



Idaho Healthcare Coalition

Meeting Agenda

Wednesday, August 9, 2017 1:30PM – 4:30PM

**JRW Building (Hall of Mirrors)
First 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/48670851/827ccb0eea8a706c4c34a16891f84e7b>

Attendee Smartphone URL:

<pulsesecure://?method=meeting&action=join&host=rap.dhw.idaho.gov&meetingid=48670851&signin=rap.dhw.idaho.gov%2Fmeeting%2F&stoken=827ccb0eea8a706c4c34a16891f84e7b>

Password: 12345

1:30 p.m.	Opening remarks; roll call; introduce any new members, guests, any new IDHW staff; agenda review; and approval of 7/12/2017 meeting notes – <i>Dr. Ted Epperly, IHC Chair</i> ACTION ITEM(s)
1:40 pm	CMMI SIM Model Test Update – <i>Dr. Stephen Cha, Director, State Innovations Group and Chris Crider, SIM Project Officer</i>
1:55 pm	Idaho Medicaid Healthy Connections Value Care CHOICE discussion – <i>Jeff Crouch, IDHW, Regional Director and Elke Shaw Tulloch, IDHW, Administrator Division of Public Health</i>
2:40 pm	Idaho Medicare Update from Noridian - <i>Dr. Dick Whitten, Vice President of Medical Policy and Sarah Baker, Product Director for Care and Delivery Management</i>
3:00 pm	Break
3:10 pm	Public Health Immunization Data Availability - <i>Kathy Turner, PHD MPH, Bureau of Communicable Disease Prevention, Idaho Division of Public Health</i>
3:30 pm	IHDE Update – <i>Julie Lineberger, IHDE Interim Executive Director</i>
3:40 pm	Cohort Three Recruitment & MentorSHIP Update– <i>Dr. Scott Dunn, District 1 RC Chair and Kym Schreiber, Project Manager, IDHW</i> ACTION ITEM
3:50 pm	WWAMI ECHO – <i>Jeff Seegmiller, Ed.D., LAT, ATC, Associate Professor, Director of WWAMI Medical Education Program</i>
4:10 pm	Telehealth Update - <i>Mary Sheridan, Bureau Chief, Rural Health and Primary Care, Division of Public Health</i> ACTION ITEM
4:20p.m.	SHIP Operations and Advisory Group reports/ Updates – Please see written report (SHIP Operations and IHC Workgroup reports): <ul style="list-style-type: none"> • Presentations, Staffing, Contracts, and RFPs status – Cynthia York, IDHW • Regional Collaboratives Update – Madeline Russell, IDHW • Telehealth, Community EMS, Community Health Workers – Madeline Russell, IDHW • Data Governance Workgroup – Dr. Andrew Baron, Janica Hardin, Workgroup Chairs • Multi-Payer Workgroup – Dr. David Peterman, Primary Health and Josh Bishop, PacificSource, Workgroup Chairs • Behavioral Health/Primary Care Integration Workgroup – Ross Edmunds, IDHW, Workgroup Co-Chair • Population Health Workgroup –Elke Shaw-Tulloch, IDHW, Workgroup Chair, Carol Moehrle Workgroup Co-Chair • IMHC Workgroup – Dr. Scott Dunn, Family Health Center, IMHC Workgroup Chair
4:25 p.m.	Additional business & next steps – <i>Dr. Ted Epperly, IHC Chair</i>
4:30 p.m.	Adjourn

Mission and Vision

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

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

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

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

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

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

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

Goal 7: Reduce overall healthcare costs



Idaho Healthcare Coalition (IHC) August 09, 2017 Action Items

- Action Item 1 – Minutes

IHC members will be asked to adopt the minutes from the July 2017 IHC meeting:

Motion: I, _____ move to accept the minutes of the July 12, 2017, Idaho Healthcare Coalition (IHC) meeting as prepared.

Second: _____

Motion Carried.

- Action Item 2 – SHIP Data Governance Workgroup Charter

IHC members will be asked to accept the Data Governance Workgroup Charter as presented by Burke Jensen at the July 12th, 2017 meeting.

Motion: I, _____ move to accept the Data Governance Workgroup Charter as presented.

Second: _____

Motion Carried.

- Action Item 3 – Cohort Three Recruitment Plan and Final Application

IHC members will be asked to support the Cohort Three recruitment plan and final application as presented to the IHC:

Motion: I, _____ move to support the Cohort Three recruitment plan and final application as presented.

Second: _____

Motion Carried.

■ Action Item 4 – Telehealth Update

IHC members will be asked to support adjustment of the success measure metric target and addition of Project ECHO to the scope of work as presented by Mary Sheridan.

Motion: I, _____ move to support the adjustment of the telehealth success measure metric target and inclusion of Project ECHO in the Goal 3 scope.

Second: _____

Motion Carried.



Idaho Healthcare Coalition

Meeting Minutes:

SUBJECT: IHC July Minutes

DATE: July 12, 2017

ATTENDEES: Russ Barron, Josh Bishop, Judy Taylor for Pam Catt-Oliason, Russell Duke, Ross Edmunds, Dr. Ted Epperly, Lisa Hettinger, Yvonne Ketchum, Deena LaJoie, Amy Mart, Dr. Rhonda Robinson-Beale, Elke Shaw-Tulloch, Mary Sheridan, Karen Vauk, Jennifer Wheeler, Matt Wimmer, Cynthia York

Teleconference: Michelle Anderson, Kathy Brashear, DR. Scott Dunn, Maggie Mann, Casey Meza, Carol Moehrle, Susie Pouliot, Geri Rackow, Larry Tisdale

Members Absent: Dr. Andrew Baron, Dr. Richard Bell, Melissa Christian, Dr. Keith Davis, Janica Hardin, Senator Lee Heider, DR. Mark Horrocks, Dr. Glenn Jefferson, Dr. James Lederer, Nicole McKay, Daniel Ordyna, Dr. David Pate, Tammy Perkins, Dr. David Peterman, Neva Santos, Dr. Boyd Southwick, Lora Whalen, Representative Fred Wood, Nikole Zogg

IDHW Staff: Jeff Crouch, Wayne Denny, Burke Jensen, Taylor Kaserman, Casey Moyer, Madeline Russell, Kym Schreiber, Stacey St. Amand, Joey Vasquez, Ann Watkins

Guests: Scott Banken, Ruby Cash, Grace Chandler, Elwood Cleaver, Melissa Dilley, Jenny Feliciano, Nancy Jaeckels-Kamp, Janice Lung, Rob Moriarty, Scott Oien, Elizabeth Spaulding, Chelsea Stevenson, Norm Varin, Moly Volk, Dr. Karl Watts, Dr. Shenghan Xu

STATUS: Draft (07/18/2017)

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

Summary of Motions/Decisions:

Motion:

Jennifer Wheeler moved to accept the minutes of the June 07, 2017, Idaho Healthcare Coalition (IHC) meeting as prepared.
Russell Duke seconded the motion.

Outcome:

PASSED

Yvonne Ketchum move to accept Russ Barron onto the IHC, replacing Richard Armstrong.
Karen Vauk seconded the motion.

PASSED

Elke Shaw-Tulloch moved to accept the SHIP Goal Two Charter as presented by Jenny Feliciano.
Mary Sheridan seconded the motion.

PASSED

Agenda Topics:

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

- ◆ Dr. Epperly welcomed everyone to the meeting and took roll. Dr. Epperly started the meeting with a quote “If I had asked people what they wanted, they would have said faster horses.” Henry Ford. Following the approval of the June IHC meeting minutes Dr. Epperly welcomed Russ Barron to the IHC as the new Director of the Idaho Department of Health and Welfare. Director Barron briefly introduced himself. Cynthia York updated the IHC on the upcoming site visit from CMMI and Office of the National Coordinator (ONC), what is expected from this visit and who will be visiting. Attending the August IHC meeting will be Dr. Stephen Cha and Chris Crider from CMMI, and Patricia MacTaggart and Craig Jones from ONC.

Mercer Update – Jennifer Feliciano, Senior Associate, Mercer

- ◆ Jennifer Feliciano presented the dashboard for Award Year 3 Quarter 1. This dashboard is based on information provided to CMMI in terms of success measures during the time period of February 1, 2017 to April 30, 2017.
- ◆ Ms. Feliciano went over each goal its success measures highlighting key numbers and indicators of progress that have been made in the current reporting period. Scott Banken, also of Mercer, presented on Goals 6 and 7 and the success measure reports for each of these goals. The financial analysis was put together from information provided by Idaho’s health insurance providers.
- ◆ Following the presentation of the dashboard Ms. Feliciano answered questions regarding the retirement of goal three success measure three. This measure was retired because the data source for the measure became unreliable; however this information will still be tracked through the Brilljent portal. Goal six, measure one includes Medicare because in order to reach eighty percent participation in the state, Medicare is needed and there is evidence that Medicare is engaging in moving from volume to value-based payments.
- ◆ Ms. Feliciano went on to present the updated Goal 2 charter; key changes to the charter include updated dates, completion status, and adding deliverable one (the establishment of the Data Governance Workgroup). Following the presentation of the goal two charter it was accepted by the IHC.

Idaho Medicaid-Healthy Connections Value Care – Jeff Crouch, IDHW, Regional Director and Lisa Hettinger, IDHW, Deputy Director

- ◆ Lisa Hettinger provided background on Idaho Medicaid's decision to implement the Healthy Connections Value Care model. Jeff Crouch presented on where the United States currently fits on the global scale in terms of effective costs of healthcare. Costs are high and quality is mixed. How we pay for care is part or most of the problem
- ◆ In moving from volume to value there needs to be increasing provider accountability along with improved value.
- ◆ In 2018, Idaho Medicaid will expand the existing Healthy Connections program to cover a broad range of healthcare transformation activities and population-based care management initiatives. Mr Crouch described the potential structure of the Regional Care Organizations (RCOs) that will maintain local governance, and in turn, contract with Idaho Medicaid on behalf of the care-delivery network. A Community advisory group called Community Health Outcome Improvement Coalitions (CHOICE) will be established to advise the RCOs. More information on CHOICE will be presented in a future IHC meeting.

SHIP PCMH Learning Collaborative Summary – Grace Chandler, Briljent?

- ◆ The PCMH Learning Collaborative was held on June 27th and 28th at Boise State University. All fifty-six Cohort Two clinics were represented with a total of 168 participants. Nancy Jaeckels-Kamp, also of Briljent, described the different sessions that took place at the Learning Collaborative. Overall all the evaluations came back as either satisfied or very satisfied. Some of the key pieces of feedback from participants included the great speakers, the helpful trainings, and the breakout sessions. Opportunities for improvement included refocusing topics to not be as heavily focused on accreditation, providing more time for breakout sessions, better and more concrete examples and assistance, and more time for networking opportunities.

Regional Collaborative Summit Summary – Elizabeth Spaulding, Langdon Group

- ◆ The Regional Collaborative Summit was held the afternoon of June 28th following the PCMH Learning Collaborative. Forty people attended. Dr. Epperly started the meeting with a high-level discussion of the RCO payment method and the afternoon was spent addressing questions around the Regional Collaboratives' role in the RCO payment method.
- ◆ There were updates provided by the Idaho Health Data Exchange, HealthTech Solutions, PCMH MentorSHIP, and then updates from each Public Health District. Examples of work done thus far included developing PCMH trainings, CHW connections, community health assessments completed, suicide prevention programs, and child safety and gun safety campaigns. State evaluators are helping tell these success stories throughout the state.

IHDE and Data Quality Improvement Process Update – Julie Lineberger, IHDE Interim Executive Director and Ruby Cash, IHDE Data Quality Improvement Specialist

- ◆ Julie Lineberger gave a brief update on the connection status of Cohort One and Two clinics.
- ◆ Ruby Cash presented on the SHIP data quality improvement process and why this process is so important. Ms. Cash went over what work she has already started in her role as Data Quality Improvement Specialist. She also covered how the data quality improvement process would take place and who would be involved in the process.

Data Governance Workgroup Charter- Burke Jensen, HIT Project Manager

- ◆ Burke presented the Data Governance Workgroup charter and highlighted key points that are instrumental in the success of the CQMs in SHIP clinics. The charter was not accepted by the IHC since there was no longer a quorum, and will be added to the August agenda.

Timeline and Next Steps – Dr. Epperly, IHC Chair

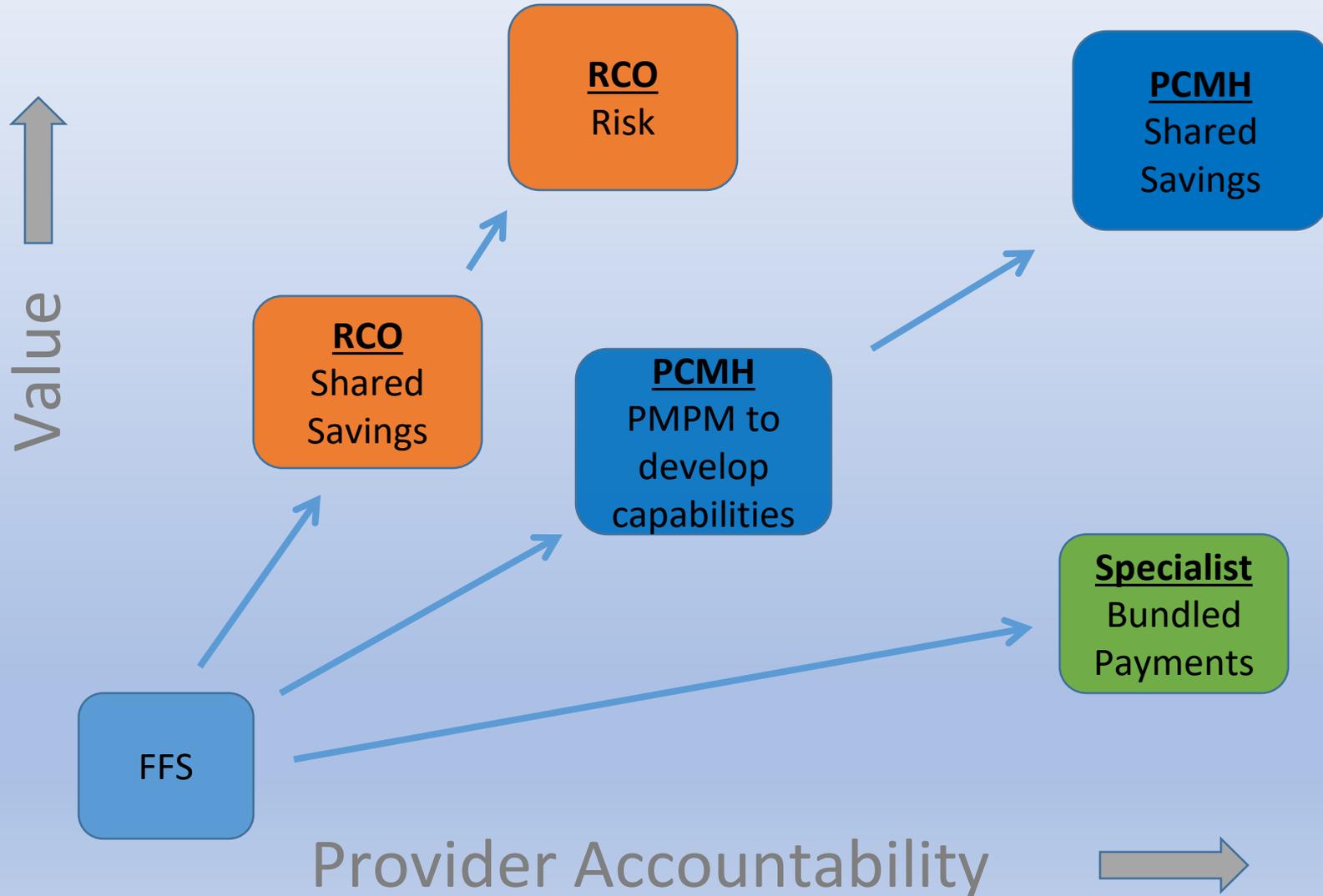
- ◆ Matt Wimmer gave an update to the group on the IMHC Workgroup that took place just before the IHC meeting.
- ◆ Cynthia York reminded IHC members that team members from CMMI and ONC will be onsite next month and participating in the IHC meeting in person.
- ◆ Registration is now open for NCQA training in Boise in September. Registration materials can be found on the SHIP website.

There being no further business Chairman adjourned the meeting at **4:34pm**.

2018 Medicaid Program Payment Reform

Integrating Community Involvement With
Regional Care Organizations

Payment Transitions



Why PCMHs & RCOs Need Each Other

PCMH

A ***Clinical*** model that needs a reformed payment system for sustainability

Regional Care Organization

A ***Financial*** model that needs a reformed clinical system for sustainability

Fee For Service Model

Hospitals

Primary
Care

Behavioral
Health

Labs

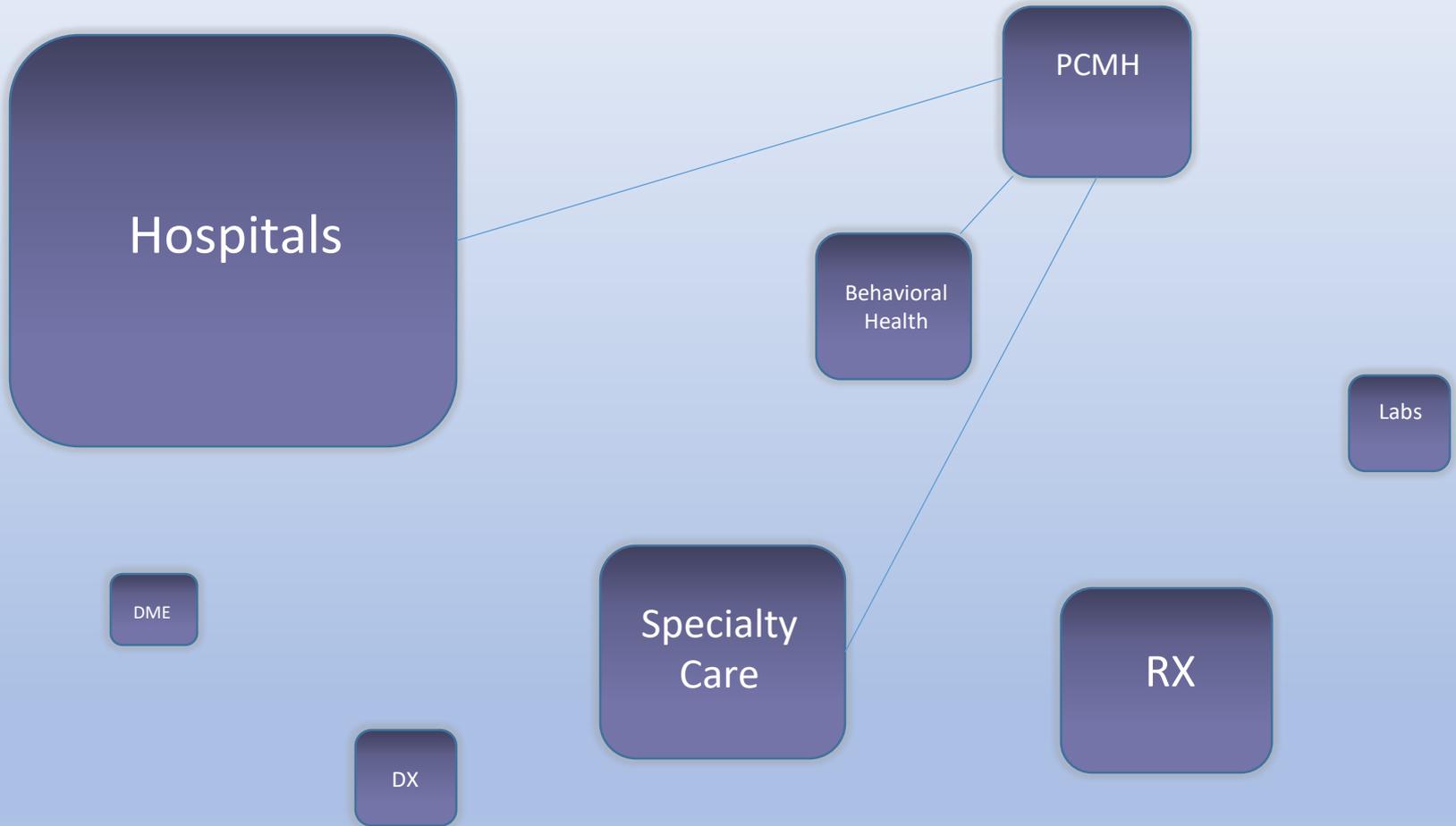
Specialty
Care

DME

RX

DX

Patient Centered Medical Home Model



Medicaid

RCO

Clinics, Hospitals and Risk Partners Organize To Improve Value

Hospital

Primary
Care

Behavioral
Health

Specialist
Care

Other
Providers

Community Involvement

Building community support, and transparency,
through the CHOICE advisory group

Medicaid

Community
Health
Outcome
Improvement
Coalition
e

Regional Advisory Group



**Regional Care
Organization**

*Physicians, facilities and
their risk partners*

Hospital

Primary
Care

Behavioral
Health

Specialist
Care

Other
Providers

Health Improvement Engagement Plan Diabetes Example – Organizational View

Typical Health Approach

Traditional Care:

- Screen
- Diagnose
- Treat
- A1C Monitoring
- Eye Exam Monitoring
- Foot Exam Monitoring



Innovative Care:

- Link to self-management education
- Diet & Nutrition Support



CHOICe Approach

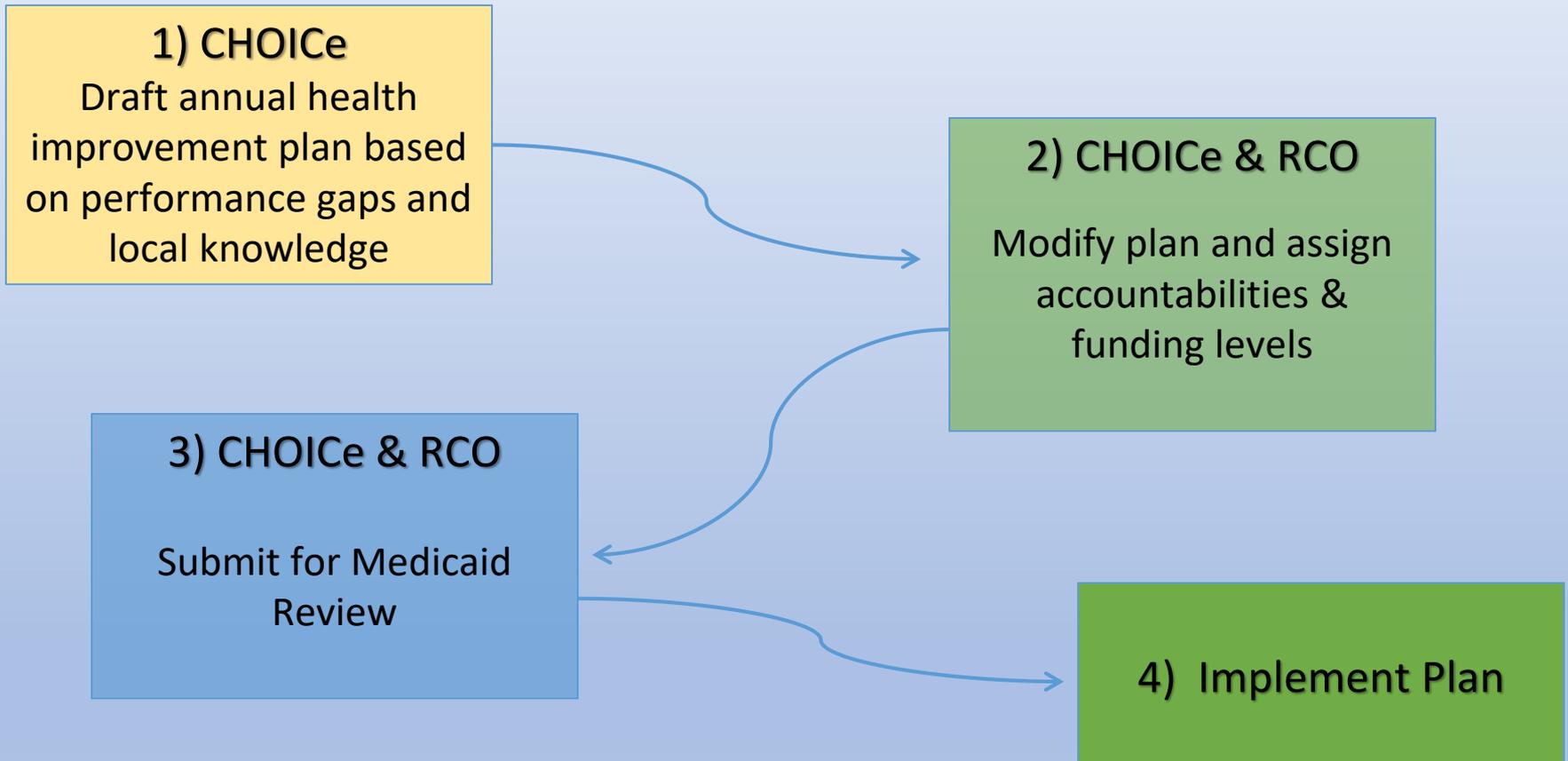
Community-Wide Health

- Community Health Workers
- Social Supports
- Improved access to physical activity



Health Improvement Plan Development

CHOICe, RCO & Medicaid



“Medical” Providers

Hospitals

Primary
Care

Behavioral
Health

Labs

Specialty
Care

DME

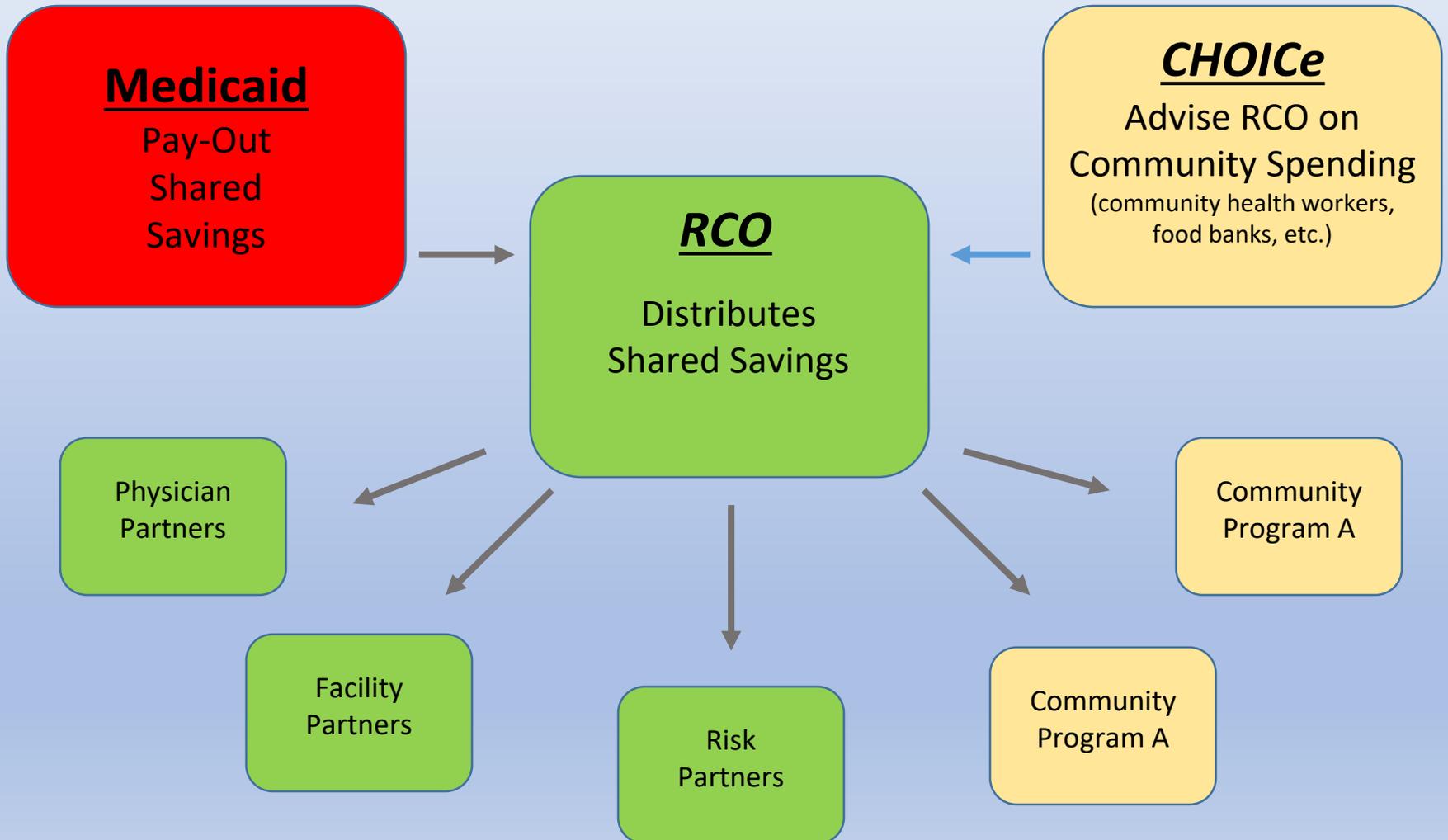
RX

DX

Full Community System



Funding CHOICe Initiatives





Idaho Healthcare Coalition

August 9, 2017

Sarah Baker

Product Director, Care & Delivery Management

Richard W. Whitten, MD, FACP

Medical Director & VP Medical Policy

Disclosure of Financial Relationships

Sarah Baker &

Richard W. Whitten, MD

**Have no relationship with any
proprietary entity producing health
care goods or services.**

Opportunities

Collaborative Efforts for
Managing Sick Populations:
Quality Measures and
Pay-for-Performance Programs

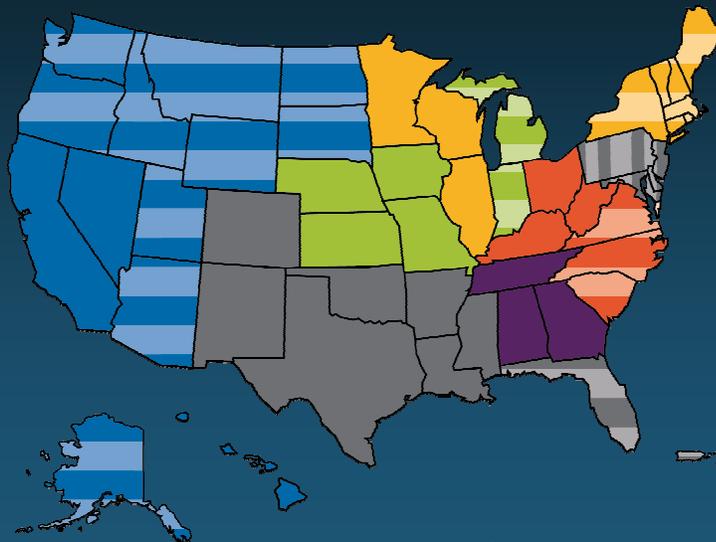
IHC 8/09/2017

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Medicare Part A/B MAC Regions and Contractors

Key

■ Noridian:	
■ JE	■ JF
■ WPS:	
■ J5/JG	■ J8/JI
■ NGS:	
■ J6/JG	■ JK
■ CGS:	■ J15/JI
■ Palmetto:	■ J11/JM
■ Cahaba:	
■ J10/JJ	
■ Novitas:	■ JH ■ JL
■ FCSO:	■ JN



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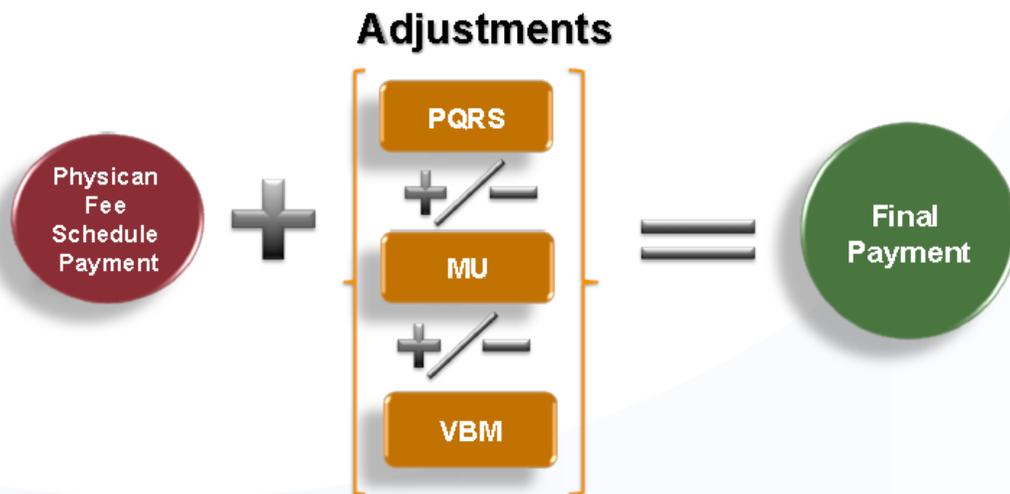
Overview

- **Current Status**
- **MACRA changes**
- **Initiatives & Options**
- **Discussion & Plans**

MACRA

- **Medicare Access and CHIP Reauthorization Act of 2015**
- Sustainable Growth Rate (SGR) repealed
- CMS: establish new Quality Payment Program
- Payment basis: Value, not volume
- Merit Based Incentive Payment System (MIPS)
- Incentives in Alternative Payment Models (APMs)

How Does Medicare Pay Me Now?



Merit-Based Incentive Payment System (MIPS)

- Quality – **replaces** prior Physician Quality Reporting System (PQRS)
- Resource use – **replaces** prior Value-Based Modifier (VBM)
- Advancing Care Information – **replaces** Meaningful Use
- Clinical practice improvement activities (**new**)

MIPS – starting 1/1/2019

(based on 2017 reporting)

- **Consolidates negative adjustments (“penalties”)**
- **Adds Clinical Practice Improvement Activity (CPIA) as a component**
- **Increases potential incentives**
- **Ranks peers nationally**
- **Publicly reports**

Very few physicians exempt

- **Low volume (< \$10,000) + Few patients (< 100)**
- **1st time participant in Part B**
- **Alternative Payment Models qualifying participant**

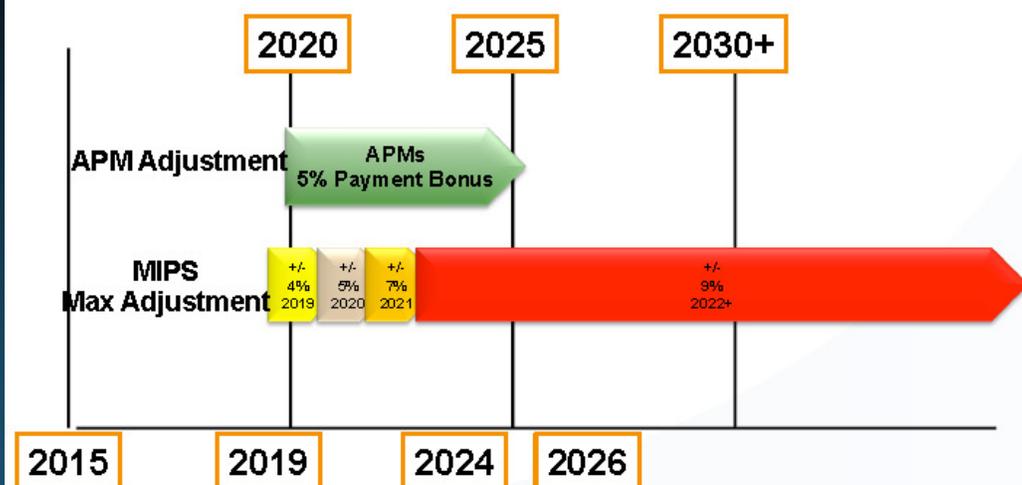
MIPS Performance Assessment

- **Penalty or bonus**
 - At the threshold: no adjustment
 - Above the threshold: bonus
 - Below the threshold: penalty
- **Range of adjustments:**
 - 2019: $\pm 4\%$; 2020: $\pm 5\%$; 2021: $\pm 7\%$; 2022 and after: $\pm 9\%$
 - May adjust to equate bonus & penalty totals

IHC 8/09/2017

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When is this all happening?



IHC 8/09/2017

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Advanced APMs - 2018

- Shared Savings Program
- Next Generation ACOs
- Comprehensive ESRD Care
- Comprehensive Primary Care Plus
- Oncology Care Model (OCM)

Accountable Care Organizations

- **Medicare now has >400**
 - Serving 8 of the 57 million Medicare beneficiaries
 - Jury remains out
- **Dartmouth's ACO**
 - reduced Medicare spending on hospital stays, medical procedures, imaging and tests
 - achieved goals for the quality of care

Dartmouth's ACO – 9/10/2016

- **“We were cutting costs and saving money and then paying a penalty on top of that.**
- **“We would have loved to stay in the federal program, but it was just not sustainable.**
- **“It’s hard to achieve savings if, like Dartmouth, you are a low-cost provider to begin with.”**

(Dr. Robert A. Greene, EVP Dartmouth-Hitchcock health system)

**Leaves most of us just in MIPS
for now...**

What are the opportunities?

Avoid 2019 Penalties!!

- One Patient, One Measure, No Penalty
- 1st year of Quality Payment Program (QPP)
- Merit-based Incentive Payment System (MIPS)
- Pick your pace reporting for 2017
- AVOID -4% negative adjustment
- One Patient, One Measure = No Penalty

Clinical Practice Improvement Activities (CPIAs) - Examples

- Expanded practice access (e.g. portal)
- Population management (e.g. data registry)
- Care coordination (e.g. remote or telehealth)
- Patient engagement (e.g. care plans, shared decision-making)
- Patient safety and practice assessments
- Participation in APMs

Working Model Options:

Clinical Outcomes Assessment Program (COAP)

<http://www.coap.org/>

The screenshot shows the COAP website homepage. At the top left is the COAP logo, which consists of the letters 'COAP' in a bold, blue, sans-serif font, with a stylized blue triangle to the right of the 'A'. To the right of the logo is the text 'CLINICAL OUTCOMES ASSESSMENT PROGRAM' in a smaller, blue, sans-serif font, and below that, 'A PROGRAM OF THE FOUNDATION FOR HEALTH CARE QUALITY' in an even smaller, grey, sans-serif font. In the top right corner, there is a search bar with the placeholder text 'search this site...' and a dropdown menu with two options: 'COAP' (selected with a radio button) and 'All Foundation Sites'. Below the header is a navigation menu with six items: 'Overview', 'Improving Quality »', 'Management Committee', 'Participating Hospitals & Outcomes »', 'Members »', and 'Contact Us'. The main content area features a large image of two surgeons in blue scrubs and masks, looking down at something. To the right of the image is the heading 'Participating in COAP' in blue, followed by a paragraph of text: 'Because they want the highest quality care possible for their patients, heart doctors and other members of the Washington heart care community developed the Clinical Outcomes Assessment Program (COAP). Heart care professionals from across the state are part of this innovative, collaborative approach to improve the quality of care for all heart patients in Washington. COAP...'. Below the text is a 'Read More' button. At the bottom of the page, there are three columns of content. The first column has a small icon of two people shaking hands and the heading 'COAP Public Reporting Platform', followed by the text: 'COAP has launched a new, interactive public website for both PCI and cardiac surgery outcomes!'. The second column has a small icon of a blue line graph and the heading 'Participating Hospitals', followed by the text: 'Welcome to the hospital outcomes section of the Clinical Outcomes Assessment Program (COAP) web site'. The third column has a small icon of two people shaking hands and the heading 'Members', followed by the text: 'Physicians, Surgeons, Nurses, Data & Quality Directors and other COAP members can log in to the secure members-only section for access to the...'. At the bottom of the page, there is a dark blue footer with the text 'IHC 8/09/2017' on the left, the URL 'http://www.coap.org/' in the center, and the number '20' on the right.

What Does COAP Do?



CLINICAL OUTCOMES ASSESSMENT PROGRAM
A PROGRAM OF THE FOUNDATION FOR HEALTH CARE QUALITY

COAP is a quality improvement organization that is data driven...

- COAP Cardiac Quality measures are the most complete (all patients), most accurate (clinical data submitted by 'tested' abstractors, not billing data) and most timely (available within a few months after the close of a quarter, not a year later).
- Outcomes are reported as a comparison with all member hospitals:
 - 1) Compared to the statewide average
 - 2) Compared to the benchmark which is determined by the mean of the top performing hospitals which when combined, represent $\geq 10\%$ volume of cases



What Does COAP Do?



CLINICAL OUTCOMES ASSESSMENT PROGRAM
A PROGRAM OF THE FOUNDATION FOR HEALTH CARE QUALITY

COAP is a quality improvement organization that is data driven...

- Outcomes are expected to be within 2 SD of the mean
- COAP data is reviewed as a yearly event as well trend outcomes over time
- Sanctions occur if these outcomes are not met
- COAP is responsive to regional activities - out of hospital arrest



Capital Medical Center
Central WA Hospital
Deaconess Hospital Rockwood Health
Evergreen Healthcare
Harborview Medical Center
Harrison Medical Center
Highline Medical Center
Kadlec Medical Center
Kennewick General Hospital
Madigan Army Medical Center
Multicare Auburn Medical Center
Multicare Good Samaritan Hospital
Multicare Tacoma General Hospital
Northwest Hospital
Overlake Hospital Medical Center
PeaceHealth St. John Medical Center
PeaceHealth St. Joseph Medical Center

PeaceHealth Southwest Medical Center
Providence Regional Medical Center Everett
Providence Sacred Heart Medical Center
Providence St. Peter Medical Center
Skagit Valley Hospital
St. Anthony Medical Center
St. Francis Hospital
St. Joseph Medical Center, Tacoma
Swedish Health Services – Cherry Hill
Swedish Health Services – Edmonds
Swedish Health Services - Issaquah
University of WA Medical Center
Valley Medical Center
Virginia Mason Medical Center
Walla Walla General Hospital
Yakima Regional Medical Center
Yakima Valley Memorial Hospital



Volumes

Percutaneous Coronary Interventions (PCI)

- ~ 13,000 Procedures Annually
- Individual hospital volumes range from 60 – 1200+

Cardiovascular Surgery

- ~ 6000 Adult procedures annually
- Individual hospital volumes range from 70 – 800+

Appropriate Use Criteria for Coronary Revascularization

- Developed by the ACC in partnership with multiple professional organizations
- National standard to quantify ‘appropriateness’ of PCI for clinical scenarios
- Stewards of self-regulation and an opportunity to improve effective utilization

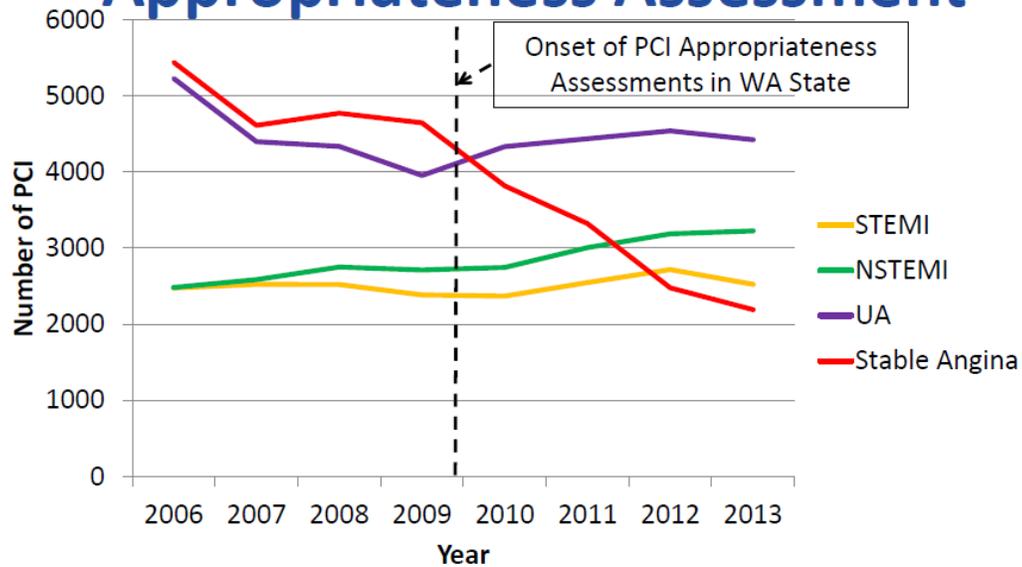
Patel MR, et al. JACC. 2009;53:530-553. **COAP IN 2015**

Trends in PCI Appropriateness in Washington State

- Apply the Appropriate Use Criteria to all PCI performed in Washington State
 - Stratified on acute and non-acute (elective) indications
- Identify opportunities to improve PCI quality by reducing variation in appropriateness

COAP IN 2015

Use of PCI after Appropriateness Assessment



Bradley SM, et al. Circulation. 2015;E-pub ahead of print.

COAP IN 2015

Areas of Substantial Variation: Outcome Metrics

Metrics with Substantial Variation Q3'14-Q2'14	Benchmark Q3'14-Q2'14	Average Q3'14-Q2'14	Highest Performers Q3'14-Q2'14	Lowest Performers Q3'13-Q2'14
PCI				
Mortality (All PCI)	.4 OE	.9 OE	A [45]: 0 OE B [292]: 0.2 OE K [474]: 0.3 OE	C [89]: 2.7 OE
% D2B <90 Min (STEMI)	100%	95%	G [6]: 100% N [48]: 100% R [26]: 100%	A [13]: 100% V [36]: 100% T [62]: 100% C [14]: 64%
CABG				
Any Blood Use	10.3%	26.7%	J [238]: 7.7% E [273]: 12.6%	N [26]: 65.4% T [187]: 55.9% U [94]: 46.2% D [96]: 45.8%
Mortality		1.2 OE	Q [103]: 0 OE L [71]: 0 OE S [248]: 0 OE	N [26]: 3.4 OE Y [110]: 2.0 OE
Prolonged Ventilation	4.2%	7.9%	H [284]: 4.2% L [71]: 4.2% J [238]: 4.6%	W [182]: 13.7% Q [103]: 13.6% T [187]: 11.8% N [26]: 11.5%
Isolated Valve				
Return to OR	0.7%	4.4%	Q [28]: 0% V [106]: 0.9% H [182]: 1.1%	P [53]: 16.7% N [17]: 11.8%
Early Extubation (<6 hrs)	80.8%	67.8%	H [182]: 80.8% K [50]: 80.0% E [85]: 78.8%	D [30]: 36.7% T [64]: 40.6%
CABG + Valve				
Any Blood Use	25.7%	51.2%	E [36]: 25.7% H [100]: 34.3% S [69]: 35.3%	O [18]: 94.4% D [19]: 89.5% N [7]: 85.7% T [35]: 82.9%

Average Rate of PCI Procedures Classified as Inappropriate per Appropriate Use Criteria:

- Best Performing Hospitals: 1% - 13%
- Worst Performing Hospitals: 20% - 30%

Average Rate of PCI Procedures with Insufficient Pre-procedural Assessment for Appropriateness Determination:

- Best Performing Hospitals: 14% - 24%
- Worst Performing Hospitals: 29% - 40%

Conclusion

Appropriate use criteria may facilitate highly effective and efficient care

Appropriateness of PCI is improving in Washington State → opportunities remain

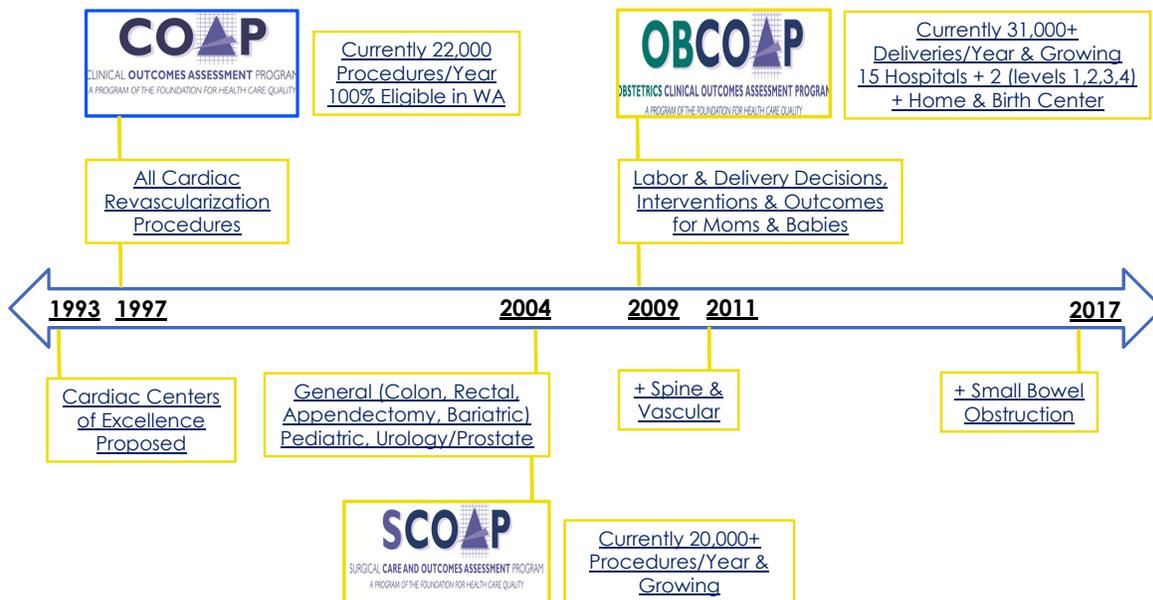
Learning from high-performers may guide improvements

Eye toward healthcare value

Now adding to COAP data:

- Medicare utilization data
- Medicaid (WA HCA) will follow
- Other payers have also indicated willingness
- Greatly increases potential for outcomes assessments

CLINICAL QUALITY IMPROVEMENT PROGRAM DEVELOPMENT



JointMan Artthritis Northwest (ANW) envelope

Patients Workflow Dashboard Admin

Diagnoses: Rheumatoid Arthritis, Rheumatoid Arthritis, Lupus

RA Characteristics SpA Characteristics SpA Measurements

John Feelbetter

- Medications
- Lab Results
- Pre-Assessment
- Pre-Auth/Authorization
- Refresh Calculated Meds

Encounter 1/8/2015

Provider: S. Admin

- Chart Notes
- JointMan
- HAQ

Add Chart Item...

- Patient Vitals
- Infusion
- BASDAI
- BASFI
- ASDAS
- PQRS

Previous Encounters

- 10/26/2015
- 7/21/2015
- 6/26/2015
- 4/16/2015
- 3/2/2015
- 1/8/2015
- 11/17/2014
- 11/11/2014
- 10/13/2014
- 10/13/2014
- 10/13/2014
- 9/15/2014
- 9/15/2014
- 9/15/2014
- 8/21/2014
- 8/2/2014
- 6/9/2014
- 4/29/2014
- 4/29/2014

Set Condition

- Normal
- Replaced
- Tender
- Swelling
- Dac ROM
- Deformity

Display: All

28 Joint Count: Completed

Physician Assessment: MD Global 1.0, MD Disease 2.0

Patient Assessment: PGA 7.9, Pain 4.4

ACR: DAS28 Combs, MTX Hold

12 mo. Infection Probability 1.23%

Active on 1/8/15

Methotrexate (Oral) 20 mg, Tocilizumab 5 mg

Lab Results

Date	ESR	CRP
10/29/2015	2	0.6
7/21/2015	1	2
4/16/2015	39	39
4/9/2015	22	21
3/3/2015	86	8

Joint Counts

	Today	Last Count	% Diff
Tender	11	2	450
Swelling	11	2	450
Dac ROM	4	0	-
Deformity	5	1	400

DAS 28 Joints

	Today	Last Score	% Diff
Tender	4	2	100
Swollen	4	2	100

Selected Labs

Lab	Date	Value
ESR	10/29/2015	2
CRP	10/29/2015	0.6
Vectra DA	1/8/2015	14

Scoring

	Today	Last Score	% Diff
DAS28	2.19	2.97	-23.7
DAS28 CRP	2.04	2.47	35
CRP	17.9	14.6	7.8
SDAI	18.5	17.6	5.1
Vectra DA	14	25	-60
Rapid3	20.6	19.3	6.7

JointMan

Select a scoring row above right to display the graph.

IHC 8/09/2017

33

What might we do together?

Thank you. Comments/discussion welcome:

Sarah Baker

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Public Health Immunization Data Availability

KATHY TURNER, PHD MPH – IDAHO DIVISION OF PUBLIC HEALTH

DEPUTY STATE EPIDEMIOLOGIST AND CHIEF, BUREAU OF COMMUNICABLE DISEASE PREVENTION

Childhood Immunization Status

CQM Baseline Data

- ▶ MEASURE: Percentage of children who, by 24 months of age, had received
 - ▶ ≥ 4 doses of diphtheria, tetanus, and acellular pertussis (DTaP) vaccine;
 - ▶ ≥ 3 doses of poliovirus vaccine;
 - ▶ ≥ 1 dose of measles-containing vaccine (e.g., MMR);
 - ▶ The full series (FS) of *Haemophilus influenzae* type b (Hib) vaccine;
 - ▶ ≥ 3 doses of hepatitis B virus vaccine;
 - ▶ ≥ 1 dose of varicella vaccine; and
 - ▶ ≥ 4 doses of pneumococcal conjugate vaccine (PCV).
- ▶ Called the Primary Series (4:3:1:3*:3:1:4)

Example Reports for Review

Clinic, Regional Collaborative, and Idaho

- ▶ Data for clinics and Regional Collaboratives generated from records included in the Immunization Reminder Information System (IRIS)
 - ▶ Patient attribution determined by clinics
- ▶ Baseline: Vaccines administered through 12/31/2016 for patients aged 24-35 months who had received primary series by 24 months of age
- ▶ Data for Idaho and the United States from the National Immunization Survey administered annually by the Centers for Disease Control and Prevention
 - ▶ Latest data year available: 2015
 - ▶ Sample includes children 19-35 months of age because children could be 24 months by the time the survey is administered



Clinic Report of Childhood Immunization Rates

Clinic A

Panhandle Health District Regional Collaborative

Data represent vaccines administered through 12/31/2016. Rates for patients aged 24-35 months who had received the primary series* by 24 months of age[‡].

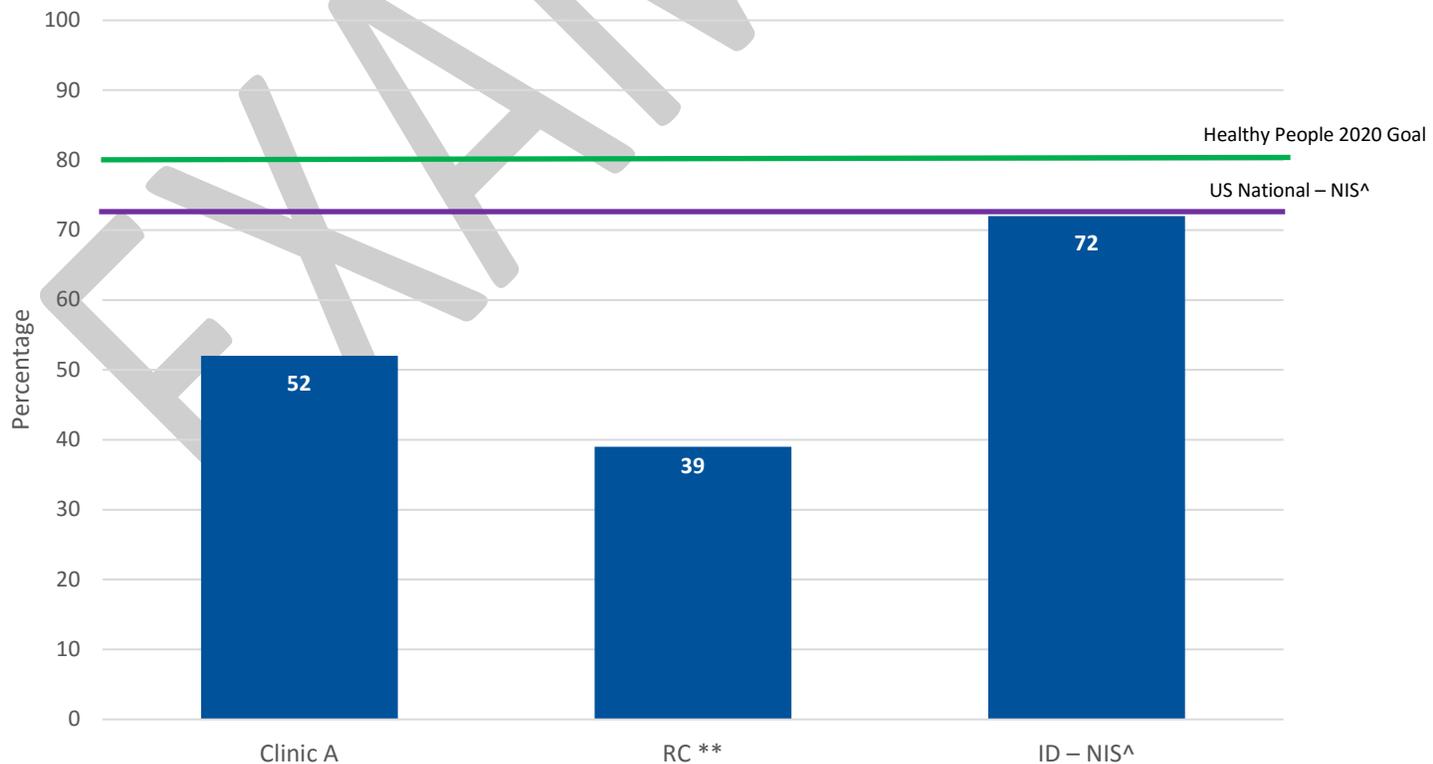
	Primary Series*	4+DTaP	3+Polio	1+MMR	Hib FS	3+HepB	1+Var	4+PCV
Clinic A	52	58	80	78	87	74	75	68
Regional Collaborative (RC)**	39	56	75	70	80	59	68	63
Idaho – NIS[^]	72	81	89	91	88	90	89	84
United States – NIS[^]	72	85	94	92	94	93	92	84

*Primary Series = 4 or more doses of DTaP, 3 or more doses of poliovirus, 1 or more doses of any MMR, primary series Hib (≥2 or ≥3 doses of *Haemophilus influenzae* type b depending on product type received), 3 or more doses of HepB, 1 or more doses of varicella, and 4 or more doses of PCV. Series rates can be lower than single antigen rates because it measures the number of children who received all doses of the included antigens. It is not an average of the single antigen rates.

** RC = Regional Collaborative. Rates are a weighted average of clinics participating in the State Healthcare Improvement Plan and do not represent public health district immunization rates.

[^]NIS = National Immunization Survey: conducted annually and used to obtain national, state, and selected local area estimates of vaccination coverage rates for U.S. children aged 19-35 months and measures children fully vaccinated with the primary series as of 24 months of age.

Primary Series* Immunization Rates



[‡] Patient immunization information from Idaho's Immunization Reminder Information System (IRIS) for patients active to each organization as of 03/31/2017; rates generated through the Centers for Disease Control and Prevention's Comprehensive Clinic Assessment Software Application (CoCASA).



Regional Collaborative Report of Childhood Immunization Rates

Panhandle Health District Regional Collaborative



Data represent vaccines administered through 12/31/2016. Rates for patients aged 24-35 months who had received the primary series* by 24 months of age[‡].

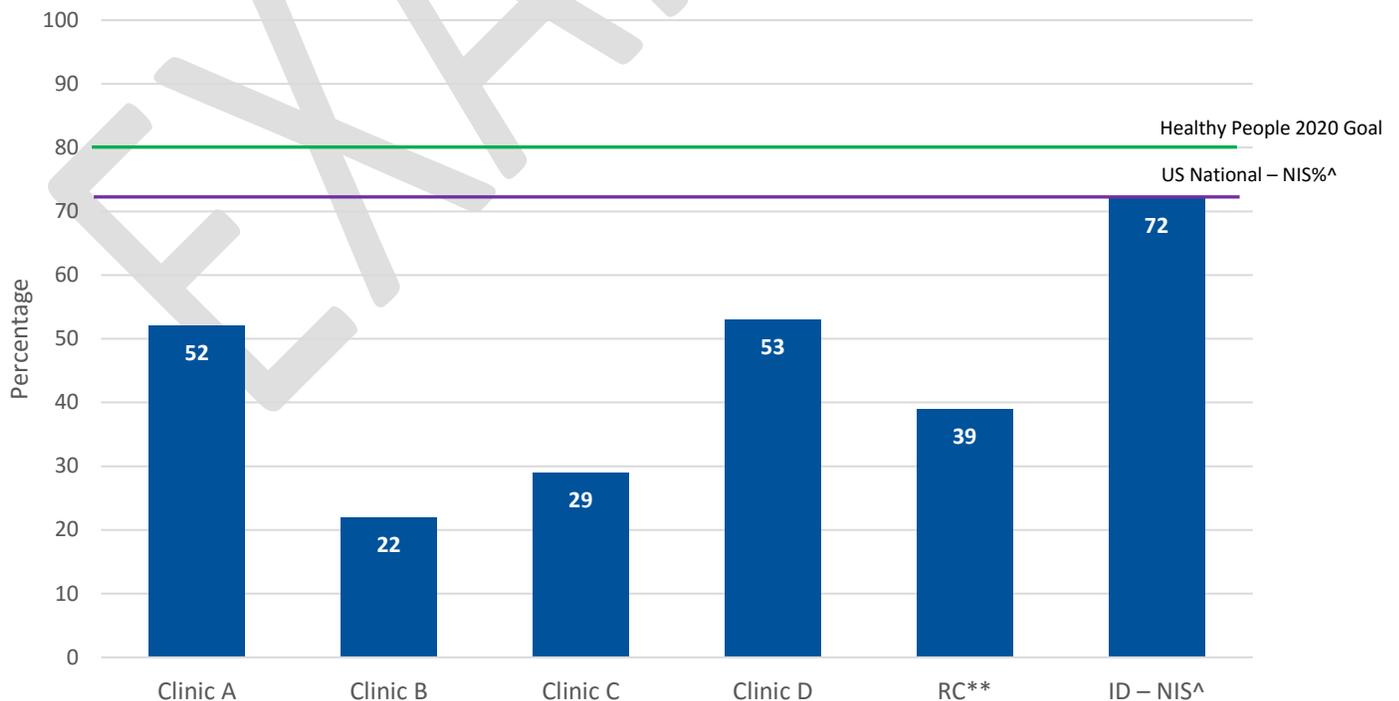
	Primary Series*	4+DTaP	3+Polio	1+MMR	Hib FS	3+HepB	1+Var	4+PCV
Clinic A	52	58	80	78	87	74	75	68
Clinic B	22	62	79	77	86	28	80	70
Clinic C	29	43	60	49	63	57	46	49
Clinic D	53	62	80	75	85	75	71	65
Regional Collaborative (RC)**	39	56	75	70	80	59	68	63
Idaho – NIS[^]	72	81	89	91	88	90	89	84
United States – NIS[^]	72	85	94	92	94	93	92	84

*Primary Series = 4 or more doses of DTaP, 3 or more doses of poliovirus, 1 or more doses of any MMR, primary series Hib (≥2 or ≥3 doses of *Haemophilus influenzae* type b depending on product type received), 3 or more doses of HepB, 1 or more doses of varicella, and 4 or more doses of PCV. Series rates can be lower than single antigen rates because it measures the number of children who received all doses of the included antigens. It is not an average of the single antigen rates.

** RC = Regional Collaborative. Rates are a weighted average of RC of clinics participating in the State Healthcare Improvement Plan and do not represent public health district immunization rates.

[^]NIS = National Immunization Survey: conducted annually and used to obtain national, state, and selected local area estimates of vaccination coverage rates for U.S. children aged 19-35 months and measures children fully vaccinated with the primary series as of 24 months of age.

Primary Series* Immunization Rates



[‡] Patient immunization information from Idaho's Immunization Reminder Information System (IRIS) for patients active to each organization as of 03/31/2017; rates generated through the Centers for Disease Control and Prevention's Comprehensive Clinic Assessment Software Application (CoCASA).





Idaho Report of Childhood Immunization Rates

All Regional Collaboratives (RC)**

Data represent vaccines administered through 12/31/2016. Rates for patients aged 24-35 months who had received the primary series* by 24 months of age[‡].

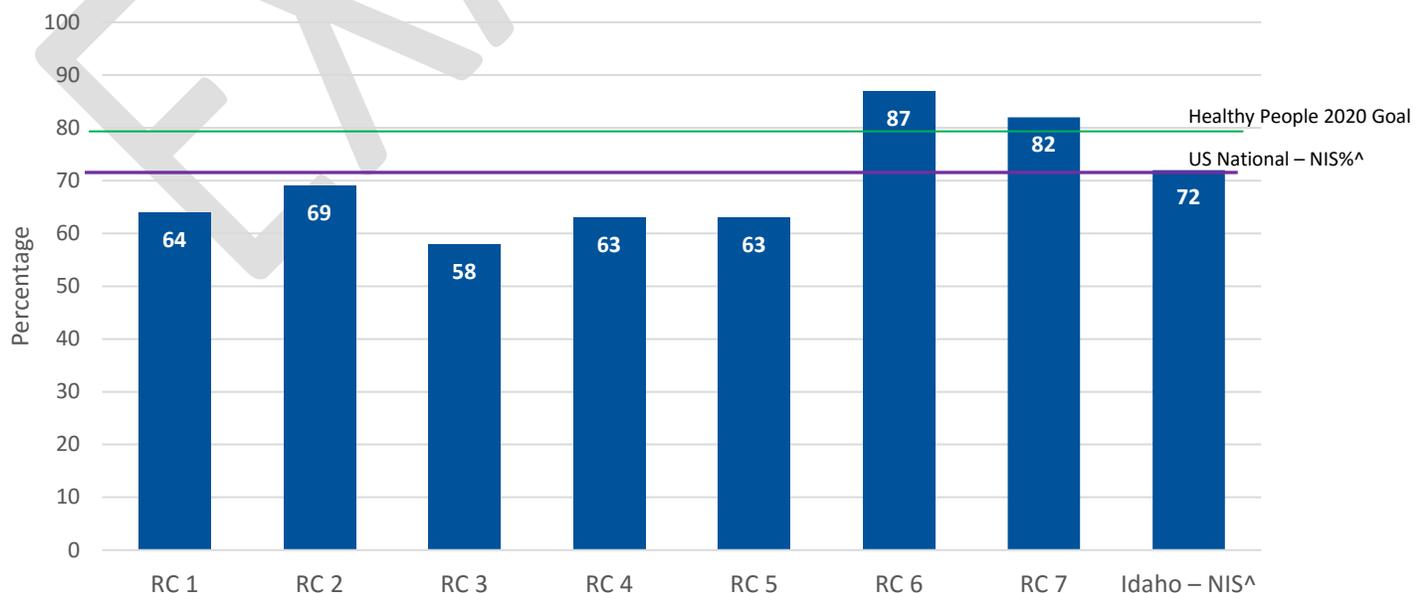
	Primary Series*	4+DTaP	3+Polio	1+MMR	Hib FS	3+HepB	1+Var	4+PCV
RC 1 – Panhandle	64	68	87	90	89	91	89	84
RC 2 – North Central	69	75	91	90	93	88	84	90
RC 3 - Southwest	58	64	86	89	91	78	74	85
RC 4 - Central	63	67	90	88	85	90	75	83
RC 5 – South Central	63	63	80	80	78	78	75	75
RC 6 - Southeastern	87	90	96	95	94	96	95	95
RC 7 - Eastern	82	88	95	93	96	92	88	93
Idaho – NIS [^]	72	81	89	91	88	90	89	84
United States – NIS [^]	72	85	94	92	94	93	92	84

*Primary Series = 4 or more doses of DTaP, 3 or more doses of poliovirus, 1 or more doses of any MMR, primary series Hib (≥2 or ≥3 doses of *Haemophilus influenzae* type b depending on product type received), 3 or more doses of HepB, 1 or more doses of varicella, and 4 or more doses of PCV. Series rates can be lower than single antigen rates because it measures the number of children who received all doses of the included antigens. It is not an average of the single antigen rates.

** RC = Regional Collaborative. Rates are a weighted average of clinics participating in the State Healthcare Improvement Plan and do not represent public health district immunization rates.

[^]NIS = National Immunization Survey: conducted annually and used to obtain national, state, and selected local area estimates of vaccination coverage rates for U.S. children aged 19-35 months and measures children fully vaccinated with the primary series as of 24 months of age.

Primary Series* Immunization Rates



[‡] Patient immunization information from Idaho’s Immunization Reminder Information System (IRIS) for patients active to each organization as of 03/31/2017; rates generated through the Centers for Disease Control and Prevention’s Comprehensive Clinic Assessment Software Application (CoCASA).



Idaho Healthcare Coalition

August 9, 2017



Cyndi Stegall, Implementation Specialist 2

Clinic Connection Status

111 Total Clinics in Cohort One and Cohort Two

- 48 Clinics currently connected bidirectionally
- 28 Clinics in progress
- 2 Clinics on hold pending Participation Agreements
- 33 Clinics have significant delays due to various build risks

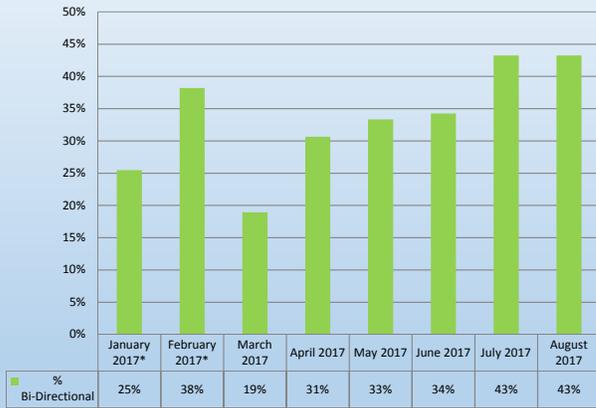
Projected Connections – August/September

Organization	# SHIP Clinics	Cohort	IB CCDA		IB TRN		OB HL7		OB CCDA	
			Go-Live ETA	Actual Go-Live						
Cascade Medical Center (CFP)	1	2			9/29/2017		8/31/2017			
Madison Memorial Rexburg Medical Clinic	1	1	8/23/2017		9/13/2017				9/27/2017	
Pocatello Childrens Clinic	1	1			9/15/2017		9/21/2017			
Season's Medical	3	2	8/23/2017		9/13/2017				9/27/2017	
SLHS	5	1&2			9/8/2017					
SMH CVH Hospital Clinics	6	1&2	8/17/2017		8/17/2017		8/24/2017			
Terry Reilly Health Services	8	1&2	9/14/2017		8/28/2017					
The Pediatric Center	1	2					8/31/2017			
Treasure Valley Family Medicine	1	2			9/29/2017					
Valley Family Health Care, Inc	3	1&2					8/11/2017			
Valley Medical Center, PLLC	1	1				8/1/2017				

Note: IB = Clinic to IHDE; OB = IHDE to Clinic

Bi-Directional Status – By Clinic

% Bi-Directional (Cohort 1 & 2 Clinics)



• Cohort 1 clinics only

16 Participants representing 33 Clinics have significant delay due to various build risks

Clinic Status



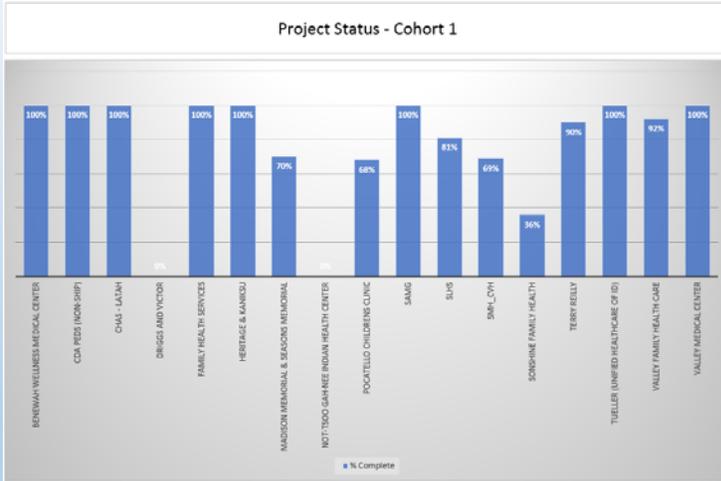
Interface Projections

Projected Interfaces 2017



Note: 26 interfaces are identified as "PERM HOLD" and are NOT anticipated to be built during this grant year.

Master Dashboard – Cohort 1

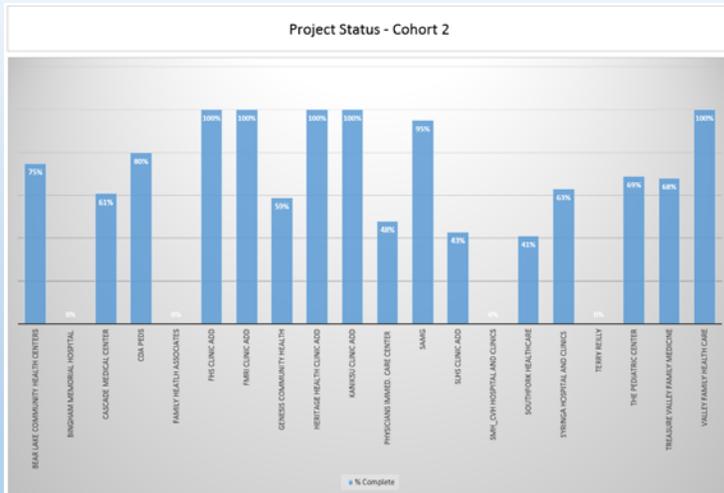


Note: Project Plans for PERM HOLD and/or CANCELLED participants have been removed from information. Seasons Medical has been merged with Madison Memorial project plan as projects are being done together.

Overview – Cohort 1:

- > 30 SHIP Organizations
- > 55 Clinics
 - > Crosspointe – Withdrawn – pending official notice
 - > Portneuf – Withdrawn – pending official notice
 - > Participants PERM HOLD (July 2017):
 - > CHAS
 - > Complete Family Care
 - > Family First Medical Center
 - > Glenns Ferry
 - > HealthWest
 - > Rocky Mountain
 - > Shoshone Family Medical Center
 - > UVCHS - Grandpeaks
- > 53 Interfaces:
 - ✓ Builds COMPLETED:
 - IB TRN = 9
 - IB CCDA = 10
 - OB LAB/RAD/TRN = 12
 - ✓ Builds IN PROGRESS:
 - IB TRN = 3
 - IB CCDA = 7
 - OB LAB/RAD/TRN = 4
 - OB CCDA = 1
 - ✓ Builds ON HOLD:
 - IB TRN = 2
 - IB CCDA = 3
 - OB LAB/RAD/TRN = 2

Master Dashboard – Cohort 2



Note: Project Plans for PERM HOLD and/or CANCELLED participants have been removed from information. Seasons Medical has been merged with Madison Memorial project plan as projects are being done together – refer to Cohort 1.

Overview – Cohort 2:

- > 29 SHIP Organizations
 - 14 Organizations (included in Cohort 1)
 - 15 New Organization Builds
- > 56 SHIP Clinics + Medicaid Clinics
 - Saltzer – Withdrawn – pending official notice
 - Participants PERM HOLD (July 2017):
 - All Seasons
 - CHAS
 - Children & Family
 - Clearwater Medical
 - HealthWest
 - UVCHS (Grandpeaks)
- > 11 Clinic Site Adds Expected:
 - Completed = 6
 - In Progress/Inception = 5
- > 31 Prior Cohort/SHIP Interfaces:
 - IB TRN = 9
 - IB CCDA = 11
 - OB LAB/RAD/TRN = 10
 - OB CCDA = 1
- > 31 Interfaces Expected:
 - ✓ Builds COMPLETED:
 - OB LAB/RAD/TRN = 2
 - ✓ Builds IN PROGRESS:
 - IB TRN = 7
 - IB CCDA = 10
 - OB LAB/RAD/TRN = 7
 - OB CCDA = 3
 - ✓ Builds ON HOLD:
 - IB TRN = 1
 - IB CCDA = 1



PCMH Recruitment Plan

Cohort Three

Version 10.0 DRAFT August 2017)

Introduction

Since February 1, 2015, the Idaho Department of Health and Welfare (IDHW) has worked to implement the Statewide Healthcare Innovation Plan (SHIP). During the four-year grant period, Idaho will demonstrate that the state's entire healthcare system can be transformed through effective care coordination between primary care providers practicing patient-centered care, and the broader medical neighborhoods of specialists, hospitals, behavioral health professionals, long-term care providers, and other ancillary care services.

Idaho envisions a statewide healthcare system transformation that changes the standard of practice for healthcare in Idaho, delivering integrated, efficient, and effective primary care services through the patient-centered medical home (PCMH), which is integrated within the local Medical-Health Neighborhood, and supported and incentivized by value-based multi-payer payment methods. Through this transformation, Idaho will improve the quality and experience of care for all Idahoans, improve health outcomes, and control costs.

Summary of Cohort One and Cohort Two Recruitment and Lessons Learned

Cohort One

Cohort One began on February 1, 2016. All primary care practices (PCPs) within the State of Idaho who were engaged in the PCMH model of care and those interested in PCMH were targeted for Cohort One recruitment. Limited specialty clinics and behavioral health providers offering primary care were also encouraged to apply for Cohort One. The primary entities that contributed to Cohort One recruitment were IDHW's Office of Healthcare Policy Initiatives, Public Health District staff and Medicaid Healthy Connections staff. Recruitment messages focused on increasing understanding and commitment to the model. Specific messages included:

- How the SHIP model test would benefit their practice and patients;
- Resources and supports available to help the practice transition to the PCMH model of care;
- The PCMH model builds on Idaho's experience with PCMHs in the State.

IDHW issued an Interest Application in August 2015 to determine primary care practices' interest in SHIP. IDHW received 134 responses to the Interest Application. The Final Application was issued in October 2015. The Final Application collected information to gauge the clinic's readiness for PCMH transformation and information to ensure broad geographic and population focused diversity in practices selected for the cohort. One hundred and five (105) practices submitted a Final Application for Cohort One.

The Cohort One selection committee was comprised of five individuals representing IDHW's Division of Public Health, Division of Behavioral Health, Division of Medicaid, and the Office of Healthcare Policy Initiatives as well as a subject matter expert from the PCMH Contractor. Using the selection criteria recommended by the IMHC and approved by the IHC, the committee selected 55 clinics to participate in Cohort One.

1 Statewide Healthcare Innovation Plan (SHIP) is supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Center for Medicare & Medicaid Services.

Cohort Two

Cohort Two began on February 1, 2017. Outreach to clinics began in July 2016. IDHW's Office of Healthcare Policy Initiatives, Public Health District staff and Medicaid Healthy Connections staff continued to be the primary entities contributing to recruitment efforts.

Though the Cohort Two recruitment and enrollment process largely followed the process used for Cohort One, IDHW did make changes to reflect lessons learned from Cohort One. For example, IDHW changed the name of the Interest Application to Interest Survey to reduce confusion during the application process. IDHW also lengthened the amount of time clinics had to complete the Interest Survey (from 2 weeks to 12 weeks), and shortened the number of Interest Survey questions to reduce duplication with the Final Application.

IDHW issued the Interest Survey in August 2016 and received 86 responses. IDHW held two SHIP interest webinars (in August and September 2016) that covered the benefits and resources of participating in SHIP, what a clinic will receive via training and technical assistance from the PCMH contractor, and an outline of expectations within their cohort year.

The Cohort Two Final Application was reviewed by the IMHC and approved by the IHC. The Final Application was released on October 3, 2016 with a deadline of October 28. Eighty-one (81) practices submitted a Final Application for Cohort Two. Similar to Cohort One, the selection committee was comprised of five individuals representing IDHW's Division of Public Health, Division of Behavioral Health, Division of Medicaid, and the Office of Healthcare Policy Initiatives as well as a subject matter expert from the PCMH Contractor. Using the Cohort Two selection criteria recommended by the IMHC and approved for the IHC, the committee selected 55 clinics for Cohort Two. After the start of Cohort Two, an additional clinic was invited to participate after a Cohort One clinic terminated its participation in SHIP.

Targeted Audiences for Cohort Three Recruitment

Cohort Three will begin on February 1, 2018. As with Cohorts One and Two, Idaho anticipates recruiting 55 clinics to Cohort Three to achieve the overall objective of 165 clinics in the Model Test. Additional clinics may be accepted to participate if budget and CMMI approval permits. The target audience for Cohort Three recruitment continues to be all primary care clinics that are interested in or have begun PCMH transformation. Within this audience, particular focus will be paid on recruiting clinics that demonstrated interest in but did not participate in Cohorts One or Two, and small independent clinics (i.e., clinics that are not part of a larger network). Another focus for Cohort Three recruitment will be on rural clinics spanning areas that have not been represented in previous cohort years.

Detailing the benefits of participating with SHIP will be the focus of conversations with interested primary care practices. Through scheduled group or individual meetings, webinars, phone calls, site visits, and discussion with stakeholders, clinics will develop an understanding of their value of their possible participation, including:

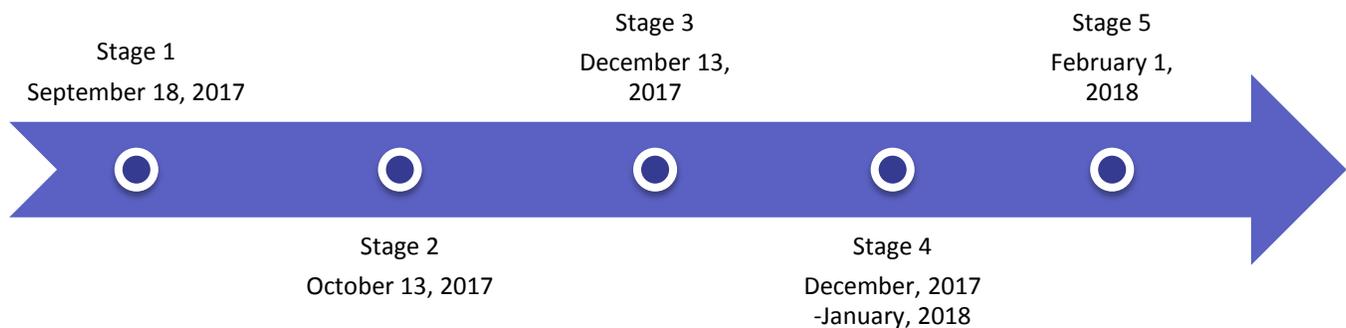
- PCMH training and support
- Mentorship opportunities
- Connectivity to the Idaho Health Data Exchange (IHDE)
- Quality improvement support utilizing clinic data
- National PCMH accreditation assistance
- Financial reimbursement up to \$10,000

Cohort Three Interest Survey, Selection Criteria and Final Application

The Cohort Three Interest Survey was approved by the IMHC in May 2017 and by the IHC in June 2017. The Interest Survey will collect the same information from clinics as the Cohort Two Interest Survey. The Cohort Three Interest Survey was launched in June 2017.

Cohort Three Application and Selection Process

The Cohort Three selection criteria and the Final Application will be revised based on lessons learned during the Cohort One and Cohort Two application processes. The Cohort Three selection criteria and Final Application will also incorporate feedback from the IMHC at their July meeting. The IMHC will present the proposed selection criteria along with the draft of the Final Application to the IHC during their July meeting. Webinars and additional application support will be scheduled for September. The Cohort Three selection process will be similar to the process used for Cohorts One and Two.



Stage 1: SHIP team will email notification to clinics that both have completed a SHIP *Interest Survey*, or were notified to complete the SHIP *Interest Survey*, that the Final SHIP Cohort Three Application has been posted online.

Stage 2: Final SHIP Application submission deadline.

Stage 3: Final selection of clinics and notification for Cohort Three will be made and presented to the IHC on December 13, 2017

Stage 4: Clinics will be enrolled into Cohort Three of SHIP.

Stage 5: Start of the SHIP PCMH Cohort Three.

	Cohort One	Cohort Two	Cohort Three
Date Span	2/1/16 – 1/31/17	2/1/17 – 1/31/18	2/1/18 – 1/31/19
No. PCPs targeted	500	450	400
Number of Clinics Selected	55	55	55*
Final App Open	10/23/15	10/3/16	9/18/17
Final App Due	11/13/15	10/28/16	10/13/17
Selection Announcement to IHC	12/9/15	12/14/16	12/13/17

*additional clinics may be accepted if budget permits and CMMI approves.



STATEWIDE HEALTHCARE INNOVATION PLAN (SHIP) Final PCMH Application for Cohort 3

Version 3.0 DRAFT (August 2017)

A Final Application **must be completed online** for each individual clinic site **by Friday, October 13, 2017**, to be considered for SHIP participation. If you encounter content or technical issues, please contact the Office of Healthcare Policy Initiatives at OHPI@dhw.idaho.gov or call 208-334-0600.

Introduction: The Idaho SHIP seeks to transform the healthcare system through use of a state developed model test design based on the Patient Centered Medical Home (PCMH) model of care. Continuing the healthcare reform process Idaho initiated in 2007, the Idaho Healthcare Coalition (IHC) was created by executive order 2014-02 to lead this process and guide Idaho's SHIP. As part of the grant, Idaho has the ability to support practice transformation with a variety of resources and tools (e.g. technical assistance, data analytics tool, incentive payments). Idaho's transformation plan is based on our experience and success with the patient centered medical home model.

This final PCMH application will be used to evaluate and determine the third cohort of clinics selected for SHIP participation. As guided by the IHC, selection criteria are based on key transformation standards and elements thought to increase the chance of successful PCMH implementation and potential recognition. These criteria in no specific order include: physician/ provider champion engagement, geographic location (within each of the seven Public Health Districts), rural vs. urban/suburban service area, electronic health record utilization and connectivity, and PMCH familiarity. The criteria selected have been based on previous experience implementing the PCMH model within the state of Idaho and our desire to select clinics able to make the transformation successfully. Previous experience with clinic recruitment has also taught us to collect selection criteria items as well as readiness assessment information during the application process. This permits readiness information to be shared with the SHIP PCMH technical assistance contractor after final cohort selection, allowing them to enter into work with this cohort better informed of the current structure. **Selection criteria question text will appear in BOLD**, while readiness assessment questions will remain in plain text format. Questions contained within this application are logic driven; meaning that depending on how questions are answered, additional questions will appear seeking further details. Please respond to all questions honestly and as accurately as possible; answers provided to readiness assessment questions will not be viewed or considered by the Department evaluation team. The selection committee will receive de-identified responses when reviewing applications for participation.

Finally, SHIP is a multi-year plan for Idaho that includes three cohorts of clinic selection. Cohort 1 spanned from 2/1/2016 to 1/31/2017; Cohort 2 began 2/1/2017 and will end 1/31/2018. Cohort 3 will span 2/1/2018 to 1/31/2019. Final notification of clinic selection for Cohort 3 is anticipated to occur during the month of December 2017; additional instruction and next steps will be provided at time of notification.

The number of clinics selected is directly tied to grant resources, funding and current change capacity.

Additional information on SHIP including a FAQ page can be found on our website at:

www.SHIP.idaho.gov.

Section 1: Clinic Profile

1 Statewide Healthcare Innovation Plan (SHIP) is supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Center for Medicare & Medicaid Services.

Rationale:

Your clinic contact information, make-up and descriptive characteristics will assist in follow-up efforts and does include several selection criteria (**BOLD** items)

Please provide the following information for each individual clinic site to be considered for SHIP participation:

1.	Clinic Name		
2.	Clinic's Physical Address		
3.	City		
4.	State		
5.	County		
6.	Zip Code		
7.	Phone Number		
8.	Fax Number		
9.	Main Contact First Name		
10.	Main Contact Last Name		
11.	Main Contact Email Address		
12.	Corporate Ownership or Healthcare System Name (if applicable)		
13. Organization Type	<input type="checkbox"/> Private Practice <input type="checkbox"/> Community Health Center (CHC) <input type="checkbox"/> Rural Health Clinic (RHC) <input type="checkbox"/> Hospital/ Health System Owned Clinic <input type="checkbox"/> Other:		
14. Predominant Specialty	<input type="checkbox"/> Family Medicine <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Pediatrics <input type="checkbox"/> Multi-Specialty <input type="checkbox"/> Other:		
15. Please complete the Clinic Staff List	a. Physicians		
	Name:	Credentials:	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	Name:	Credentials:	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	Name:	Credentials:	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	Name:	Credentials:	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	Name:	Credentials:	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	Name:	Credentials:	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	b. Physician Assistants, Nurse Practitioners		
	Name:	Credentials:	<input type="checkbox"/> Full-time

			<input type="checkbox"/> Part-time
	Name:	Credentials:	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	Name:	Credentials:	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	c. Clinic Staff (i.e. other professional licensed staff)		
	Name:	Credentials:	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	Name:	Credentials:	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	Name:	Credentials:	<input checked="" type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	d. Administrative and Support Staff		
	Name:	Credentials:	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	Name:	Credentials:	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	Name:	Credentials:	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time

FOR REFERENCE

Section 2: Transformation Plan, History and Experience

Rationale:

Through various pilot projects, we have learned engaged leadership and an effective transformation team are critical to the success of implementing and sustaining the PCMH model. Questions appearing in **BOLD** will be considered as selection criteria.

16. Please list your current or proposed Transformation Team members	Physician/ Provider Champion Name:	Title:	Role in Transformation:	email:
	Clinic Administration Name: (if applicable)	Title:	Role in Transformation:	email:
	Office Manager Name:	Title:	Role in Transformation:	email:
	Other Key Leaders Name:	Title:	Role in Transformation:	email:
	Other Key Leaders Name:	Title:	Role in Transformation:	email:
17. Has your clinic ever participated in any of the following? (Please check all that apply)	<input type="checkbox"/> Safety Net Medical Home Initiative <input type="checkbox"/> Idaho Medical Home Collaborative (IMHC) Pilot <input type="checkbox"/> Oregon's PCPCH Program <input type="checkbox"/> Other PCMH Programs (CHIC, Medicaid Health Home Program, etc.); Please list: <input type="checkbox"/> None			
18. Has your clinic achieved national PCMH recognition or accreditation? <i>Recognition is encouraged, but not required to apply or to participate in the SHIP.</i>	<input type="checkbox"/> Yes [if yes, proceed to 19, skip 20-21] <input type="checkbox"/> No [if no, proceed to 20]			
19. Please indicate, the organization(s) the national PCMH recognition or accreditation was received from, and level of recognition (if from NCQA). <i>Recognition is encouraged, but not required to apply or to participate in the SHIP.</i>	<input type="checkbox"/> AAAHC		Date Accredited:	
	<input type="checkbox"/> Joint Commission		Date Accredited:	
	<input type="checkbox"/> NCQA		Date Recognized: Level of Recognition:	
	<input type="checkbox"/> URAC		Date Certified:	
20. Are you currently in the process of applying for recognition or accreditation with AAAHC, The	<input type="checkbox"/> Yes [if yes, proceed to 21] <input type="checkbox"/> No [if no, proceed to 22]			

Joint Commission, NCQA, or URAC?	
21. Please provide information on the current status of your application process for national recognition or accreditation, with which organization you are applying, and to what level, if applicable, you are attesting to?	

FOR REFERENCE ONLY

Section 3: Health Information Technology (HIT) Capabilities

Rationale:

We understand that every clinic in Idaho has a different level of experience and may use one of several platforms (i.e. EHR). Access to data, in a timely and consistent manner is essential for effective practice transformation. Additionally, federal grant reporting requirements necessitate practice connectivity to the Idaho Health Data Exchange (IHDE) and Health Tech Solutions. Many of the questions included in this section are readiness related and will assist the IHDE once the first wave selection has been completed. Only questions appearing in **BOLD** will be considered as selection criteria. The questions in this section should be answered by or through consultation with your clinic's IT Administrator/ Manager.

22. Does your clinic have an electronic health record?	<input type="checkbox"/> Yes [if yes, proceed to 23] <input type="checkbox"/> No [if no, proceed to 36]										
23. Do you have any EHR conversion planned or being considered between 2/1/2018 and 1/31/2019? (For example: Will you be changing EHR vendors or software between 2/1/2018 and 1/31/2019?)	<input type="checkbox"/> Yes <input type="checkbox"/> No										
24. Please identify your clinic's IT Administrator/ Manager or anyone in your clinic who is involved in the daily operational management with your EHR vendor and the person completing the questions in this section of the application.	<table border="1"> <tr> <td data-bbox="824 877 1036 915">IT Contact Name</td> <td data-bbox="1036 877 1443 915"></td> </tr> <tr> <td data-bbox="824 915 1036 953">Title</td> <td data-bbox="1036 915 1443 953"></td> </tr> <tr> <td data-bbox="824 953 1036 1045">Organization (if not employee of applying clinic)</td> <td data-bbox="1036 953 1443 1045"></td> </tr> <tr> <td data-bbox="824 1045 1036 1083">Email</td> <td data-bbox="1036 1045 1443 1083"></td> </tr> <tr> <td data-bbox="824 1083 1036 1119">Phone</td> <td data-bbox="1036 1083 1443 1119"></td> </tr> </table>	IT Contact Name		Title		Organization (if not employee of applying clinic)		Email		Phone	
IT Contact Name											
Title											
Organization (if not employee of applying clinic)											
Email											
Phone											
25. Did the person listed in Question 24 complete this section of the application?	<input type="checkbox"/> Yes [if yes, proceed to 27] <input type="checkbox"/> No [if no, proceed to 26]										
26. If No, please identify the person completing this section of the application	<table border="1"> <tr> <td data-bbox="824 1192 1036 1230">Name</td> <td data-bbox="1036 1192 1443 1230"></td> </tr> <tr> <td data-bbox="824 1230 1036 1268">Title</td> <td data-bbox="1036 1230 1443 1268"></td> </tr> <tr> <td data-bbox="824 1268 1036 1306">Email</td> <td data-bbox="1036 1268 1443 1306"></td> </tr> <tr> <td data-bbox="824 1306 1036 1350">Phone</td> <td data-bbox="1036 1306 1443 1350"></td> </tr> </table>	Name		Title		Email		Phone			
Name											
Title											
Email											
Phone											
27. What is the size, make-up, and availability of your clinic's IT office staff?											
28. Who is your EHR vendor?	<input type="checkbox"/> Allscripts Professional <input type="checkbox"/> athenaClinicals <input type="checkbox"/> Centricity <input type="checkbox"/> Cerner <input type="checkbox"/> e-MDs <input type="checkbox"/> eClinicalWorks <input type="checkbox"/> Epic <input type="checkbox"/> Greenway (PrimeSuite, SuccessEHS, Intergy) <input type="checkbox"/> NextGen <input type="checkbox"/> McKesson (Practice Partner) <input type="checkbox"/> Meditech <input type="checkbox"/> Other (please specify):										

29. What EHR software version is currently deployed to production? (This can often be located on the splash screen of the program when launched)	
30. How many months has the clinic been using its current EHR system?	
Note: For questions 31-33, please contact your EHR vendor to confirm prior to responding:	
31. Does your EHR support Health Information Exchange (HIE) connectivity? (Not all EHR products support this capability. You may need to contact your EHR vendor for assistance in answering this question)	<input type="checkbox"/> Yes <input type="checkbox"/> No
32. Can your certified EHR produce a CCD (transition of care document) in the .xml format using the CCD template structure? (You may need to contact your EHR vendor for assistance in answering this question)	<input type="checkbox"/> Yes [if yes, proceed to 33] <input type="checkbox"/> No [if no, proceed to 34]
33. If yes, can your EHR automate the production of the CCDs, as opposed to having to manually create them? (You may need to contact your EHR vendor for assistance in answering this question)	<input type="checkbox"/> Yes <input type="checkbox"/> No
34. Do you have access to vendor product support? (Often referred to as 'Level 2' support - troubleshooting, configuration, database administration, and repair for server, network, infrastructure, Data Center, email, file shares, and other infrastructure issues)	<input type="checkbox"/> Yes <input type="checkbox"/> No
35. Do you have access to helpdesk support when you have questions about your EHR? (Often referred to as 'Level 1' support – device support, breaks/fixes, configuration issues, software installations, trouble shooting)	<input type="checkbox"/> Yes <input type="checkbox"/> No
36. How does your clinic or organization support your EHR product?	
37. Is your EHR currently connected to the Idaho Health Data Exchange (IHDE)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section 4: Primary Care/ Behavioral Health Integration

Rationale:

Idaho is a 100% designated shortage area for mental health professional services. As clinics transform to PCMH practices support the client, integration and access to behavioral health care will be essential elements to achieving patient wellness. Part of the SHIP plan includes goals and metrics related to increasing patient wellness and this will be support in part by behavioral health integration efforts with PMCH clinics.

38. Please indicate the level of primary care/ behavioral health integration occurring in your office?	<input type="checkbox"/> Full collaboration in a merged integrated practice for all patients <input type="checkbox"/> Close collaboration with several aspects of integrated practice <input type="checkbox"/> Co-located with close collaboration on-site with some system integration <input type="checkbox"/> Co-located with basic collaboration on-site <input type="checkbox"/> Basic collaboration off-site <input type="checkbox"/> Minimal collaboration/ coordination
39. Is your clinic completing behavioral health screenings (i.e. a PHQ 2, PHQ 9, or other universal screening)?	<input type="checkbox"/> Yes [If Yes, proceed to 40] <input type="checkbox"/> No [If No, proceed to 41]
40. If yes, are behavioral health screenings conducted only during wellness visits?	<input type="checkbox"/> Yes <input type="checkbox"/> No
41. Please describe how your clinic interfaces with behavioral health services and providers in your community. It can include efforts to meet patients' needs not previously captured.	

Section 5: Quality Improvement (QI) Activities

Rationale:

Quality improvement is a hallmark of high performing patient centered medical homes. Learning more about current practices will assist the PCMH contractor in offering technical assistance.

42. Does the clinic use performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
43. Do you have a formal quality improvement policy in place?	<input type="checkbox"/> Yes [If Yes, proceed to 45] <input type="checkbox"/> No [If No, proceed to 44]		
44. If No, do you have a plan to implement QI policies and procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
45. Please indicate frequency of QI meetings.			
46. Please list clinic role of QI committee members (e.g. RN, patients, office manager)	Name	Title	Role
	Name	Title	Role
	Name	Title	Role
	Name	Title	Role
47. Please specify the QI tool(s) being used by your clinic (e.g. Six Sigma, Lean, PDSA cycles).			
48. Please indicate what you track and measure. (Check all that apply)	<input type="checkbox"/> Clinical Quality measures <input type="checkbox"/> Preventive care <input type="checkbox"/> Care Coordination <input type="checkbox"/> Patient Experience <input type="checkbox"/> Provider Experience <input type="checkbox"/> Overall clinic efficiencies affecting healthcare costs (e.g., reduction readmissions, ER visits, redundant labs)		

Section 6: Clinic Vision and Intentions

Rationale:

An engaged physician/ provider leadership champion, clinic administration engagement and a dedicated transformation team is imperative for successful transformation and sustainability of the PCMH model. A physician (recommended), or other provider leadership champion, should be instrumental in implementing long-term changes/vision and continually encourages other physicians/providers who might be unsure if they want to participate.

49. How does your clinic’s strategic plan align with the SHIP goals to improve health outcomes, reduce healthcare costs and improve provider and patient experience?	
50. Please tell us about your identified physician/ provider champion [answered in Section 2; Question 16] and what your transformation team hopes to accomplish within the Cohort 3 timeframe (February 1, 2018 to January 31, 2019) and beyond.	
51. As the physician/ provider champion for this clinic, what will your commitment to this PCMH work look like over the next year (i.e., attending meetings, leading communications, breaking down barriers, troubleshooting challenges, etc.)?	
52. As the physician/ provider champion for this clinic, please describe: <ul style="list-style-type: none"> • One or more successful change or transformation projects you have championed within the clinic. • How did you champion that change? 	

Section 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	



Clinic Qualifying Criteria for SHIP Patient Centered Medical Home Transformation

Version 3.0 DRAFT (July 2017)

The Idaho Medical Home Collaborative (IMHC) has developed criteria to review readiness for Idaho primary care clinics interested in joining Idaho's State Healthcare Innovation Plan (SHIP) initiative for transformation to patient centered medical homes (PCMH). The goals of the criteria are to identify primary care clinics that reflect both geographic and population focused diversity as well as clinics that demonstrate readiness to take on transformation work. This information will be explained and gathered via the Final PCMH Application questions and selection process for SHIP PCMH Cohort Three participation.

- 1. The Clinic selection process should consider the following statewide factors:**
 - a. Geographic coverage - clinics will be chosen from each of the seven Public Health Districts within Idaho.
 - b. Selection will include frontier, rural, suburban and urban clinics.
 - c. Clinic types and specialties to be considered will include Family Medicine, Internal Medicine, Pediatrics, Rural Health Clinics and Federally Qualified Health Centers; and other specialties providing primary care services.
 - d. Clinic familiarity with the PCMH model of care will be considered in order to incorporate a full variety of participants.
- 2. The INTENT AND VISION of the interested clinic should align with the Quadruple Aim** to improve health outcomes, to improve quality and patient experience of care, and to lower costs of care for all Idahoans, as well as to enhance provider job-satisfaction.
 - a. Organization and clinic administration (medical & financial) will be invited to attend "SHIP Interest Webinar" via, at minimum, two scheduled online webinars to ensure that SHIP goals, participation, clinic commitment, and magnitude of effort are fully understood.
- 3. An engaged physician/ provider leadership champion, clinic administration engagement and a dedicated transformation team should be identified within the interested clinic** and is imperative for successful transformation and sustainability.
 - a. Roles of the interested Clinic's PCMH Transformation Team for each site typically include:
 - i. Physician (recommended) or other provider Leadership Champion should be instrumental in implementing the long-term changes/vision and continues to encourage other physicians/providers who might be unsure if they want to participate.
 - ii. Office Manager (or similar job position) – imperative to keep informed and buy-in for smooth transition of daily operations.
 - iii. PCMH change agent, project lead, or quality assurance lead (if different from Office Manager) – knowledgeable, enthusiastic and supported by leadership/management.
- 4. Adequate and effective health information technology (HIT) capabilities are critical to support the PCMH model** and should be reviewed by the interested clinic.

- a. The interested clinic should have an established EHR or process for population health management.
 - b. The Interested clinic's EHR should be health information exchange (HIE) compatible.
 - c. The interested clinic should intend to interface with the state health information exchange, the Idaho Health Data Exchange (IHDE).
 - d. The interested clinic should include essential information technology (IT) personnel in discussion of SHIP participation and intent to apply.
 - e. *Any interested clinics currently involved in EHR conversions or planning a conversion within 12-months of the SHIP PCMH application process are warned that the dual lift of an EHR conversion and PCMH transformation efforts may thwart the success in reaching either or both targets.*
5. The Interested clinic should have **evidence of Quality Improvement (QI) activities or defined plans for QI structured activities** which are critical to implementing and sustaining the PCMH model.
 6. The interested clinic should complete a Final PCMH Application which includes readiness components of PCMH transformation and Health IT capabilities.



PROJECT ECHO

Jeff Seegmiller EdD, AT., Director
Idaho WWAMI Medical Education Program

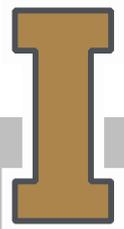


University of Idaho



OBJECTIVES & TOPICS

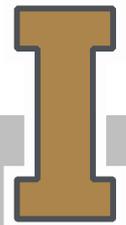
- Background of Project ECHO
- Overview of the ECHO model
- Outline of associated costs
- Discussion of benefits
- SHIP involvement
- Goals for Idaho
- Outcomes and evaluation





BACKGROUND OF ECHO

- Extension for Community Healthcare Outcomes (ECHO)
 - Collaborative model of medical education and care management
 - Created in 2003 by Sanjeev Arora, M.D., a liver disease doctor in Albuquerque, to address the line untreated Hep. C patients in the state
 - Makes specialized medical knowledge accessible where ever it is needed to save/improve lives





THE ECHO MODEL



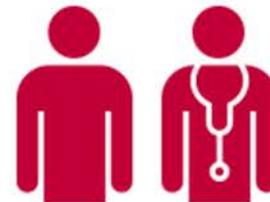
- People need access to specialty care for their complex health conditions.



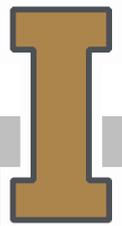
- There aren't enough specialists to treat everyone who needs care, especially in rural and underserved communities.



- ECHO trains primary care clinicians to provide specialty care services. This means more people can get the care they need.



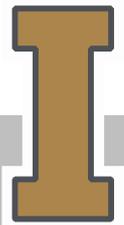
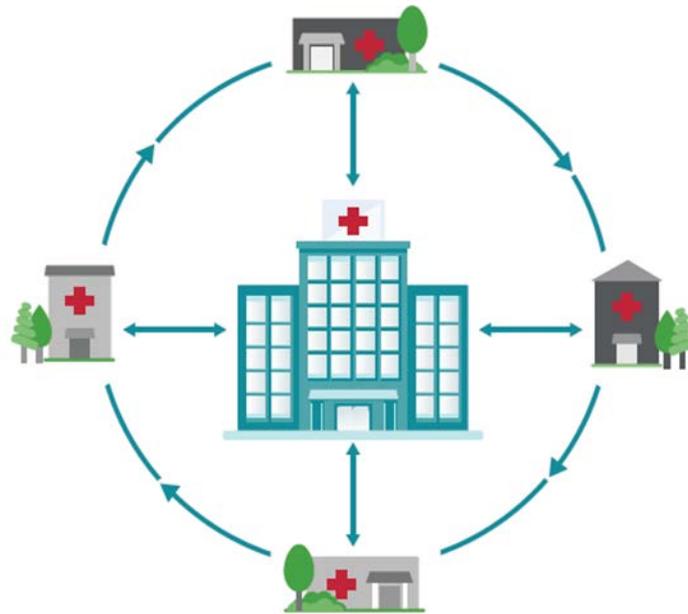
- Patients get the right care, in the right place, at the right time. This improves outcomes and reduces costs.





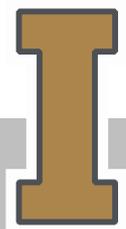
THE ECHO MODEL

- “Hub-and-Spoke” knowledge-sharing networks
 - Clinicians partner with specialist mentors at an academic medical center or “hub”
 - Links inter-disciplinary specialist teams with multiple primary care clinicians or “spokes”





ECHO HUBS & SUPERHUBS





ECHO Whale



PCA Espanola



Baton Rouge



Pecos Valley MC



DOH Las Cruces



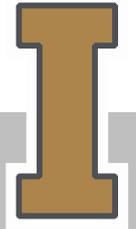
SBRT-First Choice South Vc



Memorial HDX7000

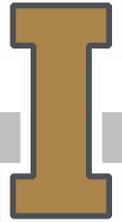


LAS VEGAS ECFH





Features	ECHO	Telemedicine
Hub and Spoke Model	✓	
Videoconferencing/Internet	✓	✓
Rural/underserved populations	✓	✓
Direct Doctor-patient relationship		✓
Patients are De-identified	✓	
Remote Patient monitoring		✓
Case-based learning	✓	
Case Consultation	✓	✓
Coverage of Services (CPT Codes)		✓
Didactic Presentations	✓	





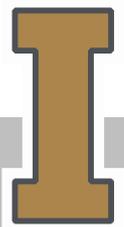
COSTS

• Hub

- IT equipment
- Specialist time
- Program staff
- *Free training and support*

• Spoke

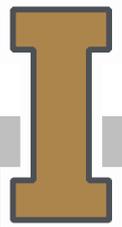
- IT equipment
- Time away from practice
- *Participation in teleECHO “clinics” is free*





PARTICIPANT BENEFITS

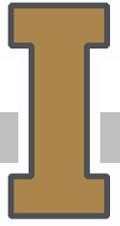
- No cost CMEs and Nursing CEUs
- Potential to obtain certification in specific field
- A mix of work and learning
 - Acquire new skills and competencies
- Professional interaction with colleagues with similar interest
 - All levels of providers welcome
 - Less isolation with improved recruitment and retention
- Access to coordinated specialty consultation





PATIENT BENEFITS

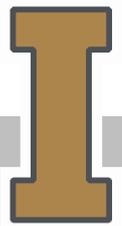
- Moves knowledge, not patients
 - Saves patients from traveling long distances
 - Reduces wait times for specialists
- Improves individualized care in rural and underserved communities
- Reduces disparities improves health outcomes





BENEFITS TO IDAHO

- Supports the **Medical Home Model**
- Rapid learning and best-practice dissemination
 - Reduces variations in care
 - De-monopolizes knowledge
 - Improves quality and safety
- Workforce training and force multiplier
 - Improves professional satisfaction/retention
- Cost effective care
 - Prevents cost of untreated disease
 - Avoids excessive testing and travel
- Provides access for rural and underserved patients to reduced disparities
- Integrates public health into treatment paradigm

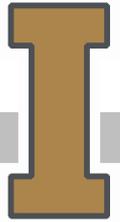


ECHO & SHIP



State Healthcare Innovation Plan

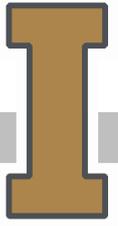
Improved health, improved healthcare, and lower cost for all Idahoans





GOALS FOR IDAHO

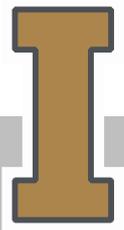
- Establish ECHO “clinics” in three clinical focus areas
 - ✓ Opioid addiction
 - ✓ Chronic pain management
 - ✓ Mental / Behavioral Health
- Increase workforce capacity
- Bring specialty knowledge to rural and underserved communities





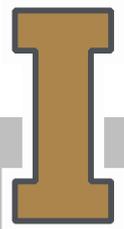
OUTCOMES AND EVALUATION

- Participants in the training will receive pre and post assessments to evaluate the teleECHO sessions
- Attendance at the sessions will be tracked
- Possible indicators include:
 - Change in participant knowledge
 - Change in participant confidence
 - Change in participant behavior / clinical practice
 - Number of buprenorphine-certified physicians





QUESTIONS





KEY CONTACTS

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E-mail: jeffreys@uidaho.edu

Shenghan Xu Ph.D.

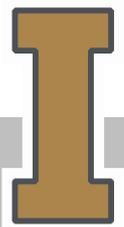
Phone: (208) 885-1083

Email: shenghan@uidaho.edu

Molly Volk, MHS

Phone: (208) 364-4037

Email: mvolk@uidaho.edu





SHIP Operations and IHC Workgroup Report to the Idaho Healthcare Coalition August 09, 2017

SHIP OPERATIONS:

SHIP Contracting/Request for Proposal (RFP) Status:

- **Report Items:**
 - CMMI requests for release of funds were approved for: 1) PHD1 RC Grant for Boundary County EMS and Shoshone County EMS; 2) Health Management Associates Telehealth TA; 3) OHPI In-State Travel; 4) Chas Latah Community Health Telehealth Grant; 5) Payette County Paramedics CHEMS Agency; 6) ONC 2017 Technical Interoperability Forum Out of State Travel Request; 7) LAN Fall Summit Out of State Travel Request; 8) Shoshone County EMS CHEMS Agency; 9) Terry Reilly Health Services Telehealth Grant
 - CMMI requests for release of carryover and award year three funds were submitted for: 1) Sandpoint Family Health Center Telehealth Grant; 2) University of Idaho State Evaluator funding; 3) Idaho State University; 4) In State Travel Other for CHEMS Stakeholder; 5) Out of State Travel Request for Telehealth TA Training; 6) PCMH TA Contractor Line Item Transfers
 - Quarterly Report for Award Year Three second quarter risk log and supplemental quarterly report for AY3 deliverables has been completed.
 - DHW Board of Directors Report for August 2017 Meeting was completed.
 - SFY2019 SHIP Budget Request was submitted to DHW Division of Finance
 - Telehealth Technical Assistance Contract was finalized.
 - Two Telehealth Sub-grants were finalized.
 - Two CHEMS Agency Letters of Notation were prepared.

SHIP Administrative Reporting:

- **Report Items:**
 - Interviews for Graduate Research Assistants from Boise State University were conducted by SHIP Project Managers.
 - The State Led Evaluation team finalized their report of the IHC interviews and have submitted the report to DHW for review.
 - Preliminary comments were provided to CMMI on the Research Triangle Institute Federal Evaluation Report for 2016.
 - Six Virtual PCMH Reimbursement Requests have been processed for payment.
 - The virtual PCMH and Telehealth Grant applications have been reopened for Cohort One and Cohort Two clinics.
 - The SHIP Blog was launched on July 27th to provide public-facing messaging that complements SHIP's newsletter and other direct stakeholder communication with timely news and events that align with SHIP goals:
www.idahohealthcaretransformation.org
 - Four projects have been recommended to advance PCMH Mentorship opportunities across the state. These include:
 - Development of a resource guide/toolkit to link individuals to mentorship resources

- Convening a provider champion mentor panel
- Development of a master list of statewide linkages
- Hosting an information-sharing webinar series

Regional Collaboratives (RC):

- **Report Items:**

- **District 1:** 6/30/2017 telephone meeting with RC Chair
- **District 2:** 6/6/17: SHIP RC2 Meeting. Discussions and sharing occurred on the use of telehealth, preview of Learning collaborative and RC Summit. PCMH application deadlines for savings. Discussion of possible projects for next year RC subgrants. Possible collaborative approach at looking at claims data.
- **District 3:** SWHC (6/6): The SWHC convened in June to discuss sustainability, workgroup updates, and Cohort Two needs; Senior Workgroup (6/27): The Senior Workgroup met to discuss their two projects, connecting EMS patients to 211 when appropriate and notifying PCPs when patients repeatedly utilize EMS but are not transported. Canyon County Paramedics (CCP) is current distributing 211 "referral" cards to vulnerable patients. In addition, CCP is working with the PHD SHIP staff and SWHC members to schedule brief presentations to local PCMHs to discuss their new initiative to notify PCPs.; Behavioral Health Workgroup (6/26) The Behavioral Health Workgroup met to discuss their projects to enhance access to behavioral health for children by facilitating a partnership between a local school and local behavioral health providers and efforts to enhance co-management relationships. It is worth noting the school project is scheduled to begin Fall 2017. In addition, the R3 BHI will take on the role of co-convenor with R4 to support local behavioral health integration efforts under the Idaho Integrated Behavioral Health Network (IIBHN).; Emergency Department Utilization Workgroup (6/19) the ED Utilization Workgroup met to finalize form letters to make available for PCPs to send to patients who are inappropriately utilizing the ED for specific conditions/symptoms. In addition, the group began developing an assessment for CHWs working with patients who are high utilizers.; Oral Health Workgroup (6/1) The Oral Health Workgroup, a partnership between R3 and R4, met on 6/1. Extensive data collection occurred in oral health provider's office regarding managed/unmanaged high blood pressure.
- **District 4:** CHC Meeting - 6/6/17 Exec Leadership Meeting 5/24/17
- **District 5:** The June Executive Committee meeting took place on June 16. Meetings generally consist of updates regarding the SHIP project, status of our cohort clinics transformation efforts, and a presenter from the MHN or a direct PCMH resource that provides brief training or material for Cohort One and Two clinics.
- **District 6:** June 14, 2017 Executive Committee Meeting. Draft minutes embedded below. June 22, 2017 Medical Health Neighborhood Meeting. Draft minutes embedded below. A monthly calendar has been developed and sent out to SHIP clinics that includes SHIP meetings and webinars, PHD6 RC meetings, NCQA or other informational webinars, etc. The "Toilet Talk" monthly poster, fluoride varnish clinics, smoking cessation workshops, and special clinic fliers are attached so these services can be accessed by patients empaneled with SHIP clinics.
- **District 7:** RC meeting July 13th

- **Next Steps:**

- **District 1:** Evaluate possible role of our RC in the future CHOICE advisory board with Medicaid.

- **District 2:** The RC will consider obtaining claims data from Medicaid to steer next year's project.
- **District 3:** The SWHC will update its strategic plan beginning in July and will plan to submit to the PHWG in September to promote sustainability. In addition, it will continue to support the efforts of the workgroups to develop and enhance resources for local primary care practices as a part of the PCMH support goal. The SWHC and workgroups will also begin several prevention focused projects in the upcoming months that target the MHN connection. For example, the SWHC will work with SLHP and the Alliance to coordinate on education for vision care providers on documenting and reporting diabetic eye exams. Lastly, the PHD SHIP team will begin meeting with other regional and state QI teams in external organizations to coordinate and share resources to better support primary care practices as a part of the communication goal.
- **District 4:** Ruby/Kim/Tara to attend clinic site visits with QI staff to orient clinics on the IHDE Data Quality Improvement Process. Palina will announce if AHC grant funding is approved. Next meeting is scheduled for 8/1/17.
- **District 5:** The SCHC will not meet during the month of July. Our next all member meeting will take place August 18th.
- **District 6:** Continue marketing efforts for Suicide Prevention Symposium. Begin recruitment efforts for Cohort Three clinic selection. Make contact with ISU counseling and social work programs.
- **District 7:** Continue meeting with MHN resources that can help further PCMH work. Child Protection Services and Drug Prescription resources to present during next RC meeting. Work with partners on Community Health Needs assessments in area.

ADVISORY GROUP REPORTS:



Telehealth SHIP Subcommittee:

- **Report Items:**
 - Established the subgrants for the three clinics participating in the Telehealth pilot project. They are in the process of getting connected with the technical assistance contractor to have an initial kick-off meeting at the end of August.
 - The telehealth grant application for SHIP Cohort One and Two clinics and SHIP CHEMS agencies is now available, and due September 15, 2017. A total of \$225,000 is available for 9 awards in the amount of \$25,000 each.
 - There will be an optional telehealth technical assistance Q & A webinar to be held August 11, 2017 from 12:30 – 1:30pm (MT)
- **Next Steps:**
 - Continue marketing the telehealth grant opportunity and follow up with clinics who have expressed interest in the past or who are currently utilizing telehealth in their clinics.



Community Health Workers:

- **Report Items:**
 - Two CHW courses will be offered through Idaho State University (ISU) this fall.

- Physical In-Person Course – will be at St. Mary’s Hospital in Cottonwood, ID on Tuesdays starting August 22, 2017 from 5:30 – 8:30pm (PT) this is a 13-week course that will be limited to 20 students.
 - Live On-Line course – will be Wednesday’s starting August 23, 2017 from 6:00 – 9:00pm (MST) This is a 13-week course that will be limited to 25 students.
 - ISU will develop eight and host up to twelve asynchronous topics as Health Specific Modules (HSM) that may be used for core course elective modules or Continuing Education modules for students completing the core.
 - First HSMs that will be developed are: Pre-Diabetes and Diabetes, Congestive Heart Failure, and Oral Health.
 - Second set of HSMs are in the process of being developed and topics include: Caregiver Resources, Tobacco (Smoking Cessation), Congestive Obstructive Pulmonary Disease (COPD), and Medication Adherence
 - IDHW staff members began outreach for the Fall 2017 training cohorts; sent email to SHIP managers and other state stakeholders that could be interested in the training
- **Next Steps:**
 - Consider additional Health Specific Modules that ISU can develop, if funding is there.
 - Opportunities for collaboration between ISU and other stakeholders to aide in the development of the Health Specific Modules

WORKGROUP REPORTS:



Community Health EMS:

- **Report Items:**
 - The statewide CHEMS workgroup has not met since our last meeting held on June 28, 2017 from 10:00-11:00 AM MST
 - The next statewide CHEMS workgroup meeting is scheduled for August 23, 2017 from 10:00 to 11:00 AM MST
 - Maintaining status quo on the following:
 - Agencies interested in the 3rd and final ISU CP Certificate Program
 - Parma Rural Fire District, Payette County Paramedics, and Cascade Rural Fire District
 - Agencies and students interested in the BLS/ILS education opportunity
 - Thirteen (13) agencies, 54 students
 - CHEMS data collection
 - BLS/ILS curriculum development remains underway with the College of Western Idaho
 - CMMI Tiered funding requests:
 - A total of 11-tiered funding opportunities are available
 - Bonner, Boundary, Canyon, Payette, and Shoshone have received funding
 - Blackfoot and Idaho Falls are drafting budgets to be submitted
 - Learning Collaborative and Webinars
 - Learning Collaborative is tentatively scheduled for January 17, 2017
 - The first webinar is scheduled for September 14, 2017 from 2:00-3:00 MST
 - Presenter: Teresa Shackelford, LCSW, Region IV Behavioral Health Clinic Supervisor

- Focus: the importance of mental and behavioral health in healthcare and healthcare recovery, accessible statewide resources for CHEMS agencies, and how to incorporate mental and behavioral health into CHEMS programs

- **Next Steps:**

- Project Charter, Deliverable 3 – in progress
 - BLS/ILS curriculum development – received line item budget from CWI. Proposal is soon to follow
- Project Charter, Deliverable 4 - sustain
 - Upcoming meetings on August 15, 2017:
 - Bonner county to discuss upcoming agency training and how we can assist
 - Shoshone county to attend a board and stakeholder meeting to assist with CHEMS program development
- Project Charter, Deliverable 6 – in progress
 - Upcoming learning collaborative and webinar logistics
- Continue to promote CMMI tiered funding and CP ISU Certificate Program
- The internal CHEMS workgroup continues to meet every Monday



Idaho Medical Home Collaborative:

- **Report Item:**

- The IMHC Workgroup met Wednesday, July 12, 2017 at 12:00 PM MT. Matt Wimmer shared information about Medicaid’s share savings program that will begin in 2018. Kym Schreiber presented the Cohort Three PCMH Recruitment Plan, Selection Criteria, and the PCMH Final Application from Cohort Two. The group reviewed all documents and provided comments and edits. Kym will take the feedback and edits the documents and redistribute to the group. The edited documents will be presented to the IHC on August 9, 2017.

- **Next Steps:**

- The PCMH Mentorship Subcommittee will convene later in 2017 to update the PCMH Mentorship Framework.
- The IMHC workgroup will return to an ad hoc status.



Data Governance:

- **Report Item:**

- The Data Governance Workgroup did not meet in the month of July.

- **Next Steps:**

- The next SHIP Data Analytics Workgroup meeting is scheduled for August 14, 2017.
 - The SHIP operations staff will provide an update on the performance of the HIT goals to CMMI.
 - The membership will consider the next draft of the issue resolution process.
 - The workgroup will continue its discussion of measure selection for Award Year Four.

MPW**Multi-Payer:****• Report Item:**

- CMMI requires information to monitor financial progress for the SHIP grant. Mercer sent a template to Commercial Payers, Medicaid and Medicare requesting this information. Mercer and the SHIP Administrator met with the MPW Chairs to discuss the draft report. Their feedback will be incorporated into the draft and the draft will be reviewed again on August 8th.
- A representative from each commercial payer, Medicare and Medicaid were asked to provide updates to the IHC about the methodologies they are using to incentivize quality outcomes. At the July 12th IHC meeting, Jeff Crouch, IDHW Regional Director and Lisa Hettinger, IDHW Deputy Director provided information on the Idaho Medicaid Health Connections Value Care program. The Medicaid Power Point Presentation is available on the SHIP website (www.ship.idaho.gov).

• Next Steps:

- Mercer anticipates presenting the final financial report to the Multi-Payer Workgroup prior to the September 13th IHC meeting.
- Noridian Healthcare Solutions provides administrative services for Medicare. At the August 9th IHC meeting, Dr. Dick Whitten, Vice President of Medical Policy and Sarah Baker, Product Director for Care and Delivery Management will describe where Noridian is as a carrier in Medicare's move to value based programs.

BHI**Behavioral Health:****• Report Item:**

- The BHI Sub-Committee met on August 1, 2017
- An update on the Telehealth/CHW and CHEMS was provided by Madeline Russell
- The IIBHN provided a report on the strategic planning session held and discussed next steps for broadening connections statewide.
- A presentation was provided by St. Luke's Health Partners by Jennifer Yturriondobeitia
- Dr. Ben Miller with the Farley Policy Center will be working with Idaho about behavioral health integration in the state of Idaho, barriers, goals and potential areas for TA assistance.
- The next phone call for this project will be on August 18th.

• Next Steps:

- The next Behavioral Health Integration Workgroup meeting will be held October 3rd 2017.

PHW**Population Health:****• Report Item:**

- The PHW met August 2, 2017 from 3:00 – 4:30.
- Reviewed the data visualization site that contains Get Healthy Idaho document, population health data, links to the regional collaborative websites and other resources. The website (gethealthy.dhw.idaho.gov) experienced a failure recently and is in the process of being rebuilt

by the vendor. The revisions will also include more data relevant to the social determinants of health.

- Dr. Christine Hahn presented an update on the working being done to address the opioid crisis. The Division of Public Health has one grant that works with the Office of Drug Policy, the Board of Pharmacy and the local public health districts to develop a strategic plan, connect prescribers' EHRs to the Prescription Drug Monitoring Program (PDMP) and prescriber education, respectively. Another grant opportunity was just applied for to do media/marketing and provide for an additional staff person. The Division of Behavioral Health also has a grant to provide for substance use treatment, additional provider education and naloxone distribution.
 - Kathy Turner presented immunization data that can be used as performance dashboards for the clinics, regional collaboratives and state. This presentation will be given to the IHC in August.
 - Burke Jensen, discussed the status of the connectivity of the clinics to IHDE, the status of the clinical measures and HealthTech's development of the data dashboards. HealthTech will be training health district staff on how to access the dashboard.
 - Madeline Russell and Wayne Denny provided updates on: the virtual PCMH application (closes 8/18 with notification to awardees 8/25); CHWs (online and in-person trainings with 6 modules available); telehealth (have clinics under contract and HMA won the award for providing technical assistance); and CHEMS (EMT and Advance EMT training for CHEMS being developed, behavioral health and CHEMS intersect webinar on 9/14, and a learning collaborative in January).
 - Kim Kane provided an overview of a new grant application recently submitted to implement best practice initiative in health care settings called Zero Suicide to address follow up of patients after leaving the healthcare setting.
 - Southwest Regional Collaborative convenes an Oral Health workgroup and Rachel Blanton provided data from their work and sought the advice from the PHW about the interface of dentists and primary care around high blood pressure.
- **Next Steps:**
 - The next Population Health Workgroup meeting will be held September 6th 2017 from 3:00-4:30pm MST.