



# Idaho Healthcare Coalition

## Meeting Agenda

**Wednesday, November 8, 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/80093017/827ccb0eea8a706c4c34a16891f84e7b>

**Attendee Smartphone URL:**

<pulsesecure://?method=meeting&action=join&host=rap.dhw.idaho.gov&meetingid=80093017&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 8/9/2017 meeting notes – <i>Ted Epperly, IHC Chair</i> <span style="float: right;"><b>ACTION ITEM(s)</b></span>
1:40 p.m.	LAN Summit Update – <i>Cynthia York, OHPI Administrator</i>
1:45 p.m.	Mercer Project Management Update – <i>Jenny Feliciano, Mercer &amp; Casey Moyer, SHIP Operations</i>
2:10 p.m.	IHC Sustainability Update – <i>Dr. Epperly, IHC Chair</i>
2:25 p.m.	Data Governance Update – <i>Janica Harden, Co-Chair DGW</i> <span style="float: right;"><b>ACTION ITEM</b></span>
2:35 p.m.	Cohort Two and Cohort Three Update – <i>Kym Schreiber, SHIP Operation &amp; Grace Chandler, Briljent</i>
2:50 p.m.	Break
3:00 p.m.	Behavioral Health Integration Farley Health Policy Center – <i>Dr. Shale Wong and team, Farley Center</i>
3:50 p.m.	IHDE Update – <i>Brad Erickson, IHDE Executive Director</i>
4:00 p.m.	CHW Update – <i>Madeline Russell, Public Health</i>
4:05p.m.	SHIP Operations and Advisory Group reports/ Updates – Please see written report (SHIP Operations and IHC Workgroup reports): <ul style="list-style-type: none"> <li>• Presentations, Staffing, Contracts, and RFPs status – Cynthia York, IDHW</li> <li>• Regional Collaboratives Update – Madeline Russell, IDHW</li> <li>• Telehealth, Community EMS, Community Health Workers – Madeline Russell, IDHW</li> <li>• Data Governance Workgroup – Dr. Andrew Baron, Terry Reilly and Janica Hardin, Saint Alphonsus, Workgroup Chairs</li> <li>• Multi-Payer Workgroup – Dr. David Peterman, Primary Health and Norm Varin, PacificSource, Workgroup Chairs</li> <li>• Behavioral Health/Primary Care Integration Workgroup – Ross Edmunds, IDHW and Dr. Charles Novak, MD, Workgroup Co-Chairs</li> <li>• Population Health Workgroup –Elke Shaw-Tulloch, IDHW and Carol Moehrle, Public Health Idaho North Central District, Workgroup Chairs</li> <li>• IMHC Workgroup – Dr. Scott Dunn, Family Health Center and Matt Wimmer, IDHW Workgroup Chairs</li> </ul>
4:15 p.m.	Additional business & next steps – <i>Ted Epperly, IHC Co-Chair</i>
4:30 p.m.	Adjourn

## Mission and Vision

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

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

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

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

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

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

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

**Goal 7:** Reduce overall healthcare costs



# Idaho Healthcare Coalition

## Meeting Minutes:

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<b>SUBJECT:</b>	IHC September Minutes	<b>DATE:</b>	September 13, 2017
<b>ATTENDEES:</b>	Russ Barron, Pam Catt-Oliason, Ross Edmunds, Lisa Hettinger, Dieuwke Dizney-Spencer on behalf of Elke Shaw-Tulloch, Cynthia York.	<b>LOCATION:</b>	700 W State Street, 1 <sup>st</sup> Floor East Conference Room
<b>Teleconference:</b>	Michelle Anderson, Janica Hardin,		
<b>Members Absent:</b>	Dr. Andrew Baron, Dr. Richard Bell, Josh Bishop, Kathy Brashear, Melissa Christian, Dr. Keith Davis, Russell Duke, Dr. Scott Dunn, Dr. Ted Epperly, Dr. Mark Horrocks, Dr. Glenn Jefferson, Yvonne Ketchum, Deena LaJoie,		
<b>IDHW Staff</b>	Casey Moyer, Ann Watkins, Burke Jensen, Kym Schrieber, Taylor Kaserman.		
<b>Guests:</b>	Scott Banken, Katie Falls		
<b>STATUS:</b>	Draft 11/7/17		

## Summary of Motions/Decisions:

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<b>Motion:</b>	<b>Outcome:</b>
The meeting lacked a quorum to approve action items.	

## Agenda Topics:

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### Opening remarks, Introductions, Agenda review, Approve minutes – *Lisa Hettinger, IHC Co-chair*

- ◆ Lisa Hettinger welcomed everyone to the meeting and took role. Following role call Ms. Hettinger introduced Norm Varin, Director of Government Relations at PacificSource, who has replaced Josh Bishop who left his position at Pacific Source earlier this month. Norm has also been selected to replace Josh as co-chair on the Multi-Payer Workgroup and will be recommended to the governor to replace him on the Idaho Healthcare Coalition. Edits to the August meeting minutes were noted.

- ◆ Cynthia York introduced SHIP's four new graduate research assistants from Boise State University.

**CMMI Site Visit Debrief** – *Cynthia York, SHIP Administrator*

- ◆ Cynthia York reviewed the August visit from CMMI partners. Dr. Stephen Cha and Chris Crider, and Patricia MacTaggart (from ONC). They conducted a site visit as a part of Idaho's participation in the SIM model design grant. During this visit they were not only able to attend the August IHC meeting but also got to visit two different SHIP cohort clinics, the Shoshone Family Medical Center in district five, and Primary Health Medical Group Pediatrics Clinic in district four.
- ◆ Dr. Cha and Chris Crider considered both clinic visits to be insightful as they were able to see the differences in operation between a rural and urban cohort clinic. Overall the visit was a huge success. Ms. York especially wanted to thank all those who participated and engaged with our CMMI partners while they were in town.

**SHIP Idaho Financial Report** – *Scott Banken, Senior Associate, Mercer*

- ◆ Scott Banken presented the Idaho financial report that was put together by Mercer for goal 6 of SHIP. There is a large amount of data provided to Mercer by Idaho payers that contribute to this report. The overall trend of 2.9 percent isn't great but it is better than the national average and shows that the efforts being made in Idaho are working.
- ◆ The activity seen in the report is environmental in that there are no direct correlations to SHIP activities; it summarizes the activity related to payments made in Idaho during the designated time period. The high level aggregation and summary has been done to protect proprietary information of the individual payers and is a required report by CMMI.

**Goal 6 Charter, Multi-Payer Workgroup Charter and Dashboard updates** – *Katie Falls, Principle, Mercer*

- ◆ Katie Falls presented the goal 6 charter update, MPW charter update, and the quarterly dashboard.
- ◆ Changes to the goal six charter included:
  - Updating deliverables to note their completion.
  - Updating target dates on deliverables.
  - Deleting deliverable four.
- ◆ Changes made to the MPW goal charter made by the workgroup at their August meeting included:
  - Updated progress to note when deliverable is complete.
  - Updated milestone due dates.
  - Added new co-chair: Norm Varin, PacificSource
  - Changes to success measures and deliverables.
- ◆ The updated dashboard for the quarter two success measures reported to CMMI included a few changes from quarter one, including the fluctuation of measures indicated by arrows next to their percentage numbers.

**MACRA/MIPS Update** – *Linda Rowe, Idaho State Director, and Deanna Graham, Quality Improvement Consultant, Qualis Health*

- ◆ Linda Rowe and Deanna Graham gave an update on the status of MACRA/MIPS program within Qualis and introduced the resources available for the program on their website.
- ◆ Deanna Graham gave a presentation on the Qualis Health Medicare resource center on their website. Resources include: MIPS minutes, video, QQP hotline, and an email inbox. Regular office hours and webinars will be available on their upcoming events page.
- ◆ Also located on their website is the clinic readiness assessment which gives clinics the ability to track progress for clinics, readiness assessment, QQP acronyms, and a MIPS calculator. The goal of this assessment is to get clinics above a score of 70.
- ◆ The last 90-day span for clinics to start tracking MACRA/MIPS begins October 2<sup>nd</sup>. Clinics should start tracking data then to avoid a penalty. Multiple resources to help clinics and clinicians determine if they are eligible or if they need to enroll/report are available online.

**State Evaluator Report** – *Janet Reis, PhD, Principle Investigator, Boise State University*

- ◆ Janet Reis presented information that was collected by Janice Lung and the state evaluator team through interviews conducted with IHC members. Sixty-three percent of the IHC members participated in these interviews.

- ◆ The findings showed that PCMH implementation was recognized as the key accomplishment of the IHC and SHIP efforts. PCMH transformation and value-based payment were the top two goals members want to see accomplished by the end of SHIP. The top three barriers to achieving these goals were payer-related delays, limited resources and sustainable funding, and IHDE-related concerns.
- ◆ In response to being asked what actions the IHC could take to address these issues, many respondents said that maintaining commitment and contributions to the IHC by members and educating providers and clinics on PCMH were important.
- ◆ Following her presentation, Dr. Reis gave a brief update on the current activities of the State Evaluation Team. The team has encountered some issues with the IRB process for interviewing patients for patient engagement, which is causing delays in their overall evaluation. Dr. Reis wanted to highlight that the team is looking to better understand why patients behave the way they do. There will be no HIPAA information collected and all contact/personal info collected will be destroyed within 30 days.

**IHDE Update** – *Brad Erickson, Executive Director, Idaho Health Data Exchange*

- ◆ Julie Lineberger introduced the new executive director for IHDE, Brad Erickson. Mr. Erickson gave a brief introduction and background on himself to the group.
- ◆ Following his introduction Mr. Erickson presented the group with an update on the bi-directional connections between cohort clinics and IHDE. There are twenty-seven organizations and forty-one clinics that have pending connections. These clinics are pending or on hold for several different reasons. The goal is by the end of September to have thirty-seven Cohort One clinics connected and thirty-four Cohort Two clinics connected.

**PCMH Mentorship Update** – *Kym Schreiber, SHIP PCMH Project Manager*

- ◆ Kym Schreiber presented an update on the PCMH mentorship framework and plan. Since the development of the mentorship framework the subcommittee has developed a resource guide, a webinar series, and it is working on putting together a provider panel that will work as part of the mentorship framework.
- ◆ The first mentorship webinar was held on August 17<sup>th</sup> and focused on Community Health Workers. There were fifty attendees on the webinar who heard from four different organizations about their programs around the state.
- ◆ The goal is to host one webinar per month covering topics that have been requested by participating clinics. Responses from a survey sent out at the end of the first webinar will be reported at a later meeting. The next webinar will cover behavioral health integration and will either be held this month or in October.
- ◆ Ms. Schreiber also provided a general update of the mentorship framework. The work currently being done for the framework and subcommittee may eventually be integrated as curriculum in the WWAMI program as part of their initiative to promote PCMH practices.

**Timeline and Next Steps** – *Lisa Hettinger, IHC Co-chair*

- ◆ Lisa Hettinger thanked the IHC members for their committed work to this project. There being no further business, Chairman adjourned the meeting at **3:30pm**



# Idaho Healthcare Coalition (IHC) November 8, 2017 Action Items

- Action Item 1 – September Meeting Action Items Bundle

IHC members will be asked to adopt the five (5) action items presented at the September 13, 2017 meeting in which a quorum was not achieved:

Motion: I, \_\_\_\_\_ move to accept all of the action items from the September 13, 2017 meeting as listed as presented.

Second: \_\_\_\_\_

Motion Carried.

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- Action Item 2 – Data Governance

IHC members will be asked to support the adoption of the final four (4) clinical quality measures as presented by Janica Harden, DGW Co-Chair.

Motion: I, \_\_\_\_\_ move to adopt the four (4) metrics as presented by Janica Harden.

Second: \_\_\_\_\_

Motion Carried.



# Idaho Healthcare Coalition (IHC) September 13, 2017 Action Items

- Action Item 1 – Minutes

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

Motion: I, \_\_\_\_\_ move to accept the minutes of the August 09, 2017, Idaho Healthcare Coalition (IHC) meeting as prepared.

Second: \_\_\_\_\_

Motion Carried.

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- Action Item 2 – IHC Membership

IHC members will be asked to recommend that the governor appoint Norm Varin to the IHC representing the Multi-Payer Workgroup.

Motion: I, \_\_\_\_\_ move to recommend the governor appoint Norm Varin to the IHC.

Second: \_\_\_\_\_

Motion Carried.

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- Action Item 3 – SHIP Idaho Financial Report

IHC members will be asked to accept the SHIP Financial Analysis Assessment as presented by Scott Banken with Mercer.

Motion: I, \_\_\_\_\_ move to accept SHIP Financial Analysis Assessment as presented.

Second: \_\_\_\_\_

Motion Carried.

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■ Action Item 4 – Goal 6 Charter Update

IHC members will be asked to accept the Goal 6 Charter as presented to the IHC:

Motion: I, \_\_\_\_\_ move to accept the Goal 6 Charter as presented.

Second: \_\_\_\_\_

Motion Carried.

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■ Action Item 5 – Multi-Payer Workgroup Charter Update

IHC members will be asked to accept the Multi-Payer Workgroup Charter update as presented.

Motion: I, \_\_\_\_\_ move to accept the Multi-Payer Workgroup Charter update as presented.

Second: \_\_\_\_\_

Motion Carried.

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# Clinical Quality Measures Catalog

## PCMH Cohort Clinics Measures – Update 11/2017

### Measures 1-4 (Award Year 2)

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

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.

## Measures 5-10 (Award Year 3)

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

## Measures 11-16 (Award Year 4)

Measure Title	Measure Description
<b>Preventive Care and Screening: Unhealthy Alcohol Use: Screening &amp; Brief Counseling</b>  NQF 2152, PQRS 431, MIPS 431	Percentage of patients aged 18 years and older who were screened at least once within the last 24 months for unhealthy alcohol use using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user.
<b>Plan All-Cause Readmissions</b>  NQF 1768	For patients 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: 1. Count of Index Hospital Stays* (denominator) 2. Count of 30-Day Readmissions (numerator) 3. Average Adjusted Probability of Readmission *An acute inpatient stay with a discharge during the first 11 months of the measurement year (e.g., on or between Jan1 and Dec1).
<b>Colorectal Cancer Screening*</b>  NQF 34	Percentage of adults 50-80 years of age who had appropriate screening for colorectal cancer (CRC) including fecal occult blood test during the measurement year or flexible sigmoidoscopy during the measures year or the four years prior to the measurement year, or double contrast barium enema during the measurement year or the four ears prior to the measurement year or colonoscopy during the measure year or the nine years prior to the measurement.
<b>Breast Cancer Screening*</b>  NQF 2372	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.
<b>Well Child Visits (&gt;5) in First 15 Months of Life*</b>  NQF 1392	Percentage of members who turned 15 months old during the measurement year and who had 5 or more number of well-child visits with a PCP during their first 15 months of life.
<b>Well Child Visits Age 3 to 6*</b>  NQF 1516	Percentage of members 3-6 years of age who received one or more well-child visits with a PCP during the measurement year.

\*Contingent on approval from Idaho Healthcare Coalition (IHC)

# Idaho PCMH Transformation Update: Cohort 2 Success Stories

Idaho Healthcare Coalition Meeting  
November 8, 2017

Nancy Jaeckels Kamp  
PCMH Coach



## COHORT 2 SUCCESS STORIES

- PCMH Transformation
- PCMH Recognition



## PCMH TRANSFORMATION

**Southfork Medical Clinic** is a nurse practitioner-operated clinic focused on serving the needs of rural (many elderly) people in Swan Valley. **Wendy Swope**, the owner and nurse practitioner, has a full-time job at the hospital and also manages this primary care clinic to ensure access to care for her community.

- She applied to participate in SHIP so that she could transition from an “urgent care” type environment to a true medical home.
- She is working diligently on applying the PCMH principles, is engaged in Quality Improvement (QI) projects for chronic disease care, and has strengthened her relationships with other community providers.
- The PHD SHIP QI staff are in the process of connecting her to the Community Health Emergency Medical Services (CHEMS) program so that she can collaborate with them for welfare checks on her elderly patients.
- The clinic is on track to apply for National Committee for Quality Assurance (NCQA) by January 2018.

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**PCMH**  
TRANSFORMATION  
TEAM

## PCMH TRANSFORMATION

**Saltzer Medical Group** was new to PCMH and in the midst of a merger that included staff reductions. They started with small Plan-Do-Study-Act (PDSA) cycles, and now have a Quality Coordinator with experience pulling reports.

- The clinic continues making improvements and the work of the PHD SHIP QI Specialist and PCMH Coach is showing positive impact.
- With help from PCMH Coaches, they developed PDSAs; learned how to pull reports and engage a team; and wrote a job description for a Clinical Champion.
- They are now working to engage leadership and have an action plan to use data to demonstrate the value of PCMH.
- The group is making progress in quality improvement even without provider support.

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**PCMH**  
TRANSFORMATION  
TEAM

## PCMH TRANSFORMATION

### Saltzer Medical Group *(continued)*

- They implemented proactive outreach to patients who need cancer screenings. With help from PCMH Coaches, the clinic designed and tested the process to ensure its effectiveness at getting patients into the clinic for cancer screening, increasing the likelihood of early detection.
- Of the 75,095 patients in the system aged 50-75, 753 patients are now compliant with colorectal cancer screening. Though the percent change is small, this is based on a large denominator of patients.

	Baseline		Current Period		Change from Baseline	
Yes	8,983	12%	9,736	13%	753	1%
No	66,112	88%	65,359	87%		
Total Patient	75,905		75,095			

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**PCMH**  
TRANSFORMATION TEAM

## PCMH TRANSFORMATION

### Saltzer Medical Group *(continued)*

- Diabetic Eye Exam: of the 7,107 patients in the system aged 18+ with diabetes, they improved accurate reporting by 17% (1,214 orders).
- This is a combination of adding results in the proper field and creating doctor's orders.

	Baseline		Current Period		Change from Baseline	
Complete	54	1%	1,268	18%	1,214	17%
Incomplete*	946	99%	440	82%		
No Order	6,107		5,399			
Total Patients	7,107		7,107			

\*Incomplete - indicates patients where results not entered in the proper field

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**PCMH**  
TRANSFORMATION TEAM

## PCMH TRANSFORMATION

**St. Luke's clinics** are working hard on PDSAs and plan to submit for PCMH recognition in Fall 2018.

- They worked hard to train and engage staff in quality improvement. They have huddles and are including staff.
- They are now able to do point-of-care testing for Hemoglobin A1c, following suggestion by the PCMH Coach. This change is improving testing rates.
- They are working on care management and mapping the workflow, following the idea and suggestion by the PCMH Coach.

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**PCMH**  
TRANSFORMATION TEAM

## PCMH TRANSFORMATION

**Kaniksu** requested help with efficiencies.

- The PCMH Coach presented the two clinic teams on Lean Methodology and conducting value-stream assessments.
- This led to them conducting a time and efficiency study at each of their clinics where they followed patients through a visit. The results will direct process improvement and QI work.

**Two clinics** with the same Electronic Health Record (EHR)--the only ones in SHIP on the same EHR--from opposite ends of the state were able to connect through the PHD SHIP QI Specialists, and are sharing EHR tips and info with each other.

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**PCMH**  
TRANSFORMATION TEAM

## PCMH RECOGNITION

**Family Health Services – Twin Falls** received NCQA 2014 recognition. It was a big lift and they did it with the help of their PCMH Coach and PHD SHIP QI Specialist.

**Seasons Medical** received NCQA PCMH Level 2 recognition for all three of their clinics.

- The recognition was backdated to allow them to use the recognition for the Merit-based Incentive Payment System (MIPS).
- The clinic was grateful to their PCMH Coach and PHD SHIP QI Specialist for their assistance in helping them to achieve this “monumental recognition.”

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**PCMH**  
TRANSFORMATION TEAM

## PCMH RECOGNITION

**Primary Health Medical Group** received NCQA PCMH Level 2 recognition for all 12 clinics. Now all 17 Primary Health clinics are PCMH recognized.

- The Primary Health clinics, spanning Cohorts 1 and 2, have appreciated the technical assistance through SHIP, specifically both the PCMH Coach and on-the-ground assistance of Region 3 and Region 4 PHD SHIP QI Specialists to get both Cohort 1 and Cohort 2 clinics ready to meet recognition requirements.
- Value of the site visits by the PCMH Coach to discuss face-to-face with providers the benefits and sustainability for adopting the PCMH model.
- Discussions during coaching calls with the Population Health Director, the PCMH lead, and the clinics’ managers on the PCMH Standards, particularly in providing resources for implementing depression and adolescent screenings, care plans, health literacy, and social determinants into their care model.

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**PCMH**  
TRANSFORMATION TEAM

## PCMH RECOGNITION

**Terry Reilly Health Services-Boise Latah** has worked with their PHD SHIP QI Specialist, Kim Thurston, and PCMH Coach to identify reasons for patient no-shows, better meet patients' access needs, and design an effective policy around no-shows.

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**PCMH**  
TRANSFORMATION TEAM

**Thank you!**  
**Questions/Comments?**



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**PCMH**  
TRANSFORMATION TEAM



**EUGENE S. FARLEY, JR.**  
HEALTH POLICY CENTER



**Lifetime cases of diagnosable mental health conditions begin:<sup>2</sup>**



**50% by age 14**



**75% by age 24**

## OUR MISSION

The Eugene S. Farley, Jr. Health Policy Center develops and translates evidence into policy to advance comprehensive, integrated strategies that improve individual, family and population health. Our health policy expertise focuses on behavioral health integration, community-based prevention, workforce, and payment reform.

To do this, we:

- » Convene stakeholders and decision-makers to improve health and healthcare together
- » Partner with communities, state and federal agencies, and foundations
- » Educate, train and mentor professionals to develop a health policy lens for approaching research and practice
- » Provide technical, adaptive, and leadership assistance for implementing strategies to integrate behavioral health across the community and healthcare systems
- » Foster collaboration among inter-professional, interdisciplinary, and community-based teams

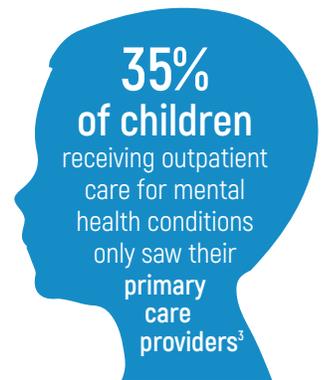
<sup>1</sup> Soni A. Top five most costly conditions among children, ages 0-17, 2012: estimates for the U.S. civilian noninstitutionalized population. Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey. Statistical Brief #472. April 2015.

<sup>2</sup> Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of general psychiatry. 2005 Jun 1;62(6):593-602.

<sup>3</sup> Anderson LE, Chen ML, Perrin JM, Van Cleave J. Outpatient visits and medication prescribing for US children with mental health conditions. Pediatrics. 2015 Nov 1;136(5):e1178-85.

<sup>4</sup> Kessler RC, Wang PS. The descriptive epidemiology of commonly occurring mental disorders in the United States. Annu. Rev. Public Health. 2008 Apr 21;29:115-29.

<sup>5</sup> Park-Lee, E., Lipari, R. N., Hedden, S. L., Copello, E. A. P., & Kroutil, L. A. (2016, September). Receipt of services for substance use and mental health issues among adults: Results from the 2015 National Survey on Drug Use and Health. NSDUH Data Review.



**46%** of adults

will experience a mental health or substance use conditions within their lifetime<sup>4</sup>



**Shale Wong, MD, MSPH**

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School of Medicine*

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Shale is a pediatrician at Children’s Hospital Colorado and serves as vice chair for policy and advocacy in pediatrics. She served as health policy advisor to First Lady Michelle Obama for development and implementation of her childhood health and obesity initiative, *Let’s Move*; and assisted in launching *Joining Forces* to address wellness of military families. She was a senior program officer and consultant for the Robert Wood Johnson Foundation. Shale sits on several boards for health policy and community-focused organizations, including the Pediatric Policy Council, AAP Council on Federal Government Affairs, RWJF Health Policy Fellows, Colorado Health Institute and Cleo Parker Robinson Dance. She co-founded CU LEADS at the CU SOM — an innovative program designed to promote leadership, education, advocacy, development and scholarship. She is committed to achieving equitable child health, expanding approaches and integrating systems for prevention, resiliency and health of families, communities and populations. A lifelong dancer, she is inspired to advance physical, emotional and social health through dance and the arts.

**Lina Brou, MPH**

*Lead Policy Analyst*

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Lina received her MPH in epidemiology from Emory University’s Rollins School of Public Health. She has developed extensive experience in data management and analysis and research methodology in a variety of fields. Her research interests focus on integration of comprehensive care to underserved populations, particularly those with young children; health services research; healthcare policy and health equity. Her experience ranges in grant preparation, research design and development, the structuring of data collection systems, data reduction and analysis, survey design and analysis, advanced epidemiological methods and preparation of presentations and manuscripts.

**Emma Gilchrist, MPH**

*Deputy Director*

[emma.gilchrist@ucdenver.edu](mailto:emma.gilchrist@ucdenver.edu)



Emma is the Deputy Director of the Eugene S. Farley, Jr. Health Policy Center and an Instructor in the Department of Family Medicine at the University of Colorado School of Medicine. Emma oversees the planning, execution, and completion of the Farley Center’s programs and projects. She has been a project manager and qualitative researcher for federal, state, and foundation grants and contracts. She works to improve health through policies that advance behavioral health integration, prevention and health promotion, workforce development, and payment reform. She received her Master of Public Health from the University of Michigan.

**Stephanie Gold, MD**

*Assistant Professor, University of Colorado Department of Family Medicine*

[stephanie.gold@ucdenver.edu](mailto:stephanie.gold@ucdenver.edu)



Stephanie’s policy interests include payment reform for primary care and integrating behavioral and public health with primary care. She practices full-scope family medicine at Denver Health and is a board member of the Colorado Academy of Family Physicians. She attended the University of Virginia for medical school and did her residency at the University of Colorado - Denver Health Track. After residency, she completed a health policy fellowship with the Farley Center.

**Stephanie Kirchner, MSPH, RD**

*Practice Transformation Program Manager*

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Stephanie graduated from Miami University and completed training as a registered dietitian at Massachusetts General Hospital. She worked in public health settings building community-based nutrition educational programs, leading to an interest in healthcare policy, care management and quality improvement. After completing her MPH at the University of Colorado, she began focusing on practice transformation in primary care, supporting practices in patient-centered medical home initiatives including the Enhancing Practice Improving Care initiative (EPIC), PCMH Foundations, and the Comprehensive Primary Care Initiative (CPCI). Currently, Stephanie manages a host of practice transformation and quality improvement initiatives for the CU Department of Family Medicine. Her research interests include behavioral health integration, practice transformation and redesign, patient self-management support and community engagement.

**Jonathan Muther, PhD**

*Clinical Integration Advisor;  
VP Medical Services – Behavioral Health, Salud Family Health Centers*

[jmuther@saludclinic.org](mailto:jmuther@saludclinic.org)



Jonathan is Vice-President of Medical Services – Behavioral Health, at Salud Family Health Centers, a large FQHC system providing behavioral health services in 12 clinics. His specialty area is integrated primary care psychology, and he is involved in direct patient care, training and supervision, program development and evaluation, as well as advocacy for healthcare policy change. His primary areas of interest are working with those traditionally underserved by existing systems and working with the Spanish-speaking population. He is committed to providing treatment and program development to address life stress and the full spectrum of mental disorders, behavioral interventions for physical illnesses, and evaluating health outcomes. Additional areas of research and clinical interest include integrated primary care and team-based approaches to care, provision of supervision and training to bilingual psychology trainees, child/adolescent therapy, and acculturation discrepancies within Latina/o families.

# Idaho Healthcare Coalition

November 8, 2017



Brad Erickson, Executive Director  
Joe Groesbeck, Sr. Project Manager  
Michael Cash, Operations Manager

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## Organizations with Bidirectional Connections as of 10/31/17

### Cohort 1

- 35 of 55 SHIP Clinics Connected
- 15 of 30 Organizations Connected
  - 2 Organizations Withdrew (Crosspointe, Portneuf Primary Care)

#### Complete

- Adams County Health Center (1 Clinic)
- Benewah Medical & Wellness Center (1 Clinic)
- Family Health Center (1 Clinic)
- Family Health Services (2 Clinics)
- Family Medicine Health Center (FMRI) (3 Clinics)
- Heritage Health (3 Clinics)
- Kanixsu Health Services (2 Clinics)
- PHMG\* (5 Clinics; excludes IB-CCDA)
- Saint Alphonsus (4 Clinics no outbound interface)
- St. Luke's (3 Clinics)
- SMH & CVH (3 Clinics)
- Terry Reilly Health Center (4 Clinics)
- Unified Healthcare of Idaho – Tueller (1 Clinic)
- Valley Family Health Care (1 Clinic)
- Valley Medical Center (1 Clinic)

#### Expected by November

- Pocatello Children's (1 Clinic)

### Cohort 2

- 30 of 56 SHIP Clinics Connected
- 68 Healthy Connections Clinics Connected
- 11 of 30 Organizations connected
  - 1 Organization Withdrew (Saltzer Medical Group)
  - 2 Organizations Unable to Connect due to EMR inability to integrate with HIE (All Seasons, Children & Family)

#### Complete

- Coeur d'Alene Pediatrics (3 Clinics)
- Family Health Services (1 Clinic + 5 Healthy Connections Clinics)
- Family Medicine Health Center (FMRI) (3 Clinics)
- Heritage Health (1 Clinic)
- Kanixsu Health Services (2 Clinics)
- PHMG\* (4 Clinics + 8 Healthy Connections Clinics)
- Saint Alphonsus (5 Clinics)
- St. Luke's (2 Clinics + 49 Healthy Connections Clinics)
- SMH & CVH (3 Clinics + 2 Healthy Connections Clinics)
- Terry Reilly (4 Clinics + 1 Healthy Connections Clinic)
- Valley Family Health Care (2 Clinics + 3 Healthy Connections Clinics)

\*Clinic has advised that they have turned off feed from EMR Vendor

# Organizations Pending

- Organization(s) waiting on next steps from Clinic/EMR Vendor:
  - Bingham Memorial Hospital (4 Clinics)
  - Cascade Medical Center (1 Clinic)
  - Clearwater Medical Clinic (1 Clinic)
  - Family Health Associates (1 Clinic)
  - Genesis Community Health (1 Clinic)
  - Madison Memorial Rexburg Medical Clinic (1 Clinic)
  - Seasons Medical (3 Clinics)
  - Sonshine Family Health Clinic (1 Clinic)
  - Syringa Hospitals & Clinics (1 Clinic)
  - Treasure Valley Family Medicine (1 Clinic)
  - Unified HealthCare of Idaho (Tueller) (1 Clinic)
- Organizations pending or in progress
  - Bear Lake Community Health Centers (1 Clinic)
  - Physicians Immediate Care Center (2 Clinics)
  - Pocatello Children’s Clinic (1 Clinic)
  - Southfork (1 Clinic)

- Organization(s) On Hold – Pending EMR Change:
  - Glenn’s Ferry (3 Clinics)
  - HealthWest (6 Clinics)
- Organization(s) On Hold – BH Filtering:
  - CHAS (IB CCDA) (2 Clinics)
- Organization(s) On Hold – PA “Modified” Agreements:
  - Driggs & Victor (PA Agreement Pending – 2 Clinics)
  - Not-tsoo Gah-nee (Pending IHS legal/ PA – 1 Clinic)
- Organization(s) On Hold – eCW Decision (IB HL7 and/or IB CCDA):
  - Complete Family Care (1 Clinic)
  - Family First Medical Group (1 Clinic)
  - Rocky Mountain Diabetes and Osteoporosis Center (1 Clinic)
  - Shoshone Family Medical Center (1 Clinic)
  - Upper Valley Community Health Services (GrandPeaks) (2 Clinics)
  - The Pediatric Center (1 Clinic)
  - Primary Health (No IB CCDA)

# Interface Projections

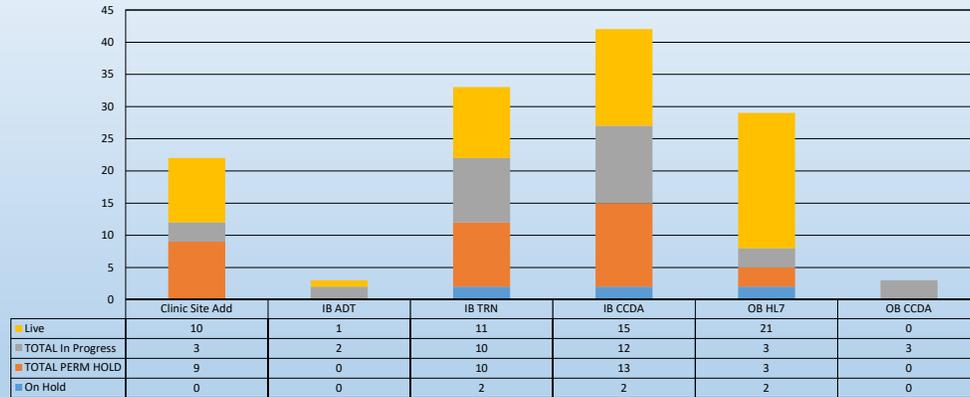
Projected Interfaces 2017



Note: 26 interfaces are on PERM HOLD and are NOT anticipated to be built based on current projections.

# Interface Summary

Cohort 1 & 2 Interface Summary



26 Interfaces (13 Participants) identified as "PERM HOLD" from interface builds from Cohort 1 & 2 due to inability to build interface – refer to risk list for description of reason.

# Interfaces – Cohort 1 & 2 Status

Interfaces (Cohort 1 & 2)



% Interfaces Completed



Interface Cohort 1 & 2	Total Completed	Total In Progress	Total Remaining	Total Interfaces	% Completed
January 2017*	20	18	31	69	29%
February 2017*	23	16	30	69	33%
March 2017	26	12	72	110	24%
April 2017	27	11	72	110	25%
May 2017	27	16	67	110	25%
June 2017	33	37	40	110	30%
July 2017	33	41	32	106	31%
August 2017	39	35	34	108	36%
September 2017	42	32	35	109	39%
October 2017	48	30	31	109	44%
November 2017 (Projected)	63	26	20	109	58%



# Spring 2018 CHW Course

- Community Health Worker Training Core Competencies course begins Thursday, January 11, 2018

- Several health specific modules available

- Live on-line course from 6:00 – 9:00pm (MST)

- Instructors:

- Rhonda D'Amico
- Veronica Conway

- CHW participant eligibility

- Be current Idaho Residents, or work full-time in Idaho
- Agree to participate in the SHIP initiative and submit data to IDHW on a quarterly basis for one full year after completing the training program
- Receive a statement of support from their employer or community sponsoring agency as part of the application process

**Idaho State**  
**UNIVERSITY**





# SHIP Operations and IHC Workgroup Report to the Idaho Healthcare Coalition November 8, 2017

## **SHIP OPERATIONS:**

### **SHIP Contracting/Request for Proposal (RFP) Status:**

- **Report Items:**
  - CMMI requests for release of funds were approved for: 1) the Idaho Healthcare Coalition (IHC) Sustainability Planning meeting; 2) Public Health District 3 NCQA PCMH Congress Conference; 3) Public Health District 2 NCQA PCMH Congress; 4) two State Evaluator funding requests; 5) out-of-state travel for LAN fall summit; 6) College of Western Idaho BLS/ILS CHEMS training; and 7) University of Idaho Project Echo funding.
  - CMMI requests for release of Award Year Two carryover and Award Year Three funds were submitted for: 1) two CHEMS Learning Collaboratives; 2) telehealth grant application funding releases for: a) Driggs Health Clinic; b) Payette County Paramedics CHEMS Agency; c) Shoshone Family Medical Center; d) Terry Reilly Clinics; e) Southfork Medical Center; f) Coeur d'Alene Pediatrics (3 requests); and g) Family Medicine Residency of Idaho.

### **SHIP Administrative Reporting:**

- **Report Items:**
  - The balance of the virtual PCMH applications/designations have been processed for Cohort One and Cohort Two clinics. Budget templates have been approved for reimbursement payment processing.
  - The Cohort Three application for the SHIP PCMH transformation initiative closed on October 20, 2017.
  - Jill Cooke was hired as SHIP's Administrative Assistant replacing Taylor Kaserman.

### **Regional Collaboratives (RC):**

- **Report Items:**
  - **District 1:** 9/27/17 RC meeting held at Panhandle Health District Offices in Hayden.
  - **District 2:** 9/19/17 RC2 meeting occurred. Presentation from Pfizer on shared medical appointment and implementing group visits.
  - **District 3:** There was no SWHC meeting in the month of Sept. Oral Health Workgroup (9/14): reviewed available project data and discussed opportunities for outreach and coordination for potential grant project to support dental-based care coordinators; Behavioral Health Integration Workgroup (9/25): discussed school-located project for enhancing access to BH services for children and youth at school, new approaches for supporting BHI in clinics (to be based on feedback from Amber Aberasturi on current clinics), and IIBHN update. ED Utilization Workgroup (9/25): reviewed current assessment and discussed opportunity for messaging to BH providers regarding appropriate ED utilization; Senior Workgroup (9/26): discussed information needed from CCP and potential new project areas (including medication adherence, wellness exams, and geriatric clinic referrals).

- **District 4:** No CHC meeting this month - transitioned to a bi-monthly frequency.
- **District 5:** The SCHC met September 8, 2017.
- **District 6:** An Executive Committee meeting was held on October 11, 2017.
- **District 7:** Upcoming RC meeting in October

- **Next Steps:**

- **District 1:** Evaluate possible role of our RC in the future CHOICE advisory board with Medicaid.
- **District 2:** None.
- **District 3:** Key SWHC stakeholders will plan to meet with key CHC stakeholders to discuss opportunities for sustainability via the CHOICE group. Rachel and Nikki will also continue to work on the development of local community advisory council to support sustainability through the Kresge Foundation grant. Amber Aberasturi will work with both the SWHC and the BHI Workgroups to identify key practice needs and promote PCMH support. Workgroups will engage in MHN enhancement activities such as project managing a plan to incorporate on-site behavioral health services into schools, develop a dental care coordinator program, and promote CHEMS/PCP communication.
- **District 4:** Next CHC meeting is scheduled for 10/3/17.
- **District 5:** Next steps include inviting Jeff Crouch with IDHW to present the Medicaid Healthy Connections Value Care proposal at our October meeting. We also plan to discuss Cohort Three, the upcoming selection period, and clinic reveal on December 13.
- **District 6:** Executive Committee Meeting scheduled for October 11th, the same day as our compliance visit. Plans are to discuss the Healthy Connections white paper, report on RC grant activities, discuss the crisis center effort and what it means for our region, and plan our next Clinic Committee Meeting (November) and Medical Health Neighborhood Meeting (December).
- **District 7:** Continue meeting with MHN resources that can help further PCMH work. Continue work with partners on community health needs assessments in area. Aggregated rates for Eastern Health Collaborative CQMs. Facilitate communication and networking among clinics to help increase sustainability of PCMH principles.

## **ADVISORY GROUP REPORTS:**



### **Telehealth SHIP Subcommittee:**

- **Report Items:**
- The telehealth subgrant application opportunity closed September 15, 2017. Total amount of funding available is \$225,000 for nine clinics, this funding opportunity supports Cohort One and Cohort Two SHIP clinics, and SHIP CHEMS agencies to establish or expand the scope of telehealth operations.

- We received nine applications that were reviewed by the telehealth review committee. Notice of Awards were sent to clinics October 2, 2017. Nine clinics will be awarded, and we are in the process of establishing subgrants for clinics that were accepted.
- As discussed in the August IHC meeting, we are repurposing telehealth funds from Goal Four to establish Project ECHO hubs in the WWAMI program through University of Idaho.
- University of Idaho's first Project ECHO clinic will cover the Opioid crisis in Idaho. They plan on starting in January 2018 with weekly clinic sessions. They will have 25 spokes participate in the first ECHO clinic, with the intention to grow.
- **Next Steps:**
- Continue to support Round One telehealth clinics through our technical assistance contractor and IDHW.
- Work with University of Idaho to promote Project ECHO to SHIP cohort clinics.

## CHW

### Community Health Workers:

- **Report Items:**
- CHW fall 2017 live-online course is underway; 19 people enrolled at the beginning of the course, one person dropped out for personal reasons.
- IDHW and ISU agreed to postpone the CHW fall 2017 in-person course due to low enrollment. Considering another in-person course starting in March. Exploring logistics for course delivery and location.
- ISU identified Rhonda D'Amico (District 6 SHIP manager) and Veronica Conway to be instructors for the Spring 2018 live-online course. This will be starting Thursday, January 11, 2018 and go for 13-weeks with additional health specific modules (HSM). Registration for this course will open at the beginning of November.
- Twelve HSMs are completed, and ISU is exploring additional HSMs to develop.
- A CHW brochure is being developed that highlights benefits the CHW brings to the community and sponsoring agencies. The brochure will be a marketing tool for the CHW course to be presented at the Bureau of Rural Health and Primary Care's Annual Conference.
- The CHW association, that was developed and sponsored by the 1305 grant, met October 25, 2017. They brainstormed ideas for their association's mission, its collective purpose, and why they exist.
- **Next Steps:**
- Promoting the Spring 2018 CHW course to potential students and organizations. There will be 25 available spots open to students.

## WORKGROUP REPORTS:

## CHEMS

### Community Health EMS:

- **Report Items:**
- The statewide CHEMS Workgroup met on September 27, 2017 and October 25, 2017.
- The next statewide CHEMS Workgroup meeting is scheduled for November 29, 2017.

- EMT/AEMT Certificate Program on Online Curriculum Delivery
  - CMMI has approved the curriculum funding proposal
  - The first cohort start date has been pushed back per agency preference and will start after the first of the year
  - The following agencies will participate in the first cohort: Albion QRU, Payette County Paramedics, Clearwater Ambulance, Meadows Valley EMS, Prairie QRU, Pine EMS, and Kuna Rural Fire District.
- ISU Community Paramedic Certificate Program
  - Third and final cohort – full.
- Approved CMMI Tiered Funding Requests:
  - Agencies: Boundary County EMS, Bonner County EMS, Shoshone County EMS, Payette County Paramedics, Canyon County EMS, and Idaho Falls Fire.
  - Currently no new requests.
- Learning Collaborative:
  - Learning Collaborative is scheduled for Wednesday, January 17, 2017.
- Webinars
  - The Transitional Care webinar logistics are currently underway.
- Data Collection
  - Patient Experience Survey:
    - Of the six agencies that have received tiered funding from CMMI, Bonner County EMS is the only agency to submit the Patient Experience Survey.
    - Ada County Paramedics has also submitted Patient Experience Surveys but it is not a tiered funded agency through CMMI.
  - Quarterly Data Collection:
    - Q1: April 1-June 30, 2017
      - All but one agency has submitted data.
    - Q2: July 1-September 30, 2017
      - All but two agencies have submitted data.
    - Remaining agencies are still in the process of developing a CHEMS program or their medics are currently getting through clinicals.

**Next Steps:**

- Project Charter, Deliverable 3 – in progress.
  - EMT/AEMT curriculum development – letter of notation is being drafted by SHIP.
- Project Charter, Deliverable 4 – in progress.
  - Continue to define, develop, and implement peer mentorship throughout the state.
- Project Charter, Deliverable 6 – in progress.
  - Upcoming learning collaborative and 2<sup>nd</sup> webinar logistics.
- Continue to promote CMMI tiered funding and the EMT/AEMT certificate program.
- The internal CHEMS Workgroup continues to meet every Monday.



**Idaho Medical Home Collaborative:**

- **Report Item:**
  - The Idaho Medical Home Collaborative did not meet this month.
- **Next Steps:**

- The workgroup will continue to meet on an ad hoc basis.



## **Data Governance:**

- **Report Item:**

The Data Governance Workgroup met on October 16, 2017.

- The workgroup discussed and agreed to recommend to the Idaho Healthcare Coalition (IHC) the following four clinical quality measures to be added to the CQM catalog. These four measures are expected to be implemented in 2018;
  - NQF 34: *Colorectal Cancer Screening*;
  - NQF 2372: *Breast Cancer Screening*;
  - NQF 1392 *Well Child Visits (>5) in first 15 Months*; and
  - NQF 1516: *Well Child Visits Age 3 to 6*.
- Idaho Health Data Exchange (IHDE) presented the current operations system and information on the Orion data outage which occurred in October. The system is back up but continues to experience performance issues. IHDE is also currently in the process of assessing its pricing model, validity, and long-term strategy in Idaho.
- HealthTech Solutions (HTS) gave an update on the data quality and number of CCD's and attribution files being received. HTS has also successfully implemented three additional measures since May.
- The workgroup discussed the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measure, and discussed whether HTS could accept a BMI result instead of a BMI percentile for meeting the numerator criteria. The workgroup determined that feedback from federal partners would be helpful.
- The workgroup also discussed the federal technical assistance received on the calculation logic for the *Preventive Care and Screening: Adult Body Mass Index Screening and Follow-Up Plan* measure. The guidance directed a small change in the calculation logic (using the most recent BMI result that has an associated eligible encounter code), which was implemented by HTS on October 30<sup>th</sup>.
- The workgroup discussed the federal technical assistance received regarding the *Use of Appropriate Medication for Asthma* measure. The guidance indicated that the use of a crosswalk table between the generic and brand name medications could be leveraged when calculating this measure. HTS reported that they have identified a code vendor to assist with this and are in the process of implementing it.

- **Next Steps:**

- The IHC will vote on the recommended CQMs.
- The next SHIP Data Governance Workgroup meeting is scheduled for November 13<sup>th</sup>.
- HTS will implement a name brand / generic medication crosswalk table for the *Use of Appropriate Medication for Asthma* measure.
- The SHIP Operations team will await feedback from CMS regarding the calculation logic for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measure.

**MPW****Multi-Payer:****• Report Item:**

- Dr. Peterman resigned as co-Chair of the Multi-Payer Workgroup (MPW). Dr. Kelly McGrath has temporarily assumed that role. The election of a permanent co-chair will take place at the next MPW meeting.
- The SHIP Administrator met with the newly elected co-chair Norm Varin and Dr. Kelly McGrath to discuss next steps for the MPW.
- Mercer requested SHIP metrics for financial progress toward paying for value from Idaho's commercial payers, Medicaid, and Medicare. This information is a requirement for the CMMI grant. Mercer expects to deliver a completed report to the IHC at the December meeting.

**• Next Steps:**

- The SHIP Administrator is working with the co-chairs to update the MPW membership and the agenda for the next MPW meeting, tentatively scheduled for December.
- The SHIP Administrator is scheduled to present a SHIP update to the State Employee Group Insurance and Benefits Legislative Interim Committee on November 8<sup>th</sup>.

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

The Behavioral Health Integration Workgroup did not meet in October.

**• Next Steps:**

The next meeting will be held on November 9<sup>th</sup>.

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

- The PHW met November 1, 2017.
- The Get Healthy Idaho assessment (pre-cursor to update of the Get Healthy Idaho: Measuring and Improving Population Health) was completed and results were analyzed and shared. The assessment was conducted through a survey of partners. The priority health issues that rose to the top for 2017 were: behavioral health/substance use disorder/suicide; tobacco use; obesity; diabetes; access to care (tie); and cardiovascular disease (tie). The priority health issues did not change significantly from last year. With the exception of behavioral health, the current priority health issues align with the current priority health issues. More detailed survey results will be included in the updated Get Healthy Idaho to be released in January 2018. It will be brought to the IHC at either the January or February meeting for endorsement.
- Elke Shaw-Tulloch provided a high-level overview of the Healthy Connections Value Care Program with an emphasis on the Community Health Outcome Improvement Coalition (CHOICE). The CHOICE advisory groups will inform the Regional Care Organizations (RCOs) on quality improvement benchmarks and initiatives in clinic settings, support the medical-health neighborhood around the RCOs and clinical-community partnerships, and create regional health priority plans.

- The group discussed the process for finalizing the updated workgroup charter. The charter will be presented to the IHC at the December meeting for endorsement.
- Workgroup members provided reports of activities. The fourth crisis center will be opening in Boise on December 8. The Idaho Integrated Behavioral Health Network is working on their strategic plan and will be convening a large meeting in the spring 2018. The Farley Health Policy Center will be convening a meeting to discuss behavioral health integration into the health care system on November 9 in Boise. The Bureau of Rural Health and Primary Care, Division of Public Health, will be convening a Rural Health Conference in Boise on November 8. South Central Public Health announced their new Director, Melody Bowyer.
- **Next Steps:**
  - No PHWG meeting will be convened in December due to schedules. The next meeting of the PHW is January 3.