



Idaho Healthcare Coalition

Meeting Agenda

Wednesday, December 14, 1:30PM – 4:30PM

JRW Building (Hall of Mirrors)

1st Floor East Conference Room

700 W State Street, Boise, Idaho

Call-In Number: 1-877-820-7831; Participation Code: 302163

Attendee URL: <https://rap.dhw.idaho.gov/meeting/19688425/827ccb0eea8a706c4c34a16891f84e7b>

Attendee Smartphone URL:

<pulsesecure:///method=meeting&action=join&host=rap.dhw.idaho.gov&meetingid=19688425&signin=rap.dhw.idaho.gov%2Fmeeting%2F&stoken=827ccb0eea8a706c4c34a16891f84e7b>

Password: 12345

1:30 p.m. 10 minutes	Opening remarks, roll call, introduce any new members, guests, any new IDHW staff, agenda review, and approval of 11/9/2016 meeting notes – <i>Dr. Ted Epperly, IHC Chair</i> ACTION ITEM
1:40 p.m. 10 minutes	Idaho’s Lifespan Family Caregiver Action Plan - <i>Sarah Toevs, PhD, Professor Department of Community and Environment Health Boise State University</i>
1:50 p.m. 30 minutes	Proposed Idaho Healthcare Legislation – <i>Senator Steven Thayne</i>
2:20 p.m. 20 minutes	Announce Cohort Two Selection – <i>Kym Schreiber & Casey Moyer, SHIP Operations</i> ACTION ITEM
2:40 p.m. 5 minutes	RC Grant Process Update – <i>Elke Shaw-Tulloch, DHW, Population Health Workgroup Chair</i>
2:45 p.m. 15 minutes	Virtual PCMH Draft Application – <i>Mary Sheridan, Bureau Chief, Division of Public Health, IDHW</i> ACTION ITEM
3:00 15 minutes	Break - <i>Enjoy holiday cookies provided by a generous donation from Neva Santos, Idaho Academy of Family Physicians and Suzie Pouliot, Idaho Medical Association</i>
3:15 p.m. 10 minutes	SHIP Dashboard – <i>Jennifer Feliciano, PMP, MBA, Senior Associate, Mercer</i>
3:25 p.m. 10 minutes	CQM Update – <i>Andrew Baron, Chair – CQM Workgroup</i> ACTION ITEM
3:35 p.m. 10 minutes	IHDE Update – <i>Rick Turner, MD, Chief Medical Information Officer, Saint Alphonsus Health System</i>
3:45 p.m. 10 minutes	SHIP Operations and Advisory Group Reports/ Updates – Please see written report (SHIP Operations and IHC Workgroup Reports – 11/9/2016): <ul style="list-style-type: none"> • Presentations, Staffing, Contracts, and RFPs status – <i>Cynthia York, IDHW</i> • Regional Collaboratives Update – <i>Miro Barac, IDHW</i> • Telehealth, Community EMS, Community Health Workers – <i>Miro Barac, IDHW</i> • HIT Workgroup – <i>Janica Hardin, St. Alphonsus, Workgroup Co-Chair</i> • Multi-Payer Workgroup – <i>Dr. David Peterman, Primary Health and Josh Bishop, PacificSource, 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, IDHW, Workgroup Co-Chair</i> • Population Health Workgroup – <i>Elke Shaw-Tulloch, IDHW, Workgroup Chair, Lora Whalen Workgroup Co-Chair</i> • IMHC Workgroup – <i>Dr. Scott Dunn, Family Health Center, IMHC Workgroup Chair</i>
3:55 p.m. 5 minutes	Additional business & next steps – <i>Lisa Hettinger, IHC Co-Chair</i>
4:00 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



Idaho Healthcare Coalition

Action Items December 14, 2016

- Action Item 1 – Minutes

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

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

Second: _____

Motion Carried.

- Action Item 2 – Next steps PCMH Cohort Two

IHC members will be asked to support the next steps for SHIP PCMH Cohort Two transformation engagement efforts as presented by the SHIP Team:

Motion: I, _____ move that the Idaho Healthcare Coalition support the next steps for SHIP PCMH Cohort Two transformation engagement efforts as presented by the SHIP Team.

Second: _____

Motion Carried

- Action Item 3 – Virtual PCMH Application

IHC members will be asked to approve the Virtual PCMH Application as presented by Mary Sheridan:

Motion: I, _____ move that the Idaho Healthcare Coalition approve the Virtual PCMH Application as presented by Mary Sheridan.

Second: _____

Motion Carried.

- Action Item 4 – Clinical Quality Measure Catalog

IHC members will be asked to approve the updated Clinical Quality Measure Catalog as presented by Dr. Baron:

Motion: I, _____ move that the Idaho Healthcare Coalition approve the updated Clinical Quality Measure Catalog as presented by Dr. Baron.

Second: _____

Motion Carried.



Idaho Healthcare Coalition

Meeting Minutes:

SUBJECT: IHC November Minutes **DATE:** November 9th, 2016

ATTENDEES: Pam Catt-Oliason, Ross Edmunds, **LOCATION:** 700 W State Street, 1st Floor East
Katherine Hansen, Lisa Hettinger, Conference Room
Yvonne Ketchum, Deena LaJoie,
Dr. James Lederer, Dr. Kevin
Rich, Neva Santos, Elke Shaw-
Tulloch, Mary Sheridan, Larry
Tisdale, Karen Vauk, Matt
Wimmer, Cynthia York

Teleconference: Dr. Andrew Baron, Rene LeBlanc,
Maggie Mann, Carol Moehrle, Dr.
David Peterman, Geri Rackow,
Jennifer Wheeler, Dr. Bill
Woodhouse

Members Absent: Director Richard Armstrong, Josh
Bishop, Kathy Brashear, Melissa
Christian, Jeff Crouch, Dr. Keith
Davis, Dr. Mike Dixon, Russ
Duke, Janica Hardin
Senator Lee Heider, Dr. Glenn
Jefferson, Nicole McKay, Casey
Meza, Daniel Ordyna, Dr. David
Pate, Tammy Perkins, Susie
Pouliot, Dr. Dave Schmitz, Dr.
Boyd Southwick, Lora Whalen,
Janet Willis, Dr. Fred Wood,
Nikole Zogg

IDHW Staff Miro Barac, Wayne Denny,
Taylor Kaserman, Casey Moyer,
Kym Schreiber, Michael Thomas,
Molly Volk, Ann Watkins, Alexa
Wilson, Stacey St.Amand

Guests: Sarah Baker, Rachel Blanton,
Elwood Cleaver, Katie Falls, Scott
Oien, Gina Pannell, Dr. Janet
Reis, Dr. Rhonda Robinson-Beale,
Linda Rowe, Elizabeth Spaulding,
Senator Stephen Thayn, Norm
Varin, Dr. Shenghan Xu

STATUS: Draft (11/09/2016)

Summary of Motions/Decisions:

Motion:

Larry Tisdale moved to accept the minutes of the October 12, 2016 Idaho Healthcare Coalition (IHC) meeting as prepared. Elke Shaw-Tulloch seconded this motion.

Outcome:

Motion Carried

Katherine Hansen moved that the Idaho Healthcare Coalition recommend the Governor appoint Dr. Rhonda Robinson-Beale to the IHC. Neva Santos seconded the motion.

Motion Carried

Neva Santos moved that the Idaho Healthcare Coalition adopt the Regional Collaborative Strategic Plans as presented by Elke Shaw-Tulloch. Dr. Kevin Rich seconded the motion.

Motion Carried

Katherine Hansen moved that the Idaho Healthcare Coalition adopt the SHIP Operational Plan as presented by Mercer. Neva Santos seconded the motion.

Motion Carried

Agenda Topics:

Opening remarks, Introductions, Agenda review, Approve minutes – Dr. Ted Epperly, Chair

- ◆ Lisa Hettinger started the meeting with a quote from Frederick B. Wilcox “Progress always involves risks. You can’t steal second base and keep your foot on first.” Ms. Hettinger called role and introduced Dr. Rhonda Robinson-Beale who will be replacing Jeff Crouch on the IHC. No changes were suggested to the October IHC meeting minutes.

PCMH Learning Collaborative Review – Grace Chandler, Brilljent

- ◆ Grace Chandler presented survey results from the Public Health District Staff Learning Session held on October 24th. Ms. Chandler went over highlights of the survey results which showed that the learning sessions were well received by participants.
- ◆ The learning session was followed by the Learning Collaborative for Cohort One clinics. Ms. Chandler presented feedback from participants in the two day learning collaborative. The results were positive and there was constructive feedback for enhancements to the next Learning Collaborative. Ms. Chandler broke down results of the survey by each day.
- ◆ Looking ahead to future trainings, Ms. Chandler presented potential topics that may be presented at the Cohort Two Learning Collaborative. Suggestions provided by attendees in the survey results will also be taken into consideration when developing the next agenda.
- ◆ Dr. Rich provided IHC members with his perspective of the learning collaborative from a physician’s point of view: he liked the format of having two half days because it made it possible for clinics to travel to the collaborative without losing an extra day for travel; Dr. Rich also enjoyed the curriculum (specifically MACRA and value-based payment systems) and the breakout sessions; he said that even as an NCQA content expert there was still information he took away from the collaborative.
- ◆ Yvonne Ketchum mentioned that she received feedback from her staff that the learning collaborative was helpful and productive.
- ◆ Dr. Baron also provided positive feedback on his experience at the learning collaborative.

Regional Health Collaborative Summit Review – *Elizabeth Spaulding, Langdon Group*

- ◆ Elizabeth Spaulding presented highlights of the Regional Collaborative Summit that was held on October 26th. She spoke about the presentations that were given in the afternoon, and also talked about the Regional Collaborative grant that will be made available soon.
- ◆ The function, role, and value of the strategic plan were the main focus of the Regional Collaborative Summit. Most of the day's conversation centered on understanding and using the strategic plans.
- ◆ Dr. Rich said it was worthwhile to attend, that it was nice to see other Regional Collaborative leadership teams, and that it was helpful to compare successes and learning opportunities. He said the summit was a good opportunity for Regional Collaboratives to combine the work and knowledge of public health and primary care practices.
- ◆ Geri Rackow commented on behalf of the Public Health District Directors that overall it was a good summit and that it was valuable to meet with peers across the state.

Regional Collaborative Strategic Plans/Recommendation from Population Health Workgroup and SHIP RC grant overview – *Elke Shaw-Tulloch, IDHW*

- ◆ Elke Shaw-Tulloch presented the highlights of the seven regional collaborative strategic plans and what the focus areas of each strategic plan were. The three primary focus areas that were identified by the Population Health Workgroup are Patient-Centered Medical Home Transformation Support, Medical-Health Neighborhood Development & Connections, and Regional Collaborative Sustainability & Population Health Initiatives. Ms. Shaw-Tulloch briefly went over these three focus areas, highlighting important objectives in each area. IHC members were asked to adopt the RC strategic plans based on the recommendation from the Population Health Workgroup.
- ◆ Following her presentation Ms. Shaw-Tulloch gave a presentation on the upcoming grant program that is being made available to Regional Collaboratives. The application has been created and the timeline for the application process is Monday November 14th until December 21st when notice of the award will go out. The award year will extend from February 1, 2017 through January 31st 2018.

Dashboard Presentation – *Katie Falls, Mercer*

- ◆ Katie Falls presented highlights of the SHIP Operational Plan which is currently being put together by the SHIP and Mercer teams and will be submitted to CMMI on December 1st 2016. Ms. Falls went over the table of contents, highlighting the key pieces of information that will be included in the Operational Plan. The five main sections of the Operational Plan include the executive summary, policy and operational areas, detailed operational plans by goals and drivers, program monitoring and evaluation, and a sustainability plan. Ms. Falls went over the subsections of each of these sections, giving a clear idea of what will be sent to CMMI in the Operational Plan.
- ◆ The Appendices to the Operational Plan include; SHIP metrics, risk assessment and mitigation strategies, state evaluation logic models, HIT component crosswalk, and a glossary. Following her presentation of the Operational Plan Ms. Falls provided members with a working timeline for submission of the Operational Plan and answered questions from members.

SHIP Operations and Advisory Group Reports/ Updates – *Cynthia York, DHW SHIP*

- ◆ Kym Schreiber provided IHC members with a brief update on the Cohort Two timeline. A total of 81 final applications were received; the selection committee is currently reviewing the applications and will have recommendations returned no later than Friday November 18th. SHIP staff will then notify the selected 55 clinics.
- ◆ Larry Tisdale asked if all of the non-selected clinics from Cohort One applied. Ms. Schreiber answered that some of them did. More detailed numbers will be presented at the December IHC meeting.
- ◆ Dr. Rich asked if the same ratios for Cohort One will be kept for Cohort Two. Ms. Schreiber responded that the geographic division will still be kept but that there will be a variety of factors that affect clinic distribution statewide. She said it should still look very similar to the breakout seen in Cohort One.
- ◆ Pam Catt-Oliason asked how and when clinics will be able to apply for the Virtual PCMH. The Virtual PCMH application and process is being developed and will be available to Cohort One and Two clinics with more information available at the December meeting. There is a target of 50 clinics over the course of three years.

Timeline and Next Steps – *Lisa Hettinger, Co-Chair*

- ◆ Lisa Hettinger addressed the issue of the presidential election results and the future of the Affordable Care Act.

- ◆ Senator Thayn expressed his concern about the SHIP program being a top down approach. He commented that there is not enough patient involvement in decisions being made. Dr. Baron commented on the need for enhancements to patient engagement strategies. Discussion on the SHIP initiative and its direction and model continued. Senator Thayn will present at the December IHC meeting.

There being no further business, Chairman Hettinger adjourned the meeting at **3:43pm**.

Idaho Lifespan Family Caregiver Action Plan



Family bonds and support are hallmarks of the State of Idaho and cornerstones of independence for older adults and individuals with physical or emotional disabilities, or chronic illnesses. The support provided by families is often fundamental to this independence and the value of unpaid family caregiving is receiving increased attention in Idaho and throughout the United States.

Why this attention now?

- In part, it is due to demographic change – 10 years ago, the ratio of working age adults to older adults was 6 to 1. By 2020, this ratio will be 3 to 1. In addition, more families of children and adults with disabilities are opting for home-based care. There are and will be fewer and fewer caregivers for a rapidly increasing number of people needing care.
- Family caregivers manage increasingly complex medical and/or psychological conditions without the support and training they need. The supports that do exist are fragmented and difficult to access.
- Family caregiving is not free. The costs include lost income to the caregiver and lost productivity to an employer. For example, the income generating potential for a caregiver is projected to be \$600,000 less over a lifetime and employers lose an estimated \$33.6 billion annually related to employee caregiving responsibilities.
- Caregiving takes its toll on caregiver health and wellbeing and impacts the entire family.
- Support from family caregivers can delay the need for costly institutional care. In 2014, Idaho spent \$271,522,099 or 48% of its Medicaid budget on care in nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICFs/ID) and inpatient psychiatric hospitals.

The absence of a solid support structure for caregivers takes a serious toll on the economic and social wellbeing of families, businesses, and communities across Idaho.

What can Idaho do to support caregivers?

The Idaho Caregiver Alliance has developed the **Idaho Lifespan Family Caregiver Action Plan**. The Plan offers an evidenced-based set of recommendations to put Idaho ahead of the caregiver crisis curve and set a course into a future that is economically viable for caregivers, employers, and service systems. The plan proposes:

Goal 1: Ensure a streamlined, coordinated system of supports for caregivers across the lifespan, recognizing the unique needs of Idaho’s diverse population.

- *Develop statewide respite resources.*
- *Ensure culturally appropriate information and resources are available to caregivers across the lifespan.*

- *Establish training resources for family caregivers on caregiving responsibilities, techniques, and strategies for self-care.*
- *Establish a statewide network of experts equipped to serve as information and support navigators or guides for family caregivers across the lifespan.*

Goal 2: Increase public awareness about unpaid family caregiving and help people within our communities identify as caregivers.

- *Family members recognize themselves as caregivers and the general public is aware of the needs and contributions of family caregivers across the lifespan.*

Goal 3: Recognize the importance of family caregiving and embed the voice of family caregivers in policy and system changes.

- *Recognize family caregivers as part of their family members' health care and social support team.*
- *Embed family caregiver perspective and involvement in Idaho's efforts to transform its primary care, long-term care, and behavioral health systems.*
- *Include family caregivers in Idaho's efforts to enhance employment opportunities and tax policies that support families and the state's economic vitality.*

Goal 4: Ensure a coordinated voice for family caregivers in Idaho through the development of a sustainable structure for the Idaho Caregiver Alliance.

- *Build on the established foundation of the Idaho Caregiver Alliance and ensure that the Idaho caregivers across the lifespan have a coordinated voice.*
- *Assure data are available to inform decision-making related to family caregiver supports and services.*

What are the Next Steps?

The perspectives and expertise of caregivers and individuals from public and private organizations in Idaho provide the foundation for the Idaho Caregiver Action Plan. The Plan, to be available on the Idaho Commission on Aging and Center for the Study of Aging, Boise State University websites, is designed to identify and enhance local supports for family caregivers.

The aim of the **ACTION PLAN** is to be proactive; to prevent or delay the need for costly institutional care, maximize independence, and keep families together in their communities. Implementation of the **ACTION PLAN** will require an investment of resources, but as demonstrated by caregiver initiatives in other states, the effort will yield significant dividends.

For more information, contact:

Sarah Toevs, Ph.D. – stoevs@boisestate.edu

Pam Oliason - Pam.Catt-Oliason@aging.idaho.gov

For access to the plan, visit: <https://hs.boisestate.edu/csa/idaho-lifespan-family-caregiver-action-plan/>

Idaho Lifespan Family Caregiver Action Plan



To advance the well-being of family caregivers by promoting collaboration that improves access to quality support and resources, including respite, for caregivers across the lifespan.



History of Alliance

- 2012 Idaho Lifespan Respite Coalition established
- 2013 Idaho Commission on Aging receives \$200,000 3-yr planning grant
 - Partnered with Boise State Center for the Study of Aging
 - Goals:
 - Enhance access to respite across the lifespan
 - Build sustainable coalition
 - Develop long range plan
- 2014 Statewide Respite Needs and Capacity Assessment
- 2015 Passage of HCR 24 recognizing value of family caregivers
- 2016 Presentation of Caregiving in Idaho report to Senate and House Health and Welfare Committees
- 2016 Created Idaho Lifespan Family Caregiver Action Plan and fostered steps for implementation

Why Now?



Why this attention now?

- Demographic changes
 - More aging baby boomers and fewer caregivers
 - More families caring for young and adult children with disabilities at home
- Caregiving more complex
- Supports are fragmented and difficult to access
- Family caregiving is not free
 - Lost income to employed caregiver
 - Lost productivity to employers
- Caregiving impacts the whole family
- It's the right thing to do and it makes cents
 - Delays need for institutional care
 - Caregivers are a key asset in the medical neighborhood

Action Plan Goal 1:

Family Caregiver Supports

Goal 1: Ensure a streamlined, coordinated system of supports for caregivers across the lifespan, recognizing the unique needs of Idaho's diverse population.

Objective 1 – Develop statewide respite resources.

Objective 2 – Ensure culturally appropriate information and resources are available to caregivers across the lifespan.

Objective 3 – Establish training resources for family caregivers on caregiving responsibilities, techniques, and strategies for self-care.

Objective 4 – Establish a statewide network of experts equipped to serve as information and support navigators or guides for family caregivers across the lifespan.

Action Plan
Goal 3:

Systems
Change

Goal 3: Recognize the importance of family caregiving and embed the voice of family caregivers in policy and system change.

Objective 6 – Recognize family caregivers as part of their family members’ health care and social support team.

Objective 7 – Embed family caregiver perspective and involvement in Idaho’s efforts to transform its primary care, long-term care, and behavioral health systems.

Objective 8 – Include family caregivers in Idaho’s efforts to enhance employment opportunities and tax policies that support families and the state’s economic vitality.

Action Plan
Goal 4:

Infrastructure

Goal 4: Ensure a coordinated voice for family caregivers in Idaho through the development of a sustainable structure for the Idaho Caregiver Alliance.

Objective 9 – Build on the established foundation of the Idaho Caregiver Alliance and ensure that the Idaho caregivers across the lifespan have a coordinated voice.

Objective 10 – Assure data are available to inform decision-making related to family caregiver supports and services.

Sustainability



What is needed?

- Resources to implement Action Plan.
- Institutional home and funding for ICA.

A voice, convener, and catalyst for support of unpaid family caregivers across the lifespan.



Resources to sustain ICA

\$100,000 a year

- \$55,000 Project Coordinator
- \$25,000 Quality Improvement/Data Manager
- \$20,000 Operating budget

Sponsoring agency

- State-wide reach
- Capacity to work across sectors



Next Steps

Your voice and leadership are key to sustainability.

Your support is essential as we establish a network of public/private partnerships.



Idaho
Caregiver
Alliance

Thank you

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Marilyn Sword, frontiergroupidaho@gmail.com

Tiffeny Stees, tiffenykiiha@u.boisestate.edu

Sarah Toevs, stoevs@boisestate.edu

Idaho's Lifespan Family Caregiver Action Plan



Idaho
Caregiver
Alliance

October, 2016

Acknowledgements

Idaho Family Caregiver Alliance

This plan is the product of countless hours of research, outreach, deliberation, and problem solving. It reflects the voice of thousands of often invisible Idaho caregivers and others. The plan is intended to create awareness among policy makers and others and is intended to stimulate dialogue and encourage movement toward an improved environment for Idaho family caregivers. As described in the plan, a perfect storm is brewing, generated by demographic shifts, advances in health care, economic challenges experienced by caregiving families, and the desire to live and age in the community. The system as it is currently configured cannot address the pressure these changes generate. Idaho must look ahead to what can be done proactively to support caregivers and deflect the catastrophe that might well occur if we do not.

We welcome your interest, ideas, and support. Thank you for your leadership, vision, and action toward advancing this plan.

“Under Medicare, we are only allowed a short time in a nursing home after a hospital stay. In 2013, my husband fell and sustained a broken neck. He was also a cancer patient. He was discharged to home at 100 days after spine surgery. The cancer doctor said go home with “hospice.” However there are NO hospice services on top of the Greer grade, our area. We had to contend with someone who should have still been in the hospital by ourselves. Total care is hard on backs. In the drug store one day a clerk told me to call the Area Agency on Aging. Our first and only real help. This was after 3 months without help, another hospital stay for my husband, and another nursing home stay. I am trying to stay alive as the only help for my husband and our son, a diabetic since age 2 on insulin for 59 years. I really appreciate the help from the Agency on Aging and wish I had known of it sooner. Thank you.”

*The voice of an Idaho senior,
No Wrong Door System Assessment, 2015*

AARP Idaho
Ada County Community Paramedics
Advocates for Families/Caregivers
Area Agencies on Aging
Blue Cross of Idaho
Caregivers
Caregiver Support Service Agencies
Boise State University –
Center for the Study of Aging
Community Partnerships of Idaho
Disability Action Center NW
Disability Rights Idaho
Friends in Action/Legacy Corps
Home Care and Hospice Agencies
Idaho Alzheimer’s Planning Group
Idaho Area Health Education Center
Idaho Association of Counties
Idaho Commission on Aging
Idaho Department of Health and Welfare
Divisions –
Behavioral Health, Public Health, and
Medicaid
Idaho Federation of Families for Children’s
Mental Health
Idaho Health Care Association
Idaho Hospital Association
Idaho Parents Unlimited
Jannus
Living Independence Network Corporation
MS Society
Northwest A.D.A. Center of Idaho
Qualis Health
Regence Blue Shield
Senior Health Insurance Benefits Advisors
(SHIBA)
St. Luke’s, Mountain States Tumor Institute
Treasure Valley YMCA
Veterans Administration

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**ICA VISION: To serve as the voice, convener,
and catalyst for support of unpaid family
caregivers across the lifespan.**



**The mission of the Idaho Caregiver Alliance is to
advance the well-being of family caregivers by
promoting collaboration that improves access to
quality support and resources, including respite for
caregivers across the lifespan.**

Executive Summary

Family bonds and support are hallmarks of the State of Idaho and cornerstones of independence for older adults and individuals with physical or emotional disabilities, or chronic illnesses. The support provided by families is often fundamental to this independence and the value of unpaid family caregiving is receiving increased attention in Idaho and throughout the United States.

Why this attention now?

- In part, it is due to demographic change – 10 years ago, the ratio of working age adults to older adults was 6 to 1. By 2020, this ratio will be 3 to 1. In addition, more families of children and adults with disabilities are opting for home-based care. There are and will be fewer and fewer caregivers for a rapidly increasing number of people needing care.
- Family caregivers manage increasingly complex medical and/or psychological conditions without the support and training they need. The supports that do exist are fragmented and difficult to access.
- Family caregiving is not free. The costs include lost income to the caregiver and lost productivity to an employer. For example, the income generating potential for a caregiver is projected to be \$600,000 less over a lifetime and employers lose an estimated \$33.6 billion annually related to employee caregiving responsibilities.
- Caregiving takes its toll on caregiver health and wellbeing and impacts the entire family.
- Support from family caregivers can delay the need for costly institutional care. In 2014, Idaho spent \$271,522,099 or 48% of its Medicaid budget on care in nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICFs/ID) and inpatient psychiatric hospitals.

The absence of a solid support structure for caregivers takes a serious toll on the economic and social wellbeing of families, businesses, and communities across Idaho.

What can Idaho do to support caregivers?

The Idaho Lifespan Family Caregiver Action Plan offers an evidence-based set of recommendations to put Idaho ahead of the caregiver crisis curve and set a course into a future that is economically viable for caregivers, employers, and service systems. The plan proposes:

- ✓ A range of supports that can mean the difference between caregivers being able to manage their caregiving responsibilities and their own health vs. losing their jobs or placing their family members in out-of-home care. These supports can range from respite care to information and training to legal, financial, and tax-based supports.
- ✓ Increased public awareness to ensure that caregivers identify themselves in order to seek support and a general public that recognizes the contributions and needs of caregivers and understands ways by which family caregivers can be supported.

- ✓ A seat at the table as Idaho pursues changes to its primary care, behavioral health, and long-term supports systems. This will ensure that the voice of family caregivers is recognized and their expertise and experience are included in caregiving decisions.
- ✓ A sustained voice for Idaho caregivers through the continuation of the Idaho Caregiver Alliance, an umbrella organization that promotes collaboration to improve access to quality support and resources for caregivers across the lifespan.

What are the Next Steps?

The perspectives and expertise of caregivers and allies from public and private organizations in Idaho provide the foundation for the Idaho Caregiver Action Plan. The Plan, available on the Idaho Commission on Aging and Center for the Study of Aging, Boise State University websites, is designed to identify and enhance local supports for family caregivers.

The aim of the **ACTION PLAN** is to be proactive; to prevent or delay the need for costly institutional care, maximize independence, and keep families together in their communities. Implementation of the **ACTION PLAN** will require an investment of resources, but as demonstrated by caregiver initiatives in other states, the effort will yield significant dividends.

An electronic copy of the Idaho Lifespan Family Caregiver Action Plan and Executive Summary is available through [Center for the Study of Aging](https://hs.boisestate.edu/csa/idaho-lifespan-family-caregiver-action-plan/) at Boise State University, <https://hs.boisestate.edu/csa/idaho-lifespan-family-caregiver-action-plan/>

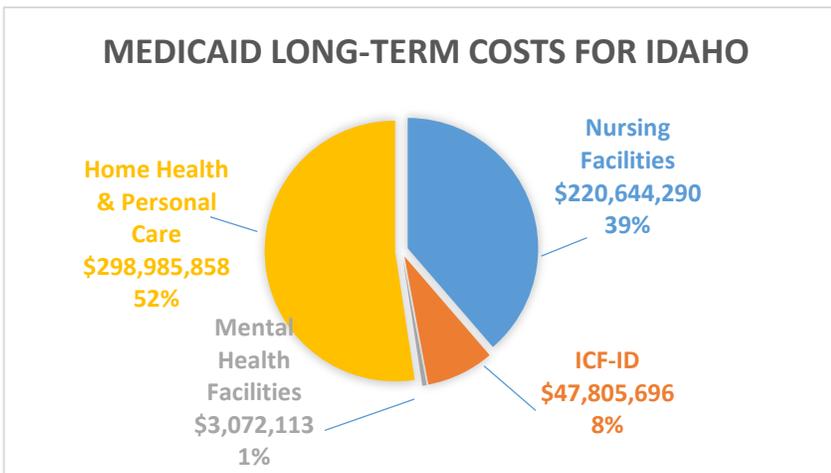
Introduction

The work force of unpaid family caregivers is receiving increased attention in Idaho and throughout the United States. This is due, in part, to recognition of the critical role families play in the health care delivery system. The **Idaho Caregiver Alliance (ICA)**, a collaborative initiative of the Idaho Commission on Aging, the Center for the Study on Aging at Boise State University, Jannus Corporation, Idaho Parents Unlimited, Idaho Department of Health and Welfare (Public Health, Medicaid, Children’s Behavioral Health, and Service Integration), AARP Idaho, family caregivers and others, is leading this effort in Idaho. The mission of the ICA is to advance the well-being of caregivers by promoting collaboration that improves access to quality support and resources for family caregivers across the lifespan. This document outlines the rationale and goals for a Lifespan Family Caregiver Action Plan for Idaho.

There is a vast, invisible workforce of caregivers in Idaho. Each year, more than 300,000 - **1 out of every 4 adults in Idaho** - assume critical, ongoing care responsibilities for aging parents, siblings, spouses, children, or grandchildren with physical or emotional disabilities, or chronic illnesses^{1,2}. These family members provide over **201 million hours of uncompensated care annually** at an estimated value of **\$2 billion to Idaho’s economy**.³ This is equivalent to Idaho’s current budget for all publicly-funded long-term care services.⁴

300,000 
Idaho family caregivers

201,000,000 
Hours of caregiving annually



Access to support for family caregivers is important in delaying the need for costly institutional care. As in many states, a significant proportion of Idaho Medicaid expenditures for individuals eligible for both Medicare and Medicaid are for services in nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICFs/ID) and inpatient

Figure 1 – Idaho Medicaid Long-Term Care Costs

¹ *Across the States: Profiles of Long-Term Care and Independent Living Idaho 2012: Valuing the Invaluable Update: Understanding the Impact of Family Caregiving on Work* (AARP Public Policy Institute)

² *Idaho Caregiver Needs and Respite Capacity Report, 2014*. (Cirerol, T & Toevs, S.E.)

³ *Across the States: Profiles of Long-Term Care and Independent Living Idaho 2012: Valuing the Invaluable Update: Understanding the Impact of Family Caregiving on Work* (AARP Public Policy Institute)

⁴ *FY 2016 Legislative Budget Book* (Department of Health and Welfare FY 2015 appropriation, p. 2-8)

psychiatric hospitals. In 2014, Idaho’s Medicaid spending for long-term care was **\$570,507,957**, just under 1/3 of its total budget. Of this amount, **48% or \$271,522,099 was spent on care in these settings.**⁵ An investment in family caregivers reflects Idaho’s values of fiscal responsibility and the Governor’s commitment, “to using common sense in ways that make better use of our tax dollars now and in the future.”⁶

Who is a Caregiver?

As expressed by Rosalynn Carter, “There are four kinds of people in the world: those who have been caregivers; those who currently are caregivers; those who will be caregivers; and those who will need caregivers.” Caregiving encompasses many responsibilities and has many different faces. A family caregiver may be a parent caring for a child with serious medical issues, or a young adult taking care of a grandparent with a heart condition. Caregiving may be a sister caring for a brother with schizophrenia, or a husband supporting and caring for a wife with dementia. Often, a caregiver fulfills a combination of these roles. The care provided may range from a trip to the grocery store or a medical appointment, to 24/7 care involving medication administration, wound care, or other complex medical services. A caregiving role may last a few months or a lifetime, and although these responsibilities are taken on willingly and with love, they come at a cost to individuals, families and society.

The ICA acknowledges that the term “caregiver” can carry a negative connotation. *Care partner* or *carer* or an individual’s relationship to the care recipient (spouse, parent, sibling, etc.) is often preferred terminology. It is important to acknowledge that words matter and can influence our thinking and actions. However, the ICA has opted to use the term “caregiver” based on its use by local and national organizations, funding agencies, and its broad recognition by the general public and stakeholders. There is no intention to demean or diminish the work being done or the reciprocal relationship between the recipient of services and the person providing the support.

- What do Family Caregivers Provide?**
- ✓ Complex medication management
 - ✓ Care coordination
 - ✓ Wound care
 - ✓ Mental health planning & supervision
 - ✓ Personal care
 - ✓ Financial management
 - ✓ Health insurance advocacy
 - ✓ Transportation
 - ✓ Emotional and spiritual support
 - ✓ Medical equipment operation
 - ✓ Interpreting medical directions

Changing demographics. While the number of older adults is increasing across the country, Idaho has the ninth fastest growing population of people over the age of 65. Based on current projections, 20% of the population in Idaho will be 65 or older by 2020, whereas the population of working age adults will

⁵ *Distribution of Spending on Long-Term Care* (Kaiser Family Foundation, 2014)

⁶ *Idaho indicators aging and work. State Perspectives at Boston College* (Wong, M., McNamara, T., Shulkin, S., Lettieri, & C., Careiro, V., 2008)

only increase by 0.2% a year over the next decade.⁷ Ten years ago, there were approximately 6 working age adults for every person age 65 and older. By 2020, this ratio is projected to decrease to 3:1 – a 50% reduction.⁸ This demographic shift foreshadows a caregiver crisis; Idaho will have significantly fewer family caregivers to care for a growing aging population.

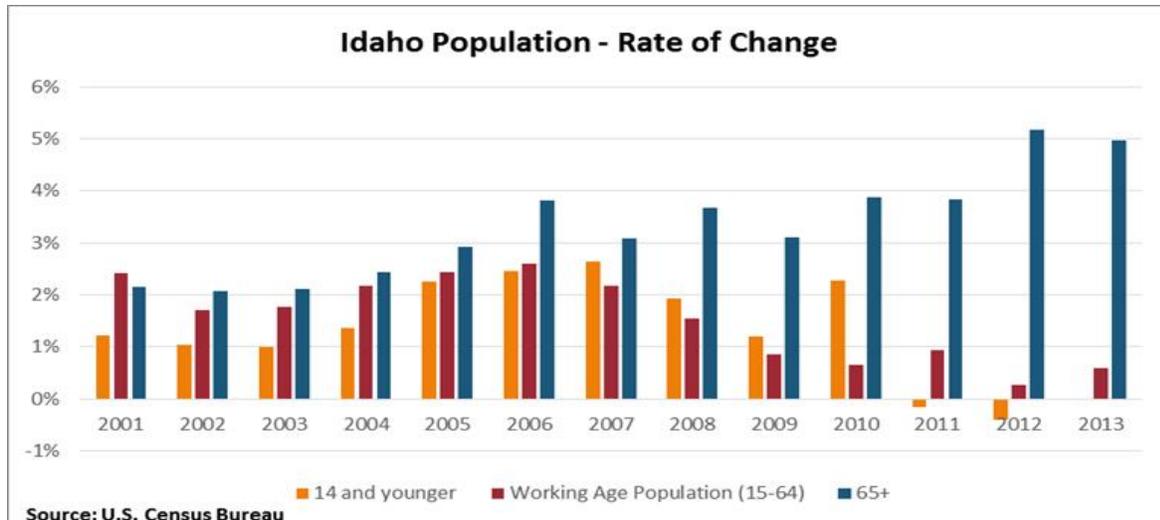


Figure 2 – Change in age distribution of Idaho population: 2001 -2013
Idaho Department of Labor

Caregiving is not just about older adults. It also impacts families caring for children with disabilities. In 2012, 8% of U.S. adults reported providing unpaid care to a child living with health challenges or disabilities, up from 5% in 2010.⁹ As the U.S. population ages and as medical advances save and extend more lives and more people across the lifespan opt for home-based care, this upward trend in the need for family caregivers will continue.

The Costs of Caregiving

Impact of Caregiving on the Caregiver and Family

Family caregiving impacts all aspects of a family’s economic and physical wellbeing. Caregiving can jeopardize a family’s ability to maintain their housing or provide care for a loved one, or cause a family member (including the caregiver) to postpone educational opportunities that could improve their future. The demands of caregiving create stress not only on the caregiver, but other family members as well. For families with children with disabilities, siblings also feel the impact as the family focuses energy and attention on the demands of the child with special needs. The demands are further heightened for individuals providing care for a child and an older family member simultaneously.

⁷ *Idaho’s Population Growth Slowed During Recession* (Idaho Department of Labor, 2015)

⁸ Ibid

⁹ *Family Caregivers are Wired for Health*. Pew Internet and American Life Project (Fox, S., Duggan, K., Purcell, K., 2013)

Uncompensated caregiving is not “free.” There are many hidden financial, physical, and emotional costs to uncompensated caregiving. Twenty-two percent of caregivers of younger adults with disabilities indicate they are experiencing financial strain from out of pocket support.¹⁰ These contributions reflect a diminished capacity on the part of many working families to take care of themselves and their (other) family members. According to a 2015 retirement confidence survey, 29% or 3 in 10 people say they are currently providing direct financial support to a relative or friend. According to a Pew Research Center study, 28% of adults with a parent age 65 or older helped their parents financially within the past year.¹¹ The financial impact of caregiving increases with the intensity of the care provided, the geographic distance between care recipient and care provider’s places of residence, and access to supportive resources.

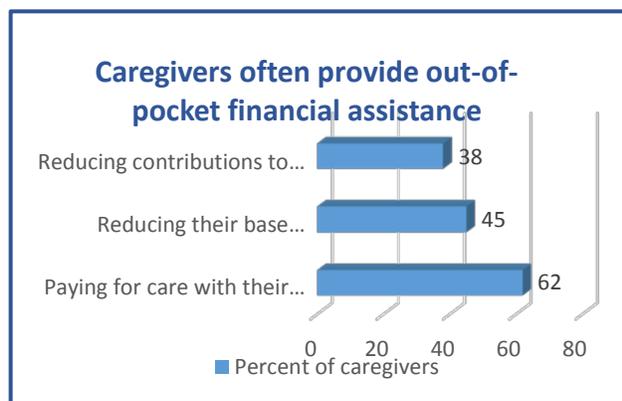


Figure 3 – Out-of-pocket financial assistance
Beyond Dollars: The Expanding Circle of Care, Executive Summary, Genworth Financial, 2016

Families are unable to manage the cost of long-term care. Insurance policies for long-term care can be purchased as a means of paying for all or part of the cost of care in a facility or at home, but this option is becoming increasingly unaffordable.¹² People with low incomes and few financial resources have no option but to rely on Medicaid. At the other end of the wealth spectrum, people can pay for extended care out of their savings. The dilemma is hardest for the large number of people in the middle. With significantly increased premiums and fewer benefits, retirees on fixed incomes are increasingly canceling their long-term care policies.¹³ A major factor in the decision to purchase – or keep – long term care insurance is whether the person will have family or friends to provide at least some unpaid help. Many people are counting on such free help, but there is a shrinking number of family caregivers, due to smaller families and other demographic shifts.¹⁴

Most caregivers are juggling work and caregiving. While each situation is unique, nearly 70% of Idaho caregivers are employed full or part-time and caring for their own children or an aging parent.¹⁵ A national study indicates that 6 out of 10 caregivers have had to make workplace accommodations to meet their caregiving responsibilities (see Figure 4). These changes can range from cutting back work

¹⁰ Caregivers of Younger Adults: A Focused Look at Those Caring for Someone Age 18 to 49, (AARP Public Policy Institute), June, 2016, p.8

¹¹ *Family Support in Graying Societies: How Americans, Germans and Italians are Coping with an Aging Population* (Pew Research Center, 2015)

¹² *Long-Term Care Insurance Less Bang More Buck* (Kaiser Family Foundation, March 17, 2016)

¹³ *Why Do People Lapse Their Long-term Care Insurance?* (Hou, W., Sun, W., & Webb, A. Center for Retirement Research at Boston College, October 2015, 15-17)

¹⁴ *Long-Term Care Insurance: Is It Worth It?* (Scism, L, Wall Street Journal, May 1, 2015)

¹⁵ *Idaho Caregiver Needs and Respite Capacity Report, 2014.* (Cirerol, T & Toevs, S.E.)

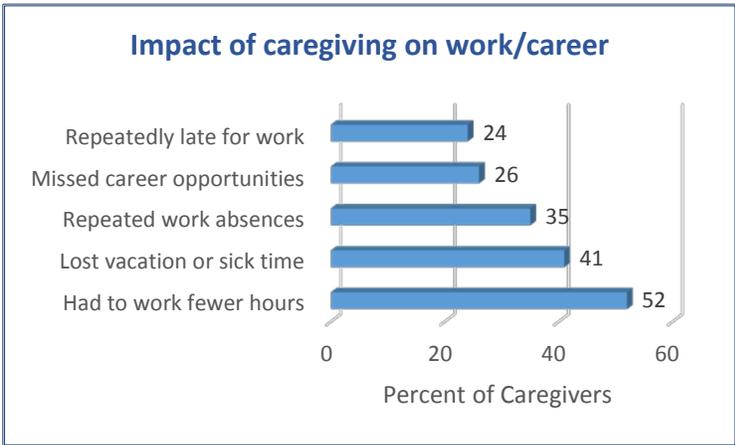


Figure 4 - Impact of caregiving on work/career
Beyond Dollars: The Expanding Circle of Care, Executive Summary, Genworth Financial, 2016

caregivers lose about \$660,000 in wage wealth over their lifetime because of work sacrifices.¹⁷

Employment difficulties such as these cause a ripple effect: loss of health care benefits, diminished financial independence, and severe physical and emotional stress for the caregiver.

hours to taking a leave of absence, to receiving a warning for poor performance or attendance.¹⁶ The demands of caregiving may also require reducing paid employment or leaving employment altogether. In fact, employment outside the home may be impossible for some parents of children or adults with disabilities, because caregiving is their uncompensated full-time job. A recent study estimates that working

Caregiving can negatively affect the health of the caregiver. According to the 2012 *Stress in America*

report, individuals who care for family members who are chronically ill have higher levels of stress and poorer health than the population at large. What’s more, while older adults often report lower stress levels, those who shoulder caregiving responsibilities are more stressed and have poorer physical health than their peers.¹⁸ This stress can lead to depression, anxiety, sleep problems, and health issues such as obesity and high blood pressure. Caregivers are also more likely to get sick than the general population, 17% versus 6%, respectively.¹⁹ There is also evidence

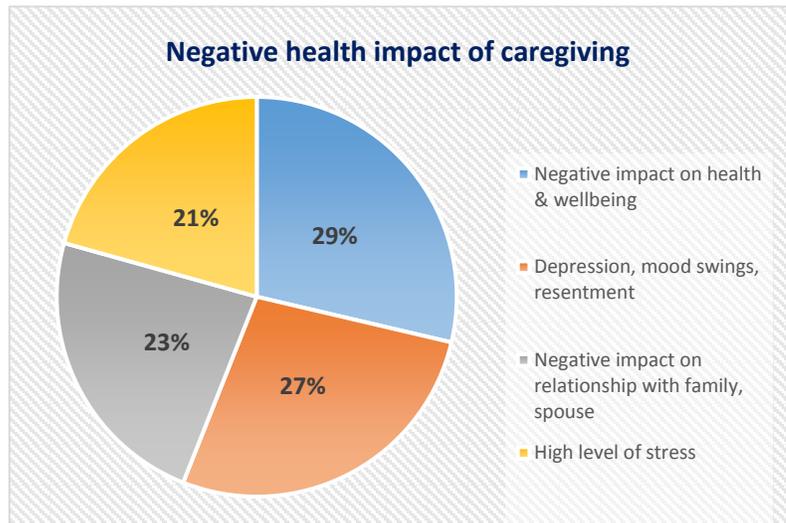


Figure 5 – Negative health impact of caregiving
Beyond Dollars: The Expanding Circle of Care, Executive Summary, Genworth Financial, 2016

that spouses caring for a partner with dementia are at an increased risk of dementia themselves.²⁰ With these negative health impacts, caregivers are ultimately at risk of needing care – and a caregiver – themselves.

¹⁶ *Caregiving in the U.S., Executive Summary* (AARP Public Policy Institute, June, 2015, p.22)

¹⁷ *About Caregiving, Guide to Long Term Care Planning* (Day, T. National Care Planning Council, 2016)

¹⁸ *Stress in America: Our Health at Risk* (American Psychological Association, January, 2012, p. 5)

¹⁹ *Stress in America: Our Health at Risk* (American Psychological Association, January, 2012, p. 8)

²⁰ *Does caring for a spouse with dementia promote cognitive decline? A hypothesis and proposed mechanisms* (Vitaliano, R.P., Murphy, Young, H.M., Echeverria, D., & Borson, S., *Journal of the American Geriatric Society*, 59, 900-908)

Economic Consequences of Caregiving on Employers

It is estimated that U.S. businesses lose \$25-28 billion annually in lost productivity due to the absenteeism of caregivers.²¹ That figure increases to \$33.6 billion when including the costs of replacing employees, workday distractions, supervisory time and reduction in hours from full to part time.^{22,23} In fact, the average annual cost to employers per full-time working caregiver is \$2,110.20.²⁴

\$2,100



Average cost to employer for caregiving employee

How Can Idaho Support the Caregiver?

We Need Caregiver Supports

Caregivers need support to sustain and expand their caregiving capacity and avoid costly health challenges. These supports include such things as transportation assistance, spiritual and emotional support, and workplace flexibility. These forms of assistance are important, often decisive factors between the care recipient remaining at home or being placed in a nursing home or other facility; between a caregiver remaining employed, or being pushed out of the workforce; between a family being able to remain in their home town, or having to relocate to access needed services. Critical supports include:

✓ **Respite Care:** Having some “time away” from caregiving prevents or delays burnout, relieves caregiver stress, and allows caregivers time to take care of themselves. A clear understanding of what respite services are and their importance, how to find and access respite care, methods of funding such services, standards for respite providers, and a statewide respite registry are needed to provide this vital form of assistance to caregivers. Respite care is an investment in both family and community wellbeing by keeping caregivers employed and socially engaged.

✓ **Information and Training:**
Caregivers are increasingly expected to manage complex medical and/or

psychological conditions with little to no information, instruction, or support. At present, assistance and information for caregivers is limited, fragmented, and based mostly on the needs of the care recipient, and not resources for the caregiver. Comprehensive information and training are needed for caregivers

“Caregiving has all the features of a chronic stress experience: It creates physical and psychological strain over extended periods of time, is accompanied by high levels of unpredictability and uncontrollability, has the capacity to create secondary stress in multiple life domains such as work and family relationships, and frequently requires high levels of vigilance.”

Schulz and Sherwood

In Physical and Mental Health Effects of Family Caregiving, 2009

²¹ *The Cost of caregiving to the U.S. economy, and what business leaders can do about it Business Journal*, (Witte, D., December 1, 2011. Data are from the Gallup-Healthways Well-Being Index, 2011)

²² *MetLife Study of Working Caregivers and Employer Health Care Costs* (MetLife Mature Institute, National Alliance for Caregiving, & University of Pittsburgh, February 2010)

²³ *Caregiving in the US. 2015 – Focused Look at Caregivers Age 50+* (National Alliance for Caregiving & AARP Public Policy Institute, 2015)

²⁴ *MetLife Caregiving Study: Productivity Losses to U.S. Business* (MetLife Mature Market Institute & National Alliance for Caregiving (NAC), 2006. The lost productivity estimates are based on the 2004 survey of U.S. caregivers conducted by NAC and AARP, Caregiving in the U.S. 2004)

to be effective, safe, and supported in their caregiving responsibilities. In addition, caregivers need to be recognized by health care providers as an important part of their family member’s medical care team.

✓ **Financial and Legal Supports:** Many caregivers face confusing and complicated legal issues connected with their caregiving responsibilities. For example, families caring for children with disabilities require information about guardianship and trusts to provide financial support to their child upon reaching the age of majority. For families caring for seniors, guardianship issues, financial, and end-of-life planning can also be complex. Although Idaho has enacted the Uniform Adult Guardianship and Protective Proceedings Jurisdiction Act, access to this expertise remains challenging and expensive. Therefore, financial and legal resources are needed to help family caregivers navigate the complexities of this nuanced, crucial area of providing support and care for a loved one.

✓ **Tax-based Supports:** Caregivers need enhanced tax-based supports to ameliorate the often staggering costs incurred by caregiving. Under Idaho tax code, Title 63, Chapter 30, caregivers are allowed up to three annual \$1,000 deductions for qualifying care recipients who receive at least half of their support from the taxpayer. Although a good starting place, this tax credit is inadequate. The growing number of national and state proposed caregiver tax credits and deductions recognize that such tax-based incentives help caregivers maximize their often limited fiscal resources and help reduce the need for publicly funded services. Updating the existing Idaho tax code to provide more comprehensive caregiver deductions as well as tax credits is a step in the right direction to ensure family caregivers remain financially stable and independent.

We Need Public Awareness to Identify Caregivers

Caregivers must be able to identify themselves as such in order to seek support. The very role of caregiving is often misunderstood, and not well defined. Public awareness campaigns and other initiatives are needed to establish a cogent, recognizable definition of caregiving that will help bridge this gap in understanding for both caregivers and the general public.

We Need Involvement in Making System Changes

Caregivers need a seat at the decision-making table as Idaho embarks on making significant revisions to primary care, the behavioral health care system, and long-term care services and supports. These efforts include:

✓ Recognition of family caregivers as an important component of the “medical neighborhood,” both as a resource and a potential recipient of services as the **Statewide Healthcare Innovation Plan** (SHIP) transforms primary care clinics into patient or person-centered medical homes (PCMHs).

✓ Inclusion of the voice of family caregivers in efforts to redesign the **Behavioral Health** care system (which encompasses mental health and substance use disorders) in Idaho. Important strides have been made in recognizing the need for preventative and crisis services at the local level; it is imperative that the voice and experience of family caregivers be included in these efforts.

✓ Inclusion of the perspectives of both the care recipient and their caregiver in efforts to coordinate and streamline transitions between care settings (hospitals, assisted living, home) across systems (Medicaid, Medicare, Veterans Health Administration) through the **No Wrong Door Initiative** (an effort by the Idaho Commission on Aging and others to work together to make it easier for people of all ages, abilities and income levels to learn about and access the services they need).

✓ Inclusion of family caregivers in Idaho's efforts to enhance workplace supports and tax policies that support families and the state's economic vitality.

We Need a Sustained Voice for Caregivers Across the Lifespan

The Idaho Caregiver Alliance (ICA), established through a 3-year Lifespan Respite Grant to the Idaho Commission on Aging from the Administration on Community Living (ACL), has made significant strides in recognizing the importance of family caregivers in Idaho. It is imperative ~~that~~ this work be ~~is~~ sustained. The continued presence of ICA as an umbrella organization is critical to the success of efforts underway to support and sustain the unpaid family caregiver workforce, but with grant funds ending, the future of ICA is uncertain. ***An organizational home and funds to sustain the work of the Alliance are needed to ensure the momentum generated through the Lifespan Respite grant is not lost.***

What are the Next Steps?

The perspectives and expertise of caregivers and allies from public and private organizations in Idaho provide the foundation for the following Action Plan. The plan incorporates evidence-based practices to enhance and build local supports for family caregivers. The aim of this **ACTION PLAN** is to be proactive: to prevent or delay the need for costly institutional care, maximize independence, and keep families together in their communities. Implementation of this **ACTION PLAN** will require an investment of resources, but as demonstrated by caregiver initiatives in other states, the effort will yield significant dividends.

Goal #1: Ensure a streamlined, coordinated system of supports for caregivers across the lifespan, recognizing the unique needs of Idaho’s diverse population.

Family Caregiver Supports

Family caregivers often require assistance to navigate the complex systems and information essential to providing quality care. They also need training on fundamental caregiving responsibilities, such as dispensing medications and managing complex medical and psychological conditions, providing personal care, financial management, and coordinating transportation. Further, caregivers need tools and information regarding prioritization of their own physical and emotional wellbeing or “self-care.” Receiving this support translates into more effective caregiving and cost savings to families and healthcare and social services systems.

Objective:

#1: Develop statewide respite resources

Steps to accomplish:

- A. Convene a respite task force comprised of family caregivers, public and private agencies and organizations, and healthcare and social service providers to:
 - Compile, maintain, and promote use of a resource directory of available respite and respite-like resources such as homemaker, companion services, personal care services, etc.
 - Explore development of a standards-based, statewide respite registry for caregivers across the lifespan
 - Inform caregivers and local information and referral networks about respite and other caregiver support programs offered through the Area Agencies on Aging (AAAs), Centers on Independent Living (CILs), and other entities

- B. Improve training for respite providers across the lifespan.
 - Identify online training resources
 - Maintain a library of resources on Idaho 2-1-1 Careline website
 - Market training opportunities to caregivers, service agencies, and individual respite workers through statewide networks

Objective:

#2: Ensure culturally appropriate information and resources are available to caregivers across the lifespan.

Steps to accomplish:

- A. Embed information about evidence-based caregiver resources into existing statewide information systems, such as the Idaho 2-1-1 Careline and websites for Live Better Idaho, Behavioral Health, Center for Disabilities and Human Development/Family Support, and others.
- B. Compile community resources to support those in a family caregiving role.
 - Partner with AARP Idaho in the development and distribution of a Question and Answer Resource Guide for family caregivers across the lifespan
 - Make these guides available through various audiences including the medical-health neighborhoods built through the seven State Healthcare Innovation Plan (SHIP) Regional Collaboratives and the Regional Behavioral Health Boards (RBHBs)
 - Coordinate with Information and Assistance/Referral specialists at the regional agencies such as Area Agencies on Aging (AAAs) and the Centers on Independent Living (CILs) to promote information and resources for caregivers
- C. Promote the availability of information resources for caregivers to employers, health care and social service providers, faith-based organizations, and others.

Objective:

#3: Establish training resources for family caregivers on caregiving responsibilities, techniques, and strategies for self-care.

Steps to accomplish:

- A. Oversee implementation of the *Powerful Tools for Caregivers (PTC)* training²⁵, ensuring that it is offered across Idaho.
 - Identify funding strategies for delivering both the traditional curriculum that focuses on caring for adults, and the newly developed version for caregivers of children
 - Promote the expanded delivery of PTC

²⁵Powerful Tools for Caregivers, 2016

- Assess the impact of the training including process (attendance, reach) and outcome (satisfaction and impact of class on participants) measures and share these findings with stakeholders.
- B. Collaborate with other organizations on training opportunities for various populations such as:
- Support an annual Family Caregiver Conference
 - Co-sponsor trainings that have a lifespan focus
 - Coordinate with Idaho Department of Health and Welfare (IDHW), Idaho Parents Unlimited (IPUL) and the Federation of Families for Children’s Mental Health (FFCMH) on training for families caring for children/youth with disabilities
 - Provide updates via the Regional Care Coordination Coalitions through Qualis, SHIP Regional Collaboratives, and others

Objective:

#4: Establish a statewide network of experts equipped to serve as information and support navigators or guides for family caregivers across the lifespan.

Steps to accomplish:

- A. Partner with existing local information and referral networks to embed assistance for caregivers across Idaho’s increasingly diverse populations.
- Identify individuals with system knowledge and care management experience within these networks in each geographical area of the state
 - Develop training tools to prepare individuals within organizations to serve as guides to needed services and supports for family members
 - Acknowledge and formally recognize people and organizations who guide caregivers to services and supports
- B. Identify sustainable funding to hire and train personnel to assist caregivers across the lifespan to access services and supports.
- C. Implement marketing campaigns to communicate the availability of assistance for family caregivers and professionals who interact with caregivers.

Goal #2: Increase public awareness about unpaid family caregiving and help people within our communities identify as caregivers.

Public Awareness

A “family caregiver” or “care partner” is a family member or friend who provides physical and/or emotional support or assistance to a loved one of any age who is ill, frail, or has disabilities. Caregivers are relatives or friends who provide support without compensation. Family caregivers are more likely to seek information, respite, and training assistance when they recognize they are in a caregiving role. Such self-identification removes a major hurdle for those who would benefit from assistance. A public campaign is needed to increase awareness about the value of caregivers and to help family caregivers identify and connect with support, information, and training.

Objective:

#5: Family members recognize themselves as caregivers and the general public is aware of the needs and contributions of family caregivers across the lifespan.

Steps to Accomplish:

- A. Expand community engagement through continued coordination of regional caregiver summits and statewide Idaho Caregiver Alliance (ICA) meetings.
 - Coordinate with regional entities such as the AAAs, the CILS, and the RBHBs regarding ICA activities and recommendations
- B. Employ a variety of media and public awareness strategies to promote the value of family caregivers.
- C. Increase awareness and support of family caregiving issues among local, state, and national elected officials.
 - Maintain regular communication with Idaho’s local, state, and federal officials regarding ICA activities and recommendations
 - Support November as National Family Caregiver Month through a Governor’s Proclamation and other means.

- Advocate for all members of Idaho’s Congressional Delegation to join the bipartisan, bicameral Assisting Caregivers Today (ACT) Caucus.
- D. Recognize Idaho employers who demonstrate exemplary accommodation of the needs of family caregivers.
- Inform Idaho employers of the needs of family caregivers and the benefits to both employer and employee of supporting those needs.
 - Develop and distribute awareness information through civic groups, business organizations, and Chambers of Commerce
 - Identify employers who express interest in increased workplace flexibility
 - Promote the use of the WorkFlex Tool Kit²⁶ to targeted employers
 - Nominate exemplary employers for the *When Work Works* Award²⁷

Goal #3: Recognize the importance of family caregiving and embed the voice of family caregivers in policy and system changes.

Systems Change

Caregivers are critical, but often unrecognized, members of the healthcare team. Integrating family caregivers into a team-based, person-centered paradigm with other health care providers will assist them in delivering more effective care. Such integration is critical to achieve the triple aim of improved care (quality and satisfaction), better health, and reduced health care costs. An integrated system provides family caregivers with information about resources and supports, and when appropriate, includes them in treatment planning with their family member and provides the training needed for specialized care.

Objective:

#6: Recognize family caregivers as part of their family members’ health care and social support team.

²⁶ Families and Work Institute, Society for Human Resource Management, & Life Meets Work. (2012). Workflex employee toolkit. Retrieved from http://www.whenworkworks.org/downloads/workflex_employee_toolkit.pdf

²⁷ The award is part of [When Work Works \(WWW\)](#), a research-based initiative which highlights how [effective and flexible workplaces](#) can yield positive business results and help employees succeed at work and at home. It is awarded annually.

Steps to Accomplish:

- A. Advocate for training programs for community health emergency medical services (CHEMS) and community health workers (CHWs) to include modules on family caregiving.
 - Ensure the curriculum for training CHEMS personnel and CHWs include learning outcomes specific to caregiver identification, assessment, and support
- B. Advocate for post-secondary education programs to include curricula that equips health care and social service professionals with the skills to identify and support family caregivers.
- C. Develop a process for use of an assessment tool to determine caregiver training and self-care needs
 - Identify and promote the use of an assessment tool
 - Provide caregiver assessment tool kits to health and behavioral healthcare providers and local and regional agencies who interact with caregivers

Objective:

#7: Embed family caregiver perspective and involvement in Idaho's efforts to transform its primary care, long-term care, and behavioral health systems.

Steps to Accomplish:

- A. Ensure the Idaho Healthcare Coalition is apprised of family caregiver issues and concerns.
 - ICA's representative to the Idaho Healthcare Coalition (IHC) will share ICA information, reports, and plans at IHC meetings.
 - Advocate for caregiver representation on each of the SHIP's seven Regional Health Collaboratives
- B. Increase the awareness and knowledge of family caregiving concerns and resources for members of the BHPC and the RBHBs.
 - Share information between the BHPC and the ICA through reports to both bodies at their respective meetings
 - Ensure that caregivers on the BHPC and the RBHBs are equipped with caregiving information to serve as advocates

- C. Promote the involvement of family caregivers in the efforts to coordinate and streamline Idaho’s long-term care system via the *No Wrong Door Initiative*.
- Ensure that the Person-Centered Planning/Counseling training curriculum includes modules on how to identify and support family caregivers

Objective:

#8: Include family caregivers in Idaho’s efforts to enhance employment opportunities and tax policies that support families and the state’s economic vitality.

Steps to Accomplish:

- A. Collaborate with policymakers to minimize barriers that prevent family caregivers from maintaining paid employment.
- Enact leave policies and benefits that are supportive of caregivers
 - Reduce restrictions on the availability of leave benefits
 - Expand the definition of care recipients and applicable conditions under which leave can be taken
- B. Work with employers and organizations representing employers to support the growing population of working caregivers.
- Enhance caregiver information and support available through benefit plan
 - Implement fair and flexible personnel policies
- C. Collaborate with policymakers and others to update the state tax code to provide more comprehensive caregiver deductions and tax credits.

Goal #4: Ensure a coordinated voice for family caregivers in Idaho through the development of a sustainable structure for the Idaho Caregiver Alliance.

Infrastructure

The Idaho Caregiver Alliance (ICA) is a broad coalition of public and private organizations and individuals. The goal of the Alliance is to advance the well-being of caregivers by promoting collaboration that improves access to quality support and resources for family caregivers across the

lifespan. All members realize the value of family caregivers and recognize the limitations of existing systems to provide support to caregivers across the lifespan. The ICA has utilized this shared commitment to

- assess the needs and capacity of caregivers and support systems in Idaho
- engage caregivers throughout Idaho by hosting regional summits in Lewiston and Idaho Falls
- build statewide capacity to support caregivers through the evidence-based Powerful Tools for Caregivers (PTC) program by providing training and technical resources
- conduct a pilot program to deliver emergency respite to caregivers
- convene and report findings to members of the Idaho Legislature, IHC and the BHPC
- represent unpaid family caregivers on the IHC.

The continued presence of ICA as a public-private organization is vital to the success of ongoing efforts to support and sustain the unpaid family caregiver workforce. **An organizational home and funds to sustain the work of the Alliance are needed.**

Objective:

#9: Build on the established foundation of the Idaho Caregiver Alliance and ensure that the Idaho caregivers across the lifespan have a coordinated voice.

Steps to accomplish:

- A. Establish sustained funding for the Idaho Caregiver Alliance.
 - Meet with public and private partners to secure commitments for ongoing funding
 - Seek grant and other funding sources to support general operations and specific projects as identified in this action plan
- B. Serve as a voice and advocate for family caregivers across the lifespan to ensure the perspective of the caregiver is considered in all agendas.
 - Collaborate with a broad array of stakeholders including, but not limited to:
 - public agencies, such as the Idaho Departments of Health and Welfare, Labor, Education, and Commerce; Idaho Commission on Aging; AAAs; District Health Departments: Veterans Administration Medical Center (VAMC) and Veterans Hospital Administration (VHA)
 - planning and advocacy groups, such as IHC, BHPC, Developmental Disabilities Council (DDC), Consortium of Idahoans with Disabilities (CID), FFCMH, IPUL, Idaho Alzheimer's Planning Group (IAPG), Justice Alliance for Vulnerable Adults (JAVA), State Independent Living Council (SILC), Senior Health Insurance Benefits Advisors (SHIBA), etc.

- professional associations, such as Idaho Guardians and Fiduciary Association (IGFA), AARP Idaho, Idaho Association of Community Providers, Idaho Hospital Association (IHA), Idaho Health Care Association (IHCA), Idaho Public Health Association (IPHA), Idaho Primary Care Association (IPCA)
- business groups and individual employers (Chamber of Commerce, etc.)
- healthcare delivery and payer systems, such as hospitals, insurance providers, patient-centered medical homes (PCMHs), behavioral health treatment facilities
- churches and other faith-based organizations
- education systems (community colleges and universities, Family Practice Medical Residency of Idaho, etc.)

Objective:

#10: Assure data are available to inform decision-making related to family caregiver supports and services.

Steps to Accomplish:

- A. Implement ongoing data collection regarding the needs of family caregivers in Idaho.
 - Continue to gather and use information from family caregivers to inform program planning and implementation
 - Continue to collect and improve existing data about caregivers at state and community levels through the use of Behavioral Risk Factor Surveillance System (BRFSS) and other existing tools
 - Partner with economic development and data analysis organizations to track and synthesize data pertaining to economic impact and implications of family caregiving

- B. Implement data collection strategies to evaluate impact of programs and systems change on family caregivers.
 - Use findings to guide quality improvement and program planning
 - Report findings to stakeholders, funders, and policy makers to ensure accountability and responsible use of resources

Acronyms and Abbreviations

ACL	Administration on Community Living (federal agency)
AARP	Formerly the American Association for Retired Persons – now just AARP
AAA	Area Agency on Aging, six of these located across Idaho
BH	Behavioral Health, a division within Department of Health and Welfare
BHPC	State Behavioral Health Planning Council
BRFSS	Behavioral Risk Factor Surveillance System
CHEMS	Community Health Emergency Medical Services
CHW	Community Health Workers – personnel that are part of the Statewide Health Innovation Plan
CIL	Center on Independent Living (same as Independent Living Center; three of these across Idaho)
CSA	Center for the Study of Aging at Boise State University
DDC	Developmental Disabilities Council
FPMR	Family Practice Medical Residency
IAPG	Idaho Alzheimer’s Planning Group
ICA	Idaho Caregiver Alliance
ICOA	Idaho Commission on Aging
IDHW	Idaho Department of Health and Welfare
IFFCMH	Idaho Federation of Families or Children’s Mental Health, a non-profit organization
IGFA	Idaho Guardians and Fiduciary Association
IHA	Idaho Hospital Association
IHC	Idaho Healthcare Coalition
IHCA	Idaho Health Care Association (nursing homes and assisted living facilities)
ILC	Independent Living Center (same as Center on Independent Living)
IPCA	Idaho Primary Care Association
IPHA	Idaho Public Health Association

JAVA	Justice Alliance for Vulnerable Adults
NWD	No Wrong Door – an initiative of the Idaho Commission on Aging
PCC/PCP	Person-Centered Counseling/Person-Centered Planning
PCMH	Person-Centered/Patient-Centered Medical Home
PTC	Powerful Tools for Caregivers, an evidence-based program teaching caregivers about self-care
RBHB	Regional Behavioral Health Board
SHIBA	State Health Insurance Benefit Advisors
SHIP	State Healthcare Innovation Plan
SILC	State Independent Living Council
VAMC	Veterans Administration Medical Center
VHA	Veterans Hospital Administration

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Fact Finding Trip to Oklahoma: How to improve the Idaho employees' health insurance system
By Senator Steven Thayn

I recently made a trip to Oklahoma to study that state's system providing health coverage to state employees. I visited with director Frank Wilson who runs the Employee Group Insurance Division (EGID), senior vice president Eric Wright of Health Smart, Rep. Glen Mulready district 68, and Dr. Keith Smith founder of the Surgery Center of Oklahoma.

My overarching concern is to improve access and outcomes for Idaho state employees while reducing costs to the taxpayers. **Any modification to the present system must be a win-win solution where the people benefit from lower costs and increased choices.**

Key points and highlights of the trip include:

- The Oklahoma system spends just over \$7,000 per employee as compared to \$12,500 in Idaho. If the Idaho system were as efficient as Oklahoma's, savings would be around \$90 million
- Overhead costs are only 3-4% for the Oklahoma plan vs. 10-15% for most plans
- Oklahoma uses market principles and choice; not managed care
- Oklahoma started a surgery and imaging diversion program on a pilot basis that is saving about \$10 - \$15 million in 2016
- Oklahoma will expand the surgery and imaging diversion program in 2017 which is expected to reduce overall medical costs by 15% while the Idaho state employee plan is experiencing a 10% increase in medical costs

Before getting into the details of the medical diversion program, a little background on the Oklahoma system is helpful. The Employee Group Insurance Division (EGID) has 185,000 covered lives which includes state employees, most school teachers, and most other public employees in Oklahoma. This is a voluntary program for cities, counties, and school districts.

EGID has \$360 million in reserves.

The total EGID budget is around \$1 billion with about \$700 million for medical care.

EGID is self-funded, has its own network of providers, makes its own contracts, and acts like a commercial insurance program.

While Idaho's program operates differently, the medical and imaging diversion program can work in Idaho just as it can in Oklahoma. My focus in this paper is the diversion program.

Context:

I have been very interested in reforming Idaho's medical delivery system believing costs can be reduced by as much as 50% while improving access, and health outcomes. Reforming Idaho's health insurance program for state employees figures prominently in this effort. I have concluded reducing medical costs while improving outcomes requires a four-pronged effort.

1. Focus on providing access to timely, affordable primary care for all using market principles. The importance of primary care has been largely ignored under the ACA.
2. Change the way primary care is funded; no insurance to pay for primary care because of paperwork costs for billing insurance for primary care are inefficient.
3. Get funds into the hands of consumers using HSAs and other strategies so that people direct the spending of a greater percentage of medical dollars
4. Price transparency

I have discovered possible solutions for points 1-3; however, the solution to price transparency has eluded me until I went to Oklahoma. The Oklahoma medical diversion program is based upon price transparency. Another piece of the puzzle may have been found.

Oklahoma's Medical and Imaging Diversion Program

The diversion program is based upon a simple concept. The biggest variable in imaging and surgery costs is facility costs not the cost of surgeons. The surgery and imaging costs can vary between 200 and 700 percent depending on the facility used.

For example, in the Boise area an abdominal ultrasound may cost between \$172 and \$635 or a variation of 369 percent. A colonoscopy varies between \$1,968 and \$4,894. Knee arthroscopy varies between \$4,720 and \$12,726.

The Oklahoma program is run by Health Smart which contacts each Oklahoma state employee that is going to have surgery or imaging services and inform them of the difference in costs between different providers. The employee has the option of using any facility; however, if they use a quality, lower cost provider then all co-pays and deductibles are waived. If the employee uses a high cost provider then they must pay the co-pays and deductibles indicated in their plan.

Let's use the above example of knee arthroscopy and look at it from the perspective of a state employee in Oklahoma. The employee needs a knee arthroscopy procedure. The employee gets pre-approval. Health Smart contacts the employee and gives him/her the following options. The employee can go to a facility that charges closer to the \$4,720 and have no co-pays or deductibles -- zero out of pocket to the employee or they can go to another facility that charges closer to the \$12,726 amount and have a \$500 deductible (if it has not yet been met) plus a 20 percent co-pay of \$2,546 for a total of \$3,046 cost to the employee.

The chart below does not provide exact numbers because of several factors explained later; however, it does give an idea of the program.

	Facility cost	Oklahoma's Share	Employee's Share
Non-diversion option	\$12,726	\$9,680	\$3,046
Diversion option	\$ 4,720	\$4,720	\$000
Savings	\$ 8,006	\$4,960	\$3,045

The Oklahoma EGID does some groundwork to make this happen using Health Smart as a vendor to help determine fair price and contact the employee. First, a fair price is determined. Second, an agreement is reached between EGID and the facility for bundled pricing. A bundled price means that the state EGID will pay the hospital a bundled payment that will pay the facility, the charge of the surgeon, and all other costs and charges. The state pays one price and the facility pays everyone involved.

Health Smart uses the Healthcare Bluebook to determine a fair price. Then, the EGID group contacts facilities and agrees on bundled pricing. Any willing provider may participate at the agreed upon rate. The state likes the program because the state saves money. The patient likes the program because they save money. The facility likes the program because they get cash payment without having to collect co-pays or deductibles. It is a win-win for everyone except the large hospitals who typically have the highest costs.

Virtual PCMH Application

<i>Question</i>	<i>Answer</i>	<i>Scoring</i>
Page 1. Clinic Profile		
Clinic Name:		
Street Address:		
City:		
County:		2 = urban 5 = rural 6 = frontier
Zip Code:		
Identify your SHIP cohort	(dropdown box with 1, 2, 3)	

Page 2. Alignment of project with shortage area designation		
<p>Are you located in a federally-designated Medically Underserved Area (MUA) or a Medically Underserved Population (MUP) Service Area?</p> <p>https://datawarehouse.hrsa.gov/tools/analyzers/muafind.aspx</p> <p><i>MUAs and MUPs apply the Index of Medical Underservice (IMU) to information in a defined service area to acquire a score for the area.</i></p>	<p><input type="checkbox"/> MUA</p> <p><input type="checkbox"/> MUP</p> <p><input type="checkbox"/> Neither</p>	<p>1= yes (MUA or MUP)</p> <p>0= neither</p>
<p>Are you located in a federally-designated Health Professional Shortage Area (HPSA)?</p> <p>https://datawarehouse.hrsa.gov/tools/analyzers/hpsafind.aspx</p> <p><i>HPSAs are federal designations which identify and indicate geographic areas or populations with a deficit in primary care services within medical, dental, and mental health categories.</i></p>	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>1= yes</p> <p>0= no</p>
<p>Check all that apply:</p>	<p><input type="checkbox"/> Primary Care HPSA</p> <p><input type="checkbox"/> Dental Health HPSA</p> <p><input type="checkbox"/> Mental Health HPSA</p>	

Page 3. Telehealth

For more information, visit:

<http://ship.idaho.gov/WorkGroups/TelehealthCouncil/tabid/3059/Default.aspx>

Do you currently have a telehealth program in your clinic?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Please describe your telehealth program:		0-3
Please estimate the number of patients per month that receive services via telehealth:		0-3
Please submit documentation to demonstrate that you have an active program. Examples include, but are not limited to, clinic policies, outreach materials, etc.	<u>Upload link</u>	

Page 4. Community Health Emergency Medical Services (CHEMS)

For more information, visit:

<http://ship.idaho.gov/WorkGroups/CommunityHealthEMS/tabid/3050/Default.aspx>

Do you currently partner with an EMS agency to provide patient care services through CHEMS?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Please describe your CHEMS program partnership services:		0-3
Please estimate the number of patients per month that receive services via CHEMS:		0-3
Please submit documentation to demonstrate that you have an active program. Examples include, but are not limited to, clinic policies, formal EMS agency agreement, etc.	<u>Upload link</u>	

Page 5. Community Health Workers (CHWs)

For more information, visit:

<http://ship.idaho.gov/WorkGroups/CommunityHealthWorkers/tabid/3054/Default.aspx>

Do you utilize CHW services through employment or an agreement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Please describe your CHW program:		0-3
Please estimate the number of patients per month that receive services from CHWs:		0-3
Please submit documentation to demonstrate that you have an active program. Examples include, but are not limited to, clinic policies, outreach materials, CHW schedule, etc.	<u>Upload link</u>	

Page 6: Alignment of project with shortage area designation and the needs of the population in the clinic's service area.

For more information, please visit:

<https://datawarehouse.hrsa.gov/tools/analyzers/hpsafind.aspx>

<https://www.ruralhealthinfo.org/am-i-rural>

<https://datawarehouse.hrsa.gov/tools/analyzers/muafind.aspx>

Please describe how your telehealth, CEMS, and/or CHW program(s) is aligned to meet the needs of your shortage area designation and needs of the population in your service area?		0-10
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Page 7: Completion & Submission

By electronically submitting this application, I attest the answers provided are complete and accurate to the best of my ability at the time of submission.

Further, I attest that I am the authorized representative of the business entity permitted to submit this application for consideration.

Name of person completing application:		
Job Title:		
Email address:		
Phone number:		



SHIP Project Management Dashboard

Prepared for the Idaho Healthcare Coalition

Grant Year 2 Quarter 3

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

Project Implementation Updates

- The SHIP Team collected 72 interest surveys in the third quarter for a total of 195 interest surveys collected to date (Goal 1, Measure 1).
- Collaboration continues between HIT vendors and the SHIP Team to develop the patient attribution report needed to count individuals participating in the SHIP Model Test (Goal 1, Measures 10 and 11; Goal 2, Measure 2).
- The quarterly target for Goal 5, Measure 3 was set to zero when quarterly targets were revised in November as part of the CMMI success measure revision process.

SHIP Success Measures

Goal 1	98%	96%	100%	100%					100%	ND	ND	
	QT = 200	QT = 55	QT = 55	QT = 55	AT = 550	AT = 550	AT = 55	AT = 55	QT = 18	QT = 275k	QT = 275k	
Goal 2	100%		ND									
	QT = 55		QT = 275k		AT = 55		QT = 0					
Goal 3					100%							
	AT = 7		AT = 55		QT = 25		QT = 0					
Goal 4												
	QT = 0	AT = 6	AT = 16	SAT = 0	QT = 0	QT = 0						
Goal 5												
	AT = 0		AT = 55		QT = 0							
Goal 6												
	AT = 4		AT = 275k		AT = 20%							
Goal 7												
	AT = TBD				AT = TBD							

- SHIP success measure is not reported.
 - SHIP success measure is slightly off target (between 75% and 89% of target).
 - SHIP success measure is on target (≥90% of target).
 - SHIP success measure is not on target (<75% of target).
- QT = Quarterly Target (Q1=Apr 30, Q2=July 31, Q3=Oct 31, Q4=Jan 31)
 AT = Annual Target (Jan 31)
 SAT = Semiannual Target (Q2=July 31, Q4=Jan 31)
 ND = No Data

Please refer to the SHIP Operational Plan and project charters for details regarding all quarterly, semiannual, and annual accountability targets.

SHIP Success Measures by Goal

Goal 1 Measurements: PCMH Transformation	
1	Q Cumulative # (%) of primary care clinics that submit an interest survey to participate in a SHIP cohort. Model Test Target: 270.
2	Q Cumulative # (%) of primary care clinics selected for a SHIP cohort that have completed a PCMH readiness assessment and a Transformation Plan. Model Test Target: 165.
3	Q Cumulative # (%) of targeted primary care clinics selected for a SHIP cohort. Model Test Target: 165.
4	Q Cumulative # (%) of primary care clinics selected for a SHIP cohort, of the total primary care clinics in Idaho. Model Test Target: 165.
5	A Cumulative # (%) of targeted providers participating in primary care clinics selected for a SHIP cohort. Model Test Target: 1,650.
6	A Cumulative # (%) of providers in primary care clinics selected for a SHIP cohort, of the total number of primary care providers in Idaho. Model Test Target: 1,650.
7	A Cumulative # (%) of primary care clinics selected for a SHIP cohort receiving an initial transformation incentive payment and achieving technical support benchmarks for retaining the payment. Model Test Target: 165.
8	A Cumulative # (%) of primary care clinics selected for a SHIP cohort that achieve their transformation goals as specified in their Transformation Plan. Model Test Target: 165.
9	Q Cumulative # (%) of primary care clinics selected for a SHIP cohort that achieve national PCMH recognition/ accreditation. Model Test Target: 165.
10	Q Cumulative # (%) of Idahoans who enroll in a primary care clinic selected for a SHIP cohort (of total state population). Model Test Target: 825,000.
11	Q Cumulative # (%) of Idahoans who enroll in a primary care clinic selected for a SHIP cohort (of target population). Model Test Target: 825,000.
Goal 2 Measurements: Electronic Health Records (EHRs)	
1	Q Cumulative # (%) of primary care practices selected for a SHIP cohort with EHR systems that support HIE connectivity. Model Test Target: 165.
2	Q Cumulative # (%) of Idahoans who enroll in a primary care practice selected for a SHIP cohort that have an EHR that is connected to HIE. Model Test Target: 825,000.
3	A Cumulative # (%) of primary care practices selected for a SHIP cohort with an active connection to the HIE and sharing/receiving HIE transactions for care coordination. Model Test Target: 165.
4	Q Cumulative # (%) of hospitals connected to the HIE and sharing data for care coordination. Model Test Target: 21.
Goal 3 Measurements: Regional Collaboratives (RCs)	
1	A Cumulative # of RCs established and providing regional quality improvement guidance and working with PHDs to integrate the Medical-Health Neighborhood. Model Test Target: 7.
2	A Cumulative # of primary care practices selected for a SHIP cohort that receive assistance through regional SHIP PHD team. Model Test Target: 165.
3	Q Cumulative # of primary care practices selected for a SHIP cohort who have established protocols for referrals and follow-up communications with service providers in their Medical-Health Neighborhood. Model Test Target: 165.
4	Q Cumulative # of patients enrolled in a primary care practice selected for a SHIP cohort whose health needs are coordinated across their local Medical-Health Neighborhood, as needed. Model Test Target: 825,000.
Goal 4 Measurements: Virtual PCMHs	
1	Q Cumulative # (%) of Virtual PCMHs established in rural communities following assessment of need. Model Test Target: 50.
2	A Cumulative # (%) of regional CHEMS programs established. Model Test Target: 13.
3	A Cumulative # (%) of CHEMS program personnel trained for Virtual PCMH coordination. Model Test Target: 35.
4	SA Cumulative # (%) of new community health workers trained for Virtual PCMH coordination. Model Test Target: 125.
5	Q Cumulative # (%) of continuing education conferences held for CHW and CHEMS Virtual PCMH staff. Model Test Target: 2.
6	Q Cumulative # of designated Virtual PCMH practices that routinely use telehealth tools to provide specialty and behavioral services to rural patients. Model Test Target: 36.
Goal 5 Measurements: Data Analytics	
1	A Cumulative # (%) of primary care practices selected for a SHIP cohort with access to the analytics system and dashboard reporting. Model Test Target: 165 by 2020.
2	A Cumulative # (%) of primary care practices selected for a SHIP cohort that are meeting the clinical quality reporting requirements for their cohort. Model Test Target: 165.
3	Q Cumulative # (%) of RCs provided a report of PCMH clinic CQM performance data. Model Test Target: 7.
Goal 6 Measurements: Alternative Payment Reimbursement Models	
1	A Count of payers representing at least 80% of the beneficiary population that adopt new reimbursement models. Model Test Target: 4.
2	A Count of beneficiaries attributed to all providers for purposes of alternative reimbursement payments from SHIP participating payers. Model Test Target: 825,000.
3	A Percentage of payments made in non-fee-for-service arrangements compared to the total payments made by SHIP participating payers. Model Test Target: 80%.
Goal 7 Measurements: Lower Costs	
1	A Total population-based PMPM index, defined as the total cost of care divided by the population risk score. Model Test Target: TBD.
2	A Annual financial analysis indicates cost savings and positive ROI. Model Test Target: 197%.

Clinical Quality Measures Catalog

PCMH Cohort Clinics Measures (proposed)– Update 12/2016

Measures 1-4 (Award Year 2)

Measure Title	Measure Description
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention CMS 138v4, PQRS 226, NQF 0028	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents CMS 155v4, PQRS 239, NQF 0024	Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP)* or Obstetrician / Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported: <ul style="list-style-type: none"> • Percentage of patients with height, weight, and body mass index (BMI) percentile documentation • Percentage of patients with counseling for nutrition • Percentage of patients with counseling for physical activity <p><i>*This measure includes all providers such as Physicians, Physician Assistants, and Nurse Practitioners in Family Medicine, Primary Care Medicine, General Practice Medicine, Pediatric Medicine, or Obstetrician/Gynecologist (OB/GYN) Medicine. The data is collected based on procedures conducted rather than the type of provider.</i></p>
Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up Plan CMS 69v4, PQRS 128, NQF 421	Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter.
Diabetes: Hemoglobin A1c Poor Control CMS 122v4, PQRS 001, NQF 0059	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9% during the measurement period.

Measures 5-10 (Award Year 3)*

Measure Title	Measure Description
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan CMS 2V5, NQF 0418, ACO 18, PQRS 134, MIPS 134	Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.
Childhood Immunization Status CDC, National Immunization Survey	Percentage of children aged 19-35 months who had ≥4 doses of diphtheria, tetanus and acellular pertussis (DTaP), ≥3 doses of poliovirus vaccine, ≥1 dose of measles-containing vaccine, full series of Hib vaccine (≥3 or ≥4 doses, depending on product type), ≥3 doses of HepB, ≥1 dose of varicella vaccine, and ≥4 doses of PCV.
Documentation of Signed Opioid Treatment Agreement PQRS 412, MIPS 412	All patients 18 and older prescribed opiates for longer than six weeks duration who signed an opioid treatment agreement at least once during Opioid Therapy documented in the medical record.
Access to care	Members report adequate and timely access to PCPs, behavioral health, and dentistry (measure adjusted to reflect shortages in Idaho). <i>The SHIP operations team will discuss how to operationalize this in the coming weeks and months.</i>
Maternal Depression Screening CMS 82v4, NQF 1401, PQRS 372, MIPS 372	The percentage of children 6 months of age who had documentation of a maternal depression screening for the mother.
Use of Appropriate Medications for Asthma CMS 126v4, NQF 0036, PQRS 311	Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period.

*Contingent on approval from Idaho Healthcare Coalition (IHC)

Measures 11-16 (Award Year 4)*

Measure Title	Measure Description
Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling NQF 2152, PQRS 431, MIPS 431	Percentage of patients aged 18 years and older who were screened at least once within the last 24 months for unhealthy alcohol use using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user.
Plan All-Cause Readmissions NQF 1768	For patients 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: 1. Count of Index Hospital Stays* (denominator) 2. Count of 30-Day Readmissions (numerator) 3. Average Adjusted Probability of Readmission *An acute inpatient stay with a discharge during the first 11 months of the measurement year (e.g., on or between Jan1 and Dec1).
Measure 13	To be determined at a later date by Clinical Quality Measures Workgroup and Data Element Mapping Subcommittee.
Measure 14	To be determined at a later date by Clinical Quality Measures Workgroup and Data Element Mapping Subcommittee.
Measure 15	To be determined at a later date by Clinical Quality Measures Workgroup and Data Element Mapping Subcommittee.
Measure 16	To be determined at a later date by Clinical Quality Measures Workgroup and Data Element Mapping Subcommittee.

*Contingent on approval from Idaho Healthcare Coalition (IHC)



SHIP Operations and IHC Workgroup Report to the Idaho Healthcare Coalition December 14, 2016

SHIP OPERATIONS:

SHIP Contracting/Request for Proposal (RFP) Status:

- **Report Items:**
 - The hiring process for the Goal 3 and 4 SHIP Project Manager (responsible for Goal 3 Regional Collaboratives development as well as Goal 4 Virtual PCMH portfolio) has been completed; Erin McIlhany started with SHIP in that capacity on 12/09/2016.

SHIP Administrative Reporting:

- **Report Items:**
 - The following items were submitted to the Center of Medicare and Medicaid Innovation (CMMI) on December 1, 2016:
 1. The Non-Competing Continuation Application for Award Year 3 (AY3) State Innovation Models Initiative (SIM) Grant Funds
 2. The SHIP Operations Plan
 3. CMMI Quarterly Report for Quarter 3, 2016
 - Multiple contracts are under development for AY3 which commences on February 1, 2017.

Regional Collaboratives (RC):

- **Report Items:**
 - District 1:
 - Report Items: RC1 met on November 16th to discuss project grant ideas, virtual PCMH, Q/I data obtained from clinics and HRSA, update on regional Q/I projects, IHDE update from our “go-live” clinic, and January 25th joint clinic RC meeting. The next meeting is scheduled for 12/7/16.
 - District 2:
 - Report Items: Executive Leadership team met informally on November 17th to discuss RC grant application and projects. **November 29th**: RC2 Regional Collaborative meeting was held to discuss and approve RC Grant application projects.
 - District 3:
 - Report Items: Upcoming meeting of SWHC-12/6 to review workgroup activities and approve RC grant, CHW next steps discussion, Pfizer PopData presentation, and policy role discussion. Region 3 BHI Workgroup meeting on 11/28 included introduction of new co-chair Dr. James Shackelford, TRHS psychiatrist; discussion of school-based program with Pathways; and an update from SAMG.
 - Wellness Group-11/15 meeting discussed the target wellness visits for 4-19yo (next meeting will include Medicaid, vision care representation, and oral health representation.) Oral Health Group meeting on 11/17 discussed work with the IOHA on distribution of communication and screening best practice materials and explored options for shared billing between medical and dental practices.

- Action Requests: Consideration of CHW reimbursement as a future agenda item and consideration of hosting a legislative summit/luncheon for legislators.
 - District 4:
 - Report Items: The CHC met on November 1. An overview of the RC Summit was provided. The Population Health Workgroup (PHW) granting process was discussed - each RC would have access to up to \$30,000/year for a project for 2017 and 2018. That money can be expanded if partnering with another district and more may be available depending on total requests from other RC's. Several ideas included:
 - Outreach/education/awareness to the refugee community on the healthcare insurance enrollment – barriers to timeliness of enrollment, education/language barriers.
 - RC infrastructure building/resources development to strengthen the foundation of the CHC – (i.e. map of resources in the community, value statement development).
 - Caregivers – how to include them as part of the care team, provide support for them in their role of taking care of medical needs; use Idaho Caregiver Alliance for support.
 - Brief overview of PCMH Congress 2016 was provided where there was a focus on the Medical Neighborhood. It was noted that “Health” was not part of the phrase and the focus of this conference was primary care to specialty care/hospital coordination. The highest identified solution was the use of a Care Coordination Compact (CCC) that identified roles of the referring and receiving physicians in pre-consultation, consultation, and co-management stages. The Oral Health representative will be meeting with HD3 and HD4 SHIP staff and the Oral HealthAlliance to discuss referral standards. Future CHC roles with the Cohort Two clinics and our responsibility in supporting these clinics in their PMCH transformation were discussed. Because of our task of moving from advisory to action, the CHC may need to look towards forming subgroups or workgroups that are extensions of the CHC.
 - District 5:
 - Report Items: A full collaborative meeting was held November 18, and action items included an approval of our September minutes and approval of moving forward with the RC grant initiative that's now available. Our members held an extensive conversation regarding initiatives they would like to pursue given that the application period is short. Discussion topics that were reviewed during the meeting included an update of the last IHC meeting, our strategic plan, next steps for our collaborative, and an update of the Cohort Two application and process.
 - District 6:
 - Report Items: upcoming meetings include the SHC Executive Committee: January 11, 2017; SHC Clinic Committee: February, 2017; and the SHC Medical Health Neighborhood: February, 2017. Two Executive Committee meetings and a Medical-Health Neighborhood meeting were convened in November, details in Attachment C. Significant time was spent planning for

submission of the RC grant application including multiple stakeholder meetings, the RC grant application webinar, research, and application responses. PHD6 SHIP staff presented PCMH 101 to an ISU Healthcare Administration class, U.S. Health Systems. The presentation was well received and the students were engaged throughout the presentation, asking questions about PCMH, Idaho healthcare programs, and SHIP. The instructor has invited us back to present to future classes. Multiple meetings were attended by PHD6 SHIP staff including: PCMH Webinar 5, RC grant application webinar, Southeastern Idaho Public Health Leadership Development training, Parents as Teachers Advisory Board meeting, Region 6 Idaho Oral Health Network meeting, Population Health Workgroup meeting, meeting with HMA coach Pat Dennehy to discuss student engagement opportunities at Idaho State University, meeting with ISU's Health Education and Promotion Practicum Coordinator, the IHC meeting, the Regional Behavioral Health Board meeting, the Chronic Disease Coalition meeting, IDHW SHIP Manager calls, District SHIP Manager calls, and SHIP staffing meeting with the Community Health Director.

o District 7:

- Report Items: EHC Executive Committee was held November 2nd, 2016 (1st Wednesday of every month) but will be moved in December to November 30th due to conflict. Clinical quality measure discussion held on regional collaborative baseline data from clinics. Strategic plan reviewed, will wait for review from Population Health Workgroup for any edits. Regional Collaborative Summit discussed. Discussion held on topics that were debated at RC Summit including IHDE, Cohort Two clinic participation, and HMA coaching. Also discussed were helping to define roles of RC going forward. Eastern Health Collaborative (EHC) Meeting: November, 2016. Agenda for Regional Collaborative focused on Medical-Health Neighborhood, PCMH transformation and health outcomes. PCMH transformation focused on baseline data that we are able to collect from clinics and other sources to help identify gaps or needs in local health resources. Discussion surrounding future barriers to PCMH transformation in region. EHC members were given updated list of pediatric mental health resources. Discussed RC grant that was recently announced. Idea generating discussion held, members will continue to generate ideas for next week and finalize potential designs for the Eastern Health Collaborative to select. No meeting in December due to end of year constraints on members. Baseline data will again be visited and PCMH efforts in region were discussed..

• **Next Steps:**

- o District 1: Regional next steps include replacing Dr. Dixon, selecting a Regional Collaborative mini grant idea, continuing to develop Medical-Health Neighborhood, and work with clinics on communication standards between partners.
- o District 2: None reported.
- o District 3: The SWHC will submit the RC grant application which is primarily aligned with **sustainability**, **PCMH support**, and **Medical-Health Neighborhood** development components of the strategic plans. Workgroups will continue to meet and will be asked to

present their project reports to the SWHC at the January meeting to support **enhanced communication and feedback**. In addition, we have asked the IHC to take two items (CHW reimbursement and legislative summit) into consideration based on the guidance of the SWHC.

- District 4: The next CHC meeting is scheduled for Dec 6 to discuss and identify RC project.
- District 5: The SCHC strategic plan will continue to be reviewed and revised as we move forward with our efforts as a collaborative. Our Cohort Two clinics will be invited to attend the next available RC meeting once their agreements are signed with the SHIP project. We will discuss the grant initiative, once it's awarded, and next steps to fulfill what's been proposed by our RC. Members continue to reinforce collaboration among Cohort One clinics, and plan to continue this effort during Cohort Two.
- District 6: Planning for Cohort One to Cohort Two transition process. Follow-up on transitions of care opportunities for the Medical-Health Neighborhood. Strategic plan updates. Plan agenda for next Clinic Committee Meeting. Plan agenda for next Medical-Health Neighborhood Meeting. Meet with ISU Nursing program to identify PCMH training and internship opportunities, follow up with Pat Dennehy, HMA coach. If RC grant is awarded, continue suicide prevention program planning. Continue PCMH transition support via QI Specialist, HMA, and state SHIP team.
- District 7: Continue to facilitate communication among healthcare services for possible solutions to referral management and HIE connection. QI Specialist continues to support PCMH transformation efforts of Cohort One clinics and looks forward to Cohort Two clinics being announced. Contact primary care clinics for Cohort Three recruitment and other PCMH transformation opportunities. Increase utilization of Medical-Health Neighborhood by PCMH clinics.

ADVISORY GROUP REPORTS:



Telehealth SHIP Subcommittee:

- **Report Items:**

- Fourth in the series of six 'SHIP Telehealth' webinars was held on November 8, 2016, and attended by 10 participants. The webinar focused on Telehealth equipment selection. Webinars are recorded and publicly available on the SHIP website.

- **Next Steps:**

- Telehealth webinars schedule*:
 1. Sep 28, 2016 Demand Analysis
 2. Oct 11, 2016 Readiness Self-Assessment
 3. Nov 2, 2016 Reimbursement, Billing, and Coding
 4. Nov 8, 2016 Equipment Selection
 5. Dec 14, 2016 Program Development
 6. Jan 10, 2017 Evaluation and Monitoring
- *Past webinars are recorded and available on the SHIP website.
- The Bureau of Rural Health & Primary Care staff is working on developing a grant application that will provide an opportunity for SHIP PCMH Cohort One clinics to apply for funding to develop and implement a Telehealth program.



Community Health Workers:

- **Report Items:**
 - Idaho State University (ISU) CHW training is finishing its last two weeks.
 - IDHW is currently recruiting for the next training cohort to begin January 10, 2017; currently there are six (6) confirmed trainees attending the next training course.
 - The CHW Advisory Workgroup is working with ISU to develop four and host up to eight asynchronous educational modules.
 - The CHW measure collection tool has been created with support from the Boise State University (BSU) research student.
 - SHIP staff has been collaborating with the IDHW Diabetes, Heart Disease, and Stroke Program in developing a marketing strategy and materials to promote the adoption of CHWs in Idaho. Two short videos have been produced and a CHW public webpage is currently in design with Davies Moore.
- **Next Steps:**
 - The CHW Advisory Workgroup will continue evaluating and accepting applications for the Spring 2017 training to start in January of 2017.
 - ISU to deploy the evaluation tool to the Fall 2016 CHW Training Cohort, and report back to IDHW with results.
 - ISU and CHW Advisory Workgroup to continue to work to find a suitable template and information for optional educational modules.

WORKGROUP REPORTS:



Community Health EMS:

- **Report Items:**
 - The statewide CHEMS Workgroup meetings will take place every other month or as needed.
 - The internal CHEMS Workgroup continues to meet every Monday.
 - November 17th – 2nd BLS/ILS Sub Workgroup meeting/conference call.
 - Attendees: Donnelly Rural Fire District, Payette County Paramedics, Ada County Paramedics, Clearwater Hospital, Shoshone County EMS, Kamiah Ambulance, Boise State University, Idaho State University, Bureau of EMS and Preparedness, and Bureau of Rural Health.
 - November 30th – CHEMS Statewide Workgroup meeting
 - Attendees: Boise State University, Central District Health Department, Idaho State University, PacificSource, Medicaid, Kamiah Ambulance, Shoshone County EMS, Ada County Paramedics, Payette County Paramedics, Donnelly Rural Fire District, Clearwater County Ambulance, Lewiston Fire Department, Blackfoot Fire Department, Salmon Advanced EMTs, Bureau of EMS and Preparedness, and Bureau of Rural Health.
 - BLS/ILS curriculum discussion with Ada County Paramedics and Idaho State University to compare existing Community Paramedic and Community Health Worker Curricula and to advance curriculum development.
 - Conference call with Data Analytics to develop data collection methods for the remaining success measures.

- Meeting materials and training information can be found at:
<http://ship.idaho.gov/WorkGroups/CommunityHealthEMS/tabid/3050/Default.aspx>
- The roster for the second ISU cohort is full and will begin January, 2017
- The 2nd ISU cohort is represented by the following agencies: Boundary County Ambulance, Donnelly Rural Fire District, Ada County Paramedics, Canyon County Paramedics, Shoshone County EMS, Payette County Paramedics, and Idaho Falls Fire.

- **Next Steps:**

- BLS/ILS CEMS curriculum is under development.
- Additional trainings are being developed for Healthcare 101 and Peer-to-Peer Mentoring.
- A survey for the remaining success measures is being developed.
- Next statewide CEMS Workgroup meeting – TBD.



Idaho Medical Home Collaborative:

- **Report Item:**

- The IMHC Workgroup did not meet this month.

- **Next Steps:**

- The IMHC Workgroup will continue an ad hoc schedule through the rest of the year.



Health Information Technology:

- **Report Item:**

- The HIT Workgroup met on November 17, 2016.
 - The Idaho Health Data Exchange (IHDE) reported that several clinics completed inbound and outbound HL7 connections for purposes of care coordination, while others are still continuing the connection build process. The inbound CCD connections for data analytics on all clinics are still progressing.
 - HealthTech Solutions provided a demonstration of their analytic tool demonstrating the clinical use cases using test data.
- The Data Element Mapping Subcommittee of the HIT Workgroup and the Clinical Quality Measures (CQM) Workgroup had a joint meeting on November 30, 2016.
 - Workgroup members discussed various alternatives for each of the Year Two and Year Three measures.
 - The workgroup members made recommendations for the measure selection.
- Coordination meetings between IHDE, HealthTech, and SHIP Operations.
 - Several clinics have now shared their first patient attribution files with IHDE. These files link a patient to a specific clinic location and will be leveraged to generate the HealthTech reports.

- **Next Steps:**

- Joint HIT, CQM, and Data Element meeting will be held on December 20th to discuss the formation of a new Data Governance Workgroup.
 - This stakeholder meeting has come about as a result of our technical assistance request to the Office of the National Coordinator for Health Information Technology (ONC), and the meeting will be facilitated by a representative from the ONC.
- IHC vote on measure selection for Grant Year 3.

MPW Multi-Payer:

- **Report Item:**
 - Mercer has received data from Medicare, Medicaid, and all but one participating SHIP commercial payer for Goal 6 CMMI metrics.
- **Next Steps:**
 - Mercer anticipates having the final report of the Payer Reporting for SHIP to CMMI by the end of December.
 - The SHIP Administrator will work with the SHIP MPW chair regarding future meetings.

CQM Clinical/Quality Measures Workgroup:

- **Report Item:**
 - Clinical Quality Measures (CQM) Workgroup and the Data Element Mapping Subcommittee of the Health Information Technology Workgroup had a joint meeting on November 30, 2016.
 - Workgroup members discussed various alternatives for each of the Year Two and Year Three measures.
 - The Workgroup members made recommendations for the measure selection.
- **Next Steps:**
 - Joint HIT, CQM, and Data Element meeting on December 20th to discuss the formation of a new Data Governance Workgroup.
 - This stakeholder meeting has come about as a result of our technical assistance request to the Office of the National Coordinator for Health Information Technology (ONC), and the meeting will be facilitated by a representative from the ONC.
 - IHC vote on measure selection for Award Year Three and Award Year Four.

BHI Behavioral Health:

- **Report Item:**
 - The workgroup met on Tuesday, December 6th. Agenda topics covered:
 - The Get Healthy Idaho report with survey data presented by Joe Pollard, Public Health Program Manager.
 - An update on PCMH Cohort Two for SHIP by SHIP PCMH project manager Kym Schreiber.
 - Rachel Blanton, SHIP Manager for Southwest District Health, provided an update on the Regional Collaborative strategic plans that have been developed.
 - Idaho Integrated Behavioral Health Network (IIBHN) Luncheon and next steps.
- **Next Steps:**
 - Next meeting is scheduled for Tuesday, February 14th, 2017 from 9:00am-11:00am at 1720 Westgate Drive, Suite A, Room 131.



Population Health:

- **Report Item:**

- The PHW met December 7th.
 - The workgroup was given an updated look at the Viaan website that hosts the population health measures. The site is becoming more robust with additional population health data and added data visualization capabilities.
 - There was discussion around what the RCs and Public Health Districts would like to see on the Viaan site in a dashboard for population health outcome measures.
 - It was reported that the interactive map depicting the inventory of clinical work that is being done will be updated with Cohort Two clinics after they are announced. This led into a discussion of materials that are needed to support the Medical-Health Neighborhoods. Gina Pannell, Health District 4, shared that the CHC has developed an infographic depicting the Medical-Health Neighborhood they would like to recommend as a visual for use by the PHW. The infographic will be sent to all members. This discussion will be continued at the January meeting.
 - Kim Kane, Manager of the Suicide Prevention Program, presented an overview of the program to the PHW and discussed how this work may be incorporated into the work of the RCs.

- **Next Steps:**

- The next meeting of the PHW is January 4th from 3:00 – 4:30.