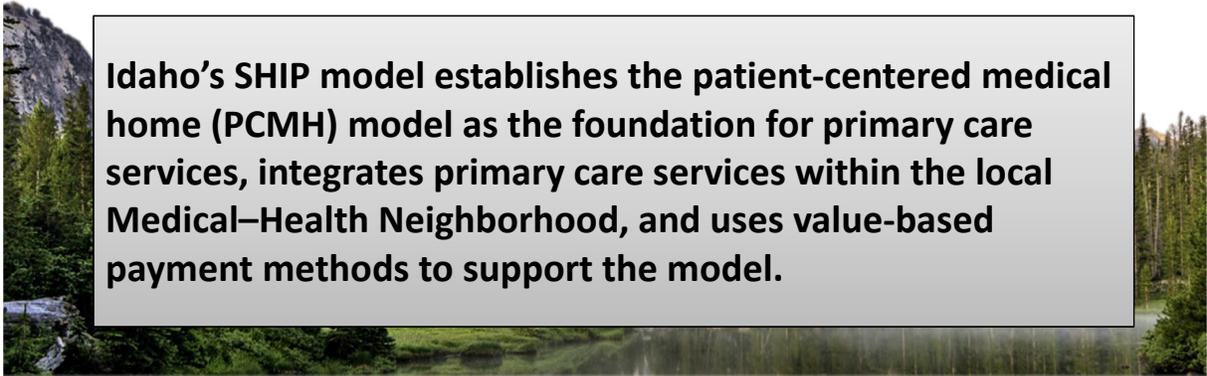
Statewide Healthcare Innovation Plan (SHIP) Model Background and Timeline





Idaho's SHIP Model

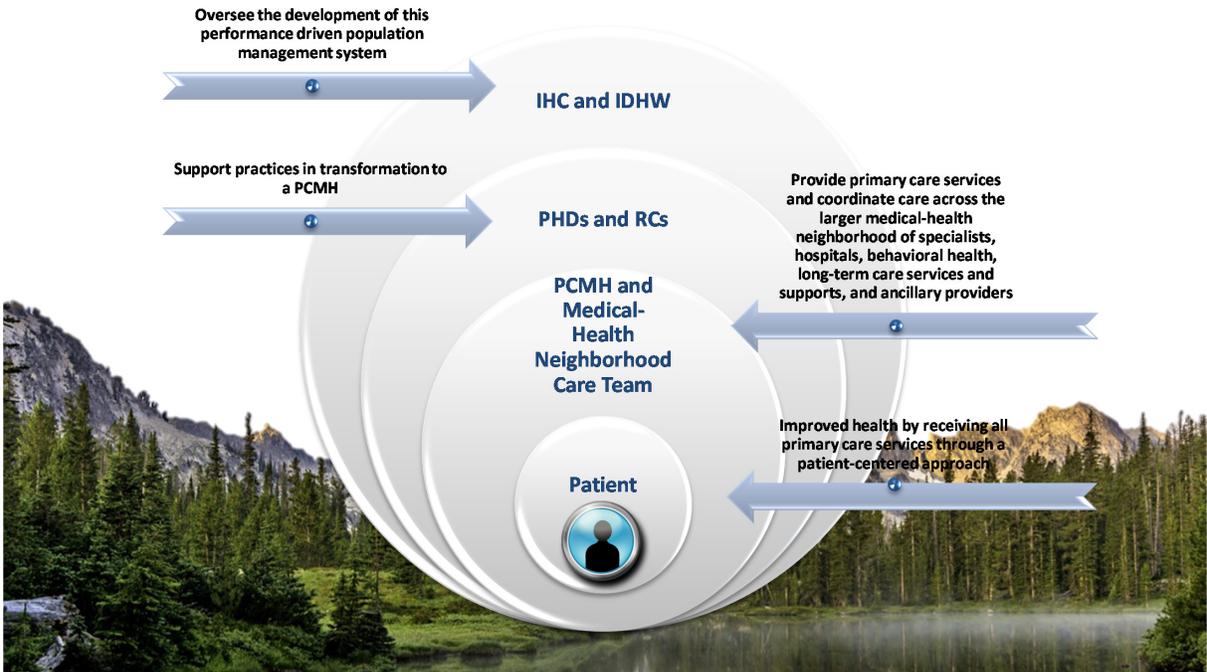
The SHIP is a statewide healthcare innovation plan that aims to **improve health outcomes, improve quality and patient experience of care, and lower cost of care for Idahoans**. Physicians and other health practitioners and healthcare system stakeholders have worked to design a care delivery model that will provide quality, coordinated services to Idahoans. Private insurers and Medicaid are working together to design healthcare reimbursement methods that pay providers for keeping people healthy.



Idaho's SHIP model establishes the patient-centered medical home (PCMH) model as the foundation for primary care services, integrates primary care services within the local Medical-Health Neighborhood, and uses value-based payment methods to support the model.



Idaho's SHIP Model Healthcare Delivery System and Supports





Idaho's SHIP Model

The Medical-Health Neighborhood

The **Medical-Health Neighborhood** is the clinical-community partnership that includes the medical, social, and public health supports necessary to enhance health and the prevention of disease.

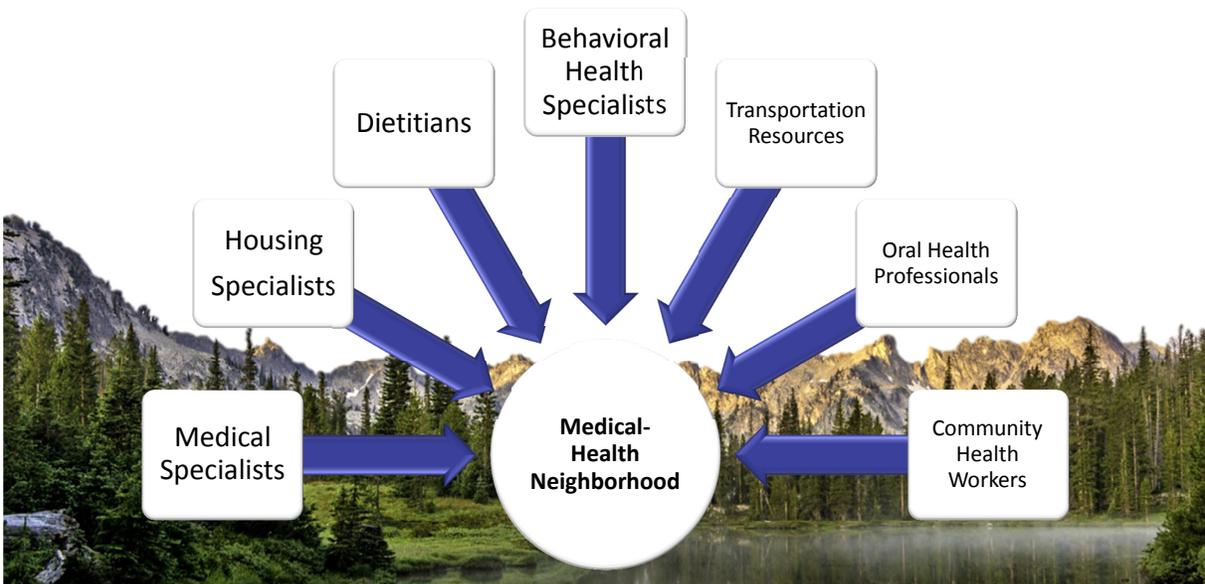
The PCMH serves as the patient's primary "hub" and coordinator of healthcare delivery, with a focus on prevention and wellness within the context of services available outside the clinic setting.



Idaho's SHIP Model

The Medical-Health Neighborhood

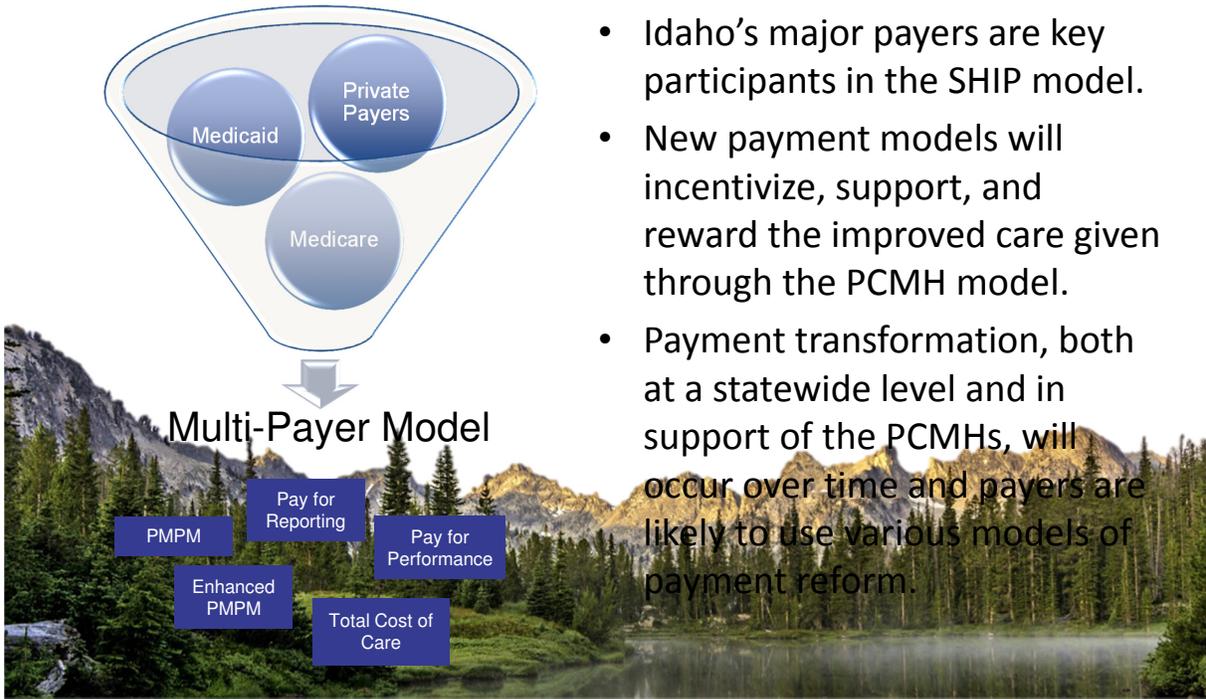
The **Medical-Health Neighborhood** can include:





Idaho's SHIP Model

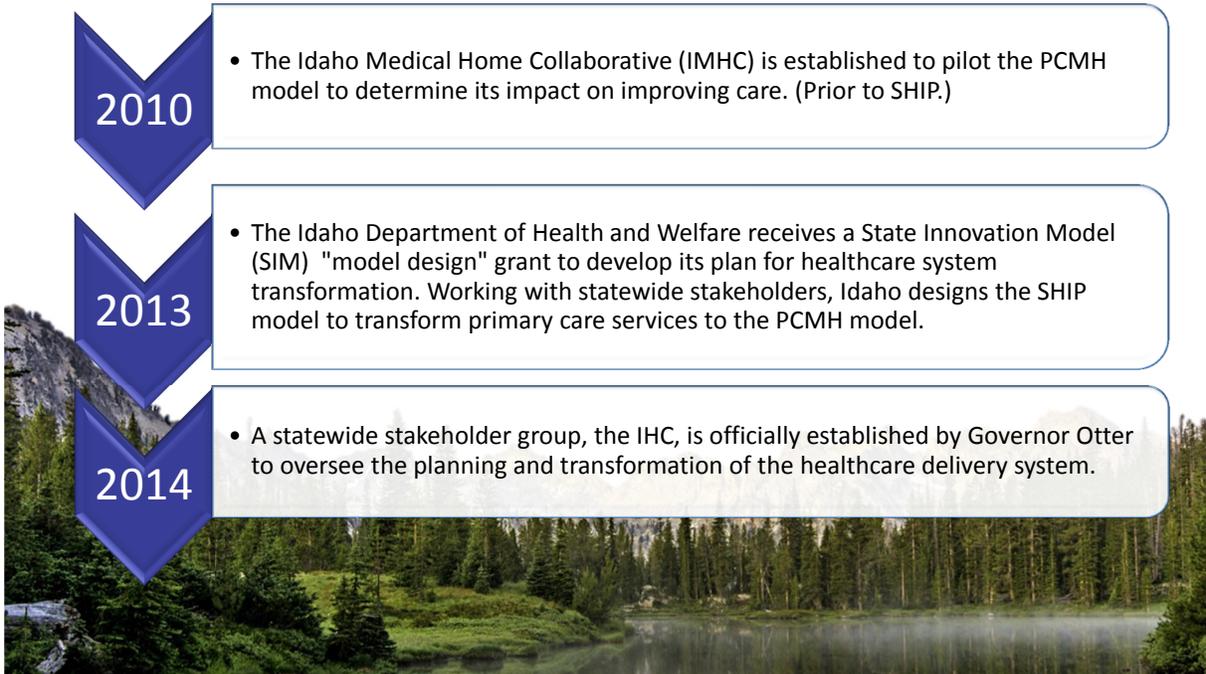
Value-based Payment Methods to Support the Model



- Idaho's major payers are key participants in the SHIP model.
- New payment models will incentivize, support, and reward the improved care given through the PCMH model.
- Payment transformation, both at a statewide level and in support of the PCMHs, will occur over time and payers are likely to use various models of payment reform.



SHIP Model Implementation Timeline





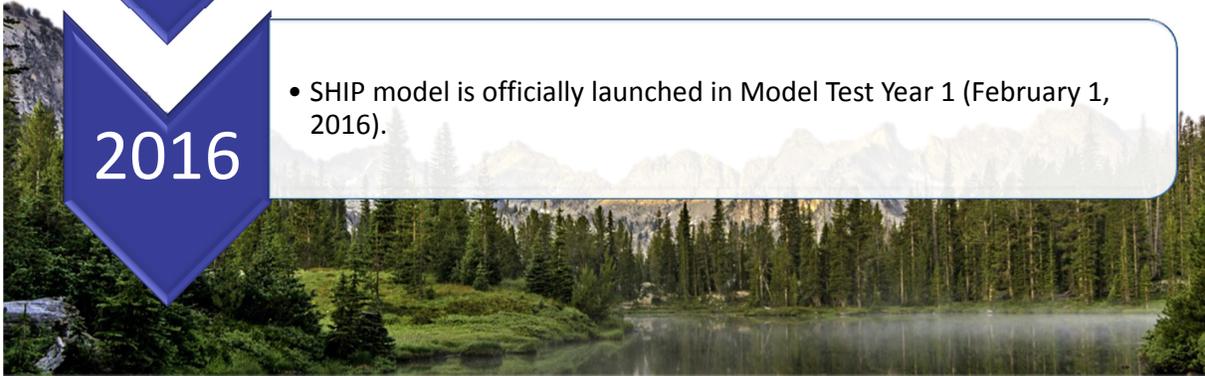
SHIP Model Implementation Timeline

2015

- \$40 million four-year "model test" grant from CMMI is received to test Idaho's SHIP model.
- During the 2015 pre-implementation year, a long-term strategy is planned for the SHIP "model test" and captured in Idaho's Operational Plan.
- SHIP technical assistance contractors are hired to help complete SHIP activities.
- 55 primary care practices are selected to participate in the first year of implementation of the SHIP model.

2016

- SHIP model is officially launched in Model Test Year 1 (February 1, 2016).



Plan for Successful Healthcare System Transformation





Plan for Successful Healthcare System Transformation



Plan for Successful Healthcare System Transformation

Seven SHIP Goals to Achieve the Triple Aim

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-health neighborhoods.

Goal 3: Establish seven Regional Health Collaboratives to support the integration of each PCMH with the broader medical-health 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.

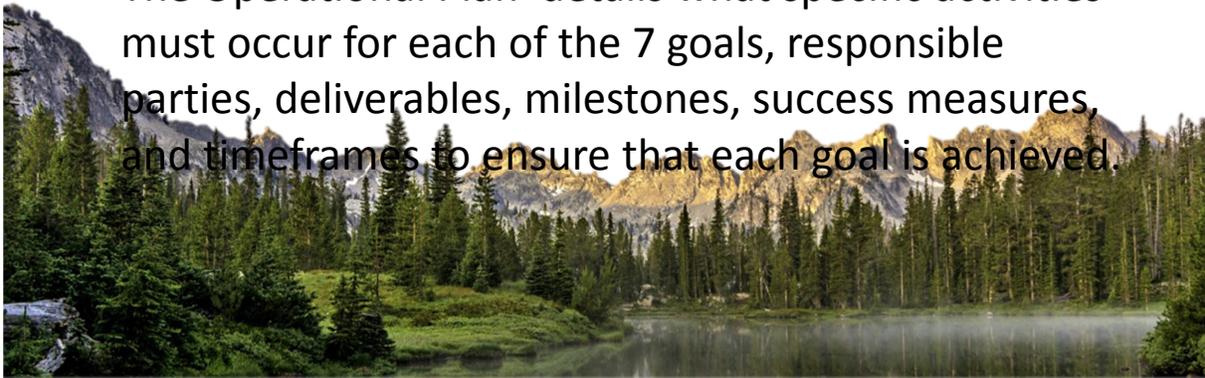
Goal 7: Reduce overall healthcare costs.



Plan for Successful Healthcare System Transformation

Operational Plan

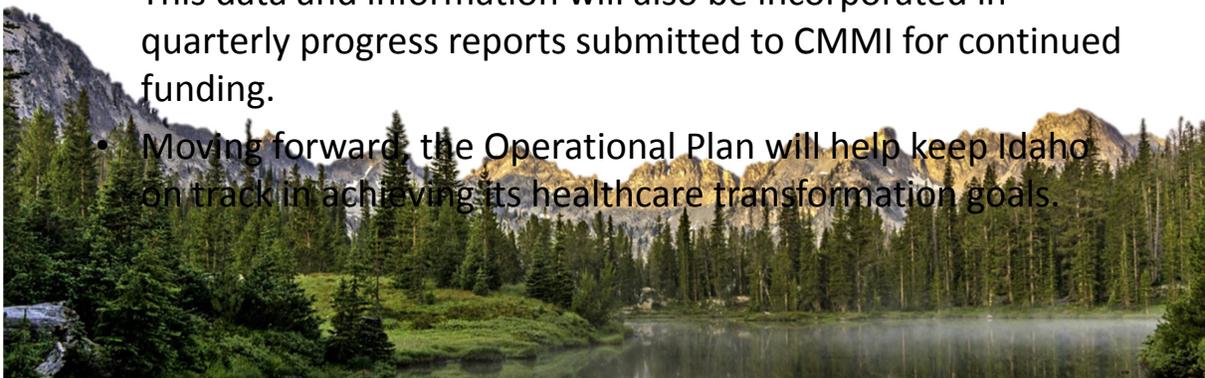
- Idaho's plan for transforming the healthcare system is memorialized in the Operational Plan, which was developed with the IHC and other stakeholder input.
- The Operational Plan details what specific activities must occur for each of the 7 goals, responsible parties, deliverables, milestones, success measures, and timeframes to ensure that each goal is achieved.



Plan for Successful Healthcare System Transformation

Managing and Monitoring Goal Success

- PCMHs will report data and information needed by the IHC, IDHW, and its contractors to help paint a complete picture of Idaho's progress in achieving healthcare system transformation.
- This data and information will also be incorporated in quarterly progress reports submitted to CMMI for continued funding.
- Moving forward, the Operational Plan will help keep Idaho on track in achieving its healthcare transformation goals.





PCMH Transformation Support

Resources and Technical Assistance



PCMH Transformation Support

Resources for Clinics

- Primary care practices will receive resources and technical assistance throughout the PCMH transformation process, including assistance from:
 - ✓ **Public Health Districts (PHDs) and Regional Health Collaboratives (RCs)** that provide technical assistance and transformation support.
 - ✓ Technical assistance contractors including **Briljent and Health Management Associates (HMA)** that provide transformation supports and resources.

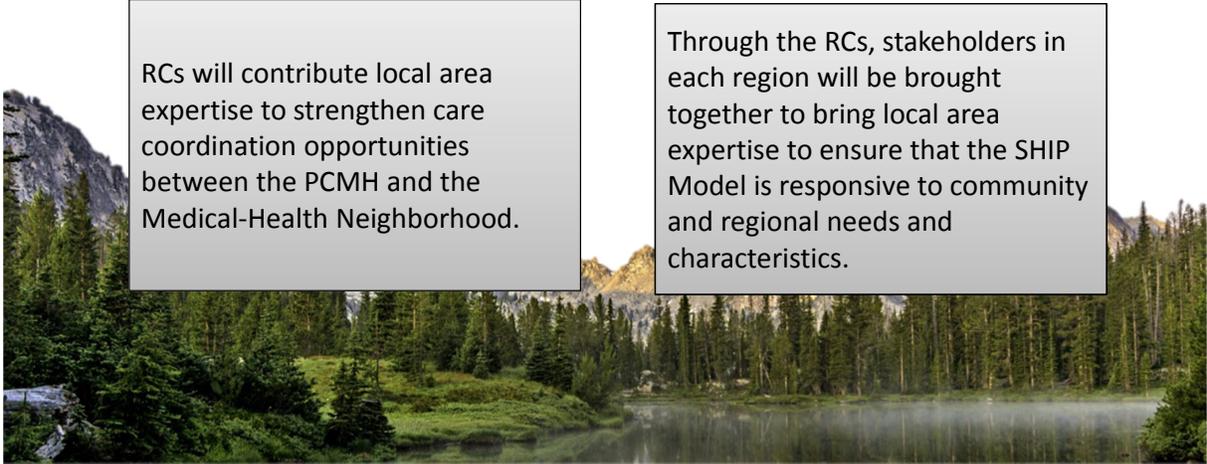




PCMH Transformation Support

Regional Health Collaborative (RC)

An **RC** is a regional body comprised of local representatives from PCMHs and the Medical-Health Neighborhood that will facilitate development of the Medical-Health Neighborhood.



RCs will contribute local area expertise to strengthen care coordination opportunities between the PCMH and the Medical-Health Neighborhood.

Through the RCs, stakeholders in each region will be brought together to bring local area expertise to ensure that the SHIP Model is responsive to community and regional needs and characteristics.



PCMH Transformation Support

The Role of RCs

- RCs have been established for in seven regions and will have a general membership of PCMHs and the key participants of the Medical-Health Neighborhood.
- RCs have a Regional Collaborative Executive Leadership Committee (RCE) that includes a Chair, Co-Chair, the PHD Director, and the SHIP Manager to lead the RCs' efforts and communicate with the IHC to share information about each region.
- RCs will link the PCMHs to the broader Medical-Health Neighborhood to facilitate coordinated patient care through the entire provider community and with other services needed to support the whole person.

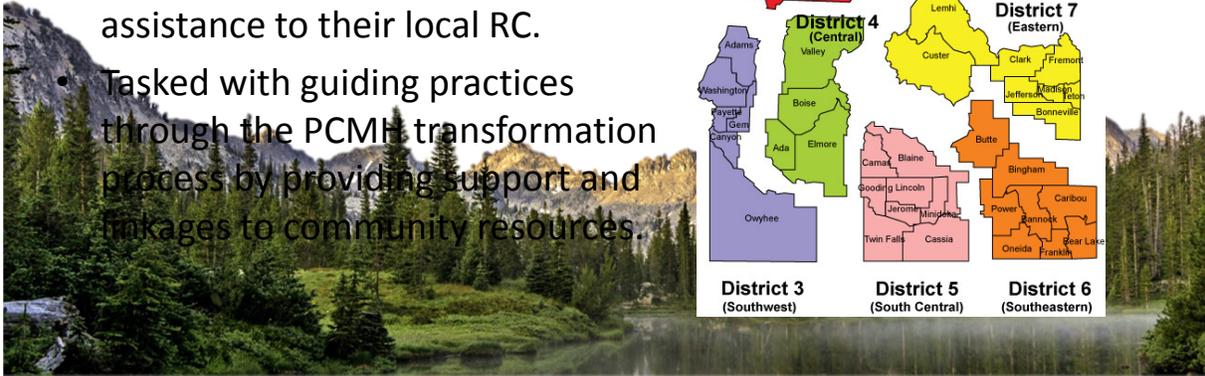


PCMH Transformation Support

Public Health District (PHD)

The seven PHDs in Idaho play an important role in facilitating healthcare system transformation.

- Designated as the convener of the Regional Health Collaboratives (RCs) and providing supports and assistance to their local RC.
- Tasked with guiding practices through the PCMH transformation process by providing support and linkages to community resources.



PCMH Transformation Support

Briljent and its Subcontractors

Briljent and its subcontractors, Health Management Associates (HMA) and Myers & Stauffer will provide training, learning collaboratives, on-site assistance, and additional support to practices.



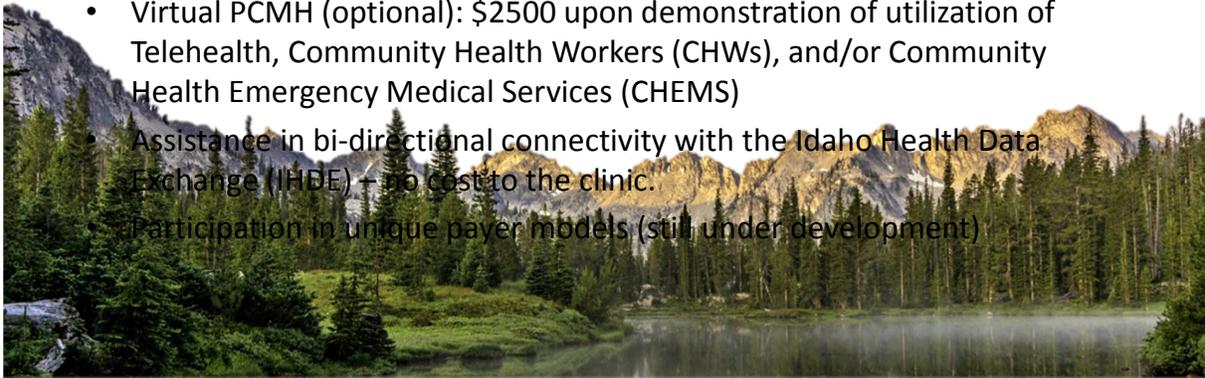


PCMH Incentives

Participating Clinics

Participation Incentives:

- Participation Incentive Payment: \$10,000 upon enrollment into SHIP program with a signed Memorandum of Understanding (MOU)
- PCMH Recognition/Accreditation: \$5,000 upon recognition or accreditation through NCQA, AAAHC, The Joint Commission, Oregon PCPCH, or other identified program/organization
- Virtual PCMH (optional): \$2500 upon demonstration of utilization of Telehealth, Community Health Workers (CHWs), and/or Community Health Emergency Medical Services (CHEMS)
- Assistance in bi-directional connectivity with the Idaho Health Data Exchange (IHDE) – no cost to the clinic.
- Participation in unique payer models (still under development)



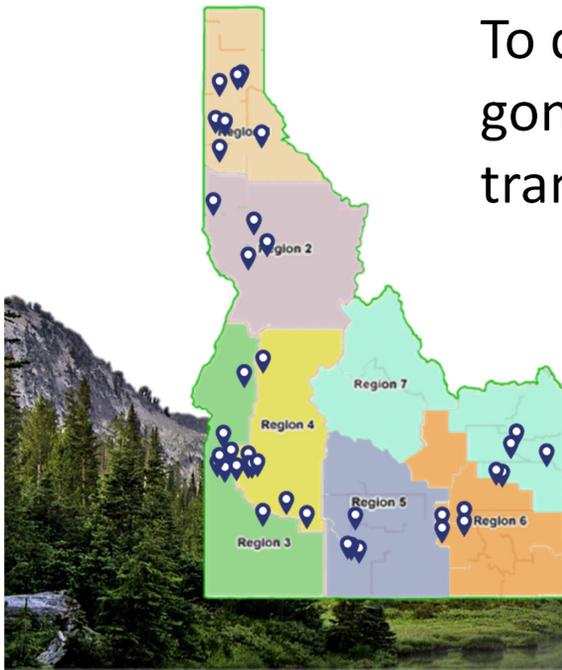
State of the PCMH





State of the PCMH

To date, 55 clinics have gone through the PCMH transformation process.



The Complete list can be found at:

SHIP.idaho.gov/PCMH

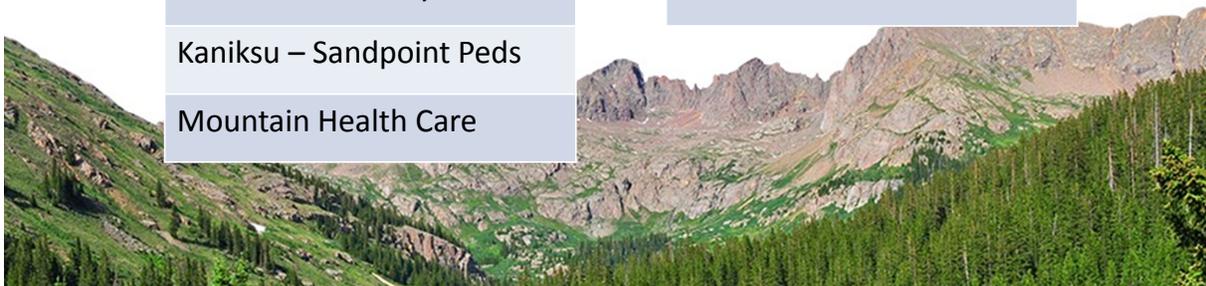


State of the PCMH

Practices selected for Model Test Year 1 Implementation

Region 1 (7 clinics)
Benewah Medical
Heritage Health Kellogg
Heritage Health TBD
Family Health Center
Kaniksu - Ponderay
Kaniksu – Sandpoint Peds
Mountain Health Care

Region 2 (5 clinics)
CHAS Latah
St. Mary’s Cottonwood
St. Mary’s Kamiah
Valley Medical Center
Orofino Health Center





State of the PCMH

Practices selected for Model Test Year 1 Implementation

Region 3 (10 clinics)

Adam County Health
Primary Health Medical Group (Nampa, Caldwell)
Valley Health Center
Valley Family HC
St. Lukes (Nampa Greenhearst)
SAMG - Elm
Terry Reilly (Homedale, Marsing, Nampa)

Region 4 (15 clinics)

Desert Sage Health
FMRI (Raymond, Meridian, Emerald)
Glenns Ferry Health
Primary Health (Overland, Peds, West Boise)
SAMG (Eagle, McMillan, Overland)
St Lukes (Cloverdale, Payette Lakes)
Sonshine Family Health
Terry Reilly (Boise 23rd St)



State of the PCMH

Practices selected for Model Test Year 1 Implementation

Region 5 (4 clinics)

Crosspointe Family Services
Family Health Services (Kimberly)
Family Health Services (Twin Falls)
Family Health Center
Shoshone Family Medical

Region 6 (6 clinics)

Health West (Aberdeen, American Falls, Pocatello)
Not-tsoo Gah-nee IHC
Pocatello Children's
Portneuf Primary Care





State of the PCMH

Practices selected for Model Test Year 1 Implementation

Region 7 (8 clinics)

Complete Family Care

Driggs Health

Family First Medial

Tueller Counseling

Rocky Mountain Diabetes

Madison Memorial Rexburg

Victor Health Clinic

Upper Valley Community

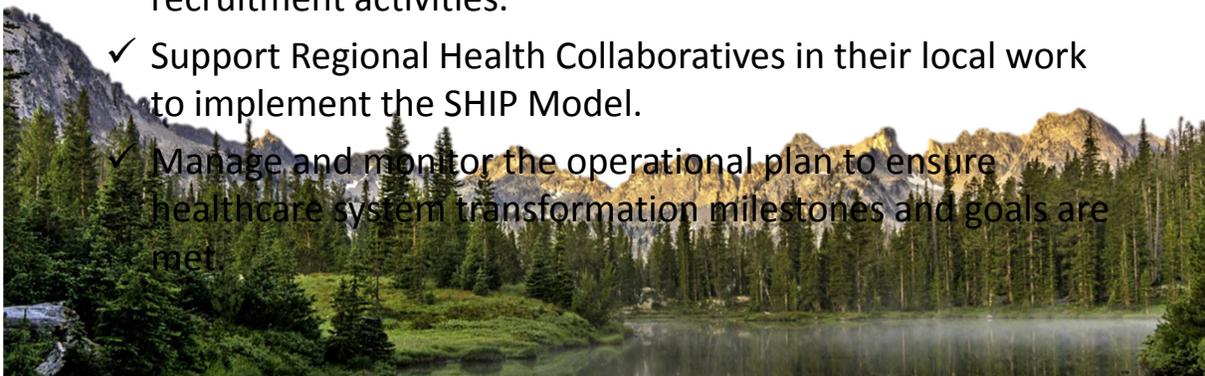


2016 Activities

IHC Activities

Over the next year, the Idaho Healthcare Coalition (IHC) will:

- ✓ Continue education efforts among practitioners, health and social services organizations, and the general public regarding Idaho's SHIP model.
- ✓ Continue PCMH and Medical-Health Neighborhood recruitment activities.
- ✓ Support Regional Health Collaboratives in their local work to implement the SHIP Model.
- ✓ Manage and monitor the operational plan to ensure healthcare system transformation milestones and goals are met.



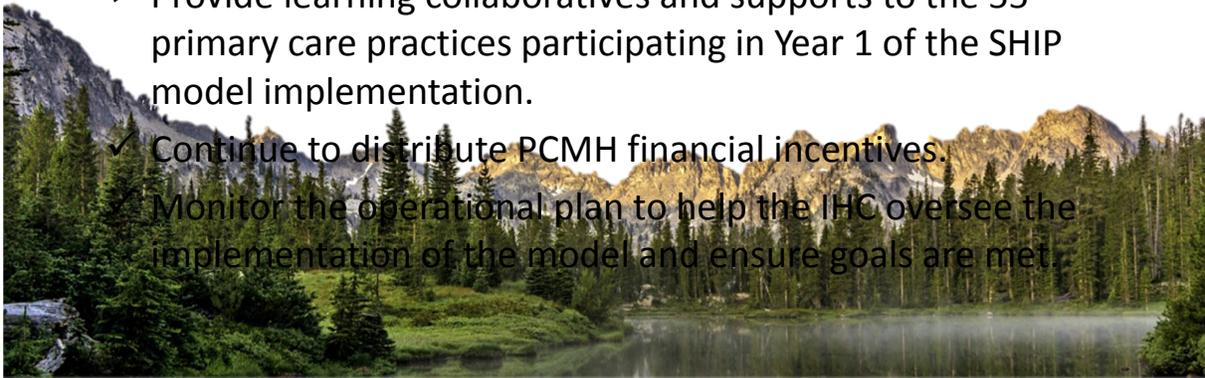


2016 Activities

Public Health Districts and IDHW Activities

Over the next year, Public Health Districts, IDHW SHIP staff, and IDHW/SHIP technical assistance contractors will:

- ✓ Engage in more educational activities with PCMHs and the Medical-Health Neighborhood to help establish fully integrated PCMHs.
- ✓ Provide learning collaboratives and supports to the 55 primary care practices participating in Year 1 of the SHIP model implementation.
- ✓ Continue to distribute PCMH financial incentives.
- ✓ Monitor the operational plan to help the IHC oversee the implementation of the model and ensure goals are met.



PCMH Participation

Idaho's healthcare system transformation requires from primary care practices:

- ✓ **Long-term Commitment**
- ✓ **Feedback**





PCMH Participation

Long-term Commitment

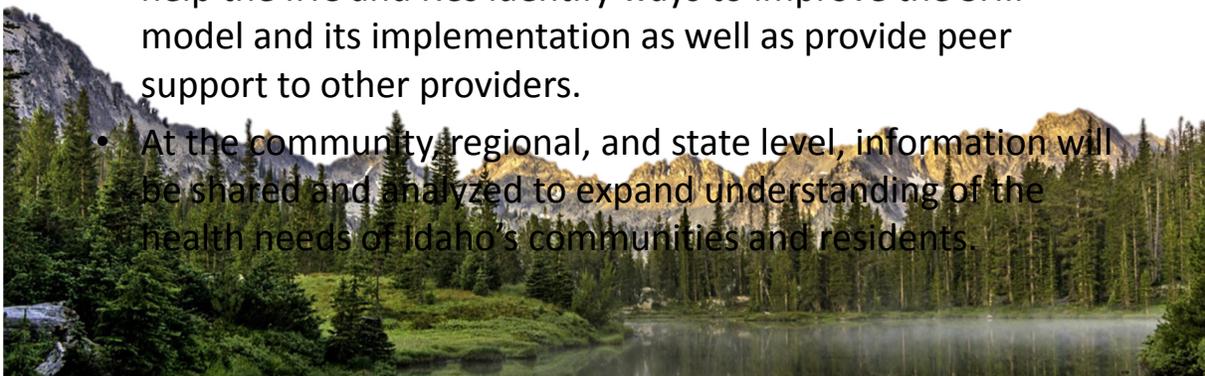
- Central to the PCMH model is a recognition that many factors impact an individual's total health—medical services, lifestyle, culture, nutrition, and socio-economic factors—factors that primary care providers have been working to address for years, are recognized in this SHIP Model.
- Collaborating on and improving these health factors will only happen with time which requires a long-term commitment.



PCMH Participation

PCMH Feedback

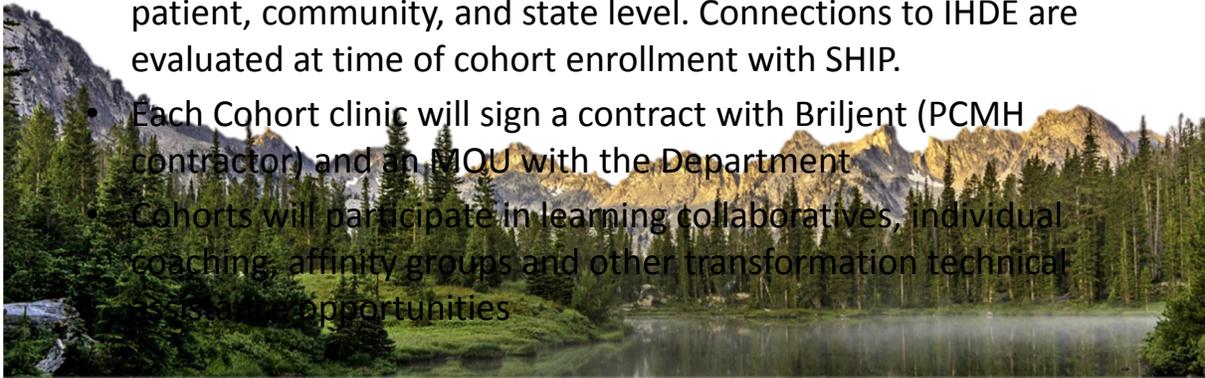
- The SHIP model includes an important focus on community and regional-specific unique healthcare system needs and the goal of improving the overall health of Idaho's population, which is why provider feedback is so critical.
- Sharing your experience as you transform your practice will help the IHC and RCs identify ways to improve the SHIP model and its implementation as well as provide peer support to other providers.
- At the community, regional, and state level, information will be shared and analyzed to expand understanding of the health needs of Idaho's communities and residents.





Next Steps

- There will be three (3) SHIP clinic cohorts; with the goal of transforming 165 practices to PCMH.
- Bi-directional data connections between EHRs and IHDE will be established to assist in care coordination among clinics, sharing of clinical data and for production of a statewide data analytics system that tracks progress of selected quality measures at the patient, community, and state level. Connections to IHDE are evaluated at time of cohort enrollment with SHIP.
- Each Cohort clinic will sign a contract with Brilljent (PCMH contractor) and an MOU with the Department
- Cohorts will participate in learning collaboratives, individual coaching, affinity groups and other transformation technical assistance opportunities



Contact Information



NAME

Title

Phone

Email

WEBSITE



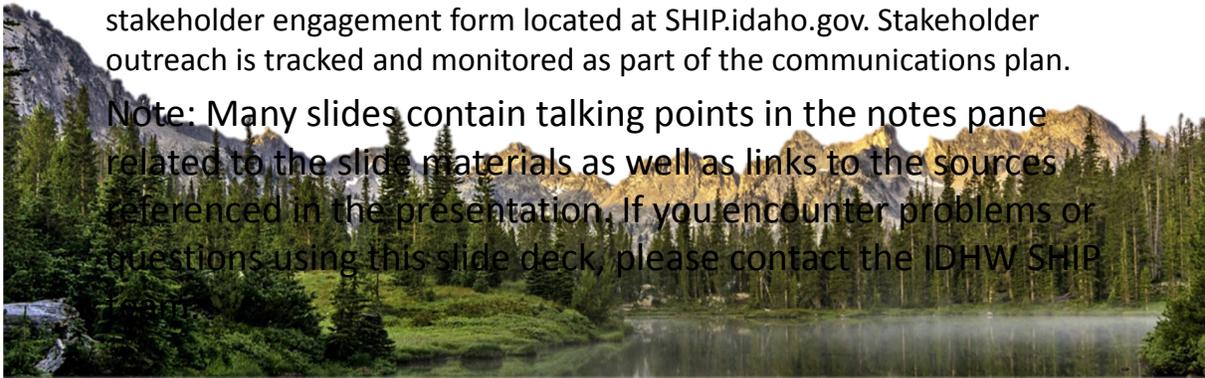


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Presentation Topics

1. Introduction of Statewide Healthcare Innovation Plan (SHIP) Model
2. Why the PCMH model of care?
3. Plan for successful healthcare system transformation
4. How you can participate in Idaho's healthcare system transformation
5. Resources and technical assistance for practices selected for the SHIP Model implementation



Introduction: Statewide Healthcare Innovation Plan (SHIP) Model



Idaho's Current Healthcare System

Need for Transformation



Focus is on disease, not the entire health of the individual.



Services are siloed with limited coordination of care.



Workforce shortages significantly impact access.



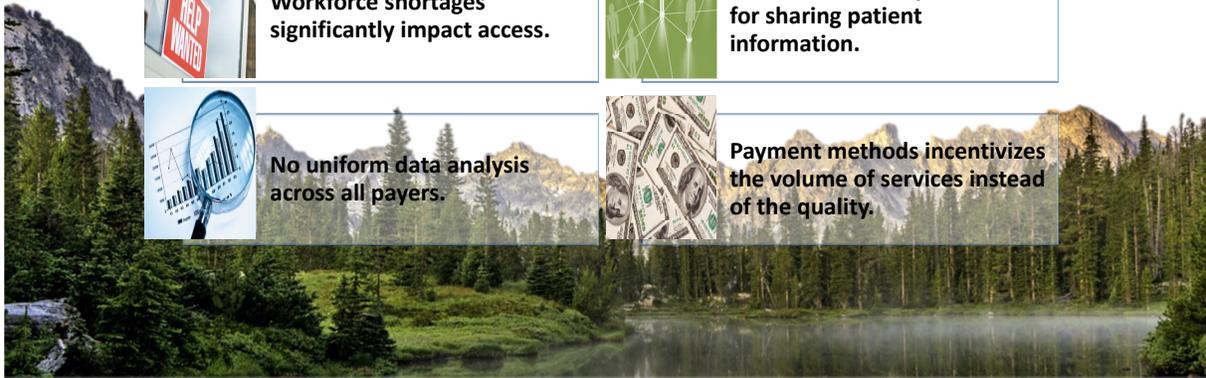
Limited tools and processes for sharing patient information.



No uniform data analysis across all payers.



Payment methods incentivizes the volume of services instead of the quality.



Idaho's Future Healthcare System

Vision for the Future



Patient-centered, integrated care delivery system.



Focus on the whole person's health needs, and the health of the population.



Regional partnerships work to improve community health.



Electronic linkages facilitate information sharing and care coordination.



Patients are engaged and educated regarding personal health decisions.



Public and private payer value-based payment models incentivize quality care.





Idaho's SHIP Model

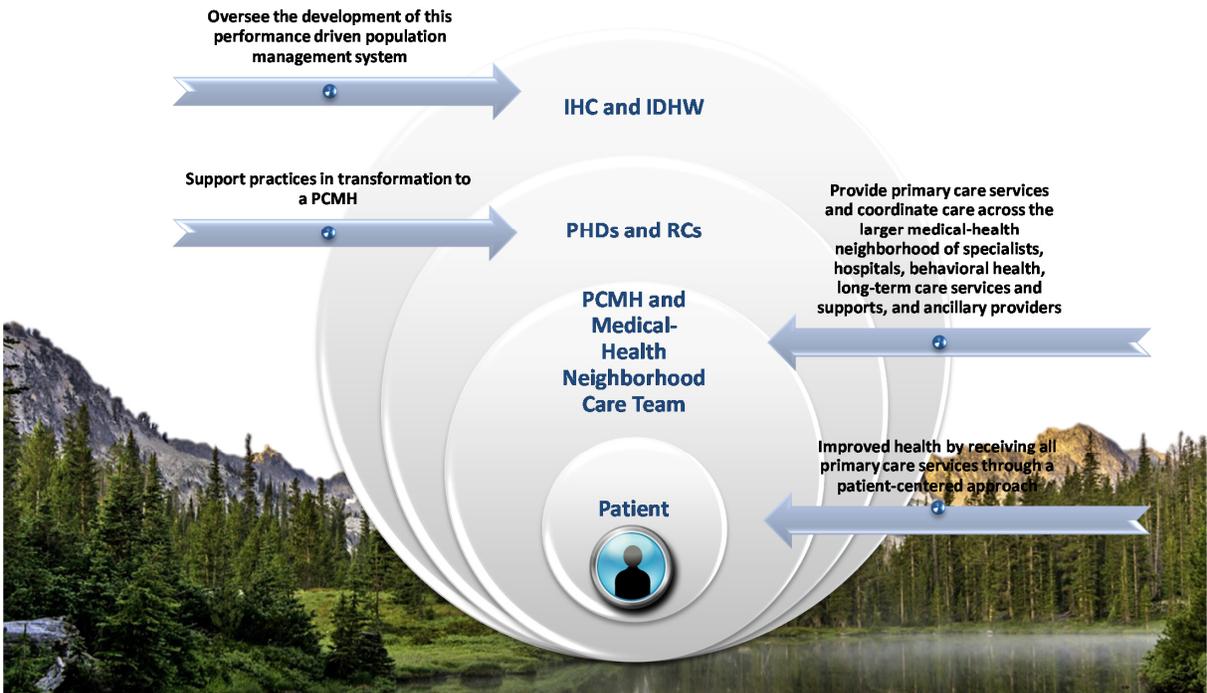
The SHIP is a statewide healthcare innovation plan that aims to **improve health outcomes, improve quality and patient experience of care, and lower cost of care for Idahoans**. Physicians and other health practitioners and healthcare system stakeholders have worked to design a care delivery model that will provide quality, coordinated services to Idahoans. Private insurers and Medicaid are working together to design healthcare reimbursement methods that pay providers for keeping people healthy.



Idaho's SHIP model establishes the patient-centered medical home (PCMH) model as the foundation for primary care services, integrates primary care services within the local Medical-Health Neighborhood, and uses value-based payment methods to support the model.



Idaho's SHIP Model Healthcare Delivery System and Supports





Idaho's SHIP Model

The Medical-Health Neighborhood

The **Medical-Health Neighborhood** is the clinical-community partnership that includes the medical, social, and public health supports necessary to enhance health and the prevention of disease.

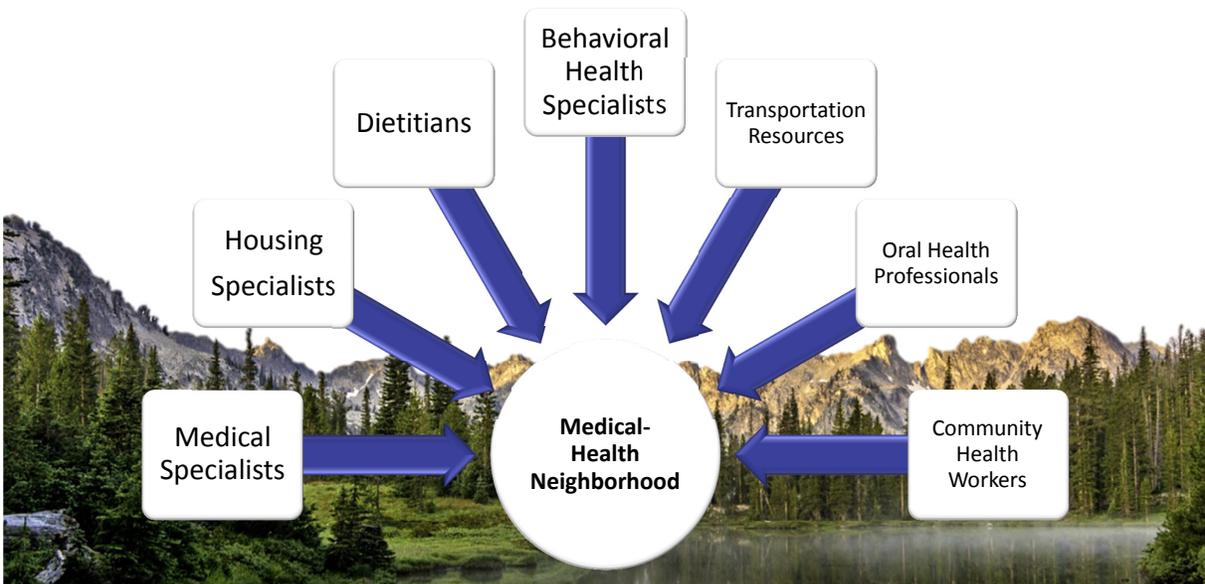
The PCMH serves as the patient's primary "hub" and coordinator of healthcare delivery, with a focus on prevention and wellness within the context of services available outside the clinic setting.



Idaho's SHIP Model

The Medical-Health Neighborhood

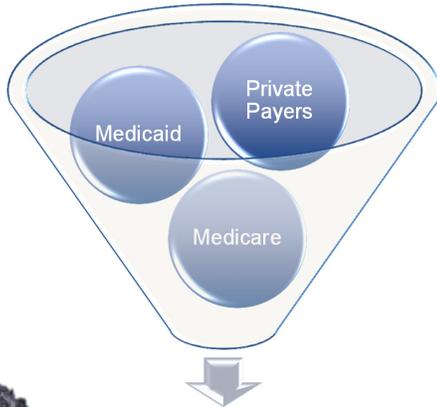
The **Medical-Health Neighborhood** can include:



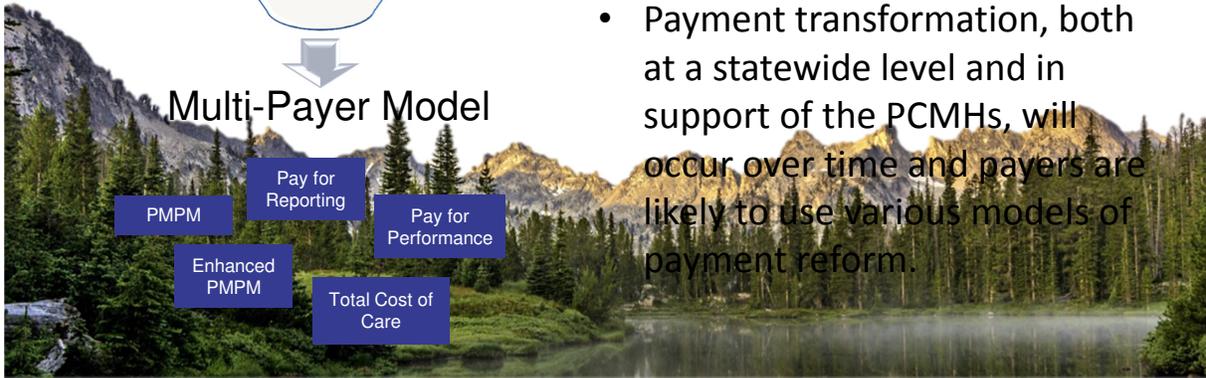


Idaho's SHIP Model

Value-based Payment Methods to Support the Model



Multi-Payer Model



- Idaho's major payers are key participants in the SHIP model.
- New payment models will incentivize, support, and reward the improved care given through the PCMH model.
- Payment transformation, both at a statewide level and in support of the PCMHs, will occur over time and payers are likely to use various models of payment reform.



Why the PCMH Model of Care?





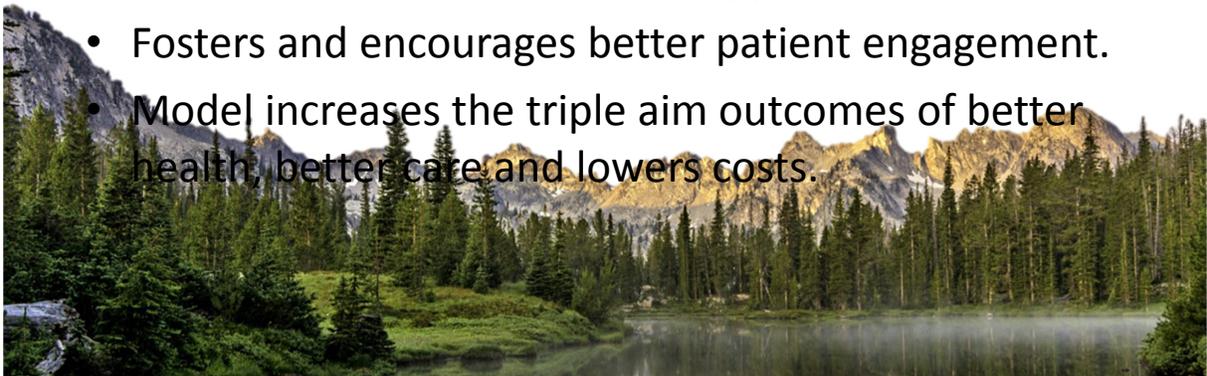
Why the PCMH Model of Care

Many benefits for patients and practitioners.
Evidence that the model inspires quality in care, cultivates more engaging patient relationships, and saves money.
Proven success in Idaho in both outcomes and cost.



Why the PCMH Model of Care

- PCMH models are designed to produce better outcomes, improved access to care, and reduced costs.
- Patient care is coordinated and provided through a person-centered, team-based approach.
- Fosters and encourages better patient engagement.
- Model increases the triple aim outcomes of better health, better care and lowers costs.





PCMH Model of Care

PCMH Benefits for Practitioners

- Idaho's PCMHs will be integrated into a larger Medical – Health Neighborhood, supporting efficient and seamless coordination of care.
- The team-based approach enables practitioners to focus their time and attention where it is most needed.
 - The PCMH model allows clinic staff members to practice at the top of their license.
 - Physicians are able to focus on clinical care requiring physician-level intervention.
 - Other staff, including nurses and community health workers (CHWs), can provide care within the appropriate scope of their practice.

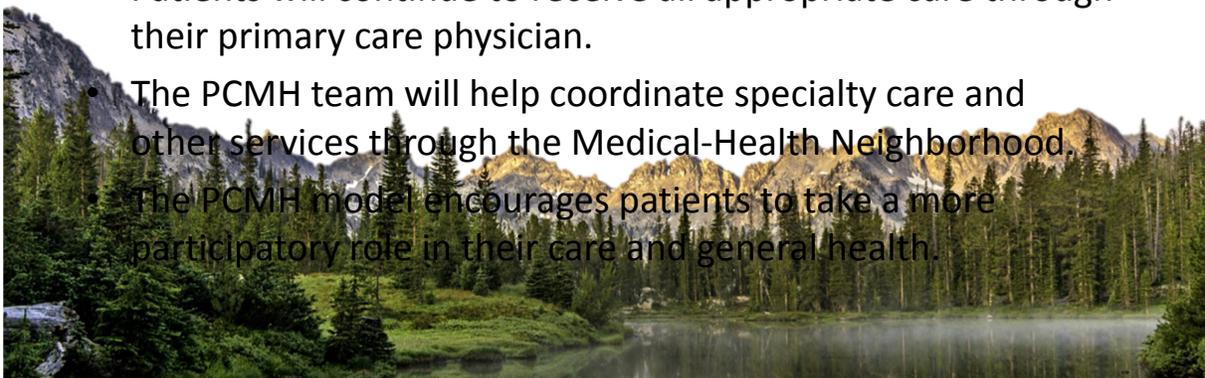


PCMH Model of Care

PCMH Benefits for Your Patients

Your patients will experience better coordination of their care through the Medical-Health Neighborhood, and care will account for an individual's total health including medical services, lifestyle, cultural, nutrition, and socio-economic factors.

- Patients will continue to receive all appropriate care through their primary care physician.
- The PCMH team will help coordinate specialty care and other services through the Medical-Health Neighborhood.
- The PCMH model encourages patients to take a more participatory role in their care and general health.





IMHC's PCMH Pilot

The Idaho Medical Home Collaborative (IMHC) Pilot Program

- Idaho chose the PCMH model as a core component of our healthcare system reform based on past positive pilot experience from the IMHC.
- The IMHC pilot was a unique Idaho initiative that began in January 2013 and transformed 36 primary care practices in Idaho into PCMHs that served 9,000 patients with chronic conditions.



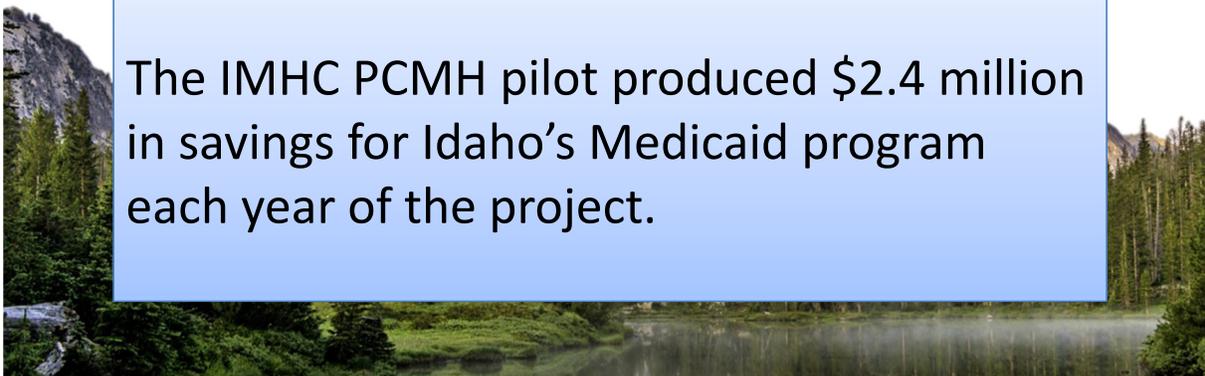
IMHC's PCMH Pilot

The Idaho Medical Home Collaborative (IMHC) Pilot Program

The IMHC pilot was shown to:

- ✓ Improve care for its patient population; and
- ✓ Reduce care costs.

The IMHC PCMH pilot produced \$2.4 million in savings for Idaho's Medicaid program each year of the project.





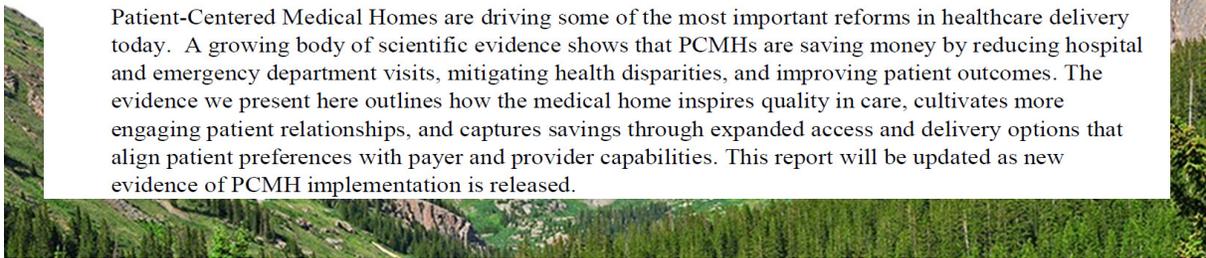
National PCMH Evidence of Success

While the PCMH model of care has already shown great promise in Idaho through the IMHC pilot, national research underscores even greater potential for expanding the work in Idaho.



June 2015

Latest Evidence: Benefits of the Patient-Centered Medical Home

A scenic photograph of a mountain landscape with green hills, a river, and evergreen trees under a clear sky.

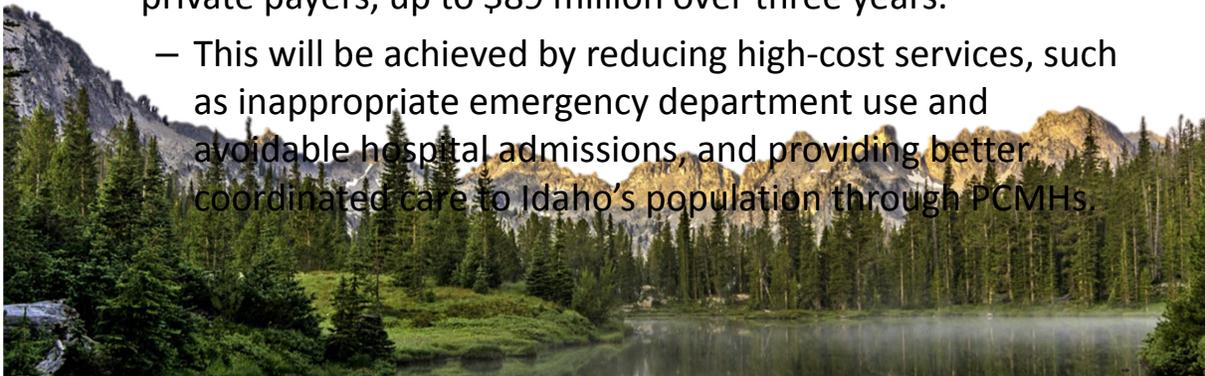
Patient-Centered Medical Homes are driving some of the most important reforms in healthcare delivery today. A growing body of scientific evidence shows that PCMHs are saving money by reducing hospital and emergency department visits, mitigating health disparities, and improving patient outcomes. The evidence we present here outlines how the medical home inspires quality in care, cultivates more engaging patient relationships, and captures savings through expanded access and delivery options that align patient preferences with payer and provider capabilities. This report will be updated as new evidence of PCMH implementation is released.



Anticipated Outcomes of Implementing Idaho's SHIP Model

Idaho anticipates that implementing a similar PCMH model of care through this SHIP Model implementation will:

- Establish patient-centered, integrated, and coordinated care for all Idahoans in a cost-effective way.
- Save Idaho's healthcare system, including both public and private payers, up to \$89 million over three years.
 - This will be achieved by reducing high-cost services, such as inappropriate emergency department use and avoidable hospital admissions, and providing better coordinated care to Idaho's population through PCMHs.





SHIP Model Implementation Timeline

2010

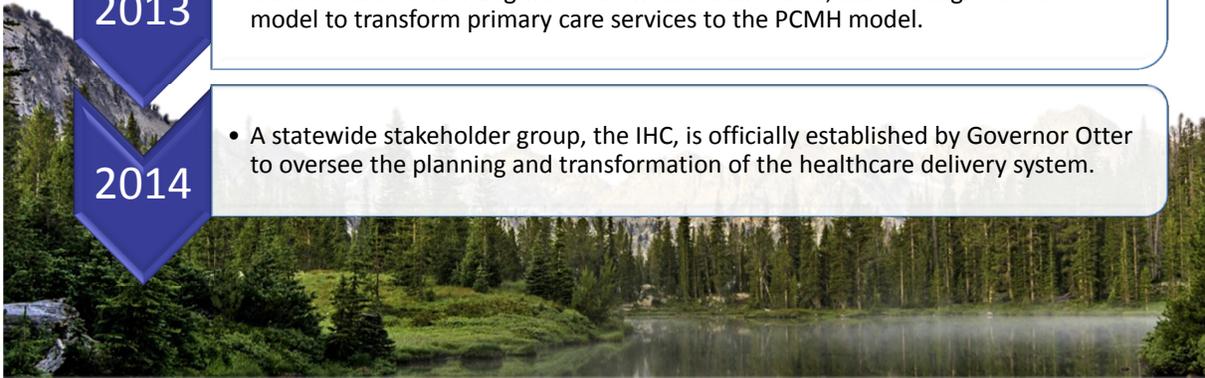
- The Idaho Medical Home Collaborative (IMHC) is established to pilot the PCMH model to determine its impact on improving care. (Prior to SHIP.)

2013

- The Idaho Department of Health and Welfare receives a State Innovation Model (SIM) "model design" grant to develop its plan for healthcare system transformation. Working with statewide stakeholders, Idaho designs the SHIP model to transform primary care services to the PCMH model.

2014

- A statewide stakeholder group, the IHC, is officially established by Governor Otter to oversee the planning and transformation of the healthcare delivery system.



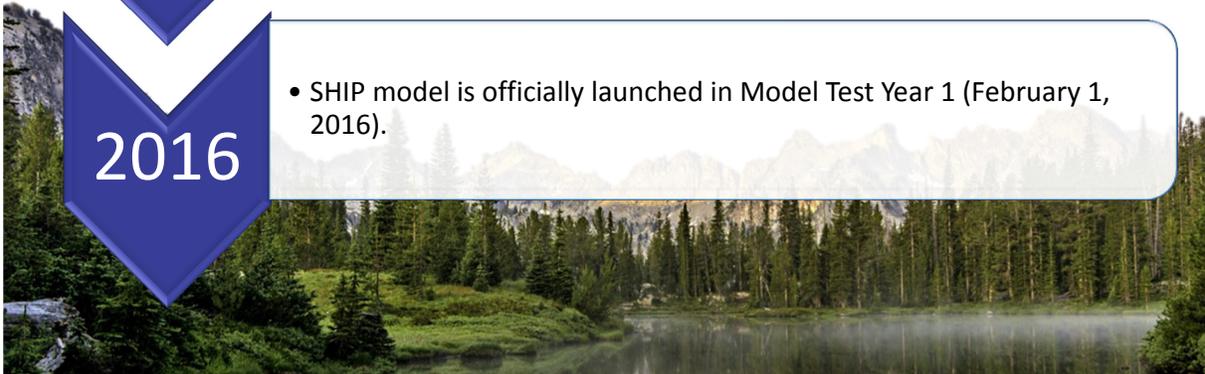
SHIP Model Implementation Timeline

2015

- \$40 million four-year "model test" grant from CMMI is received to test Idaho's SHIP model.
- During the 2015 pre-implementation year, a long-term strategy is planned for the SHIP "model test" and captured in Idaho's Operational Plan.
- SHIP technical assistance contractors are hired to help complete SHIP activities.
- 55 primary care practices are selected to participate in the first year of implementation of the SHIP model.

2016

- SHIP model is officially launched in Model Test Year 1 (February 1, 2016).





Plan for Successful Healthcare System Transformation



Plan for Successful Healthcare System Transformation



- Idaho designed 7 Idaho-specific goals for healthcare system transformation.

- Improve health outcomes,
- Improve quality and patient experience of care, and
- Lower cost of care for Idahoans.



Plan for Successful Healthcare System Transformation

Seven SHIP Goals to Achieve the Triple Aim

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-health neighborhoods.

Goal 3: Establish seven Regional Health Collaboratives to support the integration of each PCMH with the broader medical-health 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.

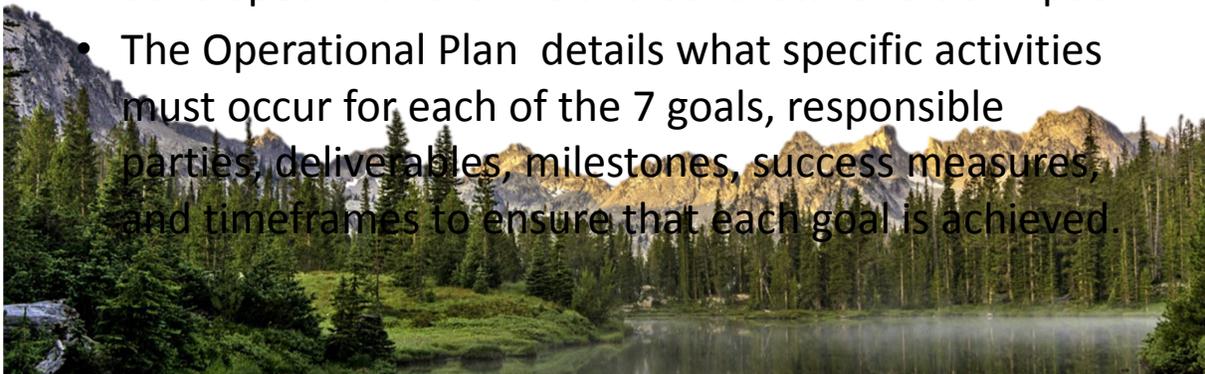
Goal 7: Reduce overall healthcare costs.



Plan for Successful Healthcare System Transformation

Operational Plan

- Idaho's plan for transforming the healthcare system is memorialized in the Operational Plan, which was developed with the IHC and other stakeholder input.
- The Operational Plan details what specific activities must occur for each of the 7 goals, responsible parties, deliverables, milestones, success measures, and timeframes to ensure that each goal is achieved.





How You Can Participate in Idaho's Healthcare System Transformation



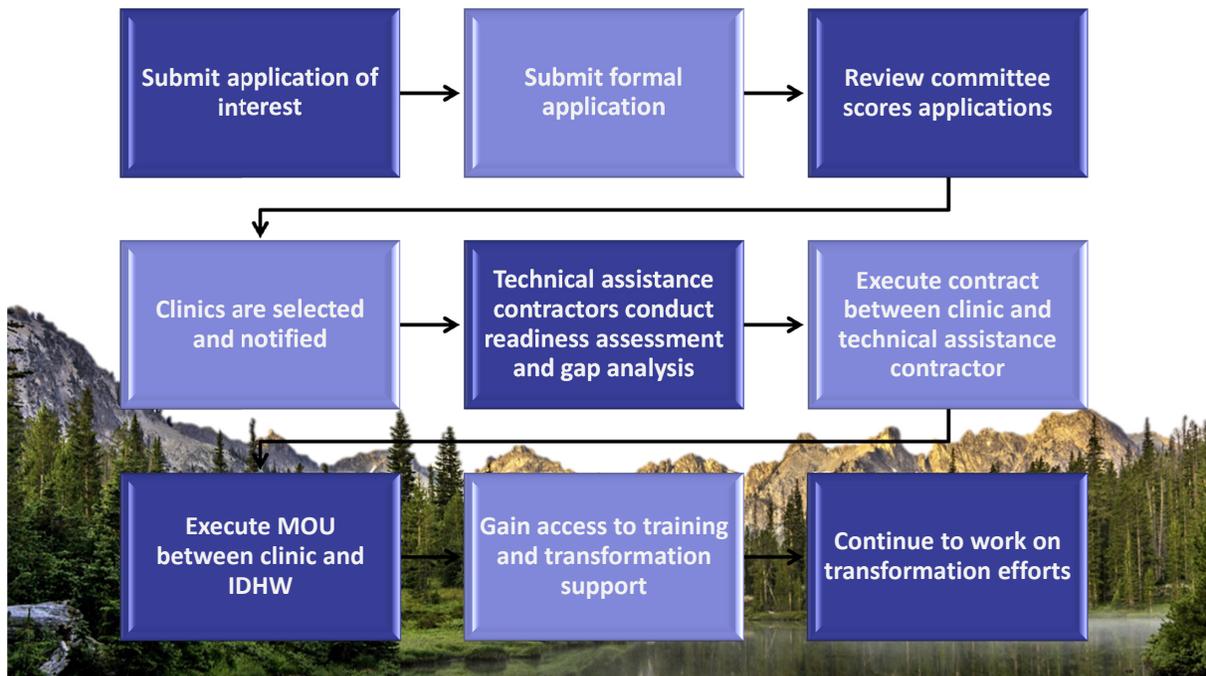
PCMH Application and Enrollment Processes

- 165 primary care practices will be enrolled the Idaho SHIP Model over the next three years (February 1, 2016 – January 31, 2019).
- The IHC and IDHW have developed a process for primary care practices to apply and enroll in the SHIP Model. Criteria for PCMH designation in the SHIP Model has also been developed by the IHC.





PCMH Application and Enrollment Processes



PCMH Application and Enrollment Processes

PCMH Selection Criteria

The criteria for a selection as a PCMH in a SHIP Model cohort is established by the IHC. Selection criteria for Cohort 1* included:

- ✓ Evidence of organizational leadership support and experience (i.e. physician champion)
- ✓ Adequacy and effectiveness of health information technology (HIT) capabilities
- ✓ National recognition or accreditation as a PCMH
- ✓ Geographic location (i.e. rural, urban & frontier)
- ✓ Previous pilot or PCMH program experience

*Note that Cohort 1 will act as mentors to subsequent participant clinics, and this emphasis on experience was intention for this cohort by the IHC.



Resources and Technical Assistance For Practices Selected for the SHIP Model

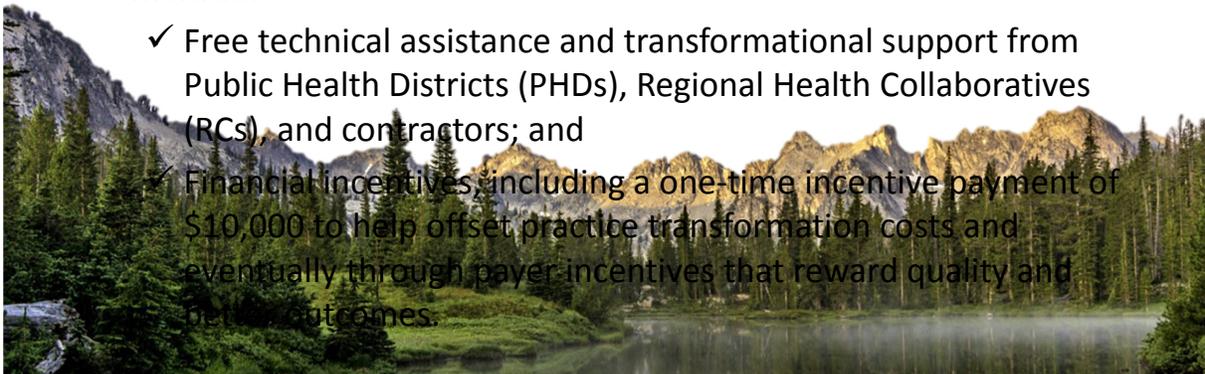


PCMH Transformation Support

Resources and Supports During Transformation

- Transitioning to the PCMH model can be challenging and requires a commitment to the model.
- To support practices and help facilitate the transformation process, the SHIP Model includes significant resources to help practices participating in the SHIP Model. Resources include:

- ✓ Free technical assistance and transformational support from Public Health Districts (PHDs), Regional Health Collaboratives (RCs), and contractors; and
- ✓ Financial incentives, including a one-time incentive payment of \$10,000 to help offset practice transformation costs and eventually through payer incentives that reward quality and better outcomes.

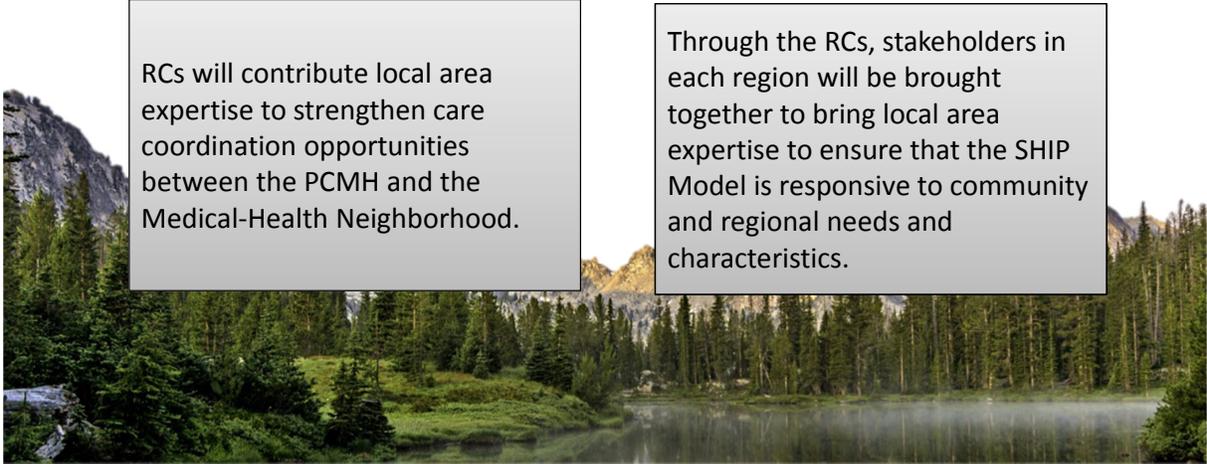




PCMH Transformation Support

Regional Health Collaborative (RC)

An **RC** is a regional body comprised of local representatives from PCMHs and the Medical-Health Neighborhood that will facilitate development of the Medical-Health Neighborhood.

A scenic landscape photograph showing a calm lake in the foreground, surrounded by dense evergreen forests. In the background, there are rugged mountains under a clear sky.

RCs will contribute local area expertise to strengthen care coordination opportunities between the PCMH and the Medical-Health Neighborhood.

Through the RCs, stakeholders in each region will be brought together to bring local area expertise to ensure that the SHIP Model is responsive to community and regional needs and characteristics.



PCMH Transformation Support

The Role of RCs

- RCs have been established for in seven regions and will have a general membership of PCMHs and the key participants of the Medical-Health Neighborhood.
- RCs have a Regional Collaborative Executive Leadership Committee (RCE) that includes a Chair, Co-Chair, the PHD Director, and the SHIP Manager to lead the RCs' efforts and communicate with the IHC to share information about each region.
- RCs will link the PCMHs to the broader Medical-Health Neighborhood to facilitate coordinated patient care through the entire provider community and with other services needed to support the whole person.

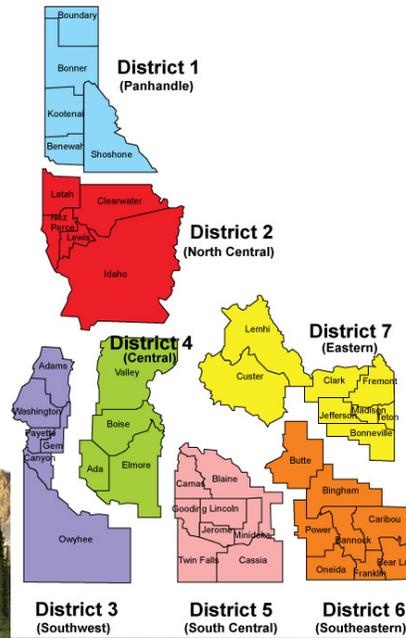
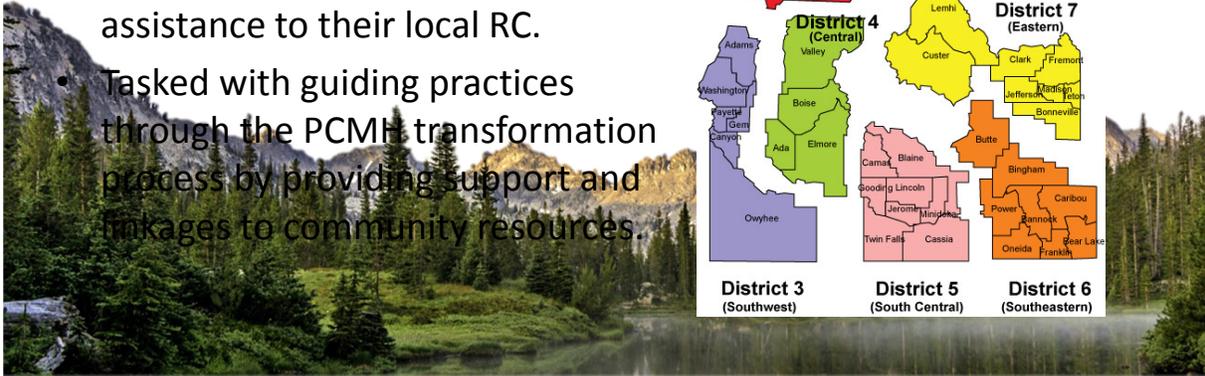


PCMH Transformation Support

Public Health District (PHD)

The seven PHDs in Idaho play an important role in facilitating healthcare system transformation.

- Designated as the convener of the Regional Health Collaboratives (RCs) and providing supports and assistance to their local RC.
- Tasked with guiding practices through the PCMH transformation process by providing support and linkages to community resources.



PCMH Transformation Support

Briljent and its Subcontractors

Briljent and its subcontractors, Health Management Associates (HMA) and Myers & Stauffer will provide training, learning collaboratives, on-site assistance, and additional support to practices.





State of the PCMH



State of the PCMH

To date, 55 clinics have gone through the PCMH transformation process.

The Complete list can be found at:

SHIP.idaho.gov/PCMH





State of the PCMH

Practices selected for Model Test Year 1 Implementation

Region 1 (7 clinics)

Benewah Medical
Heritage Health Kellogg
Heritage Health TBD
Family Health Center
Kaniksu - Ponderay
Kaniksu – Sandpoint Peds
Mountain Health Care

Region 2 (5 clinics)

CHAS Latah
St. Mary's Cottonwood
St. Mary's Kamiah
Valley Medical Center
Orofino Health Center



State of the PCMH

Practices selected for Model Test Year 1 Implementation

Region 3 (10 clinics)

Adam County Health
Primary Health Medical Group (Nampa, Caldwell)
Valley Health Center
Valley Family HC
St. Lukes (Nampa Greenhearst)
SAMG - Elm
Terry Reilly (Homedale, Marsing, Nampa)

Region 4 (15 clinics)

Desert Sage Health
FMRI (Raymond, Meridian, Emerald)
Glenns Ferry Health
Primary Health (Overland, Peds, West Boise)
SAMG (Eagle, McMillan, Overland)
St Lukes (Cloverdale, Payette Lakes)
Sonshine Family Health
Terry Reilly (Boise 23rd St)





State of the PCMH

Practices selected for Model Test Year 1 Implementation

Region 5 (4 clinics)

- Crosspointe Family Services
- Family Health Services (Kimberly)
- Family Health Services (Twin Falls)
- Family Health Center
- Shoshone Family Medical

Region 6 (6 clinics)

- Health West (Aberdeen, American Falls, Pocatello)
- Not-tsoo Gah-nee IHC
- Pocatello Children's
- Portneuf Primary Care



State of the PCMH

Practices selected for Model Test Year 1 Implementation

Region 7 (8 clinics)

- Complete Family Care
- Driggs Health
- Family First Medial
- Tueller Counseling
- Rocky Mountain Diabetes
- Madison Memorial Rexburg
- Victor Health Clinic
- Upper Valley Community





How to Prepare for the Upcoming Enrollment Period for Model Test Year 2 Implementation

The criteria for Cohort 2 has not been established yet but some activities to strengthen your practices experience include:

- Participate another improvement initiative available in your region (e.g. H2N Program)
- Reach out to your local PHD SHIP staff to learn more about support opportunities
- Get involved with your local RC
- Complete a SHIP interest application (August 2016)



Contact Information



NAME

Title

Phone

Email

WEBSITE



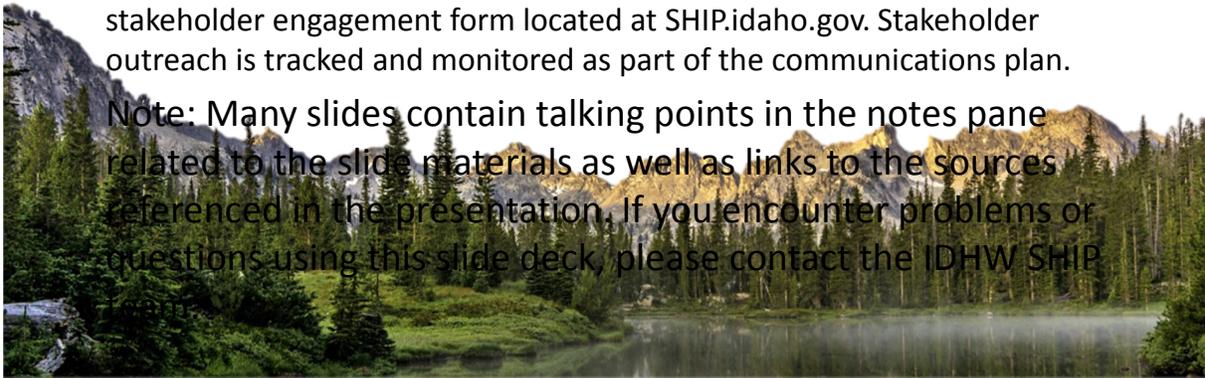


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Instructions: The following slide deck has been provided to assist in communication with targeted audience(s). Slides may be **removed** as needed by the presenter with an additional review requirement. Any materials **added** to the deck (related to SHIP) require approval prior to presentation. Please email the materials to OHPI@dhw.idaho.gov at least 2 business days before your presentation.

Upon completion of your presentation, please complete the stakeholder engagement form located at SHIP.idaho.gov. Stakeholder outreach is tracked and monitored as part of the communications plan.

Note: Many slides contain talking points in the notes pane related to the slide materials as well as links to the sources referenced in the presentation. If you encounter problems or questions using this slide deck, please contact the IDHW SHIP Team.





Presentation Topics

1. Healthcare Transformation in Idaho

- Patient-Centered Medical Home (PCMH) Primer
- PCMH Background
- Statewide Healthcare Innovation Plan (SHIP) Background
- Impact of Transformation

2. Clarifying Misconceptions

3. SHIP Model Goals and the Triple Aim



Healthcare Transformation in Idaho

Patient-Centered Medical Home (PCMH) Primer

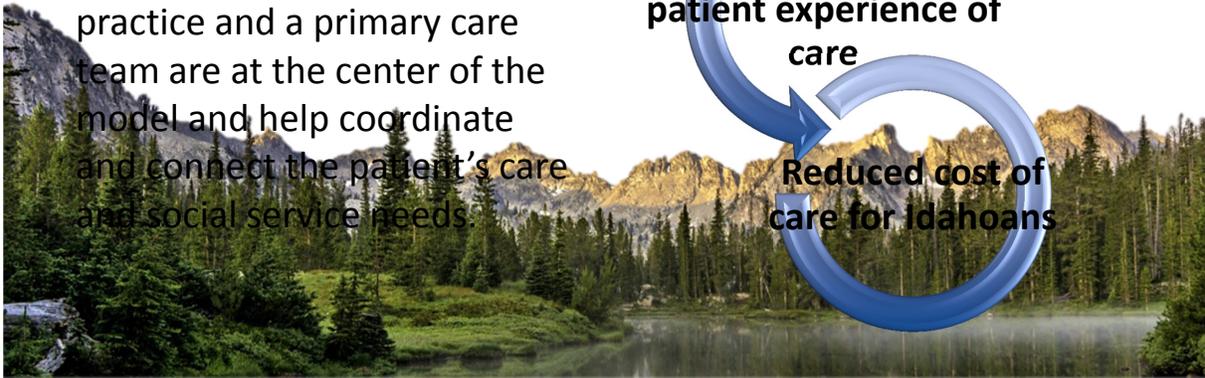




Healthcare Transformation in Idaho

PCMH Primer—What is a PCMH?

A **Patient-Centered Medical Home (PCMH)** is a model of care that uses care coordination to transform primary care. A primary care practice and a primary care team are at the center of the model and help coordinate and connect the patient's care and social service needs.



Healthcare Transformation in Idaho

PCMH Primer—What is a Virtual PCMH?

A **Virtual PCMH** is an Idaho-specific PCMH model that is used to help address health care needs in rural and underserved areas. The virtual PCMH delivery system used to provide access to the PCMH model for residents of rural, underserved areas incorporates:

- Community health workers (CHWs)
- Community health emergency medical services (CHEMS)
- Telehealth





Healthcare Transformation in Idaho

PCMH Primer—What is the Medical-Health Neighborhood?

The **Medical-Health Neighborhood** is the clinical-community partnership that includes the medical, social, and public health supports necessary to enhance health and the prevention of disease.

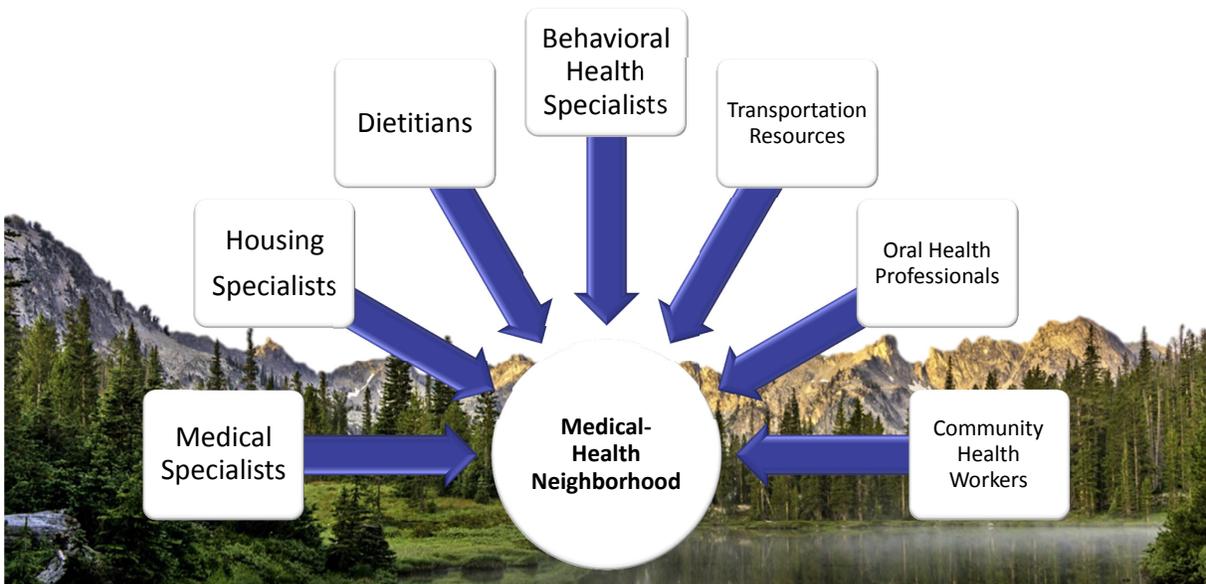
The PCMH serves as the patient's primary "hub" and coordinator of healthcare delivery, with a focus on prevention and wellness within the context of services available outside the clinic setting.



Healthcare Transformation in Idaho

PCMH Primer—What is the Medical-Health Neighborhood?

The **Medical-Health Neighborhood** can include:





Healthcare Transformation in Idaho

PCMH Primer—What is a Regional Health Collaborative (RC)?

The **RC** is a regional body comprised of local representatives from PCMHs and the Medical-Health Neighborhood that will facilitate development of the Medical-Health Neighborhood.

RCs will contribute local area expertise to strengthen care coordination opportunities between the PCMH and the Medical-Health Neighborhood.

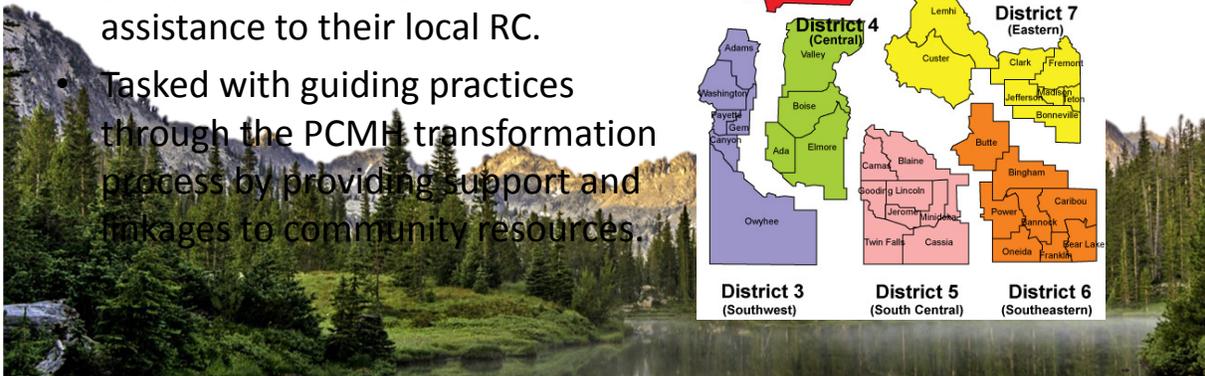
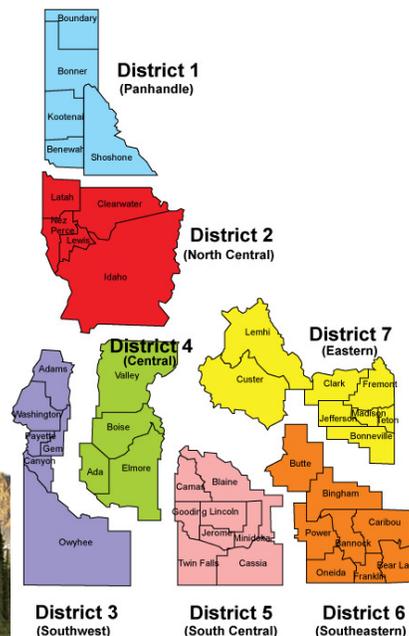


Healthcare Transformation in Idaho

PCMH Primer—What is a Regional Health Collaborative (RC)?

The seven PHDs in Idaho play an important role in facilitating healthcare system transformation.

- Designated as the convener of the Regional Health Collaboratives (RCs) and providing supports and assistance to their local RC.
- Tasked with guiding practices through the PCMH transformation process by providing support and linkages to community resources.





Healthcare Transformation in Idaho

PCMH Background



Healthcare Transformation in Idaho

PCMH Background—Origins of the PCMH Model in Idaho

- In 2010, Governor Otter established the Idaho Medical Home Collaborative (IMHC) — a collaboration of primary care physicians, private health insurers, healthcare organizations, and Idaho Medicaid — to promote the statewide development and implementation of a PCMH model of care.
- The IMHC pilot was a unique Idaho initiative that began in January 2013 and transformed 36 primary care practices in Idaho into PCMHs that served 9,000 patients with chronic conditions.





Healthcare Transformation in Idaho

PCMH Background—Origins of the PCMH Model in Idaho

The IMHC pilot was shown to:

- ✓ Improve care for its patient population.
- ✓ Reduce care costs.



The IMHC PCMH pilot produced \$2.4 million in savings for Idaho's Medicaid program each year of the project.



Healthcare Transformation in Idaho

PCMH Background—PCMH and Idaho's Statewide Healthcare Transformation Plan (SHIP)

The proven success of the PCMH model in Idaho is the reason it was chosen as the foundation for Idaho's Statewide Healthcare Transformation Plan(SHIP).



Success of
PCMH in
Idaho

PCMH as the
foundation
for Idaho's
SHIP



Healthcare Transformation in Idaho

Statewide Healthcare Innovation Plan (SHIP) Background

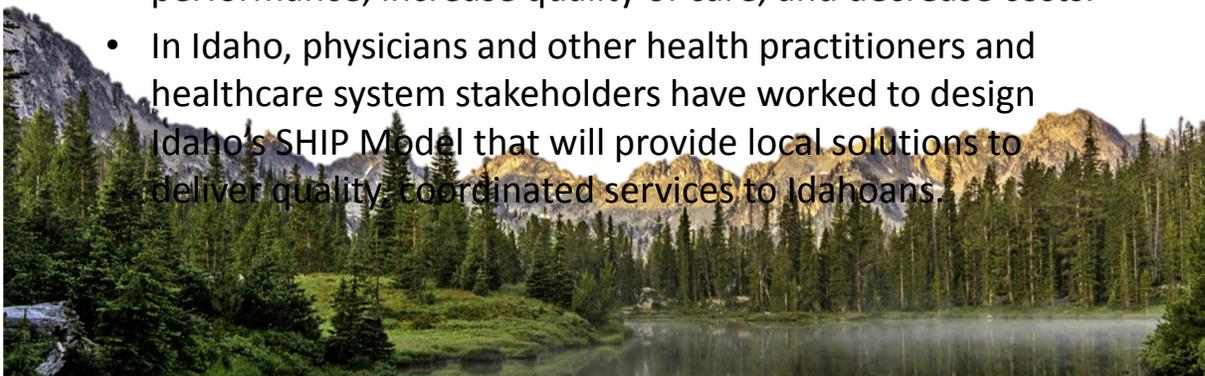


Healthcare Transformation in Idaho

SHIP Background-What is SHIP?

The Center for Medicare and Medicaid Innovations (CMMI) is providing states with grants to develop and test state-driven health transformation initiatives through the Statewide Healthcare Innovation Plan, the “SHIP.”

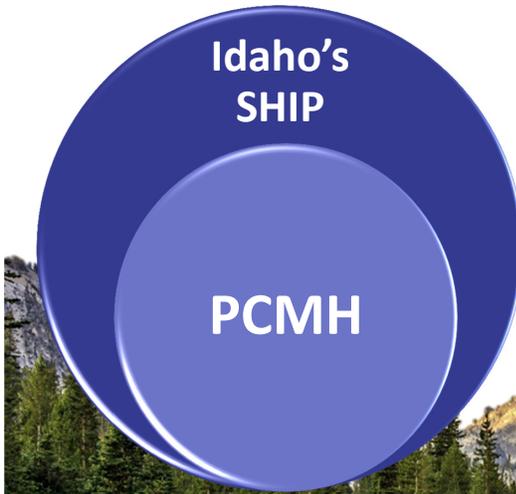
- The SHIP is intended to improve health system performance, increase quality of care, and decrease costs.
- In Idaho, physicians and other health practitioners and healthcare system stakeholders have worked to design Idaho's SHIP Model that will provide local solutions to deliver quality, coordinated services to Idahoans.





Healthcare Transformation in Idaho

SHIP Background—SHIP is more than PCMHs



Idaho's SHIP Model also includes:

- ✓ Assessments and activities to improve community health.
- ✓ Expanding the use of health information technology (HIT) among providers around Idaho.
- ✓ Changing reimbursement to reward value over volume of care through value-based reimbursement.



Healthcare Transformation in Idaho

SHIP Background—What are value-based payments?

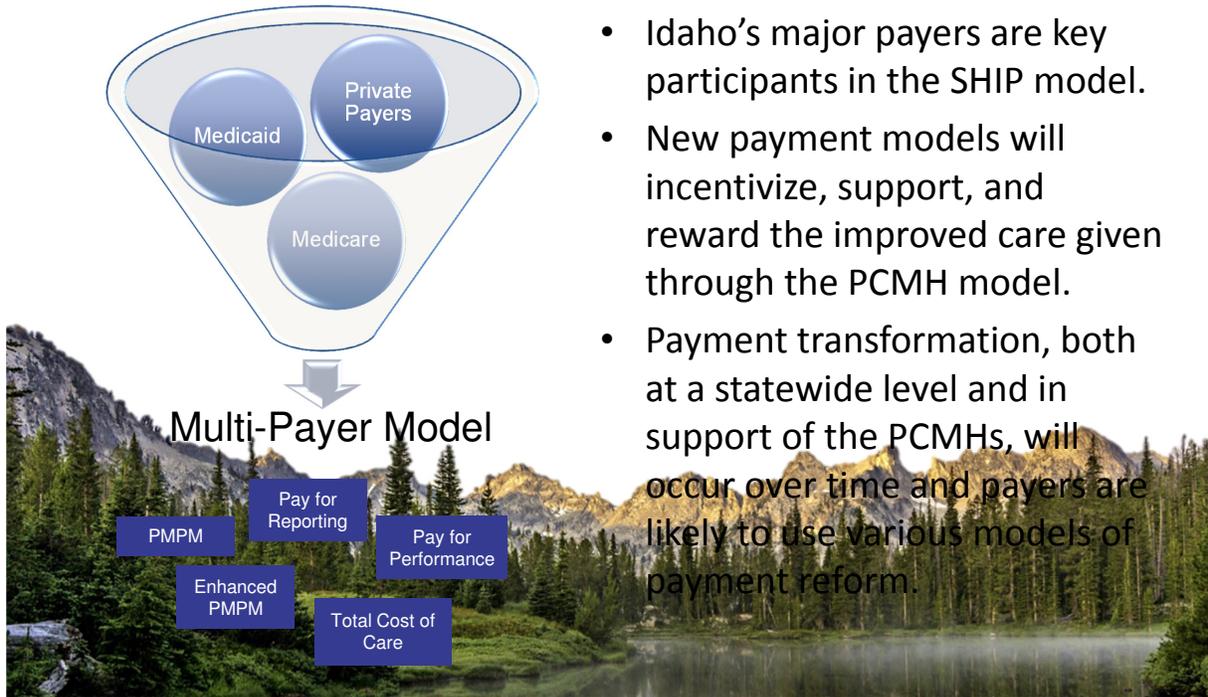
Care reimbursement will shift from fee-for-service (FFS) — where care reimbursement is based on quantity — to “value-based payments.”





Healthcare Transformation in Idaho

SHIP Background—Value-Based Payments

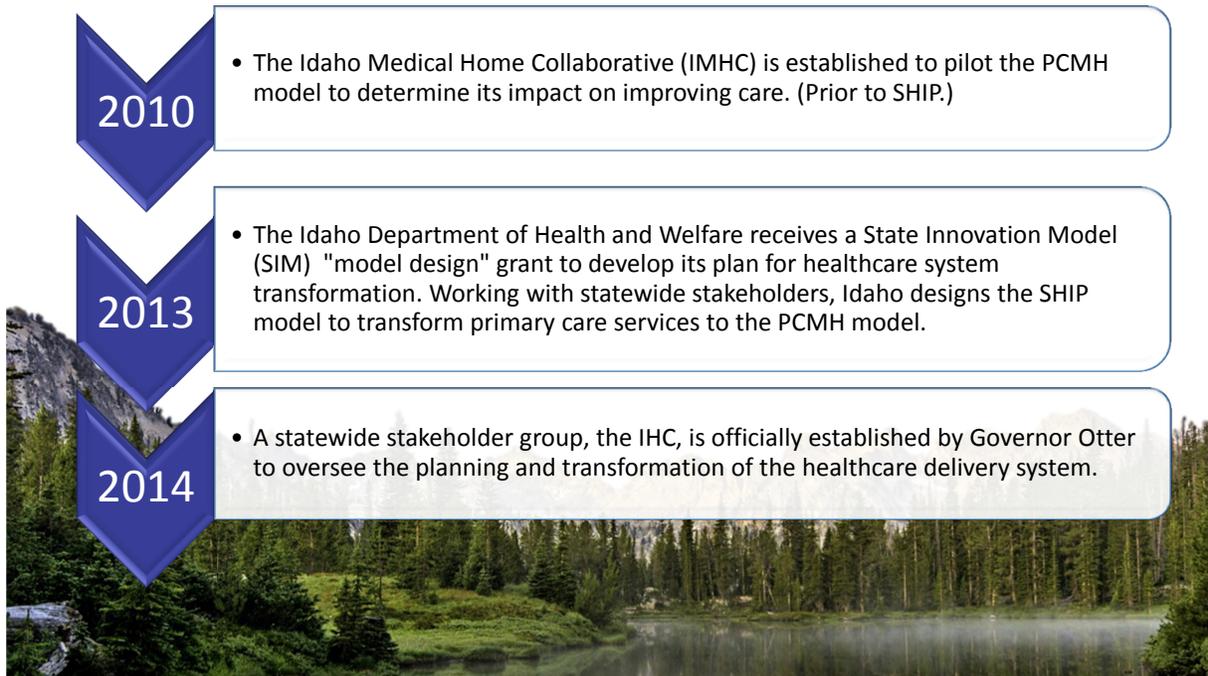


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- Payment transformation, both at a statewide level and in support of the PCMHs, will occur over time and payers are likely to use various models of payment reform.



Healthcare Transformation in Idaho

SHIP Background—Implementation Timeline





Healthcare Transformation in Idaho

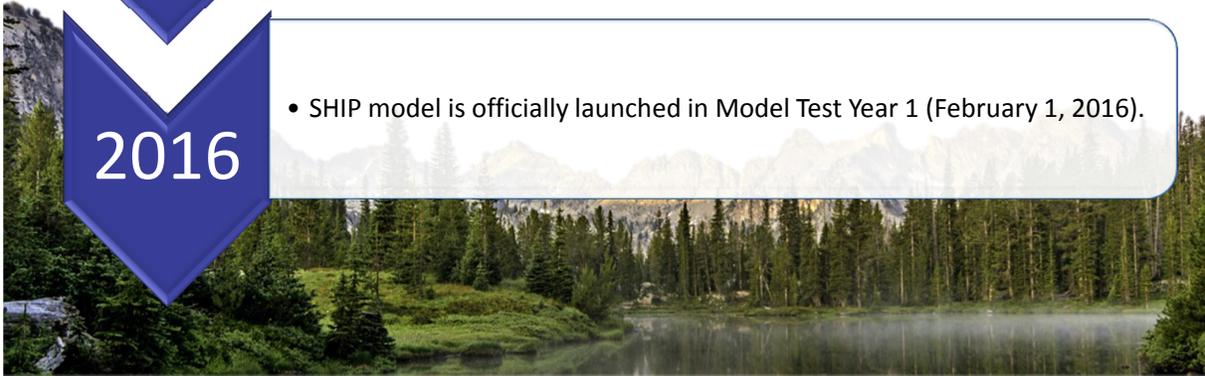
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2015

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- 55 primary care practices are selected to participate in the first year of implementation of the SHIP model.

2016

- SHIP model is officially launched in Model Test Year 1 (February 1, 2016).



Healthcare Transformation in Idaho

Impact of Transformation

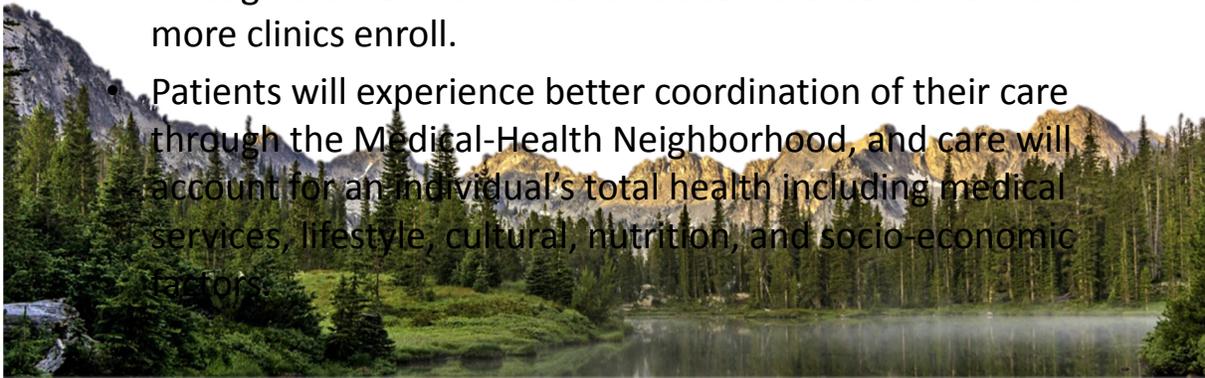




Healthcare Transformation in Idaho

Impact on Idaho's Providers and Patients

- As of February 2016, 55 clinics have enrolled as PCMHs. 165 primary care practices will be enrolled the Idaho SHIP Model over the next three years (February 1, 2016 – January 31, 2019).
- The number of patients receiving better coordinated care through the PCMHs will continue to increase as more and more clinics enroll.
- Patients will experience better coordination of their care through the Medical-Health Neighborhood, and care will account for an individual's total health including medical services, lifestyle, cultural, nutrition, and socio-economic factors.

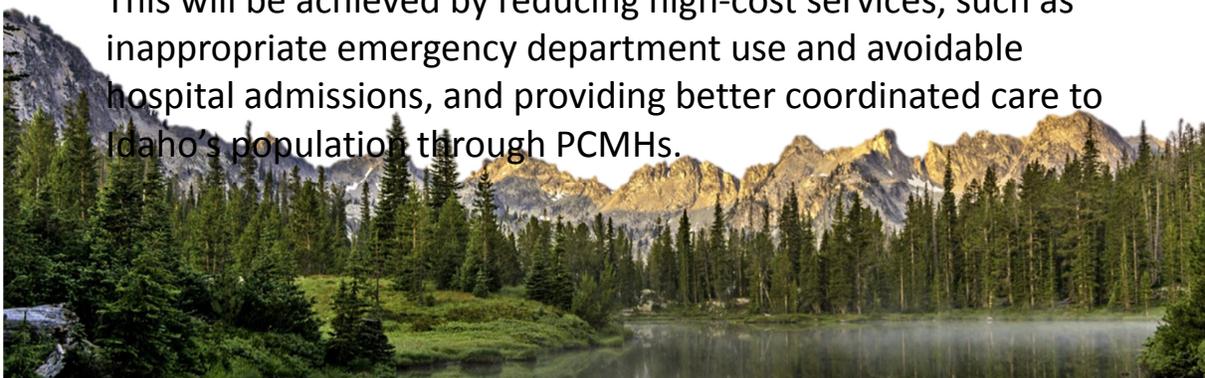


Healthcare Transformation in Idaho

Impact on Idaho's Finances

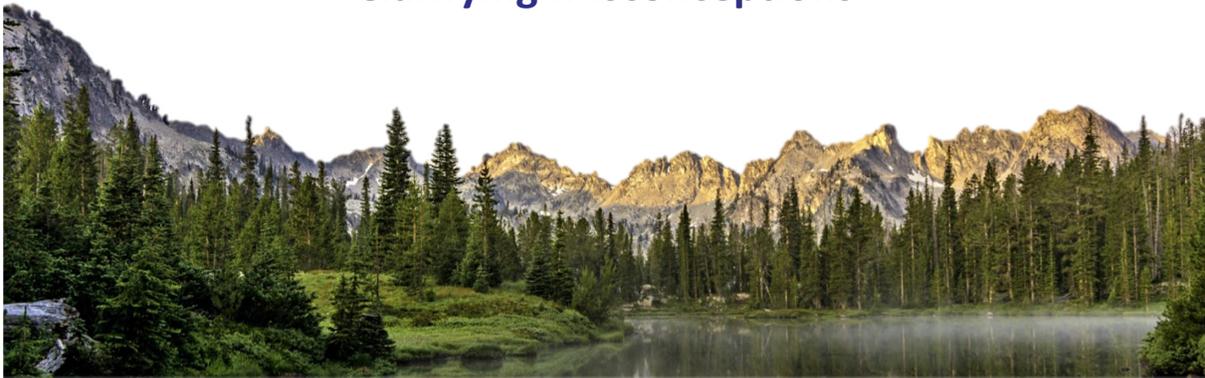
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This will be achieved by reducing high-cost services, such as inappropriate emergency department use and avoidable hospital admissions, and providing better coordinated care to Idaho's population through PCMHs.





Clarifying Misconceptions



Clarifying Misconceptions

The SHIP Model
is **DEFINITELY**
NOT:



Medicaid expansion

OR



A federally-
mandated program





Clarifying Misconceptions

The SHIP Model
DEFINITELY IS:



A homegrown healthcare reform initiative that addresses the unique needs of Idaho's diverse communities.



A healthcare reform initiative that was developed with input from a wide range of stakeholders from around the state.



SHIP Model Goals and the Triple Aim





SHIP Model Goals and the Triple Aim

Idaho's SHIP Model is supported by seven goals. These goals and the overall SHIP Model are rooted in the "Triple Aim."



SHIP Model Goals and the Triple Aim

Goal 1

Goal 1

Transform primary care practices across the State into patient-centered medical homes (PCMHs).

Outcomes



Quality of patient care will improve through PCMH coordinated care.



Savings will be generated through more efficient, value-based care.





SHIP Model Goals and the Triple Aim

Goal 2

Goal 2

Improve care coordination through the use of electronic health records (EHRs) and health data connections among PCMHs and across the Medical-Health Neighborhoods.

Outcomes



Increased the use of electronic health records (EHRs).



Increased number of Idahoans who have a EHR to improve care coordination.



Increased health information technology (HIT) adoption and use by ID hospitals.



SHIP Model Goals and the Triple Aim

Goal 3

Goal 3

Establish seven Regional Health Collaboratives to support the integration of each PCMH with the broader Medical-Health Neighborhood.

Outcomes



Increased coordination between PCMHs and the Medical-Health Neighborhood.



Improved coordination of patient care.





SHIP Model Goals and the Triple Aim

Goal 4

Goal 4

Improve rural patient access to PCMHs by developing Virtual PCMHs.



Outcomes



Better access to care coordination for individuals in rural and underserved communities.



Development of CEMS to provide primary care and preventative services to patients in rural areas.



SHIP Model Goals and the Triple Aim

Goal 5

Goal 5

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



Outcome



Improved data collection, reporting, and tracking of Idaho-specific quality measures.



SHIP Model Goals and the Triple Aim

Goal 6

Goal 6

Align payment mechanisms across payers to transform payment methodology from volume to value.



Outcome

Payers contract with PCMH practices to receive alternative reimbursements that support quality, value-driven care.



SHIP Model Goals and the Triple Aim

Goal 7

Goal 7

Reduce overall healthcare costs.



Outcome

Generate savings of \$89M and a return on investment of 225%.





Contact Information



NAME

Title

Phone

Email

WEBSITE



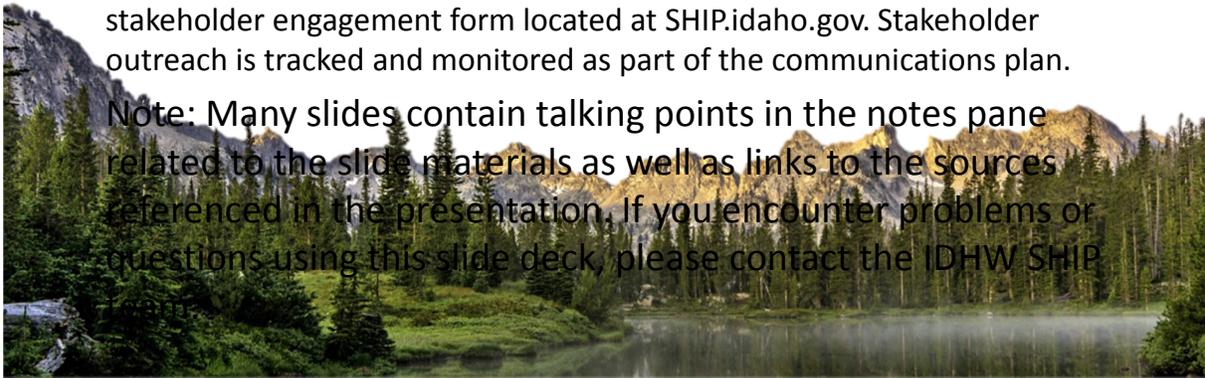


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Upon completion of your presentation, please complete the stakeholder engagement form located at SHIP.idaho.gov. Stakeholder outreach is tracked and monitored as part of the communications plan.

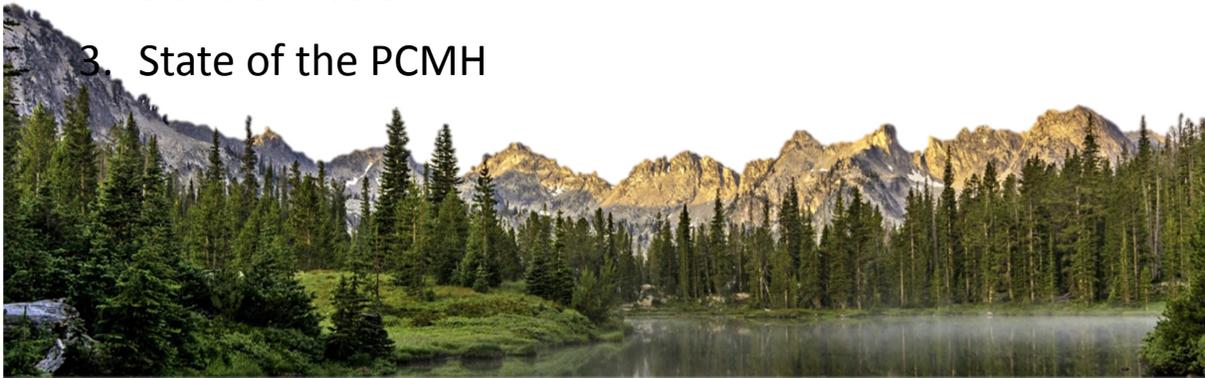
Note: Many slides contain talking points in the notes pane related to the slide materials as well as links to the sources referenced in the presentation. If you encounter problems or questions using this slide deck, please contact the IDHW SHIP Team.





Presentation Topics

1. Introduction of Statewide Healthcare Innovation Plan (SHIP) Model
2. Regional support for healthcare system transformation
3. State of the PCMH



Introduction of Statewide Healthcare Innovation Plan (SHIP) Model





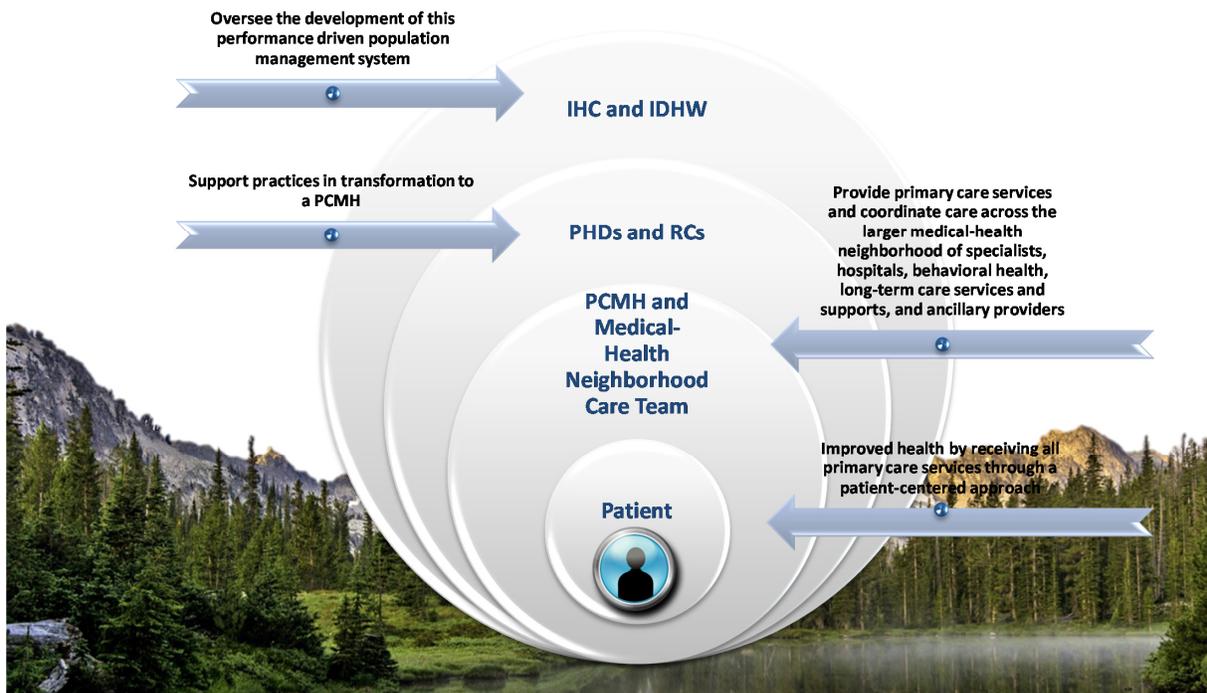
Idaho's SHIP Model

The Idaho SHIP is a statewide healthcare innovation plan that aims to **improve health outcomes, improve quality and patient experience of care, and lower cost of care for Idahoans**. Physicians, medical specialists, other health practitioners, community organizations, and healthcare system stakeholders have worked to design a care delivery model that will provide quality, coordinated services to Idahoans. Private payers and Medicaid are working together to design healthcare reimbursement methods that pay providers for keeping people healthy.

Idaho's SHIP model establishes the patient-centered medical home (PCMH) model as the foundation for primary care services, integrates primary care services within the local Medical-Health Neighborhood, and uses value-based payment methods to support the model.



Idaho's SHIP Model Healthcare Delivery System and Supports





Plan for Successful Healthcare System Transformation

Seven SHIP Goals to Achieve the Triple Aim

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-health neighborhoods.

Goal 3: Establish seven Regional Health Collaboratives to support the integration of each PCMH with the broader medical-health 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.



The PCMH Model of Care

Many benefits for patients and practitioners.

Evidence that the model inspires quality in care, cultivates more engaging patient relationships, and saves money.

Proven success in Idaho in both outcomes and cost.



Idaho's SHIP Model

The Medical-Health Neighborhood

The **Medical-Health Neighborhood** is the clinical-community partnership that includes the medical, social, and public health supports necessary to enhance health and the prevention of disease.

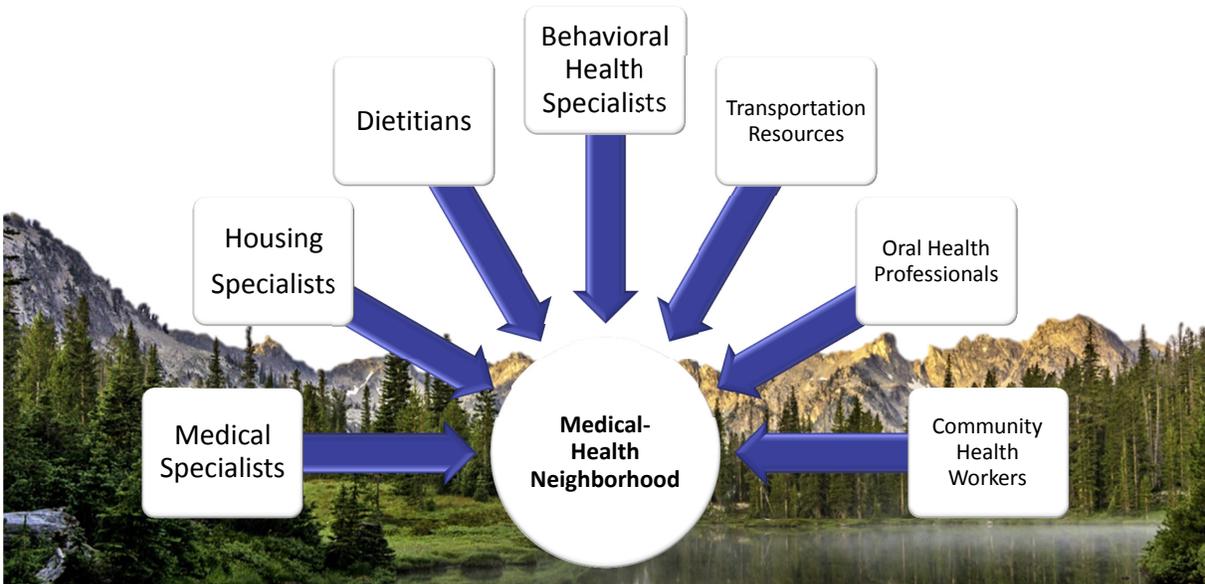
The PCMH serves as the patient's primary "hub" and coordinator of healthcare delivery, with a focus on prevention and wellness within the context of services available outside the clinic setting.



Idaho's SHIP Model

The Medical-Health Neighborhood

The **Medical-Health Neighborhood** can include:

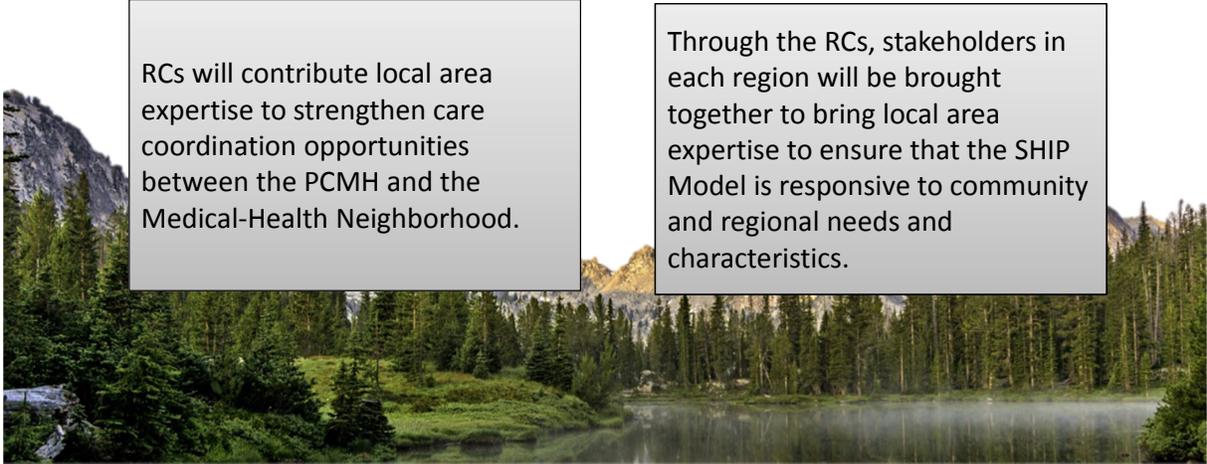




Idaho SHIP Model

Regional Health Collaborative (RC)

The **RC** is a regional body comprised of local representatives from PCMHs and the Medical-Health Neighborhood that will facilitate development of the Medical-Health Neighborhood.

A scenic landscape photograph showing a calm lake in the foreground, surrounded by dense evergreen forests. In the background, rugged mountains rise under a clear sky.

RCs will contribute local area expertise to strengthen care coordination opportunities between the PCMH and the Medical-Health Neighborhood.

Through the RCs, stakeholders in each region will be brought together to bring local area expertise to ensure that the SHIP Model is responsive to community and regional needs and characteristics.



Idaho's SHIP Model

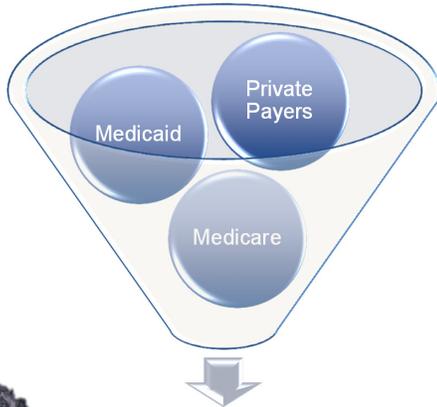
Regional Health Collaboratives

- RCs have been established in seven regions and will have a general membership of PCMHs and key participants of the Medical-Health Neighborhood.
- RCs have a Regional Collaborative Executive Leadership Committee (RCE) that includes a Chair, Co-Chair, the PHD Director, and the SHIP Manager to lead the RCs' efforts and communicate with the IHC to share information about each region.
- RCs, with support from the PHDs, will link the PCMHs to the broader Medical-Health Neighborhood to facilitate coordinated patient care through the entire provider community and with other services needed to support the whole person.



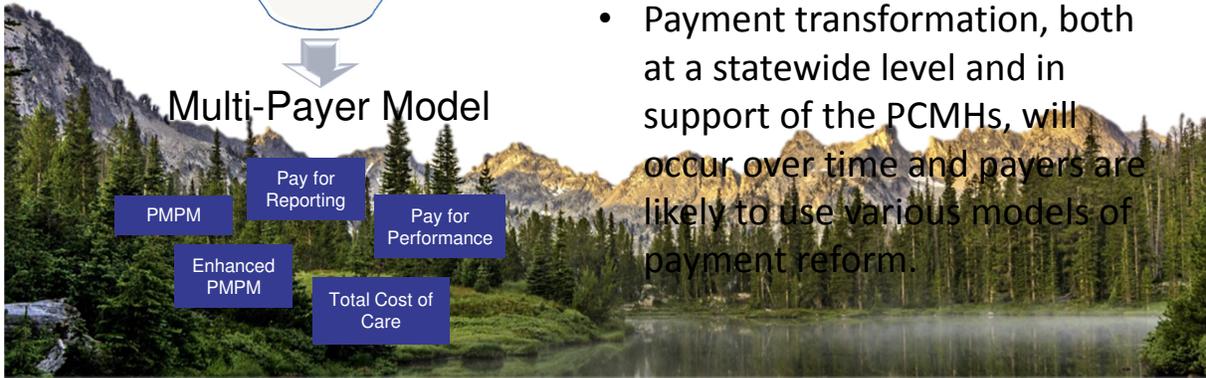
Idaho's SHIP Model

Value-based Payment Methods to Support the Model

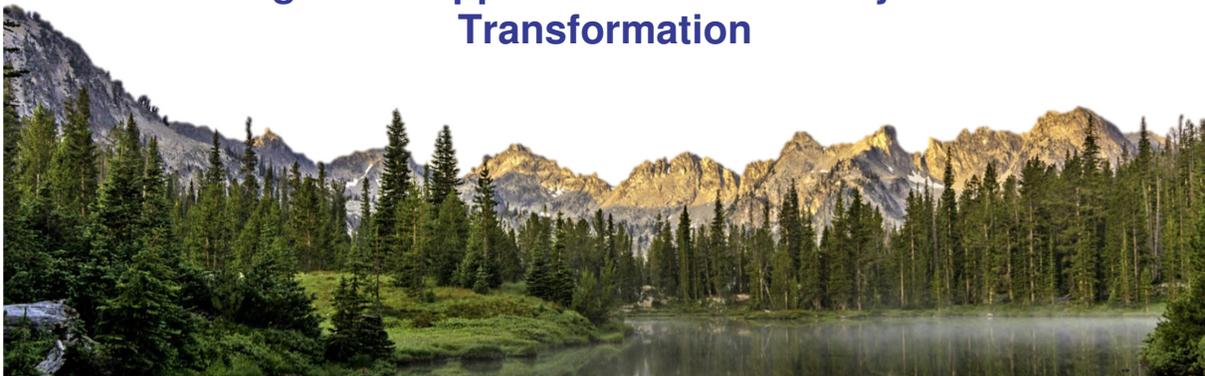


- Idaho's major payers are key participants in the SHIP model.
- New payment models will incentivize, support, and reward the improved care given through the PCMH model.
- Payment transformation, both at a statewide level and in support of the PCMHs, will occur over time and payers are likely to use various models of payment reform.

Multi-Payer Model



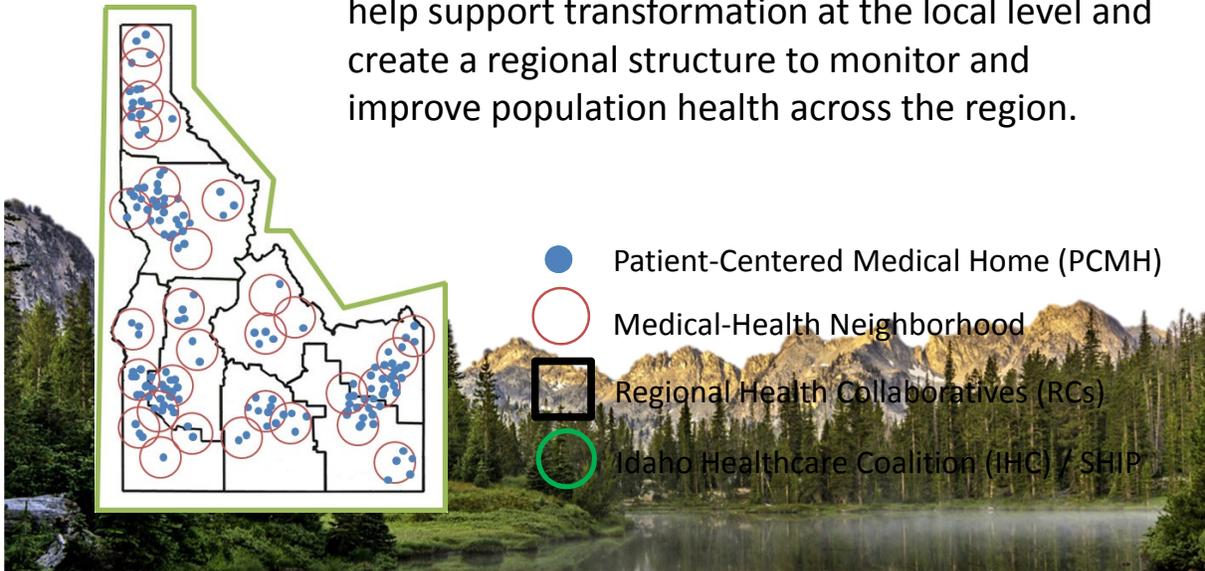
Regional Support for Healthcare System Transformation





Role of RCs in Idaho's Health System Transformation

Seven RCs have been established statewide to help support transformation at the local level and create a regional structure to monitor and improve population health across the region.



Role of RCs in Idaho's Health System Transformation

RCs will:

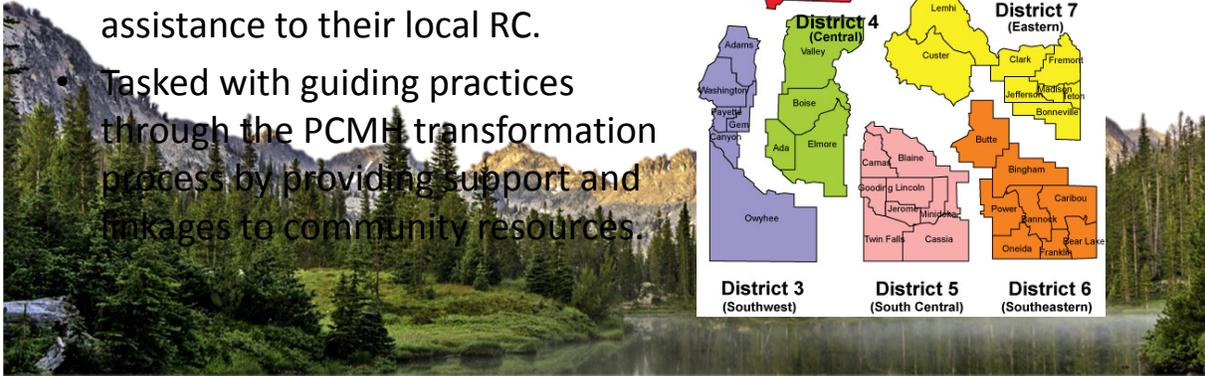
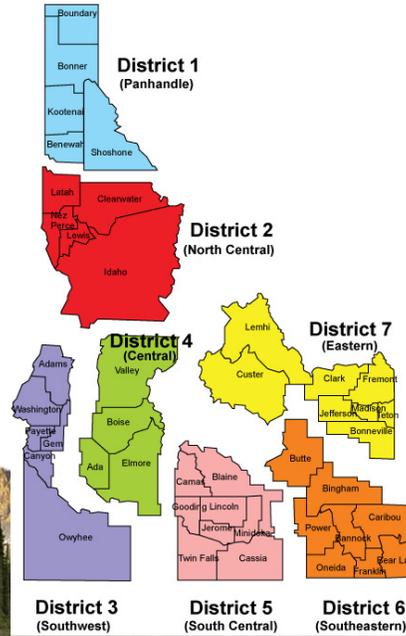
- 1) Link the PCMHs to the broader Medical-Health Neighborhood to support coordinated care.
- 2) Convene a RCE with direct input to the IHC through the PHD directors and RC chairs so regional and local concerns can be raised at the state level.
- 3) Support the PCMHs in activities to transform and improve access to healthcare services in rural and underserved communities with limited healthcare resources.
- 4) Ensure that public health initiatives, such as Community Health Workers (CHWs) and Community Health EMS (CHEMS), become an asset for the Medical-Health Neighborhoods where gaps in services exist.
- 5) Serve as the public health/physical health integrator in local communities and identify local population health needs.



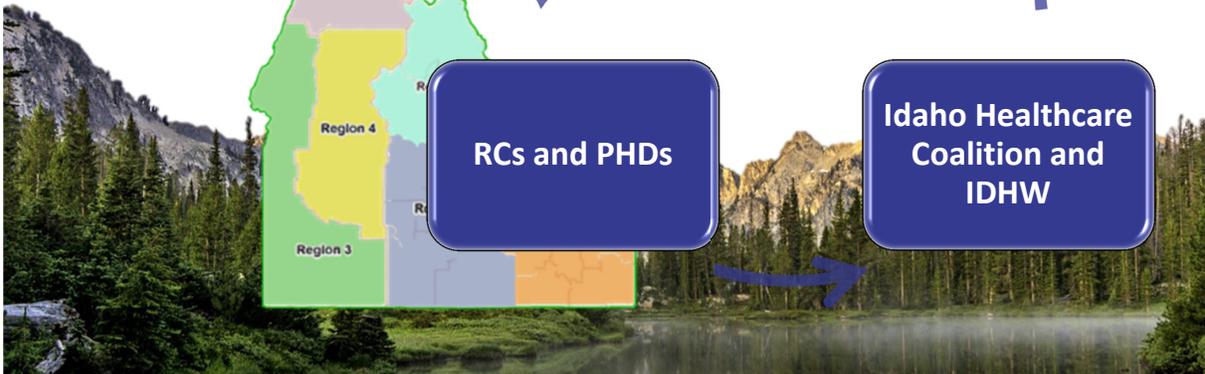
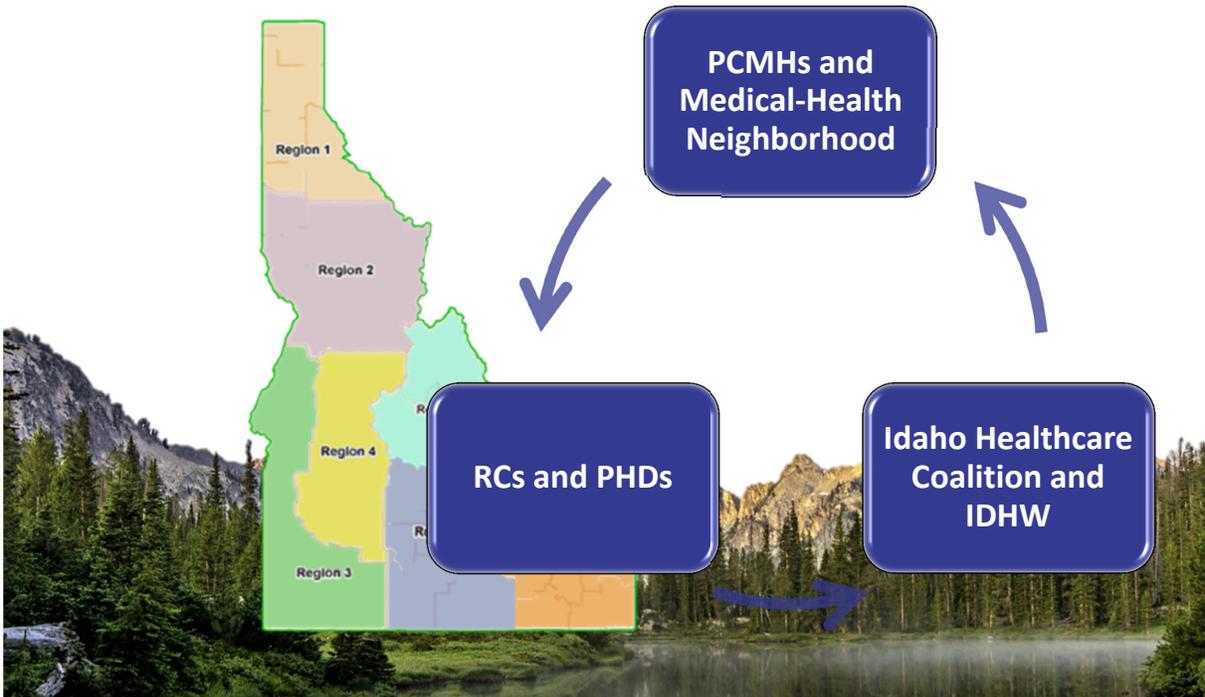
Role of the Public Health Districts

The seven PHDs in Idaho play an important role in facilitating healthcare system transformation.

- Designated as the convener of the Regional Health Collaboratives (RCs) and providing supports and assistance to their local RC.
- Tasked with guiding practices through the PCMH transformation process by providing support and linkages to community resources.



Path to Statewide Healthcare System Transformation





State of the PCMH



State of the PCMH

To date, 55 clinics have gone through the PCMH transformation process.



The Complete list can be found at:

SHIP.idaho.gov/PCMH





State of the PCMH

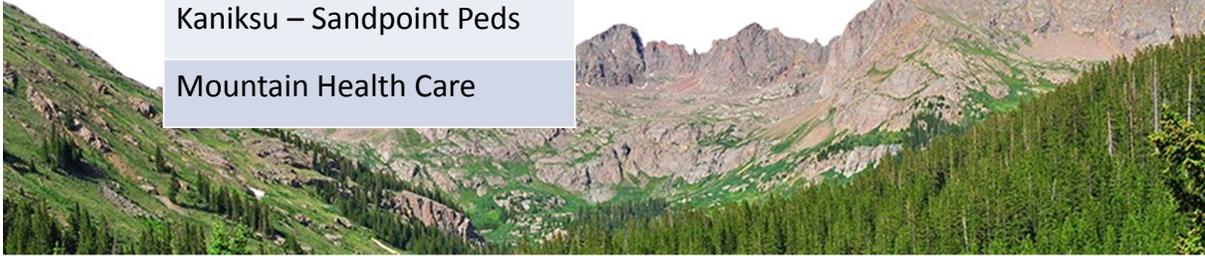
Practices selected for Model Test Year 1 Implementation

Region 1 (7 clinics)

Benewah Medical
Heritage Health Kellogg
Heritage Health TBD
Family Health Center
Kaniksu - Ponderay
Kaniksu – Sandpoint Peds
Mountain Health Care

Region 2 (5 clinics)

CHAS Latah
St. Mary's Cottonwood
St. Mary's Kamiah
Valley Medical Center
Orofino Health Center



State of the PCMH

Practices selected for Model Test Year 1 Implementation

Region 3 (10 clinics)

Adam County Health
Primary Health Medical Group (Nampa, Caldwell)
Valley Health Center
Valley Family HC
St. Lukes (Nampa Greenhearst)
SAMG - Elm
Terry Reilly (Homedale, Marsing, Nampa)

Region 4 (15 clinics)

Desert Sage Health
FMRI (Raymond, Meridian, Emerald)
Glenns Ferry Health
Primary Health (Overland, Peds, West Boise)
SAMG (Eagle, McMillan, Overland)
St Lukes (Cloverdale, Payette Lakes)
Sonshine Family Health
Terry Reilly (Boise 23rd St)





State of the PCMH

Practices selected for Model Test Year 1 Implementation

Region 5 (4 clinics)

Crosspointe Family Services

Family Health Services
(Kimberly)

Family Health Services
(Twin Falls)

Family Health Center

Shoshone Family Medical

Region 6 (6 clinics)

Health West (Aberdeen,
American Falls, Pocatello)

Not-tsoo Gah-nee IHC

Pocatello Children's

Portneuf Primary Care



State of the PCMH

Practices selected for Model Test Year 1 Implementation

Region 7 (8 clinics)

Complete Family Care

Driggs Health

Family First Medial

Tueller Counseling

Rocky Mountain Diabetes

Madison Memorial Rexburg

Victor Health Clinic

Upper Valley Community





Information on Local RC



[RC Name to be inserted]

**Placeholder for information to be completed
by local RC.**

Section may be removed if unnecessary





Contact Information



NAME

Title

Phone

Email

WEBSITE





SHIP Operations and IHC Workgroup Report to the Idaho Healthcare Coalition February 10, 2016

SHIP OPERATIONS:

SHIP Staffing:

- **Report Items:**

- Alexa Wilson joined the SHIP team on February 1, 2016 filling the vacant Administrative Assistant 2 position. Alexa is a BSU graduate with an undergraduate degree in Psychology and will be pursuing a Master's degree in the near future. In addition to the administrative skills needed for this position, she has experience in meeting and event planning. Alexa is a welcome addition to the SHIP's fully staffed team.

SHIP Contracting/Request for Proposal (RFP) Status:

- **Report Items:**

- The contract review process has begun with the newly selected Data Analytics Contractor, Healthtech Solutions, LLC. Burke Jensen, HIT Project Manager is working with Healthtech to develop contract kick off date and time, content, and next steps for Goal 5, data analytics implementation.
- The State Evaluator proposals have been scored and evaluated. Anticipated award is mid to end of March.
- Year 2 Funding (for Model Test Year 1) from CMMI has been approved. The following technical assistance contracts have been approved or are in the final phases of approval: 1) Mercer, LLC Project Management and Financial Analysis Contract, 2) Brilljent, LLC, PCMH Transformation Contract, and 3) Ada County Paramedics CHEMS contract for the provision of technical assistance and subject matter expertise for the CHEMS Outcome Measures Workgroup. Other technical contracts are under development and as soon as scopes of work are finalized; requests for release of funding will be submitted to CMMI.

Joint Finance and Appropriations Committee (JFAC):

- **Report Items:**

- On January 19, 2016, Cynthia York, the Office of Healthcare Policy Initiatives Program Administrator presented a SHIP update JFAC. Her presentation included a request for spending authority of the federal funds for the SHIP grant.

Regional Health Collaboratives (RC):

- **Report Items:**

- Public Health District staff is actively preparing for the PCMH work with the first cohort of selected clinics.
- The Regional Health Collaboratives have been meeting across the State.

- On February 29 and March 1, the PCMH contractor will conduct a learning collaborative in Boise to prepare and train PHD staff, and March 2 and 3 to train participating clinics in PCMH transformation.
- **Next Steps:**
 - Continue supporting establishment of functioning Regional Collaboratives.
 - Continue coordinating PHDs effort with other programs and entities.

ADVISORY GROUP REPORTS:



Telehealth SHIP Subcommittee:

- **Report Items:**
 - Met twice to review and discuss the Telehealth subcommittee planning summary.
 - Created a Telehealth Council Goal 2 Subcommittee web page on the SHIP website, and summary for the subcommittee.
- **Next Steps:**
 - The Telehealth subcommittee will present this summary to the IHC.
 - Request approval from the IHC for the one-page Telehealth expansion plan overview.
 - Create a Telehealth assessment tool for CHEMS providers.



Community Health Workers:

- **Report Items:**
 - CHW Workgroup met with Idaho State University representatives to begin discussions on curriculum adoption and training delivery.
 - CHW Workgroup met with the Idaho Center of Excellence (ICE) Healthcare Partnership from North Idaho College and agreed in principle to have ICE develop additional elective online modules for CHW training.
- **Next Steps:**
 - The CHW Workgroup continues to engage stakeholders in soliciting best practices.
 - The CHW workgroup received materials from CMMI following a technical assistance request, and is exploring the possibility of having an outcome measures workshop in May.



Community Health EMS:

- **Report Items:**
 - The CHEMS Outcome Measures Design Workshop met on January 22nd, at the Best Western Inn at the Airport. Keynote speaker Matt Zavadsky, gave a presentation on measuring the value of CHEMS and how this can be done. More than 30 attendees were present representing EMS Agencies, Healthcare and Educational Institutions and various Government entities.

- The CHEMS workgroup was able to work together in developing potential measures for CHEMS. Required goals and points of alignment with SHIP were also addressed. The group plans to reconvene in the near future to establish these goals and measures.
- The contract with Idaho State University is in its final phase.
- CHEMS Advisory Group is collaborating with the Boise State University's Master of Public Health Program Evaluation class lead by Professor Sara Toevs to explore avenues to address sustainability.
- **Next Steps:**
 - Establish a common foundation for Idaho CHEMS across the State.
 - Identify preliminary CHEMS measures including corresponding collection and reporting mechanisms with an ultimate goal of demonstrating the value and impact of CHEMS programs.
 - Next meeting is scheduled for February 25th, 2016.

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:**
 - The HIT Workgroup met on January 21, 2016
 - Idaho Health Data Exchange (IHDE) provided the HIT workgroup with an update related to building connections to Medicaid and SHIP clinics. Medicaid's revised PMPM four tier system launched February.
 - The workgroup agreed to convene a subcommittee to begin to data element map the 16 clinical quality measures.
 - Scott Carrell has resigned as the HIT Workgroup Chair citing increased workload at IHDE and a need to remain fully engaged with the upcoming builds. His contributions since the beginning are appreciated
 - The Data Element Subcommittee met on February 3, 2016, with membership including HIT workgroup members, providers, payers and CQM Workgroup members.
 - The subcommittee began evaluating each of the 16 measures to determine the four metrics to measure in model test year 1 and how to data map each one.
- **Next Steps:**
 - Product demonstration by HealthTech Solutions at next HIT workgroup meeting

- Data element mapping subcommittee will continue to meet and advance their objectives
- Identification of two co-chairs to lead the HIT workgroup
- Engage with the CQM subcommittee as needed to address operationalizing clinical quality measures
- Next HIT workgroup meeting is February 18, 2016.

MPW Multi-Payer:

- **Report Item:**
 - The workgroup has not met since last report. SHIP staff is working with the workgroup chairs to develop an agenda based on the SHIP activities that have taken place since the last meeting. The next meeting will be held in March.

CQM Clinical/Quality Measures Quality Measures Workgroup:

- **Report Item:**
 - No meetings have been scheduled. Nothing to report at this time.

BHI Behavioral Health:

- **Report Item:**
 - The BHI Subcommittee met on Tuesday, January 5th, 2016
 - The committee reviewed the BHI Survey results, and provided feedback regarding results and discussed next steps for moving forward.
 - Gina Westcott met with the PCMH contractor Brilljent and HMA to discuss the survey findings. The committee will continue to work with the PCMH contractor to incorporate initiatives into Learning Collaborative opportunities.
 - The BHI Subcommittee also met on Tuesday, February 2nd, 2016
 - The committee reviewed and provided feedback for the final presentation to the IHC. Members of the established a workgroup to support a Behaviorist Peer to Peer Consultation model.
- **Next Steps:**
 - The committee decided to hold meetings every other month for the next six months.
 - The next meeting will be held on April 5th, 2016 at 1720 Westgate.

PHW Population Health:

- **Report Item:**
 - PHW met on February 3rd, 2016. Meeting highlights are listed below:
 - Karen Vauk presented on the Idaho Foodbank and how they are working with organizations across the state to ensure that every Idahoan with food insecurity issues are getting their needs met. They discussed some very innovative ways to integrate with healthcare. They are working with the Idaho Suicide Prevention Hotline as well as several other healthcare

facilities to ask two food insecurity questions of callers and patients, respectively. If it is determined that there are issues with obtaining food, a referral is made to a local food pantry. In some locations there is a partnership with the healthcare entity or health screening site to have a mobile food pantry available on site and in some food pantries, a mobile healthcare screening unit is brought in. The Idaho Foodbank also offers cooking classes and prescriptions for food boxes for use by healthcare providers.

- Deena Lajoie gave a presentation on the work that Idaho Academy of Nutrition and Dietetics is doing that aligns with population health and the PCMH transformation process of SHIP Cohort One clinics. The Academy has provided a name of a volunteer dietician to all of the SHIP Managers across the state to potentially serve on the RCs. They are sending introductory letters to all of the 55 practices in cohort one to describe how a dietician could be used as part of their healthcare team. They are also registering with the online tool developed by the Division of Public Health called the Idaho Wellness Guide that provides recourses focused on chronic disease prevention and management statewide.
- The Workgroup continues to develop a white paper on the concept of the Spectrum of Population Health which will be presented to the IHC for approval. Along with the discussion paper, a graphic depiction of the concept was created. This will all be revealed to the IHC in March.
- Work continues to secure the contract and develop the site for population health metrics. The site to be used is called the Network of Care. This will be demonstrated to the IHC when we have more information to provide. The foundation for the site is around the *Get Healthy Idaho: Measuring and Improving Population Health*.

- **Next Steps:**

- PHW will request IHC approval of a white paper on the Spectrum of Population Health at the March IHC meeting.
- Next meeting is scheduled for April 6th, 2016.