Idaho Healthcare Coalition

Meeting Agenda

Wednesday, June 7, 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/55798993/827ccb0eea8a706c4c34a16891f84e7b
Attendee Smartphone URL:
pulsesecure://?method=meeting&action=join&host=rap.dhw.idaho.gov&meetingid=55798993&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 5/10/2017 meeting notes – *Dr. Ted Epperly, IHC Chair* - ACTION ITEMS (3)
1:40 p.m.	Report Out from Idaho Healthcare Summit – *Dr. Epperly, IHC Chair and Cynthia York, Administrator, IDHW*
1:55 p.m.	State of Healthcare Reform in Idaho: Past, Present and Future – *Dir. Armstrong, IDHW*
2:15 p.m.	Mercer Update – *Katie Falls, Principle, Mercer* - ACTION ITEM
2:35 p.m.	PCMH mentorship – *Dr. Scott Dunn, District 1 RC Chair and Kym Schreiber, Project Manager, IDHW* - ACTION ITEM
3:00 p.m.	Break
3:15 p.m.	Payer Update: Blue Cross – *Kevin Nielsen, Provider Network Manager, Blue Cross of Idaho*
3:45 p.m.	CHEMS Charter Update – *Wayne Denny, Bureau Chief, Public Health* - ACTION ITEM
3:55 p.m.	IHDE & Data Quality Improvement Process Update – *Julie Lineberger, IHDE Interim Executive Director*
4:10 p.m.	SHIP Operations and Advisory Group reports/ Updates – Please see written report (SHIP Operations and IHC Workgroup reports): • Presentations, Staffing, Contracts, and RFPs status – *Cynthia York, IDHW* • Regional Collaboratives Update – *Mary Sheridan, IDHW* • Telehealth, Community EMS, Community Health Workers – *Mary Sheridan, 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, Lora Whalen Workgroup Co-Chair* • IMHC Workgroup – *Dr. Scott Dunn, Family Health Center, IMHC Workgroup Chair*
4:20 p.m.	Additional business & next steps – *Dr. Ted Epperly, IHC Chair*
4:30 p.m.	**Adjourn**

Mission and Vision

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

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

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

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

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

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

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

Goal 7: *Reduce overall healthcare costs*

Statewide Healthcare Innovation Plan

Idaho Healthcare Coalition (IHC)
June 7, 2017
Action Items

- Action Item 1 – Minutes

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

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

  Second: _____

  Motion Carried.

- Action Item 2 – Minutes

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

  Motion: I, _____ move to accept the minutes of the May 10, 2017, Idaho Healthcare Coalition (IHC) meeting as prepared.

  Second: _____

  Motion Carried.

- Action Item 3 – New Membership

  IHC members will be asked to accept the candidacy of Amy Mart to replace Katherine Hansen on the IHC:

  Motion: I, _____ move to accept Amy Mart onto the IHC, replacing Katherine Hansen.

  Second: _____

  Motion Carried.

- Action Item 4 – Minutes

  IHC members will be asked to accept the candidacy of Dr. Mark Horrocks to replace Dr. William (Bill) Woodhouse on the IHC:

  Motion: I, _____ move to accept Dr. Mark Horrocks onto the IHC, replacing Dr. William (Bill) Woodhouse.

  Second: _____

  Motion Carried.

- Action Item 5 – Goal Charter Updates

  IHC members will be asked to accept the Goal Charters as presented by Katie Falls:

  Motion: I, _____ move to accept with SHIP Goal Charters as presented by Katie Falls.

  Second: _____

  Motion Carried.

- Action Item 6 – Mentorship

  IHC members will be asked to accept the recommendations and mentorship framework as presented by Dr. Scott Dunn and Kym Schreiber.

  Motion: I, _____ move to accept and adopt the recommendations and mentorship framework as presented.

  Second: _____

  Motion Carried.

- Action Item 7 – CHEMS Charter

  IHC members will be asked to accept the updated CHEMS Charter as presented by Wayne Denny.

  Motion: I, _____ move to accept the updated CHEMS Charter as presented.

  Second: _____

  Motion Carried.

Idaho Healthcare Coalition

Meeting Minutes:

SUBJECT:	IHC April Minutes	**DATE:**	April 12, 2017
ATTENDEES:	Dr. Andrew Baron, Josh Bishop, Kathy Brashear, Russell Duke, Ross Edmunds, Dr. Ted Epperly, Amy Mart on behalf of Katherine Hansen, Lisa Hettinger, Yvonne Ketchum, Deena LaJoie, Carol Moehrle, Sandy Stevenson on behalf of Dr. David Pate, Susie Pouliot, Dr. Kevin Rich, Kevin Nielsen on behalf of Dr. Rhonda Robinson Beale, Elke Shaw-Tulloch, Larry Tisdale, Lora Whalen, George Gutierrez on behalf of Matt Wimmer, Cynthia York, Nikole Zogg	**LOCATION:**	700 W State Street, 1st Floor East Conference Room
Teleconference:	Michelle Anderson, Pam Catt-Oliason, Dr. Keith Davis, Dr. Scott Dunn, Rene LeBlanc, Dr. David Peterman, Geri Rackow, Neva Santos, Karen Vauk		
Members Absent:	Director Richard Armstrong, Melissa Christian, Janica Hardin, Senator Lee Heider, Dr. Glenn Jefferson, Dr. James Lederer, Maggie Mann, Nicole McKay, Casey Meza, Daniel Ordyna, Mary Sheridan, Dr. Boyd Southwick, Representative Fred Wood, Dr. Bill Woodhouse		
IDHW Staff	Emily Bennett, Jeff Crouch, Wayne Denny, Tara Fouts, Adiya Jaffari, Taylor Kaserman, Casey Moyer, Madeline Russell, Kym Schreiber, Stacey St. Amand, Joey Vasquez, Molly Volk, Ann Watkins		
Guests:	Dr. Richard Bell, Jenni Blendu, Elwood Cleaver, Katie Falls, Hilary Klarc, Julie Lineberger, Janice Lung, Gina Pannell, Janet Reis, Linda Rowe, Corey Surber, Norm Varin, Shenghan Xu		
STATUS:	Draft (5/09/2017)		

Summary of Motions/Decisions:

Motion:	**Outcome:**
Carol Moehrle moved that the Idaho Healthcare Coalition recommend the governor appoint Dr. Richard Bell to the IHC. Susie Pouliot seconded the motion.	PASSED
Kathy Brashear moved to accept the minutes of the March 08, 2017 Idaho Healthcare Coalition (IHC) meeting as prepared. Deena LaJoie seconded the motion.	PASSED
Elke Shaw-Tulloch moved to support the creation of the Data Quality Workgroup (DQW) with its proposed membership structure. The group was directed to create its charter. The new workgroup replaces the Health Information Technology (HIT) and Clinical Quality Measures (CQM) Workgroups. Dr. Kevin Rich 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, went over the agenda items, and opened with this quote, "Genius is one percent inspiration, ninety-nine percent perspiration." Thomas Edison. Dr. Epperly had Dr. Richard Bell and Michelle Anderson introduce themselves and give brief backgrounds.
- Michelle Anderson has her doctorate in nursing practice and currently works for Pend Oreille Health Experience Care; she has had considerable experience in nursing and is looking forward to participating on the IHC. Dr. Richard Bell is a physician with Family Health Associates in Coeur d'Alene; he is also the new co-chair for the Panhandle Health District's Regional Collaborative.

CMMI SIM Model Test Update – *Dr. Stephen Cha, Director, State Innovations Group and Chris Crider, SIM Project Officer for Idaho*

- Dr. Stephen Cha spoke about the CMMI SIM Model Test Initiative and how these models are doing nationwide. He talked specifically about how Idaho is doing in comparison to other SIM states and said Idaho is making amazing progress in comparison to where it started and where it's going. He said there are still some struggles but the amount of change, progress, and improvement being made by the state is remarkable. Idaho is often used as a model for other states and shows the opportunity other states have to make a dramatic difference in their states.
- Dr. Cha discussed what is currently happening at the federal level given the change in administrations; there are three key things going on now 1) all SIM dollars have been released and are still proceeding, 2) the new administration is focusing on the key theme that there is a need for a change in healthcare, and 3) this change will include further changes that are still unknown.
- Following his presentation Dr. Cha answered questions from IHC members. Regarding his thoughts on Medicare participation in Idaho, Dr. Cha commented that clearance for these programs needs to happen proactively. These programs are new models with more questions about how the new administration will approach these new models. Change requests for Medicare take approximately 9 to 12 months to execute since it is a national program. There isn't

any knowledge that the SIM office is a part of the cuts being made by the new administration; if this changes the SIM office will be notified.

- Dr. Epperly thanked Dr. Cha for his participation and noted that he is welcome anytime.

Mercer Update – *Katie Falls, Mercer*

- Katie Falls presented the updated SHIP dashboard to the IHC. The dashboard reflects the annual and quarterly measures for Award Year Two. Ms. Falls walked through each of the goal measures and explained progress the measures have made and what direction they are moving in.
- Casey Moyer mentioned that a lot of these numbers are lower than their targets because of the time the data was pulled. The information on the Dashboard reflects activities leading up to January 31, 2017. Also, Goal Four has several projects that are underway but are not fully represented on the dashboard as they are not at full capacity yet. Goal Two and Five's biggest struggles are getting the data to IHDE and then onto HTS.
- Dr. Epperly mentioned that we are making progress and that we've come a long way from where Idaho started with this project.

Post Provider Follow-up – *Cynthia York, IDHW, SHIP Administrator*

- Katie Falls presented the themes that were discussed at the March IHC Provider Panel: supporting transformation, incentivizing transformation, data issues, and considerations for the future.
- Cynthia York presented the lessons learned and the follow up being done by the SHIP team in response to the comments and concerns expressed by the provider panel at the March IHC meeting.
- SHIP appreciates the input provided by the panel and feedback provided by the IHC.

Blue Sky Discussion/Sustainability – *Dr. Ted Epperly, IHC Chair and Lisa Hettinger, IHC Co-Chair and IDHW Deputy Director*

- Dr. Epperly invited the IHC to participate in an open discussion about the sustainability of SHIP beyond the four-year grant, what this would look like, and what people would need to carry transformation forward. Lisa Hettinger mentioned that the Regional Collaboratives have been doing a lot of work with regard to sustainability and would like this discussion to start at the IHC level outside of the Regional Collaboration participation. Dr. Baron said that the Southwest District Health Regional Collaborative discussed this last week and their members are committed to continuing their work past the SHIP grant. He said they realize how important the work being done is and are willing to continue without the support of the grant. He also said that to make this sustainable there needs to be a new payment method, but also there is a need to establish tangible values of the program.
- Dr. Epperly commented that it's all about the flow of money and asked if it's not financed how does it get done? How do we sustain the funding? IHC members suggested several ways to address these issues including: flexible spending from the provider perspective to cover CHW costs and other out of the box care providers; having a steady and reliable workforce; moving away from treating and managing illnesses but instead preventative actions; along with several other suggestions regarding sustainability and how to show value in the model.
- Dr. Epperly and Lisa Hettinger wrapped up the conversation commenting that sustainability will be a key topic at the June Regional Collaborative Summit.

PacificSource Update – *Hilary Klarc, Director of Provider Network, PacificSource Health Plans*

- Hilary Klarc introduced herself and gave a quick background on her work at PacificSource Health Plans. PacificSource has been in Idaho for ten years and Ms. Klarc has worked for PacificSource Idaho for that entire time. The top strategic pillar at PacificSource is investing in their provider partnerships and trying to build a collaborative type of care model.
- PacificSource has various payment models with providers that are fee-for-service or pay-for-performance; shared savings, shared risk; and full risk with providers. They are also aligning their product portfolios so that the payment methodologies and value-based reimbursement are more aligned with product designs that are guiding PacificSource's members to providers that are delivering high quality care, and are being paid accordingly. PacificSource has a couple of products in the market especially in Southwest Idaho that center around St. Luke's and Saint Alphonsus and their networks. This has given PacificSource an opportunity to work with the hospitals to get better discounts and pay for better infrastructure and shared savings so that there is incentive for providers and hospitals to change. The highest

performance seen has been from medical homes. The challenge is that PacificSource doesn't have the same rate of membership going to just one clinic within these homes.

- Ms. Klarc discussed how PacificSource is always trying to listen to provide support to the different resources that are needed within medical homes to support the PacificSource population. There have been lessons learned over the years to invest in ideas or initiatives where resources were being spent elsewhere rather than on the PacificSource population focused on moving to a valued-based payment model. PacificSource is working to ensure that their resources are going to help their patients. The largest growth opportunities PacificSource has seen in value-based reimbursement have come from leveraging the coordinated care models, getting better discounts from hospitals, and guiding PacificSource members to providers who are working with PacificSource. PacificSource is committed to looking at programs that help providers and has created their own quality programs that are designed to integrate workflow for providers.
- Ms. Klarc welcomed questions from IHC members regarding the payment methodologies of PacificSource. Members asked questions about where PacificSource is going with integrated healthcare. PacificSource is intent on trying to grow toward a value-based product. PacificSource is aiming to encourage employers to purchase these insurance plans. The quality measures being looked at by PacificSource align with national measures from HEDIS.
- IHC members asked if, with the new model, the usual 15-16 percent of every dollar taken by payers would go back into healthcare. Ms. Klarc responded that it is a possibility and there have been discussions but that it hasn't been done yet.

Data Governance Workgroup Charter – *Dr. Andrew Baron, CQM Chair and Janice Hardin, HIT Co-Chair*

- Dr. Baron discussed the formation of the Data Quality Workgroup and that it is an effort to combine the HIT and CQM Workgroups into one so that work can be done more quickly and efficiently. He provided IHC members with a brief overview of why the group is being created, what the establishment of the group would entail, along with membership requirements. He also reiterated that the CQM and HIT Workgroups would be dissolved.
- Casey Moyer provided further details on the background of this workgroup and its development stemming from an ONC technical assistance site visit by Dr. Craig Jones.

IHDE Update – *Julie Lineberger, IHDE Interim Executive Director*

- Julie Lineberger provided a brief update on the current status of Cohort One and Two clinics' connections with IHDE. Of the 26 clinics that are connected from Cohort One, 11 of the 30 organizations represented are connected. 20 of 56 clinics are connected from Cohort Two, 8 of the 29 organizations represented are connected. Ms. Lineberger provided additional details on the connection statuses of clinics that have recently been connected or that are still on hold. There are 76 interfaces that IHDE was charged with building for Cohort One, 36 of which are complete

Timeline and Next Steps – *Dr. Ted Epperly, IHC Chair*

- Dr. Epperly thanked everyone for their participation and asked if members and any final thoughts.
- Ross Edmunds talked about meeting with Dr. Miller last week and possibly moving forward with BHI; more updates to come.

There being no further business Chairman adjourned the meeting at **4:15pm**

Meeting Minutes:

SUBJECT:	IHC May Minutes	**DATE:**	May 10, 2017
ATTENDEES:	Director Richard Armstrong, Kathy Brashear, Melissa Christian, Ross Edmunds, Dr. Ted Epperly, Katherine Hansen, Lisa Hettinger, Deena LaJoie, Dr. Kevin Rich, Kevin Nielsen on behalf of Dr. Rhonda Robinson-Beale, Elke Shaw-Tulloch, Larry Tisdale, Cynthia York	**LOCATION:**	700 W State Street, 1st Floor East Conference Room
Teleconference:	Russell Duke, Janica Hardin, Dr. James Lederer, Maggie Mann, Casey Meza, Geri Rackow, Neva Santos, Lora Whalen		
Members Absent:	Michelle Anderson, Dr. Andrew Baron, Dr. Richard Bell, Josh Bishop, Dr. Keith Davis, Dr. Scott Dunn, Senator Lee Heider, Dr. Glenn Jefferson, Yvonne Ketchum, Rene LeBlanc, Nicole McKay, Carol Moehrle, Daniel Ordyna, Dr. David Pate, Tammy Perkins, Dr. David Peterman, Mary Sheridan, Dr. Boyd Southwick, Karen Vauk, Jennifer Wheeler, Matt Wimmer, Representative Fred Wood, Dr. Bill Woodhouse, Nikole Zogg		
IDHW Staff	Jeff Crouch, Wayne Denny, Tara Fouts, Adiya Jaffari, Taylor Kaserman, Casey Moyer, Madeline Russell, Kym Schreiber, Stacey St. Amand, Joey Vasquez, Molly Volk, Ann Watkins		
Guests:	Elwood Cleaver, Julie Lineberger, Janice Lung, Gina Pannell, Janet Reis, Linda Rowe, Ty Stevenson, Corey Surber, Norm Varin, Maggie Wolfe, Shenghan Xu		
STATUS:	Draft (5/18/2017)		

Agenda Topics:

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

- Dr. Epperly welcomed everyone to the meeting, went over the agenda items, and opened with a quote from Nelson Mandela, "It always seems impossible until it's done." Minutes from the April meeting were not approved due to a lack of quorum.

ONC Site Visit Update – *Dr. Stephen Cha, Director, State Innovations Group and Chris Crider, SIM Project Officer for Idaho*

- Burke Jensen and Joey Vasquez gave a presentation about their recent visit to Portland, Maine to meet with the Office of the National Coordinator for Health Information Technology technical assistant partners. Both thought the meeting went well and provided the SHIP and Medicaid teams with valuable take-aways that will help with their efforts to align SHIP and Medicaid activities.

Mercer Update – *Katie Falls, Mercer*

- Maggie Wolfe presented a brief general overview of the SHIP annual report. The report is a requirement of CMMI for all SIM states on an annual basis. It is related to but different from the dashboard report highlighting the goal success measures. In this report, driver diagrams highlight the various projects that help achieve SHIP's goals. The first primary driver is focused on goals one and four (looking at achievements made toward accelerating the establishment of the PCMH model of care).
- The second primary driver focuses on goals two and five, concentrating on the establishment of the first four Clinical Quality Measures (CQMs), along with working through privacy and security issues.
- The third primary driver focuses on goal three. In Award Year Two (AY2) Regional Collaboratives increased membership and developed strategic plans to help support SHIP clinics.
- Finally, the fourth primary driver focuses on goals six and seven. Payers have continued their participation in the path to value-based payments, have developed an alternative payment framework, and are working with strategic alignments with Medicaid. As the project progresses, there will be a continued effort to seek alignment between goals one through six.
- The work being done is complicated and will take a lot of effort to reach the goals set forth in the project but Idaho is moving along well and shows a lot of determination and commitment to reaching its goals. Part of this journey includes working with Medicaid and other partners toward alignment of activities along with clinics working on continuous quality improvement.

Briljent Update – *Grace Chandler, Briljent*

- Grace Chandler gave an update on where clinics are now for both Cohorts One and Two. In Cohort One, 36 out of the 55 clinics have achieved PCMH recognition. Cohort Two clinics have sent in their budget templates for reimbursement payments and have begun to work on their transformation plans.
- Nancy Jaeckels-Kamp provided additional information on the work being done by Cohort Two clinics. The key activities in the technical assistance plan for Cohort Two are the six content-specific webinars to be delivered every other month, site visits with their HMA coaches, and attending the upcoming Learning Collaborative on June 27th and 28th at Boise State University being sponsored by Blue Cross of Idaho, BSU, and PacificSource Health Plans. The Learning Collaborative will feature sessions focused on ongoing coaching and learning topics and having some Cohort One and Two teams give presentations. Clinics will hear from national and local experts.
- There has been a change in the staffing for the HMA coaches. One change made for Cohort Two is that coaching is now divided by region. In addition, Pat Dennehy is no longer with HMA.; she is being replaced by Dr. Tom Denberg.

Behavioral Health Update – *Ross Edmunds, and Gina Westcott*

- Gina Westcott is the Behavioral Health Southwest Hub Administrative Director who oversees direct service and operations taking place in regions three, four and five, and assists in the division's role in Behavioral Health Integration (BHI). BHI started out with a challenge of defining how behavioral health integration fit into all seven goals of SHIP. The BHI Workgroup was developed to help better understand how this behavioral health integration would work within the scope of SHIP. In 2016 the workgroup held seven meetings and has evaluated where Idaho clinics are with BHI. Some key achievements made by the workgroup are:
    1. pursue a behavioral health consultant peer-to-peer model,
    2. explore how regional behavioral health boards could support regional collaboratives,
    3. pursue additional trainings with NASHP, and
    4. get another survey out to clinics for behavioral health integration.

DRAFT

- In August, the workgroup made recommendations to the CQM Workgroup on behavioral health success measures for the required clinical quality measures of SHIP. The measure chosen was the depression and drug/alcohol use screenings in patients. The BHI Workgroup also sponsored a lunch at the Learning Collaborative where they talked to clinics. Upcoming activities for the workgroup include continuing work with Dr. Ben Miller from the Farley Policy Center, updating the workgroup charter, and looking for additional workgroup members.
- Ross Edmunds gave an update on the interest in Idaho in overall behavioral health planning. There are multiple groups in the state focused on behavioral health, and there must be an effort to make sure all these groups are coordinated. Anytime a request is sent to the legislature, they want to know how all these efforts are coordinated and related. A primary focus of many of these projects is behavioral health integration into primary care.
- Two of the successes that the Division of Behavioral Health has had recently are getting an adjustment in policy related to Medicaid approved to help children in poverty and providing better hospitalization of the mentally ill to help ease pressure on communities and local entities.
- Payment models are the number one issue in bridging healthcare gaps. Another problem with these programs in Idaho is the availability of patient services. The number one disease that takes the most from humans is depression, which is why all this work is extremely important.

Regence Blue Shield Update – *Melissa Christian, Vice President of Provider Services for Idaho, Regence Blue Shield*

- Melissa Christian presented the value-based program at Regence Blue Shield. She said, the insurance world is still operating in the fee for service world, and Regence is looking at how to collaborate to move this block forward toward fee for value service. Regence is working on bending the cost curve; they believe that the best care is the most cost effective care. Negotiations on reimbursements are using data around members, identifying physician partners, and starting to share data.
- Regence has started working with hospitals on a three-year program to improve performance; they use CMS metrics to avoid asking one more thing from providers. The program begins in year one with a minimal increase and years two and three have an increase in reimbursement tied to improved performance. Every hospital except one is in Regence's program.
- Physicians are on the total cost of care program, which is a PPO network with an identified medical group, that collaborates with physician partners. Regence works with physicians to engage with members that are attributing to them. Attribution is great but there are still issues with patient accountability. A lot of work being done by Regence is focused on actionable items from identifying cost drivers to identifying care gaps and evaluating the management of chronic conditions.

Virtual PCMH Update – *Madeline Russell, IDHW, RC Project Manager*

- As of April 21st, six clinics have been designated as virtual PCMHs. These selected clinics need to complete budget templates to receive the $2,500 dollars for being designated as a virtual PCMH. The virtual PCMH application will reopen soon to Cohort One and Cohort Two clinics that wish to apply. Clinics applying need to be in a medically underserved area, professional shortage area, or utilize Telehealth, CHW, or CHEMS.

IHDE Update – *Julie Lineberger, IHDE Interim Executive Director*

- Julie Lineberger provided a brief update on the current status of Cohort One and Two clinics' connections with IHDE. Of the 26 clinics that are connected from Cohort One, 11 of the 30 organizations represented are connected. Twenty of 56 clinics are connected from Cohort Two, eight of the 29 organizations represented are connected. Ms. Lineberger provided additional details on the connection statuses of clinics that have recently been connected or that are still on hold. There are 76 interfaces that IHDE was charged with building for Cohort One, 36 of which are complete.
- IHDE is looking at putting together a payer database.

Timeline and Next Steps – *Dr. Ted Epperly, IHC Chair*

- Dr. Epperly thanked everyone for their participation and, there being no further business, adjourned the meeting at 4:17pm.

DRAFT

PROJECT CHARTER

GOAL 1: Transform 165 primary care practices across the State into patient-centered medical homes (PCMHs).

Version: Award Year 3.0 (AY3.0)

Summary

SHIP Lead	Kym Schreiber
Mercer Lead	Maggie Wolfe
Key Participants	Idaho Department of Health and Welfare (IDHW) staff, IHC, PCMH Contractor (inclusive of sub-contractors), Idaho Medical Home Collaborative (IMHC),SHIP Cohort Clinics, Public Health District (PHD) SHIP staff.
IHC Charge	Accelerate establishment of the PCMH model of care throughout the State by building 165 PCMH primary care practices (a practice is defined as a clinic site). The achievement of this goal is critical to transforming how care is delivered in Idaho.

Success Measures

Success Measures	SHIP Desired Outcomes	Measurement
1.	Statewide PCMHs.	• CUM # (%) of primary care clinics that submit an interest survey to participate in a SHIP cohort. *Model Test Target: 270*. • Numerator: Number of primary care clinics that submit an interest survey. • Denominator: Total number of primary care clinics targeted to submit an interest survey.

AYR	Q1	Q2	Q3	Q4
1	-	-	100	100
2	100	100	200	200
3	200	200	270	270
4	270	270	270	270

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.

Success Measures	SHIP Desired Outcomes	Measurement
2.	Statewide PCMHs.	• CUM # (%) of primary care clinics selected for a SHIP cohort that have completed a PCMH readiness assessment and a Transformation Plan. *Model Test Target: 165.* • Numerator: Number of primary care clinics selected for a SHIP cohort that have completed a PCMH readiness assessment and Transformation Plan. • Denominator: Total number of primary care practices targeted to transform to PCMHs.
3.	Statewide PCMHs.	• CUM # (%) of targeted primary care clinics selected for a SHIP cohort. *Model Test Target: 165.* • Numerator: Number of primary care clinics selected for a SHIP cohort. • Denominator: Total number of provider organizations targeted to transform to PCMHs.
4.	Statewide PCMHs.	• CUM # (%) of primary care clinics selected for a SHIP cohort, of the total primary care clinics in Idaho. *Model Test Target: 165.* • Numerator: Number of primary care clinic selected for a SHIP cohort. • Denominator: 500 (estimate of total primary care clinics in Idaho).

AYR	Q1	Q2	Q3	Q4
1	-	-	-	-
2	55	55	55	55
3	110	110	110	110
4	165	165	165	165

AYR	Q1	Q2	Q3	Q4
1	-	-	-	-
2	55	55	55	55
3	110	110	110	110
4	110	110	135	165

AYR	Q1	Q2	Q3	Q4
1	-	-	-	-
2	55	55	55	55
3	110	110	110	110
4	165	165	165	165

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.

Success Measures	SHIP Desired Outcomes	Measurement	
5.	Statewide PCMHs.	• CUM # (%) of targeted providers participating in primary care clinics selected for a SHIP cohort. (Providers = staff employed at/represented by primary care clinics in a SHIP cohort, including licensed clinicians and other licensed professionals). *Model Test Target: 1,650.* • Numerator: Number of providers in primary care clinics selected for a SHIP cohort. • Denominator: 1,650 (estimate of total number of providers in 165 clinics participating in a SHIP cohort).	AYR / Q4 1 / - 2 / 550 3 / 1,100 4 / 1,650
6.	Statewide PCMHs.	• CUM # (%) of providers in primary care clinics selected for a SHIP cohort, of the total number of primary care providers in Idaho. (Providers = staff employed at/represented by primary care clinics in a SHIP cohort, including licensed clinicians and other licensed professionals). *Model Test Target: 1,650.* • Numerator: Number of providers in primary care clinics selected for a SHIP cohort. • Denominator: 5,000 (estimate of total number of providers in primary care clinics in Idaho).	AYR / Q4 1 / - 2 / 550 3 / 1,100 4 / 1,650
7.	Support for PCMHs.	• CUM # (%) of primary care clinics selected for a SHIP cohort receiving	AYR / Q4 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.

Success Measures	SHIP Desired Outcomes	Measurement	
		a reimbursement payment and achieving technical support benchmarks. *Model Test Target: 165.* • Numerator: Number of primary care clinics selected for a SHIP cohort receiving a transformation reimbursement payment and achieving technical support benchmarks. • Denominator: Total number of primary care practices targeted to transform to PCMHs.	**2** 55 **3** 110 **4** 165
8.	PCMHs achieve transformation goals.	• CUM # (%) of primary care clinics selected for a SHIP cohort that achieve their transformation goals as specified in their Transformation Plan. *Model Test Target: 165.* • Numerator: Number of primary care clinics selected for a SHIP cohort that achieve their transformation goals as specified in their Transformation Plan. • Denominator: Total number of primary care practices targeted to transform to PCMHs.	**AYR** / **Q4** **1** 0 **2** 55 **3** 110 **4** 165
9.	PCMHs achieve increasing levels of national PCMH recognition.	• CUM # (%) of primary care clinics selected for a SHIP cohort that achieve national PCMH recognition/ accreditation. *Model Test Target: 165.*	**AYR** / **Q1** / **Q2** / **Q3** / **Q4** **1** - - - 18 **2** 18 18 18 30 **3** 45 60 75 100 **4** 100 120 150 165

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.

Success Measures	SHIP Desired Outcomes	Measurement
		• Numerator: Number of primary care clinics selected for a SHIP cohort that achieve national PCMH recognition/ accreditation. • Denominator: Total number of primary care practices targeted to transform to PCMHs.
10.	Idahoans will be enrolled in recognized PCMHs.	• CUM # (%) of Idahoans who enroll in a primary care clinic selected for a SHIP cohort (of total state population). *Model Test Target: 825,000.* • Numerator: Number of Idahoans enrolled in a primary care clinic selected for a SHIP cohort. • Denominator: Total state population in 2014 (1.634 million).
11.	Idahoans will be enrolled in recognized PCMHs.	• CUM # (%) of Idahoans who enroll in a primary care clinic selected for a SHIP cohort (of target population). *Model Test Target: 825,000.* • Numerator: Number of Idahoans enrolled in a primary care clinic selected for a SHIP cohort. • Denominator: 825,000 (estimated members in 165 primary care clinics in a SHIP cohort).

AYR	Q1	Q2	Q3	Q4
1	-	-	-	-
2	275,000	275,000	275,000	275,000
3	550,000	550,000	550,000	550,000
4	825,000	825,000	825,000	825,000

AYR	Q1	Q2	Q3	Q4
1	-	-	-	-
2	275,000	275,000	275,000	275,000
3	550,000	550,000	550,000	550,000
4	825,000	825,000	825,000	825,000

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.

Planned Scope

Deliverable 1	Result, Product, or Service	Description	Owner	Impacted Parties
	• SHIP cohort recruitment plan	• Detailed plan with activities, dates, and responsible parties to successfully recruit three cohorts of 55 clinics each, ensuring representation from all 7 public health districts	• IDHW	• IHC • IMHC • PCMH Contractor • Healthy Connections Staff • Idaho Primary Care Association, Idaho Medical Association, Idaho Academy of Family Physicians, WWAMI
Est. Timeframe	**Start**: Annually			**End**: Annually
Milestones	**Event**			**Target Date**
	• Draft SHIP cohort recruitment plan for Cohort One.			• Complete
	• Draft SHIP cohort recruitment plan for Cohort One.			• Complete
	• Feedback from stakeholders.			• Complete
	• Finalize SHIP cohort recruitment plan for Cohort One.			• Complete
	• Implement SHIP cohort recruitment plan for Cohort One.			• Complete
	• Evaluate recruitment plan and develop recruitment plan for Cohort Two.			• Complete
	• Implement Cohort Two recruitment plan.			• Complete
	• Evaluate Cohort Two recruitment plan and develop recruitment plan for Cohort Three.			• 5/31/2017
	• IMHC and IHC reviews and approves recruitment plan.			• 6/7/2017
	• Implement Cohort Three recruitment plan.			• 6/8/2017
	• Evaluate Cohort Three recruitment plan successes and opportunities as well as potential interfaces with other initiatives.			• 1/2019
Deliverable 2	**Result, Product, or Service**	**Description**	**Owner**	**Impacted Parties**
	• SHIP cohort selection criteria	• The criteria that will be used to select clinics for a SHIP cohort	• IDHW	• IHC • IMHC • SHIP cohort applicants

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.

Est. Timeframe	**Start**: Annually			**End**: Annually
Milestones	**Event**			**Target Date**
	• IMHC develops draft SHIP cohort selection criteria for Cohort One.			• Complete
	• IHC approves selection criteria for Cohort One.			• Complete
	• Publish SHIP cohort selection criteria and process on website (Cohort One).			• Complete
	• IMHC develops draft SHIP cohort selection criteria for Cohort Two.			• Complete
	• IHC approves selection criteria for Cohort Two.			• Complete
	• Publish SHIP cohort selection criteria and process on website (Cohort Two).			• Complete
	• IMHC develops draft SHIP cohort selection criteria for Cohort Three.			• 6/30/2017
	• IHC approves selection criteria for Cohort Three.			• 7/12/2017
	• Publish SHIP cohort selection criteria and process on website (Cohort Three).			• 7/31/2017
Deliverable 3	**Result, Product, or Service**	**Description**	**Owner**	**Impacted Parties**
	• Interest survey in a SHIP cohort	• The document that practices will use to express interest in joining a SHIP cohort	• IDHW	• IHC • IMHC • SHIP cohort applicants
Est. Timeframe	**Start**: Annually			**End**: Annually

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.

Milestones	Event	Target Date
	• IMHC creates draft interest survey for Cohort One.	• Complete
	• IHC approves interest survey for Cohort One.	• Complete
	• Send interest survey to primary care practices.	• Complete
	• Practices submit interest survey for Cohort One.	• Complete
	• IDHW reviews interest survey for Cohort One and disseminates outputs to IMHC and IHC.	• Complete
	• IMHC creates draft interest survey for Cohort Two.	• Complete
	• IHC approves interest survey for Cohort Two.	• Complete
	• Send interest survey to primary care practices.	• Complete
	• Practices submit interest survey for Cohort Two.	• Complete
	• IDHW reviews interest survey for Cohort Two and disseminates outputs to IMHC and IHC.	• Complete
	• IMHC creates draft interest survey for Cohort Three.	• 5/31/2017
	• IHC approves interest survey for Cohort Three.	• 6/7/2017
	• Send interest survey to primary care practices.	• 6/8/2017
	• Practices submit interest survey for Cohort Three.	• 9/17/2017
	• IDHW reviews interest survey for Cohort Three and disseminates outputs to IMHC and IHC.	• 10/15/2017

Deliverable 4	Result, Product, or Service	Description	Owner	Impacted Parties
	• Final application	• The document that practices will use to apply for participation in a SHIP cohort	• IDHW	• IHC • IMHC • SHIP cohort applicants

Est. Timeframe		
	Start: Annually	**End**: Annually

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.

Milestones	Event	Target Date
	• IMHC and IDHW create draft final application, using information collected from the interest application.	• Complete
	• IMHC and IHC approve final application.	• Complete
	• IDHW sends final application and readiness assessment to practices (electronically).	• Complete
	• Practices begin to submit final application (electronically).	• Complete
	• Determine process for receiving/processing applications for Cohort One.	• Complete
	• Process Cohort One applications.	• Complete
	• Determine application and application process for Cohort Two.	• Complete
	• Implement application process for Cohort Two.	• Complete
	• Determine application and application process for Cohort Three. IMHC reviews/approves.	• 7/31/2017
	• IHC reviews and approves final application.	• 8/9/2017
	• Implement application process for Cohort Three.	• 9/18/2017

Deliverable 5	Result, Product, or Service	Description	Owner	Impacted Parties
	• PCMH self- assessment	• Process and materials to assess current practice capacity and identify gaps	• PCMH Contractor and PHD SHIP staff	• IDHW • IMHC • SHIP cohort clinics

Est. Timeframe	Start: Annually	End: Annually

Milestones	Event	Target Date
	• PCMH Contractor selects PCMH assessment tool.	• Complete
	• IDHW approves the assessment process and materials.	• Complete
	• PCMH Contractor sends the assessment to practices for Cohort One.	• Complete
	• PCMH Contractor works with SHIP Cohort One clinics to complete the assessment.	• Complete
	• Modify assessment as needed for Cohort Two, including to reflect any alignment with Healthy Connections. PCMH Contractor and PHD SHIP staff support clinics in completing assessment.	• Complete
	• Implement readiness assessment process for Cohort Two.	• Complete
	• Modify assessment for Cohort Three as part of final application review.	• 1/31/2018
	• Implement assessment process for Cohort Three. PCMH Contractor and PHD SHIP staff support clinics in completing assessment.	• 3/31/2018

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.

Deliverable 6	Result, Product, or Service	Description	Owner	Impacted Parties
	• Hire a PCMH Contractor	• Responsibilities of PCMH Contractor will include: develop a project management plan, provide project management services, provide data and reports to IDHW, conduct surveys and evaluations as requested by IDHW, develop and implement a PCMH training and technical assistance program, provide training to PHD staff, develop and manage a PCMH Reimbursement Qualifying and Distribution system, develop and maintain a quality assurance plan	• IDHW	• Regional Collaboratives • IMHC • SHIP cohort clinics
Est. Timeframe	**Start**: 2/1/2015			**End**: Ongoing
Milestones	**Event**			**Target Date**
	• Publish RFP.			• Complete
	• RFP responses due.			• Complete
	• Finalist selected.			• Complete
	• Send contract to CMMI.			• Complete
	• CMMI approval.			• Complete
	• Contract start date.			• Complete
	• Renew contract for Award Year 3.			• Complete
	• Renew contract for Award Year 4.			• 2/1/2018

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.

Deliverable 7	**Result, Product, or Service**	**Description**	**Owner**	**Impacted Parties**
	• Process for distributing reimbursement payments to qualifying SHIP cohort clinics.	• Process to collect data from practices to support reimbursement payment distribution, process to implement controls to prevent fraud and abuse.	• IDHW • PCMH Contractor	• IMHC • SHIP cohort clinics
Est. Timeframe	**Start**: 2/1/2015			**End**: 1/31/2019
Milestones	**Event**			**Target Date**
	• Hire PCMH Contractor (Deliverable #5).			• Complete
	• Develop reimbursement payment distribution process, including criteria for practices to receive the payments and fraud/abuse protections.			• Complete
	• Obtain any necessary approvals of the financial distribution process.			• Complete
	• Complete any logistical steps needed to implement the process.			• Complete
	• PCMH Contractor begins distribution of reimbursement payments and implementation of fraud/abuse protections for Cohort One.			• Complete
	• Update reimbursement payment distribution process and/or fraud/abuse protections for Cohort Two.			• Complete
	• PCMH Contractor begins distribution of reimbursement payments and implementation of fraud/abuse protections for Cohort Two.			• Complete
	• Update reimbursement payment distribution process and/or fraud/abuse protections for Cohort Three.			• 1/31/2018
	• PCMH Contractor begins distribution of reimbursement payments and implementation of fraud/abuse protections for Cohort Three.			• 2/1/2018

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.

Deliverable 8	**Result, Product, or Service**	**Description**	**Owner**	**Impacted Parties**
	• Ongoing stakeholder communications regarding SHIP cohort and transformation towards PCMH model of care.	• Communications plan and materials to communicate with a variety of stakeholders (primary care practices, specialists, hospitals, patients, RCs, etc.)	• IDHW	• IDHW • PCMH Contractor • IHC • SHIP cohort clinics • Patients and other stakeholders
Est. Timeframe	**Start**: Ongoing			**End**: Ongoing
Milestones	**Event**			**Target Date**
	• Develop section of draft communications plan to include communications regarding SHIP cohort clinics.			• Complete
	• IHC approves communication plan.			• Complete
	• Develop communications materials and implement the communications plan.			• Ongoing
	• Revise internal communications strategies as needed.			• Ongoing
Deliverable 9	**Result, Product, or Service**	**Description**	**Owner**	**Impacted Parties**
	• PCMH training and technical assistance	• Webinars, learning collaboratives, coaching calls, onsite visits, connections to Regional Collaborative resources and other technical assistance and training activities for SHIP cohort clinics to support attainment of PCMH transformation goals	• PCMH Contractor	• IDHW • IHC • SHIP cohort clinics • Regional Collaboratives • PHD SHIP staff
Est. Timeframe	**Start**: Ongoing			**End**: Ongoing

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.

Milestones	Event	Target Date
	• Develop PCMH training program for Cohort One.	• Complete
	• Implement PCMH training program for Cohort One.	• Complete
	• Evaluate PCMH training program for Cohort One and make adjustments as needed.	• Complete
	• Develop PCMH training program for Cohort Two.	• Complete
	• Implement PCMH training program for Cohort Two.	• Complete
	• Evaluate PCMH training program for Cohort Two and make adjustments as needed.	• 1/31/2018
	• Develop PCMH training program for Cohort Three.	• 2/1/2018
	• Implement PCMH training program for Cohort Three.	• 2/1/2018

Deliverable 10	Result, Product, or Service	Description	Owner	Impacted Parties
	• Ongoing technical support and training to SHIP cohort clinics after their first cohort year	• Continued training and technical support for SHIP cohort clinics after their first cohort year	• PHD SHIP staff	• SHIP cohort clinics • IDHW • PCMH Contractor
Est. Timeframe	• **Start**: Ongoing			• **End**: Ongoing

Milestones	Event	Target Date
	• Develop plan for continued training and technical assistance.	• Complete
	• PCMH Contractor/PHD SHIP staff develop roadmap for each Cohort One clinic without national PCMH recognition by the end of the first cohort year. The roadmap identifies next steps to continue clinic transformation.	• Complete
	• PHD SHIP staff implement ongoing technical assistance for Cohort One clinics, with support as needed from PCMH Contractor.	• 5/31/2017
	• Cohort Two clinics develop roadmap for continued transformation goals.	• 12/15/2017
	• PHD SHIP staff implement ongoing technical assistance for Cohort Two clinics, with support as needed from PCMH Contractor.	• 2/1/2018
	• Develop plan for continued training and technical assistance after Model Test Period.	• 7/1/2018
	• Implement plan for continued training and technical assistance.	• 2/1/2019

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.

Deliverable 11	Result, Product, or Service	Description	Owner	Impacted Parties
	• SHIP cohort clinic to SHIP cohort clinic mentorship	• Identification of areas of mentorship need, identification of clinics willing to provide mentorship, linkages between clinics regionally and statewide	• IDHW • PCMH Contractor • PHD SHIP staff	• SHIP cohort clinics • IMHC • IHC
Est. Timeframe	• **Start**: 2/1/2017			• **End**: Ongoing
Milestones	**Event**			**Target Date**
	• Engage PCMH Mentorship Subcommittee of the IMHC to develop a mentorship program			• Complete
	• IMHC approves mentorship program.			• 5/31/2017
	• IHC approves mentorship program.			• 6/7/2017
	• Implement mentorship program.			• 6/8/2017
	• Evaluate outcomes from initial mentorship activities and modify mentorship as needed.			• Ongoing

Deliverable 12	Result, Product, or Service	Description	Owner	Impacted Parties
	• SHIP Cohort clinic transformation plan	• Individualized plan that describes each clinic's goals during their cohort year and is regularly monitored and updated throughout the year.	• SHIP cohort clinics	• PCMH Contractor • PHD SHIP staff • IDHW
Est. Timeframe	**Start**: Ongoing			**End**: Ongoing

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.

Milestones	Event	Target Date
	• Develop transformation plan template.	• Complete
	• Develop portal on PCMH Contractor website so impacted parties can access transformation plans.	• Complete
	• Cohort One clinics develop their transformation plans.	• Complete
	• Cohort Two clinic transformation plans updated during the year.	• Complete
	• Cohort Two clinics develop their transformation plans.	• 6/30/2017
	• Cohort Two clinic transformation plans updated during the year.	• 1/31/2018
	• Cohort Three clinics develop their transformation plans.	• 5/31/2018
	• Cohort Three clinic transformation plans updated during the year.	• 1/31/2019

Deliverable 13	Result, Product, or Service	Description	Owner	Impacted Parties
	• Assist SHIP cohort clinics with providing CQM data and using CQM data reports	• Training and technical assistance for SHIP cohort clinics to improve provision of CQM data and to help clinics identify ways to use the CQM data reports to improve care delivery	• PCMH Contractor • PHD SHIP staff	• SHIP cohort clinics • IHDE • Data Analytics Contractor • Regional Collaboratives
Est. Timeframe	**Start**: 2/1/2016			**End**: 1/31/2019

Milestones	Event	Target Date
	• PCMH Contractor and PHD SHIP staff implement training and technical assistance related to CQM reporting and use of CQM reports.	• Ongoing

Deliverable 14	Result, Product, or Service	Description	Owner	Impacted Parties
	• Regular PCMH Contractor project management reports	• Detailed reports from PCMH Contractor on status of PCMH activities and success measures	• PCMH Contractor	• IDHW • IHC
Est. Timeframe	**Start**: Ongoing			**End**: Ongoing

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.

Milestones	Event	Target Date
	• Develop schedule, metrics and format of regular reports.	• Complete
	• IDHW approves schedule, metrics and format of regular reports.	• Complete
	• PCMH Contractor begins submitting regular reports to IDHW for review and approval.	• Complete
	• Make adjustments to project management reports as needed.	• Ongoing
	• PCMH Contractor continues submitting regular reports to IDHW for review and approval.	• Ongoing

Deliverable 15	Result, Product, or Service	Description	Owner	Impacted Parties
	• List of SHIP cohort clinics	• Regular list of SHIP cohort clinics	• IDHW	• PCMH Contractor • PHD SHIP staff • IHC • IMHC

Est. Timeframe		
	Start: 2/1/2016	**End**: Ongoing

Milestones	Event	Target Date
	• IDHW selects clinics for Cohort One.	• Complete
	• PCMH Contractor signs contract with selected clinics for Cohort One.	• Complete
	• IDHW signs MOU with selected clinics for Cohort One.	• Complete
	• IDHW selects clinics for Cohort Two.	• Complete
	• PCMH Contractor signs contract with selected clinics for Cohort Two.	• Complete
	• IDHW signs MOU with selected clinics for Cohort Two.	• Complete
	• IDHW selects clinics for Cohort Three.	• 10/27/2017
	• PCMH Contractor signs contract with selected clinics for Cohort Three.	• 1/15/2018
	• IDHW signs MOU with selected clinics for Cohort Three.	• 1/15/2018
	• IDHW updates list of SHIP cohort clinics if a practice terminates participation in the Model Test.	• Ongoing

Deliverable 16	Result, Product, or Service	Description	Owner	Impacted Parties

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.

	• Inventory of other initiatives in SHIP cohort clinics	• List of other state and federal initiatives that are present in SHIP cohort clinics	• IDHW	• SHIP cohort clinics • Population Health Workgroup • IHC • PHD SHIP Staff
Est. Timeframe	• **Start:** Ongoing			• **End:** Ongoing
Milestones	**Event**			**Target Date**
	• Develop inventory for Cohort One clinics and update as needed.			• Complete
	• Develop inventory for Cohort Two clinics and update as needed.			• 1/31/2018
	• Update inventory for Cohort Three clinics and update as needed.			• 1/31/2019
	• Use inventory to coordinate across initiatives operating in SHIP cohort clinics			• Ongoing
Deliverable 17	**Result, Product, or Service**	**Description**	**Owner**	**Impacted Parties**
	• Coordination with Medicaid's Healthy Connections program	• Ongoing communications to understand and align processes and support provided to clinics by SHIP and Healthy Connections to minimize duplication for clinics	• IDHW SHIP • Medicaid Healthy Connections	• SHIP cohort clinics • PCMH Contractor • IHDE • PHD SHIP staff
Est. Timeframe	• **Start:** Ongoing			• **End:** Ongoing
Milestones	**Event**			**Target Date**
	• Medicaid Healthy Connections staff assist with SHIP cohort clinic recruitment.			• Ongoing
	• Investigate opportunities for aligning PCMH self-assessment tools for SHIP cohort clinics.			• Complete
	• Identify additional opportunities for alignment and collaboration between SHIP and Medicaid Healthy Connections.			• Ongoing
Deliverable 18	**Result, Product, or Service**	**Description**	**Owner**	**Impacted Parties**

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.

	• Workforce development	• Increase the healthcare workforce in Idaho to expand opportunities for implementing the PCMH model	• IDHW	• IHC • Bureau of Rural Health • Idaho Medicaid • Idaho Health Professions and Education Council (IHPEC) • SHIP cohort clinics
Est. Timeframe	• **Start:** Ongoing			• **End:** Ongoing
Milestones	**Event**			**Target Date**
	• Continue to work with impacted parties to identify workforce development strategies in Idaho, including through quarterly meetings with IHPEC.			• Ongoing
	• Support workforce development strategies as appropriate.			• Ongoing
	• SHIP cohort clinics offer residency programs in primary health fields.			• Ongoing

Project Risks, Assumptions, and Dependencies

Risks	• See most current version of the risk log.
Assumptions	• Adequate funding is available to support this project. • There are 165 clinics in Idaho that qualify for and are interested in participating in a SHIP cohort. • Supportive business, clinical, and cultural environments are achieved. • National PCMH recognition/accreditation bodies will continue to publish PCMH standards. • Project governance will be in place to support Goal 1 implementation and resolve roadblocks. • Stakeholders will maintain a level of engagement necessary to achieve Goal 1. • Communications and stakeholder relationships remain positive and productive.

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.

Dependencies and Constraints	Dependencies • Goal 2: Improve care coordination by improving real-time communication between PCMHs, their patients, and other entities across the healthcare system (e.g., hospitals and specialty care) through adoption and use of EHRs and Health Information Exchange (HIE) connections among the 165 PCMHs, as well as building statewide capacity for data exchange across the system. • Goal 3: Establish seven RCs to support the integration of each PCMH with the broader Medical/Health Neighborhood – this must occur, either prior to, or at the start of Goal 2 activities. • Goal 5: Build a statewide system for collecting, analyzing, and reporting quality and outcome data at the PCMH, regional, and state levels. • Goal 6: Payers implement value-based products with participating clinics. Constraints • Goal 1 stakeholders must work with available funding and resources. • Time (Model Test is time-limited). • Availability of PCMH Contractor time. • Management of PHDs by Division of Public Health versus management of SHIP by Office of Health Policy Initiatives. • CMMI approval. • IMHC approval of recruitment plan, SHIP criteria, interest survey and final application.

Project Reporting and Scope Changes

Changes to scope must be reflected at the Workgroup Charter level as approved by the IHC after review by SHIP team.

Version Information

Version AY 2.0	**Author**	Maggie Wolfe	**Date**	12/11/2015
	Reviewer	Casey Moyer	**Date**	12/15/2015
Version AY 3.0	**Authors**	Maggie Wolfe and Kymberlee Schreiber	**Date**	1/05/2017
	Reviewer	Jenny Feliciano and Casey Moyer	**Date**	3/23/2017
Version AY 4.0	**Author**		**Date**	

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.

Reviewer	Date

Final Acceptance

Version	Name/Signature	Title	Date	Approved via Email
Version AY 2.0	Cynthia York	SHIP Administrator	12/18/2015	☒
	Katie Falls	Mercer Lead	12/18/2015	☒
Version AY 3.0	Cynthia York	SHIP Administrator	05/31/2017	☒
	Katie Falls	Mercer Lead	05/31/2017	☒
Version AY 4.0				☐
				☐

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.

PROJECT CHARTER

GOAL 3: Establish seven Regional Health Collaboratives to support the integration of each patient-centered medical home (PCMH) with the broader Medical-Health Neighborhood.

Version: Award Year 3.0 (AY3.0)

Summary

SHIP Staff	Madeline Russell
Mercer Lead	Jennifer Feliciano
Key Participants	Idaho Department of Health and Welfare (IDHW), Idaho Health Collaborative (IHC), Regional Health Collaboratives (RCs), Public Health District (PHD) SHIP Staff, Population Health Workgroup, Briljent (HMA and Myers and Stauffer), Idaho Medical Home Collaborative (IMHC), and Behavioral Health Integration Workgroup.
IHC Charge	Support the integration of each PCMH with the local Medical-Health Neighborhood by creating the Regional Health Collaborative infrastructure. RCs will support practices in PCMH transformation and will link the PCMHs to the Medical-Health Neighborhood to facilitate coordinated patient care through the entire provider community.

Success Measures

Success Measures	SHIP Desired Outcomes	Measurement	
1.	Support for PCMHs.	• Cumulative (CUM) # of RCs established and providing regional quality improvement guidance and working with PHDs to integrate the Medical-Health Neighborhood. *Model Test Target: 7.* • Numerator: Number of PHDs that have established RCs.	

AY	Q4
1	-
2	7
3	7
4	7

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.

Success Measures	SHIP Desired Outcomes	Measurement
		• Denominator: Number of PHDs statewide.
2.	Support for PCMHs.	• CUM # of primary care practices selected for a SHIP cohort that can receive assistance through regional SHIP PHD team. *Model Test Target: 165.* • Numerator: Number of primary care practices selected for a SHIP cohort that receive assistance from regional SHIP PHD team. • Denominator: Number of practices in a SHIP cohort.

AY	Q4
1	-
2	55
3	110
4	165

3.	Increased coordination between PCMHs and the Medical-Health Neighborhood.	• CUM # of primary care practices selected for a SHIP cohort who have established protocols for referrals and follow-up communications with service providers in their Medical-Health Neighborhood. *Model Test Target: 165.* • Numerator: Number of clinics that have established protocols for referrals and follow-up communications. • Denominator: Count of clinics in a SHIP cohort.

AY	Q1	Q2	Q3	Q4
1	-	-	-	-
2	-	-	25	55
3	75	85	100	110
4	125	140	155	165

4.	Coordinated patient care through the entire provider community.	• CUM # of patients enrolled in a clinic that is part of a SHIP cohort whose health needs are coordinated across their local Medical-Health Neighborhood, as needed. *Model Test Target: 825,000 (50.5% of Idahoans).*

AY	Q1	Q2	Q3	Q4
1	-	-	-	-
2	-	-	-	275,000
3	275,000	275,000	275,000	550,000
4	550,000	550,000	550,000	825,000

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.

Success Measures	SHIP Desired Outcomes	Measurement
		• Numerator: Total number of patients in a primary care practices selected for a SHIP cohort whose health needs are coordinated. • Denominator: Total number of members targeted to enroll in 165 PCMHs (approx. 825,000).

Planned Scope

Deliverable 1	**Result, Product, or Service**	**Description**	**Owner**	**Impacted Parties**
	• Establish RCs.	• Contract with PHDs and hire staff.	• IDHW • PHDs (led by SHIP Managers)	• Other RCs • IDHW • PHDs
Est. Timeframe	**Start**: 06/01/2015			**End**: 04/2016
Milestones	**Event**			**Target Date**
	• Negotiate sub-grant.			• Completed
	• Execute contract with PHDs.			• Completed
	• Hire SHIP staff (SHIP Manager, Quality Improvement/Quality Assurance (QI/QA) Specialist).			• Completed
	• Identify RC Advisory Group.			• Completed
	• Convene RC Advisory Group.			• Completed
	• Identify RC Representative to the IHC.			• Completed
	• Establish RC membership.			• Completed
Deliverable 2	**Result, Product, or Service**	**Description**	**Owner**	**Impacted Parties**
	• Develop and implement RC strategic plan and process for updating the plan.	• Develop plan that describes how RCs will operate and support PCMHs.	• RCs • PHDs • IDHW • PHWG	• IHC • IDHW PCMH Contractor • PCMHs • PHDs
Est. Timeframe	**Start**: 07/2015			**End**: 01/2019

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.

Milestones	Event	Target Date
	• Define services provided by RCs.	• Completed
	• Develop RC strategic plan.	• Completed
	• Implement RC strategic plan.	• Completed
	• Annual update of strategic plan for AY 3.	• 1/31/2018
	• Annual update of strategic plan for AY 4.	• 1/31/2019
	• RCs provide regional quality improvement and Medical-Health Neighborhood integration support.	• Ongoing
	• Submit status report.	• Ongoing

Deliverable 3	Result, Product, or Service	Description	Owner	Impacted Parties
	• Monitoring process to ensure RCs provide regional quality improvement and Medical-Health Neighborhood integration support.	• Process for monitoring services from RCs to PCMHs.	• IDHW	• RCs • PCMHs • PHDs
Est. Timeframe	**Start**: 11/2015			**End**: 01/2019

Milestones	Event	Target Date
	• Develop process.	• Completed
	• Review/revise process.	• Completed
	• Finalize process.	• Completed
	• Implement process (review and provide feedback on reports).	• Ongoing

Deliverable 4	Result, Product, or Service	Description	Owner	Impacted Parties
	• Communication from IDHW and PHDs to practices regarding availability of support available.	• Communication to let practices know what support is available to them.	• IDHW • PHDs	• PCMH Contractor • IDHW Staff • IMHC • IHC
Est. Timeframe	**Start**: 11/2016			**End**: 01/31/2019

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.

Milestones	Event	Target Date
	• Develop communication.	• Completed
	• Review/revise communication.	• Completed
	• Finalize communication.	• Completed
	• Obtain list of Cohort One and Cohort Two.	• Completed
	• Communication with practices in Cohort One and Two.	• Completed
	• Communication with practices in Cohort Two.	• Completed
	• Communication with practices in Cohort Three.	• 01/30/2018
	• Ongoing communication with practices.	• Ongoing

Deliverable 5	Result, Product, or Service	Description	Owner	Impacted Parties
	• Established Medical-Health Neighborhoods.	• Information sharing across Medical-Health Neighborhoods for improved care coordination.	• RCs • PHDs • IDHW	• PCMHs • Providers
Est. Timeframe	**Start**: 7/2015			**End**: 01/2019
Milestones	**Event**			**Target Date**
	• Develop plan to integrate Medical-Health Neighborhood.			• Completed
	• Implement plan to integrate Medical-Health Neighborhood			• 3/28//2017
	• Report to the IHC the status of establishing Medical-Health Neighborhoods.			• Ongoing

Project Risks, Assumptions, and Dependencies

Risks Identification	• See most current version of the risk log.
Assumptions	• Strategic plan will be required for each RC. • Ongoing monitoring by Department Project Manager and PHD staff to determine RC capacity to support PCMHs.
Dependencies and Constraints	• PHDs communicating effectively. • RC support and commitment to the initiative.

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.

Project Reporting and Scope Changes

Changes to scope must be reflected at the Workgroup Charter level as approved by the IHC after review by SHIP team.

Version Information

Version AY 2.0	**Author**	Jenny Feliciano and Miro Barac	**Date**	12/11/2015
	Reviewer	Casey Moyer	**Date**	12/15/2015
Version AY 3.0	**Authors**	Jenny Feliciano and Mary Sheridan	**Date**	1/05/2017
	Reviewer	Casey Moyer	**Date**	3/23/2017
Version AY 4.0	**Author**		**Date**	
	Reviewer		**Date**	

Final Acceptance

Version	Name/Signature	Title	Date	Approved via Email
Version AY 2.0	Cynthia York	SHIP Administrator	12/18/2015	☒
	Katie Falls	Mercer Lead	12/18/2015	☒
Version AY 3.0	Cynthia York	SHIP Administrator	06/01/2017	☒
	Katie Falls	Mercer Lead	06/01/2017	☒
Version AY 4.0				☐
				☐

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.

PROJECT CHARTER

GOAL 4: Improve rural patient access to patient-centered medical homes (PCMHs) by developing virtual PCMHs.

Version: Award Year 3.0 (AY3.0)

Summary

SHIP Staff	Madeline Russell
Mercer Lead	Jenny Feliciano
Key Participants	Community Health EMS (CHEMS), Community Health Worker (CHW) Workgroups, State EMS Agencies, Virtual Patient Centered Medical Homes (PCMHs), Idaho Department of Health and Welfare (IDHW), Regional Health Collaboratives (RCs), Telehealth Goal 2 Subcommittee, Telehealth Council, PCMHs volunteering for PCMH mentoring program, Telehealth Technical Assistance Contractor, PCMH Contractor (includes incentive distribution and technical assistance), and educational institutions to be contracted for providing CHW and CHEMS training.
IHC Charge	Support the development of the Virtual PCMH model in Idaho by utilizing CHWs, CHEMS, and integration of telehealth into rural and underserved areas to improve access to physical, behavioral, and specialty healthcare services.

Success Measures

Success Measures	SHIP Desired Outcomes	Measurement
1.	Recruit and establish Virtual PCMHs.	• Cumulative (CUM) # (%) of Virtual PCMHs established in rural communities following assessment of need. *Model Test Target: 50.* • Numerator: • Denominator:

AY	Q1	Q2	Q3	Q4
1	-	-	-	-
2	0	0	0	15
3	15	15	15	30
4	30	30	30	50

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.

Success Measures	SHIP Desired Outcomes	Measurement	
2.	Establish CHEMS programs.	• CUM # (%) of regional CHEMS programs established. *Model Test Target: 13.* • Numerator: • Denominator:	
3.	Integration of CHEMS in Virtual PCMHs.	• CUM # (%) of CHEMS program personnel trained for Virtual PCMH coordination. *Model Test Target: 35.* • Numerator: • Denominator:	
4.	Train CHWs on Virtual PCMH integration.	• CUM # (%) of new community health workers trained for Virtual PCMH coordination. *Model Test Target: 125.* • Numerator: • Denominator:	
5.	Learning Collaborative for CHEMs and CHWs.	• CUM # (%) of conferences held for CHW and CHEMS Virtual PCMH staff. *Model Test Target: 2 for Target 252 CHWS and CHEMS community health workers.* • Numerator: • Denominator:	

AY	Q2	Q4
1	0	1
2	1	6
3	6	11
4	11	13

AY	Q4
1	2
2	16
3	25
4	35

AY	Q2	Q4
1	-	
2	0	50
3	50	
4		125

AY	Q4
1	-
2	-
3	1
4	2

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.

Success Measures	SHIP Desired Outcomes	Measurement
6.	Enhanced use of telehealth tools by Virtual PCMHs for behavioral health and other specialty services.	• CUM # of designated Virtual PCMH practices that routinely use telehealth tools to provide specialty and behavioral services to rural patients. *Model Test Target: 36.* • Numerator: • Denominator: •

AY	Q4
1	-
2	12
3	24
4	36

Planned Scope

Deliverable 1	Result, Product, or Service	Description	Owner	Impacted Parties
	• Virtual PCMH requirements, standards, designation criteria, and recruitment plan.	• Requirements and recruitment plan for developing Virtual PCMHs.	• IHC • IDHW	• Telehealth Technical Assistance Contractor • PCMH Contractor • IMHC • RCs • EMS Agencies • Primary Care Providers/Potential Virtual PCMH partner sites • CHW/CHEMS Education Contractor
Est. Timeframe	**Start**: 07/20/2016			**End**: 01/23/2019

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.

Milestones	Event	Target Date
	• Develop Virtual PCMH Requirements, Standards, and Designation Process.	• Completed
	• Develop Virtual PCMH Recruitment Plan for Cohort One.	• Completed
	• Implement Virtual PCMH Recruitment Plan for Cohort One.	• Completed
	• Designate SHIP Clinics as Virtual PCMHs in Cohort One.	• Completed
	• Develop Virtual PCMH Recruitment Plan for Cohort Two.	• 11/2017
	• Implement Virtual PCMH Recruitment Plan for Cohort Two.	• 02/2018
	• Designate SHIP Clinics as Virtual PCMHs in Cohort Two.	• 04/2018
	• Develop Virtual PCMH Recruitment Plan for Cohort Three.	• 11/2018
	• Implement Virtual PCMH Recruitment Plan for Cohort Three.	• 11/2018
	• Designate SHIP Clinics as Virtual PCMHs in Cohort Three.	• 01/2019

Deliverable 2	Result, Product, or Service	Description	Owner	Impacted Parties
	• Financial reimbursement for qualifying PCMHs.	• Reimbursement structure for Virtual PCMHs.	• IDHW • PCMH Contractor	• IDHW • PCMH Contractor • IMHC • PCMHs • RCs • IMHC
Est. Timeframe	**Start**: 12/01/2015			**End**: 12/01/2019

Milestones	Event	Target date
	• Hire PCMH Contractor (and Incentive Distribution Contractor).	• Completed
	• Develop financial incentive distribution process, including criteria for practices to receive the incentive and fraud/abuse protections.	• Completed
	• Obtain any necessary approvals of the financial distribution process.	• Completed
	• Complete any logistical steps needed to implement the process.	• Completed
	• PCMH Contractor begins distribution of financial incentives.	• Completed

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.

Deliverable 3	**Result, Product, or Service**	**Description**	**Owner**	**Impacted Parties**
	• Infrastructure for collecting and analyzing data for performance reporting.	• Developing capacity for data collection and analysis	• IDHW • CHEMS Workgroup • Telehealth Goal 2 Subcommittee • CHW Advisory Group	• IDHW • CHEMS • CHW • Virtual PCMH staff • Telehealth Technical Assistance Contractor • PCMH Contractor • IHDE • Data Analytics Contractor
Est. Timeframe	**Start**: 02/01/2016			**End**: 02/29/2016
Milestones	**Event**			**Target Date**
	• Identify data points needed for CHEMS to measure against Triple Aim.			• Completed
	• Identify data points needed for CHWs to measure against Triple Aim.			• Completed
	• Identify data points needed for telehealth to measure against Triple Aim.			•
	• Scope data needs to ensure infrastructure can meet need.			• Completed
	• Align data needs and processes with Data Analytics Contractor.			• Completed
	• Build initial infrastructure.			• Completed

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.

Deliverable 4	Result, Product, or Service	Description	Owner	Impacted Parties
	• Educational program for CHEMS agencies participating in Virtual PCMHs.	• Educational program for CHEMS.	• IDHW • CHEMS Workgroup	• IDHW • Selected EMS agencies • Virtual PCMH staff • PCMH Contractor • Data Collection and Analysis Contractor • Telehealth Technical Assistance Contractor • Local EMS agencies • Selected virtual PCMHs • Telehealth Goal 2 Subcommittee • CHEMS Workgroup • CHEMS/CHW Education Contractor
Est. Timeframe	**Start**: 04/30/15			**End**: 01/31/2019
Milestones	**Event**			**Target Date**
	• Establish CHEMS workgroup and identify CHEMS sub-committee leads.			• Completed
	• Identify CHEMS standards and certification requirements.			• Completed
	• Execute contract with training vendor to provide CHEMS trainings for community paramedics (ALS).			• Completed •
	• Execute contract with training vendor to provide CHEMS trainings for EMTs (BLS and ILS).			• 05/31/2017
	• Develop training evaluation process and metrics.			• 02/31/2017
	• CHEMS Peer Mentoring Program			• 12/31/2018
	• CHEMS Learning Collaborative			• 1/31/2019

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.

Deliverable 5	**Result, Product or Service**	**Description**	**Owner**	**Impacted Parties**
	• Educational program for CHWs participating in Virtual PCMHs.	• Training program for CHW.	• IDHW	• IDHW • CHW • Virtual PCMH staff • PCMH Contractor • CHW Workgroup • CHEMS/CHW Education Contractor • Local CHWs
Est. Timeframe	**Start**: 03/1/2015			**End**: 11/30/2017
Milestones	**Event**			**Target Date**
	• Establish CHW workgroup and identify CHW sub-committee leads.			• Completed
	• Collect best practice resources and policies for program implementation.			• Completed
	• Identify CHW standards and certification requirements.			• Completed
	• Contract with training vendor to provide CHW trainings.			• Completed
	• Explore and implement feasible options for learning opportunities.			• 08/15/2017
	• Develop training evaluation process and metrics.			• 11/30/2017
Deliverable 6	**Result, Product, or Service**	**Description**	**Owner**	**Impacted Parties**
	• Technical assistance program.	• TA for CHEMS, CHWs, selected virtual PCMHs, and RCs in identified areas.	• PCMH Contractor	• All CHEMS and CHWs, Training Contractor, selected Virtual PCMHS, and RCs in identified areas
Est. Timeframe	**Start**: 01/14/2016			**End**: 01/31/2017

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.

Milestones	Event	Target Date
	• CHEMS CP Cohort 1	• Completed
	• CHW Cohort 1	• Completed
	• CHW Cohort 2	• 09/06/2017
	• CHEMS EMT Cohort 1	• 10/18/2017
	• CHW Cohort 3	• 12/29/2017
	• CHEMS CP Cohort 2	• 12/29/2017
	• CHW Cohort 4	• 05/31/2018
	• CHEMS EMT Cohort 2	• 06/20/2018
	• CHEMS CP Cohort 3	• 12/31/2018
	• CHW Cohort 5	• 12/31/2018

Deliverable 7	Result, Product, or Service	Description	Owner	Impacted Parties
	• Telehealth plan.	• Plan to implement telehealth and secure telehealth consultant.	• IDHW	• Selected PCMHs • Telehealth contractor • Telehealth Council • Telehealth Goal 2 Subcommittee

Est. Timeframe	Start: 04/01/2016	End: 01/10/2017

Milestones	Event	Target Date
	• Establish Subcommittee of Telehealth Council	• Completed
	• Develop telehealth expansion and implementation plan	• Completed
	• Educate SHIP Clinics about the Telehealth Program	• Completed
	• Secure Telehealth Consultant Contractor	• Completed
	• Develop RFQ for telehealth consultant	• Completed
	• Release RFQ for telehealth consultant	• Completed
	• Procure telehealth consultant	• Completed
	• Deliver webinars for primary care clinics	• Completed

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.

Deliverable 8	**Result, Product, or Service**	**Description**	**Owner**	**Impacted Parties**
	• Implement new CHEMS telehealth programs.	• Select CHEMS agencies to participate in telehealth program.	• CHEMS Workgroup • Telehealth Council	• CHEMS and CHW supporting agencies • Hospitals in selected areas • PCMHs • IDHW • Data Analytics contractor
Est. Timeframe	**Start**: 02/1/2016			**End**: 02/30/2017
Milestones	**Event**			**Target Date**
	• Design application process.			• Completed
	• Publish CHEMS telehealth grant application.			• Completed
	• CHEMS Telehealth Program grant application period.			• Completed
	• Application review period.			• 06/09/2017
	• Secure funding from CMMI.			• 07/21/2017
	• Begin monitoring and managing awarded CHEMS telehealth grants.			• 07/24/2017
	• Distribute CHEMS telehealth grants.			• 09/01/2017
Deliverable 9	**Result, Product, or Service**	**Description**	**Owner**	**Impacted Parties**
	• Implement PCMH Telehealth Program	• Select SHIP clinics to participate in telehealth program.	• IDHW	• PCMHs • Data Analytics contractor
Est. Timeframe	**Start**: 02/1/2016			**End**: 08/01/2017
Milestones	**Event**			**Target Date**
	• Design application Process.			• Completed
	• Publish PCMH telehealth grant application.			• Completed
	• PCMH Telehealth Program grant application period.			• Completed
	• Application review period.			• Completed
	• Secure funding from CMMI.			• 06/16/2017
	• Distribute PCMH telehealth grants.			• 06/16/2017
	• Monitor and manage awarded PCMH telehealth grants.			• 08/01/2017

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.

Project Risks, Assumptions, and Dependencies

Risk Identification	See most current version of the risk log.
Assumptions	TBD
Dependencies and Constraints	• Establishment and finalizing of the Virtual PCMH model. • Ability to recruit and train a sufficient number of practices, CHWs, and CHEMS. • Selection of the CHEMS agencies dependent on the selection of the PCMH cohorts. • Timeline for EMTs training dependent on training availability. • CHEMS metrics dependent on SHIP metrics catalog. • Identifying training program curriculum and delivery strategy is dependent on the CHW training committee recommendation, IHC approval, CMMI release of funding, and establishment of appropriate agreement (contract or sub-grant). • Testing the CHW program requires the development of metrics, data collection, and reporting strategies. • Implementing a peer-mentoring program is dependent on the identification of CHWs and primary care clinicians with successful programs and a willingness to travel to PCMHs with new programs.

Project Reporting and Scope Changes

Changes to scope must be reflected at the Workgroup Charter level as approved by the IHC after review by SHIP team.

Version Information

Version AY 2.0	**Author**	Jenny Feliciano and Miro Barac	**Date**	12/22/2015
	Reviewer	Casey Moyer	**Date**	12/23/2015
Version AY 3.0	**Authors**	Jenny Feliciano and Madeline Russell	**Date**	1/05/2017
	Reviewer	Casey Moyer	**Date**	3/23/2017
Version AY 4.0	**Author**		**Date**	
	Reviewer		**Date**	

Final Acceptance

Version	Name/Signature	Title	Date	Approved via Email
Version AY 2.0	Cynthia York	SHIP Administrator	12/18/2015	☒
	Katie Falls	Mercer Lead	12/18/2015	☒

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.

Version	Name/Signature	Title	Date	Approved via Email
Version AY 3.0	Cynthia York	SHIP Administrator	06/01/2017	☒
	Katie Falls	Mercer Lead	06/01/2017	☐
Version AY 4.0				☐
				☐

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.

PROJECT CHARTER

GOAL 5: Build a statewide system for collecting, analyzing, and reporting quality and outcome data at the PCMH, regional, and state levels.

Version: Award Year 3.0 (AY3.0)

Summary

SHIP Staff	Burke Jensen
Mercer Lead	Janet Flynn
Key Participants	Regional Collaboratives (RCs), Public Health Districts (PHDs), Idaho Health Data Exchange (IHDE), Idaho Department of Health and Welfare (IDHW), Patient Centered Medical Homes (PCMHs), HealthTech Solutions (HTS), Data Governance Workgroup (DGW), and EHR Vendors.
IHC Charge	Build a statewide data analytics system that tracks progress on selected quality measures at the individual patient level, regional level, and statewide.

Success Measures

Success Measures	SHIP Desired Outcomes	Measurement	
1.	Build a statewide data analytics system that tracks progress on selected quality measures at the individual patient level, regional level, and statewide.	• Cumulative (CUM) # (%) of primary care practices selected for a SHIP cohort with access to the analytics system and dashboard reporting. *Model Test Target: 165* (by 2020). • Numerator: Number of primary care practices selected for a SHIP cohort that have access (user name and password) to the analytics system and dashboard reporting. • Denominator: Total number of primary care practices targeted to transform to PCMHs each year.	

AYR	Q4
1	-
2	-
3	60
4	110
5*	165

*Reporting run out required through 1 year post Award Year 4

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.

<table>
<tr><th>Success Measures</th><th>SHIP Desired Outcomes</th><th>Measurement</th></tr>
<tr><td>2.</td><td>Identification of statewide measures for targeted performance reporting at PCMH level.</td><td>• CUM # (%) of primary care practices selected for a SHIP cohort that are meeting the clinical quality reporting requirements for their cohort. Model Test Target: 165.
• Numerator: Number of primary care practices selected for a SHIP cohort successfully completing the reporting requirements (adequate data for the measure) for their cohort.
• Denominator: Total number of primary care practices targeted to transform to PCMHs each year.

<table><tr><th>AYR</th><th>Q4</th></tr><tr><td>1</td><td>-</td></tr><tr><td>2</td><td>-</td></tr><tr><td>3</td><td>60</td></tr><tr><td>4</td><td>110</td></tr><tr><td>5*</td><td>165</td></tr></table>*Reporting run out required through 1 year post Award Year 4</td></tr>
<tr><td>3.</td><td>Data collection and analytics for targeted performance reporting to support quality improvement efforts.</td><td>• CUM # (%) of RCs provided a report of PCMH clinic CQM performance data. Model Test Target: 7.
• Numerator: Number of RCs that received data analytic reports to support health needs assessment results reporting.
• Denominator: Number of RCs (7).

<table><tr><th>AYR</th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr><tr><td>1</td><td>-</td><td>-</td><td>-</td><td>-</td></tr><tr><td>2</td><td>-</td><td>-</td><td>-</td><td></td></tr><tr><td>3</td><td>-</td><td>-</td><td>2</td><td>3</td></tr><tr><td>4</td><td>4</td><td>5</td><td>6</td><td>7</td></tr></table></td></tr>
</table>

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.

Planned Scope

Deliverable 1	Result, Product, or Service	Description	Owner	Impacted Parties
	• Establish plans and requirements for data analytics.	• Develop plans to address use and maintenance of data analytics solution.	• HTS • IDHW	• IHDE • PCMHs
Est. Timeframe	**Start**: 03/18/2016			**End**: 08/01/2016
Milestones	**Event**			**Target Date**
	• Project management plan.			• Complete
	• Project work plan.			• Complete
	• Disaster recovery plan.			• Complete
	• Architectural design model.			• Complete
	• Requirements traceability.			• Complete
	• Training plan.			• Complete
	• System security plan.			• Complete
	• Transition plan.			• Complete
	• Develop support/service management plan.			• Complete
	• Develop quality assurance plan.			• Complete
	• Plan for help desk support.			• Complete
Deliverable 2	**Result, Product, or Service**	**Description**	**Owner**	**Impacted Parties**
	• Functioning SHIP Data Governance Workgroup (DGW)	• Form a new workgroup that will establish processes for data quality and governance.	• DGW • IDHW	• PCMHs • IHC • IHDE • HTS • RCs • PHDs
Est. Timeframe	**Start**: 02/17/2017			**End**: 06/30/2017

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.

Milestones	**Event**			**Target Date**
	• Develop structure and membership for the SHIP DGW.			• Complete
	• Identify members for the SHIP DGW.			• Complete
	• DGW begins meeting regularly.			• Complete
	• Develop workgroup charter.			• Complete
	• IHC review and approval of charter.			• 07/12/2017
Deliverable 3	**Result, Product, or Service**	**Description**	**Owner**	**Impacted Parties**
	• Quality CQM Data	• Evaluate individual clinic data to identify and address data gaps. Provide quality CQM data to the data analytics system.	• IHDE • PCMHs • HTS • IDHW	• IHC • HTS • RCs/PHDs • Hospitals
Est. Timeframe	**Start**: 01/31/2017			**End**: 10/01/2018
Milestones	**Event**			**Target Date**
	• Develop outline of process to improve data.			• Complete
	• Onboard data quality facilitator.			• Complete
	• Develop materials for data quality process.			• Complete
	• Begin meetings with first group of clinics to assist in data quality activities.			• 06/19/2017
	• Continue meetings with additional clinics to assist in data quality activities.			• 08/01/2017
	• Schedule subsequent clinic meetings to assist in data quality activities.			• 11/01/2017
	• Enhance EHR connections with IHDE to fill data gaps as needed.			• 10/01/2018
Deliverable 4	**Result, Product, or Service**	**Description**	**Owner**	**Impacted Parties**
	• End user training.	• Training plan and training delivery for users of the data analytics solution.	• HTS • IDHW	• PCMHs • IHDE • IDHW • RCs • PHDs

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.

Est. Timeframe	**Start**: 11/30/2016			**End**: 01/31/2019
Milestones	**Event**			**Target Date**
	• Plan training.			• Complete
	• Conduct AY2 training– Cohort One Phase 1 (initial PCMHs).			• Complete
	• Conduct AY2 training– Cohort One Phase 2 (PCMHs, regional and state users).			• 11/01/2017
	• Modify training to include additional measures.			• 11/30/2017
	• Conduct AY3 training – Cohort Two/other users.			• 01/31/2018
	• Modify training to include additional measures.			• 11/30/2018
	• Conduct AY4 training – Cohort Three/other users.			• 01/31/2019
Deliverable 5	**Result, Product, or Service**	**Description**	**Owner**	**Impacted Parties**
	• Data Analytics Reporting	• Define, develop, test and implement the data analytics solutions.	• HTS • IDHW	• IDHW • PCMHs • RCs/PHDs • IHDE
Est. Timeframe	**Start**: 01/27/2017			**End**: 07/30/2018
Milestones	**Event**			**Target Date**
	• Iteration 1 (Measure 1).			• Complete
	• Iteration 2 (Measure 2).			• Complete
	• Iteration 3 (Measure 3).			• Complete
	• Iteration 4 (Measure 4).			• Complete
	• Iteration 5 (Measure 5).			• Complete
	• Iteration 6 (Measure 6).			• 07/03/2017
	• Iteration 7 (Measure 7).			• 09/05/2017
	• Iteration 8 (Measure 8).			• 11/06/2017
	• Iteration 9 (Measure 9).			• 01/02/2018
	• Iteration 10 (Measure 10).			• 01/22/2018

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.

	• Iteration 11 (Measure 11). • Iteration 12 (Measure 12). • Iteration 13 (Measure 13). • Iteration 14 (Measure 14). • Iteration 15 (Measure 15). • Iteration 16 (Measure 16).			• 04/17/2018 • 06/12/2018 • 08/15/2018 • 10/16/2018 • 12/18/2018 • 01/16/2019
Deliverable 5	**Result, Product, or Service**	**Description**	**Owner**	**Impacted Parties**
	• Patient Attribution Process Implemented	• Develop and implement a patient attribution process for SHIP clinics.	• IHDE • IDHW	• PCMHs • IHDE • IDHW • RCs • PHDs
Est. Timeframe	**Start**: 11/30/2016			**End**: 01/31/2019
Milestones	**Event**			**Target Date**
	• Design and develop solution			• Complete
	• Implement solution with HIE and Data Analytics vendors.			• Complete
	• Coordinate process with Cohort One Clinics			• 08/30/2017
	• Revise design as needed.			• 11/30/2017
	• Coordinate process with Cohort Two Clinics.			• 01/31/2018
	• Coordinate process with Cohort Three Clinics.			• 01/31/2019

Project Risks, Assumptions, and Dependencies

Risks	**See most current version of the risk log.**
Assumptions	• Success measures established for Goal 2 will also support Goal 5, and measurement activities do not need to be replicated for Goal 5.

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.

Dependencies and Constraints	Dependencies: • IDHW's ability to monitor the vendor's performance. • Adequacy of technical assistance to support PCMH reporting. • Quality of the community health needs assessments from the RCs and capability of the PCMHs to use results to guide QI initiatives. • Timeliness of Goal 2 activities (to improve care coordination through use of electronic health records) that also support Goal 5 (build a statewide data analytics system). Constraints: • The Health Tech contract and the SHIP work are limited to the SHIP award years. • Health Tech's contract is a fixed budget and IDHW's ability to add additional funding is limited by state purchasing rules. • Ability to resolve significant technology standardization to support interoperability. • Clinic engagement through data validation process.

Project Reporting and Scope Changes

Changes to scope must be reflected at the Workgroup Charter level as approved by the IHC after review by SHIP team.

Version Information

Version AY 2.0	**Author**	Janet Flynn	**Date**	12/11/2015
	Reviewer	Burke Jensen	**Date**	12/15/2015
Version AY 3.0	**Authors**	Janet Flynn and Burke Jensen	**Date**	2/1/2017
	Reviewer	Jenny Feliciano and Casey Moyer	**Date**	4/19/2017
Version AY 4.0	**Author**		**Date**	
	Reviewer		**Date**	

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.

Final Acceptance

Version	Name/Signature	Title	Date	Approved via Email
Version AY 2.0	Cynthia York	SHIP Administrator	12/18/2015	☒
	Katie Falls	Mercer Lead	12/18/2015	☒
Version AY 3.0	Cynthia York	SHIP Administrator	05/31/2017	☒
	Katie Falls	Mercer Lead	05/31/2017	☒
Version AY 4.0				☐
				☐

.

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.

Idaho's PCMH Mentorship Framework

DRAFT Version 7.0 – June 5, 2017

Introduction

A Patient Centered Medical Home (PCMH) mentorship framework is important in creating a strong network of knowledgeable and experienced primary care clinics across the State of Idaho. The framework will act as a structure to help spread best practices; to support all the Statewide Healthcare Innovation Plan (SHIP) cohort clinics in their transformation efforts; and to create additional opportunities through building clinic-to-clinic relationships.

Idaho has numerous primary care clinics who have achieved national PCMH accreditation. Many have done so from previous efforts, such as the Safety Net Initiative and the Idaho Medical Home Collaborative (IMHC)Pilot. The purpose of this framework is to assist in the development of a peer-to-peer support system to support SHIP cohort clinics in system change, PCMH transformation, data quality, and additional tasks related to their SHIP participation and the larger efforts involved in healthcare reform.

This framework reflects the state's recognition of the important role that mentoring plays in the PCMH transformation experience. The rationale is to promote effective mentoring by describing the key concepts, roles, and needs, along with practical strategies for nurturing rewarding relationships and recommendations for maintaining healthy relationship building amongst primary care clinics statewide and beyond SHIP.

The components outlined in this framework derive from the convening of the Idaho PCMH Mentorship Subcommittee during May 2017. Subcommittee members included members of IMHC Workgroup, Regional Collaborative Chairs and Co-Chairs, Public Health District staff, Department of Health and Welfare staff and contractors, participating SHIP clinic Physician Champions, Boise State University and University of Idaho faculty members, a Veterans Administration (VA) Office of Academic Affiliations Physician Consultant, as well Health Plan/ Payer staff from multiple entities. The University of Nebraska – Lincoln Graduate Mentoring Guide[i] was utilized as a base in which this framework was developed. Additional mentoring definitions were provided by the VA Office of Academic Affiliations, Centers of Excellence in Primary Care Education and the National Parkinson Foundation (NPF) Mentoring Program[ii].

Background

In December 2014, the Idaho Department of Health and Welfare (IDHW) received a State Innovation Model (SIM) grant from the Center for Medicare and Medicaid Innovation (CMMI). The grant funds a four-year Model Test that began on Feb. 1, 2015 to implement Idaho's SHIP. During the grant period, Idaho will demonstrate that the state's healthcare system can be transformed through effective care coordination between primary care providers practicing patient-centered care and broader Medical-Health Neighborhoods comprised of specialists, hospitals, behavioral health professionals, long-term care providers, and other ancillary care services. Idaho's SHIP model provides supports at every level for clinics as they transform to the PCMH model. The State

of Idaho is comprised of seven Public Health Districts (PHDs), as shown on Figure 1, which provide resources and technical assistance to clinics throughout the transformation. Seven Regional Collaboratives (RCs) support clinics by working to improve the coordination of care within the Medical-Health Neighborhood and identifying and sharing best practices for successful care coordination.

Idaho's SHIP seeks to transform primary care practices across the state into PCMHs. Idaho is establishing PCMHs as the foundation of the state's healthcare system by making them the vehicle for delivery of primary care services. The PCMH model focuses on preventive care, keeping patients healthy and stabilizing patients with chronic conditions. A portion of SHIP grant funding is being used to provide training, technical assistance and coaching to assist practices in this transformation.

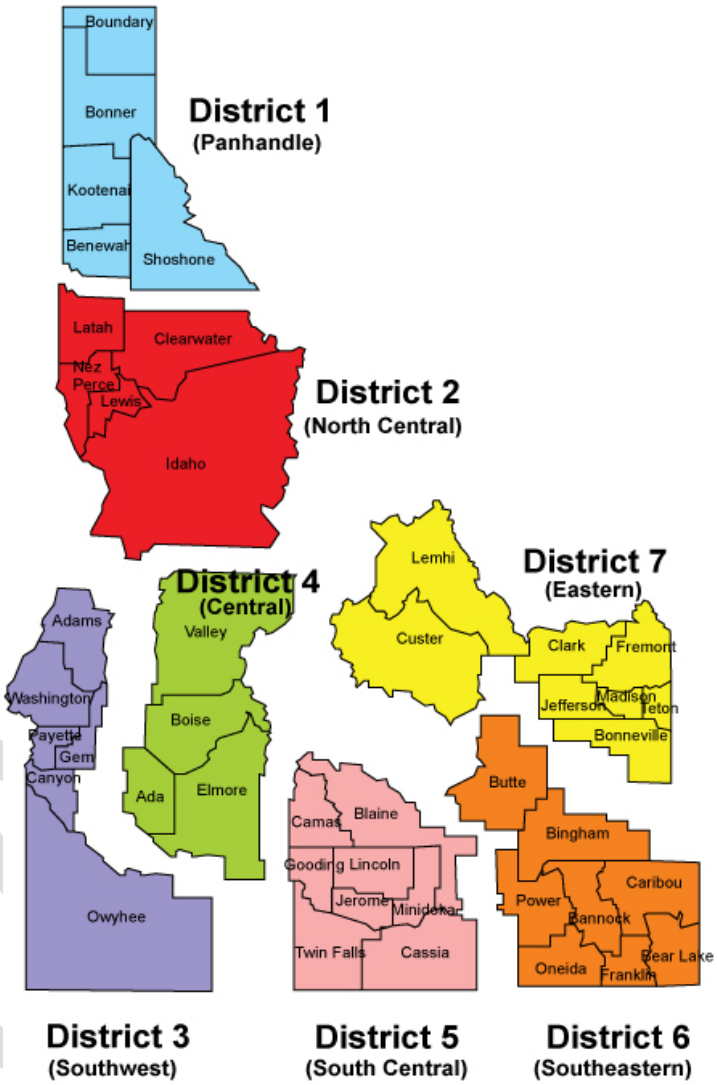


Figure 1: Map of Idaho Public Health Districts

PCMH mentorship between practices was an important component of the original Idaho SIM Test Proposal. The proposal described how, based on their experience as leaders in patient-centered primary care, some practices in Idaho are well positioned to be a valuable resource to other practices in their efforts to build capacity around the components of the PCMH model. It was determined that the Idaho Healthcare Coalition (IHC) and the RCs will seek to leverage this expertise where possible by encouraging practice mentor opportunities to help practices learn from each other's lessons and prior experience. As part of a road map for health system transformation, the proposal outlined milestones relating to PCMH mentorship. It was proposed that in the first year of SHIP, a PCMH mentoring program would commence to assist practices through the transformation process. In the second year, the program would continue mentoring less experienced PCMHs by more experienced PCMHs.

Overview of Current Mentorship Activities in Idaho

Throughout the seven PHDs, mentorship has either been discussed or is informally happening with SHIP clinics through the RCs or through the PHD SHIP staff. In the North Central Healthcare Collaborative, mentorship has been discussed as a major purpose of the RC. In the Southwest Health Collaborative, mentorship has not been discussed formally but they do support professional networking. The Central Health Collaborative expressed that

there is a great need for mentorship across clinics and systems. In addition to the technical assistance and support of the PCMH Team coaches from Health Management Associates (HMA) and PHD SHIP Quality Improvement (QI) Specialists, they have discussed the need specifically within the Central Health Collaborative, primarily in the form of PCMH transformation workgroups. The idea is that care coordinators, managers, medical assistants, etc. from Cohort One and Cohort Two clinics would be convened to help one another through the transformation process through by information sharing, best practices, electronic health record (EHR) transitions and utilization, etc. In the South-Central Health Collaborative, clinics and their PCMH teams have been mentoring each other from the beginning of the SHIP. Early on, Dr. Keith Davis, the RC Chair, went to each Cohort One clinic site to observe and aid in PCMH transformation. The Eastern Health Collaborative does not specifically define mentorship, however, they commonly use the RC to share best practices, to provide an opportunity to ask questions, and to receive help from other clinics. Similarly, the Southeastern Health Collaborative has actively engaged in mentorship opportunities, but has not clearly defined or structured them. Dr. Mark Horrocks, Co-Chair of the Southeastern Health Collaborative, has engaged Cohort One and Cohort Two clinics by fostering opportunities to deliver and facilitate discussions with clinic staff members from participating SHIP clinics to aid practices that are beginning PCMH transformation. Lastly, the Panhandle Regional Collaborative provides mentorship opportunities through PCMH meetings. These regularly scheduled meetings offer an educational portion of the meeting where one clinic presents on an identified topic area that can benefit other attendees and follows with a questions and answer session.

Mentoring activities have organically formed in the RCs but the structure varies from district to district. The North Central Healthcare Collaborative currently has a few of their SHIP clinics assisting other SHIP clinics in their implementation of, not only PCMH initiatives, but also the sharing of best practices for QI projects and other clinic programs (e.g. Transitional Care Management, Chronic Care Management, Behavioral Health Integration). Similarly, the Panhandle Regional Collaborative varies the format of their RC meetings to offer rotational groups for each clinic team in attendance. They have touched on topics such as care management, care coordination, and team based care allowing each group to begin the conversation informally. The Southwest Health Collaborative convenes a monthly PCMH workgroup that is open to all primary care practices, in addition to Cohort One and Cohort Two clinics. Healthy Connections also participates in the workgroup. The workgroup identifies a local subject matter expert (SME) for a certain topic and that individual presents to the group and takes questions. Mentorship has not been set in motion throughout the Central Health Collaborative via a formalized process. However, it is being done across clinics and systems in different ways. Specifically, the PHD QI Specialist is connecting clinics to one another based on a specific area of need that one clinic may have and connecting that clinic with another clinic that may be more advanced in that area of transformation. As a region, the Central Health Collaborative has also connected Community Health Worker (CHW) coordinators or outreach/promotion coordinators with clinics who are interested in hiring a CHW, to help them learn more about how to implement a CHW role in a primary care setting. Additionally, PHD staff also spend time connecting clinics with the same EHR, to discuss how to improve utilization and overall tips and tricks for best use of the system. Lastly, it has been found that surveying clinics on their knowledge of local resources within the Medical-Health Neighborhood seems to work well to connect clinics to existing resources that they may not be aware of in the community. Currently, in the South Central Health Collaborative, clinics are represented within the RC and frequently provide insight into success or challenges. Cohort Two clinic representatives attend monthly RC meetings and share what is occurring in their practices. The clinics maintain open lines of

DRAFT

communication with each other; specifically, emailing information from clinic to clinic has been successful. As previously mentioned, Dr. Davis, has been helping in PCMH transformation even before the inception of SHIP. The Eastern Health Collaborative does not specifically define mentorship, however, they commonly use the RC to share best practices, to provide an opportunity to ask questions, and to receive help from other clinics. Clinics have reached out to each other to set up either behavioral health connections, work on an EHR fix, or to share thoughts on chronic care management programs.

The Southeastern Health Collaborative is divided into three different meetings: executive, clinic, and the Medical-Health Neighborhood. The clinic committee meeting allows members from the cohort clinics to discuss their challenges and barriers while also discussing tips, previous experiences, and suggestions to solving problems on a quarterly basis. During Cohort One, the clinic committee meeting was held in clinic locations of those who were already PCMH recognized. This allowed non-recognized clinics an opportunity to see how recognized PCMH clinics offered services, structured their clinic, and how the clinic delivers and streamlines its services on a day-to-day basis. Job descriptions and work flow strategies have also been shared between clinics and job shadowing opportunities continue to occur. The Medical-Health Neighborhood meeting, as part of the Southeastern Health Collaborative, has allowed both clinical and non-clinical partners to convene and collaborate on existing health disparities in regionally. These relationships also provided opportunities for staff to learn about existing resources within the region and how other clinics have utilized their own resources to meet patients' needs.

Many mentoring activities are currently happening or are have been proposed to happen within SHIP. Peer-level support that clinics can offer to each other is a crucial element of PCMH transformation. Creating a strong network of "champion" clinics that can serve as mentors to other clinics is an important part of the model. The PCMH Transformation Team, consisting of Briljent and HMA, along with the PHD SHIP QI staff will recruit up to three practices to serve as champions during the current cohort year. Ideally the champions will represent different practice proficiency levels. They will participate in training activities such as the learning collaborative, providing examples of their experiences and encouragement to new practices.

The WWAMI (Washington, Wyoming, Alaska, Montana and Idaho) Medical Education Program and the Idaho State-level Evaluation Team are coordinating administrative and curriculum resources to develop Continuing Education Unit (CEU) opportunities for SHIP clinics on value-based healthcare and other topics related to PCMH. The Idaho WWAMI program aligns closely with the achievement of the Triple Aim and many goals of SHIP.

The curricular materials will also be used in the Idaho WWAMI medical curriculum. A good portion of the curricular material will draw on the cumulative experiences of the SHIP cohort clinics in implementing a PCMH model of care in the clinical and cultural contexts of Idaho primary care clinics. Interactive on-line modules will be developed with incorporation of provider and patient testimonies about the development and use of PCMH as appropriate. The VA Office of Academic Affiliations - Centers of Excellence in Primary Care Education (CoEPCE) have developed courses via an online sharing platform created for PCMH teaching clinics affiliated with the VA. Courses available in 2017 include huddles, population/panel management, and strategies for managing geriatric polypharmacy. One example already offered on the website is a "hot spotter" case conference for high-needs, high-utilization patients called PACT ICU (Patient Aligned Care Team Interdisciplinary Case Unit). Others

courses currently in development include shared medical appointments, panel management of narcotic pain medications, and primary care/mental health integration models.

The Idaho Integrated Behavioral Health Network (IIBHN) developed in 2016 as a professional learning collaborative designed to enhance and support the growth of integrated behavioral health programs to assist in team-based care management of co-morbid medical and behavioral health conditions in primary or specialty care clinics. The network began and is supported by behavioral health leaders from IDHW's Division of Behavioral Health, Family Practice Residency of Idaho, Terry Reilly Health Services, and St. Luke's Health Partners in collaboration with Southwest District Health and Central District Health. The network identified that the work demands of behavioral health consultants (BHCs), social workers, and counselors, are unique within the world of mental health. BHCs may also encounter some professional isolation as there are a limited number of BHCs in Idaho. Additionally, the Primary Care-Mental Health Integration community is inter-professional, so typical outlets for connecting with like-minded professionals can be challenging. In southwestern Idaho, the IIBHN held three BHC "get togethers" in 2016 that involved clinical discussion geared toward behavioral health integration occurring in clinics. The IIBHN will work through 2017 to create chapters within other regions of Idaho to have similar collaborative meeting with other BHCs across the state. Beginning June 2017, Southwest District Health and Central District Health will begin transitioning facilitation of regional or hub IIBHN meetings from St. Luke's Health Partners.

Several regions have identified barriers to implementing a more formal mentorship plan statewide. One identified risk could include clinics not having a vested interest in becoming mentors; there may be territorial or competitive challenges; implementing a more formal structure may restrict or redirect what is presently occurring; clinics may feel that the technical assistance support they receive through SHIP meets their current needs. Clinic needs can be very specific. Additional barriers at the clinic level include scheduling time for mentoring/training, insufficient time to dedicate to mentorship, and lack of leadership support.

Mentoring Needs under SHIP

This framework is intended to assist in the development of a peer-to-peer support system to support SHIP cohort clinics in system change, PCMH transformation, data quality, and additional tasks related to their SHIP participation and the larger efforts involved in healthcare reform. This framework can also be utilized by primary care clinics outside of SHIP, as they may likely participate in similar efforts of a support relationship with other practices. Mentoring focuses on the clinic relationships, commitments, and resources that help clinics find success and fulfillment in their PCMH transformation pursuits. At the VA Office of Academic Affiliations CoEPCE annual meeting in San Diego, April 25-27, 2017, attendees defined mentorship as a personal and reciprocal relationship between two parties. They went on to further explain that it is typically formed between experienced and less-experienced clinics and is usually achievement-focused.

Mentoring helps clinics understand how their ambitions fit into broader system change, leadership and staff engagement, PCMH principles, and continuous transformation efforts. As clinics progress through PCMH transformation, they will find that rarely is one clinic or peer able to meet all their mentoring needs. It may be necessary for primary care clinics to identify multiple mentors or subject areas in which to obtain effective guidance from peers. Mentoring is also a relationship without judgement. Together clinics partake in iterative

problem solving aimed at specific achievements, mentoring with resource connection and with change occurring in a positive direction.

A novice clinic may be a clinic which has had little or no exposure to PCMH concepts. Clinic leadership may be engaged and initiating early discussion regarding transformation, but may not have informed the rest of the clinic staff in the conversation. These clinics may have developed PCMH teams, and have engaged leadership, but are still putting things in place to begin transformation efforts. A mature clinic may be a clinic which has progressed through PCMH transformation and is continually making improvements based on the PCMH model. They may or may not be nationally accredited or recognized in PCMH, but they are proven to be doing "the work". Practices may identify as novice or mature in different areas. Clinics identify their level and the areas in which they feel they may need assistance. Peer-to-peer supports should also be in place that involve practices that are at similar levels of transformation and are seeking additional support from each other. This may involve brainstorming session on how to move past topics where they feel "stuck" or may involve advisement through the PCMH accreditation process, etc.

Many practice needs for mentorship are similar regardless of level of experience with the PCMH model. Practice teams learn by expanding PDSA cycles, and by accomplishing goals together as opposed to listening and reading transformation-related topics. Learning collaboratives and PCMH-related educational webinars lay a foundation for training in PCMH principles and concepts areas. Matching clinics by needs and resource is a way to generate further and continued collaboration amongst primary care teams.

Clinics participating with SHIP have additional resources such as technical assistance through the PCMH Team and specifically with the SMEs from HMA. These coaches act as advisors to selected SHIP clinics, providing the clinical experience and knowledge but acting more as a monitor or coach overseeing the clinic's transformation efforts. While advisement can be equally as important to change and transformation as mentorship, an advisor is not fitting to the peer definition related to mentoring. The recent VA CoEPCE annual meeting also defined an advisor as a person fulfilling program and advisee needs, frequently serving a dual role that may involve assessment in which they see themselves as an evaluator or administrator. Mentoring offers more opportunity for flexibility within the relationship between the clinic teams than advising does on a more individual or job role basis.

Primary care practices obtain many benefits from a successful mentoring relationship. Mentoring enables clinics to acquire skills and knowledge on specific transformation topics; it helps teams develop techniques for collaborating and networking; it helps engage the curiosity and energy of passionate healthcare professionals; it prepares the next generation of patient-centered focused primary care practice; it allows clinic teams to enjoy the personal and professional satisfaction integral to mentoring relationships.

Recommendations

The PCMH Mentorship Subcommittee devised multiple strategies that have worked elsewhere regarding peer-to-peer support or areas they saw that were needed to assist practices and providers across the state. One suggestion was to create a mentorship matching in certain topic areas. This would involve surveying practices

based on clinic setting, areas of interest, or characteristics of populations served to help connect practices and allow them to get the professional guidance and knowledge they need to succeed in their transformation efforts.

Additional strategies the Subcommittee suggested to address within primary care practices were data related – including EHR usage and health information exchange, team-building, and empanelment. Another suggestion was to create a "master list" comprised of subject areas for clinics can assist each other with. Subjects identified include:

- EHR systems,
- care coordination,
- behavioral health integration,
- team-based care,
- national accreditation application processes,
- Idaho Health Data Exchange (IHDE) connectivity,
- performing huddles,
- chronic care management, and
- collaboration with specialty care practices

The State of Idaho has a rare opportunity to expand upon the collaboration of participating SHIP clinics, the RCs, and the PCMH Mentorship Subcommittee members. The PCMH Mentorship Subcommittee, along with the IMHC Workgroup and the IHC, has identified the following recommendations for maintaining relationship building efforts and mentorship amongst primary care practices within the State of Idaho during the SHIP initiative and beyond.

Recommended Resource	What needs to happen?	Possible Facilitator/ Holder
Resource Guide • Recommendations and guidance to shape resources/tools/materials that will support PCMH mentorship	The State Evaluation Team has already offered assistance in this development. Recommended to include resources about Bodenheimer's 10 Building Blocks of Primary Care, Safety Net Medical Home, PCMH principles, Project ECHO network information and module topics list through UI WWAMI Medical Education Program.	RCs; State Evaluation Team; state universities
Provider Champion Mentor Panel • To assist in identifying and operationalizing priority areas related to PCMH and mentorship	Convene and facilitate a Champions discussion to prioritize the basics of mentorship and operationalize a framework that the state can commit to.	IDHW
Mentorship Webinar Series • Subject-based webinars on common issues experienced by SHIP cohort clinics throughout the state. May include topics such as: EHRs, data and pulling reports, huddles, like-clinical roles (i.e.: IT/	IDHW is in discussion with PCMH Contractor to establish frequent webinars facilitated by a SME to follow and "Ask & Give" format for a peer-to-peer/ clinic-to-clinic learning experience.	IDHW

data staff, CHWs, Care Managers).		
Master List • Checklist of clinics that have similar EHRs, care coordination, BHI, team-based care, national accreditation application processes, IHDE connectivity, huddles, chronic care management, creating MOUs or BAs for collaboration with specialty care practices.	Survey clinics to create an inventory list/ checklist to be utilized by PCPs, PHDs, RCs, Healthy Connections, etc. to grasp who is doing what and how to build relationship between clinics, providers and clinical teams.	PHDs; RCs; State Evaluation Team

[i] http://www.unl.edu/mentoring/introduction
[ii] http://www.parkinson.org/expert-care-research/centers-of-excellence/mentoring-program

DRAFT

STATEWIDE HEALTHCARE INNOVATION PLAN (SHIP) Interest Survey 2017

Version 3.0 DRAFT (May 2017)

Thank you for your interest in the Idaho Statewide Healthcare Innovation Plan (SHIP). Please complete the following contact information and brief survey questions to help us identify clinics interested in receiving further information regarding recruitment for Cohort 3 participation.

Clinic Demographic Information	
Clinic Name	
Clinic's Physical Address	
City	
State	
Zip Code	
Phone Number	
Fax Number	
Main Contact First Name	
Main Contact Last Name	
Main Contact Email Address	
Survey Questions	
How did your clinic hear about SHIP?	☐ On-line ☐ Medicaid ☐ Public Health District ☐Other:
Why is your clinic interested in participating with SHIP?	
What is your Practice type? (Check all that apply)	☐ Family Medicine ☐ Internal Medicine ☐ Pediatrics ☐Multi-Specialty ☐Other:
Is your clinic familiar with the Patient-Centered Medical Home (PCMH) model of care?	☐ Very familiar (Clinic is Nationally recognized or accredited at a higher level or NCQA Level 3; PCMH transformation has been implemented within clinic) ☐ Familiar (Clinic Nationally recognized or accredited at a mid-level or NCQA Level 1 or 2; clinic has begun implementation of PCMH transformation) ☐ Somewhat familiar (Clinic is not currently recognized or accredited but Clinic administration has outlined steps to begin implementing PCMH transformation) ☐Limited familiarity (Clinic is not currently recognized or accredited but Clinic administration has begun discussion about implementing PCMH transformation) ☐Not familiar (Clinic is not currently recognized or accredited, and Clinic administration has not discussed implementing PCMH transformation)
Has your clinic identified a Physician/Provider Champion?	☐ Yes ☐ No
Does your clinic use an Electronic Health Record (EHR)?	☐ Yes ☐ No

DRAFT

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.

Payment Innovation and Network Partnerships

The Washington Post

Once again, U.S. has most expensive, least effective health care system in survey

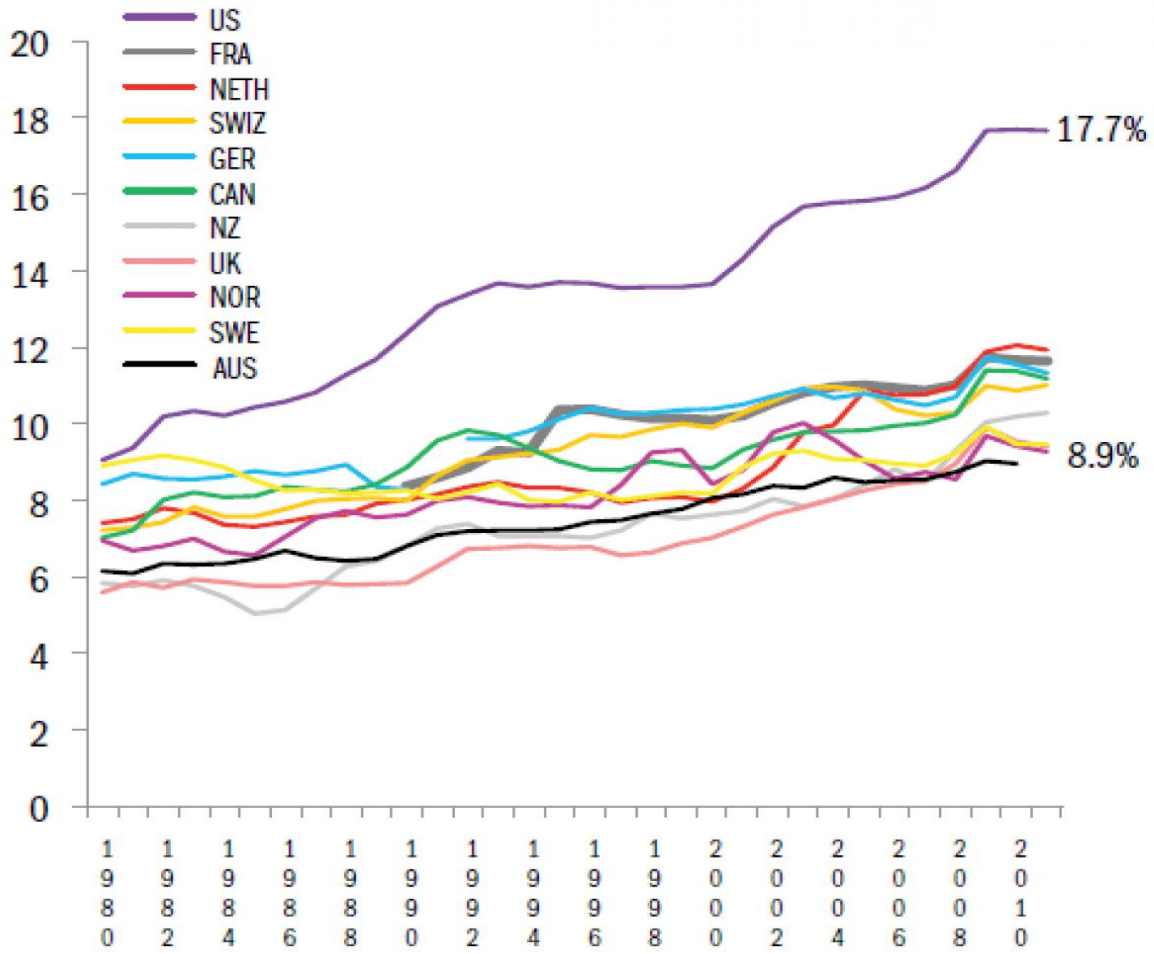
By Lenny Bernstein June 16, 2014

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

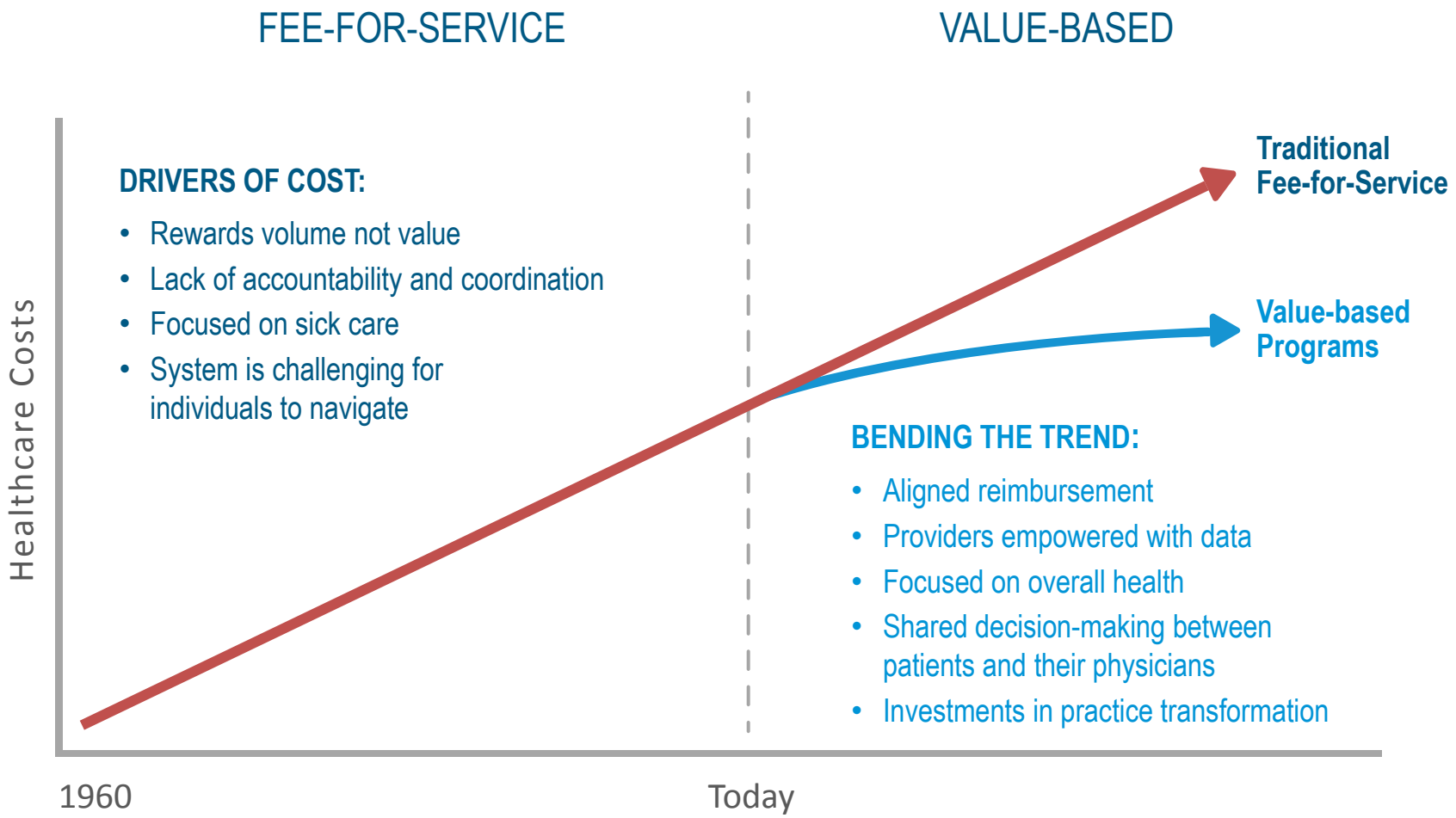
Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011;* World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

The Washington Post

Total expenditures on health as percent of GDP



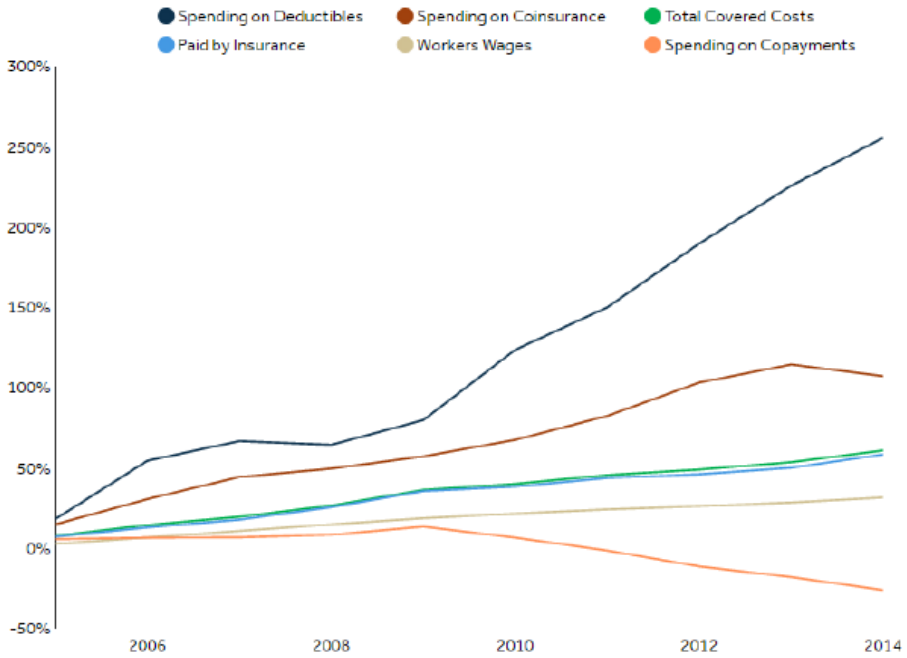
Value-Driven Care Bends the Cost Curve



Long-term trends consistently show an increase in member costs and a simultaneous reduction in benefits

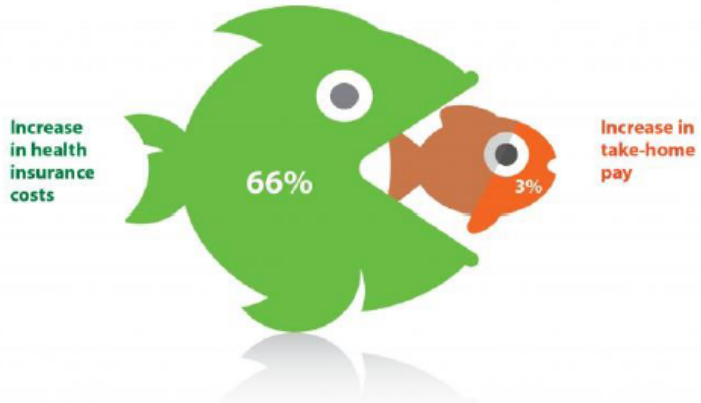
Average deductible spending rises while average copayment spending falls, 2004-2014

Cumulative increases in health costs, amounts paid by insurance, amounts paid for cost sharing and workers wages, 2004-2014



Source: Kaiser Family Foundation analysis of Truven Health Analytics MarketScan Commercial Claims and Encounters Database, 2004-2014; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2004-2014 (April to April).

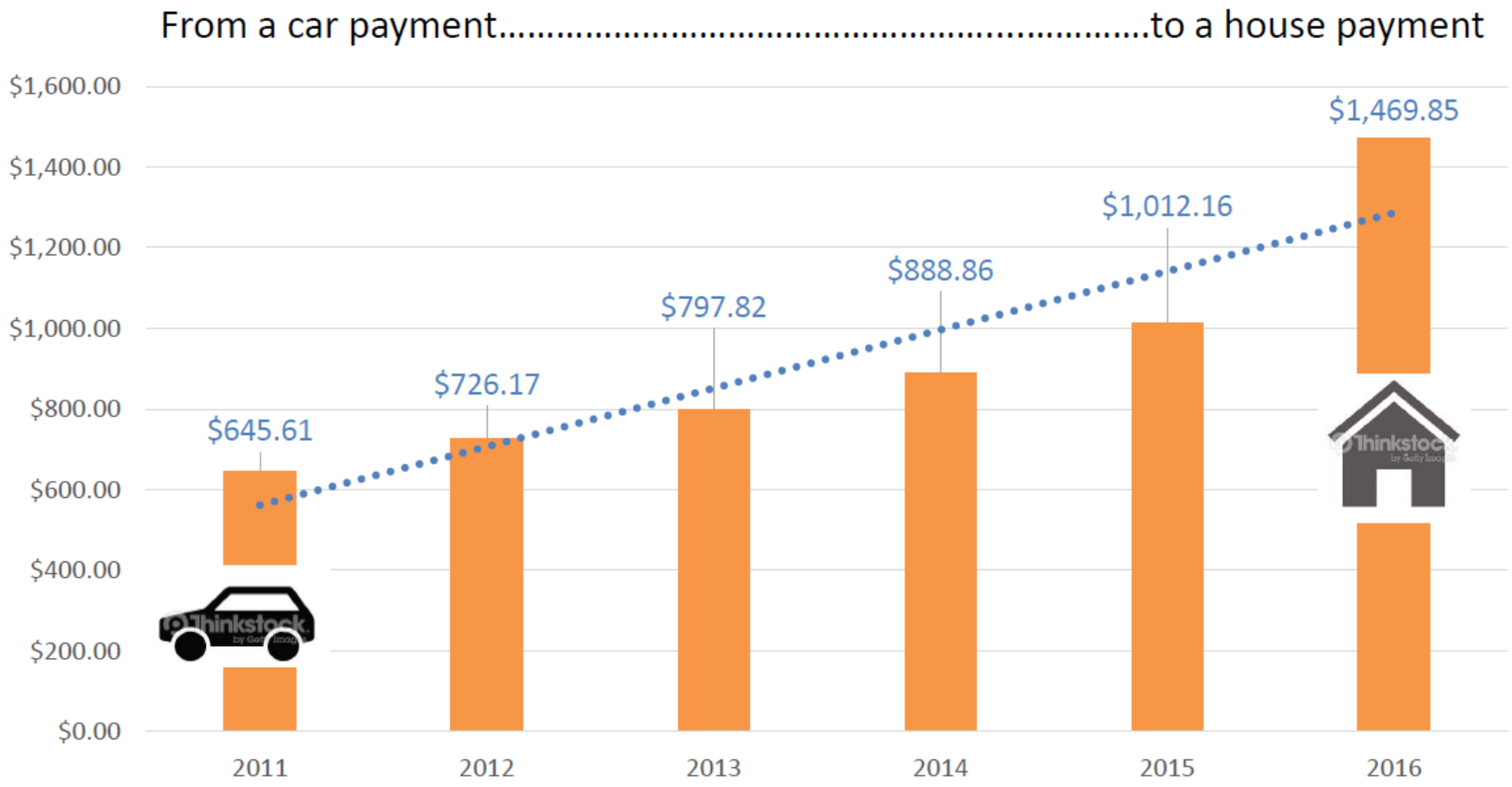
Rising Health Insurance Costs Reduce Take-home Pay



From **2000-2013,** overall health insurance costs for workers increased **66%**. This increase left less money for take-home pay — which increased only **3%**.

Source: Addressing Rising Health Care Costs: A Resource Guide for Consumer Advocates, ConsumersUnion

Monthly premium payments for a family of four have gone well beyond affordability for the average family.



Value-Based Approaches are a part of the expectations of purchasers and plan contracting

Value-Based Reimbursement in Evolution

Industry Trends

90%
of payers & 81% of providers use a mix of VBR & FFS*

2/3
Payments will include value measures by 2020*

CMS
Alternative payment will be 30% of Medicare reimbursement by 2016 & 50% by 2018†

45%
of providers are part of an ACO*

Customer Trends

20
Major health systems and payers pledged to convert 75% of their business to value-based arrangements by 2020
– *Becker's Hospital CFO*

2/3
of Blue Cross & Blue Shield of Massachusetts' commercial business is under alternative contracts
– *Modern Healthcare*

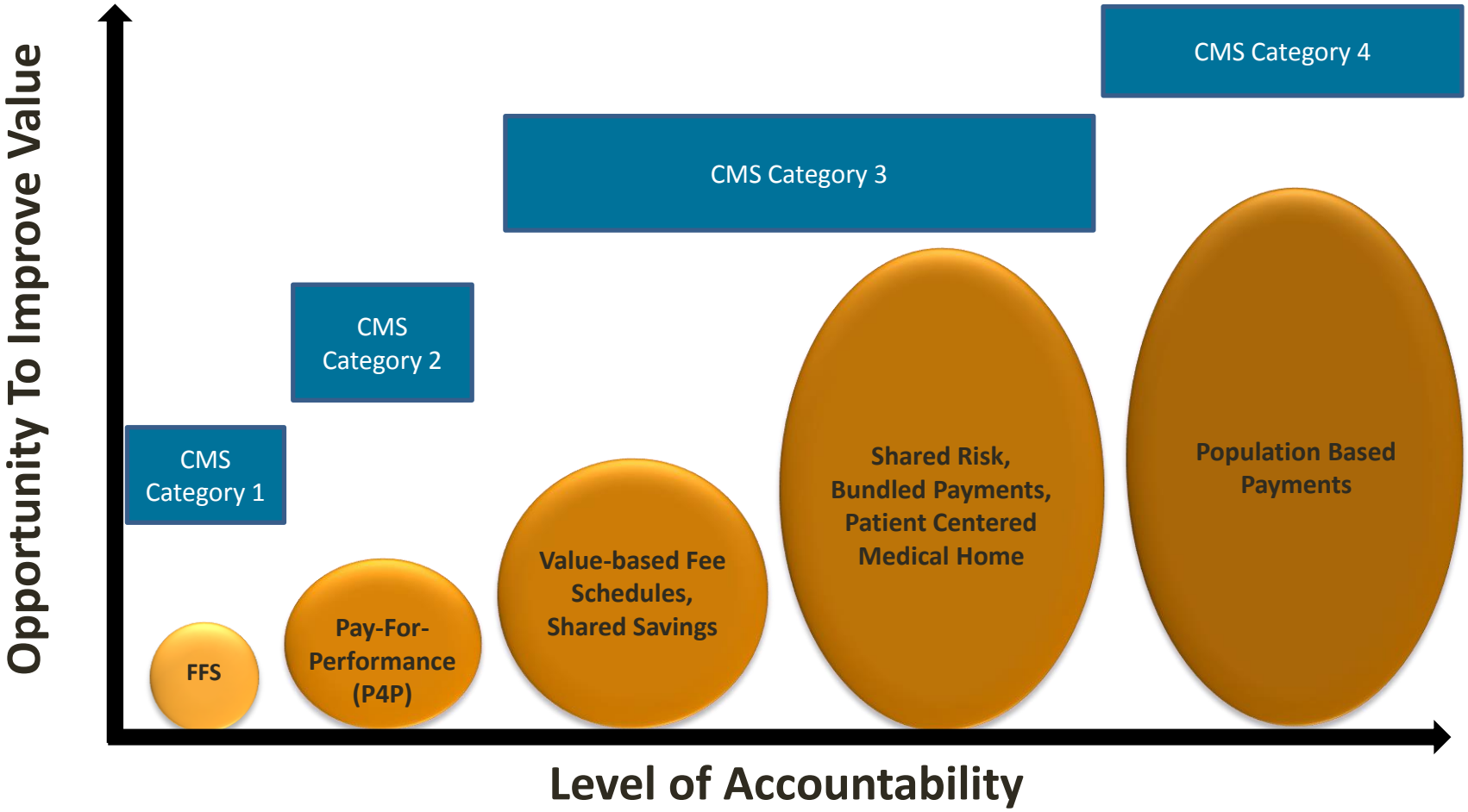
28%
of Aetna payments use value-based contracts with a target of 50% by 2018
– *Modern Healthcare*

*Source: McKesson sponsored survey of 350 Providers and 114 Payers; responses from Providers who are not fully reimbursed by FFS (281); February 2014
†Source: US Department of Health and Human Services; January 2015

CMS Approach: Better Care & Smarter Spending Value-Based Initiatives

Category 1: *Fee for Service – No Link to Quality or Efficiency*	**Category 2:** *Fee for Services –Link to Quality or Efficiency*	**Category 3:** *Alternative Payment Models Built on Fee-for-Service Architecture May be for population or episode*	**Category 4:** *Population-Based Payments not directly triggered by service delivery*
▪ Limited in Medicare fee-for-service ▪ Majority of Medicare payments now are linked to quality	▪ *Hospital value-based purchasing* ▪ *Physician Value-Based Modifier* ▪ *Readmissions/Hospital Acquired Condition Reduction Program*	▪ *ACO's* ▪ *Medical homes* ▪ *Bundled payments* ▪ *Comprehensive primary care initiative* ▪ *Comprehensive ESRD*	▪ *ACO's in years 3-5*

Payment Transformation Improves Cost Management



3 Different Business Models Crammed into 1 Payment Mechanism today

1) Finding the Problem

- Diagnostics and tests to pinpoint the health concern(s) of a patient
- Improved with focused specialty groups with deep knowledge of diseases and conditions

2) Population Health

- **General Population Health**
  - Wellness exams and services
  - Education for healthy lifestyle
  - Clinically integrated network for routine healthcare needs
- **Chronic/At Risk Population Health adds…**
  - Coordinated care teams organized around patients
  - Additional community and social service support

3) Outcomes based services

- Acute episodes with guaranteed outcomes

Source: The Innovator's Prescription, Harvard Press

Business case for each model

1) Finding the Problem

- I need to know what is wrong with my health
- I am willing to pay for individual tests and diagnostics to know my condition(s)
- *Funded through fee-for-service with Pay for Performance incentives*

2) Population Health

- Keep me healthy and out of the hospital
- Let me pay a set monthly amount that covers it all
- *Funded through payments for total cost and quality of care performance*

3) Outcomes based services

- I need a surgery/procedure with a guaranteed quality outcome
- One flat price for the entire episode – I won't pay twice if it's not right the first time
- *Funded through bundled payment with a warranty and with quality incentive*

Provider Payment Innovation Strategy

Create Economic Incentives for Cost & Quality Management

- Expand Payment Differentials Based On Performance (cost & quality)
- Move away from Simple Fee-For-Service Payments toward Value-based Reimbursement Structures
- Educate Providers With Cost & Quality Data

Payment Innovation Goals

- Maximize the proportion of provider revenue and earnings that are subject to outcomes-based payment through a mix of population based payments, episode based payments, and enhanced P4P fee-for-service.
- Create infrastructure to support provider partners to be successful in new payment arrangements
- Align payment systems with benefits, network design and consumer engagement.

PROJECT CHARTER

Community Health EMS Workgroup

Version Award Year 3.0 – May 2017

Workgroup Summary

Chair/Co-Chair	Wayne Denny, Mary Sheridan
Mercer Lead	Jenny Feliciano
SHIP/EMS Bureau Staff	Xenya Poole, Marta Tanikuni, and Bruce Cheeseman
IHC Charge	▪ Develop and implement Community Health Emergency Medical Services (CHEMS) programs in rural and underserved communities as part of the virtual patient-centered medical home (PCMH).
SHIP Goals	▪ Goal 3: Support the integration of each PCMH with the local Medical Neighborhood. ▪ **Goal 4: Improve rural patient access to PCMHs by developing virtual PCMHs.** ▪ Goal 6: Align payment mechanisms across payers to transform payment methodology from volume to value. ▪ Goal 7: Reduce overall healthcare costs.

Business Alignment

Business Need	▪ To expand primary care reach and capacity. ▪ To improve access to healthcare services in rural and underserved communities with limited healthcare resources. ▪ To ensure that CHEMS becomes an asset for the medical/health neighborhoods where gaps in services exist. ▪ To ensure that CHEMS becomes part of the primary care team and improve access to healthcare services.

Success Measures

	SHIP Desired Outcomes	Measurement	Workgroup's Role
1	• Engage EMS agencies to implement CHEMS.	• Total number of CHEMS ; Agencies. Model Test Target: 13 (9 ALS and 4 BLS/ILS agencies)	• Leverage contacts to facilitate identification and engagement of potential EMS agencies.
2	• Implement training program for community paramedics (CP).	• CUM # (%) of CHEMS program paramedics trained: 27	• Recruitment and outreach.
3	• Develop and implement training program for EMTs (ILS and BLS).	• CUM # (%) of CHEMS program EMTs trained for Virtual PCMH coordination. Model Test Target: 8	• Provide oversight of curriculum development and approval process. Recruitment and outreach.

	SHIP Desired Outcomes	Measurement	Workgroup's Role
4	• Establish CHEMS peer mentoring and/or technical assistance programs.	• CUM # (%) of ~~on-site~~ peer mentoring/technical assistance ~~visits~~ events. Model Test Target: 13	• Leverage contacts to facilitate development.
5	• Develop and implement metrics and reporting strategy.	• # of metrics identified*. Model Test Target: ~~not defined~~ 5 • ~~* 5 metrics identified as of September 2016.~~	• Facilitate stakeholder engagement to build consensus around metrics and reporting strategy, and evaluate aggregate data.
6	• Develop and implement ~~continuing education training for CHEMS agencies~~ learning collaborative.	• CUM # (%) of CHEMS staff participating in ~~training program~~ a learning collaborative • Model Test Target: 2 ~~conferences~~ in person learning collaborative events	• Assist in development and implementation of continuing training conference.
7	• Test CHEMS against the Triple Aim.	[TBD- see #6 above]	• Review outcomes and provide feedback.

Planned Scope

Deliverable 1	**Result, Product, or Service** • EMS agencies selected for each cohort.	**Description** • Selection of EMS agencies to receive SHIP support and funding to establish CHEMS programs.
Est. Timeframe	**Start**: 8/31/2015	**End**: 1/31/~~2016~~ 2018
Milestones	**Event** • Identify all EMS agencies. • Apportion by ALS and BLS/ILS agencies. • Apportion geographically. — Cohort 1 • Select potential agencies. • Conduct readiness assessment. • Make final selection. — Cohort 2 • Select potential agencies. • Conduct readiness assessment. • Make final selection. — Cohort 3 • Solicit potential agencies. • Conduct informal readiness assessment. • Make final selection.	**Target Date** • 10/01/2015 • 10/01/2015 • 10/01/2015 • 10/15/2015 • 11/15/2015 • 12/31/2015 • 10/15/2016 • 11/15/2016 • 12/31/2016 • 10/15/2017 • 11/15/2017 • 12/31/2017
Deliverable 2	**Result, Product, or Service** • Community paramedics trained.	**Description** • SHIP will support establishment of CHEMS programs by providing resources to selected agencies for program development and implementation.
Est. Timeframe	**Start**: 04/30/2015	**End**: 01/31/2019
Milestones	**Event** • Review best practices and resources. • Identify training options. • Select training. • Secure funding. • Negotiate contract(s). • Finalize contract(s). • Execute contract(s). • First cohort trained. • Second cohort trained. • Third cohort trained.	**Target Date** • 09/01/2015 • 09/15/2015 • 10/01/2015 • 12/01/2015 • 12/01/2015 • 01/15/2016 • 01/31/2016 • 01/31/2017 • 01/31/2018 • 01/31/2019

Deliverable 3	**Result, Product, or Service** • Community EMTs trained.	**Description** • SHIP will support establishment of CHEMS programs by providing resources to selected agencies to train EMTs and AEMTs.
Est. Timeframe	**Start**: 02/01/2016	**End**: 01/31/2019
Milestones	**Event** • Review best practices and resources. • Identify training options. • Develop training (if necessary). • Secure funding. • Negotiate contract(s). • Finalize contract(s). • Execute contract(s). • First cohort trained. • Second cohort trained.	**Target Date** • 04/01/2016 • 05/01/2016 • 08/01/2016 • 09/01/2016 • ~~09/01/2016~~ 06/30/2017 • ~~10/01/2016~~ 07/31/2017 • ~~11/01/2016~~ 08/31/2017 • 01/31/2018 • 01/31/2019
Deliverable 4	**Result, Product, or Service** • Establish peer mentoring, administrator trainings and/or technical assistance programs.	**Description** • Peer mentoring is an essential part of sustainability efforts regarding CHEMS programs.
Est. Timeframe	**Start**: 01/31/2016	**End**: 01/31/2019
Milestones	**Event** • Review best practices and resources. • Develop peer mentoring program support. • Develop coaching manual. • Identify potential mentors. • Secure funding. • Negotiate contracts with mentors. • Finalize contracts with mentors. • Execute contracts with mentors. • Select recipient agencies. • Implement peer mentoring program Year two. • Implement peer mentoring program Year three. • Implement peer mentoring program Year four.	**Target Date** • 03/31/2016 • • 04/30/2016 • 05/31/2016 • 05/31/2016 • 06/30/2016 • 05/31/2016 • 06/30/2016 • 07/15/2016 • 06/30/2016 • ~~08/01/2016~~ 01/31/2017 • ~~06/01/2017~~ 01/31/2018 • ~~06/01/2018~~ 01/31/2019

Deliverable 5~~6~~	**Result, Product, or Service** • Identify metrics and reporting process.	**Description** Data collection and reporting for identified metrics supports evaluation and test against the Triple Aim.
Est. Timeframe	**Start**: 09/01/2015	**End**: 1/31/2019
Milestones	**Event** • Secure funding. • Establish subcommittee membership. • Facilitate metrics subcommittee. • Identify required metrics. • Verify metrics with SHIP. • Establish reporting protocols. • Evaluate Year two metrics and reporting protocols. • Evaluate Year three metrics and reporting protocols. • Evaluate Year four metrics and reporting protocols.	**Target Date** • 10/01/2015 • 10/15/2015 • 01/31/2016 • 03/31/2016 • 04/30/2016 • 10/31/2016 • 01/31/2017 • 01/31/2018 • 01/31/2019
Deliverable 6~~7~~	**Result, Product, or Service** • Develop learning collaborative series.	**Description** • Webinar and in person learning/system development/medical health neighborhood – NO CE
Est. Timeframe	**Start**: 06/01/2017	**End**: 01/31/2019
Milestones	**Event** • Secure funding. • Conduct full-day in-person learning session. • Secure presenters. • Evaluate outcomes. • Conduct second full-day in-person learning session. • Secure presenters. • Evaluate outcomes.	**Target Date** • 10/01/2016 • 01/31/2018 • ~~09/30/2017~~ 10/31/2017 • 01/31/2018 • 01/31/2019 • ~~09/30/2018~~ 10/31/2018 • 02/28/2019
Deliverable 7~~8~~	**Result, Product, or Service** • Test CHEMS programs against the Triple Aim.	**Description** • [TBD]
Est. Timeframe	**Start**: 09/01/2015	**End**: 1/31/2019
Milestones	**Event** • [TBD]	**Target Date** • [TBD]

Formatted: Strikethrough
Formatted: Strikethrough
Formatted: Strikethrough
Formatted: Strikethrough

Project Risks, Assumptions, and Dependencies

Risk Identification	Event	H – M – L	Potential Mitigation	Potential Contingency
	• Students not finishing training or leaving the agency.	M	Address in the contract/MOUs with EMS agencies.	None
	• Lack of reimbursement.	H	Promote CHEMS reimbursement with the Multi-payer workgroup.	None
	• CMMI funding restriction for program development and implementation.	M	None.	Establish contracts with EMS agencies in lieu of the contracts with training providers.
Assumptions	• [TBD]			
Dependencies and Constraints	• Timeline for EMTs training dependent on training availability.			

Project Reporting and Scope Changes

Changes to scope must be approved by the IHC after review by SHIP team.

Version Information

Version AY 2.0	**Author**	Miro Barac	**Date**	08/22/2016
	Reviewer	CHEMS Planning Team	**Date**	08/22/2016
Version AY 3.0	**Author**	Wayne Denny and Mary Sheridan	**Date**	05/15/2017
	Reviewer	CHEMS Planning Team	**Date**	05/22/2017
Version AY 4.0	**Author**		**Date**	
	Reviewer		**Date**	

Charter Approval Signatures

Date Approved by the Workgroup: 05/22/2017

Final Acceptance

Version	Name / Signature	Title	Date	Approved via Email
Version AY 2.0	Wayne Denny	Chair	08/31/2016	☒
	Mary Sheridan	Co-Chair	09/06/2016	☒
	Cynthia York	SHIP Administrator	09/06/2016	☒
	Katie Falls	Mercer Lead	09/10/2016	☒

Version	Name / Signature	Title	Date	Approved via Email
Version AY 3.0	Wayne Denny	Chair	05/22/2017	☒
	Mary Sheridan	Co-Chair	05/22/2017	☒
	Cynthia York	SHIP Administrator	06/01/2017	☒
	Katie Falls	Mercer Lead	06/02/2017	☒

Idaho Healthcare Coalition

June 2, 2017

Julie Lineberger, Interim Executive Director

Organizations with Bidirectional Connections by end of May

Cohort 1

- 28 of 53 Clinics connected
- 12 of 28 Organizations connected
- 37 of 70 Interfaces complete

Complete

- Adams County Health Center (1 Clinic)
- Family Health Center (1 Clinic)
- Family Health Services (2 Clinics)
- Family Medicine Health Center (FMRI) (3 Clinics)
- Heritage Health (3 Clinics)
- Kaniksu Health Services (2 Clinics)
- Primary Health Medical Group (5 Clinics)
- St. Luke's (3 Clinics)
- Saint Alphonsus (4 Clinics)
- Valley Medical Center (1 Clinic)
- Valley Family Health Care (1 Clinic)

Cohort 2

- 20 of 56 Clinics connected
- 9 of 29 Organizations connected
- 60+ Additional Health Connection Clinics connected

Complete

- Coeur d'Alene Pediatrics (3 Clinics)
- Family Medicine Health Center (FMRI) (3 Clinics)
- Family Health Services (1 Clinic + 5 Healthy Connection Clinics)
- Heritage Health (1 Clinic)
- Kaniksu Health Services (2 Clinics)
- Primary Health Medical Group (4 Clinics + 8 Healthy Connection)
- St. Luke's (2 Clinics + 47 Healthy Connection Clinics)
- St. Al's (5 Clinics + remaining Healthy Connection Clinics)
- Valley Family Health Care (2 Clinics + remaining Healthy Connection Clinics)

Clinic Connection Status

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

Accomplishments - May 2017:

- Cohort 1 Clinics:
  - Madison Memorial – RA Submitted 5/16/17
  - SAMG: IB CCDA– Live effective 4/26/17 (Finalized 5/2/17)
  - Tueller: IB CCDA – Live Effective 5/10/17
- Cohort 2 Clinics:
  - Cascade Medical Center – RA Submitted 5/17/17
  - CDA PEDS: Clinic Site Add – Live effective 4/28/17 (Finalized 5/1/17)
  - PHMG – Resubmission of CSA 5/11/17
  - Seasons Medical – RA Submitted 5/16/17
  - SLHS: Clinic Site Add Submitted 5/11/17
  - The Pediatric Center – RA Submitted 5/24/17
  - Treasure Valley Family Medicine – RA Approved 5/9/17
  - VFHC – Clinic Site Add Submitted 5/1/17
- PA/BAA Status:
  - PA's Received: 8
    - All Seasons, Cascade Medical, CDA PEDS, Genesis, Seasons Medical, Southfork HC, The Pediatric Center, TVFM
  - PA/BAA Outstanding: 5
    - Bear Lake Community HC, Children & Family Clinic, Physicians Immediate Center, Sonshine Family HC, Syringa Primary Care.

Delays and Risks:

- Clinic(s) at RISK:
  - CHAS (Athena): Request from clinic to HOLD IB to IHDE until "sensitive" data issue is resolved with Athena.
  - SLHS – Participant is questioning the Medicaid clinics in addition to the SHIP clinics (Cohort 1 & 2) – IHDE was advised by Medicaid to continue with the SHIP clinics and they will get back once they have had a chance to review with management to determine course of action regarding Medicaid clinics (49)
  - Saltzer Medical: Clinic identified a concern with the eCW monthly maintenance fee and are in discussions as to whether they will move forward or not with project.
- Clinics On Hold:
  - Driggs & Victor (No PA Agreement/Possible EMR Change)
  - Glenns Ferry – (BH Filtering Issue)
  - Health West, Inc. (EMR Vendor change)
  - Not-tsoo Gah-nee (Pending IHDE Exec. direction)
- Clinics Pending Withdrawn Confirmation:
  - Portneuf
  - Crosspointe

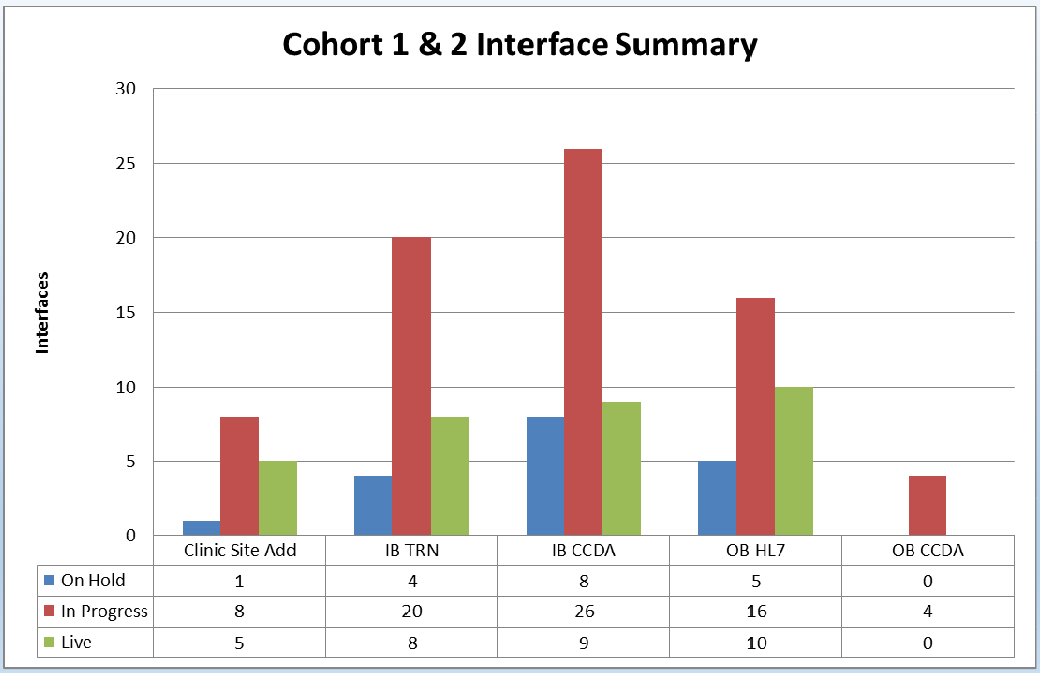
Projected Connections – May/June

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

Interface	Organization	Cohort	Go-Live ETA	Actual Go-Live
Clinic Site Add	Coeur d'Alene Pediatrics	2	5/15/2017	4/28/2017
	SLHS	2	5/22/2017	
	Valley Family Health Care	2	5/23/2017	5/9/2017
IB CCDA	Benewah Medical & Wellness Center	1	5/31/2017	
	Tueller Counselling	1	5/10/2017	5/10/2017
	Valley Medical Center	1	6/22/2017	
IB TRN	Benewah Medical & Wellness Center	1	6/1/2017	
OB LAB/RAD/TRN	Coeur d'Alene Pediatrics (LAB/RAD only)	2	6/30/2017	
	Benewah Medical & Wellness Center	1	6/8/2017	
	Valley Family Health Care	1	6/19/2017	

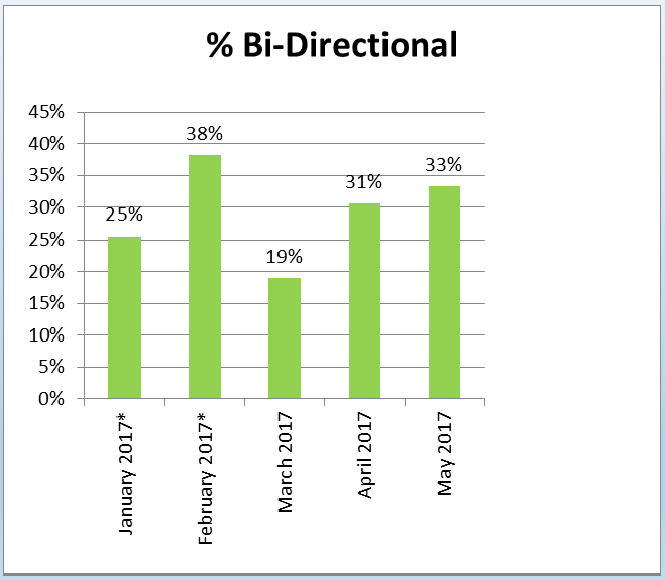
CH 1 & 2 Orgs.

Interface Summary



	Clinic Site Add	IB TRN	IB CCDA	OB HL7	OB CCDA
On Hold	1	4	8	5	0
In Progress	8	20	26	16	4
Live	5	8	9	10	0

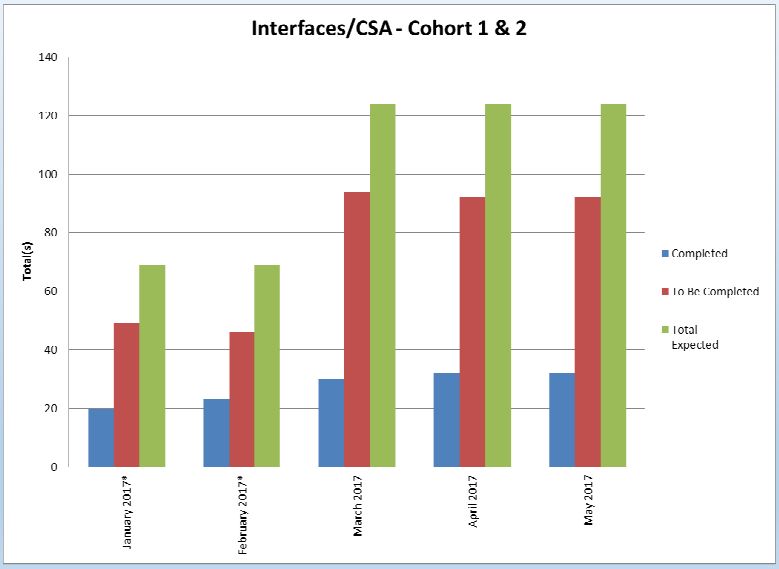
Bi-Directional Status – By Clinic

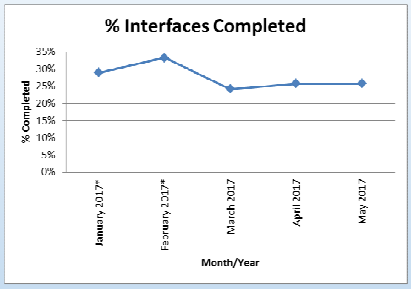


Month	Total Clinics	Total Clinics Bi-Directional	% Bi-Directional
January 2017*	55	14	25%
February 2017*	55	21	38%
March 2017	111	21	19%
April 2017	111	34	31%
May 2017	111	37	33%

* Cohort 1 clinics only.

Interfaces/CSA – Cohort 1 & 2 Status



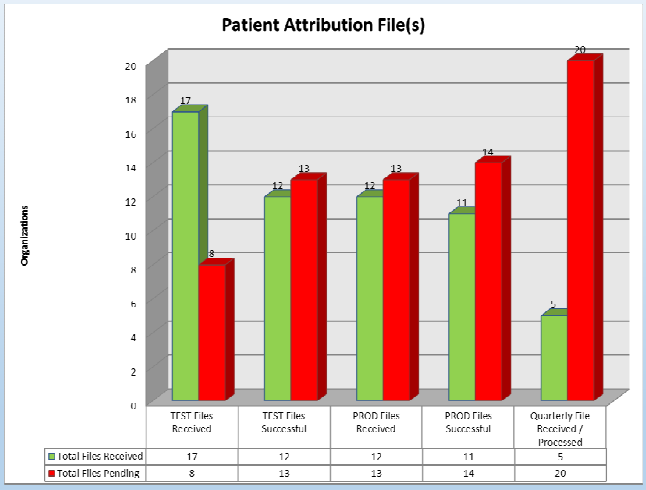


Interface/CSA Status Cohort 1 & 2	Completed	To Be Completed	Total Expected	% Completed
January 2017*	20	49	69	29%
February 2017*	23	46	69	33%
March 2017	30	94	124	24%
April 2017	32	92	124	26%
May 2017	32	92	124	26%

* Cohort 1 only

Patient Attribution File(s)

Clinic	# or Patient Records	TEST Files Received	TEST Files Successful	PROD Files Received	PROD Files Successful	Quarterly File Received / Processed
Adams County	628	Yes	Yes	Yes	Yes	Yes
BMWC						
CHAS - Latah		Yes				
Coeur d'Alene Peds	3,377	Yes	Yes	Yes	Yes	
Complete Family Care						
Crosspointe (Excluded from status - Participant closed)						
Family First Medical Center						
Family Health Center - Sandpoint	6,604	Yes	Yes	Yes	Yes	Yes
Family Health Services	11,317	Yes	Yes	Yes	Yes	
Family Medicine Health Center (FMRI)	19,311	Yes	Yes	Yes	Yes	
HealthWest						
Heritage Health	15,370	Yes	Yes	Yes	Yes	Yes
Kaniksu Health Services		Yes				
Pocatello Childrens Clinic						
Primary Health Medical Group	34,806	Yes	Yes	Yes	Yes	
Rocky Mountain Diabetes and Osteoporosis Center, PA	12,679	Yes	Yes	Yes		
SAMG	58,846	Yes	Yes	Yes	Yes	Yes
Shoshone Family Medical Center						
SLHS						
SMH_CVH Hospital Clinics		Yes				
Sonshine Family Health Clinic, LLC		Yes				
Terry Reilly	40,757	Yes	Yes	Yes	Yes	Yes
Tueller Counseling Services (Unified HealthCare)	428	Yes	Yes	Yes	Yes	
Upper Valley Community Health Svcs (Grand Peaks)		Yes				
Valley Family HealthCare, Inc	1,592	Yes	Yes	Yes	Yes	
Valley Medical Center						
Total Files(s) Received:		17	12	12	11	5
Total Files(s) Pending:		8	13	13	14	20
% of Files Received:		68%	48%	48%	44%	20%



Note: Files unable to be processed IF inbound interface associated with facilityID is not in the stage environment. As a result, IHDE will be requesting PA files from participants ONLY when inbound interfaces enter stage environment and requesting PROD files ONLY when IB interface is live to ensure that the facilityID is present.

SHIP Operations and IHC Workgroup
Report to the Idaho Healthcare Coalition
June 07, 2017

SHIP OPERATIONS:

SHIP Contracting/Request for Proposal (RFP) Status:

- **Report Items:**
  - CMMI requests for release of funds were approved for: 1) CHEMS Agency Request for Canyon County Ambulance District; 2) CHEMS Agency Request for Boundary Ambulance Service; 3) the Langdon Group for RC Summit meeting facilitation; 4) in-state travel for the Hospital Collaborative meeting in Pocatello, ID.
  - CMMI requests for release of carryover funds were submitted for: 1) IHDE; 2) HealthTech Solutions; 3) University of Idaho; and 4) OHPI Supplies.
  - CMMI requests for release of Award Year Three funds were submitted for: 1) RC Grant 3 funding restriction; 2) IHDE travel for Data Quality Specialist; 3) University of Idaho State Evaluator funding restrictions.
  - Quarterly Report for Award Year Three first quarter (2.1.2017-4.30.2017) was submitted to CMMI on May 26, 2017
  - Telehealth Technical Assistance Contract RFP has closed and contracting arrangements are underway.

SHIP Administrative Reporting:

- **Report Items:**
  - Three Telehealth grant application submissions were scored and recommendations for funding were made by the Grant Review Committee.
  - All 56 Cohort Two clinics have submitted their budget templates for PCMH technical assistance payments and all have been approved for processing and payment.
  - Four of the Virtual PCMH designees have submitted budget templates which are being reviewed.

Regional Collaboratives (RC):

- **Report Items:**
  - District 1:
    - Regional QI improvement training held in lieu of meeting.
  - District 2: No Regional Collaborative meeting held in the month of April
  - District 3:
    - SWHC (4/4): Met and discussed current workgroup projects, sustainability, and upcoming topics.
    - Senior Workgroup (4/10): met to plan project to develop community resource guide for EMS agency and develop system for PCP notification on calls to homes.
    - PCMH Workgroup (4/21): discussed social determinants of health screening.
    - BHI Workgroup (4/24): met to debrief Let's Talk event, plan school partnership for BH services, and discuss future clinic support.
  - District 4:

        - CHC Meeting 4/4/17.
        - Executive Leadership Meeting 4/19/17.
    - District 5:
        - The April 2017 meeting took place on the 21st. Meetings generally consist of updates regarding the SHIP project, status of cohort clinics' transformation efforts, and a presenter from the MHN or a direct PCMH resource that provides brief training or informational material for Cohort One and Two clinics.
    - District 6: No RC meetings scheduled for April. Next Executive Committee Meeting scheduled for May 1, 2017
    - District 7:
        - RC Executive meeting - April 5th.
        - RC meeting April 13th.
- **Next Steps:**
    - District 1:
        - Work on implementation of the Regional Collaborative's CHEMS grant project.
        - Roll out the Regional Collaborative Diabetes QI Project.
        - Continue to develop the Medical Health Neighborhood through development of communication standards among partners.
    - District 2: No Regional Collaborative meeting held in the month of April.
    - District 3:
        - The SWHC will begin to develop a formalized sustainability plan with additional information from the RC Summit.
        - The care coordination directory will be launched in June to support better communication in the medical health neighborhood.
        - In addition, the workgroups will continue to support enhanced coordination among Medical Health Neighborhood partners in vision care, dental care, and behavioral health.
        - PHD staff will include the RC in the application for Kresge funds as a part of the SWDH population health strategy.
        - Finally, the next RC meeting will include an update from the clinics to enhance PCMH support.
    - District 4:
        - Next meeting is scheduled for June 6, 2017.
    - District 5:
        - The next SCHC meeting is scheduled for May 19. Dr. Bart Ripepi with St. Luke's Magic Valley is the next presenter. He is the physician champion for their Cohort Two clinics and has been asked to discuss his previous PCMH experience prior to joining St. Luke's and current quality improvement projects. This approach aligns with the SCHC Strategic Goal A, Objective 5 and Goal B, and Objectives 2, 4 & 6 of the SCHC Strategic Plan.
    - District 6:
        - Continue Project ChildSafe promotion among law enforcement agencies.
        - Continue promotion of Regional Suicide Prevention Symposium.
        - Begin planning for June Medical Health Neighborhood meeting, focus is diabetes care.

ADVISORY GROUP REPORTS:

Telehealth SHIP Subcommittee:

- **Report Items:**
  - The telehealth review committee met on May 18 to review the telehealth applications submitted by cohort clinics; award information was sent to applicants on May 23, 2017. CHAS Latah Community Health Clinic, Terry Reilly Health Services, and Sandpoint Family Medical Center will receive SHIP funding to establish telehealth programs. IDHW is working with the clinics to establish new subgrants to begin project implementation.
  - The Request for Proposal (RFP) to provide telehealth technical assistance to SHIP cohort clinics and CHEMS agencies funded through the Telehealth grant application closed May 22, 2017. Health Management Associates is the selected vendor. The contract has not been established, although plans are underway to establish a signed contract in July 2017.
- **Next Steps:**
  - Initiate planning and outreach strategies to release new telehealth grant applications for Cohort Two clinics.
  - IDHW will draft telehealth subgrants for three Cohort One clinics by June 19, 2017.
  - IDHW will establish a contract for telehealth technical assistance with Health Management Associates in July 2017.

Community Health Workers:

- **Report Items:**
  - Idaho State University (ISU) Spring 2017 CHW training graduated 20 students.
  - The CHW Advisory Workgroup is working with ISU to develop four and host up to eight asynchronous educational modules.
  - ISU is developing an in-class CHW course to be taught this summer.
  - SHIP staff has been collaborating with the IDHW Diabetes, Heart Disease, and Stroke Program in developing a marketing strategy and materials to promote the adoption of CHWs in Idaho. Two short videos have been produced and a CHW public webpage is currently in design with an IDHW contractor.
- **Next Steps:**
  - ISU and CHW Advisory Workgroup to continue to work to find a suitable template and information for optional educational modules.
  - IDHW staff will begin outreach for the fall 2017 training cohort.

WORKGROUP REPORTS:

Community Health EMS:

- **Report Items:**
  - The statewide CHEMS Workgroup met May 24, 2017 from 10:00-11:00 AM MST.

- The next statewide CHEMS Workgroup meeting will be held June 28, 2017 from 10:00 to 11:00 AM MST
- BLS/ILS curriculum development:
  - AEMT from Ada County to instruct the course.
  - Identifying the cost for development and cost per student.
  - Wayne, Bruce, Xenya, and Marta will continue to work with CWI to advance curriculum development.
  - Updates will be given as they become available
- Numerous agencies have expressed interest in the BLS/ILS education.
  - Interested agencies to date: Emergency Response Ambulance, Albion QRU, Clearwater County Ambulance, Fort Hall Fire and EMS, Carey Fire, Horseshoe Bend, Power County EMS, Prairie QRU, Meadows Valley EMS, Shoshone County EMS, and Pine EMS.
- A total of 46 students have expressed interest. The second ISU CP Certificate Program cohort is currently in their 2nd semester and working on the following: pathophysiology, community assessments, and clinical contracts.
- CMMI funding has been approved for Bonner, Boundary, and Canyon counties.
  - Funding is available for seven additional agencies.
- The webinar for the Patient Experience Survey and the Patient Care and Data Tracking Workbook can be found on the SHIP/CHEMS website and the Bureau of EMS and Preparedness's website.
  - Agencies from the 1st and 2nd ISU CP Certificate Program cohort have received the link to administer the Patient Experience Survey.
- Final revisions to the Project Charter were presented and approved by the workgroup and will be submitted to the IHC for final approval.

- **Next Steps:**
  - Final revisions to the SHIP/CHEMS Project Charter will be presented for approval at the next IHC meeting.
  - Wayne, Bruce, Xenya, and Marta will continue to meet with CWI until the BLS/ILS curriculum has been developed.
  - Continue to recruit agencies for the 3rd and final ISU CP cohort.
  - Discussions on developing a learning collaborative for CHEMS and EMS personnel will continue.
  - The internal CHEMS Workgroup continues to meet every Monday.
  - The statewide CHEMS Workgroup continues to meet monthly.

IMHC **Idaho Medical Home Collaborative:**

- **Report Item:**
  - The group met May 31, 0217, to:
    - Review the PCMH mentorship framework
    - Review the 2017 SHIP Interest Survey.

- **Next Steps:**
  - The group will meet July 12, 2017 from 12:00 – 1:00 PM MT via teleconference.

Data Governance:

- **Report Item:**
  - The SHIP Data Governance Workgroup (DGW) held its kick-off meeting on May 23, 2017.
    - The members agreed to the membership structure as it was outlined and agreed to the draft workgroup charter as it was presented.
    - The Idaho Health Data Exchange (IHDE) presented to the workgroup both a project overview as well as a project update. So far, IHDE has established bidirectional connections with 37 of 111 clinic sites (representing both Cohort One and Cohort Two clinics). In addition, several more connections are currently in progress.
    - HealthTech presented and provided a project overview and update. They are responsible for providing the statewide data analytics system reporting on clinical quality measures (CQMs). HealthTech's tool provides data analytics for the first four CQMs with the clinics that are currently connected to IHDE. They also recently released the next CQM: Appropriate Medications for Asthma. In the next few months HealthTech will begin work to produce analytics on the Preventative Care and Screening for Clinical Depression CQM.
    - The data quality improvement process was also presented by Ruby Cash, the IHDE data quality specialist. She outlined the process that SHIP will leverage, which includes her working with each clinic, one-on-one, to determine data gaps, brainstorm solutions, work together to close the gaps, and test to verify the solutions work.
- **Next Steps:**
  - The next SHIP Data Analytics Workgroup meeting is scheduled for June 12, 2017.
    - During this meeting the workgroup will determine an issue resolution process for working through data governance issues that arise as the SHIP initiatives progresses.

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 has received the data requested and is in the process of compiling it. A draft final report will be submitted to the SHIP Administrator by the second week in June.
  - A representative from each commercial payer, Medicare, and Medicaid was asked to provide updates to the IHC about the methodologies they are using to incentivize quality outcomes. At the May 10th IHC meeting, Melissa Christian, Vice President of Provider Services for Idaho Regence Blue Shield, provided a synopsis of their value-based program. Her Power Point presentation is available on the SHIP website (www.ship.idaho.gov, governance section).

- **Next Steps:**
  - Mercer anticipates presenting the financial report to the IHC at the July 12th meeting.
  - Blue Cross of Idaho will present information on their value-based reimbursement strategies at the June 7th IHC meeting.

Behavioral Health:

- **Report Item:**
  - The BHI Sub-Committee did not meet in May; the next meeting will be on June 13th.
  - The focus of the meeting will be to generate discussion around the next steps for the BHI Sub-Committee and to begin developing focus areas and action items for the next 24 months of the SHIP grant.
  - Dr. Ben Miller with the Farley Policy Center held a discussion with the committee about behavioral health integration in the State of Idaho, barriers, goals, and potential areas for technical assistance.

- **Next Steps:**
  - The BHI Sub-Committee will review the current charter and incorporate updates over the next 2-4 months.
  - BHI Sub-Committee will review current membership and make recommendations for additional members before June 13, 2017.
  - A BHI survey will be initiated for the PCMH Cohort One using the Integrated Practice Assessment Tool and interview questions. The survey will be conducted beginning in May and ending in August. Results of the survey will be shared in September.
  - Dr. Ben Miller met with DA's from DBH, Medicaid, and SHIP to explore the possibility of Idaho working with the Farley Policy Center to further behavioral health integration efforts. No decisions were made but conversations will continue in May.
  - The next BHI Sub-Committee meeting will be held on June 13, 2017 from 9:00 to 11:00am.

Population Health:

- **Report Item:**
  - The Population Health Workgroup did not meet in June.
- **Next Steps:**
  - The next Population Health Workgroup meeting will be held August 2nd 2017 from 3:00-4:30pm MST.